FACT SHEET

Care Transitions

Getting well at home

What is Care Transitions?

When you've been sick, being discharged from the hospital can leave you feeling a bit overwhelmed. You may have new medications, detailed medical instructions, need outpatient therapy, and have appointments with specialists. It's a lot to manage!

Sometimes, with all these difficulties, people quickly end up back in the hospital. That can take a toll on you and your family. But, often, a return visit to the hospital can be prevented. That's where Council on Aging's (COA) Care Transitions can help.

Care Transitions helps you transition from the hospital to another care setting, such as your home. It helps you understand and carry out your hospital discharge instructions. It helps you take better control of your health care.

If your goal is to return home and stay home, you can get started today. Your Care Transitions care manager is:

Name: _____

Number: _____

How does Care Transitions work?

Care Transitions is a free service for eligible adults age 60 and older. It is designed to give you the tools you need to get home, stay healthy and avoid preventable return visits to the hospital.

When you leave the hospital, your COA care manager will schedule a home visit and three follow-up phone calls at times that are convenient for you.

Over the course of four weeks, your care manager will work with you and your caregiver to help you:

- Better understand and manage your medications
- Make follow-up appointments with your primary care physician and specialists
- Respond to warning signs that could mean your condition is worsening
- Create a Personal Health Record that includes information you need to take to medical appointments
- Connect to community resources that help you maintain your health and independence

Care Transitions discharge checklist

Your COA Care Transitions care manager will have you complete this checklist before you leave the facility. This will help target areas where they will work with you to ensure you have the information and tools required to help prevent a return to the hospital.

- ☐ I know what my medications are, how to obtain them and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I have side effects.
- ☐ I understand what symptoms I need to watch out for and whom to call if I notice symptoms.
- ☐ I know how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions.
- ☐ I have been involved in decisions about what will take place after I leave the care facility.
- ☐ I understand where I am going after I leave this facility 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 arises during my transfer.
- ☐ My family or someone close to me knows I am being discharged, where I am going, and what I will need once I leave the facility.
- ☐ If I am going home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

"I had so many bottles of medicine – new ones and old ones – it was a mess. She (care manager) helped me figure it all out and we made a list and all. We got it down pat now."

Bill, Care Transitions Client

Preserving Independence, Enhancing Quality of Life

Council on Aging is designated by the state of Ohio to serve older adults and people with disabilities within a multi-county region. We are experts at helping people with complex medical and long-term care needs, offering a variety of services via publicly funded programs. Our mission: Enhance lives by assisting people to remain independent through a range of quality services.

For more information about Care Transitions:

(513) 721-1025
(800) 252-0155
www.help4seniors.org

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