



## Overview

The Health Risk Screening Tool (HRST) is a web-based screening instrument that was developed to screen for health risks associated with a wide variety of disabilities, including developmental disabilities, physical disabilities, disabilities associated with aging, and many other conditions, which specifically affect systems of the body and the person's ability to engage in functional activities. Part of the instrument examines the health risks associated with psychiatric or behavioral disorders, particularly those that result from medications, self-injurious behavior or restriction of movement.

The most important outcome of the HRST screening is to guide in the provision of health care support and surveillance. The instrument is used to determine the types of further assessment and evaluation required by the person to be safe and healthy in a less restrictive setting.

The HRST was developed for use by non-licensed staff, such as case managers, independent support coordinators, program staff and others who directly impact services and supports for individuals in specialized health care settings.

## Features / Functions:

- Detects health destabilization EARLY in vulnerable populations
- Helps meet CMS health and safety requirements
- Quantifies the level of health risk based on objective criteria
- Defines acuity
- Identifies health related support needs of an individual
- Determines what types of further assessment, evaluation and staff training might be required
- Enables less restrictive settings
- Provides web-based, real-time data accessibility and oversight.
- Establishes a health baseline and allows the health status of an individual or group to be monitored and tracked over time
- Assists with budgeting and supports allocation

## History of HRST

The Health Risk Screening Tool (HRST) originated in Oklahoma in the early 90's as part of a class action court case: *Homeward Bound v. Hissom Memorial Center*. This case was overseen by a federal judge, James Ellison, in the Northern district of Oklahoma. With nearly 1100 class members, including a number of children using a range of medical technology, the institution was scheduled to close in 1994. Judge Ellison appoint a nurse to the panel (Karen Green McGowan) to assist him in protecting the health and safety of those class members whose fragile health status was of great concern to him.

The consent decree mandated that no class member could be placed in a residential facility larger than three(3). Further requirements were that the cost of all residential placements could not, on the average, exceed the daily cost at Hissom. A Federal magistrate had been appointed to mediate disagreements between the parties and/or families when there was a dispute as to the type of placement. Most families, particularly those with young children, were used to 24-hour nursing coverage. There was no mechanism to measure the fragility of these individuals and so the outcome of the disputes most often went to the families. The cost of nursing coverage for 3 person settings was often doubled in order to fulfill this requirement.

Judge Ellison asked Ms. McGowan to develop a mechanism to measure the fragility of the class members who were rapidly being placed into the community. Most of these individuals were being placed in the Metro-Tulsa area, but 25% of these class members were scheduled to be places in other areas of the state, most of which were quite rural and devoid of health care supports. At this point, there was one registered nurse serving in each of the state's three Developmental Disabilities service regions. Health care surveillance for persons with disabilities in the community was nearly non-existent at the time.

Ms. McGowan and the Area II RN, Shirley McKee, brought together a group of nurses along with an out-of-state nurse consultant, to brainstorm for a few days about the requirements for a surveillance process to protect the health and safety of this population. Since nursing supports were nearly non-existent in the three regional systems, the group decided that the tool would need to be used by someone who knew the individuals well, but who had relatively little medical background. Hence, the group that the tool was designed for became the case managers. Class Members were assigned to community consumers at a ratio of 1:25, and during the first 12 months, 1:10 following transition from Hissom.

The original paper tool was known as the Physical Status Review (PSR). This paper instrument was field tested by the RNs in the State DD system on some 6000 individuals, including those from the other two state facilities. This allowed for the honing of the instrument on a broad range of individuals with disabilities and resulted in a number of changes to the instrument. At that time there were also efforts to develop a state-wide health care policy, Health Care Policy for DDSD (Developmental Disabilities Services Division) specified that health supports were tied to Health Care Levels determined by the Physical Status Review (now called the *Health Risk Screening Tool*)

Health Care Levels were assigned based on points accumulated on the PSR, with Levels I and II being low risk, Levels III and IV being moderate risk, and Levels V and VI being the highest risk. Level VI were the

only individuals designated as qualifying as eligible for 24 hour nursing care. This designation of eligibility based on an objective instrument administered by trained and experienced health care personnel now allowed the state to win its arguments with the Federal Magistrate. This allowed the state to reduce its residential costs to meet the other requirements of the Settlement Agreement. The tool was also used to drive surveillance requirements, such as RN review, referral for therapy assessments and medical specialty assessments. Training requirements for staff were additionally delineated by the instrument.

The HRST (PSR) remained paper based until 1998, when the first attempt at an electronic version was developed in Oklahoma. This was a single user version that allowed up to 300 individuals to be entered on a single laptop and then to analyze their health care stability over time and in relation to each other.

The web-based version began development in 2005 and was introduced in Georgia in 2007. Previous to this, Georgia had some 10,000 consumers on the paper tool, but found the utility of the paper tool very limited. From 2007-2011 some 14,000 consumers were entered into the HRST Online, allowing the state the ability to monitor health status of individual consumers by region, by case manager, by provider or other individual entity.

## Examples of Use

The HRST is used in a number of states to determine the type and extent of professional support and training and its use is mandated by policy. The tool is also used independently by numerous private and non-profit agencies to monitor the health and safety of their clients.

