We Can Do This BETTER

PROVIDERS MUST WORK TOGETHER TO ENSURE THAT CARE TRANSITIONS ARE SAFE AND COMFORTABLE.

Joanne Kaldy

Go back 40 or 50 years to simpler times when elderly patients moved easily between one of four basic settings—community-based care, the hospital, a nursing facility, or home care. There was a good chance that their primary care physicians followed them wherever they went and communicated with them, their families, and other practitioners. Transition of care wasn't much of an issue because the patient's move was fairly easy to track.

Care for today's seniors is much more complex and can involve several diverse settings—including community-based, acute, subacute, and skilled nursing care, along with rehabilitation, assisted living, continuing care retirement communities, and hospice, among others. This care can involve a wide range of treatments, services, practitioners, and caregivers. So it is no wonder that care transitions have become a major source of concern.

When care transitions are handled effectively, staff at each setting get the necessary information to provide quality care, prevent medication errors and other problems, and ensure the patient's safety and comfort. The patient and family feel informed and confident, and the patient's personal or attending physician is kept in the loop and communicates with physicians caring for the individual in other settings.

This is the ideal. Unfortunately, it isn't always reality.

Too often, gaps in communication and information lead to medication errors, increased health care utilization—including multiple trips to the emergency room—inefficient or duplicate assessments, inadequate follow-up care, patient and family dissatisfaction, and even death.

What Is Transition?

Transition of care generally refers to the movement of patients from one health care practitioner or setting to another as a patient's condition and care needs change.

It occurs at multiple levels—both within settings such as primary care and specialty care and between settings such as movement from a hospital to a rehab facility. It also happens across health states, such as a patient moving from community-based care to residing in an assisted living facility.

Problems with care transitions occur for a variety of reasons. However,

broadly defined, the most common issue is miscommunication or gaps in communication that result in information not being shared with the practitioners and others who need it. Even with the best of intentions, there are so many sources of information and so little connectivity between systems and settings that information and documentation can fall through the cracks.

"The health care system is often kept in information silos, a management system incapable of reciprocal operation with other, related management systems," says Cheri Lattimer, RN, BSN, executive director, Case Management Society of America, and project director, National Transitions of Care Coalition.

"These information silos can cause problems at the patient care level such as prescribing a medication when a patient has known allergies or intolerance, discrepancies from different information sources, incomplete or inaccurate discharge instructions, and therapy duplication, to name a few issues," she says.

There are barriers to successful care transitions at all levels. For example, practitioners often haven't practiced in the setting where they transfer the patient, or they don't or can't send information to receiving practitioners. They may not know the patient and his or her preferences and wishes, or they simply don't have any accountability. Patient-level barriers include assumptions that someone is coordi-

Table 1

IDEAL DISCHARGE OF THE ELDERLY PATIENT: A HOSPITALIST CHECKLIST

Data elements	Processes		
	Discharge summary	Patient instructions	Communication to follow-up clinician on day of discharge
Presenting problem that precipitated hospitalization	X	X	X
Key findings and test results	X		X
Final primary and secondary diagnoses	X	X	X
Brief hospital course	X		X
Condition at discharge, including functional status and cognitive status if relevant	X— functional status O— cognitive status		
Discharge destination (and rationale if not obvious)	X		X
Discharge medications: Written schedule Include purpose and cautions (if appropriate) for each Comparison with pre-admission medications (new, changes in dose/frequency, unchanged, "meds should no longer take")	 X O X	 X X X	 X O X
Follow-up appointments with name of provider, date, address, phone number, visit purpose, suggested management plan	X	X	X
All pending labs or tests, responsible person to whom results will be sent	X		X
Recommendations of any sub-specialty consultants	X		O
Documentation of patient education and understanding	X		X
Any anticipated problems and suggested interventions	X	X	X
24/7 call-back number	X	X	
Identify referring and receiving providers	X	X	
Resuscitation status and any other pertinent end-of-life issues	O		

X = required element O = optional element

Source: Journal of Hospital Medicine, November/December 2006

nating their care and that they don't need to be involved. Patients—and their families—also may attempt to navigate the system with little knowledge or experience and few tools or resources.

The growing attention on this issue is resulting in quality initiatives, standardized documents and policies, studies, consensus conferences, coalition building, and clinical practice guidelines. More organizations than ever are involved in these efforts, and long term care leaders from a variety of organizations, regions, and disciplines are joining forces to create a seamless continuum of care where patients are safe and comfortable, and practitioners, families, and others enjoy a satisfactory level of communication and interaction.

