

# APPENDIX 7



## MEMORANDUM

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**Date** : August 16, 2013

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**To** : Chief Executive Officers  
Chief Medical Executives

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**From** : STEVEN RITTER, D.O., Deputy Director, Medical Services

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**Subject** : Patient Clinical Risk Reconciliation Process

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The Medical Classification Chrono (128-C3) is an essential communication tool used in the transfer process by Custody staff to inform placement of an inmate at the appropriate institution. Given the recent court order related to coccidiomycosis (cocci) risk and need to transfer large numbers of patients out of institutions located in the hyperendemic areas of cocci risk, and the opening of the California Health Care Facility (CHCF), it is even more critical that the 128-C3 is accurately completed in a timely manner prior to patient transfer to another institution.

A recent audit comparing medical risk designations on the 128-C3 chrono and the automated patient registries continue to show discrepancies and inaccuracies as our facilities address immediate needs to transfer patients from cocci infected areas and ensure appropriate placement of High Risk patients at CHCF.

As part of the Reconciliation Process, which will assist Chief Medical Executives (CMEs) in ensuring accurate and timely information on the 128-C3 chrono, a decision support tool and procedure have been developed. CMEs are required to attend a presentation that explains this procedure and tool (details on page 2). Effective immediately through at least December 31, 2013, the CME at each institution is required to complete the following four steps (see attachment for full details):

- **Step 1** – Review the clinical risk level for each patient on any proposed transfer list
- **Step 2** – Address discrepancies between the Master Registry and 128-C3 chrono
- **Step 3** – Elevate any continued discrepancies to the Regional Deputy Medical Executive (DME), who will make the final decision on Clinical Risk level changes
- **Step 4** – Submit the reviewed transfer list and Clinical Risk Change Log to HQ Utilization Management ([um@cdcr.ca.gov](mailto:um@cdcr.ca.gov)) and the appropriate Regional DME at least weekly

To support the Patient Clinical Risk Reconciliation Process and promote up-to-date and appropriate clinical risk designations, CCHCS has compiled a package of information and decision support tools (see attachment for full details):

Patient Clinical Risk Level Reconciliation Process – Complete details about each of the four steps in the reconciliation process

Patient Clinical Risk Level Reconciliation Process Workflow – A decision-making algorithm to assist CMEs with the reconciliation process

Attachment I – How to Access the Patient Risk Profile – The Patient Risk Profile provides specific clinical information that was used to determine a patient’s clinical risk designation including: diagnoses, procedures, specialty consultations, ED visits, hospitalizations, sensitive medical conditions and medications, and abnormal laboratory results

Attachment II – April 2013 Memo – This memo directs appropriate clinical risk classification in the 128-C3 for all High Risk patients

Attachment III – Clinical Risk Change Log – Use this tool to report patients to the DME if the CME believes after review of all pertinent patient information that the Master Registry clinical risk designation is incorrect

Ensuring accurate clinical risk classifications supports the organization’s goals towards effectively and efficiently transferring high risk patients to Intermediate Institutions and CHCF that have been designated for their care, as indicated in Statewide CCHCS Performance Improvement Plan:

*By December 31, 2013, 90% or more of high risk patients will reside at the appropriate institution.*

## Patient Clinical Risk Reconciliation Process – Explanation of Procedure and Decision Support Tool

Tuesday, August 20<sup>th</sup>, 12PM-1PM **OR** Wednesday, August 21<sup>st</sup>, 3PM-4PM

Call-in/Log-in: (877) 214-6371

Participant#: 145230

Webinar: [www.webmeeting.att.com](http://www.webmeeting.att.com)

Should you have any questions or concerns, please contact the appropriate designated Regional Deputy Medical Executive:

- Dr. Robert Chapnick, at (916) 691-4480, [Robert.Chapnick@cdcr.ca.gov](mailto:Robert.Chapnick@cdcr.ca.gov)
- Dr. Elizabeth dos Santos at (916) 709-5540, [Elizabeth.DosSantosChen@cdcr.ca.gov](mailto:Elizabeth.DosSantosChen@cdcr.ca.gov)
- Dr. Jasdeep Bal at (916) 691-0299, [Jasdeep.Bal@cdcr.ca.gov](mailto:Jasdeep.Bal@cdcr.ca.gov)
- Dr. Ellen Greenman at (916) 691-9253, [Ellen.Greenman@cdcr.ca.gov](mailto:Ellen.Greenman@cdcr.ca.gov)
- John Dovey at (916) 691-4928, [John.Dovey@cdcr.ca.gov](mailto:John.Dovey@cdcr.ca.gov)

Cc: Clark Kelso                      Ricki Barnett                      Ellen Greenman                      Janet Mohle-Boetani  
Steven Tharratt                      Robert Chapnick                      Renee Kanan                      Karen Rea  
Jasdeep Bal                      Elizabeth Dos Santos Chen                      Richard Kirkland                      Douglas Peterson

# Patient Clinical Risk Level Reconciliation Process

## Step 1 – Review the clinical risk level for each patient on the proposed transfer list.

- A. View the patient’s clinical risk level designation in the Master Registry.
- B. Compare it to the medical risk level designation on the most current 128-C3.

