

# Home-Based Care for Heart Failure: *Cleveland Clinic's 'Heart Care at Home' Transitional Care Program*

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New research suggests that patients with chronic heart failure (“HF”) may yield outcomes similar to those of clinic-based care when treated in the home. With hospital stays decreasing in length of stay, it is important to look at creating new models of care for HF patients that will reduce costs without increasing risks and home health’s role in transitional care. Home Based Care for Heart Failure: Cleveland Clinic’s ‘Heart Care at Home’ Transitional Care Program examines the Cleveland Clinic Heart Care at Home program, a program designed to minimize the risks that HF patients experience when being transitioned to and cared for at home.

## Overview of Heart Care at Home Program

In 2010, the Cleveland Clinic launched the Heart Care at Home program to minimize the risks associated with patients being transferred from the inpatient setting to the home setting. The basic model includes the following steps:

- During the initial hospital stay, candidates are identified, a model of care is introduced and a coaching intervention begins.
- Once discharged, home care liaisons conduct home visits after a median of two days post-discharge to continue coaching, and teach the patient how to use newly installed remote monitoring equipment.
- Telehealth nurses monitor the patient for 30-40 days, making weekly contact to reinforce coaching, coordinate care and track outcomes.
- Experienced home care and heart failure nurse practitioners provide clinical oversight and make home visits to the highest acuity patients.

## Increasing Efficiency: Telehealth Home Monitoring and Workforce Development

Home monitoring plays an important role in managing HF by facilitating early detection of clinical problems and allowing for timely intervention to prevent adverse outcomes.

Another important element to the Heart Care at Home program is the cross training provided to home care nurses to specialize in caring for patients with HF.

## Conclusion

Throughout 2012, patients in the Heart Care at Home program noted increased levels of satisfaction over an average 30 days in the program. First time enrollees had a lower readmission rate for patients in the program compared with publicly reported Cleveland Clinic rates (24.5 percent vs. 28.2 percent).

Preventable readmissions for HF ranged from 25-30 percent. For these patients, innovative programs like telehealth and specialized home care nurses appeared to greatly improve the chances that a patient would stay out the hospital. For example, providing a HF patient with a tablet at home allowed them to have virtual visits with nurses and prevented unnecessary trips to the emergency room. The virtual visits also help patients to take their care more seriously and feel more connected to the health care system.

There has been much success with the Heart Care at Home program. Given that the home will increasingly be the venue for post-acute care, the authors call for further investigation into beneficial models of care and optimal uses of technology, as well as the need to cultivate a specialized mobile workforce to care for HF patients at home.