Tool 10: Whole-Person Assessment Tool

**Purpose:** Identify patient-specific functional, social, logistical needs, and facilitate referral to supports available in the community.

**Description:** This tool provides a checklist to prompt frontline staff to identify and address basic needs.

**Staff:** Frontline staff in the hospital, including social workers, case managers, etc.

**Time required:** 20 minutes to assess; conduct at least 24 hours prior to discharge for sufficient time to act on information and make referrals.
Tool 10: Whole-Person Assessment

Readmissions rarely result from a singular breakdown in the transition of care and post-hospital supports. A team at Kaiser Permanente in Northern California reviewed more than 500 adult readmissions (all payer, all ages) from across 18 of their hospitals. Using the readmission interview technique from the STate Action on Avoidable Rehospitalizations (STAAR) Initiative (modified in this guide), they interviewed 234 primary care providers, 111 specialists, 166 hospitalists, 14 skilled nursing facility physicians, and 390 patients and caregivers. Among 250 readmissions they deemed to be potentially avoidable, there were an average of 9 factors that contributed to each readmission and 1,867 total factors. About two-thirds of the issues were related to the hospital transition process, and three-quarters were related to posthospital care and needs.¹

The message from this person-centered view of readmissions is that no single issue defines readmission risk. Take a “whole-person” view of transitional care and ongoing care needs to better identify not only risk of readmission, but also the transitional care services and supports needed to address diverse but interrelated needs. This approach will be particularly well suited for adult Medicaid patients but is borne of experience on an all-ages population and has broad applicability.

As is evident by the numerous domains on this assessment, this assessment becomes an invaluable tool for cross-setting and ongoing patient care plan development for all the patients’ current and future providers. Best practice is to share this assessment with “receiving” providers in the community. As your cross-continuum team gains experience with whole-person, cross-setting assessment, you may be able to gain efficiencies when patients return to the hospital and this comprehensive view of their needs has already been completed and is shared with the inpatient team from the outpatient setting.

Whole-Person Assessment

Use these questions as prompts to uncover patient’s individual challenges in accessing post-hospital care or to uncover nonclinical issues that require attention to prevent avoidable hospitalizations in the future. Use the improvement motto "see a problem, fix a problem" when inquiring about these broad needs. This assessment can uncover needs for social work referrals and collaboration with social services or care navigators.

Domain

Access to Ambulatory Care
- No regular source of care
- Difficulty with transportation to medical care
- Work/family responsibilities that interfere with appointments
- Regular use of emergency room for care

Access to Behavioral Health Care
- History of behavioral health services
- Concern about emotional or mental health
- Alcohol or drugs affecting health and wellness
- Prescription medications affecting function

Functional Status
- Functional limitations
- Cognitive limitations, including executive function
- Low self-activation or self-efficacy

Unstable/Inadequate Housing
- Lack of stable housing
- Lack of heat or cooling
- Environmental hazards affecting health (mold, etc.)
- Lack of safety and security within or outside the home

Financial Insecurity
- Difficulty paying for basic survival needs (shelter, food)
- Difficulty paying medical-related costs (copays, supplies)

Food Insecurity / access
- Lacks access to adequate amounts of food
- Lacks access to nutritious or medically appropriate diet

Social Connection/Isolation
- Lives alone
- Lacks friends/family/connections to help post-hospital

Legal Issues
- Barriers to access, coverage, benefits, specialty evaluations or testing, medications, utilities, stable housing
- Recent or repeated incarceration or detention

Language or Literacy Issues
- Low literacy, low numeracy
- Low health literacy—diagnoses, medications, care plan
- Low or no ability to speak English
Referrals and Resources
This list represents possible interventions you may identify for a patient. Refer to the Resource Guide Tool (Tool 12) for assistance in populating this list. Modify it to meet the most common needs for your patient population.

Clinical Interventions
- Develop individualized care plan, shared with emergency department, primary care provider, behavioral health, others.
- Convene multidisciplinary, cross-setting partners to develop plan.
- Proactively establish patient with a new primary care provider, if needed.
- Make medical appointments.
- Inform patients about evening hours, and encourage patients to “call us first.”

Managed Care Organization-Based Interventions
- Contact MCO-based care manager.
- Contact Medicaid agency integrated care program.
- Contact MCO agency to provide “wraparound services.”

Behavioral Health Interventions
- Arrange psychiatry consult to evaluate for undiagnosed mental health issues.
- Refer to social work.
- Refer to community behavioral health services.
- Call established community-based behavioral health provider.
- Establish patient with a specific behavioral health provider, if needed.
- Make the behavioral health appointment.
- Contact Medicaid behavioral health carve-out provider.
- Offer or link to health navigator, community health worker services.

Supports and Services
- Ask pharmacist to recommend lowest cost regimen.
- Refer to transitional housing.
- Refer for nutrition counseling.
- Refer to food programs.
- Refer to county health department.
- Refer to community/faith-based or volunteer services.
- Refer to Medical Legal Partnership.
- Refer to hospital or community resources for transportation.