Care Transitions Training

Care Transitions:
Concepts, Guidance and
Best Practices

St Peter's Health Partners
A Member of Trinity Health

St. Joseph's Health
A Member of Trinity Health

Training Outline

- Why do we provide Care Transitions?
- When do Care Transitions happen?
- What goes into a Care Transition?

When we provide Care Transitions

Care Transitions should be provided anytime a Member transitions from one setting or level of care to another. This may include the following.

- When a Member visits the Emergency Department
- When a Member is discharged from an inpatient hospital stay – medical or behavioral health
- When a Member is released from incarceration
- When a Member is discharged from an inpatient substance abuse facility
- When a Member is discharged from a detox facility



IMPORTANCE OF CARE TRANSITIONS

When Members are inpatient or in a structured facility, they are under the care and supervision of skilled professionals. Once discharged, those supports are completely removed.

This is where we come in to help!

Studies have found that some patients lack understanding around hospitalizations. One study of discharged patients found that at the time of discharge:

- 42% were able to state their diagnosis
- 37% were able to state the purpose of their medications
- 14% knew their medication's common side effects

Importance of Care Transitions

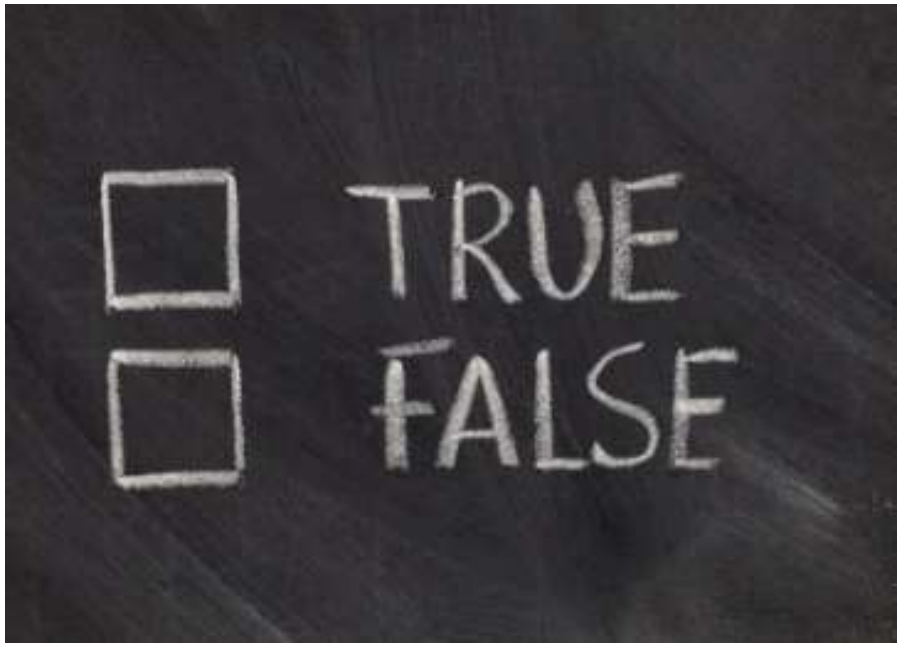
Studies among Medicaid beneficiaries (our population) have found that:

- 50% of patients who are re-admitted within 30 days of a discharge did NOT visit a provider in those 30 days
- The likelihood of a re-admission increases with the patient's number of diagnosed chronic conditions
- One of the common causes of re-admissions is a breakdown in patient education in terms of discharge instructions

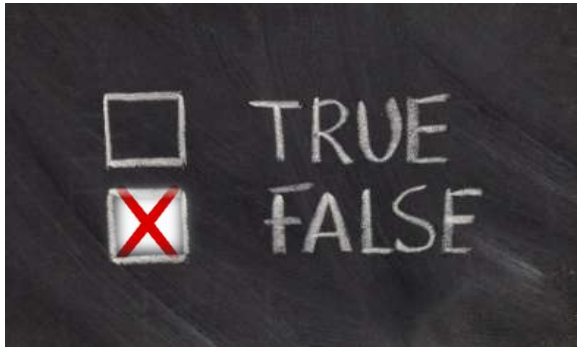
What goes into a Care Transition?

True or False?

A Care Transition is a phone call to the Member to check-in after Hixny alerts or receipt of information that they were discharged or released from another setting.



What goes into a Care Transition?



False!

Care Transitions are not a “one and done”

Care Transitions should involve a warm handoff/transition when possible

Care Transitions require documentation and sometimes updates to the Plan of Care

What goes into a Care Transition: Documentation

Give yourself credit for the work you do!

