



One Patient, Many Places: Managing Health Care Transitions, Part II: Practitioner Skills and Patient and Caregiver Preparation

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This article is the second in a three-part series. Part I appeared in the September issue of the Journal.

This series of articles addresses how health care organizations (ie, organized or integrated care systems or large provider groups that receive payment under either a capitated or fee-for-service basis) can improve the quality of transitions among care venues for patients with complex care needs. Part I provided an introduction and discussed strategies for ensuring accountability for patients in transition and facilitating the effective transfer of information. Part II focuses on enhancing practitioners' skills and support systems, and enabling patients and caregivers to play a more active role in their transitions. Part III will address the need to align financial and structural incentives to improve patient flow across care venues, and will recommend steps organizations can take to initiate a quality improvement strategy for transitional care.

PRACTITIONER SKILL SETS AND SUPPORT SYSTEM

Recommendations

Health care organizations (HCOs) should:

1. Improve practitioner knowledge of the services and settings available across the continuum of care to

facilitate the best match between a patient's care needs and the care setting.

2. Ensure that practitioners have support systems that facilitate providing treatment, information, durable medical equipment, and other services during a patient's transition.
3. Assure that practitioners incorporate patients' goals, preferences, and functional status into both short- and long-range care plans.

Statement of Problem

Practitioners generally lack training on how to execute effective transfers and often do not recognize their role in transition planning. The amount of effort expended in admitting a patient is often far greater than that expended in discharging a patient, when in fact the two should be comparable. Compounding the problem is the fact that most practitioners (eg, hospitalists, hospital discharge planners, skilled nursing facility [SNF] nurses, home health care nurses, care managers, primary care physicians [PCPs]) have had little exposure to sites of care other than those in which they practice, and are therefore unfamiliar with the ability of the receiving institution to manage complex patients. Without such knowledge, a patient may be transferred to a receiving care team that does not have the resources or skills necessary to meet the needs of particular patients.

Only rarely does a single clinician provide ongoing care to a patient transferring from one care setting to the

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Table I: Essential Skills for Practitioners

- Establish short- and long-term goals for medical care that take into account patient preferences and the natural history of the disease process.
- Determine the specific care that the patient will require in order to achieve these goals.
- Assess the patient's ability to meet his or her self-care needs, as well as the caregiver's ability and willingness to participate in the care plan.
- Be knowledgeable about the care continuum and each facility's capability for providing care.
- Determine the care site where the patient's needs will best be served.
- Actively engage the patient and caregiver in the decision to move to a new site of care.
- Initiate the transfer plan as early as possible. Recognize that patients may have difficulty processing information and require consistent information from all practitioners and continued reinforcement.
- Incorporate knowledge of the patient's health care benefits into the design and execution of the care plan.
- Communicate the patient's goals and preferences to all health care professionals who participate in the design or execution of the plan of care.
- Communicate the patient's essential clinical and functional status information to the receiving care team.
- Remain available to patients of the receiving care team should post-transfer questions or concerns arise.
- Direct the patient and caregiver to the appropriate person when questions arise about benefits.

next. Increasingly, PCPs do not follow their patients into the hospital or a rehabilitation facility. Furthermore, with the growing movement toward using institution-based physicians (ie, "hospitalists" and "SNFists"), who often work in rotating shifts, patients commonly receive care from multiple physicians in the same setting. Also, institution-based physicians often presuppose that a patient has a PCP who will assume care after discharge, which is not always the case.

Problems of continuity are not limited to physicians. A case manager or other professional in charge of coordinating care may be unaware when one of his or her patients has accessed an emergency department or was admitted to a hospital. Although the hospital or SNF may employ its own case managers, these professionals rarely have responsibility for patients after discharge, and rarely communicate directly with other case managers, disease managers, or staff at community-based organizations involved with the patient's overall care. Thus, these patients may not have the benefit of continuity and advocacy at a time when they are acutely ill and vulnerable.

Nursing shortages further exacerbate the challenge of ensuring safe and efficient transfers. This shortage disproportionately affects post-acute and long-term care nursing facilities, which commonly experience high turnover and have difficulty attracting nurses, even when

they are in reasonable supply. Newly hired nursing staff are unlikely to be familiar with the institution's transfer procedures or with the health status of any given patient residing in the facility, and thus may not convey an accurate picture to the next set of practitioners.

Health care practitioners may also lack the necessary tools and information to function effectively. Practitioners throughout the continuum often are not familiar with how to evaluate patients with acute and chronic care needs and transmit this information across settings. This information is important for making decisions regarding the type and level of post-acute care services the patient requires. For example, the discharge summary—whether from the hospital, SNF, or home health agency nurse—commonly does not include information about the patient's prior functional status; recommendations from practitioners in various disciplines such as social work, behavioral health, occupational therapy, and physical therapy; nor the informal caregiver's ability or willingness to execute the care plan. Without a frame of reference for the patient's baseline level, receiving practitioners cannot obtain a complete view of the patient's functional status.

Proposed Solutions

Practitioners require specific training to meet the needs of patients in transition. The essential skills nec-

essary to care for these patients are summarized in Table I. Practitioners need to shift their mindset from the concept of a patient discharge toward that of a patient transfer to continuous care management. All practitioners must learn how to communicate across sites and collaborate in formulating a common care plan that incorporates different disciplines; evaluate a patient's system of social support, baseline level of function, and potential for discharge; and initiate care planning for the next setting well before the transfer occurs. Informal caregivers are often worried about their ability to care for the patient when he or she arrives home; therefore, it is critical that hospital physicians, nurses, and discharge planners are knowledgeable about the range of post-hospital options available in the community and the level of care that each facility is capable of providing. Consistency of information from all of these professionals is essential.

Since there are no training programs that specifically address the management of care transitions, it behooves HCOs to initiate their own educational programs. Organizations can encourage practitioners from sending institutions to visit receiving institutions in order to gain a better appreciation for: (1) their capability to deliver care, and (2) the information that should be transmitted in the discharge or transfer summary. Changing the practice environment may also entail eliminating transfers during times when the receiving institution is not adequately staffed to receive the patient.

Interpractitioner communication is critical for the success of care transitions. For example, the quality of a patient's transfer is enhanced when registered nurses from both the transferring hospital and the receiving SNF review the patient's care plan via telephone prior to discharge. Once the patient has been transferred, the registered nurse in the SNF can contact the same nurse in the hospital to clarify any remaining issues. At some Programs of All-Inclusive Care for the Elderly (PACE) sites, practitioners follow their patients across settings, providing greater continuity and the opportunity for enhancing inter-provider communication.

Some HCOs have attempted to tailor specialized services and expertise to patients with the greatest

potential to benefit. For example, while utilization management nurses can handle most patients, some patients may need the added training and expertise of complex care managers. Specialized care management programs may be needed for patients with particularly complex care needs, including those with congestive heart failure, organ transplant recipients, and persons enrolled in home-based programs. The case managers in these programs have advanced training in the management of these conditions and are skilled in the use of specialized tools and protocols.

Finally, some HCOs are exploring the addition of a new class of practitioners, referred to as *transitional care managers*, using advanced practice nurses. The nurses assume responsibility for the comprehensive care of the patient in conjunction with the PCP for approximately 4 weeks post-discharge. They are skilled at identifying changes in health status, assessing and managing multiple complex conditions, managing medications, and collaborating with caregivers and patients of interdisciplinary teams. Their responsibilities include: (1) facilitating interdisciplinary collaboration between the sending and receiving care teams; (2) serving as a single contact person who can address questions or concerns among patients and caregivers before, during, and immediately after a transfer; (3) reviewing medications for discrepancies and potential errors; (4) following up with the patient to make sure that he or she filled all prescriptions, received durable medical equipment as ordered, and made an appointment with the next practitioner; (5) empowering the patient and caregiver to participate more in their care; and (6) educating the patient and caregiver about the care plan.^{1,2} This model has been tested in patients with congestive heart failure and older adults with complex care needs, and has been shown to be effective at reducing readmission rates, length of subsequent hospitalizations, and costs.¹⁻⁵

