Tool 12: Cross-Continuum Team How To Tool

**Purpose:** To advise and assist with the formation of a cross-continuum team.

**Description:** This tool explains the benefits and process of building a cross-continuum team and offers a template for inviting partners to join it.

**Staff:** Quality improvement leadership, cross-continuum team.

**Time required:** N/A; tool used for informing how to convene this team of variable size.
Tool 12: Forming a Cross-Continuum Team

By definition, a transition involves a “sending” (referring) and “receiving” (accepting) provider. Remember that the best transition out of your setting is only as good as the reception into the next setting of care.

Forming a cross-continuum team has several concrete and practical benefits. Some of the immediate benefits include:

- Declare to your referral partners your organization’s readmission reduction goals;
- Describe the range of efforts your organization is implementing to reduce readmissions;
- Understand what your cross-setting referral partners are doing to reduce readmissions;
- Understand what information your receivers need to facilitate a safe and stable transition into their setting to avoid a readmission;
- Form and strengthen multidisciplinary relationships among providers who share the care of common patients (putting a face to a name); and
- Identify partners that will help your hospital achieve quality, satisfaction, and/or cost goals.

Forming a cross-continuum team does not need to represent a major new strategic business decision. Cross-continuum teams start with the providers with whom you commonly share high-risk patients. Acknowledge that not all possible partners are at the table, and allow the group to expand naturally over time. Once you start hosting cross-continuum team meetings, other providers will want to be included.

An example email/letter of invitation for new members of your cross-continuum team is on the following page. Keep it simple, and send the emails today. Use Tool 5, the Cross-Continuum Inventory Tool, to identify providers and agencies to invite. As you expand your readmission reduction efforts to include adult Medicaid patients, consider reaching out to the following:

- Medicaid managed care organizations
- Medicaid behavioral health carve-out plans
- Medicaid agencies, especially in a fee-for-service market
- Behavioral health providers, community mental health, crisis teams
- Substance abuse treatment providers
- Home health agencies that serve high-volume Medicaid and/or behavioral health patients
- Physician practices that serve high-volume Medicaid patients, including community health centers
- Social service agencies, including those that provide social work services
- Elder service agencies, including those identified as aging and disability resource centers
- Pharmacies that provide bedside delivery and/or medication counseling services
- Adult day health programs
- Local emergency departments that share the care of common frequent users

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Community Partnership Meeting
[Your Organization Here] Readmission Reduction Project

Dear Colleagues,

[Your Organization] invites you to join us at the launch of our first cross-continuum team meeting to improve care transitions and reduce avoidable readmissions on [Date] from xx-xx at [location].

[Your Organization] is committed to high-quality, safe care, including at times of transition between care settings. [Your Organization] has embraced the priorities of the national Partnership for Patients and has recently made reducing avoidable readmissions through improving care a top quality initiative. Our aim is to reduce readmissions by [x%] over the next 12 months.

We know that our success depends on strong partnerships with you, the providers with whom we share the care of patients in the greater [your city/county name] community.

To that end, we are hosting an open “cross-continuum” meeting among hospitals, skilled nursing facilities, home health agencies, aging and social service providers, assisted living facilities, primary care practices, pharmacies, and other interested stakeholders. We hope to foster an active and highly productive community-based coalition of providers working in alignment toward a common goal of safe transitions in care for our shared patients.

Please join us. We will be [serving lunch] during a working meeting. Please come for all or part of the meeting. If you are not available, we would welcome a colleague from your organization.

We look forward to working together toward the improved care of our patients in [your community]. Please do not hesitate to contact me with any questions.

Kind regards,

[You - the readmission reduction champion at your organization]
Example Cross-Continuum Team Workplan

Collaborating with cross-continuum providers is a specific and action-oriented strategy to improve transitions in care. Productive cross-continuum collaboration requires fostering a team culture of engagement, commitment to shared goals, transparency, and shared learning.

If you are convening—or reinvigorating—a cross-continuum team, the first several meetings are appropriately spent in introducing individuals and learning about providers’ efforts to improve transitions (through direct service delivery, facilitating access to services, financing services, accessing data, mobilizing existing resources, etc.). Experience suggests that a trusting, collaborative environment of open feedback, shared problem solving, and improvement can be established within the first two or three regular meetings of a cross-continuum team.

