Forsyth MEDICAL CENTER

Hospital to Home Program for Older Adults

Our transitional care model bridges the existing gap between hospital and community services, creating a safety net for frail seniors.

Hospitalized patients aged 65 and older with chronic health issues are at high risk for re-admissions and post-discharge complications. The complex needs of these frail seniors often result in
1) Higher healthcare costs for patients, hospitals, and insurance providers
2) Inappropriate utilization of acute care services
3) Poor patient outcomes, including quality of life

Goals for the Hospital to Home Program for Older Adults

- Reduce the proportion of frail seniors that require a readmission for the same condition within 30 days by 50%
- Decrease unnecessary Emergency Department utilization by 10%
- Decrease total hospital charges associated with avoidable admissions by 5%
- Increase the quality of life score (from baseline to discharge) in at least three of the eight SF-36 domains by 20%
- Achieve 95% participant satisfaction with program among survey respondents

Participation Criteria

- 65 years old or older
- Medicare or Medicaid eligible
- Resident of Forsyth County, NC
- Discharge to home
- 2 or more conditions from a list of qualifications (related to risk for readmission)

Program Design

- Navigator meets with participant during the hospital stay to assess need and explain the program
- Navigator makes home visits (the first within 72 hours of hospital discharge) and follow-up phone consultations
- Navigator arranges in home care assistance (by contract with state-licensed home care agency - housekeeping, cooking, transportation, shopping)
- Navigator connects with family and community resources
- Navigator assesses the participant's status at 30 days to determine if services should continue for up to an additional three months

The Patient Navigator

- Closely monitors participants adherence to treatments and follow-up appointments
- Watches for signs that could lead to complications and/or re-hospitalizations
- Educates patients and families/caregivers about care and services available in our community to support aging in place and independence.

Information (after 20 months of service)

- Average Length of Stay in Program: 65 days
- Average number of Navigator home visits: 2.9
- Average number of Navigator phone calls: 3.9
- Average number of hours of home care services when used: 23.75
- 47% using home care services

Frequency of Home Care Service Type

- Housekeeping: 49%
- Meals/shopping: 35%
- Transportation: 34%
- Medication reminder: 8%
- Other: 25%

Other Referrals Made:

- Meals on Wheels: 34%
- Shepherd's Center informal volunteer caregiving services: 22%
- Medicaid Personal Care Services: 7%
- Senior Services: 4%
- Durable medical equipment: 3%
- Department of Social Services: 3%
- CAP: 1%
- Other: Adult Day Center, GO Program, Lifeline, Trans AID, MED AID, Area Agency on Aging, Elder Law, Hospice, Coumadin Clinic, Heart Failure Clinic, Cardiac Rehab, Caregiver Voucher, Services for the Blind, Mobile Crisis team, COMPASS, SAFEMED, etc.

Outcomes

- 65% reduction in hospital readmissions
- 30% of participants require an ED visit
- 66% of readmissions are for a different reason
- Estimated savings, as a result of prevented readmissions is $1,110,845 ($7,661/case)
- Overall satisfaction with the program by participant survey respondents is 4.84 out of 5
- Health care quality of life demonstrates a statistically significant improvement for both physical and mental health on all 8 subscales ($p<0.05$) of the SF-36

Contact

Lynn Watkins, PT, MSPT
Project Coordinator, Post Acute Services
lwwatkins@novanthealth.org
336-718-5776