THE CARE TRANSITIONS INTERVENTION: IMPROVING TRANSITIONS ACROSS SITES OF CARE

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Introduction: Bridging the Gap

Patients with chronic illness often require care from a variety of practitioners in multiple settings. For example, in a given month, an individual with chronic illness may receive care from his or her primary care physician or a specialist in the ambulatory care setting. That same person may then receive care from a hospitalist physician and nursing team during an inpatient admission, from a different physician and nursing team during a brief stay in a skilled nursing facility (SNF), and finally, from a visiting nurse in the home. Yet during times when patients are most vulnerable and their informal caregivers are often overwhelmed, systems of care fail patients by not ensuring that: (1) the critical elements of the care plan developed in one setting are transferred to the next; and (2) the essential steps that need to take place before and after transfer are executed. By default, facilitation of successful care transitions becomes the responsibility of patients and their caregivers, who often do not possess the necessary health care self-management skills or confidence to assume this role.

Although not all episodes of care have a discrete beginning, the Care Transitions Intervention begins with a person's admission to the hospital. This intervention focuses on care transitions between hospital and home, or nursing home and home.

The overriding goal of the Care Transitions Intervention is to improve care transitions by providing patients with tools and support that promote knowledge and self management of their condition as they move from hospital or nursing home to home. The goals of the Care Transitions Intervention can be achieved through a patient-centered model comprising two components:

1) A patient-centered record that consists of the essential care elements for facilitating productive communication during the care transition. These include a list of the patient's medical conditions in his or her own words; space for patient concerns for the next follow up doctor visit; warning signs that might indicate the patient's condition is worsening; and a list of medications and allergies. The patient-centered record also includes a list of structured intervention activities (a

discharge checklist) designed to empower patients to acquire the knowledge and self management skills needed throughout the transition.

2) A series of patient activation and self-management sessions facilitated by the Transition Coach and designed to help patients and their caregivers apply the principles of the program. Transition coaching sessions include a follow-up visit in the home and subsequent phone calls designed to provide continuity across the transition.

CHAPTER 1

Intervention Structure & Components

OVERVIEW

As noted in the introduction, the intervention uses two components (the Transition Coach and the Personal Health Record) to achieve its goals as patients move across settings. The intervention is based on four conceptual domains, or 'pillars': medication self-management, use of a patient-centered record, primary care and specialist follow-up, and knowledge of red flags. The intervention is designed to meet the needs of the patient and/or caregiver across a variety of settings. Thus, the patient works with the coach to enact the four pillars as he or she moves across care settings. To understand how the intervention works, we first explain the structure of the intervention, followed by an explanation of the four pillars, and finally, we provide details on how the Transition Coach enacts the four pillars within this structure

1.1: Structure of the Intervention[1]

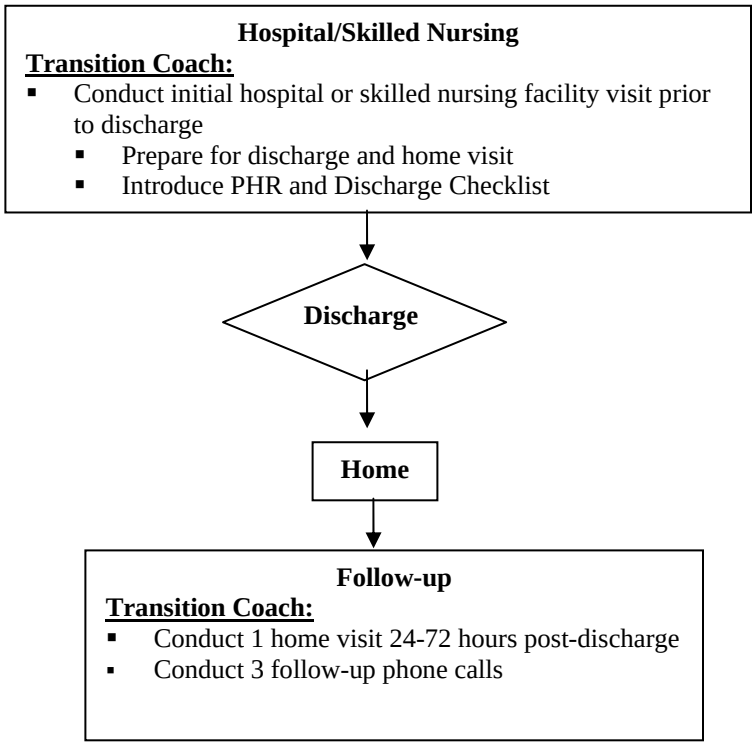
The structure of the intervention is outlined in Figure 1. Patients first come in contact with the Transition Coach at either the hospital or the skilled nursing facility. This initial visit is designed to help prepare patients and caregivers for discharge by introducing the intervention and the Transition Coach; introducing the Personal Health Record reviewing the Discharge Checklist, and addressing concerns. The home visit and follow-up phone calls are designed to empower patients to adopt a more active role in

