CARE TRANSITIONS INTERVENTION

Mr. Smith was transported to the hospital for the second time in two months and admitted when he had a critical flair up of a chronic condition. He complained, "I don't want to be in the hospital. I want to go home!"

These statements are a common refrain heard by care providers. The question is not "Do you want to go to the hospital?" The question is "How can going back to the hospital be prevented?" Recurring episodes like this are often preventable through the involvement of a new program called "Care Transitions Intervention" (CTI).

Care Transitions is a program developed by Eric Coleman MD to help individuals manage chronic conditions and prevent repeated trips to the hospital.

The Care Transitions program is offered in partnership between the Area Agency on Aging and local hospitals, and has proven that by providing patients with self-management tools after discharge from the hospital they are much less likely to have an episode requiring a trip to the hospital.

This is how the program works. Before leaving the hospital, you and your family or caregiver meet with a personal coach who will help you get started with your transition home. During the hospital visit your coach will:

- Give information about the program
- Discuss seeing your primary doctor
- Introduce you to the Personal Health Record
- Schedule the home visit or will arrange to call your within a day or two of your going home.

Once home, the coach will assist the patient in understanding and managing medications, communicating with doctors, creating a health record and recognizing red flags that indicate worsening of a chronic condition.

After the home visit, the coach will follow-up with three more calls to see how you are doing. You are able to call the coach during this time if you have any questions or need additional help with communicating to your doctor about your condition. Coaching help will end in about one month's time.

The goal of the Care Transitions Coach is to improve your transition from hospital to home and to help you avoid re-hospitalization. The program is voluntary. Older adults and family caregivers are highly encouraged to be involved in the patient's care as well.

Knowing how to manage your health, having a personal health record to take to every appointment, understanding what your medications are prescribed for, knowing how to communicate with your doctor and saving money are benefits of participating in this 30 day Care Transitions program. The skills learned and tools developed become pillars that empower you to manage your own care.

If you would like to know more about the free Care Transitions program offered by Area Agency on Aging call 800-786-5536 or 208-667-3179.

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