

# Care Transitions Success Stories and Lessons Learned

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**Aligning Forces  
for Quality** | Improving Health & Health Care  
in Communities Across America



*Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.*

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## **I. Abstract**

This document describes care transitions success stories and includes major themes for improving care transitions and reducing potentially avoidable hospital readmissions. It is meant to be a practical resource to foster community-based interventions and innovation for improving care transitions.

It is grounded in analysis and lessons learned from Stratis Health’s leadership role in four care transitions initiatives that occurred between 2011 and 2014:

- 1) Reducing Avoidable Readmissions Effectively (RARE) Campaign;
- 2) Community-based “Improving Transitions of Care” initiative;
- 3) Care Coordination for Rural Accountable Care Organizations; and
- 4) Health Information Technology for Post-Acute Care Providers (HITPAC) project.

Each of these initiatives used evidence-based strategies to achieve their goals, and were implemented in collaboration with partner organizations. Best practices and lessons learned are synthesized in this document to provide strategies and guidance for engaging community partners across the state in quality improvement interventions for better care transitions.

## **II. Introduction/Background**

Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different settings or different levels of care within the same setting.(1) Poor transitions, especially with vulnerable seniors, represent a threat to patient safety and decrease consumer confidence in the health care system while wasting scarce resources.(2) Numerous studies have shown that patients, families and caregivers are often left to contend with unexpected and unfamiliar challenges at the time of a transition, and in fact, must fix what health care professionals have neglected to do on behalf of their patients.(3)

Threats to patient safety during transitions of care can take many forms. For instance, approximately 25 percent of Medicare skilled nursing facility (SNF) residents are readmitted to the hospital.(4) Close to 13 percent of Medicare beneficiaries experienced three or more provider transfers within a 30-day period of being discharged from the hospital.(5) Between 41.9 and 70 percent of Medicare patients admitted to the hospital in 2003 received services from an average of 10 or more physicians during their stay.(6) Each of these visits represents a transition in care and presents an opportunity (or missed opportunity) for information exchange. Poor communication during transitions from one care setting to another can lead to confusion about the patient’s condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals.(7)

Care transition processes can enhance or impede the transition depending on how they are implemented. Key components of transitions include patient admission and discharge, documentation of information in the patient record, communication and exchange of information among settings and providers, and communication and exchange of information between providers and patients/caregivers. Improper or ineffective execution of these processes are frequent contributors to poor care transitions. For example, differences in computer systems can make it difficult to transmit medical records between hospitals and other settings which means

that care providers may not know when their patients have been admitted or discharged from the hospital and may lack the information needed to properly care for their patient after hospital discharge.(8) And while most communication that occurs during a care transition is done via the patient discharge summary, numerous studies have shown that discharge summaries often fail to provide important administrative and medical information such as the primary diagnosis, results of abnormal diagnostics, details about the hospital event, follow-up plans, whether laboratory results are pending, and patient or family/caregiver counseling.(9)

Research demonstrates that progress is being made to improve these processes. A variety of evidence-based resources and programs have been shown to improve transitions of care.(10) Since local settings vary substantially in health care utilization, the most effective interventions may depend on changes in the processes of care at a community level that engage more than one provider (including hospitals, home health agencies, dialysis facilities, nursing homes, physicians' offices, etc.), as well as patients and families/caregivers and community health care stakeholders.(11)

Evidence exists or is emerging which identifies five focus areas that have been shown to impact the quality of care transitions. These five focus areas served as the core approach in the RARE Campaign: (12)

- 1) Patient and Family Engagement and Activation
- 2) Medication Management
- 3) Comprehensive Transition Planning
- 4) Care Transition Support
- 5) Transition Communication

The care transitions initiatives described in this document align with these focus areas. This document is meant to serve as a practical resource to foster community-based interventions and innovation for improving care transitions.

### **III. Methodology**

Each of the following care transitions initiatives used best practices and evidence-based strategies to achieve their goals. This section describes each initiative, the interventions used, and the goals or aims in terms of impact on care transitions.

#### Reducing Avoidable Readmissions Effectively (RARE) Campaign

The RARE Campaign was designed to engage Minnesota hospitals and care providers across the continuum of care to prevent avoidable hospital readmissions within 30 days of discharge by improving transitions of care. (13) Funding for this initiative was provided by several sources including the Centers for Medicare & Medicaid Services (CMS) through the Quality Improvement Organization Program and the Robert Wood Johnson Foundation through Aligning Forces for Quality. In addition, each of the campaign operating partners provided in-kind support. The initiative began in 2011 and ended in 2014.

In 2011, the Institute for Clinical Systems Improvement (ICSI), Minnesota Hospital Association (MHA) and Stratis Health came together to form the RARE partnership.<sup>(13)</sup> The work of the campaign was organized and implemented through a network of committees and workgroups:

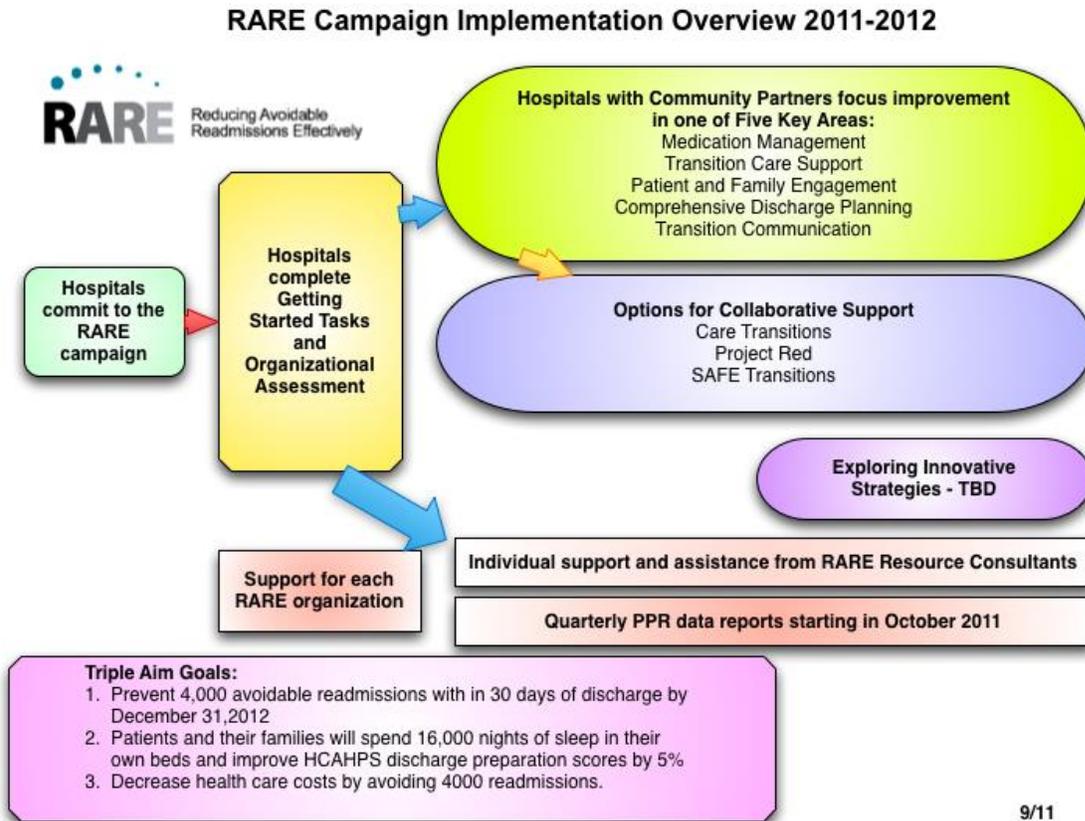
- The Operations Team was comprised of two program managers from each of the operating partner organizations who met weekly to coordinate, plan, strategize, implement the work plan and problem solve. The Operations Team also organized and facilitated the Advisory Committee and workgroups.
- The Leadership Team included members of the Operations Team as well as the CEOs, Communications Directors, and other senior leadership from the Operating Partner organizations. They met every other month to guide the overall direction of the campaign and to assure there was adequate resourcing.
- The Communications Team included communications staff from each of the operating partner organizations and met as needed to publish the RARE Report (a monthly newsletter), manage the RARE website, respond to media requests, and provide ongoing communications support to the campaign.
- The Advisory Committee included representatives of hospitals, health systems, payer organizations, trade associations, consumers and other key partners in improving care transitions. They met monthly and then quarterly to provide direction and leadership at the participant level of the campaign.
- Subject-specific workgroups focused on topics such as medication management, mental health, and measurement. They included subject matter experts and met monthly or as needed to inform implementation and interventions relevant to their respective topic.

Staff of the three operating partner organizations recruited hospitals throughout Minnesota to participate in the campaign, with an initial focus on the hospitals that accounted for 80 percent of readmissions in the state. CEOs of the three partner organizations contacted the CEOs of those top hospitals or health systems to encourage their participation. Recruitment focused on hospitals because they were subject to a new Medicare penalty for 30-day readmissions, but the operating partners recognized the need for a community-based approach to improving care transitions and encouraged hospitals to engage with other settings of care.

The RARE Campaign was designed to improve the quality of care for patients transitioning across care systems and to reduce avoidable readmissions by 20 percent by the end of 2012. Midway through the campaign the deadline was extended to 2013. The RARE Campaign involved 86 hospitals and over 100 community partners. The campaign called upon hospitals and their partners along the care continuum to focus on the five key areas previously identified which are known to improve care and reduce hospital readmissions:

- 1) Patient and Family Engagement and Activation
- 2) Medication Management
- 3) Comprehensive Transition Planning
- 4) Care Transition Support
- 5) Transition Communication<sup>(14)</sup>

Hospitals interested in joining the campaign were required to demonstrate their commitment in three ways: 1) CEO signature on a participation agreement, 2) willingness to share their readmissions data with all other participating hospitals, and 3) completion of an organizational assessment to identify the root causes of avoidable readmissions. Based on the results of the organizational assessment, RARE hospitals were asked to identify at least one key focus area for improvement from the five areas listed above.(13) A kick-off webinar was held to orient hospitals to the campaign followed by an official in-person kickoff event.(13)



Each of the participating hospitals was assigned a RARE resource consultant who worked with their teams to target areas for improvement. The consultants connected with their respective hospitals by phone or in-person every four to eight weeks. The hospitals also had the opportunity to participate in any of three learning collaboratives that were offered: Care Transitions Intervention, Project RED (Re-Engineered Discharge), and SAFE Transitions of Care. Each collaborative was structured around existing evidence-based, best practice models.(13)

Over the course of the campaign, hospitals were offered technical assistance, regular follow-up phone calls, select site visits and other resources as needed. Hospitals also received a monthly RARE Report that shared best practices, success stories and data. Quarterly reports of potentially preventable readmission data were provided as evidence of their progress in reducing readmissions. The reports included patient-specific data that allowed hospitals to follow up on specific instances of preventable readmissions and also included the readmission rates for every

other hospital that was participating in the Campaign. The RARE Campaign offered monthly educational webinars and hosted two in-person action learning days per year.(13)

#### The Community-Based “Improving Transitions of Care” Initiative

The Improving Transitions of Care initiative was designed to establish community coalitions focused on improving care transitions and preventing hospital readmissions. This initiative was facilitated by Stratis Health, in its role as Minnesota’s Medicare Quality Improvement Organization, funded by CMS. The initiative began in 2011 and ended in 2014.

The work of the initiative was organized and implemented as follows:

- A Stratis Health working team developed and implemented the work plan, which included recruiting and working with three community-based teams. The working team consisted of two program managers, a program coordinator, analytic staff, communication staff, and administrative support staff.
- The leadership team met to advise the working team on program implementation and monitor initiative progress. This team included the initiative program managers, lead analytic staff, and senior Stratis Health leadership.
- Community-based teams were recruited and convened for learning, sharing, and networking to address the issue of care transitions and preventing avoidable hospital readmissions in their communities by implementing best practices and evidence-based interventions. Stratis Health frequently served as a neutral facilitator for the community meetings.

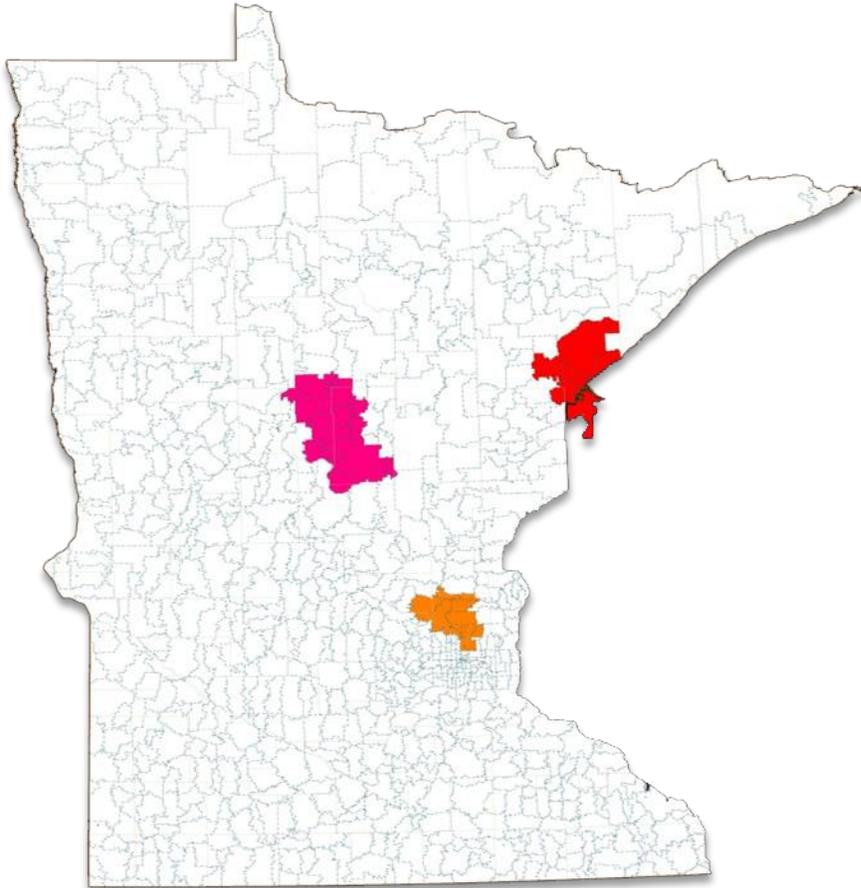
Data was used to drive recruitment efforts for this initiative. Readmission rates for hospitals, nursing homes and home health agencies were analyzed to identify the communities with the greatest opportunities for improvement. In addition, Stratis Health was open to including communities that identified care transitions as a strategic priority for their facilities and population. Per CMS requirements, the communities were defined as a geographical area of contiguous zip codes. Measurement for the initiative included the admission and readmission rates for the Medicare Fee-for-Service beneficiaries residing in the identified zip code communities.

In community recruitment efforts, the hospitals in each community were recruited first and provided their readmission data which identified the community partners they worked with most frequently and the readmission rates from these partners. Stratis Health and the hospitals invited these community partners to participate in the initiative. There were three communities that participated in this initiative across the state.

The community teams were comprised of various disciplines and provider types. The provider types included hospitals, nursing homes, assisted living facilities, home care agencies, hospice programs, clinics, and other long-term post-acute care partners. In each of the three communities, the number of participating organizations ranged from nine to nineteen, with a total of 39 organizations in all three communities. Participating in all three communities were six hospitals, seventeen skilled nursing facilities (SNFs), one assisted living facility, seven home health agencies, two hospice programs, two retail pharmacies, three clinics, one durable medical

equipment provider and one Area Agency on Aging. One community group was in the northern metro, where both hospitals were in the same health system. Another community group was located in north east Minnesota, where two of the three hospitals were a part of a large rural health system. In this community, several Wisconsin SNFs participated. The third community group was located in central Minnesota and the hospital was also a part of the same large rural health system.

### **Improving Transitions of Care Communities**



Hospitals participating in this project were required to participate in the RARE Campaign, which included completing an organizational assessment. After conducting a root cause analysis through chart review and patient interviews, each community identified and developed aim statements that described their goals for reducing readmissions and improving transitions of care. Each community used customized interventions based on their individualized goals.

The community aim statements were relatively similar across the three communities. Examples include:

- By December 2013, decrease by 20 percent the number of patients who are transferred to the emergency department (ED) when the provider has the capacity to treat them in place.
- By December 2013, for 75 percent of patients, assure that the receiving organization has complete and accurate information at the time of transfer.

- By January 2014, for patients being transferred from SNFs in the community, the emergency department (ED) receives complete and accurate documentation using a consistent transfer form for 90 percent of patients at the time of transfer to the ED.

The communities identified process and outcome measures for each of their aims and also selected evidence-based strategies or best practices designed to address the root causes of the problems that prompted these improvement aims.

The participants in each community met every one to three months to identify issues and solutions, discuss progress, and conduct plan-do-study-act (PDSA) cycles to continue to improve care transitions and reduce hospital readmissions. In addition, the Stratis Health team offered ongoing support and technical assistance including education, development of tools and resources, consultation, data assistance and analysis, and opportunities to share and learn from the other communities.

A number of evidence-based programs and tools were used by the three communities. These included Project RED (Re-Engineered Discharge)(14), a program to improve the hospital discharge process; the Care Transitions Initiative(15), which trains coaches to empower the patient after discharge; and Interventions to Reduce Acute Care Transfer (INTERACT)(16), a quality improvement program that focuses on the management of acute change in resident condition and includes clinical and educational tools and strategies for use in long-term care facilities. These evidence-based programs were implemented fully or in part by all three communities.

Other successful strategies and best practices included, but were not limited to:

- Widespread implementation of the Provider Orders for Life Sustaining Treatment (POLST) in the nursing home setting
- Use of evidence-based train-the-trainer programs on falls, nutrition, and caregiver support
- Creation of interdisciplinary discharge planning tools that included discharge orders with agreed upon data elements
- Staff education provided on common conditions, such as congestive heart failure and chronic obstructive pulmonary disease
- Use of dashboards and reports from electronic health records (EHRs) to improve care transitions
- Obtaining view-only access of the hospital medical record by skilled nursing facilities and home health agencies

There was great value that was realized from the interaction among the different settings and organizations that participated in the care transitions communities. Many of these partners had not met together before and had limited awareness of how work was done in other settings. By sitting around the same table, sharing stories and challenges of moving patients through the system of care, the participants gained new insight and respect for their partners.

### Care Coordination for Rural Accountable Care Organizations

Care Coordination for Rural Accountable Care Organizations was an initiative designed to help care coordinators build community resources for aiding chronically ill patients. Funding for this initiative was provided by the National Rural Accountable Care Organization. The initiative began in 2013 and ended in 2014.

Stratis Health partnered with the NRACO to realize its vision of helping care coordinators achieve their goals by providing coaching and training to its care coordinators. The structure of the initiative involved the two organizations working together on common goals and values. The initiative involved nine rural communities in four states.

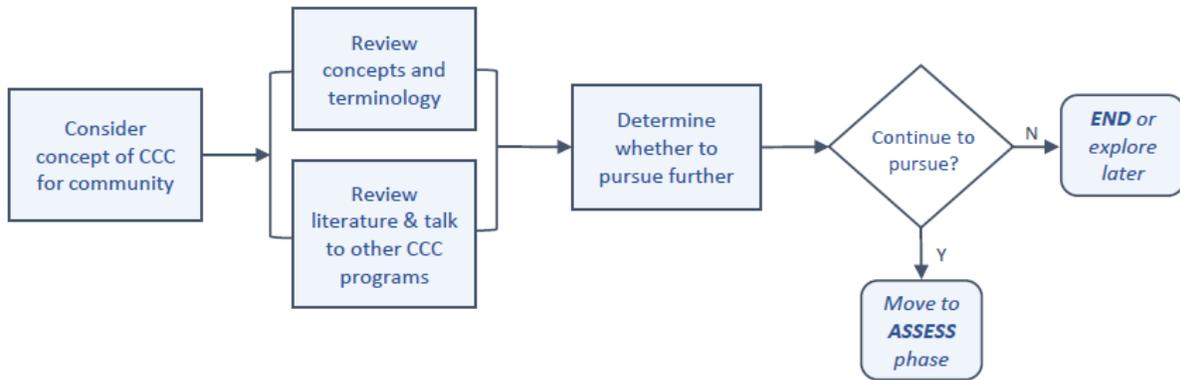
The hospital-based clinics had already been recruited for this project prior to its inception. In the first phase of the initiative, there was an on-site assessment conducted with each community. The purpose of this assessment was to understand community resources related to care coordination, and provide and create a shared vision for care coordination goals. A Maturity Assessment was completed after the on-site visits had been performed informing the communities of their strengths, needs, and gaps in current care coordination workflows and processes.

Each of the care coordination communities was assigned a coach. The coaches met with the communities two times per week and provided education and technical assistance on various care coordination topics. They also provided one-to-one coaching calls with each of the communities to help care coordinators develop individual work plans for their clients.

In conjunction with this initiative, Stratis Health saw the need to develop a robust care coordination toolkit. The toolkit development was funded by CMS through the Regional Extension Center (REC). The toolkit development was done in 2014. The overall purpose of the toolkit was to meet the needs of health care communities to:

- Engage with community partners as an integral part of a holistic approach to patient care
- Transform care delivery from provider-centric, episodic care to a patient-centered and community-based health and wellness focus
- Provide active management of transitions-in-care and tracking of referrals to help ensure a closed loop of information
- Reduce the burden on providers by supporting patients in actively manage their health conditions through patient engagement and education

With this end in mind, the toolkit is organized into six broad phases: overview, assess, plan, design, implement, maintain, and optimize. The progression through each phase is illustrated with a workflow diagram as shown below for the assess phase.



A key feature of the toolkit is a community assessment that guides selection of intervention tools. Users begin by completing an assessment of how care is coordinated in their community. Based on the results of the assessment, users are guided to appropriate tools. Stratis Health partnered with rural accountable care organizations in the initial development and testing of the resources and tools included in the toolkit.

The toolkit addresses overarching issues such as communication planning and team roles and responsibilities as well as practical implementation of tasks such as the first patient visit and tracking referrals. Each tool in the toolkit includes a brief statement about why and when to use each tool, specific instructions for effective use of the tool, and options that allow the user to customize the tool for unique needs.

The toolkit has three experience levels and provides tools for use at different stages in the development of a community-based care coordination program—including how to begin a program. Tools focus on people, functions, policy, and processes to achieve success in the community-based care coordination environment.

#### Health Information Technology for Post-Acute Care Providers (HITPAC) Project

The Health Information Technology for Post-Acute Care Providers (HITPAC) Project was designed to bring hospitals and nursing homes together to improve care transitions and improve medication management through the use of the HER and ultimately to achieve health information exchange. This project was funded by CMS as a special innovation project. It began in 2012 and was completed in March 2014.

Stratis Health convened a large external stakeholder group to guide the implementation of the project. The work was organized and implemented with the assistance of a multi-disciplinary group of internal and external partners:

- The External Stakeholder Team was comprised of representation of local and national trade associations (LeadingAge of MN, Care Providers of MN, and the National LeadingAge/CAST Organization), the Minnesota Hospital Association (MHA), Minnesota Department of Health (MDH), Minnesota Alliance for Patient Safety (MAPS),

and Community Health Information Collaborative (CHIC). It also included members from the Internal Steering Team described below. This group of stakeholders met monthly and were involved at the recruitment and decision making levels.

- The Internal Steering Team included Stratis Health members of the HIT operations teams, CIO, medical director, and project sponsor. They met monthly to provide overall leadership and guidance to the project.
- The Implementation Team was comprised of Stratis Health team members from analytics, nursing home work, internal steering team members, and communications. They assisted with day-to-day guidance for the project.
- Subject-specific workgroups focused on topics such as medication management, health information exchange, and standardized assessment content. They met as needed to provide subject matter expertise.

Recruitment efforts were focused on hospitals and nursing homes, specifically SNFs, in Minnesota. Two educational webinars were held to inform and recruit potential participants into the initiative. All of the participants were required to be using an electronic health record. Two communities were recruited that included three hospitals and 10 skilled nursing facilities. Two long term care pharmacies also participated.

Interviews were held with all of the participants to learn more about their electronic health records, how the participants were using them, what their perceptions were about their EHRs and health information exchange (HIE) in general including what they knew about privacy and security related to the use of EHRs and HIE. Education and technical assistance was tailored to the gaps identified in the interviews. Each project contact was assigned to a Stratis Health subject matter expert (SME). The participants had weekly calls with their SME throughout the initiative.

Standardized assessment content, in the form of agreed upon data elements useful in care transitions, was identified through current and future state process mapping with all of the participants. Five use cases were developed to test HIE.

A pilot program called the Prospective Medication Review (PMR) pilot was also developed and implemented during this project around medication reconciliation. After examining the current workflow for medication reconciliation in care transitions, the pilot moved the medication reconciliation workflow upstream to occur prior to hospital discharge. Data was collected identifying the numbers and types of potential issues that arise in the current workflow. One of the communities involved in this pilot project achieved live health information exchange with real patient data by the end of the HITPAC project.

At the end of the initiative, an outcomes congress was held with project participants, stakeholders, and interested community members. The outcomes congress was used to celebrate the breadth of accomplishments that had been achieved in the project as well as to inform the group of next steps and recommendations. One of the nursing homes and one of the hospitals from this project continues to work to advance HIE and to advance the work that was started in the HITPAC project to include other long term post-acute care providers in a specific community in Minnesota

## IV. Results and Impact

### RARE Campaign

Of Minnesota's 147 hospitals, 84 participated as well as one hospital in Wisconsin and one hospital in North Dakota. These hospitals accounted for approximately 85 percent of the readmissions in Minnesota.(13)

Participants achieved a 19 percent reduction in 30-day, all-cause, hospital readmissions by December 2013. The campaign was recognized by the Joint Commission and the National Quality Forum with the 2013 John M. Eisenberg Patient Safety and Quality Award. More than 7000 readmissions were prevented allowing Minnesotans to spend over 28,000 nights of sleep in their own beds rather than in the hospital.(13)

Because many of the participating hospitals implemented multiple strategies, it is difficult to attribute success to any particular strategies. However, aggregate analysis and interviews with participants suggest the following interventions were impactful: follow-up home visits, use of a discharge advocate, care team rounding, pharmacy engagement, and Teach Back.

### Community-based "Improving Transitions of Care" Initiative

All three communities achieved improvement in their care transitions as a result of this initiative. This was evidenced by a reduction in both admission and 30-day readmission rates for all three communities by the end of the initiative. Measurement was admissions or readmissions per 1,000 Medicare Fee-for-Service beneficiaries in the identified geographic communities by zip code. The admission rate for the three communities as an aggregate decreased by 7.8% compared to the state wide reduction of 7.3%. The 30-day readmission rate for the three communities decreased by 12.3% compared to the statewide reduction of 11.2%.

All of the participating communities continue to work on improving care coordination as a result of this community collaborative work.

### Care Coordination for Rural Accountable Care Organizations

All of the communities realized a reduction in cost per member per month as a result of the project. In addition, all of the communities benefited from the formalized structure of the care coordination program offered by Stratis Health. They received tools and templates and resources for care coordination that they had not previously been aware of. New tools and resources were developed as needed. All of the resources were packaged and presented at monthly learning action network activities (LANs). Best practices were identified and disseminated among the nine communities. Care coordinators expressed appreciation for the individualized intensive coaching sessions in helping them problem solve care coordination efforts.

The care coordination toolkit is available on the Stratis Health website and is free of charge. Dissemination efforts included a webinar that was provided to the Regional Extension Center (REC) staff that includes staff from Minnesota and North Dakota.

### HITPAC Project

Through education on evidence-based best practices for HIT, and medication topics facilitating collaboration between care settings and providing direct technical assistance, Stratis Health, by the end of the initiative, enabled successful test exchanges of health information between care settings: 42 skilled nursing facility to hospital, 12 hospital to SNF, and two hospital to pharmacy. In addition, seven exchanges conducted through the PMR pilot were live exchanges done in real time with patient data. Nine of the 10 skilled nursing facilities tested exchanges with hospitals. All of the participating hospitals conducted test exchanges with the SNFs.

Data was collected during the PMR pilot during this project which identified potential medication issues identified by moving the workflow of medication reconciliation upstream. Of the 514 medications reviewed during this pilot, 238 potential issues identified.

## **V. Summary and Recommendations**

Common care transitions themes emerged from all of the initiatives that should be considered important lessons learned for replicating care transitions efforts.

All of the initiatives benefited from successful collaborations that fostered community-based interventions and innovation for improving care transitions. In the RARE Campaign for example, the strength of community collaboration came from a consistent message and combined approach for participating hospitals by the organizations leading the campaign. In addition, trust from the collaboration between the hospitals and the partner organizations fostered creativity and cooperation.<sup>(13)</sup> Community collaboration in the HITPAC project was essential for testing and achieving health information exchange. The communities in the “Improving Transitions of Care” were successful because of the personal relationships developed among the community partners and the collaborative efforts that followed. They were able to draw on multiple perspectives to identify issues and develop solutions that improved the care for the patients they mutually served.

Organizations that exhibited strong and visible leadership commitment, well-established internal connections, and a focus on data for improvement were more likely to be successful. Organizational structure and culture are important foundations when it comes to effective change management and adoption of new approaches.

