Home Health Rehospitalization
RISK ASSESSMENT TOOL

The Home Health Rehospitalization Risk Assessment Tool provides a framework for interdisciplinary review, discussion, and individualized care planning for all admissions to a home health. The tool proactively identifies and implements mitigation strategies **to reduce readmission risk**.

Tips for using this tool:

1. Utilize readmission review documentation to identify any additional high-risk factors associated with the population served by your agency. Modify this form to include any additional clinical or social determinants of health risks.
2. Review readmission risk reports generated by the electronic health record (EHR). Reconcile reports with the risks identified on this assessment and ensure both tools reflect all identified risk for the patient.
3. Establish a process for regular monitoring and interdisciplinary review of patients with multiple readmission risk factors in daily stand-up meetings, case conferences and/or high risk meetings.
4. Establish a process to ensure interdisciplinary staff are aware of the 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: ______________________________ DOB: ____________________

Start of Care Date: ______________________________

Primary Physician: ______________________________ Certification Period: ____________________

Primary Focus of Care: ______________________________

Clinical Risk Factors[1] (Check all that apply, both active and chronic conditions)		
☐ Cancer, on active chemo or radiation therapy	☐ Heart failure (HF)	☐ Infection with ongoing treatment
☐ High-Risk Medications ☐ Anticoagulant ☐ Diabetic Agent ☐ Opioids	☐ Congestive Obstructive Pulmonary Disease (COPD) or Dyspnea ☐ Cardia Disease (Hypertension, CAD, Angina)	☐ Infection with ongoing treatment, infected wounds, those receiving Negative Pressure Therapy or daily wound care, and Stage III and IV Pressure Ulcers
☐ Multiple active diagnosis and/or co-morbidities (e.g., HF, COPD and Diabetes in the same patient/resident) More than 2 secondary doses	☐ Diabetes	☐ End-Stage Renal Disease (ESRD) ☐ Neoplasm as primary diagnosis
☐ Polypharmacy (e.g., five or more medications)	☐ Fracture (hip)	☐ Surgical complications

Patient hospitalized in the ***past 30 days?*** ☐ No ☐ Yes *(List dates and reasons)*

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Other hospitalizations or emergency department visits in the ***past 12 months?*** ☐ No ☐ Yes *(List dates and reasons)*

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Additional Factors That May Increase Readmission Risk		
☐ Current or previous difficulty adhering to plan of care	☐ Current or previous difficulty adhering to medication regime	☐ History of delirium
☐ No identified or engaged care partner; Lives alone and/or inadequate support network	☐ History of falls or fall with major injury; High fall risk	☐ Known home safety risk
☐ No Advance Care Planning documentation or identified goals of care	☐ Known conflict among family members around goals of care, health status or plan of care	☐ Prior declination of palliative care or hospice services
☐ Current or past complaints of poor pain control; severe pain or pain all the time	☐ Primary language other than English	☐ Low health literacy of patient/ resident and or health care agents
☐ Introduction of a new class of medication(s)	☐ History of C. Diff, sepsis or post-COVID syndrome	☐ No known primary care provider (PCP)
☐ Discharged from hospital or LTACH for more than five days in the past three months	☐ Assistance with medication management needed	☐ Depression (score of three or more on PHQ-2 or 10 or more on CSDD
☐ Two or more hospitalizations and/or ER visits in the past three months	☐ Adverse reactions, ineffective therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, and/or non-adherence revealed by drug regimen review.	☐ Overall poor status/prognosis (likely to remain in fragile health and have ongoing high risk for serious complications or death within a year)
☐ ADL assistance needed with inadequate caregiver assistance	☐ Pressure ulcer(s)	☐ Urinary catheter
☐ Dyspnea (with moderate or minimal exertion or at rest)	☐ Stasis ulcer	

Additional Resources for Proactively Mitigating Identified Readmission Risks
Alliant Health Solution's My Home Health Care Plan helps patients and caregivers document their questions and concerns prior to home health ending. Using this tool can help teams proactively implement mitigation strategies. **My Home Health Care Plan: My Questions**
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 can 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**
"Deciding About Going to the Hospital" resource can help guide proactive discussions with patients and health care agents around readmission risks, goals of care, agency capabilities and the decision process when a change in condition is identified. **Home Health 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® 1.0 Quality Improvement Tool For Review of Acute Care Transfers

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