The Playbook: Better Care for People with Complex Needs
Care Transitions Intervention: Coaching Patients to Successfully Transition from Hospital to Home
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Nearly one in six Medicare beneficiaries returned to the hospital within 30 days after discharge in 2018, costing Medicare $15,500 on average, or $35 billion a year. Many of those readmissions were likely preventable, with experts blaming poorly executed transitions from the hospital. Researchers have found transitions-of-care interventions to be effective in reducing preventable admissions, improving health care quality and equity, and lowering spending.

Background

Eric Coleman, MD, of the University of Colorado Health Sciences Center, led the development of the 30-day Care Transitions Intervention model (CTI) under a five-year grant from the John A. Hartford Foundation in 2000. A number of subsequent studies have documented its effectiveness. Since then, Coleman and his colleagues trained thousands of Transitions Coaches at more than 1,100 organizations across the country and internationally through 2019.

Program Snapshot

- **Program:** Care Transitions Intervention
- **Populations:** Primarily people aged 55 and older who are freshly discharged from the hospital.
- **Goal:** Empower patients and their caregivers with knowledge that enables them to successfully recover and manage their future health while preventing unnecessary hospital admissions and emergency department visits and reducing costs.
- **Key Features/Results:** Transitions Coaches educate and guide patients and caregivers through the transition from hospital to home via in-person visits and phone calls for 30 days post-discharge.

Care Coordination Systems Health (CCS Health), a software technology company focused on bettering community-based care coordination, acquired CTI in 2019 when Coleman retired. CCS Health added a software tool called CTI+ to help CTI providers document and coordinate the work of Transitions Coaches.

CCS Health currently works with more than 150 CTI program providers active in 35 states plus Australia, Canada, and Iran, according to Michelle Comeau, vice president for the CTI program. They provide interactive online training for an average of 60 Transitions Coaches each month. These coaches work for hospitals, area associations on aging, health insurance plans, home health agencies and organizations serving marginalized communities, with 40% of the program providers working in the aging services network.

"When new organizations want to conduct CTI in their local area, we go through a readiness assessment with them to understand the organization's goals," Comeau said. "We work with that organization to make sure they are meeting their goals while maintaining fidelity to our evidence-based program."

After the initial training, CCS holds monthly community learning calls and advanced learning opportunities for CTI program providers, "to keep everyone shined up on the philosophy of CTI," she said.

Intervention

The philosophy is to empower people and set them up for success on the 31st day.

The CTI program involves having a full-time Transitions Coach work with a patient with complex care needs and his or her family caregiver to develop self-management skills that will ease the transition from the hospital to the home. The coaches have varied training and backgrounds, including registered nurses, social workers, occupational therapists, community health workers, and case managers.

"They don't need a formal clinical background, but they need to understand how to navigate health systems and where to go to find good information," Comeau said. "The coach is always asking the patient and caregiver, 'What do you know, and who do you know? Let's get that person on the phone.'"

The program starts with a visit by the Transitions Coach with the patient in the hospital, at which time the coach introduces the program. The focus is on what CTI calls the "Four Pillars®" – medication self-management, the personal health record, timely primary and specialty care follow-up, and knowing how to respond to red flags indicating a worsening of the patient's condition.

The coach gives the patient and caregiver a personal health record pamphlet for recording the patient's individualized health information and instructions following discharge. Ideally the coach then visits the patient and caregiver at home within the first three days after discharge, and reviews the personal health record with them. After the home visit, the coach makes three weekly phone calls to follow up on the patient's progress. The case is closed after the third call, 30 days after discharge.

"The philosophy is to empower people and set them up for success on the 31st day," Comeau said. She stressed that the Transitions Coach role is separate though complementary to the role of hospital discharge planners and standard care team members (e.g., case managers, visiting nurse, etc.).

The coach works closely with the patient and/or caregiver on medication self-management, because failure to accurately follow medication regimens is a major cause of hospital readmission. The coach encourages the patient to plan for and record details of any activity he or she might reasonably be able to resume after 30 days, such as gardening or attending a

family event. The coach reminds the patient about follow-up medical appointments and can assist in arranging transportation. And the coach helps the patient develop an action plan if he or she experiences a medical setback.

