## New Hampshire ADRC Option D Evidence Based Care Transitions Belknap County SLRC Final Evaluation

September 30, 2013

ACL Grant Award Number: 90CT016002
Grant Period: September 2010 – April 2013
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### I. Introduction

In September 2010, the University of New Hampshire (UNH) received the Aging and Disability Resource Center (ADRC) Option D Care Transitions Evidence Based award by the US Administration for Community Living (ACL). Building upon ongoing collaborative work between the NH Institute for Health Policy and Practice (NHIHPP), NH Bureau of Elderly and Adult Services (BEAS) and the ServiceLink Resource Centers (SLRC), the Belknap County SLRC site was selected to pilot a care transitions model under this funding opportunity. Lakes Region General Hospital (LRGH), a 137-bed acute care facility located in Laconia, NH, and the Belknap County SLRC agreed to partner for this pilot project.

The care transitions pilot implemented in Belknap County was based on the Better Outcomes for Older Adults through Safe Transitions (BOOST) care transitions model. The BOOST model is designed to improve the care of patients as they transition from hospital to home. The Society of Medicine developed the comprehensive program in order to reduce acute hospital readmissions. The general objectives of the hospital-based program are to reduce 30 day readmission rates for general medicine patients (with particular focus on older adults); improve patient satisfaction scores; improve the hospital's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores related to discharge; improve flow of information between hospital and outpatient physicians; ensure high-risk patients are identified and specific interventions are offered to mitigate their risk; and improve patient and family education practices to encourage use of the teach-back process around risk specific issues <sup>1</sup>. This is accomplished by utilizing the BOOST Program tool kit, which includes a risk assessment for identifying patients, educating them, followed by performing a "Risk Specific Intervention" and discharge follow-up, if needed. The intervention includes telephone contact within 72 hours of discharge

http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTE NTID=27659 accessed 9.27.2013

<sup>&</sup>lt;sup>1</sup>Society of Hospital Medicine website:

by a pharmacist.

LRGH started the BOOST program in 2009, primarily focusing on the Senior Services unit. Over the course of the care transitions pilot with the Belknap County SLRC from October 2010 to June 2013, LRGH expanded the BOOST program hospital-wide. In addition, they worked with the Belknap County SLRC and an expanded BOOST Advisory Team, which introduced a range of community-based providers to the project (Appendix A includes the full list) to enhance the BOOST model. LRGH was one of the original pilot sites to offer the BOOST model and had developed and refined the follow-up processes. Therefore, building on the BOOST model foundation to incorporate the social service needs was a natural next step. This work was enhanced through the establishment of a care transition specialist (CTS) at the Belknap County SLRC, who worked directly with LRGH to enhance how the BOOST model extended to the community.

With the addition of the ServiceLink CTS position, the BOOST Advisory Team revised the referral flow sheet to include the CTS and other providers beyond the traditional pharmacist role in the risk assessment, referral, and follow-up process. The enhanced BOOST model includes follow-up by Diabetic Education, Cardiac/Pulmonary Rehabilitation, Palliative Care, and the SLRC CTS. The new flow chart is in Appendix B.

In order to implement the enhanced BOOST model and utilize the CTS, LRGH and Belknap

County SLRC entered into a Business Agreement. The agreement allowed the CTS to be onsite at the hospital, have access to patients and patient care planning, and electronic medical records. The Business Agreement between LRGH and Belknap County SLRC can be found in Appendix C.

The position of the CTS was initially filled by a new hire to the Belknap County SLRC, who was unfamiliar with the ADRC model and community services and supports. Unfortunately, the new hire had difficulty retaining all information necessary to be an informative resource on community services and supports. In response, the Belknap County SLRC then shifted to utilizing the SLRC Long Term Support

Counselor, a traditional position with the New Hampshire ADRC model, to fill the CTS role. The Long

Term Support Counselor role in the New Hampshire ADRC model provides options counseling across all

payer sources for adults with disabilities and older adults. The new CTS was oriented to the hospital and
the BOOST model, and with their previous knowledge base, no further training was needed to
implement the pilot.

A key component of the enhanced BOOST model was the follow-up from the SLRC CTS went beyond the one phone call in the traditional model. Follow up included a hospital visit, phone contact once discharged, a community visit, and continued follow-up for linkages to community long term supports and services.

Enhancing the BOOST model through this pilot continued to focus on reducing hospital readmissions; however, New Hampshire was also interested in understanding the importance of the onsite presence of the SLRC staff. Specifically, there was interest in understanding the impact of the new model on informal referrals, increased awareness of SLRCs, increased referrals to other SLRC core services, improvement in communications across medical and social service partners, and improvement in the quality of discharges made from both the hospital and community based side. The evaluation of the pilot examined all of these metrics.

The sections that follow provide a detailed review of the evaluation of the Belknap County SLRC-LRGH pilot. However, two major finding areas are noteworthy: readmission rate and program sustainability. During the March 1, 2011-December 31, 2012 reporting period, the readmission rate for individuals seen by the Belknap County care transitions specialist was 0.42%, compared to 5.21% readmission rate of other BOOST providers. The hospital also calculated the acuity of individuals using case mix. Individuals seen by the Belknap County SRLC care transitions specialist was 1.28, compared to 1.47. While individuals seen by the SLRC had a slightly less acuity level during the overall reporting

period, in an earlier reporting period, the SLRC had both a lower readmission rate and higher case mix than other BOOST providers. Because of these results, LRGH provided bridge funding for the program, and discussion in this region around financial sustainability moving forward continues.

A few of the key lessons learned from the pilot project are:

- Adequate training and understanding of the evidence-based model, community resources, and SLRC services is vital for the CTS. Training in the delivery of options counseling is critical.
- Future projects should form an advisory team that includes both hospital and other community based providers to advance coordinated care transitions to guide the program across all the program components.
- Regular meetings with hospital and SLRC leadership should be held to determine sustainability continually.
- Onsite presence of the CTS is important for providing access to all the knowledge and services of the SLRC and community supports to the hospital community.

These lessons learned will be utilized to inform the ongoing process of building the systems of care to support improving care transitions across the continuum in New Hampshire under the ADRC model.

#### II. Evaluation Results

This report presents evaluation results for the Belknap County SLRC care transitions pilot program from October 1, 2010- December 31, 2012.

