TARGET:HF℠

Review of Patients With Heart Failure Who Are Readmitted

IDENTIFY AND DOCUMENT FACTORS CONTRIBUTING TO READMISSION:

Identifying potential gaps in transitional care for patients with heart failure that contribute to potentially preventable readmissions can improve patient care and enhance quality improvement efforts.

LIST OF TYPICAL BREAKDOWNS:

Typical breakdowns associated with patient assessment:

- Failure to actively include the patient and family caregivers in identifying needs, resources, and planning for discharge
- Unrealistic optimism of patient and family to manage heart failure regimen at home
- Failure to recognize worsening clinical status prior to discharge from the hospital
- Lack of understanding of the patient's physical and cognitive functional health status resulting in discharge/transfer to a care venue that does not meet the patient's needs
- Failure to identify or address comorbid conditions (underlying depression, anemia, hypothyroidism, etc.)
- Lack of advance directive or planning
- Incomplete medication reconciliation due to inaccurate records
- Medication errors and adverse drug events caused by patient and family-caregiver confusion
- Multiple drugs and/or doses exceed patient's or caregiver's ability to manage
- Failure to optimize medication doses prospectively

Typical breakdowns found in and family caregiver education:

- Written discharge instructions can be confusing, contradictory to other instructions, difficult for patients to understand or non-relevant to the patient's current health status
- Failure to clarify in patient and caregiver understood instructions and plan of care
- Failure to address prior non-adherence about self-care, diet, medications, therapies, activity/exercise, daily weights, follow-up and testing
- Providing information on broad themes without details on how to make it work for the individual patient based on lifestyle, economic constraints, social support, and other factors impeding compliance

Typical breakdowns in handoff communication:

- Lack of communication resulting in primary care provider not knowing patient admitted
- Inadequate evidence-based heart failure care (i.e. missing/incomplete/non-optimized)
- Medication discrepancies and lack of reconciliation & optimization
- Discharge plan or important anticipated next steps to patient, caregiver, nursing home team, primary care physician or home health care team
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis
- Lack of understanding of information regarding heart failure medical and self-care management (by providers, patients and/or family care supporters)
- Too many providers, non-uniform messages by varying providers
- Discharge instructions missing, inadequate, incomplete, or illegible
- Discharge instructions provided at inopportune moments (e.g., patient cannot focus on logistic concerns about leaving hospital/arriving home)
- Patient returning home without essential equipment (e.g., scale, walker)

- Having the care provided by the facility unravel as the patient leaves the hospital (e.g., poorly understood cognition issues emerge)
- Poor assessment of social support and lack of understanding on what constitutes proper social support
- Lack of understanding by the healthcare receiver of information regarding heart failure medical and self-care management

Typical breakdowns following discharge from the hospital:

- Medication errors
- Patient lack of adherence to self-care, e.g., medications, therapies, diet (sodium restriction), and/or daily weights because of poor understanding or confusion about needed care, how to get appointments, or how to access or pay for medications
- Patient does not know or understand instructions for managing worsening fatigue or shortness of breath
- Discharge instructions are confusing, contradictory to other instructions, or are not tailored to a patient's level of understanding
- No follow-up appointment or follow-up needed with additional physician expertise
- Follow-up appointments are not within the recommended 7 days following discharge, Follow-up appointment scheduling was left to the patient
- Inability to keep follow-up appointments because of illness, transportation issues, financial issues, lack of support person
- Patient not knowing who to contact first should their condition worsen
- Lack of adequate healthcare or personal caregivers or caregivers are not knowledgeable about how to appropriately care for and monitor the patient.

This work sheet may be used to assist in identifying potential gaps in care and may aid in care transition quality improvement efforts. This provides a way to identify process change opportunities outlining barriers and potential causes.

PATIENT INTERVIEW:

Why did you come back to the hospital? *What did the patient or family think contributed to this readmission?)_____
_____
_____
_____

How helpful was the discharge instructions/transition care plan you received? What could have been better? [Are there any self-care instructions that may have been misunderstood?]_____
_____
_____
_____

Please tell me what you remember from your instructions that were given before you left the hospital. [Can the patient teach back 3 critical self-care instructions?]_____
_____
_____
_____

When did you last see your provider? The last provider's appointment?
_____

Were you able to see/call your provider before you came back into the hospital? ☐ Yes ☐ No

Often times, there are options with your doctor or nurse to care based on your needs. Were you bale to talk about options for heart failure care or talk about advance directives? Were you able to discuss options such as palliative, end-of-life care, or hospice as an option? ☐Yes ☐No
If yes, what did you decide upon? _____
_____
_____

What telephone numbers were you given to call? _____

What other hospitals, emergency rooms or other care facilities have you visisted in the last 30 days?
_____
_____
_____

Were you able to obtain your medicines that were prescribed for you during your last hospital visits?
☐ Yes ☐ No

If no, why not?_____
_____
_____
_____

INTERVIEW THE CARE TRANSITION TEAM (PHYSICIAN, CLINIC, HOME CARE, NURSING HOME, AND HOME HEALTH):

What are the contributing causes for the patient's readmission? Would you have predicted a readmission on this patient? _____
_____
_____
_____

Check all that apply:
☐ Abnormal Lab Results
☐ Vital Signs
☐ Nutrition
☐ Cognition/Depression
☐ Function/Mobility
☐ Discharge/Handover/Care Transition Plan
☐ Family support
☐ Medications
☐ Home Health
☐ Post-Procedure Complications

