

HRST Expanded Scoring Descriptors

This document gives important details about the scores related to the HRST's 22 rating items.

This instrument is intended to be used to guide the rater in determining that they have arrived at the correct score for the individual being rated. Please look over the descriptors carefully and make sure that the person you are rating fits the scoring description for each item. When entering comments please describe WHY the rating is appropriate for the person according to the descriptors listed below.

If there are any questions about whether or not the rating is appropriate, please go to the support site under HELP and submit a ticket to Clinical Support for assistance.

UNDERSTANDING 0 through 4 - A Guideline:

As a rule of thumb, scoring in each of the individual items will follow this general pattern:

- ▶ **0** - No issues within the past calendar year (12 months)
- ▶ **1** - Occasional issues within the past year. No identifiable pattern
- ▶ **2** - Emergence of a definable pattern of issues
- ▶ **3** - Increasing frequency and/or intensity of identified issues
- ▶ **4** - Potentially life-altering or life-defining issue or hospitalization in the past year

PERMANENT POINTS:**

There are four sets of circumstances, identified in the scoring descriptors by the phrase "history of", which result in points that remain elevated after the end of the 12 month period. They include:

- ▶ **C. TRANSFER = 4:** History of a fracture during a transfer procedure
- ▶ **K. GASTROINTESTINAL = 3:** History of a GI bleed
- ▶ **N. SKIN INTEGRITY = 2:** History of skin breakdown
- ▶ **O. BOWEL = 4:** History of hospitalization for an ileus or bowel obstruction

CATEGORY I – FUNCTIONAL STATUS

A. Eating

0. Eats independently: May require simple adaptive equipment (hand splint, special eating equipment) but is able to eat without assistance/supervision. Individuals needing help only to cut food into regular, bite-sized pieces still rate a 0. Those who require altered food/fluid textures require a higher score.
1. Requires INTERMITTENT physical assistance and/or verbal prompts to eat: May need occasional physical help due to physical limitation or occasional verbal prompts due to issues with attentiveness or behavior
2. Requires CONSTANT verbal and/or physical assistance to complete a meal: Has difficulty attending to task or may have motor limitations which require constant physical and/or verbal assistance. No issues with safety or swallowing
3. Requires constant assistance or other mealtime intervention to eat SAFELY OR has a feeding tube but maintains some level of oral intake: May have difficulty coordinating breathing/swallowing while eating, dangerous behaviors or other conditions which impair their ability to eat safely. Unable to obtain adequate calories and fluids without assistance. Interventions are required (specific positioning support, eating devices, presentation techniques and/or modifications in food/fluid consistency). May have enteral (feeding) tube, but maintains some level of oral eating.
4. Receives ALL nutrition/hydration via other than oral routes (gastrostomy, jejunostomy or nasogastric tube, or total paraenteral nutrition-TPN): Unable to swallow safely OR has other issues requiring other than oral feeding procedures. Individuals who receive food by mouth against physician orders still qualify for a score of 4.

B. Ambulation

0. Ambulates independently in ALL settings: May use a walker or other means of support but does so independently in all settings without problems of safety
1. Walks with minimal supervision: Requires the support of another person in close proximity in one or more settings. The primary issue is safety during ambulation.
2. Predictably dependent on wheelchair for at least some mobili-

ty needs: May or may not have the ability to walk in some settings. Non-ambulatory individuals are able to use their upper body strength for repositioning AND have the ability to independently maintain trunk alignment. Able to recognize the need to change positions on a consistent basis.

3. Requires mechanical assistance to maintain upright, seated position in wheelchair. Needs assistance to change position or shift weight: Unable to walk. Able to be placed in an upright sitting position but cannot maintain a seated posture without outside mechanical support (specialized positioning equipment, adaptive wheelchair, etc.) or assistance. Needs assistance to reposition OR may not recognize need to reposition on a consistent basis. May need assistance to propel wheelchair
4. Disability prevents sitting in an upright position: UNABLE to flex the hips to at least 45 degrees OR unable to approach reasonable alignment of the head, shoulders and pelvis. Due to degree of musculoskeletal deficits or deformity has limited positioning options

