# Hammer and wrench tool logo Tool 11: community resource guide

### Purpose

Many hospital readmission reduction teams perceive that no community resources are available, even though community behavioral health and social service providers state they rarely receive referrals from hospitals. The purpose of this community resource guide is twofold: first, to demonstrate that there are community resources; and second, to generate an updated list of those resources for use by hospital discharge planners and others charged with effectively linking patients to services to meet the full range of their posthospital needs.

### Description

This is a two-part tool: a community resource guide and a 1-page “quick reference” version. Feel free to edit these tools to fit your needs. The purpose is to stimulate the development of an extended set of contacts at community agencies, specifically agencies and providers who can meet the posthospital and ongoing clinical, behavioral, and social service needs of the Medicaid population or other high-risk patients.

The community resource guide template is modeled on a community resource guide developed by a Medicaid community-based care management agency in Alabama. It prompts the hospital readmission reduction team to identify community agencies that offer services across a range of clinical, behavioral, and social domains. The guide prompts the developer to identify and list specific contacts at community agencies to facilitate effective referrals from the hospital to a single point of contact.

The 1-page quick reference version of the community resource guide is for frontline staff, identifying commonly needed services for patients with clinical, behavioral, and social service needs posthospitalization.

### Staff

Delegate to a social worker to complete with community providers and agencies.

### Time required

12 hours initially. Take no more than 1 month to draft. Maintain these lists as living resources that will require periodic (once or twice a year) updating.

### Additional Resources

See Section 4 of the *Hospital Guide to Reducing Medicaid Readmissions* for information on the CMS Discharge Planning Conditions of Participation to know the specific capabilities of community services, including Medicaid-relevant partners. Use the quick reference part of this tool to populate **Tool 12: Whole Person Transitional Care Planning** so that once a need has been identified, the contact information to link the patient with that service is readily available.

# Tool 11: Community Resource Guide

The first step to using community resources to address patients’ social and behavioral health needs is to identify community agencies and other organizations that can help meet those needs. Many hospitals perceive that there are limited or no community resources available, without having made a concerted effort to look for these resources. This tool will help you populate a resource guide to quickly and efficiently connect patients to the services they need.

Starting on the next page is a template to fill in information about your community resources. This resource guide will be especially helpful to the discharge coordinators, community health workers, patient advocates, volunteers, or other people who will help patients access clinical, behavioral, and social services.

The best version of this guide would be developed in collaboration with community providers and agencies so that each listing includes a specific point of contact ready and willing to accept referrals from hospital staff and able to work in a timely manner with hospital staff to provide the information needed to ensure effective and timely linkage to services after a hospitalization.

To populate this resource guide, draw from the following information sources:

1. **Your cross-continuum team partners.** A highly useful function of your cross-continuum team is to ask them to help populate an inventory of community-based services that can meet the clinical, behavioral, and social service needs of patients after hospitalization.
2. **Care management contacts at Medicaid health plans.** A clinical/quality leader at the hospital (e.g., director of case management, population health, or quality) should identify a key contact at each Medicaid health plan who can identify the types of supports and services the plan is providing or can provide for patients at high risk of readmission. This point of contact is different from the existing health plan contact for utilization review. The point of contact is essential to facilitate time-sensitive discussions to ensure posthospital supports and services are in place.
3. **Your hospital social workers, especially recent hires from plans or community practice or agencies.** Social workers are trained to understand the comprehensive landscape of social services in a community. Social workers from community providers or agencies will offer updated insights into community resources.
4. **A focused online search.** Conducting an online search for community resources in your area can be a quick way to find potential partners and their contact information. This can be a useful adjunct to what the social workers and cross-continuum team partners are aware of. Specifically seek out: Medicaid health homes; behavioral health homes; community behavioral health clinics; behavioral health clinics with navigators or care managers; public health-funded navigators or care managers; aging and disability resource centers; area agencies on aging; adult day health; housing authority or housing with service providers; food banks; pharmacies offering medication therapy management; pharmacies that offer blister packs; pharmacies that deliver medications to beside or home, etc.
5. **2-1-1.** Most of the United States has access to 2-1-1, a telephone hotline that specializes in health and human services information and referral. This can also be a useful supplemental method of research for resources you may not have thought of.