## Step 2 – Address discrepancies between the Master Registry and 128-C3.

- A. If the Master Registry Clinical Risk and medical risk on 128-C3 match, No Action needed.
- B. If 128-C3 is missing or if the Master Registry Clinical Risk and medical risk on 128-C3 do not match, evaluate the discrepancy by reviewing:
  - i. Patient Risk Profile (can be viewed using the Master Registry, see Attachment I)
  - ii. eUHR documentation
  - iii. Clinical Risk Classification Criteria ([click here to view](#))
1. If you believe the Master Registry Clinical Risk is appropriate, complete a new 128-C3.
2. If you believe the Master Registry Clinical Risk is inappropriate, do the following:
  - i. Document the discrepancy on the Clinical Risk Change Log.
  - ii. Risk needs upgrade – If you identify the Master Registry is missing a diagnosis for this patient, which would qualify him or her as High Risk, then add that diagnosis using the PHIP Problem List and the Master Registry will be automatically updated by the next day.
  - iii. If a risk level downgrade or other change is needed – Initiate a request for change in Master Registry Clinical Risk level designation by submitting the Clinical Risk Change Log and justification to the appropriate Regional DME (Step 3, also see Attachment II).
- C. Submit the list of transfer patients reviewed to show reconciliation of Clinical Risk on the Master Registry and medical risk on the 128-C3 (do this even if no discrepancies/change requests).

## Step 3 – DME makes the final decision on requested Clinical Risk level changes.

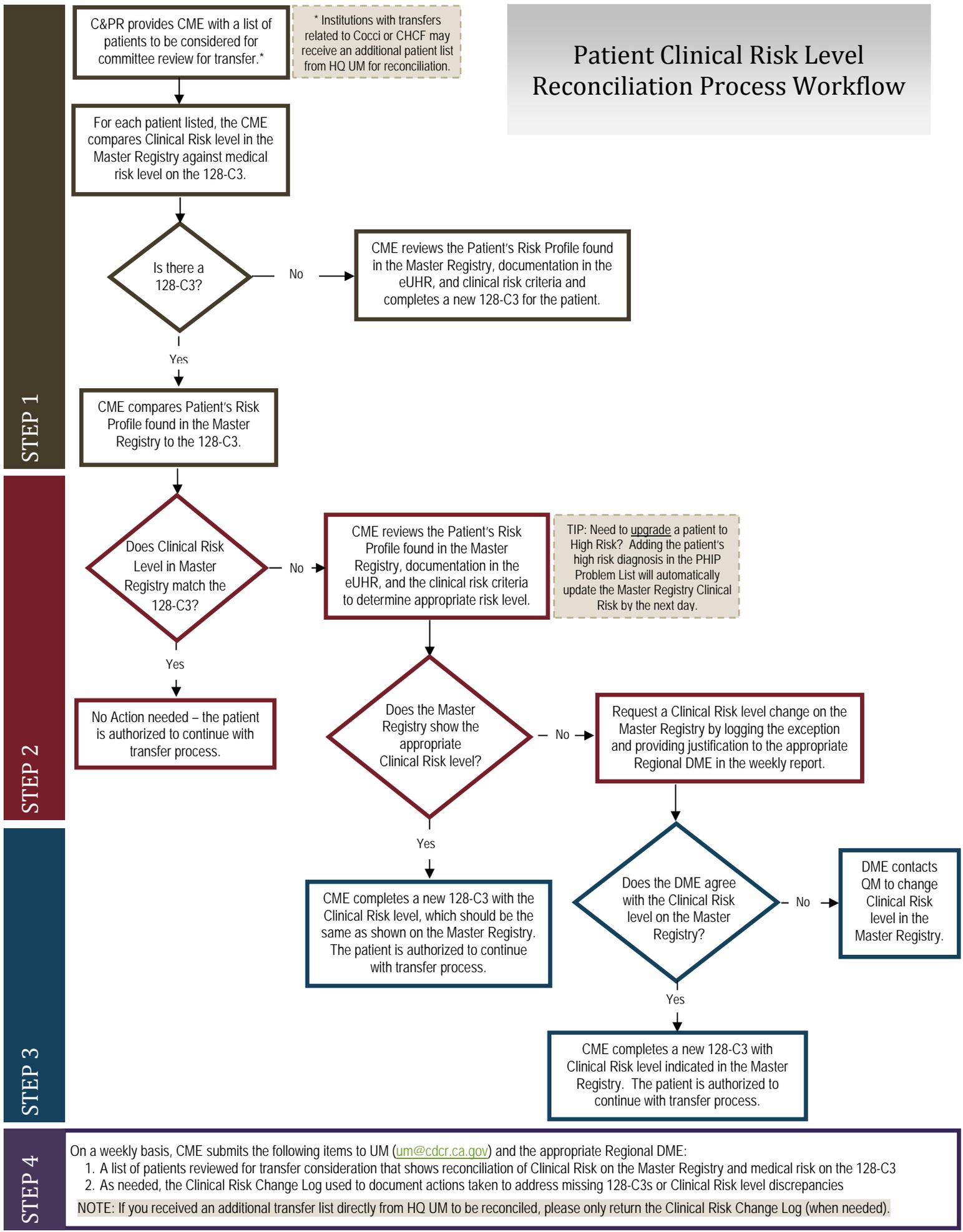
- A. Regional DME will review the CME justification and request for Clinical Risk level change.
  1. As needed, additional information may be reviewed, such as:
    - i. Patient Risk Profile (Can be viewed using the Master Registry see Attachment I)
    - ii. eUHR documentation
    - iii. Clinical Risk Classification Criteria ([click here to view](#))
  2. If DME agrees with the current Clinical Risk designation on the Master Registry, CME will complete a new 128-C3 indicating the Clinical Risk level per the Master Registry.
  3. If DME disagrees with the current Clinical Risk designation in the Master Registry, DME will inform HQ Quality Management of the approval to change patient’s Clinical Risk level.
- B. DME will communicate decision to the CME who will ensure the 128-C3 is changed if necessary.
- C. CME will provide a copy of the new/reconciled 128-C3 to the C&PR for inclusion in the C-File/ ERMS.