[1] For a more detailed discussion, please see: Parry, C., Coleman, E., Smith, J., Frank, J., and Kramer, A. (2003) "The Care Transitions Intervention: A Patient-Centered Approach to Ensuring Effective Transfers Between Sites of Geriatric Care", *Home Health Services Quarterly*, Volume 22 (3): 1-17.

their care by expanding upon the information provided in the initial hospital or skilled nursing facility visit and by assuring that care needs and concerns are addressed as the transition progresses.

The target of the Care Transitions Intervention is the patient him/herself and his or her family caregivers. In some situations, the patient may play a central role in his/her health care and the management of his/her conditions. In other cases, one or more able and willing family caregivers may play a more central role in the individual's care. Thus, the target for transition coaching is ideally inclusive of both the patient and family caregivers. As the Transition Coach introduces the Care Transitions Intervention, s/he should be sure to ask the patient to identify a family caregiver/s and include them in the home visit and follow up phone calls.

Figure 1: Structure of the Care Transitions Intervention



1.2: Conceptual Domains of the Intervention: The Four Pillars

The Transition Coach collaborates with patients and caregivers in four conceptual areas, or "pillars". The Pillars are listed below, followed by a description of the goal for each pillar.

1. Medication self-management

   Goal: The patient is knowledgeable about his or her medications and has a medication management system.

2. Use of a patient-centered record

   Goal: The patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. (The PHR is managed by the patient or by the informal caregiver)

3. Primary Care and Specialist Follow-Up

   Goal: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is prepared to be an active participant in these interactions.

4. Knowledge of Red Flags

   Goal: The patient is knowledgeable about indicators that his or her condition is worsening and demonstrates knowledge of how to respond.

Table 1, below, demonstrates how the four pillars interact with the sequencing of the intervention as the patient moves across settings.

Table 1:

Pillar	Medication self-management	Patient-centered record	Follow-up	Red Flags
Goal	Patient is knowledgeable about medications and has a medication management system	Patient understands and utilizes a Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The patient manages the PHR	Patient schedules and completes follow-up visit with Primary Care Practitioner/Specialist and is empowered to be an active participant in these interactions	Patient is knowledgeable about indicators that condition is worsening and how to respond.
Hospital Visit	Discuss importance of knowing medications and having a system in place	Explain PHR and its components	Recommend Primary Care Practitioner follow-up visit	Discuss symptoms and drug reactions
Home Visit	Facilitate reconciliation of pre- and post-hospitalization medication regimens Help patient identify and correct any discrepancies	Help patient to review and update PHR Review discharge summary with patient Encourage patient to update and share the PHR with Primary Care Practitioner and/or Specialist at follow-up visits	Emphasize importance of the follow-up visit and need to provide Primary Care Practitioner with recent hospitalization information Practice and role-play questions for Primary Care Practitioner	Discuss symptoms and side effects of medications
Follow-Up Calls	Answer any remaining medication questions	Remind patient to share PHR with Primary Care Practitioner/Specialist Discuss outcome of visit with Primary Care Practitioner or Specialist	Provide advice in getting prompt appointment, if necessary	Reinforce when/if Primary Care Practitioner should be called

1.3: Components of the Intervention: The Transition Coach

Role and Function of the Transition Coach

The Transition Coach's goal is to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as patients move from hospital to home. The Transition Coach models for the patient and

caregiver/s how to play an active and informed role in their health care. In the context of the structure outlined above, the Transition Coach first interacts with patients upon hospital admission to ensure a smooth transition home. Later, the coach visits the patient at a Skilled Nursing Facility or at home. In every setting, the coach's role is not to be a service broker or care manager, but rather, to provide information and support for the patient in identifying problems and building relationships with practitioners.