In a variation of this model, the aim of the transitional care manager is to enhance patient and caregiver participation in the management of care transitions and to coach them on how to communicate with the multiple health professionals involved in

their care.^{1,5} To date, the study has shown that the hospital readmission rate among patients who receive this intervention is approximately half that of comparable patients who did not receive the intervention.⁵

PATIENT AND CAREGIVER PREPARATION

Recommendations

Health care organizations should:

1. Identify patients likely to require care transitions in the near future and engage them and their caregivers in pretransition planning.
2. Provide patients and caregivers with the resources and tools that will enable them to participate in the formulation of their transition care plan.
3. For patients facing imminent transitions, prepare patients and caregivers for their role in the transition as soon after the date of admission as possible for nonelective admissions and before admission for elective admissions.

Statement of Problem

Patients who are transferred from the hospital as well as their caregivers often feel inadequately prepared for what to expect at the next care site. Frequently, they perceive that they have had little input into the decision to be transferred. They also sense that the various practitioners responsible for their care generally communicate poorly, if at all, across settings. Many believe that they have not received adequate instruction on how to care for themselves in the next setting (eg, managing their conditions, taking their medications), and they often regard as impractical their practitioners' expectation that informal caregivers can provide adequate care. Finally, they also feel unprepared for the emotional impact that comes from a change in health or functional status.⁴⁻¹⁰

How well the delivery system meets patients' needs during a care transition has a significant effect on informal caregivers. Often, because of poor communication and inefficiencies, patients and their informal caregivers must by default assume responsibility for care coordination across different settings. Not only does

this unanticipated role create an emotional burden for informal caregivers, it may also cause financial strain if they are no longer able to fulfill their usual role in the workplace or with the family.

Some patients have unrealistic expectations. They may believe that they are ready to be transferred from the health care institution to home, when in fact they are unable to take care of their basic needs. Such situations force physicians and care managers to make a difficult trade-off between patient autonomy and patient (and caregiver) safety. Discharge under this circumstance can place both the patient and the informal caregiver at risk for adverse physical and mental health outcomes. In some cultures, the family member who cares for the patient may not be the person who assists in making decisions concerning the patient's care. For example, the adult daughter may be involved in the day-to-day provision of care, but the eldest son may make the health care decisions on behalf of the patient.

Typically, formal mechanisms are not in place to ensure that patients and caregivers are involved in the development of the care plan, including the logistics of the impending transfer. The caregiver, who often plays a critical role in the execution of the care plan following the transfer, may not even be present when the plan is formulated. Even when the patient and caregiver do participate, the primary focus often concerns the details of the immediate treatment plan, failing to address whether the next steps in the treatment plan are congruent with the patient's overall prognosis and goals for care.

Barriers of language, education, values, and culture may compound discrepancies between patients' and practitioners' goals. For example, patients' preferences may be compromised by practitioners' personal beliefs. Language barriers arise when the patient and the provider do not share the same primary language or when practitioners use medical jargon. Finally, studies have revealed that 30-40% of older adults lack the literacy skills necessary to function in the health care environment. For example, they may be unable to read or understand the directions on their prescription bottles or the information on an appointment slip.¹¹

Proposed Solutions

Health care organizations and practitioners have multiple opportunities to engage patients and informal caregivers in discussions that elicit their care needs and preferences. The prehospital admission planning process is an ideal opportunity to discuss the potential content and location of the post-hospital care experience. Alternatively, since the majority of hospital admissions are acute and unplanned, it would also be appropriate to identify patients who have advanced chronic illness, are likely to be hospitalized, and require post-acute care services within the year. These patients could be scheduled for a pretransition planning discussion with their PCP or care manager during a routine ambulatory visit. Patients who have recently experienced such transitions may be particularly receptive to such a discussion. These pretransition visits are also an appropriate time to make certain that the patient understands the need for documentation of advance directives as well as his or her post-hospital benefits under either Medicare Advantage (formerly Medicare + Choice) or fee-for-service Medicare. Such pretransition visits might begin with a question such as: "You may need to go to the hospital, and when this happens you may be too weak to care for yourself at home and need time to recover. Do you have someone who could take care of you for three days or so after a hospitalization?"

