WHAT IS TRANSITIONS OF CARE?

Transitions of Care (TOC) programs are designed to provide continuity of care to patients as they move from the hospital to home or other care settings.

Transitions of Care utilizes components of evidenced based transitional care models to assist with the provision of seamless care across the health care continuum, improve patient outcomes, and induce financial savings. A multidisciplinary approach, staffed with registered nurses, licensed social workers and healthcare professionals, synchronizes the transitions of care prior to admission, during the hospitalization and after discharge. Screening and identification of barriers and strengths and the promotion of patient / family engagement towards addressing obstacles to obtainment of optimal health are hallmarks of the department.

Services of the Transitions of Care department are available 24/7 to all inpatients and outpatients of Hendricks Regional Health. Referrals are accepted from all sources at **(317) 745-3544**.

WHERE WILL YOU FIND THE TRANSITIONS OF CARE TEAM?

In the Pre-Op Office

- Pre-admission planning for scheduled surgeries

In the Emergency Department

- Community Resources
- Psychiatric and chemical dependence assessments and referrals
- Abuse, neglect and assault assessments and referral to services.

On the Inpatient Units (Medical, Surgery, Pediatrics, Labor & Delivery)

- Assessment of the patient's and family's social and emotional environment and ability to cope with the current situation

- Community Resources
- End of Life care discussion and advance directives
- Resolution of financial concerns related to insurance coverage, cost of hospitalization or medical needs, or income loss due to illness or injury.
- Long and short-term care planning after hospitalization
- Counseling and emotional support needed as a result of the many stresses created by the adjustments and lifestyle changes necessitated by illness and hospitalization.
- Adoption assistance
- Support Groups

In the HRH Oncology Center

- Assessment of the patient's and family's social and emotional environment and ability to cope with the current situation
- Community Resources and Support Groups
- End of Life care discussion

In the Transitions of Care Office

- Director and Clinical Managers
- Care Transitions Team
  - Contact patients after discharge to answer additional questions the patient may have, assist with follow up appointments, provides community resources and other post discharge needs the patient may have.
  - Address requests from HRH Physician practices and outpatient services requesting assistance to connect patients to resources.
- Utilization Review
  - RN's complete daily activity of prospective, concurrent or retrospective chart reviews to determine if services rendered are necessary and fiscally efficient.
- Resource Coordinators
  - Assist Case Managers by working with Community Liaisons (home health care agencies, rehabilitation facilities and hospice agencies) to secure services.

RN

Administrative Professionals

SOCIALWORKERS
leaders. advocates. champions.