Optimizing Transitions of Care Workflows Case Study

November 2025

Case Study Publication Team

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"The right team members – those who are driven to make a real difference in the community – create solutions and help members of the community overcome barriers to care."

OPEN DOOR CARE NETWORK

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INTRODUCTION

Transitions of care (TOC), also known as transitional care management, is the process where a patient moves from one care setting to another. This may include patients recently discharged from the hospital, aging out (e.g., moving from pediatrics to adult medicine), medical referrals, etc. The focus of this case study will be on care transitions between the emergency room (ER) and/or inpatient (IP) discharge to primary care. The Community Health Care Association of New York State (CHCANYS) interviewed two health centers that have significantly optimized their transitions of care processes, including utilization of various technologies, workflows, and partnerships for transitions of care activities, thereby transforming patient outcomes.

CHALLENGE

As patients move across different care settings, there can be a breakdown of communication and coordination between healthcare providers. Even with the creation of health information exchanges (HIEs) to connect data from different health systems, staff at Federally Qualified Health Centers (FQHC) are overwhelmed by excess information and cross-sector communication struggles, resulting in difficulty streamlining TOC processes.

SOLUTION

A dedicated team with effective care transitions requires comprehensive processes, accurate information transfer, data-driven approaches, internal collaboration, partnerships between different members of the care team, and use of health information technology to support continuity of care.

WHO ARE THEY

Open Door Care Network

Open Door Care Network is a federally qualified health center whose mission is to provide excellent, accessible, and personalized health care regardless of ability to pay, in order to build healthier families and communities. They serve residents in Westchester, Dutchess, Putnam, and Ulster Counties. Open Door is a PCMH (Patient-Centered Medical Home) – a one-stop for medical care and other services across the community. Locations are strategically located (within walking distance or accessible via public transportation). They have 14 multidisciplinary sites - six primary care clinics, seven school-based health centers, and one dental clinic.

Number of Sites: 14 clinic locations
2024 Patient Volume: 61,825
Population Served: Low-income, uninsured/underinsured patients, who primarily speak a language other than English
EHR System: eClinicalWorks (eCW)
Total Staff: 582
TOC Specific Staff: 1.6 FTE Registered Nurses, 2 FTE patient navigators.

Interviewee Profiles

Kirsten Sawyer, RN, BSN - Manager of Care Management Programs (TOC Lead)

Email: ksawyer@odfmc.org

Kirsten joined Open Door in August 2020 as a bilingual (English/Spanish) community health nurse. Her role initially focused on coordinating TOC outreach for Open Door patients. Her role has since expanded to supervise the care management programs at Open Door in addition to leading the TOC program.

Yanira Padilla Cruz, MPA, Associate Director Care Coordination Programs

Email: ycruz@odfmc.org

Yanira has a background in nursing and 15+ years of experience in health care. Yanira joined Open Door in September 2015 and has held multiple roles within the organization. Currently, Yanira oversees the day-to-day operations and initiatives related to care coordination programs, which include TOC, Case Management and Navigation. The main goals of the care coordination programs are to identify barriers to care and ensure timely and effective access to services and resources needed to improve health outcomes.

Keys to Success

- Shared responsibility
- Interdepartmental integration of TOC with Open Door sites, focusing on closing the loop, which fosters team collaboration
- Dedicated TOC team trained in triage

Transitions of Care History and Implementation

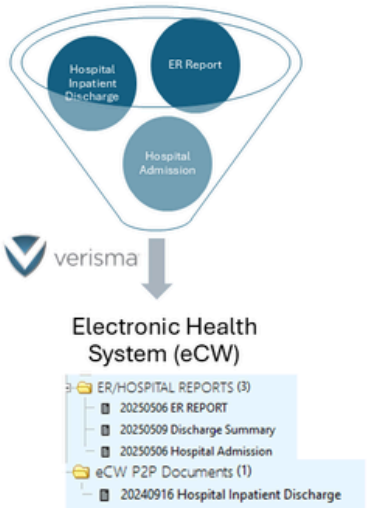
Patient care transitions were initially performed at the clinic level, but over time, it became clear that site nurses and medical assistants were too overwhelmed to conduct timely outreach. In addition to overburdening existing staff, evidence of successful TOC was also a requirement for New York State PCMH recognition, which prompted Open Door to recruit a dedicated team to meet TOC and patient needs. The program was initially funded by the Million Hearts initiative (a grant for prevention and education for patients at risk of developing cardiovascular disease (CVD)), which included a small care team and TOC for patients with cardiovascular disease. Funding for the TOC program primarily went to staff salaries and equipment. Once the funding ended, the services continued with an expanded shift in focus to cover transitions of care work with the broader patient population, with a focus on facilitating smooth transitions of care from hospitalization or emergency department visits for high-risk patients, including those with uncontrolled chronic diseases. At this time, the TOC team staffing model included a registered nurse and bilingual transition coordinators/care managers.

In 2020, Kirsten was hired as the RN coordinating the TOC work with Patient Navigators, filling the coordinator role. In 2022, the program moved under Yanira, officially becoming part of the overall Care Coordination umbrella. Kirsten and Yanira have since worked on updating the TOC Policies and Procedures under guidelines for outreach timeframes from the Joint Commission and other peer-reviewed literature.

Current Workflows

A team-based approach is essential to the success of Open Door's TOC process. They receive ED/IP admission or discharge notifications in two ways: through direct EHR-to-EHR transmission (P2P) or via faxed documents, which are routed to the fax inbox within their EHR system. They partner with an external document handling company, Verisma, which ensures each document is attached to the correct patient chart and assigns them to the TOC lead in the EHR via a telephone encounter, which is a way to document communication with a patient that occurred over the phone. Faxed documents are directed to the D Jellybean (a documentation inbox system within eCW), where they are reviewed and triaged (example EHR templates in Appendix B). Open Door uses a mixed triage model where outreach is done by acuity level. RNs are responsible for managing high-acuity and high-risk encounters while Navigators focus on low- and medium-acuity encounters, following established guidelines. Acuity and urgency can always change, consequently changing the outreach approach.

