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Key note abstract

Encouraging patients and family caregivers to assert a more active role during care hand-offs: The Care Transitions Intervention™

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Abstract

What is the model: During a 4-week program, patients with complex care needs and family caregivers receive specific tools and work with a 'Transitions Coach,' to learn self-management skills that will ensure their needs are met during the transition from hospital to home. This is a low-cost, low-intensity intervention comprised of a home visit and three phone calls.

What makes this model unique: In contrast to traditional case management approaches, the Care Transitions Intervention is a self-management model. The Care Transitions Program has modeled national Medicare data sets to demonstrate the frequency with which older adults making care transitions across settings will experience another transition in the near future. In other words, for most of these individuals, there will be a 'next time'. Using qualitative techniques, the Care Transitions Program worked with older adults 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 caregiver become more confident in this new role. Although critics are quick to point out that this is only applicable to highly educated or motivated patients, our studies have shown that most patients and family caregivers are able to become engaged and do considerably more for themselves.

In essence, the model involves making an investment in helping patients and family caregivers become 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 coaching.

The intervention focuses on four conceptual domains referred to as pillars:

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

What are the key findings: 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, imparting self-management skills pays dividends long after the program ends. Anticipated net cost savings for a typical coach panel of 350 chronically ill adults with an initial hospitalization over 12 months is USD$ 295,594. Patients who received this program were also more likely to achieve self-identified personal goals around symptom management and functional recovery. To date more than 160 organizations have adopted the care transitions intervention.

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Where Can I Learn More?: Please visit www.caretransitions.org or email: Eric.Coleman@ucdenver.edu

Keywords

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Keynote presentation