Hospitalization Risk Assessment

Purpose: Screening tool to identify those at risk for hospitalization.

Patient Name: ______________________ Record # ________

Date: ___________

<table>
<thead>
<tr>
<th>Prior pattern</th>
<th>Chronic conditions</th>
<th>Risk Factors</th>
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</thead>
<tbody>
<tr>
<td>&gt; 1 Hospitalizations or ER visits in the past 12 months (M1032)</td>
<td>History of falls * (M1032 and M1910)</td>
<td>Discharged from hospital or skilled nursing facility (M1000)</td>
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<tr>
<td>Chronic conditions: Check all that apply (M1020/1022/1024)</td>
<td>Chronic skin ulcers (Wound consult if indicated for any wounds)</td>
<td>More than 2 secondary diagnoses (M1022 and 1024)</td>
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<td></td>
<td>Diabetes</td>
<td>Low socioeconomic status or financial concerns</td>
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<td></td>
<td>COPD</td>
<td>Inadequate support network (M1100)</td>
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<td></td>
<td>HIV/AIDS</td>
<td>ADL assistance needed (M2100 and M2110)</td>
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<td>Home safety risks</td>
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<td>Dyspnea (M1400)</td>
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</table>

Consider Therapy referral (PT, OT, ST) Consider MSW referral Consider Hospice referral Consider RN referral, if not ordered

Total # of checked boxes is ___ Your agency may want to select a threshold score to target patients at high risk. (For example, 5 or greater risk factors may indicate the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)

Carry out patient specific interventions as appropriate/ordered, if patient is at risk for hospitalization:
(Coordinate with M2250)

- SN  PT  OT  ST  MSW  HHA  Dietary Consultant  Other
- Medication Management  Medication Reconciliation  Assess patient's knowledge, ability, resources and adherence  Education
- Hospice/Palliative Referral  Phone Monitoring
- Individualized Patient Emergency Care Plan  Front-loading Visits
- Fall Prevention Program  Telemonitoring

Notify the following, as appropriate, if patient is at risk for hospitalization:

- Physician
- Interdisciplinary Team
- On Call Staff
- Patient/family/caregiver
- Agency Case Manager
- Other
- Prayer (e.g. Managed Care Organizations)

Clinician Signature: ______________________ Date: __________

Adapted from Personal Touch Home Care, VA 6/25/04 Professional Practice Model.

Revised 12/21/09 to correlate with OASIS-C.

The following articles provide more information on risk assessments:

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