Care transition support

Intervention in brief

High and rising risk:	**Care transition support** includes services that help ensure patient care is maintained when the patient moves from one site of care to another. Usually, care transition programs focus on ensuring continuity of care when a patient is discharged from the hospital either to home or to another care site. The goal is to prevent gaps in care between care sites to reduce readmissions.
Strength of evidence	 High
Impact	• **Decreased cost:** 34-46% decreased total spending across periods ranging from 1-12 months; 19-25% decreased hospital costs; $1,473 decreased cost per patient at nine months; $3,363 reduced 30-day post-discharge costs • **Decreased utilization (wide range):** 26-73% decreased readmissions between 30 and 180 days; reduced ED visits (0.7-0.8), reduced hospitalizations (-0.7) • **Improved quality, clinical outcomes:** Not demonstrated • **Increased access:** Increased clinic visits (0.8-0.9) • **Improved stakeholder satisfaction:** Improved patient satisfaction, especially around quality of life and confidence in ability to self-manage as measured by patient surveys
How to succeed	To develop an effective care transitions program: • Frontload patient assessments at admission to flag patients at increased risk for readmission, then identify the drivers putting them at risk • Assess whether a post-discharge, in-home assessment is needed for patients likely to be discharged home • Standardize the transition process between hospital and frequently used post-acute care partners to ensure accurate transfer of information • Use full range of staff to bridge the hospital-primary care gap, including leveraging clinical pharmacists and social workers to prevent gaps related to medications and social needs • Assign 30-to-90-day post-discharge patient management responsibilities to an accountable care team • Standardize process of ongoing information exchange between providers To learn more about developing a care transitions program, read our research brief Beyond Readmissions: Targeting Avoidable Costs in the Post-Discharge Process here.

Source: Population Health Advisor research and analysis.

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Demonstrated impact

Literature review summary

Title: Quality Care Outcomes Following Transitional Care Interventions For Older People From Hospital to Home: A Systematic Review
Publication: BioMed Central Health Services Research
Date: 2014
Type: Systematic review
Study population: Patients were 60 or older, lived at home, and were transitioning from hospital to home.
Major findings:
- Patients receiving transitional care interventions experienced lower total cost per patient at 6 months post-discharge (45.5%) and lower Medicare spending per patient at 12 months post-discharge (39%) compared to control groups.
- Four out of six studies that measured patient satisfaction found significant improvement for patients in intervention groups compared to control groups as measured by various patient satisfaction surveys.
- One out of four studies that evaluated change in quality of life found significant improvement, as measured by patient surveys.

Source: Full article here.

Title: A Reengineered Hospital Discharge Program to Decrease Rehospitalization
Publication: Annals of Internal Medicine
Date: 2009
Type: Randomized controlled trial
Study population: 749 patients were English-speaking adults hospitalized at Boston Medical Center.
Major findings:
- Patients receiving hospital discharge support experienced lower total spending at 30 days post-discharge compared to the control group: 34%.
- Patients in the intervention group experienced decreased combined inpatient and ED readmissions compared to the control group at 30 days post-discharge: 30%.

Source: Full article here.

Title: The Care Transitions Intervention: Results of a Randomized Controlled Trial
Publication: Archives of Internal Medicine
Date: 2006
Type: Randomized controlled trial
Study population: Patients were 65 or older and hospitalized at a large integrated delivery system in Colorado for any one of eleven specified conditions. Patients lived independently, not in a care facility.
Major findings:
- Patients receiving care transition support experienced lower hospital costs at 90 days (25%) and 180 days (19%) compared to the control group.
- Patients in the intervention group experienced decreased readmissions at 30 days (30%) and 180 days (26%) compared to the control group.

Source: Full article here.

Source: Population Health Advisor research and analysis.

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Title: Cost-Effectiveness of a Care Transitions Program in a Multimorbid Older Adult Cohort
Publication: Journal of the American Geriatrics Society
Date: 2017
Type: Cohort study
Study population: 363 participants in the Mayo Clinic Care Transitions program and 365 members of the control group, average age of 83
Major findings: Mayo Clinic Care Transitions program resulted in reduced 30-day costs after hospitalization ($3,363).
Source: Full article here.

Title: Evaluation of A Modified Community-Based Care Transitions Model To Reduce Costs and Improve Outcomes
Publication: BioMed Central Geriatrics
Date: 2013
Type: Cross-sectional study
Study population: 149 patients (79 male, 70 female) ages 51-95 years old that attended either of two specific Arizona hospitals.
Major findings: Patients receiving care transition support from a community-based organization experienced:
- Cost savings at 9 months post-discharge compared to baseline (mean of $1,473.53 per patient)
- Decreased 30-day readmissions (73%)

Patient satisfaction surveys distributed to 24 of the 149 participants showed significant improvement in patients' confidence ratings in themselves regarding their ability to manage their conditions (mean change of 0.51-0.62).
Source: Full article here.

Title: The Impact of Transitional Care Programs on Health Services Utilization in Community-Dwelling Older Adults: A Systematic Review
Publication: JBI Database Systematic Reviews and Implementation Reports
Date: 2018
Type: Systematic review
Study population: 20,997 patients (76 years of age on average) across 23 studies (19 randomized controlled trials and four case control studies) from seven countries
Major findings: Transitional care resulted in reduced 30-day readmissions at 30 (42.9% probability), 90 (43.5% probability), and 180 days (40.1% probability)
Source: Full article here.

Title: Accountable Care in Transitions (ACTion): A Team-Based Approach to Reducing Hospital Utilization in a Patient-Centered Medical Home
Publication: Journal of Pharmacy Practice
Date: 2017
Type: Case study
Study population: 268 medically-complex patients identified as moderate or high risk for readmission using a UNC Hospitals tool
Major findings: A multidisciplinary outpatient-based transitions program, including care from a provider, clinical pharmacist practitioner, and care manager, resulted in:
- Reduced 30-day readmissions (7.7% vs. 18.8%)
- Reduced ED visits at one (-0.7), three (-0.7), and six months (-0.8)
- Reduced hospitalizations at one (-0.7), three (-0.7), and six months (-0.7)
- Increased clinic visits at one (0.8), three (0.9), and six months (0.8)

Source: Full article here.

Source: Population Health Advisor research and analysis.

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Title: Care Transition Program and Patient Education Leads to Reduction in Readmission Rates in Patients Discharged With COPD and Pneumonia
Publication: Respiratory Care
Date: 2018
Type: Case study
Study population: Patients at Sutter Roseville Medical Center admitted for COPD or pneumonia
Major findings: Transitional care management resulted in reduced readmissions for patients with COPD (15.4% to 8%) and patients with pneumonia (12.2% to 9%).
Source: Full article here.

Title: Predicting Risk of Readmissions for Targeting Patient Intervention
Publication: Mount Sinai Medical Center presentation material
Date: 2012
Type: Case study
Study population: Patients 19-99 years old. Nearly 60% were FFS Medicare patients and most suffered from one or more chronic illness. Specifically, 70% had CHF and two or more other diagnoses, 27% had primary or secondary diagnoses of CHF, 39% had diabetes, and 17% had a mental illness diagnosis.
Major findings: Patients receiving care transition support services experienced a reduction in ED visits (51%), hospital admissions (38%), and 30-day readmissions (58%).
Source: Presentation materials here.

Source: Population Health Advisor research and analysis.

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Appendix

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Source: Population Health Advisor research and analysis.