



# Transitions from Hospital to Home: New Evidence for Improving Health Outcomes



**Important new research** significantly improves our understanding of:

- 1** which patients being discharged from the hospital would benefit most from transitional care management, and
- 2** which components of transitional care programs are most effective in reducing hospital admissions.

The North Carolina Healthcare Quality Alliance (NCHQA) and Community Care of North Carolina (CCNC) have conducted a detailed study of how different ways to deliver transitional care impact readmission rates. Core components studied include face-to-face patient encounters (sometimes including home visits), timely outpatient follow-up, medication management, patient and family education, patient use of self-management notebooks, data support and information exchange, and collaborations with other organizations.

Detailed statistical analysis resulted in the following **findings**:

- 1** Transitional care management has far greater benefits for patients with multiple chronic conditions than for patients with one or no chronic conditions.
- 2** Among patients with multiple chronic conditions, home visits have the greatest impact on readmission rates.
- 3** Patients with multiple chronic conditions also benefit from outpatient follow-up within 7 days of discharge.

**NUMBER NEEDED TO TREAT (NNT) with transitional care to prevent one admission in the coming year**



**PATIENTS WITH MULTIPLE CHRONIC CONDITIONS**



**NNT = 6**

**PATIENTS WITH ONE OR NO CHRONIC CONDITIONS**

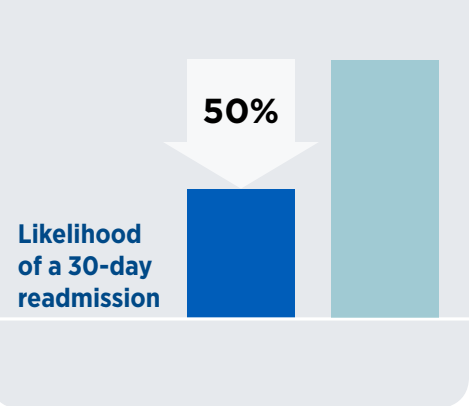


**NNT = 133**

- Patients with multiple chronic conditions who receive coordinated transitional care show a 20% reduction in readmission rates and reduced likelihood of additional admissions during the following year.
- For patients with multiple chronic conditions, home visits reduce the likelihood of a 30-day readmission by 50%. Medication reconciliation in the home setting likely accounts for the added effectiveness of a home visit. Among patients with multiple chronic conditions, the patients with the highest risk of readmission benefit the most in terms of both averted readmissions and total cost of care.
- Ensuring that highest risk patients receive outpatient follow-up within 7 days should be a top priority in allocating transitional care resources. These same patients are also the ones that benefit the most from a home visit. For lower risk patients, outpatient follow-up earlier than 30 days post-discharge is not associated with reduced readmission rates.

**PATIENTS WITH MULTIPLE CHRONIC CONDITIONS WHO RECEIVE A HOME VISIT**

are, on average, half as likely to have a 30-day readmission compared to those receiving less intensive forms of transitional care.



Visit [nchqa.org](http://nchqa.org) to view the full report.

Based on the above findings, CCNC and NCHQA recommend **three priority steps to improve the quality and efficiency of transitional care** in North Carolina:



- 1 Identify patients with multiple chronic conditions** and provide robust care management support following hospital discharge.



- 2 Include post-discharge home visits with medication reconciliation** for patients with multiple chronic conditions, giving priority to patients at highest risk of readmission.



- 3 Ensure that patients with multiple chronic conditions who are at high risk of readmission receive an outpatient follow-up visit to a health care provider within 7 days of discharge.**

*Study findings are based on analysis of transitional care activities for non-dual CCNC-enrolled Medicaid recipients and Medicaid paid claims data for hospital discharges occurring between January 2008 and March 2013.*