

# THE HOMECOMING PROJECT PARTNERS:



Catholic Charities  
Diocese of Stockton

*Help for Today...Hope for Tomorrow*

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**Sutter Health**  
Sutter Medical Foundation  
We Plus You

# THE HOMECOMING PROJECT

## TRANSITIONAL CARE PROGRAM



Hospital-to-Home transitional  
care services to ensure  
a safe and successful  
transition to home.



## WHAT IS THE HOMECOMING PROJECT?

The Homecoming Project is a hospital-to-home service that bridges the gap between a hospital discharge and a strong recovery. We provide care management and services after a patient returns home to help stabilize and achieve optimal recovery.



## WHO IS ELIGIBLE?

Sutter Tracy Community Hospital patients who are ready for discharge and will be returning home are eligible for the program. The free services are offered regardless of income. Homecoming clients may feel isolated, need additional support systems and resources and have other needs that place them at risk of readmission.



## HOW DOES THE PROGRAM WORK?

The Sutter Tracy Community Hospital Social Worker and The Transitional Care Specialist will visit the patient in the hospital and then the Transitional Care Specialist will visit the patient at home after discharge. The Transitional Care Specialist will help the patient secure arrangements to his/her medical appointments, ensure medication delivery and link the patient with resources related to health and well-being.

## HOW CAN THE HOMECOMING PROJECT BENEFIT YOU?



The program will:

- Coordinate transportation to medical appointments.
- Establish follow-up care with primary care doctor.
- Arrange for housekeeping, personal care or meal planning.
- Assess for medical equipment, grab bars, life alert, etc.
- Coordinate medication delivery.