Mercy Adult Risk Stratification Tool							
Risk Level:		**Evaluated by:**	**Evaluation Date:**		**Last Evaluation Date:**		
Patient Name:			**Provider**		**Last Risk Level:**		
Age:		**DOB:**					
Risk Stratification Level: **Score**		**Risk 1:** 0-1	**Risk 2:** 2-3	**Risk 3:** 4-6	**Risk 4:** 7-9	**Risk 5:** 10-13	**Risk 6:** 14-18
Care Planning		**LOW**		**MODERATE**		**HIGH**	**EXTREMELY HIGH**

	SCORE	0	1	2	SCORE
1	**AGE**	19 TO 64 years	65 to 79 years	80 years or older	
2	**HOSPITALIZATIONS** (last 12 months)	0 TO 1	2	3 OR MORE	
3	**ER VISITS** (last 12 months)	0 TO 1	2	3 OR MORE	
4	**ALL OFFICE VISITS** (last 12 months) exclude OB visits	1 TO 2	3 TO 6	7 OR MORE	
5	**CURRENT PRESCRIPTION MEDICATION** (including oxygen)	0-2 medications	3-5 medications	6 or more medications	
6	**LANGUAGE/HEALTH LITERACY**	• Primary language: English • Carries out plan of care • Demonstrates understanding of health care needs • Independently seeks health information	• Limited English: verbal skills • Hearing impaired • Carries out some of the plan of care • Requires some reinforcement	• Requires interpreter for all practice interactions • Not able to carry out plan of care without continued reinforcement • Requires routine reinforcement or education	
7	**CHRONIC DISEASE** (does not include mental health dx)	• No chronic disease • AT RISK: pre-diabetes, borderline hypertension • Non-smoker • BMI 18.5-25	• 1-3 chronic disease diagnoses • 1-15 years tobacco use history • BMI <18.5 or >25	• 4 or more chronic disease diagnoses • 15+ years tobacco use history • BMI >35	
8	**CHRONIC DISEASE QUALIFIER**	NA	1 or more chronic disease diagnoses uncontrolled	1 or more chronic disease diagnoses, severely uncontrolled	
9	**MENTAL & BEHAVIORAL HEALTH** (includes but not limited to: dementia, substance abuse, autistic disorders, eating disorders, developmental delays)	• No mental health diagnoses • Long-term stability demonstrated with medication	• 1-2 mental health diagnoses • Routine follow-up with provider and/or mental health provider • 1-2 significant life stressors (divorce, death, job loss, moving, etc.)	• 3 or more mental health diagnoses • 3 or more significant life stressors (divorce, death, job loss, moving, etc.)	
10	**MENTAL & BEHAVIORAL HEALTH QUALIFIER**	NA	1 or more mental health diagnoses uncontrolled	1 or more mental health diagnoses, severely uncontrolled	
11	**SOCIAL DETERMINATION & SELF-MANAGEMENT**	• Steady income • Independent • Stable residency • Family or other support • Adequate medical insurance	• Receives some support to meet social needs • Some medical insurance • Lives alone needs some assistance with ADLs	• Lives in a nursing home or assisted living or hospice • Homeless • Unsafe home environment • Unemployed • Lack of financial or family support that impacts care • Transportation barrier • No medical insurance	
Comments:					
Complex Care Coordinator Referral (Please circle)		**YES**	**NO**		

Identifying Disease Burden and Determining Health Risk Status

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Question	Is the patient healthy, with no chronic disease, or significant risk factors?	Is the patient healthy, but at risk for a chronic disease, or has other signifi-cant risk factors?	Does the patient have one or more chronic diseases, with significant risk factors, but is stable or at desired treatment goals?	Does the patient have one or more chronic diseases, with significant risk factors, and is unstable or not at treatment goal(s)?	Does the patient have multiple chronic diseases, with significant risk factors, complications, and/or complex treatment(s)?	Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?
Category	PRIMARY PREVENTION	PRIMARY PREVENTION	SECONDARY PREVEN-TION	SECONDARY PREVENTION	TERTIARY PREVENTION	CATASTROPHIC CARE
Goal	GOAL: To prevent onset of disease (Low Resource Use)	GOAL: To prevent onset of disease (Low Resource Use)	GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)	GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)	GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)	GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)

Level 1 — PRIMARY PREVENTION
GOAL: To prevent onset of disease (Low Resource Use)

CARE PLAN SUGGESTIONS
- Preventive screenings and immunizations
- Patient education
- Health risk assessment (annual)
- Appropriate monitoring for warning signs

Level 2 — PRIMARY PREVENTION
GOAL: To prevent onset of disease (Low Resource Use)

CARE PLAN SUGGESTIONS
- Preventive screenings and immunizations
- Patient education and engagement
- Health risk assessment (annual)
- Appropriate monitoring for warning signs
- Interventions for un-healthy lifestyle/habits
- Links to community resources to enhance patient education, self-management skills, or special facilities

Level 3 — SECONDARY PREVENTION
GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)

CARE PLAN SUGGESTIONS
- Preventive screenings and immunizations
- Patient education and engagement
- Health risk assessment (semi-annual)
- Appropriate monitoring for warning signs
- Interventions for un-healthy lifestyle/habits
- Links to community resources to enhance patient education, self-management skills, or special facilities

TEAM/PLANNED CARE
- Group visits
- Home self-monitoring
- Links to the medical neighborhood for care management, coordina-tion of care, treatments, communication, and exchange of information with other providers and health care settings

Level 4 — SECONDARY PREVENTION
GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)

CARE PLAN SUGGESTIONS
- Preventive screenings and immunizations
- Patient education and engagement
- Health risk assessment (semi-annual)
- Appropriate monitoring for warning signs
- Interventions for unhealthy lifestyle/habits
- Links to community resources to enhance patient education, self-management skills, or special facilities

TEAM/PLANNED CARE
- Group visits
- Home self-monitoring
- Links to the medical neighbor-hood for care management, coordination of care, treat-ments, communication, and exchange of information with other providers and health care settings
- Health coach
- Referrals, as appropriate

Level 5 — TERTIARY PREVENTION
GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)

CARE PLAN SUGGESTIONS
- Preventive screenings and immunizations
- Patient education and engage-ment
- Health risk assessment (quarterly)
- Appropriate monitoring for warning signs
- Interventions for unhealthy lifestyle/habits
- Links to community resources to enhance patient education, self-management skills, or special facilities

TEAM/PLANNED CARE
- Group visits
- Home self-monitoring
- Links to the medical neighbor-hood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings
- Health coach/personalized care plan/management and resources
- Referrals, as appropriate
- Home health

Level 6 — CATASTROPHIC CARE
GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)

CARE PLAN SUGGESTIONS
- Hospitalization
- Rehabilitation
- Long-term care
- Hospice/palliative care

TEAM/PLANNED CARE
- Support groups
- Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings
- Health coach/care management
- Referrals, as appropriate
- Home health
- Personalized intensive care plan/ management and resources