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

September 30, 2013

ACL Grant Award Number: 90CT016002
Grant Period: September 2010 – April 2013
ACL Program Officer: Caroline Ryan
ACL Grants Management Specialist: Christine Ramirez

Prepared by:
Laura Davie
Co-Director
Center on Aging and Community Living
University of New Hampshire

Marguerite Corvini
Research Associate
Center on Aging and Community Living
University of New Hampshire

In partnership with:
Susan Deyoe
Center Manager
Carroll County ServiceLink Resource Center

Susan Ruka
VP of Quality
The Memorial Hospital

CENTER ON AGING AND COMMUNITY LIVING

Table of Contents

I. Introduction

In the fall of 2010, the University of New Hampshire (UNH) received the Aging and Disability Resource Center (ADRC) Option D Evidence Based Care Transitions Award by the US Administration for Community Living (ACL). Building upon the 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 Option D project worked with 3 pilot sites across NH to implement and test care transitions models to improve hospital readmission rates, communication between social and medical system providers, and consumer ability to access community resources. The Carroll County SLRC site was selected to pilot a care transitions model under this funding opportunity along with The Memorial Hospital, a 25-bed critical access hospital located in North Conway, NH.

Prior to the grant application, The Memorial Hospital utilized a tool (see Appendix A), developed by NHIHPP, that cross-walked the evidence based models approved by ACL for funding under the original solicitation. Through this exercise, it was determined that the Care Transitions Intervention[sm] (CTI) model was the best fit for the hospital-SLRC pilot project. CTI utilizes "coaches" to work with individuals during through their in-patient hospital stay, discharge, and transition home over a 30-day period. The model emphasizes a skill transfer that empowers the individual to follow through with medical appointments, medications, and awareness of health signs to avoid hospital readmission. More information on the CTI can be found at their official website: http://www.caretransitions.org/

While the implementation of the CTI model to reduce hospital readmissions was the first goal of this pilot project, New Hampshire was also interested in understanding the importance of the onsite presence of the SLRC staff. More specifically, the use of informal referrals, increased awareness of SLRCs, referrals to other SLRC 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 were all areas to be evaluated during the pilot.

The Carroll County SLRC achieved many goals early on the pilot project, such as establishing a care transitions specialist position at the SLRC and partnership with The Memorial Hospital to implement the CTI model; participating in the Care Transitions Program regional training in Aurora, Colorado; and educating area partners in the pilot project. Overall, the Carroll County SLRC, The Memorial Hospital, and community partners' demonstrated a clear commitment to better transitions across the continuum of care.

The number of individuals served for transitional work in the pilot was very low. Carroll County SLRC faced many challenges, including losing the first trained care transitions specialist only three months after establishing the on-site presence at the hospital, and having to adequately train a new specialist with limited financial and personnel resources. In addition, it was a challenge to achieve adequate CTI referrals due to the low hospital bed count.

Through the success and challenges in the pilot, New Hampshire learned the following:

- Adequate training and understanding of the evidence-based model, community resources, and the SLRC services is vital. Training in the roles of the SLRC first and

establishing good information and referral and options counseling skill set is preferred.

- A half time position for the care transitions pilot was challenging due to the specific criteria of the CTI coaching model and variation for typical SLRC jobs and medical care jobs.
- Onsite presence of the care transitions specialist is important for providing access to all the knowledge and services of the SLRC.

These lessons learned will inform the ongoing process of building evolving systems of care with the intention of improving care transitions across the continuum.

II. Evaluation Results

Several evaluation tools were in place for the Carroll County SLRC CTI pilot. The pilot period reflected in the evaluation results was October 1, 2010- September 29, 2012.

Data Sources Carroll County SLRC Care Transitions Pilot

→ **The Memorial Hospital**- The Vice President of Quality at The Memorial Hospital provided readmission rates

→ **Refer 7 database**- Information and referral and client tracking database utilized by the SLRC Network for tracking all participants

→ **Medication discrepancy and red-flag database**- Created by the UNH Survey Center to collect the CTI model tools, medication discrepancy and red-flags (located in Appendix B)

→ **SLRC provider/community survey**- Electronic survey to evaluate the communication and success of the on-site presence (located in Appendix C)

→ **SLRC consumer satisfaction surveys**- Mail survey to evaluate satisfaction with the care transitions pilot (located in Appendix D)

→ **CTM-3 phone survey**- Post discharge calls made by UNH CACL to evaluate preparedness for discharge (located in Appendix E)

→ **Program tracking tool**- Tracking tool in Microsoft Excel 2007 used by care transitions specialist to track information received and in-person contacts with each patient involved in the pilot (located in Appendix F)

→ **Pilot reporting tool**- Tracking tool in Microsoft Excel 2007 used for overall evaluation reporting from each SLRC on required metrics (located in Appendix G)

III. Overview of Population Served

Target Population for the CTI Pilot

The Carroll County SLRC pilot used the following standard CTI exclusion criteria:

a) A person with dementia AND without a caregiver;

b) A person who is actively abusing drugs and alcohol;

c) A person with a primary psychotic diagnosis.

At the onset of the project, the following inclusion criterion was established for referrals to the care transitions specialist:

Individuals age 60+, with one of the three following diagnosis:

a) Congestive Heart Failure (CHF);

b) Chronic Obstructive Pulmonary Disease (COPD) or;

c) Coronary Artery Disease (CAD).

In addition, they needed to reside in the Carroll County SLRC service area to participate in the pilot. Upon reviewing the initial program experience in March 2011, it was clear that the referrals from The Memorial Hospital were lower then expected. The Memorial Hospital case managers, Carroll County SLRC, New Hampshire BEAS, and UNH met to evaluate the project and discuss what changes could be made for the project to generate additional referrals. It was determined that a combination of a low hospital census rate and the narrow inclusion criteria were the reasons for the low number of patients being referred to the pilot. In response, the inclusion criteria were extended to:

a) Individuals age 60+ or adults living with disabilities age 18+ (expanding the age criteria)

b) All Chronic Illness (expanding the chronic conditions the qualified for participation)

Participant Data

Participant data was tracked by the Carroll County SLRC in a Microsoft Excel file developed for the pilot. The tracking sheet included the following fields:

- ✓Hospital Admission Data
- ✓Admitting Diagnosis
- ✓Hospital Visit Date
- ✓Referral Made to CTI
- ✓Admitted to CTI
- ✓Reason Why Not Admitted
- ✓Communicated With Care Coordinator
- ✓Provided Consultation in Hospital but Not CTI Participant
- ✓Home Visit Dates
- ✓1st Patient Assessment Completed
- ✓Follow Up Phone Calls Made
- ✓2nd Patient Assessment Made
- ✓Readmission
- ✓Completed

There were 21 referrals received during the active referral period of March 2011-September 2012. Of the referrals, eight individuals agreed to participate in the program. The care transition specialist documented why the referred individuals did not participate in the program, including not meeting the criteria for participation and opting out, as listed in Table 1.

