Hospital AT Home USERS GROUP™

Finding Patients Faster: Early Transfer Recruitment Strategies For HaH

Jay Mathur, MD | Contessa Health
Leah Webster, PharmD, BCPS | Mayo Clinic
Kamia Thakur, MD | Penn State Health
Rajan Gurunathan, MD, FACP | Hackensack Meridian Health

AAHCM AMERICAN ACADEMY OF HOME CARE MEDICINE

The John A. Hartford Foundation

Webinar
January 27th, 2026

We appreciate the generous support of

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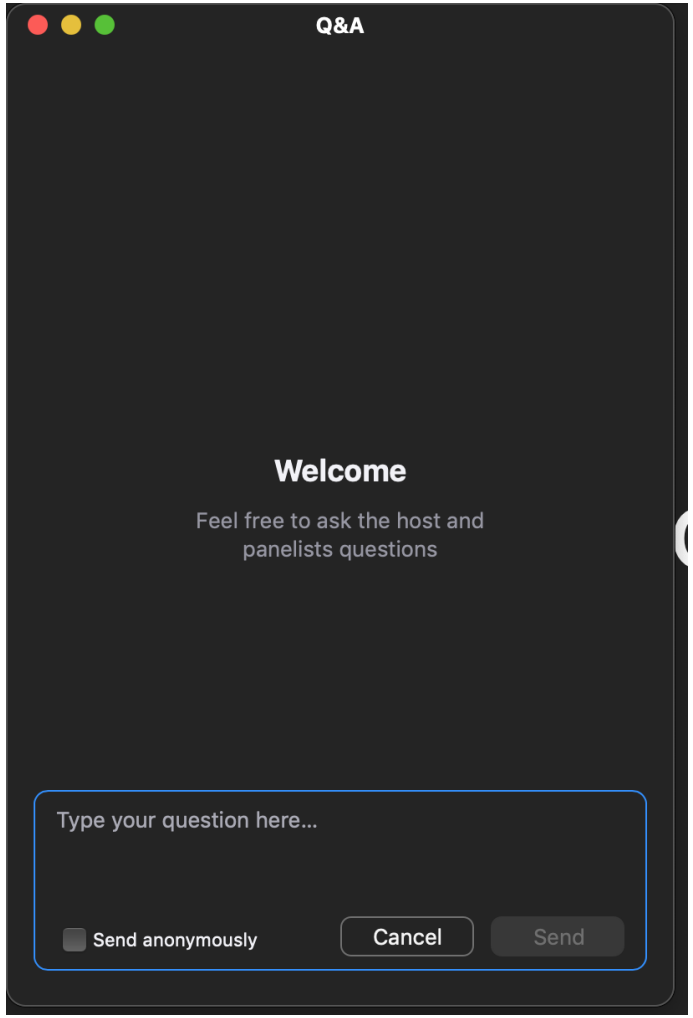
Hospital AT Home USERS GROUP

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.



Hospital AT Home
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Website: hahusersgroup.org
LinkedIn: @Hospital at Home Users Group
TA Center: hahusersgroup.org/technical-assistance-center

The HaH Users Group Webinar Series

Go Home and Go Big: Scaling Strategies for Hospital at Home Programs

Family First: Prioritizing Caregivers in Hospital at Home

Age-Friendly Beyond the Hospital: Innovation in Hospital at Home

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Hospital at Home Nursing: A view from the field

See the full list of webinars on the Events page at HaHUsersGroup.org

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The National HaH Quality Registry

- The National HaH Quality Registry (NHaHQR) is a de-identified, patient-level dataset that seeks to capture information on all patients enrolled in HaH programs nationwide.
- It's **free** to participate and health systems names **will not be shared.**
- Participants will get **annual benchmarking reports** to assess program performance, identify areas for improvement, and demonstrate value.
- First benchmarking reports were released in January 2026 with 49 hospitals representing 39k+ patients currently participating.
- **Help us collect critical data to move HaH policy and regulatory conversations forward – join today!**

