Care Transitions Intervention® (CTI) summary

The Care Transitions Intervention® is also known as the CTI®. During a 4-week program, clients with complex care needs and family caregivers receive specific tools and work with a Transitions Coach®, to build self-management skills that will ensure their needs are met during the transition from hospital to home (or in some cases skilled nursing facility to home). This evidence-based intervention is comprised of 5 encounters: a hospital visit (when possible), a home visit (typically happening within 24-72 hours post-discharge) and then three follow-up phone calls after the home visit has occurred.

Critical to the program is the role of the Transitions Coach®

The Transitions Coach® position is unique and most effective when this is the professional's only job. During the 30 days, through a patient-first method, the client (and/or family caregiver) will work with a Transitions Coach® to gain a better understanding of their health and learn key tools to be more active in their self-care management. The Transitions Coach® position is a unique role-shift from being a "do-er" to be a guide or cheerleader to that client. A Transitions Coach® does not fix problems and does not provide skilled care. Rather, they model and facilitate new behaviors, **Skill Transfer®**, and communication strategies for clients to build confidence that they can successfully respond to common problems that arise during care transitions **and beyond the 30-days**.

The Transitions Coach® works with clients/family caregivers to practice skills and gain confidence in the four conceptual areas of the CTI®:

- Medication self-management: Client/family caregiver is knowledgeable about medications and has a medication management system.
- Use of a patient-centered record: Client/family caregiver understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care across providers and settings. The PHR is owned and operated by the client/family caregiver.
- Primary Care and Specialist Follow Up: Client/family caregiver schedules and completes follow-up visit with the primary care physician and/ or specialist physician and is prepared to be an active participant in these interactions.
- Knowledge of Red Flags: Client/family caregiver is knowledgeable about indicators that suggest his or her condition is worsening and has an action plan about how to respond.

Key Findings

Patients who received the CTI® were significantly less likely to be readmitted to the hospital, and the benefits were sustained for five months after the end of the one-month intervention.

Thus, rather than simply managing post-hospital care in a reactive manner, imparting self-management skills pays dividends long after the program ends.

- When organizations are trained in the Care Transitions Intervention® and follow model fidelity, they can expect reductions in readmission rate of 20-50% (reduction depends on current readmission rate).
- Anticipated net cost savings for a typical Transitions Coach® panel of 350 chronically ill adults with an initial hospitalization over 12 months is conservatively estimated at $365,000.
- Patients who received this program were also more likely to achieve self-identified personal goals around symptom management and functional recovery. Further, majority of the patient goals reflect a better quality of life and improved functional status.

CTI Transitions Coach Training Process

Disclaimer: We feel in-person training is the best practice when learning and demonstrating these new skills. During the COVID-19 pandemic, we developed on an online training course to meet our networks need. It's very experiential and hands-on; complete with mailed workbooks and interactive learning activities throughout the courses. We've held four cohorts with great outcomes and approval from longtime partners who observed and took part in the trainings. We plan to offer in-person trainings when it's responsible to travel and gather in groups.

Training the right individual to become a Transitions Coach® is one piece in an overall implementation process. Please connect with us to have an initial exploratory conversation.

- **Readiness**: Prior to CTI Coach training, all organizations must go through a Readiness Assessment to think strategically, create workflow(s), and identify staff and stakeholders in order to execute the model appropriately. This step is designed to help program providers think through crucial elements of the CTI and adhere to model fidelity as a way to ensure successful implementation.
- **Pre-Training Course**: About 3-hours of online module work completed by each trainee in our Learning Management System. The pre-training course is administered within 2-weeks of the live training.
- **Virtual Classroom Training**: 16-hours: offered in a two (2) full day format or four (4) half days. This is where CTI concepts become reality and the trainees apply the information learned in the pre-training modules. Trainees will practice being and interacting with patients as a coach (using case studies) and examine what it means to be a Transitions Coach®.

Cost:

- ~~In-person (when responsible to travel and gather in large groups): $4,000 per person. Group rate discount: an exclusive on-site training for up to 36 people: $72,000~~
- ~~Virtual $3,000 per person Group rate discount: an exclusive virtual training for up to 24 people: $48,000~~

Now through March 31,2020, SPECIAL RATE for the Aging Network: $1,500 per person.

Contact us today to set an exploratory call with you and your team!

Care Transitions Intervention®

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