- **State of Georgia, Division of Developmental Disabilities:** The state began using the paper form of the tool under the guidance of Karen McGowan in 1999. The state was the first to implement the web-based HRST in 2007 and is now in its fifth year of use with over 13,000 individuals rated in the system. The HRST has been written into the state DD waiver and provider manual, and is also used in the state training centers. The HRST is integrated with the state's electronic case management system as well as the Systems Intensity Scale (SIS). The HRST is used to determine rate setting and exceptional rates in the state.
- **State of Kentucky, Department for Behavioral Health, Developmental & Intellectual Disabilities:** Kentucky is the second state to implement the web-based HRST state-wide. The HRST Online is written into the state DD waiver and 3,500 individuals are in the system.
- **Tennessee Department of Intellectual and Developmental Disabilities:** The Department requires that all recipients of residential services in the department receive a health care level determination using the Health Risk Screening Tool. The state currently uses the paper form of the tool and has for years.
- **Maryland Developmental Disabilities Administration:** Paper version of the HRST advocated and used by state regional nurse and broadly by providers but it is not mandated. State is currently using web-based HRST as part of a Nursing Assessment Project to assist in determining requirement of nursing for individuals at low level of health risk.

- **Louisiana Office for Citizens with Developmental Disabilities:** The paper version of the tool was originally implemented in 1998 and used in the state Training Centers, in the community and state crisis management teams. Karen McGowan initially assisted with implementation of the paper HRST and then the state carried forward with its own training on the tool. Currently the HRST is a part of the Louisiana Children’s Choice Waiver and another state Waiver and has continued to be used in the state Training Centers.
- **Southern California Integrated Health and Living Project:** This is the project that is responsible for transitioning the 390 individuals currently in the Lanterman Developmental Center in Pomona, CA into the community. The project is using the web-based HRST to establish a health baseline on all the individuals and then track their health status over a three year period once they are transitioned into the community. The HRST was chosen for use by this project due to its objective rating system, web-based data accessibility and oversight reporting features.
- **Oklahoma Developmental Disabilities Services Division:** This is the state where the HRST originated from (see History section above). The Division has incorporated the use of the HRST (known there as the Physical Status Review or PSR) as part of the health care policy—OAC 340:100-5-26.

## Outcomes and Uses

There are several potential outcomes and uses for the HRST results. The instrument assigns point scores to twenty two (22) distinct rating items. The resulting numerical totals are assigned HEALTH CARE LEVELS associated with DEGREES OF HEALTH RISK.

Each individual screened is assigned a health care level, ranging from one to six. **The initial ratings for a group serve the purposes of developing a health baseline and determining the range of clinical supports, services and surveillance needs.**

### HEALTH CARE LEVELS

**Level 1 (LOW RISK): 0 - 12 Points**

**Level 2 (LOW RISK): 13 - 25 Points**

**Level 3 (MODERATE RISK): 26 - 38 Points**

**Level 4 (HIGH MODERATE RISK): 39 - 53 Points**

**Level 5 (HIGH RISK): 54 - 68 Points**

**Level 6 (HIGHEST RISK): 69 or greater**

The HRST supplies the provider/support team with guidance in determining the person’s need for further assessment and evaluation to address identified health risks as well as guidance in determining general and individual-specific staff training.

## Acuity and Accurate Supports Allocation

The HRST Health Care Levels are based on quantifiable and objective criteria. **The HRST defines acuity and gives the ability to accurately look at the health status of individuals in a region or served by a provider or case managers, among others.** Cost can be allocated for persons who truly need a higher rate, rather than assuming that high rates are needed for persons simply because they are in wheelchairs or look like they are medically complex. Conversely, the HRST identifies individuals, such as those with behavioral challenges, who are often not identified as requiring the level of support they do need.

State resources are valuable and limited. Some regions require educational support for community providers and families; other regions require intensive medical/ nursing/ therapy supports for the individuals themselves. The HRST system allows the state and provider administrative staff to view the state as a whole with appropriate allocation of resources based on an objective, comprehensive screening of individual needs. This decreases the waste of precious dollars by drilling down to actual needs per region.

## Proactive Approach = Lower Morbidity = Reduced Cost

The HRST screens for health risks on a regular, routine and acute-event basis. The screenings detect health issues early before they develop into a health crisis, and thus reduce the incidence of morbidity and mortality. This in many instances avoids the extreme cost of additional medications, staffing, professional services, ER visits and hospital admissions.

Allowing an individual to destabilize for a period of time before treatment often results in the person requiring a higher level of health care at significantly increased cost. An example is a person who goes from eating by mouth to having a gastrostomy or jejunostomy tube. This increases the cost of eating to double or quadruple the costs of eating orally. In addition, the person's risk for GI bleeding increases substantially which increases the likelihood of requiring 24-hour nursing care.

**Early identification of health risks + early intervention = improved outcomes for the individual + lower health care costs.**

## Federal Reimbursement

**The Centers for Medicare & Medicaid Services (CMS) will reimburse 50% of the cost for the services that the HRST provides.** CMS requires that systems be in place for monitoring the health and safety of individuals receiving services and the Health Risk Screening Tool (HRST) assists in fulfilling this requirement.

The State of Georgia is in its fifth year of using the web-based HRST with over 13,000 individuals in its system. The state has received a 50% CMS reimbursement for the HRST services each year. 