Care Transitions Intervention®

Video overview: tinyurl.com/ctioverview

20–72% REDUCTION IN HOSPITAL READMISSIONS

When organizations are certified in the Care Transitions Intervention® and follow model fidelity, they can achieve significant reductions in admission rates, ranging from 20-50%, with some organizations reporting as high as 72%. This reduction can also lead to improved HEDIS and CMS Star ratings.

10X – 20X ROI WHEN SYSTEMS & COMMUNITY COLLABORATE

When healthcare and socialcare agencies leverage what they're great at, utilizing the Care Transitions Intervention® as its bridge, everyone wins.

CTI collaborations create better health outcomes yielding a high return on investments (ROI).

NATIONALLY, CLIENTS DEVELOP FOUR NEW SKILLS FROM THE FOUR PILLARS®

Using the Skill Transfer Model® significantly increases patient activation **leading to lasting benefits.** In a six-month study, patients with a 30-day Transitions Coach® had a significantly lower readmission rate (2.4%) compared to the control group (23.8%)

PROGRAM IMPACT

Patient-Driven Medication Review

Clients are 2.5 times more likely to be readmitted within their first 30-days from just one medication discrepancy. Coaches conduct patient-centered medication reviews to identify and resolve potential discrepancies, improving both patient outcomes and overall system efficiency.

Sustained Outcomes

Stop managing post-hospital member care in a reactive manner. Start coaching self-management skills that will yield lasting benefits, even after the program concludes.

Consumer Benefits

A valuable **complement** to the care team, rather than a replacement, the Coach works to improve overall support provided to clients. Clients develop skills that not only aid in their current transition but also prepare them for future healthcare encounters and empower them to effectively manage their own health.

Learn more at
caretransitions.health

The Care Transitions Intervention® featuring the dedicated position of a certified Transitions Coach® is unique, whole-person, patient-first care and it works!

During the 30-day program a client (and/or family care partner) will work with a certified Transitions Coach® to gain a better understanding of their health. They learn key tools to be more active in their health. This evidence-based intervention is comprised of 5 encounters: a facility visit, a home visit (happening within 72 hours of discharge) and three follow-up phone calls.

Critical to a safe, stable, and supportive transition is the role of the Transitions Coach. The certified Transitions Coach position requires a role shift from the traditional care management model to instead a focus on skill development, working **alongside** the client.

The Transitions Coach is about immediate **and** long-term empowerment. The program addresses the whole person and creates a space to meet clients where they are and build from there. Transitions Coaches elicit client's critical thinking and help to model solutions. This enhances the client's ability to better utilize their resource network within the health system and community. Transitions Coaches demonstrate and facilitate new behaviors, work on **Skill Transfer** and communication strategies to increase client's confidence that they can successfully respond to common problems that arise during a transition in care. These learning help with clients health self-management **beyond the 30-days**.

Transitions Coaches practice with clients to gain skills, confidence, and understanding in the four key areas of the CTI®

- Medication self-management: knowledgeable about medications and use of a functioning medication management system.
- Use of a patient-centered record: understands and utilizes the Personal Health Record (PHR) to ensures continuity of care across providers and settings.
- Primary Care and Specialist Follow Up: schedules and completes follow-up visit within the first week of discharge and is prepared to be an active participant in these interactions.
- Knowledge of Red Flags: knowledgeable about signs suggesting their condition is worsening and has a response plan.

The Care Transitions Intervention® is a new entry way into the effective **No-Wrong-Door initiative** – working alongside individuals who are in need of guidance, strengthening access to their *health neighborhood* (resources and services) through person-centered empowerment.

Be a leader in proven transitions of care.
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