



PATIENT LEAVING THE HOSPITAL

PERIOD OF COACHING



RETURN TO WELLNESS

The Care Transitions Model focuses on patients at high risk for complications or rehospitalization.

Prior to discharge from the hospital, a specially trained nurse (the coach) visits the patient to begin the process of a successful transition to self management at home.



The Transition Coach

For patients released to a skilled nursing facility, the coach makes a second visit prior to discharge home.

At the home visit, the coach:

- Reviews medication orders
- Educates about warning signs (“red flags”) of a worsening condition
- Reviews the Personal Health Record
- Provides support in communicating with care providers

Three follow-up phone calls are made by the coach: two days later, a week after that, and then two weeks later.



Geriatric Interdisciplinary Teams in Practice **Care Transitions Model**

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