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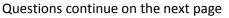
Capital Region Health Connections

Care Transitions Visit Guide for Providers

When a significant event has occurred, transitional care must be coordinated for Health Home enrolled Members. With each transition, an exchange of information is necessary to ensure safety and maintain continuity of care. Use this guide during the care transition process to help coordinate effective communication and documentation with providers from the releasing agency or facility.

Patient Information	
Member Name:	
Date of Visit: / /	Chart Number:

	Questions to consider	NOTES
	What is the current situation and overarching concerns (specific to this admission/episode)?	
	What are the Member's current needs?	
z	What are the clinical goals?	
SITUATION	What are the clinical follows-up for the Member?	
S	What are the recent key changes in the Member's status?	
	What is the Member's risk level for poor outcomes or re-admission? What are those risk factors?	Low risk Moderate risk High risk Imminent
	What is being requested of the next caregiver?	



	Questions to consider	NOTES
JRY	Does the Member have a support network? Yes No	
	What reasonable steps will be done to verify Member's supports understand the Member's next transition?	
HISTORY	What are the safety concerns for this Member?	
	Is the Member able to self-manage? Yes No If not, what reasonable steps will be provided to help Member self- manage?	
COORDINATION	What is the recommended plan or next steps?	
	What actions will be taken to ensure a safe transition?	
	How will the next site of care connect with the previous site of care if additional questions arise?	
	How will the Member know/ receive educational information about medical disease/symptoms?	
	Have appointments already been scheduled for the Member? Yes No If so, what appointments?	

Provider/Support	Name	Telephone	Address, if applicable	Next Appointment, if applicable
Primary Care				
Behavioral Health				
Substance Use				
Preferred Pharmacy				
Supports and Resources				
Specialty Provider				
Specialty Provider				
Specialty Provider				
Transportation Provider				
Child Care				
Food Pantry				

Provider/Support	Name	Telephone	Address, if applicable	Next Appointment, if applicable
Health Insurer (for recertification for SSI/Medicaid)				
Landlord/Housing				
Other:				