

# Building Support for Your Hospital at Home Program: Issues in Strategic Engagement

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**Webinar**  
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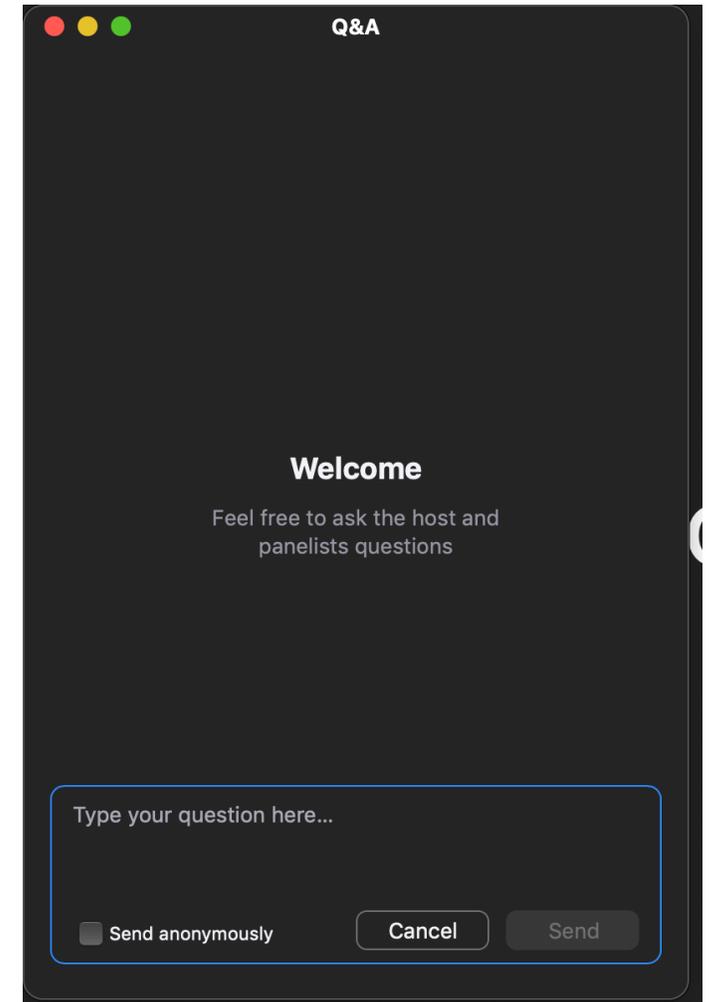
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# ZOOM Webinar Housekeeping

- Please submit your questions via the Q&A option
- Due to the large audience for today's webinar, everyone has been placed on mute
- If you have any technical issues, please contact Gabrielle Schiller ([gabrielle.schiller@mssm.edu](mailto:gabrielle.schiller@mssm.edu)) or send her a message via the Zoom chat feature





**David Levine, MD, MPH, MA**

Brigham Health

Assistant Professor of Medicine, Harvard Medical School

# Hospital AT Home USERS GROUP

<https://hahusersgroup.org/>

# Today's Webinar

## **Building Support for Your Hospital at Home Program:**

### Issues in Strategic Engagement



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# Huntsman Hospital at Home

# Huntsman at Home

## A Hospital at Home Program for Oncology Patients

### Background

- Unplanned hospitalizations and emergency department visits are common during cancer care.
- While most cancer treatment is outpatient, there are few models of care to support patients at home between treatment and clinic visits.
- Providing acute hospital level care at home adds value by decreasing unplanned hospital and emergency department use.
- The program has three-year demonstration project with three service bundles



