New Avalere study IDs 5 key practices that lead to successful hospital-to-home transitions

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Community health plans are improving how patients transition from hospital to home by breaking down silos of care, coordinating among providers, and directly engaging with patients, according to a new report entitled *Transitions of Care from Hospital to Home*.

In the report, prepared by Avalere Health for the Alliance of Community Health Plans (ACHP), Avalere researchers examined ACHP community health plans and found five practices that the plans identified as facilitating the success of their care transitions programs:

- **Using data to tailor care transition programs to patients' needs.** By identifying patients most at risk for readmission, plans can ensure that these patients get the necessary help and resources for their transition to home.
- **Anticipating patients' needs and engaging them early in the transition process.** Engaging patients prior to hospital discharge allows health plans to make sure the patient is going to an appropriate setting, prepares a patient for a home visit from a case manager or other clinician, and provides the patient with realistic expectations about their care and guidance on addressing issues that may arise.
- **Engaging providers to become program partners.** Health plans can incorporate provider feedback into the design of care transitions programs and communicate regularly with provider teams to maintain physician engagement and incentivize positive outcomes.
- **Leveraging technology to improve care transitions.** Technology, including access to a centralized and accurate patient record, plays a critical role in how health plans facilitate communication between patients and their providers during a transition of care.
- **Incorporating care transitions into broader quality initiatives.** Some plans use their care transitions programs to enroll members into other programs such as disease management, while other plans make care transitions a component of a larger program, such as a patient-centered medical home, rather than a stand-alone initiative.

"With the increased use of quality based payments, health plans and providers have shared incentives to improve the quality of care delivered to patients," said Dan Mendelson, CEO and founder of Avalere Health. "Our study illustrated that community health plans have taken on this charge to improve care transitions to better manage post-acute care and reduce disruptive re-hospitalizations."

A 2009 study published in the *New England Journal of Medicine* found that 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.1 In addition, according to the Department of Health and Human Services, one in five patients discharged from the hospital to home experiences an adverse event-or harm resulting from medical care-within three weeks of discharge.2 By managing transitions, health plans can ensure timely follow-up care, instruct patients on proper use of medications, and reduce preventable hospital readmissions.

"We must move beyond thinking about care as individual episodes of service where one piece of the delivery system hands off a patient to another,"

said ACHP President and CEO Patricia Smith. "Successful care transitions require a patient-centered approach in which providers and health plan staff are working in partnership and utilizing their unique roles and skills to provide the best care for patients."

The new Avalere report notes patient satisfaction surveys conducted by the plans that showed care transition programs are viewed positively by patients. For example, Geisinger Health Plan, an ACHP member, uses case managers to assist patients with referrals and facilitate communication between physicians and patients. Ninety-nine percent of patients surveyed rated these services as "very good" or "good." Ninety-six percent of surveyed patients enrolled in UPMC Health Plan's care transitions program were either "satisfied" or "very satisfied" with the plan's program, which uses a patient-centric care management documentation system that provides one system for all care managers to use when coordinating the care of the patient.

Additionally, Avalere found that plans featured within its report credit their care transitions programs with reducing readmission rates and decreasing costs. ACHP member HealthPartners reduced its readmission rate from 10.1 to 8.6 percent in a year for patients in its Inpatient Case Management Program. Presbyterian Health Plan estimated that its care transitions program saved approximately $1.8 million in 2010 as a result of reduced readmissions.

ACHP commissioned the report as the second in a new series, *Health Plan Innovations in Patient-Centered Care.* This series fills a gap in the literature on the role of health plans in delivering high-value care. *Transitions of Care from Hospital to Home* was developed to help other health plans build on ACHP plans' years of experience, and lessons learned, when designing or transforming their own care transitions programs.

Provided by Alliance of Community Health Plans