For those patients who are admitted nonelectively to the hospital, the process of discharge (transition) planning needs to be initiated early in the stay. Patients and informal caregivers should have the opportunity to express their concerns and actively participate in the formulation of the care plan. These discussions should be conducted in lay language and ideally should be initiated at the time of admission. Because of the critical role that caregivers play in executing the care plan, they must be consulted before any assumption is made regarding their ability and willingness to participate. In

Table II: Patient and Caregiver Care Transition Planning Questions

- How much of my prior abilities will I likely get back?
- What steps do I need to take to make this happen?
- How long will it take?
- Where can I go to recover? Will my stay be covered under my existing benefits?
- What resources and adaptations will it take to restore function?
- What is the anticipated time frame for me to regain function?
- Are my family members and friends expected to provide assistance? If so, how much assistance is required and for how long?

addition, the patient and caregiver may need time to assimilate and discuss the information provided, weigh the various options, and ask questions. At a minimum, patients who are frail or who have complex care needs and their caregivers should be encouraged to ask practitioners (eg, discharge planners, social workers, utilization management nurses, or physicians) the questions listed in Table II. Providing patients and caregivers with the opportunity to have input into the care plan is one way to invite discussion regarding individual preferences or practices that may impact the transition. These dialogues also may help practitioners identify family members who should participate in decisions regarding care planning and implementation of the care plan.

Patients and their caregivers can often be more effective participants in the planning and execution of care transitions if they acquire specific skills, analogous to the self-management skills they need to care for their medical conditions. For instance, patients can become more knowledgeable about their health care benefits and community resources (eg, companion care and respite care). One approach to enhancing the roles of the patient and the caregiver is to provide them with tools that prepare them for the upcoming transfer. Several tools have been designed for this purpose. For example, the patient transfer checklist displayed in Table III was designed for patients admitted to a hospital or SNF and their caregivers, based on input provided by patients who had recently been discharged from these institutions and their caregivers.¹

Sending institutions can also prepare patients for a transfer by ensuring that patients are able to assume an enhanced role in their recovery. For example,

Table III: Patient Transfer Checklist^{1*}

Before I leave the care facility, the following tasks should be completed:

- I have been involved in decisions about what will take place after I leave the facility.
- I understand where I am going after I leave this facility and what will happen to me once I arrive.
- I have the name and phone number of a person I should contact if a problem arises during my transfer.
- I understand what my medications are, how to obtain them, and how to take them.
- I understand the potential side effects of my medications and whom I should call if I experience any of them.
- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from becoming worse.
- My doctor or nurse has answered my most important questions prior to my leaving the facility.
- My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

* This and other transition-enhancing tools are available at <http://www.caretransitions.org>.

on their own with staff oversight. After successfully completing this trial, the patient and sending team can be confident that medications will be taken appropriately after discharge.

There are instances where the hospital care team recommends that a patient receive care in a SNF, but the patient decides to go directly home

patients receiving post-acute care in Veteran's Administration facilities can participate in a medication self-administration program that allows the patient, caregiver, and practitioners to determine whether that patient will be able manage his or her medications upon returning home. A pharmacist meets with the patient to gauge his or her understanding of the medication regimen and ability to follow it. Patients who demonstrate that they are able to follow the regimen are instructed to request their medications from the dispensing nurse at the appropriate time each day. If they are able to maintain the correct schedule, they are allowed to keep their medications in their room (with appropriate safeguards to ensure that other patients are not able to access them) and take them

instead. Health care organizations should have protocols for dealing with this situation. For example, the hospital care team could provide patients and caregivers with training in how to manage at home and encourage them to practice what they have learned before leaving the hospital. This training includes skills such as how to transfer a patient from the bed to a chair or on and off of the toilet, how to change dressings, and how to administer medications. Following discharge, these skills are closely monitored and reinforced by home health care nurses and therapists. ✧

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