Perla Hurtado

phurtado@foundationforseniorcare.org

Submission Date	Feb 29, 2024 8:31 PM
Tax Exempt Status	YES
Service Area	Bonsall, De Luz, Fallbrook, Rainbow
Will no less than 80% of the program recipients live within the communities of Fallbrook, Rainbow, Bonsall or De Luz?	YES
Collaborative/Joint Application	NO

Organization Information

Legal Name	DBA (if Applicable)
Fallbrook Healthcare Foundation Inc	Foundation for Senior Care

Contact Information

Contact Name	Title
Perla Hurtado	Executive Director
Primary Contact Phone	**Email Address**
760-723-7570	phurtado@foundationforseniorcare.org

Organization Physical Address

135 S Mission Rd
Fallbrook, CA, 92028

Board of Directors

FSC Board of Directors.docx
35.49 KB

Financial Documents - Audit

Audited Financials 2021.pdf
2.79 MB

Financial Documents - P&L and Balance Sheet

Balance Sheet 2023.pdf
36.23 KB

P&L2023.pdf
36.91 KB

Financial Documents - 990

FSC 990.pdf
393.73 KB

Organization's Mission Statement

Enhancing the wellbeing of older adults throughout the aging experience.

The Foundation for Senior Care is committed to providing services and resources to adults 65 years and older and disabled adults in the Fallbrook, Bonsall, Rainbow and De Luz communities. We currently offer the following services: transportation and grocery delivery; adult daytime care and caregiver respite; technology classes and senior-centric workshops; referrals, hands-on guidance and support advocacy for a wide variety of senior concerns and needs including healthcare, food and nutrition resources, housing, state and national entitlements, senior living facilities, hospital recovery support, legal and financial assistance, mental health resources, abuse and neglect interventions, safety issues, and more.

In partnership with the Fallbrook Regional Health District, our goal is to remove obstacles, promote resources, and facilitate access to services that enable older adults to live safely, maintain physical and mental wellness, and age gracefully with respect and dignity.

Organization's Vision Statement

To be recognized at the community, state and national levels as the primary resource and standard of excellence for programs, services and collaborations focused on adults 65 and older.

We strive to be recognized as a leader in senior services and stewardship – earning acclaim as a trusted ally and a steadfast advocate for the health and wellbeing of older adults and individuals with disabilities.

Organization History & Accomplishments

Our 501(c)3 agency was established in 1979, and most of the programs we operate today have been successfully serving seniors in this community since the early 2000s. In 2023, we provided direct services to nearly 1,000 clients through at least one of our interrelated programs.

Introduced in 2016, Door-through-Door is our newest program, initially as a pilot program with Tri-City Hospital. This program integrates two of our existing services into one comprehensive system of providing both transportation and case management services to seniors and disabled adults who are classified as high risk for falls and hospital readmission. It is designed to keep patients from returning home to an environment where there is little to no support. Since 2018, our collaboration with North County Fire enabled our Door Through Door Coordinator to respond much more quickly to a hospitalized senior. Improvements in both agencies' processes have resulted in a much quicker turnaround for us to receive those NCF referrals and act on them.

Since 2017, we have contacted over 600 seniors and disabled adults through this program and have worked closely with area hospital and Skilled Nursing Facility (SNF) Discharge Planners and family members to ensure that, prior to hospital or SNF discharge, the appropriate care needs are addressed, reducing the likelihood of falls and readmissions. We engage caring volunteers to help make wellness calls to check in on high-risk, isolated seniors.

Program Name/Title

Door through Door Program

Brief Program Description

The Door Through Door program provides critical support to hospitalized seniors, helping to ensure appropriate care and resources are available post-discharge, enabling the greatest opportunity for a full, safe recovery.

Is this a new initiative/service or established program within your organization?

Established Program

Did this program receive FRHD CHC - Grant funding last funding cycle (FY 23.24).

YES

Describe the impact of the program to date. Briefly explain how the service/intervention has worked - include cumulative metrics from the Q1 and Q2 Impact reports.