Table 1. Breakdown of individuals referred participants who did not participate

Reason why patient did not participate	Total
Admitting diagnosis not meeting criteria	8
Opted out	6
No entry	3
Transferred to other facility	4
Total	**21**

In addition to attempting to modify the program to address the low referral rates, Carroll County SLRC also sought to identify reasons for the low patient participation among those referred to the program. An evaluation of the timing and approach of the care transitions specialist with the patient was completed, and identified issues from both the patient perspective and the care transitions specialist perspective that may have impacted participation. Patients reported the following:

1. They already had help in the home from family or home care agencies;
2. They felt they didn't need help, and they could care for themselves;
3. Patient just not interested in the project;
4. Coach's comfort level in presenting the project;
5. Visiting the patient too soon upon admission to the hospital;
6. Patients were discharged home or to a Skilled Nursing Facility (SNF) before the coach could make their visit in the hospital.

The care transitions specialist perspective identified a discomfort in approaching chronically ill patients in the hospital environment to promote the program and obtain participants. This was often times due to the nature of the hospital environment and culture. In some cases the coach would unknowingly visit the patient on their admission day, or on a day that was inconvenient to the patient. Similarly, it may not have been the right time of day for a visit and/or the patient may not have been ready to receive visitors due to where they were in their medical treatment.

Several modifications and/or enhancements were made to attempt to remedy these issues. The care transitions specialist was provided additional one-on-one training, videos on the CTI model, and role-play activities to increase their comfort in approaching patients and

explaining the model. Attempts to see the patient on the second or third day of hospitalization were made, to address the concerns about visiting on inconvenient days (particularly on the day of admission). The hospital case management staff worked to distribute the pilot project information to patients during the hospital discharge process through the use of written material, in an effort to generate interest in project participation and referrals to the coach. Overall, a willingness to of hospital staff to be active partners in the project was achieved, in large part by building the rapport with the care transitions specialist.

IV. Outcomes

Six 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 summarize the measures, followed by descriptive explanations of the project findings for each outcome.

Outcome 1: Reduce hospital readmission rates for target population

Table 2. Measures of Activity for Outcome 1

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Training CTS as CTI coach and training of others as support for coaches	In January of 2011, a staff member of the Carroll County SLRC attended the CTI training in CO. In ___ of 2011, the Center Manager of the Carroll County SLRC attended the CTI training in CO. When the new CTS was hired, they received an orientation to the Carroll County SLRC, The Memorial Hospital, and the CTI model (through online webinars, one-on-one trainings with the Center Manager, and role playing).	Completed April 2011
CTI materials for community branding (Personal Health Record) are modified and updated	The CTI materials were stamped with the Carroll County of SLRC and The Memorial Hospital logos, Carroll County SLRC address, Carroll County SLRC website and Carroll County SLRC local/toll-free phone numbers. No	Completed April 2011

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
	modifications were made to the content of the PHR.	
Transition CTI documents into database version (medication reconciliation and patient assessment form)	The UNH Survey Center created an online, secure database in which the CTS reported on the medication reconciliation and patient assessment. The patient assessment was completed at the first and last visit.	Completed April 2011
Documentation of meetings to educate Memorial Hospital, other SLRC staff, and other community stakeholders in enhanced model (role of CTS)	The first stakeholder meeting was held on 6/9/10. The meetings was attended by 2 nursing facilities, the homecare agency, VNS, SLRC, Memorial hospital and a local community agency. Follow up meetings continued with additional stakeholders attending, including additional case managers.	Completed September 2012
Documentation of the total CTI participants	Participants in the pilot were documented both on a Microsoft Excel based tracking sheet and in the Carroll County SLRC Information and Referral Database (Refer7).	Completed June 2012

Outcome Indicator: As noted previously, Carroll County SLRC Care Transitions pilot had a low referral rate to the CTI program and low agreement to participate. Of the 8 CTI participants, only 1 individual was re-admitted to The Memorial hospital within 30 days of discharge. The 12 month average readmission rate for the hospital in 2011 was 6.31% and for 2012 was 6.62%.

Findings: The care transitions pilot in Carroll County did not reduce 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
Documentation of the inclusion of CTI Model with a CTS at Memorial Hospital is completed.	CTS position is defined for Carroll County SLRC and The Memorial Hospital.	Completed April 2011
Training CTS in hospital visit and follow up is completed	In January 2011, the CTS coach trained at the CTI Center in Aurora, CO. In September 2011, the Carroll County SLRC Center Manger trained at the CTI Center, Aurora, CO. In December 2011, the new CTS was trained by SLRC Center Manager.	Completed January 2011 September 2011 December 2011
Develop additional question for SLRC satisfaction survey	A specific survey for Carroll County care transitions pilot participants was created through a joint effort of the SLRC staff, NH Bureau of Elderly and Adult Services, and UNH (See Appendix D).	Completed April 2011
Determine implementation of CTM-3 (The Care Transitions Measure (CTM-3) is a three-item instrument utilized to assess patient satisfaction with the discharge process.	Following discharge home, participants were administered the CTM-3 via a phone call. A workgroup convened and developed a protocol for administering the CTM-3. Participants were entered into a database that was sent to the CTM-3 caller. A call was made within one week of the patient's discharge home. This was then entered into the CTM-3 database. The protocol form can be found in Appendix E.	Completed April 2011

Outcome Indicators: Outcome 2 was measured using the *CTM-3 question responses (medical)* and the *Consumer Satisfaction Survey response to the question about feeling prepared for discharge (social).*

Findings: Five of the eight patients who participated in the program received a followed up phone call to administer the CTI Care Transitions Measurement Tool (CTM-3).

- 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*." 1 strongly agreed, 3 agreed, and 1 had no response.

- 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.*" 1 strongly agreed, 2 disagreed, 1 strongly disagreed, and 1 had no response.

- CTM-3 question 3: "When I left the hospital, I clearly understood the purpose for taking each of my medications." 1 strongly agreed, 2 agreed and 1 strongly disagreed.

