



Inter Valley Health Plan

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Care Transition refers to the transfer of patient care between health care providers including change in care settings as their condition and care needs change during the course of a chronic or acute illness. It involves a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care.

Taking Care of Myself: A Guide for When I Leave the Hospital is a guide 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

The information provided is intended to encourage patients 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.

Providers can make use of the checklist by: (1) making staff aware of the checklist; (2) including it in admission paperwork; and, (3) by encouraging staff to work with patients and caregivers to complete the checklist.

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, 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.



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Below are additional tools that can assist providers, discharge planners, care managers and nurses with care transition processes.

Care Transition Audit Tool

Medication Reconciliation form

(Inter Valley Health Plan's policy and procedures regarding Care Transition and Medication Reconciliation is available upon request)