Risk Assessment, Goals, and Interventions Tracker New Features - OP 21.3.46

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About

Tracking risk factors, including social determinants of health (SDOH) can be an important part of monitoring a child and family's overall well-being. This article will go over the following new features in OP:

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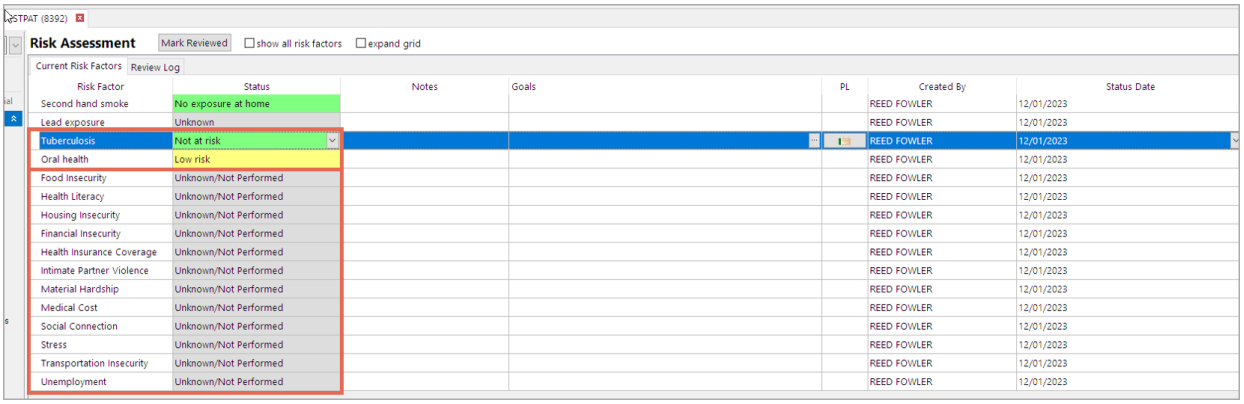
Patient Risk Assessment

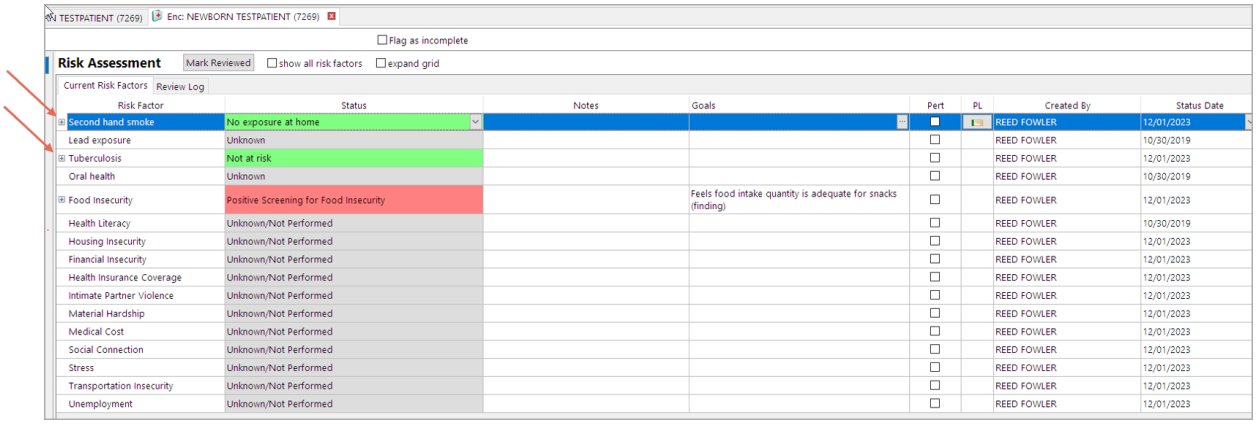
The current Risk Assessment area of the chart (**Clinical** > **Risk Assessment**) permits practices to assess multiple risk factors, including social determinants of health. Here you can see that a patient has been assessed as **not being at risk** for tuberculosis (green), while their oral health (yellow) is marked as **low risk**. Other risk factors which have not been assessed appear as **Unknown/Not Performed** and are colored grey:



Which Risk Factors display in any given patient's chart depend on the patient's age, sex, and how the practice has set up the Risk Assessment tool. See Risk Assessment Editor below.

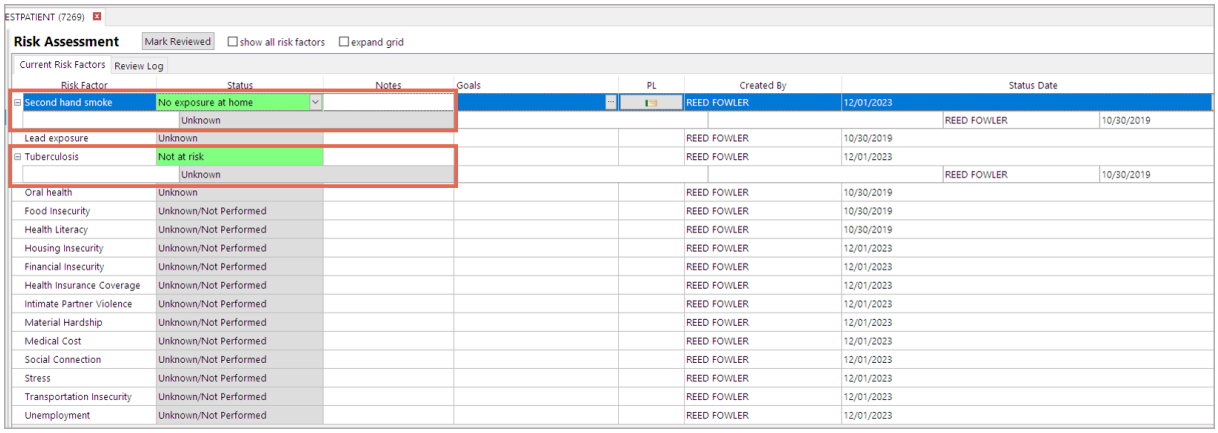
Risk Status and Historical Data

A patient's risk factors can change over time. For example, a patient might go from Unknown Lead Exposure to High Risk to Low Risk again. The visible Status is the **current/most recent Status**. But to see how a patient's risk factors have changed, click the **+ button** (expand) at the left:



Underneath, you can see **historical data** for a given Risk Factor, as well as the **date** on which a change was made and **who** made the change.

- In the example below, the current status of Second hand smoke is No exposure at home, which user Reed Fowler set as current on 12/1/23. But prior to that, the risk status was Unknown, and it had been Unknown since user Reed Fowler first opened the chart on 10/30/2019:

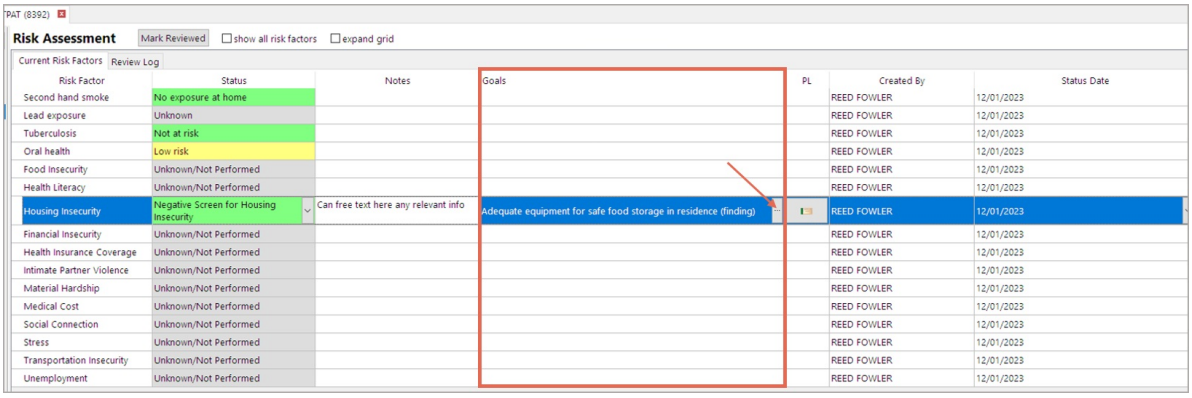


Note that a user might flip a Status of a risk factor several times during a calendar day, during the process of editing. Therefore, **historical changes only appear if they existed for at least one calendar day**

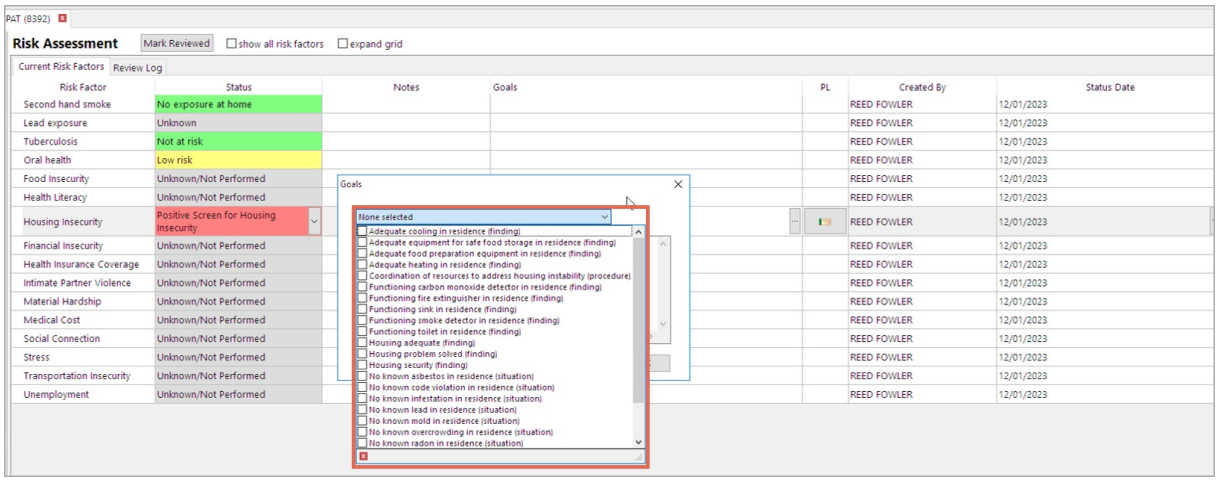
- For example, let's say a user opens a chart with a status of High Risk. The user changes the status to Low Risk that day, and then, before the day is over, changes the status to Medium Risk. Because the Low Risk status was not in place for an entire calendar day -- just a few minutes or hours -- the Low Risk status will not appear in the historical area. The current status will now be Medium Risk, and the only historical status visible will be the prior High Risk status.

Goals

Some Risk Factors have a menu of target **Goals** associated with them. The clinician and patient may set goals for certain risk factors, and the goals can be documented here. Goals may be set **irrespective of the Risk Factor status**; that is, even a patient who is Not at risk or Low risk for a risk factor may have Goals documented.