NHaHQR Interest Form

Hospital at Home USERS GROUP

Jay Mathur, MD

Regional Medical Director,
Contessa Health

Hospital AT Home
USERS GROUP

Today's Webinar

Finding Patients Faster: Early Transfer Recruitment Strategies for HaH

Hospital at Home USERS GROUP

Today's Speakers

Leah Webster, PharmD, BCPS

Clinical Pharmacy Coordinator,
Advanced Care at Home,
Mayo Clinic

Kamia Thakur, MD

Medical Director,
Hospital at Home,
Penn State Health

Rajan Gurunathan, MD, FACP

Chief Medical Officer,
Hospital from Home,
Hackensack Meridian
Health

Panelist Disclosures

- **Leah Webster, PharmD, BCPS**
  - None
- **Kamia Thakur, MD**
  - None
- **Rajan Gurunathan, MD, FACP**
  - None

Northwestern Medicine®

Finding Patients Faster

Early Transfer Recruitment Strategies for HaH

Jay Mathur

Why do early transfers and ED admissions matter?

“The more the patient remains in the hospital, the more their outcomes resemble the hospital”

- **Increased bed capacity created**
- **Streamlined admission pipeline**
  - Aids in both “today” and “tomorrow” admissions
    - Ex. Change management with clinicians or the patient “hosting” phenomena
- **Naturally builds acuity ladder**
- **Better financial performance**
- **Invites more involvement from health system**

How the heck do we define an ED admission in HaH?

5 major phenotypes

1. **Geographical** – Patient physically located in ED or ED equivalent area, not time frame or care team dependent
2. **Process based** – operational milestone the separates ED admission vs transfer (ie. Admission order)
3. **Care Team Determination** – patient only cared for by certain care teams prior to HaH Admission (ie. ED only, no hospitalist involvement)
4. **Selective** – patient identified in ED, or after admission hours, for HaH admission but requires short term hospital services (ie. held in obs unit to complete testing/procedures)
5. **Timeframe dependent** – patient is admitted to HaH within certain timeframe (ie. within 2 midnights or 24 hours

Most HaH program utilize multiple definitions

Question 1:
Which definition describes most of your ED admissions?

Geographical (ex. Physically located in ED)

Process based (ex. Before admission order)

Care team based (ex. Cared for by ED team only)

Selective (ex. Admitted overnight for additional testing)

Timeframe based (ex. Within 2 midnights or 24 hours of admission)

How our panelists define ED admissions

Mayo Clinic	Penn State Health	HMHN
Care Team Based	Processes based (admission order)	Geographical

How do I build early admissions?

- **Emphasize “Push” over “Pull”**
  - Engage ED providers and hospitalists to think of HaH at time of admission
- **Identify key diagnoses**
- **Engage ED leadership**
- **Observation upgrades (ie. CDU upgrades)**
- **Set expectations with hospitalists**
  - Both Home Hospitalists and BAM hospitalists
- **Move admission timeframes upstream**
  - Benchmark admits within 48 hours

