HRST
HEALTH RISK SCREENING TOOL

HRST Expanded Scoring Descriptors

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HRST Expanded Scoring Descriptors

This document is intended to guide the Rater and Clinical Reviewer in determining that the person rated has received the correct score. Please look over the descriptors carefully and make sure that the person you are rating fits the scoring descriptor for each item.

GENERAL RATING TIPS

- When entering Rating Notes, please describe WHY the rating is appropriate for the person according to the descriptors listed below.
- If any rating question(s) are answered "YES," please justify the answer to that question in the Rating Notes for that item.
- If the Rater is unsure if an answer should be "YES" or "NO," review the additional information by clicking the "I Don't Know" button located in each question.
- If there are any questions about whether the rating is appropriate, please click on Contact Support at the bottom of any page within the HRST application.

Throughout this document, you will see the term "Healthcare Provider." Many people receiving services do not see a physician. A healthcare provider may be a physician, a physician assistant, a nurse practitioner or other advanced practice nurse.

UNDERSTANDING SCORING

Generally, scoring in each of the 22 rating items will follow this pattern:

0. No issues within the past 12 months
1. Occasional issues within the past 12 months. No identifiable pattern
2. Emergence of an identifiable pattern of issues
3. Increasing frequency and/or intensity of identified issues
4. Potentially life-altering or life-defining issue or hospitalization within the past 12 months

Permanent Points**

The HRST Rating Items all look back at the past 12 months, except in four circumstances, identified in the scoring descriptors by the phrase "history of," which result in points that remain elevated after 12 months have passed. The four items are:

- **C. Transfer = 4:** History of a fracture during a transfer procedure. It does not include all fractures, just those that occurred ONLY as a result of a transfer
- **K. Gastrointestinal (GI) = 3:** History of a diagnosis of GI bleeding, not including hemorrhoids
- **N. Skin Integrity = 2:** History of a pressure injury
- **O. Bowel Function = 4:** History of any hospitalization for a paralytic ileus or bowel obstruction

CATEGORY I – FUNCTIONAL STATUS

A. Eating

This item measures the person's ability to safely consume an adequate number of calories and fluids to maintain health and well-being.

This item looks back at the past 12 months.

RATING TIPS

- Interventions needed to address physical limitations, swallowing disorders and alternative routes of receiving nutrition should all be included.
- Include behaviors such as eating too fast, consuming foods that have an incorrect texture, consuming foods that do not align with the person's prescribed diet, or violate NPO orders.
- If behavioral issues cause the person to score here, be sure to also rate them under Item F Self-Abuse or Item G Aggression.
- Note: a person with no risk in Item A Eating who takes the food of others without permission will not score in Item A Eating but rather in Item G Aggression.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person ate independently within the past 12 months.

- May require simple adaptive equipment (hand splint, special eating equipment, etc.) but is able to eat without assistance or supervision.
- Those needing help only to cut food into regular, bite-sized pieces should score a 0.
- Those who require altered food texture or fluid consistency require a higher score.

1. The person required INTERMITTENT physical assistance and/or verbal prompts to complete a meal within the past 12 months.

- May need occasional physical assistance or verbal prompts due to issues with attentiveness.
- May need occasional physical assistance or verbal prompts to reposition adaptive eating utensils or equipment.
- May need occasional physical assistance for repositioning due to physical limitations.
- The person providing assistance is not required to be present at all times during eating.

2. The person required CONSTANT physical assistance and/or verbal prompts to complete a meal within the past 12 months.

- Has difficulty attending to task OR may have motor limitations OR attention issues that require constant physical assistance AND/OR verbal prompts.
- No issues with swallowing or potentially dangerous eating behaviors such as consuming foods that have an incorrect texture, consuming foods that do not align with the person's prescribed diet, or violate NPO orders.
- A true and accurate score of a 2 on this item will be rare. Constant assistance with a meal usually indicates issues with safety, which would cause the score to be a 3.

3. The person required CONSTANT physical assistance, CONSTANT verbal prompts or other mealtime intervention to eat safely within the past 12 months.

OR

The person had a feeding tube (gastrostomy [G-tube], jejunostomy [J-tube], orogastric [OG-tube] or nasogastric tube [NG-tube]) but maintained some level of PERMITTED oral intake within the past 12 months.

- May have difficulty coordinating breathing/swallowing while eating OR have dangerous behaviors, such as overstuffing the mouth OR other conditions that impair the ability to eat safely.
- Unable to obtain adequate calories and/or fluids without assistance. Interventions were required (specific positioning support, eating devices and/or modifications in food texture or fluid consistency).
- May require hand feeding.
- May have behavioral OR swallowing issues that require specialized presentation techniques or restricted access to food items.
- May have an enteral (feeding) tube but is allowed or encouraged to have some level of oral eating. If a feeding tube is in place but is rarely or never used, the score is still a 3.

4. The person received ALL nutrition/hydration by other than oral routes (gastrostomy [G-tube], jejunostomy [J-tube], orogastric [OG-tube] or nasogastric tube [NG-tube], or total parenteral nutrition [TPN]) within the past 12 months.

- Has a prescription for nothing by mouth (NPO).
- Unable to swallow safely.
- Has other issues that require alternatives to oral eating.
- Persons who sneak food or otherwise receive food by mouth against the healthcare provider's prescription still qualify for a score of a 4.
- Consuming food that goes against their diatery orders for any reason.

B. Ambulation

This item measures the amount of assistance or support a person needs to safely move from one place to another.

This item looks back at the past 12 months.

RATING TIPS

- Issues that may affect the ability to ambulate safely includes both physical and intellectual challenges, body weight, visual, or hearing deficits.
- Always score the person when they are their most dependent. For example, if the person can ambulate independently in their home, but uses a wheelchair or other mobility device in the community, their score will will reflect their most dependent state, which in this example, is the use of the wheelchair or other mobility device in the community.
- If behavioral issues cause the person to score here, be sure to also score them under Item F Self-Abuse or Item G Aggression.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person walked independently in ALL settings within the past 12 months.

- May use a walker, cane or other means of support but does so independently in all settings without safety issues or other need of assistance.

1. The person walked with minimal supervision within the past 12 months.

- Requires the assistance of a support person in close proximity in one or more settings.
- The primary issue is ambulating safely.

2. The person was predictably dependent on a wheelchair or other ride-on mobility device, such as a ride-on scooter, for at least some mobility needs within the past 12 months.

- May or may not have the ability to walk in some settings.
- May be unable to walk but is able to use their upper body strength for repositioning AND can independently maintain an upright, well-aligned position.
- Able to recognize the need to change positions on a consistent basis.

3. The person required mechanical assistance to maintain an upright, seated position in a wheelchair. Needed assistance to change positions or shift weight within the past 12 months.

- A person qualifying for a score of a 3 is ALWAYS unable to walk.
- Able to be placed in an upright sitting position but cannot maintain a seated posture without outside mechanical support (pillows, specialized positioning equipment, adaptive wheelchair, etc.) or physical assistance.
- Needs assistance to reposition OR may not recognize the need to reposition on a consistent basis.
- May or may not need assistance to propel their wheelchair or other ride-on mobility device.

4. The person's disability prevented them from sitting in an upright position within the past 12 months.

- UNABLE to flex the hips to at least 45 degrees OR unable to reach reasonable alignment of the head, shoulders and pelvis.
- Due to musculoskeletal deficits or deformity, the person has limited or no seated position options.

C. Transfer

This item measures the type and amount of assistance a person needs to move from one position or surface to another.

This item looks back at the past 12 months.