# Huntsman at Home

## A Hospital at Home Program for Oncology Patients

### Background (cont.)

- **Acute Community Care: (admission avoidance early discharge)**

Rapid assessment service for patients

- **Palliative Care: (early discharge)**

Facilitate early discharge for patients requiring ongoing acute treatment

- **Hospice Care: (admission avoidance or early discharge)**

Huntsman at Home staff will support our partner hospice agency staff



# Huntsman at Home

## A Hospital at home Program for Oncology Patients

- Predominately a Nurse Practitioner-led program working with Home Health partnership, supported by palliative and medical oncology physicians
  - The current team has 9 APRN's and 8 CNS RN's and serves a 20-mile radius of HCI
  - Patients move seamlessly between acute, palliative & hospice home care and between hospital & outpatient clinics
  - 24/7 on-call care
  - Rapid response assessment and visits within 2 hours when required
  - Technology-enhanced care
  - Family caregiver support
- Addresses patients' and families' feelings of abandonment when referred to an outside home health agency. Rural expansion will also address the isolation rural patients experience due to distance from their care team.



# Why We Need Hospital at Home

## Questions to consider?

- Filling the gaps in care between acute and community care (scope the need)
- Where are the biggest pressures to the health system (demand)
- What is the low hanging fruit and therefore “quick Wins”
- What KPI’s are they wanting the program to achieve?
- What measurable outcomes will you capture?
- What is program design:  
Rapid response/admission avoidance or Early Supported discharge?

## For example. Our gap analysis found:

FY 2017 -- 4097 ED visits by 2462 Patients

40% resulted in hospital admission

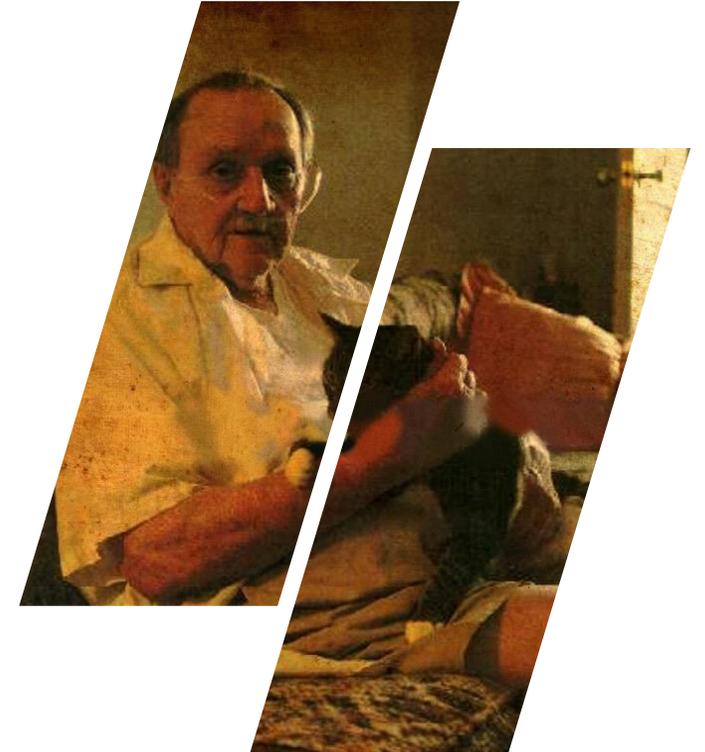
35% was >30-day readmission; Average LOS 9.8 days



# Why We Need Hospital at Home

## More questions to consider?

- Budget of program?
- What is the target patient population?
  - Over 18? Over 65?
- What will be expected average length of stay on the program?
- What will the team makeup be?
- What will hours of operation be?
- Team location?
- Inclusion/exclusion criteria?



# Huntsman at Home Health Care Utilization and Cost Comparison to Usual Care Cohort (N=367)

## *Propensity Weighted Model for Utilization and Cost 30 Days after Enrollment*

### **Health Care Utilization Endpoint -- Estimate (95% CI; p-value)**

- Percent Odds Reduction in Unplanned Hospitalization  
**57.68%** (95% CI 34.14, 72.80; p<0.001)\*
- Mean Reduction in Unplanned Hospital Length of Stay  
**1.19 days** (95% CI 0.39, 1.99; p=0.003)\*
- Percent Odds Reduction in ICU Hospitalizations  
**12.10%** (95% CI -77.79, 56.55; p=0.720)
- Percent odds reduction in Emergency Department Visits  
**48.04%** (95% CI 13.89, 68.64; p=0.011)\*
- Percent reduction in charges  
**47.63%** (95% CI 28.88, 66.39; p<0.001)\*

# Strategic Stakeholder Engagement

- Have a communications plan
- Who? What? When? How?
- Who do you want to engage with and why?  
Define you target audience and stakeholders.



