





## - READMISSIONS CHECKLIST -

A checklist to review current or initiate new interventions to prevent avoidable readmissions in your facility.

## PREVENTABLE READMISSIONS CHECKLIST



PROCESS CHANGE:	
	Know Your Numbers.
	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 – be culturally sensitive; incorporate health literacy concepts; include information on diagnosis and symptoms management, medication and post-discharge care needs. Involve family members.
	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 and community-based providers including SNFs, rehabilitation facilities long-term care acute care hospitals, home care agencies, palliative care teams, hospice, medical homes and pharmacists.
	Join a Community Coalition Meeting for your region.  Refere discharge, schedule fellow up medical appointments and past discharge tests /labs.
Н	Before discharge, schedule follow-up medical appointments and post-discharge tests/labs.
ш	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.
REGULAR MONITOR COMPLIANCE:	
	Monitor readmission rates as part of daily workflow.
	Perform Root Cause Analysis (RCA) on 7-day and 30-day readmissions.
	Evaluate staff adherence to discharge procedures and/or checklists.
	Assess post-acute goal achievement (e.g., PCP appointment completion rate, etc.)