

Social Care Services Evidence Summary: Care Transition Services

This evidence summary includes a broad range of research/resources on care transitions services and is primarily focused on health care impact. It is not intended to be an exhaustive compilation of research/resources on this topic. The information presented in this summary can inform the value proposition of partnering with a community-based organization (CBO) or a network of CBOs to offer these services and supports as part of a strategy to address social determinants of health (SDOH).

Care transitions refer to the support provided to an individual as they transition from one care setting to another as their care needs change. Settings of care may include hospitals, ambulatory care, skilled nursing facilities, specialty clinics, long-term care facilities, rehabilitation centers, and the home.^{1,2} Poor transitions of care can lead to adverse health events, poor adherence to care plans, higher hospital readmission rates, and costly expenses. Care transition services include, but are not limited to, family caregiver education, health goal planning, medication adherence training, transition planning, patient-activated education and coaching, home visits, and risk assessments. A number of different care transitions models have emerged over the years, and studies to date indicate that these models have proven effective at improving health outcomes and reducing medical costs.

For specific, further detailed information on this evidence, please review the resources listed below.

¹ <https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html>

² https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/hot_topics_transitions_of_carepdf.pdf?db=web&hash=CEFB254D5EC36E4FFE30ABB20A5550E0

Care Transitions Research and Evidence

Study	Population Studied	Objective of Study	Type of Analysis	Findings / Results
Coleman et al. (2004)	1,393 community-dwelling adults aged 65+ admitted to the hospital with one of nine specified conditions in Colorado	To test whether the intervention encouraged older patients and their caregivers to assert a more active role during care transitions and led to reduced re-hospitalization rates.	Quasi-experimental design	The results of the study showed that intervention subjects had lower rates of re-hospitalization at 30-, 60-, and 90-days post-hospital discharge than control subjects. Intervention patients also reported high levels of confidence in obtaining necessary information for managing their condition, communicating with members of the healthcare team, and understanding their medication regime.
Coleman et al. (2006)	750 community-dwelling individuals admitted to the hospital with one of 11 selected conditions in Colorado	To implement the Care Transitions Intervention (CTI) on patients and observe their participation in their health and rates of re-hospitalization.	Randomized control trial	The findings of the study showed that the individuals who received the CTI had lower hospitalization rates at 30- and 90-days post discharge than control subjects, and the mean hospital costs were lower at 180-days post discharge for the intervention group.
Epstein-Lubow et al. (2014)	2,747 fee-for-service Medicare patients recruited during inpatient hospitalizations at six hospitals in Rhode Island	To evaluate the association between family caregiver presence and patient completion of the CTI.	Effectiveness trial	The results of the study showed that patients with family caregivers were more than five times as likely to complete the intervention as patients without caregivers.

Study	Population Studied	Objective of Study	Type of Analysis	Findings / Results
<u>Kangovi et al.</u> (2014)	683 eligible Medicaid patients and 446 control patients	To determine if tailored community health worker intervention would improve post-hospital outcomes among low socio economic status patients.	Two-armed, single-blind, randomized clinical trial	The results of the study showed that intervention patients were more likely to obtain timely post-hospital care, report high-quality discharge communication, and shower greater improvement in mental health than control patients.
<u>The SCAN Foundation</u> (2014)	The return on investment (ROI) calculator included data from 16 studies on the implementation of coordinated care models as well as 2012 Medicare data.	To utilize the ROI tool to provide an estimate of the financial returns associated with implementing each of the selected care models.	ROI	The ROI analysis showed that the care transition programs under study had a positive ROI, and a number of factors that contribute to this positive ROI were highlighted.

Additional Resources

Resource Author	Description of Content	Target Audience
Centers for Medicare & Medicaid Services	This webpage gives an overview of the Community-based Care Transitions Program (CCTP) program, its partners, and eligibility requirements.	Community-based organizations or health systems interested in learning from or participating in the CCTP program.
Enderlin et al. (2013)	This table provides an overview of six different care transition interventions and then shows the commonalities between these transitional care models.	General audience- individuals, and organizations interested in learning more about the different care models that exist.
Medicaid.gov	This webpage provides an overview of the Money Follows the Person (MFP) program goals, grantee information, and various existing initiatives.	MFP grantees or individuals or organizations interested in learning more about Medicaid's work in this space.
Partners in Care Foundation	This webpage provides a description of how Care Transition Choices operates, its partners, and the results of the transition intervention.	Individuals and organizations interested in learning about the results of transition interventions.
Partnerships for Healthy Outcomes	This article provides an overview of the Eastern Virginia Care Transitions Partnership (EVCTP) with information on the service delivery model, funding, shared governance, information sharing and reporting, success factors, and more.	Those interested in learning more about the EVCTP model or are creating their own model and are interested in learning about the structure and function that led EVCTP to success.
The Care Transitions Program	This webpage provides an overview of the CTI program, includes information on supporting evidence from organizations that have adopted CTI, and highlights key findings.	Hospitals and health systems interested in adopting CTI as an intervention and want to review supporting data and evidence.
The SCAN Foundation	This report provides data points showing Medicare spending for different high-cost health conditions, outlines the need for long	Organizations interested in how LTSS may support high-cost Medicare users and what the ROI for screening is.

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	term services and supports (LTSS), and describes the opportunity at hand to enhance the use of health risk assessments.	