Care Transitions

By Sandra Dias

FAST FACTS

- The Holyoke Visiting Nurse Association's Care Transitions program ensures coordination and continuity of care from one health care setting to another.
- An up-to-date personal health record, outlining a patient's medical history and medications, is a useful tool when taken to the emergency room or to a visit with a new physician.
- The best candidates for the Care Transitions program are patients with chronic conditions who are most likely to be re-hospitalized. This program has reduced re-hospitalizations from 22% to 17% over the last year.

RESPONDENTS

- **Eugene and Catherine Murphy**
  Patients
  Holyoke Medical Center
  Holyoke, MA
- **Teresa Murray, RN**
  Transitions Coach
  Holyoke Visiting Nurse Association
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- **Jean E. Zaleski, PT, DPT, MEd**
  Director of Community Resource Development
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When Catherine Murphy, 79, was released from Holyoke Medical Center with a heart condition, requiring her to monitor her own blood pressure and take new medications, she and her husband, Eugene, were not left on their own. Mrs. Murphy, who lives in a senior apartment complex with her husband, received a month of visits from nurses through the Holyoke Visiting Nurse Association (VNA) and health care coaching through its Care Transitions program. Care Transitions is an intervention that coordinates care from one health care setting to the next, for example, from a hospital, rehabilitation center, or skilled nursing facility to home.

Mrs. Murphy met with Theresa Murray, RN, the Holyoke VNA Care Transitions coach, while still in the hospital and agreed to receive coaching services so she could successfully manage her self-care. The program complements the regular visiting nurse services that a patient receives through the VNA, as prescribed by a physician.

Coleman Care Transitions Model

Modeled after a research-based program developed by physician Eric Coleman, MD, at the University of Colorado, the Holyoke VNA Care Transitions program is designed to reduce the stress on patients who are transitioning from the hospital to home, as well as their family members, and lower the risk of re-hospitalization. "Many patients leave the hospital with new or changed medications, and their community physician has yet to see them in the office," said Jean E. Zaleski, PT, DPT, MEd, Director of Community Resource Development at the Holyoke VNA. A patient's relatives also can suddenly be thrust into the role of caregiver, and the process can be overwhelming for many families, according to Zaleski.

"The Care Transitions interventions are a set of actions designed to ensure coordination and continuity of health care as a patient transfers to a different location outside the hospital or to different levels of care within the same organization," Zaleski said. An example of the latter is when a patient transitions from traditional home care to palliative care and hospice care. Zaleski explained that it can be difficult to coordinate a patient's care across different health care settings, but the Care Transitions model provides the method for how to do that.

"It can be a real challenge to get important information to transfer from one setting to the next," she said. "We have a very complex health care system, and there are many different clinicians

Jean E. Zaleski, PT, DPT, MEd
Director of Community Resource Development, Holyoke Visiting Nurse Association, Holyoke, MA

Eugene and Catherine Murphy

coming into contact with the patient, such as hospitalists, specialists, nurses, therapists, and pharmacists. We realize that it is rare for the primary care physician to go into the hospital today."

Personal Health Records

The Care Transitions interventions help patients learn about their medical condition; develop a personal health record (PHR), outlining their medical history and medications; manage their medications; plan for future visits with physicians; and manage their specific disease process. In addition to the hospital meeting, the transition coach meets with the patient at home and then follows up with phone calls once or more each week to track the patient's progress and to answer the patient's questions. Patients typically spend 4 weeks in the coaching program.

Murray sat down with Mrs. Murphy and her husband to talk about the medications she would be taking, the amount and frequency of each dose, and what to do if she experienced side effects. Together, they also created a PHR, describing all of Murphy's medical conditions, both past and present, allergies, surgeries, medical tests, hospital stays, physician's visits, and her latest list of medications, among other information. "The PHR can very useful, particularly if patients take it when they go to the emergency room (ER) or to a new physician," Zaleski said. "They have all of their information with them, and there is no guessing what medications they might be taking and at what doses." Murray continued, "We encourage them to keep this booklet up to date and take it to any encounter they have with a health care provider. It is a nice little document that gives providers a clear picture of the patient and helps them to provide better treatment."