# Community Clinic, Behavioral, Social Services Resource Guide for [Hospital Name]

### Primary and Specialty Providers

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Community Health Center] | [Point person] | [XXX] | [Will schedule followup check with RN <48h via phone or in person] |
| [Patient-Centered Medical Home] | [Point person] | [XXX] | [Care manager will take lead on transitional care planning] |
| [Patient-Centered Medical Home 2] | [Point person] | [XXX] | [Practice has systems for posthospital followup calls, discharge plan review and appointments; uses CMS Transitional Care Codes for applicable patients] |
| [Visiting House Call Service] | [Point person] | [XXX] | [Can schedule timely in-home followup appointments; will coordinate with patient’s primary care provider and specialists] |
| [Sickle Cell Clinic] | [Point person] | [XXX] | [Contact center care coordinator for warm handoff; center has onsite social worker] |
| [HIV/AIDS Clinic] | [Point person] | [XXX] | [Care manager will take lead on transitional care planning; clinic has integrated behavioral health and social work] |
| [High-Volume Dialysis Center] | [Point person] | [XXX] | [Contact center care coordinator for warm handoff; center has onsite social worker] |
| [Urgent Care for timely followup] | [Point person] | [XXX] | [Can accommodate timely postdischarge followup checks within 1 week if patient cannot get into primary care] |

### Behavioral Health Providers

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Behavioral Health Center] | [Point person] | [XXX] | [Call on admission with any questions; call for warm handoff; will schedule all patients for posthospital followup <5 days] |
| [Behavioral Health Center] | [Point person] | [XXX] | [Taking new patients; will prioritize posthospital patients] |
| [Integrated Primary Care/Behavioral Health practice] | [Point person] | [XXX] | [Will provide timely posthospital behavioral health appointments for established patients of the practice] |
| [Living Room] | [Point person] | [XXX} | [Drop-in behavioral health peer support and onsite care management and linkage to behavioral health treatment] |
| [Regional Community Behavioral Health Service Provider] | [Point person] | [XXX] | [Community care navigators and peer advocacy specialists available for patients with xxx needs] |

### Substance Use Disorder Providers

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Hospital Substance Use Disorder consult service] | [Point person] | [XXX] | [Substance Use Disorder consult service will arrange for posthospital timely followup with medical, behavioral, and social services] |
| [Behavioral Health Center] | [Point person] | [XXX] | [Clinic works with Hospital Substance Use Disorder service to provide timely bridging of suboxone-eligible or initiated patients to clinic] |
| [Regional Community Behavioral Health Service Provider] | [Point person] | [XXX] | [Substance Use Disorder peer advocacy specialists available for patients considering engaging in treatment and recovery] |
| [Community Substance Use Disorder Agency] | [Point person] | [XXX] | [Provides a navigator immediately postdischarge and for 45 days until referral and intake to treatment can be initiated] |

### Dental Providers

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Dental provider] | [Point person] | [XXX] | [Accepts Medicaid patients; will prioritize patients who presented to acute care for dental-related pain or infection] |
| [Dental provider 2] | [Point person] | [XXX] | [Accepts Medicaid patients; will prioritize patients who presented to acute care for dental-related pain or infection] |
| [School of Dentistry] | [Point person] | [XXX] | [Accepts all patients regardless of insurance type; willing to commit to make appointments within 1 week of discharge] |

### Adult Day Programs

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Adult Day provider 1] | [Point person] | [XXX] | [Eligibility: XXX; Will prioritize hospital referrals to accommodate starts within 2-3 days of discharge] |
| [Adult Day provider 2] | [Point person] | [XXX] | [Daily activity, medication administration, nutrition] |
| [Adult Day provider 3] | [Point person] | [XXX] | [Will prioritize posthospital referrals; call 3 days prior to discharge if possible to evaluate and process eligibility] |

### Housing and Rent Assistance

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Housing provider] | [Point person] | [XXX] | [Shelter availability; case management services provided for those engaged in shelter services] |
| [Housing provider 2] | [Point person] | [XXX] | [Outreach and mobile services available] |
| [Housing provider 3] | [Point person] | [XXX] | [Temporary medical respite available postdischarge] |

### Financial Assistance

| Organization Name | Contact Person | Number/Email | Relevant Post-Discharge and/or Care Management Services |
| --- | --- | --- | --- |
| [Hospital charitable fund] | [Point person] | [XXX] | [Foundation-provided funds to provide one-time respite to patients with cash/financial assistance needs to secure medical treatment or recommendations (e.g., copays, medical equipment] |
| [Community nonprofit agency] | [Point person] | [XXX] | [description] |
| [Community social service agency] | [Point person] | [XXX] | [description] |

