

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

**State Agency:** Connecticut Department of Social Services

**Name of ADRCs and Healthcare Partners:**

North Central Community Choices ADRC and the Hospital of Central Connecticut

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

**Contact:** Jennifer Throwe  
(860) 424-5862  
[Jennifer.Throwe@ct.gov](mailto:Jennifer.Throwe@ct.gov)

**Evidence Based Care Transitions Model:** Care Transitions Intervention<sup>SM</sup>

**Project Summary:**

Connecticut Department of Social Services, State Unit on Aging, North Central Area Agency on Aging, Independence Unlimited and Connecticut Community Care, Inc. will continue partnering to strengthen Connecticut's North Central Community Choices ADRC (NCADRC). The grant will strengthen Connecticut's existing NCADRC Care Transition Intervention (CTI) pilot program with the Hospital of Central Connecticut (HCC) via the NCADRC. Two Connecticut ADRC representatives will attend national meetings for care transitions.

**Goal/Objectives:**

Reduce unnecessary hospital readmissions using the person-centered CTI model of hospital discharge, administered at HCC via the NCADRC that is capable of including assessment, information, assistance & streamlined access to public & privately funded long-term services and supports. Objectives: 1) Formally expand the HCC CTI pilot to the Southington campus; 2) Expand eligible CTI diagnoses to include Diabetes; 3) Develop greater symbiotic connection between work of NCADRC Community Choices Counselors (CCCs) and Care Transition Coaches (CTCs) and add 1 new CCC & CTC; 4) Introduce Chronic Disease Self Management Program to post-CTI participants; 5) Improve ADRC MIS capabilities for CTI; 6) Strengthen

CTC's CTI training; 7)Develop program evaluation; 8)Connecting providers throughout the healthcare system to enable safe and effective transition of patients.

**Anticipated Outcomes/Results:**

Coleman recognized CTC staff training; formal program evaluation by University of Connecticut Center on Aging; expanded MIS tracking capabilities; 2% reduction in unnecessary HCC hospital readmissions; cohesive ADRC workflow relationship between CTCs and CCCs; expanded CTI program; CTI consumer Ambassadors; & increased project partnerships including Connecticut's QIO, Qualidigm. Expected Products include: revised CTI Operating Protocols; expanded QA & Evaluation tools; CTI program brochure & script for consumer ambassador discussion with physicians; and MIS CTI enhancements.