Care Spectrum Plus

COORDINATED CARE FOR ALL

Example: Risk-Based Patient Centered Interventions Table

The following tables are examples of suggested interventions for patients with diabetes, encounter types, frequency of encounter and suggested responsible staff.

Low Risk

Intervention	Type of contact	Timeframe	Care Team Member(s)
Lab Monitoring	• Reminder calls, medical record alerts and letter when labs are due (A1c, LDL, Micro albumin)	• A1c – at least every 6 months • LDL- annually • micro albumin - annually	• Care Navigator/ Referral Coordinator
Nurse Visit – Care Plan Assessment and Renewal	• Telephone, personal meeting or home visit	• Once every six months or when a change in risk has been identified	• RN Care Manager
Diabetes Screening Exams	• Reminder calls, medical record alerts, and letter when screening exams are due (eye exam, foot exam, dental exam, flu immunization)	• At least annually	• Care Navigator/ Referral Coordinator
Health Promotion Health Prevention	• Letter (birthday card) – age and gender appropriate (e.g., mammogram, cervical cancer screening, PSA)	• Annually	• Care Navigator/ Referral Coordinator
Wellness Counseling	Individuals are eligible for services of Wellness U		• Health Coach

Rising Risk

Intervention	Type of contact	Timeframe	Care Team Member(s)
Lab Monitoring – Abnormal Results	• Letter with lab results • Establish re-testing date • RN reviews with patient to Identify treatment or self-management barriers • Communicate and facilitate physician follow-up • Facilitate medication self-management education for medication changes or additions.	• Within 1 week of having lab test • Within 1 month • Within 14 days of having lab test • Within 1 week of having lab results • Within 2 days of medication change or addition	• Care Navigator/ Referral Coordinator • Pharmacist
Lab Monitoring - Standard	• Reminder calls, medical record alerts and letter when labs are due (A1c, LDL, micro albumin)	• A1c – at least every 6 months • LDL- annually • micro albumin annually	• Care Navigator/ Referral Coordinator
Medical Nutrition Therapy (MNT) (BP, LDL, and BMI)	• Refer to Medical Nutritionist • Identify motivation to change and create patient centered self-management plan • Communicate plan to care team members • Document nutritional self-management plan • Communicate progress and/or barriers when identified to care team for input to resolve	• Within 14 days of enrollment	• Primary Care Physician • Nutritionist
Healthy Lifestyle Management (BP, LDL, BMI, other identified lifestyle risk factors)	• Referral to Health Coach • Identify interests and readiness to make lifestyle improvements and generate patient centered care plan • Communicate plan to care team • Document lifestyle self-management plan • Communicate progress and/or barriers when identified to care team for input to resolve.	• Within 14 days of enrollment	• Health Coach
Nurse Visit – Care Plan Assessment and Renewal	• Telephone, personal meeting or home visit • Review self-management plan • Identify barriers to completing goals and revise plan • Communicate nurse interactions with care team	• Every physician visit • Every missed physician visit • Post any diabetes related ER or IP • Any known change in risk • Routine: At least once every quarter	• RN Care Manager
Diabetes Screening Exams	• Reminder calls, medical record alerts, and letter when screening exams are due (eye exam, foot exam, dental exam, flu immunization)	• At least annually	• Care Navigator/ Referral Coordinator
Health Promotion Health Prevention	• Letter (birthday card) – age and gender appropriate (e.g., mammogram, cervical cancer screening, PSA)	• Annually (birthday)	• Care Navigator/ Referral Coordinator
Wellness Coaching	Individuals are eligible for services of Wellness U		• Health Coach

High Risk

Intervention	Type of contact	Timeframe	Care Team Member(s)
Lab Monitoring – Abnormal Results	• Letter with lab results • Telephone or meeting: RN reviews with patient to Identify treatment or self-management barriers • Establish re-testing date • Communicate and facilitate physician follow-up • Facilitate medication self-management education for medication changes or additions.	• Within 1 week of having lab test • Within 1 week • Within 14 days of having lab test • Within 1 week of having lab results • Within 2 days of medication change or addition	• Care Navigator/ Referral Coordinator • Pharmacist
Lab Monitoring - Standard	• Reminder calls, medical record alerts and letter when labs are due (A1c, LDL, micro albumin)	• A1c – at least every 6 months • LDL- annually • micro albumin annually	• Care Navigator/ Referral Coordinator
Medical Nutrition Therapy (BP, LDL, and BMI)	• Refer to Nutritionist • Identify motivation to change and create patient centered self-management plan • Communicate plan to care team members • Document nutritional self-management plan Communicate progress and/or barriers when identified to care team for input to resolve	• Within 14 days of enrollment	• Primary Care Physician • Nutritionist
Healthy Lifestyle Management (BP, LDL, BMI, other identified lifestyle risk factors)	• Referral to Health Coach • Identify interests and readiness to make lifestyle improvements and generate patient centered care plan • Communicate plan to care team • Document lifestyle self-management plan Communicate progress and/or barriers when identified to care team for input to resolve.	• Within 14 days of enrollment	• Health Coach
Nurse Visit – Care Plan Assessment and Renewal	• Telephone, personal meeting or home visit • Review self-management plan • Identify barriers to completing goals and revise plan • Communicate nurse interactions with care team	• Every physician visit • Every missed physician visit • Post any diabetes related ER or IP • Any known change in risk • Routine: At least once a month until risk stratification reduces.	• RN Care Manager
Diabetes Screening Exams	• Reminder calls, medical record alerts, and letter when screening exams are due (eye exam, foot exam, dental exam, flu immunization)	• At least annually	• Care Navigator/ Referral Coordinator
Health Promotion Health Prevention	• Letter (birthday card) – age and gender appropriate (e.g., mammogram, cervical cancer screening, PSA)	• Annually (birthday)	• Care Navigator/ Referral Coordinator
Wellness Coaching	Individuals are eligible for services of Wellness U		• Health Coach