

Encouraging Patients and Family Caregivers to Assert a More Active Role During Care Hand-Offs: The Care Transitions Intervention

What is the Model?

During a 4-week program, patients with complex care needs and family caregivers receive specific tools and work with a “Transitions Coach,” to learn self-management skills that will ensure their needs are met during the transition from hospital to home. This is a low-cost, low-intensity intervention comprised of a home visit and three phone calls.

What Are the Key Findings?

Patients who received this program were significantly less likely to be readmitted to the hospital, and the benefits were sustained for five months after the end of the one-month intervention. Thus, rather than simply managing post-hospital care in a reactive manner, imparting self-management skills pays dividends long after the program ends. Anticipated cost savings for a typical Coach panel of 350 chronically ill adults with an initial hospitalization over 12 months is \$ 295,594. Patients who received this program were also more likely to achieve self-identified personal goals around symptom management and functional recovery.

What Makes this Model Unique?

In contrast to traditional case management approaches, the Care Transitions Intervention is a self-management model. The Care Transitions Program has modeled national Medicare data sets to demonstrate the frequency with which older adults making care transitions across settings will experience another transition in the near future. In other words, for most of these individuals, there will be a “next time”. Using qualitative techniques, the Care Transitions Program worked with older adults to identify the key self-management skills needed to assert a more active role in their care. Next a Transition Coach was introduced to help impart these skills and help the individual and the family caregiver become more confident in this new role. Although critics are quick to point out that this is only applicable to highly educated or motivated patients, our studies have shown that most patients and family caregivers are able to become engaged and do considerably more for themselves. In essence, the model involves making an investment in helping patients and family caregivers become more comfortable and competent in participating in their care during care transitions. Five months after the Transition Coach signed off, these patients continued to remain out of the hospital demonstrating a sustained effect from coaching.

The Intervention Focuses on Four Conceptual Domains Referred to as Pillars:

1. Medication self-management
2. Use of a dynamic patient-centered record, the Personal Health Record
3. Timely primary care/specialty care follow up
4. Knowledge of red flags that indicate a worsening in their condition and how to respond

Project Sponsors

The John A. Hartford Foundation and The Robert Wood Johnson Foundation

Where Can I Learn More?

Please visit www.caretransitions.org where you can learn more about the model and its evidence base and to access patient tools, performance measures, medication safety tools and much more. You may also contact Eric A. Coleman, MD, MPH, directly at Eric.Coleman@ucdenver.edu

**EVIDENCE FOR THE CARE TRANSITIONS INTERVENTION:
MANUSCRIPTS PUBLISHED IN REFEREED JOURNALS**

1. Coleman, EA, Smith JD, Eilertsen TB, Frank JC, Thiare JN, Ward A, and Kramer AM. Development and Testing of a Measure Designed to Assess the Quality of Care Transitions. *International Journal of Care Integration* 2002;2 April-June.

This article includes the qualitative studies that formed the basis for the conceptual domains or “Four Pillars” of the Care Transitions Intervention.

2. Parry C, Coleman EA, Smith JD, Frank JC, Kramer AM. The Care Transitions Intervention: A Patient-Centered Approach to Facilitating Effective Transfers Between Sites of Geriatric Care. *Home Health Services Quarterly*. 2003;22(3):1-18.

This article provides the conceptual and methodological basis for the Care Transitions Intervention.

3. Smith JD, Coleman EA, Min S. Identifying Post-Acute Medication Discrepancies in Community Dwelling Older Adults: A New Tool. *American Journal of Geriatric Pharmacotherapy*. 2004;2(2):141-148.

This article describes the development of the Medication Discrepancy Tool, a central component of the Care Transitions Intervention.

4. Coleman EA, Smith JD, Frank JC, Min S, Parry C, Kramer AM. Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention. *Journal of the American Geriatrics Society*. 2004;52(11):1817-1825.

This article reports on clinical trial that demonstrated a 50% reduction in hospital readmissions at 30, 90, & 180 days. The 30-day Care Transitions Intervention produced a sustained effect.

