## Appendix: Readmission Review Form

### Patient Interview/Readmission Chart Review

<table>
<thead>
<tr>
<th>Patient Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Hospital Admission Date: __________________________ Account Number: _______________</td>
</tr>
<tr>
<td>Previous Hospital D/C Date: __________________________ D/C MD: ____________________________</td>
</tr>
<tr>
<td>Previous Hospital Discharge Diagnosis: CHF DM MI PNA COPD Stroke Other:</td>
</tr>
<tr>
<td>Previous LACE Score: __________________________ Current LACE Score: __________________________</td>
</tr>
<tr>
<td>Current Hospital Readmission Date: __________________________ Time: ____________________________</td>
</tr>
<tr>
<td>Number of days between the previous discharge and readmission date: 1-7 8-14 15-30</td>
</tr>
<tr>
<td>Current Hospital Readmission Diagnosis:</td>
</tr>
<tr>
<td>Fall Renal Disease PNA</td>
</tr>
<tr>
<td>Medication Side Effect Fluid overload Stroke</td>
</tr>
<tr>
<td>CHF COPD Scheduled procedure</td>
</tr>
<tr>
<td>SOB DM Other:</td>
</tr>
</tbody>
</table>

#### Hospital Review:

#### Patient Chart Review Form:

Did the patient have a scheduled physician follow-up visit after initial admission? Yes No

Was the physician follow up visit kept after initial admission? Yes No

Number of days between initial hospitalization and follow-up physician visit ______________

Did patient have Outpatient Community services post discharge? Yes No

Community Services: Home Health/Hospice, Outpatient Clinics, Dialysis Center

Case manager do 7-day follow-up phone call after initial hospitalization? Yes No

# of days between initial discharge and follow-up phone call ______________

### Provider Interview: (Call MD office and speak to Nurse Navigator if applicable)
What do you think led to patient’s readmission?

Any issues that need follow up from hospital side?

**Patient/Caregiver Interview**

Interview is with patient or caregiver:  
Patient  
Caregiver

What do you think caused you (or your family member) to be readmitted into the hospital?

When you (or your family member) encountered problems/concerns after you left the hospital, did you know who to call?  
Yes  
No

When you (or your family member) left the hospital the first time, who did you call for assistance?

**When you left the hospital the last time:**

1. Did you have a good understanding of the things you were responsible for in managing your health?  
   Yes  
   No
2. Did you have a clear understanding of the purpose of taking each of your medications?
   Yes   No   Comments:

3. Did you receive written documentation of the symptoms, warning signs, or health problems to be aware of after you left the hospital?
   Yes   No
   Comments:

4. Did the staff explain your discharge instructions in a way you could understand?
   Yes   No
   Comments:

When you were in the hospital the last time were you kept informed about your diagnoses during your stay?

No

Yes

Most of the time

Some of the time

At the time of discharge did someone talk to you about?

<table>
<thead>
<tr>
<th>Discharge diagnosis (what was wrong with you)</th>
<th>Yes</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tests or lab work to be done once you left the hospital</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What to watch out for regarding worsening of your disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What were you told to do if you were experiencing worsening of your disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Who to contact (and how) if you were experiencing worsening of your disease

Yes  No
Not sure

Were you asked about your understanding of the d/c instructions

Yes  No
Not sure

Were the discharge instructions easy for you to understand

Yes  No
Not sure

Do you still have a copy of your discharge instructions

Yes  No
Not sure

At the time of d/c, did someone talk with you about which medication to take when you left, and which ones to discontinue?

Yes  No
Not sure

Did you take your medications as they were prescribed?

Yes  No
Not sure

What difficulties did you experience with taking your medications?

Did you have a follow up appointment with your doctor?

Yes  No
Not sure

Were you able to get to your follow up appointment?

Yes  No

Review sent to Outpatient Facility

Yes  No

Name and number:

Home Health Chart Review Form

Date  Reviewer initials: __________ Case mgr initials:
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was admission visit completed within 1 day of discharge from hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, how many days from dc and why</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN visits – were visits front loaded if high risk for readmit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no why</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was Telehealth set up on day 2 post hospital, (if applicable)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no why</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone calls between visits for first two weeks if no telehealth, (if applicable)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>If no why</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did patient upon discharge from hospital have an appointment with MD within 7 days of discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did patient keep appointment with MD</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>If no why</td>
<td></td>
<td></td>
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<tr>
<td>Did the patient have all meds on admit to HH</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>If not why</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the patient compliant with meds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If not, explain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any physician Order discrepancies found?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If yes, explain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of visits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of visits by Case Manager: SN ______  PT_______  OT ____________</td>
<td></td>
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<tr>
<td>Number of different clinicians:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPN</td>
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<td></td>
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<tr>
<td>OT</td>
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<td></td>
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<tr>
<td>PT</td>
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<td></td>
</tr>
<tr>
<td>LPTA</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td># of Weekend visits completed by clinician other than Case Mgr __________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Phone visits completed by clinician other than Case Mgr __________</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>During the time between admission to home health and readmission to hospital were there any issues and any issues and how were the issues addressed? Explain:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Home Health Chart Review Form

Date                             Reviewer

Name__________________________________________

Patient name____________________________________________

First hospital DX__________________________________________

Readmission DX__________________________________________

Discharge Date from first admission__________________________

Referral date to HH________________________________________

Admission date to HH______________________________________

Was admission visit completed within 1 day of discharge form hospital  Yes  No

If no, why not

Was second nursing visit completed on day 3 post hospital  yes  No

If no, why not

SN visits performed 3 times a week for first two weeks then 2 times per week  Yes  No

If no, why not

Was Telehealth set up on day 2 post hospital  Yes  No

If no, why not

Phone calls between visits for first two weeks if no telehealth  Yes  No

If no, why not

Was Chronic Disease Mgmt implemented  Yes  No

Did patient upon discharge from hospital have an appointment with MD within 7 days of discharge  yes  no

What date_______
Did patient keep appointment with MD  yes  no  if no, why __________________________

Issues identified upon admission to home health

- Patient had all meds on admit to home health  YES  NO (elaborate)
- If no did not have RX  yes  no  could not afford  Yes  No
- Patient compliant with meds  Yes  No (elaborate)
- Physician Order discrepancies  YES (elaborate)  NO

Lack of understanding of discharge instructions  YES (elaborate)  NO

If discharged from hospitalists, was there a handoff with PCP and did PCP respond to questions or patient issues

During the time between admission to home health and readmission to hospital were there any issues and how were they addressed?

In your opinion what were the top home health reasons why patient was readmitted

1. 
2. 
3.

Any other comments

Outpatient Services Readmission Review

1.  PATIENT IDENTIFIER
2. NAME OF PROVIDER THAT REFERRED
3. OUT-PATIENT SERVICE
4. DATE OF REFERRAL
5. DATE OF APPOINTMENT
6. DIFFERENCE BETWEEN REFERRAL AND APPOINTMENT DATE
7. APPOINTMENT KEPT
   a. NO
      i. NO SHOW
         1. FOLLOW UP PHONE CALL
         2. INFO SENT TO REFERRAL SOURCE
      ii. PATIENT/FAMILY CANCELLED
      iii. MD/HOSPITAL CANCELLED
      iv. RESCHEDULED
      v. NO SHOW STATUS SENT TO REFERRING SOURCE
   b. YES
      i. STATUS (STABLE OR UNSTABLE )
      ii. REFERRAL (APPROPRIATE OR INAPPROPRIATE )
      iii. PLAN OF CARE ESTABLISHED (YES OR NO)
      iv. RETURN APPOINTMENT MADE (YES OR NO)
8. APPT REMINDER CALL MADE TO PATIENT (YES OR NO, IF NO WHY)
9. PRE-APPOINTMENT INFORMATION SENT TO PATIENT (YES OR NO, IF NO WHY)
10. IN YOUR OPINION THAT ARE THE TOP REASONS PATIENT WAS READMITTED TO THE HOSPITAL
    a.
    b.
    c.
11. ADDITIONAL COMMENTS

