## Readmissions Reduction – GAP ANALYSIS

### 1. Getting started
- Has an executive champion been named to support this work? | Y / N
- Has a measurable organizational aim been established? | Y / N
- Is there an identified person to lead this effort? | Y / N
- Have the resources that are needed been identified? | Y / N
- Have the necessary resources been allocated? | Y / N
- Has your readiness for this work been assessed? | Y / N

### 2. Establishing and running your team
- Has a multi-disciplinary team been identified? | Y / N
- Does team meet regularly (at least monthly)? | Y / N
- Are the team meetings effective, e.g., planned, well run, on task? | Y / N
- Is the team effective in getting things done? | Y / N
- Does readmission reduction teamwork occur across the continuum? | Y / N
- Does monthly tracking of readmission rate occur? | Y / N
- Does monthly tracking of key processes (e.g., teach-back, follow-up appointments) occur? | Y / N
- Does the organization prioritize improvement efforts based upon learnings from data and analysis? | Y / N

### 3. Working across the continuum
- Have you mapped your communities’ assets (clinical and nonclinical)? | Y / N
- Do you perform “warm handoffs” to community receivers, e.g., primary care providers, skilled nursing facilities, long-term acute care, home health, community case managers? | Y / N
- Do you meet with community receivers to identify barriers to effective care transitions? | Y / N
- Do you work with community receivers to improve care transitions processes? | Y / N
- Do you perform joint case review with community receivers? | Y / N
- Have your most commonly used skilled nursing facilities, home health and long term acute care facilities fully implemented INTERACT? | Y / N
- Do you schedule behavioral health follow-up in addition to medical or surgical follow-up? | Y / N
- Do you directly link patients to social services rather than asking them to self-navigate? | Y / N
### 4. Best practices

Have you performed/reviewed your administrative data to evaluate readmissions?

If yes, do you know the groups with higher than average readmissions, such as:

- Payer (Medicare, Medicaid, commercial, uninsured)
- Race, ethnicity, language
- Discharge disposition (skilled nursing facilities, home health, home, other)
- Behavioral health comorbidity
- Timing of readmissions (number of days since discharge)
- High utilizers (4 or more admissions in 12 months)
- Top 10 discharge diagnoses leading to highest numbers of readmissions
- Zip code or housing residence (group home, long-term care)

<table>
<thead>
<tr>
<th>Question</th>
<th>Y / N</th>
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<tbody>
<tr>
<td>Have you analyzed your data by asking the following questions:</td>
<td></td>
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<tr>
<td>&gt; What are your readmission rates by payer?</td>
<td>Y / N</td>
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<tr>
<td>&gt; What are your readmission rates by race, ethnicity and language?</td>
<td>Y / N</td>
</tr>
<tr>
<td>&gt; Which group(s) have the highest rate of readmissions?</td>
<td>Y / N</td>
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<tr>
<td>&gt; Which group(s) have the highest total number of readmissions?</td>
<td>Y / N</td>
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<tr>
<td>&gt; How many readmissions occur at your hospital every year?</td>
<td>Y / N</td>
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<td>&gt; How many readmissions would be reduced if you reduced readmissions by 12%?</td>
<td>Y / N</td>
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<tr>
<td>&gt; What are the top 10 discharge diagnoses leading to readmissions and how do they differ between groups?</td>
<td>Y / N</td>
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<td>&gt; Does it make clinical, operational or mathematical sense to focus on a limited set of discharge diagnoses?</td>
<td>Y / N</td>
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<td>&gt; What percentage of discharges have a behavioral health comorbidity?</td>
<td>Y / N</td>
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<td>&gt; How does the percentage of discharges differ between groups?</td>
<td>Y / N</td>
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<td>&gt; What percentage of readmissions occurs within 4 days of discharge?</td>
<td>Y / N</td>
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<td>&gt; What percentage of readmissions occurs within 10 days of discharge?</td>
<td>Y / N</td>
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<tr>
<td>&gt; Which discharge dispositions account for the most readmissions?</td>
<td>Y / N</td>
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<tr>
<td>&gt; How does the discharge disposition of groups differ?</td>
<td>Y / N</td>
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<td>&gt; How many patients were hospitalized 4 or more times in the past year (also known as “high utilizers”)?</td>
<td>Y / N</td>
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<tr>
<td>&gt; What is the readmission rate for the high utilizer group?</td>
<td>Y / N</td>
</tr>
<tr>
<td>&gt; What is the hospital’s overall readmission rate and which groups of patients have higher than average readmission rates?</td>
<td>Y / N</td>
</tr>
<tr>
<td>&gt; Which group experiences the most readmissions?</td>
<td>Y / N</td>
</tr>
<tr>
<td>&gt; Are there any high-risk diagnoses to consider?</td>
<td>Y / N</td>
</tr>
</tbody>
</table>
### 4. Best practices (continued)

- Do you use these data to develop a data informed targeting strategy to identify who will receive enhanced readmission reduction strategies?  

- Are readmissions periodically reviewed using patient interview and case review to determine reasons for readmission?  

- Do you use learnings from interviews and case reviews to prioritize improvement efforts?  

Is there a written description of your readmission reduction program that includes:

- A description of who will receive enhanced services e.g., LACE score >11, anyone who was admitted previously within the past 60 days who lives alone?  

- A description of what that will be provided based on need, e.g., followed by transitional care nurse, palliative care referral?  

Do you have a basic care transitions bundle in place for all patients?  

Upon admission, do you identify the primary learner/caregiver?  

Is the primary learner/caregiver included in the planning process?  

Do you provide patients with the CMS discharge planning checklist or similar tool?  

Do you assess patient activation using the Patient Activation Measure or similar tool?  

Do you identify the patient’s goal, e.g., what matters to you?  

Do you use health literacy principles in your educational approach?  

Do you develop a customized care transitions plan for all patients?  

If yes, does the plan include information about medications so that the patient clearly understands which medications to take?  

Is there a plan to obtain medications if the facility does not provide them?  

Does the plan include information about signs and symptoms and what to do if they occur?  

Does the plan include follow-up appointments?  

Is there a plan to get to the follow-up appointments?  

Does the plan include follow-up labs or tests, if applicable?  

Do you use teach-back to validate understanding of care transitions plan?  

Do you perform post-discharge phone calls?  

Are learnings from post-discharge phone calls aggregated and feedback provided to the team to use in prioritizing new approaches?
4. **Best practices (continued)**

Do you have/refer to enhanced programs or resources for higher risk patients including:

- ED pause (reflection to determine if readmission can be avoided) in place?  
  - Y / N
- Pharmacy intervention?  
  - Y / N
- Advance care planning, palliative care and hospice?  
  - Y / N
- Disease specific programs?  
  - Y / N
- Complex care management?  
  - Y / N
- Navigators/coaches?  
  - Y / N
- Community paramedics?  
  - Y / N
- Congregational health networks?  
  - Y / N
- Payor programs?  
  - Y / N

Do you know who your highest utilizers are?  

Do you create cross-continuum care plans for highest utilizers?  

5. **Prioritization**

What are your biggest readmission reduction gaps?

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What are the top three items you will work to improve?

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2. 

3. 