Home is Where the Heart is: Utilizing a Hospital@Home Program to Enhance the Management of Congestive Heart Failure

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Emily Ewan, MD[1]; Pitchaya (Tao) Worapongsatitaya, MD[1]; Michael Schnaus, MD[1,2]; Tia Radant, MS,NRP[2]; Chrisanne Timpe, MD[2]
[1]University of Minnesota Internal Medicine Residency Program; [2]HealthPartners

PRACTICE PROBLEM

- Congestive Heart failure (CHF) is the leading cause of hospitalization in adults over the age of 65 (1)
- Hospitalizations account for 70% of the annual cost of heart failure care (2)
- Patients with heart failure often struggle to understand and cope with the complexities of the disease, leading to dietary indiscretions and medication non-adherence, contributing to high readmission rates
- Attempts to diurese patients to dry weight in the hospital has contributed to prolonged lengths of stay, exacerbating hospital capacity issues and frustrating patients (3)

OBJECTIVES

- Identify hospitalized patients with CHF early in their treatment course and complete their acute care in the home, where social determinants can be incorporated into the plan of care
- Shorten hospital length of stay for management of acute heart failure
- Empower patients/families to engage in the treatment plan prior to release from intensive oversight by an acute care team

REFERENCES

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2. Go AS, et al. Circulation. 2013;127(1):e6-e245.
3. Bakosis G, et al. Cont Cardiol Educ 2017;3(3).

INTERVENTION

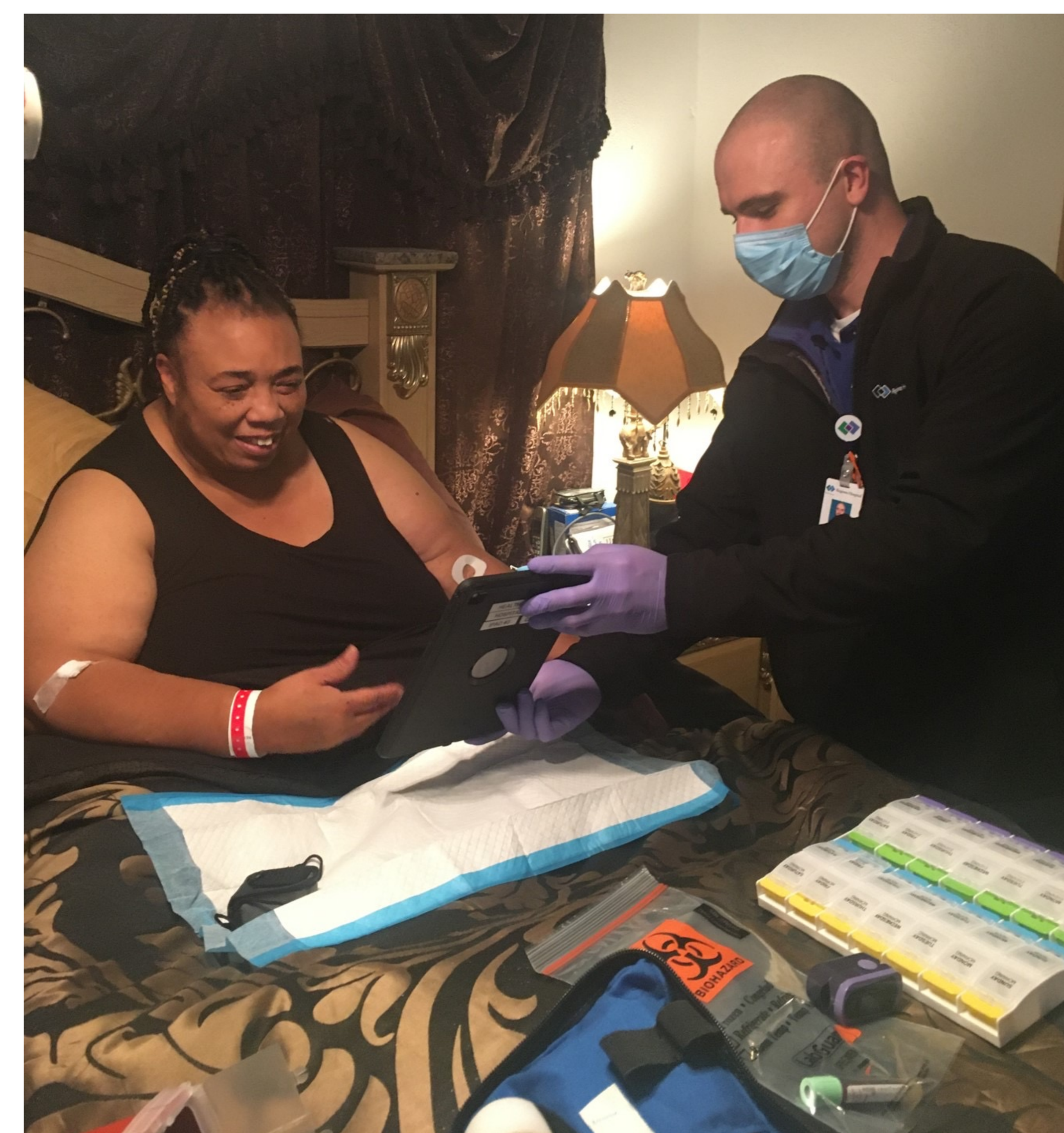

Fig 1: Patient during virtual visit with hospitalist, assisted by community paramedic

Fig 2: Community Paramedic preparing for visit

Measures of Success	Findings to Date*
Diuretic titration during H@H	61% received IV diuresis 39% BID IV diuresis
Secondary issues addressed	28% of patients
Average weight loss during H@H	4.5 lbs (max weight loss 32 lbs)
Average hospital length of stay reduction (presumed)	3.91 days
Patient satisfaction	*Data collection ongoing*

*57 patients with CHF enrolled between 6/2020 and 10/2021
Average age 74 years old; 54% Male, 46% Female
68% White, 23% Black/African American, 7% Hispanic, Remainder Other

- **Eligible patients:**
  - Admitted to hospital or ED with diagnosis of acute CHF
  - Require daily acute care and qualify for inpatient care
- **The Hospital@Home (H@H) team:**
  - Hospitalists – round virtually on a daily basis
  - Community paramedics – daily or BID in-person visits
  - Virtual health unit coordinators
  - Nurse clinicians
- **Program goals:**
  - Provide diuresis with lab monitoring
  - Daily medical decision making by a provider
  - Improve patient engagement and health literacy in management of CHF
  - Treatment plans tailored to patients' unique social determinants

CONCLUSIONS

- H@H programs can be an effective means to bridge the transition between an acute care hospital stay and home
  - Provides an effective and safe framework for management of CHF exacerbations
  - Helps tailor the bulk of patient education to the patient's unique home environment and social determinants of health
- H@H can reduce hospital length of stay, help alleviate hospital capacity issues, and provide patient-centered care outside of institutions