QUESTIONS?

If you have questions, would like additional information or would like to enroll in the IMPACT program

CALL

CARE TRANSITIONS PARTNERS AT 844-294-6891

EMAIL

CARETRANSITIONSPARTNER@STVHS.COM

OR LOG ON

WWW.STVPHYSICIANALLIANCE.COM/IMPACTREFERRAL/

St.Vincent's HEALTH SYSTEM | IMPACT Impacting Patients Across Care Transitions

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IMPACT PROGRAM

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THE ST. VINCENT'S IMPACT PROGRAM has expanded to provide population management for STVPA covered lives which currently include Humana and Viva Medicare ME. Other managed populations include SmartHealth (STVHS) and St. Vincent's East Viva Cap. The program is a comprehensive approach to managing patient care across all settings with a goal of improving their overall health and well-being by meeting them on their health journey.

The services provided are tailored to their needs and may include phone calls, home visits, and other practical supports.

St. Vincent's multi-disciplinary team includes Care Transition Partners (which may be nurse practitioners, registered nurses or social workers), pharmacists, dieticians, chaplains and paramedics. These team members communicate with physicians and other providers to coordinate care for the best possible outcomes. The IMPACT team continues to work closely with the Post-Acute Care Liaisons as well as Inpatient Acute Case Management.

THE PROGRAM IS COMPLETELY CONFIDENTIAL ...AND IT'S

FREE!!

PROGRAMS

POST-ACUTE CARE COORDINATION
Patients receive essential and helpful follow-up phone calls as well as home visits by nursing staff, social workers, and/or trained paramedics to evaluate current needs and answer their questions regarding diagnosis, medication or other needs. In addition, we can assist patients with scheduling appointments and arranging transportation as needed.

ED CARE COORDINATION
Patients receive a follow-up telephone call by a registered nurse following a visit to the emergency room. We can assist them with scheduling appointments as needed.

CHRONIC DISEASE MANAGEMENT
Our program focuses on managing chronic conditions that can sometimes be debilitating, but manageable, through early intervention, appropriate treatment and lifestyle. Conditions included in the program are: Diabetes, Hypertension, Congestive Heart Failure, COPD and Obesity.

[The services provided are tailored to patient care needs and may include phone calls, home visits, and other practical supports.]

GOAL OF THE PROGRAM

The goal of the IMPACT program is to prevent unnecessary ED visits, reduce hospital admissions and optimize the patient's health and well-being.

WHO CAN REFER A PATIENT
- Primary Care Physician
- Specialist
- Case Manager
- IMPACT staff

HOW TO REFER A PATIENT
Patients may be referred to the IMPACT program via telephone call, fax, or completion of the IMPACT referral form at www.STVphysicianalliance.com/impactreferral/
- Phone: 844-294-6891
- Fax: 205-329-2048
- Email: CareTransitionsPartner@stvhs.com