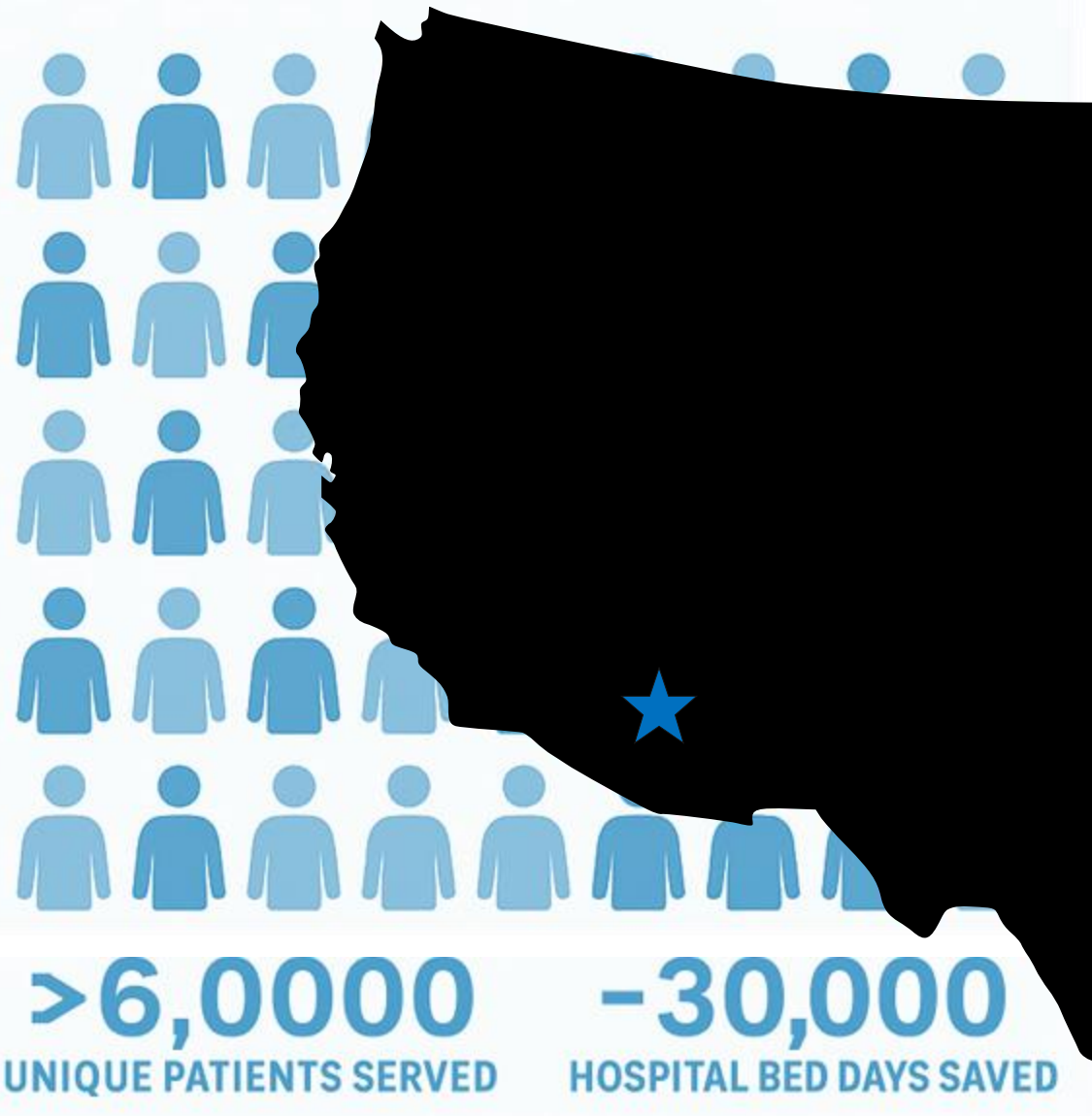
MAYO CLINIC

ACUTE SUBSTITUTIONS

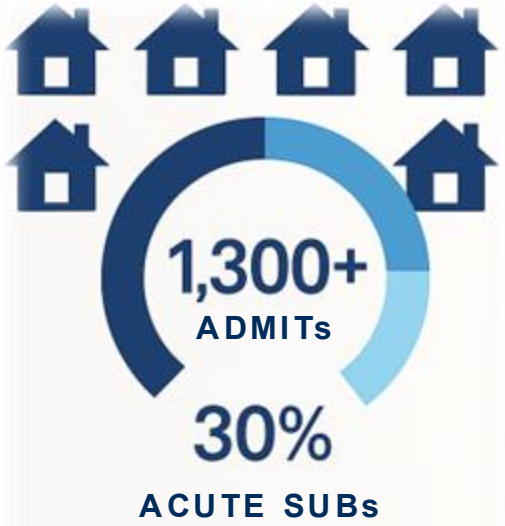
MAYO CLINIC'S EXPERIENCE WITH ED TO HOSPITAL AT HOME ADMISSIONS

Leah Webster, PharmD, BCPS
Coordinator, Pharmacy Practice – Advanced Care at Home | Mayo Clinic

