Morongo Basin Community Health Center offers the Hospital to Home program to its patients who were recently hospitalized because of a chronic disease. The program is designed to help patients successfully transition from hospital to home.

Our Care Transition Team will provide health information and teach the patient skills and behaviors necessary to manage their chronic disease and medications, facilitate communication for patients and families to build confidence for successful response to common problems related to the disease process; and partner with healthcare providers in the management of the chronic disease and patient care.

Patients must qualify to participate in the Hospital to Home program and cannot be on hospice services. The program does not support patients with manage care benefits. And we cannot enroll patients who have current substance abuse, or those with a history of poorly managed dementia or mental health.

The program supports patients who meet the following criteria:

- CHF: congestive heart failure
- COPD: chronic obstructive pulmonary disease
- HTN: hypertension / high blood pressure
- CAD: coronary artery disease
- Diabetes
- Reoccurring wounds
- Prescribed five or more medications
- Have a history or potential for readmission to the hospital

Our Nurse Case Manager will meet with the patient while in the hospital to enroll the patient in the program, discuss patient concerns and needs, and to engage the patient and family caregivers.

After discharge from the hospital, the Nurse Case Manager will call the patient within 36—72 hours and schedule a follow up appointment at the Morongo Basin Community Health Center. The nurse will continue to follow up with the patient through subsequent phone calls to determine patient status, provide preventive health coaching and any additional community resources to equip the patient for successful management of their chronic disease. The intent is to increase patient self-management skills, reach personal health goals, and provide continuity of care across healthcare transitions.

To enroll in the transition program, advise the hospital case manager you want to speak with the Hospital to Home Nurse Case Manager, or call her direct at 760-552-2782.