Transitions of Care in Addiction Treatment

Presented by: Narges Beyraghi MD; Tianna Costa, RPh; Amy Yang, OT Reg. (Ont.)

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Disclosure of Financial Support

- This program has not received financial or in-kind support.
- Potential for conflict(s) of interest:
  - None

Learning Objectives

By the end of this presentation audience members will be able to:

1. Define transition of care and highlight the importance in patient outcomes.
2. Identify opportunities to initiate addiction treatment in patients with a substance use disorder.
3. Describe the role of collaborative care to promote successful uptake of interventions and navigate complex care plans.
4. Demonstrate the importance of connecting patients to addiction specific support.

Who are we?

- Intensive Recovery Discharge Team (IRDT)

- Interdisciplinary team: two psychiatrists, a social worker, an occupational therapist, a pharmacist and a nurse practitioner.

What do we do?

- IRDT Provides two weeks of intensive outpatient relapse prevention support to patients who have been discharged from the Medical Withdrawal Service and other Acute Care units at CAMH.
  - MI sessions, Addiction Psychiatry follow up, Relapse prevention sessions, Care coordination.
  - Flexible phone, video, in-person individual appointments, family sessions and case conferences with community providers.
- Quality Improvement: Client feedback about their experience and service utilization is being reviewed.
- To date, over 500 patients have been followed by this service.

Transitions of Care

- Clients move into, within or out of a healthcare facility or between healthcare providers
- Requires coordination and continuity of health care
- Challenges:
  - Medication errors
  - Readmision
  - Lack of communication between healthcare providers
  - Lack of patient/family understanding of disease state, medications and follow-up required

Ultimate goals: improve outcomes and satisfaction and decrease readmission

WHO, 2016

Elements of Care Transitions

Medication Management	Ensuring the safe use of medications by patients and their families based on patients' plans of care. E.g. Explore medication coverage and patient preference.
Transition Planning	Creating a plan/process that facilitates the safe transition of patients from one level of care to another, including home or from one practitioner to another. E.g. Referral to a RAAM Clinic.
Patient/Family Engagement and Education	Educating and counseling patients and families to enhance their active participation in their own care, including informed decision making. E.g. Providing patient specific handouts.
Communicating and Transferring Information	Sharing of important care information among patient, family, caregiver, and healthcare providers in a timely and effective manner. E.g. Faxing discharge summary to family doctor.
Follow-Up Care	Facilitating the safe transition of patients from one level of care or provider to another through effective follow-up care activities. E.g. Book follow-up appointment for client.
Healthcare Provider Engagement	Demonstrating ownership, responsibility, and accountability for the care of the patient and family/caregiver at all times.

Adapted from Earl T et al, 2016

POLL Question

What outcome have you seen as a result of poor care transitions?

a. Mortality, morbidity and adverse effects
b. Delays in receiving appropriate treatment and community support
c. Additional primary care, emergency department visits or hospital readmissions
d. Emotional and physical pain and suffering for patients, caregivers and families
e. Patient and provider dissatisfaction with care coordination

Case Study: Sam

- Sam is a 50-year-old gay male single with no dependents, supported through ODSP, residing alone in a rental apartment.
- He has a diagnosis of an alcohol use disorder and had a 3-month period of abstinence following a completion of a residential program.
- Sam attempted Alcoholics Anonymous several times in the past since, but did not find this helpful, as he did not identify with the Twelve Steps and found conversations around alcohol use triggering.

Case Study: Sam

- Sam presented to the ED with his son requesting support for alcohol withdrawal management. Sam reported to the team that he is currently on the waiting list for another residential program and for case management.
- He is drinking about 12 cans of beer daily since 3 months ago. His last drink was this morning at 10am, before coming to the ED.
- Past Medical History:
  - Alcohol Use Disorder
  - Major Depressive Disorder
- Medications at Admission:
  - Sertraline 150mg daily (prescribed by FMD)

Case Study: Sam

- Sam is started on a CIWA protocol and his alcohol withdrawal is medically managed using diazepam.
- Sertraline 150mg daily is continued while in hospital.

Case Study: Sam

- Sam met with pharmacist and prescriber to dis
  - Reviewed possible anti-craving options.
  - Goal is reduction and prefers once daily dosing. Opted to start naltrexone (25mg x 2 days then increase to 50mg daily). LU Code: 532.
  - The following META-PHI Handou
    - Alcohol and Mood
    - Medications for Alcohol Use
- Discharge prescription sent for 1 week x 1
  - Encouraged to follow-up with family doctor for continued follow-up
- Discharge summary faxed to FMD.

- Medication Management
- Patient Engagement/ Education

- Communicating and Transferring Information
- Follow-Up Care
- Healthcare Provider Engagement

Web exclusive

Research

First-line medications for alcohol use disorders among public drug plan beneficiaries in Ontario

Sheryl Spithoff MD CCFP Suzanne Turner MD CCFP MBS Tara Gomes MHSc Diana Martins MSc Samantha Singh

Abstract

Objective To examine use of first-line alcohol use disorder (AUD) medications (naltrexone and acamprosate) among public drug plan beneficiaries in the year following an AUD diagnosis.

Design Retrospective population-based cohort study.

Key Points

- This study found that less than 1% of public drug plan beneficiaries with an AUD diagnosis were dispensed naltrexone or acamprosate in the year after diagnosis.
- Improved addictions training, resources, and clinical support might help improve access among individuals who could benefit from these medications.

Spithoff et al, 2015

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

European Addiction Research

Eur Addict Res 2019;25:224–228
DOI: 10.1159/000500521

Received: February 3, 2019
Accepted: April 18, 2019
Published online: June 19, 2019

The Prescription of Anticraving Medication and its Economic Consequences

Rüdiger Holzbach[a, b] Gunnar Stammen[c] Ute Kirchhof[d] Norbert Scherbaum[e]

[a]Klinik für Psychiatrie, Psychotherapie und Psychosomatik, Klinikum Arnsberg, Arnsberg, Germany; [b]Centre of Interdisciplinary Addiction Research (ZIS) of the University of Hamburg, Hamburg, Germany; [c]Krankenhaus Maria Hilf, Warstein, Germany; [d]AOK NordWest, Dortmund, Germany; [e]LVR-Hospital Essen, Department of Psychiatry and Psychotherapy, Faculty of Medicine, University of Duisburg-Essen, Essen, Germany

Key Points

- Two hundred and eighty-eight (2.22%) patients received anti-craving medication, 98 (0.76%) in the first 6 months after inpatient treatment
- Their routine use could reduce hospital readmission rates and save on health care costs.

Holzbach et al, 2019

METAPHI MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION PARTNERS IN HEALTH INTEGRATION

Psychosocial treatment for AUD

- Case management (broker/generalist model)
  - Individualized approach of connecting clients to services/resources that meet their needs
  - Assist with access/referrals to resources and services
- Psychological interventions
  - May include: cognitive behavioural therapy, relapse prevention, contingency management, motivational interviewing, brief intervention, group therapy

Madhombro et al, 2019; Substance Abuse and Mental Health Services Administration, 2021

Psychosocial treatment for AUD

- Case management (broker/generalist model)
  - Individualized approach of connecting clients to services/resources that meet their needs
  - Assist with access/referrals to resources and services
- Psychological interventions
  - May include: cognitive behavioural ther
    contingency management, motivational
    intervention, group therapy

- **Transition Planning**
- **Patient/Family Engagement and Education**
- **Follow-Up Care**

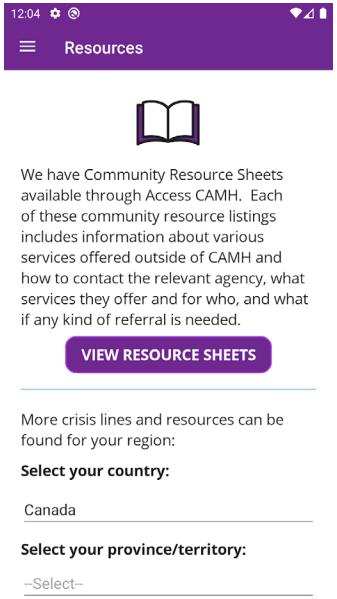
Madhombro et al, 2019; Substance Abuse and Mental Health Services Administration, 2021

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Adapting case management model

- Contact information
  - Confirm the contact information on chart
  - Discuss the importance of an active voicemail box
- Reinforce/confirm appointments and connection to supports
  - GP, case management, residential programs
  - Identify son as an alternate contact
- Handout for addiction and mental health community and online resources
- Explore other residential treatment options
- Safety planning
  - Hope App

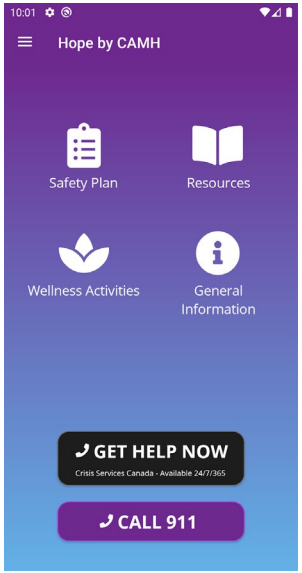
Distress (“Hot”) Lines, Warm Lines

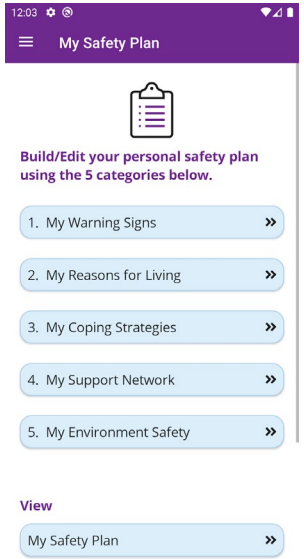


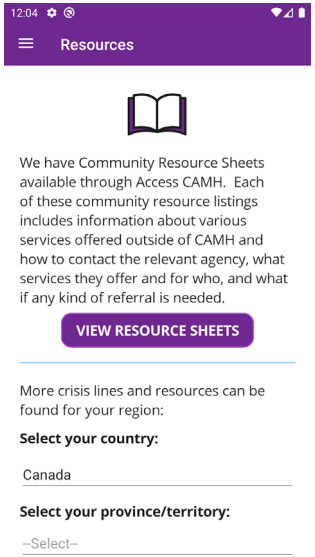
Progress Place Warm Line (Warmline.ca)

A list of warm lines and distress lines is available under “Resources” section of app “Hope by CAMH”

Hope App - Safety Planning and More







"My emotions are out of control right now."

"I'm feeling too overwhelmed."

"I can't avoid risky situations."

Available at: https://www.camh.ca/hopebycamhapp

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Case Study: Lu

- Lu is a 35-year-old heterosexual female with two kids (living with their father), supported through ODSP. She began using substances about three years ago after she experienced a traumatic sexual assault.
- She has been to residential treatment twice and was able to remain abstinent for one to two months after treatment each time, but eventually she relapsed.
- Today, Lu presents to the emergency department looking for opioid withdrawal management.

Case Study: Lu

- Substance use:
  - Fentanyl 1g IV daily. Last use ~10 hours ago.
- Past Medical History:
  - Opioid Use Disorder
- Medications at Admission:
  - None

Case Study: Lu

- Lu met with the triage nurse who noted:
  - Vitals stable
  - No signs sedation or respiratory distress
  - No withdrawal symptoms present
- Lu meets with the pharmacist and allied health to discuss options for OAT and psychosocial options.

Let’s Chat Resources

What addiction and mental health resources do you share with your patients with substance use disorders?

Which ones have the patients found particularly helpful?

Mutual Help and Peer Support Groups

- Twelve Step Programs mechanism of effectiveness: spirituality, relapse prevention/management skills, AA-specific factors, **social support** (Kelly et al., 2009)
- Twelve Steps Programs (AA, CA, NA, CMA, etc.)
  - Dual Recovery Anonymous
  - Faces & Voices of Recovery; mutual aid groups for co-occurring health conditions
- Buddhist-oriented program
  - Refuge Recovery (https://www.refugerecovery.org/)
- Secular mutual aid groups:
  - NA Agnostica, SMART Recovery (CBT- and MI-informed), Women for Sobriety, LifeRing..
- Moderation as substance use goal:
  - Moderation Management ™, could still join the groups listed above
- Twelve Steps and SMART Recovery have meetings specific to certain groups (ex. Family members, LGBTQ+, women-only)
- Librarians may be able to assist clients learn how to use virtual meeting platforms
- Individualized, client-centered approach - some may not wish to engage in these groups, and that is okay!

Self-Management Online Modules

Self-management modules

- Breaking Free Online
  - “Evidence-based wellbeing and recovery support program”
  - Free for residents of Ontario or Newfoundland & Labrador
  - https://www.breakingfreeonline.ca/
- Pain U Online
  - By Toronto Academic Pain Medicine Institute (TAPMI)
  - “Modules to help you manage your pain”
  - Free online modules
  - https://tapmipain.ca/patient/managing-my-pain/pain-u-online/#/

Online communities and discussion forums

- SMART Recovery https://www.smartrecovery.org/community/calendar.php
- In The Rooms https://www.intherooms.com/home/category/community-and-meetings/

POLL Question

For those who practice in the ED, how is OUD most often managed in your experience?

a. Provide outpatient script for buprenorphine/naloxone
b. Refer to a RAAM clinic
c. Refer to withdrawal management service/detox
d. Start buprenorphine/naloxone in ED
e. Give them a naloxone kit

Understanding current practice of opioid use disorder management in emergency departments across Canada: A cross-sectional study

Patricia Hoyeck, BSc*; David Wiercigroch, MPA*; Cara Clarke, BSc†; Rahim Moineddin, PhD‡; Hasan Sheikh, MD‡§; Jennifer Hulme, MD, CM, MPH‡§

CLINICIAN'S CAPSULE

What is known about the topic?
Buprenorphine is the first-line treatment for opioid use disorder, and many patients with this disorder present to the emergency department (ED).

What did this study ask?
How do emergency physicians manage opioid use disorder; are they satisfied with their management; and what resources are needed to improve management?

What did this study find?
Buprenorphine is infrequently prescribed in the ED, and physicians are largely dissatisfied with current management, finding various on-site supports useful.

Why does this study matter to clinicians?
Understanding opioid use disorder management, provider satisfaction, and needed resources can help design appropriate supports for ED physicians to effectively manage this disorder.

ABSTRACT

Objective: Opioid-related deaths are increasing at alarming rates in Canada, with a 34% increase from 2016 to 2017. Patients with opioid use disorder often visit emergency departments (ED), presenting an opportunity to engage patients in treatment. Buprenorphine-naloxone is first-line treatment for opioid use disorder, but current management in the ED is unknown. This study aimed to characterize opioid use disorder management in the ED.

Methods: We conducted a cross-sectional study of emergency physicians across Canada. A survey was circulated electronically to the Canadian Association of Emergency Physicians members. Participants were asked about their current management practices, satisfaction, and helpfulness of resources. SAS (version 9.4) was used for statistical analysis. We dichotomized Likert-scale responses to approximate relative risk ratios via a log binomial analysis.

Results: The survey was completed by 179 participants for a response rate of 11.1%; 143 (79.9%) physicians treated patients with opioid use disorder more than once a week. Only 7% (n = 13) of respondents always/often gave buprenorphine in the ED. Referral to an addiction clinic where patients were seen quickly was deemed the most helpful (90.5%, n = 162). Physicians who reported satisfaction with opioid use disorder management were four times more likely to prescribe buprenorphine in the ED or as an outpatient script (RR = 4.41, CI = 2.33–8.33, $p < 0.01$; RR = 4.51, CI = 2.21–9.22, $p < 0.01$).

Conclusion: This study found that buprenorphine is not frequently prescribed in the ED setting, which is incongruent with the 2018 guidelines. Care coordination and on-site support were helpful to ED physicians. Hospitals should use knowledge translation strategies to improve the care of patients with an opioid use disorder.

RÉSUMÉ

Introduction: La mortalité liée à la prise d'opioïdes augmente à un taux alarmant au Canada; celui-ci a connu une hausse de 34%, de 2016 à 2017. Les patients connaissant des troubles de l'usage des opioïdes se rendent souvent au service des urgences (SU); voilà une belle occasion de les inciter à suivre une cure. Le traitement de première intention de ce type de troubles est l'association de buprénorphine et de naloxone, mais on ne connaît pas les pratiques actuelles à cet égard dans les SU. L'étude visait donc à caractériser la prise en charge des troubles de l'usage des opioïdes au SU.

Méthode: Il s'agit d'une étude transversale menée parmi les urgentologues, partout au Canada. Un questionnaire d'enquête a été envoyé, par voie électronique, aux membres de l'Association canadienne des médecins d'urgence. Les participants devaient répondre à des questions sur leurs pratiques actuelles en matière de prise en charge, leur degré de

Hoyeck et al, 2020

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

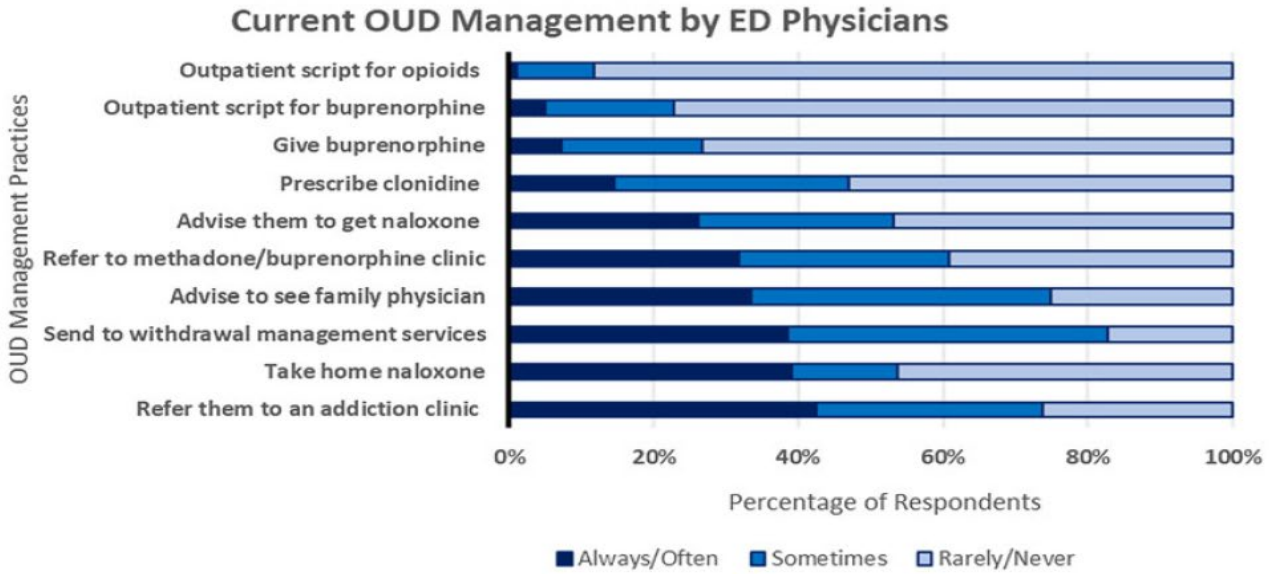


Figure 1. Current opioid use disorder management practices by Canadian ED physicians (n = 179).

Hoyeck et al, 2020

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Starting OAT in the ED

- Why the ED?
  - ED is often the primary source of medical care for those with OUD.
  - ED visits offer an opportunity to access life-saving treatment.
- Studies show that ED initiated buprenorphine with facilitated transitions to outpatient care leads to better health outcomes and is cost-effective.

SAMHSA, 2021

Interaction with Pharmacist

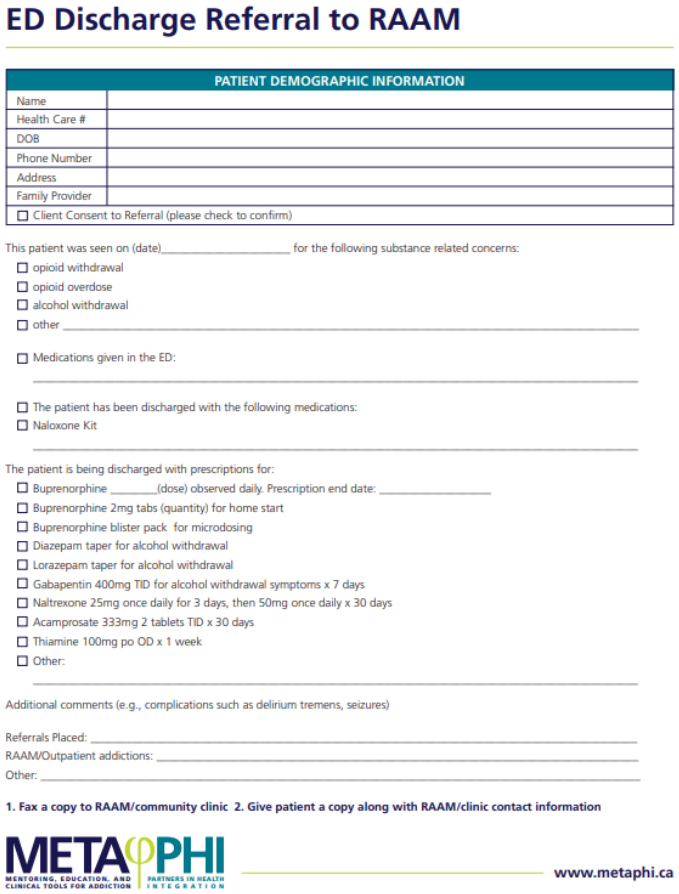
- Lu was presented with the following methods to start buprenorphine/naloxone:
  - Traditional Home Start
    - Must abstain from opioids to be in adequate withdrawal; risk of precipitated withdrawal
    - Reviewed Meta-Phi Home Start Patient Information sheet.
  - Microdosing
    - Can continue to use opioids during the initiation
    - Reviewed Meta-Phi Microdosing Patient Information sheet.

Buprenorphine/Naloxone Initiation

- Remind patients that buprenorphine must be taken sublingually
- Provide discharge script based on initiation method (e.g. 3 days for traditional home start and 7 days for microdosing start)
  - Time permitting: call pharmacy to confirm receipt of script and confirm any outstanding details
- Provide handout on buprenorphine treatment
- Offer naloxone kit and training
- Offer harm reduction resources
- Plan RAAM/clinic follow-up

Referral to RAAM

- Reason for ED presentation
- Medications given in ED
- Discharge medications (be specific)
  - For buprenorphine naloxone, specify what the plan was for initiation (e.g. traditional home start, microdosing)
- Not all RAAM clinics will give the long acting buprenorphine formulations (call in advance)



ED Discharge Referral to RAAM

PATIENT DEMOGRAPHIC INFORMATION	
Name	
Health Care #	
DOB	
Phone Number	
Address	
Family Provider	
☐ Client Consent to Referral (please check to confirm)	

This patient was seen on (date)_____ for the following substance related concerns:

- ☐ opioid withdrawal
- ☐ opioid overdose
- ☐ alcohol withdrawal
- ☐ other _____

☐ Medications given in the ED:

_____

☐ The patient has been discharged with the following medications:
☐ Naloxone Kit

_____

The patient is being discharged with prescriptions for:

- ☐ Buprenorphine _____(dose) observed daily. Prescription end date: _____
- ☐ Buprenorphine 2mg tabs (quantity) for home start
- ☐ Buprenorphine blister pack for microdosing
- ☐ Diazepam taper for alcohol withdrawal
- ☐ Lorazepam taper for alcohol withdrawal
- ☐ Gabapentin 400mg TID for alcohol withdrawal symptoms x 7 days
- ☐ Naltrexone 25mg once daily for 3 days, then 50mg once daily x 30 days
- ☐ Acamprosate 333mg 2 tablets TID x 30 days
- ☐ Thiamine 100mg po OD x 1 week
- ☐ Other:

_____

Additional comments (e.g., complications such as delirium tremens, seizures)

Referrals Placed: _____
RAAM/Outpatient addictions: _____
Other: _____

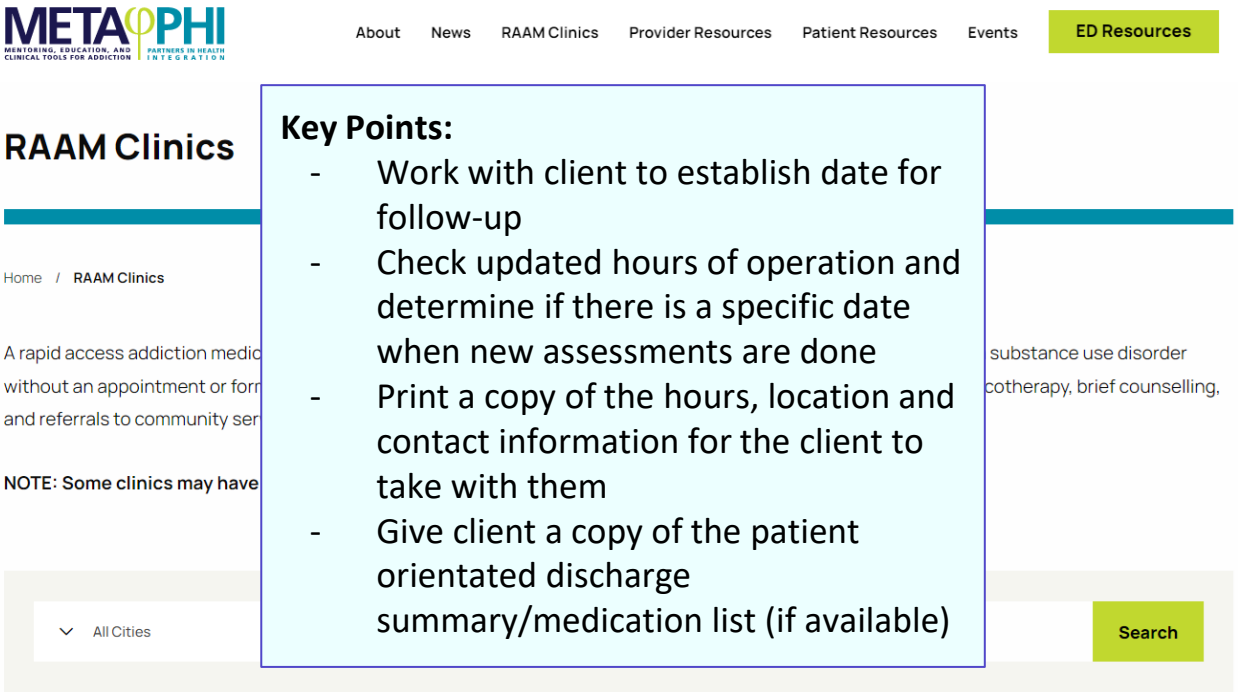
1. Fax a copy to RAAM/community clinic 2. Give patient a copy along with RAAM/clinic contact information

METAPHI MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION PARTNERS IN HEALTH INTEGRATION www.metaphi.ca

Available at: https://www.metaphi.ca/ed-resources/

METAPHI MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION PARTNERS IN HEALTH INTEGRATION

RAAM Clinics



Key Points:

- Work with client to establish date for follow-up
- Check updated hours of operation and determine if there is a specific date when new assessments are done
- Print a copy of the hours, location and contact information for the client to take with them
- Give client a copy of the patient orientated discharge summary/medication list (if available)

Available at: https://www.metaphi.ca/raam-clinics/?city=&map-search=

What If ...

- Lu presents to you, her primary practitioner, looking for treatment options for opioid use disorder.

POLL Question

What would you do? Select the best answer that describes your plan for transition of care.

a. Provide Brief counselling
b. Elicit patient preferences and expectations and educate on available services
c. Determine readiness to engage in OUD care and engage in collaborative care
d. Start OAT, discuss and agree on transition of care

Health Care Providers Engagement Spectrum

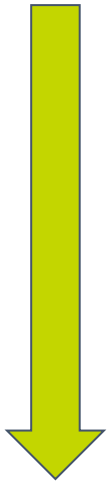
a. Provide Brief counselling.
b. Elicit patient preferences and expectations and educate on available services.
c. Determine readiness to engage in OUD care and engage in collaborative care.
d. Start OAT, discuss and agree on transition of care.

Demonstrating ownership, responsibility, and accountability for the care of the patient and family/caregiver at all times.

Levels of Transitions of Care

Transition Practices

Less Intensive



Counselling and Referral

Telephone Monitoring; Contracts, Prompts, Reinforcements

Intensive Case Management

More Intensive

Process Outcomes

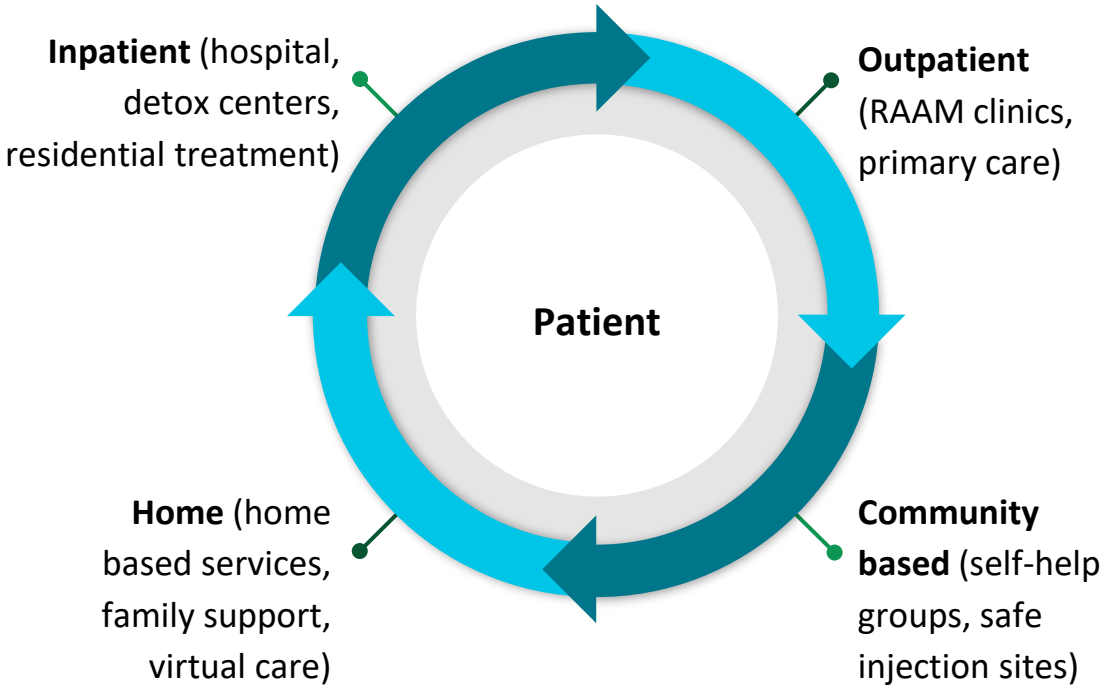
- Increased knowledge of available resources
- Increased access
- Increased engagement

Health Outcomes

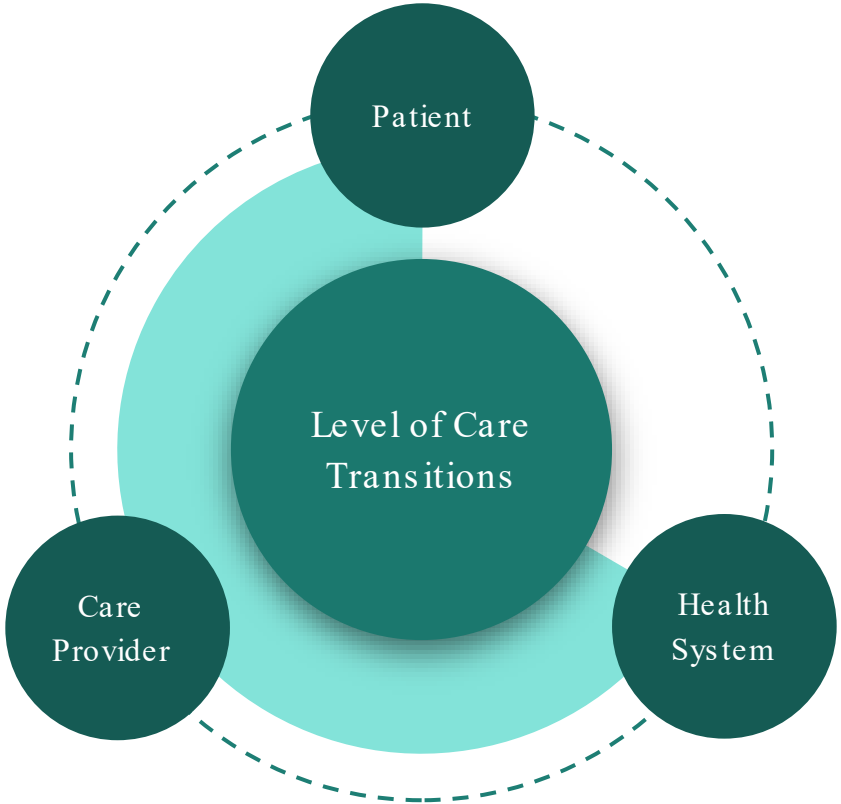
- Less substance use and misuse
- More days abstinent
- Better mental health, functioning and quality of life

Adapted from: Cucciare, et al (2015)

Collaborative Information Sharing



Barriers and Facilitators to Care Transitions



Patient Perspective

- Prior use of SUD services:
  - First time treatment seekers report less need
  - Previous experiences with care services
- Insurance coverage, geographic barriers
- Wait times
- Stigma
- Knowledge
- Psychosocial (e.g. housing, supports)
- Level of motivation
- Patient goals (harm reduction vs. abstinence)

Care Provider Perspective

- Knowledge about available and potential efficacy of treatment options
- Stigma and their perceptions
- Provider's experience with transition practice:
  - Communicate with different providers
    - Case workers, intake coordinators, RAAM clinician, Harm reduction worker, addiction counsellor, family …
  - Implement patient and family preferences in treatment plan
  - When, why and where to refer a patient

Health System Perspective

- Team based care that emphasizes care coordination
- Formal relationship between care settings
- Availability of an information system. E.g. electronic medical record
- Larger health care system vs. stand alone clinic

Conclusions

- Planning for optimal transitions of care for all patients is essential
- Key elements for care transitions include:
  - Medication
  - Psychological interventions
  - Social support or case management
- Transitions of care involve all healthcare professionals involved in the care team

References

1. Cunningham C, Edluch MJ, Fishman M, et al. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update, *J Addict Med*. 2020;14(2S):1-91.
2. Darke S, Larney S, Farrell M. Yes, people can die from opiate withdrawal. *Addiction*. 2017;112:199–200.
3. Duber HC, Barata IA, Cioè-Peña E, et al. Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department. *Ann Emerg Med*. 2018;72(4):420-431.
4. Earl T, Katapodis N, Schneiderman S. Care Transitions. In: Hall KK, Shoemaker-Hunt S, Hoffman L, et al. Making Healthcare Safer III: A Critical Analysis of Existing and Emerging Patient Safety Practices [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2020 Mar. 15. Available from: https://www.ncbi.nlm.nih.gov/books/NBK555516/
5. Health Quality Ontario. Opioid Use Disorder: Care for People 16 Years of Age and Older. 2018. Accessed via: https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Opioid-Use-Disorder
6. Hoyeck P, Wiercigroch D, Clarke C, Moineddin R, Sheikh H, Hulme J. Understanding current practice of opioid use disorder management in emergency departments across Canada: A cross-sectional study. CJEM. 2020 Jul;22(4):494-498.
7. Kampman K, Jarvis M. American Society of Addiction Medicine (ASMA) national practice guideline for the use of medications in the treatment of addiction involving opioid use. J Addict Med. 2015;9:358–367.
8. Kelly JF, Hoeppner G, Stout RL, et al. How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addict Res Theory*. 2009;17(3):236-259.
9. META-PHI. (2021, November 12). Retrieved March 22, 2022, from http://www.metaphi.ca/
10. Noska A, Mohan A, Wakeman S, et al. Managing opioid use disorder during and after acute hospitalization: a case-based review clarifying methadone regulation for acute care settings. *J Addict Behav Ther Rehabil*. 2015;4:1000138.
11. Substance Abuse and Mental Health Services Administration: Use of Medication-Assisted Treatment in Emergency Departments. HHS Publication No. PEP21-PL-Guide-5 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.
12. Transitions of Care: Technical Series on Safer Primary Care. Geneva: World Health Organization; 2016. Licence: CC BY-NC-SA 3.0 IGO.
13. Cucciare, M. A., Coleman, E. A., & Timko, C. (2015). A conceptual model to facilitate transitions from primary care to specialty substance use disorder care: a review of the literature. *Primary health care research & development*, *16*(5), 492-505.
14. Fancott, C. (2011). Interventions and measurement tools related to improving the patient experience through transitions in care: A summary of key literature. *Toronto, ON: The Change Foundation. Retrieved October*, *8*, 2014.
15. Parry C, Mahoney E, Chalmers SA, Coleman EA. (2008). Assessing the quality of transitional care: Further application of the Care Transitions Measure. Medical Care, 46(3), 317-322