

*Bridging the gap between acute care and home*

Transition Care Management (TCM) Services Provided

* Patient phone contact by clinician within 24hr of DC
* NP visit at their residence usually in 3-5 days after DC
* Refill/adjust prescriptions for up to 30 days
* Risk assessment at initial visit to determine risk of readmission and frequency of follow up visits
* Coordination of care and communication with home health, PCP, specialists at each visit
* Thorough review of hospital and facility records with follow up on labs/diagnostics/orders.
* Mobile labs, xrays, Ultrasounds, EKG as indicated
* Records left for PCP f/u appt in the patient home.
* Additional visits as clinically indicated to prevent readmissions based on risk assessment.
* Education of the patient and family on the diagnoses, disease processes, medications, follow up appointments, and discharge instructions
* Assistance with coordinating readmission to the acute care/rehab system if indicated within 30 days DC
* End of 30 day f/u visit or call to verify status/stability before discharge from services to verify clinical stability
* Referral to PCP or chronic house call MD if indicated
* Referrals of patients from the home to our partner facilities