



Using Technology to Improve Care Transitions

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Problem Statement: Nearly 20% of Medicare patients return to the hospital within a month after discharge, costing \$12 billion per year (Lamb, 2014). Poor continuity of care for patients with multiple chronic conditions often leads to unanticipated readmissions. This year more than 2600 hospitals will receive financial penalties as a result of excessive readmissions within 30 days (Vincent, W. 2015). Care Coordination has been shown to decrease readmissions and costs of care (Hong, Siegel & Harris, 2014) yet, many care coordinators are hindered in their transitional efforts because of paper based manual processes for managing caseloads, tasks and communication. Technological, theoretical and operational expertise exists to maximize care coordination efforts in delivering optimal transitional care for patients. **Results:** Effective programs use technology to bolster their efforts customizing approaches to meet the localized needs (Hong, Siegel & Ferris, 2014). There is growing evidence as to what constitutes effective transitional care management programs yet, there is little evidence on how to develop, deploy and adopt technology to maximize effectiveness. **Significance:** This presentation will use applied theory and personal experience to assist participants in identifying potential barriers to development, deployment and adoption of Health Information Technology to improve care transitions and outcomes for care coordinators and patients.