Healthcare Intelligence Network™

Managing Transitions to Care for Medicare Patients To Avoid Costly Inpatient Admissions
November 30, 2006

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Growing Need – Growing Problem

- From 1997 to 2004, the elderly represented about 12% of the U.S. population each year; but according to research by the Agency for Healthcare Research and Quality (AHRQ), they accounted for about 35% of hospital stays
- Ten conditions accounted for about 40% of those elderly hospitalizations (AHRQ)
- The elderly population is projected to more than double by 2023, and their unique care needs- more living longer with more chronic conditions- creates the need for new care models
- The lack of coordinated care for patients of all age groups is a problem in health care in general- for the 65+ it is even more pronounced due to both frequency of encounters and cognitive impairments due to the aging process

Drawn From:
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Healthcare Intelligence Network, 11/30/06

Source: Greg Lehman, INSPIRIS

For more information on the "Managing Transitions to Medicare Patients To Avoid Costly Inpatient Admissions" in CD-ROM or MP3 format call 888-446-3530 or visit: http://store.hin.com/product.asp?itemid=3542

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Care Transitions- When Do They Occur?

- **Moving from primary care to specialty physicians.**
- **Within the hospital, moving patients from ED to various other departments (surgery or ICU).**
- **Discharges from the hospital to the home setting or to an assisted or skilled living facility.**

"Transitions of care is a major issue in the United States and can only be solved by breaking down the silos and barriers between different health care settings and working collaboratively for the good of the patient."

NTOC, November, 2006

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Care Transitions- How Breakdowns Occur

- **Communications**
- **Misunderstanding of the rules**
- **Lack of common platforms for sharing data**
- **Problems inherent in the transition itself**
- **No methodology to stop frequent acute admissions**

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Key Steps in Meeting the Challenge of Managing the Senior Care Continuum

- **Developing a Comprehensive Care Team**
- **Identifying the At-Risk Population**
- **Creating an Initial Care Plan**
- **Monitoring Ongoing Health Maintenance**
- **Managing Acute Problems and Physician Relationships**

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Health Coaching: Helping Medicare Members Manage Transitions and Improve Empowerment

- **Transition Coach Program**
  - **Inclusion Criteria**
  - **Interventions**
  - **Measurement**
- **Advanced Illness and Coordinated Care Program**
- **Polypharmacy Transitions**
- **Options for Living Self-Management Programs**

Source: Danielle Butin, Secure Horizons

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Secure Horizon's Transition Coach Program Results

- **Results for Options for Living with Diabetes**
- **Results for Options for Living with Lung Conditions**
  - **Attendance to date**
  - **Claims data collected**
  - **Mean medical cost savings**
  - **Savings seen in**
  - **Attendees report**

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How to Get Your Own Copy:

Get details on how to:

- ✓ Lower re-admission rates by managing the post-hospital transition period;
- ✓ Manage the doctor-to-doctor transition;
- ✓ Develop effective targeting strategies that can be used to identify those patients who are at greatest risk for experiencing complicated care transitions;
- ✓ Create a "medical home" that can aid in managing transitions; and
- ✓ Understand and maximize the role of health coaches, patient navigators and case managers in care transitions.

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