



CALIFORNIA
HEALTHCARE
FOUNDATION

The CHCF Care Transition Projects

Final Progress Report and
Meeting Summary

Prepared for
CALIFORNIA HEALTHCARE FOUNDATION

by
Susan Baird Kanaan, M.S.W.

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About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

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I. Overview

The CHCF Initiative

At the final grantee meeting of the California HealthCare Foundation's (CHCF) Improving Care Transitions initiative, Senior Program Officer Kate O'Malley told attendees, "Initially, we didn't envision a final grantee meeting. But we were so excited by what we were seeing that we wanted to bring the groups together to celebrate your successes and share our results with a larger audience with common interests."

CHCF launched the Improving Care Transitions Initiative in May 2007 with the goal of improving post-hospital transitions and care in ten communities. The approach involved forging partnerships between hospitals and community-based organizations and providing patients with short-term "transition coaches" upon hospital discharge. In just a year, these projects established new mechanisms and relationships in their communities and demonstrated the viability and adaptability of an empowering intervention model, while helping nearly 800 Californians. The final project meeting, held in Sacramento on September 10, 2008, gave the grantees a chance not only to share their stories with each other and state policymakers in the audience, but also to consider next steps for expanding care transition improvements in California and beyond.

Eric Coleman, developer of the Coleman Care Transitions Intervention (CTI) and adviser to the project, calls the period following hospital discharge *The No-Care Zone* because neither health care institutions nor community-based organizations are set up to support patients after they leave the hospital. This is a time when patients—especially older adults—are weak, vulnerable, and faced with

new treatment regimens and medications for which they have confusing or maybe even conflicting advice. Family caregivers may be uncertain about how best to help.

The lack of a support infrastructure for people experiencing these transitions has serious consequences for both individuals and society. At a societal level, recent research shows that nearly 20 percent of Medicare beneficiaries are caught in a revolving door that lands them back in the hospital within 30 days of discharge, compounding the cost of caring for people in their later years. For individuals, this means more expenses, more disruption for themselves and their families, and less hope for a return to health and strength.

CHCF sees improving care transitions as a key strategy in meeting its broader objective of improving chronic disease care in California. One purpose of the Care Transitions initiative was to identify effective, practical approaches to supporting care transitions for possible implementation in a statewide effort.

The Care Transitions Intervention

The CTI model that project grantees implemented equips patients to play an active role in managing their health following hospital discharge. In a series of in-person and phone interactions over a four-week period, a transition coach helps the patient develop skills and confidence and use the tools provided. If available, family caregivers are coached, as well. The intervention focuses on empowering people in four key areas, called "pillars":

1. Managing medications;

2. Maintaining personal health records and sharing them with providers as needed;
3. Having a follow-up appointment with the primary care physician and/or specialist; and
4. Knowing the “red flags” for their condition—indications that it is worsening—and how to respond.

Research by Dr. Coleman, funded by the John A. Hartford Foundation and the Centers for Medicare and Medicaid Services (CMS), found that the Care Transitions Intervention reduces the incidence of rehospitalization for as long as 180 days after discharge, resulting in significant cost savings.¹ To date, 130 major health care institutions across the United States have adopted the CTI model.

II. The Evolving National Environment

IN HIS KEYNOTE PRESENTATION, DR. COLEMAN cast the CHCF initiative in a national context. He spoke of the movement of influence and learning in two directions: National organizations, government agencies, and researchers are building policies, incentives, and infrastructure to improve care transitions, while the California programs provide nuts-and-bolts examples of how to do so successfully in a wide range of settings. “This has gone from a relatively ignored aspect of health care delivery to one receiving significant attention from all the right players,” he said later. “People dedicated to improving care transitions no longer have to be the sole voice of advocacy.”²

Dr. Coleman described several “silo-busting” activities by federal agencies, Congress, physician associations, business groups, and quality improvement organizations, including efforts to engage hospitals and physicians in improving care transitions and to reward and hold them accountable for doing so. The examples ranged from CMS and the Senate Special Committee on Aging to the National Quality Forum and the “Stepping Up to the Plate Alliance” of nine physician organizations. He noted the growing business case for improving care transitions, as the Medicare Payment Advisory Commission (MedPAC), payers, and quality organizations work to align incentives to reduce readmissions. The need for incentive financing for both health care providers and community agencies was a recurrent topic of this meeting.

