Care Transitions Toolkit

Note: This is an authorized excerpt from *the Care Trannsitions Toolkit.* To download the entire report, go to http://store.hin.com/product.asp?itemid=4212 or call 888-446-3530.

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Care Transitions Toolkit

This toolkit is based on results from the second annual Healthcare Intelligence Network Care Transitions Benchmark Survey conducted in May 2010, as well as recent webinars on the successful management of care transitions.

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Chapter 1:
2010 Performance Benchmarks in Managing Care Transitions

87 healthcare organizations describe efforts to manage pivotal transitions in care such as discharge from the hospital to home or nursing home and the impact of these programs on hospital and ER utilization and the patient experience.

"We conduct a review of discharge instructions to ensure that the member understands the instructions, medication changes and need to follow up with their physician."

> Health plan

"We are excited about the early results, which reflect not only a decrease in readmissions but the increase of staff momentum."

> Comprehensive Post Acute (SNF, Home Health, Hospice and Rehab)

"We are embedding RN/health coaches in hospitals to work in conjunction with discharge planners/social workers."

> Health plan

"We are using interdisciplinary team weekly meetings to review transition of care for each member."

> Managed Care Organization (MCO)

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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

The hospital-to-home transition is the most critical transition in care.

Tighter management of transitions in care — particularly for older adults with complex acute or chronic conditions — can help to close care gaps, avoid unnecessary hospitalizations, readmissions and ER visits, and reduce medication errors.

In its second annual Managing Care Transitions Across Sites e-survey conducted in May 2010, the Healthcare Intelligence Network captured programs and activities by healthcare organizations to coordinate key care transitions. Through responses provided by 87 healthcare organizations to 26 multiple choice and open-ended questions, the survey results reveal slight increases from 2009 to 2010 in both the number of programs to manage transitions in care and the number of organizations conducting home visits as part of their efforts to improve care transitions.

Survey Highlights

- Eighty-five percent of respondents to the 2010 survey have launched a care transition management program, up from 80.2 percent in 2009. Of those with no program, two-thirds expect to launch one in the next 12 months.
- Home visits are conducted by 60.3 percent of this year's respondents, a slight increase over the 56.5 percent reported in 2009.
- The top focus of care transition management is the hospital-to-home transition, as reported by 79 percent of responding organizations, followed by skilled nursing facility (SNF)-to-home (49.2 percent) and ER-to-home transitions (45.9 percent).
- Many respondents said post-transition patient contact, such as home follow-up visits and post-discharge telephone calls, is the most successful strategy to improve care transitions.
- A nurse practitioner or certified home health agency nurse most often conducts the home visit, according to 37.1 percent of respondents.

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