



Published in final edited form as:

J Am Geriatr Soc. 2017 June ; 65(6): 1119–1125. doi:10.1111/jgs.14782.

Components of Comprehensive and Effective Transitional Care

Mary D. Naylor, PhD, RN¹, Elizabeth C. Shaid, MSN, CRNP¹, Deborah Carpenter, RN, MSN², Brianna Gass, MPH³, Carol Levine⁴, Jing Li, MD, MS⁵, Ann Malley, PhD, APRN-NP¹, Kathleen McCauley, PhD, RN¹, Huong Q. Nguyen, PhD, RN⁶, Heather Watson, MBA/HCM⁶, Jane Brock, MD, MPH³, Brian Mittman, PhD⁶, Brian Jack, MD, MPH⁷, Suzanne Mitchell, MD, MS⁷, Becky Callicotatte⁸, John Schall⁹, and Mark V. Williams, MD, MHM⁵

¹University of Pennsylvania School of Nursing, Philadelphia, PA 19104

²Westat, Rockville, MD 20850-3129

³Telligen, Greenwood Village, CO 80111

⁴United Hospital Fund, New York, NY 10018

⁵University of Kentucky, Center for Health Services Research, Lexington, KY 40536

⁶Kaiser Permanente Southern California, Pasadena, CA 91101

⁷Boston Medical Center, Boston University School of Medicine, Boston, MA 02118

⁸Louisiana State University, Baton Rouge, LA 70803

⁹Caregiver Action Network, Washington, D.C. 20036

Abstract

Transitional care (TC) has received widespread attention from researchers, health system leaders, clinicians, and policy makers as they attempt to improve patients' health outcomes and reduce preventable hospital readmissions. Yet little is known about the key elements of effective TC and how they relate to patients' and caregivers' needs and experiences. To address this gap, the Patient-Centered Outcomes Research Institute (PCORI) funded a national study, Project ACHIEVE. A primary aim of the study is the identification of TC components that yield desired patient and caregiver outcomes. Project ACHIEVE established a multi-stakeholder workgroup to recommend essential TC components for vulnerable Medicare beneficiaries. Guided by a review of published evidence, the workgroup identified and defined a preliminary set of components, then analyzed how well the set aligned with "real-world" patients' and caregivers' experiences. Through this process, the workgroup identified eight TC components: Patient Engagement, Caregiver Engagement, Complexity/Medication Management, Patient Education, Caregiver Education, Patient and Caregiver Well-Being, Care Continuity, and Accountability. While the degree of

Corresponding Author: Mary D. Naylor, PhD, RN, University of Pennsylvania School of Nursing, 418 Curie Blvd, Claire M. Fagin Hall Room 341, Philadelphia, PA 19104-4217, Phone: 215-898-6088, Fax: 215-573-4225, naylor@nursing.upenn.edu.

Conflict of Interest: The authors have no conflicts of interest to declare.

Author Contributions: All authors were involved in the deliberations regarding key concepts and design, analysis and interpretation of evidence as well as in the preparation of this manuscript.

Sponsor's Role: Other than providing project funding, PCORI did not have a role in the deliberations outlined under authors' contributions.

attention given to each component will vary based on the specific needs of patients and caregivers, workgroup members agree that health systems need to address all components to ensure optimal TC for all Medicare beneficiaries.

Keywords

engagement; education; continuity; complexity management; accountability

INTRODUCTION

For decades, transitional care (TC) has received widespread attention from researchers, health system leaders, clinicians, and policy makers as they attempt to improve patients' health outcomes and reduce preventable rehospitalizations and their associated costs. Despite the contributions of many stakeholders, little is known about the key elements of effective TC and how they relate to patients' and caregivers' needs and experiences. To address this knowledge gap, in 2015 the Patient-Centered Outcomes Research Institute (PCORI) sponsored Project ACHIEVE (Achieving patient-centered Care and optimized Health In care transitions by Evaluating the Value of Evidence).¹ A primary aim of the study is the identification of transitional care components that yield desired patient and caregiver outcomes. Project ACHIEVE established the Transitional Care Components and Measures Workgroup (TCCMW) to review published research and, guided by a multistakeholder group, identify TC core components. Workgroup findings provided a framework of core components to inform the design of patient, caregiver, and provider surveys; health system and community site visits; and data analyses. Beyond the target populations that are the focus of Project ACHIEVE, the workgroup sought to identify TC components that are essential to ensure positive health outcomes and experiences for the larger population of high-need, high-cost patient adults and their caregivers.