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

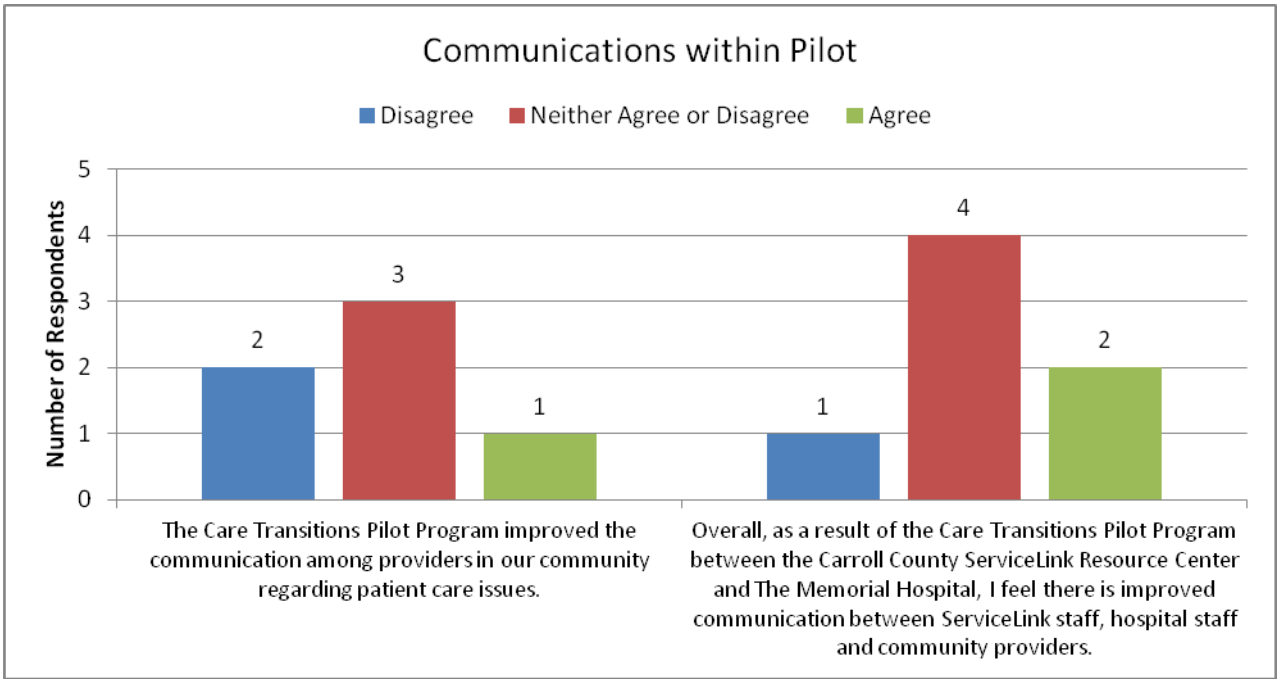
Table 4. Measures of Activity for Outcome 3

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Number of multidisciplinary team meetings with CTS is documented	Meetings occurred during rounds at the hospital, however, the content of the meetings was not documented.	Completed September 2012.
Implementation of survey questions on provider survey	A combined hospital based provider (medical) and community provider survey was developed and administered one time (See Appendix C). In November 2012, the survey was sent to the following: The Memorial Hospital- Case Managers, Clinical Nursing staff, Nurse Manager, Unit Secretary, and Hospitalists. Community- Mineral Springs Nursing Facility, Carroll County SLRC Advisory Board members, and Carroll County SLRC staff.	Completed November 2012.
Implementation of qualitative assessment tool of CTI stakeholders/ providers	Adequate funding for this activity was not secured.	Not done.

Outcome Indicators: Outcome 3 was measured using the results of the November 2012 provider survey that measured the % *of general medical and social providers reporting improved communications in Carroll County SLRC service area; and % of hospital based providers reporting onsite presence of CTS was helpful in communications.* Providers from 8 organizations (noted in table 4) were asked to complete the survey, and 13 responded.

Findings: As shown in Figure 1, 40% of participants responded that they 'Disagree', 60% that they 'Somewhat Disagree', and 16% that they 'Agree' to the question: "Overall, as a result of the ServiceLink Resource Center Care Transition Specialist on site at the hospital, I feel there is improved communication between our community regarding patient care issues." In addition, 14% of participants responded that they 'Disagree', 57% that they 'Somewhat Disagree', and 29% that they 'Agree' to the question: "Overall, as a result of the Care Transitions Pilot Program between Carroll County ServiceLink Resource Center and the Memorial Hospital, I feel there is improved communication between ServiceLink staff, hospital staff and community providers care received by patients."

Figure 1. Care Transitions Survey: Implemented in October 2013



One important survey response worth noting was: *"The program raised some awareness about ServiceLink services and associated community based services. However, it never became an integral part of the care transition from hospital to care after discharge. As acute hospital stays are by their nature brief and often very intense, there was usually not the opportunity for the care transitions coach to have meaningful interaction with the patient while they were in an inpatient status. This could be a valuable program, but only if placed elsewhere in the continuum of care for the patient and their family/support persons."*

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

Table 5. Measures of Activity for Outcome 4

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Documentation of the CTS position	All of the New Hampshire care transitions pilot sites developed a job description for a CTS with the NH Bureau of Elderly and Adult Services. (See Appendix H)	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. (See Appendix I)	Completed April 2011
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 CT.	Completed April 2011
Training of staff in tracking and training of hospital staff in SLRC model completed	The Carroll County SLRC Center Manager trained the CTS in Refer7 tracking. In addition, later in the project, an excel document was utilized by the CTS to track all the reporting requirements of the pilot. This excel document was submitted to the Center Manager and UNH monthly for quality assurance tracking. Training of hospital staff occurred during the first few multi-disciplinary meetings but was ongoing through the project due to the onsite presence of the CTS.	SLRC staff training completed April 2011 Hospital staff training completed September 2012

Outcome Indicators: Outcome 4 was measured using the referral tracking systems to measure the *# of referrals made to other SLRC programs and # of community referrals made under SLRC.*

Findings: The total number of referrals made to other SLRC programs by the CTS was 10. The number of referrals made to other programs was 3.

To augment this outcome, providers (hospital and community based) where asked if the CTS was an integral part of the discharge planning at The Memorial Hospital. Respondents did

not indicate that the CTS was an integral part of the process, and one comment was, "*I don't think there was enough time and availability to allow the program to be successful. I think that we have a good relationship with ServiceLink and that this program neither increased nor decreased the wonderful services already available.*"

The hospital and community based providers were also asked if the Care Transitions Pilot Program was in integral part of coordinating social services for individuals as they transition back to the community setting. Overall, there was not a sense that the CTI pilot defined an integral part of coordinating social services: only 29% agreed that the Care Transition Pilot Program was an integral part of coordinating social services for individuals as they transitioned back into the community setting. Again, however, the sample size was small (N).

The Carroll County SLRC reported that of the individuals assisted, 75% (89) of the consumers continued to make contact with the ServiceLink office. The type of services they sought for their needs included SLRC Long Term Care Counseling, home Care/personal care services, NH Medicaid - Choices for Independence, State Medicare, and Adult Protections Services (APS).

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

Table 6. Measures of Activity for Outcome 5

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Train CTS in CTI coaching skills	In January 2011, the CTS coach trained at the CTI Center in Aurora, CO. In September 2011, the Carroll County SLRC Center Manger trained at the CTI Center, Aurora, CO. In December 2011, the new CTS was trained by the SLRC Center Manager.	Completed January 2011 September 2011 December 2011.
Establish ongoing support for coach	CTS received supervision from the Center Managers on an ongoing basis, ad hoc from other CTS, and during CTI national couching calls.	Ongoing throughout the pilot.
Establish the CTI Personal Health Record with all participants	The CTI PHR was distributed at every hospital interaction, whether or not the person agreed to participate in the program.	Completed.
Add question to SLRC consumer satisfaction in this community.	A specific survey for the Carroll County care transitions pilot participants was created through a joint effort of the SLRC staff, NH Bureau of Elderly and Adult Services, and UNH. (See Appendix D)	Completed

Outcome Indicators: Outcome 5 was measured by the *% of target population who receives the PHR and the % reporting confidence to navigate the systems on SLRC consumer satisfaction survey*.

