Practice Policy & Guidelines

Policy: Identifying High Risk Patients	Developed by:	Approved by:
Updated:	Signature:	Signature:

PURPOSE:
To identify patients with chronic or acute conditions or other risk factors who may benefit from care management.

GOALS AND OBJECTIVES:
The practice uses a practice management system/EHR that identifies patients by ICD 10 codes that are utilized by at-risk patients, such as asthma, diabetes, ADHD and other behavioral conditions, congenital heart disease, prematurity, patients with other complex conditions. Next, the practice will set the criteria to include patients with these diagnoses who also had other risk factors such as, non-adherence with appointments or medications, frequent emergency room (ER) visits or hospitalizations, social determinants of health (ie. [family] psychosocial status, lack of social or financial support that impedes the ability for care), referrals (by outside organizations, practice staff, family/caregiver), or attendance at medical daycare. Identified patients will be assigned to a care coordinator or nurse for additional support and care management.

RESPONSIBILITY:
Care coordinator or nurse

DETAILS:
The care coordinator will run a report to identify high risk patients by the end of each quarter based on the criteria listed above. Once the high-risk patients are identified, they will be assigned to a care coordinator or nurse for ongoing support and care management. The care coordinator or nurse will make contact with the patient/family to introduce themselves as a point of contact at the practice. The care coordinator or nurse will identify the highest risk patients and discuss any special accommodations with the primary care physician (eg. Longer appointment times, direct phone numbers for emergency use, etc), and will share this information with the patient/family.

The care coordinator or nurse will track care received both within the practice and at outside facilities for their assigned cohort of patients. At minimum, cases will be reviewed by the end of each month to determine whether there are any outstanding follow-up items or care needs that should be addressed, or whether patients/families no longer require ongoing care management support.

MONITORING:
The practice administrator monitors compliance to this policy by conducting a sample retrospective analysis of patient charts and documentation completion every 6 months. This data is shared with providers.

This policy shall be reviewed at least every 2 years.

Approved Date: _____/_____/_____

APPROVALS:

Physician Partner: ___________________________ Date: _____/_____/_____

Administrative Partner: ______________________ Date: _____/_____/______

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