Hospital at Home Users Group Webinar Series | January 27, 2026



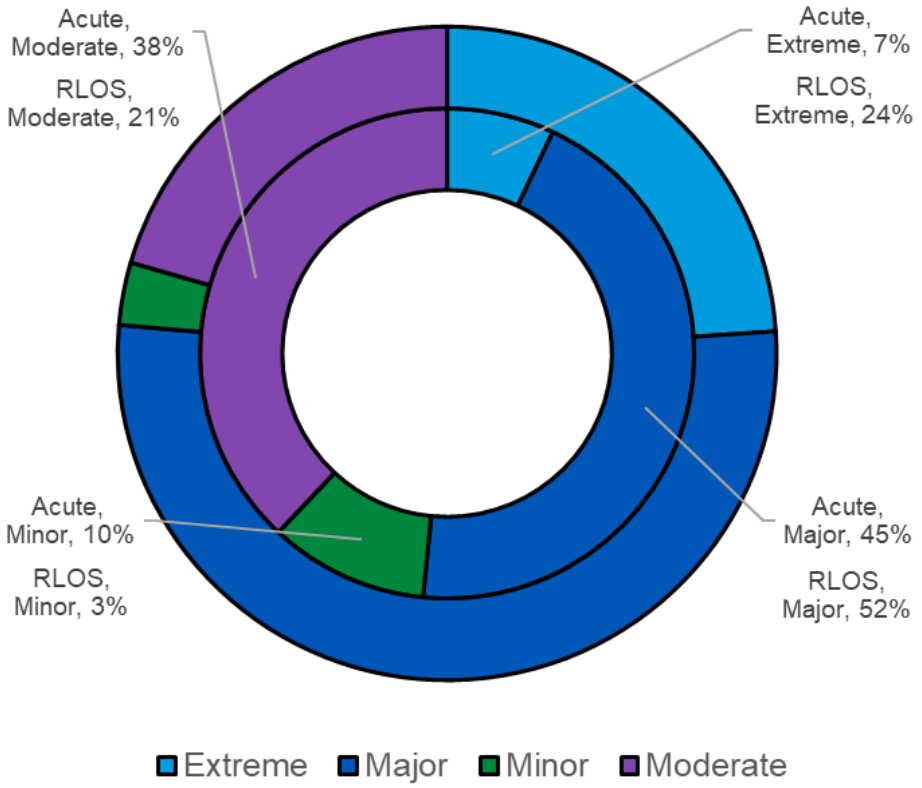
FLORIDA 2025



ACUTE SUBSTITUTION

- Definition
  - Any patient that has not been transferred or escalated to an **inpatient licensed bed or service** during their episode of care prior to ACH admission
- Observation status ineligible
- Transitional spaces leveraged
- Administrator on call for exceptions (i.e., outside radius, insurance, etc.)

2025 Severity of Illness Scores: RLOS vs Acute Sub



*RLOS: reduced length of stay – patient has been admitted to a licensed bed or hospital service before admission into home hospital program

PULL VS PUSH

- HaH Acquisition Team:
  - Dedicated APP: clinical stability screen, consent, H&P, admission orders
  - Dedicated RN: intake screen, education, coordination of transitional care
- Pull
  - Shared acquisition list in EHR
  - Probability score assignment (clinical screening tool)
  - APP signs into ED admission group chat
- Push
  - Consult orders

Goal is to minimize "pulls" and maximize "pushes"

