EmblemHealth®

Transitions of Care

Our free telephonic program targets members who are at high risk for a 30-day hospital readmission. The goal of the program is to reduce hospital readmissions by offering discharge planning, education, communication with the primary care provider (PCP) and specialists, as well as other resources. The program encourages members to better manage their health care by taking on a more active role.

Who is eligible for the program?
EmblemHealth members at highest risk for hospital readmission. They typically have conditions commonly associated with preventable admissions, for example, septicemia, heart failure, diabetes, and chronic obstructive pulmonary disease (COPD).*

How do members enroll?
The program will contact eligible members within 72 hours of hospital discharge.

How does the program benefit the member?

- Allows members to work and consult with a care coordinator or registered nurse, depending on their risk for readmission, history of hospital admissions/readmissions, and presence of select chronic conditions.
- Coordinates follow-up medical care, including PCP and specialist visits, tests and post-discharge care such as home health care and durable medical equipment (DME).
- Assesses and addresses member compliance with discharge plans, as well as their physical and emotional health, living arrangements, and support system(s).
- Empowers members and/or their caregivers through education on topics including medication management, use of a personal health record (PHR), self-management skills for their health condition(s), the importance of scheduling health care follow-up appointments and actively participating in their treatment plans, and emergency department avoidance.

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- Teaches members to recognize and react to red flag events.
- Provides referrals to community-based programs and/or other EmblemHealth services, as appropriate.
- Improves health outcomes by coordinating, educating, and supporting members through transitions of care. Facilitates the flow of information to ensure continuity of care across providers and health care settings.
- Helps members decrease unnecessary readmission to hospital in the transition period, improving their quality of life and decreasing their risk of adverse events as well as health care cost.

How can you support members/your patients in the program?

- Reinforce education provided through the program on topics including medication adherence, red flags, chronic condition management, using a personal health record, and scheduling and attending follow-up appointments.
- Schedule the member's next appointment before they leave the office. Send reminders prior to their next appointment.
- Refer members to community resources and other EmblemHealth programs from which they could benefit.

Are there additional considerations?

Members who do not meet their health goals or require ongoing support will be referred to and enrolled in our care management programs based on eligibility, and need for further care management and coordination.

How long is the program?

Four weeks.

How do I find out more?

Call our Care Management department at **800-447-0768** (TTY **711**), Monday through Friday, 9 a.m. to 5 p.m.

* Some managing entities (delegates) offer their own care management programs for EmblemHealth members under their care. For more information about their care management programs, go to **emblemhealth.com/providers/manual/health-promotion-and-care-management**, under the "Care Management Programs" drop-down, at the bottom.

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