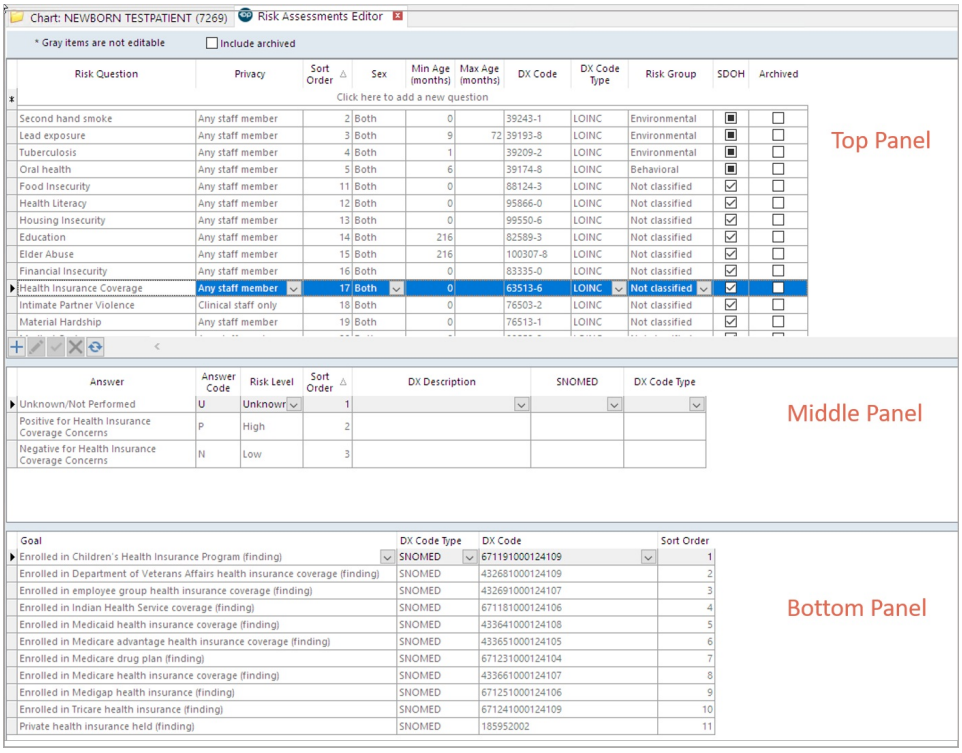
Specific goals may be accessed via dropdown by clicking the**ellipsis button** found on the right side of the Goals column (see above image). The user may click **any** or **all** of the **options listed**, as appropriate. These options are fixed, based on USCDI version 2 value set definitions new USCDI v2 requirements but individual users may still**free text customized information into the Notes field**.



Prior Goals and Notes are also trackable in**historical Risk Factor +** dropdowns, as described above.

Risk Assessment Editor

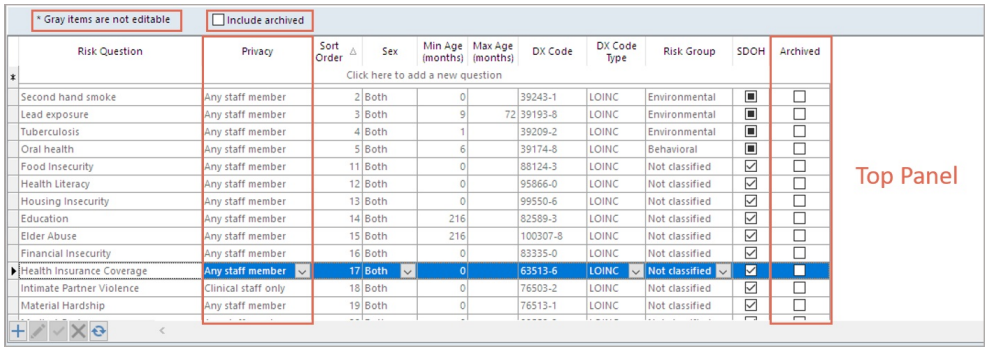
A practice can customize their Risk Assessment tool in**Clinical** > **More** > **Risk Assessments**. Here are the three panels available in the Risk Assessment Editor setup screen:



Top Panel - Risk Assessment Editor

In the **Top Panel**, a user can assess what risk assessments the practice wants to track ("Risk Questions"), along as set sex and age specifications, and any applicable SNOMEDs, ICDs, or LOINCs.

