



## Identify and Document Factors Contributing to Readmission

Identifying potential gaps in hospital, transitional, and post-discharge care for heart failure contributing to potentially preventable readmission can improve patient care and enhance quality improvement efforts.

### Classification Of Readmission

	RELATED TO INITIAL ADMISSION	UNRELATED TO INITIAL ADMISSION
Planned Readmission	<input type="checkbox"/> Planned and Related	<input type="checkbox"/> Planned and Unrelated
Unplanned Readmission	<input type="checkbox"/> Unplanned and Related	<input type="checkbox"/> Unplanned and Unrelated

Preventable Readmission:  Yes  No  Uncertain

Interval Between Hospital Discharge and Readmission \_\_\_\_\_ Days

### Transition of Care

Interval Between Hospital Discharge and First Outpatient Visit \_\_\_\_\_ Days or  No Visit

Interval Between Hospital Discharge and First Home Visit \_\_\_\_\_ Days or  No Visit

Interval Between Hospital Discharge and First Telephone Contact \_\_\_\_\_ Days or  No Contact

### Identified Contributing Causes for Rehospitalization (check all that apply)

- Patient assessment breakdown<sup>1</sup>
- Patient treatment breakdown<sup>2</sup>
- Patient and family caregiver breakdown<sup>3</sup>
- Handoff communication breakdown<sup>4</sup>
- Post-discharge from the hospital breakdown<sup>5</sup>
- No breakdown identified

<sup>1</sup> Examples of patient assessment breakdown include failure to assess for comorbid conditions and precipitating factors for decompensation of heart failure.

<sup>2</sup> Examples of patient treatment breakdown include non-adherence in providing guideline recommended therapies or treating comorbid conditions.

<sup>3</sup> Examples of patient and family caregiver breakdown include lack of skill building, recommended target behaviors, or accounting for the literacy or cognitive status of the patient.

<sup>4</sup> Examples of handoff communications can include failure to provide a discharge letter or patient letter that can be shared with the patient's primary care physician or specialists once discharged from the hospital or scheduling an early post-discharge follow up visit.

<sup>5</sup> Examples of post-discharge from the hospital breakdown include failure to provide early follow up with the patient post discharge or check post discharge laboratories.