INFORMATION FOR PROFESSIONALS

The ARC Model

The ARC model is a social work-based approach to transitional care recognizing the diverse systems uniquely affecting each individual. When working with a patient experiencing a transition in care, professionals are working with more than just the individual but with the systems supporting and affecting older adults as well.

To Make a Referral:

An Aging Resource Specialist can talk to patients and their families about community resources available to help them with a smooth return home. Assessments for services can be completed PRIOR to discharge by an ARC Specialist to ensure community resources begin as soon as possible.

To refer a patient from Adventist La Grange Memorial Hospital, Lexington Health Care of La Grange, Meadowbrook Manor Nursing and Rehabilitation of La Grange, Plymouth Place, or The British Home, be sure to have the full name of the patient as well as hospital or skilled nursing facility.

Contact the ARC by phone or email at:

Phone: (708) 245-8083
Email: arc@agingcareconnections.org

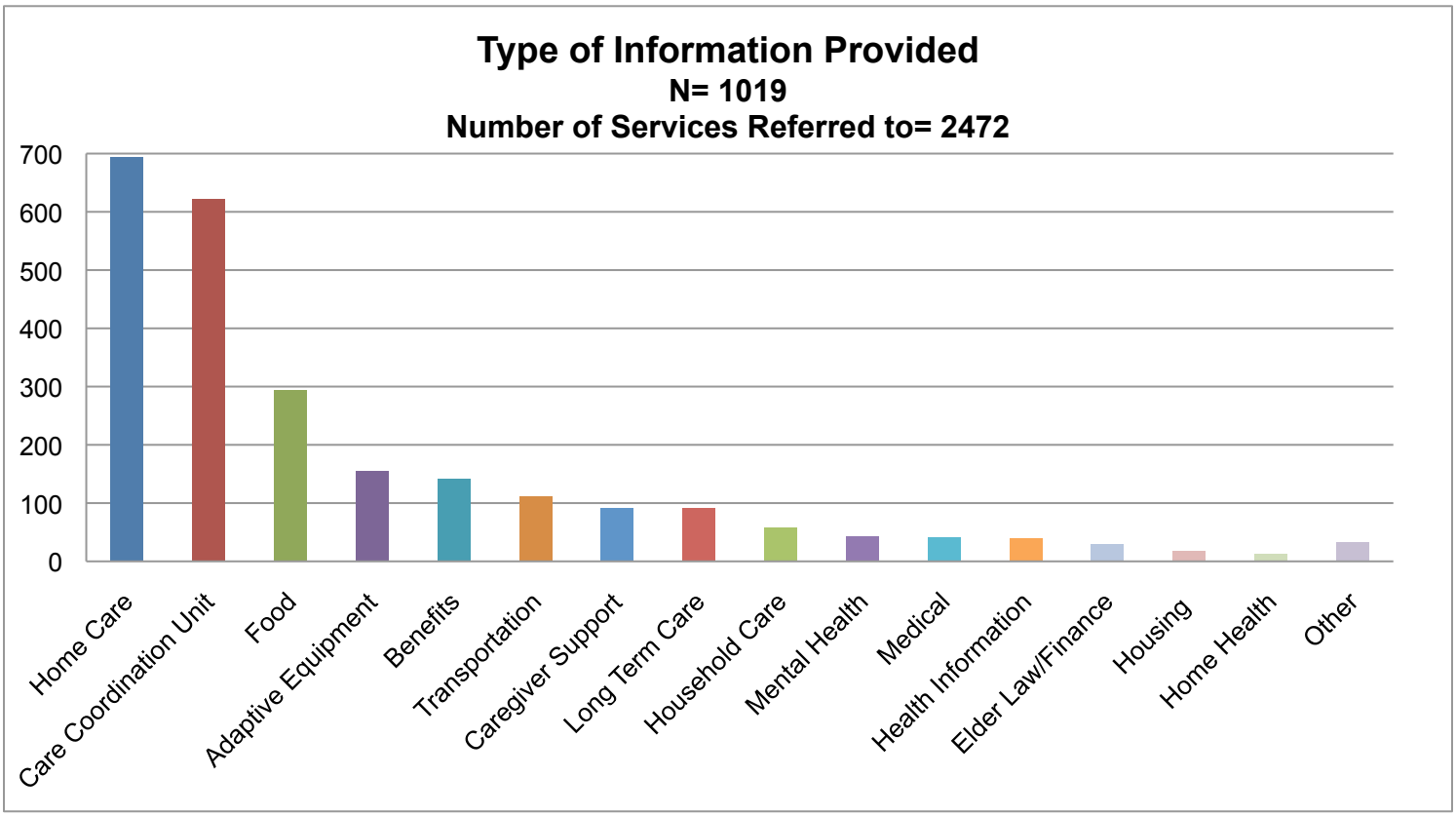
Information about the Illinois Transitional Care Consortium (ITCC):

