Practices to Improve Transitions of Care:
A National Perspective

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Improving transitions of care has significant importance to our health care system. While care transitions has been studied and researched by many individuals over the past 20 years, more work is needed to further improve the process. Those beginning to focus on transitions need not begin from scratch, but can use information and research from national and regional collaborative models, as well as other tools and resources to enhance the quality of transitions programs.

The National Transitions of Care Coalition (NTOCC) was organized nearly seven years ago with a goal of improving transitions of care in the health care industry. The Coalition is comprised of more than 30 national organizations and professional associations working together to address the gaps and barriers associated with poor transitions of care by providing tools and resources to providers and consumers to improve the transition of care process. NTOCC supports over 4,500 subscribers, 500 associate members, and 83 countries through its Web site and dissemination processes.

Over the past 7 years, NTOCC has developed and brought to the health care market extensive tools and resources for providers, consumers, legislators, and the media about transitions of care. These resources can be found on the NTOCC Web site (http://www.ntocc.org). To achieve the development and implementation of the resources offered through NTOCC, 5 major workgroups were developed that included providers, regulators, and consumers. All the work completed by the workgroups is presented to the Advisory Council and consensus among the members is required prior to posting the resources on the NTOCC Web site.

The work of NTOCC is provided to the industry at no cost, and to encourage its use the Coalition does not copyright or trademark any of it. Individuals and companies may adapt the work to address the specific critical health issues they are facing. Among those resources are publications including, a Patient Bill of Rights During Transitions, Taking Care of My Health Care, My Medicine List (for consumers and for providers), Transition of Care Checklist, and How to Evaluate and Implement a Plan. The most frequently used tools from the NTOCC website are How to Implement and Evaluate a Plan (with 148,000 downloads) and My Medicine List with (76,000 downloads). Several hospitals have reported using the consumer tools and engaging patients in monitoring and tracking their medications.

The most recent resource published on the Web site is the Transition of Care Compendium. The Compendium contains a collection of white papers, journal articles, and Web sites that contain resources that both professionals and consumers might find useful in a practice or medical situation. Tools and resources developed by NTOCC are highlighted for each component of transition. Also included in the Compendium is the newly developed tool called the "Care Transition Bundle - Seven Essential Intervention Categories and Crosswalk," created to help meet the demand for essential elements and intervention data. The Care Transition Bundle identifies the following essential intervention categories to improve transitions of care: medication management, transition planning, patient and family engagement/education, information transfer, follow-up care, health care provider engagement, and shared accountability across providers and organizations. The Crosswalk brings together evidence-based models created by health care leaders from across the US and addresses personnel, setting and length, type of patient, interventions tools, findings/results/cost, and publication/author information. (The Compendium is available at: http://www.NTOCC.org/Compendium.)

Within the Compendium are journal articles on promising practices in transitions of care and reviews of tangible savings from transitions of care models. The following information is from the Improved Transitions of Patient Care Yield Tangible Savings document located on the NTOCC website: [1]

The Care Transitions Intervention (CTI), developed by Dr. Eric Coleman, is a program that gives patients with complex care needs and family caregivers specific tools, and allows them to work with a transitions coach to learn transition-specific self-management skills. This investment in self-care pays dividends downstream as individuals who were involved in the CTI model were less likely to be readmitted

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within six months of hospitalization than those who did not receive the intervention. The anticipated cost savings of one transitions coach (responsible for 350 chronically ill adults), after an initial hospitalization and over a period of 12 months, is $330,000 [2]. The total annual intervention costs an average of $196 per patient. The CTI has been adopted by over 470 organizations in 37 states nationwide including hospitals, health plans, home health care agencies, Area Agencies on Aging, accountable care organizations, parish nurse programs, and large physician practices. The California HealthCare Foundation sponsored implementation of CTI, and saw that intervention patients experienced lower rehospitalization rates at 30 days and also at 90 days when compared to the control group [3]. In Rhode Island, the CTI reduced the hospital readmission rate from 20.0% to 12.8% [4].