### Food Assistance

| Organization Name | Contact Person | Number/Email | Relevant Post-Discharge and/or Care Management Services |
| --- | --- | --- | --- |
| [Food assistance program] | [Point person] | [XXX] | [description] |
| [Mobile food pantry] | [Point person] | [XXX] | [mobile delivery for patients who lack transportation or who are unable to travel] |
| [Church food pantry] | [Point person] | [XXX] | [Open daily from 3-6pm; services available for 1 year] |

### Transportation Assistance

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Hospital transportation assistance] | [Point person] | [XXX] | [Van service within 20 mile radius of hospital; for medical appointments, lab or radiology testing] |
| [Agency 2] | [Point person] | [XXX] | [description] |
| [Agency 3] | [Point person] | [XXX] | [description] |

### Aging, Disability, Personal Care Services

| Organization Name | Contact Person | Number/Email | Relevant Post-Discharge and/or Care Management Services |
| --- | --- | --- | --- |
| [Service provider, such as Area Agency on Aging] | [Point person] | [XXX] | [Can connect patient/family to vetted in-home personal service provider; call 2 days before discharge] |
| [Service provider, such as Aging and Disability Resource Center] | [Point person] | [XXX] | [“No wrong door” policy to connecting patients/families with aging issues or disability needs to vetted providers; often patients may be eligible for subsidized or Medicaid waiver services; call 2-3 days prior to discharge to screen for eligibility and initiate connection to services] |
| [Service provider, such as Medicaid Home and Community Benefit Waiver Program] | [Point person] | [XXX] | [Can mobilize services in the home for patients who would otherwise meet nursing home level of care; call 2-3 days prior to discharge to initiate screen for eligibility and initiate care planning] |

### Legal Assistance

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Medical/Legal Partnership] | [Point person] | [XXX] | [Legal advocacy to secure benefits, treatment, housing, utilities] |
| [Legal Service Advocates] | [Point person] | [XXX] | [description] |
| [Hospital legal department] | [Point person] | [XXX] | [Section 35 or guardianship needs] |

### Volunteer and Faith-Based Services

| Organization Name | Contact Person | Number/Email | Relevant PostDischarge and/or Care Management Services |
| --- | --- | --- | --- |
| [Volunteer Agency, such as YMCA] | [Point person] | [XXX] | [peer navigators, community volunteers] |
| [Volunteer Agency, such as community nonprofit] | [Point person] | [XXX] | [community health worker navigators to provide social support and assistance in navigating social and medical services] |
| [Faith-based organization] | [Point person] | [XXX] | [volunteers to help patients make appointments, drive to appointments, run errands, care for pets during and following a hospitalization; not limited to congregation members] |

# Quick Community Resource Reference List for [Hospital Name]

| **Patient Centered Medical Home [Name]** | Contact Name, Number:  Service: [transitional care, complex care management]  Eligibility:[accepting new patients, will prioritize new hospital referrals] |
| --- | --- |
| **Behavioral Health Clinic [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Substance Use Disorder Treatment [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Adult Day [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Pharmacy [Name]** | Contact Name, Number:  Service: [e.g., medication therapy management, blister packs, home delivery]  Eligibility: |
| **Housing [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Food [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Legal Advocacy [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Transportation [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Medicaid Home and Community-Based Waiver Program [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Area Agency on Aging [Name]** | Contact Name, Number:  Service:  Eligibility: |
| **Volunteer Navigators/Assistants [Name]** | Contact Name, Number:  Service: [e.g., social support, transportation, errands]  Eligibility: |
| **MCO Care Management [Name]** | Contact Name, Number:  Service: [e.g., telephonic care management; wraparound services available]  Eligibility:[members of the Managed Care Plan at high risk of readmission] |

