

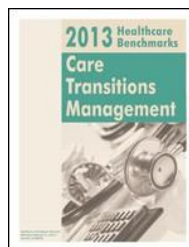
2013 Benchmarks in Care Transitions Management



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Care Transition Benchmark Data

- Efficient handling of **care transitions** is high on healthcare's agenda. Today's programs mix trademarked models with home-grown approaches to improve transitional care quality.
- Almost **3/4** go the extra mile to **visit patients at home during transitions**.
- HIN's third annual e-survey on Care Transition Management captured efforts by 86 organizations to strive for **Triple Aim goals** of *better care at improved cost during transitions of care*.
- This presentation contains highlights from those responses.

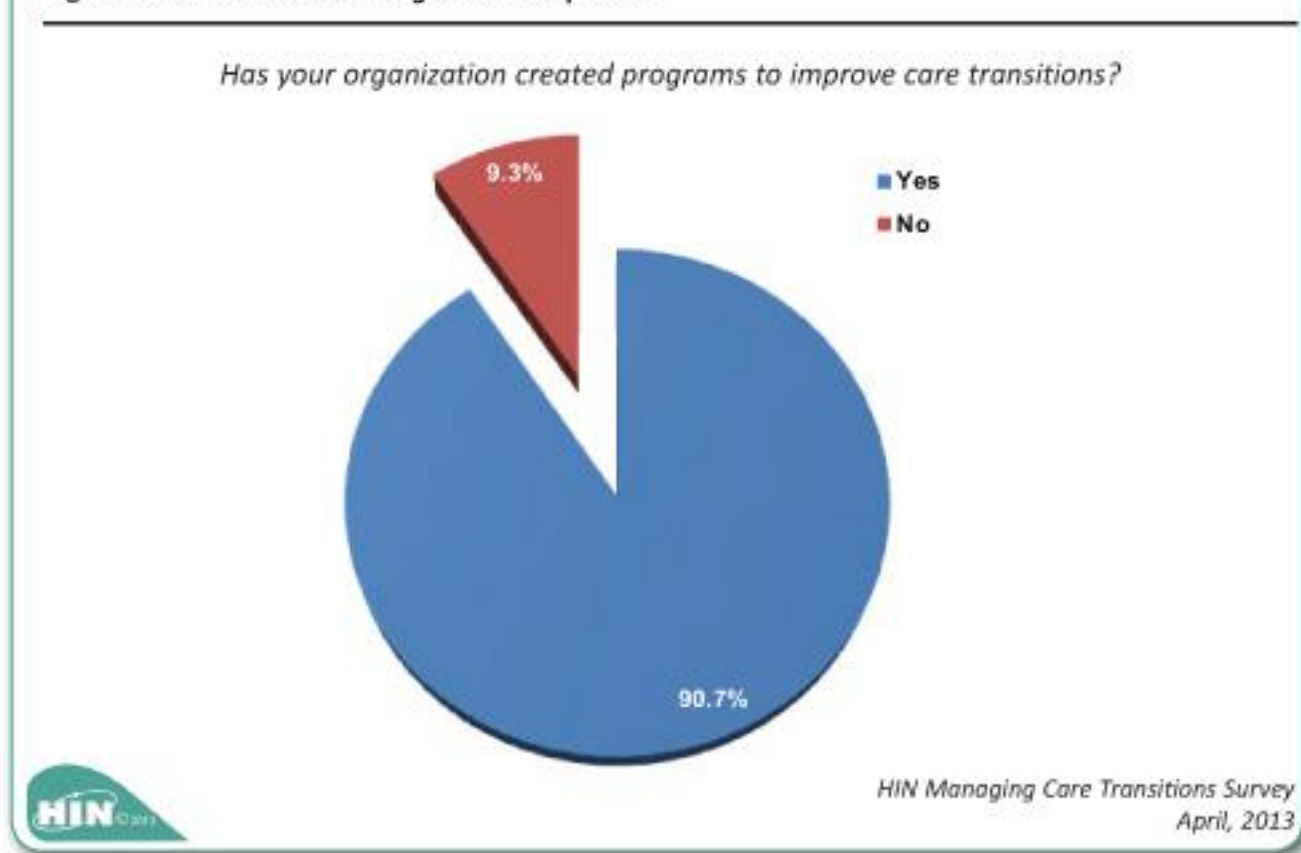


Care Transition Benchmark Data

- **Figure 1 - Care Transition Program Participation**
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- **Figure 3 - Conditions Targeted by Care Transition Programs**
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Figure 1: Care Transition Program Participation



- **91 percent of respondents** said they have created programs to **improve care transitions**.
- Of remaining respondents, **70 percent** plan to **launch a care transition management program in the next year**.