Permanent Points Item	**Transfer is a permanent points item. IF a person has EVER sustained a fracture caused by a transfer procedure, the person will always score 4 in this item, even beyond the end of the 12-month period.**

RATING TIPS

- Typical transfers involve going between sitting and standing, lying to sitting, up and down stairs and curbs, and in and out of vehicles. It also includes transferring in and out of bathing facilities, moving from solid surfaces like concrete or hard floors to carpeted surfaces or uneven grassy or dirt surfaces.
- Barriers to safe transfers are the same as those for ambulation, including physical and intellectual challenges, body weight, visual or hearing deficits, and behavioral challenges.
- Always rate the person when they are their most dependent.
- If the person sustained a fracture RELATED DIRECTLY to a transfer procedure, they will always score a 4**. A fracture for any other reason will not affect the score here.
- For HRST purposes, assistance refers to the need for verbal or slight hands on guidance without managing a portion of the person's weight.
- A one or two person transfer refers to the number of support persons needed to assist who ARE managing a portion of the person's weight.
- When the person being transferred is completely unable to participate in the transfer, the weight limits for safe lifting are 50 pounds for one support person and 75 pounds for two support persons.
- People weighing more than 75 pounds who are completely dependent for transfer assistance may require lifting equipment or specialized procedures and will score a 4.
- Gait belts are assistive devices and are NOT to be rated as lifting equipment or specialized procedures, so a person should never receive a score of a 4 for the use of a gait belt.
- Specialized procedures include precautions taken to transfer persons with significant body structure issues, morbid obesity, severe bone fragility or aggressive behavior during transfers.
- Scores for ambulation and transfer are generally very similar. There should usually be no more than a 1-point difference between the two item scores.
- Since transfers generally involve shifting the person's body weight, the score for Transfer would typically be higher than that for ambulation. As an example, a person with a score of 1 on Item B Ambulation may be expected to need assistance with stairs, curbs and unfamiliar surfaces, giving the person a Transfer score of a 1 or a 2.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person transferred independently in ALL settings within the past 12 months.

1. The person needed a support person to supervise the transfer or provide guidance for safety within the past 12 months.

- May need minor hands-on assistance, but the person is able to bear their own weight and transfer safely in all settings.
- Supervision may be required for behavioral issues as well as physical issues.

2. The person needed the physical assistance of 1 support person to transfer or change position within the past 12 months.

- Is able to participate in transfers with the assistance of 1 support person managing a portion of their weight.
- Is completely dependent for lifting assistance AND weighs less than 50 pounds.

3. The person needed the physical assistance of 2 support persons to transfer or change position within the past 12 months.

- Is able to participate in transfers with the assistance of 2 support persons managing a portion of their weight.
- Is completely dependent for lifting assistance AND weighs between 50 and 75 pounds.

4. The person needed lifting equipment or specialized procedures to safely transfer within the past 12 months.

OR

Has a history of a fracture caused by a transfer procedure.**

- Requires specialized lifting equipment due to inability to participate in transfers.
- Includes persons who weigh more than 75 pounds and are completely dependent for transfers, whether or not they actually use lifting equipment.
- May need a range of specially designed positions or transfer techniques due to severe spasticity, behavior issues, bone fragility, potential for injury due to size, or degree of musculoskeletal deficits or deformity.
- Has a history of a fracture caused by a transfer procedure at ANY time in their life.

***Note: The effect of the score on the healthcare level (HCL) extends beyond the past 12 months, because it relates to "history of." The person will never have a score less than a 4 if they have had a fracture related to a transfer procedure.*

D. Toileting

This item identifies the amount of assistance the person needs to maintain continence and hygiene. It also identifies the risks associated with procedures that are used with persons who are unable to toilet independently.

This item looks back at the past 12 months.

RATING TIPS

- Incontinence may be of bowel and/or bladder. It may be either continuous or situation dependent (nighttime, school, work, willful incontinence behaviors, urgency, etc.).
- Even though incontinence is expected in infants and very young children, it is still given the same score here as any other person. The risk remains regardless of age or abilities.
- Those undergoing invasive catheterization procedures are rated a 4 here for a full 12 months after the event, regardless of the frequency or duration.
- Condom (Texas) catheters or female external collection devices do not have the same potential to introduce pathogens into the sterile environment of the bladder so they do not score a 4 for catheterization.
- Persons who pass bowel movements or urinate through a created opening such as a colostomy or urostomy score a 4. They score a 4 even if the created opening was reversed within the past 12 months and now the person is back to using the toilet in the typical manner.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person independently accomplished ALL toileting tasks within the past 12 months. No assistance or adaptations required. Prefers, and is capable of completing toileting activities privately.

1. The person required minimal supervision or adaptation within the past 12 months.

- May require verbal prompts or supervision to maintain hygiene OR manage clothing adjustments.
- May require adaptations to restroom facilities (grab bars or built-up toilet seat). Beyond this, minimal assistance is necessary.
- Includes persons who use medications for controlling bladder spasticity, urgency or urinary incontinence.

2. The person was continent of bowel and bladder, but constant attention was needed. May have

had occasional incontinence within the past 12 months.

- Requires physical assistance to complete hygiene tasks (wiping, hand washing) and/or clothing adjustments.
- May have occasional incontinence but NOT routine, predictable incontinence.

3. The person was predictably incontinent of bowel or bladder within the past 12 months.

- Is predictably incontinent of bowel or bladder in one or more settings (nighttime, work or school settings, or engages in willful incontinence).
- May require a toileting schedule or use incontinence briefs or pads, but NOT for their own or the support person's convenience.
- The use of a condom (Texas) catheter or female external collection device.
- A female may have used urethral support devices such as a pessary or other vaginal insert.
- Include infants for whom incontinence is age appropriate.

4. The person had ANY urinary catheterization procedure.

OR

The person used an ostomy for elimination of the bowel or bladder within the past 12 months.

- Required any catheterization, such as for urine sample collection, changing an indwelling catheter, self-catheterization, a surgical procedure, etc.
- Eliminates via ostomy such as colostomy, ileostomy, urostomy, suprapubic catheter, etc. This item will score a 4 even if the ostomy was reversed within the past 12 months.
- Persons using condom (Texas) catheters or female external collection devices will NOT score a 4.

E. Clinical Issues Affecting Daily Life

This item measures how often issues related to physical, mental or behavioral health take the person away from doing or enjoying their typical daily activities.

This item looks back over the past 12 months.

RATING TIPS

- This item is one of the most difficult to grasp on the HRST and the most often incorrectly scored.
- The questions are simple: How often do issues related to physical, mental or behavioral issues take the person away from doing or enjoying their typical daily activities for at least 30 minutes? This item looks at more than activities of daily living such as bathing, grooming and toileting. A day is 24 hours, so the issue a person experiences does not have to disrupt school, work or a day program. It could be a seizure that wakes a person at night or a behavioral episode on a weekend that doesn't allow them to participate in a desired activity.
- There are two types of disruptions that are accounted for in Item E:
  - Count days when typical daily activities are disrupted by events, including illness, injury, recovery days from illness or injury, pain, seizures, asthma attacks, behavioral episodes and similar events for at least 30 minutes.
    - Days when the person receives an as-needed (PRN) medication or treatment often indicate that an event has occurred, so tracking these is important.
    - Persons in pain are often not able to participate in the activities of their choice, and pain is often under-recognized in persons with intellectual and developmental disabilities (I/DD).
    - Events do not have to disrupt a whole day to count; it can be a partial day or a few hours but at least 30 minutes.
  - Count days when healthcare appointments are needed to address DIAGNOSED health conditions that take the person away from their typical daily activities.
    - These can include hospitalizations (plus the illness days before and the recovery days after), diagnostic visits, laboratory testing, visits for prescription renewal and/or monitoring diagnosed health conditions such as seizure disorders, psychiatric disorders, high blood pressure, diabetes, wound care management, etc. Here each visit for a symptom or diagnosis counts and does not require the distruption to be at least 30 minutes.

