Transition of Care Workflow

V.3/31/2016

Suffolk Care Collaborative

Identification

Roles Involved:
1. Hospital-based Provider
2. Hospital-based discharge planner/ case manager
3. Hospital IT Staff

Patient admitted to inpatient or OBS unit

≤ 24hrs of admission

Patient identified as high risk (see TOC Model), EHR flag & social needs screen

≤ 24hrs of discharge

Does patient have a PCP?

NO

YES

Discharge Planning

Patient notified of planned discharge

≤ 48hrs of discharge

Navigation initiates based on unmet social needs screening

Written TOC plan is provided to patient (see TOC Model)

Hospital provider completes discharge summary

Unassigned patient navigation to community-based PCP

Roles involved:
1. Hospital Provider
2. Discharge Planner
3. TOC Provider
4. Community-based PCP
5. Community-based behavioral health provider

Referral made to TOC service

TOC 30-day period established & TOC provider attempts to visit patient prior to discharge

Updates to community-based PCP

Transitional Care Management

Communications occur as necessary with:
1. Community-based PCP
2. Community-based BH services
3. Health Homes
4. Community-based Social Services
5. Community-based Home Care
6. MCOs

30-day Services:

Optimize 30-day TOC management, care coordination and navigation
- Care plan is reinforced
- Duration 30 days regardless of patient disposition

Patient Disposition/Transfer (location of patient) examples:

1. SNF
2. Rehabilitation
3. Home
4. Other

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