Highlighting Tools 3 & 4:

The Hospital Inventory & Community Inventory Tools

The goal of the Hospital Inventory tool is to know about the readmission reduction efforts that are already underway at your health system or hospital.

Actions:

- **Identify and compile current activities and resources across all departments that are contributing to readmission reduction**
- **Once you know what resources and efforts already exist, ask about how well coordinated and aligned they are to your main readmission reduction goal**

The Community Inventory tool plays a similar role by identifying the resources in the community that your hospital is not aware of and engaging with stakeholders to contribute to your readmission reduction efforts.

Actions:

- **Identify and research all the community efforts taking place for posthospital needs of patients**
- **Look for clinical, behavioral, and social service agencies who are providing resources and care that you are not aware of**

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.)	
❑ 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	
❑ Community support service agencies	
❑ Behavioral health providers	
❑ Other:	

Image from Dr. Boutwell's Tool Guide

Results:

- **This prevents duplicating readmission reduction efforts**
- **It better guides you in planning whether to enhance/review existing activities or implement new practices**

Dr. Boutwell provides both a Hospital and Community Inventory Tool checklist to guide you in identifying departments and units within your hospital and agencies in the community. The inventory charts are provided in the ASPIRE toolkit for your reference, along with additional information.

Keep up your pre-work and let us know if you have any questions!