



# Best Practice: Hospitalization Risk Assessment

# Nurse Track





## Nurse Track

This best practice intervention package is designed to introduce all nurses to the hospitalization risk assessment to assist in reducing avoidable acute care hospitalizations.

### Objectives

After completing the activities included in the Nurse Track of this Best Practice Intervention Package – Hospitalization Risk Assessment, the learner will be able to:

1. State at least one reason why reducing avoidable acute care hospitalizations is a national focus.
2. Define what a hospitalization risk assessment is and how it can be used by a home health agency.
3. Identify two suitable nursing applications of the hospitalization risk assessment.

Complete the following activities:

	<b>Activity</b>	<b>Location</b>	<b>Estimated Time</b>
<input type="checkbox"/>	Read the risk assessment description and review the sample risk assessment tool	Pages 29, 31	10 minutes
<input type="checkbox"/>	Listen to the audio recording: ACH - Audio Recording for Clinicians - History & National Priority	Page 30	10 minutes
<input type="checkbox"/>	Listen to the audio recording: Hospitalization Risk Assessment for Clinicians	Page 30	15 minutes
<input type="checkbox"/>	Read the Nurse's Guide to Practical Application	Page 32	5 minutes
<input type="checkbox"/>	Read the success stories	Page 34	15 minutes
<input type="checkbox"/>	Access and explore the supporting resources for reducing acute care hospitalizations on <a href="http://www.medqic.org">www.medqic.org</a>	Page 38	15 minutes
<input type="checkbox"/>	Complete the Nursing post-test	Page 40	10 minutes
	<b>Total time for completion</b>		<b>80 minutes</b>



## Hospitalization Risk Assessment

Home health agencies are in a position to respond to patient and health care system needs by implementing strategies targeted to reduce avoidable hospitalizations. Agencies can identify patients who are at higher risk of hospitalization. Clinicians can partner with these patients to implement strategies, which reduce risk. Patients partnering with clinicians can learn to manage their own health. Experience shows that when agencies partner with patients and physicians, acute care hospitalizations can be reduced.

Completing a hospitalization risk assessment at targeted intervals is an intervention used to determine the risk level for patient hospitalization. Specific interventions are implemented for those patients rated as high-risk to reduce the potential of unplanned hospitalization. (©2006 Briggs® National Quality Improvement/Hospitalization Reduction Study Sponsored by: Briggs® Corporation, NAHC and Fazzi Associates, Inc.)

The completion of the hospitalization risk assessment should be part of a comprehensive assessment to identify those patients who are at risk for hospitalization, especially older adults. A dialogue with the patient and family is necessary to determine their wishes, goals and desires to be met by the interdisciplinary team. The team's responsibility is to commit to achieving the patient's stated goals.

Risk assessments can be paper-based or integrated into point-of-care systems. A structured communication process must be established to ensure that appropriate staff, including those on-call after business hours, are aware of patients identified as being "at-risk" for hospitalization. The risk assessment findings serve as the basis for the selection of interventions to be included in the patient's plan of care to reduce avoidable hospitalizations and emergent care.

It is the responsibility of the **home care nurse** to accurately complete the hospitalization risk assessment in a timely manner and to then communicate the high-risk status of patients to appropriate managers, other disciplines, and on-call staff. The home care nurse is also responsible for the selection of appropriate individualized interventions that may be used to assist in reducing avoidable acute care hospitalizations. Examples of interventions that an agency may offer include:

- |   |  |
|---|--|
| <input type="checkbox"/> Patient emergency planning | <input type="checkbox"/> Triage                  |
| <input type="checkbox"/> Medication management      | <input type="checkbox"/> Fall prevention         |
| <input type="checkbox"/> Front-loading visits       | <input type="checkbox"/> Immunization            |
| <input type="checkbox"/> Phone monitoring           | <input type="checkbox"/> Patient self-management |
| <input type="checkbox"/> Telemonitoring             | <input type="checkbox"/> Disease/case management |

The nurse must be able to correctly, effectively, and efficiently communicate his/her risk assessment findings to physicians to obtain necessary orders.



## Audio Recordings

### Instructions:

Listen to the two audio recordings to learn more about reducing avoidable acute care hospitalizations and the use of the hospitalization risk assessment. A sample acute care hospitalization risk assessment form is on the next page.

