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 is a partnership between The Independence Center and local health care providers that improves lives and outcomes for complex patients transitioning back into the community.

The program, which was successfully piloted with UCHealth Memorial Central, combines a well-established network of community providers with the experience necessary to coordinate the multitude of services a patient may need.

How does the H2H program work?

With our streamlined process, patients are transitioned from hospital to home in an average of three days.

- The process begins immediately upon referral from the hospital.
- We determine eligibility by verifying that the patient has a place to live upon discharge.
- We work closely with case managers to create a smoothe discharge plan.
- We coordinate services in the home and set up DME.
- Case management is continued for a minimum of 60 days after discharge.

Benefits to Hospitals & Patients

- Shortens length of stay for complex discharges.
- Reduces readmission rates and unnecessary ER visits.
- Results in better outcome for patients as they heal at home surrounded by medical and social supports.

The H2H program 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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