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Providing patient-centered enhanced discharge planning and rural transition support: Building a rural transitions network between regional referral and critical access hospitals

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PROVIDING PATIENT-CENTERED ENHANCED DISCHARGE PLANNING AND RURAL TRANSITION SUPPORT

Building a Rural Transition Network between Regional Referral and Critical Access Hospitals

The University of Montana

In Collaboration with

The International Heart Institute of St. Patrick Hospital

Missoula, Montana

Presently, many patients receive much of their education for self-management for a ... transition from hospital to home during their hospitalization. Unfortunately, the hospital setting is not an ideal educational environment … Therefore, hospital-based education for self-management should generally be focused on ensuring the patient and caregivers know what to do in the first few days after leaving, so they don't end up back in the hospital. (Instead), the Panel suggests that care coordination models consider re-focusing long-term self-management education tasks to the ambulatory setting after hospital discharge, when patients (and their caregivers) are often in a better state to receive education and other support to help them manage their condition and treatment. For medical or surgical admissions that are planned, self-management education in the ambulatory setting should take place both before and after admission to an inpatient facility.

(AMA Expert Panel on Care Transitions, 2013)[a]

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[a] Skol, P.E. & Wynia, M.K., writing for the AMA Expert Panel on Care Transitions. There and Home again, safely: Five Responsibilities of Ambulatory Practices in High Quality Care Transitions. American Medical Association, Chicago, IL 2013.

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This manual and the model it describes represent the experience and advice of many individuals. These include the staff of Providence St. Patrick Hospital, Barrett Hospital and Health Care, Deer Lodge Medical Center, Clark Fork Valley Hospital, and St. Joseph Hospital. In particular, we wish to acknowledge the contributions that patients of these programs made. A partial list of contributors includes:

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FOREWORD

This manual was used in a research project, Rural Options at Discharge – Model of Active Planning (ROADMAP). Our objective was to develop and evaluate a model that improved the likelihood of a positive recovery and reduced the likelihood of re-hospitalization. Current trends in health care delivery suggest that the right supports provided to patients at the right time may improve outcomes and reduce re-hospitalizations. For patients being discharged from a tertiary care facility back to a small town or rural community, this support includes assistance in addressing instrumental and social support needs. The methods included in this manual come from the literature, from cutting-edge practices in the field of care coordination, from recommendations of medical care providers, from patients themselves, and from lessons learned through this research process.

Modifying this model to fit your circumstances

This manual describes the procedures used to establish the experimental protocol for an intervention evaluated in Western Montana. As such, you will want to modify it to fit your circumstances. We outline procedures you can use in making those changes in Appendix 2. Appendix 2 also contains several lessons that we learned including suggested possible additions or modifications, which were not incorporated into this edition because they have not been tested. Changes that you choose to make will depend on your specific circumstances. We would be interested in hearing about any efforts you make to re-invent these procedures to fit your context.

Ethical considerations

Providing rural transition services requires a great deal of judgment. Many cases raise ethical questions. Discharge planners and Local Community Transition Coordinators come from several disciplines. We offer a guide to ethical considerations in enhanced discharge and rural transition planning in Appendix 3.

Suggested Citation

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CHAPTER 1: BACKGROUND AND INTRODUCTION

Residents of rural and frontier counties experience significant disparities in healthcare access and outcomes when compared to their urban counterparts. The organization of health care delivery contributes significantly to these disparities. Simply put, rural residents can face many challenges when they have to go to a hospital in a distant city for treatment and then return home to recover. Their personal and family routines are disrupted and they may have no one to replace them (e.g., on a farm or ranch). Their social support network is stretched in having to travel. Providers at a Regional Referral Hospital (RRH) may not be familiar with the resources available in patient's home community and might be unable to make effective referrals. The transition back home is also problematic because discharge planning generally does not adequately account for limited access to care in rural areas. The specific aim of this research project was to ascertain rural patients' actual experience of the discharge planning process, and to involve patients and rural providers in designing and testing a contextually appropriate rural model that improves patient outcomes and reduces re-hospitalizations.

Rural America and Health Care

People live in rural America because they were born there and their families live there; or because they moved there for opportunity, for its beauty, or to escape urban stress. Regardless of their reasons, some 56 million Americans live in rural areas covering 85% of the land. While rural America is their home, living there can place them at a disadvantage. Residents of rural and frontier counties – especially those with multiple chronic conditions – experience significant disparities in health care access and outcome when compared to their counterparts who live in metropolitan areas.[1, 2, 3, 4]

Contributing Factors and Proposed Solutions

Rural health analysts argue that sparse populations are unable to support services, and distances to services present additional barriers to access.[5, 6] The lack of formal medical service structures, combined with higher occupational hazards and other social determinants contribute to disparities in outcome.[7] While medical services are only one element of rural health, they are significant. Rural health advocates, medical providers and researchers have pursued several strategies to reduce or eliminate these disparities,[8] including financial incentives for providing rural services,[9] strategies for recruiting and retaining practitioners,[10] providing outreach clinics,[11] and telemedicine.[12] From a systems perspective, one can start at nearly any point. Rural residents and those who serve them suggested we begin by examining the process of discharge planning from regional referral hospitals home to a rural community.[13]

Discharge planning

Medical service providers, administrators, researchers, and health care advocates have come to see discharge from a RRH back to small town or rural community as one point at which the disparity in rural health is most apparent. Discharge planning is intended to facilitate the transition from hospital care to recovery at home and the majority of patients receive discharge instructions. A systematic review of the literature on discharge planning found that, "The evidence suggests that a structured discharge plan tailored to the individual patient probably brings about reductions in hospital length of stay and

readmission rates....”[14] Nonetheless, researchers have found that many of the studies neglected to collect data on primary variables of discharge (e.g., bridging the gap between hospital and home) and none reported on the effectiveness of communication between hospital and community. Indeed, discharge planning has been described as fragmented, uncoordinated, and contributing to both poor outcomes and patient dissatisfaction.[15]

Patient and Provider Perspectives

Little is known about the process of planning for discharge or patients’ actual experiences in transition home to a rural community.[16] Patients may have a wide range of needs when they are discharged from a RRH back home to a small town or rural community. Discharge planners and other staff at the RRH are seldom aware of the range of services and resources that a patient could use to facilitate their recovery close to home. Indeed, in our research, regional providers acknowledged that they lacked information about the many small towns they served in their catchment area. Patients, RRH staff, and small town providers all reported that this frequently led regional providers to refer patients to services and providers in the city. Additionally, staff at the local critical access hospitals we worked with acknowledged that they had difficulty maintaining familiarity with the resources available in their area.

Healthcare Cost and Utilization Project (HCUP) data from 2010 reported that there were 7,090,836 (18.2%) discharges of patients to residences in micropolitan or non-core counties (rural).[17] While many of these were from local critical access hospitals (CAH), as many as 2,666,887 discharges were from regional referral hospitals. Of these discharges to non-core counties – the most rural of areas – rates of mortality were higher, and discharges to home and to home health care were lower than for discharges to urban areas. This pattern may be due to disparities in access to appropriate health care and may contribute to disparities in outcome.

Re-Engineered Discharge Planning

Clancy[18] argued that financial incentives tied to service rather than patient outcomes have deflected attention from investing in discharge planning. Now, however, those incentives are shifting from service units to outcomes.[19] This shift creates a context in which discharge planning may become a key function of treatment. She reported that a systematic and consistent discharge planning process, the Re-engineered Discharge (RED) model, improved patient care and safety while reducing costs. Nevertheless, while the RED model has shown promise in urban areas, its creators acknowledge that it is unlikely to generalize to rural areas.

Enhanced Discharge Planning and Rural Transitions

There is a need for a method to overcome these barriers and reduce these rural disparities. Our research took a patient-centered perspective to design *rural options at discharge – model of active planning* (ROADMAP). Previous research has demonstrated that effective and efficient discharge planning can decrease re-hospitalization by as much as 30%.[20] No such discharge models have been developed for application with rural residents, however. Further, none has reported taking a patient-centered perspective.

The ROADMAP model builds strong professional relationships between staff at RRH and staff at local CAHs. Our experience suggests that these relationships benefit the hospital and provider networks while focusing on improving patient outcomes. Finally, it is worth noting that providers reported that these procedures facilitated the use of swing-bed placements.

Swing Bed Transition

As discussed above, many rural communities may lack important recovery services and supports. In some instances, the local CAH may provide "swing bed" services. A swing bed allows a patient to be discharged from a RRH to a local CAH where they can receive a higher level of services and support than if they were simply discharged home. This swing bed approach is designed to aid in a smooth discharge and rural transition.

Funding

The development and evaluation of this model and these procedures was supported by a contract with the Patient Centered Outcomes Research Institute. As such, the additional activities of hospital staff working on the project were covered with these funding resources. Relatively little additional time was needed to implement this model, however. Three of the four CAHs that participated in the research integrated these additional functions into the job of existing staff. Changes in regulations provide reimbursement mechanisms that can support these activities (e.g., Care Coordination). Further, proposed regulations for discharge planning increase requirements for activities that are consistent with the procedures described here.[b]

Patient Involvement

We have involved rural residents with multiple chronic health conditions and rural health care providers in designing a contextually appropriate patient-centered rural ROADMAP. This new "social technology"[c] is specifically tailored to fit rural systems in the emerging new health care context. Involving those who would be expected to use a system increases the probability that the ROADMAP will take into account key process and outcome dimensions – increasing the likelihood of adoption by others in similar circumstances. The rural ROADMAP method is designed to align rural services and supports with patient-centered outcomes. This approach incorporates an assessment that takes into account a rural patient's goals, preferences for approaches to achieve them, the relevance of health to those goals, and the rural context in which they live. When fully implemented, these strategies hold promise to reduce the disparities in health outcomes experienced by rural residents by improving their recovery following hospitalization. Ultimately, we believe that such incremental improvements will contribute to reducing the cost of health care.

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[b] Proposed Medicare and Medicaid Programs Revisions for Discharge Planning (CMS–3317–P). Federal Register Vol. 80 No. 212; November 3, 2015

[c] Here, social technology refers to methods for organizing groups of people into operating systems, arranging systems to produce desired outcomes reliably, and building the capacity of individuals to function within that system to gain its benefits.

Negotiating Payment of Bills

An issue of high importance to the patients we worked with involved the ability to negotiate the payment of their hospital and medical bills. For some patients, this issue seemed to create so much stress that it interfered with recovery – psychologically and physically. Reviewers from the hospital perspective uniformly commented that they each had staff that could help patients with this issue. Still, patients were either not aware of this option or had been frustrated in their attempts to reach what they saw as a reasonable agreement. While the Affordable Care Act has begun to chip away at the broader issues of medical insurance, a hospital may want to review their policies and procedures to determine if this issue might be addressed more effectively from a patient perspective.

Patient Risk, Capacity, and Needs

A small number of patients often account for a large proportion of re-hospitalizations. Researchers have suggested that providing additional resources to patients most likely to be re-hospitalized might reduce readmissions following hospital discharge. These researchers have suggested three broad perspectives for assessing the likelihood of readmission, including a medical risk, a personal capacity, and an environmental- or social-determinants perspective.

A medical risk model categorizes individuals into groups with common medical characteristics associated statistically with higher rates of re-hospitalization. The common characteristics are often determined by the data that are available in the medical record (e.g., LACE+). For example, previous hospitalizations have been shown to predict future hospitalizations. A high risk score suggests that providing a patient with added supports at discharge might reduce the likelihood of a readmission. Similarly, a personal capacity perspective uses assessments of a patient's knowledge, skills, and abilities for managing their health to predict the likelihood of being readmitted. These factors are typically assessed by provider judgment or by using a brief questionnaire (e.g., PAM10). For example, a patient may indicate that he or she has little confidence in being able to follow through on medical treatments at home. This suggests that providing a patient with more information, instruction, or training, might reduce the likelihood of a readmission.

Here, we employed the third perspective, an environmental or social determinants perspective, to develop and test a Rural Transition Needs Assessment. This involved patients in assessing their practical needs for recovery at home. Needs included several community factors (social vital signs) that may affect a patient's ability to achieve a smooth transition home.

The medical risk approach is efficient because the data are readily available in a patient's medical record but it does not suggest the types of support a patient might need. A personal capacity approach might be considered effective because it builds long-lasting skills but it might be considered somewhat less efficient because new data must be collected and someone must provide more education to the patient. Regardless, both approaches use statistical analyses to predict the outcome. As such, both are subject to Type I and Type II errors. That is, in targeting individual members of a group, they may prioritize an individual for extra services who may not need them (i.e., a false positive or Type I error).

On the other hand, individuals who do not share the characteristic but who need specific supports may not get them (i.e., a false negative or Type II error).

This needs model may be somewhat less efficient than the medical risk model because each individual's needs must be assessed but it points neatly to solutions in the community. Further, it is less likely to provide services to those who do not need them or to miss providing service to those who do. Such an approach may complement and enhance standard risk and capacity assessments.

CHAPTER 2: OVERVIEW OF ENHANCED DISCHARGE PLANNING AND RURAL TRANSITION SUPPORT MODEL

Patients from small towns and rural areas face a wide range of complex and often confusing choices when it comes to addressing their health and healthcare concerns. Because such patients live in communities with fewer resources of all types, they may benefit from information and support to understand their options and decide which ones are best for them.

This manual presents a model for providing enhanced discharge planning and rural transition supports and describes operational detail of how it works. Figure 1 outlines the components of the model. First, a Research Transition Coordinator (RTC) identifies eligible patients upon admission. The RTC establishes an Episode of Care in the patient's Epic electronic medical record and notifies a Local Community Transition Coordinator (LCTC) at the CAH serving the area in which the patient lives.[d] The RTC conducts a Rural Transition Needs Assessment and works with the patient to establish a patient's Rural Transition Agenda. This agenda is posted in the patient's Episode of Care and shared with the LCTC. The LCTC reviews the patient's file and creates a Discharge Orders Verification Checklist. After discharge, the LCTC conducts a Transition Conference (TC) with the patient and completes the development of a Rural Transition Plan that links the patient to locally available services. The patient and LCTC implement components of the plan together. The LCTC monitors the progress in implementing the plan and updates all the providers through the Epic Episode of Care.

[d] We used Epic's In-Basket for secure communication. Other systems may have similar tools.

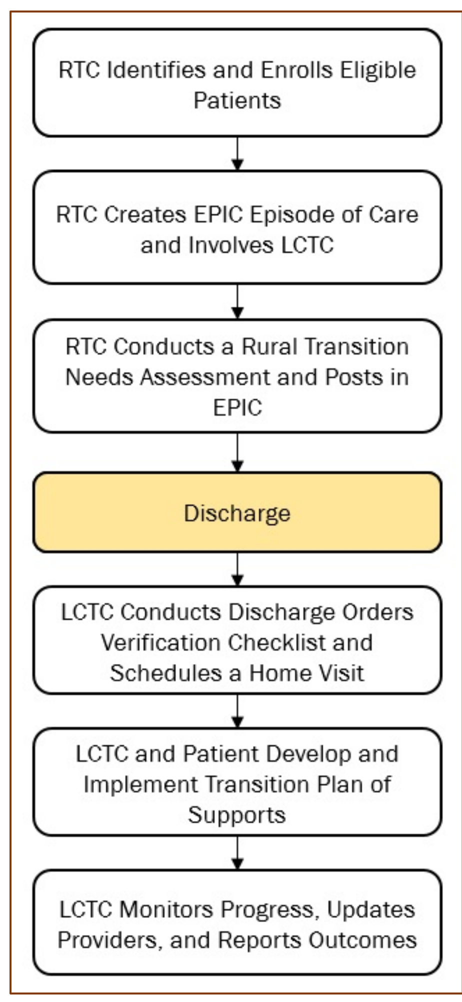

Figure 1: Basic Components and Steps of the Recommended Transition Model.

It is important to emphasize that this project was designed to test an experimental process. The methods included in this manual come from the literature, from cutting-edge practices in the field of care coordination, and from recommendations from medical care providers, and from patients themselves. The program ensures that all patients who participated in this study received the same basic discharge planning services. Some patients received these enhanced discharge planning and rural transition services. The goal of the study was to determine how these additional services and supports affected patient outcome and re-hospitalizations. To achieve these goals of the study, we organized providers involved into groups with specific roles and responsibilities. These are described in increasing levels of detail beginning below and in the following chapters.[e]

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[e] These tasks and functions may be reorganized based on your circumstances. See Foreword (p. 2).

