

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 the older adult as well.

To Make a Referral:

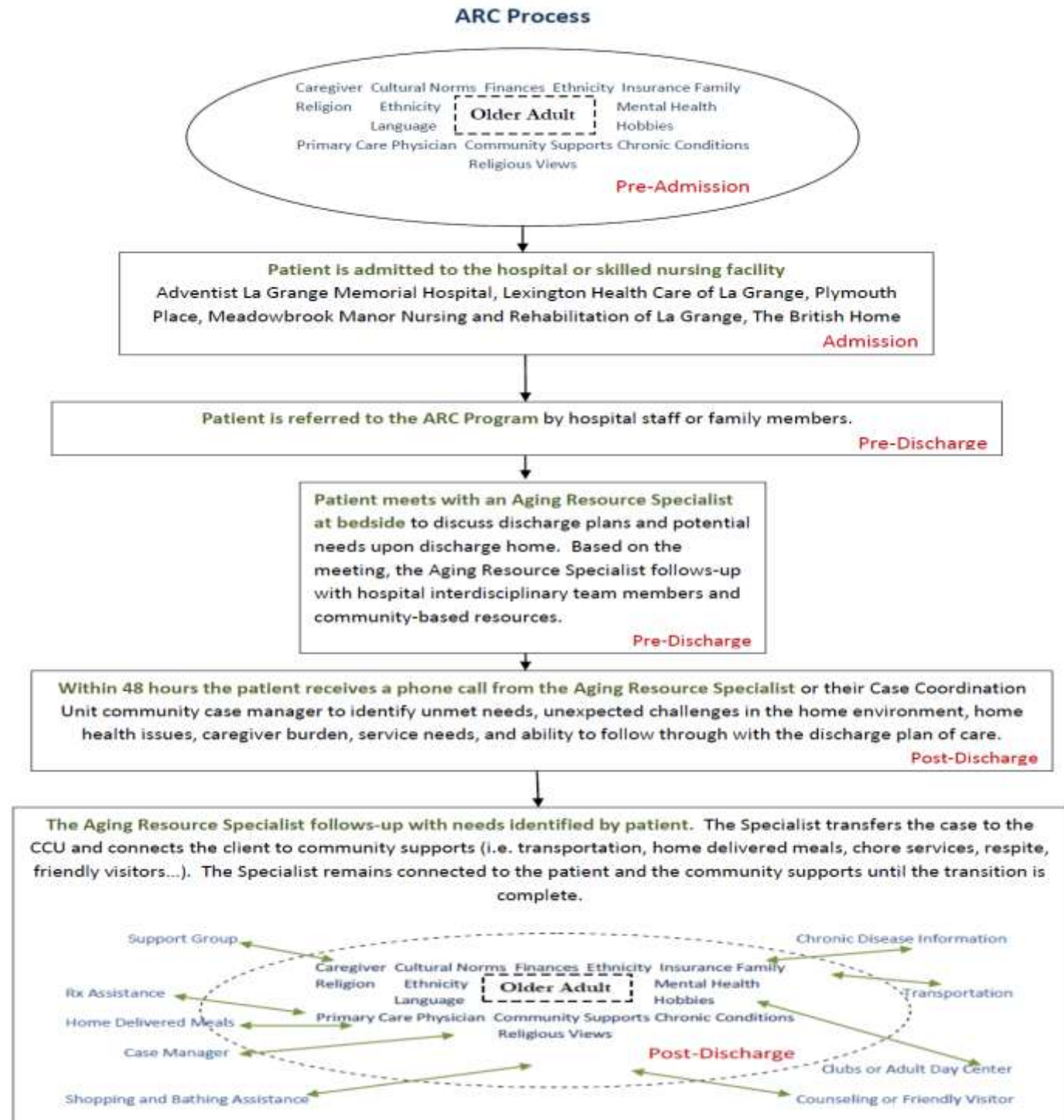
An Aging Resource Specialist can talk to patients and their families about community resources available to help them with a smooth return home. Assessments for services can be completed PRIOR to discharge by an ARC Specialist to ensure community resources begin as soon as possible.

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/>

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

OCTOBER 1, 2009 – SEPTEMBER 30, 2010

TYPE OF CLIENT	ARC DATA N=153
MALE	25%
OVER 75	84%
FRAIL	78%
LIVING ALONE	50%
SOCIAL NEED	95%
ECONOMIC NEED	11%
NON-ENGLISH SPEAKING	3%
RACE: NON-WHITE	7%
AT RISK FOR NURSING HOME PLACEMENT	93%

READMISSION DATA RESULTS

JUNE 1, 2009-JUNE 30, 2010

JUNE 1, 2009-JUNE 30, 2010	ARC CLIENTS 60+ THAT RECEIVED ASSESSMENTS FOR MEDICAID WAIVER AND TITLE III SERVICES (N=43)
READMISSION WITHIN 30 DAYS FOR ANY DIAGNOSIS	11.6%

Given the demographics of the ARC population, it is meaningful to note that the readmission rate is quite low. Adventist La Grange Memorial Hospital and Aging Care Connections are continuing to work together to build on this formative readmission data and further understand its implications.

AGING RESOURCE CENTER PROGRAM'S DIVERSITY OF REFERRED SERVICES

Type of Information Provided
N= 1019
Number of Services Referred to= 2472