During each contact with the Transition Coach, the patient and Transition Coach review the content area of the four pillars, but the specific focus varies by patient and by visit. The Transition Coach tailors the content from the Four Pillars to the needs and priorities of the patient at each contact. The patient's readiness and ability to increase his/her involvement with the Four Pillars will dictate the most appropriate timing to focus on specific content. For instance, during the home visit, the coach may find that the patient's medications are in order, but his/her condition is worsening and requires a follow-up appointment (or more immediate attention). In this case, the focus of the visit would be recognition of red flags (warning signs) and establishment of follow-up care. An abbreviated list of intervention activities and coaching support addressing each pillar are listed in Table 1 (see prior page, © Parry, et al, 2003).

The Transition Coach is key to encouraging the patient and family caregiver to assume a more active role in their care. Transition Coaches do not fix problems and they do not provide skilled care. Rather, they model and facilitate new behaviors and communication skills for patients and families to feel confident that they can successfully respond to common problems that arise during care transitions. Thus, in the role of patient empowerment facilitator, the Transition Coach provides information and guidance to the patient and/or family for an effective care transition, improved self-management skills and enhanced patient-practitioner communication.

An important distinction between the Transition Coach role and a traditional health care provider role is that the coach should be a guide for the patient, addressing critical issues and self-management tasks rather than providing skilled care. Eliciting and working with the patient's agenda are vital components of building trust and setting the stage for increased patient self-management competency. It is not essential to cover the Four Pillars in sequence. Rather, excellent Transition Coaches move fluidly between the

content of the Four Pillars according to the patient's agenda. Rather than being task or 'checklist' oriented, accomplished Transition Coaches listen to patient's concerns, notice how these concerns fit with the four pillars, and weave the four pillars into the discussion as they become relevant. While the content of the four pillars may be familiar to many coaches-in-training, the coaching style of interaction often represents a new style of patient-provider interaction to be mastered. Mastery of the process of transition coaching can be achieved with time, practice and structured shadowing and feedback.

1.4: Components of the Intervention: The Personal Health Record (PHR)

The Personal Health Record (PHR) is a dynamic tool prepared by the patient and the Transition Coach. The PHR is designed to enable the patient to take control of his or her health care issues and to facilitate effective communication of essential information and questions across settings. A MS Word version of the Personal Health Record can be found by going to http://www.caretransitions.org/documents/phr.pdf . You are welcome to add your brand or logo to this document.

In our experience, attempting to make the PHR tool into a more comprehensive record can be counter- productive because its power lies in its simplicity and accessibility to patients (versus providers). While we recognize the need to customize the PHR, we discourage adding more than three new items; reducing the font size; or making changes that conflict with the core principles of the PHR: patient-centeredness, portability, simplicity, and readability. Below we outline the key components of a PHR.

Key Components of the PHR

1. Demographic information
2. Patient's Personal Goal
3. Recent and Relevant Medical History (in the patient's words)
4. Discharge Checklist: To be completed before leaving the hospital or skilled nursing facility
    - Know medications, what they're for, when and how to take
    - Set-up home support, what caregivers need to know

- Schedule follow-up appointment with Primary Care Practitioner
- Get questions answered by physicians and nurses
- Whom to call for any Red Flags

5. Medication Record (what medications the patient is taking and how they are taking them). Please assure to leave adequate space for a person with poor eyesight or handwriting to complete this section.
    - Name of medication
    - Dosage, frequency, and timing
    - Reasons for taking
6. Space for follow-up questions for doctor and other providers (at least one page, preferably two blank pages)
7. Transition Coach name and phone number

1.5: Putting It All Together: Coaching Support and Tools by Pillar

1. Medication self-management:

Coaching Support

- Modeling behavior for how to respond to confusing or contradictory instructions from health care professionals
- Providing guidance in developing a patient-oriented medication management system.

Tools

The primary tools to reinforce coaching in the medication self-management pillar are the Medication List and Questions section of the PHR

- The patient's up-to-date Medication List reflects reconciliation of the pre- and post-hospital regimens.
- Outstanding questions or discrepancies to be clarified with the community pharmacist, home care nurse or primary care practitioner should be written by the patient in the "Questions" section of the PHR

2. Use of a patient-centered record:

Coaching support

- Teaching the patient how to complete the PHR and sitting with the patient as s/he completes important sections
- Discussing the importance of updating the PHR on a continual basis and describing how to update the information on a continual basis
- Discussing the value of taking the PHR to all health care encounters and sharing its contents with health care professionals.

Tools

The patient/caregiver assumes ownership of the PHR. The PHR facilitates cross-site communication and ensures continuity of core information across different practitioners and settings.