Verisma & eCW Integration



Low-Acuity Encounters

Patient navigators begin by reviewing the discharge documentation and then initiating outreach with a standardized TOC text message. This includes the TOC phone line: “Open Door received a notification that you were recently in the emergency room. We care about your health. If you would like to schedule a follow-up appointment with your primary care provider at Open Door, please call 000-000-0000.” Patients are encouraged to call Open Door directly if they feel a follow-up visit is necessary.

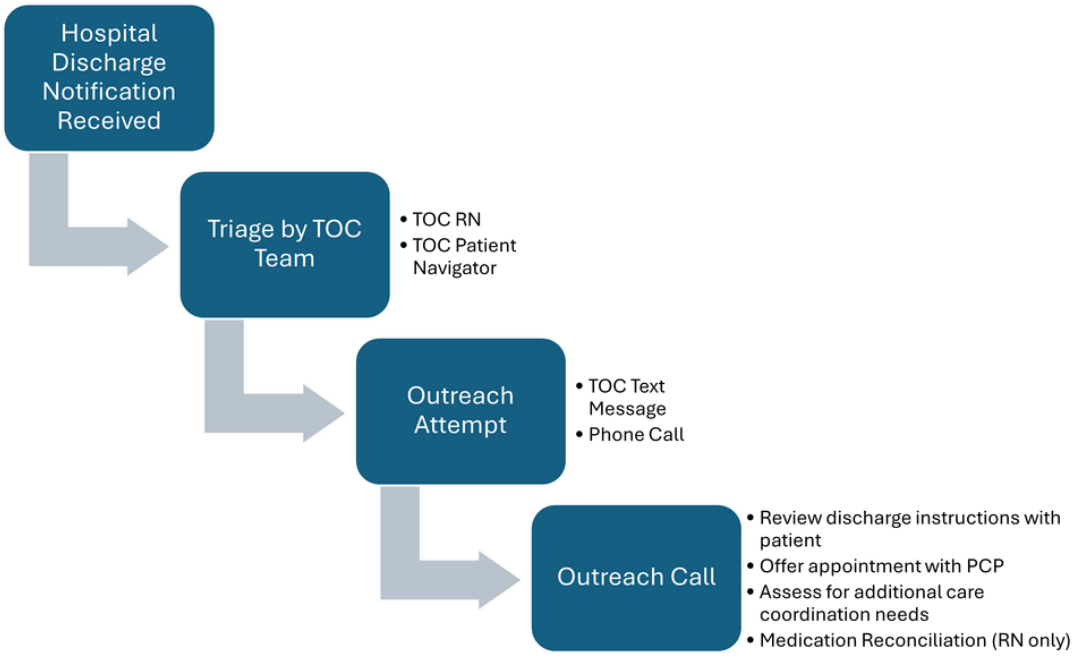
Medium-Acuity Encounters

Patient navigators or RNs, depending on the complexity of the case, conduct a mixed outreach approach. Typically, this includes one phone call and one text message, though two phone calls may be made depending on the situation.

High-Acuity Encounters

RNs are primarily responsible for handling high-acuity encounters, which include cases involving high-risk patients. However, as the patients’ needs evolve, navigators may assist with ongoing care coordination. This structured, team-based model allows Open Door to provide personalized, efficient follow-up care that supports positive outcomes across varying levels of patient need.

Open Door Care Network Workflow Chart



Obtaining Clinic Staff Buy-In

At Open Door, staff buy-in begins at the hiring process by engaging individuals who are deeply passionate about community health. This intentional approach helps minimize internal barriers and ensures the team remains aligned with the organizational mission and values. All staff participate in comprehensive 90-day training (example training documentation in Appendix B). The first 30 days of training focus on the “get to know us,” which provides insights on the health center’s culture and priorities. Regular check-ins are conducted with staff to understand what support and resources are required by them to be successful. The focus is not on rigid job duties, but on the shared responsibility all staff have in contributing to positive patient outcomes.

Partnerships

Open Door receives notifications from numerous hospitals across Westchester and Putnam counties, and even from facilities across state lines. While TOC remains a central focus, the organization is equally committed to advancing overall community health. To achieve this, Open Door actively cultivates strong partnerships, particularly with two local hospitals, with each relationship tailored to the unique needs of the patient and collaborative opportunities available with that institution. As a last resort, if they do not receive the documents from the hospital, they can always request to get that information directly from the hospital or through the patient. This individualized approach enables Open Door to support patients more effectively after hospitalization. The TOC team reviews incoming hospital documentation and conducts targeted outreach to ensure smooth transitions and continuity of care. When faced with complex hospitalizations or high ED usage, especially in cases where a strong relationship with the referring hospital is not yet in place, Open Door works in collaboration with the hospital to find patient-centered solutions. They even have a residency partnership with one of the hospitals for Internal Medicine, while the Family Medicine residency is based at Open Door.

Open Door partners with Health Homes, a care management program for Medicaid patients. Care managers take the lead on TOC responsibilities for Health Home patients and complete documentation in both Foothold, the Health Home's designated platform, and eCW, Open Door's EHR system. To ensure consistency, care managers are trained to document TOC in eCW using the same processes and formats as the core TOC team. This supports seamless communication and coordination across systems while maintaining the program requirements.

Open Door primarily receives patient records through fax and P2P transmissions. While they do not currently have a formal workflow in place for routinely checking the Regional Health Information Organizations (RHIOs), RHIOs can be a great resource when additional patient information is needed. In cases where records are incomplete or more information is required for a patient, staff turn to the RHIO to supplement the available data to make informed decisions.