A stepwise approach to change and improvement was more likely to yield positive, sustainable results. This is a core tenet of quality improvement that was borne out by the experience of the participants in these initiatives. By introducing new strategies in stages, organizations were able to test changes, make adjustments, and demonstrate success before asking their entire staff to implement something new.

Innovative use of technology was another marker of success. Though EHRs have undoubtedly added value when it comes to use and exchange of health information, they are far from perfect. Some of the more forward-thinking participants in these initiatives looked beyond the perceived

limitations of technology to identify new approaches to gathering and sharing information. For instance, several organizations found ways to modify discharge rules and medication management within their HER to allow for better tracking and follow-up.

Efforts for improving care transitions can be implemented at many different levels. The following are recommendations for replicating quality improvement efforts for care delivery organizations, communities looking to engage other community members, and for external change agents.

#### Recommendations for care delivery organizations

- Engage strong consistent leadership in every organization that participates in care transition quality improvement efforts. Leadership provides support and ensures the resources are available to teams doing the work. The value of leadership cannot be overstated. Organizations where leadership changed during the course of the initiative or whose leaders were not as supportive, were more challenged to have staff see the value of the initiative and invest the time needed to successfully complete project tasks.
- Assure all people affected by care coordination efforts have buy-in to improving care coordination processes early on. Organizations missing across the board buy-in were much more challenged to be engaged and successful.
- Continue to advance the use and optimization of the electronic health record to continue to move towards an interoperable health information exchange. EHRs provide a powerful tool for preventing errors, measuring performance, and sharing information with patients and other providers. Seamless exchange of timely health information is critical to reducing needless transfers and re-hospitalizations, clinic error, and overall costs.(17)
- Be purposeful about learning the role that each of the partners play in coordinating care, as well as gaining a basic understanding how each partner operates. For example, understanding the data elements a hospital needs in a care transition is different than what a nursing home needs. This understanding for all of the HITPAC project participants was critical to understanding has to move forward to try to meet everyone's needs.

#### Recommendations for communities who are engaging other community members:

The Field Guide for Multi-Stakeholder Mobilization and Coalition Building has excellent recommendations for communities. (18)

- Focus on shared values to unite the group and feed the urgency to act. This helps overcome differences and conflict to facilitate decision-making.
- Arrive at a compelling shared purpose. Discovering what is genuinely motivating for participants can supersede individual and potentially competing interests. Goals must be broadly shared to guide collective action.
- Motivate others to commit to taking action. Coalition efforts rely on the commitment of its members. The purposes, the work, and the rewards must build and sustain internal motivation.
- Identify coalition champions who express large aspirations rooted in shared values.
- Build trust by connecting people to their motivations to collaborate. Motivations involve a mix of self-interest and community benefit.

- Establish a broad vision early to target an early, narrower win. Build from there to more challenging activities. Starting with a specific goal that generates a win-win is more likely to result in increased capacity to collaborate than is something that is a source of conflict.
- Be clear about the role the coalition will plan. Some coalitions function as a network convener aligning existing efforts. Others develop communities of practice to share information and best practices. Still others are formed to organize and implement shared action.

Recommendations for external change agents (such as Stratis Health)

- Find and employ evidence-based interventions. While evidence-based strategies for improving care transitions are available, there is not a cookie cutter approach in doing this work. Evidence based interventions have the research behind them to show that they work before they are utilized.
- Be the neutral convener. This is an opportunity to be a facilitator when there are competing organizations working on a common goal.
- Use the resources that you have available to you to provide data and offer analysis to meet the goals of the community.
- Provide the education and technical assistance that is unique to your organization to serve as the subject matter expert.
- Facilitate the selection of interventions to meet the goals of the community.
- Facilitate the use of PDSA cycles to improve processes and practices.(18)

In addition to these recommendations, anyone who is interested in engaging community partners and stakeholders to improve care transitions should look for ways to engage patients and their families/caregivers in care transitions strategies. Patients and their families/caregivers can and do offer personal and valuable insight into strategies and interventions for care transitions. Patients and families/caregivers can participate in many different ways including satisfaction surveys, advisory council members, and stakeholder groups just to name a few.

In summary, care transitions cannot be done by individual organizations alone to be effective. This document describes care transitions success stories and includes major themes for improving care transitions and reducing potentially avoidable hospital readmissions. It is meant to be a practical resource for organizations to foster community-based interventions and innovation for improving care transitions.

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