0. The person had no days (full or partial) that were affected for at least 30 minutes by health or behavioral issues within the past 12 months.

OR

The person did not participate due to personal preference or the legal representative's choice. No health or behavioral restrictions.

- Typical daily activities have not been disrupted due to illness, injury, behavioral or mental health issues, or the person had no healthcare provider appointments to monitor a diagnosed condition.

1. **The person had 23 days or less (full or partial) that were affected for at least 30 minutes within the past 12 months due to health or behavioral issues.**

   - Able to participate in typical daily activities but participation may occasionally be interrupted by illness, injury, behavioral or mental health issues, or may have healthcare provider appointments to monitor a diagnosed condition or receive treatment.
   - Count any seizure activity, behaviors, all hospitalization days (and illness days before and recovery days after), pain, illness days, etc. that affect their typical daily activities at any time of the day.

2. **The person had 24 to 48 days (full or partial) that were affected for at least 30 minutes within the past 12 months due to health or behavioral issues.**

   - Able to participate in typical daily activities but participation may occasionally be interrupted by illness, injury, behavioral or mental health issues, or may have healthcare provider appointments to monitor a diagnosed condition or receive treatment.
   - Count any seizure activity, behaviors, all hospitalization days (and illness days before and recovery days after), pain, illness days, etc. that affect their typical daily activities at any time of the day.

3. **The person had 49 to 120 days (full or partial) that were affected for at least 30 minutes within the past 12 months due to health or behavioral issues.**

   - Able to participate in typical daily activities but due to hospitalization, convalescence, chronic health instability or progressively worsening health or behavioral issues, there is a significant impact on their typical daily activities.
   - May be due to healthcare provider appointments to monitor a diagnosed condition or receive treatment.
   - Count any seizure activity, behaviors, all hospitalization days (and illness days before and recovery days after), pain, illness days, etc. that affect their typical daily activities at any time of the day.

4. **The person had more than 120 days (full or partial) that were affected for at least 30 minutes within the past 12 months.**

   OR

   Their ability to participate in typical daily activities was completely disrupted due to the intensity of health or behavioral issues.

   - Due to chronic, unstable or progressively worsening health or behavioral issues, participation in typical daily activities is severely impaired.
   - The person may be ill or have healthcare provider appointments to monitor or treat diagnosed conditions.
   - May be completely unable to participate in typical daily activities due to intensity of health, behavioral or mental health issues.
   - Count any seizure activity, behaviors, all hospitalization days (and illness days before and recovery days after), pain, illness days, etc. that affect their typical daily activities at any time of the day.

CATEGORY II - BEHAVIORS

F. Self-Abuse

This item measures the actions taken by the person that either do, or have the potential to, cause harm to themselves.

This item looks back over the past 12 months.

RATING TIPS

- Self-abuse includes the obvious behaviors such as head banging, self-biting, scratching self, hitting self, intentional rumination and elopement.
- It also includes less obvious behaviors that we don't necessarily associate with the term self-abuse but can result in severe consequences (including jail) or death to the person who engages in them.
- Examples of such self-abusive behaviors are smoking, drug or alcohol abuse, suicide attempts and non-compliance with prescribed diets and medications or other healthcare provider prescribed interventions.
- Self-abuse also includes unsafe sexual behaviors or sex with multiple partners that can reasonably be assumed to have the potential to result in harm due to skin breakdown, sexually transmitted infections or exposure to harm at the hands of the sexual partner.
- Healthy social behaviors such as moderate alcohol use and appropriate monogamous sexual relationships while following safe sex practices are NOT considered to be self-abusive.
- Smoking is always rated without exception due to the well-documented potential for harm. This also includes smokeless tobacco and vaping. It can be scored anywhere from a 1 to a 4 based on the interventions or consequences.
- It often helps to put any identified behavior through the "any person" filter. In other words, if anyone that you know or see were doing that same behavior, would you have a concern for their health risk?
- All behaviors are scored according to the frequency of the behavior and the consequence.
- This rating item is NOT about whether the person is good or bad; it is simply trying to identify risks that could result in the actual or potential for harm or death.
- If a person scores a 4 due to increased staffing, they will remain a 4 for 12 full months after the increased staffing has been withdrawn with no re-occurence of behavior.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no self-abuse within the past 12 months.

- No behaviors exist that resulted in self-harm OR could reasonably be presumed to be potentially self-abusive.

1. **The person displayed minimal self-abuse, but no intervention was required within the past 12 months.**

   - Behavior that is considered self-abusive has been identified but has not required minor first aid or other intervention.

2. **The person displayed self-abuse and needed first aid or other intervention 23 times OR LESS within the past 12 months.**

   - Demonstrated self-abusive behavior that caused slight injury, which may have required minor first aid treatment, such as ice packs, slight pressure to stop bleeding, cleansing, applying a simple bandage, ointment or cream application, or other intervention.

3. **The person displayed self-abuse and needed healthcare provider or nursing attention, or other intervention, 24 times OR MORE within the past 12 months.**

   - Demonstrated self-abusive behavior that caused minor self-injury, which may have required healthcare provider or nursing treatment or other intervention.

4. **The person displayed self-abuse (actual or potential) and caused serious physical harm (requiring healthcare provider TREATMENT, behavior support physical devices or procedures or behavior support chemical).**

   OR

   The behaviors significantly interfered with the ability to engage in typical daily activities.

   OR

   They required increased support within the past 12 months.

   - May be due to an existing self-abusive behavior pattern or the result of a single isolated self-abusive episode.
   - Self-abuse may score a 4 due to interventions being in place to prevent self-abuse.
   - The person will continue to score a 4 after ALL supports used for controlling self-abuse are removed for 12 full months, even if no self-abuse was displayed within the past 12 months.

G. Aggression

This item measures the number of aggressive episodes towards persons, animals or the physical environment.

This item looks back over the past 12 months.

RATING TIPS

- This item includes verbal aggression such as threats, name calling, screaming at someone, etc. and physical aggression such as hitting, shoving, menacing behavior within another's personal space, unwelcome touch or contact of ANY type, etc.
- Aggression against the physical environment can be punching holes in walls, breaking windows, breaking equipment like radios, CD players or glasses, fecal smearing, etc.
- It also includes restriction of access to certain individuals such as women or children or settings when there is potential for the person to become aggressive towards others such as parks, playgrounds or crowded areas.
- Just like self-abuse, this item is NOT about the person being bad or good. It is about the behavior only.
- The behavior may even be provoked by teasing or undue stress placed on the person.
- The issue is identifying and appropriately intervening with situations or behaviors that may result in harm to others or the person themselves, including from retaliation or result in restrictive settings.
- If the person scores a 4 due to increased supports, the score will remain a 4 until 12 full months AFTER the increased supports have been withdrawn with no re-occurence of behavior.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no episodes of aggression within the past 12 months.

1. The person displayed 59 OR LESS episodes of minor aggression (verbal, physical or environmental) WITHOUT injury to others, animals, or the physical environment within the past 12 months.

2. The person displayed 60 OR MORE episodes of aggression (verbal, physical or environmental) WITHOUT injury to others, animals, or the physical environment within the past 12 months.

3. The person displayed 59 OR LESS episodes of aggression that DID result in minor injuries to others (injuries not needing healthcare provider TREATMENT), animals, or caused minor physical environmental damage within the past 12 months.

- This may have been the result of a single episode of aggression.
- The person may have a very high frequency of verbal or physical aggression but minor injury to others, animals, or minor physical environmental damage occurred 59 times or less.

4. The person displayed 60 OR MORE episodes of aggression WITH INJURY to others.

OR

They required increased supports.

OR

Other restrictive interventions were in place to prevent or decrease the severity of the episodes of aggression.

OR

The person caused serious physical harm to other persons (requiring healthcare provider TREATMENT), animals, or caused more than minor physical environmental damage, within the past 12 months.