Data Tracking & Evaluation

Data tracking at Open Door continues to evolve as the organization refines its processes to better support care coordination. Their EHR, eCW is integrated with Relevant (screenshot available in Appendix B), a data reporting and population health platform where data is aggregated and tracked. If information is entered into structured fields within eCW, it flows seamlessly into Relevant, making it easier to track and report on key metrics. However, data entered in free-text fields poses challenges in terms of the capacity to extract it when needed. To support productivity tracking, Open Door has implemented the use of non-billable artificial current procedural terminology (CPT) codes, which staff enter at the end of their documentation. These codes allow the team to monitor time distribution and productivity across different care coordination programs. Once they build reports within Relevant, they identify additional data points that could enhance the reports and work on extracting them. Though there continue to be challenges with tracking the entire scope of their TOC program, artificial CPT codes used for different care coordination workflows have been effective initial steps. Overall, Open Door has found satisfaction with Relevant for extraction and building reports and implementation of non-billable coding.

Examples of Non-billable Artificial CPT Codes

CC	CPT	Description	eHX Co	Fee
Search C	toc	Search Description		
	TOC	Transitions of Care	public	0.0
	TOCA	Transitions of Care-Assigned	public	0.0
	TOCN	Transitions of Care-No Outre...	public	0.0
	TOCTM	TOC Text Message Response ...	public	0.0
	TOCUN	Transitions of Care-Unsucces...	public	0.0

Return on Investment (ROI)

Open Door continues to receive grant funding due to its ability to demonstrate the positive patient outcomes of the TOC program. Beyond the financial ROI, the program supports patients by offering translation services, ensuring the correct medications are picked up from the pharmacy, connecting patients with their primary care provider (PCP), assisting with specialty referrals or care coordination, providing support to identified social needs, and reviewing discharge instructions. To further reinforce patient-centered care, most of the staff are bilingual in English and Spanish, recognizing that 76% of patients are Spanish speaking. Nurses frequently do medication reconciliation and update the medication system as well; not just tracking whether a patient went to the ED and received a prescription, but following up to ensure the patient filled their prescription and completed the medication course. That follow-through can significantly influence health outcomes, potentially lowering the patients' total cost of care to the health system.

Continued Challenges

Despite having a well-structured process in place, challenges still exist, such as delays in hospital transmissions of patient records, financial challenges that can impact workflow efficiency, and developing reports to gain a full view of the TOC work. Furthermore, appointment availability in primary care can also be a challenge. All PCPs have TOC visit blocks to combat this, but appointment availability may still not align with a patient's availability.

Future State

Open Door is exploring opportunities to expand its TOC program. A new part-time nurse has recently been hired, with the intention of transitioning the role to full-time as needs evolve.

WHO ARE THEY

Sun River Health

Sun River Health is a Federally Qualified Health Center providing health care to people of all ages for over 50 years. With over 40 health centers throughout the Hudson Valley, New York City, and Long Island region, they provide a one-stop-shop for services such as primary care, dental, behavioral, women's health, pediatric, substance use disorder treatment, urgent care, and more.

Number of Sites: 48 Clinic Locations
2024 Patient Volume: 231,309
Population Served: All individuals including low-income, homeless, migrant
EHR System: eClinicalWorks
Staff Volume: ~2300 staff
TOC Specific Staff: 7 FTE RN Care Managers, 1 FTE RN High Risk Care Manager, 0.2 FTE Family Nurse Practitioner, 1 Central Intake Coordinator, 5 FTE TOC Partners

Interviewee Profile

Bronwyn Gorgone, DNP, WHNP - Director of Transitions of Care
Email: TOC@sunriver.org

Bronwyn Gorgone serves as the Director of Transitions of Care at Sun River Health and is a Registered Nurse for over 10 years and a trained Women's Health Nurse Practitioner with a doctorate in nursing. She completed her training at Frontier University and fell in love with quality improvement work that aligned well with being a nurse and providing patients with the best quality of care. She started as a triage nurse at Sun River Health. She found it meaningful to work with patients in need of post ER/hospitalization care, as well as those with highly preventable ER visits, so she naturally moved into the transitions of care role.

Keys to Success

- Be intentional about making TOC a priority for the organization.
- Begin with a population of focus and identify where that may take the program.
- Celebrate TOC successes.
- Keep an open mindset about new technologies and different platforms and be proactive about how these can be optimized.
- Ensure TOC work can be tracked.

Transitions of Care History and Implementation

Sun River Health has always recognized the need for a TOC program, as it can improve the patients' overall experience with the health system and reduce their total cost of care. It was initially set up with a decentralized approach by utilizing existing staff at each location to connect and obtain ER/IP discharge reports from local hospitals. This resulted in a reactive process where clinicians relied heavily on hospitals or patients to bring their own discharge reports. This approach placed further burden on an already overextended staff, the health center reassessed its approach and took steps to centralize transitions of care workflows.

The first step was hiring an RN to evaluate current needs and gaps in the TOC process. Sun River hired Bronwyn Gorgone for this task. Given free rein to grow this program, she visited each clinic location to interview staff about existing workflows, volume of ER/IP patients, and technologies utilized. She also convened with local hospitals to foster relationships. The data collected from these interviews led to multiple process improvement projects (applying Plan, Do, Study, Act (PDSA) cycles), a push for value-based care contracts, and grants to reduce hospitalizations. This all led to a long-recognized need for a separate department for TOC. Allocating funds from the Accountable Care Organization, Sun River Health was able to hire the initial TOC staff for the program.