Findings: One hundred percent of the target population received the CTI PHR, which was handed out at every hospital based visit regardless of whether or not the person agreed to participate in the pilot. A total of 166 individuals received the PHR as it was offered to individuals beyond the care transitions target population.

The care transitions satisfaction survey included two questions that pointed to confidence in navigating the systems: (1) "I know how to find the help I need." and (2) "I know what services and supports are available in my community." Additionally, the question, "Overall, how confident do you feel that you have the skills and resources to manage your recovery at home?" was asked. However, Carroll County only received one returned survey of the eight sent. We are unable to report on these measures.

Outcome 6: Reduce the number of medication discrepancies between the first 6 months and the last 6 months

Table 7. Measures of Activity for Outcome 6

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Documentation of medication discrepancy forms	A database for the collection of the medication discrepancy forms was created. Due to low numbers, findings were only shared with The Memorial Hospital at the end of the pilot.	Throughout the pilot.

Findings: The CTI model medication discrepancy tool was utilized in this pilot for the eight participants. Four individuals had one discrepancy. No other medication discrepancies were reported.

V. Informing a state-wide ADRC care transitions project

While the Carroll County SLRC care transitions pilot project's low participation rate limits the usability of the evaluation to quantitatively inform care transition projects more broadly, there are a number of lessons learned that can inform a state-wide ADRC care transitions project.

CTI model

→ There was resistance to having a non-medical person/hospital staff visit individuals in the hospital. While patients understood the program and felt it was needed, they did not identify themselves as in need of the service. Continued education of other providers, the larger community, and support for the coach to overcome this barrier can improve this issue.

→ Draft guidelines to support the unique patient profile and needs of the pilot sites. This is particularly true in defining inclusion criteria. This pilot started with a small number of referrals, and struggled to recover and become integrated broadly into the hospital. Small rural hospitals will likely need to include all chronic health conditions and broader age ranges at the start.

→ For small rural hospitals areas, incorporating transitions from Skilled Nursing facility (SNF), in addition to the acute hospital, at the beginning of the project may provide a larger base of individuals to draw from, and therefore, overcome the low acceptance rate seen nationally.

Pilot Tracking

Utilizing a client tracking sheet was an important tool for the project. It helped to track the clients and other information in an easily accessible location, and provided the CTS a mechanism to coordinate between the hospital, SRLC, and UNH for evaluation tracking/reporting needs.

Community and Hospital relationships

→ It was easy in the early CTI development stage to have community meetings with hospital, VNS, nursing facility and SNF in order to educate about the project and build partnerships; however, keeping those participants interested in the project and adding additional community members, such as APS, physicians, medical practices and health clinic to the table was challenging. Providing resources during the pre-implementation and implementation stages to build relationships is vital.

→ It is important to create relationships early on with hospital staff beyond the leadership. For example, while the head of the social services department may be the one at the larger implementation meetings, establishing direct relationships for pilot education and trust-building with the social workers involved in direct care improves the quality of the program. In addition, meeting with the hospitalist, covering physicians, and nursing staff of the hospital across all shifts and staff rotations is crucial.

→ Including the hospital CEO early on in the project will help to develop clear messages, support, and communication channels for ongoing support and sustainability.

→ Projects should establish regularly meetings with the hospital social services department to reiterate the program, re-evaluate to the CTI criteria and referral process. It can be challenging with work schedules, but the social workers found that CTI can get lost in the many other responsibilities that they have in patient interactions.

State Level

→ To ensure sharing of experiencing and best practices, projects should establish consistent round table discussions and meetings with the CTS so they can bond and create relationships and utilize best practices.

→ Utilize conference calls and webinar technology when appropriate for meetings across SLRC sites for share learning. However, one-on-one meetings will continue to be necessary in the community to support the unique needs and issues.

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

a. Will a SLRC CTS need to partner with more than one hospital? This may mean working within more than one care transitions model.
b. 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.

→ Project should plan for provide ongoing training support for the CTS (CTI coach).

VI. Appendices

Appendix A:

Crosswalk of Evidence Based Models

Mapping Care Transitions -		
Model Characteristic	**Coleman Model - "Care Transitions Intervention"**	**If Present type Y / Not Present type N**
Staff involved / level of training required	**"Transitions Coach"** - may be nurse (RN) or social worker,or highly trained community health worker.	
Patient Eligibility Criteria	Age 65 years or older, Non-psychiatric-related admission, Community-dwelling, Close enough to hospital for home visit, Have a working telephone, Have at least one of 11 diagnoses.	
Length & Frequency of Intervention	4 week program: 1 home visit, 3 phone calls, 1 role playing session with patient prior to primary care appointment.	
Follow-up	Follow 24-28 patients.	
Cost	Total annual cost = $74, 310 for 379 patients ($196/pt). Estimated annual cost savings: $844/pt.	
1) Hospital visit	Introduce oneself and discuss program components:	
	a) Patient Health Record discussed	
	b) Medications will be reviewed at home visit	
	c) Follow-up & review questions for PCP visit	
	d) Discuss signs for concern (red flags)	
2) Home Visit	Ideally completed within 24- 48 hours after discharge	
	Reconcile medications before and after admission	
	Role-play communicating needs to Primary Provider	
	Review physical signs of concern (notify MD)	

Mapping Care Transitions -		
Model Characteristic	**Coleman Model - "Care Transitions Intervention"**	**If Present type Y / Not Present type N**
3) Phone calls	Are follow-up calls made	
	One call made after discharge	
	Two calls made after discharge	
	Three calls made after discharge	
4) Self-empowerment and training family/informal caregivers	Caregivers involved in Care Transitions process and trained alongside participants	
Model Characteristic	**Naylor Model - "Transitional Care Model"**	**If Present type Y / Not Present type N**
Staff involved / level of training required	**"Transition Nurse Manager"** - Highly trained RN or Advanced Practice Nurse	
Patient Eligibility Criteria	Older adults that are cognitively intact, Two or more risk factors, including: poor self-health ratings, multiple chronic conditions, and history of recent hospitalizations.	
Length & Frequency of Intervention	On-call seven days per week for home visits, and telephone access for one to three months of home follow-up (2 months on average).	
Follow-up	Follow 18 patients (on average).	
Cost	Total intervention cost was $115,856 per year. ($982 per patient) One study showed mean cost savings per year of $5000 per patient.	
1) Hospital visit	Transition Nurse Manager visits patient daily while in hospital	
	Patient assessment done	
	Plan of care developed	
2) Home Visit	Home visit scheduled within 24 - 48 hrs	

Mapping Care Transitions -		
Model Characteristic	**Coleman Model - "Care Transitions Intervention"**	**If Present type Y / Not Present type N**
	Assess ADL/IADL	
	Medication management & reconciliation	
	Weekly home visits during 1st month	
	Go with person to primary care appt	
3) Phone calls	Phone call during week(s) when no visit made	
	Facilitates communication with all providers	
4) Self-empowerment and training family/informal caregivers	Actively engage person/family to focus on meeting *their* goals	

Appendix B:

Medication Discrepancy and Red Flags Database

Care Transitions Instrument

Medication Discrepancy and Red Flags Data Collection Instrument

What is todays date: (MM/DD/YYYY)

_____

Is this the first assessment or the final assessment for this patient?