"Seamless" care, the smooth and safe transition of patients between settings, has long been a goal of nursing facilities. However, this initially just referred to transitions to and from the hospital. It is only in recent years that the long term care continuum has expanded to include assisted living and other settings and the objectives of seamless care embraced a broader range of patients, practitioners, and facilities.

Transitions In The Spotlight

While the increased attention to care transition is recent, these concerns are not new. However, there are several drivers beyond the increased attention to care transition. One is regulatory and governmental focus on the topic. For example, the Quality Improvement Organization 9th Scope of Work addresses both patient safety and care coordination. Elsewhere, the Joint Commission is including care transitions in its accreditation requirements, and the organization's 2009 Patient Safety Goals call for implementation of a "standardized approach to hand-off communication, including an opportunity to ask and respond to questions."

At the same time, reports from the Institute of Medicine about medication errors and news stories about patients who suffer due to poor care transition have brought public attention to the issue.

Consumers themselves also are helping to drive the focus on care transition. "We are a generation that is at the head of the health care world and experiencing firsthand the problems of poor care transitions and the challenges of managing the care of family members who are hundreds or thousands of miles away," says Lattimer.

"I've dealt with situations regarding my own mother, and such experiences are driving lots of people to embrace this issue and insist that we can do better," she says, adding, "Increasingly, baby boomers and other adult children are taking accountability and expecting providers and others to take responsibility as well."

With the rise of hospitalists, hospital

medicine specialists, long term care practitioners have important allies in the hospital who have similar concerns about care transitions. This has helped drive the issue and opened doors for communication between physicians in hospitals and long term care settings.

"As an organization, we made a conscious decision to have a role in this issue," says Tina Budnitz, senior advisor for quality initiatives at the Society of Hospital Medicine (SHM). "Care transitions, especially hospital discharges, could result in criticism or be our shining moment. We decided that this issue needed leadership, and we could provide that." She adds, "We made a commitment to look at what we can do to make it better tomorrow, as well as six years, 10 years, and 20 years from now."

Another driver is the rise of patient-centered care. "Consumers are an essential component in care transitions," says Eric Coleman, MD, MPH, professor of medicine at the University of Colorado. "As silent care coordinators, they share a disproportionate part of the burden in this area. In fact, family caregivers often see transition as a 'no-care zone.' Our work has been powerfully influenced by what patients and families have to teach us about this issue," he says.

Coleman offers two pieces of evidence to suggest the role of consumerism in care transitions. "It was largely the Consumer Council within The Joint Commission that was the lightening rod for promoting quality and safety during times of care handoffs," he says. Second, Coleman recently was asked to testify before a congressional hearing about patient-centered care.

Table 2

HAND OFF ALL ASSESSMENTS TO THE NEXT LEVEL OF CARE COORDINATION: CONTINUITY/COORDINATION OF CARE

Y N	Does the patient have a primary care physician? If appropriate, send assessment information. — Date:
Y N	Does the patient have a specialty physician, e.g., cardiologist: If appropriate, send assessment information. — Date:
Y N	Does the patient have a psychiatrist or other mental health provider? If appropriate, send assessment information. — Date:
Y N	Does the patient have an outpatient case manager who should be notified? Send assessment information. — Date:
Y N	Ensure all transition services and care (medications, equipment, home care, SNF, hospice) are coordinated and documented. — Date verified:
Y N	Ensure patient and caregiver understand all information and have a copy of the care plan with them. — Date verified:

Source: National Transitions of Care Coalition

When Patients Talk, 'We Should Listen'

"We need to listen to patients," says Coleman. "They are trying to tell us how to improve care transitions. We have asked them to help us understand what it is like for them and what we can do to help them. As time marches forward, we have valued our partnerships with community organizations such as family caregivers. They are the backbone of our health delivery system."

What are patients' concerns about care transition? "They don't feel prepared. They don't know where they are going, how long they will be there, how often they will see their physician, and other details about their future, and they worry about these unknowns," says Coleman. "They really want to know what their role is."

At the same time, patients are concerned about the amount of conflicting information they get from different sources, and they are frustrated because they don't know who they should contact about care transition issues, or they can't reach the practitioners they need to contact. "Family caregivers often say they pick up the ball when we drop it," Coleman says.

The most common concerns of physicians and other practitioners about care transitions are different and sometimes actually contrast to patient and family issues. As Coleman explains, "Ultimately, physicians and nurses want more information. To a degree, they are information junkies. When you ask them to describe a perfect post-hospitalization visit, they tick off a list of information they want."

