Evaluating a Program to Improve Patient Experiences After Discharge From the Hospital—The PArTNER Study

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ABSTRACT

**Background:** Historically, patients and caregivers have not played a major role in the development of health system interventions to reduce avoidable readmissions; therefore, it is no surprise that such interventions have not focused on improving the patient experience. In focus groups that we conducted at a minority-serving institution (MSI), patients and caregivers expressed the need for hospital-to-home transitional care services to address their emotional, social, and physical health.

**Objectives:** The specific aims of the Patient Navigator to Reduce Readmissions (PArTNER) study were the following: (1) Develop, implement, and refine a multifaceted stakeholder-supported Navigator intervention to improve the patient experience during transitions out of the hospital at an MSI; (2) compare the effectiveness of the Navigator intervention vs usual care on patient experience (co-primary outcomes: anxiety, informational support) and other outcomes in a clinical trial; (3) examine the effectiveness of the Navigator intervention in patient subgroups (secondary aim); and (4) understand the barriers and facilitators of successfully implementing the Navigator intervention across patient populations (secondary aim).

**Methods:** We engaged a multidisciplinary group of stakeholders and conducted a 2-arm, single-center, pragmatic randomized controlled trial comparing the Navigator intervention with usual care. We selected a pragmatic clinical effectiveness trial design with concurrent controls, rather than an observational study design, to provide a rigorous evidence base that is also applicable to routine clinical practice. Patients hospitalized at an MSI with a physician diagnosis of heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), myocardial infarction, or sickle cell disease were randomly allocated to either a Navigator intervention delivered by community health workers (CHWs) and peer coaches or to usual care. The Navigator intervention included (1) CHW-led, in-person visits in the hospital prior to discharge to home and a home visit; and (2) follow-up support provided via phone by peer coaches from patient advocacy organizations over a 60-day period. The co-primary outcomes were the 30-day changes (enrollment in the hospital to 30 days after hospital discharge) in (1) Patient-reported Outcomes Measurement Information System (PROMIS) emotional distress/anxiety, and (2) PROMIS informational support (ability to obtain advice, guidance, suggestions, or useful information). Secondary outcomes at 30 and 60 days included assessments of other PROMIS measures of emotional, social, and physical health. Secondary outcomes also included health care utilization using patient report and review of electronic health records at the index hospital. A 2- to 5-unit or greater difference in PROMIS T-scores is considered the minimum clinically important difference. We prespecified the primary analysis as the results of the multivariable linear regression models comparing change in anxiety and change in informational support from enrollment to 30 days after hospital discharge in the Navigator group compared with the usual care group, after adjusting for potential confounders (ie, adjusted differences).

**Results:** We enrolled 1029 adults (518 in Navigator group, 511 in usual care group) hospitalized with heart failure (28%), pneumonia (22%), myocardial infarction (10%), COPD (11%), or sickle cell disease (29%). Participants had a mean age of 50 years, about 50% were women, and just
over 80% were non-Hispanic black. Only about 50% had more than a high school education. In the Navigator group, completion rates of interventions varied across components (eg, 94% of barrier assessments, 82% of home visits, and 60% participants had 1 or more peer coaching calls). We were able to contact participants for the 30-day co-primary outcome in a total of 798 participants (409 of 511 [80%] and 391 of 518 [75%] in the usual care and Navigator groups, respectively).

Analyses of within-group 30-day change in the co-primary outcomes after hospital discharge indicate a significant reduction in anxiety in the Navigator group (T-score change –1.7 [standard error, or SE, 0.5]; \( p < 0.01 \)) but no discernible change in the usual care group (\( p = 0.63 \)). The Navigator and usual care groups had significant 30-day improvements in informational support (+2.3 [SE 0.6], \( p < 0.01 \), and +2.5 [SE 2.5], \( p < 0.01 \), respectively). In multivariable analyses that accounted for potential confounders, we found no significant between-group differences in the 30-day change in anxiety (Navigator vs usual care, adjusted difference: –1.6, 97.5% CI, –3.3 to 0.06, \( p = 0.031 \); significant difference was prespecified as \( p < 0.025 \)) or in informational support (adjusted difference: 0.0, 97.5% CI, –2.0 to 1.9, \( p = 0.99 \); significant difference was prespecified as a \( p < 0.025 \)). Exploratory analyses to assess the potential for heterogeneity of treatment effects for the co-primary outcomes did not identify subgroups that were significantly more or less likely to benefit from the Navigator intervention. We also did not find between-group 30- or 60-day differences in secondary outcomes (eg, PROMIS measures of emotional, social, or physical health, or health care utilization).

Conclusions: In this single-center pragmatic randomized clinical trial of more than 1000 adults hospitalized with heart failure, pneumonia, myocardial infarction, COPD, or sickle cell disease at an MSI, a Navigator intervention delivered by CHWs and peer coaches did not significantly improve patient experience or health care utilization over 60 days compared with usual care. Although we observed significant changes in some outcomes (eg, anxiety, informational support) within each study group over the 30-day period after hospital discharge, we did not observe a significant difference between groups (at a prespecified \( p < 0.025 \)). Our findings provide further justification for the use of concurrent controls in evaluating health system interventions.

Study Limitation: The study enrolled patients at a single MSI, which could have limited the external validity. Difficulty in implementing the Navigator intervention (especially peer coaching) and missing data may have limited our ability to discern differences in outcomes between groups.
BACKGROUND

Both patients and their caregivers value staying out of the hospital, and this interest converges with those of hospitals now that high 30-day readmission rates for heart failure, pneumonia, myocardial infarction, and chronic obstructive pulmonary disease (COPD) place hospitals at risk for financial penalties from the Centers for Medicare & Medicaid Services (CMS).¹ Minority-serving institutions (MSIs), defined as institutions that serve a high proportion (top 10 percentile) of black and other minorities, have higher risks of readmission or death for these CMS-defined conditions than do other hospitals.²,³ Also, some states (including Illinois) are instituting financial penalties for high readmission rates for Medicaid beneficiaries, a population disproportionately served by MSIs.⁴ These considerations indicate that MSIs will benefit from evidence-based strategies tailored to the populations they serve.⁵,⁶

Historically, patients and caregivers have not played a major role in the development of efforts to reduce avoidable readmissions, so it is no surprise that such strategies emphasize interventions delivered by clinicians to improve care and care coordination and to reduce avoidable readmissions.⁷,⁸ In the focus groups we conducted, patients and caregivers expressed concerns that such strategies do not adequately address their experience, including concerns about abandonment, lack of confidence in knowing what to do, and anxiety.⁹ Two previous single-center clinical trials examining the roles of community health workers (CHWs; lay patient advocates from the community) as in-person and telephone-based patient navigators for hospitalized populations suggest the potential to increase the proportion of patients who complete follow-up appointments after hospital discharge¹⁰,¹¹ and to reduce hospital readmissions within 30 days.¹⁰ However, neither of these 2 studies or others included in a systematic review commissioned by the Agency for Healthcare Research and Quality specifically examined the role of CHWs in improving patient experience as a primary outcome.¹² Based on encouraging findings in studies to date¹⁰,¹¹ and the gap in evidence for strategies to improve patient experience, our overall hypothesis was that an in-person and telephone-based, CHW-led transitional care program would improve patient experience and reduce avoidable health
care utilization in patients being discharged from the University of Illinois Hospital & Health Sciences System (UI Health), an MSI and the largest state-supported hospital in Illinois.

The overall goal of the Patient Navigator to Reduce Readmissions (PArTNER) study was to conduct a randomized 2-arm parallel group, pragmatic single-center clinical trial comparing the effectiveness of (1) CHWs and peer coaches to improve patient experience during hospital to home transitions (Navigator intervention) vs (2) usual care as defined in this study. We selected the target populations to align with conditions emphasized by readmissions reduction programs developed by CMS.

The specific aims of the PArTNER study were the following:

1. Develop, implement, and refine a multifaceted, stakeholder-supported Navigator intervention to improve the patient experience during transitions out of the hospital at an MSI.
2. Compare the effectiveness of the Navigator intervention vs usual care on patient experience (co-primary outcomes: anxiety, informational support [ability to obtain advice, guidance, suggestions, or useful information]) and other outcomes in a clinical trial.

The secondary aims of the PArTNER study were the following:

1. Examine the effectiveness of the Navigator intervention in patient subgroups.
2. Understand the barriers to and facilitators of successfully implementing the Navigator intervention across patient populations.
PARTICIPATION OF PATIENTS AND OTHER STAKEHOLDERS IN THE DESIGN AND CONDUCT OF RESEARCH

Type and Number of Stakeholders Involved

The multidisciplinary PARtNER stakeholders included patients, caregivers, and advocacy groups (23 patients and 10 caregivers as well as representatives of the Respiratory Health Association, COPD Foundation, Mended Hearts, Sickle Cell Disease Association of Illinois, Consumers Advancing Patient Safety, Social Work Policy Institute, and UI Health Sickle Cell Patient Council); 10 clinicians and representatives of professional societies (clinicians [medicine, pharmacy, nursing], American Heart Association, AcademyHealth, Society of Hospital Medicine); and 5 health system administrators at UI Health.

How the Balance of Stakeholder Perspectives Was Conceived and Achieved

Throughout the study, we emphasized the importance of input from all stakeholders. We prioritized the information obtained from patients and caregivers in defining the intervention and outcomes to be measured in the study. We relied on the input from our multidisciplinary stakeholders to ensure that the study design addressed their expressed needs regarding the target population, importance of outcomes, and practicality of the intervention.

Methods Used to Identify and Recruit Stakeholder Partners

We used “snowball” recruitment to identify additional stakeholders and build new partnerships—that is, study investigators had a history of collaborating with some stakeholders (eg, COPD Foundation, Respiratory Health Association), so early in the study planning stage, we elicited recommendations from existing stakeholder partners to identify additional partners.

Methods, Modes, and Intensity of Engagement

We employed 4 formal methods of stakeholder engagement during the study: (1) in-person focus groups for patients and caregivers in the —post-award period; (2) annual conference call with stakeholders who constituted an External Advisory Committee; (3) partnership with stakeholders who delivered the peer coaching intervention (peer coaches in
the COPD Foundation, Mended Hearts, Sickle Cell Disease Association of Illinois); and (4) inclusion of nonresearcher stakeholders (representatives of the COPD Foundation, Society of Hospital Medicine; others invited on an ad hoc basis) in the monthly PArTNER Steering Committee meetings to inform study operations.

Perceived or Measured Impact of Engagement

Relevance of the Research Question

We developed the research question in collaboration with our stakeholders, especially patients and their caregivers, who helped prioritize the focus on improving patient experience rather than on measures of health care utilization (eg, readmission).8,9 Most studies of transitional care services have focused on preventing readmission, emergency department (ED) visits, or death.

Study Design, Processes, and Outcomes

Our stakeholders helped shape the study eligibility criteria and recruitment/retention plan as well as affirmed the need for a study design that would provide high-quality evidence. Stakeholders supported the design and conduct of an individual-level (patient-level) randomized clinical effectiveness trial. Inputs from patients, caregivers, patient advocacy organizations, and other stakeholders were critical in selecting the services in the Navigator intervention. For example, patients and caregivers underscored the need for services that address (1) gaps in hospital discharge (eg, self-management education); (2) socioeconomic resources; (3) access to postdischarge care; and (4) patient anxiety and social support. We used stakeholder preferences in defining the primary and secondary outcomes, including a mix of patient-reported measures of emotional, social, and physical outcomes, as well as health care utilization outcomes. We also engaged patient advocacy organizations to identify members who could serve as peer coaches to deliver the telephone-based peer coaching calls, building on the existing COPD Foundation InfoLine.13
Study Rigor and Quality

The rigor and quality of the study was enhanced by the participation of the COPD Foundation, as it had already developed a peer-to-peer coaching program that could support clinical trials (eg, structured training program, recorded calls to permit training and quality control processes). The stakeholders affirmed the need for a clinical trial design that included a usual care group.

Participant Recruitment

Recruitment occurred as patients presented for care in the hospital setting. Our stakeholders reviewed our recruitment processes and communication supports, including consent documents and other study materials. This partnership with stakeholders helped us optimize study processes so that they were fit for purpose.

Transparency of the Research Process

We reviewed study procedures and updates regularly during meetings with a 20-member External Advisory Committee, an independent Data and Safety Monitoring Board (DSMB with 5 members: 3 physicians [2 hospitalists, 1 geriatrician], 1 pharmacist, and 1 nurse who provided direct patient care), and the University of Illinois IRB (protocol No. 2014-0614). We submitted draft written agendas prior to the meeting and written summaries of discussions and next steps after each meeting.

Adoption of Research Evidence Into Practice

Our stakeholders, including patient advocacy groups and professional organizations, have expressed interest in disseminating study findings through various stakeholder channels. Stakeholders including the COPD Foundation and the Society of Hospital Medicine have already posted information on their websites indicating forthcoming results. We are discussing with our stakeholders the potential for additional dissemination and implementation activities commensurate with study findings.
Methods

Because the specific aims reflect separate parts of the project in terms of participants and methods, we have organized the methods by aim for clarity.

Specific Aim 1

*Develop, implement, and refine a multifaceted, stakeholder-supported Navigator intervention to improve the patient experience during transitions out of the hospital at an MSI.*

We conducted patient and caregiver interviews as part of aim 1 to inform the design of the clinical trial proposed in aim 2. The methods and findings of this study have previously been described in a peer-reviewed manuscript. In brief, we recruited patients aged 18 years or older who had had at least 1 hospitalization in the past 3 months for heart failure, myocardial infarction, pneumonia, COPD, or sickle cell disease. Patients were asked to identify caregivers who might also be willing to participate in a caregiver focus group. We defined a caregiver as a family member, friend, or acquaintance who provided care for the patient during and after hospital discharge. Patients and caregivers interested in participating were scheduled to attend a condition-specific patient focus group or a caregiver focus group, respectively. Upon completion of the focus groups, participants were given $95 as compensation for their time. Study procedures were approved by the University of Illinois at Chicago IRB.

Two experienced qualitative researchers and a team of study investigators cofacilitated each 90-minute focus group. The focus groups were conducted with the help of an interview guide that used open-ended questions, which helped elicit patient and caregiver perspectives on experiences (1) around the time of hospitalization, (2) around the time of hospital discharge, and (3) at home following discharge and follow-up care. Participants were also asked for their views on the potential usefulness of a patient navigator who could assist with transitions in care and about the desirable characteristics of a patient navigator. A research assistant took observation notes to supplement audio recordings, which were transcribed verbatim. We analyzed the transcriptions using the *Atlas.ti.7.0 data analysis software package,* and 2 investigators independently examined them. Analyses focused on the recognition and
modifications of major themes and subthemes. We obtained agreement related to the content midway and at the end of analyses of transcriptions of discussions that occurred at each focus group. During this process, we compared data across focus groups for similarities and differences. This iterative process yielded content categories on which we agreed.

The principal investigator (PI) of the PArTNER study reviewed findings with front-line clinicians who provide care to the target populations in the study, as well as the health system leadership, prior to finalizing the Navigator intervention. This review with the health system leadership was intended to incorporate enterprise-level input and build support for the final intervention.

**Specific Aim 2**

*Compare the effectiveness of the Navigator intervention vs usual care on patient experience (co-primary outcomes: social support and anxiety) and other outcomes in a clinical trial.*

**Study Overview and Design**

The study employed a 2-arm pragmatic randomized controlled trial comparing the Navigator intervention with usual care to provide a rigorous evidence base that also applies to routine clinical practice (Figure 1). Several aspects of the study design were intended to reflect a priority to generate evidence closer to the “effectiveness” end of the continuum between efficacy and effectiveness. We used results of aim 1 to ensure that the Navigator intervention was tailored to the needs of end users—including patients, caregivers, front-line clinicians, and health system administrators—and feasible to implement during routine health care operations at an MSI. We designed the collection of baseline and follow-up outcomes to minimize participant burden: (1) The in-person enrollment and baseline visit occurred as the participants received care in the hospital; and (2) follow-up visits occurred by telephone (rather than in person) at approximately 30 and 60 days after hospital discharge.
In the PArTNER study, participants hospitalized with a physician diagnosis of heart failure, pneumonia, COPD, myocardial infarction, or sickle cell disease were randomly allocated to 1 of 2 groups: Navigator intervention or usual care. The Navigator intervention was initiated during the index hospitalization and continued for 60 days postdischarge and included (1) community health workers (CHWs) who conducted in-person study visits in the hospital and a single home visit 1 to 3 days postdischarge to assess barriers to patient-centered transitions from hospital to home; and (2) peer coaches who were introduced upon hospital discharge and contacted participants via telephone at approximately 1, 2, 3, 5, and 7 weeks postdischarge to continue supports initiated by CHWs. Following in-person baseline data collection prior to randomization, follow-up outcomes were assessed via telephone at 30 days and 60 days postdischarge.
Participants

Patients hospitalized at an MSI with a physician diagnosis of heart failure, pneumonia, COPD, myocardial infarction, or sickle cell disease formed the target population. We selected this target population because its members are the focus of payer-led efforts to incentivize a reduction in hospital readmissions. Trained research coordinators used IRB-approved recruitment strategies to review hospital admissions Mondays through Saturdays to identify the target population. Research coordinators obtained verbal assent from the treating physicians to confirm the admission diagnosis and permission from treating physicians prior to obtaining written informed consent from patients.

We based eligibility for study participation on the following inclusion and exclusion criteria. To be eligible, patients needed to meet all inclusion criteria and none of the exclusion criteria.

**Inclusion Criteria**

1. Received care from the inpatient medical service at UI Health
2. Aged 18 years or older
3. Received treating physician diagnosis of heart failure, pneumonia, COPD, myocardial infarction, or sickle cell disease during his or her index admission

**Exclusion Criteria**

1. Unable to understand and/or speak English
2. Unable or declined to give informed consent
3. Previous participant in the PArTNER study
4. Planned transfer to another acute care facility
5. Planned discharge to facility other than home (eg, long-term care facility)
6. Receiving hospice care or planned to be discharged to hospice care
7. Planned to leave against medical advice
Following baseline data collection, we employed block-stratified randomization with permuted blocks to promote balance in the number of participants in each of the 2 PArTNER study groups (Navigator intervention and usual care) in 3 key baseline participant characteristics: (1) enrollment condition (heart failure, pneumonia, COPD, myocardial infarction, or sickle cell disease); (2) baseline anxiety (Patient-reported Outcomes Measurement Information System [PROMIS] emotional distress/anxiety scale [v1.0, short form (SF)4a, T-score ≥ 50, yes/no]); and (3) baseline informational support (PROMIS informational support scale [v2.0, SF4a, T-score ≥ 50, yes/no]). A computerized random number generator supplied the random allocation sequence. Strata included baseline values of anxiety (PROMIS emotional distress/anxiety) and informational support (PROMIS informational support), because change from baseline values for emotional distress/anxiety and informational support at 30 days were the co-primary outcomes. Research staff who conducted recruitment and data collection at the baseline and follow-up visits were masked to treatment allocation sequence. Research staff were masked to treatment allocation prior to informed consent and baseline data collection, as our data system required this information to generate a treatment allocation. Research staff collecting postrandomization outcomes were also masked to treatment allocation, as they did not have access to treatment-related information.

Assuming 20% attrition (evaluable data in at least 904 participants) and a Bonferroni correction for 2 co-primary outcomes (2-sided \( \alpha = 0.025 \)), we estimated that 1130 participants (565 participants in each treatment group) would be needed for 95% or greater power to detect a 2.5-unit difference (25% of a standard deviation, or T-score of 2.5) for each of the co-primary outcomes in the overall population. The minimum detectable difference in T-score of 2.5 falls well within the T-score minimum clinically important difference (MCID) of 2 to 5. The proposed sample size would also provide 80% power to detect a 7.5% absolute reduction in 30-day risk of death or rehospitalization (from 30% to 22.5%) and 90% power to detect a 10% reduction.

**Navigator Intervention.** The Navigator intervention was delivered by CHWs and peer coaches during the index hospitalization and for approximately 60 days postdischarge. We
instructed the CHWs and peer coaches to use a HIPAA-compliant web-based database to record interventions completed for each study participant. We carefully selected the 2 CHWs for the PArTNER study (both women; one Latina who was bilingual in Spanish and English; the second was black and spoke English) to have at least a General Educational Development (GED) or high school diploma, a passion for working in the communities served by UI Health (primarily westside and southside Chicago), and a valid driver’s license. Newly hired CHWs received educational information from investigators and staff on the health conditions of interest as well as training on techniques for approaching and connecting with patients in the hospital setting, safety during home visits, and appropriate documentation of interactions with study participants. The project manager for the study was responsible for daily supervision, with the help of a nurse practitioner and physicians on the study team, in addition to hospital-based social workers. The training was performed under the direction of Dr. Elizabeth Calhoun, a co-investigator in the PArTNER study, leader in the National Patient Navigator Consortium, and member of the Commission on Cancer Standards Committee. The peer coaches were staff members of the COPD Foundation, the Sickle Cell Disease Association of Illinois, and Mended Hearts. Peer coaches were required to have a telephone and internet access at home to facilitate training, data entry, and ability to rapidly retrieve information about communities in which patients lived. Peer coaches underwent training that included a 45-hour web training session on (1) customer service and call etiquette; (2) HIPAA; (3) basic training about the health conditions that formed the target population; (4) program-specific training for PArTNER and how to find community resources (eg, food pantry, transportation, housing); and (5) use of a HIPAA-compliant portal to document all calls. We based the curriculum on training that the COPD Foundation was using for its call center, supplemented it with information relevant to the PArTNER study. Although the number of peer coaches varied during the PArTNER study, there were always at least 10 of them.

**CHW-led Interventions.** The CHWs interviewed participants in person to identify barriers to health and health care and provided support to promote self-management skills during the index hospitalization and at a home visit within 3 days after hospital discharge. Whenever possible, all CHW interventions occurred in person, but they could occur via phone if
needed. During the index hospitalization, a CHW conducted the activities listed below over 1 or more in-person visits; the initial visit was scheduled to occur over approximately 45 minutes. The number of visits conducted by the CHW during hospitalization depended on participants’ needs and length of stay; in some cases, participants received daily visits.

- **Completed a barrier assessment linked to socioeconomic resources (Appendix 1),** which included questions regarding a need for assistance with employment and income, family and social support, transportation to health care facilities, housing, utilities (eg, heat, light), food, and interpersonal violence. We based the selection of barriers on recommendations in the Society of Hospital Medicine’s Project BOOST\(^{16}\) and on interviews with stakeholders (eg, patients, caregivers, clinicians, administrators at UI Health). When appropriate, the CHW reviewed barriers with the participant’s clinician and social worker.

- **Supported participant-specific needs by helping patients identify and receive assistance from resources in the community that were used by the hospital’s social work department,** including those available through Purple Binder.\(^{17}\) Purple Binder is a website that contains information for medical and social service resources in the Chicago area. The CHW created a tailored, patient-centered plan for solutions to each barrier and discussed the solutions with the participant during subsequent visits. This included printing or texting solutions to the participant for his or her review; examples of the most commonly used resources are listed in Appendix 2. CHWs reassessed barriers at each participant encounter during the hospitalization and addressed new barriers as needed. The CHW assisted the participant and, if requested, included the caregiver(s) in the discussions.

- **Completed a Discharge Patient Education Tool (DPET; Appendix 3),** scheduled for approximately 45 minutes. Using the patient’s discharge instructions documented in the electronic health record (EHR), the CHW completed a DPET. The DPET was personalized to focus on aspects of the postdischarge care that the patient most needed. The CHW reviewed the DPET with the participant using teach-back (ie, participant asked to repeat the information back to the CHW in a manner that indicates understanding) to address the core content areas. Teach-back was used to educate and confirm understanding of participants’ (1) postdischarge follow-up visits and tests, (2) recommendations regarding lifestyle
changes, and (3) use of medications after discharge. If needed, the CHW offered to help the participant schedule follow-up appointments. The CHW also reviewed barrier solutions with the participant, including resources and services that had been put into place for the participant when he or she arrived home. We specifically instructed the CHWs not to provide medical advice; CHWs referred requests for medical advice to the participant’s clinicians. During the discharge visit, the CHW worked with the participant to schedule a home visit within 3 business days of hospital discharge.

During the home visit, a CHW performed the following activities over a period of approximately 1 hour:

- **Re-reviewed the DPET with the participant.** During the home visit, the CHW reminded the participant of upcoming tests and appointments, confirmed that the participant had transportation to those appointments, confirmed the participant’s understanding and adherence to lifestyle changes, confirmed the participant’s prescriptions had been filled, and confirmed the participant’s understanding and adherence to medications. If the participant was having trouble following any part of his or her DPET, the CHW would work with him or her to find a solution. The CHW was also encouraged to contact the hospital’s social worker or clinician’s office, if needed.

- **Re-reviewed solutions to barriers with the participant.** The CHW reviewed the solution(s) that was put in place and confirmed that it was working for the participant. If needed, the CHW worked with the participant to identify other options or troubleshoot with him or her if new barriers were identified.

- **Implemented peer coaching.** At hospital discharge, the CHW introduced the phone-based peer coaching intervention that could be used to support the patient after the CHW home visit. At the home visit, the CHW reminded the participant about the upcoming phone-based peer coaching calls. The peer coaches were informed by the study data system of which patients would be eligible for peer coaching calls, and peer coaches had access to barriers and solutions identified by the CHW; however, the CHWs did not contact peer
coaches to have a “warm hand-off” for each patient, because we found that it was not practical to align schedules of patients, CHWs, and peer coaches.

**Peer Coach–led Interventions.** The telephone-based peer coaching support at weeks 1 (intervention window 6 to 10 days), 2 (12 to 16 days), 3 (19 to 23 days), 5 (32 to 37 days), and 7 (47 to 51 days) after hospital discharge was intended to continue supports initiated by the CHW intervention (Figure 1). Each peer coach call was scheduled for approximately 15 minutes; the participant could have more than one peer coach across the 5 calls (mimicking real-world circumstances). Patient advocacy organizations provided peer coaching support for participants hospitalized with pneumonia or COPD (COPD Foundation), myocardial infarction or heart failure (Mended Hearts), and sickle cell disease (Sickle Cell Disease Association of Illinois). The peer coaching intervention by phone was intended to leverage existing services and to connect participants with resources in the community. The COPD Foundation had a well-developed peer coaching (patients with COPD and their caregivers) infrastructure that provided a method of tracking and recording peer coaching phone calls. Volunteers from all 3 organizations used this infrastructure to conduct the peer coaching calls. If a peer coach was not available from the specified organization, the CHW would temporarily fill in to complete the calls.

Through a HIPAA-secure database, peer coaches had access to the CHW-completed Barrier Assessments and DPET specific to their patients. Over the course of approximately 60 days postdischarge, peer coaches used a sequence of up to 5 phone calls to provide support in addressing barriers to care and used the DPET to promote self-management. The peer coaches made up to 4 attempts for each call (voicemails were left after each unsuccessful call attempt). The calls consisted of the following:

- **Greeting and reminding.** The peer coach confirmed that he or she had the correct person and reminded the participant about his or her involvement in the study using an IRB-approved script.

- **Reviewing the participant’s DPET.** The peer coach reviewed the DPET with the participant. The peer coach reminded the participant of upcoming tests and appointments, confirmed
the participant had transportation to those appointments, confirmed the participant’s understanding and adherence to lifestyle changes, confirmed the participant had his or her medications, and confirmed the participant’s understanding and adherence to medication. If the participant was having trouble following any part of their DPET, the peer coach identified it as a new barrier and worked with the participant to find a solution.

- **Reviewing previous barriers and solutions.** The peer coach followed a similar procedure as that of the CHW in reviewing any barriers and the solutions that had been put into place as well as troubleshooting new barriers.

- **Scheduling the next peer coaching intervention call.** The peer coach scheduled the next follow-up call, according to the study schedule of 5 calls. We offered flexibility in completing the calls, depending on the participant’s availability, with the last call occurring by 60 days postdischarge.

**Usual Care (comparator)**

All participants (regardless of treatment group) received usual health care as per their treating medical team. Because usual hospital-to-home transitional care can vary within and across institutions, we reviewed the discharge documentation for all participants (regardless of treatment group) to evaluated care provided by the clinical teams. We used stakeholder input and the framework proposed by the Society of Hospital Medicine’s BOOST Program (universal discharge checklist) in assessing the items below and recorded whether documentation indicated that the following transitional care elements were completed (yes or no; Appendix 4). Front-line clinicians who provide care to patients with target conditions for the PArTNER study agreed with the definitions for each of the 8 transitional care indicators below:

1. **Medication reconciliation performed on the date of discharge:** Medication reconciliation marked as complete and/or a pharmacist note documenting medication reconciliation in the EHR

2. **Medication education provided to patient on date of discharge:** Educational materials specific to a class of medications, a specific medication, or device (eg, respiratory inhaler,
oxygen equipment) provided to the patient and/or a pharmacist note documenting the education in the EHR

3. **Education on diagnosis, prognosis, self-care requirements, or procedures provided to patient on the date of discharge**: Educational materials for any medical conditions listed in the discharge summary documented in the EHR’s Patient Education Note

4. **Disease management education provided to patient on the date of discharge**: Instructions about how to seek additional care in case of clinical deterioration, or specific to the patient’s medical condition recorded in the EHR

5. **Structured discharge summary completed upon hospital discharge**: Discharge summary recorded as finalized by the attending physician in the EHR within 2 business days of hospital discharge

6. **Phone contact attempted within 2 business days postdischarge with patient or caregiver**: Call attempt documented in the EHR as successful or unsuccessful within 2 business days after hospital discharge

7. **Follow-up appointment within 7 days of hospital discharge specified in discharge instructions**: Appointment information (at a minimum, location, date, time) in the EHR with at least 1 provider scheduled for 7 or fewer days after hospital discharge; the provider location could be outside of the index hospital-affiliated clinics

8. **Discharge instructions provided to patient on the date of discharge**: Documentation in the EHR that discharge instructions were provided to patient on the same date as discharge

Trained research coordinators who were masked to treatment group reviewed the EHRs to record usual care related to hospital-to-home care transitions independent of study-related interventions. In a random 10% sample of study participants, a second research coordinator repeated the data abstraction to assess inter-rater agreement. The inter-rater agreement in the 10% random sample was high across all care indicators (kappa = 0.84 to > 0.99). The research team reviewed and adjudicated all discrepancies, and entered corrected values into the study database.
Study Outcomes

Primary Outcomes

Patient and caregiver engagement activities in aim 1 indicated the need for 2 co-primary outcomes for the clinical effectiveness trial:

1. Change in participant anxiety from baseline (enrollment to 30 days postdischarge); and
2. Change in participant informational support (enrollment to 30 days postdischarge)—informational support refers to the ability to obtain advice, guidance, suggestions, or useful information.

We used the National Institutes of Health PROMIS measures for our co-primary outcomes, because the development and validation of PROMIS scales have been extensively documented.\(^\text{18}\) We used the PROMIS emotional distress/anxiety short form (version 1.0 SF4a, 4 items) to assess participant anxiety. This anxiety measure consists of the following 4 items, with response options of Never, Rarely, Sometimes, Often, Always, Refused: *In the past 7 days . . .*

1. I felt fearful.
2. I found it hard to focus on anything other than my anxiety.
3. My worries overwhelmed me.
4. I felt uneasy.

We used the PROMIS informational support short form (version 2.0 SF4a, 4 items) to assess informational support. This informational support measure consists of the following 4 items, with response options of Never, Rarely, Sometimes, Often, Always, Refused: *In the past 7 days . . .*

1. I have someone to give me good advice about a crisis if I need it.
2. I have someone to turn to for suggestions about how to deal with a problem.
3. I have someone to give me information if I need it.
4. I get useful advice about important things in life.
For PROMIS measures, we rescaled raw scores for each measure into a standardized score with a mean of 50 and a standard deviation (SD) of 10. Higher PROMIS T-scores indicate more of the concept being measured (eg, higher anxiety T-scores indicate more anxiety). Based on a scoring manual, a T-score of 40 and a T score of 60 is 1 SD below and 1 SD above the US general population mean, respectively.\textsuperscript{19-21} Studies suggest that a 2- to 5-unit or greater difference in T-scores is likely to be the MCID,\textsuperscript{19,20} although the MCID following hospital discharge in the target population has not been established.

Using PROMIS measures confers several distinct advantages:

**Comparability:** Measures have been standardized to be patient centered, rather than disease specific, permitting comparisons of patient outcomes between the Navigator and usual care groups despite enrolling patients with multiple conditions.

**Reliability and Validity:** Metrics for each domain have been rigorously reviewed and tested.

**Flexibility:** PROMIS measures can be administered in a variety of ways (in person, by telephone, or via computer adaptive testing); for PArTNER, the baseline visit occurred while the patient was in the hospital, so the administration was in person. Follow-up visits were performed by telephone to minimize participant burden (a key principle in effectiveness trials).

**Inclusiveness:** PROMIS encompasses all people, regardless of literacy, language, physical function, or life course.

**Secondary Outcomes**

Secondary outcomes included assessments of change in participant anxiety and in informational support from enrollment to 60 days postdischarge, as well as 30-day and 60-day measures of other PROMIS outcomes:
• **Instrumental support** [version 2.0, SF4a, 4 items; defined as the ability to obtain help with tasks such as arranging transportation for a follow-up appointment]

• **Emotional support** [version 2.0 SF4a, 4 items]

• **Mental health** [version 1.1 SF, 4 items within the 10-item global health scale]

• **Physical health** [version 1.1 SF, 4 items within the 10-item global health scale]

We also assessed health care utilization as a secondary outcome. We assessed attendance at outpatient clinics within 14 days of hospital discharge (using self-report, and separately using review of EHRs at the index hospital, which is shared with the hospital and all ambulatory clinics within the health system, including a network of 13 federally qualified health care centers); death at 30 and 60 days after hospital discharge (based on caregiver report or review of EHRs at index hospital); death or rehospitalization at 30 and 60 days (rehospitalization assessed by review of EHRs at index hospital); and, finally, death or rehospitalization or ED visit at 30 and 60 days (both rehospitalization and ED visit assessed by review of EHRs at the index hospital). We did not have access to claims data to ascertain health care outside of the index hospital or ambulatory clinics outside the index health system.

**Study Setting**

The PArTNER study was a single-center clinical trial that enrolled patients hospitalized at UI Health Hospital, the largest state-supported hospital in Illinois, which includes a 495-bed tertiary care hospital, 22 outpatient clinics (primary care and specialty care), and 13 federally qualified health centers. Being an MSI (hospitalized patients are ~80% black), UI Health Hospital represents an ideal environment in which to evaluate the effectiveness of care transition services tailored to this high-risk population.

**Time Frame for the Study**

The intervention spanned the time from the patient’s hospital stay until 60 days after hospital discharge. We assessed outcomes at 30 days and at 60 days to inform patients, caregivers, and other decision makers about the potential for the Navigator interventions to
address short-term measures of health, as well as to inform payers interested in 30- and 60-day measures of health care utilization.

Data Collection and Sources

A trained research coordinator who was masked to treatment assignment ascertained patient outcomes postdischarge. We convened staff meetings every 1 to 2 weeks to review study progress and troubleshoot difficulty with study activities, including data collection or management. The research coordinator attempted to contact participants by telephone and reviewed the EHRs at the index hospital to assess outcomes at 30 days and 60 days postdischarge. Up to 14 call attempts were made to collect patient-reported outcomes for each of the 30- and 60-day assessments.

Many aspects of our study design helped reduce the frequency of missing data. We designed the study to target a population not adequately served by current services, which could have helped act as an incentive for clinicians to support the study and for participants to remain in the study. We accommodated individual preferences as much as possible when setting follow-up visits or data collection time points. We performed study enrollment and data collection as participants received care (in the hospital) and with reduced burden postdischarge (eg, data collection by phone rather than in person). Also, we did not equate treatment discontinuation with study dropout; we encouraged participants to continue in the study and provide outcomes data even if they no longer wished to remain in the treatment group assigned by randomization. We also encouraged participants to continue in the study by explaining the importance of completing the study with as many participants as were enrolled to avoid selection bias.

At the end of the original study recruitment period (October 1, 2014, to April 1, 2016), enrollment was lower than target, so we amended the study protocol to provide up to $75 in gift cards—$25 after completing each of the following: (1) baseline study visit in the hospital; (2) 30-day outcome assessment phone call; and (3) 60-day outcome assessment phone call. We collected reasons for withdrawing from the study or loss to follow-up when possible by
interviewing study participants and caregivers and review of EHRs (eg, participant died), and reported them in the participant flow diagram found in the Results (Figure 2).

**Analytical and Statistical Approaches**

Analyses consisted of 3 phases. Phase 1 used exploratory analyses to identify, correct, and confirm values or missing data, and provide descriptive statistics (frequency [proportions], mean [SDs]). Phase 2 focused on bivariate analyses to compare primary and secondary outcomes by treatment group. We used t tests, Wilcoxon rank sum tests, chi-square tests, and Fisher exact tests, as appropriate, for pairwise comparisons between the Navigator and usual care groups. Phase 3 included multivariable logistic or linear regression models, as appropriate, to account for potential confounders for the primary and secondary outcomes. We prespecified the primary analysis as the results of the multivariable linear regression models comparing change in anxiety and change in informational support from enrollment to 30 days postdischarge in the Navigator group compared with the usual care group, after adjusting for potential confounders (ie, adjusted differences). We predefined potential confounders as baseline age (> 65 years, yes/no); gender (female vs male); race (non-Hispanic black vs other); target health condition (pneumonia, heart failure, COPD, myocardial infarction, sickle cell disease); having a primary care provider (yes/no); patient-reported usual source of health care (doctor’s office, ED, community health center, other); patient-reported hospitalization in the 12 months prior to index hospitalization (yes/no); education (high school or less vs other); and health insurance (yes/no). To minimize the risk of bias in specifying potential confounders, we examined baseline characteristics while being masked to treatment group before finalizing the list of potential confounders for the multivariable analyses.

We conducted all analyses using a modified intention-to-treat principle, in which we ignored the individual with the missing data for the co-primary outcomes (complete case analyses). To assess the sensitivity of results to the complete case analyses, we conducted multiple imputations under a missing at random (MAR) assumption. We also conducted multiple imputations under a missing not at random (MNAR) assumption under a joint selection model of outcome and missingness, and employed Bayesian analyses for each of the 2 co-
primary outcomes. We used our multitiered approach to missing data to determine if the intervention (Navigator) effects were qualitatively maintained across various approaches to handling missing data. We also conducted per-protocol analyses (PPAs) for the primary outcome. In the PPAs, we considered the Navigator intervention per protocol if the participant received both hospital and home-based components of the CHW-led interventions and at least one peer coaching call. We employed a 2-sided Bonferroni-corrected $\alpha$ of 0.025 (and 97.5% CIs) for the 2 co-primary outcomes in the multivariable analyses and a 2-sided $\alpha$ of 0.05 (and 95% CIs) for all other hypothesis tests.

Secondary Specific Aim 3

*Examine the effectiveness of the Navigator intervention in patient subgroups.*

We conducted exploratory analyses to assess the potential for heterogeneity of treatment effects (HTEs) for the primary outcome by examining the consistency of the adjusted differences in prespecified subgroups (across levels of each baseline characteristic) in a series of linear regression models with covariates that included the treatment group indicator, the treatment by subgroup interaction terms, and all other covariates in the multivariable models. We collected a limited number of baseline characteristics in keeping with information that is routinely collected on hospitalizations and that has been associated with hospital readmissions at MSIs. We determined the $P$ values for consistency of adjusted differences in linear or logistic regression models across subgroups using Wald chi-square tests. The PArTNER study was not specifically powered to assess HTEs, so all such analyses should be considered exploratory. Due to multiple hypothesis tests, we employed Bonferroni corrections to reduce the risk of a type 1 error.

Secondary Specific Aim 4

*Understand the barriers and facilitators of successfully implementing the Navigator intervention across patient populations.*

A limitation of research directed at improving health systems is that inadequate attention is often given to understanding why an intervention was successful or not successful.
Health system interventions are often multicomponent, and when they successfully improve care or outcomes, it is helpful to know whether all components of the intervention were necessary for success. Also, when care or outcomes are not improved, it is unclear if barriers to implementation (fidelity) or lack of efficacy contributed to a lack of effect. We therefore implemented a mixed methods approach to assess completion of each component of the multicomponent Navigator intervention (completion of the barrier assessment, discharge visit, home visit, peer coaching calls). We also conducted interviews to debrief study staff and a convenience sample of participants spanning all 5 enrollment conditions.

Changes to Original Study Protocol

During the planning stages of the study, we learned that the patient advocacy groups could not reliably conduct peer coaching in Spanish due to variability in staffing. Thus, we enrolled only patients who spoke English. Also, during a change in study personnel, on October 15, 2015, a review of documentation by a new member of the PArTNER research team identified inconsistencies between IRB-approved and internal study documents. The PI placed the PArTNER study on administrative hold on October 16, 2015, pending consultation with the research team and the University of Illinois IRB. The PI then submitted a “prompt report” (per IRB protocol) on October 23, 2015, which specified that the IRB had no record of 2 amendments shown to have been submitted and accepted by the IRB according to internal study documents, and that several key documents, including stamped consent forms, approval letters, and the most recent continuing review, had not been issued by the IRB or were inconsistent with the documentation submitted to the IRB. The IRB reviewed study procedures, met with study staff, and convened a full review of the PArTNER study, which resulted in a Notice of Determination of Serious Noncompliance, which also linked the noncompliance actions to a former member of the PArTNER research team. In consultation with the IRB, the study PI completed a systematic internal review of all study data and procedures, implemented IRB-required procedures to reaffirm consent in all 772 participants who had been enrolled using the non–IRB approved consent forms, and completed an IRB-directed audit of a sample of study records. Audit trails in the REDCap (Research Electronic Data Capture) study database allowed auditors to identify and review time stamps of data entry and modifications by each member of the study team.25
These corrective actions identified a small number of records entered into the study database (27 records for 30-day outcome data and 63 records for the 60-day outcome data) that could not be independently verified using source documents. Following consultation with the IRB, we excluded these “unverified” data from the analyses and recorded them as missing data. An additional 10 participants declined to reaffirm consent using IRB-approved procedures, so we excluded them from the study cohort (recorded as “withdrew during reaffirmation of consent”). The study PI submitted an amendment seeking to officially launch the PArTNER trial using a new IRB-approved consent form, conduct follow-up outcomes assessments in participants who had already been enrolled, and recruit new study participants. In the interval between the administrative hold and IRB approval to restart the PArtNER study activities using IRB-approved procedures and documents, 62 participants were no longer in the window to complete the 30-day follow-up assessment and 64 participants were no longer in the window for completing the 60-day follow-up assessments; these participants contributed to missing 30- and 60-day outcome data. These findings were reviewed with the PArtNER study independent Data and Safety Monitoring Board, External Advisory Committee, the study sponsor (PCORI), and the IRB, which collectively determined that the study team had taken appropriate measures to protect the integrity of the research study.
RESULTS

Specific Aim 1

*Develop, implement, and refine a multifaceted stakeholder-supported Navigator intervention to improve the patient experience during transitions out of the hospital at an MSI.*

Results are reported in full in a previous peer-reviewed publication. In brief, we conducted 7 focus groups involving 23 patients (5 focus groups, 1 for each of the 5 target conditions) and 10 caregivers (2 focus groups). Our findings support the need for additional services to address (1) gaps in the hospital discharge procedures (eg, incomplete education or information at hospital discharge); (2) patients’ socioeconomic resources (eg, difficulty finding or arranging transportation, unstable housing); (3) lack of support to access postdischarge care (eg, difficulty arranging follow-up appointments); (4) patient self-management practices (eg, use of medications, decisions to seek additional health care); and (5) the importance of addressing patient anxiety (eg, due to apprehension about the possibility of worsening symptoms, insufficient caregiver support at home). We used these findings to finalize the Navigator intervention in aim 2.

Specific Aim 2

*Compare the effectiveness of the Navigator intervention vs usual care on patient experience (co-primary outcomes: social support and anxiety) and other outcomes in a clinical trial.*

Study Cohort

From October 2014 to July 2016, we assessed a total of 2170 patients for eligibility (Figure 2). A total of 828 were ineligible (including 94 who provided consent but subsequently developed an exclusion criterion, such as discharge to location other than home), 297 declined to provide consent, 10 withdrew consent after randomization, and 6 individuals who could not be randomized prior to hospital discharge were excluded. Thus, a total of 1029 patients formed the study population and were randomized to Navigator (n = 518) or usual care (n = 511).
The primary reason for ineligibility was not being able to speak English (n = 254) or being too ill to provide informed consent (n = 253). We were able to contact participants for the 30-day follow-up in a total of 800 participants (409 of 511 [80%] and 391 of 518 [75%] in the usual care and Navigator groups, respectively). Loss to follow-up (inability to reach participant by phone) was the most common reason we were unable to collect 30-day co-primary outcome data (10% in both groups). We followed patients to collect 60-day outcome data even if we were unable to collect 30-day outcome data. A lapse in IRB approval for the study (6% in both groups; see “Changes to original study protocol”) resulted in data that could not be independently verified (2% in usual care and 3% in Intervention groups). Deaths (1% in both groups) and withdrawal of consent (< 1% and 4%, respectively) also contributed to missing co-primary outcome data. Electronic health records for health care utilization outcomes were available in 100% of the usual care group at 30 and 60 days and in 98% of the Navigator group at 30 days (96% at 60 days); withdrawal of consent prior to 30 or 60 days contributed to less than complete access.
Figure 2. CONSORT diagram for the PArTNER Study, n = 1029 randomized

Notes for Figure 2:
Withdrawed during reaffirmation of consent: A participant who declined to reaffirm consent; these individuals were removed from the study cohort.
EHR assessed: We reviewed EHRs to assess follow-up outcomes. We could not assess EHRs in some participants in the Navigator intervention group due to withdrawal from the study.

Reached for OA: The participant answered at least one question on a follow-up call to assess outcomes (OA = outcomes assessment).

Unable to reach: The participant was not reachable for OA.

Lost to follow-up: A subcategory of Unable to reach. We were unable to reach the participant and he or she did not fall into the following categories: Died, Withdrew, Administrative hold, or Unable to verify.

Died: A subcategory of Unable to reach. The participant was unable to be reached and was known to have died before the end of his or her OA window (on or before 44 days postdischarge for the 30-day OA; on or before 81 days postdischarge for the 60-day OA).

Withdrew: A subcategory of Unable to reach. The participant was unable to be reached and withdrew consent before the end of his or her OA window (on or before 44 days postdischarge for the 30-day OA; on or before 81 days postdischarge for the 60-day OA).

Admin. hold: A subcategory of Unable to reach. The participant was unable to be reached during an administrative hold period while awaiting IRB approval, so follow-up information was considered missing data.

Unable to verify: A subcategory of Unable to reach. Source document(s) for participant data were not available, so follow-up information was considered missing data.

Either CPO @ 30: The participant provided enough data to compute either of our co-primary outcomes (CPOs) at 30 days.

Any SO @ 30: The participant provided sufficient data to compute any of our secondary outcomes (SOs) at 30 days.

Any SO @ 60: The participant provided sufficient data to compute any of our SOs at 60 days.

ITT: Intention-to-treat.
Demographic and Health Care Utilization Characteristics (Table 1). Overall, the study cohort had a mean age of 50 years, about 50% were women, and just over 80% were non-Hispanic black. Only about half had more than a high school education, and nearly all reported having health insurance. The most common enrollment condition was sickle cell disease (29%), followed by heart failure (28%), pneumonia (22%), COPD (11%), and myocardial infarction (10%). Just over 25% reported the ED as the usual source of health care. About 80% reported another hospitalization in the past 12 months.

Table 1. Baseline (on Enrollment During Hospitalization) Characteristics of Study Population

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Usual care (N=511)</th>
<th>Intervention (N=518)</th>
<th>Overall (N=1029)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at admission (continuous)</td>
<td>m=0; 49.9±17.0</td>
<td>m=0; 49.8±16.5</td>
<td>m=0; 49.9±16.8</td>
</tr>
<tr>
<td>Age (discrete): ≥65</td>
<td>m=0; 99 (19%)</td>
<td>m=0; 95 (18%)</td>
<td>m=0; 194 (19%)</td>
</tr>
<tr>
<td>Gender: Female</td>
<td>m=0; 290 (57%)</td>
<td>m=0; 277 (53%)</td>
<td>m=0; 567 (55%)</td>
</tr>
<tr>
<td>Race: Non-hispanic black</td>
<td>m=0; 422 (83%)</td>
<td>m=0; 420 (81%)</td>
<td>m=0; 842 (82%)</td>
</tr>
<tr>
<td>Socioeconomic resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest level of education: High school degree or less</td>
<td>m=0; 287 (56%)</td>
<td>m=1; 271 (52%)</td>
<td>m=1; 558 (54%)</td>
</tr>
<tr>
<td>Has health insurance: Yes</td>
<td>m=0; 494 (97%)</td>
<td>m=0; 495 (96%)</td>
<td>m=0; 989 (96%)</td>
</tr>
<tr>
<td>Clinical factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrollment condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>m=0; 148 (29%)</td>
<td>m=0; 150 (29%)</td>
<td>m=0; 298 (29%)</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>140 (27%)</td>
<td>145 (28%)</td>
<td>285 (28%)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>112 (22%)</td>
<td>119 (23%)</td>
<td>231 (22%)</td>
</tr>
<tr>
<td>COPD</td>
<td>62 (12%)</td>
<td>53 (10%)</td>
<td>115 (11%)</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>49 (10%)</td>
<td>51 (10%)</td>
<td>100 (10%)</td>
</tr>
<tr>
<td>Hospitalizations in past 12 months: At least 1</td>
<td>m=5; 427 (84%)</td>
<td>m=2; 436 (84%)</td>
<td>m=7; 863 (84%)</td>
</tr>
<tr>
<td>ER visits in past 12 months: At least 1</td>
<td>m=4; 429 (85%)</td>
<td>m=2; 436 (84%)</td>
<td>m=6; 865 (85%)</td>
</tr>
<tr>
<td>Source of healthcare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usual location for healthcare/advice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor’s office</td>
<td>m=4; 335 (66%)</td>
<td>m=0; 302 (58%)</td>
<td>m=4; 637 (62%)</td>
</tr>
<tr>
<td>Emergency department</td>
<td>124 (24%)</td>
<td>149 (29%)</td>
<td>273 (27%)</td>
</tr>
<tr>
<td>Community health clinic</td>
<td>36 (7%)</td>
<td>56 (11%)</td>
<td>92 (9%)</td>
</tr>
<tr>
<td>Other</td>
<td>12 (2%)</td>
<td>11 (2%)</td>
<td>23 (2%)</td>
</tr>
<tr>
<td>Has a primary care provider: Yes</td>
<td>m=0; 432 (85%)</td>
<td>m=0; 426 (82%)</td>
<td>m=0; 858 (83%)</td>
</tr>
</tbody>
</table>

*The total study population included 1029 individuals. Values in the table reflect frequency out of total N (% of total N); “m” is the number of individuals with missing data for that characteristic. Review of EHRs and confirmation by treating clinician was used to define diagnosis on hospital admission (enrollment condition). Other information was based on participant report.

Emotional, Social, and Physical Health on Enrollment (Table 2). Participant-reported anxiety, informational support, emotional support, and instrumental support were all approximately at the general population mean (T-score ~50) and expected standard deviation (~10). Compared with the general population, mental global health and physical global health
were about one-half (T-score 46) and more than 1 SD (T-score 37) worse than the general population, respectively. The usual care and Navigator groups had similar levels of emotional, social, and physical health.

Table 2. Baseline (on Enrollment During Hospitalization) Emotional, Social, and Physical Health

<table>
<thead>
<tr>
<th>Baseline PROMIS scores:</th>
<th>Usual care (N=511)</th>
<th>Intervention (N=518)</th>
<th>Overall (N=1029)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>m=0; 51.5±10.8</td>
<td>m=0; 51.9±11.1</td>
<td>m=0; 51.7±10.9</td>
</tr>
<tr>
<td>Informational support</td>
<td>m=0; 52.6±12.1</td>
<td>m=1; 51.9±12.8</td>
<td>m=1; 52.2±12.5</td>
</tr>
<tr>
<td>Emotional support</td>
<td>m=1; 53.5±9.9</td>
<td>m=0; 53.2±10.5</td>
<td>m=1; 53.3±10.2</td>
</tr>
<tr>
<td>Instrumental support</td>
<td>m=1; 49.6±10.3</td>
<td>m=1; 50.2±10.7</td>
<td>m=2; 49.9±10.5</td>
</tr>
<tr>
<td>Physical health (global)</td>
<td>m=0; 37.2±7.5</td>
<td>m=1; 36.8±7.9</td>
<td>m=1; 37.0±7.7</td>
</tr>
<tr>
<td>Mental health (global)</td>
<td>m=0; 45.7±7.8</td>
<td>m=0; 45.5±8.3</td>
<td>m=0; 45.6±8.1</td>
</tr>
</tbody>
</table>

*a The total study population included 1029 individuals who were asked to complete an interviewer-administered questionnaire that included PROMIS measures of emotional, social, and physical health (see Methods). Values in the table reflect mean T-scores (± SD) to permit comparisons with the US general population (mean T-score 50, SD 10). Number of individuals with missing data are reported as “m.”

**Usual Care for Hospital-to-Home Transitional Care Services (context for the PArTNER study).** The proportion of patients who received transitional care services recommended by Project BOOST varied by care indicator. Nearly all participants received medication reconciliation (99%), disease self-management education (97%), written discharge instructions (97%), and education on their diagnosis (92%). The discharge summary was finalized within 2 business days in 79% of patients, and 79% of patients received a follow-up appointment within 7 days of hospital discharge. Peer coaches provided education about home medications (40%) and attempted phone contact within 2 business days (19%) in a minority of patients. Attempting phone contact within 2 business days occurred about 6% more often in the Navigator group compared with the usual care group (22% vs 16%; \( p = 0.01 \)); otherwise, the transitional care services were not significantly different between groups.

**Barriers in the Navigator Group.** Of participants in the Navigator group who reported information about their barriers to health or health care, 16% reported none. The most commonly reported barriers to health and health care were employment and income
insecurity (63%); gaps in family and social supports (42%); transportation needs (40%); housing insecurity (37%; eg, homeless, staying with friends or family, or staying in shelters); utility insecurity (31%; eg, difficulty paying for heating or electricity); food insecurity (22%); and interpersonal violence (3%). Among those with 1 or more barriers, there were 64 distinct patterns of barriers. The top 5 most common patterns accounted for 39% of participants: (1) none of the barriers that were assessed (16% of Navigator participants); (2) employment and income insecurity alone (10% of Navigator participants); (3) employment/income, family/social support, transportation, housing, utility, and food-related barriers (5% of Navigator participants); (4) employment/income and transportation barriers (4% of Navigator participants); and (5) employment/income and family/social support barriers (4% of Navigator participants).

**Change in Patient Anxiety and Information Support from Enrollment to 30 Days Postdischarge (co-primary outcomes) and 60 Days Postdischarge (secondary outcomes).** Data for the 30-day change in anxiety and informational support were available in 406 participants (79%) in the usual care group and 391 participants (75%) in the Navigator intervention group. Participants with missing data for calculations of 30-day change in anxiety were 3 years younger at enrollment (vs those without missing data: mean difference −3.3 years; 95% CI, −5.7 to −0.8 years; \( p = 0.009 \)). Findings were similar for those without data to calculate the 30-day change in informational support vs those with the data (mean difference −3.5 years; 95% CI, −5.9 to −1.0 years; \( p = 0.005 \)). Otherwise, participants with and without missing data for the co-primary outcomes were not significantly different at baseline.

Results indicate a significant reduction in 30-day anxiety in the Navigator group (T-score change of −1.7; 95% CI, −2.9 to −0.5; \( p < 0.01 \)), but no discernible change in the usual care group (−0.2; 95% CI, −1.4 to 0.9; \( p = 0.63 \); Table 3). The 30-day (\( p = 0.046 \) for between-group difference) and 60-day (\( p = 0.08 \) for between-group difference) improvements in anxiety in the Navigator group were greater than in the usual care group, though these differences were not significant at a 2-sided \( \alpha < 0.025 \) (Figure 3).
We found significant improvements in informational support compared with baseline in both the usual care (2.3, 95% CI, 1.0 to 3.6, \( p < 0.01 \)) and Navigator groups at 30 days (2.5, 95% CI, 1.1 to 3.9, \( p < 0.01 \)) and at 60 days (usual care: 1.7, 95% CI, 0.5 to 2.9, \( p = 0.01 \); Navigator: 2.0, 95% CI, 0.7 to 3.3, \( p < 0.01 \)), though the between-group differences were not significant (Figure 4).

Table 3. 30- and 60-day Change in PROMIS Measures of Emotional, Social, and Physical Health\(^a\)

<table>
<thead>
<tr>
<th>PROMIS scores:</th>
<th>Usual care (N=511)</th>
<th>Intervention (N=518)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary 30-0 day differences:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Mean (97.5% CI)</td>
<td>P-value</td>
</tr>
<tr>
<td>m=105; -0.2 (-1.4, 0.9)</td>
<td>0.63</td>
<td>m=127; -1.7 (-2.9, -0.5)</td>
</tr>
<tr>
<td>Informational support</td>
<td>m=106; 2.3 (1.0, 3.6)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Secondary 30-0 day differences:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional support</td>
<td>m=110; -0.1 (-1.1, 0.8)</td>
<td>0.80</td>
</tr>
<tr>
<td>Instrumental support</td>
<td>m=108; 1.0 (0.1, 2.0)</td>
<td>0.03</td>
</tr>
<tr>
<td>Physical health (global)</td>
<td>m=103; 4.6 (3.8, 5.4)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Mental health (global)</td>
<td>m=108; 0.8 (-0.0, 1.5)</td>
<td>0.06</td>
</tr>
<tr>
<td>Secondary 60-0 day differences:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>m=136; 0.3 (-0.8, 1.4)</td>
<td>0.57</td>
</tr>
<tr>
<td>Informational support</td>
<td>m=138; 1.7 (0.5, 2.9)</td>
<td>0.01</td>
</tr>
<tr>
<td>Emotional support</td>
<td>m=139; 0.1 (-0.9, 1.1)</td>
<td>0.86</td>
</tr>
<tr>
<td>Instrumental support</td>
<td>m=137; 0.8 (-0.2, 1.8)</td>
<td>0.12</td>
</tr>
<tr>
<td>Physical health (global)</td>
<td>m=138; 3.4 (2.5, 4.3)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Mental health (global)</td>
<td>m=139; -1.3 (-2.2, -0.4)</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

\(^{a}\)The total study population included 1029 individuals who were asked to complete an interviewer-administered questionnaire that included PROMIS measures of emotional, social, and physical health on enrollment and at follow-up visits at 30 and 60 days (see Methods). Values reflect mean within-person change in T-scores (± SD for within-person change). A T-score difference of 2 to 5 units is generally considered the MCID; see Methods. Numbers of individuals with missing data are reported as “m.” A positive value (> 0) for the “30-0 differences” and “60-0 differences” indicates higher scores on day 30 compared with day 0 and higher scores on day 60 compared with day 0, respectively. Thus, a positive value for differences indicates more of the construct assessed (ie, higher anxiety, higher informational support, higher emotional support, higher instrumental support, higher physical health, or higher mental health). Except for anxiety, a positive difference indicates improvement. A negative difference (< 0) for anxiety indicates improvement.
Figure 3. Change in anxiety from enrollment to 30 and 60 days postdischarge, by study group

Note: The P values above the horizontal mirror bar plot represent bivariate (unadjusted) comparisons between groups using t tests among nonmissing values. The analyses prespecified a 2-sided $\alpha = 0.025$ for comparisons at 30 days between groups (primary time point for analyses of the 2 co-primary outcomes: anxiety and informational support), and a 2-sided $\alpha = 0.05$ for all other comparisons.
Figure 4. Change in informational support from enrollment to 30 and 60 days postdischarge, by study group

Note: The P values above the horizontal mirror bar plot represent bivariate (unadjusted) comparisons between groups using t-test among nonmissing values. The analyses prespecified a 2-sided α = 0.025 for comparisons at 30 days between groups (primary time point for analyses of the 2 co-primary outcomes: anxiety and informational support), and a 2-sided α = 0.05 for all other comparisons.

In multivariable analyses that accounted for potential confounders (prespecified primary analyses), we found no significant between-group differences in the 30-day change in either anxiety (Navigator vs usual care, adjusted difference: −1.6; 97.5% CI, −3.3 to 0.06; p = 0.031) or in informational support (Navigator vs usual care, adjusted difference: 0.0; 97.5% CI, −2.0 to 1.9; p = 0.99). Sensitivity analyses that employed multiple imputations for missing primary outcome data assuming MAR (Navigator vs usual care, adjusted difference in anxiety: −1.6, 97.5% CI, −3.4 to 0.2; adjusted difference in informational support: 0.2, 97.5% CI, −1.9 to...
2.3) or NMAR (Navigator vs usual care, adjusted difference in anxiety: −1.1, 97.5% CI, −2.9 to 0.6; adjusted difference in informational support: 0.5, 97.5% CI, −2.6 to 1.5) yielded qualitatively similar results as the complete-case analyses. We also conducted PPAs for the primary outcome (see “Secondary Specific Aim 4”). The 30-day change in anxiety did not significantly differ between the 219 participants in the Navigator group who received the intervention per protocol and the 511 usual care participants (Navigator group per protocol vs usual care, adjusted difference: −0.9; 97.5% CI, −3.0 to 1.1; \( p = 0.31 \)). Similarly, the 30-day change in information support did not significantly differ between the 219 participants in the Navigator group who received the intervention per protocol and the 511 usual care participants (Navigator group per protocol vs usual care, adjusted difference: −0.9; 97.5% CI, −3.4 to 1.5; \( p = 0.39 \)).

We also did not find significant between-group differences at 60 days in anxiety and in informational support in multivariable analyses (Navigator vs usual care, adjusted difference: −1.4, 95% CI, −3.1 to 0.2, \( p = 0.09 \); adjusted difference: 0.1, 95% CI, −1.7 to 1.9, \( p = 0.88 \)), respectively.

Change in Other PROMIS Measures of Emotional, Social, and Physical Health From Enrollment to 30 Days Postdischarge (secondary outcomes) and 60 Days Postdischarge (secondary outcomes). Both the usual care and Navigator groups experienced significant improvements in physical health at 30 days and in both physical and mental health at 60 days (Table 3). We also found a significant improvement in instrumental support in the usual care group at 30 days, but not in the Navigator group; however, none of the between-group differences in these secondary outcomes were significant in bivariate analyses at 30 or 60 days (all \( P \) values for pair-wise comparisons > 0.6; data not shown). We observed similar results in multivariable analyses that accounted for potential confounders; none of the between-group differences in the PROMIS-related secondary outcomes were significant at 30 or 60 days (all comparisons of adjusted differences at 30 days had \( P \) values > 0.5 and at 60 days had \( P \) values > 0.6).
Health Care Utilization Outcomes (secondary outcomes). We found no significant differences in outpatient visit attendance at 14 days (Table 4). Also, 30-day or 60-day measures of death, death or hospitalization, and death or hospitalization or ED visits were not significantly different between groups.

Table 4. 14-, 30-, and 60-day Health Care Utilization Outcomes

<table>
<thead>
<tr>
<th>Healthcare utilization outcome</th>
<th>Usual care (N=511)</th>
<th>Intervention (N=518)</th>
<th>Difference p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visit within 1-14 days (self-reported)</td>
<td>m=106; 137 (34%)</td>
<td>m=130; 112 (29%)</td>
<td>0.13</td>
</tr>
<tr>
<td>Outpatient visit within 1-14 days (EHR-reported)</td>
<td>m=0; 236 (46%)</td>
<td>m=11; 232 (46%)</td>
<td>0.89</td>
</tr>
<tr>
<td>Death within 0-30 days</td>
<td>m=9; 4 (0.8%)</td>
<td>m=22; 7 (1.4%)</td>
<td>0.35</td>
</tr>
<tr>
<td>Death within 0-60 days</td>
<td>m=19; 9 (1.8%)</td>
<td>m=32; 9 (1.8%)</td>
<td>0.98</td>
</tr>
<tr>
<td>Death or hospitalization within 0-30 days</td>
<td>m=8; 100 (20%)</td>
<td>m=23; 112 (23%)</td>
<td>0.29</td>
</tr>
<tr>
<td>Death or hospitalization within 0-60 days</td>
<td>m=18; 147 (30%)</td>
<td>m=31; 159 (33%)</td>
<td>0.34</td>
</tr>
<tr>
<td>Death, hospitalization, or ED visit within 0-30 days</td>
<td>m=8; 156 (31%)</td>
<td>m=23; 154 (31%)</td>
<td>0.97</td>
</tr>
<tr>
<td>Death, hospitalization, or ED visit within 0-60 days</td>
<td>m=17; 210 (43%)</td>
<td>m=31; 216 (44%)</td>
<td>0.56</td>
</tr>
</tbody>
</table>

Note: We found no significant between-group differences in health care utilization outcomes.

Secondary Specific Aim 3

Examine the effectiveness of the Navigator intervention in patient subgroups.

Exploratory analyses to assess the potential for HTEs for the co-primary outcomes failed to identify subgroups that were significantly more or less likely to benefit from the Navigator intervention (Figures 5 and 6).
Figure 5. Exploratory analyses to identify potential for HTEs for 30-day change in anxiety

Note: Higher PROMIS anxiety scores mean more anxiety (worse outcome). A positive value (> 0) within-group difference in PROMIS anxiety scores at 30 days minus the scores on enrollment indicates worsening anxiety. This Forest plot compares the 30-day change in PROMIS anxiety score in the Navigator group minus the 30-day change in PROMIS anxiety score in the usual care group in multivariable analyses that account for baseline characteristics (adjusted difference; see Methods). A positive value (> 0) between-group adjusted difference in the Forest plot indicates worsening anxiety in the Navigator group compared with usual care group (ie, favors usual care). These exploratory analyses did not identify a patient subgroup, based on baseline characteristics, with significantly different between-group differences in 30-day change in anxiety. A global interaction P value < 0.005 (0.05/10) was considered statistically significant using a Bonferroni adjustment for multiple comparisons. Results are based on complete-case analyses; missing data imputation was not performed.
Figure 6. Exploratory analyses to identify potential for HTEs for 30-day change in informational support

Note: Higher PROMIS Informational support scores mean more support (better outcome). A positive value (> 0) within-group difference in PROMIS Informational support scores at 30 days minus the scores on enrollment indicates improvement. This Forest plot compares the 30-day change in PROMIS Informational support score in the Navigator group minus the 30-day change in PROMIS Informational support score in the usual care group in multivariable analyses that account for baseline characteristics (adjusted difference; see Methods). A positive value (> 0) between-group adjusted difference in the Forest plot indicates improvement in the Navigator group compared with usual care group (ie, favors Navigator group); note direction of difference favoring Navigator group is different than in Figure 5. These exploratory analyses did not identify a patient subgroup, based on baseline characteristics, with significantly different between-group differences in 30-day change in informational support. A global interaction P value < 0.005 (0.05/10) was considered statistically significant using a Bonferroni adjustment for multiple comparisons. Results are based on complete-case analyses; missing data imputation was not performed.
Secondary Specific Aim 4

Understand the barriers and facilitators of successfully implementing the Navigator intervention across patient populations.

The CHWs worked with study participants in the Navigator group to complete 94% of barrier assessments, 88% of DPETs, and 82% of home visits. The timing and location of hospital-based Navigator interventions occurred per protocol in most cases (barriers assessments and DPETs completed in person during hospitalization in 92% and 62% of Navigator participants, respectively). In 29% of home visits, the CHW completed the work via phone (rather than in person) to facilitate scheduling. Completion of peer coaching calls was more challenging than the interventions delivered by the CHWs. Only 60% of Navigator participants completed 1 or more peer coaching calls (39% completed 3-5 coaching calls). Incomplete coaching calls could have been due to one or more reasons: wrong number, leaving a message with another individual but no return call from the participant, leaving a voice message but no return call, and unable to conduct calls within window periods due to an administrative hold from the IRB. A total of 219 (42%) participants in the Navigator group received the intervention per protocol (77% received CHW-led interventions in the hospital, 75% received CHW-led home visit intervention, and 47% received at least 1 peer coaching call; 42% received all 3 components).

We completed interviews with 21 PArTNER staff members (project managers, coordinators, CHWs, peer coaches, and front-line clinicians) and 10 participants spanning all 5 eligible conditions to identify barriers and facilitators of delivering the Navigator (CHW + peer coaching) intervention. Three overarching themes emerged as potential barriers or facilitators for staff implementing the Navigator intervention (Table 5):

1. **Alignment of study staff roles:** The study staff developed a shared understanding of each staff member’s role, activities, and challenges, as well as the impact these have on each other.

2. **Alignment of staff intervention activities to participant realities:** Implementing the intervention was challenging in an acute care environment (patients were ill and needed medical treatments that would interfere with conducting study procedures) and in a
complex home environment (eg, social determinants of health-related factors, such as a nonworking phone number, affected ability to schedule and conduct home visits).

3. **Alignment of study staff to hospital system staff and beyond:** The study staff highlighted the importance of working relationships with hospital and ambulatory providers when implementing the protocol. These findings present opportunities for further research to improve the operational effectiveness of implementing a patient navigator intervention during in-patient-to-home transitions.

Three overarching themes emerged as potential barriers or facilitators for participants (Table 6):

1. **Awareness:** Elements of the study that participants could recall were limited, so communication supports designed for use in the home and in the outpatient provider’s office would be helpful.

2. **Agreement:** The perceived importance of the intervention varied from patient to patient.

3. **Ability:** Enrollment is only the first step, and connecting with study staff and benefiting from supports delivered by the CHWs and peer coaches can be a challenge. These findings present opportunities for further research to improve the fit of in-person, phone-based, and print-based support systems to the needs of those transitioning from the in-patient setting to home. Frequent hospitalizations, both at the index hospital and other hospitals, also contributed to some confusion among study participants.
<table>
<thead>
<tr>
<th>Themes</th>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alignment of study staff roles</strong></td>
<td>• Training was mostly on-the-job learning.</td>
<td>• Co-located staff were able to communicate frequently to adapt to patients’ dynamic situations in the hospital.</td>
</tr>
<tr>
<td>Developing a shared understanding of each staff member’s role, activities, and challenges, as well as the impact they have on one another</td>
<td>• Dynamic, unpredictable real-world circumstances with patients required on-the-spot decision making for which staff might not have been trained.</td>
<td>• Staff were resourceful in creating their own process solutions and study supports as the needs arose.</td>
</tr>
<tr>
<td></td>
<td>• Staff turnover and added staff necessitated some training time before individuals could perform at their best.</td>
<td>• Having a trusted, responsive project manager helped resolve challenges as they arose.</td>
</tr>
<tr>
<td><strong>Alignment of intervention activities to participant realities</strong></td>
<td>• The real-life context of this project was misaligned to the prescribed processes and timing windows. A chain reaction resulted when one element of the intervention couldn’t be completed in the allotted window of time.</td>
<td>• Staff maintained a highly regimented schedule, some schedules being shifted (7-3, 10-6) in order to process participants as effectively as possible.</td>
</tr>
<tr>
<td>Aligning study processes and purpose to real-world patient contexts and behaviors for successful intervention delivery</td>
<td>• A strong emphasis on recruitment constrained enrollment time and overshadowed retention efforts and updates.</td>
<td>• Training materials and shadowing experienced staff were helpful for staff later in the project.</td>
</tr>
<tr>
<td></td>
<td>• Data entry time burdened an already tight window in which to connect with patients.</td>
<td>• Staff took time when possible to listen to participants.</td>
</tr>
<tr>
<td></td>
<td>• Patients had a variety of reasons for wanting to participate or not (some because of the intervention, some not).</td>
<td>• The study had value for many types of participants.</td>
</tr>
<tr>
<td><strong>Alignment of study staff to hospital system staff and beyond</strong></td>
<td>• At first, the patient navigator might have been seen as duplicating or invading the role of hospital floor staff—the nuances of the navigator’s purpose on the floor was not well understood.</td>
<td>• If seen as a support to staff members, navigators are more likely to be treated as valued teammates.</td>
</tr>
<tr>
<td>Developing strong relationships and value propositions with staff at all levels—inside and outside the hospital</td>
<td>• The nature of the relationship between health system staff and study staff was variable—navigators and peer coaches sometimes faced the same access challenges patients face if unit leadership was unable to engage in their activities.</td>
<td>• Navigators’ and peer coaches’ connections and influence outside the project helped resolve some barriers for participants.</td>
</tr>
<tr>
<td></td>
<td>• Navigators sometimes had to spend a significant amount of time to secure an appropriate resource to address a participant’s barrier.</td>
<td>• Purple Binder was a useful tool to find local resources, and the support team was responsive when desired resources were not included in their database.</td>
</tr>
<tr>
<td>Themes</td>
<td>Barriers</td>
<td>Facilitators</td>
</tr>
<tr>
<td>--------</td>
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</tr>
</tbody>
</table>
| **Awareness**<br>Elements of the study that participants could recall were limited. | • It was difficult for patients to differentiate between the study experience and their overall hospital experience.  
• Most participants remembered the program as “asking me a bunch of questions” rather than as receiving help or resources. | • Getting the gift card was memorable.  
• Many participants recall lists of information that they appreciated. |
| **Agreement**<br>The value proposition of the intervention varied from patient to patient. | • Resources might not have been curated, useful, or emphasized enough to make an impact, potentially resulting in limited engagement with the study.  
• Participants expressed wanting solutions—not just resources.  
• For some, there was not a strong enough return for people to share what was going on with them personally.  
• Many patients felt they didn’t need the support (even if they benefited) or were getting support from other places. | • Patients appreciated the staff’s desire to help others who did need assistance (even if they themselves didn’t need or want it).  
• Some participants wanted connection to other studies.  
• Patients liked simply being contacted and asked how they were doing within a few days of a hospitalization.  
• Patients particularly appreciated someone ensuring they knew how to take their medications/use equipment and what they were for, asking whether they needed help getting in touch with or making an appointment with someone at the hospital or their doctor.  
• Patients also appreciated receiving appointment reminders and dietary support, as well as having someone to answer general questions about their condition. |
| **Ability**<br>Enrollment is only the first step—connecting with study staff and benefiting from the information can be a challenge. | • If a person is discharged before he or she is ready, resources may have minimal impact.  
• Some people might have been too sick to participate.  
• Some participants wanted a longer engagement or more attempts to reach them.  
• Aligning navigator and patient schedules made some home visits difficult. | • Receiving calls on a regular schedule (at the same time on the same day) was beneficial.  
• Patients appreciated that staff made multiple attempts to contact them.  
• Patients appreciated that staff repeated and emphasized information.  
• Many participants recalled the staff as being helpful, polite, and respectful. |
DISCUSSION

Decisional Context

Stakeholder engagement activities and input from patients and their caregivers supported the need for transitional care services to address (1) gaps in the hospital discharge process (eg, incomplete education or information at hospital discharge); (2) socioeconomic resources (eg, difficulty finding or arranging transportation, unstable housing); (3) supports to access postdischarge care (eg, difficulty arranging follow-up appointments); (4) patient self-management practices (eg, use of medications, decisions to seek additional health care); and (5) the importance of addressing patient anxiety (eg, due to apprehension about the possibility of worsening symptoms, insufficient caregiver support at home). We used these findings to finalize the design of the patient-centered pragmatic clinical trial (PArTNER study). In 1029 patients hospitalized with heart failure, pneumonia, myocardial infarction, COPD, or sickle cell disease at an MSI, a Navigator intervention involving CHWs and peer coaches did not improve patient anxiety or information support over the 30-day period after hospital discharge compared with usual care (co-primary outcomes, using a prespecified \( p < 0.025 \)). We also did not find between-group differences in these or other any other outcomes we assessed (including health care utilization) over the 60-day period after hospital discharge. The size of the study and consistent pattern of no difference across multiple measures of emotional, social, and physical health and health care utilization are noteworthy, and are consistent with the mixed pattern of results of other randomized clinical trials examining the role of navigation services by CHWs, telephone coaching, and other patient navigation services.\textsuperscript{10,11,26,27} The following factors can affect the applicability of findings in different contexts: the study population (in PArTNER, adults hospitalized for COPD, myocardial infarction, pneumonia, or sickle cell disease); the intervention design (in PArTNER, in-hospital and home-based navigation provided by CHWs, with additional support by peers via telephone) and fidelity of execution (in PArTNER, moderate to high for CHWs, low for peer coaches); the comparator intervention (care received in the control group); and the prespecified primary outcomes (in PArTNER, patient-reported anxiety and informational support). The PArTNER study is unique in its focus on patient experience over the course of 60 days, and adds to the growing body of evidence that
the effectiveness of navigation services in one population or setting may not transfer to another.

**Generalizability of the Findings**

The focus on several CMS penalty-sensitive conditions for hospital readmissions (heart failure, pneumonia, COPD, myocardial infarction) as well as sickle cell disease, a condition responsible for some of the highest readmission rates of Medicaid beneficiaries, is potentially relevant to many health systems in the United States. However, we conducted our study in a single, state-supported MSI with relatively good transitional care services (except for education about home medications and a phone contact within 2 business days of hospital discharge); these factors could limit the external validity of study findings.

**Implementation of Study Results**

As our study did not significantly improve the primary or secondary outcomes, we cannot advocate for the use of CHWs and a phone-based peer coaching model of a navigator intervention to improve hospital-to-home transitions. While we had relatively high fidelity in implementing the CHW-based hospital and home interventions (> 80% completed), the peer coaching intervention was less reliably completed (40% did not complete a single coaching call). Our debriefing with study staff determined that a greater coordination between the various members of the PArTNER study staff, a greater alignment between study processes and real-world patient contexts, and a higher level of integration between the study and hospital operations could have strengthened the effectiveness of the Navigator intervention. A number of patient-level barriers to and facilitators of implementing the Navigator intervention were also identified, including the need for greater personalization between what the patient needed and the information/support he or she was provided (eg, the most common barrier to health and health care was insecurity with employment/income, in 63% of participants). These findings could inform the design of future studies.
Subpopulation Considerations

Our exploratory analyses failed to identify any significant evidence of HTEs according to various baseline characteristics (demographic, socioeconomic, clinical, and usual source of health care).

Study Limitations

While we employed a randomized clinical trial design in a large study population (more than 1000 participants), the study activities took place at a single MSI and could therefore limit external validity. Also, difficulty in implementing some aspects of the Navigator intervention (especially peer coaching) might have reduced our ability to detect differences in outcomes between groups. Another potential limitation is the missing data for our co-primary outcomes in slightly more than 20% of study participants; participants with missing data were about 3 years younger than those without missing data. Although no other baseline characteristics that were assessed differed according to the presence or absence of co-primary outcome data, we cannot exclude the potential for a systematic bias (selection bias). The results of sensitivity analyses using 2 different approaches for multiple imputation, which yielded qualitatively and quantitatively similar results as the complete-case analyses, argue against a selection bias due to missing data. We have moved the data about fidelity of the intervention implementation to this section and reframed these data as information about completion of the multicomponent intervention. Also, we designed the study to focus on the effectiveness of the multicomponent intervention rather than on implementation outcomes (eg, acceptability, fidelity, sustainability).28

Future Research

Our study found substantial evidence of socioeconomic-related barriers to health and health care, most commonly employment and income (> 60% of participants), followed by gaps in family and social supports, transportation, housing, utility, and food. Taken together with the high rates of health care utilization at 30 and 60 days, our study suggests the need for multilevel interventions that address more broadly the context in which people live, work, and get health care. Multilevel interventions are needed to more effectively address core social
issues, such as employment and income security. Interventions limited to the health care sector alone are unlikely to have impact; such studies should also include interventions that are integrated into existing clinical programs used by hospitals, appropriately tailored to the study context (people, infrastructure, organizational capacity for change), and with audit and feedback mechanisms to promote intervention fidelity (especially for the peer-to-peer coaching intervention). Patient advocacy organizations rather than study personnel or staff at the hospital performed the peer-to-peer telephone coaching. The limited number of completed coaching calls highlights the need for real-time monitoring and feedback for all study partners, including those outside of health systems. Our study also reinforces the need to pilot the bundle of interventions in the actual study context, even if elements of the intervention have been previously used successfully.\textsuperscript{10,11,26,27} We hope the lessons learned from the PArTNER study are of interest to hospital leaders and staff who plan transitions from hospital to home, policymakers considering the role of patient navigators in supporting hospital-to-home transitions, and researchers who intend to conduct subsequent studies.
CONCLUSIONS

The principal aim of the PArTNER study was to conduct a randomized 2-arm parallel group, pragmatic single-center clinical trial comparing the effectiveness of a Navigator intervention (CHWs and peer coaches to support patients during hospital-to-home transitions) compared with usual care. The target population was > 1000 adults hospitalized at an MSI with heart failure, pneumonia, myocardial infarction, COPD, or sickle cell disease, to be aligned with conditions emphasized by readmissions reduction programs developed by CMS. Given the lack of effect on the primary outcomes, we do not advocate implementing our Navigator intervention as a transitional care service at MSIs to improve anxiety or informational support during hospital-to-home transitions. We did, however, observe within-group improvements in anxiety, informational support, and some secondary PROMIS measures in the Navigator and usual care groups. Results of this study therefore provide further justification for the use of concurrent controls to rigorously evaluate interventions to improve health care systems.
REFERENCES


RELATED PUBLICATIONS

ACKNOWLEDGMENTS

We acknowledge funding from the Patient-Centered Outcomes Research Institute (contract No. IH 12-11-4365) and the helpful oversight by our program officer, Carly Parry, PhD, MSW, MA. We also express our appreciation for the patients who elected to participate in the study, as well as their caregivers, clinicians and staff at UI Health, the PArTNER research team, members of the PArTNER DSMB, members of the PArTNER External Advisory Committee, and the University of Illinois Institutional Review Board.
APPENDICES

Appendix 1: Barrier Assessment Questionnaire
Appendix 2: Commonly used community resources in the PArTNER intervention
Appendix 3: PArTNER Discharge Patient Education Tool (DPET)
Appendix 4: Usual Care Assessment form

Patient Navigators to Prevent Re-hospitalizations. Focus Group Moderator Guide: Clinician & Administrator Focus Group Interview
### Appendix 1: Barrier Assessment Questionnaire

<table>
<thead>
<tr>
<th>Barrier domain</th>
<th>Question number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment and Income insecurity</td>
<td>44, 45, 72, 73, 74</td>
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<tr>
<td>Family and social support insecurity</td>
<td>32, 42, 43, 49</td>
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<tr>
<td>Transportation needs</td>
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<tr>
<td>Housing insecurity</td>
<td>36, 39</td>
</tr>
<tr>
<td>Utility Insecurity</td>
<td>40, 84</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>50</td>
</tr>
<tr>
<td>Interpersonal violence</td>
<td>100</td>
</tr>
</tbody>
</table>
Barrier Assessment

ID # __________________________________
Date __________________________________
Coordinator initials __________________________________
Admitting diagnosis __________________________________
Start time __________________________________

Language
(Please read all the questions to the participant. Anything in parenthesis should not be read out loud to the participant).
(If participant refuses or says 'don't know' code as '999')

1. Is English your primary language
   - Yes (Go to 4)
   - No. (Go to 2)
   - Refused

2. Which language are you most comfortable communicating in?

3. Do you have problems finding a language interpreter?
   - Always
   - Sometimes
   - Never
   - Refused

Physical Limitations
First I would like to ask you about your health

4. In general, would you say your health is...
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor
   - Refused

5. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair? (PROMIS-Physical)
   - Completely
   - Mostly
   - Moderately
   - A little
   - Not at all
   - Refused

6. Do you use any of the following medical equipment? (check all that apply) (Modified NHIS)
   - Wheel chair
   - Walking stick/cane
   - Oxygen tank
   - Scooter
   - Crutches
   - Walker
   - Other
   - None
   - Refused

7. If Other, please specify ________________________________
8. Do you have any difficulty with your eyesight? (Modified NHIS)
   - Yes (Go to 9)
   - No (Go to 10)

9. If 'Yes', please explain

10. Do you have any difficulty with your hearing? (Modified NHIS)
    - Yes (Go to 11)
    - No (Go to 13)

11. If Yes, please explain

12. Comments

---

**Principal Diagnosis and Comorbidities**

Have you been told by a doctor or healthcare professional that you have any of the following health problems?

13. Chronic Obstructive Pulmonary Disease (COPD) such as emphysema and chronic bronchitis?
   - Yes
   - No
   - Refused

14. Heart Failure?
   - Yes
   - No
   - Refused

15. Sickle Cell Disease?
   - Yes
   - No
   - Refused

16. Pneumonia?
   - Yes
   - No
   - Refused

17. Myocardial Infarction (Heart Attack)?
   - Yes
   - No
   - Refused

18. Diabetes?
   - Yes
   - No
   - Refused

19. Arthritis?
   - Yes
   - No
   - Refused

20. Cancer?
   - Yes
   - No
   - Refused

21. Depression?
   - Yes
   - No
   - Refused

22. Bipolar disorder?
   - Yes
   - No
   - Refused

23. Anxiety disorder?
   - Yes
   - No
   - Refused

24. Other mental health condition?
   - Yes
   - No
   - Refused
25. If yes, please specify __________________________________

26. Comments ____________________________________________

**Psychological**

27. In the past seven days have you ever been bothered by emotional problems, such as feeling anxious, depressed or irritable? (PROMIS- Anxiety)

- Never
- Rarely
- Sometimes
- Often
- Always
- Refused

**Medications**

**The following questions are about your current medications**

28. Are you currently taking 5 or more medications every day?

- Yes
- No
- Refused

What medications were you taking prior to coming to the hospital?

29a. Medication (1) ________________________________________

29b. Medication (2) _______________________________________

29c. Medication (3) _______________________________________

29d. Medication (4) _______________________________________

29e. Medication (5) _______________________________________

29f. Medication (6) _______________________________________

29g. Medication (7) _______________________________________

29h. Medication (8) _______________________________________

29i. Medication (9) _______________________________________

29j. Medication (10) ______________________________________

People sometimes have a hard time remembering to take their medications.

30. How often do you have difficulty remembering to take all of your medications? (Modified Morisky)

- Never/Rarely
- Sometimes
- Always
- Refused

31. Do you sometimes forget to take your medications? (Morisky)

- Yes
- No
- Refused

32. Do you ever have difficulty getting the medication you need?

- Yes
- No
- Refused

33. What makes it hard to get your medications?

- No transportation
- Cannot afford medications
- Other
34. If other, specify

35. Comments

<table>
<thead>
<tr>
<th>Patient Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. What type of housing do you live in?</td>
</tr>
<tr>
<td>○ Place that you own</td>
</tr>
<tr>
<td>○ Place that you rent</td>
</tr>
<tr>
<td>○ In a friend's or family member's place</td>
</tr>
<tr>
<td>○ Senior independent living community</td>
</tr>
<tr>
<td>○ Shelter</td>
</tr>
<tr>
<td>○ Don't currently have a place to live</td>
</tr>
<tr>
<td>○ Other</td>
</tr>
<tr>
<td>○ Don't know</td>
</tr>
<tr>
<td>○ Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>37. If Other, please specify</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>38. How long have you stayed at your current residence?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ One week or less</td>
</tr>
<tr>
<td>○ More than one week, but less than one month</td>
</tr>
<tr>
<td>○ One to three months</td>
</tr>
<tr>
<td>○ More than three months but less than one year</td>
</tr>
<tr>
<td>○ One year or longer</td>
</tr>
<tr>
<td>○ Don't know</td>
</tr>
<tr>
<td>○ Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>39. How worried are you right now about not being able to pay your rent, mortgage or other housing costs? Are you..... (NHIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Very worried</td>
</tr>
<tr>
<td>○ Somewhat worried</td>
</tr>
<tr>
<td>○ Not all worried</td>
</tr>
<tr>
<td>○ Refused</td>
</tr>
<tr>
<td>○ Don't know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>40. Do you ever have difficulty paying for your utility bills (electricity, gas, water etc.)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
</tr>
<tr>
<td>○ No</td>
</tr>
<tr>
<td>○ Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>41. On average, how many people live with you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ 0</td>
</tr>
<tr>
<td>○ 1</td>
</tr>
<tr>
<td>○ 2</td>
</tr>
<tr>
<td>○ 3</td>
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<tr>
<td>○ 4</td>
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<td>○ 5</td>
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<td>○ 6</td>
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<td>○ 7</td>
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<tr>
<td>○ 8</td>
</tr>
<tr>
<td>○ 9</td>
</tr>
<tr>
<td>○ 10 or more</td>
</tr>
<tr>
<td>○ Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>42. Do you have someone to take you to the doctor if you need it? (PROMIS-Instrumental Support)</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ Rarely</td>
</tr>
<tr>
<td>○ Sometimes</td>
</tr>
<tr>
<td>○ Usually</td>
</tr>
<tr>
<td>○ Always</td>
</tr>
<tr>
<td>○ Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>43. Do you have someone to help you with your daily chores if you are sick? (PROMIS-Instrumental Support)</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ Rarely</td>
</tr>
<tr>
<td>○ Sometimes</td>
</tr>
<tr>
<td>○ Usually</td>
</tr>
<tr>
<td>○ Always</td>
</tr>
<tr>
<td>○ Refused</td>
</tr>
</tbody>
</table>
44. Does your medical condition prevent you from working?
   - Always
   - Sometimes
   - Never
   - Does not work for other reason
   - Refused

45. Are you worried that you may lose your job for taking too many sick days?
   - Always
   - Sometimes
   - Never
   - Does not work
   - Refused

46. Are you currently the main caregiver for a family member or friend? (Modified NHIS)
   - Yes (Go to 47)
   - No (Go to 50)
   - Refused

47. Is the person(s) you take care of... (check all that apply) (Modified NHIS)
   - Spouse/Partner
   - Parent
   - Adult child
   - Minor child
   - Grandchild
   - Sibling
   - Friend
   - Other
   - Refused

48. If 'other', please specify

49. Does your caregiving responsibilities make it difficult for you to go to your medical appointments?
   - Yes
   - No
   - Refused

50. Do you ever have difficulty getting healthy meals? (Modified NHIS)
   - Yes (Go to 51)
   - No (Go to 53)
   - Refused

51. What makes it difficult for you to get healthy meals? (let participant explain, and then code appropriately)
   - Cannot afford
   - Lack of access
   - No transportation
   - Physical limitations prevent grocery shopping
   - Other

52. Comments

Prior Hospitalizations

53. In the past 12 months how many times have you gone to the emergency room about your own health? Include emergency room visits that resulted in hospital admissions. (Modified NHIS)

54. In the past 12 months, how many times have you been admitted to the hospital and stayed overnight? (NHIS)

55. Comments
Providers

56. When you feel sick, where do you usually go for medical care? (check all that apply) (Modified NHIS)

- Doctor's office/private clinic
- Community health center/clinic
- Hospital based clinic
- Emergency room
- Some other place
- Refused

57. If Other, please specify __________________________________

58. Do you have a regular Primary Care Provider (PCP)?

- Yes (Go to 60.)
- No (Go to 59)
- Refused

59. Why don't you have a Primary Care Provider? (Check all that apply) (NHIS)

- Doesn't need a doctor/haven't had any medical problems
- Doesn't like/trust/believe in doctors
- Previous doctor is not available or moved
- Doesn't know where to go
- Too expensive/no insurance/cost
- Speaks a different language
- No care available/ care too far away/inconvenient
- Put it off/ didn't get around to it
- Other
- Refused

60. Do you feel comfortable speaking to healthcare providers about your health condition?

- Always
- Sometimes
- Never
- Refused

61. Have you felt disrespected or treated rudely by the staff at a hospital or at a medical clinic you that you have visited?

- Always
- Sometimes
- Never
- Refused

Medical Mistrust

Next, I would like to ask you questions about how you feel about healthcare organizations. When I say healthcare organizations, I am not asking about an individual doctor or nurse or any other person like that. I am asking about organizations where you might get healthcare, like a hospital or a clinic, the healthcare system in general.

62. Patients have been sometimes deceived or misled by healthcare organizations (Medical Mistrust Index)

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Refused

63. Sometimes I wonder if healthcare organizations really know what they are doing. (Medical Mistrust Index)

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Refused

64. Do you trust the information that healthcare providers give you?

- Always
- Sometimes
- Never
- Refused

65. Comments
Next I am going to ask you some questions about any difficulty you have getting to your medical appointments.

66. Do you sometimes have difficulty getting transportation to the hospital/clinic/Dr's office where you get medical care?  
- Yes  
- No  
- Refused

67. Do you think the hospital or clinic where you get medical care is too far away?  
- Yes  
- No  
- Refused

68. Comments __________________________________

Health Insurance

69. Do you currently have health insurance?  
(Modified NHIS)  
- Yes (Go to 70)  
- No (Go to 75)  
- Refused

70. What type of insurance do you have? (NHIS)  
- Private health insurance (HMO, PPO, Fee-for-service)  
- Medicare  
- Medicaid ("Family Care" / "Moms & Babies" / "County Care")  
- Military health care (TRICARE / VA / CHAMP-VA  
- Medigap  
- Indian health service  
- Other government program  
- Single service plan (e.g., dental, vision, prescriptions)  
- Other  
- Refused

71. If 'other', please specify __________________________________

Do you ever have any difficulty paying for your...

72. Insurance premium, which is an amount paid on a monthly basis to the insurance company?  
- Yes  
- No  
- Refused

73. Insurance deductible, which is an amount paid out of pocket before the insurance company will pay for any expenses?  
- Yes  
- No  
- Refused

74. Insurance co-pay, which is an amount you have to pay for a medical service, usually when you get the service?  
- Yes  
- No  
- Refused

75. Was there a time in the past 12 months when you needed medical care, but could not get it?  
(NHIS)  
- Yes  
- No  
- Refused
76. What were the reasons you did not get medical care? (Let participant answer, and then check all that apply)

- Cost
- No childcare
- No transportation
- Distance
- Office wasn’t opened when I got there
- Too long a wait for an appointment
- Too long a wait in waiting room
- No access for people with disabilities
- The medical provider didn’t speak my language
- Did not understand what my health insurance plan covers
- Other
- Refused

77. If 'other', please specify? __________________________________

78. Do you currently need any help in filling out paperwork for insurance or any other benefits?

- Yes
- No
- Refused

79. Do you currently need any help in getting copies of important documents such as birth certificate, State ID, etc.?

- Yes
- No
- Refused

80. Do you have a landline telephone in your household? (Pew internet and American Life Project poll)

- Yes
- No
- Refused

81. Do you have a cell phone, Blackberry, iPhone, or other device that is also a cell phone? (Pew internet and American Life Project poll)

- Yes (Go to 82)
- No (Go to 84)
- Refused

82. Some cell phones are called "smartphones" because of certain features they have. Is your cell phone a smartphone, such as an iPhone, Android, Blackberry or Windows phone, or are you not sure? (Pew internet and American Life Project poll)

- Smartphone
- Not a smartphone
- Not sure
- Refused

83. What kind of cell phone plan do you have? Is it (Pew internet and American Life Project poll)

- a prepaid or pay-as-you-go plan,
- a family plan where your phone is part of a contract that covers your family's cell phones, or
- a separate contract covering only your cell phone?

84. Do you need any help getting a cell phone for yourself?

- Yes
- No
- Refused

85. Comments __________________________________

---

Social History

86. How often do you have a drink containing alcohol? (AUDIT-C)

- Never (Go to 89.)
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week
- Refused

87. How many standard drinks containing alcohol do you have on a day when you drink? (AUDIT-C)

- 1-2
- 3-4
- 5-6
- 7-9
- 10 or more
- Refused
88. How often do you have six or more drinks on one occasion? (AUDIT-C)

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily
- Refused

89. Have you smoked at least 100 cigarettes in your entire life? (NHIS)

- Yes (Go to 90)
- No (Go to 91)
- Refused

90. How old were you when you first started to smoke fairly regularly? (NHIS)

- Every day
- Some days
- Not at all
- Refused

91. Do you now smoke cigarettes... (NHIS)

- Every day
- Some days
- Not at all
- Refused

92. How long has it been since you quit smoking cigarettes? (NHIS)

93. What is the average number of cigarettes that you smoke (or used to smoke, if you have quit) in one day? 1 pack=20 cigarettes (Modified NHIS)

94. For how many years have you smoked (or did you smoke) this amount? (Modified NHIS)

95. In your home?

- 0
- 1-10
- 11-20
- 21-30
- 31-40
- 41 or more
- Refused

96. In other indoor places (including work)?

- 0
- 1-10
- 11-20
- 21-30
- 31-40
- 41 or more
- Refused

97. In the last year, have you used illicit drugs such as heroin, cocaine, marijuana or others? (Modified National Survey on Drug Use and Health)

- Yes (Go to 98)
- No (Go to 100)
- Refused

98. Which drugs did you use?

99. In the last year have you felt you wanted or needed to cut down on your drug use? Would you say... (TICS- Two Item Conjoint Screen)

- Always
- Sometimes
- Never
- Refused

100. Do you ever feel like you live in an emotionally abusive or violent home?

- Always
- Sometimes
- Never
- Refused

101. Is there anything we didn’t talk about today that you think affects your health?

102. Comments
End Time

---

To be completed by staff. Do not ask participant

103. Reviewed by: ________________________________

104. Date of review ________________________________

105. Data entered by: ________________________________

106. Date of data entry ________________________________
### Appendix 2: Commonly used community resources in the PArTNER intervention

<table>
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<th>Page number</th>
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</thead>
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<td>Applications for Benefits eligibility</td>
<td>2</td>
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<tr>
<td>Pharmaceutical Assistance Program</td>
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<tr>
<td>Special needs school</td>
<td>4</td>
</tr>
<tr>
<td>Hospital services</td>
<td>5</td>
</tr>
<tr>
<td>Community Care Program</td>
<td>6</td>
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<tr>
<td>Ruth M. Rothstein Core Center</td>
<td>7, 8</td>
</tr>
<tr>
<td>Veterans Crisis Line</td>
<td>9, 35</td>
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<tr>
<td>Homeless outreach</td>
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</tr>
<tr>
<td>Food pantry</td>
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<tr>
<td>Emergency shelter</td>
<td>12</td>
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<tr>
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<td>Resource guide for people with disabilities</td>
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</tr>
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<td>17, 18, 19</td>
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<tr>
<td>SNAP/ Food stamp outreach</td>
<td>20, 24</td>
</tr>
<tr>
<td>Community Service Centers</td>
<td>22</td>
</tr>
<tr>
<td>Mile Square Health Center (UIC)</td>
<td>23</td>
</tr>
<tr>
<td>Illinois Eye and Ear Infirmary</td>
<td>25</td>
</tr>
<tr>
<td>Vision of Hope</td>
<td>26</td>
</tr>
<tr>
<td>Sickle Cell Center</td>
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</tr>
<tr>
<td>State ID card</td>
<td>28, 29, 30</td>
</tr>
<tr>
<td>Nutrition and Wellness Center</td>
<td>34</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>36</td>
</tr>
<tr>
<td>Free cell phone</td>
<td>38</td>
</tr>
<tr>
<td>Child Care resource and referral</td>
<td>39</td>
</tr>
<tr>
<td>New or replacement social security number and card</td>
<td>40, 41, 42</td>
</tr>
<tr>
<td>Immigration services</td>
<td>43</td>
</tr>
<tr>
<td>Resource guide for people with disabilities</td>
<td>44</td>
</tr>
<tr>
<td>Community Technology Center</td>
<td>45</td>
</tr>
<tr>
<td>Center for working families</td>
<td>46</td>
</tr>
<tr>
<td>Illinois Job Link</td>
<td>47</td>
</tr>
</tbody>
</table>
Appendix 2: Commonly used community resources in the PARtNER intervention

Application for Benefits Eligibility (ABE)
State of Illinois

Online application for individuals and families in Illinois to determine their eligibility and apply for healthcare, food assistance, cash assistance and Medicare Savings programs.

Intake phone
800-843-6154

Hours
Website: 24 Hours

Chicago, IL.

How to Access
To apply for benefits, start your application online (https://abe.illinois.gov/abe/access/accessController?id=0.1890233180484555).

Description
Use this site to apply for healthcare, food and cash assistance.

Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) helps low income people and families buy the food they need for good health. Benefits are provided on the Illinois Link Card - an electronic card that is accepted at most grocery stores.

Temporary Assistance for Needy Families (TANF) provides temporary financial and Healthcare Coverage for pregnant women and families with one or more dependent children. TANF provides financial assistance to pay for food, shelter, utilities and expenses other than medical.

Aid to the Aged, Blind and Disabled (AABD) Cash is for people who are aged, blind and/or disabled and need money. A person who is eligible for the AABD Cash program receives cash and Healthcare Coverage.

Illinois offers coverage to eligible children, adults, seniors and people with disabilities. These programs provide access to healthcare at a reasonable cost.

Eligibility

- To determine if you are eligible for services, use the ABE Screener (https://abe.illinois.gov/abe/access/accessController?id=0.17427738859980713).

http://app.purplebinder.com/programs/application-for-benefits-eligibility-abe?q=0&i=1&nf=0&p=1&q=Medicare
Find a Park
Chicago Park District

Tool to locate public parks in Chicago.

Intake phone
312-742-PLAY (7529)

How to Access
Search for a Chicago Park near you with the Find a Park (http://www.chicagoparkdistrict.com/parks/search/) online tool.

Contact the Chicago Park District online (http://www.chicagoparkdistrict.com/contact/) for additional information and/or with questions.

Description
The Find a Park tool allows individuals to find local parks by park name, community, zip code and/or facility. Information includes park location, hours and contact telephone number.

Eligibility

- All welcome!
Pharmaceutical Assistance Program

Medicare

Online tool to search for prescription drugs that are available at a discount or free through their manufacturer.

Hours
Website: 24 Hours

Chicago, IL
1-800-MEDICARE

How to Access
Pharmaceutical search is available to anyone.

Description
Some pharmaceutical companies offer assistance programs for the drugs they manufacture. Clients may search the database, by drug name, to see if there are any discount programs available. Eligibility requirements and application information are listed for each program.

Eligibility
Eligibility requirements vary by program. Check individual programs for complete list.

http://app.purplebinder.com/programs/pharmaceutical-assistance-program?i=8&J=cntcrs=1&nf=0&p=1&q=M

3/3/2016
Special Needs School
Chicago Lighthouse for People Who Are Blind or Visually Impaired

School for children and young adults with multiple disabilities.
Intake phone
312-666-1331
1850 W. Roosevelt Rd.
Chicago, IL 60608

How to Access
Referrals go directly to the Development Center by the local school districts, which pay the school tuition once the placement is approved, at no cost to the students and their families.

Contact Mary Zabelski by phone at 312-666-1331, ext. 3675 or by e-mail at mary.zabelski@chicagolighthouse.org (mailto:mary.zabelski@chicagolighthouse.org) for additional information and/or with questions.

Description
The Chicago Lighthouse Development Center offers the tools leading to independence and is a specialized therapeutic day school program, fully approved by the Illinois State Board of Education. The program emphasizes an educational and functional skills curriculum that fits each individual student’s age and needs.

Individual Educational Plans (IEP’s) are developed in collaboration with the local school district, staff and parents to accommodate the needs of each child. These needs are determined by formal assessment scales as well as through evaluations by certified special education teachers and licensed consultants in the areas of: speech therapy, physical therapy, occupational therapy, social work, nursing, psychology, orientation and mobility, vision and hearing. The school program, Illinois State Board of Education approved, runs twelve months, 5 1/2 hours a day with respite.

Eligibility
- For children age 3yo-21yo.
- For students with multiple disabilities, which may include blindness/visual impairments and moderate to severe/profound cognitive impairments.


Appendix 2: Commonly used community resources in the PARThER intervention
Appendix 2: Commonly used community resources in the PArTNER intervention

Hospital Services
University of Illinois Hospital & Health Sciences System (UIC)

Intake phone
312-996-7296

Hours
24/7, 7 days a week, 365 days a year

University Of Illinois Hospital & Health Sciences System
1740 West Taylor Street
Chicago, IL 60612

How to Access
Emergency room services are available 24/7 for urgent medical needs. Walk-in for services.
Call 312-996-7296 for additional information.

Please be prepared to provide:
- Photo ID
- Insurance information
- Income information (for those without insurance)
- Immunization card (for pediatric appointments ONLY)

Description
University of Illinois Hospital & Health Sciences System is made up of a 495-bed tertiary Hospital. Hospital services include:
- Children's Hospital/Pediatric (https://hospital.uillinois.edu/Patient_Care_Services/Pediatrics/Childrens_Hospital.html)
- Intensive Care Unit
- Orthopaedics (https://hospital.uillinois.edu/Patient_Care_Services/Orthopaedics.html)
- Rehabilitation
- Sickle Cell Center (https://hospital.uillinois.edu/Patient_Care_Services/Sickle_Cell.html)
- Medical/Surgical ICU
- Neurology/Neurosurgery ICU
- Neuro/Cardiac Stepdown
- GI/Liver Unit
- Transplant/ICU
- Dialysis
- General Surgery
- General Internal Medicine
- Medical Step down
- Medical Oncology
- Bone Marrow/Stem Cell
- Surgical Oncology
- Adult/Clinical Psychiatry
- Psychiatry Research
- Adolescent Psychiatry
- OB/GYN (https://hospital.uillinois.edu/Patient_Care_Services/Obstetrics_and_Gynecology.html)
- NICU (https://hospital.uillinois.edu/Patient_Care_Services/Pediatrics/Childrens_Hospital/Areas_of_Expertise/Neonatal_-_Perinatal_Medicine.html)
- Labor & Delivery
- GI Lab
- Respiratory/Pulmonary
- Cardiology/Cardiac Cath Labs
- Nuclear Medicine
- Imaging/Radiology
- Social work
- Emergency Room
- Blood Bank

http://app.purplebinder.com/programs/hospital-services/?i=7&l=1&mc=1&nf=0&p=1&q=social+services

3/3/2016
Community Care Program
Illinois Department on Aging

Supportive services for seniors, including adult day care and in-home services.

Intake phone
800-252-8966
Hours
M-F 8:30am-5:00pm

Chicago, IL

How to Access
Call the Senior Helpline at 800-252-8966, TTY: 888-206-1327.
Persons who have medical services through a Medicaid managed care organization should contact their care coordinator about the need for in-home services and for assistance with a referral.

Description
Services include:

Adult Day Services
Adult Day Service is designed especially for older adults who want to remain in the community but who cannot be home alone during the day due to a physical, mental and/or mental impairment. Adult day service also provides respite for family caregivers, especially those who are employed outside the home, and socialization for isolated adults. Services offered in adult day service centers include health monitoring, medication supervision, personal care and recreational/therapeutic activities. Nutritious lunches and snacks are served and special diets are provided. Several centers may specialize in providing care to participants diagnosed with Alzheimer's disease and related disorders while others target specific ethnic populations.

Emergency Home Response Service
Emergency Home Response Service (EHRS) is a 24-hour emergency communication link to assistance outside the home for older adults with documented health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the client that will automatically link the older adult to a professionally staffed support center.

In-Home Services
This Community Care Program service provides assistance with household tasks such as cleaning, planning and preparing meals, doing laundry, and shopping and running errands. Homescare Aides also assist participants with personal care tasks such as dressing, bathing, grooming and following special diets.

Eligibility

- Eligible participants are:
  - U. S. citizen or legal alien
  - Resident of the State of Illinois
  - Age 60 or older
  - Medicaid eligible
  - At risk of nursing facility placement as measured by the Determination of Need (DON) assessment.
- Estimated cost to the State for home care must be less than estimated cost for institutional care.
- Individuals must be able to be safely maintained in the home or community-based setting with the services provided in the plan of care.


Appendix 2: Commonly used community resources in the PArTNER intervention
Ruth M. Rothstein CORE Center
Cook County Health & Hospitals System (CCHHS)

Primary and specialty health care, mental health and social services for people of all ages.

Intake phone
312-572-4500

Hours
M - F, 8:30am-4:30pm

2020 West Harrison Street
Chicago, IL 60612
312-572-4500

How to Access
Call to schedule appointment at 312-572-4500. Walk-in services for HIV and STI counseling are offered M - F 8:30am - 3:30pm.

All new and walk-in clients are required to meet with a benefits counselor. Benefits counselors may assist patients in accessing and applying for health benefits. Please be ready to provide:
- Photo ID
- Insurance information (if applicable)

Description
CORE Center uses a “one-stop-shopping” model to offer patients all the services they need under one roof. Services include primary and specialty medical care, dental care, social and support services, prevention and education programs, and opportunities to participate in research.

The Center also has an onsite screening clinic that offers confidential testing and treatment for sexually transmitted diseases (STDs), confidential counseling and testing for HIV, and tuberculosis (TB) screening.

Eligibility

- No one is ever turned away for inability to pay!
- The CORE center is designed for patients with HIV/AIDS and other infectious diseases (tuberculosis, hepatitis, etc.)
- Confidential STI and HIV screening is available to persons 12yo+

Ruth M. Rothstein CORE Center
Cook County Health & Hospitals System (CCHHS)

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http://app.purplehinder.com/programs/health-clinic?i=0&l=0&q=1&n=0&p=1&q=The+Core+Center

Appendix 2: Commonly used community resources in the PArTNER intervention
Appendix 2: Commonly used community resources in the PArTNER intervention

Veterans Crisis Line
U.S. Department of Veteran Affairs

Confidential support for Veterans in crisis and their families and friends.
Intake phone
800-273-8255, ext. 1
Hours
24 hours, 7 days a week, 365 days a year

How to Access
If you, or a loved one, are a veteran in crisis, access a crisis team member 24/7:
1. Call 1-800-273-8255 and Press 1
2. Send text message to 838255
3. Chat online (http://www.va.gov/VistaVRChat/Support.asp)

Description
The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring, Department of Veteran Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.


3/3/2016
Homeless Outreach: Mobile Feeding  
The Salvation Army: Freedom Center  

Mobile food pantry serving daily meals to individuals and families experiencing homelessness.

Intake phone  
312-421-5753

Hours  
Daily 11:00am-8:00pm

W. 63rd St. & S. Seeley Ave.  
Chicago, IL 60636

W. 19th St. & S. Sacramento Dr.  
Chicago, IL 60623

47th Green Line Stop  
314 E. 47th St.  
Chicago, IL 60653

W. Madison St. & S. Sacramento Blvd  
Chicago, IL 60612

W. 16th St. & S. Lawndale Ave.  
Chicago, IL 60623

**Douglas Park**  
1401 S. Sacramento Dr.  
Chicago, IL 60623

W. 59th St. & S. Morgan St.  
Chicago, IL 60621

Lower Wacker Drive  
Chicago, IL 60606

S. Homan Ave. & W. 16th St.  
Chicago, IL 60623

S. Cottage Grove Ave. & E. 47th St.  
Chicago, IL 60615

W. Lake St. & N. Kedzie Ave.  
Chicago, IL 60624

W. 16th St. & S. Drake Ave.  
Chicago, IL 60623

S. Halsted St. & W. 55th St.  
Chicago, IL 60609

10 S. Kedzie Ave.  
Chicago, IL 60623

S. Kedzie Ave. & W. 13th St.  
Chicago, IL 60623

S. Vernon Ave. & E. 63rd St.  
Chicago, IL 60637

**Franciscan House**  
2715 W. Harrison St.  
Chicago, IL 60612

W. Ogden Ave. & S. Sacramento Dr.  
Chicago, IL 60623

W. Roosevelt Rd. & S. St. Louis Ave.  
Chicago, IL 60624

W. Roosevelt Rd. & S. Ayers Ave  
Chicago, IL 60624

S. Kedzie Ave. & W. 15th St.  
Chicago, IL 60623

S. King Dr. & E. 51st St.  
Chicago, IL 60615

E. 47th St. & S. Vincennes Ave.  
Chicago, IL 60653
Food Pantry
The Salvation Army: Chicago Temple Corps

Free food for individuals and families residing in zip code 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610, 60611 & 60661.

Intake phone
312-492-6803

Hours
Tuesdays and Thursdays 11:00am-1:00pm

1 N. Ogden Avenue
Chicago, IL 60607
Fax: 312-492-6804

How to Access
Must provide:
- Photo ID
- Proof of Address

Eligibility

- Must reside in zip code areas 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610, 60611, 60661
Emergency Shelter
Catholic Charities Chicago

Intake phone
(312) 655-7700

Confidential
Chicago, IL

How to Access
Call (312) 655-7700 to ask about availability.

Description
Catholic Charities operates 4 emergency shelters for families and individuals.

Eligibility
Shelter for people with children, no beds for unaccompanied adults.

http://app.purplebinder.com/programs/emergency-shelter-1?i=2&i=n&m=1&nf=0&p=1&q=catholic+charities
3/3/2016
ACCESS at Anixter Center
ACCESS Community Health Network

Primary care and psychiatry for adults.
Intake phone
773-404-5277
Hours
M-W 8:00am-5:00pm Th-F 8:30am-4:30pm

Anixter Center
2020 N. Clybourn Ave.
Chicago, IL 60614
773-404-5277
Fax: 773-404-8278

How to Access
Call 773-404-5277 to schedule an appointment OR request an appointment online (http://www.accesscommunityhealth.net/about-access/contact-us/?o=appointment).

At all appointments, please be prepared to provide:
- Photo I.D.
- Insurance information

To be screened to see what benefits you are eligible for or to sign up for the sliding fee scale program, please bring the following to your first appointment:
- Photo I.D.
- Proof of address (two pieces of mail or 1 piece of mail and a photo I.D. with address and name included)
- Proof of income (income tax forms, two pay stubs, SSI/SSA official documentation, two most recent pay stubs, letter from employer, or ACCESS housing/shelter or employment verification forms).

Description
ACCESS' services are designed to address the health of our underserved communities in such areas as preventive care, chronic disease management, and support services. To address patients' comprehensive health needs, ACCESS physicians, nurse practitioners, midwives and other providers are teamed with outreach staff, case managers, social workers and substance abuse counselors to advance a continuum of care. ACCESS at Anixter Center offers:
- Primary Health Care
- Psychiatry

Eligibility

- All patients are welcome at ACCESS regardless if they have insurance. When visiting the health center, a staff member will be happy to help patients enroll in any benefits they may be eligible to receive.
Resource Guide for People with Disabilities
Equip for Equality

Online resource guide for residents of Illinois who have disabilities.

Intake phone
312-341-0022

Equip for Equality
20 N. Michigan Ave.
Suite 300
Chicago, IL 60602
312-341-0022

How to Access
Download a copy of the resource guide here (http://www.eqipforequality.org/learn/resource-guide-for-people-with-disabilities/).

Description
The Resource Guide for People with Disabilities provide individuals with disabilities, their families, disability advocates, and service providers, information about disability-related services available in Illinois.

Eligibility

- For individuals with disabilities, their families, disability advocates, and service providers, who live in Illinois
Housing Stability Program
Renaissance Social Services

Supportive housing program for individuals and families.

Intake phone
773-645-8900, ext. 102

Renaissance Social Services
333 N. Oakley Blvd
Suite 101
Chicago, IL 60612
773-645-8900
Fax: 312-624-9849

How to Access
Contact Daisy Franco, Intake Coordinator, at 773-645-8900, ext. 102 for intake and program enrollment. All those interested in the program are encouraged to complete the Chicago Central Referral Assessment Tool (CRS) (https://www.chicagocrs.org/).

Description
The Housing Stability Program serves homeless and disabled families and individuals, chronically homeless individuals and those at risk of becoming homeless throughout Chicago by helping them attain affordable permanent housing at one of the buildings Renaissance services. Residents are provided with ongoing supportive case management services. Services are individualized in order to meet the needs of the specific individual or family and are focused on the person or family attaining a greater level of autonomy. Ultimately the goal of the program is to enable the family or person to have the skills necessary to no longer need services from RSSI. RSSI's team of case managers provides services which are tailored to meet the needs of the individual or family. Intensity of services is initially very intense when a client enters the program and less so as time passes and the client increases autonomy. Collaboration with the client is key for the process of increasing their self-determination, and goals and services are agreed upon jointly so everyone has a role in the delivery of services.

Eligibility
- For:
  - Homeless and disabled families and individuals
  - Chronically homeless individuals,
  - Individuals and families at imminent risk of becoming homeless

Paratransit Certification
Regional Transportation Authority

ADA paratransit certification for individuals who, because of their disability, are unable to use CTA or Pace fixed route transit service for some or all of their trips.

Intake phone 312-663-4357
Hours M-F 8:30am-5:00pm

RTA Customer Service
M-F 8:30am-5:00pm
69 W. Washington St.
Lower Level Pedway
Chicago, IL 60661
312-913-3110

RTA Administrative Offices
M-F 8:30am-5:00pm
175 W. Jackson Blvd
Suite 1650
Chicago, IL 60604
312-913-2300

How to Access
Call 312-663-4357 to request an application. Applications can only be sent via standard mail and take approximately 5 - 7 business days to arrive. Applications are available in:
- English
- Spanish
- Braille
- Large Print
- Audiotape

Once an applicant has filled out as much of the application as they can, call the RTA’s ADA Paratransit Certification program at 312-663-4357 to schedule an in-person interview at one of five Interview and Assessment sites. If needed, RTA will provide transportation to the interview and the services of an American Sign Language or Spanish interpreter at no charge. Please bring the completed application and a photo ID to the interview. Applicants may also bring additional information about their disability or health condition, but this is not required.

During the interview, staff will review the application form and if necessary, help applicant’s complete it. Staff will also discuss with you your travel abilities and limitations in more detail. You may be asked to take a "mock" bus trip. This will take about 30 to 45 minutes and will give a better idea of your travel abilities and limitations. Please dress for the weather as you may be asked to go outside.

A decision will be made on the application within 21 days of the completion of the interview and assessment. If a decision is not made within 21 days, RTA will provide you with ADA Paratransit service until a final decision is made. You will be notified of your eligibility by letter.

If you are determined to be eligible for ADA Paratransit for some or all of your trips, you will receive a Certification Letter, a Customer Guide with information about how to use the service and a photo ID card.

Description
ADA Paratransit is a shared ride, advanced reservation, origin-to-destination service for individuals who because of their disability are unable to use CTA or Pace fixed route transit service for some or all of their trips. ADA Paratransit is provided for individuals whose disability or health condition may prevent them from using the CTA and/or Pace fixed route services for some or all of their travel. Individuals who are interested in using ADA Paratransit service must apply and be found eligible according to ADA guidelines. The RTA ADA Paratransit Certification Program determines an individual's functional abilities and limitations for using fixed route services.

Eligibility
- There are three types of eligibility:

Low-Income Home Energy Assistance Program (LIHEAP)
Community and Economic Development Association of Cook County (CEDA)

Provides financial assistance to eligible low income households in Cook County.

Intake phone
800-571-CEDA(2332)

Wheeling Township
1616 N. Arlington Heights Rd.
Arlington Heights, IL 60004
847-259-7730

Universal Prayer Tower- Satellite
840 S. 17th Ave.
Maywood, IL 60153
708-397-4399

The Link and Option Center
15652 Homan Ave.
Markham, IL 60428
708-331-4880

Hope Organization II
6921 S. Halsted St.
Chicago, IL 60621
773-846-0883

CEDA Central Administrative Office
208 S. LaSalle St.
Suite 2010
Chicago, IL 60604
800-571-2332

Senior Assistance Center
7774 W. Irving Park Rd.
Norridge, IL 60706
708-456-7979

Leyden Family Services
10001 W. Grand Ave
Franklin Park, IL 60131
847-451-0330

Church of the Living God
2159 E. 95th St.
Chicago, IL 60617
773-221-0900

Christ United Faith Ministry
11906 S. Michigan Ave.
Chicago, IL 60628
773-840-3873

Hegewisch Community Committee
13100 S. Manistee Ave.
Chicago, IL 60633
773-646-4488

Cambodian Association of Illinois
2831 W. Lawrence Ave.
Chicago, IL 60625
773-878-7090

Hanul Family Alliance
5008 N. Kedzie Ave.
Chicago, IL 60625
773-478-8851, ext. 123

PLOWS Agency on Aging
7808 College Dr 5-East
Palos Heights, IL 60463
708-361-0219

Oak Park Senior Services
130 S. Oak Park Ave.
Oak Park, IL 60302
708-383-8060

Worth Township
6245 S. Archer Ave.
Chicago, IL 60638
312-886-0481

Stickney Township - Satellite
6721 W. 40th St
For senior (60yo+) Stickney residents ONLY
Stickney, IL 60402
708-788-9100

Universal Prayer Tower
4540 W. Washington Blvd.
Chicago, IL 60624
773-378-3464

Spanish Coalition for Housing
9010 S. Commercial Ave.
Chicago, IL 60617
773-933-7575
# Appendix 2: Commonly used community resources in the PARtNER intervention

<table>
<thead>
<tr>
<th>Resource Name</th>
<th>Address</th>
<th>Phone Number</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healing Temple Church</td>
<td>4941 W. Chicago Ave, Chicago, IL 60651</td>
<td>773-287-6964, ext. 4</td>
<td></td>
</tr>
<tr>
<td>Korean American Community Services (Satellite)</td>
<td>By Appt Only</td>
<td>664 N. Milwaukee Ave, Suite 213, Prospect Heights, IL 60070</td>
<td>847-520-1999</td>
</tr>
<tr>
<td>Community Care Outreach</td>
<td>8615 S. Ashland Ave, Chicago, IL 60620</td>
<td>773-881-9007</td>
<td></td>
</tr>
<tr>
<td>Le Penseur Youth &amp; Family Services</td>
<td>8550 S. Manistee Ave, Chicago, IL 60617</td>
<td>773-375-8637</td>
<td></td>
</tr>
<tr>
<td>WECAN (Woodlawn East Community and Neighbor)</td>
<td>6450 S. Stony Island Ave, Chicago, IL 60637</td>
<td>773-255-3000</td>
<td></td>
</tr>
<tr>
<td>Southwest Side Senior Services</td>
<td>6245 S. Archer Ave, Chicago, IL 60638</td>
<td>312-886-0481</td>
<td></td>
</tr>
<tr>
<td>Eyes on Austin</td>
<td>5430 S. Western Ave, Chicago, IL 60637</td>
<td>773-471-1569</td>
<td></td>
</tr>
<tr>
<td>Jane Addams Resource Corp</td>
<td>4432 N. Ravenswood Ave, Chicago, IL 60640</td>
<td>773-751-7119</td>
<td></td>
</tr>
<tr>
<td>Polish American Association</td>
<td>3842 S. Cicero Ave, Chicago, IL 60641</td>
<td>773-228-2806, ext. 314</td>
<td></td>
</tr>
<tr>
<td>South Austin Coalition Community Council</td>
<td>5071 W. Congress Pkwy, Chicago, IL 60644</td>
<td>312-743-1538</td>
<td></td>
</tr>
<tr>
<td>PLCCA</td>
<td>411 Madison St, Maywood, IL 60153</td>
<td>708-450-3500</td>
<td></td>
</tr>
<tr>
<td>North Lawndale Employment Network</td>
<td>3726 W. Flournoy St, Chicago, IL 60624</td>
<td>773-265-7940</td>
<td></td>
</tr>
<tr>
<td>Howard Area Community Center</td>
<td>7648 N. Paulina St, Chicago, IL 60626</td>
<td>773-262-6622, ext. 271</td>
<td></td>
</tr>
<tr>
<td>Korean American Community Services</td>
<td>By Appt Only</td>
<td>4300 N. California Ave, Chicago, IL 60618</td>
<td>773-583-5501, ext. 160</td>
</tr>
<tr>
<td>New Life Ministries</td>
<td>634 N. Austin Ave, Oak Park, IL 60302</td>
<td>708-383-5433</td>
<td></td>
</tr>
<tr>
<td>Total Resource Comm. Organization / Triedstone</td>
<td>1415 W. 104th St, Chicago, IL 60643</td>
<td>773-881-0761</td>
<td></td>
</tr>
<tr>
<td>CRDDC (Chetwyn Rodgers Drive Development Center) 25 N. Cicero Ave.</td>
<td>25 N. Cicero Ave, Chicago, IL 60644</td>
<td>773-261-6098, ext. 11</td>
<td></td>
</tr>
<tr>
<td>The New Love and Faith Church</td>
<td>611 W. Wacker Dr, Chicago, IL 60601</td>
<td>773-287-1033</td>
<td></td>
</tr>
<tr>
<td>Metropolitan Asian Family Services</td>
<td>7541 N. Western Ave, Chicago, IL 60645</td>
<td>773-465-3105, ext. 18</td>
<td></td>
</tr>
<tr>
<td>Northwest Compass</td>
<td>1300 W. Northwest Hwy, Mt. Prospect, IL 60056</td>
<td>847-392-2344</td>
<td></td>
</tr>
<tr>
<td>Muslim Women Resource Center</td>
<td>6445 N. Western Ave, Suite 301, Chicago, IL 60635</td>
<td>773-764-1686</td>
<td></td>
</tr>
<tr>
<td>Assyrian National Council of Illinois</td>
<td>2450 W. Peterson Ave, Chicago, IL 60659</td>
<td>773-262-5589</td>
<td></td>
</tr>
<tr>
<td>Metro Chicago Methodist Church</td>
<td>510 N. Lincoln Ave, #23, Chicago, IL 60659</td>
<td>773-350-4357</td>
<td></td>
</tr>
<tr>
<td>Centro Romero 6216 N. Clark St.</td>
<td>6216 N. Clark St, Chicago, IL 60660</td>
<td>773-508-5300</td>
<td></td>
</tr>
<tr>
<td>Amor de Dios United Methodist Church</td>
<td>2356 S. Sawyer Ave, Chicago, IL 60623</td>
<td>773-972-3143</td>
<td></td>
</tr>
<tr>
<td>Arab American Family Services</td>
<td>9044 S. Octavia Ave, FOR SENIOR APPLICANTS 60+y ONLY Bridgeview, IL 60455</td>
<td>708-599-2237</td>
<td></td>
</tr>
<tr>
<td>Hanover Township</td>
<td>7431 Astor Ave, Hanover Park, IL 60133</td>
<td>630-540-9085</td>
<td></td>
</tr>
<tr>
<td>Hanover Township Senior Services</td>
<td>240 S. Illinois Rt 59, Bartlett, IL 60103</td>
<td>630-483-5660</td>
<td></td>
</tr>
<tr>
<td>CEDA Cicero</td>
<td>6141 W. Roosevelt Rd, Cicero, IL 60804</td>
<td>708-222-3824</td>
<td></td>
</tr>
<tr>
<td>CEDA Calumet Park</td>
<td>12639 S. Ashland Ave, Calumet Park, IL 60827</td>
<td>708-489-1965</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 2: Commonly used community resources in the PArTNER intervention

Upcoming application periods:

**Regular Application: December 1, 2015**
Open until May 31st, 2016.

Income eligibility applies:

- **Current 30-Day Gross Income (by number of household members)**
  - LIHEAP ComEd STW
  - 1 $1,471 $2,452 $1,962
  - 2 $1,991 $3,319 $2,655
  - 3 $2,511 $4,185 $3,348
  - 4 $3,031 $5,052 $4,042
  - 5 $3,551 $5,919 $4,735
  - 6 $4,071 $6,785 $5,428
  - 7 $4,591 $7,652 $6,122
  - 8 $5,111 $8,519 $6,815

**Required intake documents include:**
- Proof of current 30-day gross income from all household members.
- Copy of most recent heat and electric bills if you pay for your home energy directly. (Must provide entire bill)
- Proof of Social Security Numbers of all household members (Hard-copy of Social Security cards, print-out from the Social Security Administration or any other form of government-issued identification that shows both name and Social Security number.)
- If a member of your household receives TANF, you must bring their Medical Eligibility Card
- Applicants that have their utilities included in the rent must bring proof of rental agreement stating monthly rental amount, that utilities are included, and landlord contact information. (Rent costs must be greater than 30% of current household 30-day gross income).

**Additional documentation needed for furnace assistance**
- Proof of property ownership (one of the following):
  - Current tax bill showing the property address and owner's full first and last name
  - Mortgage billing statement or mortgage payment book including the front cover and payment coupon showing the property address and the owner's full name.
  - Quit Claim Deed with recorded stamp by the County Court Recorder Vehicle title for mobile homeowners
  - Building Owner Certification and Work Authorization Form

**Share the Warmth Program documentation includes**
- Most recent Peoples Gas bill, issued within the last 30 days
- Current Government issued picture ID for the customer of record
- Proof of household income for the past 30 days

**Description**

LIHEAP is designed to assist income-eligible households with energy services, in the form of a one-time benefit payment to the utility companies that is applied directly to the household’s energy bills. The amount of the payment is determined by income, household size, and fuel type. Please call the Energy Services Hotline for more information.

Furnace Assistance is designed to restore the home's heating system back to a safe and effective operation. Assistance is only available to approved households that has or are eligible to receive a LIHEAP benefit and whose heating systems are not operational or have been red-tagged by their utility company. The services are free of charge for income qualifying households. Renters are not eligible to apply. Households are eligible to apply for Furnace assistance during their priority period.

The Share the Warmth (STW) Program is a matching grant program funded by Peoples Gas, its employees and customers, and the City of Chicago to assist low-income families and individuals who are having problems paying their heating gas bills. Low-income customers whose total household income is below 200% of the federal poverty level are eligible for apply for Share the Warmth grants of up to $200. Customers must make a pledge payment to their Peoples Gas heating account, which will be matched by the grant. The grant can be no larger than $200 per customer per year and cannot result in a credit balance on the account. Grants cannot be applied to charges from alternate suppliers (Rider CFY).
SNAP/Food Stamp Outreach
Greater Chicago Food Depository

One-on-one eligibility determination and application assistance for SNAP benefits.

Intake phone
773-843-5416

Hours
M-F 8:30am-5:00pm

4100 W. Ann Lurie Place
Chicago, IL 60632

How to Access
To find out if you are eligible for SNAP benefits, call 773-843-5416 during office hours for a free and confidential interview. OR
Use the Illinois DHS SNAP Eligibility Calculator (http://fscalcalc.dhs.illinois.gov/FSCalc/)

Description
The Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp Program) helps millions of individuals and families in the Unites States afford food. We help connect eligible individuals and families in Cook County with SNAP benefits.

We offer phone and in-person support to help connect individuals and families with SNAP. Whether it’s helping you apply, getting you recertified or letting you know your current status, our goal is to remove the barriers that come between people and the food they need.

Appendix 2: Commonly used community resources in the PArTNER intervention

Non-Emergency Transportation Services Prior Approval Program
First Transit

Medical appointment transportation for patients with Medicaid.

Intake phone
877-725-0569

Hours
M-F 9:00am-5:00pm

Chicago, IL

How to Access

It is recommended to make transportation reservations as far in advance as possible. You or the person calling for you will need to:

1. Call a transportation company to see if they can take you to your doctor’s appointment. You can call the transportation company you always use or if you need help finding a transportation company you can call First Transit at 1-877-725-0569,

2. Call First Transit at 1-877-725-0569 to get your trip approved. First Transit will ask:

   • Your name
   • May need to get your “OK” to talk with the person calling for you
   • Your pick-up address and phone number
   • Your Medicaid ID# (9 digit recipient identification number)
   • The general reason for your doctor’s visit
   • The name of the office/clinic/hospital where you are going
   • The name of the doctor you will be seeing
   • The address and phone number where you are going
   • The appointment date and time
   • If there are medical or non-medical reasons why you can not use public or other transportation
   • If you use a walker, wheelchair, or cane
   • If you can travel by yourself

First Transit will give you a reference number.

1. Call the transportation company and give them your reference number and schedule your pick-up time.

2. Call the transportation company before your doctor’s appointment to confirm your reservation.

Description
Provides transportation services to Medicaid patients traveling to medical appointments.

In order to be approved for Non-Emergency Transportation services, the Participant must be transported to an appointment where they will receive a covered medical service. A covered medical service is a Medicaid Eligible Medical Service (MEMS).

Covered Services include:

• Chemotherapy
• Radiation
• Wellness exam, or annual physical exam

Community Service Centers
City of Chicago

One-on-one assistance for individuals and families in Chicago who need housing and other social services.

Hours
M-F 9:00am-5:00pm

King Center
4314 S. Cottage Grove
Chicago, IL 60653
312-744-2300

Englewood Center
1140 W. 79th Street
Chicago, IL 60620
312-747-0200

Trina Davila
4357 W. Armitage Ave.
Chicago, IL 60639
312-744-2014

Garfield Center
10 S. Kedzie Ave.
Chicago, IL 60612
312-746-5400

North Area
845 W. Wilson Ave.
Chicago, IL 60640
312-744-2580

South Chicago
8650 S. Commercial Ave.
Chicago, IL 60617
312-747-0500

How to Access
Call or walk-in to the Center.
To request information on a Community Service Center, call 3-1-1.

Description
DFSS’ six Community Service Centers are open from 9 a.m. to 5 p.m., Monday thru Friday. City residents who need assistance can drop in or schedule an appointment in advance.

DFSS Community Service Centers help individuals and families in need access a wide range of resources from shelter, food and clothing to domestic violence assistance, job training/placement and prisoner re-entry. Clients can get information about rental, utility and other financial assistance programs. The facilities serve as Warming and Cooling Centers during periods of extreme weather.

Visitors participate in an initial assessment to identify their needs. Some basic services can be provided immediately. Clients with multiple or complex issues are assigned a case worker.

DFSS case workers are trained specialists who work with clients on-going. They help individuals set personal goals and develop plans to achieve them. A case worker can refer clients to specialized services in the community.

Mile Square Health Center (UIC)
University of Illinois Hospital & Health Sciences System (UIC)

Primary and preventative health care for all ages.

Intake phone
312-996-2000

Hours
MAIN CLINIC HOURS: Mon - Fri: 9:00 AM - 5:00 PM; Sat: 8:00 AM - 12:00 PM; Urgent Care: Mon - Fri: 12:00 PM - 8:00 PM; Sat, Sun, Holidays: 10:00 AM - 6:00 PM. URGENT CARE HOURS: Monday-Friday: 12pm-8pm; Saturday, Sunday, and Holidays: 10am-6pm

Hope Institute
1628 W Washington
Chicago, IL 60612
312.226.3288
Fax: 312.226.3541

Young Women's
2641 South Calumet Avenue
Chicago, IL 60616
312.949.0277
Fax: 312.949.0337

National Teachers Academy
55 West Cermak Rd.
Chicago, IL 60616
312.534.9970
Fax: 312.326.4396

New City
734 West 47th Street
Chicago, IL 60609
773.537.3960
Fax: 773.536.2406

South Shore
7131 Jeffery Boulevard
Chicago, IL 60649
312.996.2000
Fax: 773.363.5493

Englewood
641 West 63rd Street
Chicago, IL 60621
312.413.4070
Fax: 312.355.1110

Cicero Clinic
4745-51 West Cermak Road
Cicero, IL 60804
708.656.6766
Fax: 708.652.4745

Main Location
1220 S Wood St
Chicago, IL 60608
312.996.2000

Humboldt Park
3240 West Division Street
Chicago, IL 60651
312.413.7425

Davis Health & Wellness
3050 West 39th Place
Chicago, IL 60632
773.376.8008
Fax: 773.376.8099

Back of the Yards
4630 South Bishop Street
Chicago, IL 60609
773.523.2615
Fax: 773.523.8599

North Clinic
4221 North Lincoln Avenue
Chicago, IL 60618
773.537.3950
Fax: 773.435.0119

How to Access
To make an appointment, call 312-996-2000. Clients should bring medical card and a list of any medications they are currently taking.

SNAP/Food Stamp Outreach
Greater Chicago Food Depository

One-on-one eligibility determination and application assistance for SNAP benefits.

Intake phone
773-843-5416

Hours
M-F 8:30am-5:00pm

4100 W. Ann Lurie Place
Chicago, IL 60632

How to Access
To find out if you are eligible for SNAP benefits, call 773-843-5416 during office hours for a free and confidential interview. OR
Use the Illinois DHS SNAP Eligibility Calculator (http://fiscalc.dhs.illinois.gov/FSCalc/)

Description
The Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp Program) helps millions of individuals and families in the Unites States afford food. We help connect eligible individuals and families in Cook County with SNAP benefits.

We offer phone and in-person support to help connect individuals and families with SNAP. Whether it’s helping you apply, getting you recertified or letting you know your current status, our goal is to remove the barriers that come between people and the food they need.
Illinois Eye and Ear Infirmary
University of Illinois Hospital & Health Sciences System (UIC)

Intake phone
312-355-5220

Hours
M-F 8:30am-5:00pm

Orthoctic Clinic
1855 W. Taylor
Suite 2.140
Chicago, IL 60612
312-996-6599
Fax: 312-413-4916

Glaucoma Services
1855 W. Taylor
Suite 3.171
Chicago, IL 60612
312-996-7030
Fax: 312-413-8574

General Eye Clinic
1855 W. Taylor
Suite 1.45
Chicago, IL 60612
312-996-6562
Fax: 312-996-1934

Contact Lens Services
1855 W. Taylor
Suite 3.154
Chicago, IL 60612
312-996-5410
Fax: 312-996-4255

Comprehensive Ophthalmology Faculty Practice
1855 W. Taylor
Suite 1.059
Chicago, IL 60612
312-355-5220
Fax: 312-996-1259

Cornea Services
1855 W. Taylor
Suite 3.164
Chicago, IL 60612
312-996-8937
Fax: 312-355-4248

Eye Photography Services
1905 W. Taylor
Suite L 110
Chicago, IL 60612
312-996-7860
Fax: 312-996-1881

Retina Services
1905 W. Taylor
Chicago, IL 60612
312-996-6660
Fax: 312-355-0520

Low Vision Services
1855 W. Taylor
Suite 1.059
Chicago, IL 60612
312-355-5220
Fax: 312-996-1259

Laser Vision Correction Services
30 N. Michigan Ave
Suite 410
Chicago, IL 60602
312-996-2020
Fax: 312-346-5292

Neuro-Ophthalmology Services
1855 W. Taylor
Suite 3.159
Chicago, IL 60612
312-996-9120
Fax: 312-413-7895

Oculoplastic & Reconstructive Surgery Services
1855 W. Taylor
Suite 3.158
Chicago, IL 60612
312-996-9120
Fax: 312-413-7895

Pediatric Ophthalmology & Adult Stabismus Services
Address: 1855 W. Taylor
Suite 2.140
Chicago, IL 60612
312-996-6599
Fax: 312-413-4916

Uveitis Services
1855 W. Taylor
Suite 3.164
Chicago, IL 60612
312-996-8937
Fax: 312-355-4248

Pharmacy
1855 W. Taylor
First Floor
Chicago, IL 60612
312-996-6540
Fax: 312-996-1314

How to Access
Call respective clinic to schedule appointment. Or, if unsure what services are required, call general line at 312-355-5220. May also request an appointment online (http://tigger.uic.edu/hb/bin/codewrap/bin/com/eyecare/appointments/cgi-bin/request.php).


Appendix 2: Commonly used community resources in the PARtNER intervention
Vision of Hope
Illinois Eye Institute

Comprehensive eye care for uninsured, low-income adults.
Intake phone
312-949-7250 or 312-949-7182
Email
jwinters@ico.edu

Illinois College of Optometry
3241 S. Michigan Ave.
Chicago, IL 60616
312-949-7000

How to Access
If have some form of insurance, except CountyCare, call 312-949-7250 to make an appointment. Copay may apply.
If don't have insurance or just have CountyCare, call Jackie Saulsberry at 312-949-7182 to verify eligibility and be sent an application form. A case manager must fill out the form and send it back in (fax # 312-949-7489)
When the case manager will get a response with an appointment time, and when the client goes to his or her appointment, he or she must bring verification of income.

Description
VOHHA provides comprehensive eye care to uninsured, low-income adults—largely referred to the IEI by partner agencies—and helps to connect these patients, as needed, to primary healthcare providers. VOHHA patients receive comprehensive examinations, follow-up care including diagnostic testing, personalized health information, and eyeglasses and other vision aids.
Sickle Cell Center
University of Illinois Hospital & Health Sciences System (UIC)

Comprehensive medical care and support services for children and adults with sickle cell disease.

Intake phone
312-413-8666

Hours
M-F 8:00am-7:30pm

Sickle Cell Center: Adult and Acute Care
M-F 8:00am-7:30pm
1740 West Taylor Street
Suite 5E
Chicago, IL 60612

Outpatient Care Center: Pediatrics
M-F 8:30am-8:00pm Sat 7:00am-5:00pm
1801 West Taylor Street
Suite 2E
Chicago, IL 60612

How to Access
Call 312-413-8666 to schedule an appointment. For patients in need of acute care, the Acute Care Center can accept patients Monday through Friday between 8:00am and 7:30pm. Patients may come directly to the Center but it is advised that they call first at 312-413-8666. If a pain crisis occurs during the night and you plan to come in during office hours, please leave a message and phone number and staff will call you back at 7:00am Monday through Friday. Pediatric patients with a sickle cell pain crisis should access care through the Emergency Room (24/7) at:
1740 W. Taylor Street
Chicago, IL 60612

At all appointments, please provide:
- Photo ID
- Insurance information (if applicable)

Description
The Comprehensive Sickle Cell Center at UI Health offers:

- Pediatric and Adult Care
- Acute care for uncomplicated pain crisis, an alternative to emergency room treatment
- Transitional care (S.T.A.R. Clinic) – to ease the transition from pediatric to adult services
- Stem cell transplantation
- Infusion and transfusion therapy
- Pain management
- Newborn screening and genetic counseling
- Patient counseling
- Sickle cell education and outreach
- Support Groups - pediatric and adult
- Access to national research studies


Appendix 2: Commonly used community resources in the PARtNER intervention
**State ID Card**

**Illinois Secretary of State**

Illinois state photo identification card for people of all ages.

**Chicago South**
*M-Th 8:30am-5:00pm*  *W 8:30am-5:30pm*
9901 S. Dr. Martin Luther King Jr. Dr
Chicago, IL 60628
312-793-1010

**Chicago North**
*M-Th 8:30am-5:00pm*  *W 8:30am-5:30pm*
5401 N. Elston Ave.
Chicago, IL 60630
312-793-1010

**Chicago West**
*M-F 8:00am-5:30pm*  *Sat 7:30am-12:00pm*
5301 W. Lexington St.
Chicago, IL 60644
312-793-1010

**Chicago Central**
*M-F 8:00am-5:00pm*
100 W. Randolph
Chicago, IL 60601
312-793-1010

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**How to Access**

Use the Facility Finder (http://www.isos.gov/facilityfinder/facility) for the nearest Secretary of State location.

An applicant applying for a driver’s license or ID card for the first time in Illinois must present:
- An original document proving your written signature (e.g. credit card, court order, or driver's license).
- An original document proving your date of birth (e.g. birth certificate, passport, or high school transcript).
- An original document proving your Social Security number (e.g. Social Security card, IL driver's license record, or military service record).
- Two original documents proving your residency (e.g. bank statement, pay stub, deed/title, official mail). Only one document is required for applicants under 5 years old.

An applicant renewing a current Illinois driver’s license or ID card need only present his/her current valid driver’s license or ID card if no changes are required. If the applicant does not have his/her current driver’s license or ID card or changes are required, he/she must present:
- An original document proving your written signature (e.g. credit card, court order, or driver's license).
- An original document proving your date of birth (e.g. birth certificate, passport, or high school transcript).
- An original document proving your Social Security number (e.g. Social Security card, IL driver's license record, or military service record).
- One original document proving your residency (e.g. bank statement, pay stub, deed/title, official mail). Two documents are required if you are requesting a change of address.


Individuals applying for the free State ID card for people with disabilities, must provide an Application for an Illinois Person with a Disability Identification Card (http://www.cyberdriveillinois.com/publications/pdf_publications/dsd_x164.pdf) completed by his/her doctor.

The Illinois State ID card is issued for a fee and is valid for five years (not applicable for seniors 65 years old+, people with disabilities or individuals experiencing homelessness).

**Description**

Illinois-issued ID cards can help Illinois residents prove identity when banking, traveling, or in other situations. There is no minimum age for a state ID card, which provides photo identification for Illinois residents. Children traveling on airplanes may need identification of this type to fly.

**Eligibility**

State ID Card for the Homeless
Illinois Secretary of State

Provides State ID for individuals who are experiencing homelessness.

Chicago South
* M-Tu, Th-F 8:30am-5:00pm W 8:30am-5:30pm
* 9901 S. Dr. Martin Luther King
Chicago, IL 60628

Chicago North
* M-Tu, Th-F 8:30am-5:00pm W 8:30am-5:30pm
* 5401 N. Elston Ave.
Chicago, IL 60630

Central Chicago
* M-F 8:00am-5:00pm
* 100 W. Randolph
Concourse Level
Chicago, IL 60601

Chicago West
* M-F 8:00am-5:30pm Sat 7:30am-12:00pm
* 5301 W. Lexington St.
Chicago, IL 60644

How to Access
Use the Facility Finder (http://www.ilsos.gov/facilityfinder/facility) for the nearest Secretary of State location.

Must provide:
- Homeless Certification Letter
- An original document proving your written signature (e.g. credit card, court order, or driver's license).
- An original document proving your date of birth (e.g. birth certificate, passport, or high school transcript).
- An original document proving your Social Security number (e.g. Social Security card, IL driver's license record, or military service record).
- An original document proving your Illinois residency (e.g. official mail from City, County, State, Federal Agency, credit report, or utility bills).


Description
A person qualifies for the no-fee identification card, if he or she is considered homeless as defined by the federal McKinney-Vento Homeless Assistance Act, 42 U.S.C. 11302 (http://codes.lp.findlaw.com/uscode/42/119/I/11302) or 42 U.S.C. 11434(a)(2) (http://codes.lp.findlaw.com/uscode/42/119/V/1/11434a). This card is issued free of charge with the proper documentation to show proof of legal name, date of birth, social security number, and signature. The individual must also bring a completed Homeless Status Certification.

Eligibility
- For homeless individuals


Appendix 2: Commonly used community resources in the PARtNER intervention
State of IL Healthcare and Family Services Healthcare Benefits Hotline
Illinois Department of Healthcare and Family Services

Toll free number for questions about Illinois healthcare benefits.

Intake phone
1-800-226-0768
Email
hfs.webmaster@illinois.gov

Illinois Department of Healthcare and Family Services
Chicago, IL

How to Access
Call 1-800-226-0768

Menu options:
To apply to the Affordable Care Act or to request correction of name, date of birth, gender or eligibility press 2.
To get information about All kids, supportive living facilities, healthcare benefits for workers with disabilities, veterans care, or ask questions about your spend down press 3.
For assistance locating a doctor, eye doctor, dentist, or if you want to enroll or change enrollment with primary care doctor or managed care organization press 4
If you're calling to request a new medical card, change the address on your medical card, or have general questions about medicaid programs press 5
To ask about your monthly premium statement for All kids, child support, healthcare benefits for workers with disabilities, or veterans care, press 6
If you're a provider, press 7

Description
Call 1-800-226-0768 to ask questions about your healthcare benefits, apply for healthcare benefits, find out whether you're eligible for benefits, and more. Available in English and Spanish.

Eligibility
- IL healthcare benefits recipients
- Potential IL healthcare benefits recipients

Senior Housing
Chicago Housing Authority

Public housing for seniors.

Intake phone
312-742-8500

60 E Van Buren St #12
Chicago, IL 60605
312-742-8500

How to Access
To be considered for an apartment, you must submit a completed application. The application must identify which senior building/development you are interested in—see units (http://www.thecha.org/residents/public-housing/find-public-housing?pt=2) and waitlist status. You will also be asked to provide your current address, your family composition and other basic information about you. Applications are available here (https://applyonline.thecha.org/).

The CHA will notify you when your application reaches the top of a particular wait list. You will be invited to attend an in-person interview at your selected site. During this interview you will be provided additional information on housing options available to you.

Description
CHA has nearly 9,000 Senior units in 34 properties throughout Chicago. Most CHA Senior buildings have been rehabilitated with new kitchens, new bathrooms, upgraded heating/cooling systems, sprinkler systems, and many fire safety features that accommodate the needs of older residents. The properties offer city views and age-targeted amenities such as recreation rooms, scheduled activities and services, and 24-hour on-site maintenance.

Eligibility

- For seniors 55yo+
- Income eligibility guidelines apply
- Most properties have a waitlist
Low Income Public Housing
Housing Authority of Cook County

Affordable housing for low-income individuals and families.

Intake phone
312-663-5447
Email
phtenant@thehacc.org
Hours
M-Tu, Th-F 8:30am-4:30pm

Housing Authority of Cook County
M-Tu, Th-F 8:30am-4:30pm
175 W. Jackson Blvd.
Suite 350
Chicago, IL 60604
312-663-5447

How to Access
See currently open wait-lists (http://thehacc.org/low-income-public-housing/wait-list-information/), including eligibility criteria.

All completed applications should be mailed or faxed to
HACC/Public Housing Wait List & Leasing Department
175 West Jackson; Suite 350
Chicago, IL 60604
Fax 312-542-4752

When selected from a wait list, applicant is screened. If found eligible, applicant is offered a unit. If applicant accepts a unit, applicant signs a lease with the HACC. HACC is the landlord.

Description
The Public Housing Program provides affordable, decent, safe and sanitary housing to low-income families in 137 residential properties throughout Cook County. The Program is funded by the Department of Housing and Urban Development (HUD) and administered by the HACC. Each of the communities has additional specific Management and Maintenance personnel assigned to them. The Authority works closely with local municipalities and the County of Cook to provide equal access to quality housing for people of limited means.

Eligibility
- The annual income for a one person household cannot exceed $42,600, and the annual income for a two person household cannot exceed $48,650 (subject to change, per HUD guidelines).
- Households will be required to pay up to 30% of adjusted annual income.
- HACC has established preferences for admission to public housing (other than date of application), in order of priority, as follows:
  - Age 62 and older and Persons with Disabilities = 4 points
  - Applicants who meet the definition of homelessness = 3 points
  - Veterans and veterans’ widows/widowers = 2 points
  - VAWA applicants and Victims of reprisals or hate crimes = 1 point

Reduced Fare Permits
Regional Transportation Authority

Reduced cost public transportation program for seniors and people with disabilities.

Intake phone
312-913-3110

Hours
M-F 8:30am-5:00pm

RTA Administrative Offices
175 W. Jackson Blvd
Suite 1650
Chicago, IL 60604
312-913-3200

How to Access
Individuals may apply:
- In person at the RTA’s Customer Service Center at 69 W. Washington St., Lower Level Pedway in Chicago Monday through Friday between the hours of 8:30 a.m. and 5:00 p.m.
- At any one of the registration sites in the region. To find a site near you, call 836-7000 from any local area code. See Senior Registration Sites (http://www.rtachicago.com/files/documents/riderservices/Senior%20Reduced%20Fare%20Registration%20Centers_2015042112109_90066.pdf). See Persons with Disabilities Registration Sites (http://www.rtachicago.com/files/documents/riderservices/Disability%20Reduced%20Fare%20Registration%20Centers_2015042112109_88241.pdf)
- By mail, by downloading an application and mailing it to the address listed:

When applying, please be prepared to provide:
- A copy of a government-issued picture identification card that verifies your age (driver's license, state of Illinois ID card, alien registration card or passport).
- A wallet-sized color photo of yourself that is approximately 2" square. Do not wear a hat, scarf or sunglasses in the photo. Some registration centers may charge up to $5 for taking your photo. The RTA’s Customer Service Center does not charge for this service. You should receive your new reduced fare permit within 3-4 weeks.

Any individual with a valid Medicare card is eligible for a reduced fare permit. To apply as a Medicare cardholder, you will need verification of Medicare status. You can obtain a printout verifying your status by calling the Social Security Administration at 1-800-772-1213, or by visiting a Social Security Administration Office, or by downloading a statement on the Social Security website (www.ssa.gov).

Description
The RTA issues Reduced Fare and Ride Free permits to eligible riders throughout the region. The RTA Reduced Fare Permit allows older adults, age 65 and older, and qualified people with disabilities and Medicare recipients to ride all RTA fixed-route services (regularly scheduled CTA, Metra and Pace buses or trains in Cook, DuPage, Kane, Lake, McHenry and Will Counties) at a reduced fare.

Eligibility
- If you are 65 years or older and not enrolled in the Illinois Department on Aging’s Benefit Access program, you are eligible for a reduced fare permit.
- All persons with a qualifying disability who are not enrolled in the Illinois Department on Aging’s Benefit Access program are eligible for reduced fare permit.

http://app-purplebinder.com/programs/reduced-fare-permits/?i=9k17mc=1&n=0&p=1&q=People+with+Disabilities
3/3/2016

Appendix 2: Commonly used community resources in the PArtNER intervention
Nutrition and Wellness Center
University of Illinois Hospital & Health Sciences System (UIC)

Intake phone
312-355-4425

Outpatient Care Center
1801 West Taylor Street
Suite IC
Chicago, IL 60612

How to Access
To schedule an appointment for any provider, patients need first to register in the hospital system by calling 312-996-1682.
After registering, call 312-355-4425 to schedule your appointment.

For your first appointment, please be prepared to provide:
- Your medical records
- Referring physician's information (name and phone number)
- Referral
- Present medication summary
- Insurance information
- Photo ID
- Prepared list of questions that you would like to address.
Please also bring a food log, exercise log, and patient history form (provided).

Description
The Nutrition and Wellness Center provides advanced clinical expertise, specializing in bone health, diabetes, medical nutrition therapy, and weight management. Services include both non-surgical and surgical weight loss programs.

Non-Surgical weight loss programs include:
Conservative, Medically Supervised Weight Loss Program:
For those patients interested in non-surgical weight loss, the Registered Dietitian (RD) is the initial practitioner whom the patient will encounter. The initial visit to our clinic involves a thorough nutrition assessment by a Registered Dietitian (RD) followed by a medical nutrition evaluation with our Physician Nutrition Specialist (MD). Weight loss goals are then implemented with the patient and follow ups are made to assess progress.

Nutrition and Wellness Boot Camp:
This twice weekly class offers a structured diet, as well as group physical activity. The participant will learn about all aspects of nutrition from weight loss to improving overall health through nutrition.

EZ Weight Loss:
EZ Weight Loss is based on one-on-one visits with our Registered Dietitian/Certified Personal Trainer. This program is less structured in that it is ideal for the “take charge” individual who wants to have an active role in planning their weight loss strategies. It allows the patient to guide what is discussed at visits and make a more personalized plan for weight loss and health with the RD.

Surgical weight loss (Bariatric Surgery) services include:
Bariatric Nutrition 101:
In this 1-hour class the basic nutrition & lifestyle principles of the bariatric surgery patient is reviewed. This class is a mandatory component of the pre-surgery weight loss process.

Our Bariatric Surgery program offers several surgical options. Most insurance companies require "Medically Supervised Weight Loss" that consists of 3-18 months of visits with our Physician and Dietitian prior to being approved for surgery.
Support Services for Veteran Families
Heartland Alliance

Provides a variety of supportive services to veterans and their families.

Intake phone
773-728-5960
Email
SSVF@heartlandalliance.org
Hours
M-F 8:30am-5:00pm

Heartland Human Care Services
4411 N. Ravenswood Ave.
Chicago, IL 60640
773-728-5960
Fax: 773-728-4907

How to Access
Call 773-728-5960 to determine eligibility and begin program enrollment.

Must provide the following for enrollment:

- The following documentation is required to enroll in SSVF:
  - Photo I.D.
  - DD-214 Form that shows discharge status (SSVF cannot serve individuals with a dishonorable discharge status)
  - Proof of any household income
  - Housing payment receipts (if currently housed)
  - Copies of lease or landlord agreement (if currently housed)
  - Social security cards of family members
  - Birth certificates of dependent children

Description
The SSVF program is funded by the United States Department of Veteran Affairs and is administered through Heartland Human Care Services to provide supportive services for low or very low-income veteran families residing in or transitioning to permanent housing. These services are designed to increase the housing stability of veteran families that are at-risk of or experiencing homelessness.

Services include:

- Housing stability case management and housing location and inspection
- Emergency financial assistance to acquire or maintain permanent housing
- Tenant rights and responsibilities education and support
- Asset development and financial literacy
- Job readiness and employment placement services
- Referral for health care, daily living, wellness, transportation, legal, and child care services

Eligibility

- Must reside in the City of Chicago
- Must have a household income less than 30% of the Area Median Income
- Must be a member of a veteran household (individual or family) and meet at least one of the following criteria:
  - At risk of losing permanent housing within 14 days (i.e. have received an eviction notice or scheduled eviction date)
  - Residing in a "doubled up" situation and be able to provide a notarized letter from lease holder that states need to vacate unit within 14 days
  - Residing in housing that is not meant for human habitation (i.e. street, park, train)
  - Fleeing a situation of domestic violence

http://app.purplebinder.com/programs/support-services-for-veteran-families/?i=7&l=1&mc=1&nf=0&p=1&q=Human+Develop... 3/3/2016
Smoking Cessation
University of Chicago Medical Center

Intake phone
(773) 702-0880

Hours
M, W, F 9:00am - 4:00pm

The University of Chicago Medicine
5841 S. Maryland Avenue
Chicago, IL 60637

How to Access
To request an appointment for yourself or to refer a patient, please complete the Tobacco Cessation Program referral form (http://www.uchospitals.edu/pdf/uch_018745.pdf) and fax it to (773) 834-0242.
To request an appointment by phone, please call the Asthma and COPD Center at (773) 702-0880.

Description
The University of Chicago Medicine offers an individualized, comprehensive approach to help you overcome nicotine addiction. Our Tobacco Cessation Program is designed to help you quit smoking within two to three sessions.

Using an effective combination of FDA-approved medications and behavioral counseling, our skilled specialists offer:
- Nicotine addiction assessment, using the Fagerstrom Tolerance Questionnaire—a highly reliable assessment tool
- Carbon monoxide monitoring at every visit, to record differences in your carbon monoxide levels before and after you quit smoking
- Counseling, provided by a trained tobacco treatment specialist, which includes stress management, problem solving and other strategies to help prevent relapse.

Our multidisciplinary team is comprised of physicians, nurses and a tobacco treatment specialist. Social workers are also available to help patients access helpful resources as needed.

If you have questions about the Tobacco Cessation Program, please contact Ethan Israelsohn, LCSW, AE-C at 773-72-9952 or ethanis@uchicago.edu (mailto:ethanis@uchicago.edu).
Appendix 2: Commonly used community resources in the PARtNER intervention

Medication Assistance Program
University of Illinois Hospital & Health Sciences System (UIC)

Prescription payment assistance program for people unable to pay for their prescription medications.

Intake phone
312.996.7235

Chicago, IL

How to Access
Once a client is referred, they must come in for an intake appointment. They will be asked to bring proof of income. If clients qualify, they will typically be asked to do an intake appointment every year.

Description
Medication Assistance Program works directly with patients in need of prescription payment assistance. Program helps individuals receive discounted pharmaceuticals by applying directly to the manufacturer's discount programs. MAP will apply to multiple manufacturers if client's prescriptions requires, and essentially act as case managers. Discounted rates are generally available for prescriptions whose manufacturers do not have a discount program. Clients must fill their prescriptions at a University pharmacy.

Eligibility
Clients must be referred to the program by a doctor in the University of Illinois Healthcare system. Program primarily works with uninsured individuals, individuals on Medicare, or individuals with high copays.


Appendix 2: Commonly used community resources in the PARtNER intervention
Free Cell Phone
SafeLink Wireless

Free cell phone and service for eligible individuals.

Intake phone
1-800-SAFELINK (1-800-723-3546)

Hours
M - Sat: 8am - 10pm EST, Sun: 8am - 7pm EST

SafeLink Wireless
Chicago, IL
1-800-SAFELINK (1-800-723-3546)

How to Access
The easiest and fastest way to apply for service is by filing out the application online and providing your e-signature. Click here (https://www.safelinkwireless.com/Enrollment/Safelink/en/NewPublic/index.html) and enter your zip code to fill out your application online. Important: You will also need to provide a copy of a document that proves your program or income eligibility.

Alternatively, you can call us at 1-800-Safelink to have an application sent to you via fax or mail. Once you have received and completed your application, sign the application and return it to us along with copies of documents that prove you qualify for SafeLink Wireless Service.

*Note: Proof of program participation or income level is required in order to process the application. For program participation, copies of the following items are required. Your Medicaid or Food Stamp Card, a letter from SSA or state agency stating that you receive the benefit, or a similar document. For Income qualification, send copies of last year's Federal or State Income Tax return, a Social Security statement of benefit, a letter from your employer, pay stubs from 3 consecutive months, an Unemployment or Workmen's Compensation statement of benefits, a Retirement/Pension statement of benefits or a divorce decree, child support award, or other official document containing income information. Legal name and address on the documents must match the applicant. If you have any questions, please contact the SafeLink Wireless Hotline at 1-800-Safelink.

Description
SafeLink Wireless makes wireless telephone service more affordable by offering Lifeline service for qualified customers. Qualified customers will receive a free SafeLink Wireless handset and free monthly Minutes with no commitments, contracts, or bills. If you need additional Minutes, you can buy TracFone Airtime Cards at any TracFone retailer (Walmart, CVS, Kmart, Target, Radio Shack, Walgreens, Rite Aid stores, Family Dollar and Dollar General).

Our SafeLink Wireless service provides three different plans to choose from at NO COST to the customer. We also provide you with a FREE SafeLink Wireless phone at no cost. That is right, three different plans to choose from with FREE MINUTES EVERY MONTH AND A PHONE FOR FREE!

Eligibility
General Eligibility for Illinois
You are eligible if you receive benefits from one of the following programs:
- Medicaid
- Supplemental Nutrition Assistance Program (SNAP) Food Stamps
- Temporary Assistance for Needy Families (TANF) (*)
- Supplemental Security Income (SSI)
- Federal Public Housing Assistance (Section 8)
- Low-Income Home Energy Assistance Program (LIHEAP)
- National School Lunch Program’s (Free Lunch Program)


Appendix 2: Commonly used community resources in the PArTNER intervention
Appendix 2:
Commonly used community resources in the PARtner intervention

Child Care Resource & Referral
Illinois Department of Human Services (DHS)

Resources and referrals for local child care providers.

**Intake phone**

**DHS Help Line:** 1-800-843-6154 or call Local Office

**YYWCA Patterson and McDaniel Family Center**

2055 W. Army Trail Rd.
Suite 140
Addison, IL 60101
630-790-6600 (option 3)
Fax: 630-629-7801

**Illinois Action for Children**

8741 South Greenwood Avenue
Suite 300
Chicago, IL 60619
312-823-1100

**Illinois Action for Children**

1340 South Damen Avenue
3rd Floor
Chicago, IL 60608
312-823-1100
Fax: 312-823-1200

**How to Access**

To access these programs, contact a DHS Office Locator ([http://www.dhs.state.il.us/page.aspx?module=12&officetype=2&county=]). Select your county, for Cook also enter your zip code, to find the nearest office to you.

**Description**

The Illinois Department of Human Services works hand-in-hand with local communities throughout Illinois to provide low-income, working families with access to quality, affordable child care. DHS contracts with over 100 child care providers to give quality care for your child(ren) in a safe and healthy environment. These providers can connect you any one of the following programs in a community near you:

Child Care Assistance Program (CCAP) ([http://www.dhs.state.il.us/page.aspx?item=30355]) provides low-income, working families with access to quality, affordable child care that allows them to continue working and contributes to the healthy, emotional and social development of the child. Families are required to cost-share on a sliding scale based on family size, income, and number of children in care.

Migrant Head Start ([http://www.dhs.state.il.us/page.aspx?item=30353]) office provides child care and a comprehensive program of health, parent involvement, and social services for preschool children (under 6 years of age) of low-income migrant and seasonal farm workers.

Head Start State Collaboration office is a federal-state partnership organized to support and encourage collaboration with Head Start and various other state and local stakeholders that serve low-income families with young children.

Healthy Child Care Illinois ([http://www.dhs.state.il.us/page.aspx?item=30516]) provides a network of registered nurses who help child care workers provide quality care for the well-being of Illinois children.

Quality Counts Quality Rating System (QRS) assists Illinois child care programs in providing quality care for children and their families. A provider's voluntary participation in QRS means they have gone the extra mile to help make sure children are receiving an enhanced learning and care experience, which can help children succeed in school and in life. Providers caring for children eligible for the IDHS Child Care Assistance Program (CCAP) also receive a quality bonus above the standard payment rate.

**Eligibility**

Each child care program has its own eligibility requirements.

New or Replacement Social Security Number and Card
Social Security Administration

Information for individuals to obtain a new or replacement Social Security Number/Card.

Intake phone
1-800-772-1213 TTY: 1-800-325-0778

Social Security Office
M, T, Th & F, 9am - 4pm; W, 9am - 12pm
7440 Providence Dr.
Woodridge, IL 60517
1-886-303-2724
Fax: 1-630-825-2607

Social Security Office
M, T, Th & F, 9am - 4pm; W, 9am - 12pm; Closed on Weekends
230 W. Lake St.
Bloomington, IL 61708
1-800-772-1213
Fax: 1-800-325-0778

US Social Security Administration
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
9715 South Cottage Grove
Chicago, IL 60628

Social Security Administration
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
1233 West Adams
Chicago, IL 60607

Social Security Administration
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
5130 W. North Ave.
Chicago, IL 60639

Social Security Administration
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
8658 S. Sacramento Ave
Chicago, IL 60652

Social Security Office
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
6338 S. Cottage Grove Ave.
Chicago, IL 60637

Social Security Office
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
8658 S. Sacramento Ave
Chicago, IL 60652

US Social Security Administration
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
4849 N. Milwaukee Ave.
Suite 600
Chicago, IL 60630

US Social Security Administration
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
2416 S. Pulaski Rd
Chicago, IL 60623

US Social Security Administration
M-Tu, Th-F 9:00am-4:00pm W 9:00am-12:00pm
77 W. Jackson Blvd.
Suite 300
Chicago, IL 60604

How to Access
See the original documentation (https://www.ssa.gov/ssnumber/ss5doc.htm) required for the following Social Security Cards:
- Original Card for a U.S. Born Adult
- Replacement Card for a U.S. Born Adult
- Corrected Card for a U.S. Born Adult
- Original Card for a Foreign Born U.S. Citizen Adult
- Replacement Card for a Foreign Born U. S. Citizen Adult
- Corrected Card for a Foreign Born U.S. Citizen Adult
- Original Card for a U.S. Born Child
- Replacement Card for a U.S. Born Child
- Corrected Card for a U.S. Born Child
- Original Card for a Foreign Born U.S. Citizen Child
- Replacement Card for a Foreign Born U.S. Child
- Corrected Card for a Foreign Born U.S. Citizen Child
- Original Card for a Foreign Born U.S. Citizen Adopted Child


Appendix 2: Commonly used community resources in the PARtner intervention
Social Security Disability Insurance

Social Security Administration

Social Security Disability Insurance for people who cannot work due to a medical condition.

Intake phone
1-800-772-1213

US Social Security Office
230 W Lake St.
Bloomington, IL 60108
1-800-772-1213
Fax: 1-800-325-0778

Social Security Administration
5130 W. North Ave
Chicago, IL 60639
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
1233 W. Adams St
Chicago, IL 60607
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
US Social Security Administration
10718 S. Roberts Rd
Chicago, IL 60645
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
2416 S Pulaski Rd
Chicago, IL 60623
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
4849 N Milwaukee Ave
Chicago, IL 60630
1-800-772-1213 TTY: 1-800-325-0778

Social Security Office
2127 W Lawrence Ave
Chicago, IL 60625
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
US Social Security Administration
230 North Mannheim Rd
Hillside, IL 60162
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
600 W Madison St
Chicago, IL 60661
1-800-772-1213 TTY: 1-800-325-0778

Social Security Office
6338 S. Cottage Grove Ave
Chicago, IL 60637
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
US Social Security Administration
9715 South Cottage Grove
Chicago, IL 60628
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
7440 Providence Dr
Woodridge, IL 60517
1-866-303-2724 TTY: 1-630-852-2607

Social Security Administration
3260 W. Fullerton Ave
Chicago, IL 60647
1-800-772-1213 TTY: 1-800-325-0778

Social Security Administration
7222 W Cermak Rd
Chicago, IL 60654
1-800-772-1213 TTY: 1-800-325-0778

How to Access
Use the checklist (http://www.socialsecurity.gov/hp/radr/10/ovw001-checklist.pdf) for the online disability application to prepare the information you will need to gather.

Apply online (https://secure.ssa.gov/iClaim/dib) or call the toll-free number, 1-800-772-1213, to make an appointment to file a disability claim at your local Social Security office or to set up an appointment for someone to take your claim over the telephone.


Appendix 2: Commonly used community resources in the PARtNER intervention
Supplemental Security Income
Social Security Administration

Supplemental income for blind, aged and disabled people.

Intake phone
1-800-772-1213 TTY: 800-325-0778

US Social Security Administration
230 W. Lake St.
Bloomington, IL 60910
1-800-772-1213
Fax: 1-800-325-0778

US Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
8658 S. Sacramento Ave.
Chicago, IL 60652

Social Security Office
M-Th 9:00am-4:00pm W 9:00am-12:00pm
2127 W. Lawrence Ave.
Chicago, IL 60625

Social Security Office
M-Th 9:00am-4:00pm W 9:00am-12:00pm
6338 S. Cottage Grove Ave.
Chicago, IL 60637

Social Security Office
M-Th 9:00am-4:00pm W 9:00am-12:00pm
230 North Mannheim Rd
Hillside, IL 60162

Social Security Office
M-Th 9:00am-4:00pm W 9:00am-12:00pm
230 W. Lake St.
Bloomington, IL 60910

Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
5130 W. North Ave.
Chicago, IL 60639

Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
1233 W. Adams St
Chicago, IL 60607

Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
10718 S. Roberts Rd
Palos Hills, IL 60465

US Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
2416 S. Palaski Rd
Chicago, IL 60623

Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
7440 Providence Dr.
Woodridge, IL 60517
1-866-303-2724 TTY: 1-630-852-2607

US Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
9715 South Cottage Grove
Chicago, IL 60628

US Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
2116 Green Bay Rd
Evanston, IL 60201

US Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
3260 W. Fullerton Ave.
Chicago, IL 60647

US Social Security Administration
M-Th, F 9:00am-4:00pm W 9:00am-12:00pm
77 W. Jackson Blvd.
Suite 300
Chicago, IL 60604

How to Access
Use the Benefits Eligibility Screening Tool (http://ssabest.benefits.gov/) to determine if you are eligible for benefits.

http://app.purplebinder.com/programs/supplemental-security-income?i=2&l=&mc=1&n=0&p=1&q=social+security+administration

Appendix 2: Commonly used community resources in the PARtNER intervention
Immigration Services
The Resurrection Project

Information and advocacy for immigrants who want protection from deportation or to become citizens.

Intake phone
312-666-5476

Hours
M-F 9:00am-5:00pm

The Resurrection Project
1818 S. Paulina St
Chicago, IL 60608
312-666-1323

How to Access
For DACA and other Citizenship Services:
- Check online calendar (http://resurrectionproject.org/programs-and-services/calendar-of-events-and-workshops/) for upcoming events and workshops.

For Administrative Relief Information:
- Call the Citizenship Line at 312-666-3062. Leave a voicemail with your name and telephone number if no one answers. Your call will be returned promptly.

An appointment is required for citizenship services. If you attend a workshop, you will be provided with an appointment date and time. Call Lupe at 312-666-5476 for additional information.

Description
Citizenship Services:
Becoming a citizen provides residents with full access to rights in US society. Individuals might qualify for citizenship if they meet certain legal guidelines, such as having legally been in the United States for approximately five years, or if they have lived in the United States for three years, and married a US citizen. Citizenship applicants must also have some familiarity with the English language and a basic knowledge of US history, geography and government in order to pass the naturalization exam. However, some applicants might qualify to take this test in their native language. After completing the process, approved applicants become citizens in about four to six months.

DACA Services:
Deferred Action for Childhood Arrivals (DACA) is an executive action by the Obama Administration that applies to certain people who entered the United States before the age of sixteen. If these individuals meet certain academic and legal guidelines, they can apply for DACA. If approved they can obtain a Social Security number and receive a work permit to legally work in the United States. They are also protected from deportation. However, DACA is only a temporary status, not a path to citizenship. DACA recipients must re-apply for DACA every two years.

If you think that you qualify for DACA or need to renew it, please attend one of our DACA informational sessions. At this session you will learn key information about DACA. In addition, we will meet with each workshop attendee to confirm that they are eligible for DACA. If you do qualify, you will be invited to our second workshop. At this workshop, you will be asked to bring all of the documents required for the DACA application. Then, you will fill out the application at our workshop. TRP’s attorneys will review your completed application to insure that it is ready to send, and then mail it for you. You will receive a copy of the mailed version, along with information on next steps for you to take once you have been approved.

Administrative Relief Services:
Following President Obama’s November 20 announcement of administrative relief for undocumented immigrants, The Resurrection Project (TRP), in partnership with various regional and national organizations, is launching an education and information campaign, Educate Yourself! The goal is to provide access to information and resources regarding this historic action, and to help keep undocumented individuals from being exploited by scam artists.

http://app.purplebinder.com/programs/immigration-services-1?i=3&l=&mc=1&nf=0&p=1&q=social+security+administration

3/3/2016

Appendix 2: Commonly used community resources in the PARtNER intervention
Resource Guide for People with Disabilities
Equip for Equality

Online resource guide for residents of Illinois who have disabilities.

Intake phone
312-341-0022

Equip for Equality
20 N. Michigan Ave.
Suite 300
Chicago, IL 60602
312-341-0022

How to Access
Download a copy of the resource guide here (http://www.equipforequality.org/learn/resource-guide-for-people-with-disabilities/).

Description
The Resource Guide for People with Disabilities provide individuals with disabilities, their families, disability advocates, and service providers, information about disability-related services available in Illinois.

Eligibility

- For individuals with disabilities, their families, disability advocates, and service providers, who live in Illinois


Appendix 2: Commonly used community resources in the PARtNER intervention
Community Technology Center (CTC)
Back of the Yards Neighborhood Council

Free computer lab and computer skills courses for residents of the Back of the Yards community.

Intake phone
773-523-4416

Hours
M-F 9:00am-5:00pm

1751 W. 47th St.
Chicago, IL 60609
773-523-4416
Fax: 773-254-3525

How to Access
Call Norma Manzo at 773-523-4416 for more information or walk in.

Description
The Back of the Yards Neighborhood Council has a Community Technology Center (CTC) that allows its users to acquire the basic skills necessary to operate a PC by providing access to computers and the BYNC’s knowledgeable staff. Business owners, neighborhood children, job seekers, and seniors all benefit from the CTC.

The CTC offers computer classes, as well. The structured computer classes allow participants to learn the basic skills of computer use, including: using the cursor, the mouse, creating and saving a file, opening files, closing files, setting margins, editing files, using different types of fonts and sizes, mastering the use of the printer, and being able to write basic letters and documents on Microsoft Word. Advanced level classes instruct participants in using Microsoft Word, Microsoft Excel, and PowerPoint.

On Mondays and Thursdays, a shuttle bus brings seniors to the CTC so that they may learn new computer skills and connect with one another.

Access to computers, word processors, and the Internet are particularly beneficial for adults seeking employment, and for students who need to complete their homework.

Eligibility

- For residents of the Back of the Yards neighborhood
Center for Working Families
Instituto Del Progreso Latino

Free career coaching and financial education.

Intake phone
773-890-0055

Center for Working Families Pilsen
2520 S. Western ave
Apt 3
Chicago, IL 60608
773-890-0055

Center for Working Families Cicero
2138 S. 61st Court
Suite 100
Cicero, IL 60804

Center for Working Families Back of the Yards
4600 S. Wood
Chicago, IL 60609
773-927-1277

How to Access
Call 773-890-0055 to find out when the next orientation session will take place.

Documents to bring to orientation:
- Valid driver's license or state ID
- Social Security card
- Birth certificate
- Work Permit
- Proof of income

Description
The Center for Working Families offers free career counseling, including workshops, direct job placement, resume prep, mock interviews, and job search assistance. Participants also receive free financial counseling, learn computer literacy skills, and receive screening for public benefits eligibility. The program has three locations in the city of Chicago.

Eligibility
- Meets income requirements
Illinois Job Link
Illinois Department of Employment Security

Job development services, including unemployment insurance and employment services.

Intake phone  
800-244-5631  

Hours  
M-F 8:30am-5:00pm  

Joliet- Unemployment and Employment Services  
250 N Chicago  
Joliet, IL 60432

Lisle- Employment Services  
2525 Cabot Drivc  
Lisle, IL 60532

Harvey- Unemployment and Employment Services  
16845 S Halsted St  
Harvey, IL 60426

Chicago (Blue Island Pilsen) 
Unemployment and Employment Services  
1700 W 18th St  
Chicago, IL 60608

Chicago (Mid South) Employment Services  
4314 S. Cottage Grove Avenue  
Chicago, IL 60653

Chicago (Lawrence) Unemployment and Employment Services  
2444 W Lawrence  
Chicago, IL 60625

Chicago (Mid South) Unemployment Services  
715 E 47th St  
Chicago, IL 60653

Chicago (Northside) Employment Services  
5060 N. Broadway Street  
Suite 690  
Chicago, IL 60640

Maywood- Employment Services  
1701 S 1st Ave  
Suite 10  
Maywood, IL 60153

Chicago (Daley College) Employment Services  
7500 South Pulaski  
Bldg 100  
Chicago, IL 60652

Burbank- Unemployment and Employment Services  
5608 W 75th Pl  
Burbank, IL 60459

Chicago (Woodlawn) Unemployment and Employment Services  
1515 E 71st  
Chicago, IL 60619

Arlington Heights- Unemployment and Employment Services  
723 W Algonquin Rd  
Arlington Heights, IL 60005

How to Access  
Walk-in for assistance with unemployment insurance and for job search assistance. Note, some centers may offer only one of these services, while many offer both. Please be prepared to provide:  
- Photo ID  
- Social Security number  
- Employment history information

Participant may also file their unemployment claim online (http://www.ides.illinois.gov/Pages/10%20Things%20You%20Should%20Know.aspx).  

Find employment with a variety of online job resources (http://www.ides.illinois.gov/Pages/Search_for_Jobs.aspx).

Description  
IDES provides unemployment insurance (UI), employment services and guidance to workers, job seekers, and employers through a statewide network of IDES offices and Illinois workNet centers. The agency combines federally-funded job training programs in Illinois into a "workforce development" system where individuals can find a job or train for a new career.

http://app.purplebinder.com/programs/illinois-job-link?i=0&l=&mc=1&nf=0&p=1&q=IDES  
3/3/2016

Appendix 2: Commonly used community resources in the PArTNER intervention
### Appendix 3: PArTNER Discharge Patient Education Tool (DPET)

<table>
<thead>
<tr>
<th>Information</th>
<th>Page number</th>
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<tbody>
<tr>
<td>Transportation from hospital</td>
<td>1</td>
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<tr>
<td>Emergency information</td>
<td>2</td>
</tr>
<tr>
<td>Learn about the PArTNER study + UI Health</td>
<td>3</td>
</tr>
<tr>
<td>Keep track of doctor’s visits + medications</td>
<td>8</td>
</tr>
<tr>
<td>Find support in your community</td>
<td>19</td>
</tr>
<tr>
<td>Take control of your care</td>
<td>23</td>
</tr>
</tbody>
</table>
Transportation from hospital

You can get rid of this page when you are home from the hospital.

For [Patient Name]

Being picked up by [Name or service]

Phone # [Service phone number]

Going to [Home, nursing facility, etc]

At address [Street address]
[City, state, zip]

Alternate contact(s) [First name last name]
[Relationship]
[Alternate contact phone #]

Appendix 3: PArTNER Discharge Patient Education Tool (DPET)
Emergency information for [patient name]

Watch for signs + symptoms

[symptom] [symptom] [symptom]

Take action

Call [follow-up doctor] at [doctor’s phone number] if [patient’s name] has the symptoms above

Have this information when you call

Hospitalization summary
Patient name:
Medical record #:
Date of birth:
Admission date:
Discharge date:
Primary discharge diagnosis:

Insurance information
Insurance type:
Insurance #:
Insurance phone #:

Keep this page where it is easy to see.
Get rid of this page when follow-up is complete.
Get updated information from your follow-up doctor.
Learn about the PArTNER study + UI Health

What’s inside

1A PArTNER study overview

1B UI Health community clinics

Consent form

This information will help you...

✔ understand the study you enrolled in

✔ know what clinics are available in the UI health system
Many patients return to the hospital less than a month after they are discharged from the hospital.

It can be hard for patients to get back on their feet after they return home.

During this time, patients sometimes feel abandonment, anxiety, fear, or as if they can’t take care of themselves as well as they would like.

The PArTNER study is trying to find out
- what patients need when they go home
- how hospitals can help them stay healthy during this time

After you are discharged home, you will get 2 calls from a research coordinator.

They will ask you questions about your current health.

These calls last around 15 minutes each.
After you are discharged home, you will get:

- 1 home visit from your patient navigator
- 5 calls from your peer coach (iPARTNER) over the next 2 months
- 2 calls from your research coordinator who will ask you questions about your health.

Each call lasts around 15 minutes.

<table>
<thead>
<tr>
<th>iPArTNER Phone #</th>
<th>Patient Navigator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.844.iPrTNER</td>
<td>[Navigator name]</td>
</tr>
<tr>
<td>1.844.477.8637</td>
<td>[Navigator phone #]</td>
</tr>
</tbody>
</table>
Learn about the PArTNER study + UI Health

UI Health community clinics

Appendix 3: PArTNER Discharge Patient Education Tool (DPET)
Mile Square Health Centers

1. Main/Near west
   1220 South Wood St.
   Chicago, IL 60608
   312.996.2000
   Mon–Fri 9am-5pm
   Sat 8am-noon
   Sun Closed

2. Cicero
   Hawthorne Works Shopping Center
   4745-51 West Cermak Rd.
   Cicero, IL 60804
   708.656.4766
   Mon 9am-5pm
   Tues 9:30am-5:30pm
   Wed 9am-5pm
   Thurs 9am-5pm
   Fri 9am-5pm
   Sat + Sun Closed

3. Englewood
   641 West 63rd St.
   Chicago, IL 60621
   312.413.4070
   Mon–Fri 9am-5pm
   Sat + Sun Closed

4. South Shore
   7131 S. Jeffery Blvd.
   Chicago, IL 60649
   Mon + Tues 9am-5pm
   Wed 9:30am-5:30pm
   Thurs + Fri 9am-5pm
   Sat + Sun Closed

5. Back of the Yards
   4630 South Bishop St.
   Chicago, IL 60609
   773.523.2615
   Mon + Tues 8:30am-5pm
   Wed 9:30am-5:30pm
   Thurs + Fri 8:30am-5pm
   Sat 8:30am-noon
   Sun Closed

6. National Teachers Academy School-based Health Center
   55 West Cermak Rd.
   Chicago, IL 60616
   312.326.4472

7. Young Women’s Leadership Charter School-based Health Center
   2641 South Calumet Ave.
   Chicago, IL 60616
   312.949.0277

8. Davis Health and Wellness Center School-based Health Center
   3050 West 39th Place
   Chicago, IL 60632
   773.376.8008

9. Hope Health and Wellness Center School-based Health Center
   1628 West Washington Blvd.
   Chicago, IL 60612
   312.226.3288

10. Auburn Gresham Health and Wellness Center School-based Health Center
    8131 S May St.
    Chicago, IL 60620
    312.355.5801

11. North Integrated Health Care Clinic (detail)
    4221 North Lincoln Ave.
    Chicago, IL 60618
    773.537.3950
    773.537.3020
    Mon–Fri
    9am-noon, 1pm-5pm

12. South Integrated Health Care Clinic
    734 West 47th St.
    Chicago, IL 60609
    773.537.3960
    773.537.3238
    Mon–Fri
    9am-noon, 1pm-5pm

13. Humboldt Park Integrated Health Care Clinic
    3240 West Division St.
    Chicago, Illinois 60651
    312.413.7425
    Mon–Fri
    9am-noon, 1pm-5pm

UIC College of Medicine

14. Family Medicine Center at the University Village Clinic
    722 West Maxwell St.
    Suite 235
    Chicago, IL 60607
    Mon 8am-5pm
    Tues 8am-9pm
    Wed 9:30am-5pm
    Thurs 8am-9pm
    Fri 7am-5pm
    Sat 9am-Noon

Appendix 3: PArTNER Discharge Patient Education Tool (DPET)
Keep track of doctor’s visits + medications

Bring this information when you talk to the pharmacist, your doctor or your peer coach.

This information is for your follow-up period. Get updated information from your primary doctor.

Visit http://hospital.uillinois.edu/, then click “For Patients + Visitors,” then “Patient Information,” then “My UI Health.”

What’s inside

2A Appointment information

2B Medication routine

2C Your healthcare information

This information will help you...

✓ keep track of your follow-up doctor’s appointments

✓ maintain your new medication routine

[Patient name]
[Patient Date of Birth]
# Keep track of doctor’s visits + medications

## Appointment information

### February 2016

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<thead>
<tr>
<th>Su</th>
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**Appointment details**

[February appointment details]

### March 2016

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**Appointment details**

[March appointment details]

### April 2016

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**Appointment details**

[April appointment details]
2A Appointment information for [patient name]
February 2016

Su M T W Th F Sa

1 2 3 4 5 6
7 8 9 10 11 12 13
14 15 16 17 18 19 20
21 22 23 24 25 26 27
28 29

Notes

Prevent the flu

Get a flu shot every year in the fall or winter months.

Wash your hands often and well.

Avoid being near people who are sick.

Eat a healthy diet.
What is medicaid?

Medicaid is a free or low-cost insurance plan based on income.

You are eligible if you earn an income of less than $15,800 for an individual or $32,500 for a family of 4.

Notes

________________________________________________________________________

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2A Appointment information for [patient name]

April 2016

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Notes

Managing stress
Watch out for:
- Feeling sad, burned out or hopeless
- Having trouble enjoying things you used to enjoy
- Sudden, intense nervousness, fear or panic

Get support from family, friends or a healthcare professional.

[Patient name]
[Patient Date of Birth]
2A Appointment information for [patient name]

May 2016

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Notes

Support groups

Sickle Cell Center
312.413.8666

Mended Hearts
Support Group for heart conditions
312.926.2070

Stroke Support Group
312.996.3700

COPD Foundation
866.316.COPD (2673)

University of Illinois Cancer Center
312.355.1625
Healthy eating

3 tips for healthy eating:

- Eat more of certain foods and nutrients found in fruits, vegetables, whole grains, low-fat dairy products + seafood.
- Eat fewer foods with sodium, saturated fats, trans fats, cholesterol, added sugars + refined grains.
- Balance calories with physical activity to manage weight.
# 2A Appointment information for [patient name]

## July 2016

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### Notes

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### Control your blood pressure

- Take medication as prescribed.
- Follow a healthy diet.
- Reduce the salty foods you eat.
- Maintain a healthy weight.
- Get tested for sleeping problems.
- Reduce stress.

---

[Patient name]  
[Patient Date of Birth]

Appendix 3: PArTNER Discharge Patient Education Tool (DPET)
Quit smoking for good!

Stay motivated
Make a list of reasons to quit and carry it with you.

Set a date
Preparing for your quit date is key to starting a new, smoke-free life.

Find support
Spend time with non-smokers and ex-smokers.

Smoking Cessation Clinic
312.355.1700
Medication routine

This information is a guide only. Be sure to read instructions from your doctor and on the medication bottle.

Bring this information when you talk to the pharmacist, your doctor or your peer coach.

Ask your doctor if you should still be taking each of these.

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Morning</th>
<th>Noon</th>
<th>Evening</th>
<th>Bedtime</th>
<th>As needed</th>
<th>Notes</th>
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</table>
### 2C  Keep track of doctor’s visits + medications
Your healthcare information

Bring this information when you talk to the pharmacist, your doctor or your peer coach.

<table>
<thead>
<tr>
<th>For physician use:</th>
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<tbody>
<tr>
<td><strong>Hospitalization summary</strong></td>
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<table>
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<td>Address:</td>
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<td>Pharmacy phone #:</td>
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<tr>
<td>Hours:</td>
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</tbody>
</table>
3 Find support in your community

Have this information when you talk to your navigator or peer coach.

What’s inside

3A Resources for you

3B Community resources

This information will help you...

✓ gain access to resources you need

✓ keep track of resources you are in the process of getting

✓ get the most out of your navigator visit and peer coach phone calls
## Resources for you

**Find support in your community**

### Category

- [resource categories]

### Resource + description

- [resource names + descriptions]

### Contact information

- [resource contact information]
### General resources

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| **Transportation** | First Transit  
*Non-emergency transportation services for patients with Medicaid*  
ADA Paratransit  
*For patients with disabilities* | 877.725.0569  
Mon-Fri 8am-5pm  
312.663.HELP (4357)  
TTY: 312.913.3122 |
| **Childcare** | Children’s programs at Greater Food Repository | 773.247.3663 |
| **Housing** | Chicago Department of Family and Support Services  
Garfield Center  
312.746.5400  
North Side Center  
312.744.2580  
South Chicago Center  
312.747.0331  
King Center (South side)  
312.747.2300  
Englewood (South side)  
312.747.0200  
Trina Davila (North side)  
312.744.2014  
Department of Human Services  
| 312.746.5400 |
| **Food** | Greater Chicago Food Depository  
*Ask for SNAP Outreach Team*  
Illinois Hunger Coalition | 773.247.FOOD (3663)  
Mon-Fri 8:30am-5pm  
800.359.2163 |
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<td>the smoking habit</td>
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<td><strong>UI Health</strong></td>
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<tr>
<td>Dental + Oral Care clinic</td>
<td>800.866.CARE</td>
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<tr>
<td>Eye + Ear Infirmary</td>
<td>312.996.6591</td>
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<td>Family Medicine Center</td>
<td>800.866.CARE</td>
<td></td>
</tr>
<tr>
<td>Neuropsychiatry and Psychology</td>
<td>312.996.7723</td>
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<tr>
<td>Hospital + Emergency Room</td>
<td>800.866.CARE</td>
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<td></td>
<td><strong>Other needs</strong></td>
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<tr>
<td>Non-emergency police</td>
<td>311</td>
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</table>
4 Take control of your care!

Take notes!
Keep a record of questions, concerns, important information from the doctor or pharmacist, and any challenges you are having getting follow-up appointments or resources.
Have these available when you talk with your peer coach.
Appendix 4: Usual Care Assessment form
Reference the step-by-step instructions located in the Usual Care Assessment MOP while completing this form. If more than one score is applicable, check the higher score.

### 1. Medication reconciliation performed on the date of discharge (check only one):

<table>
<thead>
<tr>
<th>Comments: ____________________________________________</th>
<th>a. RxCares or PharmD note on the date of discharge (not admissions reconciliation) (   )2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b. Medical Reconciliation box marked completed (   )1</td>
</tr>
<tr>
<td></td>
<td>c. None of the above (   )0</td>
</tr>
<tr>
<td></td>
<td>d. Unable to assess (   )U</td>
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</tbody>
</table>

### 2. Medication education provided to patient on the date of discharge (check only one):

<table>
<thead>
<tr>
<th>Comments: ____________________________________________</th>
<th>a. RxCares or PharmD note on the date of discharge (   )2</th>
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<tr>
<td></td>
<td>b. Educational materials about any specific medication or a specific device (inhaler, oxygen equipment etc.) provided to the patient OR about a class of medication specific to any of the patient’s medical conditions (as listed in discharge summary or discharge instructions). (   )1</td>
</tr>
<tr>
<td></td>
<td>c. None of the above (   )0</td>
</tr>
<tr>
<td></td>
<td>d. Unable to assess (   )U</td>
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</table>

### 3. Education on diagnosis, prognosis, self-care requirements, or procedures provided to patient on the date of discharge (check only one):

<table>
<thead>
<tr>
<th>Comments: ____________________________________________</th>
<th>a. Educational materials in Cerner in the Patient Education Note on diagnosis, prognosis, procedures, or self-care for any medical condition (as listed in discharge summary or discharge instructions) is present (   )2</th>
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<tr>
<td></td>
<td>b. No educational materials in the Patient Education Note on diagnosis, prognosis, procedures, or self-care for any medical condition (as listed in discharge summary or discharge instructions) is present (   )0</td>
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<tr>
<td></td>
<td>c. Unable to assess (   )U</td>
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### 4. Disease management education provided to patient on the date of discharge (check only one):

<table>
<thead>
<tr>
<th>Comments: ____________________________________________</th>
<th>a. Detailed instructions in Discharge Instructions or Patient Education note that are specific to patient’s medical condition about what to do and who to contact in event of new or worsening symptoms (   )2</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>b. Standard template language present in Discharge Instructions or Patient Education (i.e., call 911) (   )1</td>
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</table>
5. Structured Discharge Summary completed upon hospital discharge (check only one):

[USE DATE PROVIDED TO ASSESS]

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- a. Verification date for Discharge Summary is within 2 business days of discharge
- b. Discharge Summary not present or Discharge Summary verification date is not within 2 business days of discharge
- c. Unable to assess

6. Phone contact attempted within two business days post discharge with patient or caregiver (check only one):

Note: if there is an incoming call from patient within two business days, assess if there is an outgoing call from provider made within two business days following the incoming call

[USE DATE PROVIDED TO ASSESS]

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- a. Call completed with patient within 2 business days post discharge (successful call attempt)
- b. Call attempt within 2 business days post discharge (unsuccessful call attempt)
- c. None of the above
- d. Unable to assess

7. Follow-up appointment listed in discharge instructions is scheduled within 7 calendar days post discharge (check only one):

[USE DATE PROVIDED TO ASSESS]

<table>
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<th>Comments:</th>
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- a. In discharge instructions, date of appointment is listed within 7 calendar days post discharge (appointment needs information, address/location, date and time). Clinician name not necessary
- b. In discharge instructions, date of appointment is listed beyond 7 calendar days post discharge (appointment needs information on, address/location, date and time). Clinician name not necessary
- c. In discharge instructions, no follow-up appointment is listed at discharge
- d. Unable to assess

8. Discharge Instructions provided to patient on the date of discharge (check only one):

<table>
<thead>
<tr>
<th>Comments:</th>
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- a. Verification date for Discharge Instructions is the same as the discharge date (ignore time)
- b. No Discharge Instructions provided to patient on the date of discharge
- c. Unable to assess

Total Score: ____/16 (paper form only, will be automatically calculated in Excel or REDCap) [ADDITIONAL BACKGROUND DETAILS ON THIS ASSESSMENT ARE AVAILABLE IN USUAL CARE ASSESSMENT SCORING RUBRIC.]
Introduction

Welcome, Thanks for coming.

Orientation to the setting and procedures:
- A focus group is an open, confidential discussion about a specific topic.
- We ask that each of the members of this focus group respect the privacy of the other members.
- With your consent, this focus group will be taped to assist with report generation. No personally identifying information will be used in any reports.

Framing script:

Pretense:

The causes of avoidable hospital readmissions are complex and not completely understood. Variables include: patient illness level; communication with patients and families; reconciliation of medications; coordination with community clinicians and non-acute care facilities; and the availability of longitudinal post-hospital care that can recognize problems early and work towards their resolution. While all of these factors can affect patient outcomes and readmissions, the relative importance of each is not known. {Dartmouth Atlas Project, 2013 #3763}

You have been invited to participate in this focus group given your role in the care and management of patients with one or more of the following conditions: chronic obstructive pulmonary disease, heart failure, sickle cell disease, pneumonia, myocardial infarction, vascular procedures such as coronary artery bypass surgery and stenting of vessels.

We are interested in hearing about your experiences working with patients whom you have encountered in the past calendar year with any of the above conditions.
- A patient navigator is someone who can help support a patient to be more adherent with a treatment plan around the time of discharge from the hospital. In particular, we are interested in learning where, in your opinion, a patient navigator may help to keep one or more of your patients out of the hospital.

Time constraints:
- Because we have a lot of ground to cover, part of my responsibility will be to keep us on schedule.
Occasionally, I may have to shift topics before everyone has had an opportunity to share; however, if time permits, we'll come back to any unfinished topics.

Questions or concerns: Does anyone have any questions at this point?

Questions:
Clinical Factors, Quality and Access

We would like to begin by discussing your personal interaction with patients who have been hospitalized with the listed conditions: chronic obstructive pulmonary disease, heart failure, sickle cell disease, pneumonia, myocardial infarction, vascular procedures such as coronary artery bypass surgery and stenting of vessels.

[Communication] Are you usually aware that one of your patients has been hospitalized?
   If so or not, how does that affect patient care, if at all?
   If preference is to be made aware, what is most effective way to be notified?

[Communication] Are you usually made aware when one of your patients is being discharged from the hospital for any of the conditions listed above?
   If so or not, how does that affect patient care, if at all?
   If preference is to be made aware, what is most effective way to be notified?
   If so, how soon prior to discharge?

[Communication] We have read about communication between providers being a challenge. In your opinion, we would like to hear about what works well and where you encounter challenges.
   a. Probe: How soon after a patient is hospitalized do you receive a copy of the discharge orders? discharge note?
   b. Probe: How are you notified about changes in medication therapy?
   c. Probe: Ask about communication with other specialist; clear understanding of who is in charge of what?

[Accessibility] How soon do you try to see a patient in your office post an inpatient stay?
   Probe: How often are you able to get patients in this quickly?
   Probe: What gets in the way of your ability to follow up with a patient in your office in the weeks post inpatient hospitalization?
In your opinion, how can we coordinate care so that you can provide the care you want to your patient after hospitalization?

Patient and Socioeconomic Factors around the time of discharge

[Patient Global needs] What do you think are patient’s greatest needs to be able to follow a prescribed treatment plan in the weeks surrounding a hospital discharge? What, in your opinion, gets in the way of a patient being able to fulfill these needs?

[Patient Health Literacy] How well do you think a patient understood what was happening during and after his/her inpatient treatment?
   a. Probe: How comfortable did you feel finding additional information for your patient?

[Family Involvement] Were family members involved in the support of this patient with his/her disease management plan? If so, please describe family involvement in your care.
   b. Probe: Did they understand what was happening?
   c. Probe: were they a source of help? Pls. explain.
   d. Probe: were they a source of stress? Pls. explain.
   e. Probe: were they a source of motivation? Pls. explain.

If family members were not involved, how did this affect your care of the patient?

[Mental health] Patients have a range of mental health needs following discharge from the hospital. Were you aware and/or able to inquire as to a patient’s needs for mental/emotional support?
   a. Probe: Did you ask if your patient has a history of mental health problems?
   b. Probe: Did you feel like your patient needed additional emotional support after treatment?
   c. Probe: Did you feel your patient may be in denial of his/her condition? If so, do you think denial of illness often affects a patient’s ability to cope and adherence to treatment plan? What may be the implications?

[Cultural Competency] How well did you feel you understood “where the patient was coming from” with the challenges they said they faced in managing their medical condition post discharge?
   a. Probe: If so, how were they resolved?
   b. Probe: Were there any culturally-related obstacles to following through with medical recommendations? If so, please describe them and how they were resolved.
Inpatient provider:

If you had a patient at the end of a hospitalization, what tools did you provide for patient self-management prior to discharge?
   a. Probe: none, provided by others?
   b. Probe: teaching aids? Describe?

[Desired resources] If you had the ability to equip a patient whose disease state would benefit from management with support services, what might those services look like?
   a. Probe: Home nursing services?
   b. Probe: Someone to get groceries and check in once a day?
   c. Probe: Someone to attend doctor’s appointments and manage procurement of prescriptions and clinical supplies?
   d. Probe: other?

Patient navigators

The next series of questions we have is about the use of patient navigators. Patient navigators are individuals that can help patients discharged from hospitals to get any additional support that they need, to get them to their doctor’s appointments, and hopefully allow them to stay out of the hospital in the weeks after just being sent home.

1. In your opinion, would a patient navigator who can support your discharge planning and to assist your patient with meds, scheduling appointments and assisting with obtaining necessary supplies in the weeks after your hospital discharge be of help to you patient?

2. Can you identify a situation where a patient navigator would not be helpful?

3. Is there anything that you think the patient navigator should not do or take part in?
   Can you give some specific examples?

4. The patient navigator will likely need to contact your office for any patient issues post discharge, how do you feel about that?

5. Is there anything else that you would want the patient navigator to provide?

6. In your opinion, what patient-centered outcomes would be positively impacted by an effective patient navigator? Which outcomes are the most important to capture in studying the effectiveness of patient navigators in health care?
Health information technology

The last series of questions we have is about the use of health information technology. Health information technology refers to the use of hardware or software to collect and interpret data, assist in medical decision making and facilitate communication between patients and providers. Multiple “apps” have been developed to collect information from patients through their smartphones (mobile phones that connect to the internet and can run applications).

1. Do you see a role for smartphone applications in assisting patients being discharged from the hospital? Do you think all patients would be able to access such an approach to discharge management, i.e. do all patients have smartphones?

2. If so, what type of applications would you find useful?

3. If an app were to be designed to facilitate communication between patients and providers (yourselves, what would be the appropriate nature of this communication?

4. Do you have any concerns regarding the use of the patient’s mobile phones to collect data and communicate with patients?
   a. No. Probe: Privacy concerns?

General follow-up questions:
Before we close, are there any other issues that we have not discussed that you would like to share?

Thank you for your time and sharing. We would like to remind everyone that what was said in this room today remains needs to remain confidential, thus we ask each of you to respect the privacy of all participants.

References:

Patient Navigators to Prevent Re-hospitalizations
Focus Group Moderator Guide
[Patient focus groups interview guide]

Introduction

- Welcome, Thanks for coming.

- **Orientation to the setting and procedures:**
  - A focus group is an open, **confidential** discussion about a specific topic.
  - We ask that each of the members of this focus group respect the privacy of the other members.
  - Keep in mind that there are no correct answers to the questions that we will be asking and each of us is entitled to our own opinions.
  - The focus groups will be taped (with your consent) so we can write the report. However, no identifying information will be used in any reports.

- **Framing script:**
  - We have invited you to participate in this group because you have a [diagnosis of xxx or had a vascular procedure) and have been hospitalized within the past XX.
  - We are interested in hearing about your experiences, and learning from you about potential barriers that may interfere with your ability to access the care and resources you need to manage your [disease or condition] outside of the hospital.
  - We are also interested in understanding from you whether having someone to assist with finding doctor(s), scheduling appointments, arranging transportation and dealing with reimbursement might help you to overcome these barriers?

- **Time constraints:**
  - Because we have a lot of ground to cover, part of my responsibility will be to keep us on schedule.
  - Occasionally, I may have to shift topics before everyone has had an opportunity to share; however, if time permits, we’ll come back to any unfinished topics.

- **Questions or concerns:** Does anyone have any questions at this point?

**Interview Guide for Focus Groups: Sample Questions**

Circumstances that led up to your hospitalization
1. We would like to start our conversation by talking about circumstances that led up to your need to be admitted in the hospital for [disease or condition] Can you
recall if the exacerbation came on suddenly, or could you feel yourself getting worse over the course of several days (make disease appropriate)?

2. When you feel yourself getting worse, who do you typically call? Do you call a family member like your son or daughter, a neighbor, a doctor, or someone else?

3. When you call your doctor because your disease is getting worse, how long does it typically take to get a call back (same day/next day/2 or more days?)

4. At the time you were last hospitalized, can you remember if you were taking your medications every day or perhaps had run out of medication?

5. When your doctor adds to or changes your medications because you are getting worse, how long does it typically take you to get the prescription filled? (same day, next day, two or more days….not at all if unable to afford)

Experience around the time of hospital discharge

We would now like to about your experience in the hospital around the time you were getting ready for discharge.

1. Do you remember when you were about to be discharged from the hospital after being admitted for [disease or condition]? If so, how did you feel about that experience?

2. Do you feel the people who were caring for you in the hospital adequately prepared you to manage your condition after discharge from the hospital? If so, how? If not, why?
   a. Did they talk to you about your medications…which ones you continue to take? stop taking? Any new meds prescribed? If new meds were prescribed, did they inquire as to your ability to fill the new prescriptions in a timely manner?
   b. If you smoke, did they speak with you about options to either cut down or quit?
   c. Were they able to provide you with clear instructions as to what to do if you did not start to feel any better, or found yourself getting worse once you arrived home?
d. Did you feel ready to go home at the time the doctors and nurses were ready to discharge you? If you did not feel ready, what type(s) of support may have helped you to feel more confident with the ability to manage your disease at home?

3. When you arrived home from the hospital, how did you feel? Emotionally, physically?
   a. What were some hurdles or obstacles you faced at home?
   b. Did anyone help you to address these hurdles or obstacles?
   c. Did you have help from family, friends, and other social support (churches or community members)? If so, who and how were they helpful or not helpful?

4. When you arrived home from the hospital, was there anything that could have made the transition easier? (suggest: social support, education about disease, medications, nutrition, exercise,)
   a. Did you return home alone, or were there others either living or staying with you that could help you for those first few days?
   b. Did you have all the supplies you needed upon arriving home? (food, oxygen, medications)
   c. Was there anyone available to help you with scheduling follow up tests and appointments, or were you responsible for taking care all of this on your own?

Relationship and access to outpatient follow-up care
Now we would like to spend a few minutes talking about your access to physician offices and clinics outside of the hospital

1. Do you have a regular place where you receive treatment for your [disease or condition]? If so, what type of doctor sees you there (primary care, specialist)?

2. Do you feel your regular doctor is assessable and responds to your needs when you try to contact them? If not, why?

3. After you arrived home from the hospital, did you feel your regular doctor or nurse was available to you if and when you needed them? If not, why?

4. Patients are given a follow-up appointment oftentimes with their regular doctor after being sent home from the hospital. What, if anything prevents you from getting to your doctor? (first open ended)
(ability to get appointments, money/insurance, transportation, childcare or
dercare, work loss, location, don’t remember having appointments, other
priorities…)

5. Was there anything that could have made it easier to get to your doctor?

**Patient navigators**
The next series of questions we have is about the use of patient navigators.
Patient navigators are individuals that can help patients discharged from hospitals to get
what they need to feel well, to get them to their doctor’s appointments, and hopefully
allow you to stay out of the hospital in the weeks after just being sent home.

1. Would you be interested in having a patient navigator to support your discharge
planning and to assist you with getting your meds, scheduling your appointments
and assisting you with obtaining necessary supplies in the weeks after your
hospital discharge? If not, why?

2. Would you have preference for what your patient navigator would be like? (Race,
ethnicity, gender, age, other characteristics) Is there one characteristic that is
the most important to you and why?

3. Prior to being sent home from the hospital, how could a patient navigator been of
help to you? (suggest: disease education, medication education, exercise,
nutrition, smoking cessation, travel arrangements, social support arrangements)

4. After arriving home, how could a patient navigator have been of help to you to
support your ability to carry out your treatment plan?

   a. Can you give some specific examples? (see suggested topics above)

5. What can your patient navigator do to help you get to your doctor’s visit?

6. Is there anything that you would not want the patient navigator to provide?

**Health information technology**
The last series of questions we have is about the use of mobile phones to assist
patients during the hospital to home transition. Multiple “apps” have been developed to
collect information from patients through their smartphones (mobile phones that connect
to the internet and can run applications) Applications or “apps “ can be downloaded to
smartphones (mobile phones that connect to the internet and can run applications) that
can provide information to your providers regarding your health after a hospital discharge.

1. How many of you own such a phone? Do most of your friends or relatives own one?

2. If you do own a smartphone, would you be interested in such an app to put in your health information such as symptoms and XXX which your health care providers can access?
   If so, what would you want this app to do? Not to do?
   If not, why? Privacy concerns

3. How would you feel about a smartphone that would automatically monitor you level of activity (eg, how much you are able to walk) just by carrying it around and have that information sent to your doctor?

4. During a research study, tools such as questionnaires are often use to collect information directly from patients. Would you prefer to fill out such tools yourself, if so on paper or on a computer, or have someone ask you directly?

   General follow-up questions:
   Before we close, are there any other issues that we have not discussed that are important to you?

Thank you for your time and sharing. We would like to remind everyone that what was said in this room today remains needs to remain confidential, thus we ask each of you to respect the privacy of all participants.