### Vanguard Medical Group: Risk Assessment Tool

<table>
<thead>
<tr>
<th>Risk Assessment (Check all that apply)</th>
<th>Risk Specific Intervention</th>
<th>Assessor</th>
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</table>
| **Problem Medications** (anticoagulants, insulin, aspirin & clopidogrel dual therapy, digoxin, narcotics) | o Medication specific education provided to patient and caregiver (eg: warfarin/insulin/digoxin)  
 o Medication review completed with each care coordination outreach call and on any transition of care  
 o Updated medication list sent to patient  
 o 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) | o Obtain ED Report or IP records  
 o PHQ2 screening done at each office visit and documented in EHR  
 o Assessment of need for behavioral health support; referred to practice-based provider or other in-network provider  
 o Communication with local BH sites for acute IP and IOP referrals  
 o 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) | o Outreach in 2 business days for IP d/c; Q1-4 wks for VHR management; Q4-12 wks for HR management  
 o Follow up appointment w/ PCP for TOC within 7 calendar days  
 o 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  
 o Discuss goals of care and chronic illness model with patient/caregiver  
 o Coordinate specialist visits and have those evals and outside testing/procedure notes sent to office |  |
| **Polypharmacy** (>=5 routine Rx meds) | o Elimination of unnecessary medications  
 o Simplification of medication scheduling to improve adherence  
 o Follow up care coordination outreach at regular intervals which includes medication review |  |
| **Poor health literacy** (inability to do Teach Back) | o Outreach to caregiver to collaborate on patient-specific plan of care  
 o Referral to VMG Home Visit Program  
 o 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) | o Collaborate w/ case manager in facility to create safe d/c plan  
 o Follow up appointment w/ PCP for TOC within 7 calendar days; Referral to VMG Home Visit Program  
 o Outreach in 2 business days for IP d/c; Q1-4 wks for VHR management; Q4-12 wks for HR management  
 o Confirm providers of home care services are activated with initial assessments scheduled within 3 days of IP d/c  
 o 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) | o Review reasons for hospitalization to identify preventable issues (eg: poor medication adherence; lack of care support)  
 o Outreach in 2 business days for IP d/c; follow up appointment w/ PCP for TOC within 7 calendar days  
 o Coordinate specialist visits; evals, outside testing/procedure notes sent to office  
 o 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?) | o Assess needs for palliative care services; make referrals in collaboration w/ PCP  
 o Integrate Five Wishes and POLST documents into workflow  
 o Identify services or benefits available to patients based on advanced disease status  
 o Referral to VMG Home Visit Program  
 o Assess if BH services can be supportive |  |

Adapted from Society of Hospital Medicine TARGET Tool and AAFP Risk-Stratified Tool  
VMG Risk Assessment Tool: Updated 1/20/2016
Hi Risk Stratification Codes for EMR System

<table>
<thead>
<tr>
<th>ICD9</th>
<th>Description</th>
<th>Name for Problem List</th>
<th>Target Score</th>
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<tbody>
<tr>
<td>799.91</td>
<td>Very Hi Risk Patient</td>
<td>VHR Health Management</td>
<td>7 or Above</td>
</tr>
<tr>
<td>799.92</td>
<td>High Risk Medical</td>
<td>HR Health Management</td>
<td>4-6</td>
</tr>
<tr>
<td>799.93</td>
<td>High Risk for 30 days S/P Hospital Stay</td>
<td>HR Hospitalization &lt;30 Days</td>
<td>4-6</td>
</tr>
<tr>
<td>799.94</td>
<td>High Risk Due to Behavioral Health</td>
<td>HR Behavioral Health</td>
<td>4-6</td>
</tr>
<tr>
<td>799.95</td>
<td>High Risk Due to Social Frailty</td>
<td>HR Social</td>
<td>4-6</td>
</tr>
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**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):** To 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