



CALIFORNIA  
HEALTHCARE  
FOUNDATION

# **The CHCF Care Transition Projects**

## **Interim Progress Report and Meeting Summary**

*Prepared for*  
CALIFORNIA HEALTHCARE FOUNDATION

*by*  
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## About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at [www.chcf.org](http://www.chcf.org).

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# I. Background

TEN CALIFORNIA COMMUNITIES, WITH FUNDING FROM the California HealthCare Foundation (CHCF), have launched a pilot program that zeroes in on a missing link in health care quality improvement: what happens to patients after they are discharged from the hospital. Research indicates that an intervention at this stage would empower patients to take a more active role in their health care, improve patient satisfaction and health outcomes, and reduce rehospitalization rates.

Many people are unprepared for the self-care they are expected to perform after being discharged from the hospital. They may be confused about their discharge instructions, unfamiliar with new medications, or unsure whom to contact in the hospital if they have questions. Those who are isolated, have multiple serious conditions or disabilities, or are uncomfortable advocating for themselves with health care providers are especially vulnerable.

The challenges patients experience in care transitions can cause not only a great deal of distress, but also a worsening of their conditions, which can land them right back in the hospital. Some face even worse outcomes. While hospital discharge data show improved mortality rates, data also show that for Medicare beneficiaries, deaths from three of the top four diagnoses in the 30 days after hospitalization are increasing.<sup>1</sup> The progress being made in nationwide efforts to improve care in hospitals and other settings will have a limited impact until patients' transitions between settings are improved, along with their care management at home.

Eric Coleman, M.D., M.P.H., a geriatrician at the University of Colorado, developed the Care Transitions Intervention (CTI) program with input from patients about what they found missing when they left a hospital or skilled nursing facility.<sup>2</sup> "Patients and their caregivers are often the only common thread moving across sites of care, and as such they constitute an appropriate target for an intervention to improve the quality of transitional care," Coleman writes.<sup>3</sup> The four-week CTI program is designed to engage patients in playing a larger role in managing their health and ensuring that their needs are met.

A “transition coach” helps the patient and caregiver develop skills and confidence in four key areas, known in the CTI program as “pillars.” These are:

- Managing medications;
- Maintaining personal health records that can be shared with providers;
- Scheduling follow-up appointments with the primary care physician or specialist; and
- Knowing the “red flags” for the health condition they are managing—indications that it is worsening—and how to respond.

In the CTI model, the patient is initially visited in the hospital and, if eligible and interested in the intervention, enrolled in the program. This visit is followed by a home visit and three follow-up phone calls over a four-week period, all aimed at instilling the concepts, skills, and tools that can support health management. In a recent randomized controlled trial, Dr. Coleman found that the CTI program is a cost-effective way to reduce the incidence of rehospitalization for as long as 180 days after discharge. The tools and skills also have sustained benefit and remain useful in other settings and episodes.<sup>4</sup>

### **The CHCF Care Transition Projects**

Several year-long CHCF care transition projects, which CHCF began funding in May 2007, are supporting the implementation of CTI in ten communities with grants of \$50,000 each. The overall project goals are to complete the interventions with 1,000 patients, and to identify opportunities for wider implementation. The grantee sites are briefly described on page 9. In an unusual step reflecting its intention to rigorously apply the evidence-based model, CHCF required prospective applicants to participate in a workshop prior to the application period to ensure applicants understood the model. Applicants also completed a readiness assessment before applying for funds.

Every care transition project grantee team involves a collaboration between a hospital and one or more community partners. Project clients have serious and often multiple chronic illnesses. There is also instructive variety among the ten sites, which are customizing the CTI model to be most responsive to the unique needs of their target populations. Some programs are new; others have existed for years (one for 17 years) and are now able to focus and strengthen their work with CHCF support. The communities in which they operate range from big cities to suburban areas to a large, sparsely populated rural area. The clients, most of whom have limited incomes, range in age from their 40s to their 90s (most, however, are seniors). One program serves homeless people, who stay in a shelter after leaving the hospital. Most use public health nurses as transition coaches. Two provide supervised placements for nursing students, and one uses trained volunteers.