Bonnie Darwin, director of the California Culture Change Coalition and an expert on long-term care reform and state policy, was the second keynote speaker. With Improving Care Transitions

Project Manager Dr. Monique Parrish, she is co-author of a new CHCF Issue Brief, *Navigating Care Transitions in California: Two Models for Change* (www.chcf.org/topics/chronicdisease/index.cfm?itemID=133766).

Ms. Darwin traced the common route of elders from the emergency room to somewhere in the inadequate patchwork of long-term care settings, noting the demands of post-hospitalization on individuals and families and the critical need for providers to follow patients and not just give them information. Based on the research and interviews for the issue brief, she reported that managed care organizations are taking the lead in improving care transitions, because they have the incentives to do so. She congratulated those in the hospital world who are investing in better care transitions in their communities simply because it’s the right thing to do. And she affirmed the good news about the growing attention to care transitions, adding the World Health Organization to Dr. Coleman’s list. In closing, she told the participants, “Keep up the good work—help is on the way, and we’re going to turn a corner very soon.”

III. Other Meeting Themes

A PROGRAM COMMITTEE OF GRANTEES PLANNED this final meeting as an opportunity to share experiences—“tales from the trail,” in Ms. Darwin’s words. After the keynote speeches, two project site panels, one of county-led teams and one of hospital-led teams, answered questions on their projects, and the day ended with a wide-ranging discussion of next steps for improving care transitions statewide. The participants also had time during the day to look at storyboard exhibits mounted by each project. The themes that emerged in the meeting concerned:

- The need for ongoing modification of the projects;
- What grantees learned about partnership;
- The challenges of targeting and engaging patients; and
- Ideas for activating people earlier in their lives.

Slow Start-up, Continuous Modification

A simple statement by Ms. Darwin captured the first theme of the meeting: “Change takes a long time.” Early on, CHCF decided to extend the Improving Care Transitions project by three months to give grantees extra time to handle the start-up challenges they were encountering. After the final meeting, Ms. O’Malley remarked that the complexity of this initiative became more apparent all the time. “People are doing these heroic acts in a very broken system,” she said. “Yet they were enthusiastic—they feel this is a model that really works.”

In effect, the grantees, with the foundation’s help, were introducing an entirely new component into local systems of care. The tasks to be accomplished

included lining up allies in the hospital setting, working out effective protocols for identifying and recruiting patients who could benefit from the intervention, establishing mechanisms for teamwork between the “sending” hospital and the “receiving” community organization, and successfully completing the intervention with patients in the designated four-week period. Moreover, CHCF asked the grantees to try to complete the intervention with 100 patients each, to provide outcome data with which to assess progress.

Every task required experimentation. When asked what modifications his project participants had made, one grantee joked that they had modified their approach “58 times” in about as many weeks. Another county project leader said her team treated the project as a series of quality improvement PDSA³ (Plan/Do/Study/Act) cycles, with weekly review and adaptation built into the process.

Once they mastered the start-up trials, the grantees had to be nimble in the face of ongoing changes and challenges. A common one was frequent staff turnover, calling for innovative approaches to lining up hospital and community allies and transition coaches. The systemic fiscal crises of this period added instability, and even forced one site (Santa Cruz) to withdraw from the project when key staff positions were cut. The projects serving large geographic areas (particularly Sonoma and Humboldt counties) found it difficult to get transition coaches to new patients prior to discharge, as hospital stays got shorter and shorter and the coaches had to travel some distance to get to them. All these difficulties, and more, required adaptations.

