



Navigating Care Transitions in California: Two Models for Change

Introduction

Care transitions refer to the movement of patients from one health care practitioner or setting to another as their condition and care needs change. These may include transitions from hospitals to nursing homes or home care after an acute illness, or transitions from nursing homes to home care or home without care. Medication lists that don't match, undeveloped and underdeveloped connections to care after a hospital stay, and complex discharge instructions are just a few of the most common care transition challenges.

Health Care Organizations Respond

Too often patients with complex acute or chronic conditions are ill-prepared for the transitions that occur during the course of their care, resulting in increased risk for readmission and the compromise of patient health. Because poor care transitions affect patients, clinicians, and the health care delivery system, a growing number of health care organizations and professional organizations have identified improved patient care, safe discharges, and medication reconciliation as core care transition issues requiring new performance measures and public reporting requirements.

The California HealthCare Foundation sees improvements in care transitions as central to its overall efforts to improve chronic disease care in California. With support from CHCF, two projects promoting proven care transitions models are being tested in California on a small scale; one with Kaiser Hospitals and one with ten community/hospital partnerships. To identify options to spread effective care transitions in

California, CHCF selected two consultants with expertise in California health care policy, operations and financing, to explore opportunities to spread effective care transitions models. The consultants, Bonnie Darwin and Monique Parrish, interviewed representatives from health care organizations with a history of incubating best practices for patient populations with complex health care needs and facilitated a forum to provide a broader discussion of the strengths and weaknesses of two evidence-based care transitions models piloted in California, which are discussed below. The process yielded a distinctive outline of the advantages and disadvantages with the two models—from an in-the-trenches perspective, as well as a thoughtful analysis of the barriers to effective implementation.

A Look at Two Care Transition Models

During 2007 to 2008, the California HealthCare Foundation sponsored implementation of two evidence-based care transitions models: The Coleman Care Transitions Intervention, developed by Eric Coleman, M.D., M.P.H., University of Colorado Health Sciences Center; and The Naylor Transitional Care Model, developed by Mary Naylor, Ph.D., R.N., F.A.A.N., University of Pennsylvania. Although using different approaches, both models provide patients with the tools and support they need to understand and take a more active role in managing their care. Additionally, both provide a framework for larger systems transformations, including practice and cost-savings changes. Several advantages and disadvantages associated with implementation of the two models surfaced. Examining these findings

provided important insights and contributed to the larger discussion regarding how best to spread and sustain effective care transition models in California.

Each model has been tested to prove its effectiveness. Study findings from the randomized clinical trial of the Coleman Care Transitions Intervention revealed that intervention patients had lower re-hospitalization rates at 30 days and at 90 days compared to controls.”¹

For the Transitional Care Model developed by Naylor, the most recently reported multi-site RCT tested a care transitions model addressing health problems throughout an acute episode of heart failure. When compared to the control group, members of the intervention group showed better physical function, quality of life, and satisfaction with care and fewer total re-hospitalizations resulting in a mean savings of \$5,000 per elder.²

The Coleman Model. The Coleman Care Transitions Intervention (CTI) is a four-week process designed to empower and support patients to take a more active role in their health care. Through one hospital and one home visit and a series of follow-up phone calls with a designated transition coach (typically a nurse, social worker, or community worker), whose primary role is “to coach not do;” patients with chronic or serious health conditions develop improved capacity in the areas of medication management, personal health record keeping, knowledge of “Red Flags” (health indicators that suggest that a condition is worsening and how to respond), and follow-up care with primary care providers and specialists.

CHCF sponsored a 12-month pilot of the CTI model with ten project site teams, each hosting a sender (hospital) and receiver (community organization) partnership, from around the state. Five of the teams were hospital-led and five were county-led. Patients targeted for the intervention represented California’s diverse racial, ethnic, cultural, geographic, and economic communities.

From an individual perspective, the primary goal of CTI is to empower patients with chronic illnesses to manage their health and care needs; from a population and system perspective, the primary goals of the intervention are to improve patient transitions from one care setting to another and to stimulate change within health care delivery systems.