In each of five project sites, a county health agency serves as the primary grantee in partnership with a local hospital. CHCF is closely watching these experiments, in hopes that they will point to ways to use existing county structures to introduce CTI in other communities.

### **The October 2007 Meeting**

On October 16, 2007, Dr. Coleman, the developer of the CTI protocol, met with representatives from CHCF and the ten project sites in Oakland, to begin to cull and share data at the project’s midpoint. In her welcoming comments, CHCF Senior Program Officer Kate O’Malley noted that the teams were pioneers in a national effort to improve the quality of care by improving care transitions.

The group of about sixty was professionally diverse, and included social workers, nurses and nursing students, community-based organization staff members, trained volunteers, and physicians. The participants described their projects to each other in formal presentations, exchanging stories about successes, challenges, and the solutions

they had devised. They also gathered in small learning circles to discuss key operational issues. While every community had a unique story to tell, the participants discovered many common experiences, and thus many ways they could learn from each other. The major themes that emerged are summarized below.

After the presentations, Project Manager Monique Parrish, Dr.P.H., M.P.H, L.C.S.W., observed that all the teams had been responding to local needs and conditions with considerable flexibility and a “can-do” spirit. One challenge, she noted, would be to keep the customization within the bounds of the evidence-based model, so that findings would be relevant to other communities.

Reflecting on the meeting afterward, Dr. Coleman hailed the creativity and variety represented by the ten sites. “People are taking the CTI model into different care settings and rolling it out with very diverse populations. This is wonderful for the people of California. There’s an understanding that this approach is not just for ‘some people.’ The way they are customizing the model to make it attractive for people with diverse backgrounds is exceptional.” He added that the project sites also demonstrate that people with a variety of backgrounds and training can perform the pivotal role of transition coach. In more traditional models, public health nurses served in this role. “This represents a substantial shift in our thinking,” he said. “There is a wealth of talented people who can do this.”

### Meeting Themes

The CHCF-funded care transition projects are introducing new concepts and practices in two arenas—within each community’s health care and social service system, and with individual clients and families. The two dimensions of the work figured equally in the presentations and discussions, as the participants explored their experiences in building relationships with health care providers and supporting client empowerment. They asked for further problem-solving opportunities, which the

project directors promised to provide through the monthly grantee conference calls.

### Building the Referral Network

The CTI model begins with a referral from the hospital or nursing facility. In their first few months, the project sites had to spend much of their time building their referral networks. Most participants reported receiving fewer referrals than expected and being surprised at the slow pace of the process. (One, whose hospital and home health agency are part of a single system, remarked, “Even when you’re in the same family, things don’t necessarily work correctly.”)

Outreach, public relations, and relationship-building to create a trusting, efficient referral and communication network are proving to be as key to the project’s success as the role of the transition coaches. As one person observed, “A smooth transition needs to extend in both directions—from the community into the hospital, and the hospital into the community.” The participants shared their approaches to making hospital staff and others aware of the resource they have to offer, clarifying how the model works, and getting information on eligible patients. A common remark: “We had to do a lot of marketing; no one knew what our role was or how we could help.”

Once a patient is referred, the transition coach visits him or her in the hospital to describe the intervention and invite the patient to participate. Sometimes, however, patients are discharged without advance notice, before the transition coach can make the hospital visit; then the first visit takes place in the home or nursing facility. Indeed, the lack of timely communication of discharge information was another common complaint from the grantees, and one that shows the need for flexibility in applying the model.

In general, the grantees reported challenges in completing each step of the CTI model—getting appropriate and timely referrals, enrolling patients, and completing the multistep intervention—in the

designated four-week period. They report continuing to devise more efficient processes so the maximum number of patients will be able to benefit from the intervention.