PURPOSE

The TCCMW is a multi-stakeholder group that includes transitional care experts, patients and caregivers, and other key players (Supplementary Appendix S1). In its first year, the workgroup's goals were to 1) identify a set of evidence-based TC components; 2) operationally define each component, with emphasis on perspectives provided by patients and caregivers; 3) describe strategies to accomplish each component, as suggested by published research or recommendations of workgroup members; and 4) suggest metrics to assess each component's desired processes and outcomes. The workgroup met via teleconferences and webinars multiple times throughout 2015, and received ongoing input from the larger Project ACHIEVE team. This paper describes the workgroup's findings related to its first two goals---identifying and defining TC core components.

DESIGN AND METHODS

Definition

The workgroup determined that a TC core component is “*a critical element of traditional medical care, community-based services, and non-traditional services provided by the healthcare team that patients and caregivers should receive to promote positive health outcomes throughout periods of acute illnesses extending from hospital to home.*”

Organizing Framework

After achieving consensus on the definition of a TC component, the TCCMW agreed that categories of problems and concerns experienced by the target patient population and their caregivers throughout transitions from hospital to home would guide the selection of components. Published evidence related to patients’ and caregivers’ issues throughout transitions from hospital to home, including short-stays in skilled nursing facilities (SNFs) or similar settings, guided the identification of relevant strategies and metrics.

Target Population

As defined in the original Project ACHIEVE proposal¹, the target patient population for this study is hospitalized Medicare beneficiaries (including fee-for-service and Medicare Advantage members) at high risk for poor post-hospitalization outcomes, including patients with 1) multiple chronic conditions; 2) mental health issues; 3) cognitive impairment; 4) limited English proficiency or low health literacy; 5) lower socioeconomic status; and those who are 6) rural area residents; 7) eligible for Medicaid and Medicare; or 8) disabled and younger than age 65. The Project ACHIEVE study population also includes caregivers of these patients, defined as family members, partners, friends, or neighbors who provide unpaid support.¹

Methods

The workgroup used a multi-method approach to accomplish its goals. The TCCMW used categories of common problems and concerns experienced by patients and caregivers during hospital-to-home transitions and a preliminary set of TC components identified in the original Project ACHIEVE proposal¹ as its foundation. Preliminary findings from focus groups and interviews conducted with especially vulnerable older adults and caregivers also informed the workgroup’s efforts. The TCCMW added to available knowledge by identifying newly published evidence. A National Library of Medicine database search found more than 900 abstracts, indexed from January 2013 through July 2015. The following search terms were used: Patient Readmission[MeSH] OR “patient readmission*” [tiab] OR Readmission*[tiab] OR rehospitalisation*[tiab] OR “reducing hospitalization*” [tiab] OR “reducing rehospitalization*”[tiab] OR “re-admission*”[tiab] OR “re-admit*” [tiab] OR Continuity of patient care[MeSH] AND “Care transition*”[tiab] OR “transition* of care”[tiab] OR “transitional care”[tiab] AND Eng[la]. Three Project ACHIEVE members independently reviewed all abstracts, and selected 303 full-text publications for detailed review. Among these, 33 papers offered new evidence regarding problems experienced by patients and caregivers with potential implications for TC components, relevant strategies,

and/or measures. Findings from these papers were summarized and then integrated with the body of evidence generated for the original Project ACHIEVE proposal¹.

Guided by the organizing framework and the updated body of evidence, the workgroup deliberated over a period of months to identify and then operationally define a set of TC components. Throughout this process, members of Project ACHIEVE's Stakeholder Advisory Group, comprised of patient and caregiver representatives and other key stakeholders, and other members of the larger research team provided feedback and guidance to the workgroup.