Significantly, the CTI model proved adaptable to these varied implementations and changes without compromising the fundamentals. Ultimately, the grantees were able to demonstrate that a wide variety of approaches can be used to achieve the project's goals. Both Dr. Coleman and Ms. O'Malley hailed the experimentation and variety of solutions as one of the strong pluses of the CHCF initiative. Speaking after the meeting, Dr. Coleman said, "Diversity—the range of providers, patient populations, and more—is one of the exciting outcomes of this initiative. In each case, local solutions prevail. People who know their communities are uniquely positioned to customize and tailor the intervention to make it acceptable and find where it has the most likely home."

Growing into Partnership

The engine of the CTI model is the partnership between a hospital and a community organization. As noted above, the different project sites developed unique approaches to partnership based on local conditions, and they learned as they went along. The project was structured to include some county-led and some hospital-led teams, and both proved to be viable approaches to leadership and possible models for future initiatives. Sometimes, what worked in one community—e.g., involving hospital discharge planners in identifying patients, or partnering with a home health agency—was exactly what did not work in another. Dr. Coleman said he was struck by the variety of partnership models in evidence among the grantee communities, and also by the fact that "new partners are joining the dance." He added, "These are examples of the 'It takes a village' principle. We heard the notion of *team* defined broadly across the projects. Care transition is a complicated topic, and it's hard to resolve the problems. It involves reaching

out to non-traditional partners and collaborators that people are not used to working with."

The obstacles to be overcome in building partnerships included people's very busy schedules and their feeling of already being overwhelmed, plus turf and trust issues, insufficient funds, and simply the operational challenges of working together. Tory Starr said his experience at St. Joseph's Hospital in Humboldt County taught him to take the time necessary at the beginning to create the project infrastructure—bringing in allies and working out the mechanics of cooperation. Starr, the hospital's director for quality improvement, and others spoke of the ongoing need for marketing—a recurring topic in these discussions, as it was in the first project meeting in October 2007.⁴ With potential hospital allies and community partners, as with prospective patients, the champions found they needed to build both understanding of the CTI model and trust in those carrying it out.

Identifying, Recruiting, and Working with Diverse Patients

The participants had much to say about their experiences in learning to identify appropriate hospital patients, assess whether they could benefit from the intervention, engage them, and accommodate people's diverse needs and capacities. There is a dynamic balance to be struck between identifying appropriate patients and tailoring the intervention for existing ones. Transition coaches use a Patient Activation Assessment tool at the end of the intervention to assess the patient's growth in ten areas.⁵ The final meeting discussion suggested that some form of initial assessment to stratify patients by need and capacity would be useful, as well, to indicate needed accommodations.

The first step in the intervention is to identify patients who can benefit from it—requiring either

referrals from hospital staff or direct access to patient data. Some projects learned to go directly to the data after failing to enlist the cooperation of busy discharge planners and care managers. Next comes getting the patient's agreement to participate and allow a home visit. Several sites experienced resistance that some attributed to misplaced loyalty to, or fear of offending, the primary care physician. Finally, and most importantly, the transition coach and patient work together to complete the transactions in the Coleman model: three visits and phone contacts in four weeks, aimed at helping patients understand their medications, manage their health information, follow up with their physicians, and know the warnings that signal a worsening of their condition.

Based on their different starting points and experiences, the grantees reached different conclusions about screening patients. Some, in retrospect, said their criteria could have been more inclusive; others reported that their target population got increasingly narrow over time. In general, the projects reported finding that seniors were best suited for this intervention, because they're the most motivated to take advantage of it.

