

MEDICAL RECORDS REVIEW (TEST STRATEGIES)

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

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:	<ul style="list-style-type: none"> • Adults with primary insurance Medicaid who have had a readmission within 30 days of a previous admission. • Patient is still in hospital or 7 or fewer days since discharge.
Time:	20 minutes maximum.

I. General	
1. Age	
2. Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
3. Marital status	<input type="checkbox"/> Married/partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Unknown

Public reporting burden for this collection of information is estimated to average 20 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.

4. Are patient Hispanic or Latino/Latina?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. What is patient's race? Please select one or more.	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Unknown
6. Patient's primary language spoken at home	<input type="checkbox"/> _____ <input type="checkbox"/> Unknown
7. Housing status	<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Live in someone else's home <input type="checkbox"/> Shelter <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown
8. Payer	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid Managed Care Organization or Health Maintenance <input type="checkbox"/> Medicaid and Medicare <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. If yes, what is the setting or location of the PCP?	<input type="checkbox"/> Community health center <input type="checkbox"/> VA clinic <input type="checkbox"/> Hospital-based clinic <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Name of clinic (if known) _____

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)	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No <input type="checkbox"/> Not addressed
22. Evidence of mental health issues	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No <input type="checkbox"/> Not addressed
23. Evidence of substance abuse issues	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No <input type="checkbox"/> Not addressed
24. Evidence of other chronic diseases	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
25. Were any new medications prescribed during hospitalization that must be continued post-discharge?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
26. Evidence that a medication list (or other medication instruction) was provided to the patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
27. Evidence that self-management guides, instruction, or other material was provided to the patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Was a follow-up (post-discharge) appointment with the PCP made?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
29. Are any specialist providers noted? If yes, what specialties?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
30. Was a follow-up (post-discharge) appointment made with any specialist(s)? If yes, which ones?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

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