

## Continuity of Care – Examples of What Your Grant Can Do

### **Key Elements for Providing Continuity of Care**

- Referral or follow-up appointment made within 24-72 hours
- Warm handoff
- Transmission of patient information from one setting to another
- Follow-up contacts to facilitate follow-through with referral

### **How Grantees Can Play a Role in Continuity of Care Strategies**

#### ***General Settings***

- **Community resource listings for Referring Providers**
  - Provider has updated list of community resources available; this will help address patient barriers to follow-up care
    - Create system for providing updated list
- **Organizational MOUs, MOAs**
- **Continuity of care flow-sheets**
  - Electronic medical record (EMR) and/or medical practice management system includes follow-up appointment scheduling prompts and support
- **Communications between referring (identification) and referral orgs**
  - Relevant clinical information is transmitted from the discharge provider to the follow-up care provider including information about the visit and preferable a verbal conversation between providers
    - Protocols implemented to obtain patient permission to share patient health information
    - Incorporated into provider trainings
    - EMR facilitates information transmittal
    - Reimbursements for provider-to-provider call established
- **Protocols**
  - Patient consent protocols
  - Warm handoffs
  - Train providers on agency continuity of care practices and protocols
- **Informal caregiver involvement in aftercare planning**
  - Provider discusses expectations for follow-up care with patient and his or her supports
    - Patient education materials developed by grantee to aid this conversation

- Grantee trains provider on how to have this conversation
- **Case management**
  - Barriers to accessing follow-up care are addressed by the discharge provider
  - Alternatives to outpatient mental health pursued for patients with insurmountable barriers (e.g., refer to primary care, make call to crisis center before discharge, enlist family member to make appointment and assist with linkage)
- **Financing**
  - Financing for healthcare linkage practices and services is pursued
    - Work with state payors (Medicaid, behavioral health payors, other insurers) to establish reimbursement for practices and services
    - Develop a billing cheat sheet with billing codes for these services

### ***EDs, Hospitals***

- **Crisis center follow-up**
  - Crisis center (or other hospital/community service provider) services are engaged to provide follow-up contacts for recently discharged patients
    - Facilitate the development of MOUs between crisis centers and EDs
    - Sub-contract with crisis centers to provide follow-up services in local communities
- **Follow-up appointments made within 24 – 72 hours**
  - Discharge provider schedules follow-up appointment 24-72 hours or at least within seven days after discharge, preferably before the patient is discharged.
    - Help develop protocol where the professional responsible for scheduling appointment is clearly identified, potentially supply staff to schedule appointment
  - Outpatient providers expand capacity/remove barriers to scheduling rapid follow-up appointments
    - Help establish agreements between acute care settings and outpatient providers to prioritize scheduling for recently discharged high risk patients
    - Sub-contract with outpatient providers to prioritize scheduling for recently discharged high risk patients
- **Caring contacts** (follow up postcards or texts)