Four Elements of the Coleman Care Transitions Intervention

1 Medication Self Management

FOCUS: Reinforcing the importance of knowing each medication—when, why, and how to take what is prescribed, and developing an effective medication management system.

2 Patient-Centered Health Record (PHR)

FOCUS: Providing a health care management guide for patients; the PHR is introduced during the hospital visit and used throughout the program.

3 Primary Care Provider/Specialist Follow-Up

FOCUS: Enlisting 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: Ensuring patient’s knowledge about indicators that suggest that his or her condition is worsening and how to respond.

The Naylor Model. The Naylor Transitional Care Model, a model of care coordination with an interdisciplinary approach, is delivered to elderly patients at high risk for poor post-discharge outcomes. The care is overseen by by master’s degree-prepared advanced practice nurses (APNs), identified as transition nurse managers (TNMs), who work in conjunction with physicians. Transition support lasts approximately eight weeks and includes comprehensive discharge planning and home follow-up to high-risk, high-cost, high-volume patient groups to improve post-discharge outcomes among this vulnerable population.³

CHCF sponsored an extended implementation pilot of the Naylor model in three Kaiser sites in California using several variations of the model originally delivered by advance practice nurses . One of the three sites used bachelor’s-level nurses, one used advanced practice nurses, and one used a combination of both. Despite the different professional compositions, all three models followed the same intervention outline. The transition nurse met daily with the patient during hospitalization. Following discharge, a home visit was scheduled within 24 to 48 hours. Thereafter, home visits were conducted weekly for the first month with follow-up calls during the second month. Transition nurses were available seven days a week throughout the intervention. Specific tasks of the intervention were: (1) to monitor and manage symptoms and prepare the patient for discharge; (2) to provide the patient with health care information, education, and training regarding his or her specific health condition; and, (3) to assist the patient with medication management and reconciliation.

Table 1 highlights the differences and similarities between the two models as they were implemented in their CHCF-sponsored pilots in California. As depicted, the organizational structures differed. The Coleman pilot used various hospital-community organization team combinations to facilitate the intervention, while Kaiser implemented the Naylor model at three of its sites. While the Coleman model was designed specifically as a brief intervention to capture and address immediate needs and maximize post-discharge opportunities for

learning and change, the Naylor model provided a more protracted time for patients to develop the skills and abilities to manage their health needs. Both pilots promoted improved care transitions through a process of patient empowerment (more pronounced in the Coleman model), education, and support, beginning in the hospital setting.

Advantages and Disadvantages of the Models

The central focus of the Coleman Intervention is helping patients assume greater responsibility and control over their health care through a coaching process in which the transition coach abandons the traditional role of “doing” in favor of “modeling” how patients can care for themselves more effectively. Because transition coaches do not have to be nurses (a scarce resource), there is greater flexibility in implementation. Moreover, the clearly defined four pillars the model offered a simple architecture for intervention. Regarding key disadvantages of the Coleman model, a number of the pilot sites felt the intervention lacked a built in way to identify and stratify patients for more intensive interventions for those patients with complex psychosocial and medical conditions, and moving them into case management programs. Other significant disadvantages included the cost of the transition coach, which, to be effective, required at least a dedicated half- to full-time employee, and long-term commitment to fund the care transition role. Without funds or regulatory requirement, most of the pilots’ health care delivery systems lacked the incentive to sustain the care transitions program.

Table 1. Comparison of Coleman and Naylor Care Transitions Pilots in California

MODEL	ORGANIZATIONAL STRUCTURE	TRANSITIONS LEAD	LENGTH OF INTERVENTION	INTERVENTION FOCUS			
				PATIENT EDUCATION TRAINING	MEDICATION MANAGEMENT	FOLLOW UP WITH DOCTORS	PERSONAL HEALTH RECORD
Coleman	Hospital-community organization teams	Transition coaches (nurses, social workers, community workers, student nurses, etc.)	4 weeks	✓	✓	✓	✓
Naylor	Hospital	Advanced practice and bachelor’s nurses	8 weeks	✓	✓	✓	