## Step 4 – Report to HQ Utilization Management and appropriate Regional DME.

- A. Submit documents to HQ UM ([um@cdcr.ca.gov](mailto:um@cdcr.ca.gov)) and appropriate Regional DME weekly:
  1. A list of transfer patients reviewed that shows reconciliation of Clinical Risk on the Master Registry and medical risk on the 128-C3.

*NOTE: If you received an additional transfer list directly from HQ UM to be reconciled, please only return the Clinical Risk Change Log (when needed).*
  2. Clinical Risk Change Log (as needed)
    - i. This exception report will be used to document actions taken to address missing 128-C3s or discrepancies (see Attachment III – Clinical Risk Change Log template)

# Patient Clinical Risk Level Reconciliation Process Workflow



STEP 1

STEP 2

STEP 3

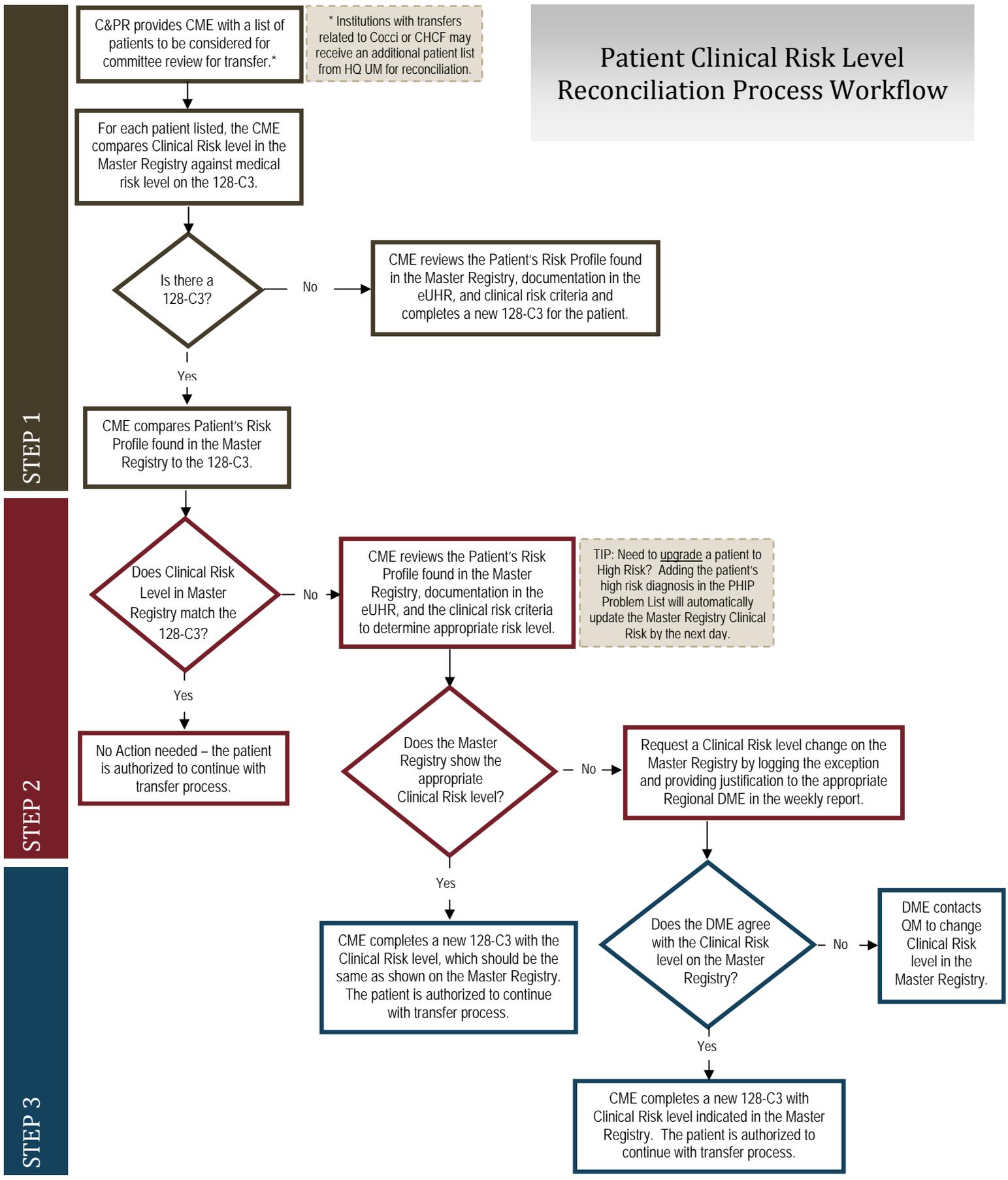
STEP 4

On a weekly basis, CME submits the following items to UM ([um@cdcr.ca.gov](mailto:um@cdcr.ca.gov)) and the appropriate Regional DME:

1. A list of patients reviewed for transfer consideration that shows reconciliation of Clinical Risk on the Master Registry and medical risk on the 128-C3
2. As needed, the Clinical Risk Change Log used to document actions taken to address missing 128-C3s or Clinical Risk level discrepancies

NOTE: If you received an additional transfer list directly from HQ UM to be reconciled, please only return the Clinical Risk Change Log (when needed).

# Patient Clinical Risk Level Reconciliation Process Workflow



**STEP 4** On a weekly basis, CME submits the following items to UM ([um@cdcr.ca.gov](mailto:um@cdcr.ca.gov)) and the appropriate Regional DME:

1. A list of patients reviewed for transfer consideration that shows reconciliation of Clinical Risk on the Master Registry and medical risk on the 128-C3
2. As needed, the Clinical Risk Change Log used to document actions taken to address missing 128-C3s or Clinical Risk level discrepancies

**NOTE:** If you received an additional transfer list directly from HQ UM to be reconciled, please only return the Clinical Risk Change Log (when needed).

# How To...Access Patient Risk Profile

Go to the Lifeline page on the Intranet.

## 1

On the Lifeline homepage, locate the "Divisions" heading on the left side menu.

Find "Quality Management" and click on it.

Next, locate "Quick Links" on the right side of the page and click on "Quality Management Portal".

A new window opens.



## 2

At the Quality Management Portal, find the center section called "Patient Lists".

Click on "Master Registry".



## 3

Once you have arrived at the Master Registry, find the patient and click on their "Clinical Risk" designation. A new window opens.

Housing		Risk Groups			
Cell Bed	Care Team or Yard	Clinical Risk	Rx Ct	Avoid Hosp	MH HU
E 520	Yard E Clinic	HIGH 1	17	3	
F 640	Yard F Clinic	MED	13*		
S INF	Other	HIGH 1	9		
S INF	Other	HIGH 2	8		
A 130	Yard A Clinic	MED	17		
B 220	Yard B Clinic	MED	9		



## 4

The Patient Risk Profile will present only data that was used to determine a patient's clinical risk designation.

Below is an example of the Patient Risk Profile.

Patient identifiers have been hidden in this example to protect privacy.

**Patient Risk Profile**

Patient Name: [Redacted] CDCR #: [Redacted] Inst: [Redacted] Care Team: [Redacted] Cell Bed: [Redacted] Arrival Date: [Redacted] Housing: [Redacted]

Clinical Risk Level: [Redacted] Birth Date: [Redacted] Age: [Redacted] Mental Health: [Redacted] DPP Code(s): [Redacted] TABE Score: [Redacted] TB Code: [Redacted] EPRD: [Redacted]

**HIGH 1**

**Chronic Conditions**

- CARDIAC
- CCCMS
- CHRONIC PAIN
- COPD
- DIABETES
- HCV
- HELP
- PHYS. DISABILITY
- WAR\*

**Active Prescriptions**

- ASPIRIN
- ATORVASTATIN CALCIUM
- CALCIUM POLYCARBOPHIL
- CARVEDILOL
- FLUOQUETINE HCL
- FLUTICASON PROPRIONATE
- FUROSEMIDE
- HYDROXYZINE PAMOATE
- INSULIN REGULAR, HUMAN
- LEVALBUTEROL TARTRATE
- LISINAPRIL
- METFORMIN HCL
- MORPHINE SULFATE
- NITROGLYCERIN
- NPH, HUMAN INSULIN ISOPHANE
- RANITIDINE HCL
- TIOTROPUM BROMIDE

