

Care Transition

What is a Care Transition?

A care transition is when your health changes and you need a change in care. Care transition refers to the movement consumers make between health care providers and settings as they access care and services and/or their condition and care needs change during the course of chronic or acute illness.

You may need healthcare provider setting such as a hospital, nursing facility, assisted living or long term care. It may be for a procedure you and your healthcare provider planned. It may be an emergency. It may be when you need more help with daily activities.

Any care transition can be hard. A person to guide you can help smooth the way.

How Can I Prevent an Unplanned Care Transition?

Preventing a transition is not always possible. However, you can reduce the odds!

- When you have new or worsening symptoms, talk with your doctor or tell a member of your care team. Early detection can often prevent an admission.
- Take your drugs as prescribed. Tell your doctor if you think you are having side effects.
- Follow diets you get from your doctor or other healthcare provider.
- Activity is important. This may include exercising while in your chair.
- Think about how you get up, sit down, and move before you do so. Moving quickly may cause missteps or accidents. Moving carefully can reduce falls.
- Hand washing is worth its weight in gold. When in doubt, wash your hands. Use hand cleaners when not at home.
- Talk to your doctor about flu and pneumonia shots.
- Talk to your care team if you have questions about your health. They are a great resource!

Who Will Help Me With A Care Transition?

You have a care team to help.

Your team includes your doctor, a case manager and other health care providers as needed.

Going to Assisted or Long Term Care

A case manager can work with you and your family if you need more help with your daily needs. This may mean getting help in your home. It may mean a move to get help you cannot get at home.

Going to the Hospital

A case manager can work with your doctor and the hospital discharge planners to coordinate your discharge and keep you and your family or caregiver up-to-date on plans. The discharge plan may be for you to go home with home care services or go to a place with skilled care for services.

Going to the Skilled Nursing Facility

If you are in a skilled nursing facility, the facility social worker can work with you, your family, and the care team. The planning starts the minute you arrive. It continues during your stay to make sure your needs are met.

When it is Time to Transition Home

A case manager may follow up with you after your discharge. He or she will make sure you understand your treatment plan and will review your medications to make sure you know how to take them. He or she checks that health care related services are being provided and that you have a follow up appointment with your doctor. He or she will help you understand when to call your doctor if you have symptoms.



If you have any questions, please call the customer service number on your ID Card.

