RISK STRATIFICATION TOOL – DETERMINE HOSPITALIZATION RISK

Patient Name:	MRN:	SOC Date:	Yes = 1 pt	No = 0 pt	N/A
1. **CHF –** Does the CHF cause marked limitation of physical activities?					
2. **Risk of Sepsis** – Does the patient receive any treatments for UTI, lung, kidney or abdominal infection?					
3. **COPD –** Does the patient have significant breathlessness walking on level ground and/or uses supplemental oxygen?					
4. **Cancer –** Is the patient undergoing chemotherapy/radiation or other cancer treatments?					
5. **ESRD –** Is the patient on peritoneal or hemodialysis?					
6. **Risk of MI** – Does the patient experience chest pain or discomfort with exertion or has he/she had a MI in the past 30 days?					
7. **Complication of device, implant or graft** – Has the patient received implant, transplant or graft in the past 2 months?					
8. **Acute CVA** – Has the patient suffered a CVA or TIA in the past 2 months?					
9. **Fall Risk** – Does a standardized fall risk assessment test indicate a high fall risk or has the patient had ≥ 2 falls in the past 3 months?					
10. **Cognition** – Does the patient have a cognitive impairment or mental illness affecting his/her safety at home?					
11. **Physical Environment** – Are there safety concerns in his/her physical environment which could result in patient fall or injury?					
12. **Vision** – Does the patient have difficulties noticing obstacles in his/her path due to impaired vision?					
13. **Wound** – Does the patient have a surgical incision or open wound?					
14. **Polypharmacy** – Does the patient take more than 7 medications?					
15. **Diabetes** – Does the patient have difficulties controlling/monitoring blood sugar levels?					
16. **Hospitalization Risk** – Is it likely that patient may need an unplanned hospitalization during the next 30-days?					
17. **Hospitalization History –** Has there been an ER visit or hospitalization in the past 6 months?					
Note, with questions 1-17 above "yes" answer receives one point and with questions 18-22 below "no" answer receives one point.			**Yes = 0 pt**	**No = 1 pt**	**N/A**
18. **Risk of Pneumonia** – If patient is ≥ 65-year-old is he/she updated with flu and pneumonia vaccinations?					
19. **Medication Adherence** – Is the patient taking his/her medications as directed by MD?					
20. **Medication Knowledge** – Does the patient/caregiver verbalize good understanding of medications?					
21. **Health Literacy** – Does the patient/caregiver understand basic health information well to make appropriate health decisions?					
22. **Socioeconomic Status** – Does the patient have adequate financial/social support system in place to function safely at home?					
					Risk Score is _____ Points.

NOTE: IF ANSWER TO #16 IS "YES", THE PATIENT IS AUTOMATICALLY SCORED AS HIGH RISK.

Did you discuss the "Call Us First" contract and get it signed?	Yes____ No____
Has the Health Confidence Form been completed?	Yes____ No____
Did you see the THA Group Welcome Letter in the home?	Yes____ No____
Is this a potential BPCI patient?	Yes____ No____
Does the patient need a monitor?	Yes____ No____

BPCI Episodes

Acute MI	AICD Generator or Lead	CABG
Cardiac Arrhythmia	Cardiac Defibrillator	Cardiac Valve
Heart Failure	Pacemaker (new or revised)	Diabetes
COPD, Bronchitis/Asthma	Major Joint Rep. of Lower Ext.	Revision of Hip or Knee
Percut. Coronary Intervention		Simple Pneumonia/Resp. Infection

SCORE	RISK STRATIFICATION	VISITS, 1ST 7 DAYS & 2ND 7 DAYS	HEALTH COACH CONTACTS	TECHNOLOGY
0 – 7	Low	2W1, 1W1	Once a week	IVR
8 – 14	Moderate	3W1, 2W1	Twice a week	Telemonitor
15 – 22	High	3W1, 2W1	Three times a week	Telemonitor

*Physician orders supersede recommended visit frequencies.
*Monitored patients receive telephonic visits weekly after week 1.
*Visit frequencies recommended are considered the minimum necessary to care for patients at that risk level. As always, determination is made on an individual patient assessment.
*The recommended number of visits includes the total number of all disciplines assigned, not just nursing visits.

Signature: _____ **Date: _____**

THAGroup
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QUALITY MEETING FORM

Patient _____ **Bundle/Monitor/Net Response** _____

DOB _____ **ZIP Code** _____ **MD** _____

Payor _____ **Auth** _____

SN / PT / OT / ST / MSW / HHA / Dietician / Palliation / _____

Certification Period: _____ **HHRG** _____ **$** _____

Lab(s): _____ **How often?** _____ **D/C** _____

Sent to: _____ **Infusion:** _____ **Infusion Company:** _____

Wound: _____ **Wound Care:** _____

Dx: _____

V/S / Monitor / Meds / Pain / HTN / CHF (wt) / DM (foot care/A1c) /COPD / Depression / PICC / Falls / Skin / O2 / Cath / Ostomy / Drains/ UTI / IV / Wound / Lab / CVA

POC: _____ **HbgA1c:** _____

HHA Supervisory Visit: _____ **LPN Supervisory Visit:** _____

SN Orders: _____ **Telephonic Scheduled:** _____

_____ **Tele-Teaching Scheduled:** _____

Progress toward SN goals: _____

_____

SN/PT Partnership: _____

Signature/Date: _____
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