Transitional Care Management

A Service of Care Coordination

Serving the Needs of People Living with Chronic Illness

What is Transitional Care Management?

Transitional Care Management is a Medicare program that assists people with chronic conditions smoothly transition from hospital to home. It starts in the hospital and continues for 30 days after discharge.

The Care Coordinator actively works individually with patients experiencing complex medical conditions and their families. The goal is to teach self-management skills, improve communication between all healthcare providers, and connect people with community resources. The Care Coordinator considers the needs of the whole patient and their family using health-coaching strategies.

Tahoe Forest Health System

What is the benefit of Transitional Care Management?

Transitional Care Management has numerous benefits to people who live with chronic illness

- Improved quality of life
- Improved coordination of care
- Improved self-management through shared decision-making
- Improved timing of appointments and tests
- Helps identify and minimize barriers to care

Who is eligible?

Any individual who has been diagnosed with two or more chronic illnesses, has been hospitalized, and has identified a local primary care provider is eligible to participate.

How much does it cost?

This is a Medicare benefit. It will be billed similar to an office visit through your primary care provider.

For referral, call (530) 550-6730
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