- The score will remain a 4 until ALL supports used for controlling aggression are removed for 12 full months, even if no aggression was displayed within the past 12 months.

H. Behavior Support Physical

This item measures the use of devices, specific procedures, hands-on contact, personal confinement, or restrictive settings for the prevention of unwanted behavior or injury to self, others or the environment.

This item looks back over the past 12 months.

RATING TIPS

- These behavior supports are sometimes referred to as physical, mechanical or environmental restraints.
- Environmental behavior support physical may be locked refrigerators and cabinets to prevent access to food or locked doors that persons cannot open independently, such as a lock placed up too high or a deadbolt that must be opened inside with a key.
- These procedures are highly controlled and, in most cases, PROHIBITED.
- For the purposes of the HRST, helmets or other headgear used to prevent injuries from a clearly identified risk are also rated in this section.
- Devices intended to provide therapeutic support, such as seatbelts, braces, head/neck positioning devices and similar equipment are NOT considered behavior support physical devices or procedures.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person did not require behavior support physical devices or procedures within the past 12 months.

OR

The person did NOT wear a helmet or other head gear to prevent injuries due to a clearly identified risk.

1. The person required behavior support physical devices or procedures less than 12 times within the past 12 months.

- May include devices or procedures to facilitate some type of urgent medical procedure or care that without using behavior support physical devices or procedures would have been impossible.
- Experienced an acute behavior event that required an immediate response.

2. The person required behavior support physical devices or procedures 12 to 60 times within the past 12 months.

- Less restrictive options have been explored and ruled out.

3. **The person required behavior support physical devices or procedures 60 or MORE times but LESS than 12 hours per day.**

   OR

   The person wore some sort of device (fencing mask, helmet, heavy gloves, mittens, etc.) on a regular basis, at least once per day within the past 12 months.

   - Generally has behavior issues (hitting, biting, head-butting, etc.) that cause injury to self or others.
   - May wear protective devices, including helmets or other headgear to protect from injuries due to a clearly identified risk.

4. **The person sustained an injury that required healthcare provider TREATMENT as the result of the use of behavior support physical devices or procedures.**

   OR

   Behavior support physical devices or procedures were used on average for 12 or more hours every day within the past 12 months.

   - Generally has significant behavior issues such as severe and frequent environmental damage, significant aggression toward others or severe self-abuse.
   - Includes confinement of the person to a restricted space such as a jail cell.
   - The person will continue to score a 4 until ALL supports used for controlling self-abuse or aggression are removed for 12 full months, even if no self-abuse or aggression was displayed within the past 12 months.

I. Behavior Support Chemical

This item measures the use of as-needed (PRN) medications on an acute basis to control anxiety associated with medical or dental appointments or to control acute anxiety, mood, mental status, behavior or sleep problems.

This item looks back over the past 12 months.

RATING TIPS

- In some settings behavior support chemical is described as PRN psychotropic medications, but some of the medications may be PRN Benadryl (diphenhydramine) or melatonin for sleep, which are not typical psychotropic medications.
- Scoring of this item is based on the actual number of uses within the past 12 months.
- Persons are ONLY to be rated based on medications they have actually taken within the past 12 months, not based on having these medications prescribed and available for these purposes.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.
- Use of PRN medication to prevent potential anxiety will only score a 1 regardless how often they are used.

0. The person did NOT require behavior support chemical on an acute basis to control anxiety, mood, mental status, behavior or sleep within the past 12 months.

- May have behavior issues but coping skills and other interventions are enough to help the person regain their composure.

1. The person required the use of behavior support chemical before a medical or dental appointment or procedure.

OR

Required the use of as-needed (PRN) medication to induce sleep within the past 12 months.

- Anxiety/pain threshold resulted in the use of behavior support chemical to calm or relax the person prior to a medical or dental appointment or procedure.
- May have difficulty sleeping and occasionally requires the use of as-needed (PRN) sleep medication.
- Anesthesia or deep sedation for procedures such as dental or gynecological exams that a neurotypical person would NOT be sedated for will score here.
- Sedation immediately prior to surgical procedures will not score here since this is something that is standard procedure for everyone.
- Hospice medications used to control anxiety will score here, regardless of the number of doses administered.

2. The person required behavior support chemical to control acute anxiety, mood, mental status or behavior issues 1 time within the past 12 months.

3. The person required behavior support chemical to control acute anxiety, mood, mental status or behavior issues 2 to 3 times within the past 12 months.

4. The person required behavior support chemical to control acute anxiety, mood, mental status or behavior issues 4 or more times within the past 12 months.

J. Psychotropic Medications

This item measures routine, scheduled medications used to treat or control anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia.

This item looks back over the past 12 months.

RATING TIPS

- As-needed (PRN) medications for the same purpose are scored in Item I Behavior Support Chemical.
- Psychotropic medications do NOT include medications used to treat movement disorders associated with this type of medication.
- Depo-Provera (medroxyprogesterone) used to treat sexual predatory behaviors in males would also be scored here as a psychotropic medication since it is being used for behavioral purposes.
- All psychotropic medications included here are taken on a regularly prescribed basis, not like those in Item I Behavior Support Chemical which are ONLY taken on a PRN basis.
- While most psychotropic medications are taken or administered daily or more frequently, some are taken less often—on a weekly, monthly or quarterly basis.
- These are still considered regularly prescribed and scheduled psychotropic medications.
- Side effects of psychotropic medications sometimes occur when the medications or dosages are changed.
- The score will be a minimum of a 3 for any person with a change in psychotropic medication or dosage (meaning the person has started, discontinued, tapered up or down, changed dosage or changed to a different psychotropic medication), regardless of how many medications the person is taking. The score will remain for 12 full months after the change in psychotropic medication or dosage.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.
- Also included in this item are ANY medications that may cause tardive dyskinesia (TD), regardless of why they are being used.

Examples of some non-psychotropic types of TD-causing medications are:

- Depakote (valproic acid or any of its derivatives)
- Compazine (prochlorperazine)
- Reglan (metoclopramide)

Medications that were developed for purposes other than psychotropic treatment will be included here if they are being used to treat or control anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia. Some medications that may be used for these purposes are:

- Lamictal (lamotrigine)
- Depakote (valproic acid or any of its derivatives)
- Catapres (clonidine)
- Inderal (propranolol)

0. The person did NOT receive regularly scheduled medication to control anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia within the past 12 months.

1. The person received 1 regularly scheduled medication that does NOT have tardive dyskinesia (TD) as a potential side effect to control anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia. Medication dosage or type has NOT CHANGED within the past 12 months.

- May or may not be taking a traditional psychotropic drug, but is taking medication such as Benadryl (diphenhydramine), Inderal (propranolol), Catapres (clonidine), Lamictal (lamotrigine), etc. for anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia.

2. The person received 2 regularly scheduled medications that do NOT have tardive dyskinesia (TD) as a potential side effect to control anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia. Medication dosage or type has NOT CHANGED within the past 12 months.

- May or may not be taking a traditional psychotropic drug, but is taking medication such as Benadryl (diphenhydramine), Inderal (propranolol), Catapres (clonidine), Lamictal (lamotrigine), etc. for anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia.

3. The person received 3 or more regularly scheduled medications that do NOT have tardive dyskinesia (TD) as a potential side effect to control anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia.

OR

Type or dosage of psychotropic medication was changed within the past 12 months.

- On 3 or more medications to control behavior or psychiatric disorder OR receives ANY medication to control anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia with at least one change in type or dosage of the psychotropic medication.
- Persons on a psychotropic drug–tapering program will remain at least score a 3 for 12 months after the medication is discontinued or dosage stabilized.
- May or may not be taking a traditional psychotropic drug but is taking medication such as Benadryl (diphenhydramine), Inderal (propranolol), Catapres (clonidine), Lamictal (lamotrigine), etc. for anxiety, mood, mental status, behavior, mental health disorder, sleep or dementia.

4. The person received 1 or more regularly scheduled medications of any type that DO have tardive dyskinesia (TD) as a potential side effect within the past 12 months.

- Includes ANY medication that has TD as a potential side effect such as Reglan (metoclopramide) or Depakote (valproic acid or any of its derivatives), even when it may not be used for psychotropic purposes.

CATEGORY III – PHYSIOLOGICAL

K. Gastrointestinal (GI)

This rating item considers all conditions of the GI tract and the frequency of signs and symptoms.

This item looks back over the past 12 months.

Permanent Points Item	**GI is a permanent points item. A person scoring 3 on this item for a history of a diagnosis of GI bleeding can never score lower than 3 even beyond the end of the 12-month period.**

RATING TIPS

- Hospitalization within the past 12 months for bowel impaction, paralytic ileus or bowel obstruction will be included under BOTH Item K Gastrointestinal and Item O Bowel Function.
- This item includes ALL conditions of the gastrointestinal tract except constipation and diarrhea, which are rated under Item O Bowel Function.
- Please be sure to ask about the use of over-the-counter (OTC) medications for nausea, heartburn or other digestive upset. Rate each use as a separate incidence of GI symptoms.
- A person who takes as-needed (PRN) medication for heartburn or GI distress 104 times or more within the past 12 months will receive a score of 3 based on frequency.
- If a person regularly takes 2 or more medications for GI symptoms their score for this item will be a 4.
- If a person takes a regularly scheduled medication daily AND a PRN GI medication 104 or more times per year, they will score a 4.
- Heartburn medications like Tums® (calcium carbonate) that are taken ONLY as calcium supplements are NOT included here.
- **If the person has a history of a diagnosis of GI bleeding, they will ALWAYS score a 3 or higher.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no GI concerns or GI diagnosis within the past 12 months AND no history of a diagnosis of GI bleeding.

1. The person experienced 24 or less episodes of GI symptoms within the past 12 months in the absence of acute illness.

- Health is very stable.
- GI distress occurs with no apparent explanation.

2. **The person experienced 25 to 72 episodes of GI symptoms within the past 12 months.**

   - A documented pattern of episodes may be developing.
   - These episodes are more likely to be associated with a disorder of the stomach or GI tract instead of an acute illness like the "stomach flu."

3. **The person experienced 73 or more episodes of GI symptoms within the past 12 months.**

   OR

   They experienced coughing within 1 to 3 hours after meals or during the night within the past 12 months.

   OR

   The person displayed hand-mouthing or pica behavior within the past 12 months.

   OR

   The person has a history of a diagnosis of GI bleeding at any time in their lifetime.**

   OR

   They have a current diagnosis of gastroesophageal reflux (GER) or other diagnosed GI disease.

   OR

   They have taken PRN medications such as Pepto Bismol® (bismuth subsalicylate), Maalox® (aluminum and magnesium hydroxide), Gas X® (simethicone), Zofran (ondansetron) or Reglan (metoclopramide), etc. 104 times or more within the past 12 months.

   - If the person has a GI diagnosis requiring PRESCRIBED probiotics, they will score a 3.

4. **The person had a GI condition requiring hospital admission.**

   OR

   Required more than 1 medication for GI disease or symptoms within the past 12 months.

   - The person had a GI condition requiring hospital admission, such as GI bleeding, GI ulcerative conditions, persistent vomiting, aspiration pneumonia, intestinal infection, bariatric surgery, gallbladder surgery, pancreatic surgery, parasites, etc.
     - Bowel impaction, bowel obstruction, bowel resection, or paralytic ileus within the past 12 months will score under both Item K Gastrointestinal AND Item O Bowel Function.

- The person takes more than 1 regularly scheduled GI medication to control a GI disease or nausea, heartburn or other GI symptoms.
- The person used PRN GI medications 104 times (average of 2 times per week) or more within the past 12 months IN ADDITION TO another PRN GI medication taken 104 times or more, or a PRN GI medication taken 104 times or more plus a regularly scheduled GI medication.

***Note: The effect of a diagnosis of GI bleeding on the HCL extends beyond 12 months because it relates to "history of." The person will never have a score less than a 3 if they have ever had a diagnosis of GI bleeding.*

L. Seizures

This item measures seizure frequency and the impact of seizure activity on the person's typical daily activities.

This item looks back over the past 12 months.

RATING TIPS

- Ratings are not dependent upon the type of seizure the person experiences, although it is a good idea to include this information in the Rating Notes for the rating item as well as in the person's diagnosis comments.
- Since the dates partly determine the ratings, it is recommended to indicate the date of the last known seizure activity and how often seizures tend to occur, such as twice a month, 3 times within the past 12 months, etc.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person never had a seizure in their lifetime.

OR

It has been more than 5 years since the last known seizure.

- The person never had a seizure OR has a known seizure history but has not had a seizure in more than 5 years.
- May or may not be taking antiepileptic medication(s).

1. The person did not have a known seizure in more than 2 years.

- Has a history of seizure activity but has been seizure-free for at least 2 years.
- May or may not be taking antiepileptic medication(s).

2. The person experienced 11 seizures or less that DID NOT interfere with their typical daily activities within the past 12 months.

- Seizure activity occurred 11 times or less within the past 12 months AND did not affect the person's ability to engage in their typical daily activities for longer than 30 minutes.

3. The person experienced 12 or more seizures within the past 12 months.

OR

Had ANY seizure activity that DID interfere with typical daily activities regardless of seizure frequency.

- Seizures of any type occurred 12 or more times within the past 12 months OR seizure activity of ANY frequency

that interfered with typical daily activities for more than 30 minutes.

4. **The person required hospital admission for seizures or seizure-related issues within the past 12 months.**

   - Any classification of seizure requiring a hospital ADMISSION (not simply an ER visit) to treat status epilepticus, seizure complications (such as injuries or aspiration), diagnose or evaluate a seizure disorder, or surgery to treat a seizure disorder will count.

M. Antiepileptic Medication

This item is intended to score antiepileptic medication(s) taken on a SCHEDULED basis to treat a seizure disorder.

This item looks back over the past 12 months.

RATING TIPS

- Antiepileptic medication prescribed for behavioral or mental health concerns will be rated under Item J Psychotropic Medication.
- Persons with any changes in type or dosage of antiepileptic medication will score at least a 3 for 12 full months after the final change.
- As-needed (PRN) medications prescribed to treat prolonged seizure activity or status epilepticus are NOT scored under this item. These medications are rarely used in most people.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person required no antiepileptic medication within the past 12 months.

1. The person received 1 regularly scheduled antiepileptic medication that did not change within the past 12 months.

- Dosage or medication DID NOT CHANGE.

2. The person received 2 regularly scheduled antiepileptic medications that did not change within the past 12 months.

- Dosage or medication DID NOT CHANGE.

3. The person received 3 or more scheduled antiepileptic medications.

OR

Had ANY change in antiepileptic medication or dosage.

OR

Took Depakote (valproic acid or any of its derivatives) in combination with any other antiepileptic medication (even if the second antiepileptic medication is used for any other reason or diagnosis).

OR

Took Felbatol (felbamate) within the past 12 months.

- For persons on a medication tapering program, the score will remain a 3 for 12 full months after the medication is discontinued or dosage stabilized.
- Persons taking Depakote (valproic acid or any of its derivatives) as a single, standalone medication will score a 1. They will only score a 3 when taking Depakote (valproic acid or any of its derivatives) IN COMBINATION with any other antiepileptic medication.
- If the person is taking Depakote (valproic acid or any of its derivatives) and any other antiepileptic medication for any purpose, they will score a 3 here even if both medications are being taken for reasons other than seizures and the person does not have a diagnosed seizure disorder.

4. **The person had an ER visit.**

   OR

   Had any hospitalization due to antiepileptic medication toxicity within the past 12 months.

N. Skin Integrity

This item is intended to score any issues that potentially or actually impact skin integrity.

This item looks back over the past 12 months.

Permanent Points Item	**Skin Integrity is a permanent points item. A person scoring a 2 in this item for a history of a pressure injury can never score lower than a 2 even beyond the end of the 12-month period.**

RATING TIPS

- This item includes typical presentations of skin dryness or minor conditions that cause skin discoloration, injuries and wounds, including surgical wounds, prolonged healing of wounds and wounds that fail to heal.
- It includes problems related to skin integrity that may cause a person to be hospitalized or require invasive treatments such as treatment at a wound care clinic, skin graft surgery, intravenous antibiotics to treat wounds, wound vacuums or the need for specialists such as infection control providers or plastic surgery providers.
- This item also accounts for diagnoses or conditions that place the person at elevated risk for issues with skin integrity. It contains an almost unlimited amount of potential issues.
- A person who has a history of pressure injuries (historically known as pressure ulcers, decubitus ulcers, bed sores, etc.) will ALWAYS score a minimum of a 2**.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no current or potential skin problems within the past 12 months AND there is no history of a pressure injury.

- No issues with skin integrity AND no known conditions associated with increased skin vulnerability.

1. The person had red or dusky discolorations or other minor disorders of the skin within the past 12 months.

- Skin may be reddened or have non-serious signs of discoloration.
- This may also include persons with minor presentations of psoriasis, acne, eczema, increased dryness and itching, diaper area rash or other skin issues.
- Persons with an active diagnosis of diabetes mellitus or other issues associated with skin vulnerability require a higher score (3 or greater).

2. The person had significant disruptions of skin integrity within the past 12 months.

OR

Has a history of a pressure injury at any time within their lifetime.**

- Includes ANY significant wound, including surgical wounds in persons who do not have a known condition associated with skin vulnerability AND persons who have had pressure injuries (historically known as pressure ulcers, decubitus ulcers, bed sores, etc.), even if they resolved more than 12 months ago.

3. **The person had a significant break in skin that required MORE than 3 months to heal within the past 12 months.**

   OR

   Has a condition directly associated with skin vulnerability.

   - Examples include spina bifida, spinal cord injury, nutritional compromise, low serum prealbumin or albumin, active diagnosis of diabetes mellitus, continuous incontinence, inability to reposition themselves or self-abusive behaviors involving skin damage.
   - The person may NOT have had actual issues with skin integrity within the past 12 months. A comprehensive skin care program may be in place.

4. **The person's skin condition required recurrent healthcare provider treatment or hospitalization within the past 12 months.**

   - The person required hospitalization or surgery for a skin problem (invasive skin cancer, graft surgery for wounds, severe burns, intravenous [IV] therapy in the hospital for skin issues, etc.) OR has required visits to a wound care clinic for longer than 2 consecutive weeks.
   - May have required treatment by an infectious disease healthcare provider, a wound and ostomy care nurse, a plastic surgeon or other healthcare specialist, or treatment at an outpatient IV clinic for 7 consecutive days for a severe or potentially life-threatening skin issue.

***Note: The effect of pressure injuries on the HCL extends beyond 12 months, because it relates to "history of" the person having a pressure injury.*

O. Bowel Function

This item measures the amount of assistance a person needs to maintain normal, healthy bowel elimination patterns.

This item looks back over the past 12 months.

Permanent Points Item	**Bowel Function is a permanent points item. A person scoring a 4 in this item for a history of ANY hospitalization for a bowel obstruction or paralytic ileus can never score lower than a 4 even beyond the end of the 12-month period.**

RATING TIPS

- This item does not rate issues with the gastrointestinal (GI) tract. Those would be rated under Item K Gastrointestinal, which includes any disorder of the GI tract, including the large intestine.
- This item basically concerns itself with constipation and diarrhea and the measures taken to address those problems.
- Please take the time to learn the difference between stool softeners, fiber supplements and laxatives. Laxatives affect the motility of the bowel. It is an important distinction that will affect a person's rating.
- Also remember that if a person takes more than 1 of ANY type of bowel medication, their score will be a minimum of a 3.
- The person will ALWAYS score a 4 on this item if they have ever had a hospitalization for bowel obstruction** or paralytic ileus** in their lifetime.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no bowel elimination problems within the past 12 months AND no history of hospitalization for a bowel obstruction **, bowel resection for any bowel disease, or paralytic ileus.**

1. The person's bowel elimination was easy to manage with diet within the past 12 months AND no history of hospitalization for a bowel obstruction, bowel resection for any bowel disease, or paralytic ileus**.**

- Receives a diet modification and/or increased fluids to assist with regular elimination.
- This includes the addition of high fiber foods and extra fluids to the diet as well as the elimination of certain foods to prevent episodes of diarrhea or constipation.

2. The person's bowel elimination was easy to manage with diet and a single fiber supplement or a single stool softener within the past 12 months.

- Had slight problems with constipation requiring a regularly scheduled stool softener or regularly scheduled fiber supplement.
- Diet may be modified to reduce constipation or diarrhea.
- Please identify whether the medication increases fiber or softens stool on bowel function in the Rating Notes section.
- Score of a 2 only applies if the person uses a single routinely scheduled fiber supplement.
- Use of more than 1 of ANY type of bowel medication will cause the person to score a 3.
- If as-needed (PRN) medications or interventions, such as a laxative, suppository or enema are used more than monthly (12 or more times) in addition to a single supplement, the score will be a 3.

3. The person received at least 1 regularly scheduled medication that affects bowel motility within the past 12 months OR regularly received more than 1 medication of ANY type to treat diarrhea or constipation within the past 12 months.

- Had a problem with recurrent episodes of constipation or episodes of intermittent diarrhea.
- May require PRN suppositories, enemas or manual assessment for severe constipation or fecal impaction 12 or more times per year (12 suppositories, enemas, PRN laxatives or manual assessments for severe constipation or fecal impaction; may be a combination of all these).

4. The person required hospitalization within the past 12 months to treat a fecal impaction, bowel obstruction or paralytic ileus.

OR

Has a history of ANY hospitalization for bowel obstruction, bowel resection for any bowel disease, or paralytic ileus**.**

***Note: The effect of this item on the HCL extends beyond 12 months, because it relates to "history of."*

P. Nutrition

This item is one of the largest items on the HRST and addresses multiple health issues that have actual or potential effects on nutritional status.

This item looks back over the past 12 months.

RATING TIPS

- Try to have access to all lab work completed within the past 12 months. Many abnormal lab values, such as hemoglobin, iron, albumin and prealbumin are directly related to nutritional deficits.
- Take the time to understand the person's issues and diagnoses that require nutritional status monitoring. These will automatically score a 3. These issues may include diabetes mellitus, metabolic syndrome from any cause, abnormal lab values and the many other issues included in the rating items below.
- Comments here should ALWAYS include the person's most current weight, their weight range (high and low) within the past 12 months, and their ideal body weight range (IBW) (high and low) OR their most current body mass index (BMI) range (high and low) within the past 12 months.
- On the person's "About Me" page in the HRST is a BMI calculator. All you need is height and weight, the HRST application will automatically calculate the BMI and indicate whether the person is within the normal BMI, underweight, overweight or obese.
- Be sure to measure the person so an accurate height can be entered.
- Normal BMI, according to the Centers for Disease Control (2020) is 18.5 to less than 25.
- If the person is on a diet prescribed by a healthcare provider, dietitian or nutritionist, list the diet along with any altered texture or altered fluid consistency.
- A regular diet with altered texture or altered fluid consistency will not score here, but will score under Item A Eating.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person was within their ideal body weight (IBW) or body mass index (BMI) range and weight/BMI were stable within the past 12 months.

- No ongoing health issues that may affect nutrition. Requires no prescribed diet, nutritional supplements or other interventions to maintain health.
- The person may voluntarily take vitamins or other nutritional supplements without a healthcare provider prescription or recommendation.
- BMI is between 18.5 to less than 25.
- May choose to follow a specialized diet for cultural reasons, personal preference or religious beliefs within the past 12 months

1. **The person was slightly above or below their IBW/BMI range. May have required extra calories or dietary restrictions within the past 12 months.**

   - Health is generally stable, although weight/BMI is not within ideal range (not more than 10% above or below the far ends of their IBW range and/or their BMI is less than 18.5 or 25 or more, but less than 30).
   - May require additional calories through nutritional supplements or snacks OR may require dietary restrictions (single servings at mealtime, low-fat and low-calorie foods, restricted sweets, etc.).

2. **The person was stable on a diet prescribed by a healthcare provider, dietitian or nutritionist within the past 12 months.**

   - Within IBW or BMI range, but has a diet prescription (low sodium, low cholesterol, diabetic, calorie controlled, etc.) for health maintenance or health conditions, which have been under control for the past 12 months.
   - This includes persons receiving tube feeding formula who are otherwise nutritionally stable and well maintained.
   - The diet must be individually prescribed and not simply agency policy.

3. **The person has demonstrated weight instability.**

   OR

   Had an identified nutritional risk that required nutrition status monitoring within the past 12 months:

   - May have displayed unstable nutritional status episodes or trends, which produced health issues requiring intervention to maintain health OR is monitored for one or more of the following:
     - Inability to reach or maintain IBW
     - BMI range is 30 to less than 35
     - Unplanned changes/trends in body weight (up or down)
     - Metabolic syndrome, regardless of cause
     - A chronic active medical condition that affects nutritional status (diabetes mellitus, diabetes insipidus, anemia, low prealbumin or albumin, kidney or liver disease, GI disorder, fecal impaction, pressure injury, etc.)
     - Medical conditions that require monitoring and control of fluid intake volume
     - Difficulty consuming adequate intake, poor appetite or frequent meal refusals
     - A food intolerance or active diagnosis that prevents them from consuming major food groups such as fruits, vegetables, protein sources, dairy or grains
     - A dangerous food allergy to shellfish, fish, eggs, tree nuts, peanuts or other foods

4. The person had a high nutritional risk or their nutritional status was unstable within the past 12 months.

- High risk with an unstable nutritional status. Required intensive nutritional intervention to address any of the following conditions:
  - Unplanned weight loss or gain of >10% of usual weight within the past 12 months
  - Morbid obesity (body weight 100 pounds greater than or twice the desired weight range, or BMI >35)
  - Hospitalization and/or treatment within the past 12 months for acute conditions such as aspiration pneumonia, choking episodes, GI bleeding, unresolved diarrhea, vomiting, unresolved wounds caused by pressure, diabetes, circulatory disorders, bariatric surgery, etc.
  - Inability to consume an adequate diet due to chewing or swallowing disorder (for persons receiving only oral intake)
  - Gastrostomy (G-tube) or jejunostomy (J-tube) tube placement OR complications with an existing feeding tube within the past 12 months (a clogged tube is not considered a complication of the TUBE, but more human failure to maintain the tube according to standard protocol)

Q. High-Risk Treatments

This item includes interventions or procedures that MAY be performed independently or by other support persons but, by their nature, are fundamentally high-risk.

This item looks back over the past 12 months.

RATING TIPS

- It also includes treatments that may not, under ANY circumstances, be delegated by a nurse to any support person.
- Scoring is intended to be consistent from setting to setting and state to state, regardless of policies and regulations dictating professional nursing practice delegation.
- This item is scored either a 0 or a 4 regardless of how many qualifying issues apply.
- This item does not rate single-event procedures like surgery or other physician treatments used to address acute medical events.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. If none of the conditions below apply, the score will be a 0.

4. The person scores a 4 if any of the following apply.

- The person had a tracheostomy that required suction at least daily for 14 consecutive days or longer within the past 12 months
- The person was dependent on a ventilator for 7 consecutive days or longer within the past 12 months (Bi-PAP or C-PAP use does not qualify).
- The person received nebulizer treatments, such as Albuterol or Ipratropium, 1 or more times daily for 30 consecutive days or longer within the past 12 months.
  - Does NOT include as-needed (PRN) treatments that are given intermittently or the use of an oral metered dose inhaler.
  - In the instance that PRN nebulizer treatments are required daily for at least 30 consecutive days within the past 12 months, the score will be a 4 in that situation.
- The person required daily or more frequent deep suction within the past 12 months, which means entering a suction catheter 6" or more into the airway or below the voice box for 14 consecutive days or longer.
- The person required complex dosage calculations for insulin (sliding scale) based on capillary blood glucose (finger stick) measurement by a human or anticipated carbohydrate consumption within the past 12 months for at least 14 days or longer.
  - Scheduled, fixed, doses of insulin will not score.
- The person has an unstable condition that requires ongoing (daily or more frequent) assessment and treatment by a licensed nurse OR high-risk treatments that may be performed by support persons in a home setting. This includes but is not limited to:

(cont'd on next page)

- Medication administration by intramuscular injections, or intravenous, peripherally inserted central catheter (PICC) or port-a-cath access 1 or more times daily for at least 7 consecutive days.
- Daily or more frequent urinary catheterization that requires sterile technique or self-catheterization daily or more frequently that used a clean or sterile technique for 7 consecutive days or longer. (Does NOT include condom [Texas] catheters, external female collection devices or indwelling catheters.)
- Healthcare provider prescribed treatments that are generally NOT delegated to a support person (except for specially trained dialysis technicians) such as chemotherapy, peritoneal dialysis or hemodialysis.
- Sterile dressing/wound treatments routinely performed only in clinical settings or by healthcare providers for at least 2 consecutive weeks. Wound must be assessed, and treatment plan reviewed by a nurse or other healthcare provider with every dressing change. Dressings do not have to be changed daily to qualify. Not all dressing changes qualify, even when performed by a nurse.
- Persons in the end stages of terminal illness, as defined by a projected 6 months or less to live, due to conditions such as cancer, lung disease, kidney disease, cardiac disease, neurological syndromes and disorders, neurocognitive disorders (Dementia, Parkinson's disease, Alzheimer's disease) and many others.
- Persons receiving hospice care.
- Persons with a jejunostomy (J-tube) tube or a combination gastrostomy/jejunostomy tube (G-J tube). A gastrostomy tube (G-tube) alone will not score.

- The person required 1:1 (or more) direct staffing, within arm's reach, AND the support person has no other responsibilities, during ALL waking hours in ALL settings to prevent episodes of self-abuse or aggression for 14 or more consecutive days. (Items F and/or G MUST be scored a 4.)

CATEGORY IV - SAFETY

R. Injuries

This item considers all types of injuries that a person may experience from a variety of sources, including accidents, falls or self-abuse.

This item looks back over the past 12 months.

RATING TIPS

- This item is intended to capture and track patterns and sources of injury that may be reversible when appropriately managed.
- Do NOT include every minor or trivial injury when no additional attention is needed.
- If a cut or bruise needs to be cleaned and a dressing applied, it should be counted. For a score of a 3, include only those injuries that needed actual healthcare provider TREATMENT, not simply an evaluation.
- Healthcare provider treatment may consist of closing a wound, casting a fracture, prescribing medication for an injury, splinting, therapeutic bandages, etc.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no injuries.

OR

Minor bruises/abrasions requiring only minor care within the past 12 months.

