Note: This is an authorized excerpt from 2015 Healthcare Benchmarks: Care Transitions Management
To download the entire report, go to http://store.hin.com/product.asp?itemid=5018 or call 888-446-3530.
2015 Healthcare Benchmarks: Care Transitions Management

116 healthcare organizations describe how they are working to manage care transitions and patient handoffs, including risk stratification methods for transition management, favored care transition models, effective tools and partnerships, most successful strategies for coordination of care transitions, and more.

Most successful strategy: “Utilization of a triage RN who screens, discharges and assigns patients to case management team members. Case managers contact the patients within 72 hours of discharge and patients are scheduled to be seen by their PCPs within 7-10 days.”
> Health plan

“Patients who have no primary care provider have problems post-discharge getting home health authorized and seem to fall through cracks.”
> Hospital/health system

Most successful strategy: “Connecting with the patient/family after patient is back home to review the discharge plan and asking for teach-back.”
> Consultant

Successful partnership: “Community partnerships with area hospitals, skilled nursing facilities, nursing homes, and home health agencies, as well as Area Agencies on Aging (AAA).”
> Hospital/health system
2015 Healthcare Benchmarks: Care Transitions Management

This special report is based on results from the Healthcare Intelligence Network’s fourth annual survey on Care Transitions Management conducted in February 2015.

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About the Healthcare Intelligence Network

The Healthcare Intelligence Network (HIN) is an electronic publishing company providing high-quality information on the business of healthcare. In one place, healthcare executives can receive exclusive, customized up-to-the-minute information in five key areas: the healthcare and managed care industry, hospital and health system management, health law and regulation, behavioral healthcare and long-term care.

Executive Summary

Call it Care Transitions Management 2.0—enterprising approaches ranging from recording patient discharge instructions to enlisting fire departments and pharmacists to conduct home visits and reconcile medications. To improve 30-day readmissions and avoid costly Medicare penalties, more than one-third of respondents to the 2015 Care Transitions Management survey—34 percent—have designed programs in this area, drawing inspiration from the Coleman Care Transitions Program®, Project BOOST®, Project RED, Guided Care® and other models.

Whether self-styled or off the shelf, the approaches enhance both quality of care and utilization metrics, according to this fourth annual Care Transitions snapshot by the Healthcare Intelligence Network. Seventy-four percent of respondents reported a drop in readmissions; 44 percent saw decreases in lengths of stay; 38 percent saw readmissions penalties drop; and 65 percent said patient compliance improved.

The survey also pinpointed more than a dozen ideas for care transition collaborations between providers and communities, including a post-acute care coalition and a community health coach program.

With communication between care sites a top barrier to efficient transitions for one quarter of respondents, this year’s survey identified information tools employed during patient discharge and handoff. Technology offers a leg up by way of telehealth and remote monitoring, and 75 percent of respondents transmit patient discharge or transition information via electronic medical records (EMR).
Recent hospitalizations is the top risk factor for care transition management, say 83% of respondents.

Using This Report

This benchmarking report is intended as a resource for healthcare organizations searching for comparable data and means to measure implementation and progress. It is also a helpful planning tool for organizations readying initiatives in this area.

The initial charts and graphs presented represent results from all respondents; images in subsequent sections depict data from high-responding sectors. (Figure titles begin with the segment they represent; for example, All, Health Plans, Hospitals, etc.)

Often, one of the largest responding sectors is composed of respondents identifying their organization type as “Other.” In general, we do not depict results from this segment because it represents a wide range of organization types, including consultants and product vendors. However, you will always find a graph indicating the demographics of respondents.

Here are some additional tips for using this report:

✔ See how you measure up: Scan this report for your sector, and see how your program compares to others. Note where you are leading and where you are behind.

✔ Evaluate your efforts: Think about where you have been focusing your efforts in this area. Look for trends in the data in this report. Look for benchmarks set by your sector and others.

✔ Set new goals: Use the data in this report to set new goals for your organization, or to raise the bar on existing efforts.

✔ Use it as a reference book: Keep this report accessible so you can refer to it in your work. Use these data to support your efforts in this area.

If you have questions about the data in this report, or have feedback for our team, don’t hesitate to contact us at info@hin.com or 732-449-4468.

“Patients who have no primary care provider have problems post-discharge getting home health authorized and seem to fall through cracks.”
Figure 21: Hospital - Risk Factors for Care Transition Management

Which risk factors qualify individuals for your program?

- Hospitalizations: 90.9%
- Comorbidities: 77.3%
- Frequent ER use: 68.2%
- Frail/elderly: 31.8%
- Other: 27.3%
- Cognitive impaired: 22.7%
- Poor self-health: 22.7%
- Homelessness: 18.2%
- SA/mental health: 13.6%
- SNP/Duals: 9.1%

Figure 22: Hospital - Program Models

On which model is your care transitions program based?

- Coleman CTI: 9.1%
- Guided Care (0%)
- Transitional Care Model: 4.5%
- AD-LIFE (0%)
- Project BOOST: 0.0%
- Project RED: 0.0%
- CMS Community-Based: 18.2%
- STAAR: 9.1%
- Hybrid: 9.1%
- Self-developed: 22.7%
- Other: 0.0%
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