UC San Diego Health
ACCOUNTABLE CARE NETWORK™

Risk Assessment Tool & Referral Form

To be completed by provider and Faxed to Population Health Care Team for Follow Up: fax 858-249-0762

ACO Beneficiary / Patient Name: _____ Best Patient Tel Number: _____ Pt DOB:_____ Today's Date: _____

Referring Provider:_____ Office / Cell Tel Number: _____

Risk Assessment Tool to help identify and refer patients who are high risk for hospitalizations/ ED visits to Population Health Care Team.
Based on Project BOOST 8 P's - http://www.hospitalmedicine.org/BOOST/

Please note: this is the foundation of the UCSDH Home Grown Risk Score that providers who have Epic or Epic Link View access will see. This tool is for those providers who do not have Epic or Epic Link View Access and need a guide to help understand what care management (CM) interventions a patient might benefit from and when to reach out to the Population Health Care Team.
Fax: **858-249-0762** or Direct ACO line: **844-827-3264**. For questions that are not answered on this form please contact Marilyn Obee at mobee@ucsd.edu,

Patient Risk Factor Check List, check or circle all that apply:	Question to Consider:	Referral & Intervention Considerations / Options	Comments for CM team
○ Prior hospitalization in the last 3 months or ED visits in the last 2 months	In your opinion / or patient's opinion, could something have been done proactively to mitigate the ED / hospitalization? Does this patient need help navigating appointments?	Refer patient to UCSDH Population Health Care Team for outreach. Consider Home Health referral, if patient is agreeable.	
○ Poor health literacy	Does the patient / family need reinforcements to better understand healthy habits / medical management? Is there a new condition that requires additional learning/behavior reinforcement?	Refer patient to UCSDH Population Health Care Team for outreach.	
○ Poor social support at home that impacts patient health management	Does the patient lack support at home. Would need social services, IHSS worker, home safety evaluation be of benefit? If you feel that without support, patient will end up inpatient, call / fax UCSD CM team	Refer patient to UCSDH Population Health Care Team. Consider Home Health referral.	
○ Principle diagnosis that is high risk and is **not managed** or is **poorly managed** (for example: COPD, HF, Hypertension, DM, (or multi co-morbidities)	Patient needs frequent reminders for health maintenance and coaching	Refer patient to UCSDH Population Health Care Team for outreach.	
○ Psych concerns / complications impacting engagement in health management	Patient has mild to moderate psych concerns causing family or patient concern. Would SW help reinforce / coach / engage patient in Behavioral health follow up care?	Refer patient to UCSDH Population Health Care Team for outreach. Consider psych evaluation / referral, if appropriate	
○ Poly pharmacy (>8 RX meds) or problem meds (for example hypoglycemic meds, anticoagulants, opioid use, high cost concerns)	Does patient appear to struggle with medication adherence? Would home medication management, medication reconciliation help? Are you concerned that patient is not following your orders / not taking medications or not taking them correctly?	Refer patient to UCSDH for Pharmacy and Population Health Care Team.	
○ Physical dysfunction / deterioration	Is patient a high fall risk? Is patient frail, weak need intense rehab for increased strength? Does patient need short term nutritional support? Is dysfunction due to meds?	Refer to Home Health and UCSD Population Health Care Team for outreach. Refer to SNF under 3-day waiver if patient meets short-term SNF criteria: has rehab potential, needs short term nutrition support, and /or brief health management to stabilize condition.	
○ Palliative care/hospice	Patient has poorly managed pain or could pass in 6 months? Patient would benefit from symptom management?	Refer to Palliative Program. Refer UCSDH Population Health Care Team for outreach.	