**High Risk Factors:**

- Age (65+)
- High Cost Patient
- High Risk Diagnosis
- High Risk Procedure
- High Risk Specialty Consultations
- Multiple ED Visits
- Multiple Hospitalizations
- Sensitive Medical Condition
- Significant Abnormal Lab (Any)
- Significant Abnormal Lab (Most Recent)

**High Risk Diagnoses / Procedures**

Date	Type	Details
	Procedure	Coronary Artery Bypass
	Diagnosis	Cad Cabg

**ED Visits / Hospitalizations**

Date	Type	Details
	INPT	Shortness Of Breath
	INPT	Chest Pain
	ED	Chest Pain Nos
	INPT	Chest Pain
	ED	Chest Pain Nos
	INPT	Chest Pain
	INPT	Chest Pain
	INPT	Chest Pain
	ED	Chest Pain Nos
	INPT	Chest Pain

**High Risk Specialty Consultations**

Date	Type	Details
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**Significant Abnormal Labs**

Date	Type	Details	Lab Value
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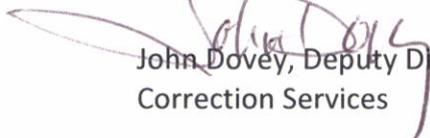


# CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

## MEMORANDUM

**Date** : April 3, 2013

**To** : Chief Executive Officers  
Chief Medical Executives  
Deputy Medical Executives

**From** : STEVEN RITTER, D.O., Deputy Director, Medical   
  
John Dovey, Deputy Director, Field Operations and Activation Management,  
Correction Services

**Subject** : **CENTRALIZED AUTOMATED RISK CLASSIFICATION SYSTEM**

Effective immediately, this memorandum supersedes the California Correctional Health Care Services (CCHCS) Centralized Automated Risk Classification System memorandum dated July 25, 2012. After further analysis related to the implementation of the July 25, 2012, memorandum, the following actions are to occur upon the receipt of this memorandum and attachments. This is the third attempt to ensure the movement of High Risk (HR) Inmate-Patients (IPs) to their appropriate institution.

The attached Centralized Automated Risk Classification System list contains IPs with HR status currently housed at your institution that have been identified as requiring transfer to an appropriate intermediate-level medical care institution. Please review the attached High Risk Patient List (referencing the attached Clinical Risk Classification System Definitions) to ensure the IP's current California Department of Corrections and Rehabilitation (CDCR) Medical Classification Chrono (128 C-3) reflects the IP's Medical Risk: HR status using the following steps:

1. Compare the attached list of HR IPs at your institution with their current Medical Classification Chrono 128-C3. If they match:
  - a. Enter "High" in the column labeled "128C-3," and
  - b. Enter the date this was verified in the field labeled "128C-3 Date."
2. If they do **not** match, for example the Medical Classification Chrono 128-C3 at your institution does not identify the IP as a HR IP, then the following steps must occur:
  - a. The PCP staff will complete a new CDCR 128 C-3 that documents the inmate's current medical classification factors, including the Medical Risk: HR factor. A copy of the completed CDCR 128 C-3 will be routed to the institution

- Classification and Parole Representative who will utilize the CDCR 128 C-3 as a trigger to initiate a classification action.
- b. If the institution PCP disagrees with the IP's HR designation, the PCP shall discuss the case with the Chief Physician and Surgeon and/or the Chief Medical Executive (CME).
    - c. If the CME believes the IP's HR designation is "Medium" or "Low Risk," he/she will case conference with their designated Field Operations Deputy Medical Executive (DME), Dr. John Zweifler – Central Region; Dr. Elizabeth dos Santos – South and/or Dr. Ellen Greenman – North, to come to a consensus on the IP's HR status.
  - d. If all parties agree the IP is **not** HR
    1. Enter "Medium" or "Low" in the column labeled "128C-3," **and**
    2. Enter the date this was verified in the field labeled "128C-3 Date."
  - e. If a consensus cannot be reached, the IP will retain the HR designation and be transferred to an appropriate intermediate-level medical care institution.
    1. Enter "High" in the column labeled 128C-3 and enter the date this was verified in the 128C-3 Date column.

The lists should be completed and returned to Blake Lim, Utilization Management, at [blake.lim@cdcr.ca.gov](mailto:blake.lim@cdcr.ca.gov) within **30 days (May 3, 2013)**. In addition, the updated IP HR list based on the CDCR 128 C-3 verification process will be provided by the institution to the Medical Classification and Case Records Unit (MCCRU). This updated list will then be provided to CDCR's Population Management Unit to be utilized by classification staff to transfer the identified HR IPs.

