**Reducing Readmissions Top Ten Checklist**

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| **Top Ten, Evidence Based Interventions** |
| **Process Change** | **In place** | **Not done** | **Will adopt** | **Notes**(Responsible & By When?) |
| Enhanced admission assessment of discharge needs and begin discharge planning upon 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 with 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 to48 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. |  |  |  |  |

**Additional resources, such as the driver diagram and change package, can be found at** [**www.HRET-HEN.org**](http://www.HRET-HEN.org/)