

Care Transitions Program[®] Participation Agreement

I. Purpose

The purpose of this agreement is to delineate the terms and conditions of the adoption of The Care Transitions Intervention[®] by your organization (name of organization: _____).

II. Brief Description

The Care Transitions Intervention[®] is a self-management program designed to encourage patients and families to assert a more active role in their health care during care transitions. A comprehensive description of the intervention can be found at www.caretransitions.org.

III. Benefits

The Care Transitions Intervention[®] promotes patient-centered care by helping patients learn self-management skills to support their self-identified goals. The Care Transitions Intervention[®] promotes greater value in health care expenditures through reduction in rates of rehospitalization, with accompanying reduction in health care costs.

IV. Minimum Qualifications for Participation

a. **Written approval of the program by organizational leadership.**

This includes financial commitment and support for the organizational changes necessary to implement and sustain the program. This includes the hiring and/or reassignment of staff to effectively function in the Transitions Coach[®] role.

b. **Readiness Assessment**

Satisfactory completion of the Readiness Assessment Tool and review with The Care Transitions Intervention[®] training team.

c. **Designation of Transitions Coaches[®]**

Prior to training, coaches will be selected, informed of their selection and introduced to the program.

d. **Organizational Preparation**

For training to be effective, it is critical that staff who will be involved with the program understand the new role and how this role fits in the organizational structure. For existing staff who are invited to assume the role of Transitions Coach[®], it will be important to articulate what responsibilities will be removed in order for them to assume the new role **prior** to training. We anticipate that discussions of organizational change and readiness will have been addressed at least one month prior to the training and communicated to those members of the organization who will participate in the training.

e. **Defining the Transitions Coach[®] Role**

It is preferable for coaches to have only one role, as a Transitions Coach[®]. In the event that dual roles are necessary (e.g. care manager and Transitions Coach[®]), the care model must explicitly focus on skill transfer and differentiate between the coaching and care management functions of the position.

f. **Attribution**

The partner organization should clearly acknowledge The Care Transitions Intervention[®] in all materials and publications.

g. **Shared Training Experience**

The Care Transitions Intervention[®] training often includes participation from more than one organization. The training focuses on the implementation of the model, as well as specific skill building related to Transitions Coaching.

V. Implementation Plan

a. Prior to Training

Your organization is asked to select its Transitions Coaches[®] and inform these individuals of their new status. These Coaches are expected to review all relevant background materials prior to the training. These include, but are not limited to: The CTI[®] Web-based Introduction to Coach Training Unit, Sections 1-5; the pre-test, Care Transitions Article, and the website <http://caretransitionsinterventiontraining.org/>.

b. Staff Training

Designated Transitions Coaches[®] are expected to attend and participate in the entire Care Transitions Intervention[®] Training. In-person participation at the entire training is essential for accurate understanding and implementation of the model. Participation will include small group work, simulation and other interactive activities designed for optimal knowledge transmission and retention. All attendees are required to participate in these activities.

Neither Transitions Coaches[®] nor their organizations are permitted to train others. The Care Transitions Program[®] has the EXCLUSIVE authority to provide training on the Care Transitions Intervention[®]. All training must be arranged through and taught by The Care Transitions Program[®] training team.

c. Core Competencies

The training will provide the Transitions Coach[®] with new skills to work with patients experiencing a care transition with an emphasis on skill transfer, goal pursuit and achievement.

d. Best Practice

The Care Transitions Program[®] will work with you to customize your organization's implementation of the CTI[®]. Emphasis will be placed on the primary role of the Transitions Coach[®] to facilitate skill transfer around particular areas the patient identifies. The patient's goal establishes the agenda that is focused on improving confidence and preparation to support self-care. The home visit is essential for true engagement and skill transfer to achieve the best results. Follow up phone calls support the patients' movement towards their goal and provide opportunities for skill transfer and patient activation that were not addressed in the home visit. Your organization recognizes that substantial deviation from the model is unlikely to result in a reduction of re-hospitalization rates or successful achievement of patient-centered goals.

VI. Obligations of Your Organization

- a. Complete the Readiness Assessment Tool and discuss it with the Care Transitions Program[®].
- b. Attend and complete Care Transitions Intervention[®] training, which will take place on the following date: _____.
- c. Implementation of the Care Transitions Intervention[®] should occur within 1-2 months of the training.
- d. All Transitions Coaches[®] must attend the training. Training is to be provided only by the Care Transitions Intervention[®] training team.
- e. Satisfactory completion of the training as defined by the Care Transitions Intervention[®] training team. Trainees will receive a certificate of completion.
- f. Registration form, pre-work, pretest, and payment for training received prior to training day.

VII. Obligations of the Care Transitions Program[®]

- a. Assist in implementation of the Care Transitions Intervention[®] via:
 - i. Collaboration during implementation planning and review of your organization's completed Readiness Assessment Tool.
 - ii. Provision of training to designated Transitions Coaches[®].

- b. Provide a packet that includes requisite materials for successful completion of the training. This includes: templates of the Personal Health Record and training materials, and tools for Coaches and patients/family caregivers.

VIII. Authorization

The participating parties hereby acknowledge by signature that they have read, understand, and agree to all the terms and conditions of this participation agreement.

Institutional Representative
(Ideally the supervisor of the Transitions Coaches®)

Date

Eric A Coleman, MD, MPH
Director, Care Transitions Program®

Date