



2.3 SNF-to-Hospital Readmission – Data Abstraction Tool

What is the tool?

This tool aids hospitals and SNFs in performing root cause analyses and tracking contributing factors on readmissions from SNFs to hospitals. Data on causes for readmissions entered into this tool will be automatically aggregated and displayed on the “Results – Charts” and “Results – Tables” sheets of this workbook. These results can then be used to identify opportunities to review and modify processes across care transitions to reduce readmissions.

When should the tool be used?

This tool should be used as part of the pre-work for the partnership team meetings to optimize the team’s understanding of your readmission patient population and any correlation between processes and readmission outcomes.

Tips and considerations for using the tool:

- NYSPPF recommends that the SNF-To-Hospital Readmission Data Abstraction Tool be completed for at least the 10 most recent medical records of patients who were readmitted from the SNF within 30 days of inpatient hospital discharge and/or are identified from high-volume readmission diagnoses, services, or other areas of concern.
- You may alter this criteria or questions in the tool to meet your hospital’s needs.
- Hospitals are encouraged to communicate with SNF(s) to ascertain their perspectives on the causes of potentially preventable readmissions. These discussions can be informal, offer instructive feedback, and cultivate relationships among leaders and frontline staff across the care continuum.
- Hospital staff may find it beneficial to identify a patient who has been readmitted within 30 days and use that case to guide a broader discussion.



What are the Instructions for the Tool?

The specific steps to complete the SNF Readmission Medical Chart Abstraction tool are specified on the “Introduction” tab of the workbook.

<https://www.nysppf.org/Members/Initiatives/Readmissions/Tools.aspx>

