Hospital-to-Home Transition: A National Practice Module

An evidence-based module for safe transitions from hospital to home, built on federal discharge rules, Medicare follow-up services, and proven care transition models, with a nationally adoptable checklist.

> **Why this module matters.** In 2020, U.S. hospitals recorded about 3.85 million readmissions within 30 days. Medicare patients had the highest rate, 17 of every 100 hospital stays, and a readmission cost $16,300 on average. Many readmissions start with a gap at home in the first days after discharge.

About this module

This module gives home care teams a shared, evidence-based approach to the move from hospital to home. It brings together federal hospital discharge rules, Medicare follow-up services, and proven care transition models, and it ends with a checklist that agencies, clinicians, and families anywhere in the United States can adopt.

Item	Details
Who it is for	Health practitioners, discharge planners, home care agencies and nurses, home care aides, and family caregivers
Format	Ten units, case scenarios, a knowledge check, and a national checklist
Time	About 3 to 4 hours as a training course, or use single units as refreshers
How to use it	Clinicians and nurses lead Units 3, 5, and 6. Aides and families focus on Units 4, 7, and 8. Agency leaders use Units 9 and the checklist.

Learning objectives

After completing this module, learners will be able to:

1. Describe the national scale and cost of hospital readmissions.
2. Explain why the first 30 days after discharge carry the most risk.
3. Summarize the federal rules and Medicare programs that shape discharge and follow-up.
4. Describe proven care transition models and their core parts.
5. Carry out the key tasks for each stage, from before discharge to day 30.
6. Support safe medication management at home.
7. Recognize warning signs and escalate them quickly and clearly.
8. Track simple measures that show whether transitions are working.

> **Scope of practice.** Aides and family caregivers observe, support, and report. Medication changes, clinical assessments, and treatment decisions belong to licensed clinicians. Follow your state scope-of-practice rules and agency policies.

Unit 1. The national picture

Leaving the hospital is one of the riskiest moments in an older adult's care. Patients go home weaker, often with new medicines, new equipment, and new instructions, while family members take on tasks the hospital staff did a day earlier.

Measure	National figure	Source
Adult readmissions within 30 days	About 3.85 million (2020)	AHRQ HCUP
Overall 30-day readmission rate	13.9 per 100 hospital stays, stable from 2016 to 2020	AHRQ HCUP
Medicare 30-day readmission rate	17.0 per 100 stays, the highest of any payer group (2020)	AHRQ HCUP
Average cost of a readmission	$16,300, about 12% more than the first stay (2020)	AHRQ HCUP
Readmissions to a different hospital	Nearly one in three (2023 data)	Vizient, 2025
Older adults with an unintended medication error at discharge	27% of patients; 81% had an error or did not understand at least one change	Ziaeian et al., 2012
Family caregivers	About 63 million; only about 1 in 5 has formal training in medical or nursing tasks	AARP and NAC, 2025
States with CARE Act laws	43 states and the District of Columbia (2023)	AARP

What these numbers mean for home care

- **The home is where the plan succeeds or fails.** A good discharge plan only works if medicines, appointments, equipment, and help are in place at home.
- **Medication problems are common and preventable.** Most older patients in one major study had at least one medication error or misunderstanding after discharge.
- **Family caregivers carry much of the load** with little training. Teaching them, and checking they understood, is central to safe transitions.
- **Readmissions cost Medicare and hospitals.** Federal payment programs now reward hospitals that coordinate with home and community providers.

Unit 2. Why transitions fail

Readmissions rarely have a single cause. Most come from a chain of small gaps.

Gap	What it looks like at home	Who can close it
Medication confusion	Old and new pill bottles mixed, doses changed without understanding, prescriptions not filled	Clinician, pharmacist, nurse, family
No timely follow-up	No appointment made, no transport, test results never reviewed	Hospital, primary care office, family
Missing information	Primary care clinician or agency never receives the discharge summary	Hospital, agency
Warning signs missed	Weight gain, breathing changes, or confusion not recognized or reported	Aide, family, nurse
Caregiver not prepared	Family not told about the discharge, not taught tasks such as wound care or injections	Hospital, nurse, clinician
Equipment and services delayed	Walker, oxygen, or home health not started on time	Hospital, home health agency, supplier
Weakness and falls	Deconditioning from bed rest leads to falls in the first weeks	PT, aide, family
Language and literacy barriers	Instructions not understood, no interpreter used	Hospital, agency
Social needs	No food, no one at home, unsafe housing, cost of medicines	Social worker, Area Agency on Aging

> **Falls after discharge.** The weeks after discharge carry high fall risk because of weakness, new medicines, and changes in routine. Use the Fall Prevention and Safe Mobility module together with this one.

