

# Understanding Facilitators and Barriers to Care Transitions: Insights from Project ACHIEVE Site Visits

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**Background:** Care transitions between clinicians or settings are often fragmented and marked by adverse events. To increase patient safety and deliver more efficient and effective health care, new ways to optimize these transitions need to be identified. A study was conducted to delineate facilitators and barriers to implementation of transitional care services at health systems that may have been adopted or adapted from published evidence-based models.

**Methods:** From March 2015 through December 2015, site visits were conducted across the United States at 22 health care organizations—community hospitals, academic medical centers, integrated health systems, and broader community partnerships. At each site, direct observation and document review were conducted, as were semistructured interviews with a total of 810 participants (5 to 57 participants per site) representing various stakeholder groups, including management and leadership, transitional care team members, internal stakeholders, community partners, patients, and family caregivers.

**Results:** Facilitators of effective care transitions included collaborating within and beyond the organization, tailoring care to patients and caregivers, and generating buy-in among staff. Commonly reported barriers included poor integration of transitional care services, unmet patient or caregiver needs, underutilized services, and lack of physician buy-in.

**Conclusion:** True community partnership, high-quality communication, patient and family engagement, and ongoing evaluation and adaptation of transitional care strategies are ultimately needed to facilitate effective care transitions. Health care organizations can strategically prioritize transitional care service delivery through staffing decisions, by making transitional care part of the organization's formal board agenda, and by incentivizing excellence in providing transitional care services.

The transition from the hospital to home or other post-acute care setting is a vulnerable period frequently marked by discontinuity<sup>1</sup> and posing significant challenges for patients and their family caregivers, particularly among those with low socioeconomic status.<sup>2,3</sup> These transitions between clinicians or settings within the current US health care system are often fragmented<sup>4–7</sup> and marked by adverse events, including medication errors, increased caregiver and patient burden, physical injuries, and higher hospital readmission rates.<sup>8–13</sup>

Transitional care is a “set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location.”<sup>4(p. 556)</sup> These transitions are “critical junctures”<sup>14(p. 312)</sup> for patients, and fragmented transitions stem from factors at the individual, organizational, system, and community level. Identifying new ways to optimize these transitions continues to be an important issue for leaders of health care organizations as the US population ages, as health care systems move away from a fee-for-service financial model to a payment-for-value approach, and as the demand for more efficient health care delivery increases.<sup>15</sup> Prior research clearly documents that poor care transitions often result in additional (and unnecessary)

health care costs due to increased lengths of stay, patient non-adherence, and preventable readmissions.<sup>4,6,8</sup> Indeed, in 2016 Jiang et al. identified quality improvement—including the need to improve care transitions—as one of the “key objectives for improving performance of the health care delivery system of the United States.”<sup>16(p. 115)</sup>

In response to the poor outcomes that often accompany care transitions, a number of specific transitional care strategies have been implemented across the country. Extant research demonstrates that several evidence-based approaches, such as the Transitional Care Model,<sup>17</sup> Care Transitions Program,<sup>18</sup> Project RED (Re-Engineered Discharge),<sup>19</sup> and Project BOOST (Better Outcomes by Optimizing Safe Transitions),<sup>20</sup> reduce rehospitalizations and improve quality of patient care. However, fidelity of implementation of transitional care services and effectiveness varies depending on structures, processes, and contextual factors (for example, systemic pressures, internal and external forces, particular situations). Determining the effectiveness of specific aspects of these multicomponent interventions has proved to be a significant challenge. One systematic review concluded that it was not possible to identify an individual intervention component that was consistently effective across studies because of the heterogeneity of intervention components and contextual influences in real-world settings.<sup>21</sup> Other studies reached similar conclusions.<sup>6,22</sup> Heterogeneity and contextual influences are key complications of routine care settings, influencing processes in ways that are not evident in research

studies. Findings from prior research point to the need to understand better how to respond to contextual influences and their heterogeneity in efforts to lead effective implementation of transitional care strategies in real-world settings.

The current investigation is part of the larger Project ACHIEVE (Achieving Patient-Centered Care and Optimized Health In Care Transitions by Evaluating the Value of Evidence),<sup>23</sup> which brings together patients and caregivers in partnership with nationally recognized leaders in health care and research methods to evaluate which combination of transitional care services is most effective for certain patient populations within particular system and community contexts. The large scope of Project ACHIEVE allowed us to examine these care transitions to gain a deeper understanding of transitional care as a whole.

The first phase of Project ACHIEVE, carried out from January through December 2015, involved collecting in-depth qualitative data in two ways: (a) in-depth interviews with 138 patients and 110 caregivers to identify what matters most to them as they move from the hospital to home or other care locations, and (b) site visits to delineate facilitators of and barriers to implementation of transitional care services that may have been adopted or adapted from evidence-based models. The site visit portion of the first phase is the basis for the present report. The qualitative findings of this first phase guided the Project ACHIEVE research team in its survey development efforts for the current second phase of the study. In the second phase—January 2016 through March 2018—Project ACHIEVE researchers are surveying approximately 15,000 patients, caregivers, and providers, and combining these results with health care utilization data and contextual information, to evaluate the comparative effectiveness of multicomponent care transitions programs occurring across the United States at more than 40 hospitals.

## METHODS

### Study Design

For the present study, we developed a standardized approach to evaluate how organizations adopted and implemented various transitional care strategies for particular patient groups or care environments as well as how they adapted different transitional care services on the basis of local resources. We visited 22 selected sites across the United States through a two-step process. First, each Project ACHIEVE team member proposed an initial list of 5 to 6 potential sites on the basis of their knowledge of the site and an existing partnership with the site. Second, the Project ACHIEVE recruitment and engagement work group reviewed the demographics of each site and finalized the list of 22 sites. The final 22 sites were selected to ensure a mix of the following criteria: geographic region, organization type, population (for example, urban, rural), and transitional care program implementation. The sites represented various types of organizations, including community hospitals, academic

**Table 1. Sites and Locations\***

Site	Location
Northeast Alabama Regional Medical Center	Anniston, AL
Kaiser Permanente Baldwin Park Medical Center	Baldwin Park, CA
Kaiser Permanente Downey Medical Center	Downey, CA
Kaiser Permanente Fontana and Ontario Medical Centers	Fontana, CA
Marin General Hospital	Greenbrae, CA
Kaiser Permanente West Los Angeles Medical Center	Los Angeles
Kaiser Permanente Los Angeles Medical Center	Los Angeles
Kaiser Permanente Panorama City Medical Center	Panorama City, CA
Kaiser Permanente Riverside Medical Center	Riverside, CA
Kaiser Permanente San Diego Medical Center	San Diego
Kaiser Permanente South Bay Medical Center	San Diego
San Diego Care Transitions Partnership	San Diego
Sutter Health California Pacific Medical Center	San Francisco
Christian Living Communities—Clermont Park	Denver
Presence Saint Joseph Hospital	Chicago
Hazard Appalachian Regional Healthcare Medical Center	Hazard, KY
Lake Health TriPoint Medical Center	Concord, OH
Trinitas Regional Medical Center	Elizabeth, NJ
Geisinger Medical Center	Danville, PA
University of Pennsylvania Health System	Philadelphia
PeaceHealth St. Joseph Medical Center	Bellingham, WA
Crossing Rivers Health	Prairie du Chien, WI

\*30-day all-cause rehospitalization rates for Medicare fee-for-service patients ranged from 13.4% to 18.1% ([Medicare.gov Hospital Compare](https://www.medicare.gov/hospitalcompare/search.html). Accessed Apr 11, 2017. <https://www.medicare.gov/hospitalcompare/search.html>).

medical centers, integrated health systems, and broader community partnerships (Table 1). The sites also represented organizations in various stages of maturity in implementing transitional care efforts, ranging from pilot testing specific strategies on independent units or floors to integrated organizationwide rollout and optimization of processes within an integrated health care delivery system (Table 2). The study protocol received Institutional Review Board approval from the University of Kentucky and from every participating organization.

### Participants

Our goal was to understand processes related to care transition services from various stakeholder perspectives. Thus,

**Table 2. Site Characteristics\***

Characteristic	No.	Percentage
Setting		
Urban	17	85
Rural	3	15
Organizational control		
Government, nonfederal	1	5
Nongovernment, not-for-profit	19	95
Academic medical center		
Yes	2	10
No	18	90
Provider type		
Inpatient prospective payment system	16	80
Rural referral center	2	10
Sole community hospital	1	5
Unknown	1	5
Total licensed beds		
Less than 100	1	5
100–299	8	40
More than 300	11	55
In system		
Yes	15	75
No	5	25
Electronic health record		
Fully implemented	8	40
Partially implemented	4	20
Unknown	8	40
Accountable Care Organization		
Yes	2	10
No	18	90
Bundled Payment		
Yes	5	25
No	15	75
Community-based care transition program/Quality improvement organization/International classification of primary care		
Yes	6	30
No	14	70
Critical access		
Yes	1	5
No	19	95

Sources: American Hospital Association Survey; Centers for Medicare & Medicaid Services Impact File.  
 \*Two of the 22 sites were nonhospital sites and are excluded from this table.

at each site we began by using purposive sampling and supplemented this with convenience sampling to recruit participants who were as follows:

- Members of the leadership team (for example, C-suite officers, board members)
- Transitional care team (for example, project leads, transitional care champions, case managers, pharmacists, social workers)
- Internal stakeholders, including various managers and other unit leaders (for example, unit managers, hospitalists, primary care physicians, specialists, staff

nurses, physical therapists, emergency department physicians, patient experience leads, utilization review leads)

- Community partners (for example, individuals from skilled nursing facilities, home health agencies, long term care facilities, hospice agencies, community-based organizations)
- Patients and their family caregivers

The composition of individuals who were interviewed was adjusted, depending on the structure and leadership of the transitional care efforts in each community. Consent was obtained from all participants.

**Data Collection**

We conducted site visits at each location from March through December 2015. The visits lasted one to two days and were conducted by two to four Project ACHIEVE staff members. At least one expert in transitional care strategies [J.L., H.Q.N, B.G., K.B.H., S.M., M.V.W.] participated in each site visit. We used three means of data collection: interviews, observation, and document review.

**Interviews.** We conducted semistructured individual and group interviews with a total of 810 individuals (an average of 37 participants per site). We interviewed each stakeholder group separately at each site, each group consisting of varying representatives by site depending on internal staffing approaches; for example, the internal stakeholder group included resident physicians if the health center had a teaching program, or social workers versus nurse case managers. Notably, the groups also included individuals of varying levels of authority, and investigators worked to facilitate conversations that might be impeded by fear of leadership being present. Importantly, we stated initially and reinforced throughout the visits that we were not evaluating the health system. Instead, we emphasized that we were collecting information to generate broad understanding about their care transition efforts and collecting stakeholder views for the purpose of developing broad conclusions and recommendations, rather than evaluating specific sites or individuals. Interview questions relevant to the present analysis included general and probing questions related to the effectiveness of transitional care service implementation, such as “What has worked well with transitional care services implementation?” and “What has been most challenging with transitional care services implementation?” Interviews were audio-recorded for transcription.

**Observation.** We observed hospital interdisciplinary rounds and toured facilities at most sites. Observations of delivery of care, work environment, work pace and flow, and interactions among leaders and providers were recorded in free-form memos by the staff researchers.

**Documents.** Finally, we reviewed various artifacts from most sites, including organizational strategic plans, transitional care programs and strategies, training manuals, patient

and caregiver educational materials, and note templates from the electronic health record systems.

### Data Analysis

We conducted an iterative content analysis of the transcribed interview data, as well as the memos from each interview, using qualitative descriptive analysis,<sup>24</sup> an inductive, low-inference method designed to gain an accurate accounting of a phenomenon in the everyday terms of stakeholders. The data analysis unfolded in two stages. First, two coders [A.M.S., S.O-E.] independently reviewed the data for each participating site and summarized key themes for the site. These coders produced 22 site-specific reports. Validity of these reports was confirmed by sharing findings from this stage of analysis with transitional care site leaders for each of the 22 sites and soliciting feedback about the coders' interpretation of the data, as well as active review by the transitional care experts on the research team who visited the sites.

In the second stage of analysis, the two coders synthesized the data from each site and conducted a cross-site comparison to identify general themes across the 22 sites. In particular, we identified common barriers to and facilitators of effective transitional care strategies, and we noted similarities and differences between sites based on their readmission rates as well as participant descriptions of the transitional care process. Findings from the cross-site analysis were validated by reaching consensus through discussion among members of the core Project ACHIEVE research team.

## RESULTS

The site visits provided insight into the relative effectiveness of different approaches to transitional care implementation in various contexts, including organizational change processes and required changes in staff behavior. Separately, we identified common facilitators of and barriers to effective care transitions that might impede effective evidence-based programs. First we present the results of our cross-site analysis, followed by the results of our thematic analysis.

### Cross-Site Analysis

We found wide variation in the type and extent of transitional care intervention across the 22 sites. Approximately 8 to 10 sites had *no formal* transitional care approach and instead appeared to be relying haphazardly on various staff (for example, bedside nurses, social workers, case managers) for coordinating care transitions. The lack of a formal transitional care program at these sites created confusion about who was ultimately responsible for care transitions.

Approximately 10 to 12 sites had *many, fragmented* transitional care approaches. These sites had implemented numerous transitional care strategies in various units of the organization targeting different patient populations, but these efforts were not always coordinated. Staff reportedly

duplicated one another's work because of this lack of coordination, which also created gaps in care transitions because the patchwork of strategies did not effectively catch all patients.

There were approximately 2 to 3 sites that appeared to be operating optimally under a *unified* transitional care approach. The sites reporting the most success with care transition outcomes had a clear transitional care strategy that had been implemented consistently throughout the organization. Having designated staff members whose job responsibility clearly included coordination of care transitions reportedly resulted in more efficient and effective transitions.

In addition to variability in the transitional care services provided and their implementation, we also found wide variability in the degree of community partnerships, an integral element of many transitional care services. Some sites demonstrated *low engagement* with community partners. Specifically, in some low engagement sites, transitional care efforts needing community contribution were siloed in the hospital without community engagement, while at other sites such efforts were siloed in the community without hospital engagement. Still other low engagement sites had multiple efforts implemented in both the hospital and community, but without any integration. These sites reported less success in delivering effective transitional care.

By contrast, some sites demonstrated *high engagement* with community partners. These sites had strong coordination between hospital and community transitional care efforts and were notable for clear communication and information sharing among partners. This strong partnering appeared to minimize duplicated effort as well as gaps in transitional care services.

To illustrate the wide variability across sites, we present four case studies in [Sidebar 1](#) (organization names are pseudonyms).

### Facilitators of Effective Transitional Care

Facilitators of effective care transitions included collaborating within and beyond the organization, tailoring care to patients and caregivers, and generating buy-in among staff. [Sidebar 2](#) displays a summary of the categorization and relative frequencies using a "heat map" of the number of sites that reported each facilitator described below.

**Collaborating Within and Beyond the Care Organization.** Several of the key facilitators of effective care transitions included strengthening collaboration within the site as well as strengthening collaboration with health partners within the broader community.

*Coordinating with Community Partners.* A key facilitator of effective transitional care was smooth coordination between the hospital and community partners. Our cross-site analysis revealed that developing and maintaining collaborations with community partners reduced overlaps and



**Sidebar 1. Case Studies Illustrating the Interaction of Facilitators and Barriers to Effective Transitional Care****Eastern Regional Medical Center: Failed Transitional Care Implementation**

Eastern Regional Medical Center (ERMC) is an acute-care hospital with an adjacent psychiatric center and cancer center that serves 20 rural counties. ERMC is disengaged from a transitional care perspective. The medical center attempted to use Lean Six Sigma as its quality improvement approach focused on facilitating the discharge process, but currently only one floor in the hospital sustained the intervention. Notably, the staff who trained to lead these quality improvement efforts left the hospital one year after implementing the initiative. Discharge planning frequently occurs at the time of discharge, and referrals to other facilities (for example, rehab) are often made the day of discharge. In addition, a delay often occurs between when a physician tells the patient about being discharged and when the discharge orders are actually signed or prescriptions are written. The hospital has a grant-funded initiative with stroke patients in which patients receive help from navigators who assist with medication reconciliation, equipment access, follow-up phone calls, home visits, and making connections with community resources. This program has been successful and well-received by staff; however, there is no infrastructure to support the program when grant funding ends. The CEO of the medical center was unfamiliar with these transitional care efforts within the organization.

There are a number of disconnects in coordinating patient care within the hospital and between the hospital and other health care facilities. ERMC uses a federally funded regional transitional care program that involves staff workers visiting the hospital and screening Medicare patients for postdischarge home visits. However, the program operates independently of the hospital system, and there appeared to be minimal interaction with hospital staff. Notably, frontline staff voiced concern that the program “cherry-picked” patients at low risk of being readmitted to optimize the results. Within the hospital, social workers and case managers do not always appear unified in the messages they deliver to patients. Patients reported receiving conflicting information in their discharge instructions. Nurses, case managers, and social workers each perform the function of discharge planning in isolation of each other. Pharmacy is a constant presence on the floors managing orders, but they are not involved specifically in discharge efforts.

The rural setting of ERMC impedes placement of patients at post-acute care facilities, particularly those with ventilator care capability (for example, long term acute care [LTAC]) or assisted living facilities, and many facilities refuse to admit patients with psychiatric disorders. Given the limited resources for transitional care services, the hospital focuses on treating patient’s acute care needs rather than addressing the longer-term care of patients. Staff voiced frustration with lack of patient adherence with postdischarge instructions and implied that some patients remain nonadherent to sustain disability benefits.

ERMC’s 30-day hospitalwide readmission rate for Medicare patients, 18.1%, is worse than the national rate of 15.6%.

**Northern Health System: Advanced Transitional Care Implementation**

Northern Health System (NHS) also serves a rural area and emphasizes the importance of population health and built a wide network of partners to provide inpatient and outpatient transitional care services. The system includes hospitals, home health, hospice care, a skilled nursing facility program, an independent living program for older patients, and outpatient clinics. The NHS Health Plan is a key driver of the system’s outpatient initiatives, and 60% of its patient population is insured through the Health Plan. Ten years ago,

NHS initiated a health navigator program when the issue of readmission rates surfaced. The program provides outpatient case managers who provide follow-up phone calls 72 hours after discharge, align home care, and make connections to community clinics. The program also utilizes lay people with medical backgrounds to make home visits and do safety assessments.

The initial transitional care team at NHS used materials from both Project BOOST and Project RED toolkits, identifying the 12 best practices from these programs, including using a readmission risk score, a follow-up appointment scheduler, discharge time-outs, advanced care planning, patient education using teach-back, and medication reconciliation. As part of these efforts, a readmission risk team receives alerts about high-risk patients being discharged. These patients are monitored for readmission within 72 hours, and an e-mail is triggered if readmission occurs, in which case a root cause analysis is performed.

NHS has active patient and family advisory councils where patients and family members share their experiences, which are then used in staff training on how to educate and engage patients in terms of the patient’s own goals. An assessment tool designed to facilitate transitions from the acute setting was developed after surveying patients about their opinions and potential reasons for being admitted.

NHS has an efficient information management system. Patient electronic health records are accessible to inpatient and outpatient case managers (including non-NHS sites), post-acute providers (that is, skilled nursing facilities [SNFs], Home Health), and physicians from community clinics. Hospital pharmacists are instantly paged when a provider writes an order for discharge so the pharmacist can review the case to determine whether the patient is high risk and requires additional medication education. NHS shares data with SNFs to identify high-risk patients, and warm handoffs occur between NHS and SNFs. NHS also uses Stratus, a software that can translate discharge instructions into different languages so that non-English-speaking patients have written documentation they can refer to at home after they have received instructions via the spoken translation service in the hospital.

There are also strong transitional care feedback mechanisms at NHS. Home Health gives feedback to the navigator case managers. “Lunch-and-Learns” with SNFs provide opportunities to learn about their decision-making process in sending patients back to the hospital. “Care Fairs” allow post-acute providers to come to NHS and share information about their services.

Leadership at NHS has cultivated a culture of prioritizing transitional care throughout the system. NHS leadership meets quarterly with the leadership at 21 SNFs (2 of which are NHS-owned) and the leadership of Home Health. NHS leadership also supports the recommendations emerging from the system’s Patient and Family Advisory Council. Of note, this council was the initial source for transitional care services becoming a priority. The NHS board reviews quarterly scorecards, which report outcomes of transitional care services.

NHS’s 30-day hospitalwide readmission rate for Medicare patients, 16.1%, is close to the national rate of 15.6%.

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**Sidebar 1. (continued)****West Coast Partnership: Successful Community Coordination**

West Coast Partnership (WCP) is comprised of 13 hospitals from different health systems within one city. Transitional care efforts began as part of a pilot grant that expanded into a financially sustainable partnership. As part of the partnership's transitional care program, social workers follow high-risk patients upon hospitalization and address social issues early, which reduces the amount of time spent linking a patient with a social worker postdischarge. Social workers also perform home visits, assess risk for adverse events, and make referrals to other services. During some home visits, nurse coaches review educational booklets with patients, perform medication reconciliation, and teach them how to self-advocate.

WCP has a strong record of evaluating transitional care interventions and making changes to the interventions based on evidence of effectiveness. Nurses follow Coleman's Care Transitions Intervention (CTI) structure, but they continuously modify components of the intervention to improve functionality. For example, some patients are more agreeable to accept transitional care services in the form of phone calls as an alternative to home visits, which prompted revision of the protocol to include enhanced phone calls as a substitute for home visits. Leadership at each of the partnership hospitals has been receptive to changes in the Coleman CTI model and have encouraged managers and nurse coaches to continue innovating. WCP also has developed an advance care planning component. Even though advance care planning originally was not reflected in Centers for Medicare & Medicaid Services (CMS) reimbursements, WCP offers expert consultant services free to hospital partners because WCP sees the value of advance care planning in easing care transitions.

Several WCP members identified medication discrepancies as an issue with discharged patients, so leadership at the hospitals found a way to allow the integration of pharmacist interventions into the CTI program beyond what CMS reimbursed. Pharmacists perform medication reconciliation during admission and discharge as well as phone consultations during CTI home visits. After discovering that medication discrepancies happened more frequently when patients move from the hospital to a skilled nursing facility, WCP has initiated a pilot remote medication reconciliation program to address this.

WCP has developed a sophisticated information-sharing system, including a Web-based invoicing and data collection system for the hospitals. This system monitors patient hospitalization events at different facilities by using their CMS ID number. Transparency of dashboard metrics creates healthy competition among the hospital systems. In addition, skilled nursing facilities (which are owned by many of the health systems) have hospital electronic medical record access, which allows them to see the most current patient medication regimen prior to discharge and prevents premature and invalid medication purchases by the facility.

The partnership provides a venue for sharing strategies and standardizing care protocols across sites. The CTI team roles are well understood, and direct communication and warm handoffs occur between inpatient and outpatient counterparts as well as with the patient so that all mutually agree on transitional care services. CTI coaches are involved in daily nurse huddles, which facilitates communication with hospital staff and also improves patient adherence by helping to explain postdischarge health management in the context of the patient's personal goals. In addition, patient feedback is consistently solicited and is presented at quarterly partnership advisory committee meetings.

**Southern University Medical Center: Championing Transitional Care Implementation**

At Southern University Medical Center (SUMC), a multisite regional health care provider for five rural counties, the effectiveness of transitional care services is largely credited to the work of one individual. Six years ago, she identified the importance of effective transitional care and worked to initiate gatherings of skilled nursing facilities, home health agencies, assisted living facilities, and hospice services. Through regular meetings the hospital and post-acute care providers work to facilitate transitional care and increasingly become familiar with each other and better understand each group's capabilities. The transitional care leader continues to personally evaluate each readmitted patient in the hospital to identify how readmission could have been prevented. Her efforts appear to have transformed transitional care at the hospital.

SUMC leadership has been proactive in seeking to understand factors related to readmission, although care transitions are not a formal item on the hospital board agenda. SUMC has disease-specific protocols in various hospital departments, which involve tracking readmitted patients, using disease-specific educational materials, and helping patients get discharge medications from the pharmacy. Hospital staff receive robust training in transitional care services, which creates buy-in among providers. The education includes a transitional care implementation team meeting with frontline care providers to assess why they made certain decisions and fostering critical thinking to evaluate how to better handle situations in the future.

Strong communication among care providers regarding the discharge process across the hospital was readily apparent. It helps that home health and hospice services are all under one roof and that case managers have offices on the same hallway so that nurses can easily communicate with them. In addition, SUMC coordinates care among various service providers beyond the hospital. For example, the transitional care team has a collaborative relationship with post-acute care facilities, including some facilities that serve the poorest communities. A local physician-based Accountable Care Organization serves as a useful information bridge between the hospital discharge planning committee and the primary care physicians, and patients and families report that the transition from the hospital to the rehab facility is "very smooth."

A culture of transparency and information sharing permeates SUMC. The hospital reports extensive data on readmission performance and shares information and cost-saving strategies with post-acute care providers. Case managers review all new patient cases independently from the physician and then communicate with the physician via electronic notes. Nurses electronically flag patients in the emergency department (ED) if they had a recent admission, and the ED tracking board alerts case management and physicians. Social workers independently conduct transitional care rounds, review cases, and make recommendations for additional transitional care interventions during hospital stays.

SUMC's 30-day hospitalwide readmission rate for Medicare patients, 15.1%, is lower than the national rate of 15.6%.

Collaborating Within and Beyond the Organization	Tailoring Care to Patients and Caregivers	Generating Buy-In Among Staff
Coordinating with community partners	Evaluating and adapting implemented transitional care approaches	Strategically prioritizing transitional care services
Managing information efficiently	Involving patients and caregivers in transitional care planning	Cultivating staff engagement
Communicating effectively face-to-face	Providing comprehensive patient and caregiver education	Championing transitional care

Note:

No. of sites reporting this facilitator
1–4 sites
5–8 sites
9–12 sites
13–16 sites
17–20 sites

gaps in transitional care, making care transitions more efficient and effective. Community partners included skilled nursing facilities, home health agencies, family care networks, elder care programs, faith-based ministries, homeless shelters, health departments, and local police and fire departments. Some sites were part of formal community partnerships, which provided a venue for sharing strategies and standardizing care programs within geographic communities. Regular multidisciplinary meetings between the acute care organizations and community partners served to build trust, provided a venue for soliciting feedback to improve care coordination, allowed for more nuanced and long-term transitional care planning, and created a sense of shared ownership of patient care among partners. One participant at a leadership team interview explained why he dedicated so much of his time to developing strong community partnerships:

Disease isn't what brings patients back to hospital. What brings them back is inability to see their doctor, inability to get food, inability to get their meds. So targeting these things, bringing [community] services in that get at these needs—once this is realized, doctors can do their part, and community supports can do their part, and we don't have all this time wasted. Lesson learned. We can do all this medical intervention, and that is important, but it's for nothing if the patient cannot manage these things at home.

Participants reported that strong partnerships with community organizations bridged gaps in patient care and markedly diminished the fragmentation of care that can occur in care transitions.

*Managing Information Efficiently.* A key facilitator of effective transitional care is efficient information management. For example, care transitions appeared to be improved when all community providers, pharmacists, and post-acute care facilities had access to patients' health records, electronic or otherwise. Some sites even coordinated their

electronic health records with community partners to facilitate monitoring patient progress after hospital discharge. By making health records accessible to clinicians at various sites of care, health partners with mutual patients enrolled in services were able to inform each other of changes in patient treatment plans. Leveraging information technology to monitor, track, and communicate with and about high-risk patients was commonly perceived by participants to improve patient outcomes. Several sites described using some form of an embedded scheduler to schedule follow-up appointments, verify availability of transportation to the appointment, and prompt registration for the health system's online health management tool. This scheduling strategy reportedly reduced the number of follow-up appointment "no-shows."

*Communicating Effectively Face-to-Face.* Effective care transitions were facilitated by strong interpersonal communication. In particular, participants at various sites reported that in-person handoffs between clinicians and regular multidisciplinary meetings among providers contributed to reductions in readmission rates: "Communication between departments is key. We believe in talking to each other, that's why we do huddles rather than simply notes or e-mails. Specialists do warm handoffs. We expect physicians to talk. We push against people's natural tendency to silo." Furthermore, participants from various stakeholder groups consistently remarked how interpersonal communication in real time was far more effective than online communication (for example, notes in patient records, e-mails) in enhancing care transitions and noted that efficient information management is not a substitute for skillful face-to-face interaction.

*Tailoring Care to Patients and Caregivers.* A second overall theme in participants' reports was the importance of tailoring care to patients and their caregivers by adapting

transitional care strategies to better fit each patient, involving patients and caregivers in transitional care planning, and providing comprehensive and tailored patient and caregiver education.

*Evaluating and Adapting Implemented Transitional Care Approaches.* Participants commonly reported that the most effective way to improve care transitions was to engage in ongoing evaluation of transitional care strategies and to adapt those strategies based on the results of the evaluation. In particular, members of the leadership team at several sites explained the value of not simply implementing transitional care strategies, but also evaluating how well the strategies are working and continually adapting them as needed. Various transitional care approaches were used at the sites (including the Transitional Care Model, the Care Transitions Program, Project RED, and Project BOOST) to optimize transitions. The effectiveness of these specific strategies was evaluated in various ways across the sites, including weekly review meetings, patient feedback mechanisms such as surveys or patient advisory councils, and case studies discussed during Grand Rounds. One participant from a utilization management team explained that for their site, “Complex case conferences focusing on high utilizers have been very instrumental in reducing readmissions.” Many organizations used ongoing evaluations of the effectiveness of transitional care services to determine how best to allocate resources and how to adapt strategies to better serve patient needs. For example, at one site, nurses found that some patients were more agreeable to accept transitional care services in the form of phone calls as an alternative to home visits, and so they altered the initial transitional care strategy to include enhanced phone calls as an option. Sites that continuously modified components of transitional care interventions to the local context and emerging patient needs reported improved functionality of the transitional care interventions.

*Involving Patients and Caregivers in Transitional Care Planning.* Another key facilitator of effective transitional care was patient and caregiver involvement in planning care transitions. Sites reported numerous mechanisms for and benefits of involving patients and their caregivers in developing transitional care approaches and discharge planning. For instance, one site had a patient advisory board where patients and family members shared their experiences with hospital leadership. These stories were then used in staff training on how to educate and engage patients in terms of the patient’s own goals. At another site, an assessment tool designed to facilitate discharge was developed after surveying patients about their opinions and potential reasons for being admitted. Results of the assessment revealed that patients appreciated when physicians listened to the patient’s spouse or other family members regarding readiness for discharge and when physicians or other members of the transitional care team gave patients their personal cell phone number.

This feedback was incorporated into the hospital’s discharge strategy at that particular site. Several sites emphasized the importance of patient and caregiver input in planning transitional care tailored to anticipated patient needs. Involving patients in transitional care planning appeared to cultivate a sense of ownership on the part of the patient and a sense of adaptability on the part of the transitional care team, as one inpatient nurse articulated: “The ideal process of transition includes planning ahead for the patient’s discharge and serving the care goals, with changes occurring depending on different patient needs.”

*Providing Comprehensive Patient and Caregiver Education.* Participants across sites reported that effective education was essential for effective care transitions. Many sites reported that patient education was most effective when it was delivered in smaller pieces that patients and caregivers could absorb and over several sessions so that key information could be reinforced over time. Ideally, patients received education upon admission and prior to and after discharge, as one nurse explained: “Education can bunch up at the end, so we try to educate from the beginning. Shortened stays means trying to fit in patient education and get a lot of reinforcement. Patients forget.”

Facilities where length of stay was more prolonged, such as in skilled nursing facilities, reported success with creating discharge plans when patients entered the facility. In one instance, “Move-out meetings” were held prior to discharge, and during these meetings clinicians engaged in patient and caregiver education (including discussions about signs and symptoms of worsening health requiring early follow-up as part of the effort to prevent rehospitalization), arranged follow-up appointments with primary care physicians, and reviewed equipment and medication for home use. These meetings ensured that patients, caregivers, and staff were on the same page with expectations and goals of care.

Several sites highlighted the importance of listening carefully to patients’ needs, preferences, and values so that clinicians could tailor education to each patient. Participants explained that showing patients how transitional care services supported their own personal goals improved patient utilization of the services. As one nurse reported:

We listen to what the patient’s goals are and repeat them back to the patient. For example, with a patient who drinks and has MH [mental health] issues but is functional, [we might say,] “You don’t want to be in the hospital, so you need to take these meds so you don’t end up back there again.” Listen to what their goals are and put services in the context of these goals, so patients will be more receptive. [Show] how you will help them accomplish their goals. This helps with adherence.

**Generating Buy-In Among Staff.** Finally, several facilitators of effective transitional care pointed to the importance of cultivating engagement from all levels of an organization’s staff through strategically prioritizing transitional



care, generating buy-in from staff, and finding someone to champion transitional care within the organization.

**Strategically Prioritizing Transitional Care Services.** One way to facilitate effective care transitions is to explicitly prioritize them within the organization. Participants from the leadership teams at various sites reported that making care transitions a strategic priority among the executive leadership team created an organizational culture focused on transitional care, which in turn improved the quality of transitional care services within the organization. When leadership was proactive in seeking to understand factors related to readmissions, other organizational staff modeled their attitudes on what they perceived to be important to their leaders. Prioritization of transitional care was evidenced in staffing decisions (for example, creating a team dedicated to implementing it) as well as formal agenda setting (for example, making transitional care efforts a regular part of the organization’s board agenda). One hospital’s chief medical officer spoke of the importance of transitional care services and explained why it is placed at the top of the hospital’s strategic priority list: “Admission to the hospital and discharge are the scariest parts of any process, the parts where there’s a likelihood of errors to occur.”

**Cultivating Staff Engagement.** Another key facilitator of effective care transitions involved generating buy-in among all levels of an organization’s staff. When multiple types of clinicians were included in transitional care improvement efforts, from conceptualization to implementation, transitions reportedly went well. Across the sites, participants reported various strategies to increase physician engagement, including integrating physicians into teams dedicated to implementation and using ongoing evaluation to demonstrate to hospital staff the improvement in patient outcomes resulting from transitional care program implementation. In addition, one site described how nurses informally spread transitional care success stories among fellow nursing staff,

which contributed to widespread buy-in among the nursing staff.

**Championing Transitional Care.** Finally, care transitions appeared to be improved by the work of a designated champion. Several sites credited their improvement in services to the work of one or two individuals who identified transitional care as a critical issue and took ownership of optimizing transitional care service delivery. Sites reported that having even just one person in the organization dedicated to leading transitional care improvement made a difference. At these sites, this “champion” helped to set these services as a priority at all levels within the organization, which ultimately helped to transform the culture in those organizations. Participants repeatedly emphasized that having the right person champion efforts was one of the most powerful catalysts to improving the effectiveness of transitional care implementation efforts.

**Barriers to Effective Transitional Care**

Commonly reported barriers to effective care transitions across the sites included poor integration of transitional care services, unmet patient or caregiver needs, underutilized services, and lack of physician buy-in. **Sidebar 3** displays a “heat map” of the number of sites that reported the barriers described below.

**Poor Integration of Transitional Care Services.** Absence of a unified approach to transitional care, breakdowns in communication, and poor information management represented major barriers to successful implementation.

**Lack of Uniform Implementation of Transitional Care Approaches.** One main barrier to effective care transitions was the lack of uniformity in implementing specific transitional care strategies. Participants reported that when efforts were not consistently integrated throughout the organization, fragmentation in service delivery occurred.

Poor Integration of Transitional Care Services	Unmet Patient or Caregiver Needs	Variation in Utilization of Transitional Care Services	Lack of Buy-In Among Staff
Lack of uniform implementation of transitional care approaches	Unaddressed social or psychological needs	Inadequate medication review	Limited resources
Communication challenges	Suboptimal patient and caregiver education	Insufficient home health breadth and quality	Inconsistent prioritization of transitional care services
Poor information management		Underutilized palliative care	

Note:

No. of sites reporting this barrier	
1–4 sites	
5–8 sites	
9–12 sites	
13–16 sites	
17–20 sites	

Although many sites reported having implemented some form of a specific transitional care approach, few sites had successfully integrated the same strategies throughout the organization, which participants acknowledged created barriers to effective transitional care. This was associated with clinicians functioning in isolation as well as redundancies or gaps in care. One member of a specialty care management team shared an example of how the lack of integration of strategies led to duplicated efforts: “High-risk patients are over-resourced. They get nine calls a day, and there’s no one who has a central knowledge of the patient. Segmented [care is] disheartening to a patient.” A leader of a medical administrative team echoed these concerns about fragmented transitional care: “We have been trying to make improvements, but [we are] still very siloed. Patients are still discharged feeling as if they’ve been dropped off a cliff. Lots of people are trying to improve care transitions, but it’s not well coordinated.”

At several sites, staff reported that they were not aware of any transitional care efforts at their organization, despite the fact that the leadership at the organization had implemented such strategies. One stakeholder said, “Here is this great tool [transitional care strategy], but nobody is using it.” Coordination between the inpatient and outpatient setting was problematic at a number of sites, and the numerous handoffs within and across service lines appeared to lead to limited accountability of any individual team member to coordinate care and ensure continuity across settings and over time. One social worker said, “Discharges fail because patients get dropped and fall between the cracks. We need someone to navigate them through the system to support them and help them through issues inpatient to outpatient.” Several sites reported that they did not have the tools to rigorously evaluate the effects of a particular transitional care strategy because so many things were changing or implemented at the same time.

**Communication Challenges.** Participants reported that miscommunication within an organization was a significant barrier to providing effective transitional care. In particular, participants described how clinicians failed to talk in person during patient hand-offs (that is, a “warm handoff”), leading to patients being less likely to receive appropriate and timely follow-up care. Limited verbal exchange among physicians and overreliance on written notes appeared to be insufficient to effectively manage patients, particularly those with complex conditions. Clinicians repeatedly commented that lengthy discharge summaries with extraneous information distracted from core issues. One physician explained how this issue was exacerbated when a patient received treatment from multiple providers: “Discharge summaries are too long, too much information. They keep cutting and pasting the notes, and it’s not very concise. It’s very difficult when the patient has seen three or four doctors.” At several sites, patients described hearing different messages from

different staff and explained how this inconsistent communication from different clinicians led to confusion about managing their own care at home.

**Poor Information Management.** Another barrier to effective transitional care was managing information poorly. Patients at several sites reported that inefficient information management resulted in misinformation being given to them and their families. Various stakeholders across some sites bemoaned the lack of an integrated electronic health record system, citing inaccessibility and clunky interfacing as barriers to coordinating care transitions: “Each unit is so different from the next. Each unit runs differently and stores things differently. There would be a benefit to standardizing processes.” Several sites had different electronic health records in different departments of the organization, which made internally sharing patient information challenging. In addition, the inability of external community partners to access health records limited the effectiveness of community-level transitional care efforts. One member of a home health team said: “Our EMR [electronic medical record] does not work for home care. We can’t build reports. The technology is not working for us, but against us.” At some sites, even the readmission rates were unknown because the information technology did not track these data, and thus the leadership’s ability to evaluate and improve transitional care efforts was stymied because they could not measure this key outcome.

**Unmet Patient or Caregiver Needs.** A second common set of barriers to effective transitional care involved the failure to adequately address patient and caregiver needs through education.

**Unaddressed Social or Psychological Needs.** When sites did not attend to a patient’s environmental concerns, such as stability of housing, access to transportation, or mobility issues, hospital readmissions were reportedly higher. Underlying social or psychological issues often overshadow patients’ medical needs, as one manager of a community-based care transition program stated: “What brings patients back to the hospital is not necessarily disease.” Following up with patients who did not have a stable living situation was particularly difficult, and many patients lacked reliable transportation, which reportedly disrupted the timeliness of discharges and transfers to post-acute care. At one site, no social workers were involved in care transitions, and thus the physical and occupational therapists bridged the gap, spending their time case managing because they saw patients more regularly and believed “no one else is doing it.” When a site lacked staff dedicated to addressing a patient’s social or psychological needs, participants at that site readily recognized the negative impact on the patient’s transitional care.

**Suboptimal Patient and Caregiver Education.** Inadequate patient or caregiver education was a commonly recognized barrier to effective care transitions. Sites reported that patient

education was often compromised due to limited time, medical complexity, and inadequate attention to individual learning needs. These constraints appeared to make it difficult for patients and family caregivers to process and retain self-care information. At some sites, patient education was delivered just prior to discharge, which often resulted in ineffective sessions, reportedly because too much information was provided within a short time frame when the patient's focus was on leaving the hospital, not on learning about self-care at home.

In addition to not receiving sufficient education about specific aspects of self-care at home (for example, equipment demonstration, dietary instruction, medication review), patients did not always receive clear education regarding the reality of managing their chronic conditions during their hospital stay, and consequently the home care nurses reported that they were reeducating patients in the home setting. The focus of patient education was often on the nuts and bolts of discharge, not on overall patient self-care, as a member of a specialty care management team said: "There are unrealistic expectations that patients can manage their self-care at home. The focus is 'Are you ready to get out of the hospital?' versus 'Are you ready to live your life at home?'" Many participants perceived that patient education was insufficiently tailored to patient needs in terms of literacy and language factors. At several sites, patients were not aware of health care facilities other than the emergency room, revealing the need to educate patients about using local urgent care clinics or accessing their primary care provider to decrease emergency department utilization for nonemergencies.

Some patients reported that they wished their physicians would not overlook their caregivers but instead consider them a resource for enacting care plans. Indeed, most education focused on patients even though participants commonly acknowledged the need to educate caregivers on how to be good caregivers because it was typically a new role. One stakeholder expressed the need to educate patients and caregivers on what a care transition is in the first place: "I don't think patients and family caregivers understand the word *transition* at all."

### **Variation in Utilization of Transitional Care Services.**

*Inadequate Medication Review.* Sites reported that medication review, reconciliation, and education were not consistently provided to all patients, which limited the benefit of transitional care efforts. There was no comprehensive medication review prior to discharge at most sites, and full medication reconciliation was often available only for special patient populations. Some clinicians reported discomfort with reconciling medications outside their specialty area. In addition, medication reconciliation meant different things to different providers, so it was not happening consistently within organizations. "[We] have a different idea than nurses do of what medication reconciliation is" stated one pharmacist.

At several sites, the inpatient/outpatient pharmacy systems were not well integrated, making medication management difficult. Medication instruction was reportedly ineffective when it was provided to patients during periods of confusion or emotional distress related to their illness. Comprehension was also limited by low health literacy. Many sites reported problems with patients leaving postdischarge prescriptions unfilled. One pharmacist explained: "Patients don't pick up their discharge meds. From a pharmacy perspective, it is important that we provide patients with medication before discharge, even if it's a starter supply." Sites also reported delays in getting pain medication for patients after transfers to skilled nursing facilities, especially after operating hours, given that a physician's authorization was required. Pharmacists reported that having medication ready for the patient before discharge was crucial, but rarely happened.

*Insufficient Home Health Breadth and Quality.* Despite home health being at the crux of care transitions, the existing structure, resources, and processes underpinning home health care at many sites were inadequate or inflexible to meet service demands, according to stakeholders in the home health groups. In addition, the need for timely communication to ensure safe, high-quality care often went unmet. Other staff members' lack of understanding of home health services constrained how well home health staff could meet patient needs, as one representative of home health said: "The physicians' understanding of home health is getting better, but there are still provisions that they don't understand. We are not based out of social services, so if patients need help but have no skilled need, we have to say that we cannot provide services."

*Underutilized Palliative Care.* Various stakeholders across the sites spoke about the need for patients and their families to better understand palliative care. Patients and their families were commonly confused by palliative care options. Advance directives were not consistently completed or uploaded to patients' electronic health records. Physicians reportedly were hesitant to initiate uncomfortable discussions about hospice care, which led to multiple hospital readmissions close to death or instances in which family members of long-stay patients on ventilators were unaware of other care options. One physician expressed that the hospital needed to keep "moving advance care planning discussions with patients and families more upstream and creating more time for this proactive process to happen." However, without a better understanding of palliative care services among staff across the hospital, moving such conversations "upstream" appeared to be unlikely.

*Lack of Buy-In Among Staff.* The last set of barriers to effective transitional care related to a lack of staff engagement in various forms, including limited resources and inconsistent prioritization of transitional care services within an organization.

*Limited Resources.* At many sites, transitional care was hampered by limited staffing resources. Individuals in hospital leadership repeatedly articulated the tension between the competing priorities of quality and affordability: “Maintaining quality with growth under affordability—we can’t catch our breath with growth.” A number of sites explained that they received external funding to initiate transitional care services, but the external funding eventually ended, requiring the organization to secure additional funding or to operate within a more limited budget. In such cases, there was a risk of reverting back to siloed funding and thus siloed service delivery. One member of the leadership team explained how staffing shortages required agency outsourcing, which made coordination of care worse: “It’s much cheaper to outsource. There’s a whole host of assumptions about ‘a lot cheaper’—can we control the quality?” In addition, at several sites, finding post-acute care facilities with necessary capabilities was difficult because it was common for such facilities to refuse to admit patients with psychiatric diagnoses. In general, at sites with limited resources for transitional care, the facility tended to manage only the acute patient needs rather than addressing the longer-term care needs, but this approach did not position the organization to provide effective transitional care in the long term.

*Inconsistent Prioritization of Transitional Care Services.* Even at sites where a standardized transitional care approach existed, there was still a struggle to make it sustainable. Participants reported gaps in hospital staff members’ understanding of transitional care services, particularly in their understanding of the various roles involved (for example, nurse navigator versus nurse case manager), which led to underutilization of those services. At many sites, we found that not all stakeholders were aware of available transitional care services, which was a barrier to transitional care service utilization. There was evidence of a need for leadership endorsement across sites; that is, for care transitions to be more effective, transitional care needed to be emphasized by hospital administrators. One participant from case management said, “Leadership and what they tell the frontline staff is important to any change. If the top doesn’t get the message, then it’s over.” When hospital leadership and clinicians did not prioritize care transitions or the long view of care, transitional care strategies were not consistently followed and patient long-term care suffered.

## DISCUSSION

The findings of our site visit analysis provide a valuable resource for health care organizations seeking to improve transitional care program implementation. Little research assesses from a macro perspective how all of the individual types of care transitions work in concert or at cross purposes within a single organization. A broad, systematic perspective on care transitions represents a key strength of our methodology. Conducting individual site analyses, as well as a cross-site

comparative analysis of 22 diverse organizations across the United States, enabled us to identify specific concrete strategies that sites reported lead to better or worse transitional care outcomes. Notably, those transitional care implementation strategies reported as yielding improved outcomes are consistent with the basic quality improvement (QI) principles of executive support, stakeholder buy-in, and ongoing evaluation.<sup>25</sup> Moreover, our findings are consistent with previous care transition and organizational research and provide further insight into the factors that are related to preventable readmissions. In particular, our study results underscore the importance of true partnerships, high-quality communication, strategic management, patient and caregiver engagement, and ongoing measurement and evaluation, as well as iterative refinement in implementation efforts to facilitate effective care transitions.

First, we found that true partnership is ultimately needed to facilitate effective care transitions, including partnership within organizations as well as coordination involving the whole community outside the hospital. This is consistent with previous studies emphasizing the importance of fostering interprofessional collaboration by changing current models in which clinicians work in isolation to the one of health care professionals having a shared mental model and a deep understanding of how their individual responsibilities fit into the larger strategy for optimizing care transitions.<sup>26,27</sup> As health care organizations seek to align their strategic priorities with federal incentives to reduce readmissions, it is becoming increasingly clear that no single health care organization can offer all the resources necessary to maintain population health.<sup>28</sup> Instead, organizations must engage in sustainable community health partnerships as key points of leverage for improving quality of care and reducing costs.