Figure 2 outlines the roles and responsibilities for implementing the components of the research study. The left column summarizes the RRH's current discharge planning process. The second column presents the framework suggested for all contributors. This adds local outpatient transition support, including a TC after discharge, provided by a Local Community Transition Coordinator (LCTC). The Patient Design Team preferred that the LCTC be an employee of a local agency and strongly supported a TC component. CAH administrators and staff emphasized the importance of the RRH involving the LCTC early in the process. In addition, RRH physicians recommended that the relationship between the hospital discharge planners and the LCTCs be parallel to that between a treating physician and the local primary care provider. Other hospital stakeholders suggested using an Epic Episode of Care to establish a working relationship between the Discharge Planners and the LCTCs as soon as the patient is admitted and enrolled in the study. The columns on the right show the activities that would be conducted by the research project staff at the RRH or through contract with the CAHs (i.e., local transition support).

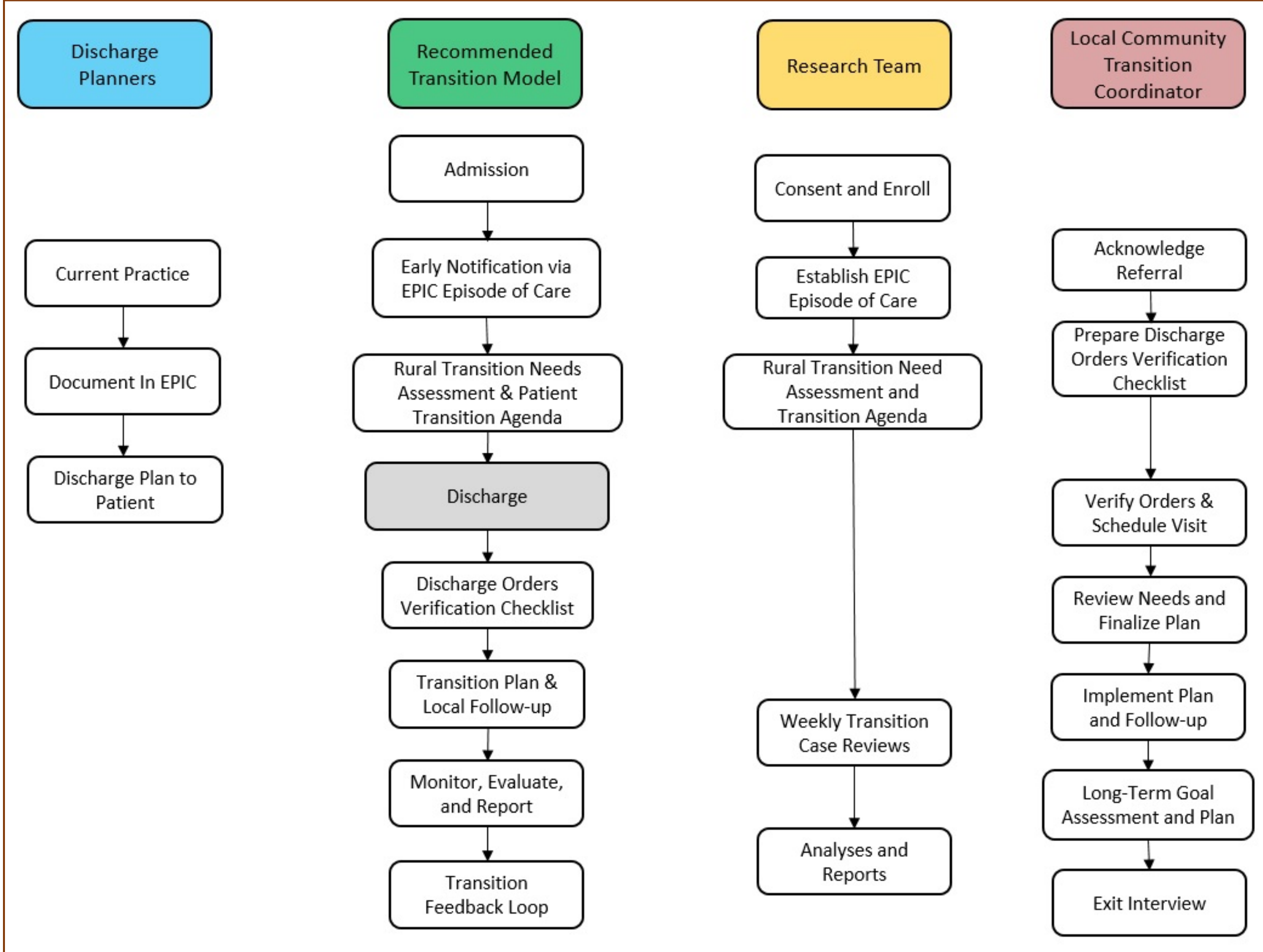

Figure 2: Roles and Responsibilities for Implementing the Components of Research Study.

CHAPTER 3: ORGANIZING AND MANAGING AN ENHANCED DISCHARGE AND RURAL TRANSITION SUPPORT MODEL

This Enhanced Discharge Planning and Rural Transition Support model requires some minor changes in the tertiary care hospital's standard discharge planning protocol. It also requires creating a position of LCTC in each participating CAH. These key actors must work closely with the patient to achieve a patient's goals. Finally, the system must be monitored so that successes can be celebrated, and so that problems can be identified and resolved.

Overview of Roles for Research

For research purposes, we divided the roles and responsibilities across those who were most directly involved in the transition from St. Patrick Hospital (SPH) to one of the four counties with a CAH participating in the study. Table 1 outlines the roles and responsibilities for the key actors in the Enhanced Discharge Planning and Rural Transition Supports project. These are summarized below and in greater detail in the following chapters.

Discharge Planners and Current Practices

One goal of this research project was to ensure that all patients receive at least the basic standard level of care, treatment, and support as was currently provided. Accordingly, for the purposes of this research, the SPH Discharge Planners continued to provide the same services and supports that currently provided. The experimental procedures were added to the current services.

Research Transition Coordinator (RTC)

Two Research Transition Coordinators at SPH, both members of the Research Team, delivered the enhanced discharge planning procedures. These enhanced procedures were designed to extend the standard practices in a way to smooth the transition home. As these activities extend current practice, the Research Transition Coordinators coordinated these new activities with the Discharge Planners and other staff.

Local Community Transition Coordinators (LCTC)[f]

This was a new role recommended by patients and providers. The purpose of this new role was to provide a smooth transition from the hospital through the immediate (30-day) post discharge transition and recovery, and to a patient's natural support systems within the community.

Patients

It was important to underscore that this was a research project and as such, patients needed to consent to both participate in the project and approve access to their medical records for evaluation purposes.

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[f] Because the LCTC's role is relatively new, Appendix 4 presents a draft job description for recruitment.

Research Team

The Research Team, including University faculty and students as well as the RTCs, collected and analyzed data to assess the progress and impact of the project. In addition, a key responsibility included reporting on our findings to Hospital Management.

Hospital Management

This project operated under the approval of the hospital administration. The Research Team provided them with updates they could use in monitoring the appropriateness and value of the project.

Table 1: Roles and Responsibilities for Key Actors in Research Study

Roles and Responsibilities	
Discharge Planners (DP) and Current Practice	1) Discharge Planners document needed services in Epic 2) Physician reviews 3) Floor Nurse Prints the After Visit Summary and delivers it to the patient 4) Discharge
Research Transition Coordinators	1) Identify patients from targeted counties 2) Consent and enroll patients 3) Initiate Epic Episode of Care 4) Involve the LCTC 5) Start Rural Transition Needs Assessment 6) Probe for insights into needs 7) Guide the patient in prioritizing needs 8) Develop a Rural Transition Agenda 9) Prepare 7 – Day Transition Calendar 10) Schedule a Transition Conference 11) Review package with patient 12) If appropriate, explore a swing bed placement
Local Community Transition Coordinator (LCTC)	1) Establish a Transition Referral 2) Prepare for a patient's discharge and Transition Conference 3) Initiate local services 4) Conduct a Transition Conference 5) Finalize a Rural Transition Plan 6) Provide transition supports to implement plans 7) Facilitate transition to routine activities 8) Close a case
Patients	1) Choose to participate 2) Meet with RTC to set a Rural Transition Agenda 3) Get home safely 4) Complete and return surveys 5) Follow Discharge Plan and initial Seven – Day Schedule 6) Meet with LCTC to finalize a Rural Transition Plan 7) Implement the plan 8) Exit when ready or by 30 days
Hospital Management	1) Monitor project activities to ensure appropriate care 2) Weekly patient case reviews 3) Meet with DPs to update on process and resolve any confusion 4) Monthly management reviews and adjustments 5) Monthly updates 6) Evaluations and reports

Weekly Coordination Teleconferences

Stakeholders in the research design process identified a lack of communication between discharge planners at the RRH and staff at the local CAH as a significant gap in the transition process. Staff of the CAHs reported that they were generally unaware of patients returning from treatment at the RRH who might present for services or treatment locally. Patients frequently reported that they were not told about services that they might be able to get in their local community. RRH hospital staff reported that they were often unfamiliar with services that were available in the many rural communities to which their patients returned and that they did not know who to contact locally for assistance. Moreover, they often received calls from patients after discharge who asked for help but they seldom learned of the ultimate outcome of their efforts.

In response, we instituted weekly phone calls between the RTCs and the LCTCs. These calls were led by an RTC. They included brief announcements, discussions of improvements to the transition procedures, case reviews, and discussions of lessons learned. LCTCs frequently shared information about strategies for securing services for patients. We strongly recommend this component.

Community Resources Bank

It is difficult for providers in rural communities to keep track of the services that are available locally. Working from a distance, it is even more difficult for RRH Discharge Planners to understand all the services that might be available in each of the many rural communities in their catchment area. An Enhanced Discharge Planning and Rural Transition Network can benefit from developing and maintaining a Community Resource Bank. Such a bank lists and describes the services and supports that may be available in each community. We have organized services available to address each of 18 standard patient needs. Together, these are programmed into a tablet computer and form the Rural Transition Needs Assessment.

A companion manual, *A Systematic Approach to Developing a Local Health and Human Services Resource Bank for Rural Communities*, is available.[g] This manual lays out the procedures and provides examples of the development of local resources and how to program a tablet computer to link the Rural Transition Needs Assessment to local resources. The resource banks for Beaverhead, Lake, Powell, and Sanders counties developed for this study are also described in the above publication.

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[g] Seekins, T., Greene, S., Long, R., Wong, J., Eisenreich, B., & Boehm, H. (2017). A Systematic Approach to Developing a Local Health and Human Services Resource Bank for Rural Communities. Missoula, MT: Rural Institute for Inclusive Communities, University of Montana.

CHAPTER 4: DISCHARGE PLANNING AND CURRENT PRACTICE

The Rural Transition Team is composed of four central players, including: (1) the patient, (2) the SPH Discharge Planners, (3) the Research Transition Coordinators, and (4) the Local Community Transition Coordinators.

It is important to note that, for the purposes of this study, the SPH discharge planners and other hospital staff continue their current practices unchanged. The RTCs and LCTCs add enhanced discharge planning and rural transition services and supports for those patients who consent to participate in the evaluation of this new model. In this way, patients who enroll only in the baseline phase of the study receive the same services as any other patient. Similarly, patients who consent to participate in the evaluation of the new model receive those same services plus the enhanced components. Figure 3 portrays the standard (shaded) and enhanced transition support process from the perspective of the LCTC.

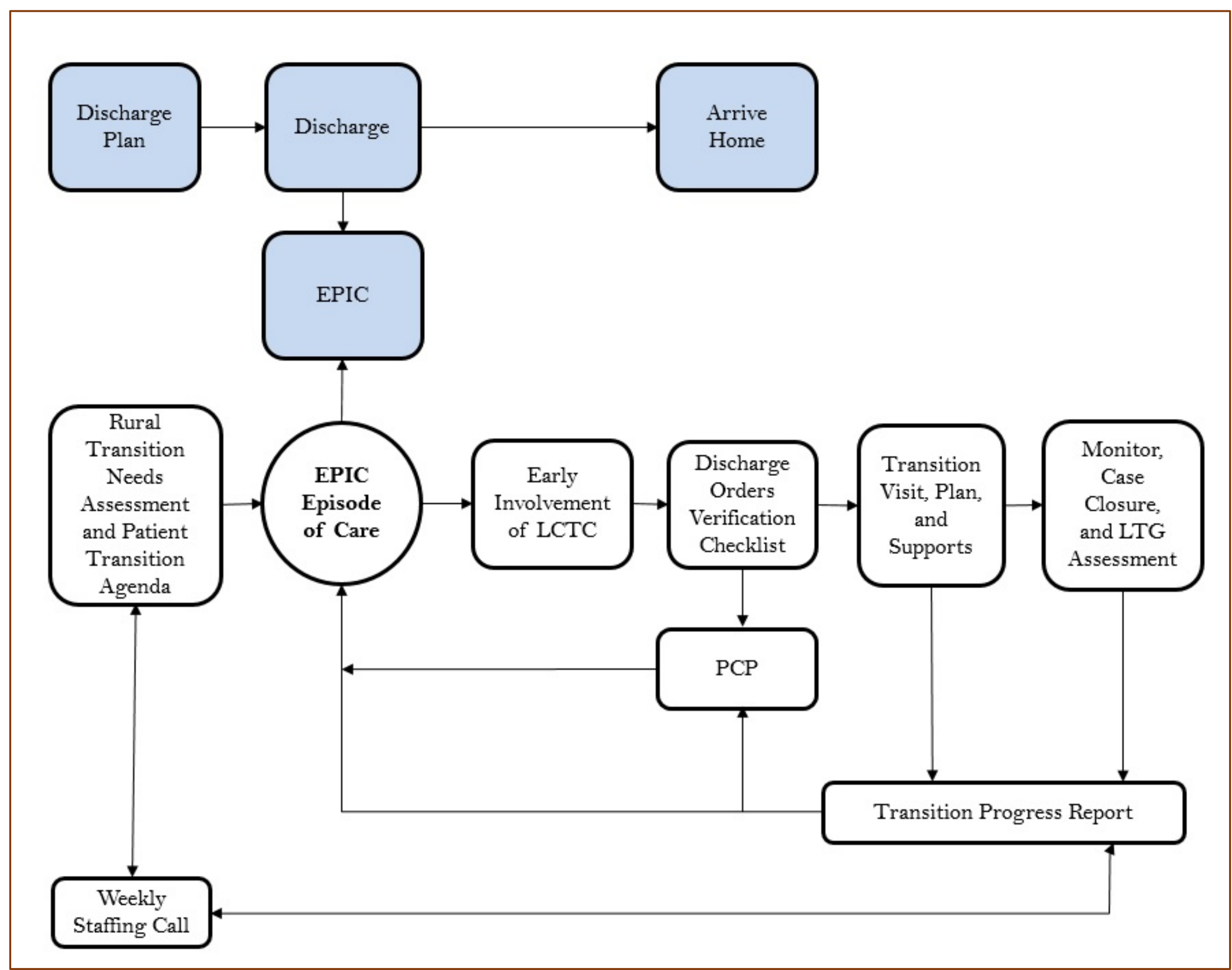


Figure 3: Enhanced Discharge Planning and Rural Transition Process

The shaded boxes at the top of the figure represent the standard practice. The open boxes at the bottom represent the experimental procedures. All patients received the standard procedures. Patients in the experimental conditions also received the enhanced procedures.

During the intervention phase of the research, the RTCs worked with the RRH Discharge Planners and other members of the treatment team to ensure that patients received the services and supports they need in the most effective way. The roles and tasks of each, beginning with the RRH Discharge Planner, are outlined in the sections below. In practice, the role and functions of the RTC may be integrated into those of the Discharge Planning staff.

CHAPTER 5: ROLES AND TASKS FOR THE RESEARCH TRANSITION COORDINATOR

The Research Transition Coordinator (RTC) initiates the Enhanced Discharge Planning and Rural Transition process. There are 12 steps that this project performed in order to initiate enhanced rural transition planning and support. These are listed below, with detailed descriptions following.

12 Tasks of Research Transition Coordinator

1) Identify patients from targeted rural counties.
2) Consent and enroll patients in research project.
3) Initiate Episode of Care tab in Epic.
4) Involve the LCTC.
5) Start a Rural Transition Needs Assessment.[h]
6) Probe for insights into patient needs.
7) Guide the patient in prioritizing needs to address.
8) Develop a Rural Transition Agenda.
9) Prepare Seven-Day Transition Calendar.
10) Schedule Transition Conference.
11) Review the package with the patient.
12) If appropriate, explore a swing-bed placement.