In a world where patients want more support in their health care needs, he adds, "information is necessary but not sufficient. We are kind of missing the point."

Stepping Up To The Plate

As the public spotlight on care transitions heats up, a variety of organizations have embraced the issue and taken action to promote a dialogue and propose solutions. For example, the American Board of Internal Medicine (ABIM) Foundation established the Step Up to the Plate Alliance to transform clinical practice to achieve the six aims of the Institute of Medicine—safe, effective, patient-centered, timely, efficient, and equitable service.

In the first phase of its work the foundation convened a broad range of stakeholders to develop strategies to engage all physicians and clinicians to take leadership and maintain active participation in quality improvement.

The foundation published an issue brief last year addressing the care transition issue, called, "White Space or Black Hole: What Can We Do to Improve Care Transitions," addressing the alliance and its efforts.

Elsewhere, the ABIM Foundation sponsored a forum, Coordination of Care: Missing Opportunity? last year that brought together more than 120 influential leaders from all health care

Table 3

MY MEDICINE LIST

This medicine list is for:

Name:_____ Birth Date:_____

If you need to get in touch with me, use:

this phone number:_____

this e-mail:_____

Emergency contact:_____

The best way to get in touch with my emergency contact is:

Phone:_____ E-mail:_____

I am allergic to:_____

I also have some other problems with medicines:_____

Keeping My Medicine List Up To Date:

It is very important to keep this information current. Use the chart below to review and update your "My Medicine List." You can do this with your doctor, pharmacist, nurse, or other health care professional.

Reviewed by:	Reviewed on:	Updated on:	Updated by:

Questions for my doctor or pharmacist:_____

_____

_____

Use the guide on the back to fill out My Medicine List →

Using the following format, fill out drug use for morning, afternoon, evening, and before bed:

Drug name *(brand name, generic name, dose)*	This looks like	How many?	How I take it	I started taking this on
Zocor, Simvastatin, 40 mg	yellow pill	1 pill	with water	June 2008

Source: The American Society of Health-System Pharmacists (ASHP) and the ASHP Research and Education Foundation

sectors to discuss care transition issues. At the same time, the American Geriatrics Society has issued a position statement on care transitions promoting bidirectional communication between clinical professionals, development of policies to encourage high-quality transitional care, and education of and interaction with patients and families in transition situations.

Earlier this year, the American Medical Association (AMA) House of Delegates passed a resolution—submitted by the American Medical Directors Association (AMDA)—addressing care transitions.

The resolution, which was years in the works, passed easily. As Eric Tangalos, MD, AMDA's delegate to the AMA House, notes, "Attending physicians have a tremendous responsibility in long term care, and it is important for us to recognize the information they need about medications and other aspects of the patients' care and history as they move through the continuum."

Tools To Ease Transition

SHM has launched Project BOOST to improve transitions out of the hospital utilizing a team approach to risk assess patients on admission and to plan and execute risk-specific discharge planning activities.

Supported by the John A. Hartford Foundation and informed by a national advisory board representing nationally recognized care transition leaders, providers, payers, and regulatory agencies, the project is comprised of three major elements: a discharge planning tool kit, training and technical support for sites implementing the kit, and national advocacy to make system changes that support safe transitions.

AMDA recently convened a multidisciplinary work group to begin the process of developing a clinical practice guideline addressing care transitions. "Our membership has begun to talk more and more about quality of care and safety as patients move through the growing and increasingly complex long term care continuum," says James Lett, MD, CMD, chair of the workgroup.

"We found that there is no definitive guidance on this issue, and no one has determined what body of information needs to move with the patient through the continuum," he says. During a recent consensus conference to produce the guideline's first draft, group members addressed issues such as accountabilities—who will take responsibility for moving information from one setting to another.

"We hope that the guideline will shift the focus back to the patients to meet their needs, improve patient safety and satisfaction, and help practitioners and staff to understand their roles and responsibilities," notes Lett. "By enabling facilities to better handle paperwork and focus on the patient, we hopefully will help everyone understand the great unknown of the long term care continuum."