Hospital  
leaders

Physicians

Nursing management

Discharge  
planners

Ward  
managers

Pharmacy

ER staff

Community  
partners

In patient  
therapists

In patient case  
managers

Clinic  
Teams

PRESENT  
PRESENT  
PRESENT  
PRESENT

# Strategic Stakeholder Engagement

- Meet with the key strategic stakeholder pre/post program start
- Involve them in service design/pathways development (clinical engagement)
- Scoping the service gaps through observations on wards/ER/clinics/community
- Present the program to as many staff groups as possible

**How do you build confidence in the program  
-- ensure program promoted and understood**



# Strategic Stakeholder Engagement

**How do you build confidence in the program- ensure program is promoted and understood**

1. Spread the good news
2. Encourage patients to share their experience with their provider
3. Ensure any blips or hiccups get addressed immediately and addressed with those concerned.
4. Staff engagement
5. Posters for staff
6. Leaflets for staff and patients



# Enablers for Success

- Strong dedicated developmental and operational leadership, with effective business support.
- Stable recurrent funding to support a sustainable, rapidly developing service.
- Service has regular meetings with strategic stakeholders
- An integrated IT and telecommunications system that is fit for purpose
- A scalable model of service delivery
- Clear patient pathways for referral and expectations for length of stay
- A single point of access, with a streamlined and integrated referral process
- Physical presence in A&E, medical wards and discharge planning meetings
- Case finders in acute hospitals
- Patient involvement and feedback
- Address challenges as they arise



# Enablers for Success

- Excellent clinical nursing care combining best practice with confidence to treat more patients traditionally cared for in acute settings.
- integrated multi-disciplinary and inter-disciplinary working, with clarity about medical responsibility.
- A consistent service presence in acute hospitals at the right level and background, working with hospital teams (based in acute)
- First dose medication kit for team
- Well-placed, appropriate office accommodation, with visible presence
- A 'ready use' equipment store, with a small number of key items





