

STRATEGIC BUSINESS PLANNING FOR HOSPITAL AT HOME: MAKING THE CASE, PROGRAM STARTUP, AND GROWTH PLANNING

While the earliest Hospital at Home (HaH) programs started many years ago, a 2020 Medicare waiver (and associated billing revenue) has caused a proliferation of HaH programs across the US. These programs carry benefits to patients, families, and to health care organizations – and strong financial planning will ensure sustainability and growth over time.

Why Hospital at Home?

A key driver of Hospital at Home uptake in the US is that HaH is high-value care. Hospital at Home has been shown to¹:

- Reduce the total direct costs of care for an acute care episode
- Result in fewer adverse events, and fewer readmissions, when compared against inpatient acute care
- Reduce the proportion of the day in which patients are sedentary
- Offer the opportunity to increase bed capacity for acute care, by shifting some hospital volume to the home.

Despite these demonstrated benefits, garnering institutional support for the initial investment required to start a Hospital at Home program can be complicated; HaH champions may meet resistance due to the fact that services do not fit neatly into either inpatient or outpatient infrastructure and workflows. To justify investment in HaH program startup, champions should design for planned expansion over time, and consider the priorities of financial and clinical stakeholders. [Here](#) is an analysis of the value drivers for Hospital at Home.

Start Small, But Plan for Scale

There are many reasons why it makes sense for a new Hospital at Home program to start small:

- Opportunity to test and refine workflows to achieve high-quality, high-reliability services
- Allow for focused education and relationship-building with referrers (culture change)
- Enable early data collection to demonstrate program value and justify additional investment in future growth

But: for a HaH program to achieve financial viability, it must eventually reach sufficient patient volumes to cover fixed costs (administrative support, technology, some degree of stable staffing to cover the extended hours required). Achieving scale will make the benefits of HaH meaningful to the organization and to referrers, and in so doing, achieve a clinical culture

¹ Levine DM, Pu CT, Blanchfield B, et al. Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. *Ann Intern Med.* 2020;172(2):77-85. doi:10.7326/M19-0600

conducive to in-home acute care. [Here](#) is a document which explores the full range of cost drivers in a Hospital at Home program, including the possible evolution over time.

Patient Identification: At Program Launch, and Over Time

Of the total number of hospital patients, not all will be appropriate for Hospital at Home care – whether because of acuity/specific care needs, or because of social factors that make safe HaH services difficult (e.g. no caregiver availability). For any potential HaH patient, both clinical alignment (willing provider) and patient alignment (willing patient and family) are required. These cultural alignment factors will have real impact on the HaH program census – inpatient providers that believe in the value of HaH will be more likely to identify potential patients, and more effective at communicating the benefits to patients and families.

The Medicare waiver restricts payment for HaH services to two populations:

- Those admitted to HaH from the Emergency Department
- Those who can be discharged early from the hospital and enrolled into HaH for the remainder of their acute care stay

Because a payment mechanism is in place for these two populations under the waiver, many programs will focus only on this model at launch. Be warned: in most hospitals, this will not be an ‘If you build it, they will come’ scenario. For excellent information on engaging key stakeholders in the design and operation of your HaH program – including referring clinicians – refer to the January 2021 webinar [‘Building Support for Your Hospital at Home Program.’](#) Ensuring that potential referrers understand and are comfortable with clinical eligibility criteria for HaH requires continuous education and communication, and will critically influence the early viability of the HaH program.

Within the population of Medicare-eligible patients, many programs choose to launch with narrower HaH criteria:

Eligibility Criterion	Rationale
Specific Diagnoses	Supports referrers to develop a comfort level with clinical eligibility criteria, to more readily identify HaH patients
Specific Patient Geographies	Enables the HaH program to concentrate services for efficient HaH care delivery with a small staff

When strong referral relationships have been established and the HaH program can comfortably accommodate a larger census, programs may choose to incrementally expand eligibility, both in terms of acceptable diagnoses and level or acuity, as well as geographical region. For more information and examples related to patient eligibility, referrals, and intake processes, see Hospital at Home Users Group Technical Assistance Center resources [here](#).

Beyond the Medicare Waiver

For HaH programs to achieve scale, they will likely need to expand beyond Medicare fee-for-service payment. This means identifying potential payer partners, aligning HaH services with the priorities of these partners, and contracting for pay for HaH services outside of traditional Medicare. Information about HaH payment mechanisms and payer contracting can be found [here](#).

Why is it important for HaH programs to seek alternative financing mechanisms?

- Allows HaH to care for patients outside of Medicare waiver eligibility criteria (e.g. patients identified in the community upstream of an ED visit or patients already being seen through a home-based care model).
- Helps the hospital or health-system leadership see a future for HaH beyond the CMS waiver.
- Allows HaH census to achieve a scale that has meaningful impact on the hospital's inpatient costs and operations (e.g. ensuring bed availability for high-acuity patients, or reducing direct inpatient staffing costs). Long-term, this can lead to business cases focused on providing more care in the home, rather than increased investment into hospital bed expansion.
- Allows for more efficient staffing for HaH by stabilizing and increasing the census.
- Justifies infrastructure investment (e.g. EHR and data capabilities, telehealth supports, on call services)
- **Ensures cultural buy-in for HaH among hospital leaders and clinician referrers** (“Hospital at Home is available to almost all of our patients, not just a single insurance. It is part of our core operations”). Note that having a clinical champion for HaH is important both at startup and on an ongoing basis.

In addition to expansion of HaH to other payers, there is also the opportunity to use the infrastructure created for Hospital at Home to deliver additional home-based services. Organizations have leveraged their HaH investment to develop in-home rehabilitation and in-home SNF programs, as well as house calls for medically frail patients. Sharing staff (administrative and supportive as well as clinical), call infrastructure, ancillary contracts and administrative overhead can offer significant savings for the HaH program as well as any additional clinical programs. And, many of the expansions can serve to support a 30- or 90-day bundled payment model by offering patients and families the support needed to continue to rehabilitate at home.

Putting it All Together

Successful Hospital at Home programs may start small, but will plan for expansion over time. This requires engaging key HaH stakeholders – organization leaders and clinicians – early and often in the program design process. Use the startup phase to refine clinical and operational processes, collect program data, and strengthen referrer relationships.

Be strategic when defining patient eligibility, taking into account stakeholder feedback and financial parameters, and continuously educate referrers on eligibility criteria to prevent

resistance and achieve culture change that supports a new model of care. Plan on stretching beyond the initial limited admission criteria to add other patient groups.

Assume that the program will need to expand beyond Medicare fee-for-service payment to achieve scale and ensure long-term viability. Consider whether a long-term plan should include other home-based services. Use HaH program data to demonstrate the quality and financial impact of the program to potential payment partners.