3-minute case study: Post-acute care comes home

By Alison Pereto | April 22, 2019

The problem

For two years, Penn Medicine's geriatric nurse consultants had monitored patients during hospital stays and identified potential post-acute care challenges. But identifying problems didn't always ensure they'd be addressed after discharge.

"When patients are in the hospital, it's very hard to really understand how they best function in their home environment, and what their real post-acute care needs are," says Rebecca Trotta, RN, director of nursing research and science at Penn.

Penn's discharge system, like many others, was missing an opportunity to address common geriatric care gaps. Elderly patients hospitalized for pneumonia would seldom be assessed for depression, dementia, and other drivers of negative outcomes. Typically sent home around 4 p.m., patients often faced empty cupboards and prescriptions that needed filling.

Exhausted from their illnesses, many postponed dealing with these errands. And formerly innocuous household fixtures, such as staircases and heavy pots, became hazards.

"These are sometimes some of the most complicated, complex, frail patients," says Trotta. "They all have multiple advanced diseases. They're dealing with functional limitations. They're dealing with cognitive limitations."

The average wait for a home nurse visit was two to three days; the wait for medications – and education on how to use them – could be as many as six days.

The solution

"We didn't just look at the existing care process and say, 'How can we shave off a minute here, a minute there?'" says Trotta. "We thought, 'How can we do things completely differently?'"

Inspired by the "flipped discharge" program at Sheffield Teaching Hospitals in England, Penn Medicine began a pilot called SOAR (Supporting Older Adults at Risk), adjusted for the realities of U.S. healthcare.

First, SOAR moved the discharge time to 10:00am. Starting small, Trotta's team worked with one provider at a time at a time to get prescriptions and discharge summaries signed by 9:00 a.m. A handoff call at 8:30am the morning of discharge synchronized providers with the home care team, sharing information and answering questions.

As part of the pilot, all patients receive transportation home from the hospital, allowing loved ones to greet them at home. At lunchtime, patients and caregivers receive a delivered meal. The meal is more than a perk – it fills nutrition gaps and improves care delivery.

"Patients love having lunch delivered," says Trotta. "They're much more likely to pay attention when their nurse shows up if they've eaten a nice lunch."

That afternoon, a home care nurse arrives to initiate the post-acute care plan, checking medications and ensuring everything is in place. What's more, the nurse can easily contact both the provider who signed the discharge orders as well as the hospital pharmacist.

"This is a classic area where the transitional period [gets] fragmented," says Trotta."It's very rare for a homecare nurse to have the direct phone number of the discharging provider."

With questions resolved, and prescriptions delivered before the end of the day, the patient can focus on rest and recovery.

The day after discharge, a nurse visits again; and the day after that, either the nurse returns or more specialized therapy, such as occupational, physical, or speech, begins.

The outcome

Nearly 80 patients in to SOAR, Penn Medicine is starting to scale up the program – and everyone is winning.

In a comparable cohort, 15 percent of patients refused home care services. But in SOAR, every patient has said yes. The morning discharge has been consistent, even if it's a bit later than 10am. And the hospital length of stay has remained the same, if not shorter.

Without the stress of hospitalization, and with in-home daily therapies, SOAR patients can begin the work of healing sooner. And patients adamant about going home, but not well enough to do so under traditional circumstances, can now receive care without delay.

"The provider feels really confident. The patient's so happy. The caregiver is happy," says Trotta. "One of our patients said, 'There's something about the magic of being home that helps me recover.'"

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