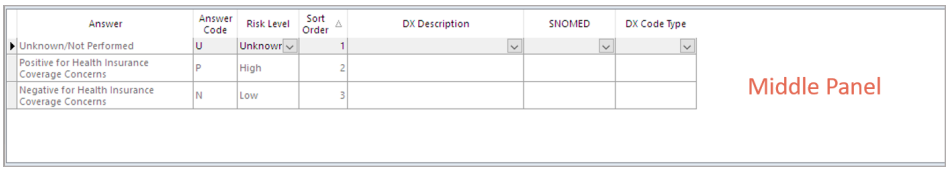
- Several **new SDOH** have been added as part of OP 21.3.45, including **health insurance coverage**, **intimate partner violence**, **unemployment**, **medical cost**, and **stress**. These items have been marked with a **Privacy level** of Any staff member, except for Intimate Partner Violence, which is marked as Clinical staff only.
- Note that some items (colored grey) are **not editable**; these are part of OP's **required minimum reporting** and cannot be amended so that certain EMR-required elements do not "break." If you have a good use case for changing a greyed-out element, see **Adding Risk Items**, below.
- If a practice does not want to see any particular Risk Question in its patients' Risk Assessment screen, the practice may click the **Archived** button on the right side of the screen to hide the Risk Question from all charts. In order to see previously archived Risk Questions, the user can check the **Include archived checkbox** at the top of the window.



Middle Panel - Risk Assessment Editor

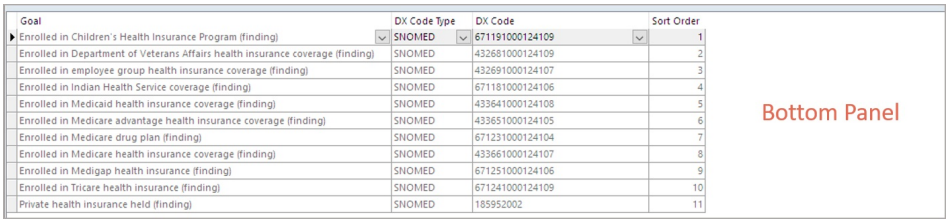
In the **Middle Panel**, the user can see specific dropdown choices, or Risk **Answers**, for each risk assessment item, and how they are coded.

- If the user created the Risk Question, the user can also add/edit the Risk Answers found here.
- Adding SNOMEDs or LOINC codes may help your practice with quality reporting, but is not required.



Bottom Panel - Risk Assessment Editor

Finally, the **Bottom Panel** contains **Goals** options for that particular Risk Question. A user can choose specific Goals as needed for a particular patient in the patient's Risk Assessment window, as described above.



Adding or Editing Risk Items

Basic instructions for customizing the Risk Assessment tool can be found at Add Risk Questions and Responses.

In some cases, a practice might need to alter or edit an existing risk question, risk answer, or risk goal set. User-created questions, answers, and goals are always editable. If a practice needs to alter a greyed-out Risk Factor, the practice should create their own "cloned" copy of the Risk Question and Risk Answer set, then archive the original unalterable risk question.

