Special Audio Report Transcript

Headline: University of Colorado-Denver's Eric Coleman on the Need for Better Care Transitions

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Text:

Eric Coleman, director of the Care Transitions Program at the University of Colorado-Denver

"The problem with care transitions has been around for quite a while. This is not a new discovery. And in many respects, the problem has been reinforced by the silo mentality of how we have organized and paid for health care delivery. Care is delivered in hospitals, in nursing homes, in doctors' offices. But it's that space in between. People sometimes call it the white space. Family caregivers sometimes call it the "no-care zone." But this is where the serious problems occur. And yet, it belongs to no one. We don't have accountability; we don't have financial incentives; and therefore, it has gone relatively unnoticed and unaddressed."

"…Our program at the University of Colorado recognizes that the point at which an individual person or patient moves from one care setting to the next is a highly vulnerable time from the standpoint of quality and safety. Our care transition program aims to take a multifaceted approach to improving care in this area. We realize that as the centerpiece, we need to help support patients and families in their role. By default, they become their own care coordinators, and yet they do this without any specific preparation, any tools, or the confidence to be effective. In a parallel effort, we think there's an opportunity to help raise the professional competency, both in terms of communication and in cross-setting collaboration…"

"…One of the most significant changes in the health care landscape over the past ten years is the growth of physicians who choose to practice exclusively in a hospital. These are the hospitalists. From the standpoint of care coordination, many of us initially were concerned about this development. These hospitalists work with these patients for just a short period of time, and then they hand them off to other individuals. They don't necessarily have a strong understanding of who these patients are and what's happened in the past with their problems, what some of their social problems are. The growth of these hospital physicians, though, creates an opportunity, and the opportunity here is to engage these physicians who are hospital-based in improving cross-setting collaboration. Project BOOST stands for Better Outcomes for Older Adults through Safe Transitions. It was launched through the Society of Hospital Medicine. They have developed tool kits; they have developed talking points for working with senior leaders; and they've

developed business cases for why hospitals should pay more attention to the transition of these patients as they move to other settings. Project BOOST has been very successful. There is now strong evidence that Project BOOST can reduce hospital readmission rates. And the model is being widely adopted across the country."