Hospital AT Home™ USERS GROUP

SNF@HOME SNAPSHOT: THREE SITES

Institution	CLEVELAND CLINIC (OHIO)	ALLINA HEALTH (MINNESOTA)	MARSHFIELD CLINIC (WISCONSIN)
Service name	HomeCare+	Elevated Care at Home	PACH (Post Acute Care at Home)
Alternative to	SNF/SAR/STR -- rehab focus	SNF	SNF
Services provided	Nursing, PT/OT/ST, SW, aide; 5 hours of contact/day in first 14 days	High intensity skilled nursing care; paramedics, respiratory therapy, PT/OT/ST, SW, pharmacy, DME/O2, labs, imaging	High-intensity skilled nursing care with up to TID visits, post-surgical, PT/OT/ST, aide, DME/O2, labs, imaging
Staffing model	Home-based primary care team: APPs with excess capacity; PCP and discharging attending involved	Hospitalists, APPs with hospital and SNF experience	4 physicians on rotation - primary care and nursing home backgrounds
Key inclusion criteria	Need for rehabilitative care; minimal skilled nursing need, 6-clicks score 14-20; caregiver support at home	Meet SNF criteria for skilled nursing care; functional mobility at min-mod assist of 1 or less with caregiver	Must have skilled nursing need (not just PT)
Key exclusion criteria	Need for 24 hr care	Marked functional debility	Ventilators
Provider visits	Up to 2 visits within first 14 days	Daily and urgent televisits	Virtual rounding 1-2 times per week, up to 2-3 weeks
# Hours CNA/aide care provided	Up to 3 hours/day for first 14 days		7 hours/day
Pre-enrollment home visit to assess?	No	No	No
Length of stay	14+ days	4.5 days	60-day episode including acute stay
Patient decline rate	50%	20%	<10%
ADC	~10-15	~20	~10-15
Payment structure/financial model	ACO shared savings for elements not billable under skilled intermittent home care - goal to reduce SNF usage/costs	Home Health episodes and provider billing; contracts with 2 payors for episodic payment; backfilling inpatient beds	Hospital health plan's bundle payment contracted through Marshfield-Contessa joint venture; working to add other payers
Selected outcomes	Compared to patients who went to traditional inpatient SNF, HomeCare+ patients have higher mobility scores at discharge	1.5% decrease in discharge to SNFs; 2-2.5% of discharges transition into this program; 18.9% 30-day readmission rate; 2.8% 30-day mortality rate	25% reduction in 60-day readmissions; 15-30% cost savings per episode; decreased readmission rates; increased patient satisfaction