8 Step Change Process for Improving Transitions of Care*

Step One: Create a Sense of Urgency

- Identify and track your community's readmission rate to area hospitals per patient diagnosis
- Meet with hospital administration to understand how your readmission rate compares with other local providers and how readmission rates vary per diagnosis. Identify and review clinical data available and the relevant financial impact of improved transitions
- Conduct focus groups with all stakeholders to gain perspective on the facilitators and barriers to effective care transitions
- Review a readmission case and illustrate what went wrong, what could have worked better and where the breakdowns in communication occurred; present this as a de-identified case study

Step Two: Form a Powerful Coalition

- Work with the hospital and local healthcare providers to form a coalition to improve transitions; include non-traditional providers such as area agencies on aging, senior centers, consumers, etc.
- Identify relationship building strategies as a coalition and for caregivers across the continuum
- Establish regular meetings to identify goals and track progress
- Identify a way to measure the coalition's progress, e.g. administering surveys prior to forming and periodically thereafter throughout the coalition process
- For organizations with more than one level of care, set up an internal transitions work team

Step Three: Develop a Vision and Strategy

- Develop a concise message that conveys WHY effective transitions of care are important and calls your community to action

Step Four: Communicate the Vision

- Hold town hall meetings that include members from the external community and across the healthcare continuum to learn about and discuss the issues of transitions.
- Ask hospital executives and physicians to provide education to your community on prevention of hospitalization and the importance of improving care transitions.
- Use the media to communicate your vision

Step Five: Empower Others to Act

- Bring front-line staff across the continuum together to discuss opportunities and challenges and to, most of all, *build relationships*.
- Coordinate site exchange visits (inviting a hospital discharge planner to spend a day with nursing home intake managers and vice versa)
- Include all stakeholders on the work team to improve transitions of care
- Communicate progress and recognize individual contributions

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Step 6: Generate Short-Term Wins

- Identify language barriers that exist between settings
- Consolidate patient/family educational materials and coaching strategies
- Collaborate on systems for medication reconciliation
- Ensure follow-up physician appointments are scheduled
- Conduct follow-up calls with patients after discharge using the Care Transitions Measure Tool
- Collaborate on person-centered documentation systems, clinical protocols, care planning process, and transition plans

Step 7: Sustain Momentum

- Review readmissions case studies as a way to consolidate improvements needed
- Review opportunities for using technology to improve transitions
- Create joint educational tools for patients and staff
- Integrate staff development and training opportunities across the continuum
- Continue relationship building
- Celebrate successes

Step 8: Anchor the Change

- Evaluate progress through annual focus groups
- Exchange targeted quality data routinely
- Measure stakeholder satisfaction, readmission rates and associated clinical and financial outcomes
- Communicate outcomes to all stakeholders

* Adapted from the Long Term Care Improvement Guide (2010)

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