C. Transfer

0. Transfers independently in ALL settings: May require verbal prompts, but no physical assistance
1. Needs someone to supervise the transfer for safety: May need minor hands-on assistance, but able to bear their own weight and transfer safely in all settings
2. Needs physical assistance of 1 person to transfer or change position: Individual is able to participate in transfers with the assistance of one other person managing a portion of their weight OR is completely dependent for lifting assistance but weighs less than 50 pounds
3. Needs physical assistance of 2 people to transfer or change position: Individual is able to participate in transfers with the assistance of two other persons managing a portion of their weight OR is completely dependent for lifting assistance and weighs between 50 and 75 pounds
4. Needs lifting equipment or specialized procedures to safely transfer OR has a history of a fracture caused by a transfer procedure**: Requires specialized lifting equipment due to inability to participate in transfers. Includes individuals who weigh more than 75 pounds and are completely dependent for transfers, whether or not they ac-

Transfer=
A Permanent
Points item. A
person scoring a
“4” in this item
will always score
a “4”, even
beyond the end
of the 12 month
period.

tually use lifting equipment. May need range of specially designed positions due to severe spasticity, history of bone fragility, potential for injury due to size, or due to degree of physical deformity OR has had a history of a fracture caused by a transfer procedure at some time in their life**

D. Toileting

0. Independently accomplishes ALL toileting tasks: No assistance required or appreciated
1. Minimal supervision or adaptation required: May require reminders or some verbal and physical assistance to maintain hygiene or manage clothing adjustments. May require adaptations to restroom facilities (grab bars or built up commode seat) Beyond this, minimal assistance is necessary
2. Continent of bladder and bowel, but constant attention is needed: Requires physical assistance to complete hygiene tasks (wiping, hand washing) and clothing repositioning. May have occasional accidents but NOT routine, predictable incontinence
3. Incontinent of bowel or bladder: Individual is predictably incontinent of bowel or bladder in one or more settings (nighttime, work or school settings or engages in willful incontinence.) May require scheduled toileting or use incontinence briefs. Includes infants, for whom incontinence is age-appropriate.
4. ANY use of catheterization procedures or colostomy for elimination within the past 12 months: Urinary catheterization for ANY reason or elimination via colostomy, urostomy or ileostomy within the past year

E. Clinical Issues Affecting Daily Life

0. None, or person does not participate due to personal preference or guardian objections. No clinical restrictions: No ADL's changed or missed within the past year due to illness, behaviors or necessary medical appointments (Full or partial day)
1. Less than 2 days (full or partial) in a month on average due to clinical issues: Able to participate in usual activities of daily living, but participation may occasionally be interrupted by illness, behavioral or mental health issues, or may have physician appointments to monitor a diagnosed condition or receive treatment

2. 2 to 4 days (full or partial) in a month on average due to clinical issues: Able to participate in usual activities of daily living, but participation may be interrupted by illness, behavioral or mental health issues, or may have physician appointments to monitor a diagnosed condition or receive treatment
3. 5 to 10 days (full or partial) in a month on average due to clinical issues: Able to participate in usual activities of daily living, but due to chronic unstable or progressively worsening health or behavioral issues, there is a significant impact on usual activities. May be due to physician appointments to monitor a diagnosed condition or receive treatment
4. More than 10 days (full or partial) in a month on average or normal daily activities are completely disrupted due to intensity of clinical issues: Due to chronic, unstable or progressively worsening health or behavioral issues participation in usual activities is severely impaired. May be ill or have physician appointments to monitor condition or receive treatment OR may be completely unable to participate in usual activities due to intensity of clinical issues

CATEGORY II - BEHAVIORS

F. Self Abuse

0. No self abuse within the past year
1. Minimal self abuse, no additional consequences: Behaviors that are considered self abusive have been identified but have not required first aid or other intervention within the past year
2. Self abuse needing additional observation LESS than 2 times a month: Demonstrates behaviors that cause minor self injury which may require treatment or other intervention, but averaging to less than two interventions per month over the past year
3. Self abuse needing medical/nursing attention or other intervention 2 OR MORE times per month: Demonstrates behaviors that cause minor self-injury, which may require treatment or other intervention, but averaging two or more interventions per month over the past year
4. Self-injury interferes with the ability to engage in structured activities, requires increased staffing or causes extensive physical harm: May be due to an existing behavioral pattern or the result of a single, isolated incident

