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2013 Healthcare Benchmarks: Care Transitions Management

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Abstracts

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Proper management of transitions in care — the handover of an individual's care from one health setting to another —has the potential to dramatically hasten that person's return to health, as well as reduce the likelihood of a return ER visit or rehospitalization.

The quality of transitional care is also shaping up to be a critical factor in value-based reimbursement, as federal and private payors begin to consider patients' ratings of the quality of transitional care they receive from providers. For example, CMS will weigh the quality of hospitals' transitional care as part of its Medicare reimbursement formula.

In its continued coverage of transitional care, the Healthcare Intelligence Network has published 2013 Healthcare Benchmarks: Care Transitions Management, its third annual analysis of care transition management.

This 50-page report is based on responses from 86 healthcare companies to HIN's third e-survey on Managing Care Transitions conducted in April 2013.

This third comprehensive collection of data points presents actionable new data on key transitions addressed, targeted health conditions and populations, care transition models in use, program components, responsibility for care transition coordination, transition team training, challenges, results, ROI, and much, much more. The data are supplemented with more than 50 easy-to-follow graphs and tables.

New metrics in the 2013 edition:

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Comparison of care transition management trends from 2010 to present;

Focus on the ER-to-Medical home transition;

Disease targets of care transition management programs by condition;

Frequent ER use and SNP/dual eligibility as risk factors for quality of care transitions;

Prevalence of health coaching in care transition management;

Contributions of pharmacist, social worker, health coach and transition coach to home visits;

Prevalence of psychosocial assessment during home visits;

Expanded training requirements for care transition teams;

Key challenges of care transition management;

Impact of programs on patient activation; and

New metrics to measure success of care transition programs.

This report, now in its third year, continues to deliver data on the following:

The prevalence of existing and planned care transition management programs;

Top three care transitions addressed by responding organizations;

Sector-specific feedback on care transition efforts by hospitals and health plans;

Top tasks that take place during home visits, as well as the key conductors, frequency, duration and impact of home visits;

Targeted populations and risk factors to identify participants for care transition management programs;

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Curators of care transitions and required training for the care transition team;

Top measurements to gauge program success;

ROI generated by these programs;

The complete 2013 Managing Care Transitions survey tool; and much more.

This annual industry snapshot is once again enhanced by advice from industry thought leaders on the management of care transitions, including tips from Cullman Regional Medical Center's award-winning hospital discharge program.

This all-new third edition is designed to meet business and planning needs of hospital, health plans, case managers, physician practices and others by providing critical benchmarks that demonstrate the impact of care transition management on key healthcare quality and cost indicators.

2013 Healthcare Benchmarks: Care Transitions Management is an essential support resource for any organization wishing to improve the overall patient experience while hitting critical quality improvement metrics of reducing avoidable readmissions.

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Product Review
I would recommend 2013 Healthcare Benchmarks: Care Transitions Management, “it has a good summary and place to start to improve transitions of care. Performance Improvement teams need to know the content of these reports to compare to their institutions practice, find gaps, implement change.”

Kathy Nold, BSN, RN, MS, CPHQ
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