



# Care Transitions

## A HealthBridge Respite Service “Work-Up...Tune-Up”

Care Transitions is a respite program designed to incorporate diagnostic services and multidisciplinary / psychosocial care planning for patients / residents in need of medical and community resources.

### What is Care Transitions?

Care Transitions is a respite program designed to incorporate diagnostic services and multidisciplinary / psychosocial care planning for patients / residents in need of medical and community resources.

Some examples of people who can benefit from Care Transitions are:

- A person living at home that is unable to appropriately manage a medical condition but not acutely ill enough for the hospital
- A patient at the hospital that is on observation status and will not qualify for a Medicare stay
- The spouse of a patient in the hospital where the patient was the spouse's caregiver
- A patient brought to the Emergency room-cannot admit but should not go home alone
- A patient with limited Medicare time due to lack of qualifying diagnosis (e.g. fall without significant injury, altered mental status, upper extremity fracture)

### What types of services are included in Care Transitions

For most patients- Medicare Part B can be utilized to provide services as appropriate/recommended by physician such as:

- Physical Therapy/Occupational Therapy/Speech Therapy evaluation and programming
- Physician / Physiatrist Consult
- History & Physical Labs and /or X-rays other diagnostic tests as ordered by physician / deemed appropriate
- Psychology consult / Depression Screen
- Neurology / Pulmonology/ Cardiology/consults as deemed necessary
- Adaptive equipment as recommended / ordered



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## Other Included Services

We offer a discounted respite rate for up to 30 days for those that don't qualify for Medicare or insurance coverage- other general services available are as follows:

- Room and Board General Care
- Housekeeping and laundry services
- Medication consultation through the pharmacy
- Dietician consult and Nutrition Management
- Disease Education
- Planning and resources given for community support
- Home Care or companion coordination
- Assisted Living, Long-term care, day care referrals

## What is needed to admit a patient for Care Transitions?

- History and Physical (if available)
- Medication list
- Pertinent labs or X-Rays
- Emergency room record if applicable
- Verification of Medicare / insurance
- Informed of Daily rate

## Where is Care Transitions Offered?

### Center Contact Information

Need locations and number from copy

*A 2-week stay is recommended to provide full availability of services.*