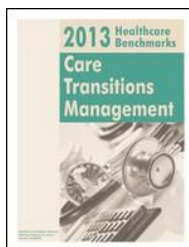
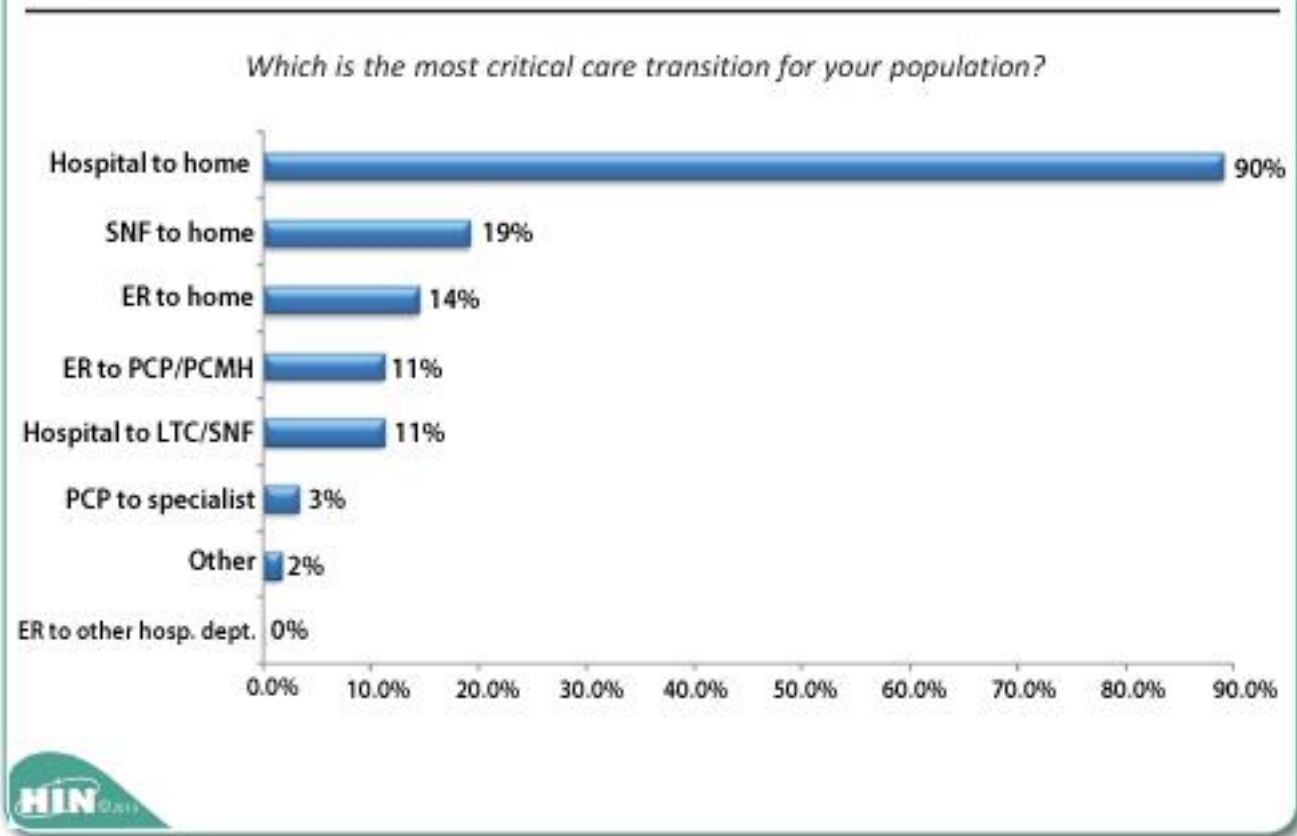


Figure 2: Most Critical Care Transition



- The **hospital-to-home transition** is the most critical, reported 89 percent of respondents, followed by **SNF-to-home** and **ER-to-home**.
- In addition, 28 percent are **working to smooth the ER-to-medical home transition**, fostering more appropriate use of both the **ER and primary care**.