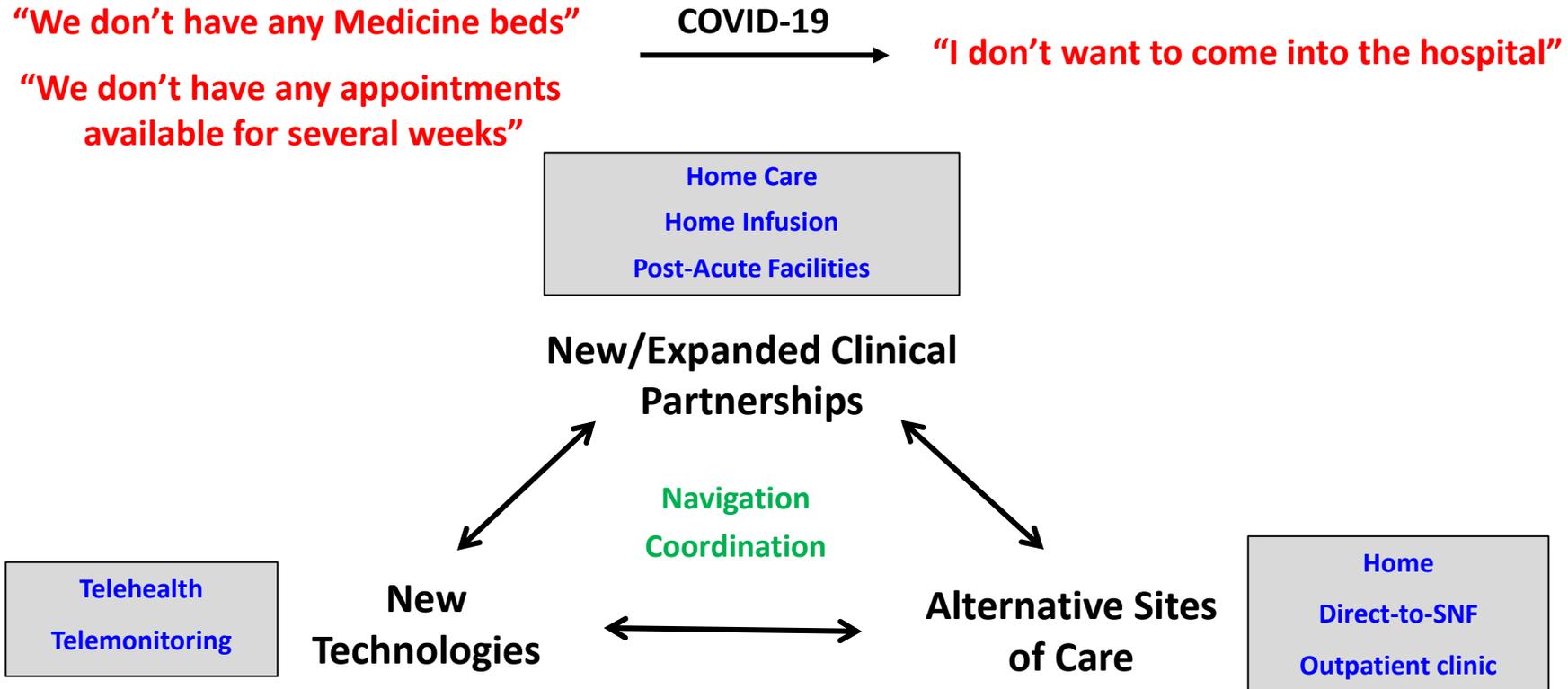
# MGH Hospital at Home

# The Return of House Calls?



- **Around 1930, ~40% of doctor-patient interactions were in the patient's home**
- **“House calls” dropped to < 1% of doctor-patient interactions by 1980**
  - Inefficiencies of travel, expanding hospital- and clinic-based specialization and technologies
- ***Hospital at Home (H@H)* – leveraging an “old school” approach to solve modern-day problems (e.g. hospital capacity, high and rising costs, and now patient fear of the hospital during a pandemic) equipped with modern tools and technologies**

# New (Old?) Models of Care to Address Modern Patient/System Needs



**“At the end of the day, you guys didn’t have a bed for me, but I did.”**

*Mass General Home Hospital patient*

# Hospital at Home “Starter Kit”

- **Executive vision, commitment, sponsorship**
  - Partners HealthCare (circa 2016) – Tim Ferris, MD, MPH (SVP for Population Health)
  - Up front financial commitment – H@H is not for the faint of heart, should not do on a whim
- **Core strategic aim(s) in launching Hospital at Home (i.e. your “burning platform”)**
  - Hospital or ED capacity needs (COVID-related, non-COVID)
  - ACO/risk contract performance → reducing total medical expense
  - Patient demand/expectation, “right thing to do”
  - Market trends, competition
  - *Mix of the above*
- **Program leadership**
  - Innovative, “adventurous” clinical leader – someone who can “sell” H@H to clinical peers
  - Needs sufficient protected time to build, lead, market the program
  - For initial 25 cases (CMS AHCAH waiver), could be wise for clinical leader to be directly involved in all or most cases
  - Having an effective, steady administrative or program manager is crucial

# Hospital at Home “Starter Kit”

- **Define your H@H delivery model**

- Build vs. Buy
- Providers – MDs vs. APPs (vs. both)
- Nursing – internal vs. partnership (i.e., subcontract arrangement)
- CMS AHCAH waiver essentially gives you the playbook for what you need
- Leverage the national H@H Users Group for suggestions – <https://hahusersgroup.org/>

