

## PATIENT ACUITY RUBRIC



SILVER CITY HEALTH CENTER

Patient Name \_\_\_\_\_

Provider \_\_\_\_\_

DOB \_\_\_\_\_

Evaluation Date \_\_\_\_\_

CATEGORY	CRITERIA		
	0	1	2
<b>Social</b>	<ul style="list-style-type: none"> <li>Steady income</li> <li>Independent</li> <li>Stable residency</li> <li>Family or other support system</li> <li>Adequate medical insurance coverage</li> </ul> <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Able to meet some of social needs with help of family/others or some form of income</li> <li>Some medical insurance coverage</li> </ul> <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Requires multiple provider interventions for social situation</li> <li>Minimal to no resources available for social needs</li> <li>Completely dependent on others for basic social needs</li> <li>No insurance coverage</li> </ul> <input type="checkbox"/>
<b>Language</b>	<ul style="list-style-type: none"> <li>Consistent with provider</li> </ul> <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Some ability to communicate in provider's language</li> </ul> <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Needs interpreter for all interactions with provider</li> </ul> <input type="checkbox"/>
<b>Health Literacy</b>	<ul style="list-style-type: none"> <li>Appropriate demonstration of understanding of health care needs</li> <li>Explores health information independently</li> </ul> <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Moderate understanding of health care needs</li> <li>Requires some routine provider reinforcement</li> </ul> <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Demonstrates minimal understanding of health care needs</li> <li>Requires routine reinforcement and explanation</li> </ul> <input type="checkbox"/>
<b>Ability to Self Manage</b>	<ul style="list-style-type: none"> <li>Minimal provider intervention to carry out plan of care</li> <li>Demonstrates self management (example: blood sugar log presented each visit with appropriate home testing regimen)</li> </ul> <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Somewhat able to carry out plan of care</li> <li>Requires some provider intervention and reinforcement</li> </ul> <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Repeated provider reinforcement and intervention required</li> </ul> <input type="checkbox"/>

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CATEGORY	CRITERIA		
	0	1	2
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>• No mental health issues <u>or</u></li> <li>• Long term stability demonstrated</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>	<ul style="list-style-type: none"> <li>• Has mental health issues but is under the routine care of a mental health care provider</li> <li>• Requires some provider intervention</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>	<ul style="list-style-type: none"> <li>• Has mental health issues not adequately controlled</li> <li>• Multiple and repeated provider intervention and support</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>
<b>Chronic Illnesses</b>	<ul style="list-style-type: none"> <li>• No chronic illnesses <u>or</u></li> <li>• Long term stability demonstrated</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>	<ul style="list-style-type: none"> <li>• Has chronic illness(es), which</li> <li>• Requires <i>some</i> provider intervention (i.e. specialist referrals, frequent monitoring, etc.)</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>	<ul style="list-style-type: none"> <li>• Has chronic illness(es) not adequately controlled</li> <li>• <i>Multiple and repeated</i> provider intervention and support</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>
<b>Chronic Medications</b>	<ul style="list-style-type: none"> <li>• 0-1 or OTC</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>	<ul style="list-style-type: none"> <li>• 2-4</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>	<ul style="list-style-type: none"> <li>• <math>\geq 5</math> <u>or</u></li> <li>• High risk medications</li> </ul> <div style="text-align: right;"><input type="checkbox"/></div>
<b>Comments</b>			

<b>Scores:</b>	
Social	_____
Language	_____
Health Literacy	_____
Self Manage	_____
Mental Health	_____
Chronic Illnesses	_____
Chronic Meds	_____
<b>Total</b>	_____

Interpretation of Total Score		
Point Range	Acuity	Category
0 – 4	Low	<b>A</b>
5 – 8	Medium	<b>B</b>
$\geq 9$	High	<b>C</b>
$\geq 9$	High, Co-manage	<b>C1</b>

**Patient's Acuity Category** \_\_\_\_\_