<b>Title</b>	<b>Description</b>	<b>Link</b>
ACH – History & National Priority – for Clinicians	A 10-minute audio recording related to ACH – the national priority outcome.	The audio link is located at <a href="http://www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx">www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx</a>
Hospitalization Risk Assessment for Clinicians	A 15-minute audio recording that can be used by clinicians in staff/team meetings or while traveling in the car. A few discussion points are included.	The audio link is located at <a href="http://www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx">www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx</a>

There are several ways you can listen to these audio recordings. You can visit the link above and listen directly through the Web site. You can also download the audio recording by right-clicking on the audio file and selecting “Save Target As...”. This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or you can burn the audio file to a CD to listen to in your car or stereo.

# Hospitalization Risk Assessment

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

Patient Name: \_\_\_\_\_ Record # \_\_\_\_\_

Date: \_\_\_\_\_

<b>Prior pattern: Check all that apply</b>			
<input type="checkbox"/> > 1 Hospitalizations or ER visits in the past 12 months	<input type="checkbox"/> History of falls * ( <i>Complete Falls Risk Assessment</i> )		
<b>Chronic conditions: Check all that apply (M0230/M0240)</b>			
<input type="checkbox"/> CHF	<input type="checkbox"/> Chronic skin ulcers ( <i>Wound consult if indicated for any wounds</i> )		
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> COPD	<input type="checkbox"/> HIV/AIDS		
<b>Risk Factors: Check all that apply</b>			
<input type="checkbox"/> Discharged from hospital or skilled nursing facility (M0175)	<input type="checkbox"/> Help with managing medications needed (M0780) ▶ ★		
<input type="checkbox"/> More than 2 secondary diagnoses (M0240)	<input type="checkbox"/> Non-compliance with medication regimen ◆ ★		
<input type="checkbox"/> Low socioeconomic status or financial concerns ◆	<input type="checkbox"/> Confusion (M0570) ◆ ★		
<input type="checkbox"/> Lives alone (M0340) ▶ ◆	<input type="checkbox"/> Pressure ulcer (M0445) ★		
<input type="checkbox"/> Inadequate support network ◆	<input type="checkbox"/> Stasis ulcer (M0468) ★		
<input type="checkbox"/> ADL assistance needed ▶	<input type="checkbox"/> Short life expectancy (M0280) ■		
<input type="checkbox"/> Home safety risks ▶ ◆	<input type="checkbox"/> Poor prognosis (M0260) ■		
<input type="checkbox"/> Dyspnea (M0490) ▶ ★	<input type="checkbox"/> Low literacy level ◆		
▶ Consider Therapy referral (PT, OT, ST)	◆ Consider MSW referral	■ Consider Hospice referral	★ Consider RN referral, if not ordered
Total # of checked boxes is _____. <b>Your agency may want to select a threshold score to target patients at high risk.</b> (For example: 5 or greater risk factors may indicate that 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.)			
<b>Consider implementing any of the following interventions, if patient is at risk for hospitalization:</b>			
Referrals: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Dietary Consultant <input type="checkbox"/> Other _____	<input type="checkbox"/> Medication Management Reconciliation • Assess patient's: knowledge, ability, resources and adherence • Education	<input type="checkbox"/> Patient/family education <input type="checkbox"/> Enrollment into a disease management program (specify): _____	
<input type="checkbox"/> Hospice/Palliative Referral	<input type="checkbox"/> Phone Monitoring	Immunizations <input type="checkbox"/> Influenza <input type="checkbox"/> <input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Individualized Patient Emergency Care Plan	<input type="checkbox"/> Front-loading Visits	<input type="checkbox"/> Care Coordination (Physicians, hospitals, nursing homes...)	
<input type="checkbox"/> Fall Prevention Program	<input type="checkbox"/> Telemonitoring	<input type="checkbox"/> Other: _____	

Consider notification of any/all of the following if patient is at risk for hospitalization:

<input type="checkbox"/> Patient/family/caregiver	<input type="checkbox"/> Interdisciplinary Team	<input type="checkbox"/> On Call Staff	<input type="checkbox"/> Payer: (e.g. Managed Care Organizations)
<input type="checkbox"/> Physician	_____	<input type="checkbox"/> Agency Case Manager	<input type="checkbox"/> Other: _____