One suggested strategy for dealing with patient resistance was to enlist primary care and hospital physicians and specialists in encouraging their patients to participate. Dr. Mike Kern, team leader and medical director in the John Muir Physicians Network, had this to say in the final project report about engaging the full spectrum of potential partners: "The issue really comes down to a cultural change in our fragmented system. Implementation of patient-centered, community-based intervention is novel in our hospital/private practice culture. We hope to build this culture over time, so that inclusion of chronically ill patients in these programs becomes an expectation of providers, practices, patients, and their families."⁶ And in its final report, Huntington

Hospital stressed the importance of support from hospital physicians: "Selecting a few physicians who demonstrate understanding and support for this work could potentiate a system-wide change in the hospital. Having the physician 'prescribe' the [care transitions] intervention in the discharge orders, as done by two cardiologists in our setting, was an efficient way to make the referral, and promoted patient acceptance."⁷

The grantees were enthusiastic about the Personal Health Record (PHR), a booklet or binder in which patients record their medications and save other information, to help them stay focused and communicate with their doctors.⁸ The grantees also affirmed the importance of reviewing medication lists with patients to check for potential adverse interactions and ensure that they understand their doctors' instructions. One site (Santa Barbara) found medication discrepancies for 40 percent of its patients.

The projects demonstrated that the intervention can be successful with a wide variety of people. Patients brought to the project differing economic and educational levels, cultural and language backgrounds, housing conditions, and literacy and skill levels, among other variables. They were a range of ages (roughly 70 percent were age 65 to 95). The Alameda Medical Center/East Oakland Community Project worked successfully with homeless individuals in a respite shelter. This housing arrangement required, among other accommodations, making allowances for patients' reluctance to record sensitive information in their PHRs because of the lack of privacy in the shelter.

Some sites served a significant number of Latinos—in all, 13 percent of the nearly 800 who completed the intervention. Most sites tailored the PHR to suit local needs and resources. Oralía Madera, a transition coach and coordinator in Santa

Barbara, translated the project tools into Spanish. At the final meeting, she urged greater attention in the future to making the tools useful for people with varied backgrounds. To serve diverse populations, a transition coach from Cedars-Sinai Medical Center suggested moving beyond health-focused organizations to form partnerships with other trusted community-based organizations such as cultural centers and senior centers.

It became apparent to the local projects that some patients need further transitional support after the CTI intervention is completed. Dr. Coleman commented that other programs and services can pick up where the more narrowly defined CTI leaves off. In addition, the transition coach can help identify complementary resources such as agencies, family support, or a care manager, and help the patient develop navigation skills. Marin County's Project Independence, a project grantee, has been providing ongoing support of this kind for seven years.

Extending Patient Activation

While the CTI model focuses on patients' time in the hospital and immediately thereafter, the meeting discussion almost inevitably widened the focus to ways to empower and activate patients earlier in their lives. One participant, a physician, noted ironically, "The hospital is the wrong place to introduce these concepts." She proposed that fifth grade was about the right time to start empowering people about their health.

Even for the older, sicker CTI target population, the participants were drawn to the idea of "pre-hab" — finding ways before people are hospitalized to prepare them for the kinds of self-care and support they will need after they are discharged. For example, those anticipating, or at risk for, hospitalization (e.g., people with congestive heart conditions) could

start learning about managing their medications and health information, communicating with providers, and spotting red flags. On a related topic, a home health organization representative suggested home visits to check for safety issues and provide various forms of support — early interventions that might actually prevent hospitalization.

Both Ms. O'Malley and Dr. Coleman acknowledged that the CTI's empowerment model fits within the broader construct of health self-management, which is an essential part of transforming health care alongside payment reform, delivery system redesign, and quality improvement.

IV. Looking Ahead

THE CARE TRANSITION INTERVENTION BUILDS concrete, practical connections among the health care delivery system, community partners, and patients and families as each party encourages and adjusts to higher levels of patient activation. As Dr. Coleman and Ms. Darwin reported, there is momentum across the country to support these changes and connections. In addition, the CHCF Improving Care Transitions initiative generated encouraging signs of momentum close to home. For example, 100 people attended a conference on care transitions sponsored by Sonoma County in July 2008. And Marin's Project Independence sought the advice of the East Oakland Community Project about setting up a homeless respite program—illustrating the kind of mutual support that is possible among local projects. Marin launched the resulting respite program on October 1, 2008.

