Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX

# MEDICAL RECORDS REVIEW (DRIVERS)

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| **Hospital Name:** | |
| **Reviewer Name:** | |
| **Case #:** | |
| **Date of Review:** | |
| **Description of Strategy/Quality Improvement Being Tested (during QI cycles):** | |

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| **Purpose:** | The purpose of the records review is to understand from the documentation in the medical record the context around the first hospitalization and the readmission, specifically as relates to patient background, circumstances and events surrounding both admissions, and transition planning. |
| **Sample Size:** | 10-20 reviews – until themes converge and very little new information is being learned. |
| **Selection Criteria:** | • Adults with primary insurance Medicaid who have had a readmission within 30 days of a previous admission.<br>• Patient is still in hospital or 7 or fewer days since discharge. |
| **Time:** | 20 minutes maximum. |

| **I. General** | |
|---|---|
| 1. Age | |
| 2. Gender | ☐ Male<br>☐ Female |
| 3. Marital status | ☐ Married/partnered<br>☐ Widowed<br>☐ Separated<br>☐ Divorced<br>☐ Single<br>☐ Unknown |

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| 4. Is patient Hispanic or Latino/Latina? | ☐ Yes ☐ No |
| 5. What is patient's race? Please select one or more. | ☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Native Hawaiian or other Pacific Islander<br>☐ Black or African American<br>☐ White<br>☐ Unknown |
| 6. Patient's primary language spoken at home | ☐ _____<br>☐ Unknown |
| 7. Housing status | ☐ Own<br>☐ Rent<br>☐ Live in someone else's home<br>☐ Shelter<br>☐ Other _____<br>☐ Unknown |
| 8. Payer | ☐ Medicaid<br>☐ Medicaid Managed Care Organization or Health Maintenance<br>☐ Medicaid and Medicare<br>☐ Other – **NOT ELIGIBLE** |
| 9. Number of hospitalizations (observation or inpatient) in past 12 months | |
| 10. Number of emergency department visits in past 12 months | |
| 11. Note any documentation of the patient's social supports, language/ cultural/ economic factors that may affect his/her ability to transition from the hospital | |
| 12. Note any documentation of the patient's functional status (ability to attend to activities of daily living (ADLs) and instrumental ADL | |
| 13. Is a primary care provider (PCP) noted in the chart? | ☐ Yes ☐ No |
| 14. If yes, what is the setting or location of the PCP? | ☐ Community health center<br>☐ VA clinic<br>☐ Hospital-based clinic<br>☐ Other _____<br>☐ Unknown<br>☐ Name of clinic (if known)<br>_____ |

| **II. First Admission** | |
|---|---|
| 15. Date of admission | |
| 16. Date of discharge | |
| 17. Length of stay | |
| 18. Admitting chief complaint | |
| 19. Admitting primary diagnosis | |
| 20. Discharge diagnoses (primary and secondary) | |
| 21. Evidence of cognitive dysfunction (delirium or dementia) | ☐ Yes _____<br>☐ No<br>☐ Not addressed |
| 22. Evidence of mental health issues | ☐ Yes _____<br>☐ No<br>☐ Not addressed |
| 23. Evidence of substance abuse issues | ☐ Yes _____<br>☐ No<br>☐ Not addressed |
| 24. Evidence of other chronic diseases | ☐ Yes _____<br>_____<br>☐ No |
| 25. Were any new medications prescribed during hospitalization that must be continued post-discharge? | ☐ Yes _____<br>☐ No |
| 26. Evidence that a medication list (or other medication instruction) was provided to the patient | ☐ Yes ☐ No |
| 27. Evidence that self-management guides, instruction, or other material was provided to the patient | ☐ Yes ☐ No |
| 28. Was a follow-up (post-discharge) appointment with the PCP made? | ☐ Yes ☐ No ☐ Unknown |
| 29. Are any specialist providers noted? If yes, what specialties? | ☐ Yes _____<br>☐ No |
| 30. Was a follow-up (post-discharge) appointment made with any specialist(s)? If yes, which ones? | ☐ Yes ☐ No ☐ Unknown |

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| 31. What setting was the patient discharged to? | ☐ Own home<br>☐ Home with home health<br>☐ Relative/caretaker home<br>☐ Rehabilitation facility<br>☐ Nursing home/long-term care facility<br>☐ Home with hospice<br>☐ Shelter<br>☐ Other _____<br>☐ Unknown |
| **III. Readmission** | |
| 32. Date of admission | |
| 33. Source of admission | ☐ Own home<br>☐ Home with home health<br>☐ Relative/caretaker home<br>☐ Rehabilitation facility<br>☐ Nursing home/long-term care facility<br>☐ Home with hospice<br>☐ Shelter<br>☐ Other _____<br>☐ Unknown |
| 34. Documented reason for referral to emergency department/hospital from above setting | |
| 35. Date of discharge (if applicable) | ☐ Not yet discharged<br>☐ Discharged – Date _____ |
| 36. Length of stay (if applicable) | ☐ Not yet discharged<br>☐ Discharged – LOS _____ |
| 37. Admitting chief complaint | |
| 38. Admitting primary diagnosis | |
| 39. Discharge diagnoses (primary and secondary) | ☐ Not yet discharged<br>☐ Discharged – Primary & secondary diagnoses _____<br>_____ |
| 40. Evidence of cognitive dysfunction (delirium or dementia) | ☐ Yes _____<br>☐ No |
| 41. Evidence of mental health issues | ☐ Yes _____<br>☐ No |

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|---|---|
| 42. Evidence of substance abuse issues | ☐ Yes _____<br>☐ No |
| 43. Evidence of other chronic disease | ☐ Yes _____<br>_____<br>☐ No |
| 44. Were any new medications prescribed during hospitalization that must be continued post-discharge? | ☐ Yes _____<br>☐ No |
| 45. Evidence that a medication list (or other medication instruction) was provided to the patient | ☐ Yes ☐ No |
| 46. Evidence that self-management guides, instruction, or other material was provided to the patient | ☐ Yes ☐ No |
| 47. Was a follow-up (post-discharge) appointment with the PCP made? | ☐ Yes ☐ No ☐ Unknown |
| 48. Are any specialist providers noted? If yes, what specialties? | ☐ Yes _____<br>☐ No |
| 49. Was a follow-up (post-discharge) appointment made with any specialist(s)? If yes, which ones? | ☐ Yes ☐ No ☐ Unknown |
| 50. What setting was the patient discharged to? | ☐ Not yet discharged<br>☐ Own home<br>☐ Home with home health<br>☐ Relative/caretaker home<br>☐ Rehabilitation facility<br>☐ Nursing home/long-term care facility<br>☐ Home with hospice<br>☐ Shelter<br>☐ Other _____<br>☐ Unknown |