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The Time to Shine

Allina Health Dusts Off a Tabled Program to Meet Unique Needs During COVID-19

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We've all heard the saying "before its time" when a great idea surfaces before the perfect application or need is ready and evident. That's what happened with Rachel Kuhnly's master's degree capstone project. When she proposed her Home Hospital idea a year and a half ago, the management team at Allina Health wasn't quite ready to invest in the idea.

"When COVID hit in 2020, it was easy to dust off that planning document," said Kuhnly, strategy and business development consultant at Allina Health. "We were able to get the program up and running in a few weeks." The leadership at Allina Health are members of the Program Advisory Council (PAC) of the Great Plains Telehealth Resource & Assistance Center (gpTRAC).

The Home Hospital Care program was the perfect way to help alleviate the demand on hospital capacity during the initial surge in the spring and now into the winter while keeping non-COVID patients safer by providing care at home.

Patient Journey

The patient's journey through the Home Hospital Care program begins with a referral from any number of providers including the hospital, ED, home health, and urgent care. "When the patient is discharged from their point of entry to Home Hospital Care, our community paramedic staff helps them safely transition home," Kuhnly explained. "We provide them with a tablet that serves as the Home Hospital Care hub. It manages vitals with Bluetooth-enabled peripherals such as a blood pressure monitor, pulse oximeter and thermometer and also facilitates virtual visits. The system runs on AT&T or Verizon, so WiFi connectivity isn't an issue."

During the initial in-home nursing visit, the nurse will conduct an assessment of the patient and see what is needed. The Home Hospital Care program coordinates home nursing visits, telehealth visits with providers, and in-home therapies including physical therapy, speech therapy, labs, respiratory therapy, and infusions.

“We try to schedule the patient’s first telehealth provider visit while the nurse is there to answer any questions or help take vital signs,” Kuhnly said. “Sometimes the timing doesn’t work out, but some patients like being checked on multiple times a day.”

All the data from the patient’s Home Hospital Care tablet is sent to a hub that is managed by a team of nurses. “If a patient’s vital signs fall outside acceptable parameters, we are contacting the patient and they are triaged appropriately to ensure safety.”

Patients are seen by a telehealth provider and nursing very frequently, all based on the patient’s condition. The program schedules extra services as needed.

“Currently, we can serve 50 patients per day and are working to secure temporary resources to manage a surge this winter to significantly expand our capacity and serve our community,” Kuhnly said. “Once they are discharged from Home Hospital Care, they usually go to a home health program.

“I think Home Hospital Care provides a better experience for patients as they can recover in the comfort of their own home and with their loved ones” Kuhnly continued. “Many of our patients simply don’t want to be in the hospital because the probability of contracting COVID is so much higher than by staying at home.”

A Success Story

Many patients have found Allina Health’s Home Hospital Care program beneficial and have appreciated the ability to stay at home and out of the hospital.

“We had one patient who was admitted to Home Hospital Care after a visit to the ER for chest pain,” Kuhnly said. “Their condition was concerning enough that the providers wanted to admit them to the hospital, but they adamantly refused and luckily, we were able to take care of them as a Home Hospital Care patient.”

Biometric monitoring was established by a community paramedic who ensured the patient’s home environment was safe and that the patient knew how to operate the equipment. The paramedic helped educate the patient’s live-in daughter who would help. A nurse practitioner connected with the patient via telehealth the next day for orientation and to take a thorough medical history.

Over the course of the next two weeks, home care nurses checked to make sure the patient was taking medications appropriately, that their blood sugar was at safe levels and that she knew how to use biometric equipment to perform self assessments.

“When the patient failed to report vital signs one morning, our nurses promptly called to check on the patient and determine she was okay,” Kuhnly said. “On another day, their daughter was concerned about the patient’s blood sugar readings and called triage. The nurse was able to educate the daughter on acceptable levels for the patient and worked with her to enter the levels in a diary to review at a later visit.”

When the patient’s blood pressure dropped too low and she was symptomatic, Home Hospital Care ordered labs and adjusted the patient’s medication to manage their blood pressure quickly.

“After almost a couple weeks of care the patient safely discharged from the program into home health services,” Kuhnly said. “In this case, Home Hospital Care was cost-effective for the patient and allowed the patient to heal at home in familiar surroundings and with their family. Patients appreciate the benefits of the program, and our providers feel a closer connection to patients and their loved ones, which leads to better overall care.”