Of the nine Improving Care Transitions project sites that completed the initiative, six have specific plans to continue their care transitions work using the Coleman model. Characteristically, they have found varied ways to stay in business. Some have grant funding. Some have ongoing support from a health care institution or community-based organization that regards CTI as a proven strategy to help meet wider objectives. Some are folding the CTI model, now tested, into preexisting programs. The other three grantee sites also hope to continue the work in some way, but have no clear plans at present. In one county, public health nurses are considering adopting the CTI in their work.

In the final discussion of the Sacramento meeting, the participants focused on what it would take to

expand care transition improvements in California. They put forward a number of suggestions:

- Look into regional approaches.
- Use home health agencies more actively.
- Figure out how to increase patients' motivation and demand for better care transitions.
- Integrate funding for care transitions into larger funding schemes, and align incentives and payment mechanisms.
- Educate all hospital personnel about care transitions, to engender system-wide support.
- Promote the principle of personal responsibility, and provide early patient education and activation on how to use health care resources and manage health.
- Document the successes, to show that the CTI model works and there's a financial payoff.

Ms. O'Malley has stressed the particular importance of the last of these strategies. "I think it is key to any next steps. The business case for CTI was based on the results of a randomized controlled trial in Denver, Colorado. We did not set out to replicate those findings, and did not include a study of rehospitalizations in this work. For a larger dissemination, we will need a better understanding of the 'winners and losers' if rehospitalizations are reduced, in order to identify our partners and align incentives."⁹

During the meeting, the panelists were asked what additional information might be useful for future projects. Most of the suggestions concerned

greater detail on patient characteristics, to enable assessment of their readiness to use the CTI tools, compare outcomes for different medical conditions, and analyze demographic variables. In addition, Marin's Project Independence hopes to study *discharge stress*, a key factor it has identified during its seven years of work in this field.

V. Summary

THE CHCF PROJECT MADE A DIFFERENCE IN the lives of nearly 800 individuals and their families.

A Project Independence client put it this way:

After I came out of the hospital, I was alone. Project Independence made my life so much easier. They helped me with everything I needed to know and needed to do. Now I know whom to call if I need help, and I know I'll always get help. I learned how to manage my life through this ordeal. I learned how to ask questions of the doctor or nurse—and not to be afraid to ask those questions. I got stronger. Now I'm back working and living.¹⁰

Both participants and observers attributed these changes to the passion and dedication that typified all the projects. It was clear, in addition, that the grantees felt successful about their projects, and for good reason. Collectively, they had completed the CTI intervention with hundreds of Californians in just over a year and shown the real-world efficacy and adaptability of the intervention in a range of settings. Many local sites not only built a cadre of people dedicated to improving care transitions but also went some distance toward restructuring a key aspect of health care in their communities. Partnerships that had not previously existed were formed among county agencies, hospitals, and community-based organizations, and many continue to attract new partners. Ms. O'Malley was optimistic about future applications: "The forces are aligning, and this is an approach that works in the real world. It's the right timing for the right model."

Appendix: The CHCF Care Transition Projects

Kate O'Malley, senior program officer
 Monique Parrish, Dr.P.H., M.P.H., L.C.S.W., project manager

| PRIMARY GRANTEE | COLLABORATING PARTNER(S) | TARGET POPULATION |
|---|---|--|
| Cedars-Sinai Medical Center (Hospital Partner) | Accredited Home Health Services (Community Partner) | Patients with heart failure, pneumonia, or chronic obstructive pulmonary disease (COPD) who have community discharges, and who are at high risk for readmission. Most clients have limited incomes and chronic medical conditions. |
| East Oakland Community Project (Community Partner) | Alameda Medical Center (Hospital Partner) | Homeless patients discharged from Alameda Medical Center to the East Oakland Community Project, a homeless shelter. |
| Huntington Senior Action Network (Community Partner) | Huntington Hospital (Hospital Partner) | Patients aged 65 and over who are admitted to Huntington Hospital with a diagnosis of congestive heart failure. |
| John Muir Physicians Network (Community Partner) | John Muir Medical Center (Hospital Partner) | Patients with multiple chronic care health needs. |
| Marin County Department of Health and Human Services' Project Independence (Community Partner) | Marin General Hospital (Hospital Partner) | Frail, socially isolated individuals with chronic health conditions. Transition coaches are nursing students from the University of California, San Francisco; University of San Francisco; San Francisco State University; and Dominican University. |
| Saint Joseph's Hospital, Eureka (Hospital Partner) | Skilled Health Care (SNF), Saint Joseph Home Care and Saint Joseph Rehabilitation Center (Community Partner) Humboldt State University (Senior RN Students) | Patients discharged from Saint Joseph's Hospital to various levels of health care in the community. The transition coaches are Humboldt State University (HSU) nursing students enrolled in their senior level community/public health nursing rotation. |
| San Mateo Medical Center (Hospital Partner) | San Mateo Aging and Adult Services (Community Partner) | (1) adults enrolled in any Health Plan San Mateo (HPSM) program, including CareAdvantage; (2) those who are likely to benefit from the program as determined by the Program Managers (for example, who have multiple medical/social conditions); and (3) those who can either themselves or with a family member/advocate engage in the coaching process. The project has additional funding from the Gordon and Betty Moore Foundation for an evaluation. |
| Santa Barbara Regional Health Authority (Community Partner) | Cottage Health System (Hospital Partner) | Patients aged 65 or older who are covered by Santa Barbara Health Initiative Medi-Cal, and who are admitted to the acute hospital with one or more chronic illnesses, such as congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, cerebrovascular accident, hip fracture, et cetera. |
| Sonoma County Human Services Agency – Adult and Aging Division (Community Partner) | Santa Rosa Memorial Hospital & Senior Advocacy Services (Hospital Partner) | Patients aged 55 or older with complex medical conditions (no severe cognitive deficits) who reside within 15 miles of Santa Rosa. |

Endnotes

1. Dr. Coleman's slides 21 to 23.
2. Quotation is from an interview with Dr. Coleman on 9/23/08.
3. *Plan/Do/Study/Act*—from the Model for Improvement, developed by the Associates for Process Improvement and disseminated by the Institute for Healthcare Improvement: www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove.
4. Interim Progress Report and Meeting Summary: www.chcf.org/documents/chronicdisease/CareTransitionsInterim.pdf.
5. The ten PAA questions provide a useful overview of the goals of the intervention:
 - 1) Demonstrates effective use of Medication Management System (medication organizer, flow chart, etc.)
 - 2) For each medication, understands the purpose, when and how to take, and possible side effects
 - 3) Demonstrates ability to accurately update medication list
 - 4) Agrees to confirm medication list with PCP and/or specialist
 - 5) Understands the purpose of PHR and the importance of updating PHR
 - 6) Agrees to bring PHR to every health encounter
 - 7) Can schedule and follow through on appointment(s)
 - 8) Writes a list of questions for PCP and/or specialist and brings to appointment
 - 9) Demonstrates understanding of red flags, or warning signs that condition may be worsening
 - 10) Reacts appropriately to red flags per education given (or understands how to react appropriately)
6. From final project report.
7. From final project report.
8. In an interview, Dr. Coleman explained that this paper resource, when appropriate and possible, can be replaced by an electronic one.
9. Written comments following the meeting.
10. From a video made about the Improving Care Transitions project.



**CALIFORNIA
HEALTHCARE
FOUNDATION**

1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org