# Hammer and wrench tool symbol Tool 4: Community Inventory TOol

### Purpose

Identify clinical, behavioral, and social service resources in the community that can improve posthospital care to reduce readmissions. The community inventory is complementary to the hospital inventory when developing a whole-person and data-informed portfolio of strategies to reduce readmissions. Knowing the resources that currently exist in the community is essential to effectively leveraging those resources through formal or informal collaborations.

### Description

This tool prompts an inventory of community providers and agencies that provide services to meet the posthospital needs of patients so as to reduce readmissions.

### Staff

Readmission reduction champion as a component of strategic planning; delegated to day-to-day lead or social worker to conduct in collaboration with community partners.

### Time Required

4 hours.

### Additional Resources

See Section 2 of the *Hospital Guide to Reducing Medicaid Readmissions* and Tool 11: Community Resource Guide.

# Tool 4: Community Inventory Tool

Many resources in postacute and community-based settings can be mobilized to support patients in the posthospital period. Too often, hospital-based teams think there are few resources in the community, without periodically updating their understanding of what resources exist. The Centers for Medicare & Medicaid Services (CMS) specifically requires hospitals to know the capabilities of postacute and community-based resources, including Medicaid home and community-based services. Specifically inquire whether timely postdischarge or transitional care services exist. Over the past several years, skilled nursing facilities, home health agencies, and provider-based, payer-based, or community agency-based (transitional or high risk) care management services have proliferated in response to delivery system transformation.

Use this tool to inventory clinical, behavioral, and social service resources in the community that could provide timely posthospital followup, monitoring, and assistance. Use this inventory to identify which resources your hospital regularly uses. Also use this inventory as an implicit gap analysis to stimulate a consideration of providers or agencies you may want to more regularly use as part of your updated whole-person, data-informed portfolio of strategies.

Tip: You might use this inventory as a brief internal team review of the postacute and community providers with whom you most frequently collaborate to provide high-quality transitional care and effective linkage to posthospital services. Your readmission reduction team can probably identify a handful of the below-listed providers or agencies. That provides you with the information you need to have a gap analysis of what other resources to look for in the community.

Tip: Specifically find out whether you currently work with providers or agencies that address the needs of the target populations identified as high risk in your data analysis and readmission interviews. Consider:

* Medicaid resources: Managed care organization care managers, home and community-based services
* Behavioral health resources: providers, drop in centers, peers, case workers
* Clinical resources: clinics with integrated social work, behavioral health, care management (e.g., dialysis, sickle cell disease, HIV, cancer), patient-centered medical homes, accountable care organizations, etc.
* Aging and disability services
* Social services
* Collaborations with law enforcement or the criminal justice system

| Provider or Agency | Transitional Care Services [Examples] | Use? |  |
| --- | --- | --- | --- |
| **Clinical and Behavioral Health Providers**  |  | Yes | No |
| Community health centers, federally qualified health centers | [ability to accept new patients; timely posthospital followup; co-located social work, nutritional, pharmacy services, etc.] |  |  |
| Accountable care organization with care management or transition care | [high-risk-care management, transitional care to reduce readmissions, etc.] |  |  |
| Medicaid managed care organizations | [high-risk-care management, social work, wraparound services, etc.]  |  |  |
| Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers | [capitated or risk-bearing providers focused on providing whole-person care to improve quality and reduce costs] |  |  |
| Medicaid health homes | [engagement, outreach, tiered care management; eligibility based on chronic and behavioral health conditions]  |  |  |
| Multiservice behavioral health centers, including behavioral health homes | [prioritized posthospital followup; availability for new patients; co-located support services, etc.] |  |  |
| Behavioral health providers | [accepting new patients, prioritizing posthospital followup, etc.]  |  |  |
| Substance use disorder treatment providers | [effective processes for linking patients from acute care to substance use disorder treatment]  |  |  |
| Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics | [urgent appointments for symptom recurrence, protocol-driven ambulatory management, social work, education, etc.] |  |  |
| Pain management or palliative care | [symptom management over time, often with behavioral health specialists and social workers, education, etc.] |  |  |
| Physician/provider home visit service | [timely postdischarge in home evaluation, coordination with primary care, specialists, pharmacy, home health, etc.]  |  |  |
| Skilled nursing facilities | [onsite providers, warm handoffs, joint readmission reviews, INTERACT (Interventions To Reduce Acute Care Transfers) processes, transitional care from skilled nursing facility to home, etc.]  |  |  |
| Home health agencies | [warm handoffs, joint readmission reviews, front-loaded home visits, behavioral health clinical expertise, etc.] |  |  |
| Hospice | [warm handoffs, joint readmission reviews, same-day home visits, etc.]  |  |  |
| Adult day health | [daily clinical, nutritional, medication management, socialization, etc.] |  |  |
| Public health nurses | [home visits, outreach, education, clinical coordination, etc.] |  |  |
| Pharmacies | [bedside delivery, home delivery, medication therapy management, affordability counseling, blister packs, etc.] |  |  |
| Durable medical equipment | [same-day delivery; 30-day transitional care monitoring, education services, etc.] |  |  |
| Other |  |  |  |
| **Social Services**  |  |  |  |
| Adult protective services | [safety evaluation, case management] |  |  |
| Area Agency on Aging (AAA) | [self-management coaching, chronic disease self-management, in-home personal support services, etc.]  |  |  |
| Aging and Disability Resource Centers | [evaluate for eligibility for benefits and services; link to vetted providers]  |  |  |
| Assisted living facilities | [onsite clinical, onsite behavioral, self-management coaching, adherence support, transportation, etc.]  |  |  |
| Housing with services | [care management, onsite social work, onsite clinical, nutritional/food support, transportation, etc.]  |  |  |
| Housing authority or agencies | [case management, facilitated process of pursuing housing options]  |  |  |
| Legal aid | [securing benefits, access to treatment, utilities, rent, etc.]  |  |  |
| Faith-based organizations | [personal and social support, transportation, meals, etc.]  |  |  |
| Transportation | [transportation to meet basic and clinical needs]  |  |  |
| Community corrections system | [case workers, social workers, collaboration on followup]  |  |  |
| Other |  |  |  |