



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	☐ Planned and Related	☐ Planned and Unrelated
Unplanned Readmission	☐ Unplanned and Related	☐ Unplanned and Unrelated
Preventable Readmission: Yes No Uncertain Interval Between Hospital Discharge and Readmission Days		
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 breakdown¹		
□ Patient treatment breakdown²		
☐ Patient and family caregiver breakdown³		
☐ Handoff communication breakdown ⁴		
☐ Post-discharge from the hospital breakdown ⁶		
□ No breakdown identified		
2 Examples of patient treatment breakdown include 3 Examples of patient and family caregiver breakdo 4 Examples of handoff communications can include or specialists once discharged from the hospital of	de failure to assess for comorbid conditions and precipitating far e non-adherence in providing guideline recommended theraples we not a fact that the still building, recommended target behaviors of failure to provide a discharge letter or patient letter that can be or scheduling an early post-discharge follow up visit.	or treating comorbid conditions. To accounting for the literacy or cognitive status of the patient, shared with the patient's primary care physician

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