After reaching agreement on a set of TC components, the workgroup agreed that an important next step would be to analyze how well the proposed set aligned with "real-world" patient and caregiver experiences. To that end, the TCCMW collected case studies voluntarily shared by patients and caregivers involved with Project ACHIEVE and reviewed published narratives related to TC. One of 12 available cases studies was carefully mapped to the set of TC components to determine if the list was comprehensive and if definitions adequately captured what matters most to patients and caregivers. The case involved a patient with cancer who had a surgical procedure resulting in a colostomy. Neither the patient nor her caregiver was prepared for this outcome. Preparation of the patient to care for her colostomy following hospital discharge did not occur when her caregiver was present. Nor did the patient have any opportunity to demonstrate what she had been taught to confirm comprehension of needed care. The lack of attention to the stress that the colostomy caused both the patient and her caregiver, and the negative impact it had on the patient's capacity to address her needs following her transition to home, resulted in the addition of "Patient and Caregiver Wellbeing" as a TC core component. Moreover, the limited attention to what this couple needed to know to ensure positive outcomes and the absence of a person designated to address ongoing questions and concerns, led to the identification of "Accountability" as a TC core component. Analysis of this case study also contributed to refined definitions of other TC core components.

RESULTS

Categories of Patients' and Caregivers' TC Issues

Published evidence, reinforced by input from Project ACHIEVE team members, led to identification of the categories of patient and caregiver issues described in Table 1. The recommended set of TC components relevant to high-risk Medicare beneficiaries transitioning from hospital to home is graphically depicted in Figure 1. Importantly, although each core component is identified separately, the TCCMW members emphasized that all are related and should be viewed as elements of a holistic care process. The definitions of each component are provided below.

Patient Engagement

Optimizing the central role of engaging patients through deliberate and consistent efforts by healthcare professionals and systems to: 1) identify what outcomes of their care are most important to these patients; 2) assess their perspectives, needs, and capabilities; 3) foster

shared decision-making regarding their plans of care; 4) promote shared accountability for actions related to these care plans; and 5) ensure trusting, reciprocal, and respectful relationships.²

Caregiver Engagement

Optimizing the central role of engaging caregivers through deliberate and consistent efforts by healthcare professionals and systems to: 1) identify what outcomes of care are most important to caregivers related to their role in caring for patients; 2) assess their perspectives, needs, and capabilities; 3) foster shared decision-making related to patients' plans of care; 4) promote shared accountability for actions related to these care plans; and 5) ensure reciprocal and respectful relationships.²

Complexity Management

Person-centered care that is holistic, consistent with patients' goals and characterized by anticipation, prevention, or early identification of problems (including health problems that develop during the acute hospitalization), that represent the most common clinical reasons for poor outcomes among the target population.^{3,4} This high-risk, chronically ill patient population presents clinicians and caregivers with challenging care issues associated with managing complex physical, emotional and social needs. One critical dimension of complexity management is the issue of medications. Medication management is person-centered care characterized by an organized effort to ensure optimum therapeutic outcomes for patients through greater accuracy in medication use and reduction of adverse events. Efforts to promote adherence are integrated within a comprehensive care plan.⁵

Patient Education

Continuous interactive teaching and learning processes involving the healthcare team and patient. Participation in these processes should be based on an assessment of patients' goals and designed to: 1) enable patients to assume increased responsibility for their own health; 2) employ strategies that encourage patients to make healthier lifestyle decisions; 3) increase patient competencies to promote adherence to medication and other therapies; 4) avoid or reduce adverse events related to their illnesses or treatments; 5) ensure continuity of care; and 6) promote independence in activities of daily living.²

Caregiver Education

Deliberate and consistent efforts to involve caregivers in decision-making regarding patient care. Caregivers are prepared with the skills needed to care for patients following hospital discharge, including skills in early identification and management of worsening symptoms. Caregivers are provided with access to community resources and supports and develop competencies and confidence that can help provide for patients' needs and address their own needs.^{2,6}

Patient and Caregiver Well-Being

Recognition of patients' and caregivers' emotional reactions to stressful experiences and deliberate efforts by healthcare team members to acknowledge such reactions, foster coping

skills, enable care recipients to be respected and treated as whole human beings, and support decisions that positively contribute to patients' and caregivers' quality of life.⁷

Care Continuity

Comprehensive implementation of individualized care plans including ensuring timely access to appropriate, high-value health and community-based services (management continuity), timely exchange of information between and among all team members (informational continuity), and access to continuous sources of care to foster trust with patients and caregivers (relational continuity).^{3,5,8,9}

Accountability (Clinician/Team/Organizational)

