5 Lessons Learned About Hospital at Home Programs

Health Recovery Solutions interviewed two Hospital at Home program leaders at **Michigan Medicine** and **Allina Health** who provided helpful insights into their Hospital at Home programs and shared their lessons for success.

HRS Health Recovery Solutions

Introduction

Health Recovery Solutions' health system partners are **leading the charge** when it comes to innovation, embracing **Hospital at Home programs** as a way to improve how healthcare is delivered. In response to the COVID-19 pandemic, many health system leaders quickly pivoted strategy to implement a technology-forward approach to care delivery that never compromised on the quality of care. HRS partners implemented Hospital at Home programs in order to:

- Facilitate early hospital discharge for COVID-19 patients (in addition to other conditions)
- Monitor lower-acuity COVID-19 patients at home
- Avoid hospital admissions for patients needing acute hospital care that could be treated in the home

Every health system has a unique workflow for staff, patients, caregivers, and the system as a whole. In the past year, with the high-volume of Hospital at Home programs that have been deployed, there have been **many lessons learned**.

HRS interviewed two hospital at home program leaders from Michigan Medicine and Allina Health who provided insight into their programs. HRS pulled that feedback together to bring you these **5 Lessons Learned About Hospital at Home Programs**.

1 Set Clear Hospital at Home Program Goals

In order for a program to be successful, health systems must establish clear goals from the beginning. Goals can evolve and change once the program kicks off (and metrics start to accumulate), but launching the program with a clear set of goals is the best way to set up the program for success.

Need some examples? Many programs begin with the goal of relieving pressure on inpatient wards by increasing hospital bed capacity, reducing length of stay, or building out a robust home-based initiative that includes the Hospital at Home program as a critical component.

Examples of goals some organizations have for their Hospital at Home program:

Increase hospital **bed capacity** in order to treat higher acuity patients

Extend care to patients in a **lower-cost environment** (i.e., the home)

Ensure patients **avoid hospital-acquired illnesses** and infection

Provide an **alternative** for patients wary of a hospital stay

When Minnesota's Allina Health launched their Hospital at Home program during the height of the COVID-19 pandemic, they had 5 main goals:

- Decrease length of stay
- Decrease total cost of care
- Reduce readmissions
- Increase patient satisfaction
- Divert patients from the emergency department or urgent care

By bringing patient care to the home, Allina Health was able to **free up hospital resources**. These goals remain in place, but Allina has expanded the program to assist patients with conditions beyond COVID-19, such as: **COPD**, **CHF**, **sepsis**, **post-surgical**, and **cardiovascular conditions**. To quantitatively measure success, Allina Health considers preventable readmissions, patient satisfaction, cost of care, and adverse outcomes.

2 Determine Patient Eligibility, Select Patients for the Program, and Prioritize Patient Safety

Once goals are established, the next step is building the Hospital at Home program framework. Keeping patients at the center, health systems can build eligibility criteria based on the needs of unique patient populations and available resources. The goal is to offer the program to patients who are sick enough to require emergency department-level care, but stable enough to be cared for at home.

Common eligibility criteria includes:

- Patient must have one or more specified conditions that can be **safely treated** in a home environment (and that meet criteria for a hospital admission)
- Patient lives in a geographic area that is a **reasonable distance** from the hospital—in case they need to be admitted
- Patient has **insurance coverage** (e.g., covered by a commercial carrier, the hospital's health plan, or Medicare)
- Patient has a **caregiver at home** to help the patient, if needed
- Patient's **home is suitable** for home-based care delivery (self-reported by the patient)

Patients are discharged from the Hospital at Home program using the same criteria that hospitals use for discharge.

Overview of Michigan Medicine's Hospital at Home Program

Michigan Medicine launched their **Hospital Care at Home program** in early 2021. Any patient admitted to the emergency department who meets inpatient criteria and can safely benefit from hospital-level care at home is eligible for the program. To determine program eligibility, Michigan Medicine starts by screening the patient in the emergency department, which includes questions such as:

What is the patient's **insurance provider**?*

What **diagnosis related group(s) (DRGs)** are associated with the patient's condition?