5. Coleman EA, Smith JD, Raha D, Min SJ. Post-Hospital Medication Discrepancies: Prevalence, Types and Contributing Factors. *Arch of Int Med* 2005;165(16):1842-1847.

This article describes the results when the Medication Discrepancy Tool is used in the field and provides further rationale for the value of the Care Transitions Intervention approach.

6. Coleman EA, Parry C, Chalmers S, Min SJ. “The Care Transitions Intervention: Results of a Randomized Controlled Trial” *Archives of Internal Medicine* 2006;166:1822-8.

This article reports on a randomized controlled clinical trial that demonstrated significant reductions in hospital readmissions at 30, 90, and 180 days. The 30-day Care Transitions Intervention produced a sustained effect. Note that 30-day readmission rate in the control group was 12%, far below the national average of over 19%.

7. Parry, C., Kramer, H, Coleman, EA. ‘A Qualitative Exploration of a Patient-Centered Coaching Intervention to Improve Care Transitions in Chronically Ill Older Adults’. Home Health Care Services Quarterly. 2006;25(3-4):39-53.

This article reports on a qualitative study designed to determine the value of the intervention from the patient’s perspective and the elements of the model that most likely produce the positive results.

8. Coleman, EA; Min, S, Chugh, A, Chalmers S, Parry C. Further Application of The Care Transitions Intervention: Results of a Randomized Controlled Trial conducted in a Medicare Fee-For-Service Setting. Home Health Care Services Quarterly. 2009:000-000.

This article reports on a randomized controlled clinical trial that demonstrated significant reductions in hospital readmissions. The 30-day Care Transitions Intervention produced a sustained effect.

9. Bennet, H; Coleman, EA; Parry, C; Bodenheimer T; Chin E. Health Coaching for Patients with Chronic Illness. (*Under review, Annals of Internal Medicine*)

This article introduces the “mainstream” medical audience to the value of coaching and prominently features the Care Transitions Intervention.

10. Parrish, MM; Malley K; Adams R; Adams, S; Coleman, EA. Implementation of the Care Transitions Intervention: Sustainability and Lessons Learned. Professional Case Management. 2009:000-000.

This article describes the results of an effort to implement the Care Transitions Interventions in 10 California Communities sponsored by the California Health Care Foundation.

The Care Transitions Intervention Is Uniquely Suited to Wide Scale Implementation

1. The model was specifically designed to be low-cost, low intensity, and capable of being implemented in a wide variety of settings. It is in the public domain with no user fees.
2. During the development and testing phase, Advanced Practice Nurses and Registered Nurses assumed the Transitions Coach role. During the adoption phase, social workers and other professionals have also served in the role of Transitions Coach.
3. Consistent with the Institute of Medicine's Report, "Retooling for an Aging America", the model recognizes and promotes patients and family caregivers as actively participating members of the care team. By introducing Transition Coaches, the Care Transitions Intervention leverages our limited health care professional workforce over larger number of Medicare beneficiaries.
4. **150 leading health care organizations have adopted the Care Transitions Nationwide.**
5. These adoptions have been made by a wide variety of care providers including: Hospitals and Health Care Systems, Home Care Agencies, Nursing Homes, Area Agencies on Aging, Parish Nurse Communities, Medicare Advantage Plans, Physician Networks, and Insurance Companies. The model is effective in Medicare fee-for-service and Medicare Advantage.
6. **As important as research evidence is to determine the benefits of a model, a strong track record of implementation with consistent and robust findings in the "real world" is essential to decisions regarding further dissemination. For example:**
 - a. John Muir Physician Network (CA) determined that the Care Transitions Intervention Program was achieving the goal of reducing hospital readmission and emergency visits. This was based on a cost benefit analysis for the 6 months prior to the intervention, to 6 months after the intervention.
 - b. Health East (MN) reduced 30-day readmission rate from 11.7% vs 7.2%
 - c. Crouse Hospital (NY) reduced 30-day readmission rate for heart failure to 9.7%, and average number of days to hospital readmission increased from 86 to 175.
7. The Centers for Medicare and Medicaid Services funded a study in Colorado that implemented the Care Transitions and reduced 60-day hospital readmission rates by 50%.
8. The results of the CMS study led to a Transitions Theme in the Quality Improvement Organizations 9th Scope of Work and 14 states successfully competed during a RFP to participate. Of these 14 QIOs, 12 selected the Care Transitions Intervention as their preferred model for reducing hospital readmissions.
9. The Care Transitions Intervention was implemented by Health Dialog in the CMS 721 Demonstration and by the Everett Clinic in the Physician Group Practice Demo.
10. The Care Transitions Intervention has been successfully implemented in a wide variety of markets: urban/rural, high performing/low performing (12% 30-day readmissions and 35% 30-day readmissions respectively).
11. The burden of chronic illness (number of conditions, number of medications, percent with fair/poor self-rated health) of Medicare beneficiaries that have been coached in this model is comparable to that found in other trials of care coordination/transitional care models (i.e., model is effective across health states). At least ¾ Medicare beneficiaries can be coached. These patients represent great diversity with respect to education level, health literacy, primary language, race/ethnicity, and presence of family caregiver.
12. Just as the intervention is low-cost and low-intensity, the training for Transition Coaches can be accomplished in 1.5 days.

National Recognition for the Care Transitions Intervention

- Dr. Coleman was invited to testify before the U.S. Senate Aging Committee--The Care Transitions Intervention was 1 of 3 models designated as a truly person-centered model.
- Dr. Coleman was invited to address the Institute of Medicine Panel of the Aging Workforce with a presentation on future models of health care that both meet the needs of older adults and reduce the demand for more health care professionals. The Care Transitions Intervention was featured.
- The Care Transitions Intervention was featured in Dr. Coleman's invited testimony before the Institute of Medicine Committee on Redesigning Benefits, Payment, and Performance Measurement Improvement Programs.
- National Quality Forum: National Priorities Partnership collaborative of 28 national organizations defined 6 national health system priorities. The Care Transitions Intervention addresses 4 of the 6 priorities.
- The Care Transitions Intervention is profiled on the Health Workforce Solutions Innovative Care Delivery Website. This website is the result of a research project funded by Robert Wood Johnson Foundation. Criteria for selecting models include: 'demonstrated positive impact on quality, safety, cost and/or patient satisfaction' and "sustainability of model and ability to be replicated".
- Institute for Health Care Improvement (IHI), "Effective Interventions to Reduce Hospitalizations: A Compendium of 15 Promising Interventions" 2009, and: "A survey of the Published Evidence", 2009 highlighted the Care Transitions Program as an effective intervention with very strong trial or evaluation data.
- Dr. Coleman received the National Council on Aging Molly Mettler Award for outstanding leadership in the field of health promotion and aging based largely on the development, testing, and dissemination of the Care Transitions Intervention
- Dr. Coleman received the American Geriatrics Society Outstanding Scientific Award for Clinical Investigation based largely on the development, testing, and dissemination of the Care Transitions Intervention.
- Dr. Karen Davis, President of the Commonwealth Fund, identified the Care Transitions Intervention as one a select few transforming, "Models for Achieving the Best Health System in the World".
- In March 2008 issue of *The New England Journal of Medicine*, Dr. Tom Bodenheimer singled out the Care Transitions Intervention for its innovative approach to improving patient centered care coordination.
- The Care Transitions Intervention has been featured on the AHRQ Web M&M.
- The Care Transitions Intervention has been featured in multiple Joint Commission publications, MedPAC Reports to Congress, and an Advisory Board monograph.
- The Care Transitions Intervention was featured in a toolkit developed by the Institute for Healthcare Improvement's Transitions out of the Hospital Collaborative.
- The Care Transitions Intervention has been featured in the New York Times, Wall Street Journal, Boston Globe, Los Angeles Times.