

Hospital to Home Program

Hospital to Home (H2H) is designed to support transitions back to the community via the hospital setting. The program works in coordination with the Alabama Gateway to Community Living (GCL) and Alabama Community Transitions (ACT) programs which are designed to transition individuals from facilities back to the community. This model established by the Alabama Medicaid Agency integrates the existing Integrated Care Network's Case Management Organizations (CMOs) with health systems to provide expedited access to the ACT or Elderly and Disabled (E&D) Medicaid Waiver services for Medicaid beneficiaries who upon discharge are at risk of institutional long-term care placement. It is part of an effort to streamline access to long term services and support for patients and families.

Intended outcomes include:

- The establishment of a clinical integration between the acute care facilities, Alabama Area Agencies on Aging, Aging and Disability Resource Centers and other community-based organizations to facilitate home and community-based interventions rather than a costly institutional admission.
- Identifying and enrolling eligible beneficiaries admitted to an acute care hospital setting and returning them to their own homes with Medicaid Waiver services rather than to a long-term care institution.
- Reaching and supporting previously unknown individuals.

The Hospital to Home program will support full integration of a community-based care coordination model linked with acute care hospitals. Partnering health systems and physicians will receive the added benefit of obtaining enhanced community-based care management that will support reduced healthcare utilization, by limiting or avoiding costly institutional care while supporting aging in place.

The H2H Transition Coordinator (H2H TC) will work with hospital discharge planners and case managers to educate them on the program and its benefits. They will teach them to identify potential candidates through an information and consent process and how and when to make referrals to their dedicated H2H TC. An H2H TC will work with area hospitals during discharge to transition qualified individuals back into the community. The intervention will be targeted toward Medicaid financially eligible beneficiaries and those who are at risk for placement in a skilled nursing facility or other institutional setting.

A H2H state coordinator will facilitate program implementation and provide ongoing coordination to include training, reporting, and dissemination of best practices.