Document both successful ***and*** unsuccessful efforts to provide Care Transitions

This may include:

- Coordination with a hospital, rehab, or jail
- Communication with outpatient providers, including provider's meetings / case conferences
- Efforts or barriers with obtaining discharge paperwork
- Reviewing discharge instructions and providing assistance with follow through
- The Member's willingness to participate with their aftercare instructions



Key Elements of a Care Transition

- ❑ Medication Management
- ❑ Transition Planning
- ❑ Patient/Family Engagement and Education
- ❑ Communicating and Transferring Information
- ❑ Follow-Up Care
- ❑ Healthcare Provider Engagement
- ❑ Shared Accountability Across Providers and Organizations

Adapted from: Making Healthcare Safer Practices: Chapter 15. Care Transitions
Authors: Tara Earl, Ph.D., M.S.W., Nicole Katapodis, M.P.H., and Stephanie Schneiderman, M.P.P

Key Element:
Medication Management

Ensuring the Member is aware of and has medications post-discharge or ER visit

- New medication prescribed
- Refills or new scripts are called into the pharmacy
- Understanding when and why to take medications
- Was missed medication the reason for the event?
  If so, there may be an opportunity to provide education on importance of taking and refilling as prescribed and problem solve for barriers

Key Element:
Transition Planning

Participate in Discharge Planning whenever possible

- Likely only applies to inpatient stays
- Help draft the plan for post-discharge - this is our opportunity to help make sure the plan can be successful
- Update our Plan of Care to reflect new needs – will we be helping to secure new supports or helping the Member to engage with new providers?

Key Element:
Transition Planning

For example, if the hospital discharge summary indicated that the Member was referred to a neurologist, then the Plan of Care should be updated with this change in needs. This might look like:

Establish with Neurologist for Migraine Treatment

Objective Status:

New

Intervention	Status	Target Date
CC to assist with making connection to Neurologist	New	02/12/202
Member to advise CC of outcome of appointment	New	03/12/202
CC to assist with scheduling MAS Transportation, as needed	New	06/12/202
Member to advise CC of follow up appointments, when needed	New	06/12/202

Key Element:
Patient / Family Engagement and Education

Provide education to Member and Family whenever possible

- Inpatient stays and ER visits: helping to understand discharge summaries and needed follow-up appointments and even the reason for the stay
- ER Visits: Education on when to use the ER and alternate resources in the community (Urgent Care and PCP)
- Reminders of coping skills and supports that can help to avoid an event

Who To Call for Help

Every Day	• Take your medications as ordered by your doctor(s). Review all new medicines, including over-the-counter medicines, with your primary care provider.
	• Go to all scheduled doctor appointments.
	• Call your primary care provider if:
	  ○ You need to change your scheduled appointment date or time.
	  ○ You have any changes in your health or if you feel ill.
	  ○ You have any questions about your treatment plan or medicines.
	  ○ You have recently visited an urgent care or emergency department/hospital.

Green Zone (Non-Urgent)	**Call your Primary Care Provider. You may need an appointment within the next 24 hours. Problems may include:** • Cold symptoms that are lasting a long time (this could include fever, runny nose, sore throat, or earache) • Backache that doesn't go away • Pain or burning when you urinate, or the frequent urge to urinate (these are symptoms of a urinary tract infection) • Simple cuts or scrapes, or tick bites
Yellow Zone (Urgent)	**Call your Primary Care Provider. Your provider will either make an urgent appointment or instruct you to go to an urgent care center. Problems may include:** • Multiple high blood sugars • Vision changes • Shortness of breath or increased cough • Harder for you to breathe when lying down, or you need to sleep with more pillows or in a chair • Feeling more tired or a lack of energy • Dizziness • Feeling uneasy, like something is not right • Increased swelling in your feet, ankles, or stomach • Minor injuries such as cuts, burns, or sprains
Red Zone (Emergency)	**EMERGENCY!!!** **Go to the Emergency Room or call 911 if you have any of the following:** • Unrelieved chest pain • Struggling to breathe or unrelieved shortness of breath while sitting still • Sudden weakness or difficulty speaking • Severe uncontrolled pain, uncontrolled bleeding, or a loss of consciousness

INNOVATIVE Health Alliance

Key Element:
Patient / Family Engagement and Education

Some questions you may want to ask Members post care transition:

- Can you tell me what medications are prescribed to you, as well as how and when to take them? If not, how can we work together to support this?
- Where are your follow-up appointments scheduled? What form of transportation will you use to get to these appointments? Do you need help scheduling or arranging transportation?
- Is there any additional support needed post-discharge? If so, are there people in your life who can help with these needs? If not, would you be open to exploring resources?
- Are there any concerns about the event or about returning home? If so, would you like any support with this?

Key Element:
Follow-up Care

Work the Discharge Instructions!

- Schedule follow-up appointments, ensure access to transportation and explore a way to remind the Member
- Ensure Members have medications
- Review for other social determinant or lifestyle change instructions and help implement this by referring Members to appropriate resources and providers

Don’t forget to update the HML Assessment!

