

EDITORIAL

Home hospitalization from the emergency department: benefits and remaining challenges

Hospitalización domiciliaria desde urgencias: muchas luces y alguna sombra

José Manuel Fandiño Orgeira

The prevalence of heart failure (HF) in the general population is 1–2%¹ and is the leading cause of hospital admission in individuals older than 65 years.² The natural course of HF, characterized by high mortality and frequent readmissions after discharge, highlights the need to optimize the care pathway to ensure high-quality attention while seeking alternatives to reduce the burden placed on emergency departments (ED) by this condition. In this context, the decision to admit or discharge patients with acute heart failure (AHF) in hospital EDs must be based on risk stratification following international clinical practice guidelines.³ This decision has a significant prognostic impact, underscoring the complexity of the care process.⁴

Hospital overcrowding is, in turn, a growing problem, with major repercussions on ED operations. Efficient time management in the ED is crucial. Prolonged ED stays have been shown to be associated with longer lengths of stay and higher mortality rates, especially among vulnerable patients, as recently demonstrated by the EDEN-18 Study.⁵ This highlights the need to promote care models that offer alternatives to conventional admission and that align with the strategic goal of the Spanish National Health System (NHS) to reduce hospitalizations and promote multidisciplinary care, integrating patient self-management and home-based care programs.⁶

Within this framework, hospital at home (HaH) has become a solid alternative in the care of AHF, as it offers high-quality, safe, cost-effective, and humanized care. The true strategic value of HaH lies in its capacity to strengthen care continuity and optimize HF treatment. Furthermore, it contributes to improving patient self-management, reinforces therapeutic adherence, and facilitates early recognition of alarm symptoms—key factors for preventing new episodes of decompensation and reducing hospital readmissions.

Integrated and multidisciplinary care models are associated with a significant reduction in both hospitalizations and mortality in this population. Direct HaH admission from the ED for patients with chronic diseases is associated with lower readmission rates, with no sig-

nificant differences in mortality vs conventional hospitalization.⁸ Among patients with AHF, clinical outcomes comparable to conventional hospitalization have been reported in terms of in-hospital mortality, 30-day adverse events, and 1-year mortality. Furthermore, HaH helps reduce hospital overcrowding and leads to an average savings of 76% in direct hospitalization costs.⁹

However, the success of HaH depends on rigorous patient selection, limited to those who are clinically stable, do not require intensive monitoring, and have adequate social and family support within the coverage area of the service. Likewise, the implementation of multidisciplinary, consensus-based protocols and clinical pathways is essential. Such coordination ensures continuity of care and patient safety, reduces hospital readmissions, improves quality of life, and decreases health care costs.

Despite the clear advantages of HaH as an efficient care strategy, an area of uncertainty remains: patients who require escalation of care. Returning a patient from HaH to the hospital to complete treatment under conventional hospitalization involves higher health care resource use and is often perceived as a failure of HaH. This may generate distrust among patients, families, and even the care team per se. Therefore, the article by Sánchez Marcos *et al.*, published in this issue of *EMERGENCIAS*, is particularly relevant, as it analyzes the clinical predictors associated with the need for escalation of care in this context.¹⁰ Among the identified factors are renal dysfunction (creatinine > 1.3 mg/dL) and hyponatremia (< 135 mmol/L), both independent markers that significantly increase the risk of requiring conventional hospitalization among patients admitted to HaH. These risk markers suggest more severe underlying decompensation in patients in whom HaH was unsuccessful. Incorporating these clinical parameters into the selection criteria for patients eligible for direct HaH admission from the ED will strengthen the care pathway for AHF and improve both patient safety and efficacy.

Currently, we must acknowledge the impact of digital health technologies on HaH. Particularly noteworthy

Author Affiliations: Servicio de Urgencias. Complejo Hospitalario Universitario A Coruña, A Coruña, Spain.

Author Contributions: The author has confirmed his authorship in the document of author responsibilities, publication agreement and assignment of rights to *EMERGENCIAS*.

Corresponding Author: José Manuel Fandiño Orgeira. Servicio de Urgencias. Complejo Hospitalario Universitario A Coruña. Xubias de Arriba, 84. 15006 A Coruña, Spain.

Email: jmfanorg@gmail.com

Article Information: Received: 31-10-2025. Accepted: 1-11-2025. Online: 11-10-2025.

Editor in Charge: Óscar Miró.

is multiparametric telemonitoring, which is highly relevant for follow-up of patients with AHF, as it enables early detection of signs of congestion or clinical instability and allows proactive interventions before a new decompensation occurs. This improves patient safety and quality of care. In this regard, the HERMeS trial—which combined real-time telemonitoring of patient data, early-alert generation, and structured proactive teleintervention based on data analysis—demonstrated a dramatic reduction in mortality and a significant decrease in exacerbations and hospitalizations among patients with chronic HF.¹¹ This evidence supports telemedicine as an essential component of HaH. Innovative experiences also exist, such as the creation of virtual short-stay units (vSSU) that integrate the care model of short-stay hospital units with remote medical care and the organizational resources of HaH. These initiatives have proven to be feasible and safe, with high levels of patient satisfaction.¹²

The incorporation of telemedicine solutions and information and communication technologies, and the implementation of telemonitoring systems and remote-tracking devices to support home-based telecare, is a priority and a strategic objective for the NHS.¹³ This path continues with the introduction of artificial intelligence to develop decision-support algorithms based on large volumes of existing data and with meaningful participation from patients—not only in self-care but also in the technological design of various devices.