Lynn Schemmer-Valleau, community services program manager at the Multnomah County Aging, Disability & Veterans Services in Portland, Oregon, described a recent successful CTI case handled by Jenny Rechel, one of her agency's five Transitions Coaches. The husband of a hospitalized patient initially refused CTI help, but then his wife returned to the hospital, and he accepted help the second time it was offered.

The patient had kidney disease, congestive heart failure, and Type 2 diabetes. Her husband didn't fully understand her conditions or how to manage her care, but he was embarrassed to ask questions and look dumb, Schemmer-Valleau said. Through a home visit and follow-up phone calls, Rechel encouraged the couple to ask questions of the physicians and take notes. She helped them identify resources such as home-delivered meals, transportation programs, local senior center activities, and home-delivered library books.

"The patient successfully graduated and is doing much better. She wasn't readmitted to the hospital during the 30-day period," Schemmer-Valleau said. "The husband was so appreciative that Jenny helped him feel empowered and ask questions at the primary care visit without his feeling dumb."

Implementation

Each local CTI provider organization does things a little differently, with its own implementation, targeted patient population, and referral mechanisms, Comeau said.

CTI providers generally don't work with patients who have cognitive issues if they lack a caregiver, because they can't necessarily learn new skills, Comeau said. They also don't work with patients in the throes of a substance use disorder who aren't ready for a personal empowerment program, she explained.

A common arrangement is for Area Agencies on Aging (AAAs) to operate CTI programs and receive referrals from hospitals or health plans. Some AAAs have contracts with hospitals or health plans that pay for the work of the Transitions Coach, while others receive funding through the Older Americans Act or foundation grants. In addition, some health plans, home health agencies, community-based organizations, and educational institutions employ their own Transitions Coaches to serve patients or members.

Prior to the COVID-19 pandemic, all CTI home visits were done in-person. Since the phase-out of the health emergency, CTI providers have gradually returned to in-person visits, though some continue to use a mix of in-person and telephonic visits. "Medication reviews and engaging patients are more challenging with telephonic delivery," Comeau said. "That's been a learning curve."

In the Portland metro area, AAAs in Multnomah, Yamhill, and Washington Counties have a paid contract with the Providence Health & Services to serve discharged patients at five Providence hospitals.

Two CTI case-finding coaches pore through the electronic health record data to find Providence's Medicare Advantage and traditional Medicare patients who are being discharged, as well as other discharged Providence patients who have high-risk diagnoses that Providence has targeted, Schemmer-Valleau said. Those diagnoses are congestive heart failure, diabetes, kidney failure, high blood pressure, chronic obstructive pulmonary disease, sepsis, and total joint replacement of the hip or knee.

Before discharge, the case-finding coaches visit the selected patients, preferably with their family caregiver, in the hospital to explain the program and enroll the patient, with an 88% success rate. Then the five home-visit coaches follow up with the patients at home and via phone calls. Each Transitions Coach conduct three to five in-person home visit a week. The Portland-area CTI program works with a total of about 530 Providence patients a year, she said.

An important role for the coaches has been working with Providence to ensure that patients receive timely appointments for primary and specialty follow-up care, which have lagged since the COVID-19 pandemic began.

"There's a shortage of staff, and patients just can't get in. Everyone's experiencing that," Schemmer-Valleau said. "But that's pretty dangerous when a patient needs a medication adjustment. We've been able to loop back with Providence and give them feedback, letting them know when patients haven't had follow-up appointments scheduled."

All the Portland-area coaches are part of the Aging and Disability Resource Connection network, helping them point patients toward community resources including nutrition and exercise.

In 2021, using county funding, Multnomah County Aging, Disability & Veterans Services piloted a new CTI program focused on communities of color that experience greater disparities in health and higher hospital readmission rates, Schemmer-Valleau said.

Her agency hired a person of color as the Transitions Coach to serve patients discharged from Providence Portland Hospital, many of them Medicaid beneficiaries. Unlike the classic CTI model, the coach continued to work with those patients beyond 30 days.

That program ended due to time-limited funding. "We learned a lot from our pilot and we'd love to offer that service, including the ongoing support beyond 30 days," she said.

Impact

For every dollar invested, we saved them $2.23. That's a good return on investment.

Traditional Medicare patients discharged from six Rhode Island hospitals who participated in the CTI program were about 30% less likely to be readmitted to the hospital within six months

than patients who didn't participate, a 2014 study published in the Journal of General Internal Medicine found.

The CTI intervention group in that study had significantly lower average readmission costs and total health care costs for the six months post-discharge. The average gross savings per patient were $3,752, subtracting the average intervention cost of $298.

A 2019 case report published by the Virginia Center on Aging found that the 30-day hospital readmission rate for traditional Medicare beneficiaries in the Richmond area was 18.4% in 2015. But beneficiaries in that area who completed the CTI program had sharply lower readmission rates of 5.4% in 2016-2017, 7.9% in 2017-2018, and 6.9% in 2018-2019.

There also are other models for transitional care programs that have been shown to be effective, according to a 2018 review of such programs published in JBI Database Systematic Reviews and Implementation Reports.

In 2014, Avalere analyzed five widely adopted care transition/care coordination models including CTI, Geriatric Resources for Assessment and Care of Elders, Project RED (Re-Engineered Discharge), and the Transitional Care Model. Based on 2012 data from the traditional Medicare program, Avalere found that the return on investment from implementing these models ranged from 32% to 607%, and the per-member per-month savings ranged from $10 to $343.

Avalere reported that the CTI model produced annual savings per beneficiary of $2,311 and per-member per-month savings of $109, with an annual cost of $999 and a return-on-investment of 131%.

Schemmer-Valleau said that since the Providence contract began in 2016, the 30-day readmission rate for patients who complete the CTI program has been around 11%, compared with an expected rate of 16% for patients without the intervention.

Based on the difference between the expected and actual readmission rate, the CTI program prevented 57 readmissions in 2021. Given the average readmission cost of $13,800, gross savings totaled $786,600. Providence paid the AAAs $243,000 to provide the CTI services.

"We saved them $543,600 net, and that's conservative," Schemmer-Valleau said. "For every dollar invested, we saved them $2.23. That's a good return on investment."

Insights

Following are key program lessons:

CTI can be valuable both for patients with or without strong financial and social resources.

CTI can benefit patients who are under-resourced and lack social supports, for instance, congestive heart failure patients who lack a scale at home for weighing themselves and spotting

worrisome weight changes, Schemmer-Valleau said. But it also can help well-resourced patients with strong social supports.

“When the discharge plan is discussed in the hospital, you’ll agree to anything because you just want to go home,” she said. “But when you get home, you realize you are supposed to do something. We hear time after time from patients who initially were reluctant to have the transitions coach come to their home that they got useful information that made them feel so much more in control of what’s going on.”

Ad hoc transitions efforts that don’t follow the evidence-based model are not as effective as CTI.

Some organizations try to take elements of the CTI model and do it themselves, without the formal CTI staff training. They may assign the transitions coaching work to navigators or discharge planners who have other duties.

“When someone is already engaging with the patient on other things, the waters get muddy and the impact is not as great,” Schemmer-Valleau said. “The beauty of our program is that our coach is there just to focus on the patient, identify red flags, understand the patient’s medications, look at their resources, and identify the people to whom the patient can go to with questions.”

“Some health systems think a simple phone call within a week after discharge is sufficient,” Comeau said. “CTI’s philosophy goes deeper than that, to look at long-term behavior change.”

CTI programs need a champion in the leadership of the hospital or other sponsoring organization.

“A critical part of [CTI’s success] is having a hospital champion, someone inside, behind the scenes, who really gets it and makes the pitch,” Schemmer-Valleau said. “At Providence we have an amazing hospital champion. We’re funded through their population health program. Providence is very invested in looking at our data and supporting us in having good outcomes.”

Acknowledgments

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Author Harris Meyer is a freelance journalist who has been writing about health care policy and delivery since 1986.

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