OTHER SERVICES

Care Transitions

When you are hospitalized, it may be helpful to have a medical professional to assist you once you are discharged. The impact of your illness as well as the medications and paperwork provided at discharge may seem overwhelming once you arrive home. If appropriate, our team of care transitions certified nurses will contact you after discharge from the hospital to review you instructions. They can assist you over the phone or schedule a home visit. They are equipped with copies of all your documentation so that you can go over all your discharge paperwork in the comfort of your home.

Behavioral Health Liaison

Depressed? Anxious? Help is available! We have access to resources and the expertise to navigate complicated insurance systems. Our licensed clinicians can help you get connected to behavioral health resources.

Care Coordination

Our coordinators will ensure that you have access to all resources (such as Durable Medical Equipment, community referrals, etc.) related to your health care.

MERITAGE MEDICAL NETWORK CARE MANAGEMENT SERVICES

Care Management Supervisor
Simone Howard, RN
415.884.1834

Care Coordination Services
Deborah Tool
415.884.1826

MERITAGE MEDICAL NETWORK
A Babylon Company

800.874.0840 | meritagemed.com

BETTER CARE IS HERE.

MERITAGE MEDICAL NETWORK
A Babylon Company

CARE MANAGEMENT SERVICES

Serving Marin, Sonoma, Napa and Solano Counties

NORTH BAY

WE ARE HERE FOR YOU

Perhaps you have had a recent hospitalization or a noticeable change in your health. Sometimes, you might need a little extra help and guidance even if you haven't been hospitalized or had a major illness recently.

Whatever the circumstance, our Care Managers are available to provide whatever support you need in order to assist you in taking the very best care of yourself. Depending on your situation, the wisest decision might be to allow our medical professionals to assist in the management of your illness and recovery.

You may have long term chronic issues that are becoming confusing — medication regimens can increase and change, your ability to manage your ADLs (activities of daily living) can decrease, you may have difficulty getting to doctor's appointments, or difficulty in scheduling or even getting medical supplies from the pharmacy.

CARE MANAGEMENT

Our Meritage Medical Network licensed professionals are here for you to assist in making sure you have the best opportunity to recover from illness, maintain the healthiest lifestyle possible, and to help you navigate through an often complex healthcare system.

If appropriate and you agree, we can send a licensed RN to your home to go over your medical issues with you, identify problem areas and together, make a plan to create solutions to improve your well-being. The care manager will then call at regular intervals to check on your progress and see if there are ways she/he can help ensure that you get the care you need and are doing everything possible to optimize your health.

Your participation in our Care Management program is always at **no cost to you**, always optional and you can opt out at any time. This service is **free**, no copay, a part of your plan's package and we encourage you to take advantage of this valuable resource.

Answers to questions you may have about Care Management.

How do I get referred to Care Management?

There are multiple ways you can be referred to our services:

1. Your Primary Care Provider sends a direct referral to our team.

2. Your health plan sends a direct referral to our team.

3. The hospital or other community based organizations can refer you to our services.

4. You can self-refer; simply call us at **415.884.1840**.

How long is a home visit?

A typical visit takes 45-60 minutes. If we feel you need more time, a second visit will be scheduled. After the home visit your Care Manager will make follow-up telephone calls to check in on your progress.

What should I expect at the home visit?

1. Our Care Manager will review your medications to ensure you are taking them correctly and answer any questions.

2. The Care Manager will review any discharge, Doctor and Medical documentation with you to ensure you understand any follow-up plans with your healthcare team.

3. The Care Manager will discuss any chronic conditions you may have: red flags, preventative teachings, disease management.

4. The Care Manager will help schedule visits with your physicians or other services i.e. home health.

5. The Care Manager will help you manage your care as well as help you navigate the healthcare system, link you to different services your health plan offers, and connect you with community resources.