Identify patients from targeted counties

The first step in providing enhanced discharge planning and rural transition support is to identify patients from targeted counties. For the purposes of this project, this involved identifying individuals who were admitted as in-patients from and were planning to go home to Beaverhead, Lake, Powell, or Sanders counties. Examples of how these patients could be identified include: a social worker who may identify a patient who has a pre-planned admission from Beaverhead County or a nurse who may identify a patient transferred from Clark Fork Valley hospital's emergency department. Alternatively, the RTC may review the record of patients admitted each day to identify patients who qualify for the study. Identifying patients from rural counties starts a process designed to smooth the transition home by establishing a link to the LCTC, a case manager in the local community who can facilitate access to services and needed support.

Consent and enroll patients

The second step is to consent and enroll patients. For our project, this involved the RTC visiting with the patient while they are in the hospital and following a standard script that informs the patient about the study.i If the patient expressed interest, the RTC gave the patient a copy of the informed

[h] In the Foreword (p. 3), we recommend that these functions be exchanged with the LCTC's function of preparing a Discharge Orders Verification Checklist (p. 35).

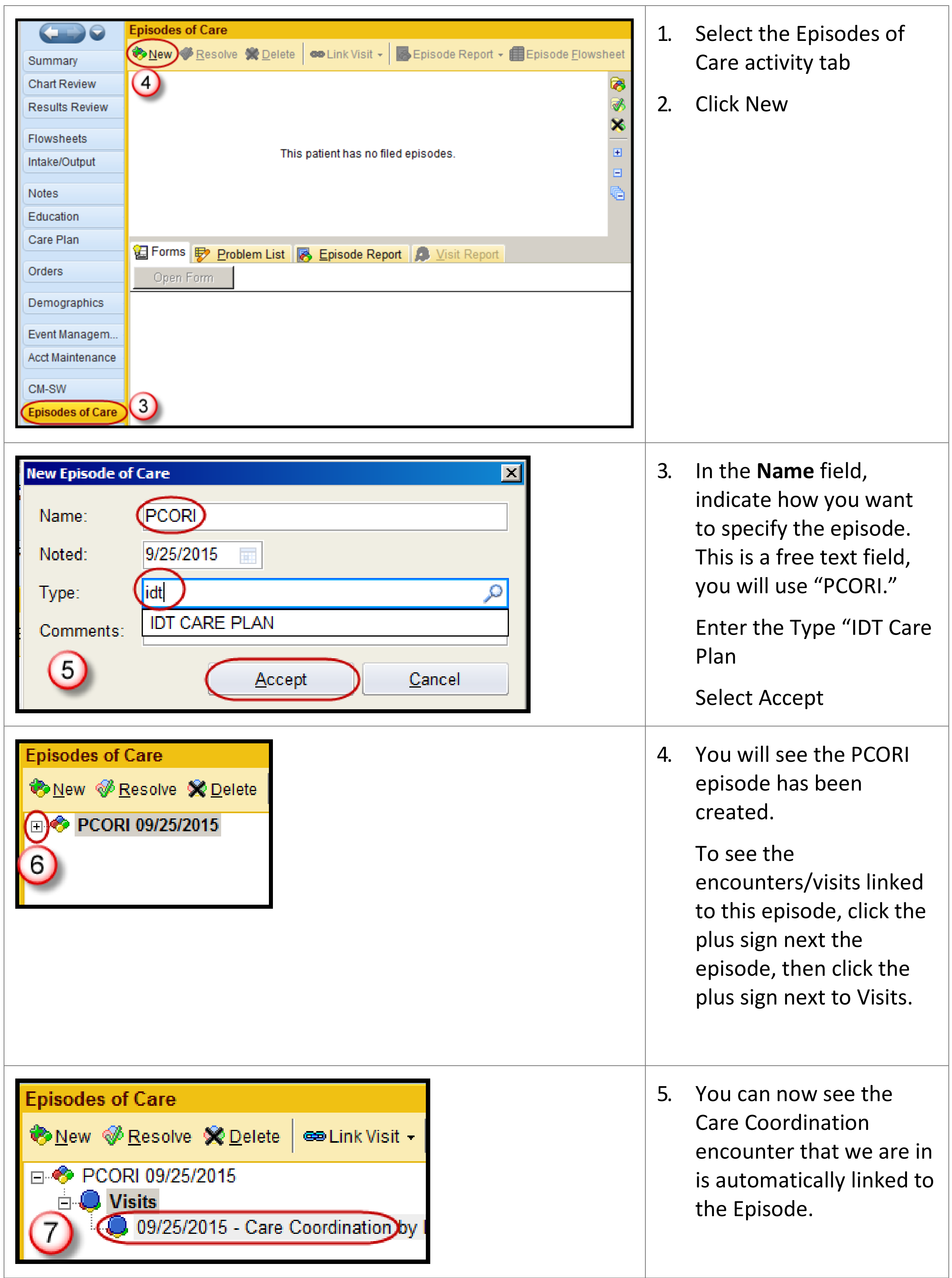
[i] The services provided were described to the patient as part of enrollment. If adopted as a program, we recommend explaining the services to the patient at this point. Appendix 5 provides a sample script.

consent to review and sign. This process gave patients the opportunity to participate in the study or to decline to do so.

Initiate an Episode of Care in Epic

If a patient consented to participate in the experimental phase of the study, the third step was to initiate an Episode of Care in Epic.[j] This involved a series of procedures that created a section in a patient's Epic chart to document the issues present and treatments provided in one easy-to-find and easy-to-review place. Figure 4 shows an example of this file. Initiating an "Episode of Care" in Epic creates a platform for engaging the LCTC in the discharge and rural transition process. It provides one location in the patient's electronic file where all providers can easily find the information they need to facilitate the patient's discharge and transition home. It also provides a place in the electronic medical record where a patient's local community providers can easily find the information they need to support the patient's transition to routine activities.

[j] Some patients were enrolled in a baseline condition only. These patients received only the current discharge planning services but they provided the same data as those in the experimental condition.



1. Select the Episodes of Care activity tab
2. Click New
3. In the **Name** field, indicate how you want to specify the episode. This is a free text field, you will use “PCORI.”

   Enter the Type “IDT Care Plan

   Select Accept
4. You will see the PCORI episode has been created.

   To see the encounters/visits linked to this episode, click the plus sign next the episode, then click the plus sign next to Visits.
5. You can now see the Care Coordination encounter that we are in is automatically linked to the Episode.

Figure 4: Sample Episode of Care in Epic.

Involve the LCTC

The fourth step is to involve the LCTC. This involves sending an alert to the LCTC to notify the LCTC that a patient from their community has enrolled in the study and that you have (or will) start an Episode of Care in Epic. For example, you might send an email to your colleague that a patient that lives in their area has been admitted to St. Patrick Hospital and is expected to be discharged back to their community within the week. This alert invites the LCTC to review the Episode of Care document and to contact you to begin participating in planning the transition back home.

Start a Rural Transition Needs Assessment

The fifth step is to start a Rural Transition Needs Assessment. This involves engaging the patient in completing ratings of 18 specific patient-centered transition needs using the Rural Transition Needs Assessment programmed into the ROADMAP tablet computer. Table 2 below lists the needs considered. These include several patient, community service, and community factors (social vital signs) that may affect a patient's ability to achieve a smooth transition home, the ease of securing needed services locally, the speed of recovery, and re-hospitalization.

Table 2: Listing of 18 Rural Transition Needs Assessed

Areas of Rural Transition Needs	
Housing	Counseling and Emotional Support
Groceries and Meals	Medical Bills and Insurance
Medications	Scheduling Follow-Up Appointments
Personal Assistance for Daily Activities	Rehabilitation Appointments
Home Health Care	Transportation
Home Modifications	Recovery Expectations
Performing Daily Chores	Management of Treatment Tasks
Care of Dependents	Medical Contacts for Complications
Income and Finances	Long-Term Lifestyle Changes

The Rural Transition Needs Assessment is conducted using a tablet application. Figure 5 presents an example of such an assessment for one patient. Each item is structured so that it begins with a patient education statement followed by an opportunity for the patient to rate his or her confidence that they can meet the need. Ratings are recorded on a scale of "0" to "4" where a rating of zero means the patient is not at all confident and a rating of four means the patient is very confident. The patient may also rate an items as not applicable (NA). The Rural Transition Needs Assessment program treats each item a patient rates as "2" or less as a potential problem to include on the patient's Rural Transition Agenda. It also automatically prepares a list of local resources that a patient might find useful in addressing the need. Completing the ratings provides the data to begin to focus on the needs a patient may want to address in order to maximize their recovery.

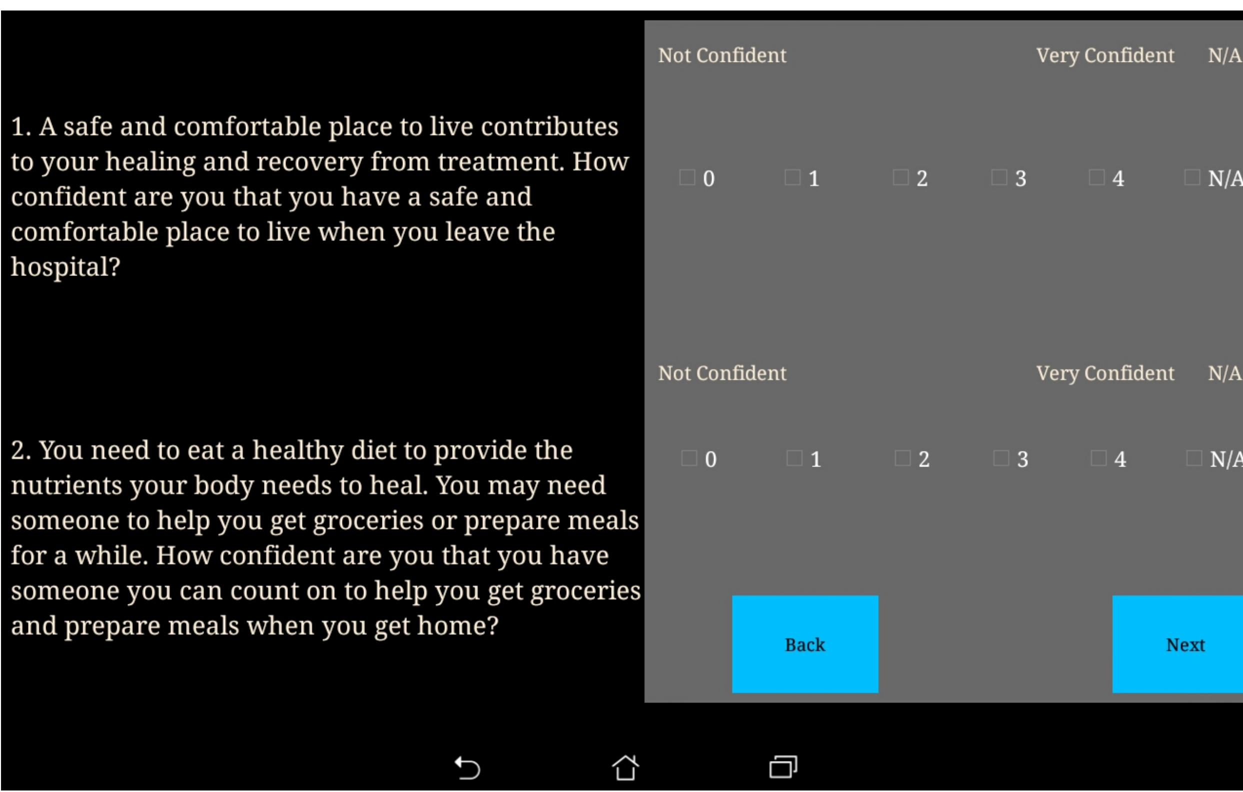


Figure 5: Sample Rural Transition Needs Assessment Template. Screen shot of the tablet computer showing two needs items and the rating scale.

To start the needs assessment, you might introduce yourself and explain why you are visiting the patient. Then you might say, "The resources and supports you have at home and in your community can make a difference in how well you heal and how quickly you recover. I'm going to ask you to rate your confidence in meeting several issues that you may face once you get home. Please, rate your confidence in achieving each one on a scale of "0" to "4," where zero means that you are not confident and a rating of "4" means you are very confident. You can also rate an item as not applicable (NA) to you."

Probe for insights into a patient's needs

The sixth step is to probe for insights into a patient's needs. This involves asking the patient to provide more details about items rated as "2" or less in confidence. For example, if a patient rates their confidence in the housing item as "1," you might ask, "Can you tell me more about that?" This encourages the patient to describe more precisely the details of their situation. You can record the additional information about potential problems in the tablet.

Guide the patient in prioritizing needs

The seventh step is to guide the patient in prioritizing needs. This involves reviewing items a patient rates as "2" or less, discussing the benefits to recovery of addressing the need, and asking if the patient would like assistance in addressing the issue once he or she returns home. For example, you might say, "The assessment shows that you are concerned about the possibility of falling on the stairs at home. Arranging your house to be more accessible would help prevent a fall and make your recovery

easier. Would you like help from the LCTC in addressing this issue once you get home?" Similarly, you might say, "The assessment shows that you are not confident that you can get an appointment with a local rehabilitation provider. Getting into physical therapy in a timely fashion can speed your recovery. Do you want to add this issue to your Rural Transition Agenda?" Involving the patient in the selection of issues to address orients the discharge planning and transition supports to the patient's needs.

Develop a Rural Transition Agenda

The eighth step is to develop a Rural Transition Agenda. This involves using the tablet application to link a patient's prioritized needs to locally available resources and posting the resulting agenda in the Epic Episode of Care. Figure 6 shows an example of one patient's Rural Transition Agenda. Each item lists the need addressed (e.g., Performing Daily Chores), provides additional information about the issue, and lists resources available locally that might be used to help address the issue.

Patient Transition Agenda

1. Performing Daily Chores

Additional Patient Info: Patient is ready to take things slow and is strategizing how to do daily chores like taking out the trash (making sure it's not too heavy), etc.

Resources Available:

Lake County Council on Aging 406.676.2367 528 Main St. SW, Ronan

2. Care of Dependents

Additional Patient Info: Patient cares for her daughter who has a disability. Currently a friend is caring for daughter while she is in the hospital. A co-worker has also helped at times. Patient is concerned that this help will not continue once she discharges from the hospital and returns home.

Resources Available:

Mountain View Care Center 406.676.5510 829 Main St SW, Ronan

3. Medical Contacts for Complications

Additional Patient Info: Patient plans to go to walk in clinic as needed as it's the closest to her home (4 blocks away).

Resources Available:

Providence St. Joseph Medical Center, Ronan Clinic	406.883.5680	Six 13th Ave E, Polson
St. Luke's Community Healthcare	406.675.4441	107 6th Ave SW
CSKT DHRD	406.675.2700	
Providence St. Joseph Medical Center	406.676.5680	63351 US-93, Ronan

Figure 6: Rural Transition Agenda for a hypothetical patient.

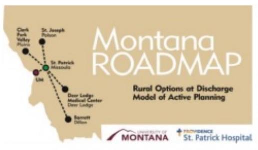
The Transition Tablet Application generates the Patient Agenda by linking needs to resources listed in a Community Resource Bank. This agenda provides a starting place for the patient and the LCTC to develop a plan of support. If the patient adds this issue to the Rural Transition Agenda, the program will flag it for the LCTC. She will use the assessment to identify local resources that might help the patient. (The development of a Community Resource Bank is described in a companion manual, *A Systematic Approach to Developing Local Resource Banks for Rural Communities*.)

Prepare a Seven-Day Transition Calendar

The ninth step is to prepare a Seven-Day Transition Calendar. This involves working with the patient to plan a daily schedule for at least the first three days of his or her return home, integrating care instructions into a calendar. Figure 7 shows a sample of a schedule for the first days of one patient's transition back home. A Transition Schedule helps the patient understand the likely course of recovery and reminds the patient of what he or she needs to do.

THE SEVEN-DAY CALENDAR

Part of the Enhanced Discharge process involves preparing a "seven-day calendar" for a patient before they leave the hospital. This calendar lists tasks, events, and appointments for the first seven days after a patient arrives home. This might include tasks such as changing dressing or taking prescribed medications. It might list events such as having meals delivered at certain times on certain days. It might also list things a patient wants to do such as attending a grandchild's school play. It will also include medical and other appointments scheduled before the patient leaves the hospital. Once a patient gets home, he or she may discover problems completing or managing the scheduled activities. These discoveries may present additional needs that should be addressed.



This Seven-Day Transitions Calendar is meant to help you plan for important tasks and events when you get back home. Think through what you need. Then write the key events and tasks you need to do in the box for different times each day. This will help you and others to prepare for and remember to do the things that will help you to heal.