# Example Quick Resource Reference for Hospital ABC

| *Care Management*  **Readmissions Community Care, Inc.** | **Contact:** Mary, Director (555) 555-5555  **Services:** Community agency-provided care management, focusing on basic social services; referrals to short-term or ongoing care management based on their funders’ approved criteria. They are working with us to align definitions. |
| --- | --- |
| *Behavioral Health*  **Psychiatric Assessment Center** | **Contact:** Penelope, Program Director (555) 555-1234  **Hours:** 24/7  **Services:** Urgent outpatient (<24hr) mental health treatment services to Readmissions County residents suffering from acute or serious mental disorders or an emotional crisis. All individuals determined to require urgent mental health care are initially assessed and treated at the Center, then linked to other mental health programs as needed. |
| *Behavioral Health*  **Mental Health Services of Readmissions County** | **Contact:** Pat, Director (555) 555-5678  **Hours:** 9am-5pm, Mon-Fri  **Services:** Full range of mental health services, primarily intensive case management services, psychiatric medication evaluation, and followup to 30 seriously mentally ill homeless individuals. Services can include providing funding for housing, emergency housing, and one-time rental subsidies. |
| *Substance Use Disorder Treatment*  **Courage Recovery Center** | **Contact**: Bob, Director (555) 555-4321  **Services:** Comprehensive substance abuse treatment and other health care services at its clinics or through community linkages. Outpatient methadone maintenance, HIV testing and counseling, group therapy, opiate detoxification, primary medical care, counseling, pregnancy services. |
| *Substance Use Disorder Treatment*  **Readmissions County Cares** | **Contact**: Chelsea, Director (555) 555-6666  **Services:** First-time screening for alcohol or tobacco use, short outpatient counseling including focus on motivation, intensive outpatient treatment, residential (live-in) care, medically managed detoxification, marriage and family counseling, self-help groups, drug substitution therapies, and newer medicines to reduce craving. |
| *Substance Use Disorder Treatment*  **MedReadmissions Treatment Centers** | **Contact:** Terry, Program Director(555) 555-7777  **Services:** Outpatient addiction treatment services for individuals dependent on opioids/narcotics. Provides supervised medication-assisted treatment with the use of methadone. Treatment team includes a Medical Director, Program Director, Clinical Supervisor, nurses, and trained counselors who work with each patient to create an individualized treatment plan based on their specific needs. Also offers case management services and referrals to community resources. |

| *Homeless Services*  **Multi-Service Drop in Center** | **Contact:** Jennifer, Manager (555) 555-8888  **Hours:** 10am - 2pm, Mon-Fri  **Services:** Offers access to snacks and water; hot showers and laundry facilities; assistance for acquiring identification, benefits, and/or employment. |
| --- | --- |
| *Homeless Services*  **Hope House** | **Contact:** Marcos, Program Director (555) 555-1111  **Hours:** 7:30am – 6pm Mon – Fri, 7:30am – 1pm Sat-Sun.  **Services:** Daytime showers, laundry services, free medical and dental clinics and day shelter. Has a client services manager and case manager on staff who provide referrals for housing, mental health, and substance abuse treatment. |
| *Housing Services*  **Community Housing Resource Center** | **Contact:** Nick, Manager (555) 555-2222  **Hours:** 12-5pm Mon, 10am-3pm Tues-Thurs (appointments required)  **Services:** Partial payment assistance for rent/mortgage (must provide copy of current least agreement); new housing (first month’s rent only, deposits must be paid); utilities (must provide past due notice; deposits and late fees are not paid).  **Eligibility:** Must have an appointment, show proof of Readmissions County residency, proof of income and Social Security cards for all family members, and confirm changes in situation that require assistance. |
| *Housing Services – Mentally Ill*  **Pine Haven Transitional Housing** | **Contact:** John, Director (555) 555-3333  **Office Hours:** 8am – 4pm, Mon-Fri; staff hours 24/7 **Services:** Temporary housing for adults (18+) with diagnosed mental illness during their transition from the hospital to another care provider, for 3-10 days, until another form of housing is ready to receive the individual (e.g., assisted living facility). Staff available 24/7, case manager onsite. Medication assistance available. |
| *Food Services*  **Readmissions Valley Food Bank** | **Contact:** Angel, Manager (555) 555-4444  **Hours:** 10-4 Mon-Wed, 12-3 Thurs-Fri  **Services:** Food pantry available for those requiring emergency food assistance. Clients may be eligible once every 30 days with proper documentation. Encouraged to apply for SNAP assistance.  **Eligibility:** Show proof of Readmissions County residency. |
| *Transportation Assistance*  **Readmissions Express Transit** | **Contact:** Greg, Transportation Manager (555) 555-1010 x555  **Service Hours:** Planned service routes at 6am, 12pm, and 6pm, Mon-Fri.  **Services:** Buses travel a predetermined route and schedule Mon-Fri from several designated stops that span Readmissions County. $1 fare each way. No preregistration/qualification required. |
| *Transportation Assistance*  **South Readmissions County Transit** | **Contact:** Rhonda, Manager (555) 555-5566  **Service Hours:** 7am – 5:30pm  **Services:** Prearranged transit services coordinated by Senior Center volunteers with volunteer drivers who are willing to transport residents living in rural unincorporated communities of Readmissions County. |