National Caregiver Support Collaborative
Building our capacity to support family, kinship, and tribal caregivers

Caregiver Promising Practice Spotlight
Care Transitions Intervention®

About This Series: The National Caregiver Support Collaborative's (NCSC) Caregiver Promising Practice Spotlights highlight a series of innovative, evidence-informed, and evidence-based practices to effectively support older adult family, kin, and tribal caregivers. The Spotlights provide an overview of the promising practice and suggested actionable steps for organizations to implement the practice.

Featured Promising Practice: Implement a care transitions initiative to foster shared decision-making and equip caregivers and care recipients with skills and confidence to manage care following hospital discharge.

Promising Practice Overview

Effective care transitions between health care settings—such as from a medical facility to home—are critical for improving health outcomes and ensuring continuity of care for older adults and their caregivers. Recognizing the importance of care transitions, the Administration for Community Living (ACL) has supported community-based organizations in developing strategies to improve care transitions, such as the Aging and Disability Resource Center (ADRC) Evidence-Based Care Transitions Program. Many organizations have also adopted or applied elements from established models, including the Care Transitions Intervention (CTI®)[1] model, currently managed by Care Coordination Systems (CCS Health), to support care transition processes. The CTI® model featured in this Spotlight aligns with efforts to enhance care transitions and incorporates implementation strategies that are broadly adaptable across communities and health care contexts.

CTI®, a short-term evidence-based empowerment model, is designed to equip the care dyad (i.e., the caregiver and the care recipient) with skills and support to navigate the care transition from a medical facility to home. This 30-day person-centered program uses a team-based approach and engages the care dyad in skill-building and goal setting with support from a Transitions Coach and the care team.

Participants first meet with a trained Transitions Coach—a professional who may be a registered nurse, social worker, community health worker, or case manager—while in the facility, when possible. The Transitions Coach supports the care dyad in establishing individual and shared goals aligned with CTI®'s four key areas of health, known as the Four Pillars®:

1. Medication self-management
2. Maintaining a personal health record
3. Prepared and timely follow-up with primary or specialty care
4. Recognizing red flags signaling worsening condition

This goal setting approach fosters meaningful conversations, encourages shared decision-making, and helps coaches avoid assumptions about needs

> *"The CTI® philosophy is to empower people to thrive beyond the program—equipped with new skills and stronger connections to their care team and community."*
>
> ***— Michelle Comeau, CTI® National Program Director***

[1] Disclaimer: ACL does not endorse a specific care transition model. CTI® is highlighted in this Promising Practice Spotlight as one evidence-based example among several approaches that community-based organizations have successfully implemented.

Last Updated: 12/2025

The National Caregiver Support Collaborative is funded by the Administration for Community Living, an operating division of the U.S. Department of Health and Human Services.

or priorities. Support continues through a home visit within three days of discharge (or via phone, depending on location) and three weekly follow-up calls to reinforce skills and address emerging needs. Through these touchpoints, the program builds lasting self-management skills and strengthens participants' connection to community-based resources to extend the intervention's impact beyond the initial 30-day engagement. CTI® helps caregivers and care recipients sustain improvements and remain engaged with local supports that promote activation for long-term well-being.

> *"The CTI® role is perfect for me. It makes me happy to ignite a voice in a new client to have them speak their wants and hopes for themselves. Facilitating, empowering, and showing someone that they have the strength to prevail is what makes me happy every day."*
>
> ***— Joleane Martel Schwartz, Transitions Coach, Caring People***

Since its launch, the CTI® National Office has trained over 1,400 organizations worldwide, with successful program adoption in multiple contexts, including the Kaua'i Care Transition Intervention in Hawai'i, the Eastern Virginia Care Transitions Partnership in Virginia, and the Suffolk County Community-based Care Transitions Program in New York. The aging network, including organizations such as area agencies on aging (AAA), ADRCs, and community-based organizations, represents approximately 40 percent of CTI® Program Providers. Hospitals, senior centers, health plans, and educational institutions also serve as CTI® Program Providers.

