Key Points: Transitions of Care from Hospital to Home

Part of the ACHP Series: *Health Plan Innovations in Patient-Centered Care*

The issue:

- Hospital readmissions are high - nearly one in five Medicare patients discharged from a hospital is readmitted within 30 days, leading to high costs of care, poor quality, and low patient satisfaction according to research published in the *New England Journal of Medicine*.[1]
- These high rates of readmissions are partly due to a fragmented delivery system, leading to poor coordination of care among providers and across care settings.
- Health plans can play a key role in coordinating patients' care as they transition from one site of care or provider to another, reducing the likelihood of readmissions, and improving patients' and caregivers' care experiences.

Promising approaches:

- *Transitions of Care from Hospital to Home*, a report by Avalere Health for the Alliance of Community Health Plans, found that community health plans credit their care transition initiatives with improving health outcomes and patient satisfaction and lowering the costs of care.
- The report discusses five practices that plans identified as key facilitators of their programs' success, helping to break down silos of care, promote coordination among providers and engage patients to facilitate effective transitions from hospital to home.

The five key practices are:

- Using data to tailor care transition programs to patients' needs
- Anticipating patients' needs and involving them early in the transition process
- Engaging providers to become program partners
- Leveraging technology to improve care transitions
- Incorporating care transitions into broader quality initiatives

The Alliance of Community Health Plans (ACHP) is a national leadership organization that brings together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care in their communities.

The 22 not-for-profit, community-based and regional health plans and provider organizations that belong to ACHP improve the health of the communities they serve and are on the leading edge of innovations that aim to improve affordability and the quality of care that patients receive.

The bottom line:

- Drawing on a broad scope of information and coordinating the efforts of providers, health plans play a key role in managing the successful transition of patients from hospital to home.
- Community-based health plans are partnering with physicians, provider practices, and community organizations to improve transitions of care from hospital to home.
- Innovative use of health information technology can support providers and patients at every step of the care transitions process, from assessing patients' risk before hospitalization to monitoring patients' health once they return home.
- Promising approaches have been developed across health plans that appear to reduce the risk of readmission, improve quality of care, and lower costs; these can serve as models for other organizations seeking to improve or initiate their own transitions programs.

[1] Jencks, Stephen F., Mark V. Williams, and Eric A. Coleman. "Rehospitalizations among Patients in the Medicare Fee-for-Service Program." New England Journal of Medicine 2009; 360:1418-28

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