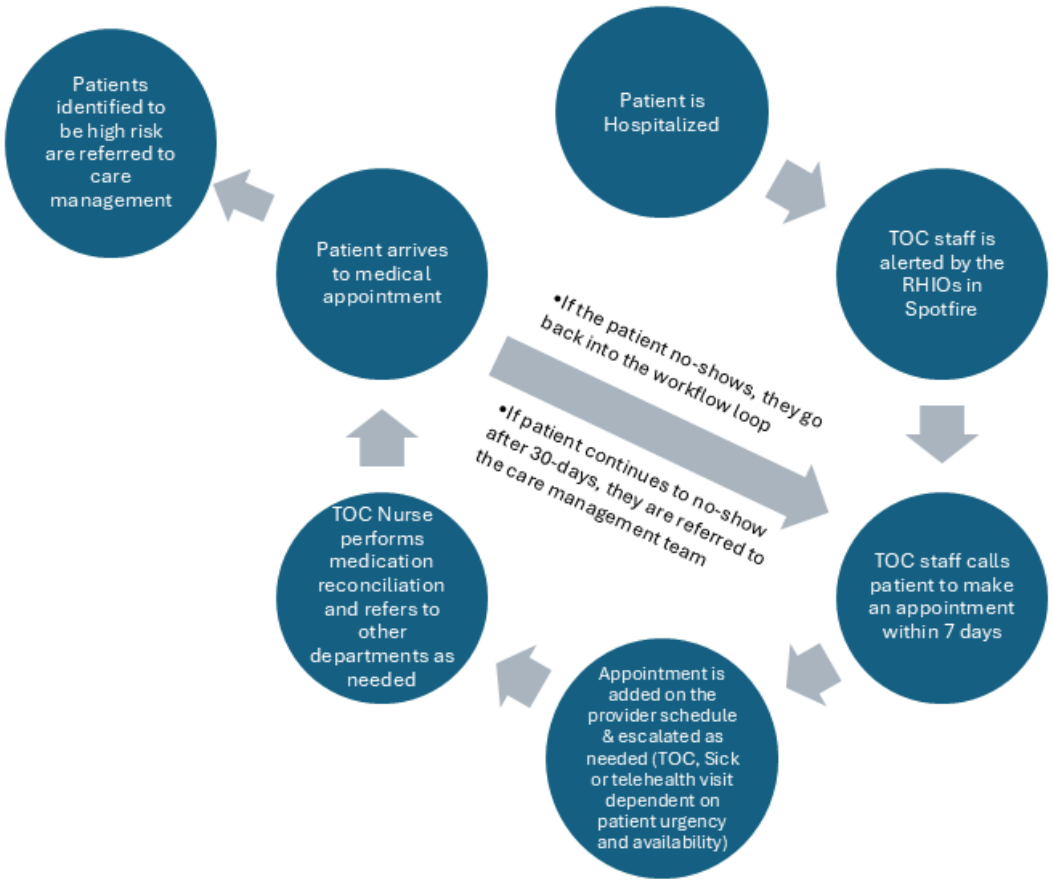
Current Workflows

Upon recruiting initial staffing, the health center transitioned to a more centralized approach. In addition to the TOC Director, the program employs seven Registered Nurses and five TOC Care Partners. During the hiring process, potential nurses are assessed for experience with care management and experience with specific clinical diagnoses often seen with TOC patients, such as wound care, chronic illness, etc. Potential TOC care partners are also evaluated for skills and knowledge working in various health care settings and coordinating patient care.

TOC nurses are primarily patient-facing. They identify and outreach to TOC patients based on acuity and chronic illness. With access to health information exchange portals, the nurses obtain discharge summaries, perform medication reconciliation, and identify additional needs before the medical appointment. TOC Care Partners provide support to patients with lower acuity, and actively communicate with internal site staff as well as external partners to advocate for transitions of care needs. TOC patients are assessed for possible medical and non-medical needs, and may be referred to transportation services or other internal teams, such as health homes, those with experience working with substance use disorders, homelessness, maternal health, etc.

Department manuals, policies and procedures, scripts, and decision trees were also developed to enhance the workflows for TOC staff training. Staff training courses are primarily virtual and include use of recorded TOC calls for quality improvement, audit tools, daily team huddles, office hours with the director, individualized meetings, and monthly case reviews. Case reviews are staff-driven, in which one obstacle and one success story are shared and reviewed as a learning opportunity. New TOC staff are also given the opportunity to visit Sun River locations to develop relationships with site clinical staff and better understand their workflows.

Sun River Health's TOC Workflow Chart



Obtaining Clinic Staff Buy-In

Staff buy-in is obtained by actively listening to the needs of each clinic location, identifying opportunities to close patient data gaps, and consistently building ongoing relationships with each location's staff, including case managers, providers and directors. This active listening involves daily communication and support through shared responsibilities. For those not immediately engaged, buy-in is cultivated through education, training, and communicating the purpose of TOC, to establish timely transition of care appointments (within 7 days), and to reduce readmissions. Consistent follow-up with clinic staff, proven reliability, and open communication are crucial to earning trust and long-term engagement for the TOC program.