#### **Data sources Belknap County SLRC Care Transitions Pilot:**

- → Lakes Region General Hospital The Director of Quality at Lakes Region General Hospital provided readmission and case mix rates
- → Refer 7 database- The Information and Referral (I&R) and client tracking database utilized by the SLRC Network for tracking all participants (which was used to track referrals)
- → SLRC provider and community surveys- Electronic surveys used to evaluate the communication and success of the on-site presence (located in Appendix D)
- → **SLRC consumer satisfaction surveys** Mail survey used to evaluate satisfaction with the BOOST pilot (Appendix E)
- → **Pilot reporting tool** Tracking tool in Microsoft Excel 2007 used for overall evaluation reporting from each SLRC on required metrics was created (located in Appendix F)

## III. Overview of Population Served:

**Target Population** 

The target population for participation in the hospital's BOOST pilot was individuals at high-risk for readmission. All patients who were admitted to LRGH underwent the BOOST prescribed risk assessment (see SHM Website). Patients deemed to be at risk for readmission were part of the BOOST program at LRGH. Those referred to the SLRC CTS pilot were patient identified as high risk for readmission for medical /psychosocial reasons. Regardless of patient's home address, all referred patients to the CTS received on-site options counseling and/or follow-up phone call. Individuals who resided within the Belknap SLRC catchment area received a home visit by the CTS, if appropriate. All patients received referrals to community based services as needed, including follow up by other NH SLRC's.

A total of 343 individuals were referred to the Belknap County SLRC CTS from LRGH. All those referred were officially part of the pilot, and all 343 received, at a minimum, an on-site hospital visit or

follow up phone call.

### IV. Outcomes

Five measurable outcomes were established for the pilot evaluation. Associated with each outcome is a set of process measures that tracked project activities during the pilot implementation. The tables below present the measures and descriptive explanations of the project findings for each outcome.

## Outcome 1: Reduce hospital readmission rates for target population

Table 1. Measures of Activity for Outcome 1

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Training of CTS in BOOST model is complete	Training in the BOOST and enhanced BOOST model was provided to Belknap County SLRC CTS prior to seeing individuals. The first CTS was hired in the winter of 2011 and training was completed by April.	Completed April 2011.  New CTS trained in  December 2011
	The second CTS was an existing SLRC employee and was trained in December of 2011.	
Modifications of BOOT materials for inclusion of CTS		1st modifications made April 2011.
and social supports are complete	(Appendix B).	Multiple revisions made since onset of pilot, most recently in Feb. 2012
CTS participation in multi- disciplinary team meetings is documented	CTS participated in BOOST rounds weekly and attended morning team meeting daily.	Completed December 2012
Documentation of number of total participants at LRGH in BOOST model	Requested quarterly from LRGH and reported to UNH.	Completed December 2012

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Documentation of number of BOOST participants who are directly referred to the CTS	Participants in the pilot were documented in Refer7 database and reported quarterly.	Completed December 2012

#### **Outcome Indicators:**

Table 2 presents the readmission rates for the first year of the pilot and the overall pilot reporting period. In addition, it includes the case mix of individuals seen by the SLRC CTS and other BOOST providers (pharmacist, diabetes educator, hospice program, and cardiac/pulmonary rehabilitation). The case mix was added to the evaluation by request of the Chief Executive Officer at LRGH. Given the low readmission rate, the CEO wanted to further understand the acuity level of individuals seen by the SLRC. The first year case mix of pilot participants, at 1.532, was higher than individuals seen by other BOOST providers. In essence, these individuals were sicker, on average, but had a lower readmission rate. Continuing to track both readmissions and case mix will be part of ongoing evaluation in New Hampshire.

**Table 2: Readmission Rates** 

Lakes Region General Hospital:	Readmission rate for Overall Hospital	Readmission rate for BOOST participants and non-BOOST participants	Readmission rate for Belknap SLRC care transitions specialists participants
March 1, 2011- February, 28, 2012	5.64%	4.38%	0.85%
March 1, 2011 – December 31,2012	5.59%	5.21%	0.42%
		Case Mix BOOST providers	Case Mix SLRC- CTS
March 1, 2011- February, 28, 2012	N/A	1.259	1.532
March 1, 2011 – December 31,2012	N/A	1.47	1.28

Findings: The care transitions pilot in Belknap County reduced hospital readmission rates.

## Outcome 2: 80% of participants report feeling prepared for discharge

**Table 3. Measures of Activity Outcome 2** 

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Document inclusion of CTS in BOOST model.	The enhanced BOOST flow chart was completed by the BOOST Advisory Team (See Appendix B).	Completed April 2011
Train CTS in hospital visit and follow up	Training in the BOOST and enhanced BOOST model was provided to Belknap County SLRC CTS prior to seeing individuals. The first CTS was hired in the winter of 2011 and training was completed by April.  The second CTS was an existing SLRC employee and they were trained in December of 2011.	Completed April 2011 New CTS trained in December 2011.
Develop additional question for SLRC satisfaction survey	A specific survey for Belknap County care transitions pilot participants was created through a joint effort of the SLRC staff, NH Bureau of Elderly and Adult Services, and UNH. To answer this outcome, the Care Transitions Intervention CTM-3 questions were used in a paper-based mailed survey (See Appendix E).	Completed April 2011

#### **Outcome Indicators:**

Participants in the Belknap County SLRC care transitions pilot were asked, in a paper-based mail survey, three questions to evaluate feeling prepared for discharge. The questions were part of the Care Transitions Intervention program that was occurring in two other areas of New Hampshire. They were added to the paper-based mail survey for Belknap County care transitions participants. Twenty-seven (27) of the 177 surveys mailed were returned for analyses (15% response rate).

In Figure 1, the number of responses and corresponding percent is provided for each question. The full questions are as follows:

- CTM-3 question 1: "The hospital staff took my preference and those of my family and caregiver into account in deciding what my health care needs would be when I left the hospital." (n=24)
- CTM-3 question 2: "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health." (n=26)
- CTM-3 question 3: "When I left the hospital, I clearly understood the purpose for taking each of my medications." (n=25)

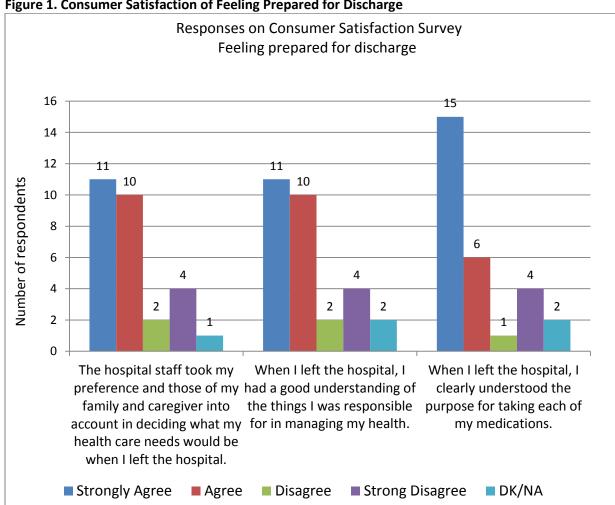


Figure 1. Consumer Satisfaction of Feeling Prepared for Discharge

Findings: Belknap County SLRC care transitions pilot did not meet the 80% goal of feeling prepared for

discharge, but responses to the survey indicated that the goal was almost met. Of the survey respondents (which, notably, was a small population), 77% agreed strongly or agreed that the hospital staff took their preferences into account, and they had a good understanding of managing their health, and 75% left the hospital with a good understanding of taking their medications. These questions are shared with LRGH as they are designed to measure the hospital staff work in preparing individuals for discharge. LRGH also utilizes a follow up survey, HCAHPS. Having two concurrent surveys may have impacted the number of people who participated in this survey, which had a low return rate.