Steps In The Right Direction

The National Transitions of Care Coalition (NTOCC) is among the broadest and most prominent care transition initiatives. Established in 2006, the organization brings together thought leaders, patient advocates, and health care providers from various settings—including long term care—to address care transition issues. NTOCC has 29 participating organizations and associations. To improve care transitions, NTOCC suggests several steps, including:

■ Improved communication during transitions between providers, patients, and caregivers;

■ Implementation of electronic medical records that include standardized medication reconciliation elements;

■ Establishing points of accountability for sending and receiving care, particularly for hospitalists, physicians practicing in skilled nursing facilities, primary care physicians, and specialists;

■ Increasing the use of case management and professional care coordination;

■ Expanding the role of the pharmacist in transitions of care;

■ Implementing payment systems that align incentives; and

■ Developing performance measures to encourage better transitions of care.

To date, NTOCC has taken a lead role in developing tools and materials for practitioners, policy makers, and consumers addressing care transition issues.

These include a transition-of-care checklist, medication reconciliation essential data specifications, "my medication" list (*see box, page 28*), informational slide decks, and an informational brochure.

All of these tools and materials can be downloaded from the organization's Web site at www.ntocc.org.

"Everything you see on the Web site was developed via consensus with a multidisciplinary advisory task force," says Lattimer.

"We looked at key barriers to successful care transitions—such as medication reconciliation and communication problems—and what we needed to address these and connect all the dots." Expert work groups developed the tools and materials, which underwent extensive reviews and revisions before full consensus was reached and the items were posted on the Web site.

There are several sample forms on the site—such as the transitions-of-care checklist—but Lattimer stresses that these are not meant to encourage cookie cutter practices.

"We urge people to use any portion or part of the forms and to adapt them to their needs and their environment," she says.

While NTOCC already has received positive feedback about its tools, the organization will establish a formal discussion board later this fall to enable people to post their comments, suggestions, and experiences. "We will have an opportunity to learn more about how people have used the materials. We will go back to the advisory board with any suggestions we hear," Lattimer says.

'IT TAKES TIME TO EDUCATE OTHERS ABOUT WHAT WE DO AND THE SERVICES WE OFFER.'

Challenges In Assisted Living

Addressing transitions through the full spectrum of the long term care continuum is key. This includes assisted living facilities (ALFs), a growing presence and a source of mystery and misunderstanding for many. Because ALFs have many different characteristics, provide a wide array of services, and are overseen by diverse state regulations, practitioners, patients, family members, discharge planners, and others often don't realize what going to an ALF means.

Ensuring safe transition of residents in and out of ALFs is a special—and growing—care transition challenge. For example, as Lett observes, "If you write orders that are impossible for the ALF to perform, you set it up for the patient to fail and bounce right back to the emergency room."

Alex Pruchnicki, MD, an assisted living medical director in New York, adds, "When a hospital or other setting sends a patient to a nursing home, they generally know what services are available, how the facility works, and what orders have to be written. ALFs, on the other hand, have a wide variety of services, and discharge planners from other settings don't necessarily understand what information or documentation we need. As a result, we often have to track down documentation and scripts."

Helping key players in other care settings to know the ALF is essential, says Pruchnicki. "Having discharge planners, community agencies, and others who know how assisted living works is best. But it takes time to build these relationships and educate others about what we do, what services we offer, and what information we need about new residents," he notes.

Communication Disconnects

Lack of understanding about assisted living can result in frustration on the part of hospital nurses and physicians.

As Pruchnicki explains, "They often don't realize that the ALF may not have clinical staff or access to medical records after hours. Some don't even have such records. If physicians try to contact the facility after hours and can't get the information they want, it can cause problems. The ALF needs to work with these practitioners to establish a process for getting information after hours."

At the same time, the hospital's procedures can cause challenges for the ALF. Pruchnicki says, "Hospitals tend to want patients out on Friday afternoon, and admission to a new setting must be done quickly. This can be difficult for some ALFs with limited staff and access to clinicians. The regulations aren't as strict as in nursing facilities, and there may not be an opportunity for the patient to see a physician for weeks."

Many ALFs have devised creative

solutions to ensure smooth transitions. "We use case managers to talk with the family and discharge planner or social worker making the referral," says Pruchnicki. He adds, "We have a screening process to ensure that our facility is a good fit and that we get all necessary information and documentation to protect the patient's health and safety."

Pruchnicki also takes responsibility for communication during transitions.

"When one of my patients goes to the hospital, I try to call the hospitalist and give him or her a heads up. If a patient for whom I am not the primary physician is hospitalized, the nursing staff will contact the facility and handle all subsequent communications," he says. Pruchnicki and his staff also keep the family informed about the patient's progress.

