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

September 30, 2013

ACL Grant Award Number: 90CT016002
Grant Period: September 2010 – April 2013
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CENTER ON AGING AND
COMMUNITY LIVING

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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 Evidence Based Care Transitions 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 Monadnock SLRC site was selected to pilot a care transitions model under this funding opportunity. Cheshire Medical Center/Dartmouth Hitchcock Keene (CMC/DHK), a nonprofit community 169 bed acute care hospital and multispecialty group practice located in Keene, NH, and the Monadnock SLRC agreed to partner for this pilot project.

Prior to the grant application, CMC/DHK utilized a tool (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 in Monadnock. CTI utilizes "coaches" to work with individuals during their in-patient hospital stay, at discharge, and during the transition home over a 30-day period. The model emphasizes a skill transfer that empowers the individual to follow through with medical appointments and medications, and raises awareness of health signs to avoid hospital readmission. More information on the CTI can be found at: 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. 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 Monadnock SLRC project. Overall, the Monadnock SLRC achieved many goals of the pilot project, including: establishing a Care Transitions Specialist (CTS) position at the SLRC and a partnership with CMC/DHK to implement the CTI model; educating area partners in the pilot project and the role of ADRC's in care transitions; establishing connections with care coordinators at the CMC/DHK medical home, and providing linkages to community long term services and supports. Included in the findings is the realization that maintaining fidelity to the CTI model within the context of the ADRC model and in a small, rural hospital is challenging. The Monadnock SRLC project has transitioned since the close of this funding to a hybrid care transitions model, continuing to utilize the Personal Health Record (PHR) and coaching/empowerment tools of CTI paired with the traditional role of options counseling.

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

- CMC/DHK added the Monadnock SRLC to the hospital's eDischarge system. This allowed the SLRC CTS to receive the pilot referrals, and see referrals and notes about other provider interactions in the system. This was an important piece of the

improving communication between medical and socials system providers. However, sustaining the use of eDischarge is difficult in the absence of continued funding.

- A half-time position for the care transitions pilot was challenging. The specific criteria of the CTI coaching model and variation from the typical SLRC jobs and medical care jobs made this function difficult to fulfill in a half-time person.

- 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.

- Onsite presence of the CTS in the hospital is important for providing access to all the knowledge and services of the SLRC.

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

Several evaluation tools were in place for the Monadnock SLRC CTI pilot. The pilot period reflected in the evaluation results was October 1, 2010- December 31, 2012.

→ **The Memorial Hospital**- The Case Manager at CMC/DHK provided readmission rates

→ **Refer 7 database**- Information and Referral (I&R) and client tracking database utilized by the SLRC Network for tracking all participants, which was used to track referrals

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

→ **SLRC hospital and community provider surveys**- Electronic surveys 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)

→ **Care Transitions Measurement Tool (CTM-3) Phone Survey**- Post discharge calls made to evaluate preparedness for discharge (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 throughout the pilot (Appendix F)

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

III. Overview of population served

Target Population for the CTI Pilot

The Monadnock 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:

a) Individuals over 64 years of age who were readmitted within 30 days of the last hospitalization with one of the following diagnosis: Congestive Heart Failure (CHF), Chronic Obstructive

Pulmonary Disease (COPD) or Coronary Artery Disease (CAD) and will be discharged to home with or without other services.

b) Reside in the Monadnock SLRC area.

As the CTS became more comfortable with the CTI model and the processes for referrals and follow up, and as data collection processes were firmly established, the pilot workgroup met and decided to expand the inclusion criteria to individuals over 18 years of age with a patient profile and list of co-morbidities including at least 2 of the following: breast cancer, constipation, anorexia, obstructive sleep apnea, COPD, dizziness, diabetes, malaise, GI bleed, mental status change, severe osteoarthritis or uncontrolled pain, and AMI (acute myocardial infarction).

Participant Data

Participant data was tracked by the Monadnock 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

Monadnock SLRC reported 545 referrals received during the active referral period of March 2011-October 2013. Of the referrals, 88 individuals agreed to participate in the program. The CTS

documented reasons why referred individuals did not participate in the program (457), including when individuals did not meet the criteria for participation (Table 1).