- ❑ *First Assessment*
- ❑ *Final Assessment*

Which hospital was the patient discharged from?

- ❑ *Memorial Hospital*
- ❑ *Cheshire Medical Center / DHK*
- ❑ *Nursing Facility*

Please Enter Nursing facility name

_____

What floor of the hospital was the patient on?

- ❑ *First*
- ❑ *Second*
- ❑ *Third*
- ❑ *Fourth*

Patient Name or Identifier:

_____

(ASKIF First Visit)Patient Contact Phone Number:

_____

(ASKIF FIRST)Patient Date of Discharge (MMDDYYYY):

_____

Coach's Name

- ❑ *Karen Hildreth*
- ❑ *Carrie Johnson*
- ❑ *Other - Specify*

Specify:

_____

Did you previously enter this person's demographics?

- ❑ *Yes*
- ❑ *No*

Was the home visit completed?

❑ *Yes*
❑ *No*

Patient Activation Assessment

Rate Level of Performance in Four Pillars (Score 1 point for each check below)

Medication Management

Rate patient level of performance (Check all that apply)

❑ *Demonstrates effective use of Medication Management System (medication organizer, flow chart, etc.)*
❑ *For each medication, understands the purpose, when and how to take, and possible side effects*
❑ *Demonstrates ability to accurately update medication list*
❑ *Agrees to confirm medication list with PCP and/or Specialist*

Comments

_____
_____
_____
_____
_____

Patient Activation Assessment

Rate Level of Performance in Four Pillars (Score 1 point for each check below)

Red Flags

Rate patient level of performance (Check all that apply)

❑ *Demonstrates understanding of Red Flags, or warning signs that condition may be worsening*
❑ *Reacts appropriately to Red Flags per education given (or understands how to react appropriately)*

Comments

_____
_____
_____
_____
_____

Patient Activation Assessment

Rate Level of Performance in Four Pillars (Score 1 point for each check below)

Medical Care Follow Up

Rate patient level of performance (Check all that apply)

- ❑ *Can schedule and follow through on appointment(s).*
- ❑ *Writes a list of questions for PCP and/or specialist and brings to appointment*

Comments

_____
_____
_____
_____
_____

Patient Activation Assessment

Rate Level of Performance in Four Pillars (Score 1 point for each check below)

Personal Health Record (PHR)

Rate patient level of performance (Check all that apply)

- ❑ *Understands the purpose of PHR and the importance of updating PHR*
- ❑ *Agrees to bring PHR to every health encounter*

Comments

_____
_____
_____
_____
_____

Medication Discrepancy Tool (MDT)

MDT is designed to facilitate reconciliation of medication regimen across settings and prescribers.

Medication Discrepancy Event Description: Complete one form for each discrepancy

How many Medication Discrepancy Events do you need to report for this patient

- ❑ *0*
- ❑ *1*
- ❑ *2*
- ❑ *3*
- ❑ *4*
- ❑ *5*
- ❑ *6*
- ❑ *7*
- ❑ *8*

❑ *9*
❑ *10 or more*

Medication Discrepancy Tool (MDT)

Causes and Contributing Factors

Please complete a brief description of the discrepancy and the questions that follow for the FIRST Medication Discrepancy Event.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Level: check all that apply

❑ *Adverse Drug Reaction or side effects*
❑ *Intolerance*
❑ *Didn't fill prescription*
❑ *Didn't need prescription*
❑ *Money/financial barriers*
❑ *Intentional non-adherence - "I was told to take this but I choose not to."*
❑ *Non-intentional non-adherence (ie: Knowledge deficit) - "I don't understand how to take this medication."*
❑ *Performance deficit - "Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level: check all that apply

❑ *Prescribed with known allergies/intolerances*
❑ *Conflicting information from different informational sources. For example, discharge instructions indicate one thing and pill bottle says another.*
❑ *Confusion between brand & generic names*
❑ *Discharge instructions incomplete/inaccurate/illegible. - Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
❑ *Duplication. - Taking multiple drugs with the same action without any rationale.*
❑ *Incorrect dosage*
❑ *Incorrect quantity*
❑ *Incorrect label*
❑ *Cognitive impairment not recognized*
❑ *No caregiver/need for assistance not recognized*
❑ *Sight/dexterity limitations not recognized*

Resolution: check all that apply

- ❑ *Advised to stop taking/start taking/change administration of medications*
- ❑ *Discussed potential benefits and harm that may result from non-adherence*
- ❑ *Encouraged patient to call PCP/specialist about problem*
- ❑ *Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit*
- ❑ *Encouraged patient to talk to pharmacist about problem*
- ❑ *Addressed performance/knowledge deficit*
- ❑ *Provided resource information to facilitate adherence*
- ❑ *Other (specify below)*

_____
_____
_____
_____
_____

Medication Discrepancy Tool (MDT)

Causes and Contributing Factors

Please complete a brief description of the discrepancy and the questions that follow for the SECOND Medication Discrepancy Event.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Level: check all that apply

- ❑ *Adverse Drug Reaction or side effects*
- ❑ *Intolerance*
- ❑ *Didn't fill prescription*
- ❑ *Didn't need prescription*
- ❑ *Money/financial barriers*
- ❑ *Intentional non-adherence - "I was told to take this but I choose not to."*
- ❑ *Non-intentional non-adherence (ie: Knowledge deficit) - "I don't understand how to take this medication."*
- ❑ *Performance deficit - "Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level: check all that apply

- ❑ *Prescribed with known allergies/intolerances*
- ❑ *Conflicting information from different informational sources. For example, discharge instructions indicate one thing and pill bottle says another.*
- ❑ *Confusion between brand & generic names*
- ❑ *Discharge instructions incomplete/inaccurate/illegible. - Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
- ❑ *Duplication. - Taking multiple drugs with the same action without any rationale.*
- ❑ *Incorrect dosage*
- ❑ *Incorrect quantity*
- ❑ *Incorrect label*
- ❑ *Cognitive impairment not recognized*
- ❑ *No caregiver/need for assistance not recognized*
- ❑ *Sight/dexterity limitations not recognized*

Resolution: check all that apply

- ❑ *Advised to stop taking/start taking/change administration of medications*
- ❑ *Discussed potential benefits and harm that may result from non-adherence*
- ❑ *Encouraged patient to call PCP/specialist about problem*
- ❑ *Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit*
- ❑ *Encouraged patient to talk to pharmacist about problem*
- ❑ *Addressed performance/knowledge deficit*
- ❑ *Provided resource information to facilitate adherence*
- ❑ *Other (specify below)*

_____
_____
_____
_____
_____

Medication Discrepancy Tool (MDT)

Causes and Contributing Factors

Please complete a brief description of the discrepancy and the questions that follow for the THIRD Medication Discrepancy Event.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Level: check all that apply