## Outcome 3: 50% of medical and social providers report good communication of medical and social services

**Table 4. Measures of Activity Outcome 3** 

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Number of multidisciplinary team meetings with CTS	BOOST rounds occur every day at the hospital. The CTS attended these 3 times/week through the project period. Tracked monthly on Activity Report.	Completed December 2012
22 Advisory Team Meetings	Monthly meetings were held beginning March 2011 through Dec 2012 for a total of 22 consecutive months. Meetings were attended by representation from the hospital, as well as partner organizations within the community. Hospital attendees included the director of medical safety, quality, and health care management; the chief of hospitalist service; the chairman of provider quality; the director of medical safety and pharmacy; and the director of inpatient services and intensive care unit to name a few. Community attendees included representation from two local VNAs; a manager of the local ServiceLink; two hospital liaisons one from a local assisted living facility and one from a rehabilitation hospital; and a director from an outpatient care center (Full list	Completed December 2012

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
	available in Appendix A)	
Implementation of survey questions on provider survey	A provider survey was drafted in order to assess the BOOST program enhancement of hospital discharge communication and coordination efforts from the perspective of the provider (see Appendix D)	Completed January 2013
Implementation of qualitative assessment tool of BOOST partners	This outcome was not completed. During the design phase of the evaluation, it was determined there were not sufficient resources to complete this assessment.	N/A

#### **Outcome Indicators:**

A survey of hospital and community-based providers who were involved with the enhanced BOOST model was administered electronically at the end of the pilot (January 2013). The LRGH Director of Quality sent the survey out to hospital providers, and the Belknap County SLRC Center Manager sent the survey out to community providers (see Appendix D for the full survey). Approximately, 40 individuals received the survey and there were 19 respondents. Overall, the review of the CTS from Belknap County SLRC was positive; 74% agreed that as a result of the ServiceLink Resource Center Care Transition Specialist on site at the hospital there was improved communication between ServiceLink staff and hospital staff. Similarly, 68% of respondents agreed that the ServiceLink Resource Center Care Transition Specialist at the hospital improved the level of care received by patients.

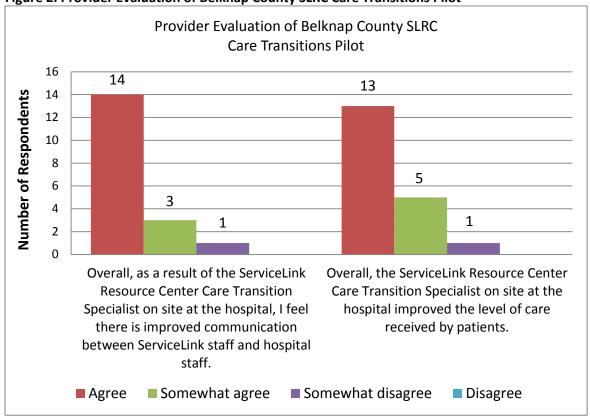


Figure 2. Provider Evaluation of Belknap County SLRC Care Transitions Pilot

**Findings:** Belknap County SLRC care transitions pilot met the goal of 50% of medical and social providers reporting good communication of medical and social services.

Outcome 4: The referral process to link patients to community resources improved

**Table 5 Measures of Activity Outcome 4** 

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
The BOOST flow chart, defining the role and referral process of the CTS, hospice, pharmacy, and nursing, is completed	The enhanced BOOST flow chart was completed by the BOOST Advisory Team (See Appendix B)	Completed April 2011
Documentation of changes to Refer7 database to track referrals.	All of the New Hampshire care transitions pilot sites agreed upon changes in the Refer7 database to track the pilot project with the NH Bureau of Elderly and Adult Services (Appendix G)	Completed July 2011

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Changes are made to Refer 7.	BEAS made changes to Refer7. Modules were customized to include data elements and triggers to document the work of CTS.	Completed April 2011
Training completed.	Training in Refer7 for pilot documentation/reporting was done by the Belknap County SLRC Center Manager.	Completed

#### **Outcome Indicators:**

Outcome 4 was measured by tracking the number of referrals made by the CTS to other SLRC programs. The Belknap County SLRC CTS made 150 referrals to other SLRC programs; these referrals reflect the times that an individual was followed for ongoing SLRC services beyond the 30-day readmission window. Table 6 provides the description of the referred-to SLRC programs.

**Table 6. Referrals to other SLRC programs** 

SLRC Program	Number of Referrals for ongoing following up beyond 30 days
Caregiver Specialists	13
Long Term Support Counseling	119
Information and Referral Specialist	8
Other: (Medicare /Assisted Technology)	10

A core goal of the pilot is linking individuals upon discharge from the hospital with community-based providers to address social service needs. The CTS tracked the number of referrals made to other community providers as part of the outcome 4 evaluation. There were 96 referrals made to community based providers by the Belknap County SLRC care transitions specialist within the 30-day readmission window. Table 7 provides the description of the top four referred-to programs.

Table 7. Top four referrals to community based social service programs

Community programs	Number of referrals
Chronic disease self-management	5
Home Health/Home Maker	16
Transportation	16
Personal Emergency Response System	11

It is worth noting that the tracking of referrals made from another SLRC programs (long term support counselor, caregiver specialist, or information and referral specialist) when individuals were followed beyond the 30 days was not possible due to limitations in Refer7; therefore, the overall number of the community based linkages made to social service programs may be under-reported.

The on-site presence of the Belknap County SLRC care transitions specialist provided key connections for improving care for individuals who were part of the pilot. There was also a goal to understand if the onsite presence was of value to hospital providers beyond the model. The CTS tracked the number of times the CTS was asked to consult on a non-pilot patient. Belknap County SLRC reported 123 times that the CTS on-site at the hospital was consulted by non-pilot patients. Due to the ad-hoc nature of this tracking, it is likely this number is under-reported.