Table 1. Reasons referred individuals did not participate in CTI

Reason why not admitted to CTI	
Discharged prior to being seen	134
Patient declined participation	126
Nursing Facility Resident	57
Admitted to Hospice	38
Does not meet eligibility criteria	26
Passed away during hospital stay	22
Discharged from hospital out of service area	6
Other	27
Unknown	21
Total	457

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 is complete.	In January 2011, a staff member of Monadnock SLRC and the Center Manager attended the CTI training in CO. In June of 2012, the original CTS left the Monadnock SLRC, and an existing staff person was transitioned into the CTS position. They received an orientation to the Monadnock	Completed April 2011 June 2012

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
	SLRC, CMC/DHK, and the CTI model through online webinars, one-on-one trainings with the Center Manager, and role playing.	
CTI materials for community branding (Personal Health Record) are modified and updated.	The CTI materials were stamped with the Monadnock SLRC and the CMC/DHK logos.	Completed April 2011
Transition CTI documents into database version (medication reconciliation and patient assessment form) completed.	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 visit.	Completed April 2011
Documentation of meetings to educate Memorial Hospital, other SLRC staff, and other community stakeholders in enhanced model (role of CTS) is completed.	Multidisciplinary team meetings with CTS, and community based advisory team meetings were reported to UNH through an excel evaluation form.	Completed December 2012
Documentation of CTI participants is completed.	Participants in the pilot were documented both on a Microsoft Excel based tracking sheet and in the Monadnock SLRC Information and Referral Database (Refer 7)	Completed December 2012

Outcome Indicator: Of the 88 CTI participants, CMC/DHK reported that 21 individual were re-admitted to the hospital within 30 days of discharge.

Findings: From the information provided, 24% (21/88) of CTI participants were readmitted within 30 days of discharge. There was not a defined comparator group for this population that allows comparison of readmission rates. Overall, the readmission rate for the hospital for the project period, March 2011-December 2012, was 8.9%, compared to 12% in the period prior,

May 2009-Febuary 2011, to the project. While it is unclear of the exact role that the Monadnock SLRC project had in this decrease, there was a demonstrated decrease in readmissions during the project period.

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

Table 3. Measures of Activity for Outcome 2

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
Documentation of the inclusion of the CTS in the CTI Model at CMC/DHK is completed.	CTS position is defined for Monadnock SLRC and CMC/DHK.	Completed April 2011
Training CTS in hospital visit and follow-up is completed.	In January 2011 the CTS coach, Monadnock SLRC Center Manager and the Case Manager at CMC/DHK trained at the CTI Center in Aurora, CO. In December 2011, the new CTS was trained by the SLRC Center Manager.	Completed April 2011
Develop additional questions for SLRC satisfaction survey.	A specific survey for Monadnock 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 Care Transitions Measurement Instrument-3	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. Full protocol in (See Appendix E)	Completed April 2011

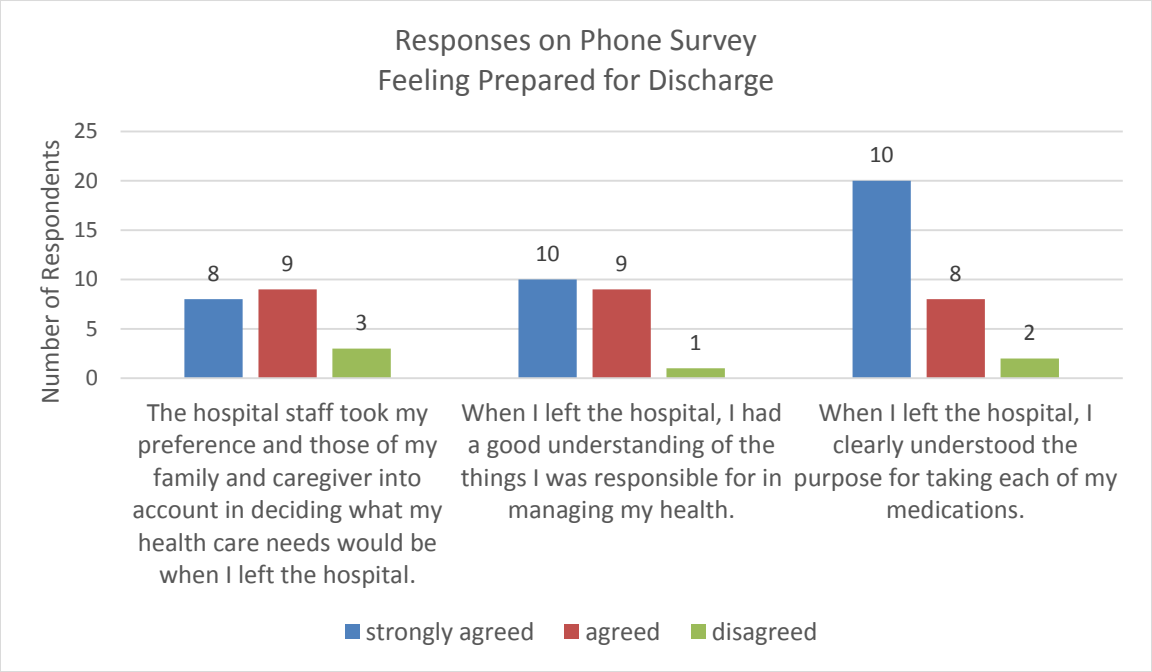
Outcome Indicators:

