Comprehensive Healthcare for the Community

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Introduction

In the United States, health disparities and inefficiencies result in overutilization of Emergency Rooms, exorbitant healthcare costs and adverse health outcomes, especially for underserved patients. In order to provide patient-centered care for the most complicated, high-risk patients, effective communication and collaboration between the hospital and community must be established to provide patient-centered care to underserved patient populations. Wesley Health Center, a Federally-Qualified Health Center in Phoenix, Arizona, is uniquely equipped as a Patient-Centered Medical Home to implement a care management program through a Dignity Health Grant. This program will help patients transition from the Emergency Room at St. Joseph's Hospital to a primary care setting at Wesley Health Center where they will receive comprehensive healthcare services. This paper will discuss the implementation of the planning phase of the Comprehensive Healthcare for the Community Program at Wesley Health Center, funded by the Community of Care Program through Dignity Health.

Background

According to the National Health Interview Survey in 2012, 79.7% of adult Emergency Room (ER) visits in the United States are due to a lack of access to other healthcare providers (Centers for Disease Control, 2012). Along with expected reasons for ER visits, including that only a hospital could help or the provider's office was not open, 46.3% of all patients stated that they visited the ER because they had nowhere else to go (CDC, 2012). Unfortunately, uninsured patients are particularly vulnerable, as 61% of uninsured patients surveyed did not have any other place to access healthcare services at their last ER visit compared to 38.9% of privately insured patients and 48.5% of patients with public healthcare plan coverage (CDC, 2012).

Another research study found that out of 1.5 million annual ER visits in the United States, 2.3 million ER visits per year are made by patients who had been discharged from the ER in the last seven days (Burg, Craig & Simon, 2008). Uninsured patients were three times more likely to make a hospital visit following discharge than insured patients, providing compelling evidence that uninsured patients are at greatest risk for overuse of ERs. Additionally, ER visits are expensive. A study conducted by the NIH in 2013 revealed that the average ER visit costs $2,168, which is 40% more than what the average American pays on monthly rent (Caldwell, Srebotnjak, Wang & Hsia, 2013). It is not cost-effective or sustainable for patients to receive healthcare services in the ER that they could be receiving in a primary care setting, like urinary tract infections or back pain. In order to reverse this drastic health disparity and drive down costs of services from improper ER use, new interventions must be developed to improve access to services, prevent unnecessary ER visits and hospital readmission, and increase collaborative efforts to transition patients from the hospital back to their home or community.

While research continues to demonstrate the national trend towards overutilization of emergency rooms, the healthcare system has responded by developing care management and transitions to care programs to ameliorate the cost and provider burden of such high ER use. Care management describes a set of activities in a healthcare setting designed to 1) improve patients' functional health status 2) enhance coordination of care 3) eliminate duplication of services and 4) reduce the need for expensive medical services (Bodenheimer & Berry-Millet, 2009). Many care management programs are embedded within the primary care setting and hospital-to-home care management has been shown to decrease hospitalizations and reduce medical costs for complex patients (Bodenheimer & Berry-Millet, 2009). Likewise, the term "transitions of care" connotes the scenario of a patient leaving one care setting (i.e. hospital,

emergency department (ED), nursing home, assisted living facility, skilled nursing facility, primary care physician, home health, or specialist) and moving to another. The care transition frequently involves multiple persons, including the patient, family or other caregiver, nurses, social workers, case manager, pharmacists, physicians, and other providers (National Transitions of Care Coalition, 2009). Transitions to care principles include the care team process, for instance discharge planning and medication reconciliation, information transfer between providers and patient education and engagement, which takes health literacy and language barriers into consideration (National Transitions of Care Coalition, 2009). Patient outcomes include patient experience, provider experience, patient safety, health care utilization and health outcomes like therapeutic endpoints (National Transitions of Care Coalition, 2009). Hospitals, primary care setting and community health centers are beginning to develop programs based on care management and transitions to care in order to support the most complicated, high risk patients with multiple comorbidities and frequent ER use or hospitalizations.