Many project sites are now exploring ways to extend their scope, both geographically and with new health care sectors and providers in their communities. They have found it especially important to differentiate themselves from, and to coordinate with, home health care providers. One encouraging sign of receptivity is that four project sites sent physicians to the October meeting, suggesting that physicians see promise in the CTI model. Several participants' comments reinforced this impression. One quoted a hospital cardiologist: "This is the best thing that's happened to cardiology in our hospital in years." Another said the medical residents in his hospital had welcomed the knowledge that patients would have support after being discharged.

### Supporting Empowerment

Cooperation among hospitals and their community-based CTI partners lays the groundwork for the Care Transitions Intervention itself. The project teams are discovering what it takes for clients who are facing heightened health challenges to take an active role in their own care.

As noted, the process begins with the hospital visit, where many prospective clients express enthusiasm for the opportunity to work with a transition coach. One coach spoke of the "light in people's eyes" when they learned about this opportunity for support. Another said her client was "thrilled to have someone on her side."

Medications are an early focus for the transition coach. Besides the well-known risks of adverse reactions and interactions, newly discharged patients face the risk of discrepancies between their pre- and post-hospitalization medications. Some don't fully understand their prescribing physician's instructions. The coach reviews the purpose of the medications with the client and helps work out ways to organize

them. Some, for example, come supplied with pill-organizer boxes, in case a client doesn't have one. Another key component of the intervention, along with "red flag" information, is the follow-up medical appointment. The coach makes sure that the client gets a timely appointment and then helps prepare for it, discussing questions for the doctor and perhaps role-playing the conversation.

The personal health record (PHR), a paper document for client record keeping, is proving to be a valued bridge between home and medical providers. Coaches report that both clients and providers are enthusiastic about the tool, which clients are encouraged to maintain and bring to all medical appointments. Several sites have adapted and expanded the PHR—translating it into Spanish, converting it to a large-print format, and putting it in a binder with other resources, such as disease-specific toolkits and advance directives.

In some cases, the contrast between the hospital and home visits can be striking. Several transition coaches described their surprise at what they found "behind closed doors." The Marin County ICT has coined the term "discharge stress" for the setbacks patients may experience when they are discharged from the hospital. Several presenters told of the multiple barriers and challenges encountered in the home visits, including hostility, unwillingness to engage, undiagnosed physical or cognitive limitations, confusion about their multiple providers, family resistance, and more. The meeting discussions highlighted the importance of assessing clients' needs and capacities at the outset, to clarify how to help each individual win at least small victories within the intervention's brief time frame. A common theme for coaches accustomed to doing things for people was the challenge of "sitting on their hands" instead encouraging clients to do things for themselves.

### Success Story Themes

Throughout the day, the participants shared anonymous client success stories that highlighted the themes of the presentations. These anecdotes about

individual lives told a collective story of helping clients; for example, by:

- Defining health goals;
- Identifying and meeting unaddressed needs (e.g., vision, literacy, or language problems);
- Engaging family caregivers;
- Discovering and resolving dangerous medication discrepancies;
- Improving compliance with physicians' instructions;
- Helping to communicate preferences and needs to health care providers; and
- Bringing about a more hopeful and confident approach to health.

### Keynote: Dr. Coleman

Dr. Coleman, the CTI developer, was on hand to observe the meeting and provide the national context for the California projects. In his keynote remarks, he described national developments that are creating strong momentum for care transition improvements. He told the grantees, "You are in the center of this forward momentum to have this be part of our daily practice. People across the country will learn from your work. There's a confluence of national attention now, and you're in the center of it."

He noted that care transition improvements can enter through a variety of doors, including quality measurement and improvement activities and incentives, patient-centered reforms in the health care system, and advances in health information technology. He then outlined some initiatives and organizations that are opening these doors by making care transitions a priority. A few examples:

- **Performance measurement.** The National Quality Forum has endorsed a care coordination measure. There is also a trend toward measuring quality across an episode of care, thus encouraging collaboration. In addition, Congress recently

mandated a Continuity Assessment Record and Evaluation (CARE) instrument.

