ABSTRACT: 2023 ELH Institutional Action Project

Project Title: Heal at Home: Improving Transitions of Care

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Topic Category: Clinical Care

Significance of Project:
Workforce shortages, capacity constraints, and decreased margins are impacting academic healthcare centers nationally [1]. Home-based care in the post-acute setting affords an opportunity to address these challenges and impact how we deliver patient centric, value - driven care. For episode-based hospital stays coordinated home health following early discharge may benefit patients, providers, and hospitals. Early discharge and home nursing visits have been associated with reduced readmissions, reduced all-cause mortality, and reduced overall cost of care [2,3]. These programs have shown significant benefit even In high risk populations, such as the elderly [4]. Heal at Home (HAH), a program created by the University of Utah, provides seamless transitions of care for our patients leaving the hospital to home with home health services. We plan to partner with Community Nursing, valuing their expertise and services, to improve transitions of care to decrease the length of stay, improve outcomes, and provide better patient experience.

Purpose:
The goal of this program is to establish and implement a “best-practice” approach to transitions of care for widespread adoption in our institution. This will lead to better patient experience while sustaining or improving outcomes. Ultimately, this will improve bed capacity, reduce average length of stay, reduce readmission rates, and reduce ED visits in the post-acute setting.

Approach:

- Identify and recruit core and stakeholder HAH teams.
- Design a standardized intake process for onboarding new programs.
- Support and further develop existing HAH pilot programs to use as models.
- Evaluate and Implement new programs.
- Develop sustainability plan.

Outcomes:

Leveraging the relationship between the University of Utah and Community Nursing Services (CNS), we have successfully identified our core and stakeholder groups with key voices within the health system representing facets of a patient's journey. Using this team, we are refining our strategy to expand, enhance, and evaluate existing and new programs. This includes creating critical educational material for standardizing the intake process and developing protocols for nursing, physical therapy, occupational therapy, and other home health services. Through this process we are improving our communication to system leaders about the opportunity to serve the needs of our patients and our providers while improving the fiscal health of our hospital.

Statement of Impact:

Home based care initiatives are integral to the growth and expansion of a health system. The implementation of an integrated transitions of care program will allow patients to recover in the home safer and sooner. HAH offers continuity of care, with a trusted team in a coordinated effort with accountability. This plan has both patient and health system benefits including providing better patient experience and improved health outcomes while reducing readmissions and improving capacity.