Health care spending for people with five or more chronic conditions is 17 times higher than for people with no chronic conditions (Anderson et al, ?),. Given the exponential nature of healthcare costs based on the number of chronic medical conditions a patient has, it is important to address deficiencies in health literacy, patient education, appropriate medical follow-up, and communication among health care providers in all settings where these patients receive healthcare services as well as to prevent adverse health outcomes following ER discharge. For example, in a recent study of patient and caregiver understanding of discharge instructions, 78% of patients demonstrated deficiencies in one of 4 domains: 1) diagnosis and cause, 2) ED care, 3) post-ED care, and 4) return instructions (Engel KG et al, 2009). Greater than one-third of the deficiencies involved understanding of post-ED care. Furthermore, research has revealed that

providing additional support for patients in primary care settings reduces ER rates. Patients enrolled in a medical home in Orange County for longer periods were less likely to have ER visits or multiple ER visits while switching medical homes three or more times was associated with enrollees being more likely to have any ER visits or multiple ER visits (Roby et al, 2009). Patient-centered medical homes, care management programs and transitions-to-care services show promise in addressing many of the disparities in healthcare that affect patients with multiple comorbidities, inadequate health insurance and lack of access to care.

Comprehensive Healthcare for the Community

Dignity Health is a national healthcare system in 17 states that is committed to providing "high-quality, affordable healthcare" to the communities it serves based on the values of dignity, collaboration, justice, stewardship and excellence (Dignity Health, 2013). The Dignity Health Foundation currently operates a Community Grants Program to partner its hospitals with 501 (c)(3) nonprofit organizations that are aligned with the strategic priorities of Dignity Health. In Phoenix, Arizona, St. Joseph's Hospital, a Dignity Health Hospital, has identified Clinical and Preventative Services as one of its health priorities for its Comprehensive Healthcare for the Community Program in collaboration with local partners. In 2012, Wesley Health Center was selected as a recipient of a $31,600 Dignity Health Grant to collaborate with St. Joseph's Hospital to provide services to 200 uninsured or uninsured unduplicated patients within the service area who have diagnoses of asthma and daily inhaler use, obesity with a BMI over 30, hypertension with a blood pressure over 140/90 or diabetes with a Hemoglobin A1C value over 9.0%.

Wesley Community Center has provided community programs, services and development for low-income, primarily Hispanic families residing in Central Phoenix and now all of Maricopa

County since 1950. In 2009, Wesley Community Center opened Wesley Health Center as one of three Federally-Qualified Health Centers in Phoenix and a freestanding primary care clinic in the Nuestro Barrio Neighborhood. In partnership with St. Joseph's Hospital, Valle del Sol and Hope Lives, Wesley Health Center focus discussions with patients about the following topics: understanding chronic disease and its complications, nutrition, physical activity, stress management, communication with the provider, medications, setting goals, and motivational coaching (Grant?). All patients enrolled in Comprehensive Healthcare for the Community will be screened for depression, and referred for individual sessions with the Behavioral Health Specialist or at Valle del Sol or Hope Lives. In addition, each patient will have a new patient appointment with a primary medical provider, including a physical exam and follow-up treatment. Wesley Community Center's main responsibility will be to partner with the case manager or discharge planner to ensure that patients who qualify for the program are followed up with and enrolled in healthcare, including follow-up visits at other partner organizations based on patient complexity. As the lead organization, Wesley Health Center's Care Coordinator will act as the point of contact to coordinate for each patient will be the one responsible for communication with St. Joseph's and triaging patients as they are referred from the hospital. The stated goals of Comprehensive Healthcare for the Community include patient self management and disease control, decreasing the incidence of complications associated with hypertension, diabetes, obesity and asthma, and finally decreased hospitalizations over the two-year time period of the grant.

