Washington State ADRC Care Transitions Intervention Model

Whatcom County - Phase I

At Hospital

- Hospital staff engage individual to participate in CTI
- Hospital staff enter CTI referrals into hospital's electronic patient information system (Care Cast).
- ADRC and QIO coordinate CTI coaching assignment
- ADRC CTI coach conducts visit with individual before discharge:
  - Introduce self & CTI
  - Enroll in CTI
  - Introduce PHR (electronic &/or hardcopy)
  - Administer PAM or CAM (if possible)
- Hospital staff Discharge to Home

←30 days→

At Home

- Home Visit by ADRC CTI Coach
  - Administer PAM or CAM (if not completed in hospital)
  - Administer ABA
  - Medication Reconciliation
  - PHR – Goal Setting, Shared Care Plan training
  - Review Red Flags
  - Discuss Primary Care Physician (PCP) follow-up
- PCP Follow-up
- Telephone Follow-up #1
  - Review Progress
- Telephone Follow-up #2
  - Review Progress
- Telephone Follow-up #3
  - Final PAM/CAM completed

Data Collection and Post - CTI

- At end of each month, ADRC completes the Coaching Monthly Report and Client Spreadsheet
- Caregiver or Individual Client can continue with PHR (Shared Care Plan or My Family Care Plan)
- Continued PCP Follow-up
- ADRC Options Counseling & Assistance as requested
- Home & Community-based Supports and Services