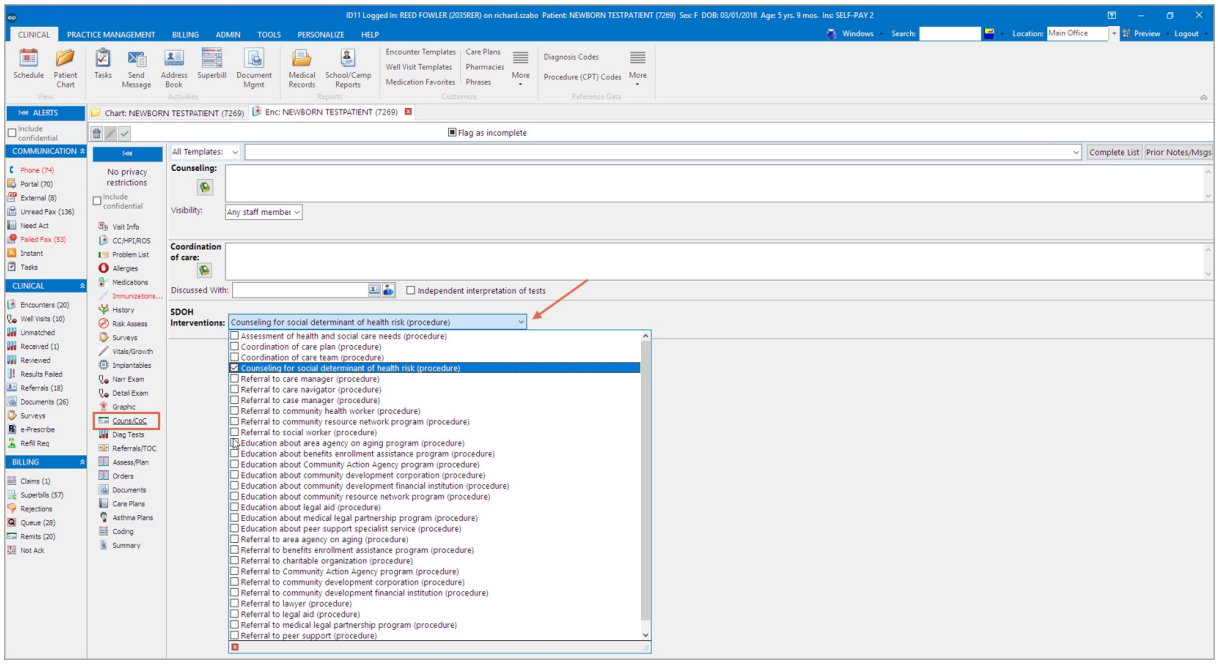
Social Determinants Interventions During Visits

Sometimes, as part of a visit, a clinician might institute interventions for particular risk factors. For example,

- A patient who has been screened for food insecurity and is positive might get a referral to the local food bank.
- The family of a patient with complex medical needs might be referred to a local nonprofit respite care service.

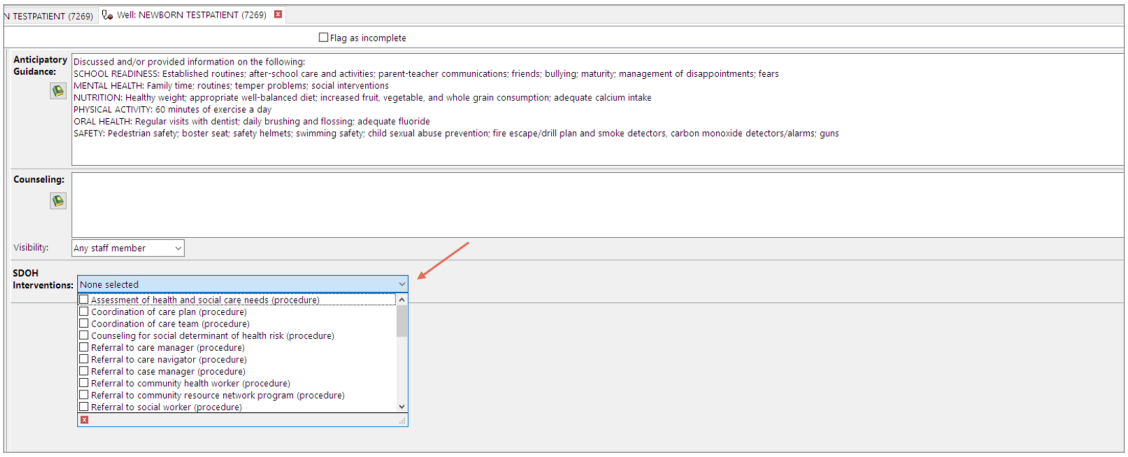
Encounter Note

In an **Encounter Note**, a practice can enter SDOH interventions in a structured way from the SDOH Interventions dropdown in the **Couns/CoC** tab:



Well Visit Note

In **Well Visit Notes**, the parallel location for documenting SDOH interventions is in the **AG/Counseling** tab:

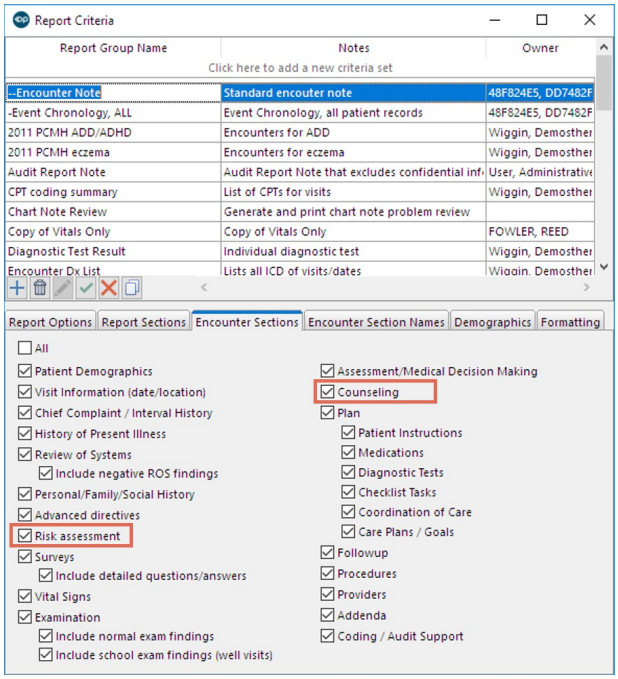


The list of dropdowns is not exhaustive and is predetermined by the USCDI version 2 requirements. That said, if a clinician wants to free-text additional information about the intervention or referral, he/she may do so in the Counseling field above the SDOH Interventions dropdown.

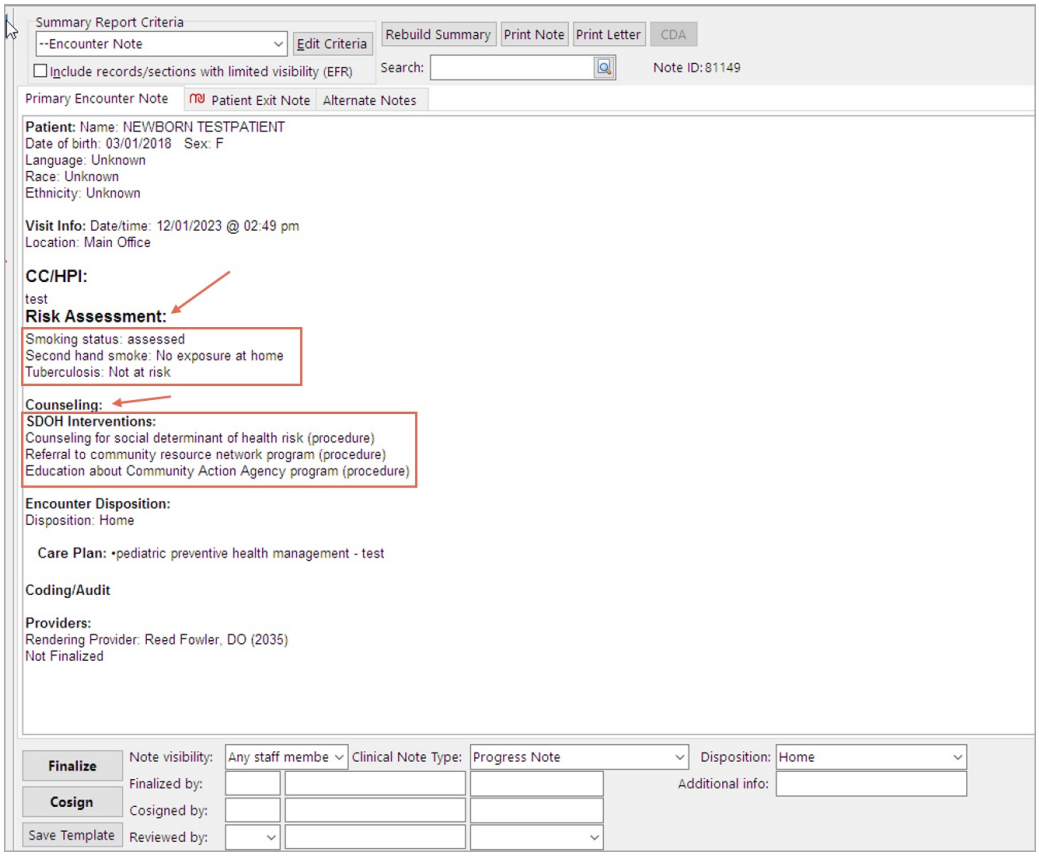
Note Summary - Include Risk Assessment and SDOH Interventions