Participants in the Monadnock SLRC care transitions pilot were asked, in a follow up phone call after discharge from the hospital, three questions to evaluate feeling prepared for discharge. Forty-one (41) individuals followed the program through at least one home visit, and were eligible to receive a phone call to administer the Care Transitions Measurement Tool (CTM-3). Twenty individuals completed the phone survey.

Figure 1 provides the number of responses and corresponding percent 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=20)
- 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=20)
- CTM-3 question 3: *"When I left the hospital, I clearly understood the purpose for taking each of my medications."* (n=20)

Figure 1. Consumer Satisfaction of Feeling Prepared for Discharge



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
Documentation of the eDischarge by community providers.	A contract with Curaspan Health Group to add Monadnock SLRC to CMC/DHK's eDischarge system was set up, and the CTS was trained to use the system.	Completed October 2011
Number of multidisciplinary team meetings with CTS is documented.	The CTS attended 30 multidisciplinary meetings.	Completed December 2012
Implementation of survey questions on provider survey.	A provider survey was drafted in order to assess the CTI communication and coordination efforts from the perspective of the provider (See Appendix C) In November 2012, the survey was sent to CMC/DHK Case Managers, Clinical Nursing staff, Nurse Manager, Unit Secretary, and Hospitalists.	Completed November 2012
Implementation of qualitative assessment tool of CTI stakeholders/ providers.	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 Monadnock SLRC pilot model was administered electronically. The CMC/DHK Senior Director of Ambulatory Care sent the survey out to hospital providers, and the Monadnock SLRC Center Manager sent the survey out to community providers (See Appendix C for the full survey). These surveys measured the level of improvement in communications in the Monadnock ServiceLink service area, and the helpfulness of the

onsite presence of the CTS in communications. The hospital provider survey was implemented in July 2012 and January 2013. Twenty medical providers from CMC/DHK were asked to complete the surveys. In July 2012, 10 medical providers responded, and in January 2013, 7 medical providers responded. The community provider survey implemented April 2013[1]. A total of 13 community providers were asked to complete the survey and a total of 4 responded.

Findings:

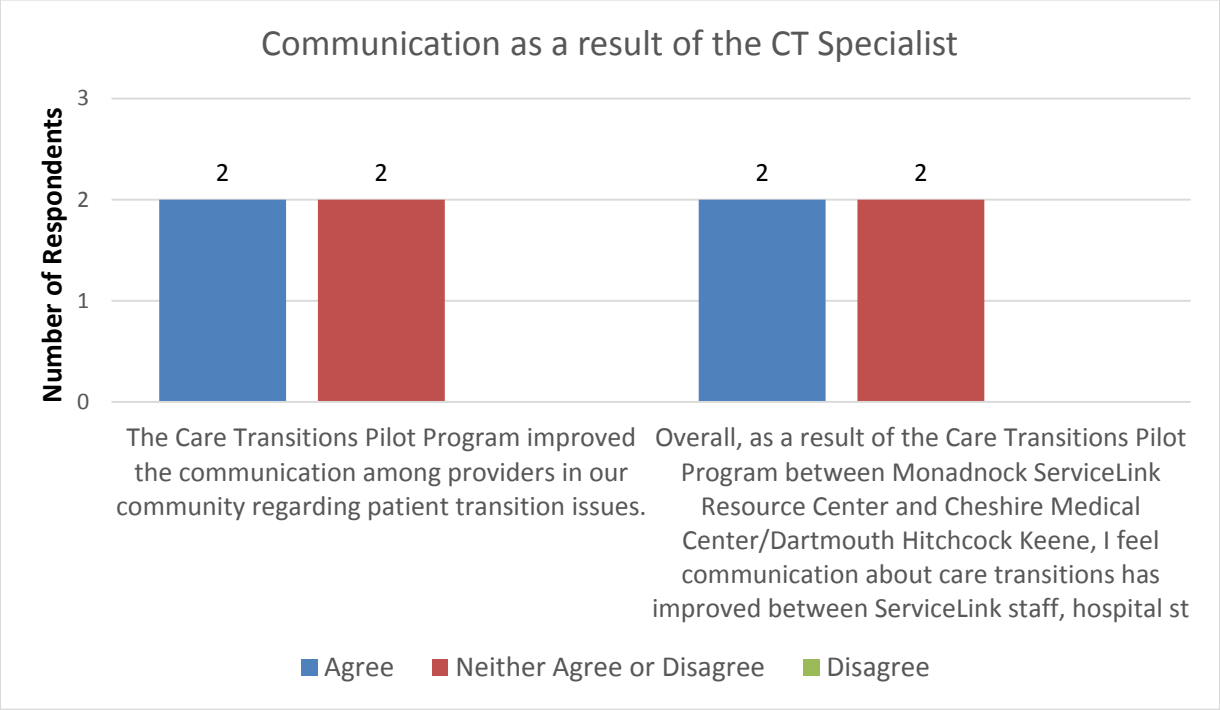
Community Provider survey

As seen in Figure 2, respondents indicated that the Care Transitions Pilot Program improved the communication among providers in our community regarding patient transition issues (although the survey sample was small). To the statement, "The Care Transitions Pilot Program improved the communication among providers in our community regarding patient transition issues," 50% Agreed and 50% Neither Agreed nor Disagreed (5 survey participants did not respond).

To the statement, "Overall, as a result of the Care Transition Pilot Program between Monadnock ServiceLink Resource Center and Cheshire Medical Center/Dartmouth Hitchcock Keene, I feel communication about care transitions has improved between ServiceLink staff and hospital staff," 50% of respondents said they "Neither Agreed nor Disagreed" and 50% "Agreed"(5 survey participants did not respond).

[1] Please note that the community provider survey was implemented in February of 2013, but received only 3 respondents. As a result, the survey was redistributed in April of 2013 to include nursing facilities.

Figure 2. Community Providers indicating communication and care as a results of the care transition Specialist, n=4



> One important survey response worth noting was: "This program offered the opportunity for ADRC/SL to open lines of communication with the hospital and the community. Any process that improves communication and understanding is positive."

Medical provider survey:

From the perspective of medical providers, the results indicate an improvement of communication over the first 7 month period (although the sample was, again, small).

When asked, "Overall as a result of the ServiceLink Resource Center Care Transition Specialist on site at the hospital, I feel there is improved communication between ServiceLink staff and hospital staff."

→ In July 2012, 50% of participants responded that they "Agreed", 20% "Somewhat Disagreed" and 30% "Disagreed" (Figure 3).

→ In January 2013 (7 months later), 60% of responded "Agreed" or "Somewhat Agreed," and 10% "Somewhat Disagreed" (Figure 4).

When asked "Overall, the ServiceLink Resource Center Care Transition Specialist on site at the hospital improved the level of care received by patients,"

→ In July 2012, 40% "Agreed", 10% "Somewhat Agreed", 20% "Somewhat Disagreed," and 30% "Disagreed" (Figure 3).

→ In January 2013, 60% "Agreed" or "Somewhat Agreed", and 10% "Somewhat Disagreed" (Figure 4).

