Print Form

Readiness Assessment Tool

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http://www.caretransitions.org/

Desired Training Date:

Organization:

Address:

City, State, Zip

Person filling out this form:

Name:

Position:

Phone:

Email:

OVERVIEW

This tool is designed to help you think through the elements of the Care Transitions Intervention. It is a critical step toward successful implementation, and will help the Care Transitions Team better support you through this process. Be as specific as possible in your responses to allow for reproduction of your program in other settings.

Please submit the completed Readiness Assessment Tool one month prior to your desired training date to:
susan.rosenbek@ucdenver.edu

GOALS: What do you hope to accomplish by adopting the Care Transitions Intervention?

1. Have goals been established internally? (If 'no', define goal(s) before proceeding)

2. What are the goals for the intervention?

3. How will you define success? (List specific outcomes that you hope to see as a result of this intervention)

4. What tools do you have in mind to measure your outcomes?

- ☐ Reduction in readmission rates
- ☐ Patient Activation Assessment (PAA)
- ☐ Patient Satisfaction Survey **Please attach copy**
- ☐ Other **Please attach copy**

5. Once the targeted outcomes have been defined, how will data be collected and reported?

COMMITMENT

Note that the minimum resources required for this intervention include the salary and benefits for the Transition Coaches, cell phones, laptops, and mileage. There are also nominal printing costs associated with producing the Personal Health Record. **We cannot emphasize strongly enough that Transition Coaches must have time dedicated during their daily schedules for coaching.** Coaching, which includes imparting and practicing new skills and tools, takes time. Simply adding coaching responsibilities onto a health care professional's current workload without removing significant responsibilities is discouraged.

6. Who are the key internal and external stakeholders? (List by name, organization and title)

7. Who are the 'champions' at each partner facility? (List by name, organization and title)

8. Have key leaders been consulted? (if 'no', establish top-level commitment before proceeding)

9. Have key leaders in your organization allocated resources to the implementation of this project? If not, what would be required?

10. Briefly (in 100 words or less), please explain why you are committed to implementing the Care Transitions Program at your organization/facility (think of this as your "elevator speech" that you can use to garner support and interest):

ROLE CHANGE

Care professionals are trained to be "doers". Making a role change from a "doers" to a Coach can represent a major cultural shift. This usually involves unlearning some previous behaviors. The Care Transitions Intervention also represents another cultural shift - one from *setting-centered* care to *patient-centered* care.

11. How will the Transition Coaches be supported in their new role? (For example, will they be allotted structured time to role-play with colleagues or dedicate to other development activities?)

12. If this is not a new FTE, who will be assigned the prior work of the new coach?

13. Does your organization plan to implement the Care Transitions Intervention as it was developed or do you anticipate needing to alter the model? If so, how?

14. If you plan to alter the model, how do you anticipate your outcomes may differ?

15. What is the population being targeted for the program?

16. Are there any exclusion criteria? (Individuals who may not benefit from coaching include: dementia with no family caregiver and those with active substance abuse issues)

17. What barriers or challenges does your organization anticipate when adopting the CTI? How will your stakeholder group address these issues?

18. Do you currently employ individuals who could fulfill the role of coach or would you need to hire new health care professionals for this role? If the latter, who do you envision hiring to fill the coach role? Be sure to match coach resources to volume of targeted population (for tips on hiring Coaches, please see "What is a Transitions Coach?" on our website: http://caretransitions.org/what-is-a-transitions-coach/)

19. What is your documentation plan? Please review "Tools and Resources" on our website (http://caretransitions.org/tools-and-resources/) before answering

a) For coaching activities:

b) Do you plan to use the Medication Discrepancy Tool?

c) Do you plan to use the Care Transitions Measure?

d) Do you plan to use the Patient Activation Assessment?

20. Have the workflows needed to implement the model been determined?

a) How will patients be identified? Who screens admissions at the hospital?

b) How will referrals be made to the Coach? How will the Coach be notified of the patients' admission and discharge?

c) What is the process for documentation?

d) How will coaches be assigned?

e) What will be the size of each coach's patient panel?

PLANS FOR ONGOING SUPPORT OF YOUR CARE TRANSITIONS PROGRAM

21. How will Transition Coaches continue to be supported in their new role?

22. What is the process for adjusting workflows that may not be effective?

23. What is the contingency plan when there is staff turnover in the coach role?

24. What data over which time frame will be used to determine the success of the program?

25. What are the criteria for expansion of the program?

26. Questions for the Care Transitions team?