# THERE'S NO PLACE LIKE HOME: Developing an Acute Home Hospital in an Academic Health System



Eve Dorfman, DNP, RN, NEA-BC<sup>2</sup>; Jeanmarie Moorehead, EdD, MA, RN, NEA-BC<sup>2</sup>; Jenna Blind, DNP, RN, CPHQ<sup>2</sup>; Jonathan Kelly, D.O<sup>2</sup>; AnnMarie Short, BSN, RN, PCCN<sup>2</sup>; Joseph Greco, MD<sup>2</sup>; Debra Albert, DNP, MBA, RN, NEA-BC<sup>1</sup>

**NYU Langone Home Hospital** 

NYU Langone Health<sup>1</sup>; NYU Langone Hospital—Long Island<sup>2</sup>

## **PRACTICE PROBLEM**

High bed occupancy in hospitals can negatively impact patient flow, quality of care, and patient satisfaction. Hospitals with high bed occupancies often suffer from overcrowding of the emergency department (ED), limiting access to crucial emergency services for community members and prolonging acute inpatient ED boarding. Previous strategies to address high occupancy in this organization include the increase in the percentage of patients discharged before noon (DBN), and the reduction of both the length of stay (LOS) and the median discharge time. Utilizing new and innovative growth strategies to create bed capacity is crucial in maintaining efficient patient flow, high-quality outcomes, and a positive patient experience.

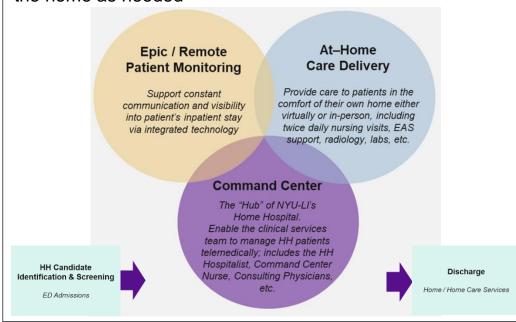
#### **INTERVENTION**

NYU Langone Home Hospital (NYULHH) is an innovative program that provides acute-level care at the patient's home setting as a substitute for inpatient hospitalization using a hybrid remote/in-person visit model in the comfort of their own home while maintaining the same high-quality care they would otherwise receive in the traditional brick and mortar. This Registered Nurse (RN) and Hospitalist Dyad model utilizes an interdisciplinary team approach that provides personalized care, improves communication between all team members, provides exceptional patient experience, and promotes the satisfaction of health care professionals.

#### **PATHWAY & CARE DELIVERY MODEL**

#### **Home Hospital Inpatient Admission**

There are three key components of the Home Hospital care delivery model, all working seamlessly together to manage patient care and coordinate clinical services virtually and in the home as needed



# **CANDIDATE SCREENING & IDENTIFICATION\***

Decision to Admit and Initial Candidate Patient Arrives to the **Emergency Department** HH Candidates are admitted via the Once a Decision to Admit is made, candidates are identified Emergency Department meet specific and screening initiated by a HH Nurse Navigator, Case clinical conditions, reside within 12 Management / Social Work, and the ED Physician miles of the hospital, and be insured by Patient HH Introduction and Candidates continuing to meet non-clinical and program to gauge interest for a preliminary Home Hospital Assessment: Candidates that no longer fit **Patient Consent and Final Physician** criteria or are not interested in the program will follow "Patients can "fall out" of the HaH screening at any Patient consent into the HH program is obtained. The point and revert to traditional inpatient processes HH Hospitalist completes the inpatient H&P and initial

#### Physician Communication of Admission

The Admitting Hospitalist is notified of potential HH candidate in order to communicate the inpatient admission to the patient's private / community physician and assign the dedicated HH Hospitalist appropriately

\*This workflow represents admission from the ED. Patients can also be transferred to HH from the inpatient unit.

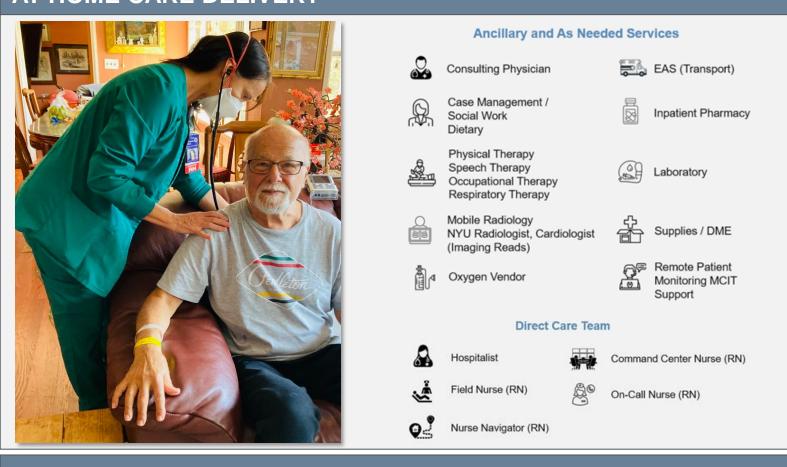
#### AT-HOME CARE DELIVERY

at this point in the admission process\*

orders.\* The patient is transported home for their

\*Patients are officially admitted to the HH Department

inpatient admission.



## **REMOTE PATIENT MONITORING**

#### Real-time biometric monitoring\*

- Wearable: measures pulse, respiratory rate, oxygen saturation, and body temperature
- Tablet: view care plan and communicate with clinicians
- Peripheral Devices: includes blood pressure cuff and weight scale



\*Clinicians utilize a dashboard to monitor the patients' vitals, review alarms, and take action

## **MEASURES OF SUCCESS**

Since September 2022 over 240 patients have been admitted, Average daily census is 3.89

## **Clinical Outcomes**

- *Mortality* (*O:E*) = **0.00**
- *30-Day Readmission Rate* = **6.9%** (brick & mortar = 11.2%)
- Length of Stay (O:E) = **0.75** (target 0.82)
- Hospital-Acquired Conditions = Zero Harm!

# **Patient Experience**

100% Overall Rating of Care

# **Staff Engagement**

• 8 points higher than the organizational average (via Employee Engagement Survey)

#### WHAT MAKES OUR HOME HOSPITAL PROGRAM THE BEST?



NYU Langone Home Hospital leverages its existing portfolio of home care services as a foundation

 NYU Langone's home care portfolio includes Home Health Care via NYU Langone's Certified Home Health Agency and Home Dialysis



NYU Langone Home Hospital maintains the NYU Langone standards and expectations for clinical excellence and quality patient care and outcomes

Utilizes NYU Langone resources rather than outsourcing services and clinicians wherever possible



NYU Langone Home Hospital was created through robust internal and external collaboration

- Designed through partnership with clinical, ancillary, MCIT, and support NYU Langone departments
- Incorporates lessons learned and success factors from external Hospital at Home rolationships



NYU Langone Home Hospital focuses on patient outcomes and safety rather than rapid growth

 Offers a tailored acute care solution rather than taking the Hospital at Home standard model and retro-fitting to our population

#### **REFERENCES**

References available upon request