HOSPITAL 2 HOME H2H - FAQ

The Hospital to Home (H2H) pilot program assists individuals with disabilities transition safely from the hospital back into their homes and communities. The Care Transition Coordinator (CTC) will work with the hospital on complex discharge cases to determine the best candidate for the program.

What makes a patient eligible for the H2H program?

The eligibility criteria that a patient must meet to be considered for the H2H program is as follows:

- The patient must have a disability.
- The patient must have a home or place to live upon discharge.
- The patient must have family or support system to help with their transition and care.

What are the goals or expectations of the H2H program?

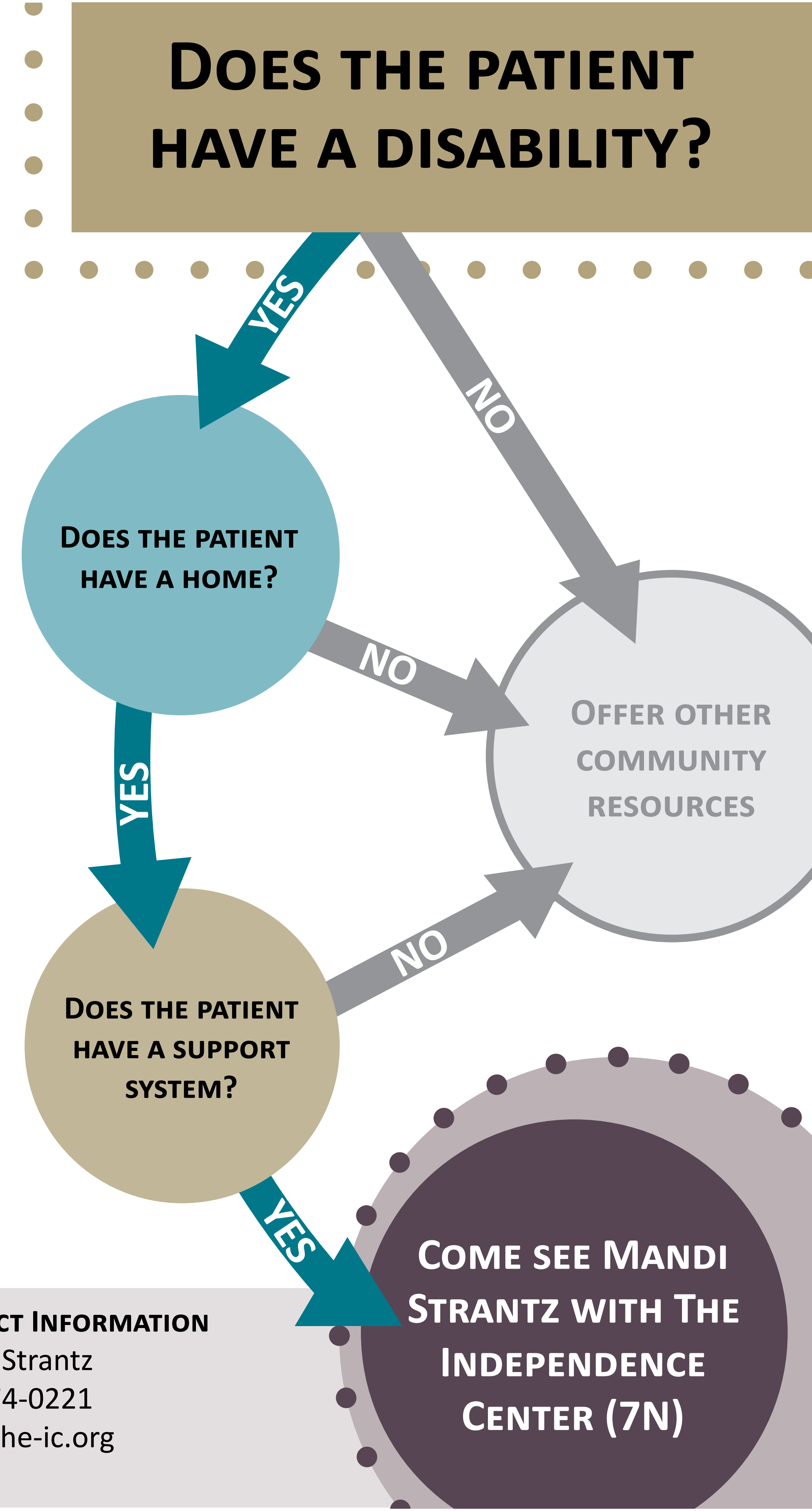
- A goal of the H2H program is to help an individual in the hospital, who has a disability, transition back into the community safely.
- Another goal of the H2H program is to help patients that would typically end up in a nursing home, return to their own home and back into the community without readmission into the hospital. This is important for the quality of life of those individuals.

What is the timeframe for the H2H pilot program?

The H2H pilot program begins April 2018 and it will last six months, ending in October 2018. The program will take on ONE patient per month during the six month period, accepting a total of SIX patients.

How does the H2H program work?

- First, the CTC will attend the weekly complex discharge meeting to identify patients who are eligible.
- Once a patient is determined to be eligible, the CTC will meet and assess the patient, family or support system, and the home.
- The CTC will collaborate with the discharge manager at the hospital to complete the discharge plan.
- The CTC will coordinate all needed resources before the patient is discharged, to include transportation from the hospital home, meals, medication (fill/delivery), and any skilled care necessary when returning to the community.
- The CTC will coordinate any community resources that are needed once the patient has safely discharged from the hospital back home.
- The CTC will continue to be a support for the patient for a minimum of 60 days until the patient is stable and connected with community resources necessary to avoid being readmitted to the hospital.



Contact Information
Mandi Strantz
719-374-0221
h2h@the-ic.org