The Naylor model exhibited a similar array of strengths and weaknesses. A well-tested intervention over the past twenty years, the Naylor model proved flexible in accommodating various nursing configurations for the role of transition nurse. Additionally, the intensive education, monitoring, and interdisciplinary team approach was well received by patients with chronic illness, and gave them increased confidence in their ability to manage their health conditions. Challenging to Kaiser's implementation of the intervention, however, were difficulties with staff continuity and recruitment, and experience and comfort level of nurses acting in new roles. The latter referenced the identification of transition nurses who could fulfill clinical nurse functions and care management functions, while simultaneously promoting patient empowerment. Finally, as a health maintenance organization assuming financial risk for the costs of care, Kaiser has more incentives to test and implement care transitions models. Other organizations without those incentives struggle to pay for the costs of the model, especially if they do not reap the benefits of reduced hospitalizations.

Implementation of the Coleman and Naylor models represented an important step forward in deconstructing how to improve care transitions in multiple health care delivery systems using different approaches. Both care transition models initiated change in the care transitions process, engaged multiple stakeholders, and promoted consumer-centered care. Feedback from both models however, underscored that each intervention has advantages and disadvantages. Feedback from the larger statewide care transitions discussion with stakeholders broadened the discussion, distilling the core elements and processes for a viable care transitions effort.

The Elements of a Viable Care Transitions Program

Building on the Coleman and Naylor models, interviewed stakeholders identified a list of core care transitions elements (see sidebar) and care transition processes. The latter include: pre-hospital care transitions work—that is, health plans identifying high-risk patients before acute care admissions based on diagnoses and utilization patterns; stratification of care transitions, that is, establishing different interventions for patients based on individual need (information, intensive case management, etc); variable lengths of care transitions interventions governed by need and including a more comprehensive overview of available home and community-based services; and, finally, a process for engaging a wider group of natural partners—hospitals, community organizations, home health agencies, primary physicians, patients, and family members.

The process recommendations were informed by examples of other care transition models currently in place in California. Contra Costa Health Plan employs a three-

Expanded Care Transitions Core Elements

- **Medication reconciliation** (to include accurate lists of medications transferred from one setting to another).
- **Red flags** (health indicators that suggest that a condition is worsening and how to respond).
- **Personal health record** (maintained by the patient and containing current medications, health status, and questions for providers).
- **Interdisciplinary team approach** (recommend that nurses, social workers, and physicians provide the core interdisciplinary approach to promoting and sustaining effective care transitions).
- **Engaged primary provider** (focus is on engaging community physicians in the care transitions process before and after acute care stays).
- **Information dissemination** (accurate and timely sharing of appropriate patient information among providers).

tiered patient support program that stratifies members into the following services: member services for general resource information; a modified care transitions service, facilitated by nurses; or, intensive case management. Patricia Tanquary, Executive Director of Contra Costa Health Plan noted, “our [stratified] care transitions approach allows us to respect the diversity of our patient population and move away from a one-size-fits-all model of health care.”

Moving Toward Widespread Dissemination of Improved Care Transitions

Twenty five years have elapsed since the Diagnostic Related Group (DRG) payment mechanism for hospitals ushered in widespread public concern over the “quicker, sicker” discharge of patients; however, little attention has been paid to the clinical and logistical challenges many patients face following discharge. Although Medicare patients report greater dissatisfaction related to discharges than any other aspect of care that the Centers for Medicare and Medicaid (CMS) measures, and anecdotes abound about the difficulties elders and persons with chronic illness often face, little has been done to address the problem until recently. However, it appears that interest in improving care across settings is now growing. Organizations and agencies ranging from the Medicare Payment Advisory Commission (MedPAC), CMS, the Quality Improvement Organizations, the Joint Commission, the World Health Organization, National Transition of Care Coalition, and the American Board of Internal Medicine have all recommended strategies for improving care transitions.

Although the two models described provide more than adequate evidence of reduced hospital admissions, improved clinical outcomes, and increased patient satisfaction, these outcomes alone are not sufficient to induce health care providers to embrace implementation. Significant barriers—operational, regulatory, and fiscal—abound. The second half of this paper examines both the incentives for and impediments to widespread

adoption of improved care transitions, as well as public policy options that could encourage all payers to embrace implementation. Widespread adoption of new practices across health care settings necessitates change in:

- Payment mechanisms;
- Standards and regulations; and
- Medical culture and operations.