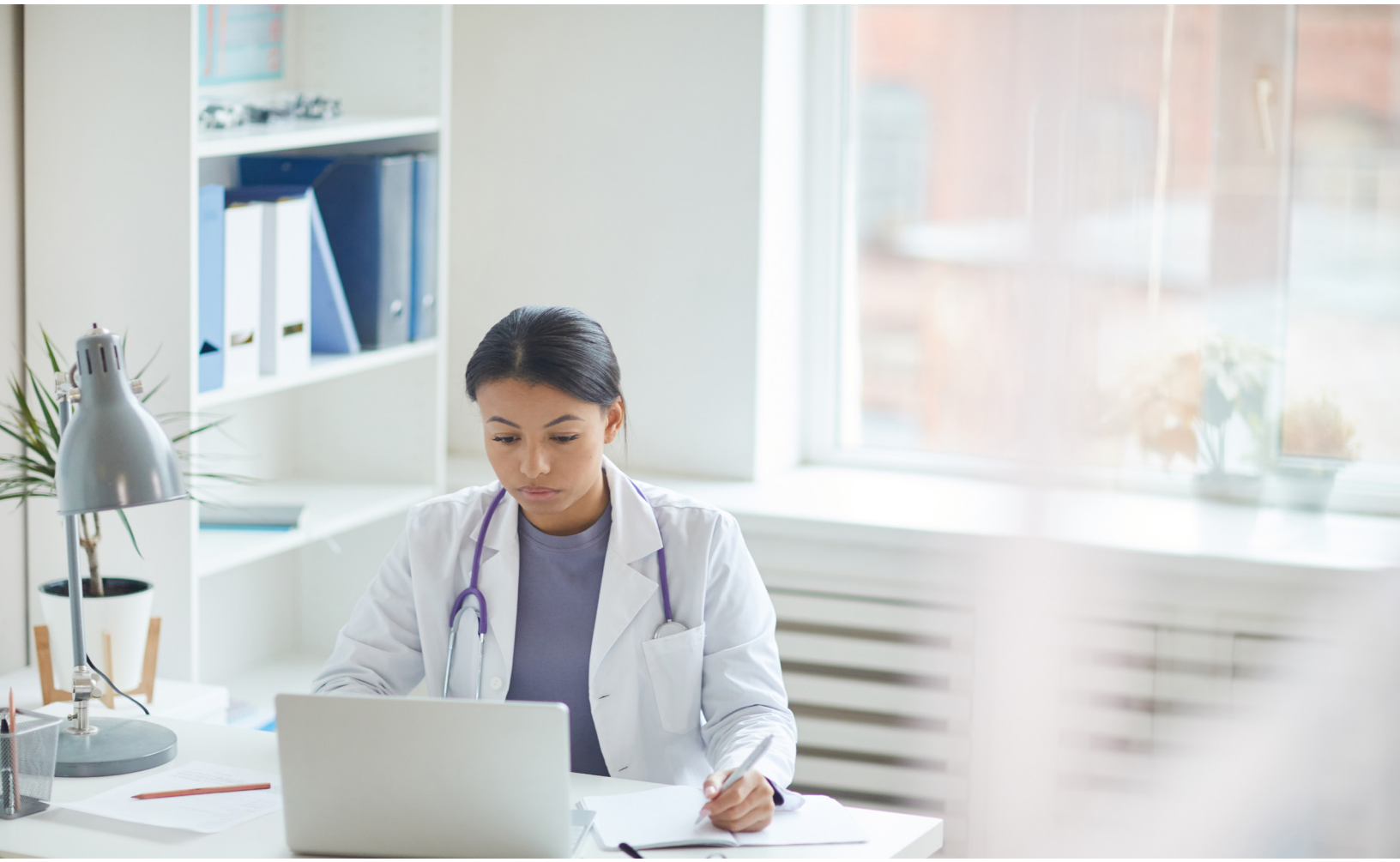
What is the patient's **geographic location** relative to the hospital?

* For the Hospital Care at Home program, Michigan Medicine is contracted with Blue Cross Blue Shield of Michigan (BCBSM). The program has not yet enrolled patients under CMS' Acute Hospital Care at Home waiver.

