Success Story

In November 2018, a patient with a complicated history of Crohn's disease had surgery to remove part of his bowel. Unfortunately, the incision became infected and he was readmitted to the hospital a few days later. The wound got worse when the patient ate, so he was put on Total Parenteral Nutrition (TPN), a method of feeding that bypasses the digestive system and instead drips nutrients directly into the vein.

Due to his lack of insurance outside of the hospital, he was unable to afford TPN at home. This meant he might need to stay in the hospital, possibly up to six months, until he was able to have his next surgery.

Instead, the hospital and the H2H program teamed up to get the patient home. The hospital worked diligently to get him off the TPN feeding, and H2H was able to provide skilled home health, wound care supplies, and his medications upon his return home. The patient has now been at home for 60+ days with regular check-ins with his surgeon.

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A Non-Profit Organization

the-ic.org

People with disabilities building community

The Independence Center

H2H Hospital to Home

Assisting people safely from the hospital back into their homes and communities.

Center for Independent Living | Advocacy
Home Health | CNA Training | Veterans

The Hospital to Home (H2H) program assists people to transition safely from the hospital back into their homes and communities. The Care Transition Coordinator (CTC) will work with the hospital case managers and social workers to determine if a patient is eligible for the program.

What makes a patient eligible for the H2H program?

The eligibility criteria to be considered for the H2H program is:

- The patient must have a place to live upon discharge.
- The program successfully meets the patient's needs with the available services.

How does the H2H program work?

The CTC will work with the case manager at the hospital to create a smooth discharge. Patients and families will have one point of contact to coordinate all services after discharge.

The CTC will continue to be a support for the patient temporarily (minimum 60 days) until the patient is stable and connected with community resources necessary to avoid being readmitted to the hospital.

Temporary case management that can assist with:

- Transportation from the hospital to home and to/from appointments.
- Meals
- Medication (fill/delivery)
- Benefits application
- Home evaluations
- Peer support
- DME assistance
- Skilled care including nursing, physical therapy, occupational therapy, and speech therapy.
- Unskilled care including assistance with daily living tasks, cleaning, cooking, and laundry.
- Guidance with community resources (such as support groups and training family and friends).

For more information, contact:
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