In conclusion, direct HaH admission from the ED represents an alternative to the traditional care model: a patient-centered strategy that uses resources efficiently and is supported by technological innovation. Furthermore, it improves the care pathway for AHF, making it safer, more cost-effective, and more humanized. Nonetheless, further progress is needed in the direction indicated by Sánchez Marcos *et al.*, particularly in identifying predictors of HaH failure—such as renal dysfunction and hyponatremia—to refine patient-selection protocols and risk stratification, ultimately making HaH a more precise, robust, and clinically safe model.

Conflicto de intereses: None reported.

Financiación: The author declares the non-existence of funding related to this article.

Responsabilidades éticas: All authors have confirmed the maintenance of confidentiality and respect for patients' rights in the author's respon-

sibilities document, publication agreement and assignment of rights to EMERGENCIAS.

Article commissioned and internally reviewed by the Editorial Board.

References

- 1 Dobarro D. Pronóstico actual de la insuficiencia cardíaca en Spain y Europa. Una llamada de atención. REC.CardioClinics. 2020;55:201-3.
- 2 Farre N, Vela E, Clèries M, Bustins M, Cainzos-Achirica M, Enjuanes C, et al. Medical resource use and expenditure in patients with chronic heart failure: a population-based analysis of 88,195 patients. Eur J Heart Fail. 2016;18:1132-40.
- 3 McDonagh TA, Metra M, Adamo M, Gardner RS, Baumbach A, Böhm M, et al. 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure. Eur Heart J. 2021;42:3599-726.
- 4 Miró O, Llorens P, Gil V, López Díez MP, Jacob J, Herrero P, et al. Decisión de hospitalización o alta en pacientes con insuficiencia cardíaca aguda en urgencias, su adecuación con la gravedad de la descompensación e impacto pronóstico. Emergencias. 2023;35:261-9.
- 5 Miró O, Rodríguez-Cabrera M, Alquézar-Arbé A, Piñol C, González del Castillo J, Burillo-Putze G. Tiempo de permanencia en urgencias de los pacientes hospitalizados y resultados a corto plazo (Estudio EDEN-18). Emergencias. 2025;37:343-52.
- 6 Ministerio de Sanidad. Subdirección General de Calidad Asistencial. Estrategia para el abordaje de la cronicidad en el Sistema Nacional de Salud. Documento de desarrollo 2025-2028. (Consultado 29 Octubre 2025). Disponible en: https://www.sanidad.gob.es/areas/calidadAsistencial/estrategias_abordajeCronicidad/docs/20250704_EAC_DOCUMENTO-DESARROLLO_2025-2028_Final.pdf
- 7 Pascual-Figal D, González-Juanatey JR. Comentarios a la guía ESC 2021 sobre el diagnóstico y tratamiento de la insuficiencia cardíaca aguda y crónica. Rev Esp Cardiol. 2022;75:458-65.
- 8 Arsenaault-Lapierre G, Henein M, Gaid D, Le Berre M. Hospital-at-Home Interventions vs In-Hospital Stay for Patients With Chronic Disease Who Present to the Emergency Department: A Systematic Review and Meta-analysis. JAMA Netw Open. 2021;4:e2111568.
- 9 Bibiano Guillén C. Ingreso directo desde urgencias a domicilio: factible, eficiente y necesario. Emergencias. 2023;35:163-4.
- 10 Sánchez Marcos C, Espinosa B, Coloma E, Nicolás D, San Inocencio D, Gil V, et al. Factores asociados a la necesidad de escalada asistencial en pacientes con insuficiencia cardíaca aguda derivados desde urgencias a hospitalización a domicilio. Emergencias. 2025;37:411-9.
- 11 Yun S, Comín-Colet J, Calero-Molina E. Evaluation of mobile health technology combining telemonitoring and teleintervention versus usual care in vulnerable-phase heart failure management (HERMeS): a multicentre, randomised controlled trial. Lancet Digit Health. 2025;7:100866.
- 12 Bibiano-Guillén C, Mir-Montero M, Rodríguez-Rodríguez B, Vinat-Prado S, Sánchez-Pérez M, Pantoja-Zarza MC. Implementación de una unidad de corta estancia virtual domiciliaria: viabilidad, seguridad y satisfacción. Emergencias. 2025;37:312-5.
- 13 Ministerio de Sanidad. Subdirección General de Calidad Asistencial. Estrategia para el abordaje de la cronicidad en el Sistema Nacional de Salud. Documento de desarrollo 2025-2028. (Consultado 29 Octubre 2025). Disponible en: https://www.sanidad.gob.es/areas/calidadAsistencial/estrategias_abordajeCronicidad/docs/20250704_EAC_DOCUMENTO-DESARROLLO_2025-2028_Final.pdf