

“What Physicians Need to Know about Transitions Coaches® and The Coleman Care Transitions Intervention®”

1. The Transitions Coach® is key to encouraging the patient and family caregiver to assume a more active role in their care. The Transitions Coach® does not fix problems and does not provide skilled care. Rather, Transitions Coaches® model and facilitate new behaviors, skill transfer, and communication strategies for patients and families to build confidence that they can successfully respond to common problems that arise during care transitions.
2. Selected patients will have a meeting with a Transitions Coach® in the hospital (where possible—this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers in the Care Transitions Intervention®. After discharge the Transitions Coach® will make a home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment and provide continuity across the transition.
3. Transitions Coaches® work with your patients to develop a reliable approach to medication management and encourage them to co-own their medication list with you. They also have patients rehearse their medication questions to more effectively and efficiently communicate with you.
4. Patients who received the Coleman Care Transitions Intervention® are:
 - Significantly less likely to be readmitted to a hospital.
 - Less likely to incur further high cost utilization
 - More likely to achieve self-identified personal goals around symptom management and functional recovery.

These findings are sustained for at least six months after working with the Transitions Coach®.

5. There is NO cost to you or your patients for Transitions Coaching®.
6. To learn more about The Coleman Care Transitions Intervention® and the role of Transitions Coaches® role visit: www.caretransitions.org