Covenant Health Partners Welcome Letter

[Date]

Dear [Recipient Name]:

Thank for allowing me to introduce Covenant's Care Coordination Program to you. As I mentioned during our last visit, I would like to phone you at least once a month, or more frequently if you prefer to touch base with you and ensure you have everything you need to better take care of your health needs.

Our Care Coordination Program is designed to ensure the coordination and continuity of health care as patients transfer between their inpatient stay and their home. Our goal is to be an extension of your patient care and coordinate with your primary care physician to educate and navigate you towards effective management of your chronic condition(s). We specifically want to help patients achieve the objectives set by your physician. Listed below are several highlights of the patient navigation program.

- Utilizes motivational interviewing to motivate patients to adapt behaviors more congruent with a healthy lifestyle.
- RN Care Coordinators can provide medication review.
- Patient Navigators provide appropriate education regarding the patient's chronic conditions, as well as referrals to community resources.
- Patient Navigators are able to attend office visits with the patient in attempts at reinforcing the physician's instructions during future visits.

Please let me know if you would like to schedule a home visit.

We look forward to working with you. Please do not hesitate to call if you have any questions.

Thank you,