BARRIERS

- Manual, time consuming, *uncomfortable* "pull" process
- Providers unaware of program existence and capabilities - limits “push”
- Patient hesitation
- Logistics, service-provider availability
- Extended on campus needs: advanced imaging, procedure, blood, etc
- Complex medication regimens

RECRUITMENT STRATEGIES

Cross functional teams	Provider convergence, relationships Multidisciplinary partnership Leadership alignment
Technology	AI for eligibility EHR/ED Board pop ups promoting consults Dashboards to streamline communication
Marketing	Clinician orientation presence Patient-facing information, stories, FAQ
Transitional spaces	Non-licensed beds Additional clinical needs Logistical delays

EARLY INTERVENTIONS

Quality improvement project

- Goal
  - ↑ Acute Sub rate from 2% to 10% in 3 months without adversely effecting ED hold time
- Results
  - Acute sub increase from **2% to 14%** ($P < 0.001$)
  - No impact on ED hold time
  - Sustained results 30 days post
    - Acute sub rate **18.5%**

› Am J Med Qual. 2024 May-Jun;39(3):99-104. doi: 10.1097/JMQ.0000000000000186. Epub 2024 Apr 24.

Bypassing the Brick-and-Mortar Hospital: Increasing Direct Admissions from the Emergency Department to Inpatient Hospital-at-Home

Leah W Webster [1], Matt D Cox [2], Jacey R Fazio [3 4], Heidi M Felix [4 5], Holly R Greenwell [1], Rachel M Botella [4 6], Michael J Maniaci [4 6], Ami A Grek [3 4]

Affiliations + expand

PMID: 38683730 DOI: 10.1097/JMQ.0000000000000186

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Abstract

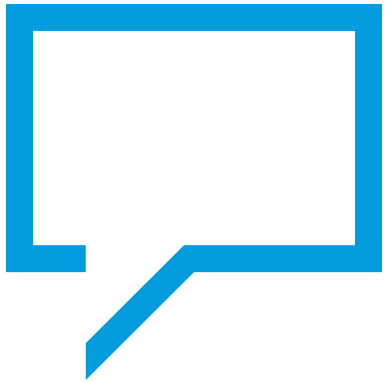
Home hospital programs continue to grow across the United States. There are limited studies around the process of patient selection and successful acquisition from the emergency department. The article describes how an interdisciplinary team used quality improvement methodology to significantly increase the number of admissions directly from the emergency department to the Advanced Care at Home program.

Webster LW, Cox MD, Fazio JR, et al. Bypassing the Brick-and-Mortar Hospital: Increasing Direct Admissions from the Emergency Department to Inpatient Hospital-at-Home. *Am J Med Qual.* 2024;39(3):99-104. doi:10.1097/JMQ.0000000000000186

KEY POINTS

- HaH admissions from the ED may provide greater financial benefit, but clinicians and patients may need time to gain understanding and trust.
- Prioritize interventions that increase “push” referrals.
- Reinforce interdisciplinary partnerships to develop strategies for overcoming barriers that consistently delay transport.

CONTACT



Leah Webster, PharmD, BCPS
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PSH Home Recovery Care Driving Early Admissions

JANUARY 2026

How We Define Early Admission

Early admission occurs -

- Before ED registration
- At the time of registration
- Before inpatient admit order is placed
- OR within the first 12 hours of admission

Earlier identification preserves eligibility (Value based*) and has shown improves outcomes

Ownership of Screening

- Screening is owned by the HaH team
- Referrals are helpful, but quality improves when our team identifies patients
- Standardized screening tools reduce variability

Ownership drives consistency and safety.

