

Hospital at Home: Implementation and Scaling in a Health System

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Conflicts

No conflicts of interest

Dr. DeCherrie is a full time employee of the Icahn School of Medicine, which in turn has an ownership interest in a joint venture with Contessa Health, a venture that manages acute care services provided to patients in their homes through prospective bundled payment arrangements. Dr. DeCherrie has no personal financial interest in the joint venture.

Can Mount Sinai be serious? The answer is a resounding yes. In fact, we couldn't be more serious.

Mount Sinai's number one mission is to keep people out of the hospital. We're focused on population health management, as opposed to the traditional fee-for-service medicine. So instead of receiving care that's isolated and intermittent, patients receive care that's continuous and coordinated, much of it outside of the traditional hospital setting.

Thus the tremendous emphasis on wellness programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease.

Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The core team involves physicians, nurse practitioners,

registered nurses, social workers, community paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides.

Meanwhile, Mount Sinai's Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify known risks such as

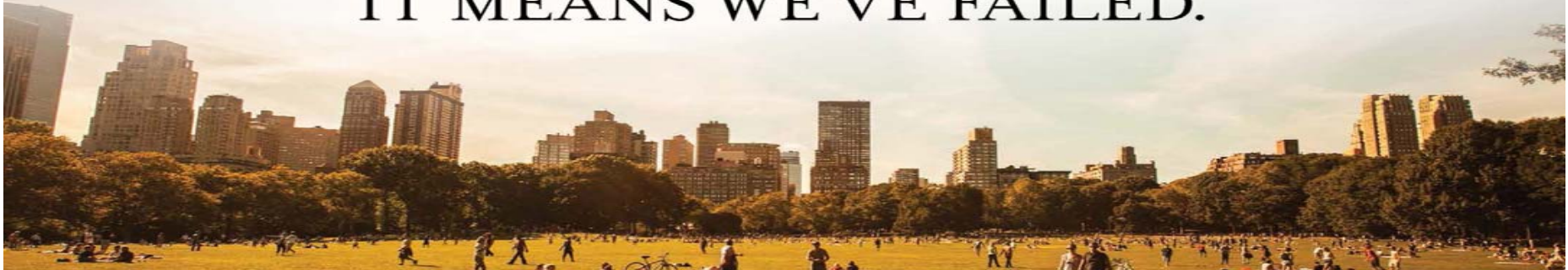
problems with medication management and provide continuing support after discharge.

It's a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds.

1-800-MD-SINAI
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IF OUR BEDS ARE FILLED, IT MEANS WE'VE FAILED.



New York Times, 2015-present

Hospital at Home – Plus



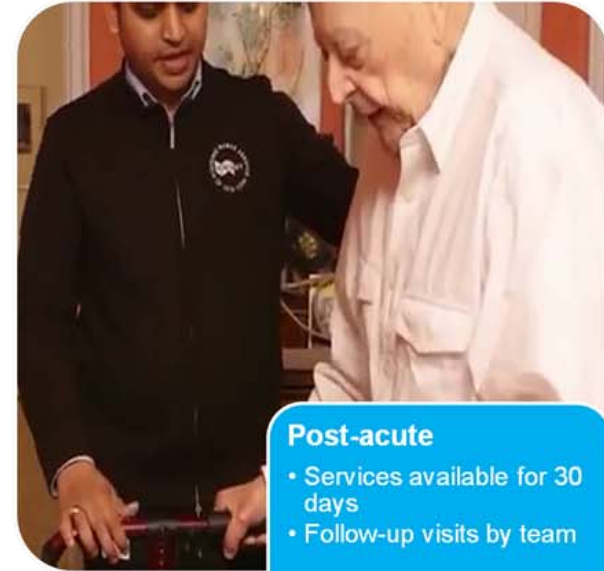
Admission

- Eligibility and home situation reviewed
- Services organized
- Transport home



Acute Care

- 3-5 days
- Daily MD & nursing visits
- IV medications, oxygen, x-ray, lab tests
- 24/7 support
- Community Paramedics
- Discharge



Post-acute

- Services available for 30 days
- Follow-up visits by team

Why consider Hospital at Home

- ❑ Improved care (avoiding hazards of hospitalization)
- ❑ Increased patient satisfaction
- ❑ Lower cost

Outcomes

Hospitalization at Home v. Control

	HaH* n=247	Control n=178	p
Length of stay in days, <i>mean (sd)</i>	3 (2)	5 (3)	<0.01
30-day ED revisit	5%	10%	0.06
30-day hospital readmission	8%	16%	0.01
Escalations	7%	-	-

* HaH group includes Acute patients and Observation at Home patients who converted to Acute due to a length of stay ≥ 2 midnights.