Summary/Assessment of Readmission Review

Name of CM doing this assessment:___________________________
Date assessment completed:           ____________________________
Was this admission related to previous admission?  Yes  No

Category of readmission unforeseen* related to problems in the previous admission:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unforeseen and caused by new problem</td>
<td></td>
</tr>
<tr>
<td>Unforeseen related to problems in the previous admission</td>
<td>Yes</td>
</tr>
<tr>
<td>Foreseen (planned)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Unforeseen= unexpected, unanticipated, unpredicted

Potentially preventable issues-PATIENT ISSUES: Based on the interviews conducted and chart review; identify actions or issues that may be contributed to this readmission (choose all that apply)

Lack of adherence to:

<table>
<thead>
<tr>
<th>Lack of adherence to:</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Therapies</td>
<td></td>
</tr>
<tr>
<td>Daily Weights</td>
<td></td>
</tr>
<tr>
<td>Diet</td>
<td></td>
</tr>
</tbody>
</table>

Did not have adequate understanding of medications on medication list
Yes

Did not accept HH referral
Yes

Did not accept HH planned visit
Yes

Did not accept referral to outpatient clinics
Yes

Accepted referral to outpatient but did not go to f/u appointment
Yes

Did not go to follow-up doctor appointment
Yes

Financial issues
Yes

Did not accept referral to Palliative Medicine
Yes

Did not accept referral to Hospice
Yes
Psycho-social issues
Yes

Potentially preventable issues - **SYSTEM ISSUES**: Based on the interviews conducted and chart review, identifying systems issues or actions that may have contributed to this readmission (chose all that apply)

**Inadequate assessment by the care planning team (MD, CM/SW, RN, PT/OT) of patient or caregiver needs while in the hospital**
Not adequately assessing functional status prior to discharge  
Yes

Not adequately assessing psychological or social needs prior to discharge  
Yes

Not adequately assessing patient needs in the home  
Yes

Not adequately assessing patient needs post discharge  
Yes

Patient discharged too soon, e.g. failure to diagnose prior to discharge or not recognizing worsening of clinical status in hospital  
Yes

**Inadequate care planning and education**
Not adequately assessing patient understanding of who to call or when at home  
Yes

Not adequately assessing caregiver understanding of who to call or when at home  
Yes

Not adequately assessing patient understanding of care plan or self-management instructions prior to leaving the hospital  
Yes

Not adequately assessing care provider of care plan instructions prior to leaving the hospital  
Yes

Not adequately assessing patient understanding of warning s/s for calling provider  
Yes

Not adequately assessing care provider understanding of warning s/y for calling provider  
Yes

Not adequately assessing patient inclusion in discussion of d/c instructions  
Yes

Not adequately assessing caregiver inclusion in discussion of d/c instructions  
Yes
Not adequately planning for follow-up of care
Yes

Potentially preventable issues - SYSTEM ISSUES:
Inadequate post discharge follow up
Inadequate referral made such as palliative care, hospice, HH
Yes
Lack of timely HH visit or phone follow-up
Yes
Lack of timely follow-up appointments with MD
Yes
Lack of follow up MD appointment
Yes
Inadequate coordination and or communication across Outpatient Services (wound clinic, home health CHF etc)
Yes

Inadequate medication management (med review and med rec)
Wrong or contra-indicated medication prescribed at time of discharge
Yes
Medication discrepancies resulted because of lack of adequate coordination between inpatient-outpatient
Yes
Patient did not leave the hospital with accurate printed med list
Yes
Med list in discharge summary did not match what the patient takes at home
Yes

Lack of timely or accurate exchange of health care information
PCP, Home Health, Nurse Navigator, Outpatient clinics or other providers did not have information they needed (information was not transferred or received adequately after d/c to accountable providers) Yes

Explanation for systems issues identified in previous question and WHY readmission occurred:
Actions Taken