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

The following articles provide more information on risk assessments:

Rosati, R.J., Liping, H., Navaie-Waliser, M., & Feldman, P.H. (2003) Risk Factors for Repeated Hospitalizations among Home Healthcare Recipients. *Journal for Healthcare Quality, 25*(2).  
 Fortinsky, RH, Madigan, EZ, Sheehan, TJ, Tullai-McGuinness, S. & Fenster, JR. (2006) Risk factors for hospitalization among Medicare home care patients. *West J Nurse Res, 28*(8).





# Hospitalization Risk Assessment

## Nurse's Guide to Practical Application

**Purpose:** To assist the nurse in becoming more effective and efficient at completing a hospitalization risk assessment or if the home health agency is not using a risk assessment, to learn to recognize high-risk factors. Also, to identify the need for selecting and implementing targeted interventions to reduce avoidable hospitalizations.

- Discuss hospitalization risks with referral source upon referral.
- Complete a hospitalization risk assessment at SOC/ROC, Recertification or Significant Change in Condition (SCIC).
- Initiate a discussion with patient/family regarding patient's hospitalization risk factors that include patient-specific interventions to achieve the goal to stay home while avoiding emergent care and hospitalization.
- Utilize the findings of the risk assessment to trigger referrals to other disciplines to minimize risks of hospitalization. Therapy referrals when ADL/IADL status impaired, cognitive dysfunction, swallowing difficulty, etc. MSW referrals with safety issues, medication non-adherence, financial difficulties, etc. Home health aides as a temporary intervention until strength/balance regained, endurance or shortness of breath improved, etc.
- Participate in interdisciplinary case conferences to assist with the development of patients' plans of care, utilizing interventions to assist in reducing hospitalization.
- Therapy-only cases need to have a process for a nurse to review patient's medications for potential medication complications, interactions, etc.
- Recommend interventions to minimize hospitalization risks such as front-loading visits or telehealth (electronic and/or phone).
- Proactively, notify physician when patient is identified as high-risk for hospitalization and obtain orders to enable early interventions when signs and symptoms of deterioration in health status have been identified.
- Include patient's hospitalization risk level when reporting SOC/ROC information to manager, other disciplines, on-call staff and scheduler.



- ❑ Include hospitalization risk factors in patient report when obtaining visit authorizations from Medicare Advantage organizations.
- ❑ Encourage patient/caregiver self-care activities and establish parameters to call the agency [provide patient-specific self-care management tools as appropriate].
- ❑ Consider the hospitalization risk assessment factors and re-assess risk throughout episode of care as patient condition changes, possibly increasing risk of hospitalization and need for additional changes.
- ❑ Update the hospitalization risk assessment if the patient's condition changes throughout the episodes of care. The patient may be potentially at increased risk for hospitalization and may need changes in care interventions.



**“As home care becomes more involved in the prevention of acute care hospitalization, the risk assessment tool provides a standard mechanism to identify clients that need more intense preventative measures. When staff is also provided with agency specific algorithms to guide clinician interventions, then this risk assessment tool becomes doubly useful. We have also found this tool useful for new clinicians who may not have strong home care backgrounds.”**

Bobbie Warner, RN, BSN  
Performance Improvement Manager  
Home Health Care Management



## Success Stories

### **Home Health Agency Uses Case-Mix Analysis to Decrease Hospitalizations**

A.T. Home Care, Inc. was one of 17 home health agencies to participate in the March 2005 pilot program sponsored by the Centers for Medicare & Medicaid Service (CMS). The target outcome for the pilot was to reduce acute care hospitalization in the home health setting, and A.T. Home Care, Inc. worked with the Delmarva Foundation, the Medicare Quality Improvement Organization (QIO) for Maryland and the District of Columbia, during the project.

Quality Improvement Manager Carol Elrod said that obtaining the Case Mix Analysis Summary in the pilot project in March 2005—along with an explanation on how to use the reports to lower ACH rates from the QIO—was highly beneficial. The Case Mix Analysis Summary Report compares the differences in an agency's case mix factors (including demographic, payment sources, caregivers, ADLs/IADLs, home care diagnosis groups, length of stay, etc.) among patients that were hospitalized and those that were not hospitalized. Case-mix reports are available to HHAs through the CASPER system. (Contact your state Quality Improvement Organization to learn more about the Case-Mix Analysis Summary Report.)