Partnerships

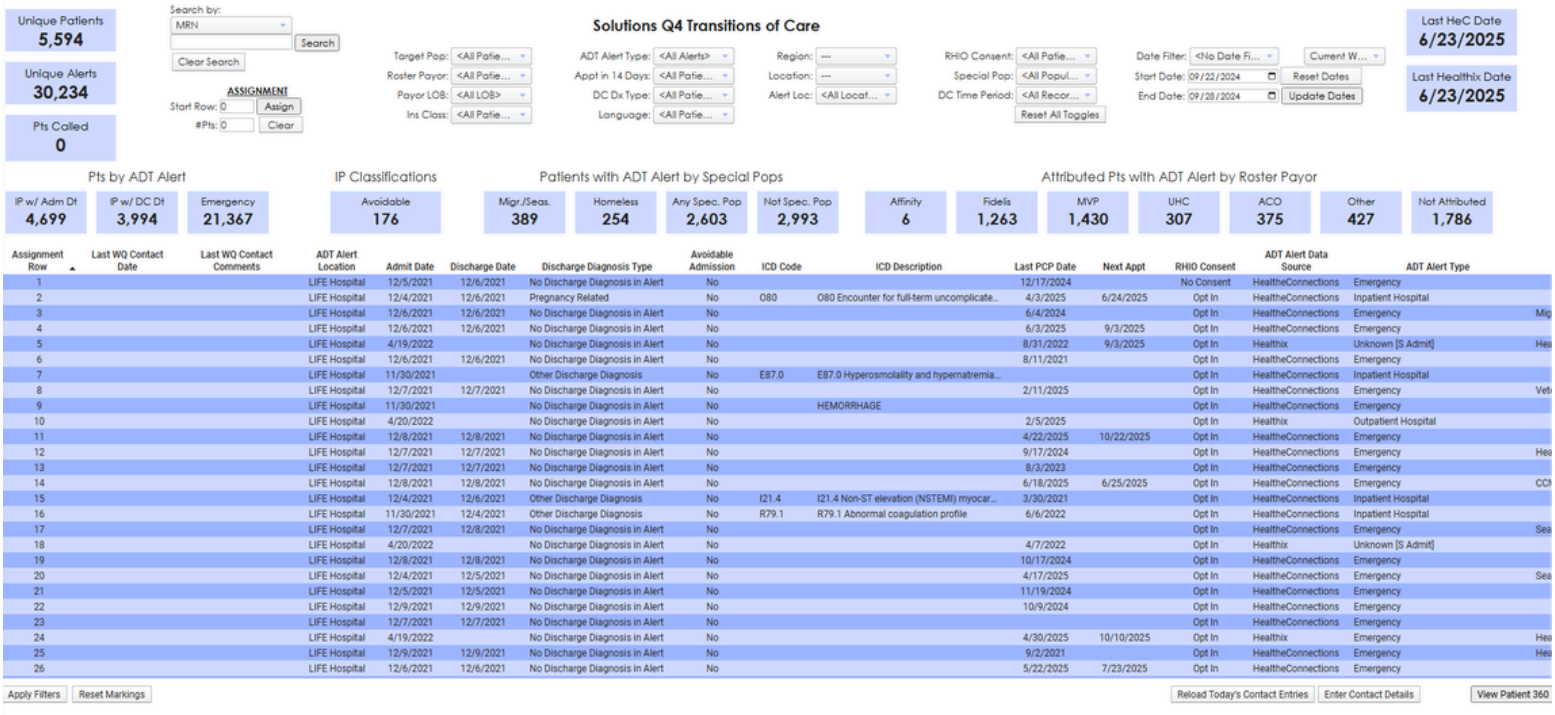
Partnerships with local hospitals, RHIOs, and technology teams have been an integral component of the success of Sun River Health's transitions of care program. The team serves as a liaison between the local hospital and the health center, advocating for care transition-related needs and patients. Due to the large geographic area Sun River Health covers, many partnerships were built based on location-specific needs and the hospital's scope of collaboration. Some hospitals have formally signed agreements to directly share discharge summaries electronically. Some hospital systems take the agreement a step further and permit transitions of care coordinators to visit their Emergency Departments to set follow-up appointments with the health center. This not only streamlines processes for existing patients, but also increases opportunities to establish relationships with new patients. The team also leverages its medical residency program where residents rotate between the hospital and Sun River Health. In these instances, residents also serve as liaisons, allowing them to see patients in the hospital and set up TOC appointments with Sun River Health as needed.

Formal relationships with local RHIOs (HealtheConnections, BronxRHIO, and Healthix) were developed to obtain alerts and discharge summaries. Recognizing the great number of alerts the team was receiving, Sun River staff worked with a platform called Spotfire to integrate the alerts from the RHIOs and streamline workflows to only receive relevant data points identified by the TOC team. Spotfire also functions as an analytics tool to continually assess performance, integrate claims data for revenue tracking, and as a work queue to assign patient lists to specific staff members for follow-up.

Data Tracking

Tracking transitions of care efforts is a multi-layered process at Sun River Health that relies on the integration of tools like Spotfire, eClinicalWorks, and RingCentral. These platforms are used in tandem to streamline TOC data coming to the staff, continually track patient volume, obtain reimbursement for follow-up visits, and demonstrate productivity of the team.

Spotfire serves as the central hub for tracking patient data across New York through its integration with health information exchanges (HIEs) like Healthix, HealtheConnections, and the BronxRHIO. This home-grown system consolidates HIE alerts into a unified data feed, allowing for a comprehensive view of patients in their catchment area and pulls in relevant TOC reimbursement codes. Spotfire was designed with continual input from the TOC team and functions as a work queue for documentation and tracking Transitions of Care (TOC) visits.



Spotfire Image (also in Appendix A)

Tracking visit types and claims data was a collaborative effort between EHR teams, Sun River Health's informatics staff, and eCW technical teams. Specific TOC visit templates, structured fields, and dropdown options were built into the EHR to ensure consistency and ease of reporting. These structured templates allowed TOC staff to document patient interactions in a standardized format, enabling data reporting for quality improvement efforts. eCW is also used to monitor if patients show up for their appointments and trace back issues like rescheduling that affect TOC visits.

RingCentral is the phone system used by Sun River Health to call patients, and was also employed to track productivity and operational efficiency of TOC patient interactions, such as call durations and team response times.