3. Primary Care and Specialist follow-up:

Coaching Support

- Discussing the patient's personal goal, concerns, and topics/questions to be discussed with physician.
- Discussing how to phrase questions to achieve desired responses
- Practicing asking questions and making phone calls (role plays).

Tools

The primary tools to reinforce coaching in the primary care and specialist follow-up pillar are personal Goal and Questions sections of the PHR. These two sections, along with the PHR more generally, help patients prepare for effective communication during follow-up visits.

4. Knowledge of Red Flags:

Coaching Support

- Asking the patient to identify signs and symptoms that his or her condition may be worsening
- Asking the patient how s/he would respond to those 'red flags'.

Tools

The primary tool to reinforce coaching in the red flags pillar is the PHR, in which patients may list red flags and note who to call.

1.6: Becoming A Coach: Attending to Issues of Process *and* Content

In all patient-coach contacts, the intervention is enacted at two levels: a process level (***how*** the coach communicates with the patient) and a content level (***what*** occurs during the patient-coach interaction, or what is accomplished.) The process aspects of the patient-coach interaction are as important as the content in enacting the Care Transition Intervention.

CHAPTER 2

Transition Coaching In the Hospital or Skilled Nursing Facility

OVERVIEW

The Transition Coach first engages with the patient prior to discharge from the hospital or skilled nursing facility. The Transition Coach works closely with patients and family caregivers to ensure a smooth transition home following an acute hospitalization. The Transition Coach's role is not that of a service broker or care manager. Rather, the Transition Coach encourages the patient and family caregiver to assume a more active role in his or her care. For example, if the patient or caregiver had a critical concern or question, the Transition Coach would help the patient to articulate that question and then empower the patient to make contact with health care practitioners.

During the hospital or skilled nursing facility visit, the Transition Coach introduces her/himself to the patient and conducts the initial session aimed at imparting skills for greater self-management. The visit is designed to introduce patients and their family caregivers to the PHR, to prepare patients and caregivers for discharge, and to arrange for the home visit.

2.1: Hospital or Skilled Nursing Facility Visit: Coaching Process and Content

The hospital or skilled nursing facility visit is used to establish rapport between the Transition Coach and the patient and family caregivers. At this encounter, the coach:

- Encourages the patient to take charge of his/her care.
- Talks about the support the coach will provide after the transition home.
- Begins discussing the four pillars as they relate to the patient's current needs and priorities
- Asks the patient to call the Transition Coach when s/he is discharged.

2.2: Enactment of the Four Pillars in the Initial Visit

Coaching support is outlined below for each of the four pillars in the context of the initial visit.

1. Medication Self-Management

Coaching Support

- Reinforce the importance of knowing why, when and how to take each medication.
- Encourage the patient to ask the facility staff to review the list of medications and clarify which medications are new, which medications have a different dosage, and which medications should be stopped.

2. Personal Health Record (PHR)

Coaching Support

- Suggest that the Transition Coach and patient fill out the PHR at the upcoming home visit.

Tools

- Introduce the PHR (especially the Discharge Checklist section) and discuss its purpose.

3. PCP or Specialist follow-up

Coaching Support

- Encourage the patient to schedule an appointment with the PCP or Specialist before discharge or as soon as possible after discharge to discuss the reasons that brought the patient to the hospital in the first place.
- Practice or role-play how to get a timely appointment when the clinic initially does not accommodate the patient's request.

4. Red Flags

Coaching Support

- Explore the patient's understanding of signs and symptoms that their condition may be worsening and how to respond.

CHAPTER 3

Transition Coaching In the Home

OVERVIEW

The majority of patient activation occurs during the home visit. The context of the patient's home provides important information about the patient's functional abilities, social support, environmental challenges and self-management capabilities and needs. The home visit should be conducted as soon as possible after the patient arrives home, ideally within 48-72 hours of discharge from the hospital or skilled nursing facility. Typically, the home visit is scheduled for one hour. When scheduling the home visit, it is important to ask the patient if they would like to invite a family caregiver(s) to participate.

While the hospital or skilled nursing facility setting is the initial place of introduction for the Care Transitions Intervention, the home visit provides an opportunity to fully operationalize the Four Pillars. At the home visit, as with all coach-patient interactions, it is critical to note both the process and content aspects of the intervention. An experienced coach will facilitate the interaction, encouraging the patient to do most of the talking and 'doing' as the pair addresses the four pillars according to the patient's agenda.