Patients' Experiences with Care (HCAHPS) HaH vs. Control

	Medicare HVBP 2018 Benchmark	HaH	Control	P
Communication with Nurses	86.7	88.0	75.9	.006
Communication with Physicians	88.5	98.2	88.1	.0004
Communication about medications	62.5	85.8	64.0	<.0001
Care transitions (CTM-3)	62.4	60.7	47.3	.02
Overall rating	84.6	80.5	69.3	.03

HCAHPS scores adjusted according to the Medicare Hospital Value Based Purchasing program Patient Mixed Adjustment criteria. HVBP benchmark is the mean of the top decile of scores from contributing hospitals.

By Lesley Cryer, Scott B. Shannon, Melanie Van Amsterdam, and Bruce Leff

INNOVATION PROFILE

Costs For 'Hospital At Home' Patients Were 19 Percent Lower, With Equal Or Better Outcomes Compared To Similar Inpatients

- Length of stay shorter: HaH 3.3, Hospital 4.5 days
- Satisfaction better
- 19% lower costs – lower rates of procedures and tests

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NO. 6 (2012): 1237–1243
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The People-to-People Health
Foundation, Inc.

Who are the patients?

- Require Hospital admission (not a home care episode)
- Require daily physician/NP monitoring, frequent labs
- Safe home environment
- ~575,000 FFS Medicare admissions each year could qualify for such a program (~5%)

Who are the patients?

86 yo woman with dementia, HTN, DM aspirates and develops pneumonia, becomes dehydrated and in the ED cannot maintain oxygen above 90% with 4 L of oxygen



ICU/step down in hospital

86 yo woman with dementia, HTN, DM aspirates and develops pneumonia, becomes dehydrated and in the ED can oxygen saturation stays >90% on 2 L, safe home environment



Hospital at Home

75 yo woman with HTN, DM who develops pneumonia, not dehydrated, can take oral medications, does not require oxygen – treated at home and follows up with PCP in 3 days



Does not require admission to a hospital

Current payment/system does not match what is needed for this program

- ❑ Daily MD/NP in person and video visit
- ❑ Nursing daily, twice daily or three times daily
- ❑ IV antibiotics delivered to home within 2 hours
- ❑ Labs processed like inpatient 2-3 hours
- ❑ SW and PT to home for assessments
- ❑ DME delivery to home within 2 hours
- ❑ Oxygen not covered for acute conditions (ie pneumonia)
- ❑ Community paramedics

Payment

- Contracting with Medicare Advantage, Managed Medicaid and Commercial Insurances
 - Challenging – fitting inpatient payment into an outpatient payment model
 - Contracting for bundle payments – acute period only and 30 day periods

- Submission to Medicare through Physician Focused Payment Model Technical Advisory Committee (PTAC) - **Hospital at Home Plus** – recommended for implementation
 - 95% DRG payment for 30 days of care
 - Shared savings for total care based on quality metrics

General Considerations

- Start up: ideal in a supportive health system and home based primary care program
- Need to provide 24/7 care but can leverage other services with existing health system providers with training (hospitalist, home care nurses, social work)
- Insourcing vs Outsourcing (ie contracting) staff and services
- Most HaH programs stay within 1 hour geography
- 200-300 admissions annually is minimum volume for a program

The HaH “At Home” Platform

Hospital at Home

Short-term (3-5 day) acute inpatient-level care at home with 30 day follow up

Hospital at Home Acute Care Team

The Platform: Home-based Care Team

Medicine, nursing, social work, rehabilitation, community paramedics, pharmacy, laboratory, radiology, other community-based services, and transport

Diversifying the HaH “At Home” Suite of Services

<i>Hospital at Home</i>	<i>Observation Unit at Home</i>	<i>Palliative Care Unit at Home</i>	<i>Hospital Averse at Home</i>	<i>HaH@Nite</i>	<i>Pediatric Hospital at Home</i>	<i>Completing Hospital Stay at Home</i>	<i>Rehab at Home</i>
Short-term (3-5 day) acute inpatient-level care at home with 30 day follow up	Short-term (1 day) acute observation unit level care at home that can transition to Hospital at Home with 30 day follow up	Short-term (3-5 day) acute level care at home for hospice-eligible patients with 30 day follow up (and possible transition to hospice)	Short term (3-5 day) acute level care at home for patients who decline being in the hospital	Recruitment at night with overnight care in the hospital with transition to home in the morning	Short-term (3-5 day) acute inpatient-level care at home for children up to age 18 with select illnesses.	Short-term (<20 day) completion of acute inpatient level care at home for hospital inpatients	Short-term (<20 day) post-acute rehabilitation, medical, and nursing services in lieu of a nursing home stay with follow up to 30 days
Substituting for Full Hospital Stay						Shortening Hospital Stay	Substituting for SNF

Hospital at Home Acute Care Team
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