- **Define your population(s)**

- By condition or status – “ambulatory care sensitive conditions” best place to start? COVID positive patients? (i.e., Atrium Health model) Oncology?
- By location – ED and/or inpatient (“transfer” to H@H) both supported by CMS waiver
- By contract or payor – payor- or risk-blind vs. risk contract specific vs. Medicare (DRG payments during PHE)
- By demographic – general patients vs. geriatric vs. other
- 30-day readmission populations (beware...H@H under the CMS waiver may not help solve readmissions)



# Hospital at Home “Starter Kit”

- **Identify your partnerships**

- Home care (nursing, PT/OT, home health aide)
- Home infusion/pharmacy
- Technology/monitoring
- Diagnostics (laboratory, radiology)
- Respiratory (oxygen, nebulizers)
- DME
- Paramedicine / Mobile Integrated Health (MIH)
- Food services

- **Most of these “partnerships” exist within your hospital already; otherwise, local home care agencies will have partnerships in place for delivery of care in the home**

# Hospital at Home “Starter Kit”

**Define your program stakeholders and organizational structure – who needs to be at the table?**

- Executive sponsor
- Clinical leadership (provider, nursing)
- Home care partnership
- Pharmacy / home infusion
- Diagnostic partners (laboratory, radiology, other)
- “Intake” partners – ED, inpatient, other
- Case Management
  - Care Coordination for patients on service, discharge planning
  - Utilization Management for patient leveling
- Social Work
- Technology partners (if any)
- Quality & Safety
- EHR team
- Billing/finance
- Compliance
- Data/analytics (for tracking/reporting, outcomes measurement)
- Public relations, development

# Hospital at Home Start-up Tips

- **Define your inclusion/exclusion criteria**
  - H@H users group and published studies can be helpful here
- **Learn by doing – “Let’s Try One”**
  - H@H operations are difficult to figure out in a lab
  - Try a case, review during/after for lessons learned (*always prioritizing patient safety*)
  - Continuous process improvement / PDSA (weekly process at MGH)
- **Clinical marketing or “academic detailing”**
  - Very important for clinician buy-in
  - Regularly share successful cases, anecdotes – in particular feedback from patients
  - Regularly call-out successful intake or referral anecdotes
- **Build health equity considerations into your H@H model from the get-go**
  - When considering patient selection, technology implementation, etc.

# Hospital at Home Start-up Tips

## 1. Finding the right patients – “needle in a haystack” problem

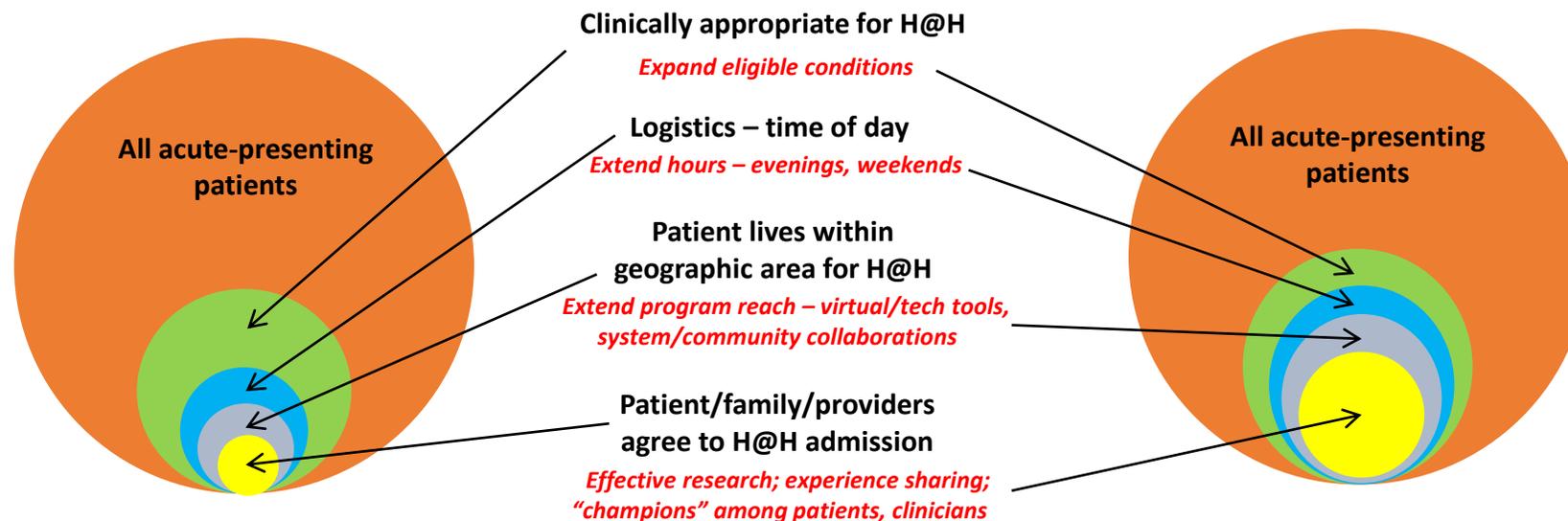
- Need processes in place to continually seek out appropriate patients in the hospital

