

## Control Readmissions with Patient Transition Coaching

### Some Hard Facts about Readmissions:

- Did you know, 20% of patients discharged from hospitals are readmitted within 30 days?
- Did you know that many of these readmissions stem from a lack of patient follow-up?
- Are you aware that this issue was recognized in the recently passed "Patient Protection and Affordable Care Act" which mandates reductions in Medicare payments for preventable readmissions?

### Many Readmissions Are Preventable

Clearly, patient readmissions are a big concern. And, many of them are preventable. It just requires a commitment to patient follow-up and education. Alicare Medical Management's Patient Transition Coaching Program is designed to provide both. It helps patients make a safe and effective transition from their hospitals to their homes; while it helps you control readmissions. Here's how it works.

### From Outreach and Assessment to Education and Follow-up Care

AMM's Patient Transition Coaching Program service begins with outreach by one of AMM's Registered Nurse (RN) Health Coaches. Immediately after patients leave the hospital, they are contacted by an RN Health Coach who assesses their health status and identifies any potential problem areas. A key role of the RN Health Coach is to make certain patients are properly informed about essential follow-up care and self-management requirements, have their medications and understand when and how often to take them, are properly educated about potential problems, and know when to reach out to their physician. When appropriate, the RN Health Coach will contact the physician for additional information, intervention and to coordinate follow-up care.

**Start Controlling Readmissions Now with the Patient Transition Coaching Program.**

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### What Patients Is the Transition Coaching Program Best Suited to Help?

This program is ideally suited to address the post-discharge needs of patients who don't require intensive management, medical equipment, and/or on-site services addressed through discharge planning. Typical cases that would most benefit from the program include:

- Patients discharged post-surgically
- Patients with chronic obstructive pulmonary disease
- Patients with congestive heart failure
- Patients with various cardiac conditions

### For Hospitals, Managed Care Firms, Insurers & Utilization Management Clients

In addition to healthcare providers, the AMM Patient Transition Coaching Program can be used by managed care firms, insurers and utilization management clients for appropriate cases. AMM's nurses rely on their judgments and certain system-generated triggers to determine which patients at discharge are best suited for the program. AMM is also working with its clients to develop referral criteria to further identify appropriate cases specific to clients' population.

### A Cost-effective, Cost-control Tool

AMM's Patient Transition Coaching Program is not only a valuable cost-control tool, it is also extremely cost-effective. Fees for the program are based on a one-time case rate for each enrolled patient. This fee covers all short-term services, including: RN Health Coach assessment and evaluation of the patient's status and needs, patient education, and patient monitoring in the first four weeks following hospital discharge.