G. Aggression Towards Others and Property

- 0. No aggression within the past 12 months
- 1. LESS than 5 incidents per month of minor aggression (verbal or physical) WITHOUT injury to others or property damage within the past 12 months
- 2. 5 OR MORE incidents per month of aggression (verbal or physical) WITHOUT injury to others or property damage within the past 12 months
- 3. LESS than 5 episodes of aggression per month WITH minor injuries to others (injuries not needing medical TREATMENT) or property damage within the past 12 months
- 4. Episodes of aggression have required increased staffing ratios, restrictive interventions OR caused serious physical harm within the past 12 months

H. Behavioral supports - physical:

Defined as the use of devices, hands-on contact or restrictive settings for the prevention of unwanted behaviors or injury to self or others. Sometimes referred to as physical or mechanical restraints. These procedures are highly controlled and in most cases PROHIBITED. For the purposes of the HRST, helmets used to prevent injuries from anticipated falls are also rated in the restraints section. Devices intended to provide therapeutic support, such as seatbelts, braces, head/neck positioning devices and similar equipment are NOT considered physical restraints.

- 0. Has NOT been physically restrained in the past 12 months
- 1. Has been physically restrained less than once per month on average in past 12 months: May include restraints used to facilitate some type of urgent medical procedure or care that without using restraint would have been impossible OR an acute behavioral event that required an immediate response
- 2. Has been physically restrained more than once per month on average in past 12 months: Restraint use would require a physician's approval. Less restrictive options would have been explored and ruled out.
- 3. Use of physical restraint procedures or devices MORE than 5 times per month on average but LESS than 12 hours per day: Generally has behavioral issues (hitting, biting, head-banging, etc.) that cause injury to self and/or others. May wear protective devices, including

helmets to protect from injuries due to anticipated falls

4. Individual sustained and injury requiring medical TREATMENT as the result of application of physical restraint procedures/devices OR use of some sort of device 12 or more hours per day: Generally has significant behavioral issues (severe and continuous tissue damage, significant aggression, causing injuries). Includes use of helmets to protect from injuries due to anticipated falls or confinement of individual to a restricted space such as a prison cell

I. Behavioral supports - medications:

The use of medications on an acute basis for the purpose of pre-sedation or to control undesirable mood, mental status or behavior. Scoring of this item is based on the number of uses within the past calendar year, NOT on the average number of uses per month. Individuals may ONLY be rated based on medications they have actually taken within the past year, not merely because they have had medications prescribed and available for these purposes.

0. Has NOT received additional medications to control mood, mental status or behavior in the past 12 months: May have behavior issues, but coping skills and behavioral intervention are sufficient to help the individual calm down without the necessity of drug/medication administration
1. Received pre-sedation before any medical or dental appointment in the past twelve months: Anxiety/pain threshold has resulted in use of drugs prior to medical or dental procedure
2. Has received medications to control mood, mental status or behavior 1 time in last 12 months
3. Has received medications to control mood mental status or behavior 2-3 times in last 12 months
4. Has needed medications to control mood, mental status or behavior 4 or more times in last 12 months

J. Use of Psychotropic Medications

0. Has NOT received medication to control behavior or a psychiatric disorder within the past year
1. Receives 1 medication not associated with or known to cause tardive dyskinesia (TD) to control behavior or psychiatric disorder. Medication dosage has NOT CHANGED within the past year

Gastrointestinal= Permanent points item. A person scoring a “3” in this item can never score lower than a “3” even beyond the end of the 12 month period.

2. Receives 2 medications not associated with or known to cause tardive dyskinesia (TD) to control behavior or psychiatric disorder. Medication dosage has NOT CHANGED within the past year: May or may not be taking a “traditional” psychotropic drug, but is taking medication (e.g., Benadryl, Inderol, Tegretol) for identified behavior or psychiatric diagnosis
3. Receives 3 or more behavioral or psychiatric medications not associated with or known to cause tardive dyskinesia (TD) OR psychotropic medication type or dosage has been changed in the past year: On 3 or more medications to control behavior or psychiatric disorder OR receives ANY medication to control behavior or psychiatric disorder with at least one change in type or dosage in past year. Individuals on a drug tapering program will remain a 3 for one year after the medication is discontinued.
4. Has received one or more medications associated with or known to cause tardive dyskinesia (TD) or other extrapyramidal side-effects within the past year: Includes medications such as metoclopramide (Reglan), even when they are not used for psychiatric purposes

CATEGORY III – PHYSIOLOGICAL

K. Gastrointestinal (GI) Conditions

Includes ALL conditions of the gastrointestinal tract except constipation and diarrhea, which are rated under Item O, Bowel Function. Hospitalization for bowel impaction or obstruction will be rated under BOTH sections.