## 2. “Selling” the program – to patients/families, to referring and collaborating clinicians

- Leveraging patients longitudinal MD(s) to facilitate patient acceptance helps greatly
- Important to share positive stories, highlight positive outcomes, continual “academic detailing”

## 3. Aligning H@H availability with ED capacity surges

- Requires evening admission capacity; “Mobile Integrated Health” (MIH) paramedics can support PM admissions



# H@H Expansion Opportunities

SURGICAL PERSPECTIVE

A Different Kind of Perioperative Surgical Home  
*Hospital at Home After Surgery*

*Kyan Cyrus Safavi, MD,\*✉ Rocco Ricciardi, MD,† Marilyn Heng, MD,‡ Eric Lawrence Eisenhauer, MD,§  
Dana Sheer, ACNP,|| Ryan Wesley Thompson, MD,¶ and Marcela Guadalupe del Carmen, MD§*

Journal of Clinical Oncology®  
An American Society of Clinical Oncology Journal

The oncology hospital at home: Health care utilization outcomes from the huntsman at home trial.

[Kathi Mooney](#), [Karen Titchener](#), [Benjamin Haaland](#), [Lorinda Adaire Coombs](#), [Brock O Neil](#), [Richard Nelson](#), ...

## Other service lines we are piloting (or considering) for Hospital at Home:

- Oncology
- Surgical populations, post-op recovery (i.e., Urology, Orthopedics)
- Sickle Cell Disease
- Gastroenterology (cirrhosis, GI bleed)
- Cystic Fibrosis
- Pediatrics

# MGH Experience with CMS AHCAH Waiver

- **Our view: CMS has worked hard to make this as easy as possible for hospitals to launch (while maintaining critically important patient safety standards and expectations for appropriate care). CMS has also been very responsive to our questions.**
- **Important early on to crosswalk CMS Conditions of Participation for H@H**
- **We were fortunate to have an inpatient-like encounter built within our EHR already. Billing is the same as submitting an inpatient charge (DRG and professional; only need to add condition code DR to indicate care occurred at an alternative site)**
- **We've found that ~2/3 of our H@H patients are Medicare. We are evolving most of our processes to align with CMS Waiver for all patients in order to streamline operations.**
- **A challenge for MGH has been that ACHAH waiver does not support H@H admissions directly from home or clinic; we are continuing to do this when we feel it's the right pathway for a patient. We are pivoting heavily to draw more "transfers" from inpatient to H@H.**



Questions?

# Learn More

- Hospital at Home Users Group  
<https://hahusersgroup.org/>
- Hospital at Home Users Group Tools and TA  
*(Beta version, powered by CAPC)*  
<https://www.capc.org/strategies/acute-hospital-home/>

# THANK YOU



The  
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Please make sure to join our next webinar:

## *Who's In? Who's Out?*

*Deciding Which Patients Are Right  
for Your Hospital at Home Program*

January 28<sup>th</sup>, 2021 - 4pm – 5pm ET