SENIOR HOME NUTRITION PROGRAM

Year One Progress Report

The two-year pilot program aims to reduce readmissions and senior malnutrition by providing nutritional meals and home visits to older adults discharged from medical facilities. Year One of the pilot presented successes and challenges as we rolled the program out into the community. While the sample of participants is smaller than anticipated, early outcomes have been meaningful. These early outcomes, overall program design, and the positive impact on the lives of seniors show promise as we close the first year. Early returns show that the program is working, with participants nearly three times less likely to be readmitted to the hospital.

LESSONS LEARNED

- **Readmission Improvement is Promising:** While still a small sample set, the impact of post-discharge meals is encouraging. In Year One, 10% of the participants were readmitted during the 8-week service period (on target with program goals). Meanwhile, of the seniors who were referred to the service but declined to participate, 28% were readmitted.
- **Nutrition Needs Vary After Discharge:** Of the 48 participants, 40% completed the full 8-week program. 50% voluntarily ended participation as they healed in place and no longer needed the service. However, of those completing the full 8-week program, 84% presented long-term nutrition needs and transitioned to traditional daily Meals on Wheels programming without ever missing a day of meal service.
- **Frontline and Referral Barriers:** The cross-sector (healthcare v. human services organization) communication proved difficult at times, but a willingness on both sides helped overcome barriers. Getting the right information in the correct hands of the healthcare system to send referrals for the program did not ramp up as quickly as expected. We anticipated service to 90 seniors in Year One but served only 48 (53% of goal), though the program did gain traction each quarter.

Program Background

The Senior Home Nutrition Program provides nutrition and wellness checks to high-risk seniors in their home for an 8-week period following discharge. The service aims to increase in-home interactions with a care continuum team, reduce readmission rates, and provide seamless transitions to long-term senior nutrition services for those who need it. Through providing these social determinants of health we seek to improve the health outcomes for high-risk seniors.

Lead Agency: *Senior Resources, Inc., Columbia, South Carolina*
Pilot Funding: *$120,000, provided by a grant from the UnitedHealth Care Foundation*
Pilot Term: *July 1, 2021 – June 30, 2023*
Pilot Partners: *PRISMA Health*
Support From: *South Carolina Department on Aging, Central Midlands Area Agency on Aging*

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OUTCOMES PROGRESS

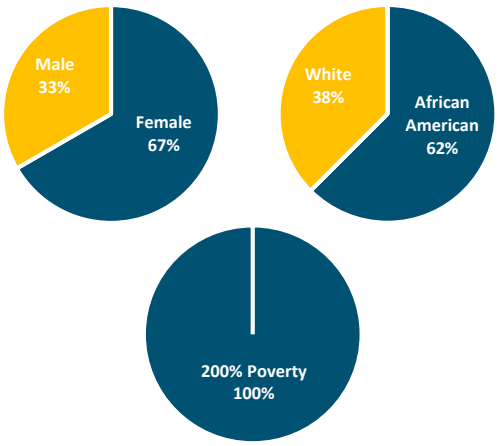
- **Prevent readmission to the hospital during the 8-week service period.**
  Goal: 90% of those served are able to avoid hospital readmission due to the nutrition received and weekly visits from volunteers/staff.
  Year One Actual: 90%

- **Avoid delays for clients needing long-term nutrition services.**
  Goal: 100% of high-risk clients receiving a full nutritional assessment by the eighth week.
  Year One Actual: 100%

- **Improve post-service health, well-being and food security.**
  Goal: Surveys will be collected to score improvement in health, well-being and food insecurity.
  Year One: 84% on meal services

- **Assess long-term nutritional needs.**
  Goal: Annual assessments will be given to clients who are enrolled in our long-term nutrition program.
  Year One: Not yet able to report

PROJECT DIVERSITY & INCLUSION



PERSONAL IMPACT

Susan

was hospitalized for heart problems, requiring her to have a pacemaker implanted. Upon discharge, she was feeling extreme fatigue and had a hard time standing. By week five, we noticed a difference in her energy and spirit. The meals, combined with a wellness check ensured she was safe and healthy in her home. "I am very pleased with you all," she reported. "The meals are delicious and I really appreciate how you take the time to really see how I am doing and if I need anything instead of just dropping off the food and leaving. I feel truly blessed."

Ike

was admitted at age 71 for neck and back surgery and was referred during discharge. Now relying on a motorized wheelchair for all mobility, his daily activities of life were challenged. He received 8-weeks of meal service, which he stated, "helped a whole lot when I didn't have to cook while I was trying to get better." It allowed him to focus on healing and recovery, avoiding readmission and also provided the time for a long-term home-delivered meal service assessment, preventing any gap in service.

Wilma

is 70-years-old, blind, food insecure, and living in poor conditions. At our first delivery, she answered the door with only a blanket wrapped around her. She had no clothes and very few household items in her home. We know these meals provided important nutrition to help her heal in her home, but this program has also been critical in providing other much needed resources and care for her. While she was receiving meals, we were able to collaborate with another local non-profit and our volunteers to provide a new wardrobe and household items to help her heal comfortably at home.

**Names may be changed for anonymity*