Assuming responsibility for ensuring high quality implementation of TC services customized to meet individualized needs of patients and caregivers. Clinicians' accountability refers to the partnerships between healthcare professionals and patients in designing plans of care and ensuring effective implementation of these plans. Team accountability refers to the responsibility of each healthcare professional to contribute expertise and actively collaborate with all team members to ensure patients and caregivers achieve their health goals. Organizational accountability refers to the system's responsibility to ensure an environment and services conducive to optimizing the TC experiences of patients and caregivers.¹⁰

Strategies to Implement TC Core Components

Specific strategies to achieve TC core components were identified from published evidence and are presented in Table 2. Strategies to achieve TC components are linked with examples of common patient and caregiver concerns identified in Table 1.

LIMITATIONS

As noted earlier, Project ACHIEVE is designed to target both FFS Medicare and Medicare Advantage beneficiaries at high risk for poor post-hospital outcomes. Importantly, the patient and caregiver issues identified in Table 1 are common among all Medicare recipients. Indeed, the multi-method approach used by this workgroup to identify components of transitional care was intentionally broad. There are, however, limitations to this effort that warrant consideration.

The first is that special attention was not given to subgroups of Medicare beneficiaries whose transitional care needs and outcomes may be influenced by differing health issues (e.g., mental health problems or cognitive impairment) or social issues (e.g., low health literacy or the absence of caregiver support).

Additionally, this framework of TC components was tested using only one in-depth case study; this case is not representative of the range of issues and experiences of diverse Medicare beneficiaries. Finally, workgroup efforts focused transitions of Medicare beneficiaries from hospitals through SNFs or other settings to home, and, thus, may not be inclusive of components unique to transitions across other settings.

CONCLUSION

A comprehensive review of the evidence and a case study analysis informed the deliberate engagement of patients, caregivers, transitional care experts and other stakeholders and contributed to the identification and definition of eight TC core components. While the degree of attention given to each core component will vary based on the specific needs of patients and caregivers, TCCMW members agree that health systems need to employ TC strategies that address all of the components. That will ensure that the population of vulnerable adults targeted in Project ACHIEVE receive transitional care that is person-centered, comprehensive, equitable, effective, and efficient. In addition to offering a framework for evaluating programs in representative health systems across the United States (the focus of Project ACHIEVE), workgroup findings help to clarify core elements of effective TC essential to ensure positive health outcomes and experiences for high-need, high-cost patient populations and their caregivers. Organizations can use this framework of TC core components as a guide to determine the level of transitional care that their patients and caregivers receive.

While workgroup and Project ACHIEVE team members agree that the TC components are sufficiently robust to guide the examination of existing TC programs, future findings likely will result in refinements of this framework. Assessment of the alignment of the TC components with a more representative set of patient and caregiver cases, across a broader range of health care settings and against existing frameworks of health outcomes¹¹ will contribute to such refinement.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

The authors would like to acknowledge the contributions made by the TCCMW that resulted in the findings reported in this manuscript. See Supplementary Appendix S1 for the complete list of TCCMW members. We gratefully acknowledge Karen B. Hirschman, PhD, MSW (University of Pennsylvania School of Nursing; Project ACHIEVE Co-Investigator) for her review and editorial support of this manuscript.

Funding Sources: This work was supported through a Patient-Centered Outcomes Research Institute (PCORI) award [Contract #TC-1403-14049]. All statements in this publication, including its findings and conclusions, are solely those of the authors and do not necessarily represent the views of the Patient-Centered Outcomes Research Institute (PCORI), its Board of Governors, or its Methodology Committee. Dr. Ann Malley was supported by the National Institutes of Health, Ruth L. Kirschstein National Research Service Award (T32NR009356) as well.