Establishing a shared action agenda is essential for engaging sustained participation in cross-continuum team efforts and for converting good intentions into demonstrable improvements in transitions between settings and providers. There are numerous potential actions for a cross-continuum team; the specifics are determined by your local partnerships, your high-risk populations of interest, and the strengths of the change agents you have convened. Your cross-continuum team can—and should—make improvements in several domains in parallel process, such as improving cross-setting handoffs, developing efficient referral pathways for community-based services, and reviewing and sharing readmission data across organizations.

Below is an example cross-continuum team workplan, which organizes numerous specific actions into a smaller number of priority domains of focus. Assigning responsibility for leading, coordinating, or reporting at future meetings engages a diverse membership in coproducing the agenda and work of this team. The last page of this tool is an example from the field of a cross-continuum team agenda and minutes.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Action</th>
<th>Person(s) Responsible</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Causes of Readmissions</td>
<td>Overview of recent papers or presentations about readmissions</td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Discuss recently readmitted patient to identify opportunities for improvement</td>
<td></td>
<td>Every meeting</td>
</tr>
<tr>
<td></td>
<td>Discuss hospital-specific readmission trending data</td>
<td></td>
<td>Every meeting</td>
</tr>
<tr>
<td>Community Resources and Capabilities</td>
<td>All skilled nursing facilities complete INTERACT “Nursing Home Capabilities” Checklist</td>
<td></td>
<td>Within a month</td>
</tr>
<tr>
<td></td>
<td>All providers fill out their part of the “cross-continuum team inventory”</td>
<td></td>
<td>By next meeting</td>
</tr>
<tr>
<td></td>
<td>Group education on topic:</td>
<td></td>
<td>Rapid-fire presentations at Q2 meeting</td>
</tr>
<tr>
<td></td>
<td>* Adult Day Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* X , Y, Z Community Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timely Communication and Improved Handoffs</td>
<td>“Receiving providers” create a list of information that is frequently missing</td>
<td></td>
<td>By next meeting</td>
</tr>
<tr>
<td>Hospital and primary care provider workgroup meet to discuss “executive summary” or “one-liner” options for real-time notification of issues at time of transition</td>
<td></td>
<td>6-week task force to report back on [date]</td>
<td></td>
</tr>
<tr>
<td>Timely Referrals to Community Services</td>
<td>Task force on identifying how to refer hospitalized patients to the following on an urgent basis:</td>
<td></td>
<td>6-week task to report back on [date]</td>
</tr>
<tr>
<td></td>
<td>* Meals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Transitional housing</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>* Behavioral health services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
XXX Regional Medical Center  
Home Health, SNF, and Hospital Leaders Meeting Minutes

Date:  
Time:  
Location:  
Facilitator:  
Note Taker:  
Timekeeper:  
Attendees: List names and organizations of all present.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Topic</th>
<th>Discussion Leader</th>
<th>Notes</th>
<th>Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome/Introductions</td>
<td>Host</td>
<td>XX welcomed everyone.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Resources</td>
<td>[Specific Agency]</td>
<td>XX provided an overview of the community transition of care team roles and responsibilities for the [target] population. She discussed how the medication reconciliation process is a main focus of the transition of care team. The group discussed opportunities to strengthen relationships to improve transitions of care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Health Information Exchange | HIE update – Home Health | • XX reported that she has been working with XX and XX to get connected with [the local HIE]. They are waiting on a quote for needed equipment to do this.  
• XX reported physician practices that are partnered with XX are also connecting with the local HIE. She stated that 28 practices in the community are connecting with the local HIE. | XX will call the vendor to assist with getting the needed quote |
| Readmission Data – Trending and Insights | Readmission Data and Case Reviews by Facility/ | Group | Each facility and agency reported on their case review of the May readmissions (see attachments). Overall findings revealed that many patients are readmitted from SNF facilities due to family members insisting residents are sent to hospital when their condition changes. The group discussed possible ways to talk with families to help them understand options for residents versus immediately sending to hospital. XX also discussed the possibility of using Telehealth communication systems in SNF's | |
| Improved Handoffs | Home Health Electronic Orders and Medication Reconciliation Form to SNF's | XX reported she will set-up a meeting with Dr. XX and Hospital IT staff to discuss ways to get an electronic signature on the Home Health orders and to streamline the medication reconciliation forms with appropriate MD signatures. | XX and Dr. XX will report at next meeting |

Meeting adjourned at 8:30 a.m. Next meeting scheduled for XXX.