- ❑ *Adverse Drug Reaction or side effects*
- ❑ *Intolerance*
- ❑ *Didn't fill prescription*
- ❑ *Didn't need prescription*
- ❑ *Money/financial barriers*
- ❑ *Intentional non-adherence - "I was told to take this but I choose not to."*
- ❑ *Non-intentional non-adherence (ie: Knowledge deficit) - "I don't understand how to take this medication."*
- ❑ *Performance deficit - "Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level: check all that apply

- ❑ *Prescribed with known allergies/intolerances*
- ❑ *Conflicting information from different informational sources. For example, discharge instructions indicate one thing and pill bottle says another.*
- ❑ *Confusion between brand & generic names*
- ❑ *Discharge instructions incomplete/inaccurate/illegible. - Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
- ❑ *Duplication. - Taking multiple drugs with the same action without any rationale.*
- ❑ *Incorrect dosage*
- ❑ *Incorrect quantity*
- ❑ *Incorrect label*
- ❑ *Cognitive impairment not recognized*
- ❑ *No caregiver/need for assistance not recognized*
- ❑ *Sight/dexterity limitations not recognized*

Resolution: check all that apply

- ❑ *Advised to stop taking/start taking/change administration of medications*
- ❑ *Discussed potential benefits and harm that may result from non-adherence*
- ❑ *Encouraged patient to call PCP/specialist about problem*
- ❑ *Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit*
- ❑ *Encouraged patient to talk to pharmacist about problem*
- ❑ *Addressed performance/knowledge deficit*
- ❑ *Provided resource information to facilitate adherence*
- ❑ *Other (specify below)*

_____

_____

_____

_____

_____

Medication Discrepancy Tool (MDT)

Causes and Contributing Factors

Please complete a brief description of the discrepancy and the questions that follow for the FOURTH Medication Discrepancy Event.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Level: check all that apply

- ❑ *Adverse Drug Reaction or side effects*
- ❑ *Intolerance*
- ❑ *Didn't fill prescription*
- ❑ *Didn't need prescription*
- ❑ *Money/financial barriers*
- ❑ *Intentional non-adherence - "I was told to take this but I choose not to."*
- ❑ *Non-intentional non-adherence (ie: Knowledge deficit) - "I don't understand how to take this medication."*
- ❑ *Performance deficit - "Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level: check all that apply

- ❑ *Prescribed with known allergies/intolerances*
- ❑ *Conflicting information from different informational sources. For example, discharge instructions indicate one thing and pill bottle says another.*
- ❑ *Confusion between brand & generic names*
- ❑ *Discharge instructions incomplete/inaccurate/illegible. - Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
- ❑ *Duplication. - Taking multiple drugs with the same action without any rationale.*
- ❑ *Incorrect dosage*
- ❑ *Incorrect quantity*
- ❑ *Incorrect label*
- ❑ *Cognitive impairment not recognized*
- ❑ *No caregiver/need for assistance not recognized*
- ❑ *Sight/dexterity limitations not recognized*

Resolution: check all that apply

- ❑ *Advised to stop taking/start taking/change administration of medications*
- ❑ *Discussed potential benefits and harm that may result from non-adherence*
- ❑ *Encouraged patient to call PCP/specialist about problem*
- ❑ *Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit*
- ❑ *Encouraged patient to talk to pharmacist about problem*
- ❑ *Addressed performance/knowledge deficit*
- ❑ *Provided resource information to facilitate adherence*
- ❑ *Other (specify below)*

_____
_____
_____
_____
_____

Medication Discrepancy Tool (MDT)

Causes and Contributing Factors

Please complete a brief description of the discrepancy and the questions that follow for the FIFTH Medication Discrepancy Event.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Level: check all that apply

- ❑ *Adverse Drug Reaction or side effects*
- ❑ *Intolerance*
- ❑ *Didn't fill prescription*
- ❑ *Didn't need prescription*
- ❑ *Money/financial barriers*
- ❑ *Intentional non-adherence - "I was told to take this but I choose not to."*
- ❑ *Non-intentional non-adherence (ie: Knowledge deficit) - "I don't understand how to take this medication."*
- ❑ *Performance deficit - "Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level: check all that apply

- ❑ *Prescribed with known allergies/intolerances*
- ❑ *Conflicting information from different informational sources. For example, discharge instructions indicate one thing and pill bottle says another.*
- ❑ *Confusion between brand & generic names*
- ❑ *Discharge instructions incomplete/inaccurate/illegible. - Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
- ❑ *Duplication. - Taking multiple drugs with the same action without any rationale.*
- ❑ *Incorrect dosage*
- ❑ *Incorrect quantity*
- ❑ *Incorrect label*
- ❑ *Cognitive impairment not recognized*
- ❑ *No caregiver/need for assistance not recognized*
- ❑ *Sight/dexterity limitations not recognized*

Resolution: check all that apply

- ❑ *Advised to stop taking/start taking/change administration of medications*
- ❑ *Discussed potential benefits and harm that may result from non-adherence*
- ❑ *Encouraged patient to call PCP/specialist about problem*
- ❑ *Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit*
- ❑ *Encouraged patient to talk to pharmacist about problem*
- ❑ *Addressed performance/knowledge deficit*
- ❑ *Provided resource information to facilitate adherence*
- ❑ *Other (specify below)*

_____
_____
_____
_____
_____

Medication Discrepancy Tool (MDT)

Causes and Contributing Factors

Please complete a brief description of the discrepancy and the questions that follow for the SIXTH Medication Discrepancy Event.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Level: check all that apply

- ❑ *Adverse Drug Reaction or side effects*
- ❑ *Intolerance*
- ❑ *Didn't fill prescription*
- ❑ *Didn't need prescription*
- ❑ *Money/financial barriers*
- ❑ *Intentional non-adherence - "I was told to take this but I choose not to."*
- ❑ *Non-intentional non-adherence (ie: Knowledge deficit) - "I don't understand how to take this medication."*
- ❑ *Performance deficit - "Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level: check all that apply

- ❑ *Prescribed with known allergies/intolerances*
- ❑ *Conflicting information from different informational sources. For example, discharge instructions indicate one thing and pill bottle says another.*
- ❑ *Confusion between brand & generic names*
- ❑ *Discharge instructions incomplete/inaccurate/illegible. - Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
- ❑ *Duplication. - Taking multiple drugs with the same action without any rationale.*
- ❑ *Incorrect dosage*
- ❑ *Incorrect quantity*
- ❑ *Incorrect label*
- ❑ *Cognitive impairment not recognized*
- ❑ *No caregiver/need for assistance not recognized*
- ❑ *Sight/dexterity limitations not recognized*

Resolution: check all that apply

- ❑ *Advised to stop taking/start taking/change administration of medications*
- ❑ *Discussed potential benefits and harm that may result from non-adherence*
- ❑ *Encouraged patient to call PCP/specialist about problem*
- ❑ *Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit*
- ❑ *Encouraged patient to talk to pharmacist about problem*
- ❑ *Addressed performance/knowledge deficit*
- ❑ *Provided resource information to facilitate adherence*
- ❑ *Other*

_____
_____
_____
_____
_____

Thank you!