**Findings:** These indicators summarize the linkages the Belknap County SLRC CTS provided on behalf of individuals in the pilot. There were many linkages made, for both pilot participants and non-pilot patients. Improving the data collection method for this outcome would decrease the estimated under-reporting, and, therefore, provide more accurate data to demonstrate outcomes (and support ongoing funding for the program).

# Outcome 5: 80% of participants report confidence in their ability to navigate the medical and social system

**Table 8. Measures of Activity Outcome 5** 

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Training of CTS in utilization of the Patient PASS is complete.	Patient PASS was modified to reflect all components of Enhanced BOOST model. The BOOST Advisory Team guided the modifications, to ensure that the end product reflected information community-based providers needed for ongoing support of individuals in the community.	Completed April 2011
Establish the PASS with all BOOST participants	LRGH provided the modified Patient PASS to all Enhanced BOOST providers (medical and community based) at the time of discharge.	Completed April 2011
Questions for SLRC consumer satisfaction survey are developed and implemented	A specific survey for Belknap County care transitions pilot participants was created through a joint effort of the SLRC staff, NH Bureau of Elderly and Adult Services, and UNH (Appendix E)	Completed April 2011

## **Outcome Indicators:**

The Belknap ServiceLink, in coordination with UNH, distributed a consumer satisfaction survey to 177 pilot participants. The questions reflected the participants' experiences after returning home from the hospital and being followed by the Belknap County SLRC CTS for 30 days. Some questions were designed to gather information on pilot participant's ability to navigate the medical and social system. Participants responded to the following statements: "I know how to find the help I need"; "I know what services and supports are available in my community"; "I can find the correct service provider(s) for my needs"; "I am able to get answers

and solutions even if a service provider staff is not helpful"; and "Overall, how confident do you feel you have the skills and resources to manage your recovery at home?"

Out of the 177 participants, 28 responded. There was a positive response to feeling confident in navigating the medical and social system among respondents. (Figures 3 & 4): 75% indicated they knew how to find the help they would need, 75% indicated they knew what services and supports are available in their community, 75% indicated they can find the correct service provider(s) for their needs, and , 75% indicated they are able to get answers and solutions even if a service provider is not helpful. In addition to the 82% confidence participants report in their ability to manage recovery at home, 73% of participants know what resources are available to them and are able to access them.

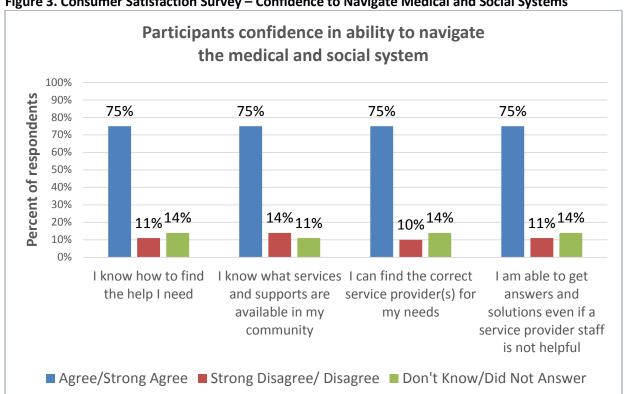


Figure 3. Consumer Satisfaction Survey - Confidence to Navigate Medical and Social Systems



Figure 4. Consumer Satisfaction Survey – Confidence in Personal Recovery

**Findings:** The Belknap County SLRC pilot met the 80% goal of people being confident in having the skills and resources to manage recovery at home.

## V. Informing a state-wide ADRC care transitions project

There are a number of lessons learned and recommendations from the Belknap County SLRC care transitions pilot project, which can inform a state-wide ADRC care transitions project.

#### **BOOST** model

The BOOST model is a hospital-based care transitions intervention, which LRGH had implemented in 2009. The willingness of LRGH and other community providers to enhance the model in late 2010 under this pilot facilitated the alignment of caring for both the medical and social needs of individuals upon discharge to decrease the likelihood of readmissions. The enhanced BOOST model utilized the core services of the ADRC model in New Hampshire, namely, the Long Term Support Counselor serving as a Care Transitions Specialist. This model provided the person-centered approaches to supporting individuals of the SLRC on-site at the hospital, and for an extended period of time upon discharge.

## Pilot tracking

Utilizing the Refer7 database in its current iteration limits the ability to adequately track linkages with community long term services and supports. Updates to the Refer7 database are needed to demonstrate the ongoing value.

## Community and hospital relationships

Two groups need to be established in order to develop, implement, and sustain a care transitions model. An advisory group made up of both hospital and community social service providers is key to developing and implementing a successful care transitions program that aligns the medical and community social services systems. For sustainability, a small group of hospital and SLRC leaders is needed to review results and develop funding strategies.

## State-level implications

SLRCs should be supported to work with hospitals to demonstrate the value of the onsite options counselor, which can improve readmission rates and quality of care for individuals. Options counseling may be able to enhance care transitions projects that hospitals are undertaking. Individual relationships between hospitals and SLRCs will likely differ, responding the different patient mixes, hospital processes, community resources, and geographic dispersion.

Projects will likely need to address differences in the catchment areas of the SLRC network and hospital catchment areas to develop processes to address such things as:

- → Will a SLRC CTS need to partner with more than one hospital? This may mean working within more than one care transitions model.
- → What will happen if a CTS in one SLRC area starts working with a patient that will be discharged to another SLRC service area?

To support referrals, projects need to provide consistent training and follow-up support for Refer 7 data entry by the CTS. Each CTS needs to understand how to use and understand the taxonomy, notes, markers, etc. in the referral database.

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VI. Appendices

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Appendix A:

**Advisory Committee List** 

**BOOST/Care Transition Advisory Committee** 

Meetings: Last Thursday of every month, 2:00pm-3:00pm, Conference Room 1A/B

Gloria Thorington, Director, Medical Safety, Quality, & Health Care Management

Vercin Ephrem, M.D., Chief of Hospitalist Service

Myat Myo, M.D., Hospitalist

Ted Capron, M.D., Chairman of Utilization Review Committee

Richard Wilson, M.D., Chairman of Provider Quality

Margaret Franckhauser, Director Central New Hampshire VNA & Hospice

Tracie Fitzpatrick, Director Practice Management

Amy Newbury, Manager, Servicelink Belknap County

Marge Kerns, Director, Medical Safety & Pharmacy

Toni FitzMorris, Hospital Liaison, Genesis Healthcare Center

Sally Minkow, Director, Education

Jayne White, Director, Franklin VNA & Hospice

John Lane, Hospital Liaison, Health South Rehab

Elaine Cartier, Director, Inpatient Services

Jeanne Sanders, Director, Golden View Healthcare Center

Monetta Sharpe, Director, Inpatient Services & Intensive Care Unit

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Appendix B:

**Boost Referral Flow Chart** 

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Appendix C:

**Business Agreement** 

New Hampshire ADRC Person-Centered Care Transitions Hospital Discharge Planning Project **BOOST Follow-Up Phone Call Process** Celebrating 10 Years LRGHealthcare ServiceLink **BOOST Patient Risk Assessment Completed On All Patients** Aging & Disability Resource Center Following Information copied on all Patients at Discharge: history & physical, medication list, discharge instruction, who is doing follow-up phone call, face sheet Yes No Patient Is Patient Is **Determination By BOOST High Risk Not High Risk** team on whether patient is For Readmission For Readmission high risk and who will make follow up phone call Patient is **Not High Risk** Patient is identified Patient is Patient is identified as Patient is or Readmission as High Risk for identified as identified as **High Risk for** Patient identified as **Follow up Phone** Readmission **High Risk for** Readmission (BOOST) for **High Risk for** High Risk for Call by Nurse/CM (BOOST) Readmission Readmission **Medication Related** Readmission (BOOST) and is Cardiac or (BOOST) and is (BOOST) (including difficulty For Medical **Pulmonary Patient** and is Palliative obtaining meds) a Diabetic /Psychosocial Follow up Phone **Care Patient** IF Home Health involved, **Follow up Phone Call Patient** Call by Follow up Follow up they will call pharmacy bv Cardiac/Pulmonary Phone Call by for information Phone Call by **Transition Care** Rehab Palliative Care Diabetic Follow up Phone Call by **Specialist** Education Team **Pharmacist** 

- 1. If patient has care management concern, refer to care manager
- 2. If the patient has a medication concern, refer to the pharmacist
- 3. If medical concern, refer to attending physician
- 4. If patient needs home visit, follow up by Transition Care Specialist (patient w/o Home Health or visit needed in addition to home health)

All patients will be given a number to call (patient care unit) if they can not reach PCP

### Services Agreement Between LRGHealthcare And

## Lakes Region Partnership for Public Health on behalf of the ServiceLink Resource Center of Belknap County

This AGREEMENT made and executed in duplicate, effective the 1<sup>st</sup> day of March, 2013, by and between, LRGHealthcare, a not for profit corporation, organized under the laws of the State of New Hampshire, with its principal place of business at 80 Highland Street, Laconia, NH 03246 (hereinafter referred to as "LRGH"), and Lakes Region Partnership for Public Health on behalf of ServiceLink Resource Center of Belknap County a not for profit corporation having a principal place of business at 67 Water Street, Suite 105, Laconia, NH 03246 (hereinafter referred to as "LRPPH/ServiceLink").

#### **RECITALS**

WHEREAS, LRGH is duly licensed by the State of New Hampshire Department of Health and Human Services; and,

WHEREAS, ServiceLink is a statewide network of locally administered community-based resources for seniors, adults with disabilities and their families; and, ServiceLink of Belknap County is a program of the Lakes Region Partnership for Public Health

WHEREAS, LRGH and LRPPH/ServiceLink mutually desire that LRGH provide or arrange for the provision of services and that LRGH be delegated the broad responsibility for various services relating to the development, management and delivery of such services in accordance with the provisions of this Agreement:

#### **AGREEMENT**

NOW, THEREFORE, in consideration of the mutual representations, warranties, covenants and agreements hereinafter set forth, the Parties hereby agree as follows:

#### I. Services.

- The parties agree that LRGH is to provide general and administrative services under the terms and conditions of
  this Agreement and in accordance with all applicable requirements of federal, state or local laws, rules, and/or
  regulations, third party reimbursement sources (public or private), or other reimbursement sources covering these
  services.
- 2. LRGH will work in conjunction with ServiceLink Resource Center of Belknap County to provide the following services through the ServiceLink Transition Care Specialist who will:
  - a. Work with the LRGH Care Management Team to identify patients at risk for readmission to identify and implement strategies to prevent readmission
  - b. Attend patient care rounds on the patient care units
  - c. Make follow up phone calls and visits as outlined by the BOOST Team
  - d. Document follow up phone calls and visits and make documentation available for patient's medical record
  - e. Assist in providing data on the effectiveness of the program
  - f. Serve as part of the BOOST Advisory Committee

#### 3. LRGH will provide:

- a. Office space for the ServiceLink Transition Care Specialist
- b. Internet access
- c. Telephone and voice mail
- d. Provide LRPPH/ServiceLink readmission rates and case mix on Care Transition patients semi-annually

#### II. Term & Termination.

- 1. This Agreement shall remain in effect for a term of one (1) year effective on March 1, 2013 and ending on February 28, 2014 unless otherwise terminated as provided herein. Services have been provided through a pilot program since March, 2010.
- 2. Termination. This agreement may be terminated;
  - a. Without cause by either party upon at least ninety (90) days prior written notice to the other party; or
  - b. Immediately, with cause, if either party:
    - becomes insolvent, makes a general assignment for the benefit of creditors, suffers or permits the
      appointment of a receiver for its business or its assets, or avails itself of, or becomes subject to, any
      proceeding under federal bankruptcy laws or any state statutes relating to insolvency or the protection of
      rights of creditors;
    - (ii) ceases to render contracted services for a period of sixty (60) days;
    - (iii) suspension, limitation or termination of licensure;
    - (iv) fraud or misrepresentation in reporting requirements as specified in Section VII:
    - (v) incurs a conviction of a felony or of a misdemeanor involving fraud
    - (vi) failure to maintain liability insurance in accordance with the terms of this agreement
    - (vii) is unable to secure funding from the NH Bureau of Elderly and Adult Services or other government or non-governmental funder
  - c. Immediately, with cause, by either party, if one party fails to perform any of the services or obligations under this agreement after notice of such failure has been given and a 30-day opportunity to cure has passed and such failure results in or is reasonably likely to result in material deterioration in the level of care or service being provided.

#### III. Qualifications.

1. Licensure. LRGH represents that it maintains all current licensures needed to provide healthcare services in the State of New Hampshire.

#### IV. Insurance.

1. Each party shall, at its sole cost and expense at all times during the term of this Agreement, procure and maintain general and professional liability insurance (including personal injury, workers compensation, property damage, products liability and complete operations liability), with a minimum limit of liability equal to One Million Dollars (\$1,000,000) per incident, Three Million Dollars (\$3,000,000) in aggregate, or such greater amount if required by any applicable state or federal law or regulation. Each party shall cause to be issued to the other party, upon request, proper certificates of insurance evidencing that the foregoing provisions of this Agreement have been complied with and said certificates shall provide that prior to any cancellation or change in the underlying insurance during the policy period the insurance carrier will first give thirty (30) calendar days written notice to the other party.

### V. Reporting.

If applicable, pursuant to Section 1395X(V)(1)(I) of Title 42 of the United States Code, until the expiration of four
(4) years after the termination of this contract, both parties shall make available, upon written request to the
Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller
General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of
this contract and such books, documents and records as are necessary to certify the nature and extent of costs of

the services provided by LRGH under this Agreement.

#### VI. Confidentiality.

- 1. Confidential Information. Both parties recognize and acknowledge that, by virtue of entering into this Agreement and providing services to LRPPH/ServiceLink hereunder, both parties may have access to certain information that is confidential and constitutes valuable, special and unique property of the other party. Both parties warrant and covenant to each other that neither party will at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without the other party's express prior written consent, except pursuant to their duties hereunder, any confidential or proprietary information of the other party, including, but not limited to, information which concerns the other party's costs, prices and/or methods used, developed or made by the other party, and which is not otherwise available to the public.
- 2. Terms of this Agreement. Except for disclosure to their legal counsel, both parties warrant and covenant to the other that neither party shall disclose the term of this Agreement to any person who is not a party or signatory to this Agreement, unless disclosure thereof is required by law or otherwise authorized by this Agreement or consented to by the other party. Unauthorized disclosure of the terms of this Agreement shall be a material breach of this Agreement.
- 3. Patient Information. Both parties warrant and covenant to the other party that neither party shall disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by the other party in writing, any patient or medical record information. Both parties shall comply with all Federal and State laws and regulations, and all reasonable rules, regulations, and policies of LRGH and its medical staff, regarding the confidentiality of such information.
- 4. HIPAA. Both Parties warrant that all elements of the HIPAA requirements will be met without limitation.

#### VII. Miscellaneous.

- 1. Governing Law. This Agreement has been made and executed in, and shall be construed, interpreted and governed by the laws of the State of New Hampshire.
- Indemnification. Each party shall protect, indemnify and hold the LRPPH/ServiceLink harmless from and against
  any and all liability and expense of any kind, arising from injuries or damages to persons or property in connection
  with the provision of services by the indemnifying party hereunder. The obligations set forth in this Section shall
  survive the termination of this Agreement.
- 3. Non-discrimination. Both Parties agree that for the purposes of carrying out the terms of this Agreement they will be in accordance with all aspects of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin, and Section 504 of the Rehabilitation Act of 1973 which prohibits discrimination on the basis of handicap or disability and the Age Discrimination Act of 1975, which prohibits discrimination on the basis of age for the term of the agreement.
- 4. Assignment. This Agreement and the respective rights and obligations of the Parties hereto shall not be assigned or transferred in any manner without the prior written consent of all parties, and, in the absence of such consent, any purported assignment shall be wholly void; provided however, that this Agreement may be assigned by any Party to any entity owned or controlled by, or under the common control with, said Party. Other than as expressly provided by this Agreement, any attempted assignment, by operation of law or otherwise, shall constitute a material breach of this Agreement. All of the terms and provisions of this Agreement shall be binding upon and shall inure to the benefit of the Parties and their respective transferee, successors and assigns.
- 5. Waiver. The waiver of any breach of any term or condition of this Agreement shall not be deemed to constitute the waiver of any other breach of the same or any other term or condition.
- 6. Section and Other Headings. The article and other headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
- 7. Enforceability. In the event any provision of this Agreement is found to be unenforceable or invalid, such provision shall be severable from this Agreement and shall not affect the enforceability or validity of any other provision contained in this Agreement.

- 8. Entire Agreement. This Agreement contains the entire contractual understanding between the parties and supersedes and terminates any prior agreement(s) between the parties hereto. No amendments or additions to this Agreement shall be binding unless such amendments or additions are in writing and signed by LRGH and LRPPH/ServiceLink, except as herein otherwise provided.
- 9. Remedies. In addition to those remedies provided herein, LRGH and LRPPH/ServiceLink shall have available all remedies provided by law.
- 10. Force Majeure. Each Party shall make a good faith effort to meet all of the obligations under this Agreement in the case of an event clearly beyond the control of the Party. These events include, but are not limited to, war, riot, civil insurrection, epidemic, public emergency and natural disaster. Other causes include partial or complete destruction of the facilities LRGH or LRPPH/ServiceLink for the purposes of this Section, an event is not within the control of either LRGH or LRPPH/ServiceLink if neither one can exercise influence or control over the occurrence.
- 11. Governmental Action. The Parties recognize the existence or potential existence of legislation or administrative rules and regulations or actions, which may affect or impair the delivery of the services described herein by LRGH or LRPPH/ServiceLink. The parties commit to respond to any such changing circumstances by working together to restructure the Agreement to address such changes and provide the services under this Agreement within the scope of such changes.
- 12. Amendments. No modifications of or amendment to this Agreement or its attachments shall be effective or binding on either party unless mutually agreed to in writing signed by both parties.
- 13. Contractual Compliance.
  - a. Each department involved in the delivery of this service is responsible, on an ongoing basis, for insuring that it is in compliance with legal and regulatory standards as set forth by the U.S. Department of Health and Human Services, the Office of the Inspector General, and CMS, as well as the ethical and business standards and practices of LRGH, and that everyone associated with the department, including outside contractors, understands expectations and their role in the process.
  - b. It is the responsibility of Departmental Managers and Directors to evaluate overall compliance and specific compliance issues as they may be identified. All department employees are expected to be aware of the basic compliance standards and assist in identifying problems and/or sub-standard processes.
  - c. The monitoring of the fulfillment of the terms of this agreement will be the responsibility of the Director of Health Management Services. The Director will utilize all available information in reviewing the aspects of compliance with this agreement by all parties.
- 14. Notice. Except as otherwise expressly provided, all notices, demands, requests, or other communications which may be or are required to be given, served or sent by any party to the other party pursuant to this Agreement shall be in writing and shall be hand-delivered (including delivery by courier), mailed by first-class, registered, or certified mail (return receipt requested, postage paid), or transmitted by hand delivery, telegram telex or facsimile transmission, addressed as follows:
  - a. If to LRGHealthcare:

President & CEO LRGHealthcare 80 Highland Street Laconia, NH 03246

b. If to LRPPH/ServiceLink:

Executive Director LRPPH/ServiceLink Resource Center of Belknap County 67 Water Street Laconia, NH 03246 Either party may designate by notice in writing a new address to which any notice, demand, request, or communication may thereafter be so given, served, or sent. Each notice, demand request, or communication which shall be mailed, delivered, or transmitted in the manner described above shall be deemed sufficiently given, served, sent and received for all purposes at such time as it is delivered to the addressee (with return receipt, the delivery receipt, the affidavit of the messenger or (with respect to telex) the answerback being deemed conclusive evidence of such delivery) or at such time as delivery is refused by the addressee upon presentation.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the day and year first above written.

