PART 5: APPENDICES

APPENDIX I: TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current, or initiate new interventions to prevent avoidable readmissions in your facility.

Reference: www.hret-hen.org

Preventable Readmissions Top 10 Checklist

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible And By When?)
Enhanced admission assessment of discharge needs and begin discharge planning on admission. Formal assessment of risk of readmission—align interventions to patient's needs and risk-stratification level.	☐	☐	☐	
Accurate medication reconciliation at admission, at any change in level of care and at discharge.	☐	☐	☐	
Patient education—be culturally sensitive; incorporate health literacy concepts; include information on diagnosis and symptom management, medication and post-discharge care needs.	☐	☐	☐	
Identify primary caregiver, if not the patient, and include in education and discharge planning.	☐	☐	☐	
Use teach-back to validate patient and caregiver's understanding.	☐	☐	☐	
Send discharge summary and after-hospital care plan to PCP within 24 to 48 hours of discharge.	☐	☐	☐	
Collaborate with post-acute care and community based providers including SNFs, rehabilitation facilities, long-term acute care hospitals, home care agencies, palliative care teams, hospice, medical homes and pharmacist.	☐	☐	☐	
Before discharge, schedule follow-up medical appointments and post-discharge tests/labs.	☐	☐	☐	
For patients without a PCP work with health plans, Medicaid agencies and other safety net programs to identify and link patient to a PCP.	☐	☐	☐	
Conduct post-discharge follow-up calls within 48 hours of discharge; reinforce components of after-hospital care plan using teach-back; and identify any unmet needs such as access to medication, transportation to follow-up appointments, etc.	☐	☐	☐	