CARE TRANSITIONS

As a part of our ongoing commitment to improve health and quality of life for the local community, we created our Care Transitions program. The program is designed to assist you or a loved one during the critical period of healing following hospital discharge.

The Importance of Care Transitions

The Centers for Medicare and Medicaid Services (CMS) reports that nearly 15% of all initial acute care hospital stays in New York State, resulted in a readmission within 30 days following the initial admission. These readmissions are often preventable and are sometimes a result of confusion over medications and how to take them, a lack of education about the cause of the initial admission and awareness of what could cause a readmission and/or a lack of timely follow up with a primary care physician or specialist in the community.

ST. JOHN'S RIVERSIDE HOSPITAL 150 YEARS STRONG

Care Transition Service

Care Transitions is an evidence-based program that focuses on helping reduce preventable readmissions by providing you with the knowledge, confidence and ability to self-manage your health condition. Our Care Transitions Patient Navigator follows, educates and supports individuals from the day of discharge through their transition home. When you're a part of our Care Transitions program, you won't feel like a number. You'll receive personalized care to fit your exact needs.

Some of the most common services provided by Care Transitions include the following:

- Ensuring timely physician follow-up care
- Connecting you with follow-up testing and physician appointments as well as helpful community resources.

Contact
Call our Patient Navigator at 914-964-4881.

WE ARE COMMUNITY STRONG

RiversideHealth.org