Readmissions Discovery Tool

Review a minimum of **5** and a maximum of **10** medical records.

Focus:

For this review, focus on the review of medical records of currently readmitted patients. You will need to review the index (first admission) medical record, along with the current readmission medical record. In addition, whenever possible, it is important to interview the patient to find out reasons for readmission in the patient's own words.

Instructions:

When reviewing the medical record, if documentation is found for the process, mark "**Yes**" in the box. If documentation is not found for the process, mark "**No**". If the process being reviewed is not applicable to the medical record, mark "**N/A**". After completing the review of all records, note the rows with the highest number of "*No*" responses. This will identify priority focus areas for improvement.

Note: Do not spend more than 20-30 minutes per medical record.

SUBMIT YOUR DISCOVERY TOOL FINDINGS WHEN COMPLETE: Take a 2 minute survey to report your findings. By submitting your findings, you will have taken the time to identify process gaps in which to focus improvement and to guide educational activities.

CLICK HERE TO SUBMIT YOUR FINDINGS

Medical Record Review

Medical Record #										
Is the Index Admission Diagnosis a chronic condition?										
Discharge disposition from index admission. (**WRITE:** home, home health, SNF, other)										
# Days between discharge date and readmission date. (**WRITE:** 1-7, 8-14, 15-21, 22-30)										
Have there been 4 or more hospitalizations at this organization in last 12 months for this patient?										
Documentation that a medication list was provided to patient or caregiver at discharge.										
Information about the patient's condition was documented and provided to the next level of care receiver.										
For patients with a comorbid behavioral health condition, a follow up appointment with a behavioral health provider is documented.										
For patients that require assistance from social services, a direct linkage documented instead of asking patient to self-navigate.										
The primary learner/caregiver is identified and documented in the medical record.										

Teach-back is documented when discharge education is provided.										
A customized care transitions plan was developed and documented in the medical record that includes:										
information about obtaining and taking medications										
information about signs and symptoms and what to do if they occur										
plan for follow-up appointments										
plan for transportation to get to the follow-up appointments										
follow-up labs or tests, if applicable										
A post-discharge phone call is documented.										
A follow up appointment was scheduled and documented for patient.										

Patient Interviews

Instructions for this section: For the same medical records identified above, interview the patient while hospitalized during the readmission. Mark **YES** for the reasons for readmissions according to the patient. Mark as many as apply.

Medical Record #										
Unable to obtain or take prescribed medications										
Patient or caregiver did not understand discharge instructions										
Symptom relief for chronic condition										
Unable to attend follow up appointment										
Skilled Nursing Facility sent patient to ED for physician assessment										
Unable to access basic needs such as food, transportation, housing										
Other reasons not listed										

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