0. None: No GI concerns within the past 12 months AND no history of GI bleed
1. Occasional (2 or less) episodes of GI symptoms per month in the absence of acute illness: Health is very stable. Only has an occasional episode of GI symptoms (2 or less per month). GI distress occurs with no apparent explanation
2. 3-6 episodes of GI symptoms per month: Occasional episodes of GI symptoms occurring 3 - 6 times per month. A documented pattern of incidents 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 flu. This includes individuals who take over the counter medications for upset stomach, heartburn or other GI symptoms
3. MORE than 6 episodes of GI symptoms per month, OR coughing within 1-3 hours after meals or during the night, OR hand-mouthing

or PICA behaviors, OR has a history of GI bleeding** OR has a current diagnosis of gastroesophageal reflux (GER)

4. GI condition requiring hospital admission in past 12 months OR receives more than one medication for GER: Conditions requiring hospital admission include GI bleeding, ulcerative conditions, vomiting, persistent dehydration, aspiration pneumonia, intestinal infections, bariatric surgery, gallbladder or pancreatic surgery, bowel impaction, obstruction or ileus, parasites, etc. OR individual regularly takes more than one medication (including over-the-counter medications) to control GER

L. Seizures

0. No seizure in lifetime OR more than 5 years since last seizure: Individual has never had seizures 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
1. More than 2 but less than 5 years since last seizure: Has a history of seizure activity but has been seizure-free for at least the last 2 years. May or may not be taking antiepileptic medication
2. Less than 1 seizure per month which DOES NOT interfere with functional activity: Seizure activity occurs less than one time per month AND does not affect the person's ability to engage in functional activities for longer than 30 minutes
3. Seizure activity that DOES interfere with functional activities: Seizures of any type which occur more than once a month OR seizure activity of ANY frequency that interferes with functional activities for longer than 30 minutes
4. Has required hospital admission for seizures in past the 12 months: Any classification of seizure requiring a hospital ADMISSION (not just an ER visit) to treat seizure complications, diagnose or evaluate a seizure disorder or for surgery to treat a seizure disorder

M. Antiepileptic Medication Use

(if prescribed for behavioral or other psychiatric concerns, rate under item J)

0. None: Has not taken antiepileptic medication within the past year
1. Use of SINGLE antiepileptic medication: Dosage or medication type has NOT CHANGED within the past year

Skin Integrity= Permanent points item. A person scoring a “2” in this item can never score lower than a “2” even beyond the end of the 12 month period.

2. Use of 2 antiepileptic medications: Dosage or medication type(s) have NOT CHANGED within the past year
3. Use of 3 or more antiepileptic medications OR any change in antiepileptic medication type or dosage in past 12 months OR receives valproic acid derivatives (Depakene or Depakote, etc.) in combination with any other antiepileptic medication OR receiving felbamate (Felbatol): Individuals on a drug tapering program will remain a 3 for one year after the medication is discontinued.
4. ER visit OR hospitalization due to antiepileptic drug toxicity in past 12 months

N. Skin Integrity

0. No current or potential skin problems within the past year: No issues with skin integrity in the past 12 months AND no known conditions associated with increased skin vulnerability
1. Red or dusky discolorations or other minor disorders of skin: Skin may be reddened or have signs of poor circulation. This may also include individuals with typical presentations of psoriasis, acne, eczema, severe dryness or other skin issues. Individuals with diabetes mellitus or other issues associated with skin vulnerability require a higher score (3 or greater)
2. Either currently has or has had significant disruptions of skin integrity within last 12 months OR has a history of pressure sores**: Includes ANY significant wound, including surgical wounds, in individuals who do not have a known condition associated with skin vulnerability AND individuals who have had pressure sores, even if they resolved more than 12 months ago
3. Within the past 12 months a significant break in skin has developed which required MORE than 3 months to heal OR has a condition directly associated with skin vulnerability: Examples include spina bifida, spinal cord injury, nutritional compromise, low serum albumin, diabetes mellitus, continuous incontinence, self-injurious behaviors involving skin damage. Individual may NOT have had any actual issues with skin integrity in the past year
4. The skin condition required recurrent medical treatment or hospitalization in past 12 months: Individuals have required hospitalization or surgery for a skin problem (invasive skin cancer, graft surgery for wounds or burns, etc) OR have required visits to a wound care clinic, infectious disease or other specialist for a severe or potentially life-threatening skin issue

Bowel Function= Permanent points item. A person scoring a “4” in this item can never score lower than a “4” even beyond the end of the 12 month period.

O. Bowel Function

- 0. No bowel elimination problems within the past year AND no history of hospitalizations for bowel obstruction or ileus**
- 1. Bowel elimination is easy to manage with diet: Receives a diet modification and/or increased fluids to assist with proper elimination
- 2. Bowel elimination is easy to manage with diet and routine supplements: Has slight problems with constipation requiring intermittent or routine stool softener or fiber supplement
- 3. Receives at least one medication that affects bowel motility OR regularly receives more than one supplement or medication of ANY type to treat diarrhea or constipation: Has recurrent problem with constipation or experiences episodes of intermittent diarrhea. May require suppositories, enemas or manual assessment for impaction
- 4. Any hospitalization in past 12 months required to treat an impaction, bowel obstruction or ileus OR history of ANY hospitalizations for bowel obstruction or ileus**

P. Nutrition

- 0. Within ideal body weight range and able to maintain weight: Requires no diet modifications, prescribed nutritional supplements or other intervention to maintain health. Individual may voluntarily take vitamins or other nutritional supplements without physician prescription or recommendation.
- 1. Is slightly above or below ideal body weight range. May require extra calories or some dietary restrictions: Health is generally stable, though weight is not within ideal range (not more than 10% above or below the far ends of the ideal body weight range.) May require additional calories through supplemental products or snacks, OR may require dietary restrictions (single servings at mealtime, low fat and low calorie foods, restricted sweets, etc.)
- 2. Is well managed on a prescribed diet: Within desired weight range, but has a diet prescription for health maintenance or health concerns which have been under control for the past 12 months (low sodium, low cholesterol, etc.) This includes individuals receiving tube feeding formula who are otherwise nutritionally stable and well maintained.
- 3. Has demonstrated weight instability in the past OR has an identified

nutritional risk which required nutrition status monitoring within past 12 months: May have displayed unstable nutritional status episodes or trends in past 12 months which have produced health issues requiring intervention to maintain health OR is being monitored for one or more of the following:

- ▶ Inability to reach or maintain desired body weight
- ▶ Unplanned changes/trends in body weight (up or down)
- ▶ A chronic medical condition which affects nutritional status (diabetes mellitus, anemia, low serum albumin, renal or hepatic disease, GI disorder, impaction, pressure ulcer, etc.)
- ▶ Medical conditions that require monitoring and control of fluid intake levels
- ▶ Difficulty consuming adequate intake, poor appetite or frequent meal refusals
- ▶ Food allergies or intolerance which limits intake of major food groups

4. Nutritional status 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 >10% of usual weight in past 12 months
- ▶ Morbid obesity (body weight 100 pounds greater than, or twice the desired weight range or BMI >35)
- ▶ Hospitalization and/or treatment in the past 12 months for recurrent aspiration pneumonia, choking episodes, GI bleeding, unresolved diarrhea, vomiting or unresolved wounds caused by pressure, diabetes, circulatory disorders, etc.
- ▶ Inability to consume an adequate diet due to chewing or swallowing disorder (for individuals receiving only oral intake)
- ▶ Gastrostomy or jejunostomy tube placement OR complications with existing enteral tube in the last 12 months

Q. Treatments

Includes interventions or procedures which MAY be performed independently or by unlicensed family/staff but, by their nature, are inherently high-risk. Also includes treatments which may not, under ANY circumstances, be delegated to non-licensed personnel. Scoring is intended to be consistent from setting to setting, regardless of policies dictating professional practice delegation. In many cases a Q-score qualifies the person to receive 24 hour nursing services, although not all individuals require such a restrictive setting. Item is scored either 0 or 4 regardless of how many qualifying issues apply.

