



In the Incubator: Transition Coaches

With visits from a transition coach before and after leaving the hospital and user-friendly discharge instructions, San Joaquin General Hospital is hoping to improve care transitions from hospital to primary provider.

Seeing the Problem

Although not every admission is preventable, a number of strategies can be implemented to lower preventable readmission rates. Based on anecdotal practice knowledge, 9 of 10 readmissions that take place within one week of discharge—when many readmissions happen—could be prevented with an organized transitional care program. Nationally, avoidable 30-day readmissions cost Medicare \$12 billion annually.

The Patient Perspective

- Patient-perspective interviews found that few patients could produce the discharge instructions they were sent home with; most either threw them away or found them too complicated to follow.
- Patients who are discharged late in the day may get home after the pharmacy has closed. If discharge happened on the weekend, there could be a 2-3 day delay getting medication.
- Some patients did not hear from the hospital and didn't know whom to call with questions.
- Some heart failure patients didn't understand discharge instructions about restricting fluids and didn't realize that some familiar foods contained unhealthy amounts of sodium.

“It takes a village of providers to meet the needs of our chronically ill patients, and this requires alignment. It has been fascinating to see the collaborative process that has started between the clinic setting, family practice, and the hospital as well as the community pharmacist, inpatient clinicians, and others. All these evolutions have come from understanding the need to get out of siloes.”

**-Praba Koomson, RN,
Transitional Care Champion
Consultant, Sutter Health**

Best Uses, Biggest Impacts

Patients who are at the greatest risk and who place the greatest burden on the healthcare system are the ideal target for this program: pre-discharge hospital inpatients with congestive heart failure, chronic obstructive pulmonary disease or Diabetes Mellitus who have had two or more hospital or emergency visits in the past 12 months. Proper management of these chronic conditions can make the difference between a decent quality of life and repeated trips to the hospital for emergency or inpatient treatment.

How It Works

- A nurse practitioner serves as a “transition coach,” helping the patient and their caregivers understand the complexities of the patient’s care plan and reporting to both hospital and primary care provider.
- A pre-discharge visit to the patient by the transition coach establishes a relationship and serves as an opportunity to collect information on the patient’s plans and where they will go after discharge.
- Before discharge coaches provide a user-friendly “stoplight” handout that outlines three “zones” for managing the patient’s condition.
- A phone call after discharge is used to schedule a home visit. Then a transition coach visits within 48 hours for medication and diet review, safety scan, self-monitoring instructions, and a health check.
- Instead of simply providing a medication list at discharge, the transition coach reviews the list with the patient to assure that the patient is able to access and afford the medication they need.
- Patients are encouraged to “source” all of their medication from one pharmacy. This helps providers track medications to make sure patients are requesting them in a timely manner, so they do not run out of medications. The pharmacist is also able to check for potential drug interactions and adverse effects, and follow-up with the patient’s physicians for clarification or changes.

Lessons from Practice

SJGH explored the idea of having paramedics serve as transition coaches for uninsured patients because paramedics are trained to assess the home environment, do a health check, and serve as a two-way translator between patients and health care providers. However, because this role is currently outside paramedics’ scope of practice in California, the possibility has been deferred pending the results of a Community Paramedicine Pilot planned by state agencies in 2014.

What’s Next?

San Joaquin General Hospital will test its “Hospital in the Home” care transition model in its hospital/clinic system over a six-month period in 2014. Over time, the innovation team plans to bring representatives of other parts of the care continuum based outside the hospital and clinic, such as in-home support services and hospice, into the process.

Learn More

Created in partnership with: [San Joaquin General Hospital](#).

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