Acute CHF Management in Hospital@Home

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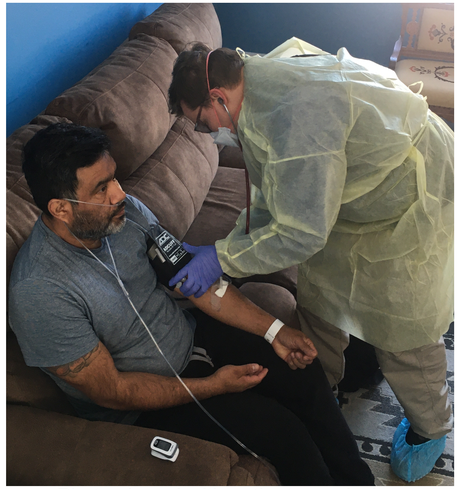
BACKGROUND

The HealthPartners Hospital@Home (H@H) multidisciplinary team is comprised of community paramedics (CPs), internal medicine physicians, virtual hospital unit coordinators (HUCs), and nurse clinicians. Patients are screened based on specific criteria focused on safety and are enrolled from either the emergency department or inpatient units. The patient is transferred home and then visited by a CP daily, with telemedicine rounding by the physician during the home visit. Nurse clinicians also complete a daily plan of care telephonic encounter each day.

Hospital@Home treatment for CHF includes the following elements:

- 2 daily home visits by a Community Paramedic
- 1 daily telemedicine visit by a hospitalist
- 1 daily phone visit by a nurse clinician
- Daily lab monitoring
- 1 or 2 doses IV diuretics
- Oral medical titration
- Oxygen titration as needed
- Other cares as needed



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CASE PRESENTATION

This patient had a 16 day Hospital@Home admission, thereby reducing his hospital length of stay by 16 days. Patient was going to leave AMA from the hospital, but was accepting of H@H due to being in the comfort of his own home. This lead to better patient outcome and satisfaction.

CASE PRESENTAION

63y/o male admitted to hospital with congestive heart failure (CHF) needing aggressive IV diureses was enrolled into H@H on hospital day 4 for ongoing diuresis and management of chronic renal failure.

Comorbidities include: diabetes type II, cardiomyopathy, hyperlipidemia, anemia.

Once home, IV diuretic was given twice daily, along with regular monitoring of BMP and BNP lab values.

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Impact of this H@H enrollment:

- Reduced LOS by 16 days
- Comfortable in own home as compared to hospital
- Increased patient satisfaction
- In-home medication reconciliation
- Lowered cost of care for patient and insurance company

DISCUSSION

This case demonstrates how a Hospital@Home program can substantially reduce days spent in a hospital bed. Research on the detrimental effects of long-term hospitalization are well documented. This patient was very happy to have the opportunity to participate in his care at home where he was more comfortable and better able to learn how to manage his chronic disease. This case also demonstrates sub-acute CHF management can safely be done in the home by a multidisciplinary team, utilizing home visits and telemedicine after a short in-hospital stay where a successful plan of care is initiated.