Hospital to Home
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While there are many defining moments for older adults in their pursuit to maintain independence, there are few others that equal the challenge of effectively transitioning from hospital to home. Formal linkages between health and community-based care are tenuous, at best, and many of those charged with implementing the acute care discharge plan are ill-prepared to address the health related issues that often lead to re-admissions or emergency room visits by older adults.

Hospital to Home (H2H) will provide a well-defined model for formal linkages between health and community-based care to improve health, social and functional outcomes for older adults being discharged from the hospital with a primary diagnosis of congestive heart failure. Feasibility for such a model will first be tested by community case managers from Sheltering Arms Senior Services and discharge planners from The Methodist Hospital. An analysis of the costs and patient outcomes will be used to refine the model so that it may be further disseminated to other Houston area community case management agencies. Utilizing an interdisciplinary approach, H2H will combine evidence based interventions and best practices to ensure an automatic and effective transition from the hospital to the community for project participants. Special attention will be given to addressing CHF symptoms as well as other well-documented threats to successful community living for the target population, namely depression, medication errors and inadequate information sharing and transfer between settings.

A logic model will be developed for the project to ensure consensus about the priority performance measures for H2H, and the key client and systems outcomes to be realized. Anticipated client level outcomes include: improved clients' understanding and participation in self-management of their chronic disease, improved function and clients' ability to manage their ADLs, and improved clients' emotional well-being. Further, reduced in-patient readmissions due to CHF, reduced use of the hospital's emergency room by CHF patients, and reduced medication errors and contraindications are all anticipated outcomes of H2H.

It is expected that H2H will yield results that will be attractive to both fee-for-service and capitated health care systems. A solid business case for H2H's ability to reduce health care costs by reducing in-patient hospital readmissions and/or visits to the emergency room by CHF patients should be the result of this PCF initiative. It is our intent to use the results of this project to negotiate with Methodist and other hospitals for funding to support community case managers as a necessary element in their quest for comprehensive delivery of health care.

Please email Jane with any questions or comments regarding this project.