Transition of Care Toolkit

THE TRANSITION OF CARE (TOC) 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 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 TOC 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 (TCM) codes
- Workflow examples
- Sample TOC Policies
- Examples of Post Discharge Scripting and Documentation

MORE INFORMATION

If you have questions regarding the Targeted Cost of Care, please contact your assigned Provider Account Liaison, Clinical Transformation Consultant or Population Health Specialist. If you do not have an assigned contact, you may submit your inquiry to:

PopulationHealthUniversityInquiries@highmarkhealth.org

When submitting your inquiry, please include your Practice's Blue Shield ID number.

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