Care Transitions Program

Care transitions involve the movement of patients from one site or level of care to another. During care transitions, patients are at risk for adverse outcomes due to medication errors and other errors of communication among the healthcare providers and between providers and patients/family caregivers.

CAIPA's Care Transitions program focuses on transitions from hospital to home and involves contacting patients after hospital discharge to:

- Identify any needs requiring urgent/emergent intervention
- Ensure understanding of discharge instructions
- Review medications
- Assist in coordinating follow up care if necessary
- Assist with any issues regarding post hospital services, from home care, to medical equipment

A summary of the Care Transitions assessment and intervention will be provided to you.

If you are interested in finding out more about **CAIPA Care Management Program**, please visit CAIPA.com "For Providers" (www.caipa.com/for-provider/clinical-guidelines/) email to **complexCM@caipa.com** or call us at **212-965-9888** (option 6).

CAIPA MSO
Management Services Organization

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CAIPA Care Management Program

What is Care Management?

CAIPA Care Management Program is developed to assist high-risk, high-cost AAACO patients to address their care needs and reduce preventable utilization while lowering your administrative burden and creating additional savings.

Key objectives

- Reinforce and facilitate patients' ability to adhere to treatment plan created by the provider
- Enable patients to achieve an optimal level of physical and psychosocial wellness by addressing both medical and social determinants of health
- Reduce preventable utilization

Why is Care Management becoming so important?

- Commercial and government payers are moving toward payment models involving greater financial risk on the part of providers
- While greater risk has the potential of greater reward, achieving great reward requires increased focus on managing total cost of care
- CAIPA Care Management Program can assist in creating additional savings by focusing on high-risk, high-cost patients, addressing their needs and reducing preventable utilization

CAIPA Care Management Program focuses on three components:

(1) Complex Case Management
- Focus on high-cost, high-utilizing patients
- Focus on patients with modifiable risk factors

(2) Diabetes Disease Management/DSMES
- Focus on patients with diabetes
- Target interventions based on condition severity and risk of complications

(3) Care Transition
- Focus on patients transitioning from hospital to home
- Ensure discharge plan and follow-up care is understood and implemented

How CAIPA Complex Case Management Program can help you and your patients?

Educate	Provide patient education about chronic health conditions, medications, special diets and insurance benefits
Modify	Work with patients to initiate behavior modifications that can have a positive impact on health, for example tobacco cessation, increased exercise, healthier eating, adhering to medication regimen
Coordinate	Help patients coordinate care by assisting with doctor appointments, preventive screenings, prescribed medications, referrals to Diabetes Self-Management and Education Support (DSMES) Program
Review	Review eligibility and provide guidance to patients in applying for benefits and entitlement programs that can assist with financial hardship, food insecurity, housing instability, transportation and caregiving
Connect	Connect patients with community-based resources that can assist with social isolation, behavioral care and other services
Support	Support caregivers to reduce burnout