The case manager's role is key. According to Pruchnicki, "She'll communicate with discharge planners at the hospital and tell them that before we can take a patient back, we need this specific information and we need the individual to be ambulatory, able to self-feed, and medically stable." He stresses that this type of communication takes time. Turnover can add to the challenge, so the case manager can't assume that hospital personnel know what the ALF needs. "It is an ongoing process that requires consistent and vigilant communication and education," he says.

Understanding the patient's needs and concerns is important. As Harriet McGreal, director of resident service at Lott Residence, an assisted living community in New York City, says, "Their biggest fear is that they won't be able to return to the assisted living facility. We visit them in the hospital and talk to them about how they can come back to us. They don't want to have to depend on someone, and this can be a major source of anxiety. We have to do what we can to ease these fears."

Increasingly, assisted living is part of the care transitions dialogue because it is experiencing the challenges firsthand.

"You can have four to five transitions because of one acute episode such as a hip fracture, and this is under the best of circumstances," Pruchnicki says. "There are several points along the way where something can go wrong or fall between the cracks. We have to build, maintain, and rebuild relationships. You have to know who to call and how to cut through the paperwork—all with the goal of keeping the patient safe and comfortable."

'YOU CAN HAVE FOUR TO FIVE TRANSITIONS BECAUSE OF ONE ACUTE EPISODE.'

High-Tech Solutions

There is a tremendous amount of work going on with technology and electronic interface to improve care coordination. "When I look at care coordination software, all have promise and are trying to move in this direction," says Lattimer.

While she and many others see technology—such as the widespread implementation of electronic health records (EHRs)—as having an important role in care transition solutions, they stress the need for systems to communicate with each other.

"Technology is great, but it won't go far toward improving care transitions if there isn't widespread interoperability," Lattimer notes. "The challenge is to understand that technology can help us in the process, but it must account for sending and receiving information and creating the ability to share data," she says.

While regional health information organizations and other groups are looking at standard data elements, interoperability continues to be an issue. "We need to open up and communicate across the country about how to do this. The banking industry has standardized so that you can use your ATM card in a country thousands of miles away, and we should be able to do so as well," says Lattimer.

Bridging Technology Levels

A related issue is the technological inequities between long term care settings, where some have sophisticated EHRs and others have one computer that they use primarily to transmit minimum data set information.

One company has addressed this by developing a system that enables electronic communication between high- and low-tech organizations. The Referral Management System and Discharge Referral System from Patient Placement Systems include a fax server capability where each user gets a toll free number that is a dedicated fax line. Information comes to a secure box instead of a fax machine, and the fax is scanned into a PDF document. Once the information is online, the facility can manage it accordingly.

"It isn't new technology but an innovative use of existing technology," says Patient Placement Systems President Eric Christ, MBA. He adds, "It enables the recording of structured data and the ability to do approvals and make changes within the document. It also helps facilities avoid rewriting medication information—a common source of med errors."

PointClickCare's Inquiry Referral Management is another system designed to improve care transitions. It is designed to decrease the amount of time an elderly patient must wait to be transferred from a hospital to a long term care facility. The pre-admission

inquiry process involves the management of inquiries, referrals for inquiries, and activities entered against the inquiries.

If a resident is entered into the system, all of his or her demographic information, contact information, identifiers, insurance, and assessment information will flow through into the associated financial and clinical sections of the application.

"We are at a volatile stage in technology. We've turned a corner where nursing facilities realize that technology—such as automating the admissions process—can improve their environment," says Christ.

"Facilities should be looking to vendors who are active in standard setting and who recognize interoperability as a key goal. They should seek vendors who 'get it' and who support what the facility is doing today and what they want to do tomorrow."

Coleman cautions against pinning all hope on technology as a panacea.

"There is some potential, but even in highly integrated systems there are big gaps in interoperability. Technology can be part of the answer, but I don't think it will be the solution. Instead, it is just one of the steps along the way to get there," he says.

Involving Patients

With the expanding long term care continuum, the involvement of patients in their own care is key, and researchers and others are looking at what patients can do to help ensure smooth transitions. One study suggests that coaching chronically ill older patients—along with their caregivers—with the use of tools to promote cross-site communication may reduce subsequent rehospitalization rates.

The study, "The Care Transitions Intervention," which appeared in the *Archives of Internal Medicine* in 2006, involves care transition intervention activities developed by Coleman and colleagues and categorized by four pillars—medication self-management, patient-centered record, follow-up, and red flags. These were derived from patient and caregiver feedback about what was most important to them during care transitions.

