Published in final edited form as:

Fam Community Health. 2012 ; 35(4): 334–344. doi:10.1097/FCH.0b013e31826666eb.

Staff Interaction Strategies that Optimize Delivery of Transitional Care in a Skilled Nursing Facility: a Multiple Case Study

Mark Toles, PhD, RN¹, Julie Barroso, PhD, ANP, APRN, BC, FAAN¹, Cathleen Colón-Emeric, MD, MHS^{2,3}, Kirsten Corazzini, PhD¹, Eleanor McConnell, PhD, RN^{1,3}, and Ruth A. Anderson, PhD, RN, FAAN¹

¹Duke University School of Nursing, Durham, North Carolina

²Duke University School of Medicine, Durham, North Carolina

³Geriatric Research, Education and Clinical Center, Durham Veterans Affairs Medical Center, Durham, North Carolina

Abstract

After hospitalization, 1.5 million older adults each year receive post-acute care in skilled nursing facilities (SNF). Transitional care services, designed to prepare older SNF patients (and their family caregivers) for their transitions from a SNF to home, have rarely been studied. Thus, we conducted a longitudinal, multiple case study of transitional care provided in an SNF to explore the care processes and staff interaction strategies that SNF staff members used to optimize delivery of on transitional care. Using qualitative data from 89 interviews, 118 field observations, and 70 chart or document reviews, we observed that transitional care services were not solely formalized processes, but rather were embedded in the interactions among older adult patients, their family caregivers and members of interdisciplinary care teams. We found, moreover, that staff member interactions with patients and family caregivers increased the capacity of patient care teams for optimizing patient-centered care, information exchange, and coordination of transitional care.

Keywords

Transitional Care; Skilled Nursing Facilities; Older Adults; Family Caregivers; Interactions

Each year, more than 1.5 million older adults complete acute hospitalization and transfer to skilled nursing facilities (SNF), where they participate in 3–4 week courses of post-acute care before most patients transition, again, to home.¹ Vulnerability of SNF patients² and fragmentation among health care providers^{3–5} increases the risks for complications during older adult transitions from SNFs to home, including omissions or missteps in care, poor health outcomes (such as falls and medication errors), and over-utilization of healthcare resources.^{4,6–10}

For care transitions from hospitals to home, a set of time-limited services, known as transitional care, has proven effective for preventing poor health outcomes and ensuring continuity of care.^{11,12} Although transitional care has not been studied in SNFs, findings from studies in other settings suggest that it may be a useful model which could also benefit

The study was conducted in the Duke University School of Nursing

An earlier version of this manuscript appeared as a dissertation chapter. Toles, M. Transitional Care in a Nursing Home [dissertation]. Durham, NC: Duke University; 2011.

older adults and family caregivers as they transition from SNFs to home. Studies of transitional care describe a range of hospital and community outreach services that improved health outcomes for older adults and decreased rates of costly hospital readmissions.^{11,13} The centerpiece of these interventions was the use of added transitional care providers (e.g., transitional care nurses or coaches),^{12,13} who established relationships with patients and family caregivers and delivered transitional care services such as medication reconciliation, patient/caregiver education, ensuring information receipt by next care providers, and scheduling appropriate follow-up.^{14–17}

Providing transitional care with added staff is likely cost-prohibitive in SNFs, where resource constraints limit the availability of professional caregivers. Moreover, in prior studies in nursing homes, staff interaction strategies (such as interactions that promote problem solving) have been identified as untapped resources for improving care processes and patient outcomes.^{18,19} Understanding how interaction strategies influence the delivery of transitional care may provide new knowledge for optimizing the delivery of transitional care in SNFs. Thus, we conducted a longitudinal, multiple case study to describe transitional care provided by existing staff in a SNF and to explore the influence of staff interaction strategies on the delivery of transitional care.

Conceptual Model

We used prior work on transitional care and staff interactions to guide this study. We defined transitional care using two concepts, interaction strategies and care processes designed ensure continuity of care and promote health outcomes of older adults during transitions between settings and providers of care.^{12,20} For the care processes, we used the definition and attributes of transitional care gleaned from an extensive literature review and explored care processes that promoted patient and family caregiver engagement, education, discharge planning and care coordination (Table 1, right column).^{12–15,21} For staff interactions, we used Anderson's Model of Local Interaction and explored interaction strategies that fostered: (a) connections, e.g., the quality of relationships such as open, trusting, or helpful; (b) information flow, e.g., the rate at which new information is introduced to the system; and (c) cognitive diversity, e.g., the degree of attentiveness to care needs and willingness to develop new ideas using a variety of perspectives (Table 1, left column).¹⁸ Using these concepts and definitions, we conceptualized the *delivery* of transitional care as the use of the interaction strategies to optimize the effectiveness of transitional care processes.

Design and Methods

A longitudinal, multiple case study design^{22–24} was used to explore transitional care interactions in a continuing care retirement community (CCRC) in the southeastern United States. The study setting was purposively selected based on a positive community reputation for providing SNF care, greater than average quality indicators in Nursing Home Compare, and a pattern of providing SNF care for older adults who did and did not reside in the CCRC. The university Institutional Review Board approved all study procedures and informed consent was obtained from all study participants prior to study enrollment and participation.

Sample and procedures

A “case” was defined as a transitional care team, comprised of an individual patient, a family caregiver, and the six to eight SNF staff members who provided transitional care processes (identified in Table 1) to this patient. Three transitional care teams were recruited and case studies were completed consecutively. The delivery of transitional care was studied

prospectively from the patient's day of admission through the day of discharge. Recruitment of care team members began with selecting the SNF patient in each case. The inclusion criterion for patients was an anticipated length of stay of 15 to 45 days; exclusion criteria were moderate to severe cognitive impairment and inability to speak English. SNF patients were purposively selected to ensure diversity of admitting diagnoses, psychosocial issues and discharge destinations. Inclusion criteria for nursing home staff were willingness to participate and being a provider of transitional care to the selected patient. Family caregivers were included based on availability and willingness to participate. Participants in the three cases included 3 patients, 20 unique staff members in the SNF, and 2 family caregivers. All invited patients, family caregivers and staff members enrolled in the study. The characteristics of the transitional care teams are described in Table 2.

Data collection

The principal investigator collected all case study data. Data collection methods included direct observation, document reviews, and scheduled or impromptu interviews that were conducted as transitional care activities emerged over the complete patient stay in the SNF.²³ During data collection, the researcher "shadowed" care team members as they interacted in meetings, rounds, and transitional care activities with patients and family caregivers. An observational guide, developed in a feasibility study, was used to ensure that the researcher consistently followed study protocols for shadowing and focused observations of interaction strategies and care processes (described in Table 1). For example, using an observation schedule, the researcher observed staff member interactions with patients and families at consistent time points across SNF stays in each case study. Field notes (n=118) were hand written immediately after observations, and transcribed daily for subsequent analysis. In addition, the researcher conducted scheduled and impromptu interviews (n=89) to explore the staff, patient, and family caregiver perspectives on interaction strategies and care processes. An interview protocol was followed to ensure consistency in scheduled and impromptu interviews across cases. Finally, the researcher reviewed documents (n=70) such as institutional policies and protocols, care team chart notes and care plans and discharge materials. All data files were analyzed using Atlas.ti software.

Analysis

Using *a priori* codes developed from the interaction strategies and care processes described in Table 1, the researcher coded all data using manifest content analysis²⁵ and then conducted a thematic analysis²⁶ of units of coded data. As data were collected, preliminary findings were used to guide ongoing data collection; this step provided a continuous process of reliability checks with patients, caregivers and staff members.²⁶ When all data collection and data coding was complete, a second investigator (JB) coded a random sample of 10% of the data to ensure the accuracy and consistency of coding. There was 95% agreement between the coders. Members of the analysis team (MT, RA, JB) discussed emergent themes. Written descriptions of the main themes and exemplar fragments of data were then discussed with the full research team. Adding revisions from the team discussion, the researcher presented the study findings to a small group of staff participants in the study setting (no SNF patients attended this meeting). Finally, incorporating feedback from discussions with participants, the researcher wrote clinical vignettes to describe exemplars of the way staff used interactions strategies to optimize the delivery transitional care.

Results

Patient needs and transitional care varied between cases: (a) one patient with multiple advanced illnesses engaged in a plan for long term antibiotic treatment and added support at home; (b) a second patient, who over-estimated his ability to walk, accepted a plan for

outpatient rehabilitation and home care; and (c) a third patient, with an infected abdominal wound, returned home with a visiting nurse for wound care and plans to increase her calorie intake. Before presenting the case vignettes, we provide an overview of the nature of transitional care as delivered in this SNF and the staff interactions used.

The SNF had few protocols, policies and little training to support transitional care. We found inconsistencies and gaps in their use of care processes and the interaction strategies. Each type of interaction strategy and five of the care processes were used by one or more staff members in delivering transitional care (see Table 3). However, we observed that SNF staff members did not (a) consistently include family caregivers in care; (b) provide some essential care processes (e.g., written instructions to guide care at home); and (c) consistently use interaction strategies that promote problem solving and mutual understandings or consistently forming connects with family or other transitional care staff (see Table 3).

As staff members delivered transitional care, we observed that the care processes (such as engagement, teaching and discharge planning) were consistently embedded in staff member interactions with patients, family caregivers and other staff. Further, when staff members used the interaction strategies to elicit and address transitional care needs, we found that they delivered care processes more effectively to prepare and support patients and family caregivers during their transitions to home; specifically, using the interactions strategies, staff:

- a. created connections with patients or caregivers that facilitated integrating patient/caregiver preferences into the care plan;
- b. uncovered and relayed new information needed to select and complete appropriate care processes; and
- c. engaged patients and families in problem-solving conversations to address patient challenges, establish priorities and plans, and facilitate active participation by patients in carrying out prescribed care.

We found that the delivery of transitional care was largely confined to dyads of individual staff members and patients or family caregivers; we did not observe them using family meetings or care team meetings that might have optimized transitional care processes (e.g., set priorities, integrate care, double check on the status of tasks). Accordingly, our main findings are described in three clinical vignettes that identify exemplars of the way individual staff members' use of the interaction strategies optimized the effectiveness of transitional care with patients and family caregivers.

Vignette One: Interactions that Fostered Experimentation and Promoted Safety

Across cases, we found that staff members helped SNF patients reconcile their dependence on others with their wish to return home and manage things as usual. For instance, in an interview with an 85 year old male patient, we learned that the patient was livid about his need for SNF care:

I am not obliged to spend another week in this hell-hole...I'll wait another week, then I will go home...if they say I cannot go back to my home, I will leave the retirement community.

At the time of this remark, ten days had passed since the patient had a knee replacement. He required assistance from two staff members for transfers from the bed to a wheelchair. Further, when staff members approached him to describe steps in self-management or resources for continuing care at home, his anger and frustration limited his attention and participation.

The patient engaged in transitional care processes only after a staff member used interactions that helped him to experiment and subsequently discover that he needed added supports to be mobile. In an exit interview, an occupational therapist described how she garnered the patient's participation:

I want [patient name] to see for himself that he has limitations...but I can see that we are dealing with his dignity and pride...He tells me he can get up without help. So I help him get to a safe place where he can try to show me...When he is not able to do all that he says, I point out the areas we need to work on. I have to do that over and over.

There are two important points to note here. First, the care processes were not services that the therapist delivered and the patient passively received; rather, the patient and the therapist negotiated when and how the care processes were delivered. Second, the therapist's care was exemplary because (a) she consistently showed respect for the patient's preferences and succeeded in creating a connection with him, (b) she used her interactions with the patient to create a safety net to accommodate his need to identify mobility limitations for himself, and (c) she continuously provided the patient with feedback to reinforce lessons they had already learned together. In sum, these interactions helped the patient to see his situation with new understanding and this motivated his active involvement.

We found strong evidence that transitional care services provided by the therapist were effective. During the patient's third week of SNF care, he acknowledged the need for assistance and his openness to added care at home care:

I've been talking with [occupational therapist] about the need for aides to come in at home...I have not needed that help in the past...having help may be the only way to get back home, and I am thinking about that.

Vignette Two: Interactions that Fostered Patient Self-Efficacy and Promoted Learning

Throughout the case studies, we found that staff members used the interaction strategies to help patients recover their sense of control and ability to use new information to manage their changing health needs. When we observed patients develop resources for learning and growth, we also observed more successful transitional care. For example, in one case we encountered a patient with a slow-healing wound and anxiety about the wound that limited her ability to learn during patient teaching. The patient told us, "I am afraid of going home. I have the nurse here to take care of this wound and all the drainage. At home I will be alone."

Although several staff members in the SNF provided wound care, most attended to immediate needs such as assessments of the wound and the effectiveness of the dressings. The day nurse, however, made a habit of talking with this patient about the wound and discovered that the patient was overwhelmed by even the thought of the wound, which limited her engagement in the care processes.

The nurse described the patient's behavior, "Every day she had several kinds of questions about the wound...she would keep looking at it." As part of routine care in the SNF, the day nurse repeatedly visited this patient and interacted with her by listening, explaining, verifying understanding, and giving feedback, and thus created a learning lab at the patient's bedside. In an interview the nurse said:

I told her "You can look at it if you want to." And, "You can tell if something is wrong by every day looking at it." "[You can see] if there is any redness or if it's tender when you touch that area."

As the patient interacted with the nurse and explored the wound, she became less anxious, more familiar with it, and was gradually able to learn. We observed that the patient developed the skills to recognize changes in the wound and accepted the need for visiting nurses at home. The patient said, “I could almost change this dressing myself.”

In this exemplar, the nurse’s communication with the patient contributed to the successful transitional care outcome; more importantly, however, the nurse’s interactions - that facilitated the patient’s discovery that she was capable of caring for the wound - optimized transitional care by ensuring that the patient learned what the nurse was communicating.

Vignette Three: Interactions that Fostered Family Caregiver Assessments of Patient Needs and Promoted their Participation in Care for Patients at Home

We did not observe routine care team meetings with patients, family caregivers and members of the multidisciplinary team in the SNF. Thus, care team members were often uncertain of care processes provided by others and were unaware whether some care processes were delivered at all. Staff members managed this uncertainty individually, using interaction strategies to build connections with patients and family caregivers to solve emerging problems in care.

In one case, near the day of a patient’s discharge to home, a family caregiver visited the SNF and initiated a conversation with the physical therapist about the patient’s safety at home. He stated, “It would be a real shame if [patient name] left here and she was not ready, if she came home and had a fall because she left here before it was safe.” The physical therapist did not confront the caregiver about whether the patient was prepared for returning home. Instead, using interaction strategies (e.g., seeking assistance, coaching, and giving and receiving feedback) she facilitated the caregiver’s assessment of the progress his loved one had made in the SNF. In this exemplar, we saw a complex interplay of interaction strategies and care processes through the dialogue between the therapist, family caregiver and patient.

First, the therapist interacted with the patient as a coach and spoke directly to *her*. She said, “[Patient name], we’ve worked together very closely. You have done every single thing we’ve asked you to do and you have made a lot of progress.” Second, the therapist waited which gave the patient an opportunity to articulate the progress that she had made in the SNF. The patient said, “Yes, it has been very helpful here.” Third, the therapist reviewed the critical task for a safe transition to home with the patient and family caregiver. She said, “The thing that matters...is that you take your time and use all the safety skills that you have shown us you can do.” When the patient stated that she understood the therapist, it became evident that the therapist’s interactions were helping the family caregiver revise his assessment. He appeared more confident and responded, “They are telling me that you have learned what you need to know, you need to follow the instructions they gave you.” Then, the family caregiver looked at the therapist and continued, “Now, after all this, she looks better to me, she does.”

Thus, in this exchange, the physical therapist optimized transitional care when she used her interactions with the caregiver to help him apply information about his loved one’s care to form his own assessment of her readiness for going home. As this part of the impromptu meeting concluded, the therapist and the family caregiver discussed grab bars for preventing falls in the patient’s home and other medical equipment that was needed for safety. The family caregiver appreciated the therapist’s assistance. In an exit interview, he told us,

I thought the rehabilitation people were real helpful...that day we sat down about the grab bars...it was then that I could see what was going on up there. These

people cared about what we were doing. They were giving us ideas about how to make things safer.

Discussion

Across the case studies, we identified strengths, gaps and inconsistencies in the delivery of transitional care in the SNF. Although many evidence-based care processes were used to support and prepare patients for care at home, we identified critical care processes that were inconsistently used or absent, including reconciliation of discharge medications with medications previously used at home and complete, written instructions to guide care at home. We also found that interaction strategies were interpersonal resources that SNF staff members used to deliver effective transitional care. The study expands existing knowledge about transitional care by explaining how and why the interaction strategies support transitional care activities, such as establishing goals for planning, or to develop new information.

In accordance with the Model of Local Interaction, the study also contributes new knowledge by showing how transitional care was embedded in interactions between providers and patient and, significantly, that these interactions frequently optimized the delivery of transitional care. Prior studies have emphasized associations between transitional care processes and the safety of patient transitions to home.^{14,15,27} Building on this work, our findings suggest that the capacity for effective transitional care emerges when staff members interact with patients in ways that build connections, promote information exchange, and develop shared understandings. We found, in particular, that the interaction strategies optimized transitional care when the staff members used them to foster opportunities for patients or caregivers to learn by trial and error, discover their ability to change or grow, and explore multiple points of view to solve or understand problems in care. These strategies helped the patients to assume an active role in recovery.

More often than not, delivery of transitional care was confined to one to one interactions between individual patients and staff members, limiting outcomes that might otherwise have been achieved by interactions among the larger care team. This lack of team member interaction meant that care team members were not always aware that there was “a team” and did not necessarily know all of the members, including family members that were involved. This reveals important opportunities for improving transitional care in SNFs.

Thus, our exploratory findings have implications for practice. This is the first study to describe the work of SNF staff members who prepare older, post-acute care patients for transitions to home; moreover, few studies have described approaches to relationship-building and communication used by care coordinators, in hospital-based studies of transitional care.^{17,28,29} Our findings suggest that transitional care in SNFs can be improved by using a wider range of the available, evidence-based care processes to prepare older adults and family caregivers for safe and effective transitions to home. For example, immediate focus is needed to provide complete written materials, such as schedules for appointments, complete contact information for referrals, and detailed descriptions of procedures to continue at home. Moreover, individuals and groups of staff can optimize delivery of transitional care by using interaction strategies to facilitate patient exploration and discovery of resources needed to become an active participant in care at home.

In addition, research is needed to explicate the way that transitional care teams bring the team into focus for the work group and to identify structures that will support team member interactions, sequences of care, and protocols for collaboration that will optimize transitional care outcomes. An immediate research priority is to explore the way that professional staff

members use local interaction strategies and what they identify as barriers as well as where and why such barriers may occur in their encounters with family members and each other. This research is needed to describe the role of local interactions and how they may be used to create patient care teams in SNFs that fully engage their inherent capacity to provide optimal transitional care.

Our findings are congruent with recent studies that described staff interactions as resources for improving effectiveness of care processes in nursing homes, including care planning, care plan implementation,^{30,31} and urinary incontinence management.^{32,33} However, our findings are limited by the exploratory nature of this research. In particular, research is needed to describe the rate or intensity of staff interactions that are needed for effective delivery of transitional care. Further, the study was conducted in a single, high-performing SNF, in a small sample of transitional care teams, and with SNF patients with no cognitive impairment; moreover, the study described transitional care delivered only in the SNF and with no participant interviews after discharge. Thus, research is also needed to confirm these findings in a larger sample of SNFs and patients and to explore transitional care provided across settings of care and in samples of patients with cognitive impairment. Nonetheless, the case study data included 89 interviews and 118 observations in the sample of three cases; thus, opportunities for follow-up confirmation of initial observations created rich descriptions of care processes as they developed. This abundance of contextual data permitted us to explore patterns in staff interactions in considerable depth and to observe, over an average of 25 days in each case, how interactions shaped the effectiveness of transitional care processes over time. In addition, our interpretations of the data were improved by comparing individual events using data collected from multiple sources and points of view.

Conclusion

In this study of transitional care in an SNF, we observed that professional staff used interaction strategies and many evidence-based care processes and to deliver transitional care. We learned that transitional care processes were embedded in interactions among patients, family members and staff members; moreover, we found that staff use of the interaction strategies optimized the delivery of transitional care provided for patients and their family caregivers during their transitions from SNFs to home. We concluded that these findings offer resources for improving practice and guiding future research designed to optimize delivery of transitional care in SNFs.

Acknowledgments

Three grants provided for Mark Toles supported this research: John A. Hartford Foundation Building Academic Geriatric Nursing (BAGNC) Pre-doctoral Scholarship ; a John A. Hartford Foundation/Atlantic Philanthropies Claire M. Fagin Postdoctoral Fellowship; a National Institute for Nursing Research T-32 (T32NR009356) from the University of Pennsylvania School of Nursing (PI: Mary Naylor)

References

1. Ng T, Harrington C, Kitchener M. Medicare and medicaid in long-term care. *Health Aff (Millwood)*. Jan-Feb;2010 29(1):22–28. [PubMed: 20048356]
2. Mason SE, Auerbach C, LaPorte HH. From hospital to nursing facility: Factors influencing decisions. *Health Soc Work*. Feb; 2009 34(1):8–15. [PubMed: 19281098]
3. Coleman EA. Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. *J Am Geriatr Soc*. Apr; 2003 51(4):549–555. [PubMed: 12657078]

4. Coleman EA, Min SJ, Chomiak A, Kramer AM. Posthospital care transitions: patterns, complications, and risk identification. *Health Serv Res.* Oct; 2004 39(5):1449–1465. [PubMed: 15333117]
5. Sofaer S. Navigating poorly charted territory: Patient dilemmas in health care “nonsystems”. *Med Care Res Rev.* Feb; 2009 66(1 Suppl):75S–93S. [PubMed: 19074306]
6. Boockvar KS, Fishman E, Kyriacou CK, Monias A, Gavi S, Cortes T. Adverse events due to discontinuations in drug use and dose changes in patients transferred between acute and long-term care facilities. *Arch Intern Med.* Mar 8; 2004 164(5):545–550. [PubMed: 15006832]
7. Boockvar KS, Litke A, Penrod JD, et al. Patient relocation in the 6 months after hip fracture: Risk factors for fragmented care. *J Am Geriatr Soc.* Nov; 2004 52(11):1826–1831. [PubMed: 15507058]
8. Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med.* Feb 4; 2003 138(3): 161–167. [PubMed: 12558354]
9. Makaryus AN, Friedman EA. Patients’ understanding of their treatment plans and diagnosis at discharge. *Mayo Clin Proc.* Aug; 2005 80(8):991–994. [PubMed: 16092576]
10. Murtaugh CM, Litke A. Transitions through postacute and long-term care settings: Patterns of use and outcomes for a national cohort of elders. *Med Care.* Mar; 2002 40(3):227–236. [PubMed: 11880795]
11. Chiu WK, Newcomer R. A systematic review of nurse-assisted case management to improve hospital discharge transition outcomes for the elderly. *Professional Case Management.* Nov-Dec; 2007 12(6):330–336. quiz 337–338. [PubMed: 18030153]
12. Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB. The care span: The importance of transitional care in achieving health reform. *Health Aff (Millwood).* Apr; 2011 30(4):746–754. [PubMed: 21471497]
13. Hansen LO, Young RS, Hinami K, Leung A, Williams MV. Interventions to reduce 30-day rehospitalization: a systematic review. *Ann Intern Med.* Oct 18; 2011 155(8):520–528. [PubMed: 22007045]
14. Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: Results of a randomized controlled trial. *Arch Intern Med.* Sep 25; 2006 166(17):1822–1828. [PubMed: 17000937]
15. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization: A randomized trial. *Annals of Internal Medicine.* Feb 3; 2009 150(3):178–187. [PubMed: 19189907]
16. Naylor MD, Brooten DA, Campbell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: A randomized, controlled trial. *J Am Geriatr Soc.* May; 2004 52(5):675–684. [PubMed: 15086645]
17. Parry C, Kramer HM, Coleman EA. A qualitative exploration of a patient-centered coaching intervention to improve care transitions in chronically ill older adults. *Home Health Care Serv Q.* 2006; 25(3–4):39–53. [PubMed: 17062510]
18. Anderson, RA.; McDaniel, RR, Jr. Taking complexity science seriously: new research, new methods. In: Lindberg, C.; Nash, S.; Lindberg, L., editors. *On the Edge: Nursing in the Age of Complexity.* Bordentown: Plexus Press; 2008.
19. Toles M, Anderson RA. State of the science: relationship-oriented management practices in nursing homes. *Nurs Outlook.* Jul-Aug; 2011 59(4):221–227. [PubMed: 21757079]
20. Coleman EA, Boulton C. Improving the quality of transitional care for persons with complex care needs. *J Am Geriatr Soc.* Apr; 2003 51(4):556–557. [PubMed: 12657079]
21. National Transitions of Care Coalition. [Accessed November 14, 2009] Improving Transitions of Care. 2008. www.ntocc.org
22. Anderson RA, Crabtree BF, Steele DJ, McDaniel RR Jr. Case study research: The view from complexity science. *Qual Health Res.* May; 2005 15(5):669–685. [PubMed: 15802542]
23. Barley SR, Kunda G. Bringing work back in. *Organization Science.* 2001; 12:76–95.
24. Yin, RK. Case study research: Design and methods. 2. Beverly Hills, CA: Sage Publishing; 1994.
25. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res.* Nov; 2005 15(9):1277–1288. [PubMed: 16204405]

26. Silverman, D.; Marvasti, A. Doing qualitative research. London: Sage Publications; 2008.
27. Naylor MD, Brooten D, Campbell R, et al. Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized clinical trial. *The Journal of the American Medical Association*. Feb 17; 1999 281(7):613–620.
28. Krichbaum K. GAPN postacute care coordination improves hip fracture outcomes. *West J Nurs Res*. Aug; 2007 29(5):523–544. [PubMed: 17526868]
29. Naylor MD, Feldman PH, Keating S, et al. Translating research into practice: Transitional care for older adults. *J Eval Clin Pract*. Dec; 2009 15(6):1164–1170. [PubMed: 20367721]
30. Colon-Emeric CS, Lekan-Rutledge D, Utley-Smith Q, et al. Connection, regulation, and care plan innovation: A case study of four nursing homes. *Health Care Manage Rev*. Oct-Dec;2006 31(4): 337–346. [PubMed: 17077708]
31. Piven ML, Ammarell N, Bailey D, et al. MDS coordinator relationships and nursing home care processes. *West J Nurs Res*. Apr; 2006 28(3):294–309. [PubMed: 16585806]
32. Lyons SS. How do people make continence care happen? An analysis of organizational culture in two nursing homes. *The Gerontologist*. Jun; 2010 50(3):327–339. [PubMed: 20008040]
33. Rantz MJ, Flesner MK, Zwygart-Stauffacher M. Improving care in nursing homes using quality measures/indicators and complexity science. *J Nurs Care Qua*. Jan-Mar;2010 25(1):5–12.
34. Schreyogg G, Kliesch-Eberl M. How dynamic can organizational capabilities be? Towards a dual-process model of capabilities dynamization. *Strategic Management Journal*. 2007; 28(9):913–933.
35. Anderson, RA.; Colon-Emeric, C. CONNECT for Quality, “Connect and Learn Session One Workbook”. 2010.
36. Hansen LO, Williams MV, Singer SJ. Perceptions of hospital safety climate and incidence of readmission. *Health Serv Res*. Apr; 2011 46(2):596–616. [PubMed: 21105868]
37. Lyons, WL.; Coleman, EA. Transitions. In: Halter, JB.; Ouslander, JG.; Tinetti, ME.; Studenski, S.; High, KP.; Asthana, S., editors. *Hazzard’s geriatric medicine and gerontology*. New York: McGraw Hill; 2009.
38. National Transitions of Care Coalition. [Accessed July 16, 2009] Transitions of Care Measures. 2008. http://www.ntocc.org/portals/0/TransitionsOfCare_Measures.pdf

