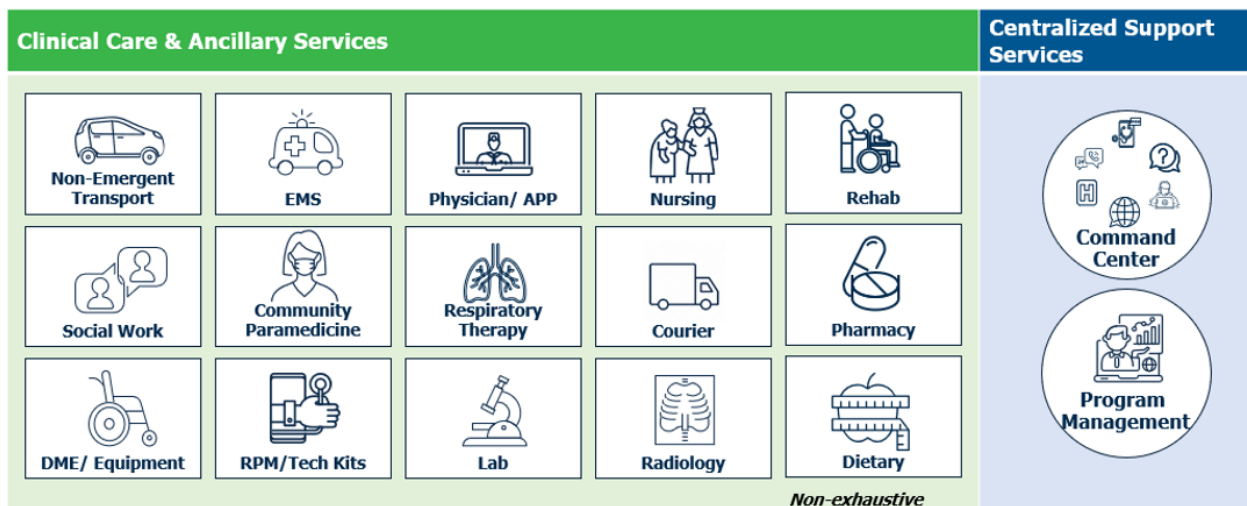


**Key Cost Drivers to Hospital-at-Home Deployment:**

**Program Evolution and Third-Party Relationships**

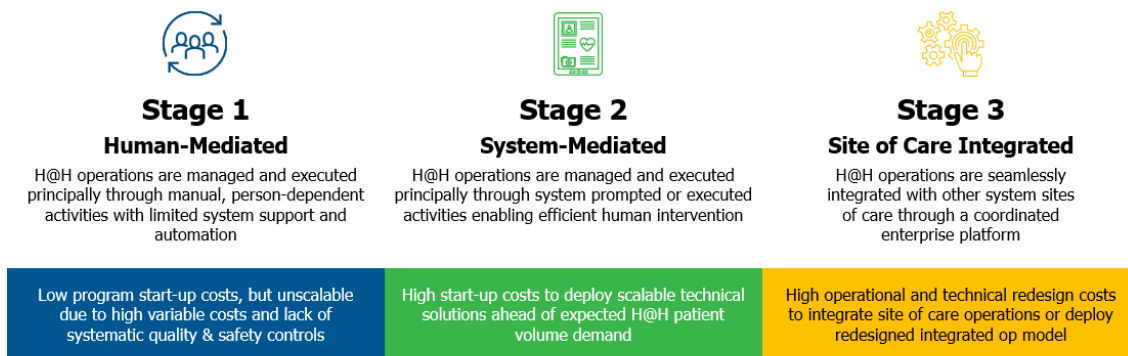
Significant incremental investments are required to deploy a distributed care model with acute-level care in hundreds or thousands of patients’ homes. The standalone (as opposed to enterprise-wide impact with value creation opportunities like higher acuity backfill) profitability of Hospital-at-Home, then, will depend on which services – both clinical and operational – need to be deployed and how an organization delivers on those requirements. Imagine for a moment, all the resources that touch a typical patient on an inpatient floor. Now imagine distributing those services to a patient’s home. Hospital-at-Home requires efficient orchestration and deployment of a multitude of resources in a fashion that demands the highest patient safety and clinical outcomes.

**Illustrative Example of Resources Required for a Hospital-at-Home Program**



However, how an organization chooses to deploy these capabilities can vary widely. For example, a health system may choose to completely outsource its RPM technology and associated command center that manages clinical monitoring, logistics coordination, patient engagement touchpoints and program management (among a variety of other services). Similarly, whether a health system can provide coverage for distant nursing care and remote hospitalist services may depend on the organizations maturity and clinical leadership preferences. The ways in which these resources are deployed all have associated incremental costs to the program, thus there are two key cost drivers that have the greatest impact to the bottom line:

- 1. Hospital-at-Home Program Evolution:** program costs will depend on the evolution of management and operations, moving from human-mediated, manual processes at launch through systems-mediated solutions that eventually become seamless integration across all sites of care.



**2. Third Party Relationships:** To deploy a distributed care model, organizations will rely on third party relationships. As H@H programs obtain scale and layer-in sophistication, reliance on partnerships will alter the economics. Below are some illustrative considerations for when to insource vs outsource capabilities:

**Note:** the categorizations below **vary by organization** and thus are an early planning requirement for H@H – both for the waiver application and because of a long lead time to safely care for the first patient.

**Insource**

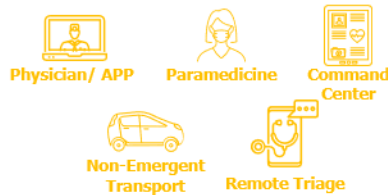
Some capabilities organizations should build from the beginning:



Best for components require a **higher degree of control** – e.g., clinical care delivery, high patient safety risk

**Initially Outsource**

Until organizations reach scale, it may make sense to pay an initial premium to leverage vendor economies of scale:



Target capabilities with advanced **vendors who can deliver on specific service level agreements**

**Always Outsource**

There are also several core competencies that very few health systems (if any) are positioned to build internally:



Capabilities that **align with other industries** – e.g., manufacturing, supply chain and intellectual property

When designing a Hospital-at-Home program, organizations will need to review insourcing vs outsourcing decisions across all clinical and operational capabilities. As part of the CMS Acute Care Hospital at Home waiver application process, organizations must articulate how they plan to deliver these capabilities to patients. For example, organizations are expected to describe how they plan to perform diagnostic testing (e.g., lab, imaging) in their remote model. Each of these decisions are a multifactorial decision that has scale, integration and financial implications.