Second, our results point to the importance of high-quality communication among health care professionals in facilitating effective care transitions. Many of our participants reported the need for efficient, accurate, complete, and accessible electronic health records, consistent with reports from other studies that have found that poor documentation and lack of information sharing are risk factors for negative patient outcomes associated with poor transitions.<sup>8,29</sup> However, efficient and accessible documentation is not equal to effective communication.<sup>30–32</sup> Participants in our sample clearly expressed the need for effective in-person communication in facilitating transitional care. Growing evidence suggests that health care professionals as well as patients attribute to “warm patient handoffs” that involve conversation among clinicians to minimize information gaps during care transitions.<sup>26,27,31,33</sup> Crucially, improving communication involves not fostering *more* communication but rather improving the *quality* of communication. In fact, our participants explained that more communication is not always better, particularly in terms of documentation. Specifically, our results suggest that communication is effective to the extent that it is in-person, patient-centered, and goal-directed.



Third, our findings support the idea that strategic management plays a critical role in leading community health partnerships. In particular, strong leadership fosters staff engagement and establishes clear accountability for transitional care service delivery. We found that effective care transitions depend not only on the collection of services offered by a health care organization, but instead on how well those services are integrated within the organization as well as within the community. Shortell et al. identified several key issues faced by health care organizations in facilitating coordination between their organizations and community partners, including communication, priority-setting with a common shared vision, and continued monitoring; our analysis confirmed the importance of each of these challenges.<sup>34</sup> Moreover, Dixon-Woods and colleagues reviewed evaluation reports from five improvement programs and concluded that implementing effective QI entailed efficient data collection and monitoring, prioritization by leadership, generating staff engagement, and securing sustainability.<sup>35</sup> Our results provide additional evidence that these strategies also improve care transitions within system and community contexts. Furthermore, we found that having an individual or a team that champions transitional care service delivery within an organization can be a powerful catalyst for change, consistent with previous research.<sup>34</sup>

Fourth, we found that involving patients and their caregivers in planning care transitions is essential to delivering effective care. Extant research has established the key role that family members and other members of a patient's social network play in monitoring and helping patients with managing self-care after discharge.<sup>26,27,36</sup> In particular, our results suggest that patient-centered transitional care involves engaging not only the patient, but also listening to and addressing the needs of the patient's caregivers. Family members are often better positioned than patients to identify potential adverse events that could undermine a patient's care, thus involving family members as "safety experts"<sup>36(p. 716)</sup> in planning and coordinating care transitions is one way to improve outcomes.

Finally, our results demonstrate the importance of continually evaluating and adapting transitional care strategies to tailor them to patient and caregiver needs. Most of the programs implemented at the different sites in our sample were based on elements from established models (for example, Transitional Care Model, Care Transitions Program, Project RED, Project BOOST). However, sites reported a great deal of variability in which components they used and how. In our sample, leaders at nearly all sites recognized the need to implement a particular transitional care model aiming to improve publicly reported readmission rates, although not all sites had successfully completed such implementation. Most programs at the study sites underwent many changes during implementation, particularly in the early stages, and organization leaders and staff recognized that the changes were inevitable and necessary in the context of practice-based

implementation. Nonetheless, the most successful sites were those that conducted ongoing evaluation of their transitional care services and made changes based on their assessments versus simply adapting for convenience. Sites that undertook evaluation reported that interventions were meaningfully enhanced through a process of continuous quality improvement. Tailoring strategies to fit the specific patient, unit, organization, and community needs was essential in facilitating effective care transitions.

The present study was limited in several ways that point to potential directions for future research. First, our sample was not representative of all health care organizations. However, the purposive and convenience sampling methods allowed us to examine variance in organization type, performance, location, and stages of transitional care implementation, and the broad set of characteristics demonstrated by the sites included in our analysis bolster the broad applicability of our findings. Sites from a single large integrated health care system were heavily represented in the sample. This system had well-developed regional and local strategies to improve care transitions for its high-risk populations but also reported experiencing similar barriers and facilitators as the other sites. Second, the composition of the group interviews had participants representing different levels of power within an organization. Concerns about anonymity or power differences during the group interviews might have affected participant responses, and it is not clear the extent to which this may have inhibited participant contributions to the group interview. Future work could include more systematically recruiting a representative sample of various stakeholders to examine in greater detail the relevant variations in the experiences reported within each group interview. Third, our study was not designed to establish causal inferences, but rather to provide broad as well as in-depth understanding of how transitional care implementation is facilitated across various health organizations. Future work can build on the groundwork laid by our initial investigation to draw causal conclusions about factors that facilitate or inhibit effective transitional care service delivery. Fourth, retrospective self-report data are subject to recall and self-serving biases. To address this, we conducted multiple interviews with numerous stakeholder groups, and we triangulated interview data with observation and document review. Fifth, our typically one-hour interviews with the stakeholder groups did not always allow us to fully explore specific issues and innovations in care transitions in great detail. Finally, due to logistical or scheduling challenges, not all stakeholder groups were interviewed across all sites, so the views of those who made time or had time to speak to the research team may not fully represent the views of those who declined or were not asked to participate.

### Practice Implications

Our findings provide the basis for several recommendations for health care organizations seeking to effectively

implement transitional care services. First, it is critical for organizations to strategically prioritize transitional care service delivery. In particular, leaders have the potential to transform organizational culture into one that values transitional care services through staffing decisions, such as creating a team dedicated to implementing transitional care strategies. Leaders can also champion the importance of transitional care by making it part of the organization's formal board agenda or by incentivizing excellence in providing these services.

Second, health care organizations would do well to monitor carefully the effectiveness of their transitional care implementation. We found that leaders of successful organizations continually adapted their strategies based on readmissions data as well as feedback from staff, patients, and caregivers. Organizations must explicitly measure transitional care performance to determine what works, what does not work, and how to best allocate resources. Evaluating implementation also allows organizations to see how best to structure service care delivery to prevent duplication of staff efforts and over-resourcing high-risk patients.

Our findings also suggest that health care organizations must forge partnerships within the community. One of the most significant challenges in integrating new strategies is to coordinate the implementation within the units of an organization as well as with community partners.<sup>37</sup> Involving internal and external stakeholders in the conceptualization, implementation, and evaluation of transitional care services is key to such integration. For example, creating a patient and family advisory board council, generating buy-in from organizational staff, establishing community coalition and identifying common goals, and facilitating regular interdisciplinary meetings with community partners are concrete ways that managers can facilitate effective partnership. Improvement strategies require multiprovider participation to achieve integrated transitional care processes, as well as high-quality communication among patients, caregivers, and inpatient and community-based teams.<sup>38</sup>

## CONCLUSION

The present study provides important insight into how health care organizations can lead effective implementation. Specifically, we found that the facilitators of and the barriers to effective transitional care were fairly consistent across sites, suggesting that the strategies that have proven effective in improving services at some sites may likely prove successful in addressing similar issues at other sites. Improving transitional care services is a complex challenge that requires clear structure and flexibility, committed leadership and engaged staff, and ongoing adaptation and evaluation of multiple implementation efforts. Many barriers to and facilitators of effective transitional care are structural in nature, and changing these deep-set patterns takes time, but identifying these structures represents a first step in addressing

them. The barriers and facilitators identified in our analysis can and should be leveraged to develop true partnerships within a health organization and within the community beyond.

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