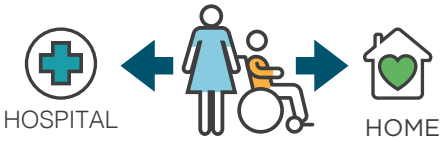
RightTransitions®

PROGRAM

A Study: Hospital to Home Program for Older Adults.



In a study in conjunction with Forsyth Medical Center, Right at Home's transitional care model was shown to bridge the gap between hospitals 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 readmissions 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.

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 rehospitalizations.
- Educates patients and families/caregivers about care and services available in the community to support aging in place and independence.

Goals for the Hospital to Home Program for Older Adults

50%
REDUCTION
of frail seniors that who require a
readmission for the same condition
within 30 days

10%
DECREASE
of unnecessary
emergency department
utilization

5%
DECREASE
in hospital charges associated with
avoidable admissions

in the quality of life score
(from baseline to discharge) in at least three of the eight SF-36 domains

with program among survey respondents

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PROGRAM

Information

(after 20 months of service)

65 DAYS Average length of stay in program

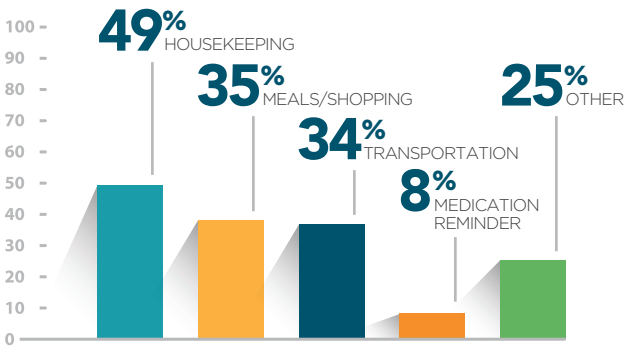
2.9 HOME VISITS Average number from navigator

3.9 CALLS Average number from navigator

23.75 HOURS Average for home care services

47 % Using home care services

Frequency of Home Care Service Type



Other Referrals Made

34 % Meals on Wheels

22 % Shepherd's Center informal volunteer caregiving services

7 % Medicaid personal care services

4 % Senior services

3 % Durable medical equipment

3 % Department of social services

1 % CAP

OTHER

- Adult day center
- Lifeline
- MED AID
- Elder law
- Coumadin Clinic
- Cardiac rehab
- Services for the blind
- COMPASS
- GO program
- Trans-AID
- Area Agency on Aging
- Hospice
- Heart failure clinic
- Caregiver boucher
- Mobile crisis team
- SafeMed

Hospital to Home Program Outcomes

65% REDUCTION in hospital readmissions

30% REQUIRED emergency department visits

66% READMISSIONS were for a different reason

SATISFACTION

overall with the program by participant survey respondents

4.84

ESTIMATED SAVINGS

as a result of prevented readmission

$1,110,845 TOTAL

$7,661 PER CASE

HEALTHCARE 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

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