Vanguard Medical Group: Risk Assessment Tool

Risk Assessment (Check all that apply)	Risk Specific Intervention	Assessor
Problem Medications (anticoagulants, insulin, aspirin & clopidogrel dual therapy, digoxin, narcotics)	○ Medication specific education provided to patient and caregiver (eg: warfarin/insulin/digoxin) ○ Medication review completed with each care coordination outreach call and on any transition of care ○ Updated medication list sent to patient ○ Medication management resources offered (eg: 28-compartment pill boxes and prescription packaging services)	
Psychological (+ depression screen , bipolar, malaise/fatigue dx, ED/IP BH, significant or progressive dementia)	○ Obtain ED Report or IP records ○ PHQ2 screening done at each office visit and documented in EHR ○ Assessment of need for behavioral health support; referred to practice-based provider or other in-network provider ○ Communication with local BH sites for acute IP and IOP referrals ○ Referrals for patient / caregiver dementia support (VMG Home Visit Program, United Way Caregivers Coalition, others)	
Principal diagnosis (Progressive Cancer, Stroke, Uncontrolled DM, COPD, CHF, ESRD /Dialysis, Cirrhosis, Seizure, New Afib, PE, Smoker, Falls)	○ Outreach in 2 business days for IP d/c; Q1-4 wks for VHR management; Q4-12 wks for HR management ○ Follow up appointment w/ PCP for TOC within 7 calendar days ○ Action Plans for disease specific education (eg: diabetes, HTN, CHF, weight management, tobacco cessation); action plan reviewed with patient/caregivers regarding what to do in the event of worsening or new symptoms ○ Discuss goals of care and chronic illness model with patient/caregiver ○ Coordinate specialist visits and have those evals and outside testing/procedure notes sent to office	
Polypharmacy (>=5 routine Rx meds)	○ Elimination of unnecessary medications ○ Simplification of medication scheduling to improve adherence ○ Follow up care coordination outreach at regular intervals which includes medication review	
Poor health literacy (inability to do Teach Back)	○ Outreach to caregiver to collaborate on patient-specific plan of care ○ Referral to VMG Home Visit Program ○ Link to community resources for additional patient/caregiver support (eg: geriatric care managers, social worker)	
Patient support (absence of a caregiver to assist w/discharge & care; VMG Home Visit Program)	○ Collaborate w/ case manager in facility to create safe d/c plan ○ Follow up appointment w/ PCP for TOC within 7 calendar days; Referral to VMG Home Visit Program ○ Outreach in 2 business days for IP d/c; Q1-4 wks for VHR management; Q4-12 wks for HR management ○ Confirm providers of home care services are activated with initial assessments scheduled within 3 days of IP d/c ○ Link to community resources for additional patient support (eg: geriatric care managers, social worker)	
Hospitalization (>/= 1x/non-elective in last 6 months; ICU in last year)	○ Review reasons for hospitalization to identify preventable issues (eg: poor medication adherence; lack of care support) ○ Outreach in 2 business days for IP d/c; follow up appointment w/ PCP for TOC within 7 calendar days ○ Coordinate specialist visits; evals, outside testing/procedure notes sent to office ○ Obtain hospital abstract for PCP	
Palliative care (Is the patient at a higher risk of dying within the next year, or, does this patient have an advanced or progressive serious illness?)	○ Assess needs for palliative care services; make referrals in collaboration w/ PCP ○ Integrate Five Wishes and POLST documents into workflow ○ Identify services or benefits available to patients based on advanced disease status ○ Referral to VMG Home Visit Program ○ Assess if BH services can be supportive	

Hi Risk Stratification Codes for EMR System

ICD9	Description	Name for Problem List	Target Score
799.91	Very High Risk Patient	VHR Health Management	7 or Above
799.92	High Risk Medical	HR Health Management	4-6
799.93	High Risk for 30 days S/P Hospital Stay	HR Hospitalization <30 Days	4-6
799.94	High Risk Due to Behavioral Health	HR Behavioral Health	4-6
799.95	High Risk Due to Social Frailty	HR Social	4-6

Risk Scoring: Add 1 point for each category with a positive response except for Principal Diagnosis. In Principal Diagnosis, add 1 point for *each diagnosis in that category.*

Very High Risk (7 and Above): May range from restoring health to only providing comfort care. CC interventions and team-based care includes:

- Care levels may include: IP, rehab, long-term care, hospice/palliative care
- Individualized intensive health care management and coordination including needs of family/caregiver
- Support groups for patient/family
- Links to community resources in the medical neighborhood including treatment, care, referrals as appropriate, VNA
- Exchanging information w/ other health care providers on regular basis

High Risk (4-6): T**o treat disease state(s), avoid serious complications, and minimize disability. CC interventions and team-based care includes:**

- Preventive screenings and immunizations
- Patient education including self-management skills or specialty programs (DM clinics); group visits
- Health risk assessment every 3-6 months w/ interventions for unhealthy lifestyle/habits
- Links to community resources in the medical neighborhood including treatment, care, referrals as appropriate, VNA
- Exchanging information w/ other health care providers on regular basis

Medium Risk (2-3): To prevent onset of disease or treat disease to avoid complications. CC interventions and team-based care includes:

- Preventive screenings and immunizations
- Patient education including self-management skills or specialty programs (DM clinics); group visits
- Health risk assessment every 6-12 months w/ interventions for unhealthy lifestyle/habits
- Links to community resources in the medical neighborhood including treatment, care, referrals as appropriate
- Exchanging information w/ other health care providers on regular basis