

“Person-Centered Models for Assuring Quality and Safety
During Transitions Across Care Settings.”

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Bring Older Citizens Back into the Heart of Society Approaches.”

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Good morning. My name is Dr. Eric Coleman and I am a professor of medicine and a practicing primary care geriatrician based at the University of Colorado. I thank you for inviting me to participate in this important hearing dedicated to promoting greater person-centered care.

We have heard earlier in this hearing how the Green House model and the Medical Home model offer great promise for assuring person-centered care in long-term care and in outpatient care respectively. I would like to submit before the Committee that these models are particularly suited for persons whose medical conditions are primarily in a stable or steady state. Inevitably, many of these persons will experience a worsening or exacerbation of their medical conditions or a sudden traumatic event that requires a transfer to settings such as an emergency department or a hospital.

These transfers are often referred to as transitional care, the area of health care that is primarily concerned with the relatively brief time interval that begins with preparing a patient to leave one setting and concludes upon being received in the next setting. Transitional care poses challenges that distinguish it from other types of care. Many transitions are unplanned, result from unanticipated medical problems, can occur at all hours of the day or night as well as on weekends, involve clinicians who may not have an ongoing relationship with the person, and happen so quickly that even the most dedicated health care professionals and family caregivers are not able to respond in a timely manner. As a result, these persons are largely unprepared for what transpires and are often uncertain about their role.

Poorly executed care transitions can confound our best attempts to provide person-centered care. The excellent care provided by a Green House or Medical Home can quickly unravel as the individual is whisked out the door to an unfamiliar care setting. Despite our professional advantages, many of us in this room today have unfortunately learned from personal experience that health care delivery has become increasingly fragmented and lacks effective mechanisms to ensure continuity and coordination of care across settings.

As director of the Care Transitions Program I have devoted my career to ensuring quality and safety for persons at the time of care transitions or the “hand-offs” that occur as persons transfer from one care setting to the next. These settings may include hospitals, skilled nursing facilities, outpatient clinics, assisted living facilities and private residences. Over the past decade, we have learned three key lessons that are particularly relevant to our proceedings this morning:

1. Care transitions occur with astounding frequency and variability. For example, a nationally representative sample of Medicare beneficiaries discharged from the hospital experienced 46 unique care patterns in just 30 days.

2. Care transitions represent a highly vulnerable time for errors that compromise quality and safety. Our research has found that over 40 percent of older adults transferred out of the hospital experience at least one medication discrepancy.
3. By default, patients and their family caregivers have become the silent care coordinators, performing a significant amount of their own care coordination with no specific preparation, tools, or support.

Yet the challenges to providing person-centered care during care transitions can be overcome. With the generous support of the John A. Hartford Foundation, our Care Transitions Program has developed and disseminated the Care Transitions Intervention model to 128 of the nation's leading health care organizations.

What is the Care Transitions Intervention?

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

What Is the Evidence that the Model is Effective and Reduces Health Care Costs?

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, the investment in imparting self-management skills pays dividends long after the program ends. Annually, a single Transitions Coach can manage at least 350 chronically ill hospitalized adults. During this time, the model produces a conservative net cost savings of \$300,000 per Transitions Coach. In keeping with the goal of promoting true person centered care, participants who received this program were more likely to achieve self-identified personal goals around symptom management and functional recovery.

What Makes the Care Transitions Intervention Unique?

In contrast to traditional case management approaches, the Care Transitions Intervention is a self-management model. The Care Transitions Intervention represents a truly person-centered care model as it was developed with direct input from patients and family caregivers who contributed to the overall design. Using qualitative techniques, the Care Transitions Program worked directly with older adults and their families to identify the key self-

management skills needed to assert a more active role in their care. Next a Transition Coach was introduced to help impart these skills and help the individual (and the family caregivers) become more confidence in this new role. Although critics are quick to point out that this is only applicable to highly educated or motivated patients, our experience has shown that most patients and family caregivers (including those from diverse backgrounds) are able to become engaged and do considerably more for themselves during transitions. 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 Coach signed off, these patients continued to remain out of the hospital, demonstrating a sustained effect from investing in a self-care approach.