Return on Investment (ROI)

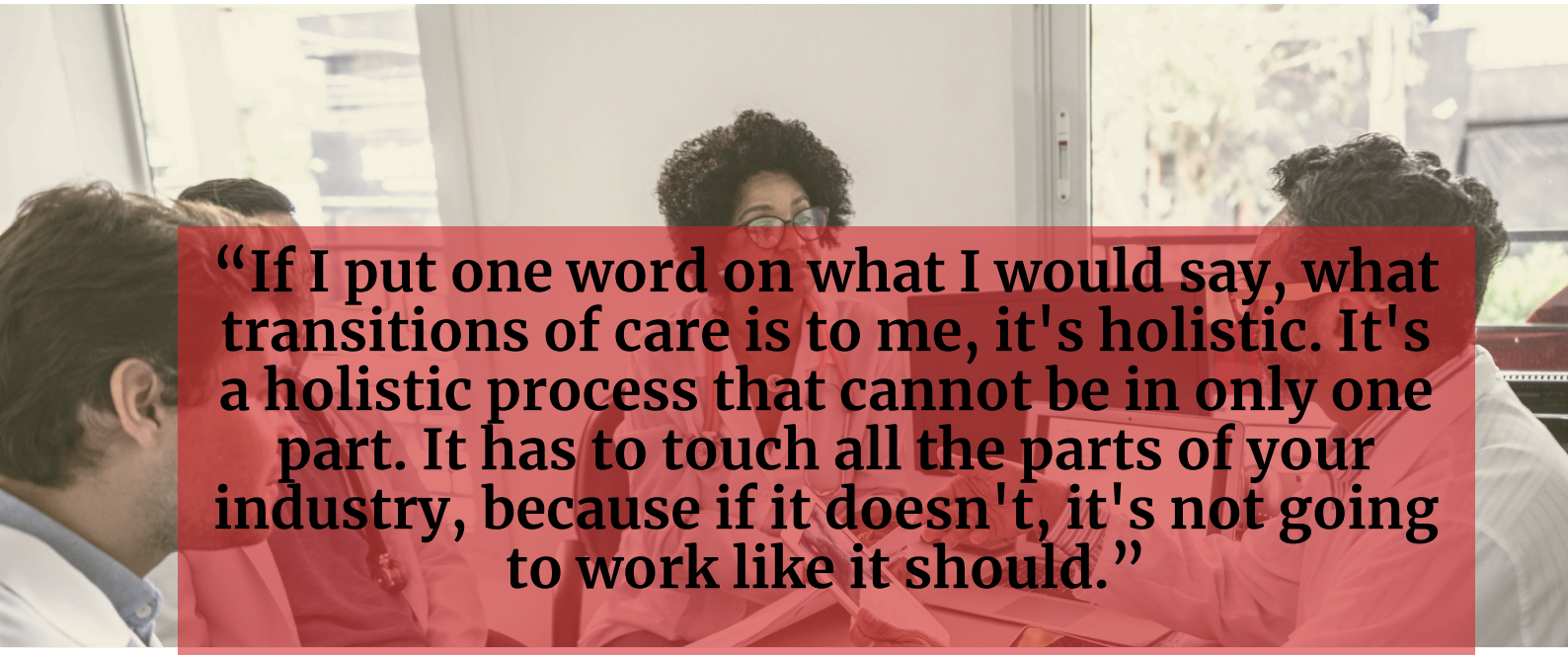
Sun River strategically leveraged available resources and aligned financial incentives in order to demonstrate ROI for TOC initiatives. One effective strategy was to utilize grant funding to support TOC staffing, which resulted in reduced upfront costs while establishing essential care infrastructure. In the value-based care space, Sun River Health identified alignment between health center risk and payer risk, participated in risk-based payment models, and shared savings under risk contracts. By overlaying claims data with TOC data in Spotfire, the team can integrate patient information and prioritize resources, thereby reaping the benefits of value-based care payments. Appropriate coding and billing for transitions of care ensured that services are accurately documented and reimbursed, thereby sustaining the program.

Continued Challenges

Despite the many issues in transitions of care Sun River Health has overcome, many challenges continue to persist. There are challenges with obtaining hospital data, and patients may fall through the cracks, especially transient patients, such as those experiencing homelessness. It can also sometimes be difficult to build relationships with New York City hopsitals. Additionally, the lack of tracking mechanisms to capture the nuance of data make it harder to close the loop with hospitals.

Future State

Many new and exciting initiatives are in store for the Sun River Health Transitions of Care team. They will begin to call patients within thirty days post the TOC visit to better prevent readmission. The team will focus on bringing the patient perspective into the work by obtaining feedback on their follow-up care experiences and insights on their perceived risk of rehospitalization. Lastly in order to better support medically complex patients they: (1) hired a new TOC staff and high-risk care manager, (2) beginning to hire a part time Psychiatric-Mental Health Nurse Practitioner and an additional RN high-risk care manager, and (3) launched a nurse managed phone line for high-risk TOC support.



“If I put one word on what I would say, what transitions of care is to me, it's holistic. It's a holistic process that cannot be in only one part. It has to touch all the parts of your industry, because if it doesn't, it's not going to work like it should.”