Step 1: Upload clearly labeled supporting HML documentation

File	Signature Date (for signed forms) / Relevant Attachment Date (for non-signed documents)	Category	Description
[redacted] 9.10.26 DC Sum.pdf	09/10/2026	HML Verification / Discharge Summaries	[redacted] 9.10.26 DC Summary

Step 2: Update HML Assessment

6. Has the member been discharged from an inpatient stay for a mental or physical illness within the last year?

The member was discharged from an inpatient stay due to physical health within the past year

6a. When was the member discharged from the inpatient stay for the illness?

09/10/2026

Key Element: **Communication and Transferring Information**



This is what we do!!

Coordination and **Communication** is the cornerstone of Health Home Services

- Notify providers about:
  - The event and what led up to it (missed appointments, missed meds, etc.)
  - If they have a role in the discharge instructions
  - What next steps may entail to avoid another event

Community Health Connections (CHC) — **Participating Partners**

Health Home Name

Copy this page as necessary to list all participating partners

JS — 1/14/22

Patient Initials — Date

Community Health Connections (CHC) JS 1/14/22

Name of Participating Partner

Care Management Agency (CMA) - Samaritan Care Management - JS 1/14/22

Name of Participating Partner

Managed Care Organization (MCO) - Fidelis - JS 1/14/22

Name of Participating Partner

Social Support Contact - Marcus Smith (son) JS 1/14/22

Name of Participating Partner

Primary Care Provider - Capital Physicians (all staff working on my case) JS 1/14/22

Name of Participating Partner

Preferred Pharmacy -

Name of Participating Partner

Preferred Hospital - Albany Medical Center (all staff working on my case) JS 1/14/22

Name of Participating Partner

Local Department of Social Services (DSS) - Albany County JS 1/14/22

Name of Participating Partner

Albany County Mental Health (all staff working on my case JS 1/14/22

Name of Participating Partner

Key Element:
Healthcare Provider Engagement and Shared Accountability

The ongoing engagement of providers in the Care Transitions process is critical!



Some things to consider:

- ✓ Facilitating a provider's meeting
- ✓ Engage the MCO
- ✓ Use the Complex Case Discussion forum
- ✓ Contact CHC to talk through provider connectivity challenges

Care Transitions Workflow Sheet

Care Transitions Workflow

A Member of Trinity Health

The following workflow follows CHC Policies and Procedures D1. Critical Events and Incidents: Care Transitions.

Care Transitions
☐ Respond to alerts of hospitalizations and ED visits within two business days of receiving the alert.
☐ Provide education to the Member regarding appropriate emergency room utilization if the reason for the visit could have been handled by primary care or urgent care.
☐ Update the Plan of Care for ER/Hospitalizations that result in the need for new providers or any other significant change in needs.
☐ Obtain and review discharge instructions with the Member from ER/Hospitalizations to help transition back to the community (i.e. appointments kept, review medications, etc.). • If the discharge summary cannot be obtained, efforts/barriers must be documented.
☐ Document attempts to collaborate with the Care Team upon notification of a Member's transition to/from an ER/hospital. **The Care Team may include inpatient and outpatient providers as well as the MCO.*
☐ If the Member has social support/support resources, persons were identified with Member to assist in the time of crisis and aide in preventing future crisis. **Social support is defined as consented contacts (on 5055) that have demonstrated an active role in the Member's care. Support resources such as suicide prevention hotline, AA/NA, emergency contact phone numbers, safety plan, etc.*
☐ Facilitate a warm handoff if a Member transitioned between a criminal justice or inpatient setting. • If attempts are unsuccessful, efforts must be documented.

Care Transitions – High Hospital Utilization
It is recognized that some Members present to Emergency Departments (ED) often, sometimes daily or more frequently. In those situations, Care Transitions will focus less on each individual presentation and need to obtain discharge summaries for each, but rather should focus on the larger issue causing the repeat presentations.
☐ Address barriers and root causes for repeat hospital encounters (i.e. connecting with outpatient care, meeting SDOH needs, etc.).
☐ Ongoing case collaboration with Care Team (outside of formal case conferencing) should occur to help address Member needs and reduce utilization. Ensure all efforts are documented.
☐ Update the Plan of Care to address the Member's high utilization (i.e. achievable steps the Member and Care Coordinator can take to decrease hospital presentations, etc.).

CareManager Documentation
☐ Update HML when applicable (i.e. Members who are discharged from an inpatient medical or psychiatric hospitalization, inpatient substance use stay, or incarceration). Please ensure the date of discharge reflects the date listed on the uploaded discharge summary.
☐ Discharge summary uploaded. **In cases with high hospital utilization patterns, it is not expected that every discharge summary is uplooaded. In these situations, Care Transitions will focus less on each individual presentation and the need to obtain discharge summaries for each, but rather should focus on the larger issue causing the repeat presentations.*

Policy References and Helpful Documents

Policy:

Policy D1: Critical Events and Care Transitions

Use the tools and you'll be sure to address all potential areas of need and help prevent a re-admission!

CHC Website Documents and Tools:

