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Hospitalists Without Walls:

Building capacity to keep patients at home for high acuity care

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Hospitalists Without Walls - Introduction

- **HaH models have demonstrated desirable impacts on readmission rates, care-acquired adverse events, patient satisfaction, and cost**
- **Despite this, adoption and scaling of these models has remained difficult due to multiple factors:**
  - **Complex logistics**
  - **Cumbersome supply chain management**
  - **Coordinating appropriate clinical workforce**
  - **Lack of broadly workable payment model**
- **Integration of high acuity model into growing in-home acute care system of care offers opportunity to impact appropriate patients**

Advanced Care: Which Patients?

Common medical diagnoses:

- ✓ CHF
- ✓ COPD
- ✓ Cellulitis
- ✓ Respiratory infections and pneumonia
- ✓ Complicated UTI
- ✓ Metabolic disorders
- ✓ Acute kidney injury

>60 total DRGs

Multiple chronic conditions or medications - complex, high-risk patients

80% of our patients have > 5 comorbidities with an average Charlson co-morbity index >5

More than 50% of our patients have been in the hospital in the past 6 months

Unique Multi-pronged Patient Access Model

Three pathways for access

- Admissions from **DispatchHealth mobile ER care teams in the home**
- Admissions from **PCP, specialist clinics, RN case managers**
- Admissions from **hospital or emergency department**

All Advanced Care visits managed as extended episodes with two phases

Days 0-4

Advanced Care Team: High Acuity Phase

Hospital Medicine NP or PA

RN Navigator

Internal Medicine Hospitalist

+ RN Partners

+ PT/OT Partners

- RN coordinating daily
- Activities with morning huddles
- Daily physician / APP visit
- RN visit 2x per day
- Respiratory therapy
- PT/OT
- 24/7 call center access

Up to 30 days

Advanced Care: Transitional Phase

Navigator-led 24/7 coverage to manage the episode of care

- Home health as needed
- DispatchHealth acute care visit
- 24/7 call center access
- Integrated Plan of Care

- Remote Monitoring
- PCP + Specialist Engagement

- Transportation
- Meal delivery
- EMS / Paramedicine

Transition back to community PCP + specialist care

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Care Model Delivers Broad Coordination in the Home

Customized support based on patients' clinical and social needs.

Care Coordination

- Nurse navigator
- Daily huddles
- Scheduling appointments
- Patient focused care plan development
- Patient engagement
- Data/reporting

Network Management

- Imaging
- Bedside nursing
- DME
- Hospitals
- SNFs
- PT,OT
- Respiratory therapy
- Pharmacy

Social Services

- Food delivery
- Home attendant
- Transportation

Clinical Services

- 24/7 coverage
- Physician led daily rounds in the home
- Lab services (internal / external)
- Imaging (x-ray, ultrasound)
- Medications (IV/PO)
- Bedside nursing
- On-demand urgent care
- Advanced procedural capabilities
- Poly-pharmacy review, optimization

Remote Monitoring

- Heart rate
- Pulse oximetry
- Blood pressure
- Weight
- Disease management education
- Telemedicine
- PERS device “call button”

Highest Acuity Advanced Care Model in the Country

Rolling 12-month Outcomes Data for Advanced Care admissions

92% patient growth 2022 to 2023

- **8 comorbidities per patient on average**
- **60% DRGs with MCC**

8.6% 30-day readmissions

vs. benchmarks 18-24%

21% proactive escalation prevention intervention during transitional phase

0.5 % SNF admission rate

SDOH need directly addressed in 28%

0%
serious safety events or unexpected mortality

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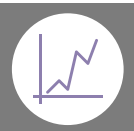
Quintuple Aim

Rolling 12-month Outcomes Data for Advanced Care admissions

29% Goals of Care Revised
100% Goals of Care Discussed



+89 Patient NPS
+98 Caregiver NPS

vs. benchmarks 18-24%

$5000-7000
Medical Cost Savings per Episode

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Thank You!
(Q&A)