Sun River Health

APPENDIX

Appendix A

Terms

CVD – Cardiovascular Disease
CPT – Current Procedural Terminology
eCW – eClinicalWorks
EHR – Electronic Health Record
ER – Emergency Room
FQHC – Federally Qualified Health Centers
HIE – Health Information Exchange
IP – Inpatient
PCMH – Patient-Centered Medical Home
PCP – primary care provider
PDSA – Plan-Do-Study-Act
RHIO – Regional Health Information Organizations
RN – Registered Nurse
TOC – Transitions of Care

Appendix B

Open Door Care Network TOC Workflow Training
EHR & Reporting Images

TOC Workflow Training

Clinical Integration				
Skill	*Reviewed?*	*Date*	*Initials*	*Notes (optional)*
TOC				
PHM				
TOC texts				
Relevant				

eCW

Skill	*Reviewed*	*Date*	*Initials*	*Notes*
Looking up patients				
Creating a new patient				
Making appointments				
Managing schedules				
Documenting patient encounters				
Labs/Dis				
Referrals				
Letters				
Telephone encounters				

Referrals

Skill	*Reviewed*	*Date*	*Initials*	*Notes*
Food pantries				
Mental health referrals (internal and external)				
Specialist referrals with insurance				
Specialist referrals without insurance (WMC, SSMC, etc.)				
Domestic violence assessment & referral				

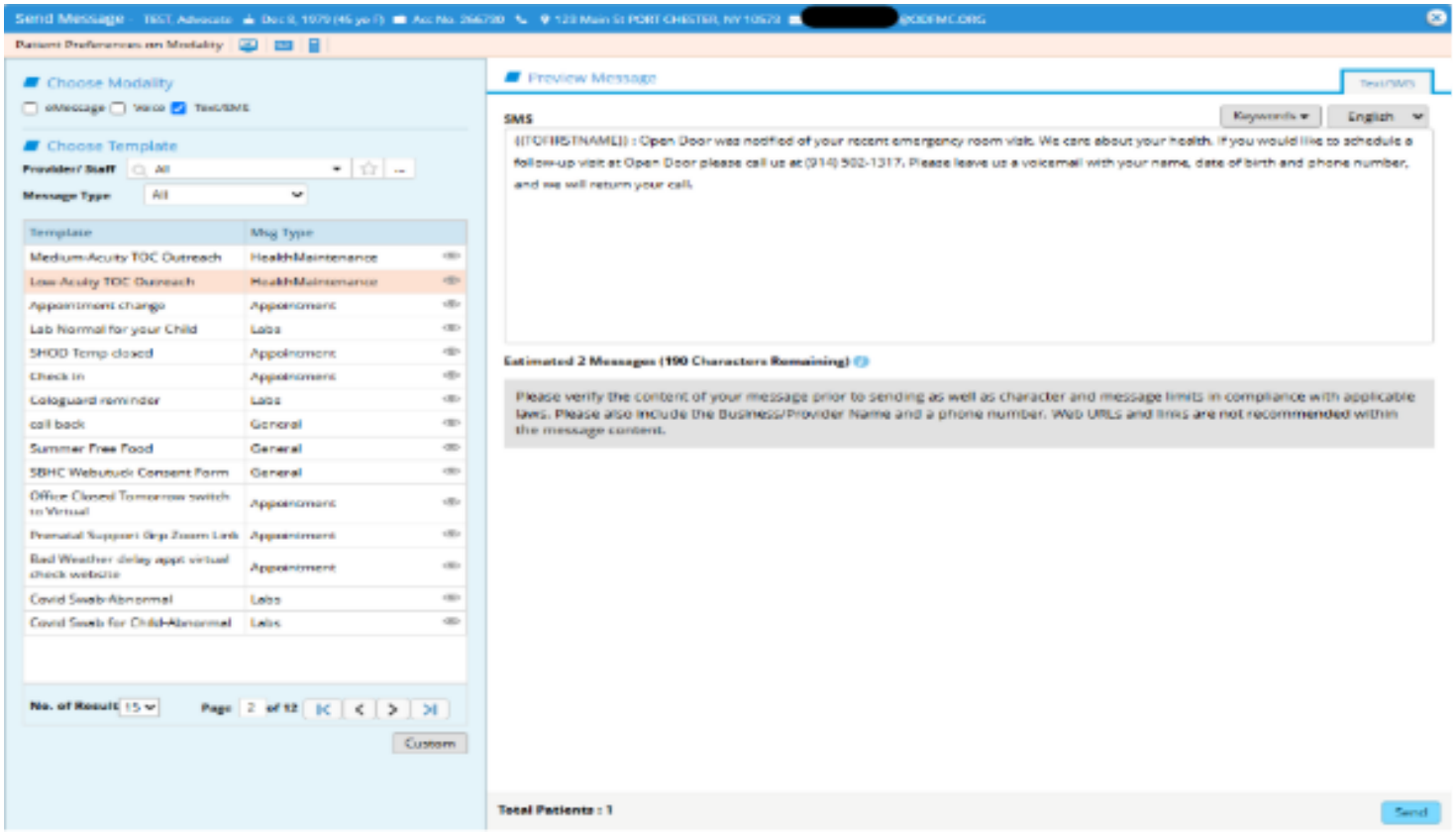
Pharmacy Assistance Programs

Skill	*Reviewed?*	*Date*	*Initials*	*Notes (optional)*
rxassist.org				
f/u needed re: refills and re-enrollment				
340B				

