Key Changes to Create an Ideal Transition Home

I. Perform an Enhanced Assessment of Post-Hospital Needs

A. Involve patients, family caregivers and community providers as full partners in completing a needs assessment of patients' home-going needs.

B. Reconcile medications upon admission.

C. Create a customized discharge plan based on the assessment.

II. Provide Effective Teaching and Facilitate Enhanced Learning

A. Identify all learners on admission.

B. Redesign the patient education process.

C. Redesign patient teaching print materials.

D. Use Teach Back regularly throughout the hospital stay to assess the patient's and family caregivers' understanding of discharge instructions and ability to perform self-care.

III. Provide Real-time Handover Communications

A. Reconcile medications at discharge.

B. Provide customized, real-time critical information to next clinical care provider(s).

C. Give patients and family members a patient-friendly discharge plan.

D. For high-risk patients, a clinician calls the individual listed as the patient's emergency contact to discuss the patient's status and plan of care.

IV. Ensure Timely Post-Hospital Care Follow-Up

A. Identify each patient's risk for readmission.

B. Prior to discharge, schedule timely follow-up care and initiate clinical and social services based upon the risk assessment.