Red Tree Health makes house calls to provide primary care for your members under our uniquely designed Transition Care Management Program, as well as for those members that are homebound and cannot get to their PCP's.

Transition Care Management-Upon discharge from a hospital or skilled nursing facility, we dispatch a PCP to the member's home for primary care. Our chief goal is to prevent hospital readmissions. We have an extraordinarily low readmission rate because of our robust program. We are able to provide better patient care and outcomes while saving the plan money on frivolous readmissions.

Primary Care at home for Medicare and Medicaid members- if a member has difficulty getting to their PCP, or if they have missed appointments and not been seen in some time, we can send our PCP to the member's home. In addition to primary and preventive medicine, we focus on obtaining HEDIS measures to ensure the member is up to date with all requirements.

For more information, please contact:

David Maymon, CEO
dmaymon@redtreeheatlh.com
954-881-8230

Or visit http://www.redtreehealth.com