Our program has directly benefited 50 out of 115 projected adults through direct interaction following hospitalization. This intervention has proven effective in preventing readmissions and mitigating unsafe discharges. We identified 11 possible unsafe discharges and through proper support, prevented 11 unsafe discharges. Contributing to a 100% reduction in adverse outcomes among identified individuals.

These statistics underscore the tangible impact of our program, illustrating our ongoing efforts to address the diverse needs of older adults and individuals with disabilities in the Fallbrook Regional Health District.

If this program was previously funded, please provide an example of how the District's funding of this program was acknowledged.

PDF FRHD Acknowledgements_23-24.pdf
252.92 KB

Funding Amount Being Requested

10600

Program Information - Type

Ongoing

Projected number of residents that will directly benefit (participant/client) from this program.

100

Target Population - Age

	Percent of program participants	Estimated number of participants
Children (infants to 12)		
Young Adults (13-17)		

	Percent of program participants	Estimated number of participants
Adults (18-60)	5	5
Seniors (60+)	95	95
We do not collect this data (indicate with 100%)*		

Target Population not collected - Age

NA

Target Population - Gender

	Percent of program participants
Female	50
Male	50
Non-binary	
Unknown*	

***Target Population - Gender**

NA

Target Population - Income Level

	Percent of program participants
Extremely Low-Income Limits, ceiling of $32,100	25
Very Low (50%) Income Limits, ceiling of $53,500	40
Low (80%) Income Limits, ceiling of $85,600	20
Higher Than Listed Limits	15
We do not collect this data (indicate with 100%)*	

***Target Population - Income Level**

NA

What language(s) can this program accommodate:

English Spanish

What demographic group does this program predominately serve:

Older Adults Special Populations

Program/Services Description - Social Determinants of Health

Economic Stability (Employment, Food Insecurity, Housing Instability, Poverty)

Social & Community Context (Civic Participation, Discrimination, Incarceration, Social Cohesion)

Healthcare Access & Quality (Access to Health Care, Access to Primary Care, Health Literacy)

Neighborhood & Built Environment (Access to Foods that Support Healthy Eating Patterns, Crime and Violence, Environmental Conditions, Quality of Housing)

Social Determinants of Health - Economic Stability

The DTD program promotes economic stability by reducing healthcare costs through safe transitions, empowering informed decision-making, and leveraging community resources to minimize financial burdens for patients and their families.

Social Determinants of Health - Social and Community Context

The DTD program plays a crucial role in addressing the social determinant of health of Social and Community Context by providing comprehensive support and resources to patients transitioning from hospital to home care. By securing resources like in-home county support services and liaising between the hospital, patients, and their families, the program builds upon social capital, fostering stronger connections within the community and better safeguarding against hospital readmission. The coordinator's knowledge of the patient's living situation, social, nutritional, and environmental needs ensures a safe discharge-to-home process, facilitating appropriate care arrangements and transitions. Additionally, by working with family members or caregivers to retrofit the home for mobility aids and addressing fall risks, the program promotes a safer living environment, enhancing social support and community integration. Through follow-up home visits, assistance with transportation to health provider visits, and support for medical equipment, the program continues to address healthcare access and quality social determinants, ensuring ongoing support and improving overall health outcomes for patients within their social and community context.

Social Determinants of Health - Healthcare Access and Quality

The DTD program enhances healthcare access and quality by facilitating safe transitions from hospital to home care. Through coordination with hospitals and skilled nursing facilities, it ensures patients receive necessary resources and support. Education on healthcare options and Medicare benefits empowers informed decision-making. Addressing living situations and fall risks improves care quality, while follow-up visits and assistance with appointments ensure ongoing access to healthcare services.

Social Determinants of Health - Neighborhood and Built Environment

The DTD program addresses the social determinant of health of Neighborhood and Built Environment by focusing on enhancing the safety and accessibility of patients' home environments. By addressing fall risks, and installing safety equipment like wheelchair ramps and grab bars, the program ensures a safer built environment for patients. By mitigating environmental hazards and promoting accessibility, the program contributes to creating healthier and more supportive neighborhoods. Additionally, by collaborating with local volunteers to install safety equipment, the program fosters community engagement and strengthens social connections within the neighborhood. Overall, the DTD service plays a crucial role in improving the neighborhood and built environment by prioritizing the safety and well-being of patients in their homes.

Statement of Need/Problem

Recent data underscores the critical importance of timely access to home care services for older adults, particularly after hospitalization. Care services are often sought too late, typically after hospital readmission or a rapid decline in health status, leaving family caregivers overwhelmed and burnt out. This pattern persists within communities nationwide, including the FRHD community, where older adults frequently find themselves caught in a cycle of hospital readmissions due to inadequate post-hospitalization support.

Repeated hospital readmissions not only take a toll on the health and wellbeing of older adults but also incur substantial healthcare costs. Hospital

readmissions among Medicare beneficiaries alone cost the healthcare system billions annually. Yet, many of these readmissions could be prevented through effective home care interventions following discharge.

Recognizing the urgency of the issue, our DTD aims to provide proactive support and education to clients and their families, bridging the gap between hospitals, skilled nursing facilities, and home care services. Our DTD Coordinator intervenes early, working closely with healthcare professionals to ensure that appropriate care plans are in place before hospital discharge.

Additionally, our program addresses transportation challenges faced by isolated seniors, ensuring they have a safe and reliable means of returning home from the hospital (as well as reliable transportation for follow up appointments and care). While ride-sharing services like Uber and Lyft are sometimes utilized, we understand their limitations, particularly in rural areas. As such, we coordinate transportation directly, easing the burden on patients and their families.

By intervening early and addressing the multifaceted needs of older adults, our DTD program seeks to break the cycle of hospital readmissions, improve health outcomes, and reduce healthcare costs. It is imperative that we prioritize access to quality home care services to support the growing population of older adults and alleviate the strain on caregivers and the healthcare system alike.

How are other organizations addressing this need in the community?

There are no other organizations providing this service. Informed family members who are experienced with healthcare, insurance, and post-hospitalization risks and needs, may be the only alternative to our service. Through our Door Through Door Coordinator's collaboration with local hospitals and SNFs, we are able to proactively plan for and address patient's care needs before it's too late, avoiding hospital readmissions or falls.

Program/Services Description - Program Entry & Follow Up

Most of our Door Through Door clients come to us via a referral from our partner, North County Fire. Whenever NCF responds to a 9-1-1 call for a senior in need, they ask the patient if they would like free support through our specific DTD program and have them sign a release. NCF then emails that release form to our DTD Coordinator who initiates action to locate the senior and begin assistance.

Temecula Valley Hospital is also a great partner in this program. When a senior is about to be discharged from TVH, and the hospital knows they’re from the Fallbrook/Bonsall/Rainbow/De Luz area, they will often call our DTD Coordinator to inform us and will sometimes request our assistance to coordinate some post-hospitalization care. Most often, the hospital will discharge the client to a skilled nursing facility for continued therapy and strength building. But when the patient refuses that path, or the skilled nursing facility is full, the hospital will discharge the patient to their home and contact us to have us check in with the patient and determine if more assistance is needed.

Sometimes a neighbor or family member will contact us to tell us of their concern for a recently hospitalized neighbor/relative.

For complex cases when a client needs a significant amount of support, our DTD Coordinator will typically manage the case and client needs for two to three months. After stabilizing such a client’s needs, the DTD Coordinator may assign the client to a volunteer to make regular weekly calls to check in on them and report back on their status and needs. For some who need other types of help, the follow-up call is transitioned to a Senior Care Advocate until regular support is no longer required.

