



MEDSTAR MANAGEMENT

IN COLLABORATION WITH COMMUNITY CARE PLAN



We partner with you at **no additional cost to you or your** patient to optimize medication regimens, reduce avoidable hospitalizations, & eliminate medication access barriers.

WHY WORK WITH US?

- Enhance medication safety & outcomes
- Improve value-based outcomes
- Lessen follow-up burden for your team
- Personalized support for your patients with diabetes
- Strengthen continuity of care post-discharge

EXPERT TEAM

- Highly qualified pharmacy clinicians specialized in ambulatory & transitions of care
- · Compassionate patient care representative

SERVICES OFFERED



CHRONIC DISEASE MANAGEMENT

Recommend medication adjustments, monitor labs/home readings, and support therapeutic goals



TRANSITIONS OF **CARE**

Post-discharge medication reviews within 7 days of discharge and access support to reduce readmissions and ED visits



MEDICATION ADHERENCE

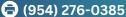
Simplify regimens, address barriers, and ensure access for continued therapy



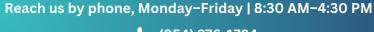
REFER IN 2 EASY WAYS



Complete the referral form attached & send via:











DATIFNT INF					
ATTENT	ORMATION				
-ull Name			Date of Birth	MM/DD/YYYY	Sex: M / F
Address					
Iome Phone		Ema	il		
Cell Phone					
nterpreter S	ervices Needed:	Y / N	Language	Spoken: _	
Reason for R	eferral:				
relevant labs Medication A understandir	ng adjustments to the p and home monitoring va Adherence: Clarify meding, address adherence collso, assist with medicati	alues. cation names, ind hallenges, and col	ications, and sid	de effects to e atients on com	nsure
) Transitions comprehens	of Care: Conduct post-dive medication review a	lischarge outreach	n to prevent rea	dmission by pr	=
care.	ion Review: Evaluating		ns to identify co		Iternative
	or relevant condition(s)	and recommendin	ig changes to th	e physician/pr	
treatments f		and recommendin	ig changes to th	e physician/pr	
treatments f		and recommendin	g changes to th	e physician/pr	
treatments f		and recommendin		e physician/pr	
treatments f eferral Sour Provider Name			Organization Email		escriber.

Authorizing Provider Signature:

Phone: (954) 276-1784 Fax: (954) 276-0385