AMH, Senior Services Plus Partner on Care Transitions Program

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Helping senior citizens make a successful transition from hospital to home, while also reducing the readmission rate, is the goal of a new partnership between Alton Memorial Hospital and Senior Services Plus.

Stacey Loveland is the Care Transitions coach at Senior Services Plus, located in Alton. She is working closely with AMH to identify inpatients at least 60 years of age who do not have the resources or support needed to have a successful transition from hospital to home.

“Our goal is to reduce readmission, particularly in areas that pose a high risk of readmission such as heart failure, heart attack, pneumonia, COPD, hip and knee

replacements," Loveland said. "I work closely with Angie Liley (manager of Case Management at AMH) to identify those patients. Then I will introduce myself to them while they are still an inpatient."

From there, Loveland will focus on the "4 Pillars of Care" with each patient for the next 30 days. Those include completing a Personal Health Record (including discharge papers); medication management; follow-up; and "red flags."

"The red flags might be questions about what was happening before the patient was admitted, so we can help them to avoid going back in the hospital," Loveland said.

Loveland has a master's degree in Gerontology and is a certified Care Transitions Intervention coach. Within 48 hours of a patient's discharge, she will contact the patient to arrange a home visit. At the home visit, she will assist the client in making a strong effort to gain control of his or her health needs.

"After the home visit, I will make three follow-up calls approximately a week apart to make sure they are doing what they need, getting what they need as far as any services we might have arranged, and that they are feeling confident in their own health care needs."

Loveland said the community-based program is an extension of what Alton Memorial is doing through its Case Management department.

"Many patients don't have the support they need because maybe their family was in town when they were in the hospital, but now they have to go back home after discharge," Loveland said. "We're here to make sure they get that support when they need it."

Angie Liley, manager of Case Management at AMH, says the program fits perfectly with the hospital's mission.

"It's another way we help improve the health of the people and communities we serve," Liley said. "Excellent care extends beyond just the time patients are in the hospital. We are thrilled to partner with Stacey and Senior Services Plus."

For more information about Care Transitions, contact Stacey Loveland at 618-225-9919 or sloveland@seniorservicesplus.org