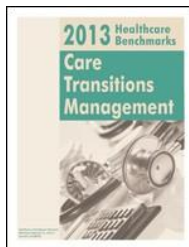
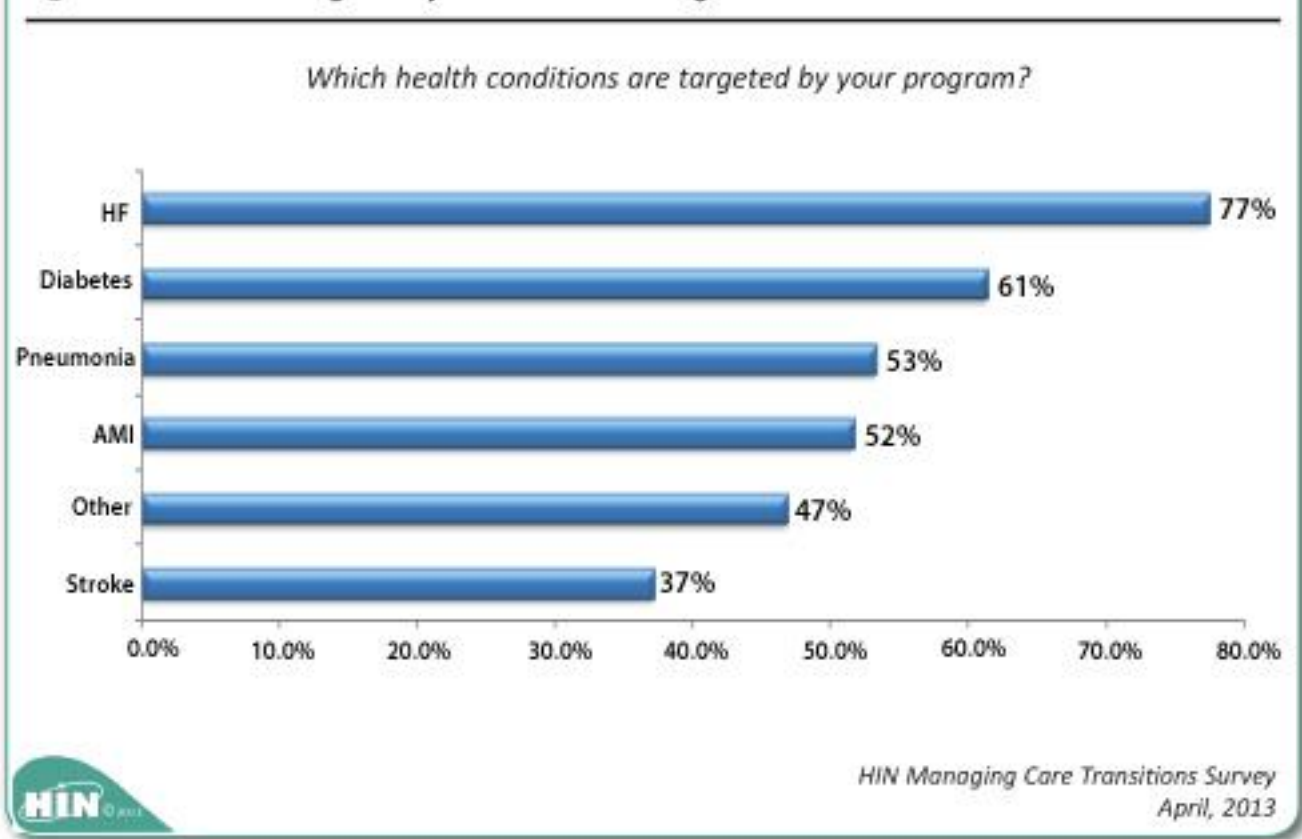
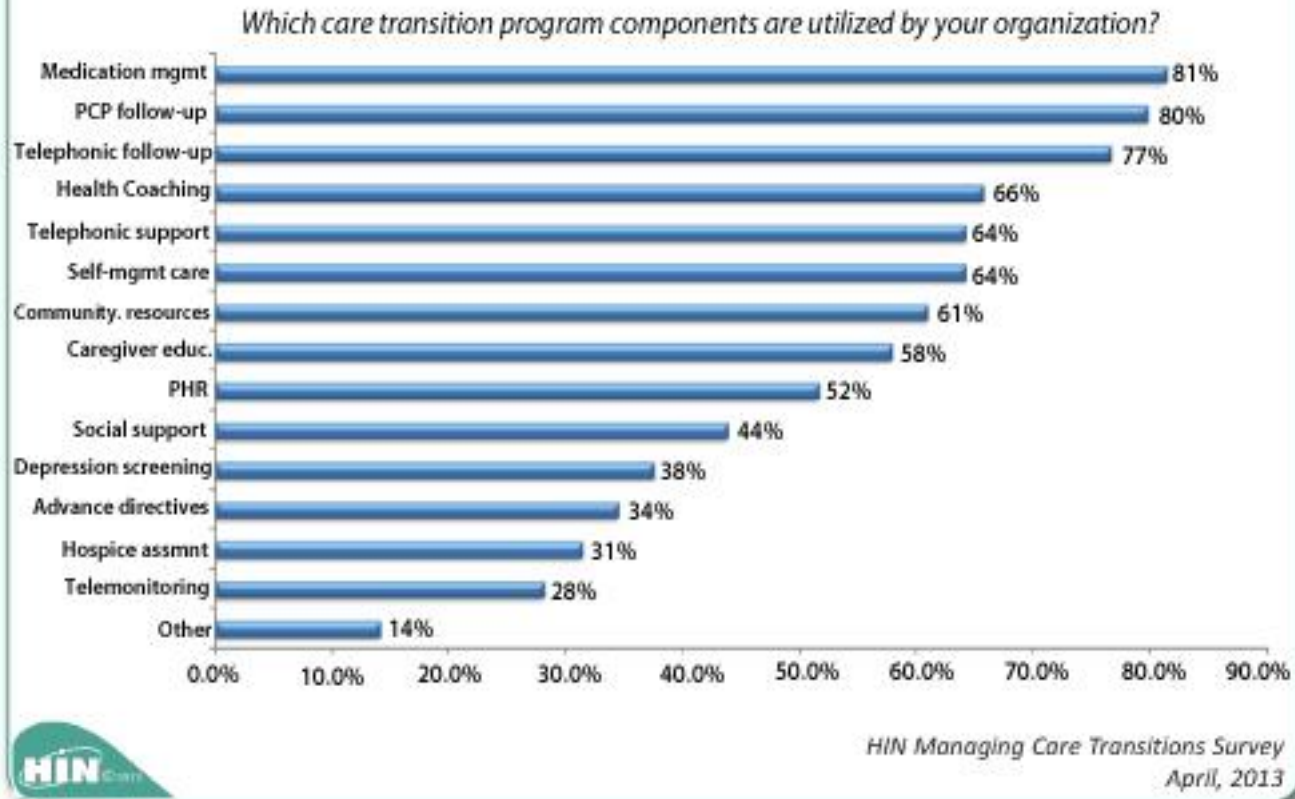