Program/Services Description - Program Activities

Our DTD service fills a critical gap in care by securing resources, like in-home county support services, upon a patient’s hospital discharge. The liaising

between the hospital, the patient, and their family builds upon the social capital that can better safeguard against hospital readmission and quicker recovery for our clients. Whenever one of our Advocates has a relationship with a referred senior, the DTD Coordinator has knowledge of, or access to advocate notes regarding the senior's living situation, social, nutritional and environmental needs. Our coordinator ensures that a discharge-to-home can be done safely, helps to arrange appropriate home or alternate care, or safe transition to another care facility. The DTD Coordinator also helps the client and their family navigate the complex healthcare system, educating them about their options, answering questions they might have, and helping with transitional plans. We help them to understand their Medicare benefits and, when appropriate, encourage a skilled nursing facility for care to help them recover and gain strength from an intensive hospital visit.

CMS has recognized an increased demand for the Care Advocate and transportation services from local hospitals and skilled nursing facilities. Our DTD coordinator will work with family members or care givers to retrofit the home, if necessary, to accommodate the use of a walker, wheelchair, or scooter. They will physically remove or mitigate fall risks. They will ask about medications and help, if needed, to remind them to take their medications or check blood sugar levels. If the client struggles with maintaining their medication regimen, they will recommend a home health program. Depending on the situation, a home visit may take place to guarantee the safety of the home environment before the patient returns home – and often these home visits will trigger calls to our volunteers to help install wheelchair ramps, grab bars, smoke alarms, or other safety equipment. At times, the DTD Coordinator may also provide a ride home from the hospital for a senior who does not have local family support.

Once a client is home and stabilized, a DTD Coordinator will follow up with home visits, assist the client with transportation to subsequent health provider visits and establish support for medical equipment and other rehabilitative systems addressing the Healthcare Access and Quality Social Determinants. We use a recent hospital visit as a wakeup call to encourage advance planning, to set up a Vial of Life for emergency responders, to secure medical alert devices to call for emergency assistance if needed, and to think about pet care, insurance, food resources, and other essentials that may be impacted in the event of a hospitalization.

Program Goal

Within the next 12 months, our DTD service aims to reduce hospital readmissions among discharged patients while improving their overall well-being. This will be achieved by providing comprehensive support during the transition from hospital to home care, including the installation of safety equipment, and follow-up home visits. Progress will be measured through monthly tracking of hospital readmission rates and patient satisfaction surveys, ensuring that our program effectively supports patients and enhances their health outcomes.

Program Objectives & Measurable Outcomes

1. Connect with at least 115 older adults who are or have recently been hospitalized, to provide resources and support to improve their safety and wellbeing.

2. Actively provide interventions, referrals, and/or education services for at least 70% of referred clients. (Note that some referred clients refuse help, or do not survive the hospital stay.)

3. Through our interventions, 90% of those clients whom we actively engage with will not be readmitted within 30 days due to preventable conditions.

4. Successfully prevent a wrongful or unsafe discharge from a healthcare facility in at least 40% of such identified cases.

Organization Collaborations

Fallbrook Food Pantry and Fallbrook Senior Center – after a hospital discharge, assess/coordinate enrollment in food home delivery programs

North County Fire – handle referrals from NCF for any senior or disabled resident who appears in need of support

Interfaith Community Services – work to obtain transitional housing and support case management when discharged client has no home to go to

Temecula Valley Hospital, Palomar Medical Center, Tri-City Hospital, and Fallbrook Skilled Nursing – work directly with Discharge Planners to get updates on the patient's status and plans for discharge, collaborating to secure appropriate transitions based on client needs.

Home Health and Hospice Agencies – work with 10-12 agencies to assist getting appropriate care in place prior to or after a hospital discharge

Independent Caregivers – connect Caregivers with the unique needs of each client

Anticipated Acknowledgment

Social Media Postings | Signage at Service Sites | Print Materials to Service Recipients | Website Display | Other

Anticipated Acknowledgment

Fallbrook Regional Health District's support is consistently acknowledged as a grantor/supporter with logo (and map when appropriate) on our website, social media, Care Vans, impact reports, and other promotional and educational communication materials.

Funding History

NO

Program Budget

XLSX 24_25 FRHD CHC Program Budget Form_... .xlsx
55.07 KB

Terms and Conditions

Accepted

Authorized Signature