Table 1**Delivery of Transitional Care in SNFs**

Concept	Interaction Strategies	Care Processes
Definition	Staff behaviors that increase the capacity in nursing homes for effective care processes and optimal patient outcomes ³⁴	Time-limited services designed to ensure health care continuity, avoid preventable poor outcomes and promote the safe & timely transfer of patients ^{12,20}
Attribute	<p>Interactions that promote:</p> <ul style="list-style-type: none"> • Connections, e.g., be approachable, pitch in, seek assistance, reciprocate, show appreciation, give respect, say thank you, coach/mentor³⁵ • Information exchange, e.g., listen, give and share information, receive information, explain, and verify the meaning of information³⁵ • Cognitive diversity, e.g., pay attention, ask questions, give and receive feedback, suggest alternatives, include multiple perspectives to solve emerging problems in care³⁵ 	<p>Tasks including:</p> <ul style="list-style-type: none"> • Assess and plan care • Engage patients and family caregivers • Teach patients and family caregivers • Plan discharge • Arrange follow-up, referrals and tests • Provide written plans • Reconcile medications • Transfer information • Phone calls or home visits after discharge^{12,36–38}

Table 2

Sample Cases: Three Transitional Care Teams

Case	Patient	Staff	LOS / Discharge Destination
1	90 year old, Caucasian Female	Geriatrician, medical fellow, 2 rehabilitation therapists, LPN, social worker and dietician	22 days / Home, not in CCRC
2	85 year old, Caucasian Male	Geriatrician, NP, 2 rehabilitation therapists, LPN, social worker and dietician	24 days / Home, in CCRC
3	68 year old, African American Female	Geriatrician, NP, 3 rehabilitation therapists, LPN, social worker and dietician	26 days / Home, not in CCRC

Table 3**Delivery of Transitional Care in the Case Studies**

	Interaction Strategies		Care Processes	
Consistently Provided	1	Strategies that promoted connections between staff members and patients, e.g., such as being approachable, pitching-in, seeking assistance, coaching/mentoring	1	Assess and plan care
	2	Strategies that promoted information exchange with patients and other staff members, e.g., listen, give and receive information, explain	2	Engage patients
	3	Strategies that promoted problem solving with patients, e.g., ask questions, give and receive feedback, suggest alternatives and solve emerging problems in care	3	Teach patients
Inconsistently Provided			4	Plan discharge
			5	Arrange follow- up/referrals
	1	Strategies that promoted connections with family members	1	Engage Family Caregivers
Not Provided	2	Strategies that promoted information exchange with family caregivers	2	Teach Family Caregivers
	3	Strategies that fostered problem solving with patients, family caregivers, and each other	3	Transfer Information
			4	Reconcile Medications
			1	Provide Written Plans
			2	Phone Calls/Home Visits after Discharge