1) Tracheotomy that requires suction

- 2) Ventilator dependent
- 3) Nebulizer treatments one or more times daily: Receives medications such as Ventolin or Theophylline, by oxygen mist nebulizer at least once per day.
- 4) Deep suction: Requires deep suction, which means entering a suction catheter 6” or more into or below the voice box either via tracheotomy, oral or nasal routes.
- 5) Requires complex medication calculations for insulin given via insulin pump or injection.
- 6) Has an unstable condition that requires ongoing (usually daily or more frequent) assessment and treatment by a licensed health care professional. Including but not limited to:
 - ▶ Medication therapy requiring intramuscular or intravenous injections or hemaport irrigations one or more times daily
 - ▶ Daily or more frequent catheterization, requiring sterile technique
 - ▶ Physician ordered treatments that CANNOT be delegated to a non-licensed person such as chemotherapy or renal dialysis
 - ▶ Sterile dressing/wound treatments routinely performed only in clinical settings or by licensed practitioners
 - ▶ Individuals in acute and/or end stages of cardiac, liver, lung or kidney disease
 - ▶ End-stage terminal illness (cancer, AIDS) or persons with end-stage progressive neurological disorders (San Phillip Syndrome, Multiple Sclerosis, Huntington’s chorea)
- 7) 1:1 staffing for behavioral issues: Requires 1:1 staffing 16 or more hours EACH day due to behavioral issues

CATEGORY IV - SAFETY

R. Injuries

0. No injury within the past year OR minor bruises/abrasions requiring only simple first aid: Small cuts or scratches that do not require attention beyond cleansing and simple bandaging or minor bruises, sprains or strains that do not require immobilization
1. Bruises or cuts 1 or 2 times in the past year requiring first aid or nursing intervention within the past year: Injuries of any type requiring minor first aid or nursing attention (but NOT physician treatment)

2. Bruises or cuts requiring first aid or nursing intervention occurring 3 or more times within the past year: Injuries of any type requiring first aid or nursing intervention (but NOT physician treatment) occurring 3 or more times within the past year
3. Injury requiring medical TREATMENT in the past year: Sustained an injury that required treatment by a physician or in an emergency room (sutures, casting a fracture, etc.) within the past year. Injuries receiving physician evaluation as a precaution but NOT requiring treatment should receive a lower score
4. Major injuries requiring hospital admission within the past year: Has documented evidence of fracture or other major trauma which required hospital admission within the past year

S. Falls

0. No falls within the past year
1. 1 - 3 falls within the past year
2. 4 - 6 falls within the past year OR wears a helmet to protect from injuries due to anticipated falls from events such as seizures or narcolepsy
3. More than 6 falls in the past year
4. Any fall that resulted in a fracture or hospital admission due to injuries in the past year

CATEGORY V- FREQUENCY OF SERVICE

T. Professional Health Care Services

Includes visits to ANY health care providers (physicians, therapists, nurses, etc.) intended to treat or identify a health care condition

0. No visits other than routine screening or health maintenance visits within the past year: Visits to licensed health care providers that did NOT identify or manage a diagnosed condition. These visits are normally only to primary health care providers and NOT to specialists
1. Required 2 visits per quarter on an average over the past year to health care provider(s): Visits to ANY health care providers intended to identify or manage a diagnosed condition

2. Required 1 – 2 visits per month on average to health provider(s) OR required daily nursing services greater than 14 days continuously in past 12 months
3. Required 3 visits per month on average to health care providers within the past year
4. Required 3 visits per month to health care providers PLUS unscheduled appointments within the past year: In addition to 3 or more visits per month, unplanned visits to health care providers were required to treat acute health incidents within the past year

U. Emergency Room Visits

0. No emergency room visits within the past year
1. Emergency room visit due to physician absence or non-emergency situation within the past year
2. One emergency room visit in last year for acute illness or injury
3. Two or more emergency room visit for acute illness or injury in the past year
4. Any emergency room visit in the past year that resulted in hospital admission

V. Hospital Admission

0. No hospital admissions within the past year
1. Hospital admission in the past year for scheduled surgery or procedure: Normally for conditions that are not deemed urgent where there is an elapsed period of time (days to weeks) between diagnosis and admission, including routine childbirth
2. Hospital admissions for acute illness or injury within the past year: Often occurs from an emergency room or physician's office with little or no elapsed time between diagnosis of the condition and hospital admission. Includes admissions to psychiatric facilities or ICF's
3. 2 or more hospital admissions for acute illness or injury in the past year
4. Admission to ICU during a hospitalization in past year: 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