Should you have any questions or concerns, please contact the appropriate designated Field Operations, Deputy Medical Executive: Dr. John Zweifler (Central), at (916) 838-4746 or via email @ ([John.Zweifler@cdcr.ca.gov](mailto:John.Zweifler@cdcr.ca.gov)), Dr. Elizabeth dos Santos (South) at (916) 709-5540 or via email @ ([Elizabeth.DosSantosChen@cdcr.ca.gov](mailto:Elizabeth.DosSantosChen@cdcr.ca.gov)), Dr. Ellen Greenman (North) at (916) 205-5428 or via email @ ([Ellen.Greenman@cdcr.ca.gov](mailto:Ellen.Greenman@cdcr.ca.gov)), or Jay Powell at (916) 691-0336 or via email @ ([jay.powell@cdcr.ca.gov](mailto:jay.powell@cdcr.ca.gov)).

## Attachments

- High Risk Patient List (as of 3/27/13)
- Clinical Risk Classification System

cc:	J Clark Kelso	David Runnells	Jared Goldman
	Steven Tharratt, M.D.	Mitzi Higashidani	Joyce Hayhoe
	Steve Kessler	Evelyn Matteucci	Yulanda Mynhier
	Renee Kanan, M.D.	Tim Belavich, Ph.D.	Karen Rea, PHN, FNP
	Ricki Barnett, M.D.	Morton Rosenberg, D.D.S	Douglas Peterson, M.D.
	Jay Powell	Janet Lewis	Stanley Ota
	Blake Lim	Robert Calderon	

# Clinical Risk Change Log

*INSTRUCTIONS: Use this report to log discrepancies between a patient's Clinical Risk Classification (Master Registry) and medical risk found on the most recent 128-C3 that requires DME review. Requests for Clinical Risk level changes on the Master Registry must be accompanied by appropriate justification. Submit this report to HQ UM and the appropriate Regional DME at least weekly.*

Institution Make a Selection

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CME Name \_\_\_\_\_

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Date \_\_\_\_\_

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[Click here to access Clinical Risk Definitions](#)

[Click here to access the Master Registry](#)

[Click here to email HQ UM](#)

Line #	CDC #	Last Name	Patient Clinical Risk Level		Match? (Y/N)	Action Requested and/or Resolution (Explain)
			Per Registry	Per Most Recent 128-C3		
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
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25						
26						
27						
28						
29						
30						

### High Risk - Priority 1

Patients who are High Risk Priority 1 trigger at least **2 flags** from the selection criteria found in the table below

### High Risk - Priority 2

Patients who are High Risk Priority 2 trigger only **1 flag** from the selection criteria found in the table below

Flag	Description	Data Source	Timeframe
<b>Sensitive Medical Condition</b>	Medications associated with important diagnoses which, if not taken, may lead to a serious adverse event (e.g. immunosuppressants, chemotherapy Rx) <b>See Table 1 and 2 below</b>	Guardian	6 months
<b>High hospital, ED, Specialty Care and Pharmacy Costs</b>	Patients whose care in the past 6 months has a cost of more than \$100,000	Guardian, TPA Claims	6 months
<b>Multiple Hospitalizations</b>	2 or more inpatient admissions	CADDIS	12 months
<b>Multiple Emergency Department Visits</b>	3 or more emergency department visits	TPA Claims	12 months
<b>High Risk Specialty Consultations</b>	2 or more appointments to 'high risk' specialist(s) (e.g., oncologist, vascular surgeon) <b>See Table 3 Below</b>	TPA Claims	6 months
<b>Significant Abnormal Labs</b>	1 or more abnormal lab value that suggests poor control of a chronic condition or serious medical condition (most recent) <b>See Table 4 Below</b>	Quest	All - Most Recent or Any
<b>Age</b>	65 years of age or older	SOMS	Current Age
<b>Specific High-Risk Diagnoses/Procedures</b>	1 or more ICD-9 codes from ED visit, hospitalization or specialist visit, suggesting serious condition (e.g., cancer, SLE, dementia) <b>See Table 5 Below</b>	TPA Claims	All

### Medium Risk

Patients with at least 1 chronic condition who do not meet any selection criteria for Clinical High Risk Priority 1 or Priority 2 (Excluded from the Medium Risk group are patients whose chronic condition(s) are limited to those listed in the Low Risk and that meet the criteria for well controlled or at low risk for adverse health event)

Flag	Description	Data Source	Timeframe
<b>1 or More Chronic Conditions</b>	1 or more chronic illness, based upon prescribed medications, laboratory tests, or MHSDS enrollment. Also includes MH High Utilization and Permanent ADA.	Guardian, Quest, MHTS, DECS	Variable

### Low Risk

All patients who do not meet the selection criteria for the High Risk Priority 1, Priority 2, or Medium Risk categories  
Includes some patients with medical conditions considered to be well controlled or at low risk for adverse health event.