The Transitional Care Model (TCM), developed at the University of Pennsylvania and spearheaded by Mary Naylor, PhD, RN, establishes a multidisciplinary team, led by a master's prepared transitional care nurse (TCN), to treat chronically ill high-risk older patients before, during, and after discharge from the hospital. Significant reductions in total health care costs (ie, hospital, home health, physicians) after accounting for the additional costs of the intervention have been demonstrated in a number of multi-site, NIH-funded randomized clinical trials. In one study that tested the TCM with Medicare enrollees hospitalized with common medical and surgical conditions, total health care savings for intervention vs. control patients at 24 weeks were $3,000 per patient ($3,630 vs. $6,661) [5]. In a second study targeting older adults hospitalized with heart failure, the average savings at 52 weeks for intervention vs. control patients were $5,000 per patient ($7,636 vs. $12,481) program [6]. The improvements in quality demonstrated in these studies, coupled with health care savings, contributed to the selection of the TCM as a top-tiered evidence-based approach by the Coalition for Evidence-Based Policy [7].

The Guided Care Model, developed at Johns Hopkins University, is led by a highly-skilled guided care nurse (GCN) who coordinates care for chronically ill patients. After one year into a randomized controlled trial, Guided Care patients experienced, on average, 24% fewer days in hospital, 37% fewer skilled nursing facility days, 15% fewer emergency department visits, and 29% fewer home health care episodes, as well as 9% more specialist visits [8]. Although these reductions were not statistically significant, they are consistent with an annual net savings of $75,000 per nurse or $1,364 per patient [8]. After the second year of the trial, home health care episodes were significantly reduced (by 30%), but other differences were not statistically significant [9].

Project Re-Engineered Discharge (RED) was developed and launched by Dr. Brian Jack at Boston University Medical Center and further refined with the help of Dr. Timothy Bickmore at Northeastern University. Project RED focuses on a standardized discharge process to ensure patients are prepared when leaving the hospital. In 2008, a randomized controlled trial found that patients who utilized Project RED experienced a 30% lower rate of hospital utilization 30 days post discharge and that readmission or emergency department visit was prevented for every 7.3 subjects receiving the intervention. Additionally, patients who received the intervention incurred 33.9% lower costs than those who did not receive intervention, translating into a savings of $412 per person [10].

Home-Based Primary Care (HBPC), a national program managed by the US Department of Veterans Affairs, provides primary care and care coordination in home for patients with complex, chronic, and progressive diseases. In 2002, veterans enrolled in HBPC experienced a 63% decrease in hospital spending, and in 2008 there was a nearly 24% reduction in 30-day readmission rates. Additionally, newly enrolled veterans had 68% fewer inpatient bed days of care, including 44% fewer hospital bed days of care [11].

Geriatric Resources for Assessment and Care of Elders (GRACE), a program being piloted by Indiana University, is a physician/practice-based care coordination model conducted over the long-term that requires a nurse practitioner and social worker to offer in-home assessment and care management. A randomized controlled study of GRACE indicated the total annual intervention costs for high-risk patients to be $315,040 ($1,432 per patient) [12]. The study concluded the intervention to be cost-neutral for high-risk patients due to reductions in hospital costs.

Project BOOST (Better Outcomes for Older Adults through Safe Transitions), developed by the Society of Hospital Medicine, provides hospitals with project management tools and expert mentoring to improve the discharge transition process and decrease readmissions. Entities that have implemented the BOOST program have seen significant decreases in patient readmission rates. For example, a hospital in St. Louis, Missouri decreased its 30-day readmission rates by nearly 42% after implementing BOOST [13]. Implementation of BOOST at a hospital in Atlanta, Georgia lead to lower rates of mortality, and 30-day readmissions rates dropped from 25.5% to 8.5% for those under age 70 [14].

NTOCC has continued to bring education and awareness within the industry about transitions of care through its speaker bureau that provides a significant number of presentations to practitioners, hospitals, payers, and community organizations throughout the continuum of care. The Coalition will continue to work on public policy issues regarding the improvement of transitions of care as defined in the provisions of the Patient Protection and Affordable Care Act on improving quality and reducing health care cost. NTOCC's work will address issues of reducing preventable hospital readmissions, creating community-based transition teams, and supporting the development and implementation of accountable care organizations and patient-centered

medical homes. Success in these programs is largely focused on improving care coordination and transitions for patients as they move through the continuum of care.

Changing and improving transitions of care is about delivering services and interventions in a patient-focused model of care that truly integrates the patient and family as part of the clinical team and demands accountability from providers for bidirectional communication and information transfer. Achieving this requires more than providing new tools and resources or better health information technology; it is a commitment to building strong care teams, changing cultures, and changing individual behaviors. Providers cannot accomplish this by themselves, but by working together as a team with other providers, payers, and community agencies they can and will make a difference for patients and family caregivers, improve the quality of care they deliver, and lower the cost of that care. NTOCC seeks to send that message clearly as we move forward in improving transitions of care. NCMJ

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