



Summary and Strategies for Getting Started: Creating an Ideal Transition Home How-to Guide¹

The Institute for Healthcare Improvement (IHI), through a grant supported by The Commonwealth Fund, is engaged in the State Action on Avoidable Rehospitalizations (STAAR) initiative, a four-year, multi-state initiative to measurably reduce avoidable rehospitalizations.

Evidence suggests that several specific interventions reduce the rate of avoidable rehospitalizations: improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for self-management.

The following are four things that organizations can begin working on immediately:

1. Measure your hospital's all-cause 30-day readmission rate
2. Form a cross-continuum team (include "receivers" in the community such as nursing homes, home health agencies, skilled nursing facilities, hospice, office practices; and include a patient/family representative)
3. Review the stories of 5 recently readmitted patients (using the Diagnostic Tool in the How-to Guide)
4. Improve the following core processes, in collaboration with partners on the cross continuum team:

I. Perform Enhanced Admission Assessment for Post-Hospital Needs

- A. Include family caregivers and community providers as full partners in completing standardized assessments, planning discharge, and predicting home-going needs.
- B. Reconcile medications upon admission.
- C. Initiate a standard plan of care based on the results of the assessment.

II. Provide Effective Teaching and Enhanced Learning

- A. Identify all learners on admission.
- B. Customize the patient education process for patients, family caregivers, and providers in community settings.
- C. Use "Teach Back" daily in the hospital and during follow-up phone calls to assess the patient's and family caregivers' understanding of discharge instructions and ability to perform self-care.

III. Conduct Real-Time Patient and Family-Centered Handoff Communication

- A. Reconcile medications at discharge.
- B. Provide customized, real-time critical information to the next care provider(s).

IV. Ensure Post-Hospital Care Follow-Up

- A. High-risk patients: Prior to discharge, schedule a face-to-face follow-up visit (home care visit, care coordination visit, or physician office visit) to occur within 48 hours after discharge.
- B. Moderate-risk patients: Prior to discharge, schedule a follow-up phone call within 48 hours and schedule a physician office visit within five days.

¹ Nielsen GA, Rutherford P, Taylor J. *How-to Guide: Creating an Ideal Transition Home*. Cambridge, MA: Institute for Healthcare Improvement; 2009. Available at <http://www.ihl.org>.