TRANSITIONAL CARE MANAGEMENT

Supporting Your Safe Recovery After a Hospital Stay

WHAT IS TRANSITIONAL CARE MANAGEMENT?

Transitional Care Management (TCM) helps Medicare patients safely transition from the hospital, skilled nursing facility or rehabilitation center back home. Our care team provides follow-up care, medication review and care coordination to support your recovery and help reduce the risk of hospital readmission.

WHO QUALIFIES?

You may be eligible if you:

- Recently left a hospital, skilled nursing facility or rehabilitation center
- Have Medicare coverage
- Need follow-up care, medication management or help coordinating your recovery

WHAT YOU CAN EXPECT

After you are discharged, our care team will:

- Contact you within 2 business days
- Schedule a follow-up visit within 7–14 days
- Review your medications and care plan
- Coordinate care with your specialists and other providers
- Answer questions and support your recovery needs for 30 days post-discharge

Talk to your provider or call us at 208-997-1402.

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