Figure 3: Conditions Targeted by Care Transition Programs

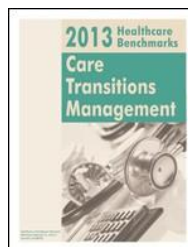


- Patients with **heart failure** are the *top targeted condition* during care transitions, say **77 percent** of respondents.
- Other top targeted conditions include **diabetes**, **pneumonia** and **AMI**.

Figure 4: Care Transition Program Components



- Medication management is **utilized by** 81 percent of organizations with care transition programs.
- **Keeping in touch is key.** Other components include PCP follow-up, telephonic follow-up and health coaching.



In Respondents' Own Words

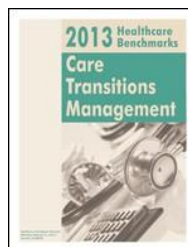
■ Most Successful Tools for Care Transition Management:

- *“Transitional care nurse managing transition of care starting in hospital until 30 days post-discharge.”*
- *“Use of the EMR to reconcile meds, to make sure the relevant care information has been obtained, and to document the transition of care process.”*
- *“Having physician engaged in the process and assuring patient or caregiver is active in care through the transition.”*



Sources

- See ***2013 Healthcare Benchmarks: Care Transitions Management***, available at store.hin.com.
- Responses and data were derived from HIN's third annual industry survey on care transitions conducted in April 2013.



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