Reducing Readmissions Top Ten Checklist

TOP TEN EVIDENCE BASED INTERVENTIONS				
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 – 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 primary care provider (PCP) within 24 to 48 hours of discharge.	☐	☐	☐	
Collaborate with post-acute care and community based providers including skilled nursing facilities, 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.	☐	☐	☐	

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