Project Methodology

The Comprehensive Healthcare for the Community program is currently in Phase 1 of the Dignity Health Community Grant implementation, which involves the planning and implementation of the process. Although Wesley Health Center has been funded for over 8 months, they have not yet begun to enroll patients because of delays in receiving the Memorandum of Agreement from St. Joseph's Hospital. In order to pilot a cohort of patients at Wesley Health Center, my project objectives involved developing the patient information brochure and intake forms, finalizing an individualized action plan form, translating forms into Spanish, piloting the enrollment forms with patients at Wesley Health Center who qualify for the program and arranging meetings with St. Joseph's discharge planner and staff to develop a system for effective transitions to care. Throughout this process, another objective was to support the Care Coordinator in rolling out the Comprehensive Healthcare for the Community Program in whatever capacity was necessary.

The timeline for the project was divided into thirds: the first two weeks were dedicated to meetings with the Care Coordinator, Donna Gomez, the COO, Emma Viera, and the Comprehensive Healthcare for the Community program team of Wesley Health Center, Valle del Sol and Hope Lives staff that had team meetings every Monday afternoon. During that time, I also read the grant, final budget breakdown and all documents for the program. The second third of the project involved form development and meetings with the Care Coordinator to determine The final two weeks of my placement at Wesley Health Center involved editing the forms, translating the forms into Spanish and preparing the Comprehensive Healthcare for the Community presentation at the all-staff meeting on Friday, July 26th.

Patient information and intake forms were developed based on the indicator of preventing re-hospitalization or repeat visits to the ER for patients, the National Transitions to Care

Coalition (NTOCC, 2009), care management principles (Bodenheimer & Berry-Millet, 2009) and with the help of Anne Thibault, the Nurse Care Manager at the UCSF Department of General Internal Medicine. Wesley Health Center's model for chronic disease management has been successful in achieving health outcomes based on functional health tests. However, this program requires more in-depth needs assessment and patient self-management coaching to add an additional layer of support to prevent hospital readmission and ER overutilization. Categories in the patient needs assessment included medication, transportation, medical care and health at home to assess patients' risk factors and potential reasons for ER or hospital overutilization. The Individualized Action Plan was developed to help patients identify one issue related to their health that they would like to set goals for through motivational interviewing and behavior change strategies. And finally, the Recent ER and Hospitalization Questionnaire included questions to assess patients' understanding of the purpose for their most recent visit to the ER or hospital, discharge instructions and reasons for hospitalization. The Patients Needs Assessment form is designed to be completed once during the intake visit, whereas the Individualized Action Plan can be used as needed and the Recent ER and Hospitalization Questionnaire is intended to be filled out after each hospitalization or ER visit. The Patient Orientation Packet, including the Patient Information Form, Participating Organizations Information and Reminder Postcard are meant to be reviewed, signed and given to the patient during the initial contact, whether that is at the St. Joseph's ER or at the intake appointment.

Results

A Patient Orientation Packet was created, including a Patient Information Form (Appendix 1), Participating Organizations Information (Appendix 2) and a laminated Reminder Postcard (Appendix 3). For the intake appointment, the forms developed included a Patient Needs

Assessment (Appendix 4), Individualized Action Plan (Appendix 5) and Recent ER and Hospitalization Questionnaire (Appendix 6). All forms were translated into Spanish with the help of the Health Educator who is responsible for translation services at Wesley Health Center.

Although we had intended to schedule a meeting with the St. Joseph's Hospital Emergency Department discharge coordinator, social workers and medical staff during the time of my internship, the meeting was scheduled for after my PCLP fellowship was completed.