Hospital Readmission: How Payment Mechanisms Encourage or Discourage Improved Care Transitions

Although hospital readmissions are just one symptom of the many clinical and social problems related to poorly coordinated hospital care transitions, issues associated with readmission offer both an explanation for the early adoption of improved care transitions practices and the seeming disinterest on the part of other providers.

MedPAC, an independent Congressional agency established to advise the U.S. Congress on issues affecting the Medicare program, reports that 18 percent of Medicare hospital admissions result in readmissions within 30 days of discharge, accounting for \$15 billion in spending. The Commission found that Medicare spends about \$12 billion on potentially preventable readmissions. And the most costly beneficiaries, those the top 20 percent, have an average of 1.7 admissions per year.

Managed care organizations. For organizations that manage risk, reducing costs associated with readmission and improving member satisfaction provides a strong incentive for investing in improved care transitions. Not surprisingly, organizations in California that bear risk are already in the process of implementing improved care transitions practices, although not by any means universally. A number of organizations have tested either the Naylor or Coleman models and others have modified and embellished these models to suit the patient populations they serve.

Such diverse organizations as SCAN Health Plan, Kaiser, Health Care Partners, On Lok, Contra Costa Health Plan and CalOptima have adopted variations of either the Coleman or Naylor models. These providers have a history of innovation with the populations traditionally thought of as needing additional support in transitioning between settings. In some of the implementation efforts, care transitions coaching is extended to include care coordination when necessary. America's Health Insurance Plans (AHIP), representing 1,300 member companies, convened the HMO Workgroup on Care Management, which met quarterly for seven years to discuss ways in which the delivery of care to Medicare beneficiaries can be improved. In its report *One Patient, Many Places*, the Workgroup reflected that Medicare Advantage plans have the flexibility and incentives necessary to coordinate care seamlessly across integrated settings. These organizations move beyond traditional utilization management aimed at monitoring service use in individual settings to a broader focus that includes improving the efficiency and effectiveness of transfers to different venues.

Fee-for-service. Traditional fee-for-service, on the other hand, rewards readmission. Throughout the fee-for-service delivery system, paying for each individual service and staying within current payment system “silos” inhibits changes that might result in better coordination across services that could lead to efficiencies or enhanced quality across settings. Currently, Medicare pays for all admissions based on the patient's diagnosis, regardless of whether it is an initial stay or readmission for the same or a related condition. As such, it does not reward hospital-based initiatives that could successfully avert many readmissions. In addition, hospital discharge planning is a cost center rather than a revenue generator.

In June 2007, MedPAC examined payment policies that rewarded hospitals that reduced readmissions, as well as policies that penalized hospitals for readmissions that could have been prevented. From its findings, MedPAC reported that many readmissions could be avoided by

improving certain aspects of care: reconciling medications at the time of discharge; improving communication with patients so they understand post-discharge instructions and have adequate information about self-care; communication with other providers; and timely summaries at the time of discharge. These recommendations are consistent with the improved care transitions practices in both the Naylor and Coleman models.

Based on MedPAC recommendations, CMS is seeking comment on three proposals to take the financial reward out of readmissions: (1) direct adjustments to DRG payments for preventable readmissions; (2) make adjustments to DRG payments through a performance-based payment methodology; and (3) publicly report readmission rates.

Recognizing disincentives for coordinating care across settings, in June 2008, MedPAC additionally recommended creating a voluntary program to test the feasibility of “bundling” payment policies that would pay for care that spans across provider types and would hold providers accountable for quality over the course of the episode of care. Under bundled payment, Medicare would pay a single provider entity (composed of a hospital and its affiliated physicians) an amount intended to cover the costs of providing the full range of care needed.

Standards and Regulations Related to Care Transitions

Standards set by CMS and other organizations serve to impede or promote the adoption of improved care transitions strategies. The Joint Commission and the World Health Organization have identified medication accuracy during transitions in care as one of nine patient safety issues that need to be addressed and for which solutions need to be developed.