You should make note of both the things you've been told to do for treatment and the things that you want to do to get back to your routine.

Depending on your condition, you should plan to rest more in the beginning and then gradually add routine activities as you recover.

Post it on your refrigerator where you will see it.

Local Contact:

Sally Myrna
Clark Fork Valley Hospital
(406) 360 - 1234

SEVEN DAY TRANSITIONS CALENDAR – First 3 Days

Time	Day 1	Day 2	Day 3
7:00 AM			
8:00 AM		Breakfast (Daughter)	Breakfast (get myself)
9:00 AM	Daughter arrives to pick you up	Check Dressing	
10:00 AM	DISCHARGE	Sponge Bath	Ride to Clinic (Bob)
11:00 AM		Rest	Dr. Jones Remove Dressing
12:00	ARRIVE HOME	Lunch (Daughter Prepares)	Home Rest
1:00 PM	Lunch with Daughter		Late Lunch (on my own)
2:00 PM	REST	Rest (TV or Books)	LCTC Visit
3:00 PM			
4:00 PM			Rest
5:00 PM	Daughter Dinner	Meals on Wheels	Meals on Wheels
6:00 PM	Call John (brother)		Nightly news
7:00 PM	Check Dressing	Check Dressing	ROADMAP Survey
8:00 PM		Amazing Race	
9:00 PM	Early to bed	Early to bed	Early to bed
10:00 PM			
Night Time			

SEVEN DAY TRANSITIONS CALENDAR – Days 4 through 7

Time	Day 4	Day 5	Day 6	Day 7
7:00 AM	Breakfast		Breakfast	
8:00 AM	Dress for PT		Dress for PT	
9:00 AM	Ride to Hospital (Carol)		Ride to Hospital (Carol)	Call John (brother)
10:00 AM	Physical Therapy	Ride to Café (Rick)	Physical Therapy	
11:00 AM	Home Rest	Francine Tea	Home Rest	
12:00	Lunch (on my own)	Ride Home	Lunch (on my own)	
1:00 PM		Lunch/Rest		Grizzly Football Game
2:00 PM				
3:00 PM				
4:00 PM				Ride to Church (Rick)
5:00 PM	Meals on Wheels	Meals on Wheels	Daughter Dinner	Church Potluck
6:00 PM	Nightly news	Nightly news	Nightly news	Ride Home
7:00 PM		Grandson's School Play		ROADMAP Survey
8:00 PM			Laundry (Grandson helps)	
9:00 PM				
10:00 PM				
11:00 PM				
Night Time				

Figure 7: Seven-Day Transition Calendar. Sample of a schedule for the first seven days of one patient's transition back home.

Schedule a Transition Conference

The tenth step is to schedule a Transition Conference. This involves working with the patient and the LCTC to set a tentative date for a TC. This date may change after the patient arrives home but it provides a point of transition planning.

A TC involves a conversation between the LCTC and the patient in which they develop a Rural Transition Plan. A TC may involve a home visit, a meeting at the local critical access hospital, or a conversation over the phone. While the patient's preferences should be respected, the preferred option for this project involved a home visit.

Review the package with the patient

The eleventh step is to review the package with the patient. This involves summarizing the findings of the needs assessment, the selection of the issues the patient has chosen to address with the help of the LCTC once they get home, and reminding them of the Seven-Day Calendar and contact information for the LCTC. Provide the patient with a printed packet including their Rural Transition Agenda and tell the patient that the LCTC will contact them once they get home.

Explore a swing-bed transition, if appropriate

Finally, given your assessment of the patient, the twelfth step is to explore a swing-bed transition, if appropriate.[k] This involves working with the medical providers to determine if a patient meets the criteria for a discharge to a swing bed at the local hospital. Swing-bed placements are specifically designed to provide a higher level of initial support to promote a healthy transition home for patients who may require such support.

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[k] Information about swing-bed placements can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html.

CHAPTER 6: ROLES AND TASKS FOR THE LOCAL COMMUNITY TRANSITION COORDINATOR

Current trends in health care delivery suggest that the right supports provided to patients at the right time may improve outcomes and reduce re-hospitalizations. For patients being discharged from a tertiary care facility back to a small town or rural community, this support includes the assistance of a Local Community Transition Coordinator (LTC). In the current era of short hospital stays and rapid discharges, the LCTC must work quickly and systematically. The LCTC has several important jobs to perform, including initiating transition support services, developing a Rural Transition Plan, implementing the plan, and closing the case. This manual describes each of these steps in detail and provides examples of how they can be completed.

The primary job of a LCTC is to assist patients in making the transition from dependence on medical providers back to their routine activities and to natural systems of support. The major activities in the job include:

A) Establish a Transition Referral
B) Prepare for patient's discharge and Transition Conference
C) Initiate local services
D) Conduct the Transition Conference
E) Finalize the Rural Transition Plan
F) Provide transition supports to implement plans
G) Facilitate patient's transition to independence and natural systems of support
H) Close the case

The following sections of this manual explain the rationale behind each of these major steps, lists the tasks for completing each step, and provides examples of how you might complete the tasks. While this section presents an overview of an LCTC's role in the transition process, it is not a complete description of what you might do. Each individual will present different needs and perspectives. Each LCTC must apply their own unique values and skills in providing support within their community.

A. Establish a Transition Referral

The LCTC's first task is to establish a Transition Referral. There are four steps in this job, including:

1) Monitor Epic for referrals
2) Acknowledge referrals
3) Communicate with the Research Transition Coordinator
4) Notify the primary care provider of the patient's transition

Monitor Epic for referrals

The first step in establishing a transition referral is to monitor Epic for referrals. This involves checking the Epic report file, In-Basket, or phone messages for any referrals at least once each day. For example, you might check your phone messages and be notified that there is a patient from your area that

has been admitted to St. Patrick Hospital who has consented to participate in the study. Such a phone call would alert you to check Epic for referral information.

Acknowledge referrals

The second step in establishing a transition referral is to acknowledge referrals. This involves returning phone calls or email alerts to let the RTC know that you have received the referral and are initiating the rural transition process. For example, you might reply to an email from a Discharge Planner to let that person know that you received their early alert and are starting your part of the transition process. Your acknowledgement lets the RTC know that you are available and that you will be following the case.

Communicate with the Research Transition Coordinator

The third step in establishing a transition referral is to communicate with the Research Transition Coordinator (RTC) about a patient's Rural Transition Needs Assessment. This may involve a phone call or secure email exchange with the RTC so that you have the pertinent information (i.e., patient's full name, date of birth, gender, etc.) so you can access the Rural Transition Agenda in patient's Epic Episode of Care. It may also involve reviewing a patient's potential needs and available resources with the RTC. For example, you might call the RTC who referred the patient to you, and ask if he or she has completed a Rural Transition Needs Assessment. If the RTC has not yet completed the assessment, you might work with her to do so. If she has completed it, you can ask for a copy or access it in Epic. This will give you a head start in planning the supports you may need to provide.

Notify the primary care provider

The fourth step in establishing a transition referral is to notify the primary care provider (PCP) of the patient's transition. This involves insuring that a patient's local PCP is informed of the patient's hospitalization and imminent discharge. For example, you might send a note via Epic In-Basket to a patient's PCP that one of their patients has enrolled in the ROADMAP project and that you will be providing transition support. Further, you might let them know that they can access the patient's "Episode of Care" in the Epic system. This step promotes continuity of care and care coordination once the patient returns home.

B. Prepare for a Patient's Discharge and Transition Conference

The LCTC's second task is to prepare for a patient's discharge and their Transition Conference (TC). Preparing for the patient's discharge and TC while the patient is still in the hospital will familiarize you with the patient's needs and desired levels of assistance. While the initial plan may change significantly once you meet with the patient, having a plan to review enhances the confidence a patient might have in working with you. You should have access to the Rural Transition Agenda through Epic before or at the time of discharge. There are six steps to perform in order to prepare for the patient's discharge and the TC. These include:

1) Prepare Discharge Orders Verification Checklist
2) Review the Patient's Rural Transition Agenda

3) Summarize potential resources and gaps
4) List questions about patient's goals and circumstances
5) Note any special conditions or circumstances from local perspective
6) Prepare draft plan for the Transition Conference discussion

Physicians and other health care providers give patients a variety of "orders" to be followed once a patient is discharged and returns home. Such orders range from starting, maintaining, or discontinuing medication routines to participating in physical therapy. Generally, patients understand and can follow these directions. Occasionally, however, a patient may encounter obstacles that impede following the orders or there may be miscommunication with various providers. For example, in one case, a physician ordered home oxygen for a patient. The patient understood that the oxygen would be delivered to him at his home and that he did not need to do anything to follow up on this. The patient waited several days without receiving the delivery. When the LCTC contacted the patient, she learned about this situation and checked with the local oxygen providers and discovered that they had no record of the order. She checked with the patient's physician to communicate this gap in service. They worked together to rectify the situation, likely preventing a visit to the emergency room and a possible hospital readmission.

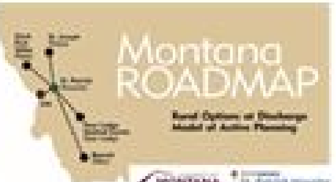
Prepare a Discharge Orders Verification Checklist

The first step of a Local Community Transition Coordinator is to prepare a Discharge Orders Verification Checklist. This involves reviewing a patient's After Visit Summary and other relevant records to identify those things a patient should do to manage their recovery once they get home. For example, you may find that the After Visit Summary instructs a patient to continue to take the medications he was prescribed by his PCP and that he should take a prescribed antibiotic for the first 14 days after returning home. Any orders should be entered into a Discharge Orders Verification Checklist. Figure 8 shows a standard form of a Discharge Orders Verification Checklist you can use. You should enter the orders you identify in the appropriate fields of the Discharge Orders Verification Checklist. In this example, the LCTC noted three orders – for a medication, oxygen, and a PCP appointment. Preparing a checklist gives you a structure to use in reviewing the patient's status when you make your first contact. This checklist provides a simple tool for reviewing the patient's progress when your first contact them. It also helps ensure that the important tasks for recovery are completed. This is a simple, easy-to-implement patient service that can reduce the potential for unnecessary emergency room visits or hospital readmissions.

WHAT IS A TRANSITION CONFERENCE?

A Transition Conference (TC) is a meeting with the patient after they return home. The purpose of the TC is to review the patient's Rural Transition Needs Assessment and Rural Transition Agenda, and to complete a Rural Transition Plan.

Patient Name:	Joseph Smith
Patient Research Code:	1001
Transitions Conference Date:	7/31/2016



Discharge Treatments and Services Confirmation

Review the patient's discharge plan or after visit summary. Make notes of any physician orders or provider recommendations. Note them as appropriate, circling "No" if there is none. When contacting the patient to schedule a transitions conference, summarize orders and ask if they have gotten the recommended services. If the patient indicates that he or she has not gotten an ordered service, explore the reasons and probe to see if the patient may need assistance with the issue.

	Ordered (Are any of the following ordered as part of the discharge plan?)	**Received** (Has the patient gotten the ordered services?)	**Notes**
Medications	(Yes circled) No	(Yes circled) No	Atorvastatin 80mg
Oxygen	(Yes circled) No	Yes (No circled)	Scheduled to be delivered
Home Health Care	Yes (No circled)	Yes No	
Durable Medical Equipment	Yes (No circled)	Yes No	
Home Modification	Yes (No circled)	Yes No	
Follow-up Appointment	Yes (No circled)	Yes No	
Local PCP Appointment	(Yes circled) No	Yes (No circled)	
Rehabilitation Appointment	Yes (No circled)	Yes No	
Other:	Yes No	Yes No	
Other:	Yes No	Yes No	

Figure 8: Sample Discharge Orders Verification Checklist.

Review the patient's Rural Transition Agenda

Once the RTC alerts you to the posting of the patient's Episode of Care, the second step in preparing for a patient's discharge and Transition Conference is to review the patient's Rural Transition Agenda. This involves opening the patient's file in Epic and reading their Rural Transition Agenda. The Rural Transition Agenda is a brief document that shows the needs the patient might want help in addressing. For example, one patient's agenda - as shown in Figure 6 (presented previously) – indicates the patient has expressed concerns about three issues. First, she has expressed concerns about Performing Daily Chores. Specifically, she understands she will need to take things slow and was beginning to

strategize how to perform daily chores (e.g., taking out the trash). She also expressed concerns about taking care of her daughter and where to go if she had medical complications.

Summarize resources and gaps

The third step in preparing a patient's return home is to summarize resources and gaps. This involves preparing a case note for the patient's Epic chart that lists the identified gaps and resources. For example, in the case presented in Figure 6, the patient's agenda may show that the first need is in the area of "Care of Dependents." Specifically, the patient reported she "cares for her daughter who has a disability." The Rural Transition Agenda lists one local resources that the patient may use to address that issue. Summarizing resources and gaps in this way begins to suggest the elements of a plan.

List questions about a patient's goals and circumstances

The fourth step in preparing for a patient's Transition Conference is to list questions about a patient's goals and circumstances. This involves noting any questions about a patient's hopes for recovery that are not clear to you and any confusing issues related to their needs and resources. For example, a patient may report living alone with several pets but not indicate a need for pet care during hospitalization or recovery at home. You may have questions about whether this has simply been overlooked, if the patient has assumed that she can manage without help, or whether someone is already caring for the animals. Identifying such questions provides you with an agenda of issues to clarify with the patient.

Note any special conditions or circumstances from the local perspective

The fifth step in preparing for a Transition Conference is to note any special conditions or circumstances from the local perspective. This involves taking your knowledge of the community into account in drafting a plan. For example, the patient may have indicated a need for alternative housing and you may be aware of a new rental that has recently become available. Similarly, the RRH discharge planner may not be aware that the local YMCA is now offering rehabilitation services reimbursed by Medicare or that the local hospital has recently added a cardiac rehabilitation specialist. Noting these special conditions and circumstances expands the quality of services you can tell the patient about during the first TC. Patients have indicated a strong desire to have the support of a local coordinator because you are more likely to have useful information and advice for their transition back into the community.

Prepare a draft plan for the Transition Conference discussion

The sixth step in preparing for a Transition Conference is to prepare a draft plan for the Transition Conference discussion. This involves pairing the patient's identified needs with resources that you can present to the patient during the TC. For example, Figure 9 below shows a discussion draft for a visit with a patient who is to be discharged after a hip replacement. In this case, the patient identified four agenda items, including medications, assistive equipment, daily chores, and rehabilitation. The LCTC identified and listed several different potential sources of service or support that might help the patient address these needs. The LCTC also listed some actions that might form part of the plan. Such a draft is not meant to make the decisions for a patient but to provide a convenient starting place of discussion with the patient about how she would like to address these needs.

ROADMAP Transition Plan					
Patient Name:	Smith	Joseph			
Patient Research Code:	**1001**				
Transitions Conference Date:	7/31/2016	**Page 1**	**Added Pages**	**0**	

Montana ROADMAP
Rural Options at Discharge Model of Active Planning
MONTANA
St. Patrick Hospital

Patient Agenda Item	Patient Specific Issue	Potential Local Resources	Plan Steps	Who is Responsible?
Medications	A pharmacy that will provide the medication I need at an affordable cost.	1. CAH 2. Foster's Drug 3. Mail-order site	Make calls to resources to check availability of medications and financial assistance.	Caregiver
Home Modifications	Needs portable toilet for the main floor.	1. Foster's Drug	Check Foster's for toilet and cost.	Caregiver
Performing Daily Chores	Someone who can do specific chores (i.e., feed cattle) that I will not be able to do for a while.	1. Neighbors 2. Church members 3. High school AG students	Call to ask for help and schedule tasks.	Caregiver
Rehabilitation Appointments	Physical therapy of other rehabilitation services that will aid my recovery.	1. Local hospital has a physical therapy program and services.	Schedule appointment	LCTC
Briefly describe patient need.	What would help address this need or solve this problem?	List Potential Resources or Services.	What needs to be done?	Who is responsible for this step?
Comments:	The patient lives out of town, but has transportation. His wife is a strong, significant caregiver.			

Figure 9: Sample Draft Rural Transition Plan.

C. Initiate Local Services

The third task of a Local Community Transition Coordinator is to initiate local services. There are 6 tasks to perform in order to prepare for the patient's discharge and the Transition Conference. These include:

1. Contact the patient.
2. Review Discharge Orders
3. Probe for problems and resolutions
4. Confirm or schedule a Transition Conference
5. Get directions to the patient's home
6. Ask for any special instructions upon arrival

Contact the patient

The first step in initiating local services is to contact the patient within two days of discharge. This may involve several efforts to make contact with the patient to introduce yourself and begin providing services. You might make contact with a patient by phone, email, or in person. If by phone, you should introduce yourself and explain your role in facilitating their recovery at home. For example, you might say, "Hello, my name is Susan Briggs. I am the Local Community Transition Coordinator working with the regional hospital to facilitate your transition from your recent treatment back home." Introducing yourself establishes your authenticity.

Review and resolve discharge orders

Once you feel the patient is comfortable in talking with you, the second step is to review and resolve discharge orders. This involves asking the patient how they are doing and asking if they have been able to implement their discharge orders. For example, you might say, "I have a list of your discharge orders that I'd like to review with you. First, your After Visits Summary says that you are supposed to get a prescribed medication, Atorvastatin, and take it once a day. Have you been able to get the prescription filled and have you taken it as directed?" Reviewing the patient's discharge orders helps identify any gaps or problems that you might help the patient address.

Probe for problems and solutions

If the patient reports that he or she has been unable to initiate or complete an order, you should probe for problems and solutions. This involves asking the patient if there are impediments to filling the orders and offering to help resolve them. For example, you might say, "Not having the oxygen that was ordered seems like a significant problem. Is there an obstacle you see? Can I help resolve this issue?" Identifying potential problems in the period immediately after discharge can help avoid unnecessary visits to the ER or hospital readmissions.

Confirm or schedule the Transition Conference

The fourth step in initiating services is to confirm or schedule the Transition Conference. This involves either confirming the date and time for the TC, rescheduling it, or scheduling a time for the visit. For example, during your call, you may learn that a patient's spouse cannot be at a scheduled TC unless

the visit is set for a different time. In such a case, you should do your best to accommodate the patient and their caregivers. Confirming a convenient time ensures that you will get the time you need and increases the acceptance you are likely to receive from the patient and their family.

Get directions to the patient's home

The fifth step in initiating services is to get directions to the patient's home. This involves checking the patient's record for his or her address and looking it up using an electronic directions application to obtain a map from your office to the patient's house. For example, you might use Google Maps to get directions to the patient's home. Getting specific directions helps you plan how much time you will need to get from your office to their home.

Ask for any special instructions upon arrival

The sixth step is to ask for any special instructions upon arrival. This involves asking the patient if there are any special instructions on getting to or getting into the house. For example, while you are on the phone with the patient to remind them of your scheduled visit, you might ask, "Are there any special directions for getting to your house?" or "Do you have any animals or other things I should watch for when I get to your house?" Going to a patient's home for the TC may seem obvious but it can present challenges. In rural areas, the roads may not be well marked. Further, when you get to the house, there may be animals in the yard – from dogs to horses to chickens – that need to be treated properly. Getting instructions from the patient or a caregiver helps ensure that you can find your way there and that you are not disruptive when you arrive.

D. Conduct a Transition Conference

As mentioned above, a Transition Conference (TC) is a meeting with the patient after they return home. The purpose of the TC is to review the patient's Rural Transition Needs Assessment and Rural Transition Agenda, and to complete a Rural Transition Plan. You can hold a TC in several ways. For example, you might meet the patient at their home, at your hospital, at a local clinic, or at a local human service agency. You might also conduct the TC by phone, a Transition Tele-Conference. The preferred method for holding the TC is to meet with the patient (and caregivers, as appropriate) at the patient's home. Meeting at the patient's home helps you better understand a patient's needs and the resources they have available to address them. Nonetheless, if a patient expresses a desire for an alternative to meeting at his or her home, you should honor the patient's preferences by offering the alternatives. These guidelines assume that you will hold the TC at the patient's home. They easily apply to any setting, however. There are 13 tasks to conducting a TC, including:

1. Call to alert patient and care givers at least an hour before visit
2. Follow any established safety procedures
3. Arrive on time
4. Introduce yourself
5. Verify that you are at the patient's home
6. Verify that this is a convenient time
7. Ask for a convenient place to talk

8. Make observations about the level of organization of the home
9. Start the conversation by commenting on your observations
10. Explain the purpose of the Transition Conference
11. Remind the patient that this is part of a research project
12. Explain the process
13. Re-affirm confidentiality

Call to alert patient and caregivers

The first step in conducting a Transition Conference is to call to alert patient and caregivers at least an hour before visit. This involves calling the patient's home phone or cell phone to remind them of your appointment and that you are leaving to meet them. For example, you might call a ranch family to remind them that you will be visiting at 3:00 PM, that you are on your way, and that you may arrive a few minutes late because of the weather. Calling to alert the patient that you will be there within the hour allows them time to prepare for your arrival. It also provides a chance for the patient to re-schedule the TC if he or she is not feeling up to it yet. (It is important to note, however, that you should go to the scheduled appointment, even if you do not reach them by phone. They may be busy doing something else but still expect you at the scheduled time.)

Follow safety procedures

The second step is to follow safety procedures. This involves following any protocol established for the safety of staff who conduct home visits. For example, your hospital may ask a staff member who conducts home visits to inform a designated person where you are going and when you expect to return. Then, when you return, you should let the designated person know. Such processes help ensure your safety.

Arrive on time

The third step in conducting a home Transition Conference is to arrive on time. This involves leaving so that you will arrive about 5-10 minutes early. This gives you time to account for any problems in travel. For example, in visiting someone who lives on a ranch outside of town, you may find yourself travelling on a rough road or you may encounter obstacles such as moving cattle.

Introduce yourself

The fourth step is to introduce yourself. This involves telling the person who greets you your name and your organizational affiliation, and explaining the purpose of your visit. For example, you may say, "Hello, my name is ________. I am from ____________ hospital. I am here for a follow-up visit with ________________ who was just treated at St. Patrick Hospital." Introducing yourself puts the person who greets you at ease and helps them accept your visit.

Verify that you are at the patient's home

The fifth step in initiating a home visit is to verify that you are at the patient's home. This involves telling the person who greets you who you are here to see and asking if they are at home. For example, you might ask, "Is ____________ home?"

Verify that this is a convenient time

Even if a patient is at home and you have alerted them that you were on your way, the patient's circumstance and condition may have changed. It is important that the visit be convenient for the patient and caregivers. Accordingly, the sixth step in conducting a Transition Conference is to verify that this is a convenient time. This involves asking the patient if this is still a convenient time, as the visit may take an hour or more. For example, you might say, "I hope that this is still a convenient time for you." Checking to see if this is still a convenient time demonstrates to the patient that they are in control of their recovery and that you are there to support them in that process.

Ask for a convenient place to talk

If the patient invites you into his or her home for a home visit, the seventh step in starting the home visit is to ask for a convenient place to talk. This simply involves asking the patient where he or she would like to talk. In some instances, a caregiver may answer the door because the patient is still not able to get up and move around easily. In this instance, you may meet wherever the patient is resting. In other instances, the patient may still be resting and simply call you into the house and tell you where to come. You should be aware of your surroundings at all times, especially when entering someone else's home. There may be unforeseen hazards such as power cords, toys, or throw rugs that may trip you or a lamp that you might knock over and break.

Make observations about the home

The eighth step in starting the home visit is to make observations about the level of organization of the home. This involves taking note of the degree of organization or disorganization of the house. For example, you might notice that there are many toys in the yard. There may be several cats on the porch. There may be several people in the living room. There may be a stack of recently washed dishes on a kitchen counter by the sink. Taking note of the conditions in the house may provide useful insights into the patient's needs and resources. It may also provide a handy way to start your conversation.

Start a conversation by commenting on your observations

The ninth step in starting the home visit is to start a conversation by commenting on your observations. This involves focusing on one of your observations and asking about it. For example, you might say, "I see you have lots of toys in the yard. Do you have grandchildren who visit often?" "I saw three nice looking cats on the porch. Are they yours?" Asking about the conditions of a patient's house gives them the opportunity to begin to tell their story. This is a helpful way to break the ice. It also helps you begin to gather more information that might help you provide proper supports to the patient.

Explain the purpose of the Transition Conference

The tenth step in starting the home visit is to explain the purpose of the Transition Conference. This involves reminding the patient that you are there to help organize their recovery. For example, you might say, "I am here to follow-up on the Rural Transition Agenda you started with (name) at St. Patrick Hospital. My job is to help you through the steps to maximize your recovery. In particular, my job is to help you think through the things that you need to facilitate your full and speedy recovery, and to identify and get connected with local services that might help. Some of those resources may be formal services or

programs such as physical therapy. Others may be less formal, such as organizing your friends and neighbors to help you care for pets while you recover."

Remind the patient that this is part of a research project.

The eleventh step in conducting the home visit is to remind the patient that this is part of a research project.[1] This involves reminding the patient that the services and supports that you provide are part of a research project and that he or she is free to withdraw at any time. You may also remind them that they will receive an honorarium for providing data about their discharge and transition experience. Reminding the patient that they can withdraw at any time meets one's obligations as a researcher.

Explain the process

The twelfth step in conducting the home visit is to explain the process. This involves summarizing the services and supports that you will provide and the data that they will be asked to provide. For example, you might say, "Today, we will review the Rural Transition Agenda you created while you were still in St. Patrick Hospital. I will show you the types of services and supports that are available here locally that might help you address your needs. You can decide which of them might interest you and we will talk about how to arrange for assistance you need." Outlining the process helps the patient understand that you will provide information and support that the patient needs to arrange for the quickest and best recovery they can achieve. Table 3 provides a brief summary of the process.

Table 3: Summary of the Transition Process

Transition Process
1. Review your Rural Transition Agenda
2. Review a draft plan I prepared while you were still a patient in St. Patrick hospital
3. Revise the Rural Transition Plan to reflect your current needs
4. Implement the plan to get the services and supports that will help you recover
5. Facilitate your transition back to your natural routines.
6. Complete our work together within 30 days, if possible

Re-affirm confidentiality

The thirteenth step in conducting the home visit is to re-affirm confidentiality. This involves reminding the patient that both the services you provide and their involvement in the research project (if applicable) will be strictly confidential. For example, you might say, "As you recall, the services and support I can provide are part of a unique research project. So, you are free to withdraw at any time and

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[1] If you are not replicating this research project but instead implementing this model, we recommend explaining your program to the patient at this point.

anything we discuss will be kept confidential; shared only with others who you might choose to provide support or the research team." When we were conducting this as a research project, reminding the patient that this work is part of a research project helped the patient understand that the home visit and other supports provided were unique and may have limits.

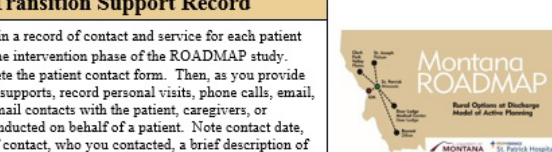
E. Finalize the Rural Transition Plan

The primary function of the home visit is to finalize a plan that will facilitate the patient's transition from dependence back to routine activities and involvement in community life. There are twelve steps in finalizing the Rural Transition Plan. These include:

1) Start a patient Transition Record
2) Check on the patient's progress
3) Review the patient's Seven-Day Transition Calendar
4) Offer guided problem solving, if there are questions
5) Review and discuss the draft Rural Transition Plan
6) Modify the plan as appropriate
7) Describe the local resources that might provide needed support or assistance
8) Ask the patient if he or she has any other ideas
9) Ask the patient which ones he or she would like to pursue
10) Determine who will take the next step in pursuing a particular solution
11) Check to see if the patient has concerns about paying for his or her medical treatment
12) Finalize the Rural Transition Plan

Start a Patient Transition Record

The first step in finalizing a patient's Rural Transition Plan is to start a Patient Transition Record. This involves filling in the information in the Transition Support Record. Figure 10 below shows one example, Joe Smith who lives in Dillon. He says that his preferred mode of communication is by phone, although he has an email account. The record shows that, over time, the LCTC has had six contacts on his behalf and that these have totaled 185 minutes so far. Tracking contacts made on a patient's behalf will help researchers or program evaluators estimate the cost-effectiveness of the ROADMAP program.



Transition Support Record

Maintain a record of contact and service for each patient enrolled in the intervention phase of the ROADMAP study. First, complete the patient contact form. Then, as you provide services and supports, record personal visits, phone calls, email, and regular mail contacts with the patient, caregivers, or providers conducted on behalf of a patient. Note contact date, the means of contact, who you contacted, a brief description of the issue(s) addressed, any actions taken or decisions made, and estimate the time this contact took in minutes.

Patient Contact Form	
Patient Name	Smith, Joseph
Date of Birth	April 23, 1951
Research Code	1001
Street Address or P.O. Box	201 Main Street
City	Dillon
Zip Code	59725
Phone Number	678-2345
Email Address	JosephSmith@dillon.com
Preferred Mode of Communication	Phone
Other	Other Notes.

ROADMAP Services and Supports Record

Contact Date	Contact Type	Who Contacted	Issue	Actions or Decisions	Time in Minutes
2/8/2016	e-mail	Research Transition Coordinator	Early Notification and Transition Referral	Reviewed Transition Agenda	45
2/8/2016	Phone	Patient	Scheduling home visit	Scheduled for the 4/28 @ 3PM	10
2/10/2016	Phone	PCP	Follow-Up Appointment	Get done within 30 days	15
2/9/2016	Home Visit	Patient and Spouse	Transition Plan	Finalized Transitions Plan	90
2/10/2016	Phone	Physical Therapy Clinic	Get appointment moved sooner	Next available May 3 @ 10:45am	15
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
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Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time
Date	Means	Who contacted	Issue Addressed with Contact	Action or Decisions	Time

Comments
Add comments that expand upon services and supports provided. Spaces will expand to accommodate your notes.

Figure 10: Sample Patient Transition Record.

Check on the patient's progress

The second step in finalizing a plan is to check on the patient's progress. This involves asking, generally, how the patient's recovery is going. For example, you might say, "Well, I understand that you were discharged Monday. How have you been doing since then?" Alternatively, you might say, "When we talked by phone and reviewed your discharge orders, you were having some trouble getting an appointment with your local physician. Did that get resolved?"

You should specifically ask the patient (or caregiver) whether they have been able to follow the recommendations on the Seven-Day Transition Calendar. For example, you might ask, "Did you post your Seven-Day Transition Calendar in a handy place? Has it helped you remember the things you need to do to recover as quickly and as completely as you would like?" If they do not raise any concerns, you should ask if they have any concerns or questions to be sure the patient has the information and help they need. For example, you might ask, "It looks like your physician has prescribed several medications. Have you been able to get those prescriptions filled? Have you had any difficulties taking them as recommended?" Checking on the patient's progress gives you additional insight into how the patient is approaching their recovery and how you might best help their efforts.

Review the patient's Seven-Day Transition Calendar

The third step is to review the patient's Seven-Day Transition Calendar. This involves discussing the successes and any problems a patient had in completing or managing the tasks, events, or appointment list in the seven-day calendar. For example, you might ask if the patient has followed the medication regime laid out in the calendar. She might reply, "I think so but I'm not sure." Such a response suggests a potential new agenda item.

Offer guided problem solving

The fourth step is to offer guided problem solving, if the patient has concerns or questions, or if you note a problem that seems important. This involves helping the patient think through issues and decide whether and how to address them. For example, the patient might report that he or she has not been able to get the prescription medications they were prescribed. You might say, "That sounds pretty serious. Would you like to talk through ideas on how you might get them?" If the patient indicates that he or she would like some help thinking through the problem, you might ask, "Well what seems to be the problem?"

Not all concerns are the obvious ones. In this case, the patient might say, "The prescription is ready at the local pharmacy but I haven't been able to get there to pick it up." You might ask, "Do you have any family or friends that could pick it up for you?" Alternatively, you might ask, "Have you checked with the pharmacy to see if they would deliver it?" Very often, problems that seem complex at first have easy solutions.

In this case, if the patient and you cannot devise a plan to solve the problem, you may offer to pick up the prescription and deliver it for them. In other cases, the patient may need to consult with their PCP or other specialists. In still other cases, a problem might be addressed by referring the patient to an agency that specializes in the sort of support that would help the patient solve their problem.

Review the draft Rural Transition Plan

Once you have checked on the patient's progress and provided any needed guided problem solving, the fifth step is to review the draft Rural Transition Plan you have prepared. This involves giving the patient a printed copy of the draft Rural Transition Plan, and reading through it sequentially. You should use your tablet computer to update the plan. Figure 9 (above) shows an example of a draft Rural Transition Plan. You might give the patient a copy of the draft plan you prepared and say, "This is a draft for a plan to address the needs you identified while you were still in the hospital. Let's go through it one item at a time. You can use this draft – it is for you to keep – to take any notes. Once we finalize the plan, I will print it out and send a final version to you."

