Community Assessment

As a group, review your collected data and anecdotal experiences to thoughtfully answer the following questions.

Patient Activation

1. What do patients who frequently return to the hospital have in common?
2. What is different about patients who use hospital services the most frequently (top 10% utilizers)?
3. What barriers to patient activation (regarding health and chronic conditions) can we address?
4. What happens when a patient is at higher risk for rehospitalization?
    a) Dually enrolled in Medicare and Medicaid
    b) Multiple chronic conditions with three or more medications
    c) Behavioral health issues
    d) Alzheimer's or other dementia disorders
    e) Socioeconomic barriers or other social determinants of health (e.g. unsafe housing, lack of transportation, lack of access to healthy food, etc.)
    f) Other high-risk group

Information Transfer

5. How is information about a patient transferred when the patient moves from one care setting to another?
6. How do we assure that all of the patient's care team (everyone in each setting where the patient receives care) has access to the complete health, treatment, and care plan information?

Systems of Care Across Settings

7. What contributes to a more successful transition home and back to primary care?
    a) Before hospitalization
    b) During hospitalization
    c) After hospitalization
8. What systems do we have in place to assure safe transitions from one setting of care to another?
9. What systems are lacking?
10. How do we assure medication management is consistent with the most current plan of care?
11. How do we track and resolve any adverse events related to medication management?

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