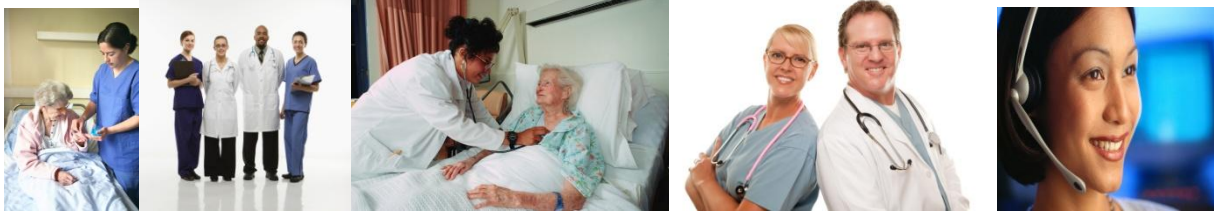




# Inter Valley Health Plan

For health. Not for profit.



## Care Transition:

Care Transition is the transfer of patients from one doctor to another or from one facility such as a hospital to a nursing home or another care setting. The goal during care transition is to provide seamless care and prevent any loss of important medical information.

Patients, caregivers and families are encouraged to focus on the following:

- Medication Self Management – know what medications you take and discuss any changes with your primary care physician (PCP)
- Follow-up care with primary care physician (PCP) and specialists – understand the importance of follow-up care after discharge can prevent re-hospitalization.
- Red Flags – know what are the important signs and symptoms of your medical condition to report to your primary care physician (PCP).
- Personal Health Record (PHR) –keep track of important medical information so you can share it with health care providers.

*Taking Care of Myself: A Guide for When I Leave the Hospital* is a booklet for patients to help them care for themselves when they leave the hospital. The easy-to-read guide can be used by both hospital staff and patients during the discharge process and provides a way for patients to track their medication schedules, upcoming medical appointments, and important phone numbers. This is a publication provided by Agency for Healthcare Research and Quality (AHRQ).

<http://www.ahrq.gov/qual/goinghomeguide.pdf> - English

<http://www.ahrq.gov/qual/goinghomesp.pdf> - Spanish

Inter Valley Health Plan offers assistance with our Care Management and Disease Management Programs, we provide members, families and providers with telephone access to a dedicated nurse-led care management team and a social worker for assistance with complex medical care needs and coordination, self management education and tools as well as assistance with accessing community resources. The program supports members by reinforcing the treatment plans developed by their healthcare providers and by educating members on making responsible decisions about their healthcare. Care coordination is a collaborative process that focuses on ensuring that members receive the right care in the right place at the right time. Inter Valley Health Plan's nurses and social worker serves as members advocate in the health care system by anticipating and providing problem resolution,



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providing education and tools for self-management skills, and overall, helping members navigate the health care system effectively.

Inter Valley Health Plan's Care Management and Disease Management team can be reached at (909) 623-6333 x249 for any care management referrals or assistance with care coordination and discharge planning process.

The information provided is intended to encourage Inter Valley Health plan members and caregivers to actively participate in the discharge planning process and reflects Inter Valley Health Plan's goal to achieve high-value, person-centered health care.

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