Discussion

Hospital-to-home care management has been shown to decrease hospitalizations and reduce costs for complex patients. From the literature, interdisciplinary teams embedded within primary care settings with medical doctors, registered nurses and care coordinators have been the most effective in achieving health outcomes, reducing costs and improving the transition from hospital to home (Bodenheimer & Berry-Millet, 2009). The most successful care management programs have targeted patients recently discharged from the hospital and include teaching self management and medication management principles (Coleman, Parry, Chalmers & Min, 2006). Complex patients in primary care, defined by patients with multiple comorbidities and frequent ER use or hospitalizations who can benefit from medical-psychosocial interventions, also demonstrated improved quality of life in care management programs (Bodenheimer &Berry-Millet, 2009).

Through the development of the Patient Orientation Packet and Patient Intake forms for Comprehensive Healthcare for the Community, Wesley Health Center is now ready to pilot its first cohort of patients through this program. The approval of English and Spanish forms was based on piloting the forms with Wesley Health Center patients who qualify for care management through Comprehensive Healthcare for the Community. Sharing about the

development of this infrastructure for patients and the importance of the Comprehensive Healthcare for the Community program at the all-staff meeting was also crucial in making sure the Wesley Health Center staff understand the rationale behind this program and their potential roles in referring, supporting and identifying patients who are eligible for these services. Although we were not able to attend a meeting at St. Joseph's with medical and administrative staff who are working on this program at the hospital, a meeting was scheduled to include a presentation by both the Care Coordinator and the Medical Director from Wesley Health Center in order to convey the opportunities and benefits of this program. Wesley Health Center is in many ways alleviating some of the burden of frequent flyers at the St. Joseph's Emergency Department and this valuable service must be effectively communicated to the providers at the emergency room to ensure buy-in for this new partnership.

At Wesley Health Center, a Federally-Qualified Health Center, the implementation of a care management program is both timely and necessary, as low-income, uninsured or underinsured patients are the most common overutilizers of emergency rooms due to insufficient access to healthcare providers in other settings. The Care Coordinator at Wesley Health Center is well-equipped to pilot and coordinate the implementation of this program under Dignity Health, however based on the current literature about care management principles, the program will be most successful if it is interdisciplinary in nature and includes clinical staff as well as programmatic or administrative staff. Time constraints and staffing may also present a challenge in the enrollment 200 new patients at the clinic. Rearranging staff responsibilities may be necessary for this endeavor.

Areas for further research and quality improvement for this program are discussed in the Recommendations section of this paper. As the Comprehensive Healthcare for the Community

program is rolled out, interdisciplinary and inter-organizational collaboration will be necessary to effectively manage patients, monitor and evaluate the program and write Letters of Intent for grant funding renewal. The infrastructure is now in place for patient enrollment and intake at Wesley Health Center following the point of contact with St. Joseph's Hospital and eligible patients. However, the larger context and infrastructure for this program rollout, including interprofessional collaboration, communication systems between St. Joseph's, Valle del Sol and Hope Lives and between the patient and his or her providers must be given due attention to ensure consistency of care, patient-centeredness and meeting targets according to the Dignity Health Foundation Community of Care principles.

Recommendations

1. Define realistic, measurable outcomes for program success and data collection. In other words, how will progress in defined health indicators be measured? For instance, by how much will HgAIC or use of inhalers need to change from baseline patient information to determine success?

2. Establish effective communication between Wesley and St. Joseph's to ensure buy-in, sustainability and partnership. For example, a Wesley primary care provider could present at St. Joseph's with Donna Gomez regarding program objectives or schedule a noon conference for St. Joseph's internal medicine residents. Wesley must develop a relationship with Emergency Department staff who are responsible for the disposition of patients upon discharge from the ER. A weekly meeting or phone call with the discharge planner or case managers is one idea currently being pursued for the program.

3. Schedule a 30 minute time slot for new patient intake appointments with Care Coordinator or Health Educator prior to a new patient appointment with the physician.

4. Include questions about recent ER visit or hospitalization in patient intake forms that are conducted by medical assistants or in the phone triage system.

5. Consider home visits as part of grant renewal for patients with challenges documented in the Health at Home section of the Needs Assessment.