Figure 3: Provider Evaluation of Monadnock SLRC Care Transitions Pilot-July 2012, n=10

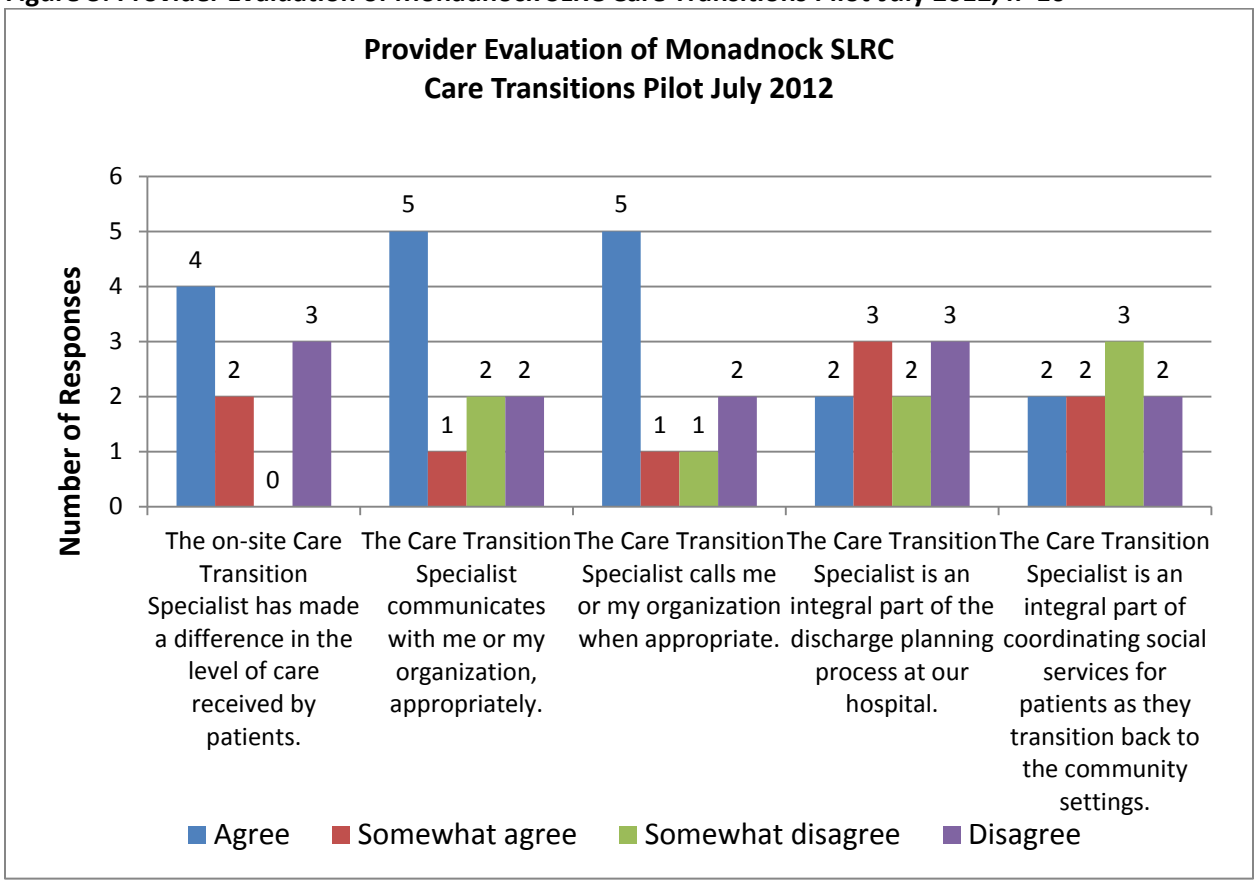
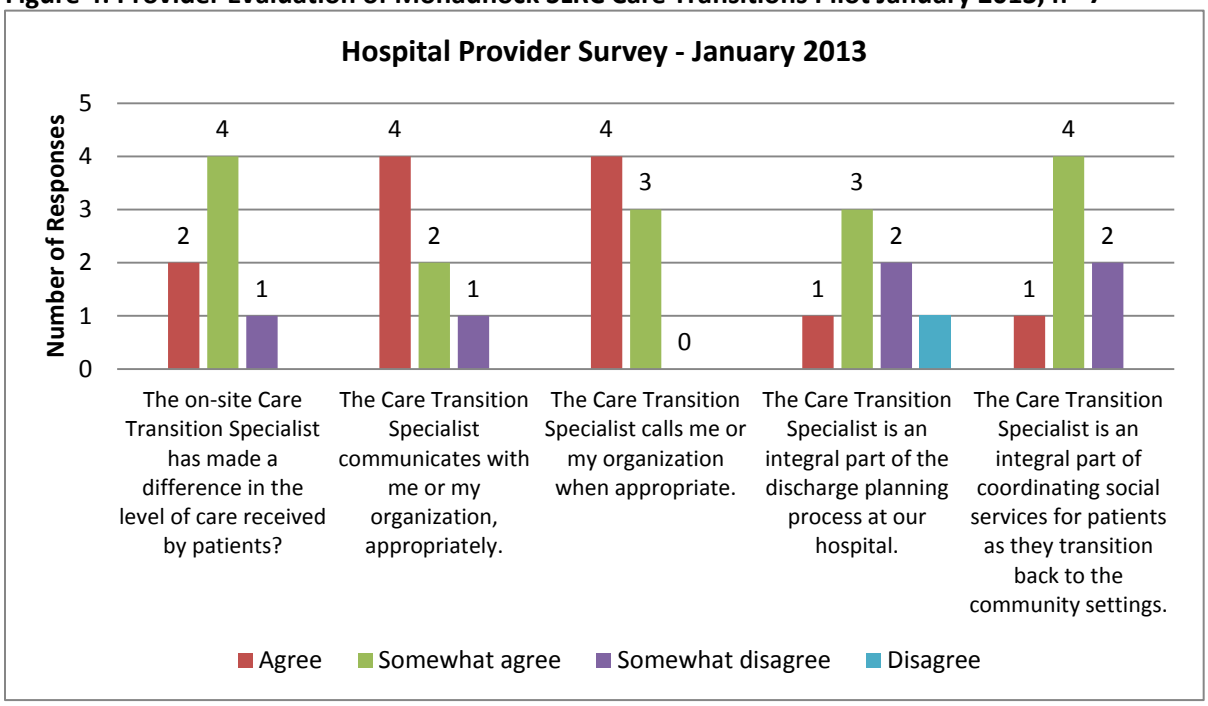