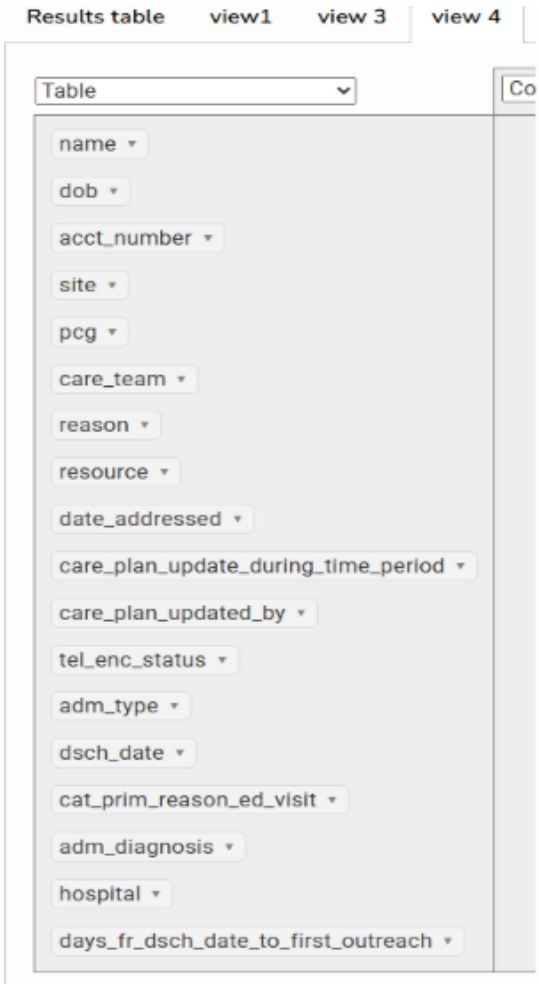
Insurance

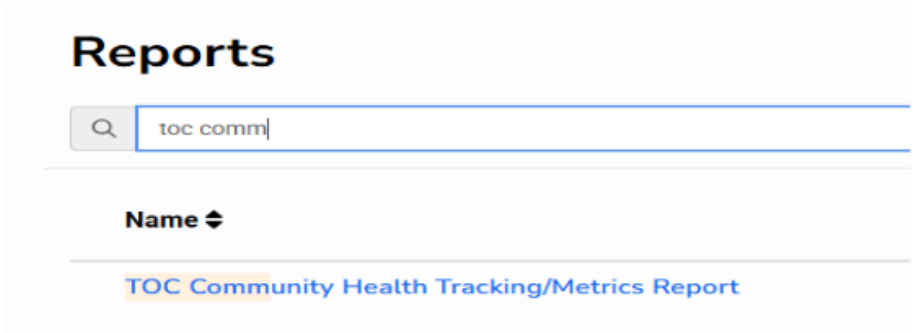
Skill	*Reviewed*	*Date*	*Initials*	*Notes*
Explanation of 'Medicaid Managed Care'				
Difference btwn Medicaid and Child Health Plus				
NY Medicaid Choice				
Medicaid re-cert & (DSS VS NYSOH)				
Emergency Medicaid				
ePACES				

EHR Templates



Relevant Reporting System



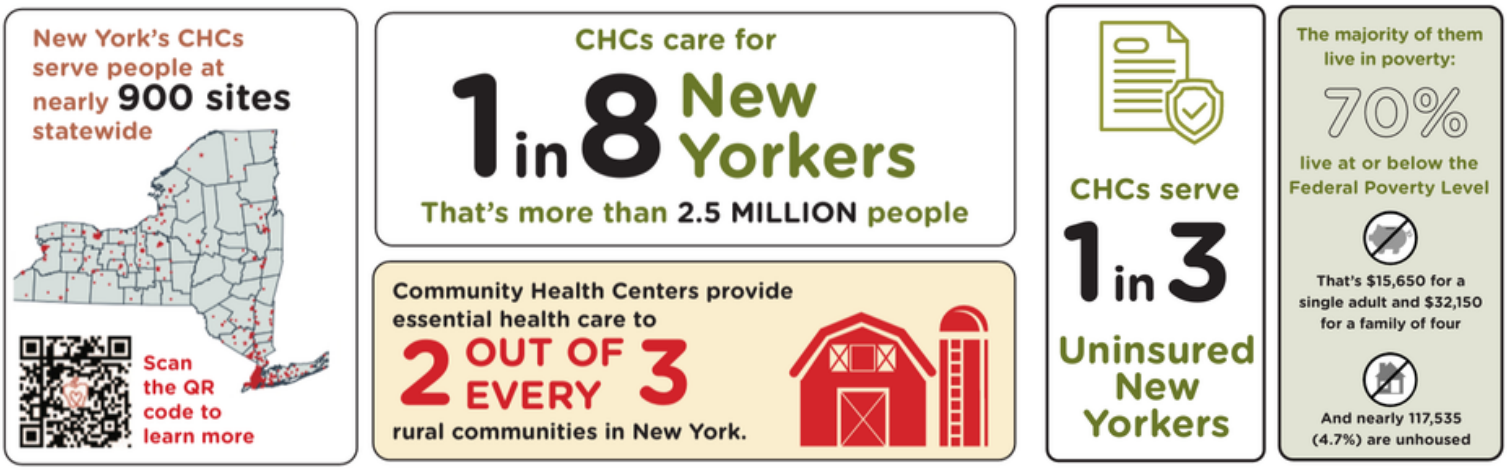


About the Community Health Care Association of New York State (CHCANYS)

The Community Health Care Association of New York State (CHCANYS) is a primary care membership association (founded in 1971) that supports more than 80 community health centers (CHCs) with over 900 sites throughout the state. CHCANYS has represented a diverse membership, from large metropolitan community health systems in New York City to rural health centers in Upstate and Western New York, New York State community health centers serve over 2.5 million patients (1 in 8 New Yorkers), many of whom are among the most vulnerable populations. CHCANYS vision is to ensure that every New York State community has primary care that encompasses all aspects of each patient's health and well-being, and its mission is to champion community-centered primary care in New York State through leadership, advocacy, and support of CHCs.

About the CHCANYS NYS-HCCN

Established in 2012, the New York Statewide Health Center Controlled Network (NYS-HCCN) is one of forty-nine HRSA funded networks that work together to strengthen and leverage health information technology (HIT) to improve health centers' operational and clinical practices that result in better health outcomes for the communities they serve and is the only HCCN dedicated 100% to New York State CHCs. The NYS-HCCN is committed to empowering CHCs across New York State with the tools and strategies needed to optimize health IT, improve data analytics, and enhance interoperability. Through a collaborative network model, the NYS-HCCN aims to advance clinical, operational, and financial data management to drive quality improvement, strengthen care coordination, and promote bidirectional interoperability to facilitate seamless information sharing.



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Have questions or need more information, please contact hccn@chcanys.org.