springwell

May 8, 2025

Chair and Members of the Joint Committee on Aging and Independence:

Springwell and Newton-Wellesley Hospital are writing to express our joint support of Bill H780 An Act Establishing the Hospital to Home Partnership Program filed by Representative Kate Lipper-Garabedian and Bill S495 An Act Codifying the Hospital to Home Partnership Program filed by Senator John Velis.

In the first year of the Hospital to Home partnership between Springwell and Newton-Wellesley Hospital, our liaison engaged with over 585 patients. The opportunity to meet each of these patients at bedside in the hospital has connected many of these patients to various services that may not have been offered, adequately explained, or followed up on by the patient once they returned to the community. The critical role of the liaison in connecting patients to services in the community and bridging the gap during the crucial transition home has been impactful in keeping elders from readmitting to the hospital, preventing unnecessary skilled nursing facility stays, and allowing elders to remain at home with the services needed to support their well-being.

One of the key goals of this program is to disrupt the cycle of readmissions and reduce the length of stay for unnecessary hospital visits. An example of the program's impact in this area involves a 74-year-old female who lives alone and was initially hospitalized for a routine hip replacement in August of 2023. In January of 2024, she was diagnosed with a rare infection from surgery and from January through March she spent 17 days in the hospital and 57 days at rehab experiencing multiple discharges home and quick readmissions. In April 2024, she was on her 3rd hospitalization in 3 months when she was one of the first referrals to our Hospital to Home Liaison. Our liaison explained service options that were available to support the patient at home. At that time the patient expressed reluctance around accepting help and elected to discharge home without services. She was readmitted to the hospital within 12 days. When our liaison knocked on the hospital room door during this readmission, the patient was thrilled to see a familiar, trusted person and was eager to work with the liaison to create a plan to address the challenges of living independently with her current mobility issues. Our liaison provided continuity for this patient by meeting with her at home on the day of discharge to enroll her in services including personal care, homemaking, laundry, and a Personal Emergency Response System. Once services were implemented, this patient remained at home for six months without a hospital visit or rehab stay. One year later, this patient remains successfully at home receiving the services she needs to manage her ongoing needs without unnecessary visits to the hospital.

Another key goal of this program is the prevention of unnecessary nursing home placements. An example of success in this domain is a 92-year-old male patient living with his 89-year-old spouse who was admitted to NWH in October 2024 with pneumonia, malnutrition, and failure to thrive. This patient had many chronic medical conditions and required assistance with all activities of daily living and instrumental activities of daily living. The medical team suggested 24/7 care be provided through a long-term nursing facility placement. The family was dedicated to keeping this patient at home per the patient's wishes, but was overwhelmed with providing the level of support required in addition to working full time. The Hospital to Home Liaison provided education about in-home care that could be provided to support a transition home and the patient and family chose this option. Within 24 hours of discharge, the Hospital to Home Liaison and a Springwell RN were at the

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family home to assess for services. The spouse of this patient was also eligible for services and was assessed at the same time. Within 4 days of assessment, the patient and his wife each began receiving 42 hours a week of Home Health Aide services with no cost for services to the family. The patient continues to be assessed on a regular schedule by an ongoing Springwell case manager. Over time, his services have increased further to meet his significant needs and he currently receives 84 hours a week of Home Health Aide services. The intervention by the Hospital to Home Liaison was able to divert what would have resulted in a nursing facility placement while enabling this patient to live successfully in the setting of his choice.

Results of a satisfaction survey which is sent on an ongoing basis to patients who worked with our Hospital to Home liaison further highlight the impact of this work. 100% of respondents found the resources provided by the liaison useful, 95% of respondents felt more confident discharging home from the hospital after their interaction with the liaison, and 100% of respondents who received a post-discharge call from the liaison reported that they received any assistance they identified during that check-in. One respondent reported, "We have never needed a service like Springwell and (were) not sure what at home help would be needed. Because of the Hospital to Home Liaison's patience, support and continued follow-up my sister is safe at home getting the help she needs." Others reported, "The liaison understood our needs and quickly pointed us in the right direction" and "I am so pleased with all the services I am now getting thanks to the Hospital to Home Liaison."

We are eager to continue this collaborative effort to support patients in discharging to the community while reducing hospital readmissions, length of stay, and unnecessary nursing facility placements. Thank you for your time and consideration in reviewing the important impact of this program and we hope you will support bills H780 and S495 to maintain these critical partnerships.

Sincerely,

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