# Improving Care Transitions

## California's 10-Site Care Transitions Intervention Project

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# Improving Care Transitions Project Framework

- 12-month pilot of the Care Transitions Intervention (CTI)
- Ten sites were selected via a request for proposal process
- Sites were required to work in a hospital (sender) and community-based organization (receiver) team

- Five were hospital-led, and five were county-led
- Each site was expected to enroll 100 patients
- Pilot was sponsored by the California HealthCare Foundation

# Project Objectives

- 1) Implement CTI in different settings with various sender-receiver partnerships;
- 2) Build a learning collaborative among the grantees; and
- 3) Evaluate the efficacy of the intervention as well as opportunities for sustainability and wider implementation.

# Project Tools & Data Measures

- **Tools:**
  - The Personal Health Record (PHR)
  - The Medication Discrepancy Tool (MDT)
- **Measures:**
  - The three-item Care Transitions Measure (CTM-3)
  - The Patient Activation Survey (PAA)

# Data Collection Tools

- Excel Registry
- Excel Spreadsheet (with CTM-3, PAA, and brief list of demographics)

# Achieving Project Objectives: Implementing CTI in Diverse Settings

- Site teams reflected considerable diversity in their partnership arrangements, targeted patient populations, and Transition Coaches.
- Transition Coaches were nurses (including student nurses), social workers, trained layperson volunteers, and experienced community workers.

# Achieving Project Objectives: Build a Learning Collaborative

- Grantees participated in:
  - Pre-project Transition Coach training,
  - Monthly conference calls
  - Mid-project and final grantee meetings.
- Monthly conference calls addressed topics such as Transition Coach responsibilities and challenges; data collection; patient enrollment and referral; and, research and evaluation.

# Achieving Project Objectives: Grantee Feedback

- Engage hospital and community-based leaders, early and often; develop CTI champions;
- Provide more pre-project Transition Coach training and simulation; and,
- Assign consistent and dedicated (funded) Transition Coaches with nurses and social workers working in tandem, supported by a strong project manager

# Achieving Project Objectives: Sustainability

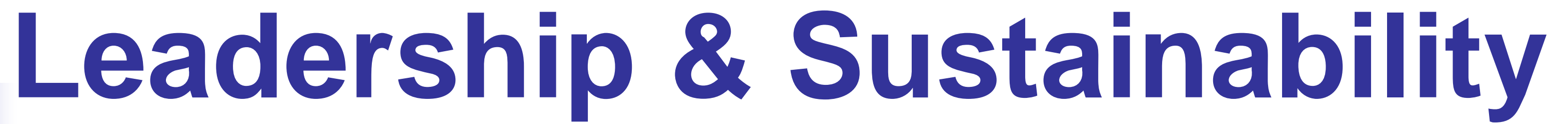
- Three sites reported plans to fully sustain the model going forward.
- Three sites indicated plans to partially continue the intervention, defined as continuing with two or more of the pillars with, possibly, some transition coaching.
- Four sites reported no formal sustainability plans but did indicate they would encourage their respective organizations to employ, in a minor fashion, incorporating one or more of the four pillars into their daily workflow.

# Sustainability Factors

- Attributes likely to influence sites’ capacity to continue the project:
  - 1) The presence of executive leadership support for the CTI or the presence of a CTI champion, at either the sender or receiver organization or both;
  - 2) Dedicated (funded) and consistent Transition Coaches
  - 3) Effective and strong project management leadership;
  - 4) Site team commitment to the CTI; and
  - 5) a viable sustainability plan.

# Leadership Scores Sustainability Findings

- The presence of executive leadership support for CTI or the presence of a CTI champion, and an effective project management leader, represented the two variables likely to influence sites' capacity to continue the project.
- Sites were assigned a leadership score based on these attributes



# Leadership & Sustainability

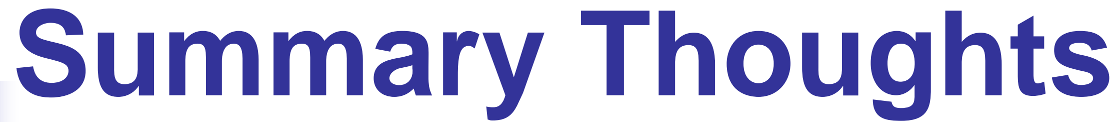
- The three project sites with *full* sustainability plans received the highest total leadership scores.
- The three sites indicating *partial* plans to continue with the project all scored similarly, with lower total leadership scores.
- Four sites with *minor* plans to continue with the project, the presence of external (executive leadership) and internal (project management leadership) support for the project was less developed.

# Key Data Findings

- Medication management, e.g., knowing what medications to take, when and how to take them, their purpose, and possible side effects, was identified as a challenge for patients.
- Downward trend in mean PAA scores for patients managing cardiovascular and diabetes diagnoses, patients over the age of 85, and Latino and African-American patients.

# Additional Data Findings

- The hospital-led group reported slightly higher PAA means than the county-led sites.
- Sites with full plans for continuation presented with modestly higher PAA means than for sites with partial or minor plans.



# Summary Thoughts

- The *Improving Care Transitions Project* highlighted the importance of:
  - Strong care transitions leadership;
  - Collaborative hospital-community partnerships;
  - Addressing the needs of diverse communities;
  - Patient-level medication reconciliation and management; and,
  - Tailoring the model to the unique needs of patients with cardiovascular conditions and diabetes.

# Post-Project Findings

- **<u>Sustainability</u>** - *five sites employing full model CTI; five employing CTI in minor way (incorporating one or more of the pillars) or not at all*
- **<u>Value of Four Pillars and CTI Stages</u>** -*Four pillars are patient-centered and effective; they should not be altered*

# Post-Project Findings

- **Patient Stratification** - *Sites no longer endorsed an up-front stratification strategy, preferring instead that eligible patients be offered the opportunity to participate in the CTI and then directed to tiered services and programs as needed*
- **Patient Targeting** - *majority of sites support offering the CTI to patients of all ages with chronic illness and/or comorbidity*