A.T. Home Care implemented a plan of action to reduce ACH, which included the following interventions:

- Emergency care plan
- High-risk screening tool
- Disease-specific teaching maps
- Front-loading visits and employing evidence-based practices.

In analyzing the case-mix reports to determine which patients were being hospitalized, Elrod said the agency learned those most at risk were dependent on personal care. She also learned by comparing notes with others in the pilot program that every agency had a different patient base that was most at risk for being hospitalized. "Nobody else had the same top five or the top two patients," she said. "This really is a 'drill down' into your specific case mix analysis," Elrod added.

Thanks, in part, to the use of the case-mix reports, A.T. Home Care's ACH rates went from 25.8 in 2003 to 20.5 in 2005, and 20.2 as of June 2006. As part of the ongoing analysis, Elrod also continuously adjusts for those at high risk, based on report findings. "Dependence on personal care," for example, has dropped out of the top five patient profiles for those at risk. In addition, she is taking a closer look at admissions, trying to figure out if one hospital is better or worse than another in terms of re-admitting patients. "If more of our patients from hospital 'X' go back into the hospital than those from hospital 'Y,' then we may have to conduct research to see what disease condition from this hospital is causing patients to be readmitted," Elrod said.



A.T. Home Care adjusted the high-risk screen during flu season when respiratory patients started showing up as high-risk patients (with disease management as a secondary condition). The agency subsequently added chronic diseases as a risk factor, and expanded disease management teaching maps to cover the scope of this disease process.

Elrod said the agency also expanded its diabetic care map, after agency officials noted that many of A.T. Home Care's patients admitted for treatment in a hospital have diabetes as a secondary diagnosis and, due to poor control and compliance, are readmitted for related complications.

Staff now assess all areas of diabetic management, use standardized care delivery and also use the hemoglobin A1c to assess diabetes control and compliance. If recent results aren't immediately available (e.g., with referral information), home health staff contact the patient's primary care provider. If a current report does not exist, staff request a physician order to draw an HbA1c level.

What's the key to maintaining improvements while shifting the focus on high risk areas? Elrod said the agency employs rapid cycle improvement, which is also known as Plan-Do-Study-Act (PDSA) cycles. A.T. Home Care learned about the use of PDSA while participating in the pilot program mentioned above. "Now we have the tools to run rapid cycles, and from month to month, I'll be able to see a difference," she said. "Using small groups and isolated groups study ... we will [implement] small best practices, and see if they work. In my opinion, with rapid cycling or PDSA, if you have the information and if something's not working, you have to either add or look further."

*Data in this article was provided by Carol Elrod, A.T. Home Care.*

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### **Virginia Home Health Agency Employs Various Strategies to Reduce Avoidable Hospitalizations**

Twin County Regional Home Health (TCRHH) is a service of Twin County Regional Hospital, a rural hospital serving a large Medicare population within a total population of approximately 60,000. The hospital is located in Galax, Virginia, and offers hospice and home health care services to as many as 195 patients each week.

The staff at TCRHH has found it beneficial to work with the state's Medicare Quality Improvement Organization (QIO), the Virginia Health Quality Center (VHQC), to improve the care provided to their patients. The agency actively participated in both the OASIS demonstration project and with OBQI projects.

Twin County's decision to participate in a reduction of Acute Care Hospitalization (ACH) project with VHQC was based more on the desire for ongoing reinforcement. Their ACH rate for November 2005 (reported January 2006) was 27.7. The agency's goal was to decrease their ACH rate by one percent. Based upon their September 2006 data (reported December 2006) Twin County's rate



was 25.1 has decreased their ACH rate by 2.6percent. which is three percent below the national average and one percent below the state average.

How did they accomplish this goal? Twin County first used the Outcome Based Quality Improvement process. A team was selected and chart audits completed. Meta Smith, agency director, said that she knew that improving any outcome, including ACH, takes a team effort. The team developed a risk assessment using QIO-provided materials which they adapted for the agency.

Staff used the case mix analysis summary report and other reports, and found that their internal audit findings mirrored the report. Patients with diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) and/or requiring oxygen therapy were more likely to be hospitalized. The majority of the agency's patients returning to the hospital also did so within the first 30 days of care. Findings further revealed issues with consistent assignments of staff and a wide variation on the frequency of visits by staff.

The agency developed an organizational plan of action, identifying best practices and key strategies. The plan included:

- Risk assessment
- Front-loading visits
- Phone monitoring
- Consistent staff assignments
- Extensive staff education
- Patient education
- Emergency contact plan

A **risk assessment** is conducted at admission and resumption of care post hospitalization. If the patient is determined to be at risk, he/she is seen two to three times a week during the first three weeks (**front-loading visits**). Because telemonitoring is not available (due to financial constraints), the staff use a structured telephone assessment form to make frequent targeted follow-up calls to high-risk patients between home visits (**phone monitoring**). Staff indicate that it is not a burden to conduct additional monitoring of patients, and said that sometimes a simple phone call can make a big difference for the patient and their families.

**Consistent staff assignments** (sometimes called primary or permanent assignment) are defined as having the same caregivers (whether that is a registered nurse, licensed practical nurse, certified nursing assistant or therapist) consistently caring for the same patients every time they are on duty. This is an important part of the plan for patients that are identified as high-risk. High-risk patients are "flagged," which indicates the need for a consistent caregiver.

**Extensive staff education** was initiated and remains ongoing. Written processes and instructions were developed and each member of the team was assigned staff to review and provide feedback on the processes.



**Patient education**, including an **emergency contact plan**, was initiated. The plan identifies concerns for patients such as when to call the home health agency, when to go to the hospital, and symptoms of problems related to the patient diagnosis. Because of the high, recognized use of the hospital emergency room in this community, physicians are willing to call on the home health staff to visit patients who call the physician for care and/or advice. “Although we use many QIO tools, the emergency contact plan for patients is the best tool the QIO provided,” said Smith.

In addition, the agency continues its work on telephone triage, also known as teletriage. Teletriage occurs when the patient or family calls the agency with a concern or question. Because teletriage is a patient contact for which agencies can be held legally liable, certain documentation must be included in the patient record. The agency documented patient calls in the past, but not always consistently, according to Smith. The agency is now using a telephone triage documentation form to ensure compliance.

Twin County conducts monthly audits and adjusts strategies based on the audits to sustain or improve the ACH outcome. Agency staff adds additional risk areas based on patient population and demographics. More specifically, staff has added:

- Pulmonary diagnosis (improved respiratory assessment included)
- O<sub>2</sub> therapy of two or more liters continuously
- Non-healing wound and indwelling urinary catheter
- Inpatient facility stay or emergent care in past three months
- Dependence in medication administration
- Intractable pain

Continuing staff and patient education has also contributed to the agency’s success in reducing ACH. A fall prevention program and immunization program were instituted as part of the education process, and agency leaders reported these programs have been paramount in decreasing ACH. The agency is developing clinical paths and launching a disease management program, including promotion of patient self-management.

“The whole outcome process is dependent on accurate OASIS assessment,” said Smith. “Outcomes are only as good as the integrity of the assessment.”

*Data in this article was provided by Meta Smith, Twin County Regional Home Health.*



## Investigating Resources



There are many valuable resources to assist you in reducing avoidable acute care hospitalizations. MedQIC ([www.medqic.org](http://www.medqic.org)) is the Web site developed by Centers for Medicare & Medicaid Services (CMS) as a comprehensive online resource of quality improvement information.

### ACH Clinical Resource Kit

The Acute Care Hospitalization Clinical Resource Kit was created to organize select tools and resources used by home health agencies to reduce avoidable acute care hospitalizations. It is located on [www.medqic.org](http://www.medqic.org).

#### How to Access the ACH Clinical Resource Kit:

After reaching the home page on MedQIC, select the tab for Home Health, then on the left bar, select Acute Care Hospitalizations, and then in the right box select Tools. All available tools related to ACH are listed here. Find the ACH Clinical Resource Kit title and click it.