Flag	Description	Data Source	Timeframe
<b>Health Patients Including: Well Managed Asthmatics, Diabetics, Hypertension, Low Risk HCV Patients, Low Risk LTBI</b>	Otherwise healthy patients, including: Those who use <= 4 SABA dispenses in 12-months <u>and</u> not on an ICS Those with all HgA1C < 7.7 in 12-months <u>and</u> not on insulin Those who only receive monotherapy for blood pressure management Those who do not meet criteria for chronic HCV infection or those who have low probability for advanced liver disease based off Fib-4 calculation Those who are receiving treatment for LTBI, and have ALT <2x's normal elevation	Guardian, Quest	Variable

**Table 1: Examples of Medications Indicating Sensitive Medical Conditions**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• <b>Immunosuppressant:</b> TNF inhibitor (Adalimumab)</li> <li>• <b>Anti-rejection Medication:</b> Cyclosporine</li> <li>• <b>Chemotherapy</b></li> <li>• <b>Multiple Sclerosis:</b> Interferon Beta 1A</li> </ul> | <ul style="list-style-type: none"> <li>• <b>ALS:</b> Riluzole</li> <li>• <b>Anticoagulant:</b> e.g. warfarin</li> <li>• <b>HIV or HBV:</b> anti-retroviral</li> <li>• <b>Hemophilia</b></li> <li>• <b>Myasthenia Gravis:</b> Edrophonium</li> </ul> |
|--|---|

**Table 2: Complete List of Medications Indicating Sensitive Medical Conditions**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• ‡ABACAVIR SULFATE</li> <li>• ‡ABACAVIR SULFATE/LAMIVUDINE</li> <li>• ‡ABACAVIR SULFATE/LAMIVUDINE/ZIDOVUDINE</li> <li>• ADALIMUMAB</li> <li>• ALBENDAZOLE</li> <li>• ANTIHEMOPHILIC FACTOR, HUM REC</li> <li>• ANTIHEMOPHILIC FACTOR,HUMAN</li> <li>• ANTIHEMOPHILIC FACTOR,HUMAN/VON WILLEBRAND FACT,HUMAN</li> <li>• APREPITANT</li> <li>• ‡ATAZANAVIR SULFATE</li> <li>• AZATHIOPRINE</li> <li>• *BETAMETHASONE ACETATE/BETAMETHASONE SODIUM PHOSPHATE</li> <li>• BICALUTAMIDE</li> <li>• BORTEZOMIB</li> <li>• *BUDESONIDE</li> <li>• CAPECITABINE</li> <li>• CERTOLIZUMAB PEGOL</li> <li>• CHLORAMBUCIL</li> <li>• CLOZAPINE</li> <li>• CYCLOSPORINE</li> <li>• CYCLOSPORINE, MODIFIED</li> <li>• ‡DARUNAVIR ETHANOLATE</li> <li>• DASATINIB</li> <li>• *DEXAMETHASONE SOD PHOSPHATE</li> <li>• *DEXAMETHASONE SODIUM PHOSPHATE/PF</li> <li>• ‡DIDANOSINE</li> <li>• DRONABINOL</li> <li>• EDROPHONIUM CHLORIDE</li> <li>• ‡EFAVIRENZ</li> <li>• ‡EFAVIRENZ/EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE</li> <li>• ‡EMTRICITABINE</li> <li>• ‡EMTRICITABINE/RILPIVIRINE HCL/TENOFOVIR DISOPROXIL FUMARATE</li> <li>• ‡EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE</li> <li>• ‡ENFUVRTIDE</li> <li>• ERLOTINIB HCL</li> <li>• ETANERCEPT</li> <li>• ETRAVIRINE</li> <li>• FACTOR IX</li> <li>• ‡FOSAMPRENAVIR CALCIUM</li> <li>• GLATIRAMER ACETATE</li> <li>• GOLIMUMAB</li> </ul> | <ul style="list-style-type: none"> <li>• INTERFERON BETA-1A/ALBUMIN HUMAN</li> <li>• INTERFERON BETA-1B</li> <li>• ‡LAMIVUDINE</li> <li>• ‡LAMIVUDINE/ZIDOVUDINE</li> <li>• LEFLUNOMIDE</li> <li>• LEUPROLIDE ACETATE (Men-Only)</li> <li>• ‡LOPINAVIR/RITONAVIR</li> <li>• ‡MARAVIROC</li> <li>• MELPHALAN</li> <li>• MERCAPTOPYRINE</li> <li>• MESALAMINE</li> <li>• MESALAMINE WITH CLEANSING WIPES</li> <li>• METHOTREXATE SODIUM</li> <li>• METHOTREXATE SODIUM/PF</li> <li>• *METHYLPREDNISOLONE</li> <li>• *METHYLPREDNISOLONE ACETATE</li> <li>• *METHYLPREDNISOLONE SODIUM SUCCINATE</li> <li>• *METHYLPREDNISOLONE SODIUM SUCCINATE/PF</li> <li>• MYCOPHENOLATE MOFETIL</li> <li>• MYCOPHENOLATE SODIUM</li> <li>• ‡NELFINAVIR MESYLATE</li> <li>• NEVIRAPINE</li> <li>• NILOTINIB HCL</li> <li>• NILOTINIB HYDROCHLORIDE</li> <li>• PILOCARPINE HCL</li> <li>• *PREDNISONE</li> <li>• *PREDNISOLONE</li> <li>• *PREDNISOLONE SOD PHOSPHATE</li> <li>• PYRIDOSTIGMINE BROMIDE</li> <li>• ‡RALTEGRAVIR POTASSIUM</li> <li>• RILUZOLE</li> <li>• ‡RITONAVIR</li> <li>• ‡SAQUINAVIR MESYLATE</li> <li>• SIROLIMUS</li> <li>• SORAFENIB TOSYLATE</li> <li>• ‡STAVUDINE</li> <li>• SULFASALAZINE</li> <li>• SUNITINIB MALATE</li> <li>• TACROLIMUS</li> </ul> |
|--|--|