Conclusion

Wesley Health Center is uniquely equipped as a Patient-Centered Medical Home to implement a care management program through the Dignity Health Grant. This program will help patients transition from the St. Joseph's Emergency Room to a primary care setting and receive the other comprehensive healthcare services provided by Wesley, Valle del Sol and Hope Lives. In our current healthcare system, there are many barriers to effective partnership between healthcare providers in the hospital setting and the community. In order to provide patient-centered care for our most vulnerable patients, we must establish effective communication and collaboration between the hospital and community to best serve the underserved population in Phoenix and Maricopa County.

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Appendix 1: Patient Information Form

Welcome to Comprehensive Healthcare for the Community

Part of the Community of Care Program funded by Dignity Health

The Comprehensive Healthcare for the Community Program is an exciting new program for people with unmet healthcare needs. We are here to offer you additional support and resources to help with your healthcare needs.

What to Expect:

- Your own *personal* Care Coordinator to help you manage your healthcare through services at Wesley Health Center, Valle del Sol and Hope Lives
- A dedicated team and support network to help you improve your health and reduce your Emergency Room and hospital visits
- Follow-up appointments
    - Quality healthcare at Wesley Health Center
    - Mental health and behavioral health support services at Valle del Sol
    - Nutrition, exercise, and wellness programs at Hope Lives

Benefits of the Program:

- Access to services at Wesley Health Center, Valle del Sol and Hope Lives to help you take good care of your health and reach your goals.
- Your Care Coordinator, Donna Gomez, will be your contact person at Wesley Health Center on Monday-Friday from 8am-5pm.
    - Your Care Coordinator will help you communicate with your primary care doctor, specialty clinics and the emergency department or hospital if needed.
    - She will work with you to create an action plan for feeling better and improving your health and will help you follow the plan.
- Low-cost appointments and services based on your insurance status.

The staff at Wesley Health Center, Valle del Sol and Hope Lives will follow-up with you to connect you further with our services.

Call **(602) 368- 9609** with any questions.
We're looking forward to working with you!

Appendix 2: Participating Organizations Information

Comprehensive Healthcare for the Community

Participating Organizations

Mission:
Wesley Community Health Center's Mission Statement is, "together, we empower positive change." Wesley Health Center provides primary healthcare services and preventative/health management classes for uninsured and underinsured patients.

Services:
Routine Wellness Exams, Family Planning, Laboratory Services, Chronic Disease Management, Prenatal Care, Vaccines for Adults and Children, Health Education, Care Coordination, Urgent Care, Cancer Screening, Mental Health

Mission:
Valle del Sol is an organization about people, helping them to achieve a better life. Valle del Sol's mission statement is to "inspire positive change by investing in health and human services to strengthen families with tools and skills for self-sufficiency and by building the next generation of Latino and diverse leaders."

Services:
Counseling, Youth and Family Support Services, Crisis Management, Substance Abuse Prevention Services, Mental Health and Behavioral Health Care Services, Psychiatric Evaluation and Treatment, Outpatient Treatment for Alcohol and Drug Abuse

Mission:
Hope Lives – Vive La Esperanza is an organization that strives to increase patients' access to services for culturally and ethnically diverse communities in Maricopa County, Arizona. Their commitment is to promote mental health recovery and wellness. Their message is simple – good mental health is fundamental to the health and well being of everyone in Maricopa County.

Services:
- Direct Peer Support Services
- Workshops (for example: Pre-Vocational, Whole Health, HeartMath)
- Support Services (for example: ASH Line, G.E.D. study and testing services, mental health first aid responders, Social Security Administration Benefits, Restoration of Civil Rights, Department of Economic Security/SSI MAO Benefits)

Contact Information:

Wesley Health Center **Address:** 1300 South 10th Street Phoenix, AZ 85034 (Buckeye Rd. & 10th St.) **Hours:** Mon-Thurs: 8am - 9pm, Fri: 8am - 5pm **Phone:** (602) 257-4323	**Valle del Sol** **Address:** 1209 S. 1st Avenue Phoenix, AZ 85003 (1st Ave. & Buckeye Rd.) **Hours:** **Phone:** (602) 258-6797	**Hope Lives** **Address:** 1016 East Buckeye Rd, Suite 145, Phoenix, Arizona, 85034 (10th St. & Buckeye) **Hours:** Mon-Sat: 7am - 7pm **Phone:** **1 (855) 747-6522**

Appendix 3: Patient Reminder Postcard

Comprehensive Healthcare for the Community

Make an appointment for hospital follow-up:

1) Call Donna Gomez, Care Coordinator at Wesley Health Center to schedule your appointment:
(602) 368- 9609

2) For your first appointment, please bring:
- Your discharge instructions from the hospital
- Your medication bottles and/or list

Comprehensive Healthcare for the Community

Your appointment is scheduled for:
Date: _____
Time: _____

Location:
1300 South 10th Street
Phoenix, AZ 85034
(South of Buckeye Rd., on 10th St.)
Phone: 602-257-4323

Appendix 4: Patient Needs Assessment

COMPREHENSIVE HEALTHCARE FOR THE COMMUNITY

Part of the Community of Care Program through Dignity Health

PATIENT INFORMATION

Patient Name:: _____ _____ _____ DOB: _____ Zip Code ___ - ___

Today's Date: _____

NEEDS ASSESSMENT

MEDICATIONS

Do you have any allergies to any medications?	Y	N
Which medications: _____		
Do you have your medications with you today?	Y	N
Do you have any trouble taking your medications?	Y	N
Do you have trouble keeping track of your medications at home?	Y	N
How do you keep track of your meds (e.g. Medi-Set?): _____		
If yes, does anyone help you with your medications?	Y	N
Name/Relationship: _____		
Do you ever miss doses or go without your medications?	Y	N
How often: _____		
Do you get any side effects from your medications?	Y	N
Do you have any trouble paying for your medications?	Y	N
What pharmacy do you use? _____		
Do you ever have problems getting your medications from the pharmacy?	Y	N

TRANSPORTATION

What type of transportation do you use? _____		
Do you have difficulty getting the transportation you need?	Y	N

MEDICAL CARE

Are you being seen by any other doctors or in any other clinics or agencies? List below:

Do you have health insurance?	Y	N
Would you be interested in more information about qualifying for health insurance?	Y	N
Do you already have a social worker or case manager?	Y	N
If so, who and through what agency? _____		
Have you been in the emergency room or hospital in the last year?	Y	N
Have you ever filled out a form giving your health wishes, in case you were to get very sick and not be able to speak for yourself?	Y	N

If no, could I give you more information so we can talk about it next time?	Y	N
HEALTH AT HOME		
Do you ever need help taking care of your healthcare needs?	Y	N
Do you need caregivers or other helpers at home for your healthcare needs?	Y	N
If yes, do you have the caregivers that you need?	Y	N
If yes, who are the healthcare helpers in your home, how often do they come and what do they do? _____		
Do you currently use any assistive devices at home?	Y	N

Glasses:	Has	Needs	Wheelchair:	Has	Needs
Walker:	Has	Needs	Tub/Shower:	Has	Needs
Prosthesis:	Has	Needs	Commode:	Has	Needs
Cane:	Has	Needs	Hospital bed:	Has	Needs
Grab Bars:	Has	Needs	Hearing aids:	Has	Needs

Do you ever need help bathing or using the bathroom at home?	Y	N
Do you ever need help grocery shopping or cooking at home?	Y	N
Do you ever need help getting up from bed or sitting in chairs?	Y	N
Are you able to get around your house safely?	Y	N
Do you ever feel afraid of falling or getting hurt at home?	Y	N

Appendix 5: Individualized Action Plan

COMPREHENSIVE HEALTHCARE FOR THE COMMUNITY

Part of the Community of Care Program through Dignity Health

PATIENT INFORMATION

Patient Name:: DOB:

_____ _____ _____ _____ _____

__ _ _ _ Zip Code: _

Today's Date: _____

Check all that apply: I would like to receive messages by: ❑ phone: (___)

❑ text (same #) ❑ text: (___)_____ Best time to reach you:_____

email:_____ What type of residence do you live in? _____ Do you live ❑ alone or ❑ with someone else? Do you have someone to call in case of an emergency? Y N Name: _____

INDIVIDUALIZED ACTION PLAN

❑ Current A1C: _____ ❑ Current BP: _____ ❑ Current BMI: _____

❑ Asthma - daily inhaler use ❑ High depression score: _____

❑ Other _____

What are your biggest concerns about your health right now? _____

Tell me about the things that make it hard for you to take care of your health: _____

_____

Which health concern would you like to work on first? _____

Is there anything you would like to do to improve your health? Y N If yes, what? If no, why?

_____

What would you need to do to achieve your health goals? _____

Health Goal I am working on now:	**Action Plan** 1. What 2. How Much 3. When 4. How Often
Health Issue	
Follow-Up Date & Comments:	How confident am I about my Action Plan?

	1 2 3 4 5 6 7 8 9 10 not confident very confident

Patient Signature: _____ Date: _____

Care Coordinator Signature: Date:

Appendix 6: Recent ER or Hospitalization Questionnaire

COMPREHENSIVE HEALTHCARE FOR THE COMMUNITY

Part of the Community of Care Program through Dignity Health

PATIENT INFORMATION

Patient Name:: _____ _____ _____ DOB: _____ Zip Code: _____

Today's Date: _____

EMERGENCY ROOM VISITS:

Have you been in the emergency room in the last year? Y N

If yes, about how many times have you been in the emergency room in the last year? _____

Which hospital(s) did you go to? _____

How do you get to the emergency room? ❑Do you call 911? ❑Do you drive yourself there?

❑Do you go ambulance or other transportation? ❑ Are you sent there by police or a social worker?

❑Are you sent there by a clinic or doctor?

What do you usually go to the emergency room for? _____

(Prompt: Do you go there because you are having pain, trouble breathingor to get med refills?)

What is your experience in the emergency room?

(Prompt: Do you have to wait long? Do you get what you need there? Do you like to go to the ER to get help or do you go because you don't have any other way of getting help?)

If multiple ED visits: Why do you think you have had to go to the emergency room so many times?

_____

As you think back, is there anything you or your doctor could have done to prevent your having to go to the emergency room any of those times? _____

PRIOR HOSPITALIZATIONS:

Have you been in the hospital in the last year? Y N

If yes, about how many times have you been in the hospital in the last year? _____

Which hospital(s) did you go to?

_____

How do you get to the hospital? ❑Do you call 911? ❑Do you drive yourself there?

❑Do you go ambulance or other transportation? ❑ Are you sent there by police or a social worker?

❑Are you sent there by a clinic or doctor?

What were you in the hospital for? _____

What is your experience in the hospital?

_____

(Prompt: Did you get what you needed there? Do you like to be in the hospital to get help? Did you feel better in the hospital? If so, what made you feel better?)

If multiple hospital visits: Why do you think you have had to be hospitalized so many times?

_____

As you think back, is there anything you or your doctor could have done to prevent your going to the hospital?

_____

MOST RECENT HOSPITALIZATION OR ER VISIT: **Date of Admission or ER Visit: _____**

What was your diagnosis in the hospital?What did the medical team think was wrong with you?

_____

What was done for your medical problem in the ED?

_____

Did you take home any discharge instructions? What were you told to take care of your medical issue at home?

_____

Were you counseled about your medications when you were discharged?

_____

Did the hospital case manager/discharge planner coordinate any services for you or your caregiver?

_____

What symptoms or changes should cause you to return to the emergency department?

_____