

ACP makes recommendations to improve transitions between health care settings

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Challenges with transitioning patients from one health care setting to another can result in significant health implications and financial costs, says the American College of Physicians (ACP) in a new policy paper

published today. "[Beyond the Discharge: Principles of Effective Care Transitions Between Settings](#): An American College of Physicians Policy Position Paper," makes recommendations for more successful care transitions that can improve patient safety, health care outcomes, and patient and caregiver satisfaction.

"Moving from one care setting to another is a critical time for patient care," said Ryan D. Mire, MD, MACP, president, ACP. "A disjointed [health care](#) system, where many patients lack a [primary care physician](#), and the electronic records systems of different care settings cannot communicate with each other, present significant challenges to optimal care transitions. The challenges due to the nature of our health care system are often further compounded by systemic socioeconomic injustices that create health and health care disparities for many in our society."

ACP's paper details [best practices](#) for successful care transitions, emphasizing the importance of establishing a coordinated, communicative, patient centered, and physician-led care team, and serves as a call to action for stakeholders to improve transitional care. The paper calls for physicians to engage in conversations with patients and families on care goals; for policymakers to address the social drivers of health affecting transitions; for researchers to inform comprehensive transitional care metrics and payment model development; for increased attention to be given to the social, economic, and cultural forces that impact the individual and intergenerational health of marginalized populations during care transitions; and for increased efforts to ensure that clinical care teams are informed of the patient's total care trajectory, prioritizing clear and concise communication across sites of care.

This paper builds on ACP's previous work to improve care transitions and specialty care coordination in the papers "[Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care](#)

[Collaboration"](#) and "[The Patient-Centered Medical Home Neighbor, The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices.](#)"

More information: assets.acponline.org/acp_policy_settings_2023.pdf

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