Program Title: Care Transitions
Interim VP: Ashley Lehmkuhle, LSW
Point of Contact(s): Jennifer Cotton, RN (Care Transitions Coordinator)

Information about the program (this is to explain to other staff members who may not have any idea what is done in your division.)

1. The Care Transitions programs are designed to provide individuals who have had multiple institutionalizations extra in-home support upon transition home throughout a 30-day timeframe aimed to prevent re-institutionalization.
2. Care Transitions consists of a Registered Nurse (RN) completing in-home visits and telephonic follow ups with the individual to discuss their discharge orders, diagnoses, and complete a medication reconciliation.
3. The Care Transitions team also provides an extra layer of support by following up with physicians for medical equipment prescriptions, coordinating follow up physician appointments and transportation, and other social determinates of health like housing and food insecurities.
4. The Care Transitions team collaborates with Care Managers to assist individuals transition back to community living.
5. AAA3 has a contract with Anthem and Medical Mutual of Ohio (MMO) to conduct care transitions visits and calls with their plan members who had a recent hospitalization or high utilization of insurance.
6. AAA3 also completes internal care transitions work for PASSPORT waiver enrollees.

Include any additional information that could be helpful to a member of the public that all staff may not be aware of.

- Care Transitions is currently only offered in AAA3's original 7-county region (Allen, Auglaize, Hancock, Hardin, Mercer, Putnam, and Van Wert).
- Care Transitions are referral based from their PASSPORT Care Manager or through Anthem and Medical Mutual of Ohio.
- Surveys are completed with recipients of Care Transitions to evaluate the effectiveness of the program.

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