Please click "Submit" below.

Appendix C:

ServiceLink Resource Center Provider/Community Survey

Default Question Block

For the past year the Carroll County ServiceLink Resource Center (SLRC) has been partnering with The Memorial Hospital 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 Carroll County SLRC and The Memorial Hospital. Your participation in this brief, anonymous 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.

Please tell us which organization you represent:

What is your role within your organization?

- Case Manager
- Director
- Staff RN
- Ancillary Dept. Staff (PT, OT, SLT, Imaging, Lab)
- Clinical Manager
- Administration
- Hospitalist
- Physician
- Long Term Support Counselor
- Information and Referral Specialist
- Caregiver Specialist
- Other

Are you familiar with the Care Transitions Pilot Program between the Carroll County ServiceLink Resource Center and The Memorial Hospital that occurred over the past year?

- Yes

- No

Please select the most appropriate answer:

	Never	Rarely	Sometimes	Often	All of the Time
How frequently did you interact with the care transitions pilot project?					

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

- Yes
- No
- Don't know
- Not Applicable

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

	Disagree	Neither Agree nor Disagree	Agree	Don't Know
The Care Transitions Pilot Program improved the communication among providers in our community regarding patient care issues.				
The Care Transition Pilot Program was an integral part of the discharge planning process at The Memorial Hospital.				
The Care Transition Pilot Program was an integral part of coordinating social services for individuals as they transition back to the community settings.				

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

	Disagree	Neither Agree nor Disagree	Agree	Don't Know
Overall, as a result of the Care Transitions Pilot Program between the Carroll County ServiceLink Resource Center and The Memorial Hospital, I feel there is improved communication between ServiceLink staff, hospital staff and community providers.				

Overall, do you agree that the Care Transitions Pilot Program increased access to home and community based-services for individuals discharged from The Memorial Hospital?

- Yes
- No
- Don't know

Please provide any comments related to your response above:

In your experience with the Carroll County ServiceLink Resource Center, would you agree they are an important partner in an effective care transitions program in your community?

- Yes
- No
- Don't know

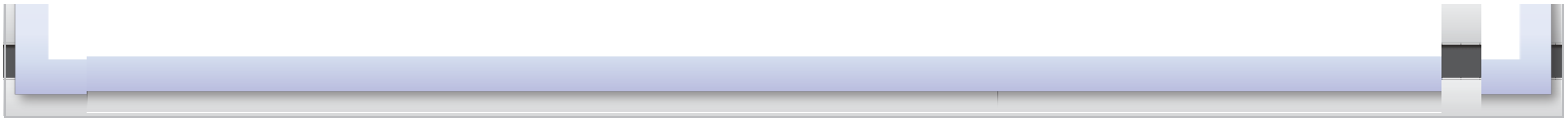
Please provide any comments related to your response above:

Are you aware of the community-based services that the ServiceLink Resource Center Network provides to individuals?

- Yes
- No

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

	Disagree	Neither Agree not Disagree	Agree	Don't Know
In my experience with the ServiceLink Resource Center Network I have found the resources available to individuals beneficial.	○	○	○	○



Appendix D:

ServiceLink Resource Center Consumer Satisfaction Survey

UNIVERSITY of NEW HAMPSHIRE

The ServiceLink Resource Center of Carroll County and The Memorial 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.

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 confident do you feel that you have the skills and resources to manage your recovery at home?

(1) Very Confident	(2) Somewhat Confident	(3) Not Very Confident	(4) Not Confident At All	(9) Don't Know / Not Applicable

If not, why? _____

_____

If you need additional assistance please call your local ServiceLink Resource Center at: 603-999-9999

Appendix E:

CTM-3 Phone Survey

1. Patient Identifiers

*1. What is today's date?

MM DD YYYY

Date ____ / ____ / ____

*2. Which hospital was the patient discharged from?

- ◯ Memorial Hospital
- ◯ Nursing Facility
- ◯ Cheshire Medical Center/DHK

Enter the name of the nursing facility

2.

***1. What floor of the hospital was the patient on?**

- ◯ First
- ◯ Second
- ◯ Third
- ◯ Fourth

3. Care Transition Measure (CTM-3)

I am calling to invite you to please help (YOUR hospital) better understand how to improve their patients' experience and be best prepared to leave the hospital.

I would like to ask you if you would answer a three-question survey. These questions will take no more than a few minutes to answer.

Please know that your decision about participating in the survey will not in any way affect your health care coverage. Also, your responses will not be directly shared with your doctors or nurses or transition coach.

Would you be willing to take this survey today?

[If the patient agrees to take the survey, next explain the response options.]

"For each question, your response options include Strongly Agree, Agree, Disagree, Strongly Disagree "

[Do not initially introduce these options--Don't Know/Don't' Remember/Not Applicable but offer them if it becomes clear the above four do not pertain.]

[An alternative approach is to provide them only with Agree or Disagree. If the interviewee responds with agree, then ask if s/he strongly agrees or just agrees. Similarly, if the interviewee responds with disagree, then ask if s/he strongly disagrees or just disagrees]

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.

- ◯ Strongly Agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree
- ◯ Don't Know/Don't Remember/Not Applicable

2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

- ◯ Strongly Agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree
- ◯ Don't Know/Don't Remember/Not Applicable

3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

- ◯ Strongly Agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree
- ◯ Don't Know/Don't Remember/Not Applicable

4. Completion & Thank You

Thank you for participating in this survey today.

Appendix F:

Program Tracking Tool

	Client Info	Hospital Admission & CTI Admission Information								SLRC	Nursing Home Visits			Home Visit	1st Patient Assessment and Med Reconcillation entered on line	Follow Up Phone Calls			2nd Patient Assessment entered on line	Re-Admission		completed	Notes
	Name	**Hospital Admission Date**	**Admitting Diagnosis**	**Hospital Visit Date**	**Edischarge referal for CTI**	**Admit to CTI (Yes/No)**	**Reason why not**	**Communicated with Care Coordinator**	**Provided Consultation in hospital (but not CTI participant)**	**Refer7**	**1st NH Visit Date**	**2nd NH Visit Date**	**3rd NH Visit Date**	**Date**	**Yes/No**	**1st Call Date**	**2 nd Call Date**	**3 rd Call Date**	**Yes/No**	**No or list date**	**Reason**	**Completed**	
1																							
2																							
3																							
4																							
5																							
6																							
7																							
8																							
9																							
10																							
11																							
12																							
13																							
14																							
15																							
16																							
17																							
18																							
19																							
20																							
21																							
22																							
23																							
24																							
25																							
26																							
27																							
28																							
29																							
30																							
31																							
32																							
33																							
34																							
35																							
36																							
37																							
38																							
39																							
40																							
41																							
42																							

