UNIVERSITY OF COLORADO AT DENVER AND HEALTH SCIENCES CENTER

News

UNIVERSITY OF COLORADO HOSPITAL

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Care Transitions Intervention Reduces Medical Bills

DENVER (Sept. 25, 2006) – Patients who require treatment in multiple sites of care may now be able to reduce their hospital bills and rates of re-hospitalization, according to a study that will appear in the Sept. 25 issue of the *Archives of Internal Medicine*.

The trial was led by Eric Coleman, MD, an associate professor at the University of Colorado at Denver and Health Sciences Center's School of Medicine, and conducted through its Division of Health Care Policy with the support of The John A. Hartford Foundation of New York.

The Care Transitions Intervention helps patients receive better care by encouraging them to assert a more active role in their health care. Patients receive specific tools and skills that are reinforced by a 'transition coach' who follows patients across settings for the first 30 days after leaving the hospital. Coleman and his colleagues found that patients who participated in the intervention were less likely to require re-hospitalization, significantly cutting their health care costs. These findings are particularly pertinent to older individuals with complex care needs.

While the intervention yielded immediate results, the skills acquired by the patient also had long-term positive effects. "We were excited to see the significant reduction in hospital readmissions during the first 30 days while the coach was involved. What was even more exciting, however, was the finding that these patients were significantly more likely to stay out of the hospital up to six months later," Coleman said.

The transitional period between sites of care is an especially vulnerable time for patients, often characterized by conflicting medical advice, medication errors and a lack of follow-up care. These factors diminish the quality of care, thus necessitating additional treatments that might have been avoided. The intervention is designed to target these problems and ease the transition between care sites.

Coleman described the care transitions intervention as "truly patient-centered care." The transition coach works with patients and their families to improve care in four areas, referred to as "pillars": medication self-management, the creation of a personal health record maintained by the patient, obtaining timely follow up care and developing a plan to best seek care if particular target symptoms arise. Each of these goals allows the patient to actively enhance the quality of care received.

"Despite the fact that these older individuals were recovering from their acute hospital stay, were sleep deprived and dealing with changes to their health status, they were able to learn new skills to ensure their needs were met during this vulnerable time," Coleman said.

Beyond the benefits to the patient, the intervention lowers costs for Medicare providers who would otherwise finance the re-admissions to hospital. Because the intervention opens beds for other patients, hospitals may benefit financially. Researchers estimate that for every 350 patients who receive the intervention, hospital costs will be reduced by approximately $300,000.

The intervention was designed to be low intensity and low cost. The first meeting between the patient and transition coach was held in the patient's home and focused on reconciling the patient's medication, teaching effective communication skills and even role-playing. The remaining contacts between the coach and the patient were conducted by telephone and were designed to reinforce the four pillars.

The universal benefits of this program have led to its rapid spread. Coleman said, "There has been great demand for this model of care. We have successfully implemented the Care Transitions Intervention in more than 12 leading healthcare organizations nationwide."

A more detailed description of the care transitions intervention, along with a free training video and manual, are available online at www.caretransitions.org

Founded in 1929, the John A. Hartford Foundation is a committed champion of training, research and service system innovations that promote the health and independence of America's older adults. Through its grantmaking, the Foundation seeks to strengthen the nation's capacity to provide effective, affordable care to this rapidly increasing older population by educating "aging-prepared" health professionals (physicians, nurses, social workers), and developing innovations that improve and better integrate health and supportive services. The Foundation was established by John A. Hartford. Mr. Hartford and his brother, George L. Hartford, both former chief executives of the Great Atlantic & Pacific Tea Company, left the bulk of their estates to the Foundation upon their deaths in the 1950s. Additional information about the Foundation and it programs is available at www.jhartfound.org.

The University of Colorado at Denver and Health Sciences Center is one of three universities in the University of Colorado system. Located in Denver and Aurora, Colo., the center includes schools of medicine, nursing, pharmacy, and dentistry, a graduate school and a teaching hospital. For more information, visit the Web site at www.uchsc.edu or the UCDHSC Newsroom at http://www.uchsc.edu/news.

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