- **National quality entities.** A Joint Commission initiative now requires that hospitals show evidence of care coordination. Additionally, Medicare's Quality Improvement Organizations (QIOs) are adopting a new focus on cross-setting collaboration.
- **Incentives.** The Medicare Payment Advisory Commission, or MedPAC, is exploring a policy to offer incentives to hospitals to reduce readmissions.
- **Health care coordination.** It is becoming less difficult to engage physicians in care transition improvement. Several professional associations (such as the American Board of Internal Medicine) are compiling standards for care coordination. The rise of the medical home concept is another positive development.
- **Family caregivers.** The United Hospital Fund's Inventing the Wheel project helps caregivers navigate the health care system. In addition, Dr. Coleman is working on a classification system to clarify the roles of different family members and help physicians communicate with families.
- **Health information technology.** The U.S. Department of Health and Human Services recently funded a study by Dr. Coleman and colleagues of information exchange across health care sites. Commercial electronic personal health record products are being developed. The Robert Wood Johnson Foundation is funding research into how consumers handle their health information.

Dr. Coleman noted that another CTI implementation project is underway in New York. Project leaders there are sharing data and results with the CHCF project leaders.



## II. Project Summary

THE CARE COORDINATION INITIATIVES SPRINGING UP around the country compensate for gaps in the health care system as they create new infrastructures to help move toward the ideal of a “seamless web of care.” Research suggests that patients who are supported in their care transitions will have a better experience with recovery and are less likely to be rehospitalized.

In California, the CHCF care transition projects are showing how to build relationships within the health care system, and between it and community resources. The projects are also discovering how to engage vulnerable patients and their caregivers in personal health management.

The October 16, 2007 project meeting produced these findings:

- The project sites show success in adapting the CTI model to diverse clients and environments. The CTI model makes use of the skills and talents of a variety of health care providers, including nursing students, social workers, and volunteers.
- There is evidence that a cross section of stakeholders, including health care organizations, county agencies, physicians, and community organizations, recognize the utility of the Care Transition Intervention protocol.
- Implementing the intervention requires cultural change on both sides, so that community-based organizations and health care organizations can work together to improve patients’ care transitions. This is hard work, and it takes time.

## III. Looking Ahead

### Areas for Further Inquiry

- Coaches report that they need better tools to assess patient capacity and needs at the outset, so they can identify how best to intervene.
- More information is needed on how the county-led collaborations are working. These will provide insights for refining the current models and spreading it to other California communities.

## Appendix: The CHCF Care Transition Projects

Kate O'Malley, senior program officer

Monique Parrish, Dr.PH., 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.
Santa Cruz County Human Resources Agency (Community Partner)	Dominican Hospital (Hospital Partner)	Patients aged 60 and older who meet specific program low-income criteria and have chronic medical conditions.
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. *MedPAC Data Book*, June 2006; cited by Cedars-Sinai presenter.
2. Care Transitions Program Web site.  
([www.caretransitions.org](http://www.caretransitions.org))
3. Coleman, E.A., C. Parry, S. Chalmers, S.J. Min, “The Care Transitions Intervention Results of a Randomized Controlled Trial,” *ArchInternMed*, Vol. 166, September 25, 2006, pp.1822–8.  
([www.caretransitions.org/documents/the%20CTI%20RCT%20-%20AIM.pdf](http://www.caretransitions.org/documents/the%20CTI%20RCT%20-%20AIM.pdf))
4. University of Colorado at Denver and Health Sciences Center’s School of Medicine, press release, September 25, 2006. ([www.caretransitions.org/documents/the%20CTI%20RCT%20-%20PR.pdf](http://www.caretransitions.org/documents/the%20CTI%20RCT%20-%20PR.pdf))



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