Overcoming Operational Friction in Hospital Care at Home Transfers: Aligning Incentives and Workflows to Optimize Growth

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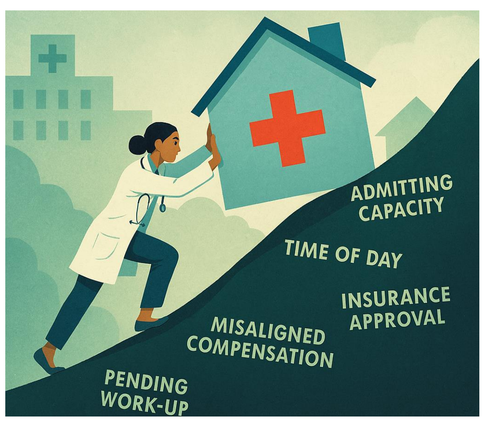
BACKGROUND

- An in-person History & Physical (H&P) is required at time of hospital care at home (HCAH) admission under the CMS waiver[1].
- Operational friction exists due to this requirement and typical hospitalist admitting workflow in the brick-and-mortar setting.
- Hospitalist compensation models and wRVU requirements and/or incentives may create a disincentive to admit patients to hospital at home.
- Existing hospitalist admission workflows are not optimized to prioritize rapid identification and transfer to home-based alternatives.
- Misalignment of compensation and workflows may contribute to underutilization of home hospital services and unnecessarily extend the brick-and-mortar portion of hospitalization.



PROPOSED INTERVENTIONS

To address the misalignment of current workflows and incentives, we propose three complementary intervention strategies:

Dedicated swing shift admitter

- Advanced practice provider with physician oversight
- Target peak ED admission volume hours
- Hospital care at home admissions (same or next day transfers)

Virtual wRVU for admissions or transfer

- Assign virtual wRVU to admitting or transferring hospitalist
- Create "dummy" codes to capture work
- Differentiate admission (day 0) vs transfer (day 1 or greater)*

Nocturnist admitter as screener

- Nocturnist admitter siphons eligible patients for AM transfer
- Identifies and expedites AM needs – consults, testing (e.g., echo)
- Directs handoff to hospital care at home team for follow-up

Example virtual wRVU modeling for admission vs transfers

Brick & mortar wRVU generation[2]
Admit wRVU (3.5, level 3) + 3 days x level 2 (1.59 wRVU) + > 30 min discharge (2.15 wRVU) = 10.42 wRVU

Virtual wRVU model
1. Admit (day 0): Admit wRVU (3.5, level 3) + 3.46 "virtual" wRVU = 6.96 wRVU

2. Transfer (day 1): Admit wRVU (3.5, level 3) + 1 day x level 2 (1.59 wRVU) + 1.33 "virtual" wRVU = 6.42 wRVU

PROPOSED SUCCESS METRICS

Percentage of eligible patients admitted/ transferred to HCAH

Data sources:
- Manual or automated chart review for eligibility
- HCAH admissions data

Brick-and-mortar length of stay (LOS) for HCAH patients

Data sources:
- EHR inpatient admit time stamp to transfer to HCAH

Time from ED presentation to HCAH admission/ transfer

Data sources:
- EHR time stamp ED arrival
- HCAH transfer order time stamp
- Transfer time to home

CONCLUSIONS

These strategies offer a practical blueprint for health systems aiming to scale their HCAH service lines.

- Scaling hospital care at home programs requires alignment of hospital-based workflows and incentives with program goals.

- Potential incentive structures include:
  - ✓ Dedicated swing admitter (*optimize throughput*)
  - ✓ Virtual wRVUs for admission or transfer (*incentivize timely admit or transfer*)
  - ✓ Nocturnist admitter as screener (*optimize throughput*)

- Shifting key work to off hours unlocks early transfers and may reduce the B&M component of the inpatient stay.

- Testing and implementation of hospital care at home program growth strategies should be a research priority.

1. Centers for Medicare & Medicaid Services. "Acute Hospital Care at Home – Resources." *QualityNet*, n.d. Web. 8 Sept. 2025. https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab2.

2. Bohney, Patty, and Dave Hesselink. *2023 Changes to the Physician Fee Schedule: Considerations for Production-Based Compensation Plans.* SullivanCotter, 2023. PDF file. Retrieved 8 Sept. 2025, from https://sullivancotter.com/wp-content/uploads/2023/01/2023-Changes-to-the-Physician-Fee-Schedule.pdf