3.1: Enactment of the Four Pillars in the Home Visit

Coaching support and tools are outlined below for each of the four pillars in the context of the initial visit. In each pillar, the coach:

1. Medication Management and the PHR

Coaching Support

- After the patient gathers all of his or her medications, the coach asks the patient to show her what he/she takes and how he/she takes it.
- Explores whether the patient has a reliable strategy for taking his/her medications and if not, asks the patient to identify better strategies.
- Encourages the disposal or safe storage of expired or non-essential medications

Tools

- The coach encourages the patient to record his/her medications in the PHR and waits patiently as the patient does so.
- Helps the patient identify and record questions for his or her doctor about any medication discrepancies (in the Questions section of the PHR)

2. Personal Health Record

Coaching Support

- Provides the rationale for the PHR (not all health care professionals have timely and accurate information)
- Encourages the patient to understand that s/he has a role to play in maintaining and owning key aspects of their information
- Reminds and encourages the patient to take the PHR to her follow up visits and to ask the questions written in her PHR

3. PCP or Specialist follow-up

Coaching Support

- Encourages the patient and caregiver to view their relationship with their PCP and Specialist as a collaborative partnership.
- Encourages the patient to schedule an appointment with the PCP or Specialist
- Discusses and role-plays what to do if the clinic does not have any openings.
- Co-creates questions with the patient to ask his/her doctors during the follow-up visit and has the patient write the questions in the PHR.

- Role-plays possible patient/PCP or patient/Specialist interactions

4. Red Flags

Coaching Support

- Explores the patient's understanding of signs and symptoms that his or her condition may be worsening and how to respond.
- Practices with the patient how to access the health care system in the event of an exacerbation of their condition.
- Quizzes the patient about responding to red flags.

Tools

- Encourages the patient to record their red flags and potential responses in the PHR.

CHAPTER 4

Follow-Up Phone Calls

OVERVIEW

The follow-up phone calls are tailored to the individual patient's on-going self-management issues, comfort with patient-provider communication, and the patient's progress towards their stated goal. The follow-up calls also provide an opportunity to revisit the key coaching areas from the home visit to address any of the Four Pillars that received less attention, due to time constraints.

4.1: Key Content of the Phone Calls

The phone calls provide an opportunity to schedule the home visit and address selected issues. These are as follows:

- First call:
  1) Schedule Home Visit (if this was not done during the hospital visit). Remember to encourage the patient to suggest whether any family caregivers should also be included.
  2) Address any immediate concerns/issues/problems that cannot wait until the home visit.
- Second and third calls:
  1) Follow up with patient on specific events such as doctor appointments or home care encounters.
  2) Inquire about the patient's progress towards their stated goal since the last contact.

3) If the patient was able to demonstrate any progress made on self-care or activation, celebrate this progress and provide positive reinforcement.
4) Alternatively, if the patient stepped outside of their comfort level and tried a new skill unsuccessfully, problem solve new approaches and prompt them to try again.
5) Address any concerns/issues/problems
6) Emphasize sustained use of self-management skills and tools

4.2: Enactment of the Four Pillars in the Follow-Up Phone Calls

The follow-up phone calls are designed to empower patients to play a more active and informed role in managing their care and are intended to address specific areas of concern to each individual patient. In doing so, each patient's follow-up call will be tailored to the needs of that patient and the events that have transpired since the last contact. In each pillar, the coach:

1. Medication Management:
    - Inquires about the resolution of any medication discrepancies
    - If the patient is using a new medication management system, asks the patient how this is working for him or her.

2. PHR:
    - Reminds and encourages patient to "take your PHR wherever you go" (doctor visits, ER, vacation, etc.).
    - Reinforces the importance of updating the PHR after each health care encounter.

3. Red Flags:
    - Quizzes patient about identifying and responding to red flags.
    - Inquires about the patient's success in accessing the health care system.

4. PCP and Specialist follow-up:
    - Asks the patient whether the follow-up visit has been scheduled/completed.

- If the patient had a follow-up visit, the coach asks about the outcomes of that visit and if the patient was able to get his questions answered.
- Asks about the resolution of any medication discrepancies.

CHAPTER 5

Identifying Post-Acute Medication Discrepancies

OVERVIEW

Despite significant national awareness of the problem of medication safety, there has been relatively little attention paid to problems faced by patients receiving care across multiple settings. Attention has primarily focused on errors occurring in specific settings. Patients with complex acute and chronic care needs often require care in multiple settings. As a consequence, they receive prescriptions from multiple practitioners. Due to lack of coordination and communication between institutions, these prescribers may unknowingly contribute to duplicative and potentially harmful medication regimens.