Figure 4: Provider Evaluation of Monadnock SLRC Care Transitions Pilot January 2013, n =7



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
Documentation of the CTS position	All of the New Hampshire care transitions pilot sites developed a job description for the 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	Completed April 2011

Outputs and Process Indicators (Measures of Activity)	Summary of Activity	Status
	of the CTS.	
Training of staff in tracking and training of hospital staff in SLRC model completed	The Monadnock County SLRC 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.	Completed April 2011

Outcome Indicators:

Outcome 4 was measured by tracking the number of referrals made by the CTS to other SLRC programs. The Monadnock SLRC CTS made 20 referrals to other SLRC programs. 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 SLRC services
Long Term Support Counseling	4
Information and Referral Specialist	16

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

29 referrals made to community based provider by the Monadnock SLRC care transitions specialist. 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) once individuals were followed by other SLRC staff 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 Monadnock SLRC CTS 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. Monadnock SLRC reported 152 times that the CTS on-site at the hospital was consulted for 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 that the Belknap County SLRC CTS provided on behalf of individuals in the pilot. 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 7. Measures of Activity 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 Monadnock SLRC Center Manager trained at the CTI Center, in Aurora, CO. New CTS coach was trained by the Monadnock SLRC Center Manager in Fall 2011.	Completed- Formal CTI training in January and September of 2011 December 2011- informal model training onsite.
Establish ongoing support for coach	CTS received supervision from the Center Managers ongoing, ad hoc from other CTS, and during CTS national coaching calls.	Completed
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 Monadnock SLRC 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:

The Monadnock SLRC, in coordination with UNH, distributed a consumer satisfaction survey to 18 pilot participants. The questions reflected the participants' experiences after returning home from the hospital and being followed by the Monadnock SLRC CTS for at least

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 18 participants who were sent a survey, zero responded.

Findings:

The Monadnock SLRC pilot did not receive responses to evaluate this outcome.

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

Table 8. Measures of Activity 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 CMC/DHK at the end of the pilot.	Completed

Outcome Indicators:

The CTI model medication discrepancy tool was utilized in this pilot for the 77 participants. The Monadnock SLRC CTS reported thirty-five individuals with one or more discrepancies (detailed in Table 9).

