About Care Transitions:
The Care Transitions program provides outreach to patients after hospitalization to assist with:

- Understanding their discharge instructions
- Arranging follow up with their primary care physician and specialists
- Referrals to other services they may need

Email: cmr@jhmco.org
Phone: (718) 206-8509

Our Mission:
To serve our patients and the community in a way that is second to none

Department of Care Management
8900 Van Wyck Expressway
Jamaica, NY 11418
www.jamaicahospital.org
What is Care Management?
The Care Management Programs at Jamaica Hospital Medical Center (JHMC) are designed to assist people who require frequent medical attention.

Our goal is to improve the health of our community by working closely with our patients and their families as well as their primary care physicians (PCP) and other health care providers. By doing so, we reduce and avoid frequent and unnecessary hospitalizations.

We strive to improve the quality of life of our patients and connect them with the support services they need.

Our Programs
We offer a wide range of services. All are free of charge and include:

- Care Transitions
- EMPOWER
- Co-Managed Care (Behavioral Health and Medical)
- Complex Case Management

About EMPOWER:
The EMPOWER Team serves patients who have frequent hospitalizations and high use of medical services, including the Emergency Room.

EMPOWER provides all the services of the Community Based Care Program plus long-term health management to improve health and prevent frequent hospitalizations through:

- Intensive medical management by a Board-Certified Doctor and a Nurse Practitioner
- Health education
- Supportive counseling

About Co-Managed Care:
Our Co-Managed Care team serves our patients who need assistance with coordinating their mental health and medical needs through:

- Coordination between the patient and their health care team including their PCP and other providers
- Coordination and education on behavioral and medical conditions
- Medication education and support

About Complex Case Management:
Registered nurses telephonically assist patients with intensive disease management, health education and quality and preventative gap in care closure. The RN Case Managers will work directly with the patient, family, their PCP as well as other specialists to meet their needs. Clinical and non-clinical support services will also address all of the patient’s psychosocial needs.

Diagnoses we address:

- Cardiovascular Disease (including Congestive Heart Failure, Heart Attack, Hypertension, etc.)
- COPD (Chronic Obstructive Pulmonary Disease or Emphysema)
- End Stage Renal Disease
- Diabetes
- Asthma
- HIV/AIDS