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

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| 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 supports are 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. |

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| 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.). |

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| 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 uploaded.* *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.* |

The overall goal and purpose of providing a Care Transition is to avoid a re-admission, re-incarceration, re-presentation to an ED, etc. By helping Members to ensure they have what the need to be successful outside of the setting, they are less likely to be re-admitted or re-present to an Emergency Department, etc.

**The overall goal and purpose of the Health Home program is to reduce those unnecessary or avoidable admissions/presentations and thus reduce Medicaid spending overall in NYS.**

* Care Transitions occur when a Member moves between healthcare settings or providers as their care needs change. These transitions can happen for a number of reasons, including:
* Being admitted to a hospital
* Being discharged from a hospital to a long-term care facility
* Being discharged from a long-term care facility to the community
* Being released from incarceration
* Care Transitions are not unique to Health Homes. Care Transitions are widely viewed in healthcare as a proven way to help patients through transitions in settings and maximize patient success when it comes to those changes.
* When someone is in an inpatient setting (hospital, rehab, or incarceration), they have all their supports provided for them. They have place to sleep, they are getting three meals a day, they are getting needed services, supports and programming, someone is monitoring their medications, etc. When our Members leave those settings, all those supports are no longer in place.
  + That is where we can come in to help.
  + We know that some of our Members do not have caregivers at home who are going to help with this transition back into the community.
  + We help our Members get situated back home (or wherever they are going) and ensure that they have what they need in terms of food, medications, and follow-up appointments. Our job is to help them follow those discharge instructions, which should lead to success at home.

**Care Transitions play a critical role in reducing unnecessary admissions/presentations, which is the overall goal of the Health Home program.**