In its Ninth Scope of Work contract with quality improvement organizations (QIOs), CMS will work with

selected state QIOs to implement initiatives throughout their local communities concerning quality care for Medicare beneficiaries at or after hospital discharge. Three measures of care coordination are specified: (1) reductions in global re-hospitalization rates; (2) inclusion of patient assessment of hospital discharge performance in the *Hospital Consumer Assessment of Healthcare Providers & Systems (H-CAHPS)* survey, developed by CMS to collect information on hospital patients' perspectives of the care they received while in the hospital; and (3) insuring timely physician visits post discharge.

An alternative to hiring separate staff to coordinate care transitions would be for the hospital to contract with a home health agency to provide transitions coaching. Albeit a seemingly natural partner, two regulatory hurdles were identified by leaders in the CHCF forum that would limit use of this option. First, the requirement that home health agencies administer the lengthy Outcome and Assessment Information Set (OASIS) patient assessment required by the federal government would be operationally unfeasible within the care transitions process. Second, there is concern expressed over the recent prohibition of home health and hospice agencies visiting patients in the hospital prior to discharge. The particular application of this "restraint of trade" provision is outside the scope of this paper; however, while home health agencies could be a natural partner in managing care transitions, the perception exists that current federal requirements would prohibit their involvement.

Medical Culture and Operations

Neither the Coleman model nor the Naylor model explicitly addresses connecting recently discharged patients with social supports in the community. However, any number of non-medical issues can threaten a safe discharge to home, including shopping for food after discharge, driving to medical appointments, and the need for personal care services. The coordination of these services is generally thought to be the domain of social service agencies in the community. Yet, if these needs

are not met, the result can be as problematic as errors in medication reconciliation.

In general, medical providers and social service agencies have little understanding of each other's cultures. It is not uncommon for social service agency personnel to disparage the inadequate job that hospital discharge planners do, not recognizing that hospitals are not paid to follow patients after discharge. And, it is also not uncommon for medical personnel to feel frustrated with the constraints of social service agencies. In a hospital, a quick turnaround is often an hour, while for social service agencies with limited personnel a quick turnaround can be several days. Moreover, social service agencies may not be able to accept all the referrals that medical care providers send them. An additional challenge for hospitals is simply keeping an updated list of the myriad number of community agencies and the services they provide.

Neither care transitions model specifically addresses whether social service agencies that are already connecting people with services could be trained to "take the baton" and provide care transitions coaching. However, in some parts of the state, well-organized home and community-based service networks have stepped up to respond to their client's need for additional support following a discharge. The advantage of reaching out to non-traditional partners is embodied in the work of the San Francisco Homecoming Services Program. Led by the San Francisco Senior Center, this unique collaborative addresses care transitions for frail older adults returning home after hospitalization. Director Kathleen Mayeda pinpointed the reason for the program's success, "All the partners are at the table. We have hospitals, senior centers, In-Home Supportive Services, Meals on Wheels, etc. It is a true partnership."

CMS has taken a small step toward creating new models for collaboration between hospitals and social service agency through their Real Choice Systems Change and Aging and Disability Resource Center (ADRC)

grants. The purpose of the grants is to establish “person-centered” discharge planning and long-term community support models through partnerships involving hospitals, community organizations, patients, and caregivers. The ADRCs are dedicated to providing consumers with a one-stop entry for information and support—a benefit for hospitals trying to keep updated lists of community agencies. The ADRCs are also committed to improving the critical pathways between hospital and home for patients discharged to home or other community settings.

Legislatively, California has also recognized the need for improved care transitions and safe discharges. California Senate Bill 633 (Alquist, 2007) attempts to bridge the gap between hospitals and social service agencies by requiring hospitals to “provide every patient anticipated to be in need of long term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based, long term care options in the patient’s county of residence and appropriate to the needs and characteristics of the patient.”

It is always a challenge to make changes in an entrenched culture. Based on their experience, health care providers who were interviewed recommended that care transitions needs to be “someone’s job,” rather than an adjunct duty for someone employed within the hospital. If care transitions functions are an “add on,” it is all too easy for home visits to be skipped when duties within the hospital are pressing. And, successful implementers stressed the need to engage physicians and administrative leaders early and often.

