

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

What is the Model?

During a 4-week program, patients with complex care needs and family caregivers receive specific tools and work with a Transition CoachTM to learn self-management skills that will ensure their needs are met during the transition from hospital to home.

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 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 InterventionSM is a self-management model. The Care Transitions ProgramSM has modeled national Medicare data sets to demonstrate the frequency with which older adults making care transitions across settings will experience this again in the near future. In other words, for most of these individuals, there will be a “next time”. Using qualitative techniques, the Care Transitions ProgramSM worked with older adults to identify the key self-management skills needed to assert a more active role in their care. Next a Transition CoachTM was introduced to help impart these skills and help the individual (and the family caregivers) 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 is about making an investment in helping older adults and family caregivers more comfortable and competent in participating in their care during care transitions. Five months after the Transition CoachTM signed off, these patients continued to remain out of the hospital demonstrating a sustained effect from investing in a self-care approach.

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

The Following Materials Are Available at No Cost:

- The business case for implementing the Care Transitions InterventionSM model
- Training manual, video clips of the model in action, training DVD request form
- Medication reconciliation tool, the Medication Discrepancy Tool (MDT)^{©TM}
- NQF endorsed quality measure, the Care Transitions Measure (CTM)^{©TM}

The Evidence Base for the Model

1. 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.
2. 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. J. of the Amer Geriatrics Society. 2004;52(11):1817-1825.
3. 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.
4. 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 Quart. 2003;22(3):1-18.
5. Coleman, EA, Mahoney E, Parry C. Assessing the Quality of Preparation for Post-Hospital Care from the Patient's Perspective: The Care Transitions Measure. Medical Care. 2005;43(3):246-255.
6. 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.
7. 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.

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.