Connect-Home
Transitional Care

CONNECT-HOME

Lutheran Services in America
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 post-acute care providers through a four-step process (see page 2) that prepares 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.

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

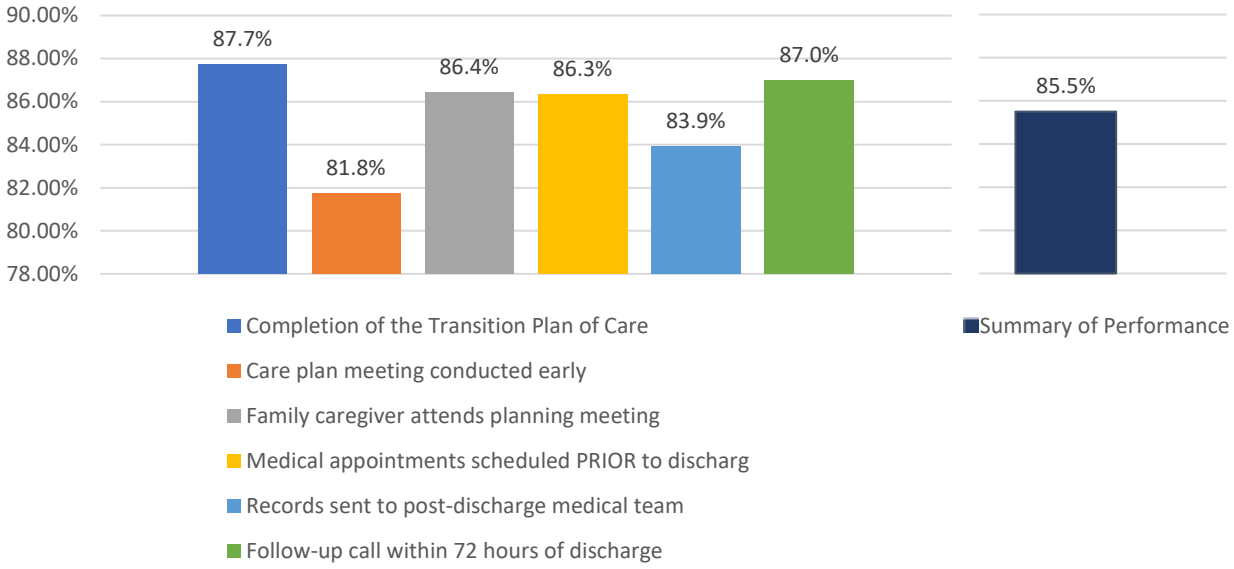
- **Person-centered transition care plan.** Goals and priorities are set with older adults and their caregivers. Connect-Home includes teaching care strategies, medication management, scheduling follow-up appointments and transferring medical records to community providers. Social workers follow-up with 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.

Connect-Home
Transitional Care

CONNECT-HOME

Lutheran Services in America
Connect-Home

Program Success to Date



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. 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