Lakes Region Partnership for Public Health on behalf of	LRGHealthcare
ServiceLink Resource Center of Belknap	
By: County	By: 1 am Calemin
Lisa Morris, Executive Director	Tom Clairmont, President & CEO
Date: $3/2/13$	Date:3 15 13

## Appendix D:

**ServiceLink Provider and Community Surveys** 

## **Belknap Care Transitions Community Survey**

Q1 For the past two years the Belknap County ServiceLink Resource Center (SLRC) has been partnering with Lakes Region General Healthcare on a care transitions pilot project. This service sought to reduce readmissions through connections to informal and formal community based services. The Institute for Health Policy & Practice (IHPP) at the University of New Hampshire is conducting this survey on behalf of the Belknap County SLRC and Lakes Region General Healthcare. Your participation in this brief, anonymous survey will assist in evaluation of the care transitions pilot project, and the information gathered will be used to improve Care Transitions in collaboration with community partners. This survey will take less than five minutes of your time and your feedback is appreciated.

22 Please tell us which organization you represent:
Q3 What is your role within your organization?
Direct Care Staff (1)
Administration (2)
Other (3)
Q4 Are you familiar with the Care Transitions Pilot Program between the Belnak County ServiceLink esource Center and Lakes Region General Healthcare that occurred over the past two years?
<b>Y</b> es (1)
No (2)

If Yes Is Selected, Then Skip To Please select the most appropriate an...If No Is Selected, Then Skip To Are

Q5 Please select the most appropriate answer:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	All of the Time (5)
How frequently did you interact with the care transitions pilot project?	•	•	0	0	•

Q6 Did the pilot make a difference in the level of community based care individuals received or	nce
discharged from the hospital?	

- **O** Yes (1)
- O No (2)
- O Not Applicable (3)
- O Don't know (4)

Q7 Please answer if you "Disagree", "Neither Agree nor Disagree", "Agree" or "Don't know" to the following statement:

	Disagree (1)	Neither Agree nor Disagree (2)	Don't Know (5)	
The Care Transitions Pilot Program improved the communication among providers in our community regarding patient transition issues (1)	•	•	•	0
The Care Transition Pilot Program was an integral part of coordinating social services for individuals as they transition back to the community settings. (2)	O	O	•	0

Q8 Please answer if you "Disagree", "Neither Agree nor Disagree", "Agree" or "Don't know" to the following statement:

	Disagree (1)	Neither Agree nor Disagree (2)	Agree (3)	Don't Know (4)
Overall, as a result of the Care Transitions Pilot Program between the Belknap County ServiceLink Resource Center and Lakes Region General Healthcare, I feel communication about care transitions has improved between ServiceLink staff, hospital staff and community providers. (2)	•	•	•	0

Q9 Overall, do you agree that the Care Transitions Pilot Program increased access to home and community based-services for individuals discharged from Lakes Region General Healthcare?
<ul><li>Yes (1)</li><li>No (2)</li><li>Don't know (3)</li></ul>

Q10 Please provide any comments related to your response above:

Q11 In your experience with the Belknap County ServiceLink Resource Center, would you agree they are an important partner in an effective care transitions program in your community?
<ul> <li>Yes (1)</li> <li>No (2)</li> <li>Don't know (3)</li> </ul>
Q12 Please provide any comments related to your response above:
Q13 Are you aware of the community-based services that the ServiceLink Resource Center Network provides to individuals?
O Yes (1) O No (2)
If Yes Is Selected, Then Skip To Please answer if you "Disagree", "NeiIf No Is Selected, Then Skip To End of Survey

Q14 Please answer if you "Disagree", "Neither Agree nor Disagree", "Agree" or "Don't know" to the following statement:

	Disagree (1)	Neither Agree not Disagree (2)	Agree (3)	Don't Know (4)
In my experience with the ServiceLink Resource Center Network I have found the resources available to individuals beneficial. (1)	•	•	•	•

For the past year you and the hospital have been participating in Care Transitions to enhance the BOOST Model. This service seeks to reduce readmissions through connections to informal and formal community based services. The University of New Hampshire requests your participation in this brief, anonymous survey to help evaluate the model. Information gathered through this survey will be used to improve Care Transitions in collaboration with community partners. The survey will take less than five minutes of your time and your feedback is appreciated.

*1	I. What is your role?			
0				
0	Social Worker			
0	Nurse			
0	Nurse Caremanager			
0	Physician			
0	Other			

*2. Are you familiar with the Care Transition Specialist from the ServiceLink Resource						
Center, Nancy Bacon, who works part time within your hospital?						
C yes						
C no						

3. Please choose				Offen	Alwaya
ow frequently do you teract with the Care ransition Specialist?	Never	Rarely	Sometimes	Often C	Always O

*4. The on-site Care Transition Specialist has made a difference in the level of care received by patients?
O Yes
C No
O Not Applicable

## \*5. Please indicate if you Disagree or Agree with the following statement: Disagree Agree Not Applicable 0 0 0 The Care Transition Specialist communicates with me or my organization, appropriately. The Care Transition 0 0 0 Specialist calls me or my organization when appropriate. The Care Transition Specialist is an integral part of the discharge planning process at our hospital. The Care Transition 0 0 0 Specialist is an integral part of coordinating social services for patients as they transition back to the community settings.

f st6. I trust the Care Transition Specialist to make appropriate referrals with community based services for patients.
© yes
O no
f *7. If there were a full-time Care Transition Specialist available, care transitions would be improved at my facility.
○ yes
O no

	Disagree	Agree	Not Applicable
verall, as a result of the erviceLink Resource enter Care Transition pecialist on site at the ospital, I feel there is approved communication etween ServiceLink staff and hospital staff.	©	6	©

imes9. Overall, the ServiceLink Resource Center Care Transition Specialist on site at the hospital improved the level of care received by patients.						
O yes						
O no						

10. Please provide any additions comme	

Thank you for your participation!	