Next Steps for California

Seemingly, the success of widespread dissemination of improved care transitions practices is dependent on having cost and payment for services all in the same place. Fortunately, diverse partners are starting to come to the table to explore how best to work together—hospitals

and health care systems, community organizations, professionals from all backgrounds and disciplines, patients and families, and government and public officials.

On the face of it, Medicare Advantage plans have an inducement to adopt improved care transitions practices. The data suggests implementing either of the two models will result in the reduction of member complaints and lowered readmission rates. Once the case is made, it is likely that implementation will naturally result. However, the prevalence of the delegation of risk in California muddies the incentive to put care transitions into operation. Whether the plan or the networks they contract with has the incentive to enhance care transitions will depend on the risk arrangements. One of our participants remarked “if you want a universal solution, you have to go to scale.” This suggests that on a case by case basis, managed care organizations or provider networks will invest in improved care transitions practices if they believe there will be a net savings.

Aligning incentives for Medi-Cal managed care is also tricky, either because the plans don’t manage the long term care benefit or they serve as the payment administrator of the state rate. Consequently, there is an incentive for plans to institutionalize the very members who would most benefit from improved care transitions protocols. However, there is considerable interest on the part of County Organized Health Systems and some Local Initiatives to manage the long term care benefit—which could, as one plan has stated, “be accomplished by the stroke of a pen.” Based on their experience as one of the participating organizations in the CHCF-sponsored pilot, San Mateo County has proposed the state add care transitions as a component of their Long Term Support Services Program (LTSSP). The plan’s intent is to keep members in the community and to ensure that the savings achieved by not institutionalizing a member could be used to enhance services provided to safely keep people at home—including enhanced care

transitions processes. Improving care transitions goes a long way to ensuring that older individuals and persons with chronic conditions can continue to be safe at home.

Despite the fact that hospitals continue to be paid for readmissions, there is interest in care transitions from the perspective of patient safety. Many hospital readmissions are preventable. Reducing in-hospital medication errors has also been of interest to hospitals seeking to improve patient care and reduce their associated liability. Medication reconciliation is a key component of improved care transitions.

The California Hospital Assessment and Reporting Taskforce (CHART) was established in 2004 to develop a statewide hospital performance reporting system. More than 220 of California's 359 acute care hospitals have chosen to participate in the voluntary effort that creates the data displayed on a consumer-friendly Web site. In addition, the California Hospital Association has established a patient safety organization that could permit the examination of care transitions on a statewide or regional level with the same peer review protections that an individual hospital currently receives. This suggests that on a regional basis, networks—which could include non-traditional providers of home and community based services—could implement improved care transitions protocols across settings and study the results.

Although none of the regulatory, operational, or fiscal issues are insurmountable; changing the payment policies for hospital readmissions is the key to widespread dissemination of improved care transitions practices.

Conclusion

Today's health care system is burdened with rising health care costs; limited resources; an aging population with a growing list of chronic conditions requiring months, years, and occasionally decades, of detailed care management; and a lack of coordination with the community from which it receives and returns its patients. With so many challenges, hoping that patients get the continuity of care they need won't make it so. Patients suffer when they don't have well thought out coordination of their care after discharge. And it has a negative impact on those beyond the patients—family members, hospitals and health systems, community providers, and government agencies, to name a few. In fact, the impact of inadequate discharge planning trickles down to society's fundamental infrastructure, adding to the health care crisis and the potential for a more serious degradation of our nation's health care system. For all these reasons addressing care transitions needs to be a priority.

ENDNOTES

1. Coleman, EA, *The Care Transitions Intervention, Archives of Internal Medicine*, 2006;166:1822–1828
2. Naylor, MD, "Transitional Care for Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial," *Journal of the American Geriatrics Society*, 2004; 52:675–684
3. Hartford Center of Geriatric Nursing. Transitional Care. 2005. www.nursing.upenn.edu/centers/hcgne/TransitionalCare.htm. Accessed August 17, 2008.