Eligibility and Processes

To become a CTI® Program Provider, agencies begin with an exploratory call with the CTI® National Office and complete a readiness assessment to ensure alignment with CTI®'s implementation standards. Once enrolled, Program Providers participate in ongoing professional development opportunities offered by the national office through a dynamic online social forum, live monthly CTI® Community Learning calls, and other advanced learning opportunities.

While no clinical license is required, Transitions Coaches must complete a four-hour self-paced pre-training course followed by 18 hours of live virtual training. The role is most effective as a full-time, dedicated position by a person who is curious about the care recipients' abilities and experiences rather than focused only on task compliance. Caseloads typically average 25-30 clients per month, which allows Transitions Coaches to provide consistent, tailored support, and maintain the level of engagement necessary for successful transitions.

All care recipients are eligible to participate in the program unless they are experiencing an acute health crisis or other circumstances that would prevent them from effectively engaging in the CTI® program, which relies on participation from both members of the care dyad. Adaptations to enhance the program's support for individuals with dementia, intellectual and developmental disabilities (I/DD), and Alzheimer's disease are underway through initiatives such as Emergency Departments Leading the Transformation of Alzheimer's and Dementia Care (ED-LEAD), a nationwide trial focused on improving emergency and post-emergency care approaches to better support caregivers and care recipients.

Why It Works

- Equips caregivers and care recipients with practical skills to build confidence in managing medications, recognizing warning signs, and delivering care through hands-on practice
- Integrates caregivers as active members of the care team in a person-centered, team-based approach that supports shared decision-making
- Helps identify non-clinical support needs during coaching interactions, empowering caregivers and care recipients to advocate for themselves and reduce stigma around seeking help, including respite care

ACL Administration for Community Living

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- Ensures continuity during care transitions through in-person visits and follow-up calls to identify and address needs early
- Improves health outcomes and reduces avoidable hospital visits by promoting self-management and utilization of community resources as needed after care transitions

Implementation Tips

Organizations within aging, tribal, and kinship networks can use the following strategies, as applicable to their priorities and resources, to establish or strengthen caregiver support services.

- Conduct a readiness assessment to identify current partnerships, resource gaps, and available local supports (e.g., transportation, meals, respite) for integration during transitions and beyond the short-term program
- Establish a dedicated position responsible for supporting seamless care transitions (e.g., Transitions Coach) rather than adding new tasks to an existing role
- Collaborate with hospitals, clinics, and tribal health services to embed components of established care transition models into discharge and follow-up plans
- Partner with clinical providers to introduce care transition programs to patients with high-risk diagnoses (e.g., congestive heart failure, diabetes, kidney failure, high blood pressure, chronic obstructive pulmonary disease, sepsis) who may especially benefit from program participation
- Encourage participation in care transition model activities (e.g., CTI® Community Learning calls and online forums) to foster peer support, share implementation strategies, and support continuous improvement in program delivery
- Develop a business case highlighting the high return on investment:
    - *Value to potential payers:* Demonstrate value to potential payers by quantifying savings achieved through prevention and reduced hospital readmissions (e.g., each avoided hospital readmission can save $16,000 or more, while CTI® contracts average $700 per person served)
    - *Investment for implementing sites:* Outline the investment for implementing sites by emphasizing that CTI® Training and licensing fees create opportunities for new partnerships, sustainable revenue opportunities, and integration into the No Wrong Door system, bridging clinical care and social care services provided through ADRCs

Learn More

Recommended Resources:

- CCS Health Care Transitions Intervention Publications
- ACL Evidence-Based Care Transitions Program
- ACL Care Transitions Resources

Contact:

For more information on supporting older adult family, kin, and tribal caregivers, please contact the NCSC by e-mail (caregivercollaborative@acl.hhs.gov).

Access other Promising Practice Spotlights in this series on the NCSC website.