Unit 3. The federal framework

Several federal rules and Medicare programs shape what hospitals and community providers must do during a transition. Knowing them helps agencies and families ask for what patients are entitled to.

Rule or program	What it requires or pays for	Why it matters at home
Hospital discharge planning rule (42 CFR 482.43)	Hospitals must identify patients at risk early, evaluate post-discharge needs, include patients and caregivers as active partners, honor patient choice of post-acute providers, share quality data to help choose, and send necessary medical information to the next providers and practitioners.	Families can ask to be involved, to see their options, and to make sure information reaches the agency and clinician.
Hospital Readmissions Reduction Program	Reduces Medicare payments to hospitals with higher-than-expected readmissions. The FY 2027 rule adds a 30-day readmission measure after sepsis, with payment effects starting in FY 2030.	Hospitals have a financial reason to partner with home care.
TEAM model (Jan. 2026 to Dec. 2030)	Mandatory for selected hospitals. Holds them accountable for spending and quality for 30 days after discharge for joint replacement, hip and femur fracture surgery, spinal fusion, bowel surgery, and bypass surgery.	Hip fracture and joint replacement patients need strong home follow-up.
Age Friendly Hospital measure	Hospitals attest yearly on care of patients 65+: goals of care, responsible medication management, frailty screening, social vulnerability, and leadership. Reporting began for calendar year 2025.	Encourages hospitals to address the needs that drive older adults' readmissions.
Transitional Care Management (CPT 99495, 99496)	Medicare pays clinicians to contact the patient or caregiver within 2 business days, complete a visit within 7 or 14 days, and reconcile medicines by that visit, over a 30-day period.	A prompt follow-up visit is a covered service. Ask for it.
Caregiver training services	Medicare pays clinicians to train family caregivers in skills needed for the patient's treatment plan (since Jan. 2024).	Caregivers can be taught tasks such as wound care and transfers.
Medicare home health benefit	Covers skilled nursing and therapy at home for eligible homebound patients. The initial assessment must take place within 48 hours of referral or return home, unless the physician orders another date.	Confirm the start date before discharge.
CARE Act (state laws)	In 43 states and DC, hospitals must record the family caregiver, notify them before discharge, and teach them the medical tasks they will perform.	Families should give the caregiver's name at admission.

Unit 4. Proven care transition models

Several models have strong evidence. Their common parts can be used by any agency or family.

Project RED (Re-Engineered Discharge), AHRQ

In its original trial, RED patients had 30% less hospital use within 30 days than usual-care patients. Emergency visits fell from 24% to 16%, and costs were $412 lower per patient. The 12 components:

	Component		Component
1	Arrange language help if needed	7	Give a written discharge plan the patient can understand
2	Schedule follow-up appointments and tests	8	Teach about the diagnosis and medicines
3	Arrange follow-up of tests pending at discharge	9	Review what to do if a problem arises
4	Coordinate outpatient services and equipment	10	Check understanding (teach-back)
5	Identify the correct medicines and how to get them	11	Send the discharge summary promptly to the next clinicians
6	Check the plan against national guidelines	12	Follow up by phone

Care Transitions Intervention (Coleman model)

A transitions coach meets the patient in the hospital, makes a home visit within about three days, and follows with three weekly calls over 30 days. In a Rhode Island study, traditional Medicare participants were about 30% less likely to be readmitted within six months. The four pillars:

Pillar	What the patient and caregiver learn
Medication self-management	Know each medicine, why it is taken, and how; spot discrepancies
Personal health record	Keep one up-to-date record of conditions, medicines, and questions, and bring it to every visit
Timely follow-up	Make and keep primary and specialty appointments
Red flags	Know the warning signs of a worsening condition and whom to call

> **What they share.** Both models rest on the same ideas: plan early, reconcile medicines, involve the caregiver, check understanding, hand off information, and follow up quickly.

