

From Home to Hospital: Escalating for a Smooth Transition

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Home Hospital
NYU Langone Hospital – Long Island

BACKGROUND

Patients admitted to the NYU Langone Home Hospital program may experience changes in clinical status, ultimately warranting escalation of care and further testing necessitating a return to the hospital.

Effective strategies to facilitate a smooth transition in care back to the brick-and-mortar include interdisciplinary coordination, nursing and physician assessments, patient and caregiver communication, logistics, handoff communication, and in-hospital follow-up.

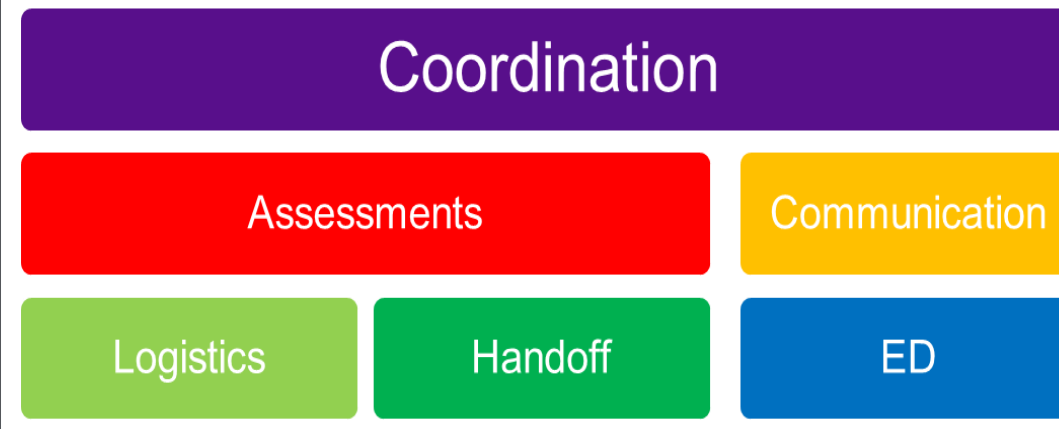
Once stabilized, clinically appropriate patients may then be transferred back to their homes to complete the duration of their hospitalization in the comfort of their home. Escalations of care are reviewed in real-time and debriefs are conducted to identify any opportunities for improvement.

TOP ESCALATION REASONS

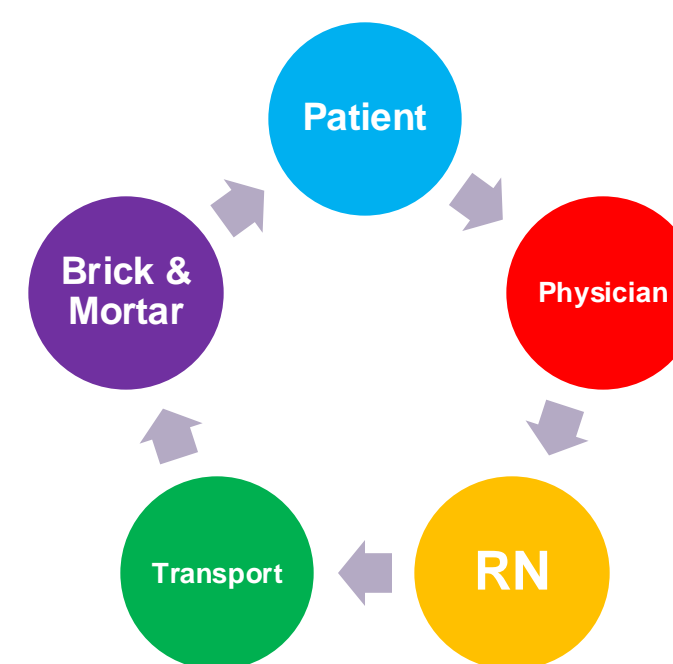
- Imaging unable to be done in the home**
 - MRI
 - CT Scan
- In-person consult needed**
 - Surgery
 - Infectious Disease
- Home safety concerns**
 - Lack of caretaker
 - Challenges with electricity
- Acute Clinical Condition**
 - Respiratory decompensation
 - Telemetry

STRATEGIES FOR IMPROVEMENT

An advanced escalation pathway (FIGURE 1) results in the prompt recognition of patients at the first inclination of decompensation. This leads to prompt and seamless escalation of care to facilitate high quality outcomes.



COMMUNICATION



HOME HOSPITAL PROGRAM METRICS

September 2022 – September 2024

Metric	Outcome
Admissions	778
Rate of Escalation	5.43 (42 escalations)
Unexpected Mortality	0.00
Median LOS (rolling 90-day)	3.42
O:E LOS (rolling 90-day)	0.71

ESCALATION PATHWAY (FIGURE 1)

