Once enrolled, your Transition Coach will guide you in the following areas:

- Review my discharge instructions with me after being discharged from the hospital
- Help me identify questions I have for my doctor
- Improve my ability to schedule timely follow-up care
- Improve my knowledge of my symptoms related to my conditions and when I should seek medical advice
- Provide me with a booklet where I can write down my medical conditions, medications that I am taking at home, and any questions I have for my doctors or nurses

**What to Expect**

- It is a 30-day program
- One in-hospital meeting
- One in-home visit
- Two follow-up phone calls

**For Caregivers**

Bringing your loved one home from the hospital can be overwhelming. There are so many things to remember and to do. Having a good plan is the first step. Our Transition Coaches will help you with all of this.

**Testimonials**

"Your visit was very helpful to me. I don’t feel powerless."

"The program laid out everything that I needed to do. You explained that it was up to me to handle my own recovery."

Spouse: “It is very helpful to talk freely with someone without being judged.”

PCP comment during office visit: “I wish everyone has this (PHR) and was this prepared. It would save so much time.”

"Coaching has been wonderful, I feel like I know I can do this now."

“I appreciate all that you have done. It has helped me think about what I want to do. You have given me the information on what to do if I am stuck.”

**This is a Medicare benefit. There is no cost to you.**
Discharge Checklist:
Before I leave the hospital the following tasks should be completed:

☐ I have been involved in decisions about what will take place after I leave the hospital.

☐ I understand where I am going once I leave the hospital and what will happen to me once I arrive.

☐ I have the name and phone number of a person I should contact if a problem happens during my transfer.

☐ I understand what my medications are and how to get them and how to take them.

☐ I understand the potential side effects of my medications and whom I should call if I experience them.

☐ I understand what symptoms I need to watch out for and whom to call should I notice them.

☐ I understand how to keep my health problems from getting worse.

☐ My doctor or nurse has answered my most important questions before I leave the hospital.

☐ My family or someone close to me knows that I am coming home and what I will need once I leave the hospital.

☐ If I am going directly home, I have scheduled a follow up appointment with my doctor, and I have transportation to this appointment.

Central MA MetroWest Transitions in Care is a Shared effort of:

Aging Service Access Point Partners:
Bay Path Elder Services
Elder Services of Worcester Area
Greater Springfield Senior Services
HESSCO
Montachusett Home Care
Springwell
Tri-Valley
Western Mass Elder Services

Medical Partners:
Metro-West Homecare & Hospice
Tenet Healthcare System
UMass-Memorial Medical System
Baystate Wing Hospital

Transition Coach:____________________
Home Visit Date:_____________________
Home Visit Time:_____________________