You should review each listed need and agenda item. Ask the patient to tell you a bit about the issue and what they would like to see happen. For example, you might say, "The first need you identified as part of your Rural Transition Agenda involves housing and shelter. Can you tell me a bit about the issue and what you want to see happen?" This gives the patient an opportunity to explain the problem as they see it and to describe what they want as a solution. (NOTE: A patient may be reluctant to discuss the issues if caregivers are present. If a caregiver is present, you should ask if the patient would like to start

the conversation with you alone. You can explain that the caregiver can join the conversation at any time the patient desires.)

Modify the Rural Transition Plan, as appropriate

The sixth step is to modify the Rural Transition Plan, as appropriate. This involves reviewing the patient's Rural Transition Agenda to see if any of the issues have changed, and dropping, modifying, or adding needs based on the patient's experience since returning home. For example, a patient may say that an item identified as a need while he was in the hospital (e.g., daily chores) took care of itself, but that another issue (e.g., paying medical bills) has emerged. You should note this change in the Rural Transition Plan and examine options for the added issue.

Describe the local resources that might provide needed support or assistance

The seventh step is to describe the local resources that might provide needed support or assistance. This involves telling the patient about the services available from each local resource listed as part of the draft plan and summarizing how you think they might help the patient meet his or her objectives. For example, you might say, "You indicated that you were not confident that you could get the transportation you needed. You said that in particular you did not think you would be able to drive your car to your doctor appointments and that you would like to find someone to give you a ride. The Senior Center does not have a volunteer driver program but does have a van service you could use. An alternative might be to see if someone from your church would be willing to give you a ride. Another option might be to see if you might be able to hire someone temporarily to use your car to drive you."

Ask the patient if he or she has any other ideas

The eighth step is to ask the patient if he or she has any other ideas. For example, you might ask, "Have you had any thoughts about how to address this need?"

Ask the patient which ones he or she would like to pursue

Once you have identified as many options as you think useful, you should ask the patient which ones he or she would like to pursue. This involves the patient deciding which path or solution he or she thinks would be most convenient and effective.

Determine who will take the next step in pursuing a particular solution

The tenth step is to determine who will take the next step in pursuing a particular solution. The goal in this step is to maximize the patient's control and independence. You should provide just enough assistance to ensure the needed steps are completed but not so much that the patient is depending on you alone.

See if the patient has concerns about medical payments

One of the most significant concerns reported by patients who are discharged from a referral hospital to a small town or rural community involves dealing with the billing and payment process. Specifically, patients report that they have difficulty negotiating a reasonable way to pay their bills with the hospitals. This concern is despite the desire of hospitals to do so. This gap in understanding is particularly acute

among those who lack medical insurance. This situation creates a great deal of tension among these patients and simply is not healthy for them. Functionally, it may lead a patient to stop purchasing and taking prescribed medications because they feel they cannot afford to buy them. As such, addressing this issue may smooth the transition process significantly for some patients and in itself improve outcomes. In this case, your job is to check to see if the patient has concerns about medical payments that have not yet been addressed. If a patient has concerns about medical payments, determine their nature. For patients who are concerned about paying their bills, you can refer them to the payment coordinator and explain that part of their job is to help patients find resources to address the payment issues, not to simply put pressure on the patient to "pay up" or to try to collect what someone cannot pay. For those who lack medical insurance, review their options with them. If they are interested, facilitate enrollment in an insurance plan, such as those available through federally assisted programs.

Finalize the Rural Transition Plan

Finally, once you have addressed the agenda items and developed a plan, you should finalize the plan. This involves summarizing your notes to confirm the decisions the patient wants to pursue. Your summary and the patient's should coincide. Next, you should note any changes on your copy of the TC and be sure that the patient has noted the changes on their copy.

Thank the patient for taking time to be involved in the study. Tell them that you will send a copy of the Rural Transition Plan and that you will begin working on the tasks assigned to you.

F. Provide Transition Supports to Implement the Rural Transition Plan

The central function of the rural transition process is to provide transition supports. This involves implementing and monitoring the progress of the Rural Transition Plan. This personalizes the relationship you will develop with the patient. As such, it helps to develop a "therapeutic alliance." This means that the patient gains trust in you and you gain trust in them. The following provides detailed suggestions on seven tasks you should complete in implementing the Rural Transition Plan, including:

1) Complete updates of the patient's Rural Transition Plan
2) Send a copy of the final plan to the patient
3) Update Episode of Care
4) Facilitate referrals and appointments
5) Follow through on action items
6) Monitor patient's progress and achievements
7) Keep Episode of Care up-to-date

Complete updates of the Patient's Rural Transition Plan

The first step in providing transition supports is to complete updates of the patient's Rural Transition Plan. This involves revising and editing the plan based on the home visit once you return to your office. For example, once you get back to your office, you might review any notes you made, add them into the Rural Transition Plan file, edit the information to be sure it is clear, and save the file. Documenting any final changes quickly helps ensure that you capture all the details you worked out with the patient.

Send a copy of the final plan to the patient

The second step in providing transition supports is to send a copy of the final plan to the patient. This may involve sending a version by email or through regular mail, or even dropping off a copy at the patient's home. Getting the final changes to the patient quickly helps reinforce the tasks the patient needs to complete and the ones the patient should expect from you.

Update the Episode of Care

The third step in providing transition supports is to update the Episode of Care. This involves carefully labeling the file and posting the finalized Rural Transition Plan in the Epic Episode of Care. For example, we saved the file as "IDT CARE PLAN" to distinguish it from other Episodes of Care. Then post it to the patient's Episode of Care. Figure 11 provides an example of where you might file this finalized plan. Posting the finalized plan makes it accessible by most providers who are serving the patient.

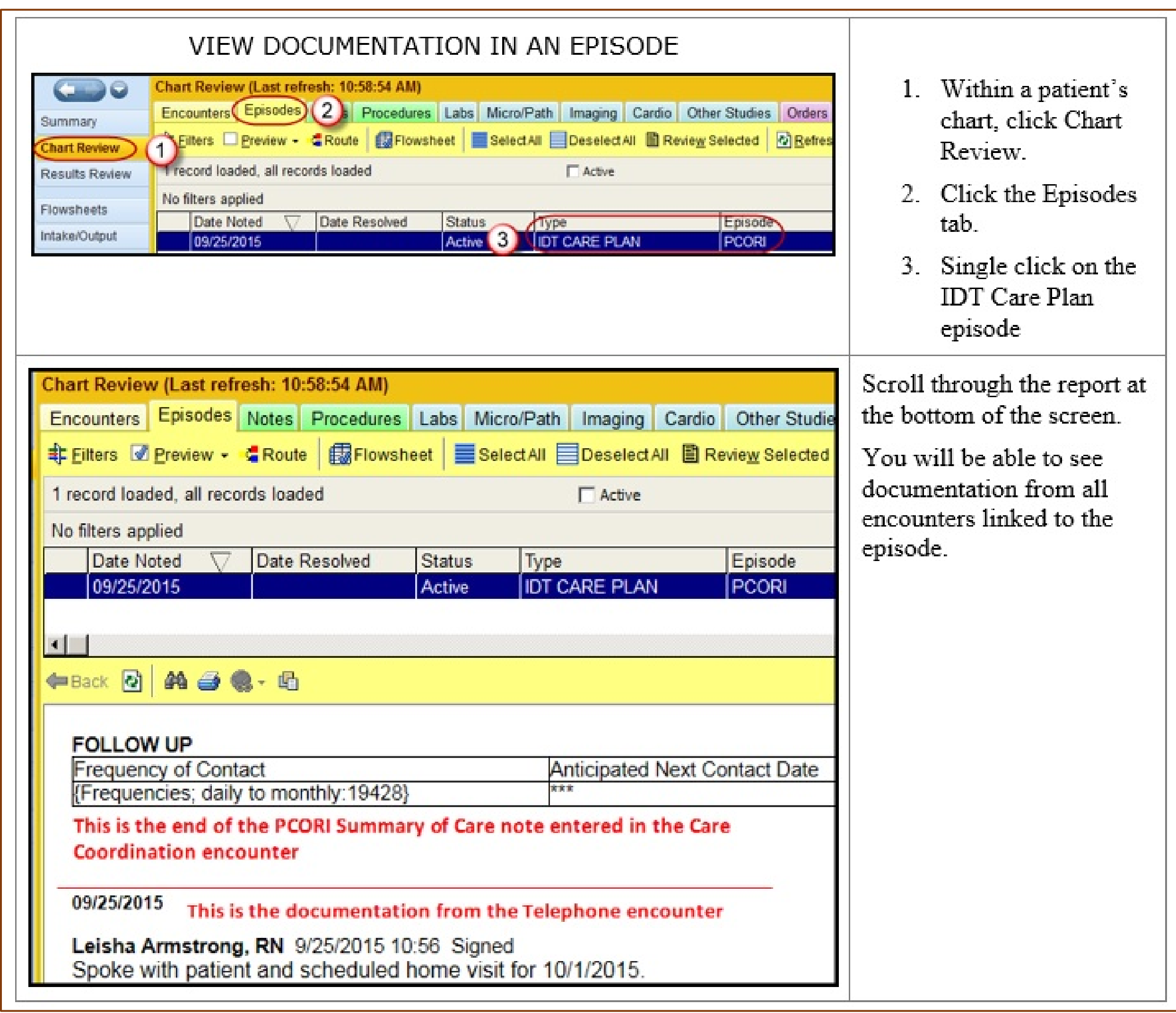


Figure 11: Sample of Epic Episode of Care.

Facilitate referrals and appointments

The fourth step in providing transition supports is to facilitate referrals and appointments. This involves calling any agencies you agreed to contact for the patient to make a referral. For example, the patient may identify needing help in planning more nutritious – and less salty meals – as a need. Together, you might have agreed that the patient would check the Internet for appealing recipes and that you would contact the hospital dietician to see if she would meet with the patient to discuss meal planning. You would contact the dietician to see if she would be available for such a consultation and how the patient might schedule a meeting. Facilitating referrals and appointments increases the likelihood that these tasks will be completed and that the patient's needs will be addressed.

Follow through on action items

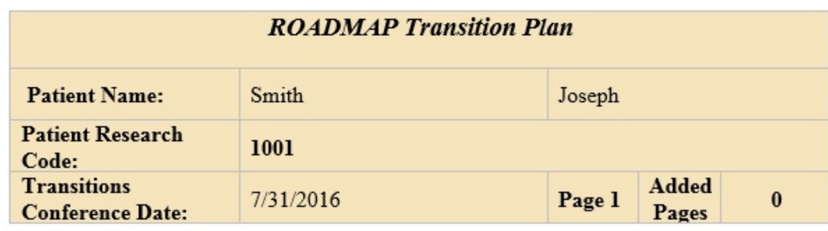
The fifth step in providing transition supports is to follow through on action items. This involves completing the tasks in the plan you have agreed to do for the patient. For example, you might contact the CAH pharmacist to see if there is a medication assistance program for which the patient might be eligible and get the information to the patient. Following through on action items is the key to facilitating a smooth and effective transition.

Monitor a patient's progress and achievements

The sixth step in providing transition supports is to monitor a patient's progress and achievements. This involves checking in with the patient by phone, email, or visit to report what you have done to facilitate referrals and appointments, to explain any actions that they need to take to complete the connections you have made, and to ask what progress they have made on the tasks they agreed to pursue. For example, you might call a patient and say, "This is Kathy from the ROADMAP Project. I am just calling to check in with you. I wanted you to know that the Dietician here at the hospital would be happy to provide you with some assistance in planning the changes in your diet. You just need to call her at 245-0989 to set up an appointment. Were you able to find any help on the Internet?" Sometimes having another person actively involved in working with a patient reinforces the patient's efforts to manage their health.

Keep the Patient Transition Record and Epic Episode of Care up to date

The seventh step in providing transition supports is to keep the Patient Transition Record and Epic Episode of Care up to date. This involves using the Patient's Transition Record to document any contacts you have with the patient or on the patient's behalf, and posting any changes to the Rural Transition Plan in the *Epic Episode of Care*. Figure 12 shows a sample of updated Transition Record.



ROADMAP Transition Plan					
Patient Name:	Smith	Joseph			
Patient Research Code:	**1001**				
Transitions Conference Date:	7/31/2016	**Page 1**	**Added Pages**	**0**	

Patient Agenda Item	Patient Specific Issue	Potential Local Resources	Plan Steps	Who is Responsible	Progress
Medications	A pharmacy that will provide the medication I need at an affordable cost.	1. CAH 2. Foster's Drug 3. Mail-order site	Make calls to resources to check availability of medications and financial assistance.	Caregiver	Foster's will stock it at a cost to the patient of $40/month.
Home Modifications	Needs portable toilet for the main floor.	1. Foster's Drug	Check Foster's for toilet and cost.	Caregiver	Foster's has them in stock and will rent for $10/month.
Performing Daily Chores	Someone who can do specific chores (i.e., feed cattle) that I will not be able to do for a while.	1. Neighbors 2. Church members 3. High school AG students	Call to ask for help and schedule tasks.	Caregiver	No problems and received extra help from neighbors when it snowed.
Rehabilitation Appointments	Physical therapy of other rehabilitation services that will aid my recovery.	1. Local hospital has a physical therapy program and services.	Schedule appointment	LCTC	Called CAH to schedule an appointment for 8/15/2016
Briefly describe patient need.	What would help address this need or solve this problem?	List Potential Resources or Services.	What needs to be done?	Who is responsible for this step?	
Comments:	The patient lives out of town, but has transportation. His wife is a strong, significant caregiver.				

Figure 12: Sample of an Updated Transition Record.

G. Facilitate Transition to Independence and Natural Systems of Support

Health is a personal resource and a means to other ends. Patients seek treatment because a health condition is interfering with things they want to do. We believe that providing supports that address a patient's immediate needs facilitates this process. It is important to limit your support to that which is needed to ensure that the patient can manage their health and health care on their own. Another job for the LCTC is to help ensure that a patient is on a path not just to recovery but also to health and wellness. As such, before closing a case, you may work with the patient ***to assess his or her long-term goals*** and help get them in touch with programs, services, or other resources that can help them achieve their long-term goals. This involves using the long-term goal assessment on your Transition Tablet.

The Long-Term Goal Assessment is conducted using another tablet application. Figure 13 presents an example of using the application for such an assessment of one patient. Each item is structured so that it begins with a patient education statement followed by an opportunity for the patient to rate his or her confidence that they can meet the goal. Completing the ratings provides the data to begin to focus on the needs a patient may want to address in order to maximize their recovery.

Once a patient has identified their goals, you should ask them if they see a connection between their health and their goals. For example, you might ask, "Do you see any connections between achieving you goals and maintaining your health?" This type of question prompts a patient to consider how their health affects their ability to do what they want to do or achieve the things they desire.

Next, use the Tablet Application to assess the level of confidence a patient has in meeting their goals. As with the Rural Transition Needs Assessment, this will help identify goals for which there may be local resources that can help a patient. Figure 14 below shows three long-range goals identified by one patient. It also shows the resources available in the community to which you might refer the patient for assistance in addressing these goals. If a patient is interested, draft a **Long-Term Goal Plan**.

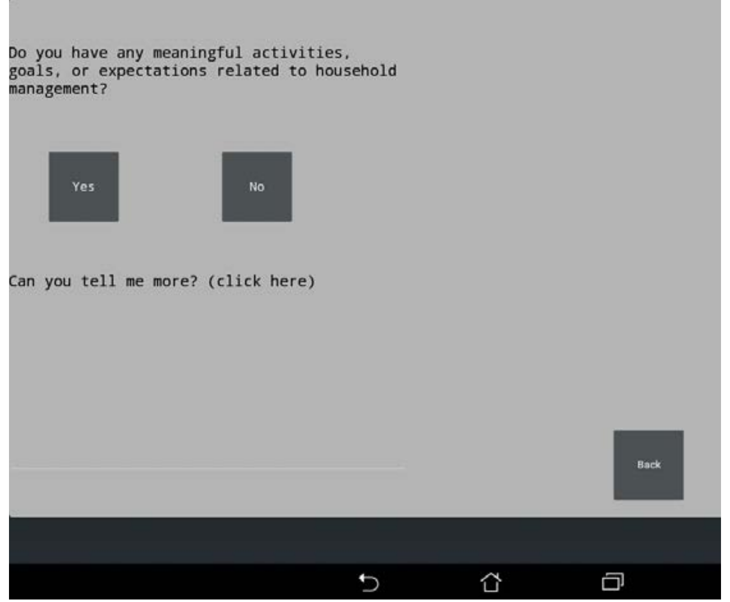


Figure 13: Sample Long-Term Goal Assessment

GOALS, HOPE, PATHWAYS AND MOTIVATIONAL INTERVIEWING

A person must do many things to manage their recovery from significant health issues and medical treatment. Providers often note that their patients do not follow through on needed changes. Researchers combined several theories of human behavior change – Stages of Change, Learned Optimism, Hope, Sense of Coherence, and behavior modification – to create structured procedures for helping an individual make and maintain needed changes. Motivational interviewing prompts a person to identify their personal **goals**, asks them to identify problems or barriers in achieving those goals, and helps them identify solutions or **pathways** and **resources** for solving the obstacles they face. In a medical context, providers include health as one aspect of the pathway to one's goals. A patient who sees a clear connection to achieving their goals and maintaining their health is more motivated to do the things he or she needs to do to achieve those goals.

