PNW Mobile Clinic

Compassionate care.
Clinical excellence.
Right where you are.

ABOUT US

PNW Mobile Clinic delivers patient-centered wound care directly to the patient's home whether in an Adult Family Home (AFH), Assisted Living, Independent Living, or private residence. Our mission is to promote faster healing, reduce complications, and minimize hospitalizations through seamless collaboration with PCPs and Home Health Providers. We prioritize comfort, consistency, and clinical excellence in every visit.

Wound Care Services

Services Provided
· Wound Evaluation & Treatment
· Wound Debridement
· Negative Pressure Wound Therapy (Wound VAC)
· Infection Management

Wound Types Treated

We specialize in chronic, non-healing wounds, including:
· Pressure ulcers
· Diabetic foot ulcers
· Trauma wounds
· Venous stasis ulcers
· Other complex wounds

Visit Frequency

· Weekly visits by Nurse Practitioners or Physicians
· Frequency may increase based on wound severity and healing progress

Collaboration with PCPs

· Direct coordination with Primary Care Providers
· Detailed assessments, treatment plans, and regular updates
· No referral required to initiate services

Collaboration with Home Health Agencies

Our mobile wound care service delivers:
· Timely, consistent, and appropriate home health orders
· Direct coordination with Home Health teams to reduce delays
· Weekly visits that offer flexible, reliable care
· Support that helps alleviate staffing shortages and ensures specialized treatment without disruption

Insurance Accepted

· Medicare & Medicaid
· UnitedHealthcare
· Tricare
· Blue Cross Blue Shield
· Molina Healthcare
· Aetna
· Cigna
· Humana
· Kaiser Permanente
· Regence
· Private Pay also accepted

Referral Process

· Fax referrals to (253) 218-6989
· Initial visits typically scheduled within 24–72 hours

Contact Us
PNW Mobile Clinic, LLC
Laisa.fnp@pnwmobileclinic.com
(253) 459-5014

PNW Mobile Clinic

Your Care. Your Home. Your Health.

Comprehensive Primary Care – Brought to you at PNW Mobile Clinic, we believe quality healthcare should be accessible, personal, and convenient. Our licensed nurse practitioners provide comprehensive primary care services right where you are – whether in your home, group home, or adult family home.

SERVICES

Acute Care

Same-day visits for sudden illnesses
Respiratory infections, flu, COVID symptoms
Minor injuries or infections
Medication management

Preventative Care

Annual wellness exams
Screening labs & health risk assessments
Immunizations & lifestyle counseling
Education to promote long-term health

Why Choose PNW Mobile Clinic

Convenient mobile visits – no waiting rooms
Experienced nurse practitioners
Personalized and holistic care
HIPAA-compliant and Medicare-accepted

Chronic Health Management

Diabetes, hypertension, thyroid disorders
COPD, asthma, heart disease
Medication adjustments & lab monitoring
Ongoing care plans to help you stay well

Our Approach

Patient-Centered Care Your health journey is unique – and so is our approach.

We focus on

Building trusted relationships
Listening to your needs and goals
Coordinating care with your specialists
Delivering compassionate, evidence-based care in a setting where you feel comfortable

Bringing healthcare home — one visit at a time.

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PNW Mobile Clinic

Keeping Your Patients Healthy, Safe, and Out of the Hospital

Weekend Post-Acute Nurse Practitioner Rounding

Our Weekend NP Services Include

- Prevent Rehospitalizations – Early assessment and intervention for post-acute patients
- Address Acute Health Issues – Quick evaluation and management of new or worsening conditions
- Medication Management & Signing Prescriptions – Ensuring timely continuation or adjustment of therapy
- Review Labs & Imaging – Monitor results promptly for early interventions
- Support Facility Nursing Staff – Collaborative care to assist weekend nurses and enhance patient safety
  Available to Nurses 8 AM – 5 PM for C
  onsults – Guidance and clinical support throughout the day

Why Choose PNW Mobile Clinic for Weekend Coverage?

Experienced Nurse Practitioner specializing in post-acute and primary care

Convenient, on-site weekend visits

Focused on preventive and proactive care

Patient-centered approach: early detection, quick interventions, and continuity of care

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PNW Mobile Clinic, LLC
Supporting Facilities, Protecting Patients, Improving Outcomes

PNW Mobile Clinic

Keeping Your Patients Healthy, Safe, and Out of the Hospital

Transition Care Management (TCM) Program for SNF/LTC Discharges

Purpose and Goals

- Support residents discharging from SNF/LTC to home or community setting
- Prevent avoidable readmissions within 30 days of discharge
- Ensure medication reconciliation, follow-up, and care plan understanding
- Review Labs & Imaging – Monitor results promptly for early interventions
- Strengthen communication between facility, caregivers, and primary providers
- Improve CMS quality measures and reduce financial penalties

Common Post-Discharge Challenges

- Support residents discharging from SNF/LTC to home or community setting
- Prevent avoidable readmissions within 30 days of discharge
- Ensure medication reconciliation, follow-up, and care plan understanding
- Strengthen communication between facility, caregivers, and primary providers
- Improve CMS quality measures and reduce financial penalties

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Transition Care Management (TCM) Program for SNF/LTC Discharges (Con't)

NP-Led TCM Program Overview

The Nurse Practitioner leads the transition from SNF/LTC to community care through:

- Review of discharge summary and medication list before discharge
- Initial contact within 2 business days with patient, family, or caregiver
- Face-to-face visit within 7–14 days post-discharge at home, AFH, or clinic
- Communication with PCP and specialists to align ongoing care
- Monitoring for complications or changes that could lead to rehospitalization

Reimbursement and Compliance

- Contact within 2 business days after discharge is mandatory
- Face-to-face visit required within 7 or 14 days depending on risk level
- If the patient is rehospitalized within 30 days, TCM reimbursement is forfeited
- Documentation must show active care coordination and medication reconciliation

Benefits to SNF/LTC Facilities

- Demonstrates continuity of care beyond discharge
- Reduces unplanned readmissions and hospital penalties
- Improves facility reputation with hospitals, ACOs, and managed care plans
- Encourages hospitals to refer more post-acute patients due to strong outcomes
- Supports compliance with value-based and bundled payment programs

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Transition Care Management (TCM) Program for SNF/LTC Discharges (Con't)

How the Program Works

1. Resident identified for discharge from SNF/LTC to home, AFH, or group home
2. NP reviews discharge documents and reconciles medications prior to discharge
3. NP or care team contacts patient/caregiver within 2 business days
4. Face-to-face visit within 7–14 days at home, AFH, or clinic
5. Care coordination with PCP, home health, and pharmacy
6. Monitor for complications – if rehospitalized within 30 days → no TCM billing

Impact Summary for Facilities and Partners

- Fewer readmissions protect quality scores and referrals
- Patients and families experience safer, more confident discharges
- Facilities demonstrate accountability for post-acute outcomes
- Aligns with CMS goals for continuity and population health

"The NP-led TCM program ensures every resident discharged from SNF/LTC transitions safely home – reducing risk, improving outcomes, and sustaining reimbursement integrity.

By leading the transition from facility to home or community settings, the post-acute NP bridges the gap between discharge and recovery, ensuring safe continuity, reducing rehospitalizations, and supporting both patient and facility success.

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