

Cross-Continuum Collaboration in Health Care: Unleashing the Potential

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for the Cross-Continuum Study Panel⁵

The growth of accountable care organizations (ACOs), bundled payment initiatives, and other performance-based payment arrangements signals a shift in the health care landscape toward rewarding value, rather than the volume of services provided.¹ Although this shift is still unfolding, many health care organizations are adopting population health approaches that expand their focus beyond acute, episodic care, to ensure that relevant post-acute and primary care, as well as community services and supports, are available in a coordinated fashion to meet the needs of patients across the care continuum. However, creating effective linkages across the care continuum requires overcoming challenges related to the historic fragmentation of health care service delivery within most communities, in which provider organizations may not share a common mission, orientation to the goals of care, or information exchange platform.

The need to bridge organizational boundaries is neither new nor limited to health care. Growing interest in the concept known as *collective impact*—defined as “the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem”²—highlights the importance of collaboration in addressing complex social issues. This approach is considered particularly valuable for tackling “adaptive problems”—such as those confronting cross-continuum teams in health care—in which “the answer is not known, and even if it were, no single entity has the resources or authority to bring about the necessary change.”³

Our combined experience studying and working with organizations engaged in readmission reduction efforts throughout the country has yielded valuable insight into effective mechanisms of collaboration among acute, post-acute, and community-based providers to identify and address coordination issues that span the care continuum.^{4,5,6} In this commentary, we summarize our learning about factors that facilitated successful cross-continuum collaboration, which helped improve care for individuals transitioning between care settings and highlighted how such efforts can help accelerate broader cost- and quality-related improvements.⁷

Enabling Factors for Cross-Continuum Collaboration

Designate a dedicated convener

Typically, a locally trusted individual or entity invited a range of stakeholders to come together to address the common challenges of improving care transitions and reducing readmissions. The convener may, but need not be, a neutral party or observer; we have seen a wide range of conveners including hospitals, Quality Improvement Organizations, academic medical centers, and Area Agencies on Aging.

Nurture trust to engage participation

Initial team meetings represented the first time that many organizations had sat together with competitors or with organizations who were their primary source of patient referrals. Therefore, early on, many teams found it worthwhile to spend time getting to know one another. In doing so, participants were able to channel disparate motivations to productive ends by clarifying how each organization could benefit from the partnership and contribute to the common goal of improving the health status of those they serve.

Make site visits to accelerate the discovery of shared interests

Conducting site visits and “shadowing” one another at their respective organizations was a powerful way for team members to more deeply understand the challenges and capabilities inherent in different care settings. This real-world interaction enabled participants to clarify misconceptions and identify ways in which they could work together more productively.

Start small and obtain “quick wins” to build confidence

Teams often began by identifying a common challenge, such as gaps in transferring critical information between care settings. This allowed them to codesign solutions such

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as standard transfer forms. Small successes built confidence and trust for making broader changes, such as the development of standard educational materials to be used across care settings and the use of “teach-back” techniques to assess patient understanding.⁸

Expand team composition to gain traction in solving complex problems

Although team composition varied, some organizations initially viewed the meetings as a networking opportunity for their marketing representatives to increase patient referrals. However, as teams began working to improve transitions in care, participation naturally shifted to staff who were best equipped to make frontline improvements. In addition, many teams found value in expanding participation beyond care delivery settings. For example, ambulance services offered insight on issues arising during patient transport, while community agencies helped create needed linkages with nonmedical services, such as housing, that support successful transitions. As one participant said, “Don’t exclude partners because of what you assume they do; let them come to the table and tell you what they can do.”

Use data to uncover insight and motivate change

Teams found value in using both quantitative and qualitative data to help identify opportunities for improvement as well as to monitor progress. One team effectively employed a Quality Improvement Organization’s shared measurement system to produce data on regional referral patterns and sources of readmissions, which reinforced a sense of interdependency among stakeholders. Team members from a skilled nursing facility determined that readmissions from their facility were concentrated among certain high-risk patients and subsequently developed routines for more closely monitoring these patients and for more timely interventions to prevent deterioration in their condition.

Focus on patient interests and experiences to drive improvement

Some teams began every meeting by discussing “diagnostic reviews” or stories of patient experiences to understand opportunities for improvement both within and across care settings. Other teams engaged patients and family members on their teams or as advisors. One participant characterized an emerging group mind-set as follows: “We’re not looking at placing blame or fault; we want to provide the best care to our patients, and we want to be aligning ourselves with providers that have the best practices.”

Discussion

Cross-continuum collaborations can offer many benefits to participating organizations. Hospitals benefit by avoiding penalties levied by the Centers for Medicare & Medicaid Services’ Hospital Readmission Reduction Program. ACOs and other provider groups participating in value-based payment initiatives benefit through shared savings if cost and quality targets are met. Skilled nursing facilities and home health agencies, which likely will face payment and

delivery reforms in the near future, also may be better positioned for inclusion into preferred provider networks. Community-based organizations such as Area Agencies on Aging may welcome the opportunity to strengthen connections with health care settings to ensure that nonmedical determinants of health are given appropriate consideration. Most important, collaborations between acute, post-acute, and community care settings yield great potential in their ability to ensure that patients are able to receive the right care, at the right place, at the right time.

Although the benefits of collaboration across care settings are significant, so are the challenges. To overcome them, teams had to take a long-sighted view to sustain the momentum of their efforts. This involved “onboarding” new team members because of staff turnover at participating organizations, and ensuring that the value of collaboration outweighed competing demands on team members’ time.

The enabling factors cited herein do not represent a “formula for success.” Rather, successful efforts incorporated multiple elements that varied based on community size, history, and culture. The nation would benefit from learning about the experiences of additional approaches to cross-continuum collaboration as health reform continues to unfold.

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