- \*HYDROCORTISONE (NON-TOPICAL)
- HYDROCORTISONE ACETAE
- \*HYDROCORTISONE SOD SUCCINATE
- \*HYDROCORTISONE SODIUM SUCCINATE P/F
- HYDROXYCHLOROQUINE SULFATE
- IMATINIB MESYLATE
- ‡INDINAVIR SULFATE
- INTERFERON BETA-1A

- TEMOZOLOMIDE
- ‡TENOFVIR DISOPROXIL FUMARATE
- THALIDOMIDE
- ‡TIPRANAVIR
- \*TRIAMCINOLONE ACETONIDE
- WARFARIN SODIUM
- ‡ZIDOVUDINE

\*Requires a dispense in 5 of the previous 6 months to be High Risk

‡ Used to identify HIV treatment only

**Table 3: High Risk Specialty Consultations**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Cardiac Surgery</li> <li>• Dialysis</li> <li>• Hematology</li> <li>• Nephrology</li> <li>• Thoracic Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Neurosurgery</li> <li>• Oncology</li> <li>• Pulmonary</li> <li>• Radiation Oncology</li> <li>• Rheumatology</li> <li>• Vascular Surgery</li> </ul> |
|---|---|

**Table 4: Significant Abnormal Labs**

Lab Name		Labs Timeframe	Values Queried
ANCA	Anti RNP	Any Recorded Abnormal Result	Positive Lab Results
Anti CCP	Anti SCL 70		
Anti Centromere	Anti SM		
Anti DS	Anti-AchR		
Anti DS DNA	Sjogrens AB SSA		
Anti RNA Polymerase	Sjorgrens AB SSB		
	Hgb SS		
Absolute Neutrophil Count		Most Recent Lab	<750
Albumin			<2.8
Bilirubin Total			>5
Calcium			>12
CD4			<200
Creatinine			>2
Hemoglobin			<9
INR			>4
Platelet Count			<75000 -OR- >1000000
White Blood Cell Count			<1

**Table 5: Hospitalization Associated High Risk Diagnoses/Procedures**

Diagnoses			
<p><b>ID:</b> Sepsis ,Fungal Infections-Systemic, Coccidioidal/or Cryptococcal Meningitis, Endocarditis, Decubitus Ulcer</p> <p><b>Cardiac:</b> Acute MI, CAD, CHF, PVD, Aneurysm (Coronary, Myocardial, Aortic, Iliac, Renal, etc), Congenital Heart Disease</p> <p><b>Heme/Onc:</b> Cancer, Lymphoma/Leukemia, Myelofibrosis, Aplastic Anemia, Sickle Cell Disease, Coagulation Factor Def</p> <p><b>Neuro:</b> Parkinson’s, MS, Plegia (Hemi-, Para-, Quadra-), Anoxic Brain Damage, Hydrocephalus, Huntington’s, Head Trauma, Freidreichs Ataxia, Dementia, Neurogenic Bladder, Subarach. Hemorrhage, Stroke (Ischemic/Hemorrhagic)</p> <p><b>Resp:</b> COPD, H/O Respiratory Arrest, Primary Pulmonary Cocci, Primary Pulmonary Hypertension</p> <p><b>GI:</b> Hepatic Coma, Biliary Cirrhosis, Hepatorenal Syndrome, Chronic Pancreas Disorder, Esophageal Varices, IBD</p> <p><b>Renal:</b> Intrinsic Renal Disease, Chronic Renal Failure Stage 3 or Above, Kidney Transplantation,</p> <p><b>Rheum:</b> RA, Ankylosing Spondylitis, SLE, Scleroderma, Dermatomyositis, Polymyositis, Giant Cell Arteritis, Goodpasture’s Wegener’s, Myasthenia Gravis</p> <p><b>Other:</b> Cystic Fibrosis , Amyloidosis , Sleep Apnea</p>			
Procedures			
Ventricular Shunt	CABG or PTCA	Coronary Thrombolysis	Pacemaker or Defibrillator
Peripheral Vascular Bypass	TIPS	AV fistula	Hemodialysis
Survivor of CPR	Chemotherapy	Kidney Transplantation	Nephrectomy (partial/complete)
Bone Marrow Transplant	Abdominal Paracentesis	Control Upper GI Bleeding	Hepatic or Pancreatic Surgery