Aging Care Connections is a member of the Illinois Transitional Care Consortium (ITCC). The ITCC was formed to more effectively address needs of older adults transitioning from the hospital to the community by linking hospital based services with the aging network. The ITCC has developed and is implementing the Bridge Program, a social work-based transitional care service model that ensures the safe transition of vulnerable older adults and their caregivers across the healthcare system, promotes successful reintegration to the community, and minimizes health disparities. The ARC model is a part of the Bridge Program.

More information about ITCC can be found at: http://hmprg.org/programs-projects/illinois-transitional-care-consortium/

Partnering with the Community:

Through the Aging Resource Center, participants and their families receive information and consultation on a wide range of services offered by the community. Aging Resource Center participants are informed of services available to help ensure they can live as independently as possible in the community. The graph below highlights the scope of services referred to ARC participants.



The Community Response Network

The combination of delays in service referrals and the unpredictable response time of service providers can slow the start of supportive services, which can negatively impact the transition home for many vulnerable older adults and their caregivers. Aging Care Connections has reached out to local community-based service providers that have the capacity to expedite services to form a “Community Response Network”. The Community Response Network is comprised of private in home agencies, private meal providers, private hair care agencies, and volunteer organizations.

Preliminary Findings:

Changing the Time Between Discharge and Start of Services

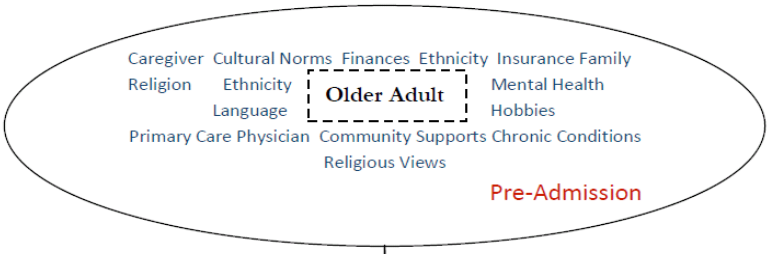
Since the Aging Resource Center program began at Adventist La Grange Memorial Hospital in January 2007, the average time between discharge and start of services was reduced **from 14 days to less than 2 days**. The ARC Program also effectively improved access to community-based services from within the healthcare system. Of ARC clients, **78%** had no prior history with Aging Care Connections. These patients benefited from an expanded range of assessments completed on-site at the hospital and sub-acute facilities and a broader array of information provided to clients at these sites.

Aging Resource Center Program Demographic Information

Type of Client	**Aging Care Connections** *5/1/2010-12/31/2010* **N= 349**
Male	39%
Over 75	71%
Frail	79%
Living Alone	43%
Social Need	89%
Non-English Speaking	2%
Race: Non-white	6%
At Risk for Nursing Home Placement	95%(n=57)

This is a visual model of the ARC process following the older adult participant from pre-admission to the return to the community after discharge.

ARC Process



Patient is admitted to the hospital or skilled nursing facility
Adventist La Grange Memorial Hospital, Lexington Health Care of La Grange, Plymouth Place, Meadowbrook Manor Nursing and Rehabilitation of La Grange, The British Home
Admission

Patient is referred to the ARC Program by hospital staff or family members.
Pre-Discharge

Patient meets with an Aging Resource Specialist at bedside to discuss discharge plans and potential needs upon discharge home. Based on the meeting, the Aging Resource Specialist follows-up with hospital interdisciplinary team members and community-based resources.
Pre-Discharge

Within 48 hours the patient receives a phone call from the Aging Resource Specialist or their Case Coordination Unit community case manager to identify unmet needs, unexpected challenges in the home environment, home health issues, caregiver burden, service needs, and ability to follow through with the discharge plan of care.
Post-Discharge

The Aging Resource Specialist follows-up with needs identified by patient. The Specialist transfers the case to the CCU and connects the client to community supports (i.e. transportation, home delivered meals, chore services, respite, friendly visitors…). The Specialist remains connected to the patient and the community supports until the transition is complete.