CONNECT-HOME

Connect-Home is an evidence-based transitional care process that empowers patients and their caregivers to manage patients' serious illness at home, improve function, and prevent avoidable re-hospitalizations. Developed by Dr. Mark Toles at the University of North Carolina, Connect-Home is comprised of a set of protocols and tools that guide Skilled Nursing Facility (SNF) staff through a four-step process (see page 4) that prepares SNF patients and their caregivers for the transition to home.

Connect-Home Collaborative

With support from the Harry & Jeanette Weinberg Foundation and in partnership with Dr. Toles, Lutheran Services in America (LSA) implemented Phase 1 of the Connect-Home model in collaboration with four Lutheran senior services organizations in 2018. The goal of the Connect-Home Collaborative is to implement transitional care services in LSA member organizations that provide skilled nursing, expediting the delivery of services, maximizing impact and expanding the potential for broad change. In the future, Connect-Home will be scaled and replicated in other locations across the LSA Network.

Phase 1 Participating Organizations

- Samaritas (Grand Rapids, MI)
- National Lutheran Communities & Services (Rockville, MD)
- Lutheran Social Ministries of New Jersey (Florham Park, NJ)
- Lutheran Services Carolina (Wilmington, NC)

Phase 1 Program Summary

The program team began implementing the Connect-Home project in January 2018. Through September 2018, more than 220 older adults have received the benefit of the Connect-Home Transitional Care protocol from the on-site care teams. Of these patients, 192 (87.3%) are low-income vulnerable older adults. The composite profile of the patients that have been served are white females who are, on average, 82.5 years, are low-income older adults who remain in post-acute care for nearly 28 days depending upon their condition and recovery plan.

Goals of Connect-Home

Outcome	Definition and Key Attributes
Preparedness for discharge	The quality of the post-hospital care transition experience from the patient's perspective
Quality of life	The sense of well-being from the patient's perspective, including physical symptoms, psychological symptoms, outlook on life, and meaningful existence.
Life-Space functioning	"Mobility based on the space through which a person moves over a specified time period," - where a person is able to go, how often, and what equipment is used.
Days at home	Days at home is defined as the number of days a person is at home without using acute medical care such as ED and hospital.

Connect-Home Benefits

- **Person-centered transition care plan.** Goals and priorities are set with older adults and their caregivers. Connect-Home includes teaching care strategies, medication management, scheduling follow-up appointments and transferring medical records to community providers. Social workers follow-up with older adults and caregivers to monitor and reinforce the transition care plan
- **Empowered staff.** Connect-Home clearly defines roles for nurses, rehabilitation therapists and social workers in the older adult's transition from post-acute care to the home, promoting a culture that empowers staff to address the obstacles to successful transitions home.
- **Auditing and quality improvement.** Data is collected to monitor the successful implementation of the model and identify any necessary adjustments.

Participants Expectations

Role	Who	Function	Time Commitment
Executive Sponsor	Key executive at member organization	Coordinates Connect-Home implementation with LSA and the University of North Carolina team	Quarterly status calls and episodic calls to address challenges unresolved at the facility-level
Two SNF Site Champions	Usually the MDS nurse and Social Worker but other roles optional	Lead Connect-Home implementation within facilities	Participate in two day-long off-site Collaboratives Lead implementation team meetings (bi-weekly for four months and then monthly for 10 months) Participate in bi-weekly technical assistance phone calls
Implementation Team Members	A representative from Social Work, Rehabilitation, Nursing, and Administrative support	Develop the plan to implement Connect-Home in the SNF and monitor and overcome barriers to its execution	Meet bi-weekly for four months and then monthly for 10 months
IT Contact	IT person(s) responsible for maintaining and updating the EMR	Make modifications to the EMR up front to install the Connect-Home Transition Plan of Care Template	Time needed to install the Connect-Home Transition Plan of Care Template in the EMR (February – April 2019)
On-Site Personnel	Nurses Therapists Social Workers Department Leads	Deliver Connect-Home	Majority participate in on-site 4-hour training Majority participate in two 2-hour webinar training sessions

Connect-Home Implementation Timeline

3 Months

Pre-implementation activities, including member engagement, mapping of current discharge planning processes, and installation of Connect-Home template in electronic medical record systems

9 Months

Connect-Home implementation, monitoring, and continuous improvement.

