Transition of Care Toolkit

Avoidable hospital readmissions are a challenge that physicians, hospitals, and health plans continually face. Identifying patterns of use and guiding patients to appropriate sites of care can help reduce costs and improve quality of care. The Transition of Care (TOC) Toolkit is a reference guide to help you reduce avoidable hospital readmissions through the application of evidence-based materials and clinical experiences.

What's Included in the Transition of Care Toolkit?

The toolkit provides:

- Definition of the four pillars of TOC
- Practice self-assessments and sample action plans to assist in practice transformation
- Resources to identify patient prioritization and those at risk for readmissions
- Links to guidelines and policies for completion and billing of TOC management codes
- Transition of Care Code Decision Tree
- Workflow example
- Sample TOC policies
- Examples of post discharge scripting and documentation
- Medications during Transitions of Care: Impact, TOC Best Practices, Disease Specific Recommendations
- Care Management/Disease Management referrals
- Health behavior impact and Social Determinants of Health (SDoH)
- Provider resources

More Information

If you have questions regarding the Transition of Care Toolkit, please contact your Highmark representative.