If the patient qualifies for the program, the Emergency Department (ED) care management team and ED provider introduces the **Hospital Care at Home Program** and consults with **Dr. Grace Jenq**, Michigan Medicine's Geriatrics Specialist and Associate Chief Clinical Officer for Post-Acute Care.* Dr. Jenq then meets with the patient to explain how the program works and what to expect. Dr. Jenq emphasizes that safety is the number one priority: if care cannot be delivered safely in the home, then the patient remains admitted to the emergency department. Some patients do not feel comfortable being treated at home, while others are eager to return home and start the remote monitoring process.

Discharge from Michigan Medicine's Hospital Care at Home program occurs when the patient no longer needs inpatient clinical interventions (IV antibiotics, fluids, treatment) and daily visits. Patients being monitored post discharge continue to use remote patient monitoring to **remain connected to their clinician** and to ensure medications and other interventions are continued.

Dr. Grace Jenq,
Michigan Medicine



[1] More Michigan Medicine patients will get hospital-level care at home through new programs." 14. Michigan Medicine. https://www.uofmhealth.org/news/archive/202101/more-michigan-medicine-patients-will-get-hospital-level-care.

* Title provided for identification purposes only. The views and opinions expressed are those of the individual only and do not necessarily reflect the positions of the University of Michigan.

3 Build a Robust Hospital at Home Program Team and Provide Continuous Internal Education

Oftentimes, there are multiple interdisciplinary teams involved in managing Hospital at Home programs. **Coordinating across teams** is essential for success—and can also present challenges. The health system has to consider (and plan for) all teams that are involved in the Hospital at Home program and ensure buy-in at every level.

How Do You Gain Buy-In Across the System?

> Gaining program buy-in starts with demonstrating to internal stakeholders that the program works, that it's beneficial, and (most importantly) that it's safe for patients who qualify and enroll. Buy-in for a Hospital at Home program starts at the very top of the health system leadership chain, and includes key leaders within each department, such as operational and front-line staff.
>
> Every Hospital at Home program needs a **champion**—someone who is responsible for bringing together departments under the same umbrella, highlighting the program benefits and providing transparency into how the Hospital at Home program can help improve outcomes.

Clinicians involved in a Hospital at Home program must be:

Comfortable with the Hospital at Home model, understanding why (and how) the program can benefit patients

Knowledgeable about technology, with the ability to use technology hardware and software to administer at-home care independently

Many Hospital at Home programs have been successful when they include primary care providers who want to support their patients in **more innovative ways**. For example, providers who want to extend their services and spend more time with a patient than a typical 20-minute in-person clinic visit. The most successful clinicians are those accustomed to making quick decisions based on changing circumstances—and are comfortable coordinating care with internal teams.

At **Allina Health**, clinician and stakeholder education is an essential part of the program's continued success (and sustainability) since it launched in mid-2020. **Rachel Kuhnly**, Strategy and Business Development Consultant at Allina Health, leads the program. She explained that when clinical teams were approached about the Hospital at Home model, they were advocates of the program because they clearly understood the program's mission and values.

In order to prove efficacy for the model, stakeholders at Allina Health were presented with best practices, lessons learned, and success metrics from other health systems with Hospital at Home programs. Kuhnly discussed the "whole-person care mission of Allina" and how the Hospital at Home program aligns with their goal of, **"bringing the right care at the right time in the right setting to all patients."**

4 Ask the Right Questions—and Plan Ahead for Challenges

In order to successfully launch a Hospital at Home program, health system leadership must ask fundamental questions about how the program will work:

1. Will the health system work with an affiliated home health agency or a third party to ensure care is delivered properly into the home?
2. Day-to-day, who is responsible for monitoring patients?
3. Who is in charge of overseeing the remote patient monitoring clinical dashboard?

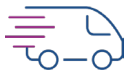
How Do Health Systems Overcome Logistical Challenges?

> CMS' Acute Care at Home stipulates that patients can only be accepted into the Hospital at Home program from either the emergency department or after an inpatient admission. To ensure safe and effective care delivery at home, there's many logistics to consider. Michigan Medicine's Dr. Jenq plans ahead for logistical issues that could create challenges for her team, addressing things like:

Arranging medication **delivery**

How to manage and respond to **abnormal test results**

Ensuring a **nurse or another clinician** will be at the home at the right time, aligning with the patient's schedule



Delivering equipment such as nebulizers, oxygen, x-ray machines, or assisted devices

Partnering with a local home health organization, ambulance service, mobile diagnostics company, and a medical equipment company, Michigan Medicine has provided **coordinated care** to patients in the home setting successfully, avoiding many logistical challenges. Rachel Kuhnly at Allina Health says that in order for a program to be successful: **it takes a village**. Allina Health has a robust home health agency within the health system that is responsible for the day-to-day care of patients. Also, Allina Health outsources to third-party partners for imaging and other equipment needs.

5 Harness the Power of Telehealth

For patients enrolled in a Hospital at Home program, telehealth and remote patient monitoring is essential—and required, per the Acute Care at Home waiver. Although every health system leverages telehealth technology differently, there are a few common themes: every health system uses telehealth to improve care delivered across the continuum, and telehealth is helpful for providers to stay in constant contact with patients who are most in need of care and attention.

Telehealth solutions provide:

- ✓ Daily check-ins with patients
- ✓ Remote monitoring to track symptoms and vitals
- ✓ Help with medication adherence and activity tracking
- ✓ Promotion of patient education, helping patients become more involved in their own care
- ✓ Direct contact with their provider should a patient have concerns about their health or condition

To deploy a telehealth and remote patient monitoring program, both Michigan Medicine and Allina Health leverage HRS' technology solution, **PatientConnect**. Every day, the patients enrolled in the program take their vitals, connect with their nurses, and record their symptoms on the remote patient monitoring tablet.

Dr. Jenq of Michigan Medicine often checks in with patients using the **HRS tablet** in the evening, ensuring patients are on track for recovery and are safe at home. Remote patient monitoring provides each patient with an extra layer of connectivity to their provider.

The Future of the Hospital at Home Model as a New Hospital Unit

*"Hospital at Home programs are undoubtedly **the care delivery model of the future**...they leverage the highest quality technological capabilities available, [and offer] lower-cost, safe, high-quality hospital-level care in the home."*

Rachel Kuhnly,
Allina Health

A force outside of the healthcare system—a novel virus—ushered in a wave of change and innovation, forcing health systems to adjust processes and adopt technology to enable better quality of care for patients. A new wave of connections was forged across health systems to support care delivery, and **historical barriers were broken**.

Looking ahead to the next pandemic—and to the future care of patients, all the time—there's a need for health systems across the country to **embrace these changes and explore Hospital at Home programs**. The patient's home should be considered an extension of the hospital, serving as a place for high-quality care to be delivered (for those patients that qualify), acting as an integral part of the larger health system.

Now more than ever, Hospital at Home programs are feasible and cost-efficient to the larger health system:

- Technology continues to innovate, opening new doors to more patient populations
- CMS waivers are in place, making the Hospital at Home model financially and logistically possible from a reimbursement and billing perspective
- Patients are adopting the Hospital at Home model more than ever before, reinforcing that a patient's home can serve an extension of the hospital to deliver high-quality care
- Clinicians understand the efficacy of the Hospital at Home model and are open to the value home-based care offers to patients

There is already widespread evidence that **Hospital at Home programs are successful**. Health systems must look to those who have implemented programs already, analyzing what other organizations have done to plan for (and set up) a Hospital at Home program, what that organization's challenges were, and how they've overcome those issues.

If your organization is considering launching a Hospital at Home program, Health Recovery Solutions offers the support you need. HRS has clients who are constantly launching new Hospital at Home programs. We can share lessons learned and best practices for success.

HRS also has a talented and trusted clinical services team—staff that have served in various departments across hospitals and health systems and who understand the "boots on the ground" perspective for how to successfully launch (and maintain) a Hospital at Home program using remote patient monitoring and telehealth.

Get in touch with HRS about Hospital at Home programs

About Health Recovery Solutions

Health Recovery Solutions (HRS) empowers the nation's largest providers and payers to deliver care to patients across the care continuum—improving patient satisfaction, reducing readmission, decreasing costs, and optimizing clinician workflow. Ranked #1 by KLAS for Remote Patient Monitoring in 2020 and 2021, the HRS mission is to create a new standard of care by providing advanced telehealth and remote patient monitoring solutions.

To learn more about HRS, visit us at **healthrecoverysolutions.com**.