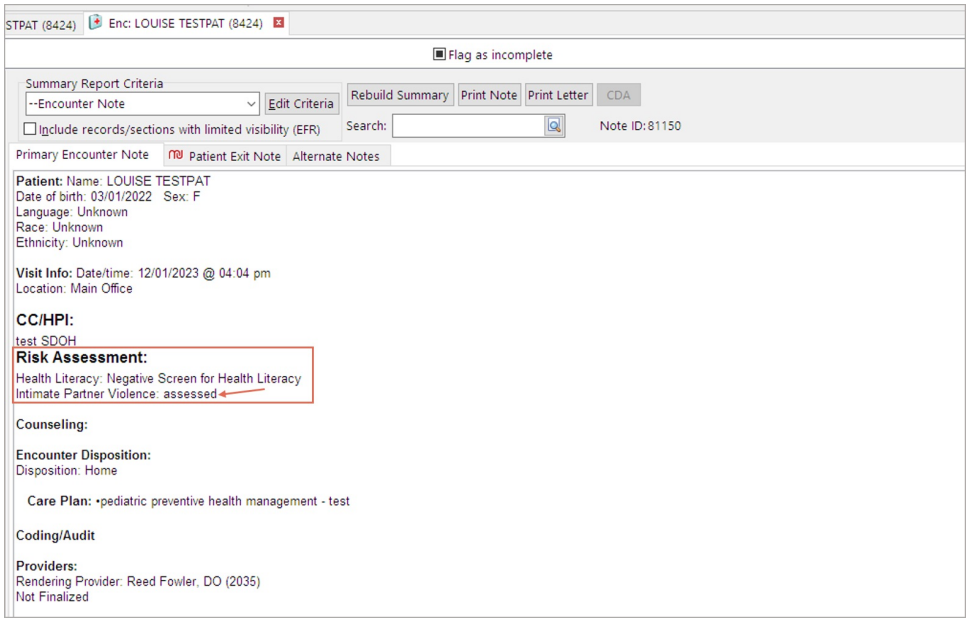
To have the Risk Assessments and SDOH interventions both appear in **Note Summaries:**

1. Navigate to **Report Criteria**.
2. Select the **Risk assessment** (shows Risk Assessments) and **Counseling** (shows SDOH interventions) checkboxes.



Risk Assessment items appear under the **Risk Assessment** header, and **SDOH Interventions** appear as a subheader under the **Counseling** header:



Notes: Risk Questions in Note Summary

- Only Risk Questions for which the **Risk Answer have changed** appear in the **Risk Assessment** section.
  - This means that clicking the Mark Reviewed button in a patient's Risk Assessment does not cause the entire list of reviewed Risk Questions to appear here.
- Risk Questions with a **privacy level of Clinical staff or higher** will show that they were **assessed**, but the specific Risk Answer will not show.
  - For example, this is how a patient whose **Intimate Partner Violence** screen was marked positive would show in the summary (and only if the Risk Assessment checkbox in Report Criteria was checked, as described above):