Continuity of Care - Fragmentation of the Healthcare System

*Continuity of care correlates with **reduced hospital admissions** & emergency department visits, leading to **cost savings***

Managing care among multiple providers

- **Schedule follow-up appts** prior to discharge
- Communicate action items **in writing**
- Include all follow-ups in **discharge paperwork**

Living in a rural or underserved area?

- Evaluate if patients need to return to the hospital for **specialty care not available in their area**
- Determine if they can **follow up closer to home** or virtually

Various EMRs & information barriers

- Provide a **printed copy** of discharge summary
- Ensure patient has copies of all **critical results**

Insurance coverage

- Proactively **verify network status** for all referrals
- Ensure outpatient providers **take the patient's insurance**

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Continuity of Care - Patient and Provider

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Patient-specific factors for apts

Do they have a PCP?

- Notify of admission/discharge
- Follow-up 7-14 days after discharge

Comorbidities:

- ESRD (non-HD days)
- Cognitive status (caregiver availability)

Communication with PCP

- Info to convey to the **PCP office** at discharge:
  - Conclusive diagnosis
  - Medication changes
  - Pending lab results
  - Serial imaging to follow up
- If discharging to SNF/SAR, **warm handoff** to facility provider is preferred

Follow-up appointments

- **SAR/SNF:** Specialists covered; rehab provider fulfills PCP role.
- Is the appointment scheduled at the clinic closest to their home?
- Is transportation an issue?
- Are scheduled appointments soon enough?

Home care and services

- Home PT/OT
- Outpatient PT/OT
- Nursing
- Line Care
- Wound Care
- Home Health Aid (HHA)

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