Aging and Disability Resource Centers
Implementing the Affordable Care Act:
Making it Easier for Individuals to Navigate Their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access
Evidence Based Care Transition Program

State Agency: New Hampshire DHHS Bureau of Elderly and Adult Services

Name of ADRC and Healthcare Partners:
Monadnock SLRC (ADRC) and Cheshire Medical Center-Dartmouth-Hitchcock Keene, Carroll County SLRC (ADRC) and Memorial Hospital, Belknap SLRC (ADRC) and Lakes Region General Hospital (LRGH)

Project Period: September 30, 2010 to September 30, 2012

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Evidence Based Care Transitions Model: Better Outcomes for Older adults through Safe Transitions (BOOST) and Care Transitions Intervention℠

Project Summary:
This project is a collaborative between three community based ServiceLink Resource Centers (SLRC's), NH's ADRC, and three local hospitals to implement and/or enhance evidence-based models for care transitions. Through this project, two care transition models will be piloted in three regions of the state. The Better Outcomes for Older Adults through Safe Transitions (BOOST) model is currently being implemented at Lakes Region General Hospital (LRGH) in partnership with the Belknap SLRC. This work will be enhanced through the establishment of a care transition specialist position at the Belknap SLRC, who will work directly with LRGH to enhance how the BOOST model extends to the community. The Care Transition Intervention (CTI) model will be implemented at Cheshire Medical Center- Dartmouth-Hitchcock Keene (CMC-DHK), in partnership with Monadnock SLRC; and at Memorial Hospital, in partnership with Carroll County SLRC. Both the Monadnock SLRC and Carroll County SLRC will hire a SLRC care transition specialist to provide resources for implementing the Coleman model in those hospital-SLRC partnerships.

Goal/Objectives:
The primary program goals of the project are: 1) Establish an SLRC care transition specialist in three of NH's ADRC's to serve as the SLRC-hospital liaison for care transitions, 2) Define and evaluate the relationship of the SLRC care transition specialist with the provider organizations in an evidence-based care transition model, 3) Define and evaluate the role of the SLRC care transition specialist within the scope of other SLRC programs.

Anticipated Outcomes/Results:
Across all three counties expected outcomes align with the published outcomes of care transition models: reduced hospital readmissions and improved quality of life. The enhanced relationship between the SLRC and the hospitals will improve the connections with community based services,

increase support for caregivers, earlier assessment of long- term care current and projected needs, and working with hospital patients and their caregivers to begin long-term planning.