A note on definitions…

- **Care plan** is the comprehensive plan of services and other activities to achieve patient/family goals, and care planning is the process that generates a care plan ("plans of care" are time-limited or specialty/problem-focused parts of the overall care plan) (The CCD is an evolving data structure to transfer information about chronic conditions and does not yet provide for transferring a longitudinal care plan.)
- **Care Coordination** designates the processes that the care team uses to assure that the care plan is implemented across time and settings
- **Care Team** is either an organized group or ad hoc and includes patient and caregiver
- **Care Coordinator** is a role designating the person most responsible for care coordination (in addition to the responsibility that rests with the primary medical care provider). This is often a nurse or social worker for complex patients and a non-licensed team member for lower complexity patients, and may be employed by a community-based organization or a health system.
- **Care integration** is organization of the delivery system to bring medical care, behavioral health, and social/supportive services into close relationship for individual clients and for system function.

	Low Care Coordination Needs	High Care Coordination Needs	Intense Care Coordination Needs
Medicare Population with 2 or more chronic conditions	70% - chronic disease but doing well	25% - chronic disease, high risk of avoidable use	5% - high utilizers
Automated	Mostly this: reminders, care gap prompts, screening, etc.	Some reminders and prompts (more personal contact from rows below)	Automated prompts go to care coordinator and assistant
Non-licensed staff possible	Assessment for social changes or medical changes not yet picked up through system interaction	Assist care coordinator	Assist care coordinator
Professional staff, mostly Nurse or Social Worker	None	Goal setting, coaching to action, care transitions services, connecting w/non-medical services, supporting shared decisions, advance care planning, comprehensive care planning	As for high, plus: frequent interaction in various settings (home, etc.), problem solving

Care plan elements and relation to risk

	Life goals	Summary	Care gaps	Contact information	SMART goals	Action plans
All	Simple, default, e.g. "disability-free longevity" (though could include more)	• Problem list with **plan of care** for acute issues • Medications • Recent utilization • Risk score (low here) • Care Transitions	Age and gender preventive care Transition services	• Personal contact information • Emergency contact • PCP (if established)	• Exercise • Nutrition	Sick plans: who/where to call for injury or illness
Chronic disease, doing well	Simple, default, e.g. "disability-free longevity"; might be "get off certain meds"	***As above and*** • **Plan of care for** each chronic disease • attention to interactions	As above plus chronic disease services needed	***As above and*** • Health care team (PCP, specialist, etc.)	• Exercise • Nutrition • Adherence to medication and plans of care • Self care	Sick plans: red flags Action plans: how to respond to changes in chronic disease status

Complexity: risk of avoidable utilization – medical, functional &/or social issues	Likely to have more subtlety and help teams across continuum tailor care: e.g. #1 goal: I want to see daughter's wedding with clear mind	***As above and***
		• Recent utilization with **plan of care** to avoid
		• Services and supports
		• Functional status
		• Upcoming planned activity
		  • Visits/appointments
		  • Tests, procedures
		  • Pending referrals
			As above plus ensuring care plan elements such as services and supports are completed & addressed	***As above and***
				• More detail on office contacts 24/7 , care plan
				• Para-health care contacts (community organizations, etc)
				• Non-emergency contacts with role
					• Exercise
					• Nutrition
					• Adherence to medication and care plan
					• Preventive utilization
					• Self-care
						• Above, & Pre-planning visits
						•Action plans for likely complications and progression
						•Honest prognosis for function /survival
						•Advance care planning
						•Care Plan

Current High needs	Multiple goals likely, often personal. May change frequently as problems solved, or situation changes.	***As above and*** • Contributors to high utilization (e.g. homelessness, frail elderly w/o support, substance abuse,) with **plan of care** to mitigate • Longitudinal care plan	As above plus ensuring care plan elements present (e.g. action plan for COPD, financial contributors)	***As above and*** • More detail on home dwellers, other caregivers	• Housing, transport • Nutrition • Caregiver support • Adherence to medication • Preventive utilization • Responsible Care Coordinator	• Above, and • Planned response for urgent situation(e.g. if shows up in ER, call sister) • Regional service supply and quality management