# OU Care Transition Program

**Clients who may qualify for Transition Coach services:**

- Frequent hospitalizations
- Readmissions due to chronic disease symptom exacerbation
- Community-acquired and hospital-acquired pneumonia
- New onset of falls/syncope
- Emergent general surgery
- COVID-19 positive

**Population exclusions:**

- Dementia and/or unable to self-manage (unless active caregiver is available)
- Active use of drugs and/or alcohol abuse
- Hospice enrolled
- Unable to take medications or attend physician appointments

**For patient referrals for the OU Care Transition Program, please contact:**
**Phone: 405-271-8767 | Fax: 405-271-2626**
**Email: caretransitions@ouhsc.edu**

**OU Nursing Care Transition Coach provides the following services:**

- A hospital visit with the client for program overview, to provide client with copy of Personal Health Record, and to notify client of future contact.
- Scheduled home visit with client to address medication self-management, review symptom awareness and red flags, support patient with scheduling primary care and other specialist appointments, and advising client to complete Patient Health Record.
- Follow-up phone calls to increase client self-management skills, personal goal attainment, and to provide continuity across the transition.

The Transition Coach will assist the client to develop a reliable approach to medication management and will rehearse the client's health-related questions so the client can more efficiently communicate with their healthcare providers. The Transition Coach seeks to empower the client to manage their own healthcare.

**This OU Care Transition Program is offered at no cost to the client.**

The UNIVERSITY of OKLAHOMA
Health Sciences Center
Fran and Earl Ziegler College of Nursing
Care Management