Table 9. CMC/DHK Medication Discrepancy

Number of Medication Discrepancies Reported	Number of patients who with medication discrepancies
1	25
2	5
3	4
9	1
Total	**56**

Findings: Participants did not often choose to utilize the medication discrepancy tool; however, those who did were coached to follow up with the care coordinator at CMC/DMK medical home (the primary care provider for the participants).

V. Informing a statewide ADRC care transitions project

The following are lessons learned and recommendations reported from the Belknap County SLRC care transitions pilot project that serve to inform a state-wide ADRC care transitions project.

CTI model

→ In the beginning of the project, the criteria established for referral to the Monadnock CTS limited reaching all those who would benefit from SLRC programs.

→ Matching the CTI coaching role with traditional ADRC roles was difficult. New Hampshire should evaluate if the CTI coaching role fits within the ADRC model.

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

→ Work with project partners early to establish buy-in for the model and establish the documentation and evaluation tools.

→ Work with the hospital's Human Resources department very early in the process to establish the on-site presence at the hospital.

State-level

→ Care Transitions Specialist models are very helpful for training and shifting traditional ways of thinking about providing services, but they do not completely reflect the full range of work that can be done when working with consumers and staff at the hospital. More work can be done to determine and realize the value of having ServiceLink staff at the hospital to support transitions, based on an evidenced-based model, but being flexible about how to define the role as referral specialist/options counselor on site at the hospital.

→ Look to the New Hampshire Caregiver Specialist model for effective tools and trainings established to roll out the care transitions position statewide. These tools reduced the burden on the SLRC management in establishing a successful program.

→ Developing a consistent and clear message regarding the SLRC care transitions project for each organization to use in communicating with other providers is vital for success. The message needs to address concerns often expressed from other medical and social system based providers about duplication of services, and the rationale and value of having the SLRC working more closely with the hospital.

Three to five barriers within the current SLRC Network model that need to be addressed for formal care transitions models or formal partnerships to be implemented/expanded.

→ The Network needs to continue on its current path of becoming an independent group that has the capacity to represent itself, make decisions as group, and speak with one voice.

→ The Network needs to agree to common approaches to collecting data and pulling report information to allow for effective comparisons, there is little value in the data to the broader community of stakeholders.

→ The Network should agree that care transitions is something worthy of pursuing, and then identify what a realistic care transitions would be for the ServiceLink Network, so that the effort can be shared and promoted as a group.

→ Opportunities exist for the Network to meet with the Hospital Associations and others provider groups to discuss potential roles in a shared care transitions effort.

What, if any, challenges did you face during the project and what actions did you take to address these challenges?

→ The NH Care Transitions pilot tried many different staffing patterns and incorporated use of technology as much as possible to allow for CMC/DHK patients to access ADRC staff, but limited hours were a problem, due to the nature of working with hospital discharge expectations.

1. Limitations of Referral Criteria

   Challenge: Small populations limit the number of possible referred patients.

   Addressed challenges by:

   →The pilot group expanded the inclusion criteria to add additional diagnoses during the project period, but the number of referrals remained an issue. Future projects could look at non-medical factors to trigger referrals as well.

2. Data Collection Goals and Mechanism

   Challenge:

   →Data collection was a struggle throughout this the project; our systems for making referrals and documenting data did not align well with the reporting needed for evaluation.

   Addressed challenge by:

   →Recognizing the limits in referral tracking tools, supplemental tracking sheets and other documentation workarounds were developed.

VI. Appendices

Appendix: A

Cross Walk of Evidence Based Models

Mapping Care Transitions -			
Model Characteristic	**Coleman Model - "Care Transitions Intervention"**	**If Present type Y / Not Present type N**	**Comments**
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**	**Comments**
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**	**Comments**
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**	**Comments**
	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

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 Hospital and Community Provider Surveys

Monadnock Care Transitions Community Survey

Q1 For the past two years Monadnock ServiceLink Resource Center (SLRC) has been partnering with Cheshire Medical Center/Dartmouth Hitchcock Keene 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 Monadnock SLRC and Cheshire Medical Center/Dartmouth Hitchcock Keene. 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.