What Are the Four Pillars?

The intervention focuses on four conceptual domains referred to as pillars, which were directly informed by qualitative studies of older adults and their family caregivers:

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

Who Supported the Development of the Model?

The John A. Hartford Foundation and The Robert Wood Johnson Foundation

Where Can I Learn More About the Model?

The Care Transitions Intervention is in the public domain and there are no licensing fees. 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. You may contact Eric Coleman, MD, MPH, via email Eric.Coleman@uchsc.edu.

What Are the Barriers to Further Dissemination?

Although demand for the Care Transitions Intervention continues to grow, the primary barrier to making this model available to all Americans with chronic and complex care needs concerns the lack of financial support for self-management. We must realign our approach to Medicare reimbursement to support new self-care models that have been proven to improve outcomes, reduce health care costs, and promote greater person-centered care.

Two Innovative Approaches to Promoting Greater Person-Centered Care

Next I would like to highlight two additional innovative approaches to promoting greater person-centered care through greater support of family caregivers. Family caregivers are often the first and last line of defense when it comes to ensuring patient quality and safety. They are the “glue” that keeps care from unraveling and they are frequently the ones who complete tasks left undone by health care professionals. One cannot consider person-centered care or transitional care without prominently underscoring the essential but largely unrecognized contributions of family caregivers.

United Hospital Fund’s “Next Step in Care”

Family caregivers are often responsible for coordination of a loved one’s care after hospital or nursing home discharge, and when formal home health care services end. Yet they are rarely trained to provide care or included in transition planning. Next Step in Care is a multi-year campaign created by the United Hospital Fund in New York City under the leadership of Carol Levine that will launch in the Fall of 2008. The goal of Next Step in Care is to change professional practice and improve patient transitions by helping family caregivers and health care professionals work more effectively together. The program stresses careful planning, clear communication, and ongoing coordination as patients are admitted to and discharged from hospitals, rehabilitative settings, and home health care agencies. The Next Step in Care program offers free, easy-to-use, web-based practical guides, checklists, and other materials for both family caregivers and providers. For example, the new website, nextstepincare.org, will have guides to medication management, hospital discharge planning, home care, and rehabilitation, as well as a unique tool for family caregivers to assess their own needs after discharge.

National Family Caregivers Association’s Comprehensive Care Benefit

The National Family Caregivers Association (NFCA), under the leadership of Suzanne Mintz, has issued a policy statement outlining a comprehensive care coordination benefit that targets the most expensive Medicare’s beneficiaries and their family caregivers. NFCA maintains that family caregivers and their loved ones must have affordable, readily available, high quality and comprehensive services that are coordinated across all care settings. NFCA has termed transitions “no-care zones”. The most complex and expensive of Medicare’s beneficiaries need the services of a patient/family advocacy and navigator team. Although there

is no consensus on the definition of navigator as it applies to healthcare, the NFCA envisions this team being comprised of nurses, social workers, and others as deemed appropriate, that are assigned to patients and their primary family caregiver who meet certain established criteria. The team would stay with the patient and their primary caregiver as long they continue to meet the established criteria so they may assist that patient/caregiver during periods of crisis, transition, and also stasis to help ward off further crises

Person-Centered Care Requires Greater Accountability On Behalf of Professionals.

The majority of my testimony has focused on innovative strategies for supporting patients and family caregivers become more active participants in their health care towards achieving better outcomes. However, investing in such approaches does not obviate the responsibility of health care professionals to become more responsive to the needs of persons undergoing care transitions. Greater alignment of financial incentives through bundled payment approaches as described by the MedPAC commission is an important step in this direction. Further, health care professionals need to be more engaged in the process of defining and assuring accountability for persons undergoing transitions. The ABIM Foundation, in partnership with nine physician professional organizations has launched a national effort entitled, “Stepping Up to the Plate” that has made real progress in this regard.