



Skilled Nursing Facility (SNF) Rehospitalization RISK ASSESSMENT TOOL

The SNF Rehospitalization Risk Assessment Tool provides a framework for interdisciplinary review, discussion, and individualized care planning for all admissions to a skilled nursing facility. The tool proactively identifies and implements mitigation strategies **to reduce readmission risk**.

Tips for using this tool:

1. Utilize facility readmission review documentation to identify any additional high-risk factors associated with the population served by your facility. Modify this form to include any additional clinical or social determinants of health risks.
2. Review readmission risk reports generated by the facility's electronic health record (EHR). Reconcile reports with the risks identified on this assessment and ensure both tools reflect all identified risk for the facility's patient and resident population.
3. Establish facility process for regular monitoring and interdisciplinary review of patients and residents with multiple readmission risk factors (e.g., for x number of days post admission, in daily stand-up meetings, care conferences and/or readmission risk meetings).
4. Establish a process to ensure interdisciplinary staff on all shifts are aware of risks and are closely monitoring and communicating changes in condition.
5. Consider both the readmission risk for this stay and for the transition to the next level of care.
6. Develop an individualized, person-centered care plan intervention for each identified risk.

Patient Name: _____ Admission Date: _____ Room Number: _____

Primary Physician: _____ Anticipated Date of Discharge or Length of Stay: _____

Clinical Risk Factors¹ (Check all that apply, both active and chronic conditions)

<input type="checkbox"/> Cancer, on active chemo or radiation therapy	<input type="checkbox"/> Heart failure (HF)	<input type="checkbox"/> Infection with ongoing treatment
<input type="checkbox"/> High-Risk Medications <input type="checkbox"/> Anticoagulant <input type="checkbox"/> Diabetic Agent <input type="checkbox"/> Opioids	<input type="checkbox"/> Congestive Obstructive Pulmonary Disease (COPD) or Dyspnea	<input type="checkbox"/> Dementia
<input type="checkbox"/> Multiple active diagnosis and/or co-morbidities (e.g., HF, COPD and Diabetes in the same patient/resident)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> End-Stage Renal Disease (ESRD)
<input type="checkbox"/> Polypharmacy (e.g., nine or more medications)	<input type="checkbox"/> Fracture (hip)	<input type="checkbox"/> Surgical complications

Prior Hospitalizations or Emergency Room Visits²

<input type="checkbox"/> Hospitalization in the 30 days before their most recent admission to the hospital (Other than the one being reviewed in this tool)	<input type="checkbox"/> Other hospitalizations or emergency department visits in the past 12 months (Other than the one being reviewed in this tool)
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Additional Factors That May Increase Readmission Risk		
<input type="checkbox"/> Current or previous difficulty adhering to plan of care	<input type="checkbox"/> Current or previous difficulty adhering to medication regime	<input type="checkbox"/> History of Delirium
<input type="checkbox"/> No identified or engaged care partner	<input type="checkbox"/> History of falls or fall with major injury	<input type="checkbox"/> Known home safety risk
<input type="checkbox"/> No Advance Care Planning documentation or identified goals of care	<input type="checkbox"/> Known conflict among family members around goals of care, health status or plan of care	<input type="checkbox"/> Prior declination of palliative care or hospice services
<input type="checkbox"/> Current or past complaints of poor pain control	<input type="checkbox"/> Primary language other than English	<input type="checkbox"/> Low health literacy of patient/resident and or health care agents
<input type="checkbox"/> Introduction of a new class of medication(s)	<input type="checkbox"/> History of C. Diff, Sepsis or post-COVID syndrome	<input type="checkbox"/> No known primary care provider (PCP)

Next Steps:

1. Attending physician informed of identified risks: _____ Date: _____
signature
2. Care plan intervention verified in place for each identified risk: _____ Date: _____
signature
3. Interdisciplinary team on all shifts informed of identified risks: _____ Date: _____
signature

Additional resources for proactively mitigating identified readmission risks:
Alliant Health Solution's My Care Transition Plan helps patients and care partners document their questions and concerns throughout their stay. Use of this tool in either brochure or portrait versions can help facility teams proactively implement mitigation strategies. My Care Transition Plan
Alliant Health Solution's bite-size video on the Scripps Gerontology Our Family Our Way free virtual and printable resources for family meetings and templates to help plan for care and support post-discharge. Our Family Our Way
Alliant Health Solution's library of zone tools can be used to initiate patient and care partner education beginning on admission and to engage patients and care partners in knowing and communicating changes in condition. Alliant Zone Tools
"Go To the Hospital or Stay Here" virtual and printable resources in multiple languages can help guide proactive discussions with patients and health care agents around readmission risks, goals of care, facility capabilities and the decision process when a change in condition is identified. Alliant Health Solutions has a variety of tools to guide facility implementation of these resources. Hospital Decision Guide
INTERACT® resources for a quality improvement program to improve identification, evaluation and communication around changes in resident status. INTERACT

1-2 Interact® 4.5 Quality Improvement Tool For Review of Acute Care Transfers