The patient profile lists the goals for which a patient lacks confidence. You can use the goals profile provided by the tablet application to discuss which, if any, of the issues the patient may want to address. Still, the patient is asked to decide which issues they would like assistance in addressing. Those issues selected form the basis of the patient's Long-Term Goal Plan. If the patient adds this issue to the agenda, you can use the tablet application to generate a list of local resources a patient might find useful in pursuing their goals. You can then send them a copy through the mail or email.

Long-Term Goal Plan and Resources

1. Work and Income

Goal: I would like to return to work, but it has taken me longer to recover from back surgery than I expected. I can no longer work in my field because I can no longer lift over 10lbs.
Family Resources: No
Social Network and Community Resources: Not that I am aware of

Resources Available:

MT DPHHS disability and Employment Transitions
Description: Advancing the employment, independence, and transitions of people with disabilities
Contact: http://dphhs.mt.gov/detd

MT Weatherization Training
Description: Weatherization Training
Contact: http://weatherization.org

Sanders County Community Development
Description: Support for new business, expansion, and increasing employment
Contact: 406.827.6935 1111 Main Street, Thompson Falls, 59873

Sanders County Job Service
Description: Employment applications, training, education, and veteran services
Contact: 406.827.3472 2504 Tradewinds Way, Thompson Falls, MT 59873

Figure 14: Sample Long-Term Goal Plan of Support. A sample of three long-range goals identified by one patient with suggested resources

H. Conduct an Exit Interview and Close a Case

One of the primary goals of the Enhanced Discharge Planning and Rural Transition model is to facilitate the patient's return to their routine activities and involvement in community life. As recovery proceeds, a patient may discover that they are not recovering as quickly as they expected. Alternatively, they may find that the treatment has led them to a place where they can address issues that they had not been able to address before. One way to set those criteria is to set a time limit to how long you can provide support before the support they may still need should come from other community sources. There are four options for completing this transition to independence and natural systems of support. Whatever option is best for leading to closure of a patient's case, the final meeting with the patient is to conduct an exit interview. These are the four options listed below: (1) Close case upon completing plan; (2) Close case at patient's request; (3) Close case at 30 days; (4) If needed, extend services for up to 60 days.

Close the case upon completing the plan

The first option for closing a case is to close the case upon completing the plan. This means that once all the tasks that the patient and you included in their Rural Transition Plan are completed, you should close the case. Closing the case involves talking with the patient to explain that your involvement will end. For example, you might say to the patient, "We have completed all the tasks we set for ourselves when we developed your Rural Transition Plan. So, unless there is a significant issue we have overlooked, you seem to be doing well independently. I would like to close my work with you." Restating the criteria and explaining the process of your support allows the patient to make any final requests, if they believe they have additional needs for your assistance. If there are no significant issues on which you might provide support, you can close the case after this interview.

Close the case at the patient's request

The second scenario for closing a case is to close the case at the patient's request. This involves talking with the patient about exiting services. For example, after completing most (or all) of their tasks, a patient may tell you that they feel that they can take care of the rest of their needs independently. You should honor such requests, even if there are ways that you feel the patient or their caregivers might benefit from your continued involvement.

End services and supports after 30 days

Another option for closing a case is to end services and supports after 30 days. This criterion reflects the established threshold for re-hospitalization. As such, for the purposes of this study, we recommended that each of the cases be closed after 30 days.

Extend services for up to 60 days

Alternatively, you can extend services for up to 60 days, if circumstances warrant such an extension. Because such circumstances are difficult to predict, we recommend that you discuss extending these services to a patient with your supervisor to verify a need, to ensure that you have the time and resources for doing so, and to consider alternatives for the patient. In addition, we ask that you present the case to the LCTC team. If you are conducting a research project, the Principal Investigator should be consulted.

Some patients may have extensive and complex needs that require support that extends past these transitional support services. You may refer them to chronic care coordination, case management, or independent living services.

Thank the patient

Finally, once you and the patient agree on closing the case, thank the patient for taking time to be involved in the study. Tell them that you will send them a copy of the Long-Term Goals Plan, if you helped develop one. For our project we also informed them that, once the study was completed, they could find a copy of the findings on the PCORI website (http://www.pcori.org/research-results/pcori-literature) or at similar sites (https://clinicaltrials.gov).

Final Notes

In your role of Local Community Transition Coordinator, you may also be expected to build local resources that patients can use to aid in their recovery. This may involve simply building a Community Resources Bank. It may also involve managing the program by participating in various meetings or submitting evaluation reports. It might also involve representing the program to various stakeholders. We offer some additional material to help you with these tasks.

Thank you, we hope you have found this manual helpful. Please, let us know how you do.

APPENDIX 1: GLOSSARY

Community Resource Bank – A Community Resource Bank is a list of services and agencies that address patients' transition needs. Community resources are linked to each patient-centered need in the Rural Transition Needs Assessment. Each community creates and maintains its own list but shares it with other hospitals.

Critical Access Hospital (CAH) – Critical Access Hospital is a designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services (CMS). The CAHs in this research study included Clark Fork Valley Hospital, Deer Lodge Medical Center, Barrett Hospital and Healthcare, and St. Joseph Medical Center. Each CAH was located in a rural and frontier county in Montana and were planning to adopt Epic.

Discharge Orders Verification Checklist – The Discharge Orders Verification Checklist is a form that helps the LCTC review orders placed at the regional referral hospital and subsequently received by the patient. The checklist is a tool to help prevent unnecessary complications such as a readmission post discharge from the regional referral hospital.

Discharge Planning – The process intended to facilitate the transition from hospital care to recovery at home.

Epic – Epic is the electronic medical record system that served as a valuable documentation and communication tool for providers at the regional referral hospital and the rural critical access hospitals which participated in this project.

Episode of Care – An Episode of Care is a section or portion of an electronic medical record (EMR) that captures encounters, notes and other documentation related to a patient's hospitalization and follow-up care. It provides a method of documentation that tells a patient's story from hospitalization to recovery. All providers in the EMR can subsequently link their work to the Episode of Care in the patient's electronic medical record. The Episode of Care continues until the patient's reason for hospitalization is resolved. Additionally, the Episode of Care provides outlying providers with a one-stop place to find information related to their patient's hospitalization, rather than searching through the electronic medical record to find important information.

Exit Interview – The exit interview is a discussion between a patient and an LCTC at the end of services to summarize the work they completed. This discussion determines if the patient is no longer in need of additional supports and services. Completion of the Rural Transition Plan may indicate that the patient is ready to exit the program. Patients with extensive and complex needs may require an extension, or referral to more intensive services such as chronic care or case management.

In-Basket Message – An In-Basket message is a way to securely communicate between providers in Epic, an electronic medical record system. In our research, the In-Basket Message was used to notify LCTCs of a patient's enrollment into the study. The LCTC could access and review the patient's Episode of Care directly from the In-Basket Message.

Local Community Transition Coordinator (LCTC) – The LCTC provides rural transition support services in order to ensure a smooth transition from hospital to home. In our research, the LCTC

completes the Discharge Orders Verification Checklist, conducts a Transition Conference, creates a Rural Transition Plan, and supports, monitors and documents patient progress throughout the 30-day period post hospitalization. Nurses, social workers, and counselors served in the LCTC role.

Long-Term Goal Assessment – The Long-Term Goal Assessment is housed in the Tablet Computer. Similar to the Rural Transition Needs Assessment, the Long-Term Goal Assessment helps patients identify goals and associated community resources. The LCTC conducts this assessment when immediate needs are met and the patient is ready to talk about their long-term goals.

PCORI – The Montana ROADMAP Research Project was funded by the Patient-Centered Outcomes Research Institute.

Regional Referral Hospital (RRH) – A regional referral hospital is a tertiary referral hospital (also called a tertiary hospital, tertiary referral center, or tertiary care center, or tertiary center) that provides specialty services to patients in a large geographic area. Providence/Saint Patrick Hospital was the RRH included in this research study. Providence/Saint Patrick Hospital is a tertiary-care facility located in Missoula, MT.

Research Transition Coordinator (RTC) – The RTCs are social workers, nurses, or other qualified staff who deliver the enhanced discharge planning procedures, including: screening for eligible patients, enrolling patients, conducting Rural Transition Needs Assessment, establishing the Episode of Care, and providing early notification to the LCTCs to begin rural transition support services. The RTCs work in coordination with existing regional referral discharge planners. All enrolled patients continue to receive normal discharge planning services along with the enhanced discharge planning procedures. This position might also be referred to as the Hospital Transition Coordinator (HTC).

ROADMAP – (Rural Options at Discharge Model of Active Planning) A patient-centered approach to discharge planning which enhances the current discharge planning process from a regional referral hospital to rural communities. ROADMAP also adds a critical component: rural transition support services.

Rural Transition Agenda – The Rural Transition Agenda is created through the Rural Transition Needs Assessment tablet application. The agenda lists patient needs identified and associated local community resources. The agenda is given to the LCTC in order to prepare for the patient's transition home.

Rural Transition Needs Assessment – The Rural Transition Needs Assessment is a brief assessment including 18 patient-centered questions. It helps the provider and patient anticipate the needs a patient may have upon returning home to their rural community. This needs assessment was programmed into a tablet computer and populates the Rural Transition Agenda which is provided to the LCTC in order to inform the beginning of the transition support process.

Rural Transition Plan – The Rural Transition Plan is created in collaboration between the LCTC and the patient during the Transition Conference. The plan lists the patient's identified needs (agenda items), associated community resources, and action steps required in order to secure local resources to meet patient needs.

Seven-Day Transition Calendar – The Seven-Day Transition Calendar is a tool created to help the patient organize their first few days following discharge from the hospital. The calendar helps the patient understand the likely course of recovery and reminds the patient of what he or she needs to do.

Swing Bed – A swing bed hospital is a hospital or critical access hospital (CAH) that provides post-hospital skilled nursing facility care and meets certain Medicare requirements. This includes post-hospital extended care services furnished in a swing bed hospital. Swing bed placements offer rural patients an intermediary place to recover closer to home.

Tablet Computer – The tablet computer houses the Rural Transition Needs Assessment application which is conducted by the RTC at the regional referral hospital.

Transition Conference – The Transition Conference is a discussion between a patient and an LCTC to review the patient's Rural Transition Agenda and together develop a Rural Transition Plan. It occurs after the patient returns home and is conducted by the LCTC. While it is preferable to conduct the Transition Conference at the patient's home, it can also be conducted at a convenient and safe location such as the local CAH, or even over the phone.

Transition Referral – A Transition Referral occurs between the regional referral hospital RTC and the critical access hospital LCTC in order to initiate transition support services. There are multiple ways to make a referral. In our research project, we used Epic In-Basket Messages to make referrals to the LCTCs.

Transition Support Record – A Transition Support Record is a form that assists the LCTC in keeping record of the time they spend providing transitional support services to each patient. Keeping record of supports helps administrators determine the viability and funding for an LCTC position.

Transition Supports – For the purposes of our research study, transition supports include connecting patients to a variety of community resources.

Weekly Staffing Call – The weekly staffing call is a teleconference between RTCs, LCTCs, the Research Team (if applicable), and Team Management. The teleconference provides an opportunity to discuss research protocol, review cases, and share knowledge. The call creates a feedback and communication loop between providers otherwise separated by geographic location.

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APPENDIX 3: MODIFYING THIS MODEL TO FIT YOUR CIRCUMSTANCES

As stated in the Foreword to this manual, you will want to modify these procedures to fit your circumstances. This appendix suggests a broad framework for considering such changes. It also offers recommendations for changes based on the lessons we learned in the development and evaluation of this model.

Framework for Change

The discharge planning and transition process is surprisingly intricate. If you tug on one of its strings, many parts of the fabric will move. There are several stakeholders with overlapping and sometimes conflicting interests. Treating physicians may believe that a hospital's responsibility ends when the patient leaves. Patients may just want to get home. Discharge planners with a background in social work may be sensitive to the patient and family's emotional needs and want to provide support. Discharge planners with a nursing background may want to provide more in-depth patient education. Supervisors may highlight the need for meeting requirements efficiently. Providers in the rural communities to which patients are discharged want to be involved early. Administrators will be concerned with costs and network development. All of these factors need to be considered in changing the existing system. One way to approach this task is to invest in building a rural transition network.

You can begin the process in several ways but an early step should involve establishing a consensus on the importance of the problem and a vision for the future. Generally, this involves agreement that more attention on discharge planning and rural transition could improve patient outcomes and might reduce readmissions. It may also involve agreement that the medical system has a responsibility to address the social and environmental needs of its patients. Indeed, it should acknowledge that the two are linked.

A next step is to seek support for planning from key administrators at the regional hospital and the partners in the rural communities being served. (We recommend that a partnership involve a local critical access hospital or similar organization but it may also involve an aging services program, an aging and disability resource center, or center for independent living.) As you talk with these key stakeholders, you should note their concerns and interests. What are their aspirations related to this feature of medical services? What are their goals? What are their limitations?

Once you secure support for planning from key stakeholders, you might hold a series of discussions to outline the way the current system functions and to assess how the components of the ROADMAP model might help achieve their aspirations. During this phase, you may find that you might be able to drop some components of the ROADMAP model, modify others, and add some of your own. The goal is to identify elements of a coherent system that responds to your program's circumstances.

Recommendations

In addition to focusing on the transition process, this model also offers some additional options each referral network (hospital to home network) might consider. These include questions about how to

assign discharge planners to patients, and questions about what resources are available in each rural community that might facilitate recovery and promote long-term health.

Discharge planner's role

First, we created a separate role of a Research Transition Coordinator (RTC) for the purposes of our research design. The RTC delivered the experimental procedures in a way that separated the procedures received by patients in the control group. In practice, we recommend that the role and functions of the RTC be integrated into the role of existing discharge planners.

Rural Transition Needs Assessment and Discharge Orders Verification

The RTCs conducted the Rural Transition Needs Assessment (described in Chapter 5). At the same time, the person filling the role of the Local Community Transition Coordinator (LCTC) prepared a Discharge Orders Verification Checklist (described in Chapter 6). Our experience suggests that these responsibilities should be reversed. That is, we believe now that the person serving as discharge planner should prepare the Discharge Orders Verification Checklist and the LCTCs should be responsible for conducting the Rural Transition Needs Assessment. In our research, many needs were not identified before discharge but were added once a patient returned home. In addition, some issues identified as needs before discharge became less salient once the patient returned home.

This shift in functional roles reduces the time required by regional referral hospital (RRH) staff but does not substantially increase the time needed by the person serving as the LCTC. This makes it easier to integrate this model into the RRH but may make it more difficult for the local critical access hospital to adopt it. These changes might be negotiated by participating entities.

We also recommend that two items from the Rural Transition Needs Assessment, specifically the Recovery Expectations and Management of Treatment Tasks, be moved to the Discharge Orders Verification Checklist. Regional referral hospital staff who provide the treatment are best situated to specify the discharge orders.

Scheduling the Transition Conference

We recommend, based on our experience, that the LCTC initiate contact with the patient or a caregiver to schedule the Transition Conference. Trying to coordinate a scheduled visit from the RRH proved quite difficult. If you choose this option, the LCTC should initiate contact with the patient within 24 hours of discharge in order to maximize the effectiveness of the Discharge Orders Verification Checklist.

Eligibility for program services

Our research focused on patients 18 to 75 years old who were discharged home. Nonetheless, we recommend that these services be expanded to include patients of all ages.

We also excluded patients admitted with a primary diagnosis of mental illness or substance abuse. This population accounts for many readmissions but their patterns of need and systems of services are often distinct and more intense than that of the general population. While the procedures described in this manual may generalize to these patients, it may require more operational resources (e.g., staff time). If you include this population, we encourage you to plan accordingly.

Otherwise, we included all patients, regardless of their medical risk, personal capacity, or needs for support services. We did not prioritize patients for intervention. Rather, we allowed patient need to determine the supports provided. It may be possible to prioritize patients for these services and supports. But our experience shows that no one measure is adequate to do so. We encountered patients with high risk scores (i.e., LACE+) but low needs, and we encountered patients with low risk scores but high needs. And we encountered patients with low risk levels and few needs but who had limited capacity for self-care.

Include advance directives and physician orders for life sustaining treatment

Several providers integrated steps to ensure that their patients had advance directives and physician orders for life sustaining treatment (POLST) completed as part of this model. We encourage you to consider doing so, as well, but those procedures are not described here.

Seven-day Transition Calendar

While the literature, current practice, and several key stakeholders, including our patient design team, recommended using a Seven-Day Transition Calendar, it was difficult to execute. One of the reasons was that pertinent information was seldom available until just before the patient was discharged, leaving no time to prepare one while the patient was still in the hospital. There are potential solutions to this problem (e.g., programming an auto-fill function in the electronic medical record so that orders automatically populate a calendar) but they require time and resources. Unless you have those resources, we recommend that the calendar be dropped.

Electronic or paper records

The use of the same electronic medical record by all participants greatly facilitated the process. Not all potential partners may have access to the same electronic medical records. In such a case, it may be necessary to revert to a combination of paper-and-pencil forms, fax machines, email, and the telephone.

Zone vs. man-to-man assignment

There are many ways to organize and assign discharge planners. One way is to assign discharge planners to patient groups treated or to physician groups providing the treatment. For hospitals that discharge a large proportion of their patients to surrounding rural communities, discharge planning managers might also consider assignments based on the areas to which patients are discharged. This is referred to as a “zone” approach. This involves assigning individuals so that they work with patients from specific counties. For example, one case manager might be assigned to work with patients primarily from Beaverhead County. This creates the opportunity for that discharge planner to become familiar with the

resources in the county, and to establish and maintain working relationships with specific local providers. Research in other areas has shown this strategy to be effective.

Chronic conditions and peer support

As the American Medical Association noted (see AMA quote at beginning of manual), "... the hospital setting is not an ideal educational environment … Therefore, care coordination models (should) consider re-focusing long-term self-management education tasks to the ambulatory setting after hospital discharge, when patients (and their caregivers) are often in a better state to receive education and other support to help them manage their condition and treatment." This perspective extends even more into the local community for those patients who have chronic conditions. Several models of patient education and peer support have been shown to be quite effective in helping individuals manage their health and maintain active participation in their community.[m]

[m] Many resources for organizing and maintaining support groups are available on the internet. They range from quite simple to extensive. For example, see http://www.endurance.org/so-you-want-to-start-a-support-group/.

APPENDIX 4: ETHICAL CONSIDERATIONS

We encourage you to be explicit about the ethical principles that serve as a foundation to your work. The following are derived from the National Association of Social Workers (1999)[n] code of ethics. Other professional organizations offer similar guidance.

Privacy and Confidentiality

The Code of Ethics of the National Association of Social Workers provides a useful framework for hospital discharge and rural transition planning. They state that … providers … should respect clients' right to privacy. Providers should not solicit private information from clients unless it is essential to providing services or conducting evaluation or research. Once private information is shared, standards of confidentiality apply. These include:

(a) A provider may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(b) A provider should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that a provider will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, a provider should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

Termination of Services

Similarly, social work guidelines offer a useful structure for terminating services. They suggest that a provider should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests. Importantly, a provider should take reasonable steps to avoid abandoning clients who are still in need of services. A provider should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. A provider should assist in making appropriate arrangements for continuation of services when necessary.

A provider who anticipates the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences. Similarly, a provider who is leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

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[n] National Association of Social Workers. (1999). Code of ethics of the National Association of Social Workers. Washington, DC. NASW Press.

APPENDIX 5: SAMPLE LCTC JOB DESCRIPTION

Local Community Transition Coordinator

Overview

Current trends in health care delivery suggest that the right supports provided to patients at the right time may improve outcomes and reduce re-hospitalizations. For patients being discharged from a tertiary care facility back to a small town or rural community, this support includes the assistance of a Local Community Transition Coordinator (LCTC). In general, the job of the Local Community Transition Coordinator is to provide rural transition supports to patients after discharge from the hospital. This job involves the LCTC initiating transition support services, working with the hospital discharge planner, research team and patient to develop a Rural Transition Plan, implementing the plan, evaluating and reporting progress, and closing the case.

An LCTC works within a critical access hospital serving a rural catchment area. He or she establishes referrals from regional referral hospitals for rural transition supports, works with the patient and hospital discharge planner along with the research team to develop a Rural Transition Plan designed to smooth the transition home, improve health outcomes, and reduce the need to go back to the hospital for further services. The LCTC conducts home visits, interviews a patient to understand a patient's needs and goals, identifies a patient's support needs, clarifies a patient's role in managing their health care needs after discharge, determines needed referrals, and provides assistance in arranging appointments as needed, arranging needed supports, making referrals, monitoring and assessing progress, modifying the plan and responsibilities as needed, and closing the case.

Knowledge Skills and Abilities

A LCTC should be knowledgeable about medical care and or community support services systems; should be knowledgeable about patient or client rights, including confidentiality; and should be knowledgeable about patient-centered or client-centered services. An LCTC should have skills of organizing and maintaining patient/client service records, skills in working with individuals to develop plans for achieving an individual's goals. An LCTC should have the ability to work well with other professional service providers from a wide range of public and private agencies (e.g., medical to social services). He or she should have the skills and ability to conduct individual needs assessments and develop linkages to local service providers to meet those needs.

Education and Experience

LCTCs should have a bachelor's degree in Social Work, Nursing, or related discipline plus two years of experience in providing services, or a Master's degree.

APPENDIX 6: SCRIPT FOR DESCRIBING ROADMAP RESEARCH PROJECT TO PATIENTS

Hi my name is ________________. I work for a research project that is looking at patients when they land here at St. Pats and then return home to their rural communities. We understand traveling for care can be challenging, so we're looking at the discharge planning process and how it goes for rural patients. We're hoping to develop tools that enhance the discharge planning process and make the transition home smoother for patients.

We're currently enrolling patients from Lake, Powell, Sanders and Beaverhead counties. You're from __________ county, correct?

Participation in the research study includes three main components:

1. Together we'll complete a **needs assessment** here at the hospital to anticipate some of the needs you might have when you return home. We ask you questions like "Do you have a safe and comfortable place to live when you go home?"

2. Second, you'll complete a series of **surveys** that ask you questions about your experience once you arrive home. There are 7 total surveys, sent to you at the following time intervals, 3, 7, 14, 21, 30, 60, and 90 days. Here is an example of a survey so you can get a sense of the questions we'll be asking you.

3. Third, you'll be **partnered with a Local Community Transition Coordinator**, someone from your community who will follow up with you within 3-7 days of discharge. They'll be in touch with you to schedule a Transition Conference which can be at home, over the phone, or another convenient location. They'll help connect you with community resources if needed and then follow up with you again at 30 days post discharge for a long-term goal assessment and exit interview.

Does this sound like something you might be interested in? Okay, let's go through the informed consent form together, and find a time to complete the needs assessment before you are discharged home.

APPENDIX 7: FIGURE TEXT DESCRIPTIONS

Figure 1: Basic Components and Steps of the Recommended Transition Model

Figure 1 depicts one view of the enhanced discharge and rural transition program process using a series of stacked boxes with arrows linking them in sequence. Starting from the top, the first step is the RTC identifies and enrolls eligible patients. The second step is RTC creates Epic Episode of Care and involves LCTC. The third step is the RTC conducts a Rural Transition Needs Assessment and posts in Epic. This is followed by discharge. The fourth step is the LCTC conducts Discharge Orders Verification Checklist and schedules a home visit. The fifth step is the LCTC and patient develop and implement Transition Plan of Supports. The final step is the LCTC monitors progress, updates providers, and reports outcomes.

Figure 2: Roles and Responsibilities for Implementing the Components of Research Study

Figure 2 depicts one view of the roles of the current hospital discharge planning staff, the phases in the overall recommended transition model, the role of the Research Team, and the role of Local Community Transition Coordinators using a series of stacked boxes. The stacked boxes form columns and rows. Each column represents either the recommended transition process or one of the three main roles in the process. Starting on the left, the current discharge planners are responsible for conducting discharge planning following current practice, documenting their work in Epic, and providing a discharge plan to the patient. The next column to the right represents the phases of the recommended transition model, including: admission; early involvement of LCTC via Epic Episode of Care; Rural Transition Needs Assessment & Patient Transition Agenda; discharge; Discharge Orders Verification Checklist; Transition Plan & local follow-up; monitor, evaluate, and report; and transitions feedback loop. The third column describes the research team's roles: consent and enroll, establish an Episode of Care, administer a Rural Transition Need Assessment and Transition Agenda, conduct weekly transition case reviews, and analyses and reports. The last column presents the Local Community Transition Coordinator's roles and activities: acknowledge the referral, prepare a Discharge Orders Verification Checklist, verify orders and schedule a home visit, review patient needs and finalize a plan, conduct a Long-Term Goal Assessment and plan, and conduct an Exit Interview.

Figure 3: Enhanced Discharge Planning and Rural Transition Process

Figure 3 uses a flow chart to depict 13 key components of the Enhanced Discharge Planning and Rural Transition program research protocol. A series of 12 boxes and one circle form columns and rows that are linked by arrow lines indicating the flow of activity. Starting on the left in the center, box 1 indicates that the Rural Transition Needs Assessment and Patient Transition Agenda are completed. This box is linked to a circle representing the Epic Episode of Care. Two lines lead from the circle to two sets of boxes. First, a line leads up to box 2 that represents a patient's primary Epic file; indicating that the Needs Assessment and Transition plan are posted to that file. Above the Epic box (2), a row of boxes representing current discharge planning practice (box 3), patient discharge (box 4), and a patient's arrival home (box 5) are linked back to the Epic box (2). This shows that all patient information is posted in a patient's Epic file.

Second, a line leads to the right connects the circle representing the Epic Episode of Care to a box (6) representing early involvement of the LCTC. That box (6) is linked by an arrow line leading right to a

box (7) representing the discharge orders verification process. Two lines lead from the discharge orders verification box (7). The first line leads down to a box (8) labeled PCP for primary care provider, representing notification of a patients' primary care providers that the patient is enrolled in the program. In turn, the PCP box is linked back to the circle representing the Epic Episode of Care where the PCI can find patient information general by his or her involvement in the program. The second line leads to a box (9) to the right that represents conducting a transition visit at the patient's home, creating a Transition Plan with the patient, and providing transition supports.

Two lines branch from the box (9) representing the Transition Visit, Plan and supports. The first leads down to a box (10) representing a process of recording patient progress in a Transition Progress report. In turn, two arrows lead from that box (10). One leads back to the circle representing the Epic Episode of Care (indicating a written progress report is filed). The other leads to a box (11) representing weekly teleconferences between LCTCs and research staff. The second leads right to a box (12) that represents the process of monitoring the patient's transition, case closure, and conducting a Long-Term Goal assessment.

From box 12, the monitoring box, one line leads down to the box (10) representing the transition progress report. Two line branch from this box. One line leads back to both the PCP box and Episode of Care circle. The second leads to a box (13) representing a weekly staffing call where information is shared between all LCTCs. This final box leads back to the beginning of the process, suggesting the information is used to shape the entire process.

Figure 4: Sample Episode of Care in Epic

Figure 4 presents several screenshots of a computer screen presenting the Epic program's Episode of Care. This includes views of the screen where one can find the tab to create, edit, or delete a patient's Episode of Care.

Figure 5: Sample Rural Transition Needs Assessment Template. Screen shot of the tablet computer showing two needs items and the rating scale

Figure 5 presents a view of a tablet computer screen presenting the Rural Transition Needs Assessment. This includes two items from the needs assessment – addressing a patient's confidence that they will have a safe and comfortable place to live while they recover and their confidence that someone will help them get groceries and prepare meals, if they need such assistance. The rating scale is shown to the right of each item. The scale runs from “0” or “Not Confident” to “4” or “Very Confident.” There is also a choice to mark “N/A” for not applicable.

Figure 6: Rural Transition Agenda for a hypothetical patient

Figure 6 shows a screen shot from the Epic Episode of Care depicting a patient's Transition Agenda. This image shows that this patient identified three needs – performing daily chores, care of dependents, and medical contacts for complications. Additional patient information is listed for each need describing the particular patient's exact need. It also shows that at least one local resources is available to address each of the needs including the name for the resource and contact information.

Figure 7: Seven-Day Transition Calendar. Sample of a schedule for the first seven days of one patient's transition back home

Figure 7 shows a completed example of a patient's Seven Day Transition Calendar. The images shows a text statement that explains the purpose and use of the calendar, "This Seven-Day Transitions Calendar is meant to help you plan for important tasks and events when you get back home." Then it presents a standard daily calendar organized by rows and columns. The first column on the left lists times of the day to head each row. The next three columns are labeled for days of the week. Intersecting cells contain patient notes of the activities that are schedules for specific times on specific days.

Figure 8: Sample Discharge Orders Verification Checklist

Figure 8 shows a completed example of a Discharge Treatments and Service Verification Checklist. This checklist presents spaces to record the patient's name and other identifying information. Then it provides a matrix that lists eight typical discharge treatments that might be ordered for a patient and offers two open boxes where other orders can be listed. Three columns are on the right of the list of potential discharge order. The first column is labeled, "Ordered (Are any of the following ordered as part of the discharge plan?)" Boxes in each cell of the column are labeled "Yes" and "No" are organized so that one can indicate whether or not an item had been ordered. The second column is labeled, "Received (Has the patient gotten the ordered services?)". Again, boxes in each cell are labeled "Yes" and "No" are organized so that one can indicate whether or not an item had been received. The final column presents boxes in which one can record specific notes related to each item. For example, this image shows that medications were ordered and that the patient had received them. A note next to the medication order indicates the medication ordered was Atorvastin 80 mg.

Figure 9: Sample Draft Rural Transition Plan

Figure 9 presents an example of a completed ROADMAP Transition Plan template. The template has spaces for recording patient information (e.g., name) as well as key elements of the plan, including the patient agenda item, the patient's description of the issue, potential local resources that the patient might consider for addressing the need, the steps agreed on by the patient and LCTC in creating the plan, and a space to record who is responsible for the planned steps.

Figure 10: Sample Patient Transition Record

Figure 10 present an example of a Transitions Support Record template. Spaces are provided to record patient information (e.g., name and address). Then the template presents a matrix organized into 6 columns followed by rows in which service information can be recorded. The six columns are headed date, contact type, who contacted, issue, actions or decisions, and time in minutes. Spaces are provided in a series of rows across each column in which the LCTC can record pertinent information. For example, the first row shows that the LCTC sent an email to the RTC on February 8, 2016 that addressed the transition referral. The email reviewed the Transition Agenda posted in the Episode of Care and took 45 minutes to review, compose, and send.

Figure 11: Sample of Epic Episode of Care

Figure 11 presents a series of screenshots of a computer screen of the Epic program. This includes a view of the screen where one can find the Episode of Care to review it.

Figure 12: Sample of an Updated Transition Record

Figure 12 presents an example of a completed ROADMAP Transition Plan template with an updated column of progress. The template has spaces for recording patient information (e.g., name) as well as key elements of the plan, including the patient agenda item, the patient's description of the issue, potential local resources that the patient might consider for addressing the need, the steps agreed on by the patient and LCTC in creating the plan, a space to record who is responsible for the planned steps, and a space for progress notes.

Figure 13: Sample Long-Term Goal Assessment

Figure 13 presents a view of a tablet computer screen presenting an item of the Long Term Goal Assessment. This includes the item – asking whether the patient has any meaningful activities, goals or expectations related to household management. The rating scale is shown under the item either "yes" or "no." There is also a choice for the patient to click in a text box and explain their activities, goals, or expectations or why they do not have any.

Figure 14: Sample Long-Term Goal Plan of Support. A sample of three long-range goals identified by one patient with suggested resources

Figure 14 shows a screen shot from the Epic Episode of Care depicting a patient's Long Term Goal Plan and Resources. This image shows that this patient identified one needs – Work and Income. Additional patient information is listed the goal describing the particular patient's goal. It lists the resources available to address the goal including the name for the resource and contact information.

CONTACT INFORMATION

Thank you for reviewing this manual. Your suggestions and critiques are welcomed. If you have any questions or comments, you may call the numbers below or email either of the two corresponding authors.

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