NCHQA
North Carolina Healthcare Quality Alliance

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.

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

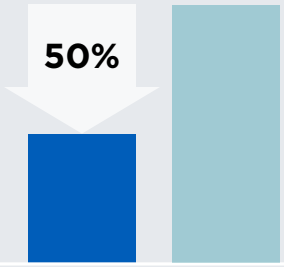
Detailed statistical analysis resulted in the following **findings:**

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.**

- 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.

Visit nchqa.org to view the full report.

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.



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.

NCHQA North Carolina Healthcare Quality Alliance

Community Care of North Carolina

North Carolina Office of Rural Health & Community Care