# Hammer and wrench tool logo Tool 12: Cross-continuum collaboration tool

### Purpose

This tool helps teams develop specific effective and timely linkages to services with cross-continuum clinical, behavioral, and social services providers.

### Description

Hospital readmission reduction teams need to identify the clinical, behavioral, and social services providers ready, willing, and able to collaborate with the hospital to ensure effective linkage to services and timely followup contact. Central to developing improved processes for posthospital care is to work with cross-continuum providers on developing a clear understanding of potential referral volume and to discuss shared expectations for what an effective referral-linkage process looks like.

Use this tool to prepare for and initiate a series of structured discussions about how to more effectively link patients to cross-continuum provider services. After testing this process with a few key providers, build a portfolio of effective referral pathways to meet the timely posthospital needs of your patients. Create efficiencies by “batching” the types of needs and services and creating more direct, less time-consuming processes for linking patients to services. Collaboration is key to establishing a shared understanding and agreement of how processes can be improved to accommodate more patients, with the services they need, in a timely manner.

### Staff

Readmission day-to-day champion.

### Time required

2 hours to review and apply recommendations.

### Additional Resources

See Section 5 of the *Hospital Guide to Reducing Readmissions* for more information on how specific efforts to improve care transitions by working with providers and agencies across the continuum are part of an effective and robust portfolio of efforts to reduce readmissions for all patients, including Medicaid patients.

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## PREPARE

1. **Reach out** to a service provider, or group of providers who provide similar services, to initiate a transparent, data-informed planning discussion to explore improving linkages to services for patients. Set up a meeting.
2. **Prepare data** on your hospitals’ target population and how many target population discharges there are per day/week, and describe your working understanding of what factors contribute to readmissions.
3. **Prepare questions** to learn more about the services they offer and their capabilities.

## Ask

1. **Make a request - capacity:** Ask the provider to consider whether they have capacity to accept a consistent volume of referrals. What volume of daily/weekly referrals could they absorb?
2. **Make a request - timeliness:** Timely posthospital contact is a priority. Ask the provider/agency to work with you to develop a reliable process to ensure linkage to posthospital services, optimally before discharge or within 1-2 days of discharge.
3. **Make a request - getting started:** You have a process in place to identify patients at high risk of readmission who are admitted everyday at your hospital. Ask the provider/agency if you can initiate your test of better linking high-risk patients to their services by testing the new process on the next 10 patients who need their services.

## Test

1. **Test 10 patients**. Reflect:

* How long did it take to identify 10 patients who needed the provider/agency’s service? (1 day, 1 week, 1 month?)
* What does that say about the hospital’s processes for screening for the social/behavioral or other transitional care needs among patients identified as at high risk of readmission?
* How did the process go on the hospital side?
* How did the process go on the provider/agency side?
* How long did it take to initiate contact/service for the patient postdischarge?
* How can the processes to identify, refer, link, and connect within 48 hours of discharge be improved?

1. **Decide** whether to adopt, adapt, or abandon elements of this “referral pathway.”
2. **Continue to improve** the process so that:

* Your staff reliably identifies patients with needs that can be met by the service provider;
* Your staff can place a referral easily with minimal wasted time;
* The organization can receive high-quality referrals to minimize wasted rework;
* The organization staff can anticipate a start date and plan schedules accordingly;
* The patient accepts the service with a minimum of waste (late refusals); and
* Services are delivered in a timely manner within hours to days of discharge.

## Measure

1. **Reliability of Hospital-Based Needs Assessment**

* How many patients were identified to have a need [for a service] this month?
* What percentage of the target population is that?
* Do we believe we are effectively screening and identifying the need in the hospital?

1. **Effectiveness of the “Referral Pathway”**

* How many patients were referred to [the service] this month?
* How many patients were effectively linked to [the service] this month?
* Is there a difference between the number of patients referred and the number of patients effectively linked? If so, why? Can that gap be closed?
* Does the hospital staff report that the referral pathway is easy and straightforward? What barriers do they encounter in attempting to refer and definitively link the patient to [the service] before discharge?
* Does the provider/agency staff report the referral pathway is easy and straightforward? What barriers do they encounter when receiving the referrals and acting to definitively link the patient to [the service]?