Q2 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 Monadnock ServiceLink Resource Center and Cheshire Medical Center/Dartmouth Hitchcock Keenethat occurred over the past year?

- ❍ Yes (1)
- ❍ No (2)

If Yes Is Selected, Then Skip To Please select the most appropriate an...If No Is Selected, Then Skip To Are you aware of the community-based ...

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? (1)	❍	❍	❍	❍	❍

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

- ❍ Yes (1)
- ❍ No (2)
- ❍ Not Applicable (3)
- ❍ 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 care issues. (1)	❍	❍	❍	❍
The Care Transition Pilot Program was an integral part of coordinating social services for individuals as they transition back to the community settings. (2)	❍	❍	❍	❍

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 Monadnock ServiceLink Resource Center and Cheshire Medical Center/Dartmouth Hitchcock Keene, I feel there is improved communication between ServiceLink staff, hospital staff and community providers. (2)	❍	❍	❍	❍

Q9 Overall, do you agree that the Care Transitions Pilot Program increased access to home and community based-services for individuals discharged from Cheshire Medical Center/Dartmouth Hitchcock Keene?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

Q10 Please provide any comments related to your response above:

Q11 In your experience with the Monadnock ServiceLink Resource Center, would you agree they are an important partner in an effective care transitions program in your community?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Don't know (3)

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?

- ❍ Yes (1)
- ❍ No (2)

If Yes Is Selected, Then Skip To Please answer if you "Disagree", "Nei...If 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 two years, Cheshire Medical Center/Dartmouth Hitchcock Keene has been participating in a Care Transitions project with Monadnock ServiceLink Resource Center to implement the evidence based care transitions Coleman model. This project seeks to provide enhanced informal as well as connection to formal support to patients after they have been discharged back to the community

The University of New Hampshire is working to evaluate this model. As part of the evaluation, we are requesting your participation in a brief, anonymous survey. This is a follow up to a survey conducted in the early spring of 2012. Whether or not you participated in the previous survey, we ask that you complete this survey. 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. What is your role?

- ◯ Social Worker
- ◯ Patient care Coordinator
- ◯ Case Manager
- ◯ Director
- ◯ Clinical Leader
- ◯ Hospitalist
- ◯ Other

***2. Are you familiar with the Care Transition Specialist from the ServiceLink Resource Center, Carleigh Warner, who works part time within your hospital/clinic?**

- ◯ yes
- ◯ no

*3. Please choose the most appropriate response.

	Never	Rarely	Sometimes	Often	Always
How frequently do you interact with the Care Transition Specialist?	☐	☐	☐	☐	☐

*4. Please indicate if you Disagree or Agree with the following statement:

	Disagree	Somewhat disagree	Somewhat agree	Agree	Not Applicable
The on-site Care Transition Specialist has made a difference in the level of care received by patients?	◯	◯	◯	◯	◯
The Care Transition Specialist communicates with me or my organization, appropriately.	◯	◯	◯	◯	◯
The Care Transition 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 Specialist is an integral part of coordinating social services for patients as they transition back to the community settings.	◯	◯	◯	◯	◯

***5. I trust the Care Transition Specialist to make appropriate referrals with community based services for patients.**

- ◯ yes
- ◯ no

***6. If there were a full-time Care Transition Specialist available, care transitions would be improved at my facility.**

- ◯ yes
- ◯ no

*7. Please answer Disagree or Agree to the following statements:

	Disagree	Somewhat disagree	Somewhat agree	Agree	Not Applicable
Overall, as a result of the ServiceLink Resource Center Care Transition Specialist on site at the hospital, I feel there is improved communication between ServiceLink staff and hospital staff.	◯	◯	◯	◯	◯
Overall, the ServiceLink Resource Center Care Transition Specialist on site at the hospital improved the level of care received by patients.	◯	◯	◯	◯	◯

8. Please provide any additions comments:

Thank you for your participation!

Appendix D:

ServiceLink Consumer Satisfaction Survey

UNIVERSITY of NEW HAMPSHIRE

The Monadnock ServiceLink Resource Center and Cheshire Medical Center/Dartmouth Hitchcock Keene 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:

Care Transitions Measurement Tool 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**	
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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
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

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 Property Tax Rebate Information (pls specify program type)	0	0	0	0	0	1	0	1
#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 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

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**
# 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.

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