Unit 5. The transition timeline: who does what

Stage	Key tasks	Lead
Before discharge (in hospital)	Name the family caregiver. Assess home needs. Choose post-acute services with quality data. Order equipment. Teach caregiver tasks with teach-back. Schedule follow-up within 7 to 14 days. Arrange interpreter.	Hospital team, family
Discharge day	Review the written plan and medicine list. Confirm prescriptions are filled or can be. Confirm transport, someone at home, and equipment. Send the summary to the primary care clinician and agency.	Hospital, family, agency
First 48 to 72 hours	Contact within 2 business days. Home health start of care within 48 hours where ordered. Home medication reconciliation. Check food, safety, and red flags.	Clinician office, home health, agency nurse
Days 3 to 7	Follow-up visit (within 7 days for high-complexity patients). Daily checks for warning signs. Reinforce teaching.	Clinician, aide, family
Days 8 to 14	Follow-up visit if not done (within 14 days). Review pending test results. Adjust the plan.	Clinician, nurse
Days 15 to 30	Weekly check-ins. Watch for falls, weight loss, low mood, and confusion. Plan longer-term services.	Agency, family
After day 30	Hand over to routine care. Review what worked. Update the care plan.	Agency, clinician

Unit 6. Medication safety at home

Medication reconciliation means comparing every medicine the person was taking before the hospital with the discharge list, and resolving every difference with the prescriber. Under Transitional Care Management, it must be done by the date of the follow-up visit.

The “brown bag” review

1. Gather every medicine in the home: prescriptions, over-the-counter products, vitamins, supplements, inhalers, creams, and eye drops.
2. Compare each one with the discharge medicine list.
3. Mark each one: **continue**, **changed** (new dose or time), **new**, or **stopped**.
4. Remove stopped medicines from the daily supply, following the clinician’s or pharmacist’s advice for disposal.
5. Ask the prescriber or pharmacist about any medicine that is on one list but not the other.
6. Write one updated list and keep copies with the person, the caregiver, and the agency.

Higher-risk medicines to watch closely

Medicine type	What to watch for	Report promptly
Blood thinners (anticoagulants)	Missed or double doses, interactions with new medicines	Unusual bleeding or bruising, black stools, a fall or head strike
Insulin and other diabetes medicines	Dose changes, changes in eating	Shakiness, sweating, confusion, very high or low readings
Opioid pain medicines	Drowsiness, constipation, combination with sleep medicines	Hard to wake, slow breathing
Diuretics (“water pills”) and heart medicines	Dizziness, dehydration, urgency	Fainting, very low blood pressure, rapid weight change
New antibiotics	Completing the course, side effects	Severe diarrhea, rash, swelling

> **Caregivers:** Never stop, start, or change a medicine without the prescriber. If something seems wrong, call the clinician or pharmacist the same day.

Unit 7. Warning signs and escalation

Every person should leave the hospital with a written list of their own red flags and a number to call. The signs below are common examples. Always follow the specific instructions from the person's clinician.

Condition	Common warning signs to report the same day
Heart failure	Weight gain of 2 to 3 pounds in a day or 5 pounds in a week (or the limit the clinician set), more swelling, more shortness of breath, needing more pillows to sleep
COPD or pneumonia	More breathlessness, change in mucus color or amount, fever, lower oxygen readings than usual
After surgery	Redness, warmth, swelling, or drainage at the wound; fever; new or increasing pain; calf pain or swelling
Stroke	Any new face drooping, arm weakness, or speech difficulty: **call 911 immediately**
Diabetes	Repeated high or low blood sugar readings, not eating, vomiting
Any condition	New confusion or unusual sleepiness (possible delirium), not eating or drinking, unable to pass urine, a fall, new pain

> **Emergency.** Call 911 for chest pain, severe trouble breathing, signs of stroke, fainting, heavy bleeding, or if the person cannot be awakened.

Reporting clearly: SBAR

Aides and families can use this simple structure when calling a nurse or clinician:

Step	What to say	Example
Situation	Who you are, who the patient is, and the problem	"This is Ana, aide for Mr. Lee. He is more short of breath today."
Background	Recent hospital stay and main condition	"He came home from the hospital four days ago with heart failure."
Assessment	What you observed, with numbers	"His weight is up 3 pounds since yesterday, and his ankles are more swollen."
Request	What you need	"Can the nurse call him or visit today?"

Delirium: a hidden warning sign

Delirium is a sudden change in attention and thinking. It is common in older adults after a hospital stay and can be mistaken for dementia or tiredness. Signs include confusion that comes and goes, trouble paying attention, unusual sleepiness or agitation, and seeing things that are not there. Report any sudden change in thinking the same day.

Unit 8. Preparing the home and the caregiver

Home readiness

- [ ] Someone is home, or checking in, for at least the first 24 to 72 hours.
- [ ] A clear path from the entrance to the bed and bathroom.
- [ ] Equipment delivered and working: walker, commode, shower chair, hospital bed, oxygen, or others ordered.
- [ ] Food and fluids that fit the diet plan.
- [ ] Medicines filled, with a pill organizer if helpful.
- [ ] Emergency and clinician numbers posted by the phone.
- [ ] A scale, thermometer, or blood pressure monitor if the plan calls for one.

