Connecting the Dots: Partnering Hospital@Home with a Home Care Agency to Help a Vulnerable Patient with CHF

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INTRODUCTION

- A gap exists between the hospital and the home of each unique patient and so we work to improve connection between the healthcare teams in these spaces using Hospital@Home programs
- Management of complex conditions, such as CHF, can be tailored to patient's unique social and physical needs in the home

CASE STUDY

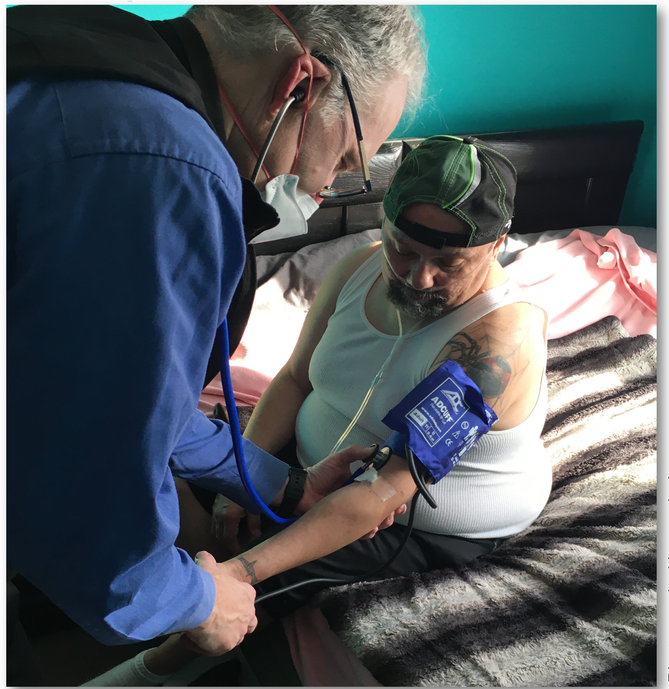
A 52 year old male living alone in apartment with family support is admitted to the hospital for management of CHF exacerbation. Past medical history includes:

- Chronic Systolic Heart Failure (ef:15%)
- Non-Ischemic Cardiomyopathy
- Diabetes Mellitus Type II
- Alcohol Use Disorder

The final five days of his management occurred in his home via the Hospital@Home (H@H) program, including:

- Twice daily home visits by community paramedic (CP) with a telemedicine visit by hospitalist
- IV and oral diuretic administration/titration
- Monitoring of labs

At the final H@H visit, a nurse from his Medicare-certified home care agency joined the team for a handoff.



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CASE STUDY

One week later the patient was noted by home care RN to have a concerning weight gain and the patient was safely escalated to the H@H program, thereby avoiding a readmission.

Upon stabilization several days later, the final CP H@H note stated: "Met with Whitney from Home Health Care. She will be seeing pt weekly for vital signs, medication reconciliation, and weight assessment.
Home Care RN will connect with PCP for ongoing management. Patient continues to thrive independently in his apartment."

IMPACT

- Despite state-of-the-art healthcare and medical decision making done to manage acute illness in a hospital, a blind spot exists regarding the reality of the patient's unique home space.
- Home care teams often have insight into the challenges patients will face after discharge from the hospital but may lack access to the acute care team.
- Through home visits in a Hospital@Home program, a safe plan of care can be tailored to account for the social determinants. This plan can be passed on directly to the post-acute team, which may include members of a home care agency.