Appendix G

Pilot Reporting Tool

Care Transitions evaluation data reporting form								
Evaluation item	Reporting Period							
	Mar-11	**Apr-Jun 2011**	**Jul-Sep 2011**	**Oct-Dec 2011**	**Jan-Mar 2012**	**Apr-Jun 2012**	**Jul-Sep 2012**	**Total**
Participants								
# of referrals to the formal pilot from the hospital	2	2	0	0	68	47	0	119
# of participants in the formal pilot	2	2	0	0	3	1	0	8
# of participants who completed formal pilot	1	2	0	0	2	1	0	6
# of "consults" conducted at the hosptial (non-pilot patients)	0	0	0	0	29	28	0	57
# of total referrals to made to other SLRC programs by the CTS	0	1	0	0	2	7	0	10
Please take the top 4 referrals to other SLRC programs and report the number by category in lines 12-15								
# referred to Caregiver Specialists	0	0	0	0	0	0	0	0
# referred to LTSCs	0	0	0	0	0	2	0	2
# referred to I& R	0	1	0	0	2	5	0	8
# referred to "other"- please specify SLRC program here	0	0	0	0	0	0	0	0

Care Transitions evaluation data reporting form								
Evaluation item	Reporting Period							
	Mar-11	**Apr-Jun 2011**	**Jul-Sep 2011**	**Oct-Dec 2011**	**Jan-Mar 2012**	**Apr-Jun 2012**	**Jul-Sep 2012**	**Total**
Age								
# of participants age 60+	2	1	0	0	3	2	0	8
# of participants under age 60	0	0	0	0	0	1	0	1
# of participants age unknown	0	0	0	0	0	0	0	0
Services								
# of total community referrals made by CTS	0	0	0	0	1	2	0	3
Please break out the top 4 referrals to community programs and report the number by category in lines 24-27		0						
#referred to chronic disease self-management	0	0	0	0	0	0	0	0
#referred to Personal Emergency Response Systems (pls specify program type)	0	0	0	0	1		0	1
#referred to Property Tax Rebate Information (pls specify program type)	0	0	0	0	0	1	0	1

Care Transitions evaluation data reporting form								
Evaluation item	Reporting Period							
	Mar-11	**Apr-Jun 2011**	**Jul-Sep 2011**	**Oct-Dec 2011**	**Jan-Mar 2012**	**Apr-Jun 2012**	**Jul-Sep 2012**	**Total**
#referred to General Paratranist/Community Ride Program (pls specify program type)	0	0	0	0	0	1	0	1
Staff								
# multidisciplinary team meetings with CTS*								
# Advisory team meetings*								
*For recurring meetings, list staff who generally 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 to CTS								
# of referrals								

Care Transitions evaluation data reporting form								
Evaluation item	Reporting Period							
	Mar-11	**Apr-Jun 2011**	**Jul-Sep 2011**	**Oct-Dec 2011**	**Jan-Mar 2012**	**Apr-Jun 2012**	**Jul-Sep 2012**	**Total**
from CTS to other BOOST providers								
# referred to diabetic education								
# referred to cardiac/pulmonary rehab								
# referred to palliative care team								
# referred to pharmacist								
# referred to nurse/care manager								
# of referrals to BOOST mobile								
CTI								
# of participants who receive PHR	2	1	0	0	88	75	0	166
# of medication discrepancies	2	1	0	0	88	75	0	166

Appendix H

Care Transitions Specialist Job Description

Job Title: Care Transitions Specialist

Basic Purpose: The Care Transition Specialist, under the direction of the ServiceLink Resource Center Manager, functions as a facilitator of interdisciplinary collaboration across the care continuum. The primary role of the Care Transition Specialist is to empower the patient/caregiver 1) to become an active participant in their care and 2) to assist in developing lasting self-management skills. Care Transition Specialists will support individual patient/caregiver with complex needs that will include a hospital visit, home visit and follow-up phone calls.

Qualifications:

- Trained in person-centered approach and demonstrates of skill/understanding.
- Knowledge of care transitions and demonstrates willingness to implement evidence-based care transitions models.
- Possesses ability to function as an integral member of a multi-disciplinary team.
- Ability to work independently to coordinate services among staff, partners and customers.
- Highly organized, able to work in a fast-paced environment and demonstrate prioritization skills and effective time management.
- Knowledge of community resources.
- Demonstrates critical thinking skills.
- Fluent in written and verbal communications.
- Moderate computer proficiency in MS Office applications.
- Valid driver's license and reliable transportation.

Skills:

- Sufficient administrative, public relations and computer skills to manage an information and referral database that tracks calls, consumer demographics, and data resources;
- Knowledge and/or experience with information and referral taxonomy a plus;
- Good interpersonal skills, openness and flexibility in working with diverse groups, and enthusiasm for working collaboratively and with a team;
- Basic skills in: listening, customer service, interviewing, understanding of services, advocacy, and documentation.

Experience:

- Experience working with older adults and/or adults with disabilities. Familiar with of chronic disease management strategies. Working knowledge of human service delivery system. Some experience in customer relations, call management, information and referral or related field that includes phone skills and preliminary assessment and triage ability of contacts. Comfortable working knowledge of computers.

Accountabilities:

- Work with partner medical provider to implement a person-centered care transition model.
- Coordinate care across health-care and community-care delivery systems with client, caregivers, providers and others.
- Participate in all relevant meetings, conferences, and committees as assigned.
- Assist in educating service providers, the general public and others about community resources for person-centered care transitions services.
- Establish rapport with other care providers and facilitate meetings as needed to resolve unmet needs, service gaps, and barriers to care transitions model.
- Identify barriers, service gaps, etc and strategize possible systems change solutions with health-care and community-care.
- Carry on a positive working relationship with both inter- and intra-Agency sources.
- Participate in person-centered care transitions trainings, in-services, and conferences to develop professional skills.

Education:

- Bachelor degree in human services or health related field preferred. Associates degree **or other credentials** with 3 years experience as described above will be considered.
- Alliance of Information Referral Specialist (AIRS) certification within one year of hire.
- Trained within 12 months of hire in State Health Insurance Assistance Program (SHIP).

Other Requirements:

Must be able to answer telephone and perform light work that includes walking or operating computer and office equipment for extended periods of time – as well as occasional strenuous activity like reaching or bending.

Maintain a valid driver's license, good driving record and automobile insurance.

Maintain appearance appropriate to assigned duties and responsibilities as determined by the agency appointing authority.

This is a part time position supervised by SLRC manager. Will be working at the hospital and traveling in the community.

X

Michael Major
Care Transition Specialist

Appendix I

Documentation to Changes in Refer

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	1. "Hospital Visit" 2. "Consult/PCHDP Project"	1. Everyone 2. 3 pilot sites only/everyone can see	1. Used by any SLRC staff that sees a client while in the hospital- Care Transitions Specialist, Caregiver Specialist and/or Long Term Support Counselors. 2. When Care Transitions Specialist in one of the 3 pilot sites consults on non-pilot patients with hospital staff.
Follow-up	1. Care Transitions appointment-hospital 2. Care Transitions appointment-home 3. Care Transitions appointment-follow-up phone-call	3 pilot sites only/everyone can sees	1. Per model 2. Per model 3. Per model

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