RARE Reducing Avoidable Readmissions Effectively

Case Example One - Assistance from Metropolitan Area Agency on Aging Senior LinkAge Line

Yvonne, aged 78, was discharged from a hospital to her home. She and husband Floyd, aged 79, have lived in a townhome since selling their farm 4 years ago. Yvonne's admitting diagnosis was weakness and falls. She was discovered to have IDDM (insulin-dependent diabetes mellitus) and uncontrolled hypertension. She has early stage dementia. It was also discovered she has urinary incontinence.

Discharge plan from hospital included referral to skilled home-care provider to monitor diabetic management and blood pressure, and continue diabetic teaching with Yvonne and her husband.

Call to Senior LinkAge Line came 2 days after discharge, from caregiver son Bruce. He and two siblings very concerned about parents' ability to manage at home given new complexity of blood sugar checks, insulin management and administration, and new dietary restrictions. Yvonne not able to understand the requirements, also minimizing the importance of staying on the program. Family situation revealed to the Senior LinkAge Line professional: Floyd with severe alcoholism and inability to manage. Yvonne had been caring for him. The 3 children did not know how severe her dementia was, and how difficult the home situation had become. Floyd did not like the home care providers coming in.

Resources and Information/Guidance Provided by the Area Agency on Aging Senior LinkAge Line staff member:

1. Home Care, both skilled and private duty - review of who pays for what, when and how much. Kids assumed skilled homecare agency could come out twice a day, indefinitely. Hospital had arranged homecare for day after discharge. Senior LinkAge Line staffer quickly got them linked with two private duty providers to interview, and who could assist with ongoing nursing and custodial needs, once Medicare homecare ended.
2. Educated adult children about how services work, as they had not been included in hospital d/c planning, and Floyd could not remember details.
3. Provided Long-term Care Options Counseling about types of housing, costs, services available – adult children wanted Yvonne to move to assisted living, and Floyd refused to move at all. Adult children wanted her in setting that could manage her diabetes, medications, increasing dementia, and incontinence. Because of Floyd's life choices and behaviors, they did not think in-home services to the townhome were an option.
4. Coaching to adult children on how costs of care in Assisted Living are determined – based on ADL's (Activities of Daily Living) and IADL's (Instrumental Activities of Daily Living). Explained what these are.
5. Provided Nursing Home and Assisted Living compare websites to check quality and complaints.
6. Provided Live Well at Home cost comparison information, to compare costs for in-home care, versus Assisted Living, versus Nursing Home care.
7. Explained Adult Day Care as an option for one or both. MADSA info provided, and several nearby options identified with cost comparisons.
8. Adult children already had an elder law attorney. Possibility of Veteran's benefits explored: neither was a veteran.

9. Alzheimer's Association info given to adult children.
10. Offered caregiver support information but adult children not interested... not very far along on the journey yet, and too much else to do.

Area Agency on Aging Senior LinkAge Line specialist followed individuals over time. The family selected an assisted living residence near the family home, which would be able to care for Yvonne even as dementia increases. Floyd still drives to see her. All is well.

Case Example Two - Assistance from Local Faith in Action Non-profit

Client A began services upon returning home from a hospital stay due to a COPD condition. A Great River Area Faith In Action case consultant met with the client to discuss ways to help her Live Well at Home. During the Rapid Screen interview, the consultant learned that the client needed to be on oxygen 24/7, had lost a lot of weight due to not eating and had a number of hospital stays during the past year. In addition, the client was fighting depression due to lack of family involvement in her life. Her Rapid Screen score indicated she was at high risk.

An action plan was put in to place to address each risk factor, including suggestions on how to deal with the long oxygen cord which now posed a fall threat.

1. A referral was made to Meals on Wheels.
2. Contact was made with family members, who were willing to help.
3. A Title IIIB matching grant was made to pay a family member for helping 2x/week to help prepare healthy meals, take out the garbage, help with bathing, and other household chores that were difficult for the client to do due to the loss of energy that accompanies the COPD.

The case consultant checks in periodically and at this time the client has not had any recent hospital stays, is eating healthily and seems to be less depressed.

Case Example Three - Assistance from a Local Faith in Action Non-profit

Client B is in her 90's. After returning home from the hospital/nursing home rehab stay she was visited by the Live Well At Home case consultant from the local Faith in Action program. A rapid screen indicated she was at high risk for needing to move from her home. She is living alone, frail, using a walker and still trying to drive. The Risk action plan was put in place to address the following:

1. Volunteers were brought in to take her grocery shopping…helping her reach items and read labels.
2. Neighbors get the mail and check in on her daily.
3. Volunteers also come and help with household chores and visit with her…since she doesn't get out much, she loves the visits.

Client B still likes to cook and is able to stay in the home that her grandfather built over 100 years ago.