References

1. Li J, Brock J, Jack B, et al. Project ACHIEVE - using implementation research to guide the evaluation of transitional care effectiveness. *BMC Health Serv Res*. 2016; 16:70.doi: 10.1186/s12913-016-1312-y [PubMed: 26896024]
2. Naylor MD, Hirschman KB, O'Connor M, et al. Engaging older adults in their transitional care: what more needs to be done? *J Comp Eff Res*. 2013; 2(5):457–468. [PubMed: 24236743]
3. Krumholtz HM. Post-hospital syndrome- an acquired, transient condition of generalized risk. *N Engl J Med*. 2013; 368(2):100–102. [PubMed: 23301730]

4. Greenwald JL, Halasyamani L, Greene J, et al. Making inpatient medication reconciliation patient centered, clinically relevant and implementable: a consensus statement on key principles and necessary first steps. *J Hosp Med*. 2010; 5(8):477–485. [PubMed: 20945473]
5. Hohmann C, Neumann-Haefelin T, Klotz JM, et al. Providing systematic detailed information on medication upon hospital discharge as an important step towards improved transitional care. *J Clin Pharm Ther*. 2014; 39(3):286–291. [PubMed: 24877212]
6. Levine C, Halper D, Peist A, et al. Bridging troubled waters: family caregivers, transitions, and long-term care. *Health Affairs*. 2010; 29(1):116–124. [PubMed: 20048369]
7. Centers for Disease Control and Prevention. [Accessed May 31, 2016] Well-Being Concepts (online). Available at: <http://www.cdc.gov/hrqol/wellbeing.htm>
8. Kripalani S, Jackson AT, Schnipper JL, et al. Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists. *J Hosp Med*. 2007; 2(5):314–323. [PubMed: 17935242]
9. Snow V, Beck D, Budnitz T, et al. Transitions of care consensus policy statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. *J Hosp Med*. 2009; 4(6):364–370. [PubMed: 19479781]
10. Naylor MD, Aiken LH, Kurtzman ET, et al. The importance of transitional care in achieving health reform. *Health Aff (Millwood)*. 2011; 30(4):746–754. [PubMed: 21471497]
11. Tinetti ME1, McAvay GJ, Chang SS, Newman AB, Fitzpatrick AL, Fried TR, Peduzzi PN. Contribution of multiple chronic conditions to universal health outcomes. *J Am Geriatr Soc*. 2011; 59(9):1686–91. Epub 2011 Aug 30. DOI: 10.1111/j.1532-5415.2011.03573.x [PubMed: 21883118]



FIGURE 1.
TRANSITIONAL CARE CORE COMPONENTS

Table 1

Categories of Patient and Caregiver Issues Throughout Transitions and Specific Examples of the Issues

Issue Category	Examples of Issue
Lack of Patient and/or Caregiver Engagement	<ul style="list-style-type: none"> • Patients' or caregivers' levels of engagement are not assessed. • Transition planning does not include patient or caregiver. • Plan of care does not include patients' (e.g., ability to work in garden) or caregivers' (e.g., confidence in capacity to manage loved one's care) goals or preferences. • Patients and caregivers lack necessary information to participate in decision-making regarding their plans of care.
Poor Continuity of Care	<ul style="list-style-type: none"> • Patients and caregivers do not know whom to call with questions or concerns following transitions to home. • Information regarding the plan of care is not transmitted among organizations, healthcare team members, patients, and caregivers.
Inadequate Preparation	<ul style="list-style-type: none"> • Health literacy or language barriers are not identified or addressed. • Patients and caregivers are not provided adequate time to absorb instructions or demonstrate knowledge and skills regarding follow-up care, or symptom or medication management. • Caregivers are not adequately prepared and lack confidence, resources, and support to care for patients.
Gaps in Services	<ul style="list-style-type: none"> • Healthcare team members lack organizational support needed to ensure seamless transitions. • Coordination of services between hospitals and community providers are often inadequate.
Absent or Inadequate Communication	<ul style="list-style-type: none"> • Absence of relationships between patients and caregivers, and healthcare professionals has negative impact on patients' level of trust and adherence to care plans.
Limited Collaboration	<ul style="list-style-type: none"> • Patients and caregivers are not considered part of the healthcare team. • Healthcare team members do not communicate with one another or fail to resolve differences regarding key elements of care plans.
Multiple Health and Social Challenges	<ul style="list-style-type: none"> • Patients often have multiple co-existing health conditions often complicated by functional deficits, cognitive impairment, substance abuse, or depression as well as social problems, such as poverty, that affect needs and outcomes. • Seriously ill patients often are not provided with the opportunity and support needed to explore palliative care and end-of-life decisions.
Complex Treatment Regimens	<ul style="list-style-type: none"> • Errors of omission and commission involving complex medication plans are common. • Patients and caregivers often feel overwhelmed and experience emotional distress because of responsibilities for managing complex care needs at home.

Table 2

TC Components and Sample Strategies to Operationalize the Components

TC Component	Strategies	Categories of Patient and Caregiver Issues
Patient Engagement	<ul style="list-style-type: none"> • Conducting comprehensive assessment to identify patients' goals • Demonstrating respect for patients as partners in developing care plans reflective of their goals • Monitoring patients' progress at achieving their goals • Enabling timely bi-directional communication and care continuity • Continually evaluating patients' levels of engagement 	<ul style="list-style-type: none"> • Lack of patient and/or caregiver engagement • Poor continuity of care • Absent or inadequate communication • Limited collaboration
Caregiver Engagement	<ul style="list-style-type: none"> • Conducting comprehensive assessments to identify caregivers and determine their preferences and capabilities • Demonstrating respect for caregivers as partners in developing care plans reflective of their goals • Monitoring caregivers' progress at achieving their goals and helping patients to meet their needs • Enabling timely bi-directional communication and care continuity • Continually evaluating caregivers' levels of engagement 	<ul style="list-style-type: none"> • Lack of patient and/or caregiver engagement • Poor continuity of care • Absent or inadequate communication • Limited collaboration
Complexity/ Medication Management	<ul style="list-style-type: none"> • Identifying high-risk patients. • Anticipating and planning for common TC problems • Managing common coexisting chronic conditions and other health and social risks • Preventing the occurrence of post-hospital syndrome³ • Aligning health and community services with patients' and caregivers' goals throughout transitions • Ensuring that the medication management plan is based on evidence • Respecting patients' choices in adherence to plan • Providing appropriate information and training so that patient is knowledgeable and confident • Evaluating access to medications • Monitoring to avoid medication errors 	<ul style="list-style-type: none"> • Lack of patient and/or caregiver engagement • Inadequate preparation • Gaps in services • Limited collaboration • Multiple health and social challenges • Complex treatment regimens
Patient Education	<ul style="list-style-type: none"> • Identifying and addressing health literacy and language • Presenting health information in easily accessible, accurate, and usable formats 	<ul style="list-style-type: none"> • Lack of patient and/or caregiver engagement • Inadequate preparation

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

TC Component	Strategies	Categories of Patient and Caregiver Issues
	<ul style="list-style-type: none"> • Confirming patients' understanding of instructions 	<ul style="list-style-type: none"> • Multiple health and social challenges • Complex treatment regimens
Caregiver Education	<ul style="list-style-type: none"> • Involving caregivers in planning care. • Respecting and valuing caregivers' contributions to the team • Providing appropriate information and training to help caregivers feel knowledgeable and confident • Referring caregivers to community-based resources for support 	<ul style="list-style-type: none"> • Lack of patient and/or caregiver engagement • Inadequate preparation • Multiple health and social challenges • Complex treatment regimens • Gaps in services
Patient and Caregiver Well-Being	<ul style="list-style-type: none"> • Fostering early identification and interventions to address emotional distress • Recognizing caregivers' common concerns regarding reactions to the caregiving role including fear of harming their loved ones • Identifying and implementing effective strategies to support patients' and caregivers' emotional well-being 	<ul style="list-style-type: none"> • Lack of patient and/or caregiver engagement • Poor continuity of care • Inadequate preparation • Absent or inadequate communication • Multiple health and social challenges
Care Continuity	<ul style="list-style-type: none"> • Ensuring follow-up with primary care clinicians and specialists, home care or community-based services, etc. • Communicating effectively among the inpatient team and community-based healthcare team • Encouraging members of the healthcare team to engage patients and caregivers in trusting, reciprocal, and respectful relationships 	<ul style="list-style-type: none"> • Lack of patient and/or caregiver engagement • Poor continuity of care • Absent or inadequate communication
Accountability (<u>Clinician/ Team/ Organizational</u>)	<ul style="list-style-type: none"> • Fulfilling each clinician's responsibilities in a comprehensive, timely manner • Collaborating as team to ensure that patients' and caregivers' goals and preferences are met • Providing reliable performance improvement support for TC programs 	<ul style="list-style-type: none"> • Lack of patient and/or caregiver engagement • Poor continuity of care • Gaps in services • Absent or inadequate communication • Limited collaboration

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript