Job-Aid

Louisiana Department of Health and Hospitals
Office of Aging and Adult Services

DEPARTMENT OF HEALTH AND HOSPITALS

# Risk Assessment & Referral Screening Tool

(Check out OAAS website for other services provided at home: www.oaas.dhh.louisiana.gov)

Risk assessment and management is an ongoing element of quality care practices and an ongoing and essential part of assuring health and welfare in Home and Community Based Service (HCBS) Waivers. This ***Risk Assessment & Referral Screening Tool*** aims to guide the Support Coordinator/Assessor in identifying potential risk factors, documentation of risk information, communication of risk, and the implementation of appropriate risk management strategies based on the information collected. The checklist and Risk Assessment Criteria outlined below shall be used by the certified assessor over the phone or during a home visit, as applicable to help determine the participant's level of risk and need for referral.

**Referral Criteria: Consider the following when assessing for risk factors and possible need for referral(s):**

- **Individual's pre-hospitalization functional ability**
- **Informal supports – able willing, available caregiver**
- **Cognition**
- **Client's current functional ability**
- **Prior home care services**
- **Multiple hospitalizations/ER visits**
- **Chronic illness**
- **Special needs – Durable Medical Equipment (DME)**
- **Environmental Accessibility Adaptations (EAA)**
- **Teachability/understanding of illness**

✓ **Check All That Apply**

## Low Risk Criteria

- ☐ Independent in ADLs
- ☐ Caregivers in the home & available to assist
- ☐ Lives alone with community support
- ☐ Independent with management of chronic disease/ meds
- ☐ Adherence to treatment plan
- ☐ Able to direct medical care
- ☐ Consistently followed by MD/Practitioner

## Moderate Risk Criteria

- ☐ Lives alone with limited community support
- ☐ Requires assistance with medications
- ☐ Issues of health literacy
- ☐ History of mental illness
- ☐ Polypharmacy (9 or more meds)
- ☐ Requires temporary/intermittent assistance with IADLs & ADLs
- ☐ Requires assistance in:
  - Ambulating
  - Wound care
  - Transferring
  - Management of oxygen and/or nebulizer

**If ≥ 2, evaluate/discuss possible need for referral. Consider referral for:**

- Skilled Nursing
- Observation and assessment
- Teaching and training
- Performance of skilled treatment or procedure
- Management and evaluation of client care plan
- Physical, occupational, speech therapy, and/or respiratory therapy
- Medical social work
- Home health aide service for personal care and/or therapeutic exercises
- DME/Medical Supplies
- Adaptive Devices

## *High Risk Criteria

- ☐ Lives alone with no community support
- ☐ Lives with family that is not actively involved in care
- ☐ Clinically complex (multiple co-morbidities, repeat hospitalizations or ER visits, needs considerable assistance to manage or is unable to manage medical needs independently)
- ☐ History of falls
- ☐ Acute/chronic wound or pressure ulcers
- ☐ Incontinent
- ☐ Cognitive impairment
- ☐ History of mental illness
- ☐ Chronic Heart Failure (CHF) and/or Chronic Obstructive Pulmonary Disease (COPD), and/or diabetes, and/or HIV/AIDS
- ☐ End stage condition
- ☐ Requires considerable assistance in:
  - Transferring
  - Ambulating
  - Medication management (greater than 9 meds)
  - Management of oxygen and/or nebulizer

***If ≥ 4, evaluate/discuss AND refer for Home Health/Therapy/ Environmental Accessibility Adaptations Evaluation/Services, as applicable.**

**This individual is High Risk for re-hospitalization, deterioration in condition requiring the need for 24 hour care in an institutional setting, caregiver stress/burnout, loss of independence, medical complications, and/or other predisposing conditions that could lead to negative outcomes. It is critical that the importance and benefits of other services (formal and informal) that may assist the individual/caregiver/family in meeting the individual's goal to remain in his/her home and community setting, be stressed and discussed during the care planning process and ongoing evaluation/monitoring processes of the individual's status and progress/lack of progress in attaining care plan goals.**

**Participant Name:** _____ **Last 4 of SSN:** _____

**Support Coordinator:** _____ **Date of Review:** _____