



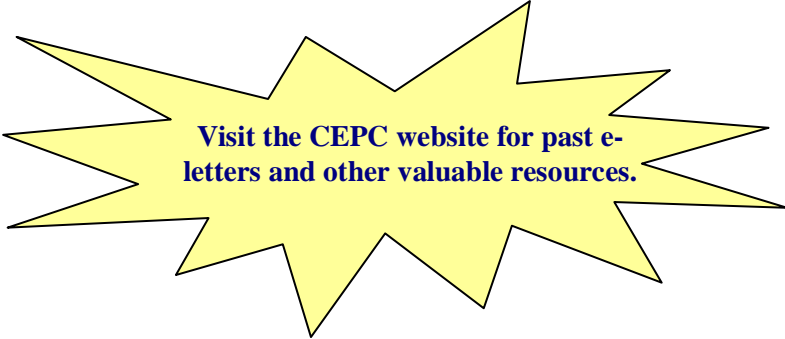
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Primary Care e-Letter

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Interview with Eric Coleman:

Transitions from one care setting to another are frequently stressful and challenging for patients and their families. To address this problem, especially in the setting of a hospital discharge to home, Dr. Eric Coleman developed the Care Transitions Intervention, a patient-centered coaching intervention designed to help patients and their families manage their transition and care coordination successfully. Information about the Care Transitions Intervention is available on the web at www.caretransitions.org.

In October 2007, Leslie Kernisan (LK) interviewed Eric Coleman (EC) about the Care Transitions Intervention, what makes a good coach, and how coaching can help patients receive more coordinated and comprehensive care.

LK: Can you briefly describe the Care Transitions Intervention for our readers?

EC: The Care Transitions Intervention is a self-care model which explicitly recognizes the significant amount of work that patients and caregivers do in managing their transition from the hospital to the next setting of care. They are, in fact, the silent care coordinators. To develop our model, we first conducted qualitative research to better understand the experience that older adults and their caregivers were having post-hospitalization. We wanted to have older adults teach us what they needed during a transition.

Based on that qualitative research, our first step was to identify the skill set needed for the patient to feel comfortable with their transition. We decided to focus on four particular skills: 1) having the patient develop a system for keeping track of and taking their medications; 2) having the patient understand their symptoms and know what to do about them; 3) having the patient take ownership over key elements of their medical history and share these with the different providers they encounter, and 4) enabling the patient to arrange follow-up appropriately.

The next step was to develop an appropriate vehicle to deliver these skills to patients for which we incorporated a Transitions Coach. Our intervention consists of coaching the patient in these skills over the 4 week period post-hospitalization. The intervention consists of one home visit shortly after discharge, and at least 3 phone calls to the patient. The Transition Coach's emphasis is not on directly managing the transition or providing skilled nursing services, but rather on helping the patient and/or the caregiver develop those 4 key skills that can enable a patient to successfully manage their own transition.

LK: How does this intervention compare with other efforts that have been made to improve transitions and care coordination?

EC: We've been very fortunate to be able to build upon the work of colleagues who had already done some very important work on transitions.

We explicitly made our model low-cost and low intensity. We initially tested the model using both registered nurses and advanced practice nurses as coaches. There are many good ways to improve transitions. Our model has really tried to emphasize empowering the patient to manage their care, rather than case-managing the transition. Our goal is for patients to continue to be successful in managing their care, even months after the coach is no longer in touch with them.

LK: What makes a good coach, and how do you recruit and train coaches?

EC: As we have partnered with many of the nation's leading health care systems in disseminating the model, we have moved away from delineating the precise initials that should follow the name of the coach and now are emphasizing "key attributes" of coaches. The most important quality the coach needs to have is the ability to encourage the patient and/or caregiver to do as much as possible independently. This can be harder than it seems, since most of us in healthcare are trained to be "doers" rather than "enablers". The coach also needs to have some experience in helping patients communicate their needs to different health care professionals. Finally, although we don't specify a professional background for the coach, the coach does need some competence in medication review and reconciliation, so as to be able to teach the patient those skills as well. As such, in addition to nurses, some of our partners are using social workers or other retired health care workers.

We currently recommend a 1.5 day training program for coaches. We really try to encourage our partners to not make coaching an add-on to someone's existing responsibilities, as we feel the coach should have time explicitly dedicated to this job.

LK: You see geriatric patients in an outpatient clinic. Have you considered using some variant of your coaching intervention for your clinic patients?

EC: We haven't yet specifically applied a coaching intervention to clinic patients, although we've considered the possibility of using coaching to teach some self-care transition skills in the context of group ambulatory visits.

LK: You also developed a Care Transitions Measure, a 3-item patient survey that reflects how well a hospital has prepared the patient for discharge.

The 3-item Care Transitions Measure:

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.

2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

The CTM has been endorsed by the National Quality Forum. Widespread adoption and reporting of this measure has the potential to significantly improve the way hospitals prepare patients for discharge. These questions could also be adapted to primary care settings.

Have you considered developing a similar short survey that would provide a patient-centered assessment of how well a primary care practice is serving their patients?

EC: That's another good idea that we haven't yet had a chance to work on. It's a timely topic since the NCQA (National Committee for Quality Assurance) is working on developing qualifications for the medical home. There is certainly a need for better measures of ambulatory care and of care coordination, and starting with qualitative assessments of patients' needs can be very valuable.

Care Coordination Presentation by Tom Bodenheimer

Care Coordination Document by Tom Bodenheimer