Program Success to Date

1. **Connect-Home was successfully deployed** in four LSA partner organizations. Through September 2018, more than 220 older adults have received the benefit of the Connect-Home Transitional Care protocol from the on-site care teams (see page 4). The protocol continues to be part of the standard of care in each partner site with an intent to make this a part of the long-term care delivery.

2. **Overall Protocol Compliance is strong and improving.** Site compliance overall is at 85.8% through September 2018 for the steps defined as essential to ensuring post-discharge outcomes for low-income vulnerable older adult patients (see page 4).

   - *Care plan meetings were conducted early for 88.9% of discharges with family caregivers attending 92.5% of the time.*
   - *Family Caregiver attended care plan meeting 92.5% of the time.*
   - *Post-discharge medical visits were scheduled PRIOR to discharge 83.6% of the time by the on-site care team.*
   - *Records were sent to post-discharge team 78.6% of the time. This number is lower than the number of visits scheduled and reflects the challenges of sharing medical records with health care and community providers. The Collaborative is continuing to share best practices to address this challenge.*
   - *85.5% received follow up calls to the patient or family caregiver within 72 hours of discharge*

3. **The Collaborative Model worked and brought benefit to all team members.** The teams report that this collaboration, validation, and interaction were extremely beneficial and they wish to continue working together in the future.

Next Steps and Sustainability

As the program enters Phase 2 in 2019, Lutheran Services in America is in search of other Lutheran Senior Services providers who desire the opportunity to scale and replicate Connect-Home. Participating sites will benefit from Dr. Toles expert training and technical assistance, and project costs including travel and meeting expenses will be covered under the Weinberg grant. As health systems search for better strategies to reduce unnecessary re-hospitalizations, we believe Connect-Home is an excellent program that prepares post-acute older adults to transition home. LSA is mission-driven to enhance care and support for low-income, vulnerable and underserved older adults. By bringing together resources and partners, LSA implements strategic efforts that improve health outcomes and quality of life for older adults.

Connect-Home: 4-Steps of Transitional Care

Day 1 → Discharge

- **Step 1**
  - At the time of admission, help patients and caregivers understand the goals of care and the procedure for deciding the duration of the patient's stay in the SNF.
  - Over the course of the admission, use the Transition Plan of Care template to write detailed goals and instructions the patient and primary caregiver will need to safely continue care at home

Day 8 → Day 14

- **Step 2 – Convene a Care Plan Meeting**
  - Identify priorities in care at home, educate the patient and family members and revise the Transition Plan of Care.

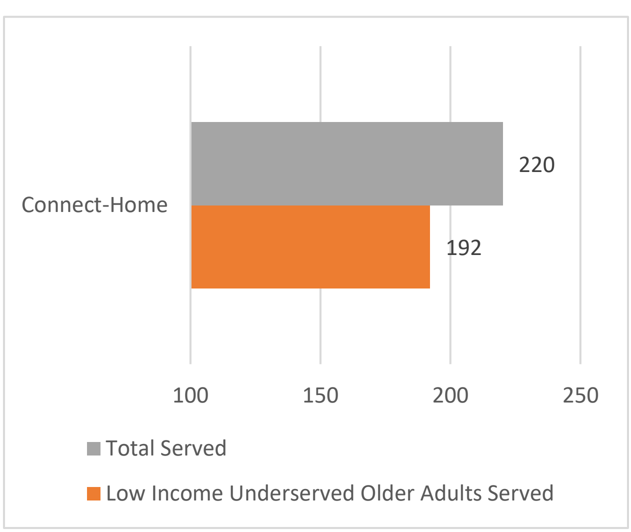
Day 7 → Disharge

- **Step 3 – Implement the Transition Plan of Care**
  - Help the patient and primary caregiver learn the transition plan and develop skills to manage the patient's serious illness at home.
  - Reconcile the medication list, activate community providers, and initiate the transition to home.

<72 Hours → After Discharge

- **Step 4 – Call the Patient at Home**
  - After patient discharge, call the patient or caregiver at home, reinforce the Transition Plan of Care and make referrals for immediate needs.

Patients Served to Date



Protocol Compliance