



Care Transitions Education Project

Nurses Leading Patient-Centered Care Transitions

Overview

Delivering quality healthcare outcomes and patient satisfaction in the context of payment reform is a top priority for healthcare leaders. Care coordination across the continuum is critical to achieving those goals, and nurses are central in every patient's transition from one care setting to another. When effective care transitions occur each and every day, the chance of unnecessary re-hospitalizations decreases and quality improves.

The Care Transitions Education Project (CTEP) provides an interactive educational experience that better equips nurses with the foundational knowledge, skills and attitudes needed to lead and improve patient-centered care transitions. CTEP educates nurses from all care settings and roles together, and increases their abilities to collaborate to achieve common patient-centered goals, including reducing avoidable hospital readmissions.

Project Objectives

Nurses, nursing students and cross continuum team members who participate in CTEP gain competencies needed to successfully implement any care transitions intervention. The program is designed to achieve the following objectives:

1. **Increase competency** of practicing nurses and nursing students to lead and improve care transitions
2. **Increase mutual respect** among practicing nurses across care settings
3. **Improve cross continuum coordination and collaboration** among care team members
4. **Demonstrate nurse-led quality improvement** in care transition practice and work processes

Development Process

The Massachusetts Senior Care Foundation and the Western Massachusetts Nursing Collaborative developed the curriculum based on an extensive gap analysis and competency assessment. In 2013, 28 service and academic organizations in Western Massachusetts piloted the curriculum with 350 nurses & nursing students.

Partners

The Care Transitions Education Project was developed through a grant from *Partners Investing in Nursing's Future*, a collaborative of the Robert Wood Johnson Foundation and the Northwest Health Foundation.

Co-Funders

- Massachusetts Senior Care Foundation
- Davis Foundation
- Healthcare Workforce Partnership of Western MA
- Regional Employment Board of Hampden County
- Home Care Alliance of MA
- United Way of Pioneer Valley
- Commonwealth Corporation

Employers

- Baystate Health
- Berkshire Health Systems
- Calvin Coolidge Nursing Home
- Commonwealth Care Alliance
- Cooley Dickinson Hospital
- Elaine at Hadley Nursing Home
- Genesis/Heritage Hall
- Holyoke Health Center
- Holyoke Medical Center
- Holyoke VNA
- Jewish Geriatric Services
- Noble Hospital
- Noble VNA
- Sisters of Providence Health System
- Westfield Nursing & Rehab
- Wingate Healthcare
- VNA and Hospice of Cooley Dickinson

Education

- American International College
- Elms College
- Holyoke Community College
- Greenfield Community College
- Springfield Technical Community College
- Westfield State University
- UMass Amherst

Workforce Development

- Regional Employment Board of Hampden County
- Central Massachusetts Area Health Education Center

Curriculum Toolkit

The competency-based curriculum includes three components:

1. Four Interactive Learning Modules
2. A Patient Tracer Experiential Learning Activity
3. Care Transitions Quality Improvement Activity

The curriculum toolkit includes:

- An implementation guide with recommendations for how to customize and implement the approximately 24 hour in-person training with nurses and cross continuum teams, including planning tools and detailed training plans.
- Four interactive curriculum modules focused on the foundational knowledge, skills and attitudes nurses need to lead effective patient-centered care transitions. Each module includes detailed trainer notes, a PowerPoint overview of the module content, interactive and independent learning activities, worksheets and handouts, and optional related resources and readings
- Recommendations for engaging nurse learners in a patient tracer experience
- Evaluation tools for measuring knowledge acquisition

Recommendations for Implementation

To successfully implement CTEP training, it is recommended that organizations have the following in place:

- Identified cross-continuum partners
- Senior level champions in each care setting
- Experienced educator or staff developers to deliver training
- Commitment to bringing nurses from different settings together to learn from one another
- Ability for nurses to visit other care settings

For More Information

If you would like more information about the project or are interested in implementing CTEP training please contact:

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What People Are Saying ...

"The CTEP training curriculum connects to everything needed for our nurses in today's changing work environment. We see increased tolerance, increased respect and now see better communication in terms of hand offs with our partners."

Hospital Administrator

"During the CTEP training we very quickly saw nurses from different settings talking to each other, listening to each other and learning about each other's settings."

VNA Nurse

"Our patients reap the benefits of nurses who learned together, now providing care together as the patient transitions from one health care setting to another."

STAAR Program Director

"One of the most exciting things was how quickly nurses from home care, skilled nursing and the hospital started working together on a QI project related to care transitions."

Nurse Educator

"The patient tracer is a good way to find out what patients can expect when they go to different places and to see what patients are going through. Now I can educate them better and make it easier for them to transition."

Hospital Nurse