Serving the Needs of People Living with Chronic Illness

What is Chronic Care Management? Chronic Care Management assists people with chronic conditions better manage their illness for an improved quality of life.

The Care Coordinator actively works with patients experiencing complex medical conditions, their families and caregivers. The goal is to teach self-management skills, improve communication between all healthcare providers, and connect people with community resources.

For referral, call (530) 550-6730
Fax (530) 587-7454
Care Coordination Department
Tahoe Forest Hospital
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Why should I enroll in Care Coordination?
Care Coordination has numerous benefits to people who live with chronic illness

• Improved quality of life
• Increased functional status
• Shared decision-making
• Improved timing of appointments and tests
• 24-hour Nurse Advice Hotline linked to your individual plan of care
• Improved coordination of care
• Improved self-management through shared decision-making
• Helps identify and minimize barriers to care

Who is eligible?
Any individual who has been diagnosed with two or more chronic illnesses such as high blood pressure, diabetes, heart disease, high cholesterol, arthritis, emphysema or depression is eligible. You may be referred to Care Coordination through your primary care provider, hospital staff, specialist or public health clinic. Families and caregivers may also directly refer a patient for Care Coordination services.

Where is Chronic Care Management provided?
Chronic Care Management services range from home visits, phone calls, e-mails and office visits. The Care Coordinator works closely with your primary care provider and will often accompany you to your doctor visits. The primary aim is to offer support and provide education regarding self-management goals.

How much does it cost?
This is a Medicare benefit. You may be responsible for a 20% copay (approximately $8) if you do not have secondary insurance.

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