Caregiver teaching with teach-back

Teach-back means the caregiver explains or shows the task in their own words, so the teacher can check understanding. It is part of Project RED and of CARE Act laws.

Instead of asking	Ask
“Do you have any questions?”	“Can you show me how you will give the injection?”
“Do you understand the medicines?”	“Tell me which pills changed and why.”
“Do you know when to call?”	“What would you do if his weight goes up 3 pounds?”

Caring for the caregiver

- Ask the caregiver what they can realistically do, and plan help for the rest.
- Connect them with the Area Agency on Aging, through the Eldercare Locator (1-800-677-1116), for respite and support.
- Watch for exhaustion and stress, and include their needs in the plan.

Unit 9. Measuring results

Measure	How to calculate	Who tracks
30-day readmission rate	Clients readmitted within 30 days ÷ clients discharged home	Agency, clinician
Emergency visits within 30 days	Clients with an ED visit ÷ clients discharged home	Agency
Contact within 2 business days	Clients contacted in 2 business days ÷ discharges	Clinician office, agency
Follow-up visit within 7 or 14 days	Clients seen in the time frame ÷ discharges	Clinician office
Home medication reconciliation	Completed by the first visit ÷ discharges	Nurse, clinician
Caregiver teach-back documented	Discharges with teach-back recorded ÷ discharges	Hospital, agency
Falls within 30 days	Clients who fell ÷ clients discharged home	Agency

Reading the numbers. Track measures for at least two quarters before drawing conclusions. Compare similar groups of clients.

Unit 10. Case scenarios

Case 1. Mrs. D, age 79, heart failure

Mrs. D came home two days ago. Her aide notices her ankles are more swollen and she is sleeping in a chair. Her daughter says the hospital changed her “water pill,” but the old bottle is still in the kitchen.

- What are the warning signs?
- What medication risk is present?
- How should the aide report this?

Discussion: Swelling and needing to sleep upright suggest worsening heart failure. Two versions of a diuretic risk a wrong dose. The aide uses SBAR to call the nurse today, and the nurse completes a home medication reconciliation with the prescriber.

Case 2. Mr. E, age 84, after hip fracture surgery

Mr. E lives with his wife, who has arthritis. No one showed her how to help him to the toilet. He has not had a follow-up appointment scheduled.

- Which federal programs may apply?
- What should happen in the first 72 hours?

Discussion: His hospital may be in the TEAM model, and he may qualify for home health and Transitional Care Management. Contact within 2 business days, a home health start of care, PT for transfers, caregiver training, a follow-up visit within 7 to 14 days, and a fall prevention plan.

Case 3. Mrs. F, age 72, speaks Spanish

Mrs. F received written instructions in English only. She is unsure which pills to take.

- Which RED component was missed?
- What should the agency do?

Discussion: Language help (component 1) and an understandable written plan (component 7). The agency arranges an interpreter, contacts the clinician or pharmacist, and provides a translated medicine list.

Knowledge check

1. What was the Medicare 30-day readmission rate in 2020? *(17.0 per 100 hospital stays)*
2. What must hospitals do under the federal discharge planning rule? *(For example: involve caregivers, honor patient choice, share quality data, and send medical information to next providers)*
3. Under Transitional Care Management, how soon must the patient or caregiver be contacted? *(Within 2 business days)*
4. Within how many days is the follow-up visit for high-complexity patients? *(7 days)*
5. What are the four pillars of the Care Transitions Intervention? *(Medication self-management, personal health record, timely follow-up, red flags)*
6. What is a “brown bag” review? *(Gathering all medicines at home and comparing them with the discharge list)*
7. What does the CARE Act require? *(Record the caregiver, notify them of discharge, and teach them medical tasks)*
8. Give a common heart failure warning sign. *(Weight gain of 2 to 3 pounds in a day or 5 in a week)*
9. What does SBAR stand for? *(Situation, Background, Assessment, Request)*
10. Why is delirium important after discharge? *(It is common, often missed, and signals a medical problem)*

National Hospital-to-Home Transition Checklist

This checklist puts national guidance into one tool that hospitals, agencies, clinicians, and families in any state can adopt. The "National basis" column shows where each item comes from. Adapt it to your state rules and agency policies.