Teaching Self-advocacy Skills

The Care Transitions coach also guides patients to schedule appointments with primary care physicians and specialists and talks to them about questions they may want to ask. Murray will even role-play as a physician to make patients feel more confident when talking to a health care provider; she also coaches patients on self-advocacy skills. Zaleski adds, "It helps to empower patients to say 'I have just been in the hospital and need an appointment soon and cannot wait 2 months for an appointment.'"

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Theresa Murray, RN, *Transitions Coach,* Holyoke Visiting Nurse Association, and Catherine Murphy, *a patient*

Murray also goes over "red flags" with patients for their particular medical condition, so they know if it is worsening and when to contact a physician or go directly to the ER. In the case of someone with congestive heart failure, for example, Murray advises them to weigh themselves daily to detect weight increases and to watch for shortness of breath, edema of the legs and feet, and other symptoms, and then talks to the patient about what to do when those things happen.

Murray and Zaleski said the best candidates for the Care Transitions program are patients with chronic conditions who are most likely to be re-hospitalized, including people with congestive heart disease, heart attack, chronic obstructive pulmonary disease, and other illnesses. "These are the patients who need more support to be successful," Zaleski said.

Patient Feedback

For Mrs. Murphy and her husband, Eugene, the program was invaluable. She learned that her dose of Coumadin was too high, and she was urged to go to the ER for treatment when a small pinprick wound would not stop bleeding, an indication that her medication also needed to be adjusted. "It made me feel good that she was checking up on me that thoroughly," Mrs. Murphy said of Murray. "They do a really good teaching job so that once they leave, you know you can successfully manage your own care; you also know you can always call them if you have a question."

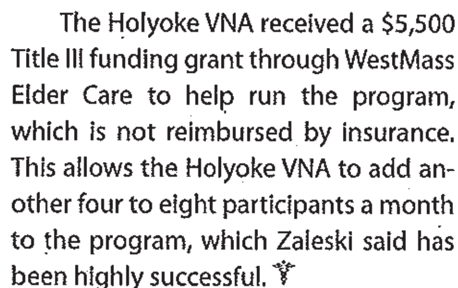
Mrs. Murphy said she has found the PHR to be especially useful, and she brings it to all her physician's visits. "It is wonderful," she said. "I keep it up to date with my new medications." Mr. Murphy said the entire Holyoke VNA program, including the Care Transitions coach, gave him peace of mind when his wife was released from the hospital after a 5-day stay. "It helped to calm me down a bit; they explained everything that was going on with my wife," he said. "They advised me when I should call 911, when we should call her physician, and when we should call her nurse."

MassPro: A Performance Improvement Organization

The Holyoke VNA participated in a yearlong pilot program through MassPro to learn how to adopt the trademarked Care Transitions model developed by Coleman. MassPro is a Waltham-based performance improvement organization dedicated to advancing health care delivery. Zaleski said the Holyoke VNA is the only visiting nurse group in the state that went through the pilot training program and has continued the specific Coleman Care Transitions model to its patients.

Zaleski said the research- and evidence-based Care Transitions program has been shown to reduce the rate of re-hospitalization for participating patients. She said the program improves patient safety by creating increased awareness and oversight of a patient's medications. One of the main reasons patients are re-hospitalized are issues with medication. "The number of elderly patients age 80 and over is growing, and they are often on a lot of different medications," she said. "We are helping them learn how to manage these."

Zaleski said participating in the pilot program gave the Holyoke VNA an opportunity to analyze results. The rate of re-hospitalization for patients participating in the program locally dropped from 22% to 17%. Recent statistics are continuing to show an improved trend for reduction of re-hospitalizations.



The Holyoke VNA received a $5,500 Title III funding grant through WestMass Elder Care to help run the program, which is not reimbursed by insurance. This allows the Holyoke VNA to add another four to eight participants a month to the program, which Zaleski said has been highly successful.