- Includes small cuts or scratches that do not require treatment beyond cleansing and simple bandaging (such as a Band-Aid®) or minor bruises.

1. The person had bruises or cuts requiring minor first aid or nursing oversight 1 to 2 times within the past 12 months.

- Includes injuries of any type requiring minor first aid, such as ice packs, slight pressure to stop bleeding, cleansing, applying a simple bandage, ointment or cream application, or other intervention.
- May have required nursing oversight (but NOT healthcare provider TREATMENT).

2. The person had bruises or cuts requiring minor first aid or nursing oversight 3 or more times within the past 12 months.

- Includes injuries of any type requiring minor first aid, such as ice packs, slight pressure to stop bleeding, cleansing, applying a simple bandage, ointment or cream application, or other intervention.
- May have required nursing oversight (but NOT healthcare provider TREATMENT).

3. The person had an injury requiring healthcare provider TREATMENT within the past 12 months.

- Sustained an injury that required treatment (sutures, casting a fracture, etc.) by a healthcare provider. Injuries receiving healthcare provider evaluation (scans, X-rays, labs, etc.) only as a precaution but NOT requiring healthcare provider treatment should receive a lower score.

4. The person had major injuries that required hospital admission within the past 12 months.

- Had documented evidence of a fracture OR other major trauma that required hospital admission.

S. Falls

This item measures falls that occurred for any reason, including intentional falls and near falls.

This item looks back over the past 12 months.

RATING TIPS

- A near fall is a situation in which the person would have fallen had there not been a support person there to catch them or something for the person to grab on to.
- Any person who wears a helmet or other head gear for a clearly identified risk will score a minimum of a 2.
- The score will be higher if the person had a fall that resulted in a fracture or a hospitalization.
- If the person fell and had a fracture during a transfer procedure, clearly indicate that in your Rating Notes, rate it in Item C Transfer and add to the person's diagnosis list with a comment on the cause of the fracture.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no falls or near falls within the past 12 months.

1. The person had 1 to 3 falls or near falls within the past 12 months.

2. The person had 4 to 6 falls or near falls within the past 12 months.

OR

Wears a helmet or other head gear to protect them from injuries due to a clearly identified risk such as seizures, balance or coordination issues, etc. within the past 12 months.

3. The person had more than 6 falls or near falls within the past 12 months.

4. The person had any fall or near fall that resulted in a fracture or hospital admission due to injuries within the past 12 months.

CATEGORY V - FREQUENCY OF SERVICE

T. Professional Healthcare Services

This item counts visits to ANY licensed medical or mental healthcare provider intended to identify a diagnosis or to treat a previously diagnosed condition.

This item looks back over the past 12 months.

RATING TIPS

- This is another HRST item that is frequently rated inaccurately.
- Licensed medical or mental healthcare providers may include physicians, therapists, nurses, chiropractors, neurologists, mental health professionals, endocrinologists, etc.). The visit must be to establish a diagnosis or to treat a previously diagnosed condition.
- Include diagnostic visits, laboratory testing, visits needed for prescription renewal, monitoring and surveillance of diagnosed health conditions, etc.
- Include all days the person is hospitalized or otherwise receiving inpatient care.
- Do NOT include screening or wellness visits that do not treat or manage a diagnosis.
- Likewise, visits that are the result of policy mandates such as monthly or quarterly nursing assessments which are not driven by the health needs of the person are not included.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no visits other than screening or health maintenance visits within the past 12 months.

- May have had visits to healthcare providers that did NOT identify or manage a diagnosed condition. These visits are normally only to primary healthcare providers and NOT to specialists.

1. The person required 8 visits or less to healthcare providers intended to identify or manage diagnosed conditions within the past 12 months.

- Include visits to ANY healthcare providers intended to identify or manage diagnosed conditions.

2. The person required 9 to 24 visits to healthcare providers intended to identify or manage

diagnosed conditions within the past 12 months.

OR

Required daily nursing services for 14 consecutive days or more.

3. **The person required 25 or more visits to healthcare providers intended to identify or manage diagnosed conditions within the past 12 months.**

4. **The person required 25 or more scheduled visits to healthcare providers intended to identify or manage diagnosed conditions PLUS acute unscheduled appointments within the past 12 months.**

   - In addition to 25 or more scheduled visits, unplanned visits to healthcare providers were required to treat acute health episodes.

U. Emergency Room (ER) Visits

This item counts the number of visits made to the emergency room (ER) within the past 12 months.

This item looks back over the past 12 months.

RATING TIPS

- Include care settings such as ambulatory care clinics, walk-in clinics or an inhouse infirmary when these settings can perform the same level of care as would have been provided at a hospital ER.
- Visits to these other settings should include in the Rating Notes the reason for the urgency of the visit.
- Include visits when the person is going for social visits rather than medical reasons ("the nurses are nice and give me soda and chips," "there is a really good looking nurse that works on Thursdays," "my friends went out and I have nothing to do," etc.) or when an appointment with the person's healthcare provider would have been preferred but was not available.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.
- Also include in the Rating Notes section the dates and reasons for each ER visit. If they have ER visits and are admitted to the hospital, indicate the date of the ER visit, when the person was admitted and why.

0. The person had no ER visits within the past 12 months.

1. The person had ER visits due to healthcare provider absence or unavailability, or non-emergency situation, including social visits within the past 12 months.

2. The person had 1 ER visit for acute physical illness, injury or psychiatric issue within the past 12 months.

3. The person had 2 or more ER visits for acute illness, injury or psychiatric issues within the past 12 months.

4. The person had any ER visit that resulted in a hospital admission for acute illness, injury or psychiatric issues within the past 12 months.

V. Hospital Admissions

This item counts all admissions to any inpatient setting for medical, mental health, behavioral health or rehabilitation services.

This item looks back over the past 12 months.

RATING TIPS

- If the person is admitted to a setting that provides more health/behavioral services than can be provided in their own home, this is considered a hospital admission.
- Because outpatient procedures and surgeries can result in serious consequences or even death, these outpatient admissions are considered a hospital admission.
- This item also counts scheduled procedures, even though the exact date may not be predictable, such as routine childbirth.
- Admissions for emergency cesarean births, premature labor or other complications of childbirth would be rated as acute admissions.
- If a person is admitted to multiple settings for a single issue, each setting counts as an admission. For example, if a person had a serious injury or stroke and was initially treated at the acute care hospital, transferred to an acute rehabilitation setting and finally was admitted to a long-term care rehabilitation facility, the person would have 3 separate admissions.
- Use the Rating Notes section to explain any questions answered "YES" when scoring the item.

0. The person had no hospital admissions within the past 12 months.

1. The person had a hospital admission for a scheduled surgery or procedure within the past 12 months.

- Normally for conditions that are not deemed urgent where there is an elapsed period (days to weeks) between diagnosis and admission, including outpatient surgery and routine childbirth.

2. The person had 1 hospital admission for acute illness or injury or worsening of any chronic disease (medical or psychiatric) within the past 12 months.

- Often occurs from an emergency room or healthcare provider's office with little or no elapsed time between diagnosis of the condition and hospital admission.
- Includes admissions to psychiatric facilities or intermediate care facilities (ICFs).

3. **The person had 2 or more hospital admissions for acute illness or injury or worsening of any chronic disease (medical or psychiatric) within the past 12 months.**

   - Often occurs from an emergency room or healthcare provider's office with little or no elapsed time between diagnosis of the condition and hospital admission.
   - Includes admissions to psychiatric facilities or ICFs.

4. **The person had an admission to the intensive care unit (ICU) during a hospitalization within the past 12 months.**

   - Initial hospitalization may have been for an acute illness or injury, but ICU admission may also occur as the result of scheduled or elective procedures.
   - ICU admission may occur at any time during the hospitalization.