REVIEW THE PATIENT MEDICAL RECORDS FROM CURRENT AND PREVIOUS ADMISSION-30 DAYS OR LESS BETWEEN ADMISSIONS)

Note the number of days between the previous discharge and readmission date: _____ ☐ Unknown

Did patient have a follow-up physician visit scheduled? ☐ Yes ☐ No ☐ Unknown

If yes, did the patient follow-up with his/her visit? ☐ Yes ☐ No ☐ Unknown

Number of days after previous discharge for urgent care/ED/outpatient visits: _____ ☐ Unknown

Were there any urgent clinic/ED/outpatient visits? ☐ Yes ☐ No ☐ Unknown

Number of days after previous discharge: _____ ☐ Unknown

THE PREVIOUS ADMISSION:

Discharge Date: _____ Time: _____ Day: _____

When discharged from previous admission, the patient went:

- ☐ Home
- ☐ Nursing Home _____
- ☐ Home with Home Health Care _____
- ☐ Home with Home Care _____
- ☐ Hospice _____
- ☐ Other: (List) _____
- ☐ Unknown

Functional Status of the patient on discharge: ☐ Fully dependent ☐ Somewhat dependent ☐ Independent ☐ Unknown

Was a clear discharge/ transition plan documented? ☐ Yes ☐ No

Does documentation exist for appropriate patient education? ☐ Yes ☐ No

Was there evidence of Teach Back? (Checking patients understanding or recall) ☐ Yes ☐ No

Referrals were made to the following:

_____

_____

_____

_____

_____

_____

Medications were provided to patient at time of discharge? ☐ Yes ☐ No ☐ Unknown

THIS READMISSION:

Readmission Date: _____ Time: _____ Day: _____

Admission was related to previous admission above: ☐ Yes ☐ No ☐ Unknown

Note reason(s) for readmission

_____

_____

Category of Readmission

☐ Foreseen or planned – device replacement, cardiac catherization, cardiac surgery, chemo radiation therapy, treatment follow-up, planned surgery, etc.; ☐ Unforeseen, caused by new problem ☐ Unforeseen, related to problems with the previous admission

Potential Hospital Problem:

Care given in the hospital was either directly or indirectly responsible for the readmission (Example: Post-operative infection, lack of lab or x-ray diagnostic results follows up). ☐ Yes ☐ No ☐ Unknown

Potential Outpatient Problems:

Caused or contributed to the environment into which the patient was discharged (Example: Patient went home and had much poorer social support than indicated by patient during discharge planning) ☐ Yes ☐ No ☐ Unknown

Notes on any opportunities or circumstances of the patient that may help determine reasons for this readmission:

Identified Opportunities & Area Involved	Corrective Action	Responsibility to Address	Interventions for this Patient Encounter (if currently admitted)	Responsibility to Address

IDENTIFIED CAUSES

Medication Management

- ☐ No prescription given
- ☐ Medication prescription not filled
- ☐ Medication not on insurance formulary causing delay in prescription fill/refill
- ☐ Medications not listed for patient
- ☐ Adverse reaction to newly prescribed medication (List drug category/name _____)
- ☐ Medication list incomplete (patient did not inform caregivers of all medications being taken at home)
- ☐ Choose not to adhere to medications
- ☐ Dose up-titrated – Led to side effects (List drug category/name _____)
- ☐ Dose down-titrated – Led to side effects (List drug category/name _____)

Self-Management

- ☐ Lack of transportation access
- ☐ Financial barriers
- ☐ Language barriers
- ☐ Unable to perform care
- ☐ Self-neglect/abuse
- ☐ Non-adherent to ☐ One ☐ More than one med category
  - Medication regimen
  - Low sodium diet
  - Weight monitoring
  - Daily exercise/activity plan and/or recommendation for cardiac rehabilitation
  - Monitoring for new or worsening signs or symptoms of heart failure

Lack of Communication – (Pending diagnostic results not communicated with PCP)

- ☐ No transition/discharge summary sent to PCP
- ☐ No PCP noted at time of admission with no follow-up to find provider prior to discharge

Infectious Process

- ☐ Colonized (Requires Isolation)
- ☐ Infection (Active Process)

Referral/Outpatient Needs Process

- ☐ No referral noted
- ☐ Lack of referral follow-up with: _____
- ☐ Referral to agency unable to meet individual needs: _____
- ☐ Unaddressed co-morbidity
- ☐ Mobility/Home Safety

TARGET:HF[SM]

Identify and Document Factors Contributing to Readmission

Identifying potential gaps in hospital, provider, patient/support system, transitional, and post-discharge care for heart failure that may contribute to potentially preventable readmission.

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

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[1]
- ☐ Patient treatment breakdown[2]
- ☐ Patient and family caregiver breakdown[3]
- ☐ Handoff communication breakdown[4]
- ☐ Post-discharge from the hospital breakdown[5]
- ☐ No breakdown identified

Related to Patient's

- ☐ Financial status/economics
- ☐ Social support
- ☐ Cognition/Memory
- ☐ Frailty
- ☐ Knowledge/Understanding of HF medications, therapies, and/or self-care

1 Examples of patient assessment breakdown include failure to assess for comorbid conditions and precipitating factors for decompensation of heart failure.
2 Examples of patient treatment breakdown include non-adherence in providing guideline recommended therapies or treating comorbid conditions.
3 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.
4 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.
5 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.

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