Patient name or ID	Hospital and discharge date	Completed by and role
Primary care clinician	Agency or home health	Family caregiver and phone

A. Before discharge

Action	National basis	Done	Notes
Family caregiver named in the record	CARE Act; 42 CFR 482.43	☐	
Caregiver and patient included in planning, with goals and preferences recorded	42 CFR 482.43	☐	
Post-discharge needs evaluated and documented	42 CFR 482.43(a)	☐	
Patient told of the right to choose post-acute providers, with quality data	42 CFR 482.43(a)(8), (d)	☐	
Language help arranged if needed	AHRQ RED	☐	
Equipment and outpatient services arranged	AHRQ RED	☐	
Caregiver taught tasks, with teach-back	CARE Act; AHRQ RED	☐	
Follow-up appointment scheduled within 7 to 14 days	AHRQ RED; Medicare TCM	☐	
Follow-up for pending tests arranged	AHRQ RED	☐	

B. Discharge day

Action	National basis	Done	Notes
Caregiver notified of discharge time	CARE Act	☐	
Written plan in plain language and preferred language	AHRQ RED	☐	
Discharge medicine list marked new, changed, continued, stopped	AHRQ RED	☐	
Prescriptions filled or a plan to get them	AHRQ RED	☐	
Red flags and the number to call reviewed	AHRQ RED; CTI	☐	
Discharge summary sent to primary care clinician and agency	42 CFR 482.43(b); AHRQ RED	☐	
Transport and someone at home confirmed	Best practice	☐	

C. First 48 to 72 hours

Action	National basis	Done	Notes
Interactive contact within 2 business days	Medicare TCM	☐	
Home health initial assessment within 48 hours, if ordered	Medicare home health rules	☐	
Home medication reconciliation (brown bag)	Medicare TCM; CTI	☐	
Equipment working and home safe; fall risk checked	CDC STEADI; best practice	☐	
Food, fluids, and help in place	Best practice	☐	
Personal health record started or updated	CTI	☐	

D. Days 3 to 14

Action	National basis	Done	Notes
Follow-up visit within 7 days (high complexity) or 14 days	Medicare TCM	☐	
Medication reconciliation completed by the follow-up visit	Medicare TCM	☐	
Pending test results reviewed	AHRQ RED	☐	
Daily check for red flags and delirium	CTI; best practice	☐	
Follow-up phone call to reinforce the plan	AHRQ RED; CTI	☐	

E. Days 15 to 30

Action	National basis	Done	Notes
Weekly check-ins with the patient and caregiver	CTI	☐	
Falls, weight, appetite, mood, and thinking monitored	Best practice	☐	
Caregiver needs reviewed; respite or support offered	ACL National Strategy	☐	
Longer-term services planned	Best practice	☐	

F. Agency program (yearly)

Action	National basis	Done	Notes
Policy on accepting hospital discharges and starting care promptly	Best practice	☐	
Staff trained in medication reconciliation support, red flags, and SBAR	Best practice	☐	
Referral relationships with local hospitals and clinicians	HRRP; TEAM	☐	
Readmission, ED visit, follow-up, and falls measures tracked quarterly	Best practice	☐	
Program reviewed and updated yearly	Best practice	☐	

Completed by: signature	Printed name and title	Date
Reviewed by (nurse or clinician): signature	Printed name and title	Date

Sources and further reading

AHRQ HCUP Statistical Brief 304: Readmissions, 2016–2020 (hcup-us.ahrq.gov)

42 CFR 482.43: Hospital discharge planning (law.cornell.edu)

CMS: FY 2027 IPPS Final Rule fact sheet (July 31, 2026) (cms.gov)

AAPM&R: Transforming Episode Accountability Model (TEAM) (aapmr.org)

McCarter & English: CMS Age Friendly Hospital measure (mccarter.com)

ACP: Transitional Care Management fact sheet (acponline.org)

Rural Health Information Hub: Caregiver Training Services (ruralhealthinfo.org)

AHRQ: Re-Engineered Discharge (RED) Toolkit (ahrq.gov)

CHCS: Care Transitions Intervention (chcs.org)

Ziaeian et al., J Gen Intern Med 2012: Medication reconciliation after discharge (pmc.ncbi.nlm.nih.gov)

Becker's: Vizient report on readmissions to different hospitals (Aug. 2025) (beckershospitalreview.com)

AARP LTSS Scorecard: CARE Act legislation (longtermscorecard.org)

AARP: Caregiving in the US 2025 (aarp.org)

ACL: National Strategy to Support Family Caregivers (Oct. 2026) (acl.gov)

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