



Improving Care Transitions:

Testimony Before a Joint Informational Hearing of the Assembly Committee on Aging and Long-Term Care, Assembly Committee on Health, and California Commission on Aging

October 3, 2007

I. Introduction

The California HealthCare Foundation is funding a one-year project to improve care transitions in California. The purpose of this project is to stimulate change in practice and care delivery systems to improve patient transitions from one care setting to another (for example, from hospital to nursing home). Evidence-based research indicates that better management of patient transitions improves continuity of care; reduces error and delay; and increases patient control of health decisions. The specific approach selected for this project is the Coleman Care Transitions Intervention (CTI), based on the work of Eric Coleman, M.D., from the University of Colorado. The CTI is being implemented in ten locations in California, ultimately serving 1,000 patients and demonstrating the adaptation of a tested model to community programs.

II. The Intervention Model: Coleman Care Transitions Intervention

CTI is a four-week intervention that supports patients to assert a more active role in their health care. Patients receive specific tools and skills that are reinforced by a “transition coach” (a nurse, social worker, or trained volunteer) who follows patients across settings for the first four weeks after leaving the hospital and focuses on four components:

1. **Medication Self-Management.** *Focus:* Reinforce the importance of knowing each medication – when, why, and how to take what is prescribed, and develop an effective medication management system.
2. **Patient-Centered Health Record (PHR).** *Focus:* Providing a health management guide for patients; the PHR is introduced in the hospital visit and used throughout the program.
3. **Primary Care Provider/Specialist Follow-Up.** *Focus:* Enlist patient’s involvement in scheduling appointment(s) with the primary care provider or specialist as soon as possible after discharge.
4. **Knowledge of Red Flags.** *Focus:* Patient is knowledgeable about indicators that suggest that his or her condition is worsening and how to respond.

These areas are addressed through a combination of visits and follow-up calls by the transition coach and the use of several care transition tools such as the Personal Health Record. The schedule of visits and follow-up calls represent the “stages” of the Care Transition Intervention over the four-week intervention period and include the following: an initial hospital visit; one home visit scheduled 24 to 72 hours post-discharge; and follow-up phone calls to the patient on days 2, 7, and 14 after discharge. To flexibly address the patient needs, the calls may be either delayed or scheduled around specific events, such as appointments or home care encounters.

In a randomized controlled trial, use of CTI resulted in lower hospital re-admission rates: **on average, for every 17 patients that works with a transition coach, one re-hospitalization will be prevented.** Researchers estimate that for every 350 patients who receive the intervention, hospital costs will be reduced by approximately \$300,000. In addition, people who have experienced the care transitions model rate their hospital discharge experience as very good or excellent (*Archives of Internal Medicine*, September 2006).

Not only did older participants stay out of the hospital while a transition coach was working with them (the first four weeks after discharge from the index hospitalization), but also they were significantly more likely to remain out of the hospital for up to six months following the initial hospitalization. Despite facing the challenges of a change in health status, anxiety, and sleep deprivation, these older adults learned and applied new skills and tools that led to a sustained benefit long after the coach was gone. This approach represents an investment in self-care.

III. Project Description

CHCF funded ten CTI implementations. Each team consists of a hospital and a community partner and will provide at least 100 patients with transition support during the 12-month grant period. The primary grantee is indicated in **bold** type.

Hospital Partner	Community Partner
1. Huntington Memorial Hospital	Senior Care Network
2. Cottage Health System	Santa Barbara Regional Health Authority
3. Saint Joseph’s Hospital, Eureka	Skilled Health Care (SNF), St. Joseph Home Care and St. Joseph Rehabilitation Center
4. Dominican Hospital	Santa Cruz County Human Resources Agency
5. Cedars-Sinai Medical Center	Accredited Home Health Services
6. John Muir Medical Center	John Muir Physicians Network
7. Santa Rosa Memorial Hospital & Senior Advocacy Services	Sonoma County Human Services Agency
8. San Mateo Medical Center	San Mateo Aging and Adult Services
9. Alameda County Medical Center	East Oakland Community Project
10. Marin General Hospital	Marin County Department of Health and Human Services (Project Independence)

IV. Results to Date

All projects have submitted a work plan for the one-year grant and have completed a two-day educational session with Eric Coleman and his team to learn the skills of transition coaching. Seven projects have begun working with patients, and the projects have served a total of 80 patients, who have either completed the transition coaching experience or are in process. We are collecting data from all projects related to patient satisfaction and also how well the project implemented all four areas of the model. Grantees will meet in October 2007 in Oakland to discuss progress, successes, and challenges. A final project meeting will be held in April 2008 to consolidate all the learning. This meeting will be open to others interested in this intervention.

V. Observations to Date

We do not have any official results since the project is in progress. CTI is a patient-empowerment process and it is different from a case management process, where providers assume a central role in care coordination. Individuals who are accustomed to case management undergo a change in attitude about their role to be successful as a coach. In addition to the cognitive leap that the transition coaches make themselves, the workplace environment also needs to adapt to a different way of working with patients – coaching versus directing. In addition, implementing this model in certain groups like homeless populations requires a different and flexible strategy. An additional benefit to this model is that it takes advantage of resources already in place through established case management programs working with vulnerable populations.

VI. Barriers to Using CTI

Patients have a range of interests in and capacity for self management. For some, working with families is beneficial. For CTI, hospital and community partners must find value in this work and have a way to align their incentives. Willingness and ability of case management providers to change their focus to a coaching role – and to move between roles within their client base – is a challenge. Full case loads may also inhibit the ability to extend this model beyond the early adopters in community programs if it is perceived as an “add on” expectation.

VII. Recommendations Regarding Improving Care Transitions Overall

Long-term solutions to completely remedy the problems caused by poor care transitions will require action in key areas, such as: reimbursement for care transition activities; exploration of health information technology as an efficient mechanism to transfer information across settings; and improvements in the hospital discharge process. In all of these efforts, care must be taken to integrate solutions into existing care practices and resist the temptation to create another specialized role in care transitions, further splintering an already fragmented set of health care services.

Creating enhanced standards for discharge planning could ensure better transitions between settings—assessing patient preferences; assessing service needs; developing a written service plan to accompany the patient (including medications); ensuring communication across settings (to community providers as well as home health or nursing home); having discharge planning available for 72 hours after discharge for problem solving; ensuring that discharge planners are trained and exposed to the care delivery sites in the community; and doing a one-month post discharge follow-up.

The development of patient-centered and patient-empowered efforts is central to any solution.

VIII. For More Information

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