SpiriTransition™

Coordinated care after discharge

SpiriTrust Lutheran®

SpiriTrust Lutheran®
Life Plan Communities

Skilled Care Centers

The Village at Gettysburg
1075 Old Harrisburg Road
Gettysburg, PA 17325
717-334-6204

The Village at Luther Ridge
2781 Luther Drive
Chambersburg, PA 17202
717-267-0677

The Village at Shrewsbury
200 Luther Road
Shrewsbury, PA 17361
717-235-6895

The Village at Sprenkle Drive
1801 Folkemer Circle
York, PA 17404
717-767-5404

The Village at Utz Terrace
2100 Utz Terrace
Hanover, PA 17331
717-637-0633

SpiriTrust Lutheran®
Home Care & Hospice

York Office
180 Leader Heights Road, Suite 1, York, PA 17402
800-840-9081

Chambersburg Office
2700 Luther Drive, Chambersburg, PA 17202
800-840-9081

www.SpiriTrustLutheran.org

Your Trusted Partner

SpiriTransition™ combines the best-practice clinical services of our skilled care centers and home health care to deliver unprecedented coordinated care. This program has helped SpiriTrust Lutheran® rank among the highest skilled care centers for maintaining low re-admission rates.

The SpiriTransition program incorporates the expertise of different disciplines all under the SpiriTrust Lutheran family of services.

SpiriTrust Lutheran® exemplifies quality, setting the standard in senior care for nearly 70 years.

With five skilled care centers in York, Adams and Franklin Counties, **SpiriTrust Lutheran® Life Plan Communities** offer a full continuum of quality care. At any one of SpiriTrust Lutheran's communities, residents and short-term guests can anticipate the same clinical excellence, level of experience and quality care that has earned us an esteemed place in preferred provider networks for skilled nursing and rehabilitation.

SpiriTrust Lutheran® Home Care & Hospice is also well regarded throughout south central and northeastern Pennsylvania and northern Maryland for quality clinical, patient-focused care, empowering families to engage in life for more than 40 years. Last year*, 7,106 individuals trusted us as their partner for home health needs, totaling 238,519 visits within the comfort of their own homes.

**2018*

Whether a hospital stay for surgery, illness or injury was planned or not, it can be a stressful time for the patient as well as family members. SpiriTransition is here to help navigate the system and make a smooth transition out of the hospital to return home safely, confidently and independently and back to everyday activities.

Through SpiriTransition, team members from SpiriTrust Lutheran work together to improve care coordination and assist with everything from notice of hospital discharge to one of our five skilled care centers through the care required to return home for a successful recovery. Our experienced team members include social workers, with Masters of Social Work degrees, and registered nurse liaisons, who coordinate and provide oversight over all Home Health services.

This single-point coordination helps to eliminate gaps in needed care and services, reducing frustration and confusion for the patient and/or family.

Contact the SpiriTrust Lutheran skilled care center of your choice or let your hospital discharge planner know your desire to utilize the SpiriTransition program, and we'll take care of the rest.

SpiriTransition™ Coordinated Care

Hospital Discharge

- **Care Transition Coordinator** facilitates discharge between the hospital and a SpiriTrust Lutheran skilled care center.
- **Guest Services Coordinator** serves as the liaison.
  - Manages the transfer from hospital to our skilled care center.
  - Explains admissions process.
  - Completes skilled care center admission paperwork.
  - Greets guest and family on day of admission, ensuring their comfort.

At Skilled Care Center

- Our **nursing team, social services, Medical Director and** attending physicians create a care plan.
- Departure goal meeting led by **Social Services**, held within 48-72 hours of admission.
- Review and reconciliation of medications.
- Personal Health Record, which serves as a tool to collect all relevant health information in one place, is created.
- Referral evaluation by **Home Health Care RN.**
- **Therapy department** conducts home evaluation.
- **Guest Services Coordinator** regularly checks in with guest/family during stay.

Pending Skilled Care Center Discharge

- **Social services** readies for discharge.
  - Provides medication list.
  - Ensures primary care physician visit is scheduled.
  - Arranges for discharge transportation.
  - Provides discharge summary to the primary care physician.
  - Reviews Personal Health Record.
  - Notifies physician's office of pending discharge.
- **Guest Services Coordinator** sends discharge checklist to your physician's office.
- **Nursing team** coordinates with Home Health Care liaison for any home care needs upon discharge.
- Meets with **Home Health Care liaison** if utilizing services after discharge.

At Home Post-Discharge

- **Guest Services Coordinator** checks in via phone calls to offer support and answer questions.
  - Provides reminder to take Score Card and Personal Health Record to primary care physician visit.
- **Home Health Care RN** coordinates necessary nursing, therapy and social services as needed.
- Health Coach or care coordinator at your physician's office offers support for a successfully recovery.
- **Home Health Care Social Worker** facilitates return to skilled care center or admission to SpiriTrust Lutheran Road to Home program at one of our personal care residences if needed.