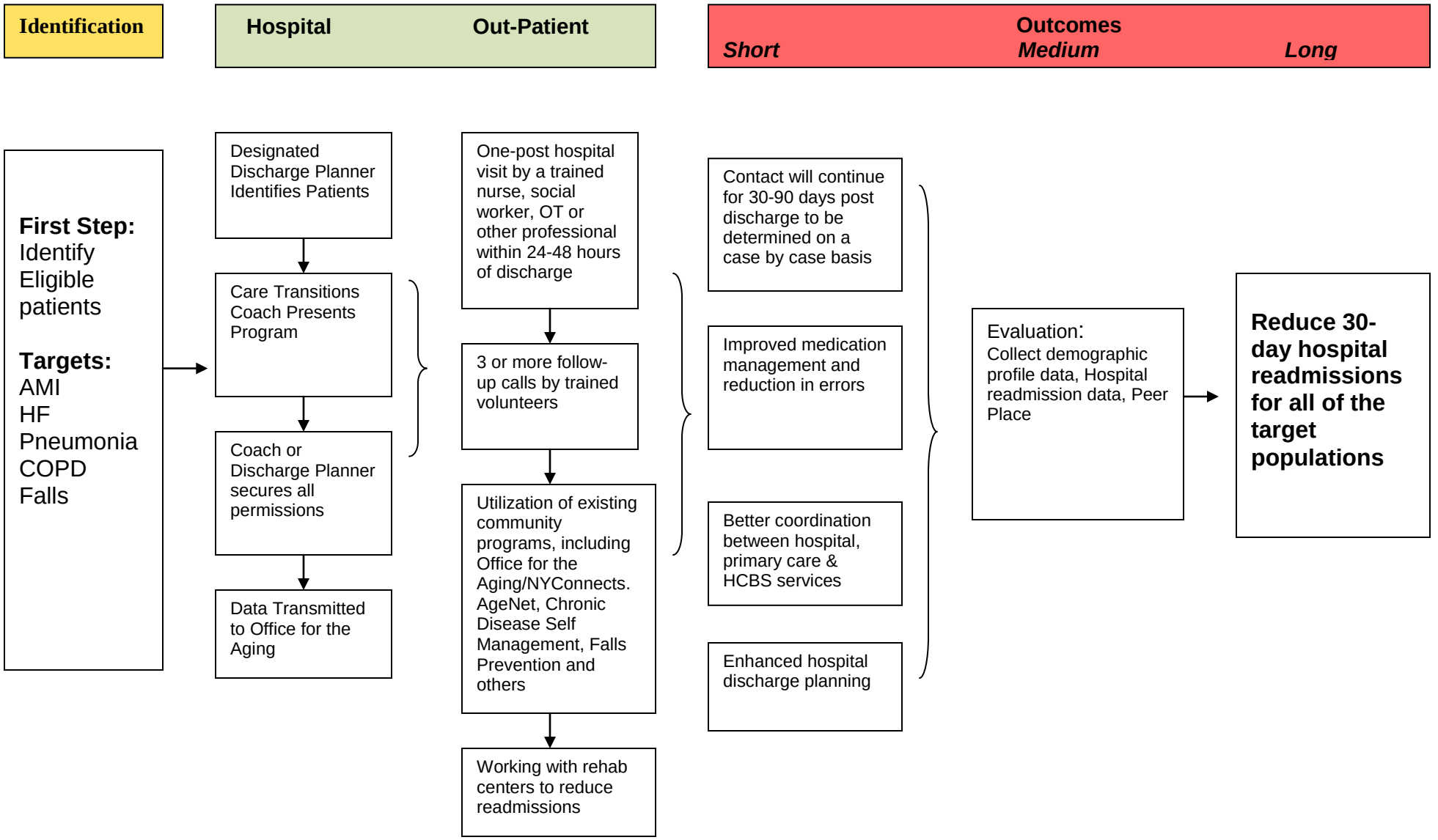
Oneida County Care Transitions (OCCT) Logic Model



Staffing: Designated hospital discharge planer, Care transitions coach in hospital, professional (s) for home visits, volunteers to make follow-up phone calls, Project Coordinator, OFA & NYConnects staff, Steering Committee, Care Transitions Team, Advisory Council and program sponsors.

Training: (1) Training developed by the Steering Committee using existing evidenced-based materials, (2) Training will be tested and delivered by local professionals, (3) Digital training modules will be developed using AgeNet and (4) the “teach-back” method will be used and employed by coaches, home-visit professionals and volunteers.