Heal at Home: An Innovative Solution for Hospital Capacity Challenges

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Learning Objectives
- Identify select methods used to ease the transition from acute to post-acute care.
- Discuss successful strategies employed to improve genuine two-way communication between a hospital and home health.

Background

- Health system capacity challenges impact patient care through added emergency department wait times and delayed transfers to and within hospitals, including postponed surgeries.
- Capacity strains can be eased by accelerating the transition from the hospital to the patient's home among select post-operative and medical care populations.
- University of Utah Health partnered with Community Nursing Services (CNS) to promote these safe earlier transitions by establishing the Heal at Home program.

Program Overview

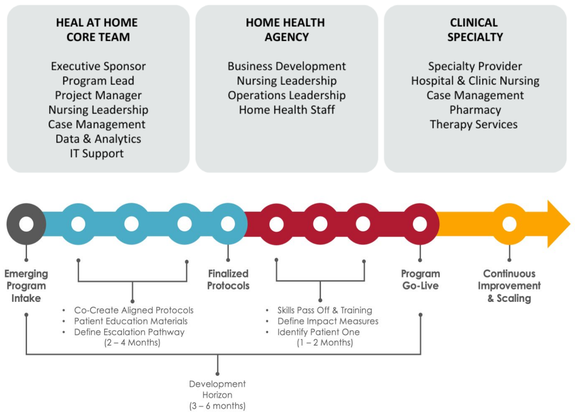
- Heal at Home aims to optimize hospital capacity by streamlining transitions of care, specifically targeting reduced length of stay.
- Combines technical expertise with home health infrastructure, enabling safe post-operative and medical care transitions across various specialties.
- The home health benefits in most insurance plans means that no novel reimbursement mechanism is necessary for program sustainability.

Participating Specialties

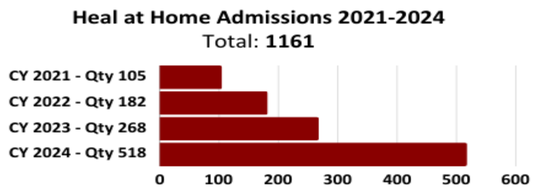
17+ Established Programs
- Breast Mastectomy, Colorectal Surgery, Emergency Medicine, Gynecology, Gynecologic-Oncology, Hospital Medicine, Neurosurgery (Spine), Ortho Hip and Knee, Ortho Shoulder, Ortho Spine, Physical Medicine and Rehab, Transplant Surgery (Liver), Transgender Health, Urogynecology, Urology (TURP), Uro-Oncology (RALP), Vascular Surgery

6+ Expanding Programs
- Acute Care Surgery, Neurosurgery (Skull-Base), Ortho Trauma, Plastic Surgery (Free Flap), Postpartum, Urology (Abdominal Reconstruction)

Program Development



Enrollment



**2024 enrollment has been annualized based on 6-month enrollment numbers*

How Does Heal at Home Differ From Traditional Home Health?

Home Services	Skilled nursing, therapy, labs, remote monitoring, vitals, virtual visits
Dedicated Team	Consistent home health team to care for the patient = trust & consistency
Accountability	Bi-directional accountability - clinical care, quality, safety
Shared Protocol	Co-developed nursing and therapy protocols
Communication Tools	Electronic Medical Record access, HIPPA secured communication
After-Hours Support	Defined escalation of care pathways - U Health provider participates
Measured Impact	Outcomes tracked/trended

Outcomes

Bed Days Saved	791 bed days saved since program inception
Patient Satisfaction	95% of Heal at Home patients are likely or very likely to refer
30-Day Readmission Rate	4.6% compared to 17% for other home health agencies in Utah
ED Utilization	8.38% compared to 10% for other home health agencies in Utah

Lesson Learned and Key Takeaways

Lessons Learned
- Clinical program champion and multidisciplinary program development is essential.
- Dedicated personnel are critical for program expansion.
- IT infrastructure requires time and resources and is necessary for scaling.

Key Takeaways
- A partnership between hospital and home health agency can improve patient experience and increase hospital capacity.
- Start small, build on successes, and focus on patient safety and experience.
- The future vision is to have seamless transitions of care across all hospital to home discharges across the entire health system.

References
- Arogyaswamy, S., et al., The Impact of Hospital Capacity Strain: a Qualitative Analysis of Experience and Solutions at 13 Academic Medical Centers. J Gen Intern Med, 2022. 37(6): p. 1463-1474.
- Levine, D.M., et al., Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med, 2020. 172(2): p. 77-85.
- Gorbenko, K., et al., A national qualitative study of Hospital-at-Home implementation under the CMS Acute Hospital Care at Home waiver. J Am Geriatr Soc, 2023. 71(1): p. 245-258.

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