Traditionally, the definitions and tools used to identify medication errors have been developed for individual settings, have primarily addressed the problem from the perspective of the system or practitioner, and have not included the perspective of the patient and caregiver. The Medication Discrepancy Tool (MDT) was developed to fill this current gap in identifying transition-related medication problems and characterize accompanying action steps at either the patient or system level.

5.1: Creation of the Medication Discrepancy Tool (MDT)

A series of "guiding principles" informed the development of the MDT:

- Patient-centered
- Application across a variety of health care settings
- Account for intentional and non-intentional patient non-adherence

- Account for performance deficits attributable to physical or cognitive function
- Account for knowledge deficits due to education or health status
- Representation of patient- and system-level contributing factors
- Actionable items that could be incorporated into continuous quality improvement initiatives
- Meaningful to patients, caregivers, practitioners, health care systems, and payers

Errors versus Discrepancies

When considering medication safety, it is important to differentiate between the terms error and discrepancy. Traditionally, the definitions and tools used to describe medication errors have applied to the inpatient setting and were either provider-based or setting-specific. To suggest that a medication "error" has occurred for patients receiving care across settings is to suggest that a gold standard for the correct medication regimen exists and is readily available for confirmation. For example, a hospital discharge summary may not account for the patient's pre-hospital medication regimen or may not be available to practitioners in the next setting in a timely manner. In the absence of such a gold standard, use of the term discrepancy may provide a more practical approach for capturing the events that occur for patients in transition between acute and post-acute care settings.

5.2: Components of the Medication Discrepancy Tool

Problems found in post-acute medications regimens are generally not uni-dimensional. For the MDT, the coach is given a variety of potential reasons for discrepancies and asked to check all that apply. The MDT is divided into patient level and system level causes and contributing factors.

Patient Level Discrepancy: This section is intended to assess the patient's role in managing their medication regimen. An important focus of this section is the differentiation between intentional non-adherence and non-intentional non-adherence. The former infers that a patient knows the regimen and chooses not to adhere, while the latter infers that a patient was not aware that they were not adhering.

System Level Discrepancy: This section is intended to assess the role of practitioners working within health care systems for ensuring safe and effective medication regimens for patients transitioning across settings. An example of a system level discrepancy is when a patient's discharge instructions are either incomplete, illegible or has inaccuracies.

Resolution: This section is intended to capture what potential action(s) could be taken to correct the identified discrepancies.

5.3: Examples of Medication Discrepancies:

- Patient was taking Lisinopril 10 mg once daily prior to hospitalization. This drug was discontinued while patient was in the hospital and stated so on discharge instructions. At home visit, patient was taking "Lisinopril 10 mg once daily".
- Patient was discharged from the hospital on several new medications. During the home visit, it was discovered that two drugs were missing. Patient had already completed a follow-up appointment with her primary care physicians who did not recognize that these two prescriptions were missing.
- During a home visit, a patient stated that she did not receive any discharge instructions from the skilled nursing facility. She did, however, have the leftover medications from the skilled nursing facility that had been sealed in blister pack. The blister-packed medications did not match her pre-hospital medication regimen. The patient could not read the labels on the blister-packed medications. The patient was very confused about what she should be taking.

5.4: Medication Review

The Transition Coach encourages patients to collect all medications (prescription and non-prescription) for review during the home visit. The coach asks the patient to describe what they are taking and how they are taking their medications. They compare what the patient is actually taking with the pre and post hospitalization lists and identify discrepancies. The coach and patient then discuss how the patient will follow up with practitioners for clarification and how to update the Medication list in the PHR.

Appendices

A. Personal Health Record:

http://www.caretransitions.org/documents/phr.pdf

B. Care Transitions Measure:

http://www.caretransitions.org/measures.htm

C. Sample Transition Coach Charting Form

http://www.caretransitions.org/documents/Intervention-Pillars.pdf

D. Medication Discrepancy Tool

http://www.caretransitions.org/documents/MDT.v3.pdf

E. Patient Activation Assessment

The Patient Activation Assessment (PAA) was designed to help Transition Coaches ascertain a patient's progress on each of the Four Pillars using a numeric scale
http://www.caretransitions.org/documents/Activation_Assessment.pdf