### Appendix E:

ServiceLink Consumer Satisfaction Survey



# University of New Hampshire

The ServiceLink Resource Center of Belknap County and Lakes Region General Hospital have joined together in a program to improve the quality of the transition from the hospital back to your home. The University of New Hampshire is evaluating the program.

Please tell us about your experience in returning home after being hospitalized by taking a few minutes to complete this survey. Just circle the number of the response that best represents your opinion. If the question does not apply to you circle the "9". When you are finished, place the survey in the return envelope provided and drop it in the mail. You do NOT have to put a stamp on the envelope.

Hospital Discharge	Strongly Disagree	Disagree	Agree	Strongly Agree	DK / NA
The hospital staff took my preferences and those of my family or caregiver into account in deciding <i>what</i> my health care needs would be when I left the hospital.	1	2	3	4	9
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.	1	2	3	4	9
When I left the hospital, I clearly understood the purpose for taking each of my medications.	1	2	3	4	9

Resources	Strongly Disagree	Disagree	Agree	Strongly Agree	DK / NA
I know how to find the help I need.	1	2	3	4	9
I know what services and supports are available in my community.	1	2	3	4	9
I have the tools and skills I need to manage my care at home.	1	2	3	4	9
I am well informed and capable of making choices about my care.	1	2	3	4	9
I can find the correct service provider(s) for my needs.	1	2	3	4	9
I am able to clearly describe my needs to service providers.	1	2	3	4	9
I am able to follow through with recommendations about my care.	1	2	3	4	9
I am able to get answers and solutions even if a service provider staff is not helpful.	1	2	3	4	9

Overall, how confid home?	ent do you feel that yo	ou have the skills and	resources to manage y	your recovery at
(1) Very Confident	(2) Somewhat Confident	(3) Not Very Confident	(4) Not Confident At All	(9) Don't Know / Not Applicable
If not, why?	litional assistance pleas	se call your local Servi	ceLink Resource Cente	r at: 603-528-6945
	The Universi	ty of New Hampshir	e Survey Center	

Appendix F:

**Pilot Reporting Tool** 

Evaluation item	Reporting Period							
			I	Oct-Dec			Jul-Sep	
	Mar-11	Apr-Jun 2011	Jul-Sep 2011	2011	Jan-Mar 2012	Apr-Jun 2012	2012	Total
Participants			·			·		
# of referrals to the formal pilot from the	11	112	60	50	58	25	27	343
# of participants in the formal pilot	11	112	60	50	58	25	27	343
# of participants who completed formal	11	112	60	50	58	25	27	343
# of "consults" conducted at the hosptial								
(non-pilot patients)	3	15	31	19	3	25	27	123
# of total referrals to made to other SLRC								
programs by the CTS	16	19	9	3	51	25	27	150
Please take the top 4 referrals to other SLRC								
programs and report the number by								
# referred to Caregiver Specialists	1	2	2		1	1	6	13
# referred to LTSCs	14	11	5	2	47	23	17	119
# referred to I& R	1	4	1	1		1		8
# referred to "other"- please specify								
SLRC program here (Medicare/Assisted		2	1		3		4	10
	16	19	9	3	51	25	27	150
Age								
# of participants age 60+	5	29	34	30	29	15	17	159
# of participants under age 60	2	20	26	16	13	10	6	93
# of participants age unknown	4	63		4	16		4	91
	11	112	60	50	58	25	27	343
Services								
# of total community referrals made by CTS	6	13	21	18	22	7	9	96
Please break out the top 4 referrals to								
community programs and report the								
number by category in lines 24-27								
#referred to chronic disease self-	0	1	2	1	1	0	0	5
#referred to Home Health/Home	1	3	4	2	4	1	1	16
#referred toTransportation	2	3	1	5	2	2	1	16
#referred to PERS	2	2	1	2	3	1	0	11

Staff								
# multidisciplinary team meetings with								
CTS*/BOOST Rounds occur everyday. CTS								0
# Advisory team meetings*Monthly								
Meetings (see attached listing)								0
attend								
Meeting 1 (pls specify type of meeting)	-							
Meeting 2 (pls specify type of meeting)								
Meeting 3 (pls specify type of meeting)								
Meeting 4 (pls specify type of meeting)								
Meeting 5 (pls specify type of meeting)								
BOOST								
# of referrals from other BOOST providers								0
# of referrals from CTS to other BOOST								0
# referred to diabetic education								0
# referred to cardiac/pulmonary rehab								0
# referred to palliative care team								0
# referred to pharmacist	3	5	2	1	0	0	0	11
# referred to nurse/care manager								0
# of referrals to BOOST mobile Delete								0
СТІ								
# of participants who receive PHR								0
# of medication discrepancies								0

Appendix G:

Documentation of Changes to Refer7

#### Tracking in Refer7:

Refer7	Content	Who should use/who sees	When to use
Referral	"Hospital Care Transitions Pilot Program"  *Taxonomy term: transitional case/care management	3 pilot sites only/everyone can see	Used for all CTI/BOOST referrals by the 3 pilot locations
Client Marker	"Hospital Care Transitions Pilot"	3 pilot sites /Everyone sees	Used for all CTI/BOOST referrals
Contact Marker	<ol> <li>"Hospital Visit"</li> <li>"Consult/PCHDP Project"</li> </ol>	<ol> <li>Everyone</li> <li>3 pilot sites only/everyone can see</li> </ol>	<ol> <li>Used by any SLRC staff that sees a client while in the hospital- Care Transitions Specialist, Caregiver Specialist and/or Long Term Support Counselors.</li> <li>When Care Transitions Specialist in one of the 3 pilot sites consults on non-pilot patients with hospital staff.</li> </ol>
Follow-up	<ol> <li>Care Transitions appointment-hospital</li> <li>Care Transitions appointment-home</li> <li>Care Transitions appointment-follow-up phone-call</li> </ol>	3 pilot sites only/everyone can sees	<ol> <li>Per model</li> <li>Per model</li> <li>Per model</li> </ol>

Reminder: If a provider is the contact than their organization name should be noted in the organization spot in contact demographics.

#### \*Definition:

Transitional Case/Care Management:

Programs that develop, implement, assess and follow up on plans for the evaluation, treatment and/or care of people who are experiencing a specific, time-limited problem such as a transition from hospitalization to independent living and who need assistance to obtain and coordinate the support services that will facilitate the change.

#### USE TERM (S):

Short Term Case Management, Transitional Case Management