TOTAL LONG-TERM CARE CONSULTANT SERVICES, INC.

Certified Geriatric Care Management & Professional Guardian Services

CARE TRANSITIONS

BRIDGING THE GAP WITH THE 4 C's

Facilitating smooth transitions, improved outcomes and preventing hospital re-admissions:

- **Collaboration** within all health/social realms and with providers
- **Communication** with patient and family
- **Coordination** of discharge with community healthcare providers
- **Continuity** of care over the health care continuum.

PROGRAM PROCESS

- ✓ **Identify at risk** individuals and caregivers
- ✓ **Connect at risk** with transitional staff prior to discharge
- ✓ **Facilitate** Interdisciplinary health/social team communication and coordination
- ✓ **Patient education** to ensure understanding of the discharge plan and process
- ✓ **Connect with** key community players, services and supports prior to discharge
- ✓ **Prevent re-admission** by recognizing and responding appropriately to adverse symptoms post-discharge

COMMUNITY PARTNERS

TLCCS Care Managers can bridge the social and medical arenas effectively and efficiently with a holistic focus on each client's individual needs, goals and resources for their discharge back home. **TLCCS Care Managers** are experts in care planning and management designed to maximize the health, independence, resources and quality of life for persons with an acute or chronic illnesses and/or a disability.

Individualized care planning and management are essential in preventing hospital re-admissions, ensuring efficient use of resources and addressing individual goals. **TLCCS Care Managers** can accomplish this by assisting with:

1. **Patient and family Education and engagement**
2. **Development of a post discharge follow- up plan**
3. **Transitional planning for follow-up care**
4. **Engagement of and communication among patient's community healthcare provider(s)**
5. **Medication Management**
6. **Coordination and management of family/community care providers**

. **TLCCS Care Managers** emphasize coordination and continuity of care, prevention and avoidance of complications and close clinical oversight **AND** care management --- accomplished with the active engagement of patients, their family and caregivers, and the collaboration with the patient's healthcare providers