



## OHIO NURSING HOME QUALITY IMPROVEMENT PROJECT

### The Care Transitions Intervention (CTI®)

#### Description

Adoption of the CTI® and training of a Transitions Coach® by the [Care Transitions Program®](#) faculty can help decrease avoidable hospital readmissions for your rehabilitation patients as they transition home.

The CTI® was co-designed with patients and families and was evaluated using the most rigorous scientific approach – randomized controlled trials.

This evidence-based intervention is comprised of a home visit and three phone calls. In the four weeks following discharge from your facility, patients and family caregivers work with a Transitions Coach®. 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 though she or he possesses these skills from prior health professional training.

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. The patient's goal drives the agenda. Thus the role of the Transitions Coach® is to promote more effective care transitions through improved self-management skills, and enhanced patient-provider communication.

The registration cost of training a Transitions Coach is \$3,000 per person plus travel costs to Denver for a one-day training. The registration cost includes:

- Customized readiness evaluation with attention to workflow and partner engagements through the completion of the Readiness Assessment Tool (prior to the face-to-face training experience).
- Access to our Web based training platform to review the content and the process of the intervention and take a pre-training quiz to ensure adequate understanding of the key content (prior to the face-to-face training experience). Participants have access to this ongoing educational tool for one year from the date of training. Access can be renewed annually for a modest fee.

- Participation in the highly interactive simulation-based face-to-face CTI® training experience. Attendees have the opportunity to learn how to incorporate CTI® tools into the role of Transitions Coach® so that they become second nature. Participants also have access to our expert training team to get individual questions answered.
- Invitation to our monthly CTI® Community Learning calls. During the peer-to-peer learning calls colleagues bring challenging cases, new techniques and best practices, and provide positive reinforcement for the Transitions Coach® role. These calls are also an opportunity to learn about upcoming changes in health policy to help organizations be prepared. Joining these calls is a great way to stay connected with colleagues and the Care Transitions Program® team.

### How to Join

Contact Sue Rosenbek at 608-831-2365 or [susan.rosenbek@ucdenver.edu](mailto:susan.rosenbek@ucdenver.edu) to discuss project participation.

### Brief Description of Required Activities

- Contact Sue Rosenbek for the adoption planning documents
- Appoint a clinical or management lead for the project
- In collaboration with the Care Transitions Program faculty complete the readiness tool
- Send staff chosen to be the Transitions Coach to Denver for training

### Participation dates

March 2016 – June 2017

### Evidence of Participation in the Project

*Expected evidence of participation in the project should be kept by the nursing home for use in state survey to demonstrate compliance with Sec. 3721.072 (B) which states that “Beginning July 1, 2013, each nursing home shall participate every two years in at least one of the quality improvement projects included on the list made available by the department of aging under the nursing home quality initiative established under section 173.60 of the Revised Code.”*

Completed [Readiness Assessment Tool](#)

Roster of project lead and transitions coach(es)

[Participation Agreement](#) signed by facility and Care Transitions Program® faculty

**Tools Available to Participants:** <http://caretransitions.org/tools-and-resources/>

**Contact:**

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