

# Frequently asked questions about the Care Transitions Program

## How does the Program Work?

Care transitions usually begins while an individual is still in the hospital or rehab facility. The purpose of the program is to ensure the individual understands their medications and takes them as prescribed, schedules and attends doctor and hospital follow-up appointments and other supports in order to prevent re-hospitalization. The Health Coach will visit with the individual before they are discharged to explain the program and, if they agree to participate, will make a visit within 3 working days once they return home. The Health Coach will then continue support as needed and make regular follow-up calls for 30 days.

## Is there a fee?

There is no charge for the individual.

## Who is Eligible?

Individuals referred by the hospital, insurer or physician who are in the hospital or nursing facility transitioning home or have had a recent stay in the hospital and need assistance with transitioning safely to home in order to prevent rehospitalization.

## How do I begin?

Individuals need to be referred to the CVACL Care Transitions Program by the hospital, insurer or physician.