Listen to Your Patients
They Are Telling You How to Improve the Quality of their Transitional Care

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What Do We Know?

Does the Current Evidence Support Business as Usual?

Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries
15 Randomized Trials

Original Contribution
Recent Evidence
- Gives us reason for pause
- Results are underwhelming and join growing number of negative Medicare demos in disease management/case management/care coordination
- We need to be careful not to over emphasize assessment, care planning, and patient education vs. implementation and patient/family engagement
- Time to move from provider-centered care to patient-centered care

Chronic Care Model

Listen to Your Patients: They Are Telling You How to Improve Care Transitions
- Inadequately prepared for next setting
- Conflicting advice for illness management
- Inability to reach the right practitioner
- Repeatedly completing tasks left undone
Transition-Related Medication Errors:
The Perfect Storm
Welcome to the “No-Care Zone”

Aliens Did Not Build The Pyramids...

And Case Managers Do Not Perform The Majority of Care Coordination...
Adding More Case Managers Won’t Fix It!

By default, patients/family caregivers perform a significant amount of their own care coordination. Employing the Care Transitions Intervention can transfer a core set of transition-specific self-care skills to help patients/family caregivers ensure that their needs are met.

Self-Care Support for the “Silent” Care Coordinators
Key Elements of The Care Transitions Intervention™
- Low-cost, low-intensity, adapt to different settings
- One home visit, three phone calls over 30 days
- “Transition Coach” is the vehicle to build skills, develop confidence and provide tools to support self-management
  - Model behavior for how to handle common problems
  - Reconcile pre- and post-hospital medications
  - Practice or “role-play” next encounter or visit

Four Pillars
- Medication self-management
- Patient-centered record (PHR)
- Follow-up with PCP/Specialist
- Knowledge of “Red Flags” or warning signs/symptoms and how to respond
Care Transitions Intervention™
Summary of Key Findings

- Significant reduction in 30-day hospital readmits (time period in which Transition Coach involved)
- Significant reduction in 90-day and 180-day readmits (sustained effect of coaching)
- Net cost savings of $300,000 for 350 pts/12 mo
- Adopted by over 145 leading health care organizations nationwide

Dissemination Partners

- California Health Care Foundation
- Community Health Foundation New York
- Centers for Medicare & Medicaid Services/QIOs
- United Health/Ovations
- Health Dialog
- Blue Cross Blue Shield (Highmark) in PA
- Rosalyn Carter Caregiving Institute

How to Pay for the Transition Coach?

- Under capitation, incentives are aligned and Transition Coach pays for her/himself
- Home Health Care Agencies may consider the Transition Coach a “loss leader” in exchange for a higher volume of referrals
- Large ambulatory clinics may adopt to improve efficiency or meet PCMH standards
- Community agencies mission may align with coaching
- APN and MSW Transition Coaches can bill for visits
Why Would a Hospital Invest in Transition Coaching?
- Improve community image (discharge is lowest rated aspect of hospital stay)
- Meet Joint Commission standards
- Reduce diversion/create greater capacity for higher revenue patients
- Improve market share/“preferred provider”
- Improve relationships with ambulatory providers
- Avoid litigation
- Prepare for likely changes in readmission reimbursement

Lessons Learned
- Engage both clinical and administrative leadership
- Articulate how model responds to real pressures
- Do not underestimate value of neutrality
- Health professionals may need modest “de-programming” to become Transition Coaches
- Maintain model fidelity-essential to future success

Our Champion!
**Winds of Change:**
National Transitional Care Initiatives

**Senate Aging Committee**

- Hearing in July 2008 on “Person Centered Care”
- Care Transitions was one of three key themes
- Build the case for greater support for Beneficiary self care, learning from experience with diabetes

**ABIM Foundation + 9 MD Organizations**

*Stepping Up to the Plate Alliance*

1. At all times, a personal physician must be accountable for ensuring that patients experience effective transitions through the timely exchange of appropriate information.
2. Accountability should be clearly established – parties should reach consensus on accountability for outcomes.
3. To demonstrate accountability for care across transitions, a system must have agreed upon, feasible, reliable and valid measures for meeting established standards of care.

(continued)
4. The sending provider/institution/team maintains **responsibility** for the care of the patient until receiving clinician/location confirms assumption of responsibility.

5. The sending provider should **be available** for clarification of issues related to the care episode within a reasonable timeframe after the transfer has been completed.

6. The patient should be able to **identify the responsible provider**.

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**The goal of Project BOOST (Better Outcomes for Older adults through Safe Transitions)** is to improve the care of patients as they transition from hospital to home.

- Grant from John A. Hartford Foundation to develop a discharge toolkit, resources, and technical support
- Includes implementation field guide
- Scripts for getting buy-in from leadership
- Recruiting hospitals nationwide

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**National Transitions Of Care Coalition (NTOCC)**

- NTOCC was formed to bring together stakeholders from various care settings to improve coordination when patients, especially older adults, leave one health care setting and move to another.
- www.NTOCC.org includes resources, tools, measures, bank of presentation slides, & more
Medicare Payment Advisory Commission (MedPAC)
Policies to align incentives to reduce readmissions
1) Public disclosure of hospital 30-day (risk-adjusted) readmission rates
2) Adjust payment based on performance (i.e., readmissions may not receive full payment)
3) Bundling payment across hospitals and MDs

CMS Special Study: CFMC/Care Transitions Program
- Goal: reduce hospital readmission rates
- Apply rigorously tested intervention (Care Transitions Intervention)
- Community building efforts
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Quality Improvement Organizations

- 9th Statement of Work includes explicit focus on care transitions
- Aim is to reduce hospital readmissions by 2%
- 14 QIOs competed successfully
- Our Care Transitions Program is providing training and technical support on the CTITM

www.caretransitions.org

- Care Transitions Measure (CTM)
- Care Transitions Intervention
  - Manual
  - Video clips/Order DVD
  - Tools for patients and caregivers
- Medication Discrepancy Tool (MDT)
- Much much more….
Care Transitions URLs

www.caretransitions.org
www.NTOCC.org
www.nextstepincare.org
www.hospitalmedicine.org/BOOST
www.pacdemo.rti.org
www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/TCABHowToGuideTransitionHomeforHF.htm