Community Partnerships:
Improving Care Transitions

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Team: Spencer Hospital Discharge Planners & Elderbridge Options Counselors

Objective

1. To assist non-Medicaid eligible consumers, age 60 or older who indicate a preference to return to their community and are deemed appropriate for discharge following a hospital stay.
2. To help seniors maintain their independence by keeping them in their homes with a comprehensive set of wrap around services and support
3. To reduce unnecessary facility placement, unnecessary hospital admissions and readmissions and emergency department use.

Background

The Iowa Return to Community (IRTC) Program is a collaborative effort with a variety of partners including hospitals, long-term care facilities, Area Agencies on Aging, home and community based service providers that assists non-Medicaid individuals age 60 and older, return to their community following a hospital or long term care facility stay.

Returning Home after a Hospital or Skilled Care Stay?

Sometimes it's hard to return home from a hospital or nursing home. Elderbridge's Return to Community program can help you make a transition back home easier. Elderbridge can provide you a Options Counselor to advocate and support your return home.

Communication: Your Options Counselor can talk with your family, doctor and healthcare providers to ensure that everyone is aware of your care plan to return home and that they have the same information.

Care Coordination: Your Options Counselor can help arrange services and supports such as:

- Home-delivered meals
- Transportation to a congregate meal site to eat with others
- Make phone calls to ensure that medications are available to you
- Schedule doctor appointments and transportation
- Arrange for home cleaning, chore services, or personal care in your home
- Arrange installation of safety bars, a lifeline, ramps, and more
- Help you run errands, shop, attend doctor appointments with you or anything else necessary for you to return and stay safe in your home
- If finances are a concern, Elderbridge may be able to offset the cost of services

Regular Visits: Your Options Counselor will check in on you 2-3 days of your return back home and will contact you regularly for up to 90 days. They will see how you're feeling and if you have any concerns with your care plan. You can be discharged from the program any time before 90 days.

Actions Taken

Metrics

Service	Clients Served
Emergency Response System	7
Home Delivered Meals	35
Home Visit	229
Homemaker	118
Info. And Assistance	224
IRTC 30 day follow up	157
IRTC 60 day follow up	152
IRTC 90 day follow up	151
IRTC Options counseling	343
Material Aid	146
Material Aid other	43
TOTAL	**346**

	2019	2020	2021	2022	2023
Readmission Penalty Rates – Spencer Hospital	0.24	0.29	0.47	0.17	0.07

Analysis

The 4-year partnership has provided to be a successful tool for discharge planning and a valuable service for keeping individuals in their homes.

Other benefits

- Reduction in ER traffic
- Reduced inpatient length of stay
- Decreased discharge delays
- Decreased low acuity in nursing facility care
- Increased patient and provider satisfaction

A strong relationship has been developed with Elderbridge and Spencer Hospital.

Next Steps

- Continue with community partnership
- Add screening assessments for social determinants of health
- Determine how to sustain the program long-term
- Research available funding sources