Below is the direct link to the Kit:

[www.medqic.org/dcs/ContentServer?cid=1157485199261&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools](http://www.medqic.org/dcs/ContentServer?cid=1157485199261&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools)

On the right box, go to the bottom of the page and select the Toolkit PDF (It will take a few minutes to open a file this large. You may want to right-click and select Save As...). This PDF file is the entire ACH Clinical Resource Kit.

### ACH Clinical Resource Kit Investigation Activities

A small magnifying glass icon.	Locate the ACH Clinical Resource Kit (using either the navigation information or the link from above.)
A small magnifying glass icon.	Locate and read the Hospitalization Risk Assessment Tip Sheet, <b>“The ACH Connection: Hospitalization &amp; Emergent Care Risk Factor Assessment.”</b>
A small magnifying glass icon.	Review the table of contents for other resources that may be appropriate for your patients.



## Home Health Compare

Since fall 2003, CMS has posted on [www.medicare.gov](http://www.medicare.gov) a subset of OASIS-based quality performance information showing how well home health agencies assist their patients in regaining or maintaining their ability to function. Measures of how well people can get along in their homes performing activities of daily living (ADLs) form the core of the measures, and are supplemented with questions about physical status and two use-of-service measures (hospitalization and emergent care). The language on home health compare is written in lay terms for the consumer's understanding of the measure. Several agencies can be selected and outcome data can be compared to each other, as well as to state and national averages.

### Home Health Compare Investigation Activities

	Go online to <a href="http://www.medicare.gov">www.medicare.gov</a>
	Scroll down the page to the Search Tools section, then click on "Compare Home Health Agencies in Your Area"
	Read the information contained on this site from the column entitled "This website has information for:"
	Follow the directions to find your home health agency's outcomes – begin by following the directions on the left column entitled "How would you like to find a Home Health Agency?" or follow the specific instructions below.
	Under "How would you like to find a Home Health Agency," click on either "By Geography" or "By Name"
	Step 1 of 4 – Enter the required field(s) – click "next step" Step 2 of 4 – Select all services your HHA provides – click "next step" Step 3 of 4 – Select your HHA – click "next step" Step 4 of 4 – Select all – "click next step"
	Review and compare all your outcomes to your state and national averages.
	Go to the bottom of the page to "Percentage of patients who had to be admitted to the hospital"
	<b>Fill in the blank:</b> My agency's percentage of patients who had to be admitted to the hospital is _____.
	You can review the other outcomes on this page and see how your HHA is doing compared to your state and the national averages.

Clinician name: \_\_\_\_\_

Date: \_\_\_\_\_



## Nursing Post-Test

1. Best practice interventions assist in reducing:
  - a. All hospitalizations
  - b. Avoidable acute care hospitalizations
  - c. Prospective payment costs
  - d. Number of therapy visits

### Patient Scenario:

Mr. Smith is a 72-year-old man who lives alone. His son checks on him every other day. Mr. Smith was recently hospitalized with exacerbation of CHF as a result of misunderstanding his medication regimen. Secondary diagnosis includes HTN, anemia and chronic renal failure. He often forgets to take his second daily dose of Lasix. Patient is complaining of shortness of breath on exertion, poor endurance and generalized weakness. Mr. Smith has been hospitalized three times this past year. The physician has made a home care referral for skilled nursing for skilled assessment, medication, dietary and disease management teaching.

2. Using the sample hospitalization risk assessment tool on page 31, how many risk factors are evident in this patient scenario?
  - a. 2
  - b. 4
  - c. 7
  - d. 10
3. Which of the following interventions does **NOT** assist in reducing the risk for acute care hospitalizations?
  - a. Notify physician of high risk
  - b. CHF Disease Management Program
  - c. Declining all referrals for patients with high risk diagnosis
  - d. Front-loading visits including phone monitoring
  - e. Medication Management
4. Hospitalization risk assessment should be completed on Start of Care (SOC)/Resumption of Care (ROC) and may also be performed at recertification or with significant change in condition (SCIC).
  - a. True
  - b. False
5. It is important to not only identify high risk patients, but to also communicate that information. After high-risk patients are identified, who should be notified?
  - a. Patient/family/caregiver
  - b. All ordered disciplines
  - c. Nurse Manager
  - d. On call staff
  - e. Physician
  - f. All of the above