Patients worked with a transition coach, who encouraged them and their caregivers to take a more active role during care transitions, to provide continuity between settings, and to make sure that patients' needs were met.

"Patient safety for a long time was approached with very specific information about disease states," says Budnitz. "However, more novel—and more successful—approaches focus much more

on self-care functions; that is, what patients and families need to know [about] what they need to do."

For example, what do patients need to know to successfully change wound dressings? "You can't drill a hole in their heads and pour the information in," says Budnitz. "There has to be a dialogue with patients." The BOOST tool kit includes patient education components to help practitioners with these efforts in a way that ensures better care transitions out of the hospital to the home.

What Is The Answer?

It is to be hoped that some solutions for the care transition issues facing long term care will arise from the many initiatives currently in effect. However, facilities, individual practitioners, and providers have a role to play now.

"This is a quality improvement process that involves the full care team," says Lattimer. "We need to look at systems, workflow, and behavioral barriers to effective care transitions and start devising and implementing changes." She adds, "Facilities and their teams need to adapt the forms and other tools that are out there to their needs and make good use of the many resources available to them. The team needs to agree this is a problem and work together to solve it."

'WE NEED TO LOOK AT SYSTEMS, WORKFLOW, AND BEHAVIORAL BARRIERS.'

Long term care facilities can promote team buy-in by tying care transitions to their patient-centered care culture. This involves policies, procedures, and educational initiatives and tools that make patients and families a part of the solution and encourage staff to interact more closely with these individuals during transitions to ensure their needs are met.

It also is important to encourage practitioners and staff to reach out to colleagues in other settings. "Too often, people see those in other settings as the enemy. It is important to bring people from all settings together to talk about what they need from each other and how they can share documentation and information," says Coleman. He suggests a "Welcome to My World" day where care teams can visit others' settings. "This really opens people's eyes and helps them see what it is like for their colleagues in other settings," he says.

Forms and other tools are great, Coleman emphasizes. However, he says, "Work flow and relationships are the secret ingredients to successful care transitions, so we really need to attend to these issues."

Reaching The Right People

Nancy Istenes, DO, a geriatrician with the Summa Health Systems in Ohio, adds that forms and other tools are only beneficial if they are used. "There needs to be some accountability in completing forms and making sure that they are received by the right people," she says, adding, "We have established a care coordination network. Facilities that agreed to participate and comply with using set forms and tools are considered preferred providers. It has resulted in a great relationship between the hospital and about 26 area nursing facilities."

SHM's BOOST tool kit is available to everyone, and while it is designed to address what is happening in the hospital, it includes information that is useful to long term care facilities. Budnitz also suggests that long term care practitioners and providers can use the kit to start partnerships with hospitalists in their communities.

"Working together, they can improve the information flow, and it doesn't have to be high-tech or cost millions of dollars," she says.

Part of the solution is changing the language of transitions. According to Marianna Gracheck, MSN, president and chief executive officer of the American College of Health Care Administrators, "We are starting to refer to 'hand-offs' and not 'discharge.' The word 'discharge' suggests that your responsibility for the patient ends when they leave your facility. In truth, we all have accountability for patient outcomes wherever they occur. We need to change the mindset about this, the way we moved to a culture of patient-centered care."

Measuring Outcomes

Once solutions are in place, it will be important to measure their effectiveness. To enable this, Coleman and colleagues have developed a performance measurement called the Care Transition Measure. This is a patient-reported assessment of his or her transition experience.

There are 15- and three-item versions of the measure, available free at caretransitions.org. In addition to determining the patient's satisfaction with his or her transition experience, the tool measures the extent to which patients are prepared to participate in designated self-care activities after leaving the hospital.

Such measurements increasingly will be important, not only to assess care transition initiatives but also to demonstrate quality improvement programs related to these efforts.

As Coleman notes, "It will be difficult for accountability, payment reform, and other changes to happen without this. Measurement and payment go hand-in-hand." He adds, "Obviously, you can look for lots of eyes to measure care transitions, but we ultimately decided that this needed to be a patient-centered measure."

Everyone can—and should—be involved in addressing care transitions. "Administrators in all settings—especially nursing facilities and hospitals—should embrace this issue and empower their teams to address it," says Lett.

"We need to make sure that someone has their hands on the patient at all times. He or she should never be alone in the transition process; there should always be someone managing care, addressing needs and wishes, and ensuring the patient is safe and comfortable and has all of his or her questions answered." ■

JOANNE KALDY *is a freelance writer and communications consultant based in Hagerstown, Md.*