# Hammer and wrench tool symbol Tool 3: Hospital Inventory Tool

### Purpose

Readmission reduction efforts at your hospital have likely proliferated over the past several years, and many of these efforts may have developed in isolation from each other. The purpose of this tool is to prompt a comprehensive inventory of all readmission reduction-related efforts and other operational assets that can contribute to achieving your readmission reduction aim. This inventory will help your strategic planning work to formulate a data-informed, multifaceted portfolio of strategies.

### Description

This tool prompts a comprehensive inventory of readmission reduction activity and related organizational and operational assets across departments, service lines, and units within the hospital.

### Staff

Day-to-day champion, in collaboration with readmission reduction team. Engage a variety of stakeholders across the organization, as you and your colleagues will have varying knowledge of what is going on at the hospital.

### Time Required

4 hours. Take no more than 2 weeks (2 meetings) to complete.

### Additional Resource

See Section 2 of the *Hospital Guide to Reducing Medicaid Readmissions* for additional information.

# Tool 3: Hospital Inventory Tool

You probably have multiple types of readmission reduction activities underway at your hospital. You probably also have access to “assets” relevant to a robust readmission reduction effort. An inventory of readmission reduction efforts will reveal the administrative, clinical, health information technology, and other organizational assets already in place. Once you know what efforts and assets already exist, you can consider whether they are optimally aligned and coordinated. The inventory will also serve as an implicit gap-analysis of activities or assets not currently in place. You may identify the need to implement new practices as part of this process.

| Readmission Activity/Asset | For which patients? |
| --- | --- |
| Administrative Activities/Assets |  |
| * Specified readmission reduction aim
 |  |
| * Executive/board-level support and champion
 |  |
| * Readmission data analysis (internally derived or externally provided)
 |  |
| * Monthly readmission rate tracking (internally derived or externally provided)
 |  |
| * Periodic readmission case reviews and root cause analysis
 |  |
| * Readmission activity implementation measurement and feedback (PDSA, audits, etc.)
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| * Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.)
 |  |
| * Other:
 |  |
| Health Information Technology Assets |  |
| * Readmission flag
 |  |
| * Automated ID of patients with readmission risk factors/high risk of readmission
 |  |
| * Automated consults for patients with high-risk features (social work, palliative care, etc.)
 |  |
| * Automated notification of admission sent to primary care provider
 |  |
| * Electronic workflow prompts to support multistep transitional care processes over time
 |  |
| * Automated appointment reminders (via phone, email, text, portal, or mail)
 |  |
| * Other:
 |  |
| Transitional Care Delivery Improvements |  |
| * Assess “whole-person” or other clinical readmission risk
 |  |
| * Identify the “learner” or care plan partner to include in education and discharge planning
 |  |
| * Use clinical pharmacists to enhance medication optimization, education, reconciliation
 |  |
| * Use “teach-back” to improve patient/caregiver understanding of information
 |  |
| * Schedule followup appointments prior to discharge
 |  |
| * Conduct warm handoffs to postacute and/or community “receivers”
 |  |
| * Conduct postdischarge followup calls (for patient satisfaction or followup purposes)
 |  |
| * Other:
 |  |
| Care Management Assets |  |
| * Accountable care organization or other risk-based contract care management
 |  |
| * Bundled payment episode management
 |  |
| * Disease-specific enhanced navigation or care management (heart failure, cancer, HIV, etc.)
 |  |
| * High-risk transitional care management (30-day transitional care services)
 |  |
| * Other:
 |  |
| Cross-continuum Process Improvement Collaborations With: |  |
| * Skilled nursing facilities
 |  |
| * Medicaid managed care plans
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| * Community support service agencies
 |  |
| * Behavioral health providers
 |  |
| * Other:
 |  |