Impact of Agile Feedback on Physicians' Referring to Hospital at Home

Background

Lack of consistent referrals to Hospital at Home programs is a barrier to sustained census and resource utilization.

Our objective was to create data-driven feedback systems as an implementation strategy to facilitate adoption of the novel care delivery model by referring providers.

Pre-feedback Census Variability: Daily Count of AH-HaH Encounters Across Two Facilities
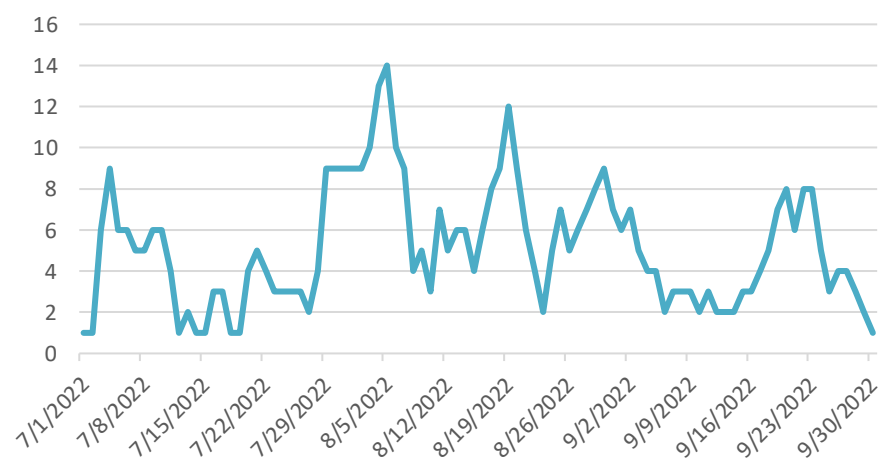
Methods

We developed two feedback mechanisms across the programs within our 2-year REACH-IT (Realizing Equitable and Accessible Care Through Hospital at Home Implementation and Testing) implementation evaluation.

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Hospitalist at Home
Early supported discharge/high risk readmission model

Dashboard including H@H-to-discharge ratio, by provider
Options to filter on patient diagnosis
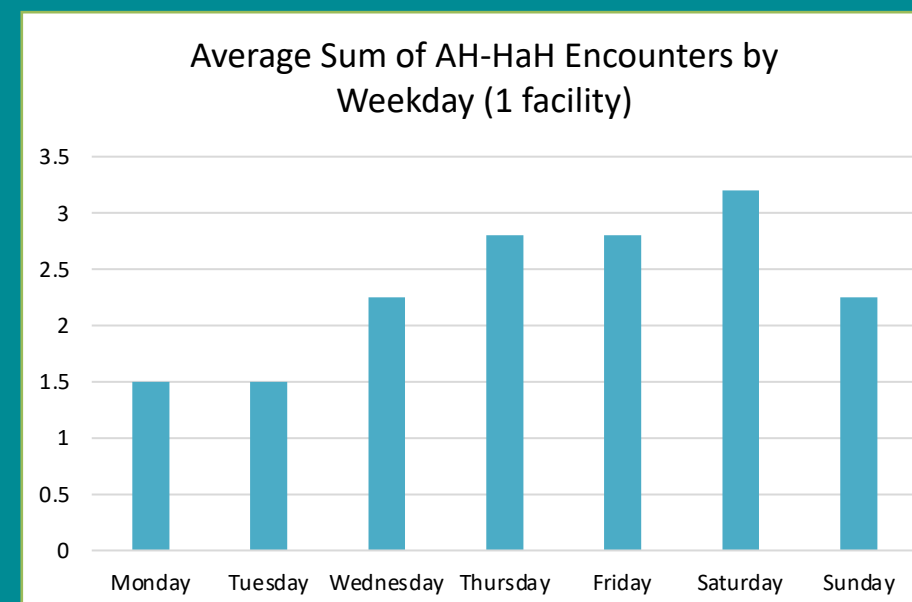
Atrium Health

Hospital at Home
Alternate to inpatient-level care (covered by CMS waiver)

Scorecard AH-HaH census metric calculated as the % of the Hospitalist census devoted to AH-HaH, and raw counts
Additional reports on counts by day of the week and insurance status

List of Discharging Providers

Average Sum of AH-HaH Encounters by Weekday (1 facility)

Month	Facility	Target	Stretch	HaH: 7am census	CHG: 7am census	HaH/CHG % of 7am census	HaH: Unique patients	CHG: Unique patients
2022	AH 1	2.5%	5%	74	9865	0.75%	24	1362
2022	AH 2	2.5%	5%	43	5023	0.86%	18	775

Preliminary Dashboard Results

11.9% → **14.7%**

(Increase in referrals over 3-months)

Conclusions – Keys to Success

Leadership Involvement: Creating Buy-In

Mechanisms identified in collaboration with system leaders

Used to facilitate leader-physician discussions on barriers to referring eligible patients

Agile Feedback: Increasing Understanding Through Transparency
Dashboard allowed leaders and providers to filter to focus on the most relevant information

Scorecard includes % to adjust for different facility sizes and report provides context data