Transitions in Care is coordinated by a group of community-based agencies in the Central MA MetroWest area.

The program provides personal health coaching to help you manage the transition from the hospital emergency department back to home. It's a great way to get connected to health care support and resources in your community.

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

Aging Service Access Point Partners:

Elder Services of Worcester Area

Tri-Valley



## Have questions?

Call **774-312-7920** or
email **eswa-cctp@eswa.org**.

Transitions in Care Coach:

Home Visit Date:

Home Visit 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."

The cost of this program is covered by Blue Cross Blue Shield of Massachusetts.

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MASSACHUSETTS

# Central MA MetroWest Transitions in Care

**A Blue Cross Blue Shield of Massachusetts service provided at no cost to you**

# Transitions in Care Coaching

**Our Transitions in Care Coaches will help you maintain better health at home and avoid returning to the hospital.**

Your Transitions in Care Coach will:

- Review care instructions with you after you're discharged from the hospital emergency department
- Help you identify questions to ask your doctor
- Assist you with scheduling timely follow-up care
- Discuss health warning signs and when to seek immediate care or call 911
- Give you a booklet to write down your conditions, medications, and questions

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

Doctor comment during office visit: "I wish everyone had this Personal Health Record and was this prepared. It would save so much time."

## What to Expect

Transitions in Care is a 30-day program. During this time period, you'll receive:

1 x  in-home visit

3 x  follow-up phone calls

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

## 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 Transitions in Care Coaches will help you with all of this.

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

Information is protected based on Blue Cross Blue Shield of Massachusetts Privacy Standards.

## Hospital Discharge Checklist:

- ☐ I have been involved in decisions about my care after I leave the hospital.
- ☐ I have a contact name and phone number to call if a problem happens during my transfer.
- ☐ I understand what my medications are, how to get them, and how to take them.
- ☐ I understand the possible side effects of my medications and what to do about them.
- ☐ I understand what symptoms are dangerous and what to do if I have them.
- ☐ I understand how to keep my health problems from getting worse.
- ☐ I have scheduled a follow-up appointment with my doctor, and I have transportation to it.

This checklist was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation.