Hospital at Home USERS GROUP™

Another Way: Opportunities and Challenges of Ambulatory Models of Hospital at Home

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AAHCM AMERICAN ACADEMY OF HOME CARE MEDICINE

The John A. Hartford Foundation

Webinar

October 28th, 2025

We appreciate the generous support of

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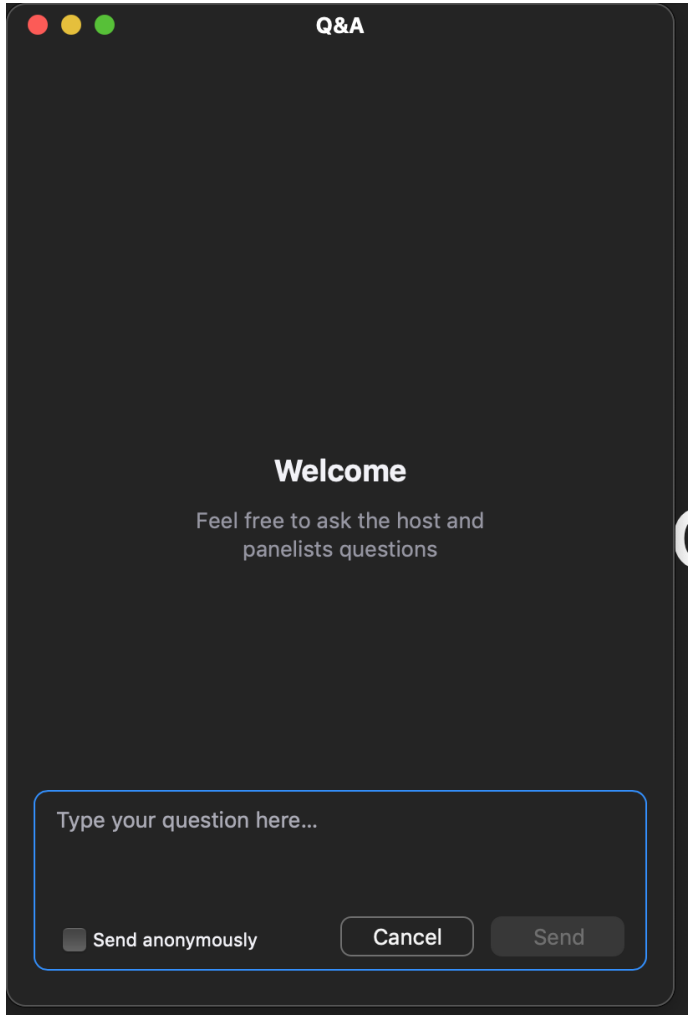
Hospital AT Home USERS GROUP

ZOOM Webinar Housekeeping

- Please submit your questions via the Q&A option.
- Due to the large audience for today's webinar, everyone has been placed on mute.
- If you have any technical issues, please contact Jane Donahue (jdonahue@aboutscp.com) or send her a message via the Zoom chat feature.



The National HaH Quality Registry

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HaH QR Interest Form

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Winter 2025 - *Matching Phase*

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Website: hahusersgroup.org
LinkedIn: @Hospital at Home Users Group
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See the full list of webinars on the Events page at HaHUsersGroup.org

Stephen Dorner, MD, MPH, MSc

Chief of Clinical Operations & Medical Affairs,
Mass General Brigham Healthcare at Home

Hospital AT Home
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Today's Webinar

Another Way: Opportunities and Challenges of Ambulatory Models of Hospital at Home

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Today's Speakers

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Clinical Programming,
Continuing Care
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Medical Director,
UnityPoint Clinical
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Kamia Thakur,
MD

Medical Director,
Penn State Health
Hospital at Home

Panelist Disclosures

- **Katie Westman, DNP, MSN, ACNS-BS, PHN**
  - None
- **Ron Li, MD**
  - None
- **Sophia Loo, MHA, BSN, RN**
  - None
- **Colin Findlay, MD**
  - None
- **Peter Read, DO**
  - None
- **Kamia Thakur, MD**
  - None

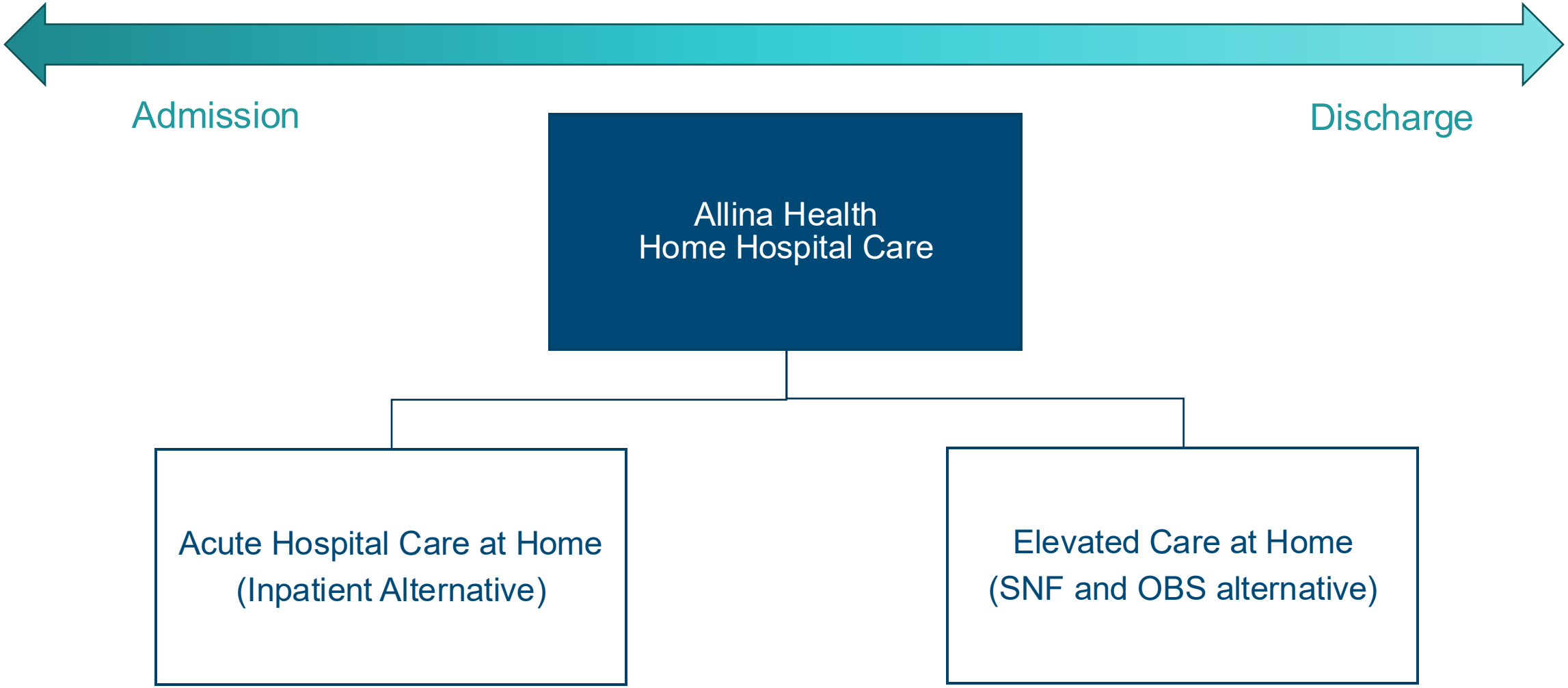
Inbound Health

Allina Health Home Hospital Care

October 2025

Allina Health

Two Distinct Programs



Offering Differences between Acute Hospital Care and Elevated Care Programs

Home Hospital Care Program		
Care Model Component	**Acute Hospital Care at Home**	**Elevated Care at Home**
MD/APP Oversight	At least daily telehealth visits	At least daily telehealth visits
RN Visits	At least 2x visits daily	Daily visits for first 2 days and as needed after
Community Paramedic Visits	Initial visit within 2 hours of discharge in-home	Same-day visit of discharge
Medications	IP Pharmacy delivered to patient's house via courier	OP Pharmacy
Medication Administration	Every medication admin is viewed in-person and/or via video [including overnight]	Self-administered
PT/OT/ST	Available based on patient need	Available based on patient need
Biometric/Vital Monitoring	Available 24/7	Available 24/7
Food Delivery	Available based on patient need	Available as a resource
Triage/On Call Provider	Available 24/7	Available 24/7
DME	Available based on patient need	Available based on patient need
Imaging [EKG, X Ray, US]	Available in-home based on patient need	Available in-home based on patient need

Stanford MEDICINE
Health Care

Stanford Health Care at Home

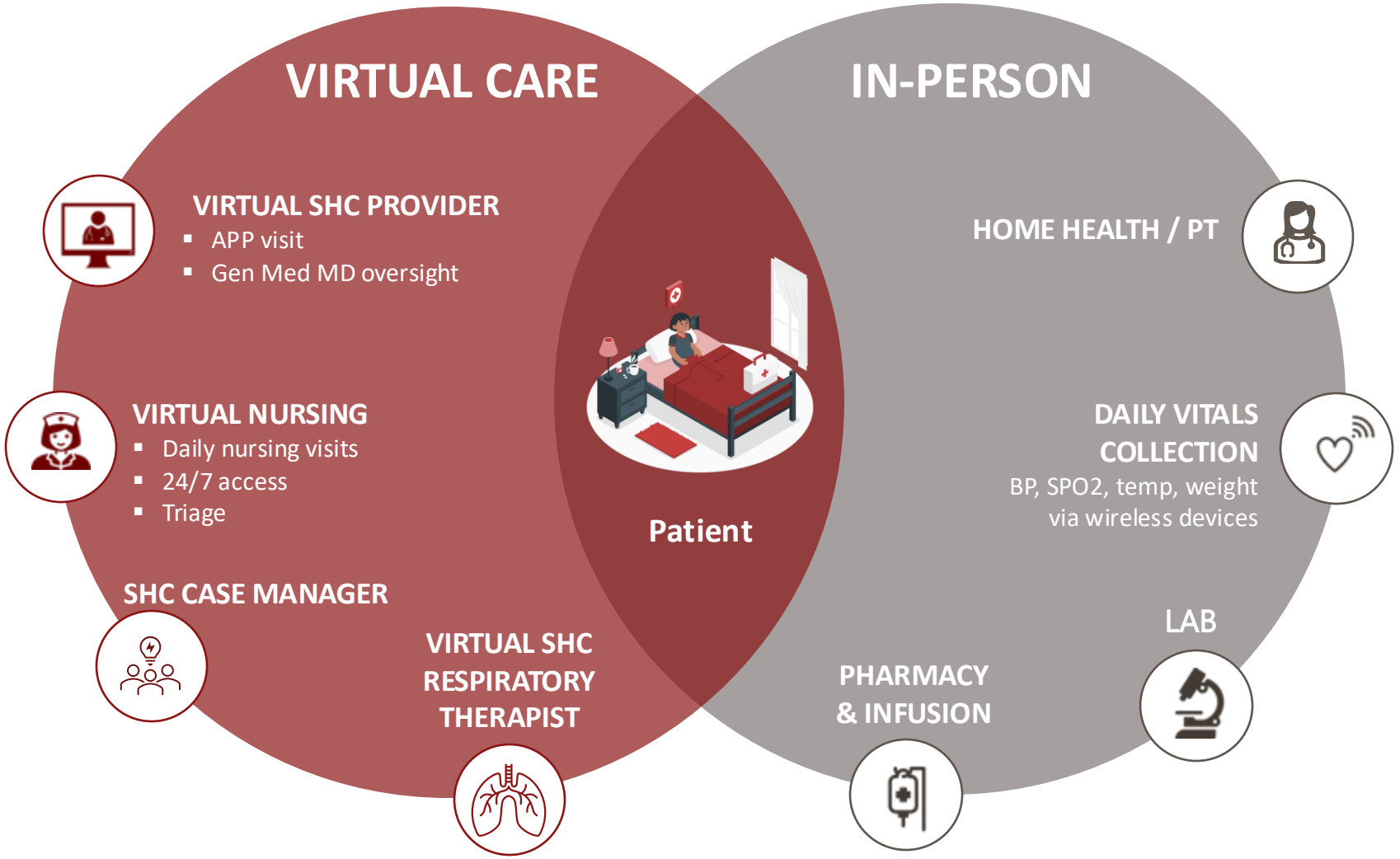
October 28, 2025

Program Overview

The Stanford Health Care At Home Program is a virtual care at home model to improve transitions of care to home post-discharge with the aim to increase hospital capacity.

Value Drivers: Inpatient bed days saved via inpatient LOS reduction *(not yet quantified)*

Existing SHC at Home Care Model Capabilities



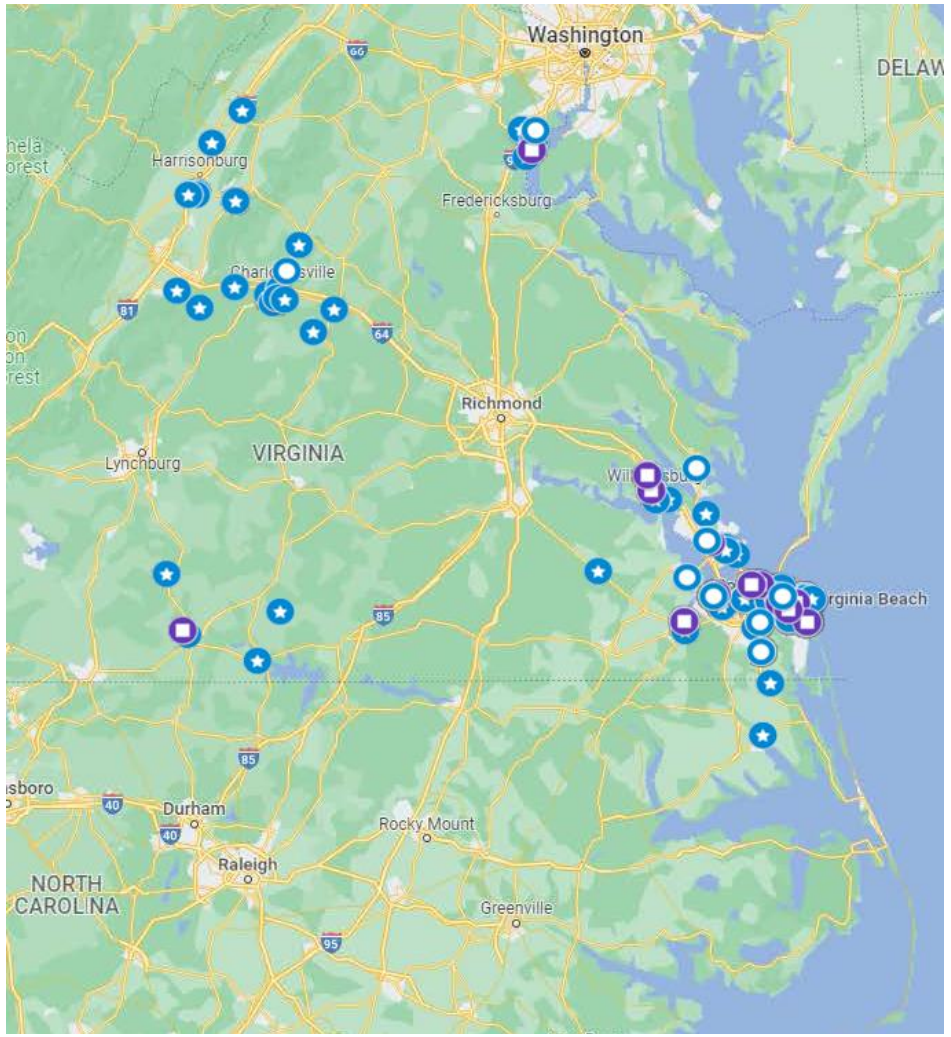
Ambulatory Care Model and Billing Practices

Follow patients for 5 – 7 days post-discharge

Modality	Service	Frequency	Billing
Virtual 	SHC APP Visits, with MD Oversight	2 – 3 times per stay	Ambulatory E&M codes to SHC
	Third-party Nursing	▪ Daily ▪ 24/7 on-demand access	N/A
	SHC Transition of Care Pharmacy	As needed	N/A
	SHC Case Management	Daily and ad-hoc	N/A
	Vitals Collection	Daily	N/A
	SHC Respiratory Therapy	Referral pathway as needed	N/A
In-Person 	Home Health	As needed	Following existing billing pathways for patients who qualify for home health
	Infusion Pharmacy	As needed	Following existing billing pathways for patients who qualify for home infusion
	Labs	As needed	Following existing billing pathways for labs

Sentara Healthcare

- 9 Markets Across 2 States
- 12 Acute Care Delivery Sites
- 24 lines of business, 28 Care Divisions
- Clinical Access Center, 15 Urgent Care Centers, Virtual Care
- 370 Practice, Lab, Imaging and Therapy locations
- Home Care, Hospice, and Home Infusion Services
- Owned Health Plan
- 1,300+ FTE Providers
- 28,000+ Employees
- 700,000+ Unique Patients



SENTARA®

Sentara to Home – Early Transitions Program

- **History:**
  - ✓ April 2020 – S2H was launched to provide capacity capabilities for hospitals due to Covid surges
  - ✓ Designed to provide hospital level care to patients at home, to facilitate early discharge and improve transition outcomes
  - ✓ Patients discharged from hospital while still meeting inpatient criteria
  - ✓ Eligibility Requirements
    - Clinically stabilizing (if on O2 <6LPM)
    - Predictable course
    - Eligible for home health
    - Caregiver support

Sentara to Home – Early Transitions Program

- **Clinical Model**:
  - ✓ Discharged from inpatient to home health
  - ✓ Partnership between home health and hospital medicine
  - ✓ Remote patient monitoring
  - ✓ Daily RN visits with virtual visit with hospitalist to replicate daily rounding for 3-5 days before transitioning to PCP
  - ✓ Patient nursing visits reduced to intermittent ranges until discharge to traditional home health

UNITYPOINT HEALTH: AMBULATORY HOSPITAL AT HOME

UNITYPOINT CARE AT HOME CLINIC

Program

- Opened September 2018
- Suite of home-based care options ranging from proactive/preventative to urgent/interventional visits: a clinic that makes house calls
  - E.g. Annual wellness visits in the home -> Hospital at Home
    - Both ambulatory and inpatient Hospital at Home
- To provide care for patients who have barriers to accessing traditional clinic care->avert the need for higher-level care
  - Not concierge care
  - Extension of the PCP into the home (do not carry a unique panel)
- Markets served: Des Moines, Waterloo, Cedar Rapids, Quad Cities

Initial Program Goal

The program aimed to capture shared savings through alignment with at-risk contracting models.

Volume

- Providers see 4-5 pts/day (8am-5p)
- Mix of routine follow-up and urgent/HaH
- HaH ADC: 3-6

UNIQUE ASPECT OF OUR PROGRAM

In-Person Home Visits

All patient visits are conducted in person at their homes

Place of Service Code 12

The clinic uses place of service code 12 for home visits, distinguishing it from traditional clinic visits with a place of service code of 11.

E/M codes: 99347-50

Partnerships

Insourced Home health, home infusion pharmacy, and HME

Hospital-level services

Not all markets have an active HaH program

CHALLENGES

Efficiency

Windshield time

Culture change

Leadership, Clinic providers, Payors

Flexibility

Finding unique ways to care for patients

Staffing

Finding the right providers and RN’s

Ambulatory Hospital-at-Home (HaH) Program Setup Flowsheet
Penn State Health

- Phase 1: Strategic Foundations
  - Insurance Contracts – Value-based payor partnerships
  - Executive Leadership Buy-In – Executive champions and alignment

- Phase 2: Clinical & Cultural Alignment
  - Physician Buy-In – Identify HaH advocates
  - ED Partnership – Define referral pathways and education

Ambulatory Hospital-at-Home (HaH) Program Setup Flowsheet
Penn State Health

- Phase 3: Outreach & Integration
  - Specialty Clinic Education – Train referral sources
  - Patient Education – Engage and empower HaH ambassadors

- Phase 4: Continuous Improvement
  - Operational Readiness – Build multidisciplinary team and telehealth infrastructure
  - Continuous Improvement – Track KPIs: LOS, readmissions, patient satisfaction, cost savings

Q&A

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Check Out Our TA Center

A comprehensive library of helpful resources on a range of essential HaH topics, updated regularly.

Webinars

WHEN DIGITAL GOES DOWN: ENSURING CARE CONTINUITY IN A CATASTROPHIC TECH CRASH

Recorded September 10th, 2024 The Hospital at Home Users Group, in partnership with the American Academy of Home Care Medicine, is pleased to present our latest webinar for hospital and system...

Learn More

THE STATE OF STATE POLICY: OPPORTUNITIES AND CHALLENGES FOR HOSPITAL AT HOME

Recorded June 24th, 2024 The Hospital at Home Users Group, in partnership with the American Academy of Home Care Medicine, is pleased to present our latest webinar for hospital and system...

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AGE-FRIENDLY BEYOND THE HOSPITAL: INNOVATION IN HOSPITAL AT HOME

Recorded April 11th, 2024 The Hospital at Home Users Group, in partnership with the American Academy of Home Care Medicine, is pleased to present our latest webinar for hospital and system...

Learn More

Information/ Research

OFFERING OBSERVATION AT HOME SERVICES: PAYMENT PATHWAYS AND FEASIBILITY

Last updated: March 2024

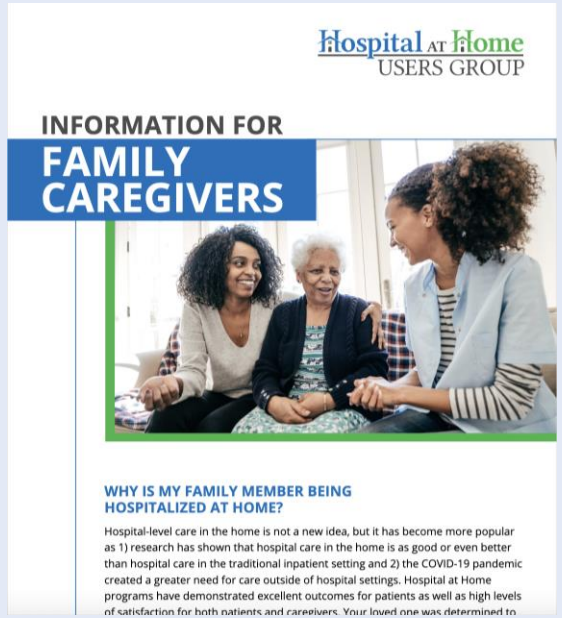
In January 2024, members of the HaH Users Group assembled to discuss Observation at Home. Dr. Anthony Wehbe of SENA Health described how they are implementing Observation at Home for their health system partner, Inspira Health.

As of this writing, there is no waiver or Medicare payment for Observation care at Home. A few hospital systems and implementation partners have negotiated with commercial payors for an Obs at Home rate. Others, including SENA Health, have navigated a path to operationalize Obs at Home without a direct Obs at Home payment. Typically, it involves treating the patient in the brick-and-mortar through workup and Observation status determination, and billing for an Observation stay. While undergoing Observation care, the patient is discharged from the facility and moved home, where the necessary equipment and supplies are delivered, medications are provided, and ongoing in-person (and, if available, virtual) care continue, as with any HaH episode. Certain elements of the care, such as provider visits (in-person or virtual), are billable to insurance. Costs for care that cannot be billed and that are not covered by the Observation rate would be covered by the hospital or health system, which benefits from additional bed capacity, less burdened brick-and-mortar staff, and satisfied patients. If the patient ultimately requires inpatient admission after their Observation stay, that can potentially occur in the home if the patient is otherwise eligible for HaH care; note that the CMS waiver requires an in-person admission H&P be completed for all HaH waiver episodes.

Offering Observation care at Home at your institution may make sense if:

- You already have the infrastructure (staffing, operations, in-home service providers, etc.) in place to provide acute care in the home – e.g. an existing Hospital at Home or ED in the home service.
- Your institution's observation unit is consistently at or over capacity, with negative downstream effects on other units and the patient and staff experience.
- You have outlined a workflow to admit patients who may need ongoing inpatient care after an Observation episode, including steps to ensure that there is an in-person H&P before a HaH episode, or transfer back to the facility if necessary.

Tools



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