Front-End Focus: ED & Observation Units, clinics and patients

- Education of ED physicians, nurses, and APPs for referral but also understanding the program to avoid confusion
- Educating patients who were already admitted – patients now call from home or ask for us in the ED
- Referral lines from specialty clinics, IM clinics locally
- Screening is focused on the front end – arrange patients based on LOS on screening tool

Clinical Confidence & Team Consistency

- Same physician and nursing team from inception – onboards and trains new members
- Selecting a **Clinically strong team that is comfortable managing uncertainty – less dependence on consulting specialties for lower acuity conditions**
- Even with a clinically strong team “consistency” is important

Value-Based Care as an Enabler

- To benefit from our Value based option(30 day monitoring)– patients have to be admitted within 24 hrs of admission
- Reduced readmissions and improved outcomes - staff and patients both see the benefit
- Sharing outcomes with teams – Value based despite same CMI do better than patients that have stayed in facility. Also LOS is shorter

Operational Discipline & Feedback

- Our workflow is designed around early admits – screen patients in the ED
- Program culture is built around early admissions as opposed to early discharge
- Real-time feedback on missed opportunities
- Daily awareness of capacity and staffing*

“Early admissions is a program goal”

Key Takeaways

- Early admission should be intentional
- Requires ownership of admissions and clinical confidence
- Build workflows (Program culture), leadership , and system design to align with early admission as a goal

- Early admission used as a strategic performance lever.

Early Transfer Strategies for Hospital at Home

Hospital at Home Users Group, Jan 2026

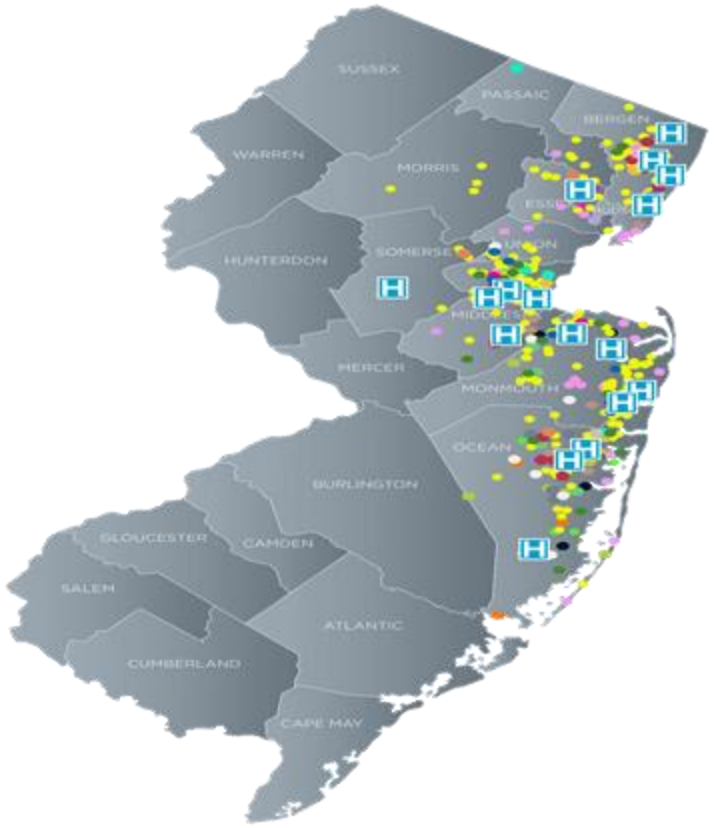
R. Gurunathan, MD
Chief Medical Officer, HMH Hospital from Home
Hackensack Meridian Health

Hackensack Meridian *Health*
KEEP GETTING BETTER

Hackensack Meridian Health : Who We Are

18 hospitals

- **3** Academic Medical Centers
- **1** University Teaching Hospital
- **8** Community Hospitals
- **2** Rehabilitation Hospitals
- **2** Children's Hospitals
- **1** Behavioral Health Hospital
- **1** Long Term Acute Care Hospital
- **1** Center for Discovery & Innovation
- **1** School of Medicine



MISSION

Transform health care and be recognized as the leader of positive change.

VISION

Innovation is in our DNA, compelling us to create a world where: the highest quality care is human-centered, accessible and affordable; we deliver outcomes that matter most; and excellence is the standard.

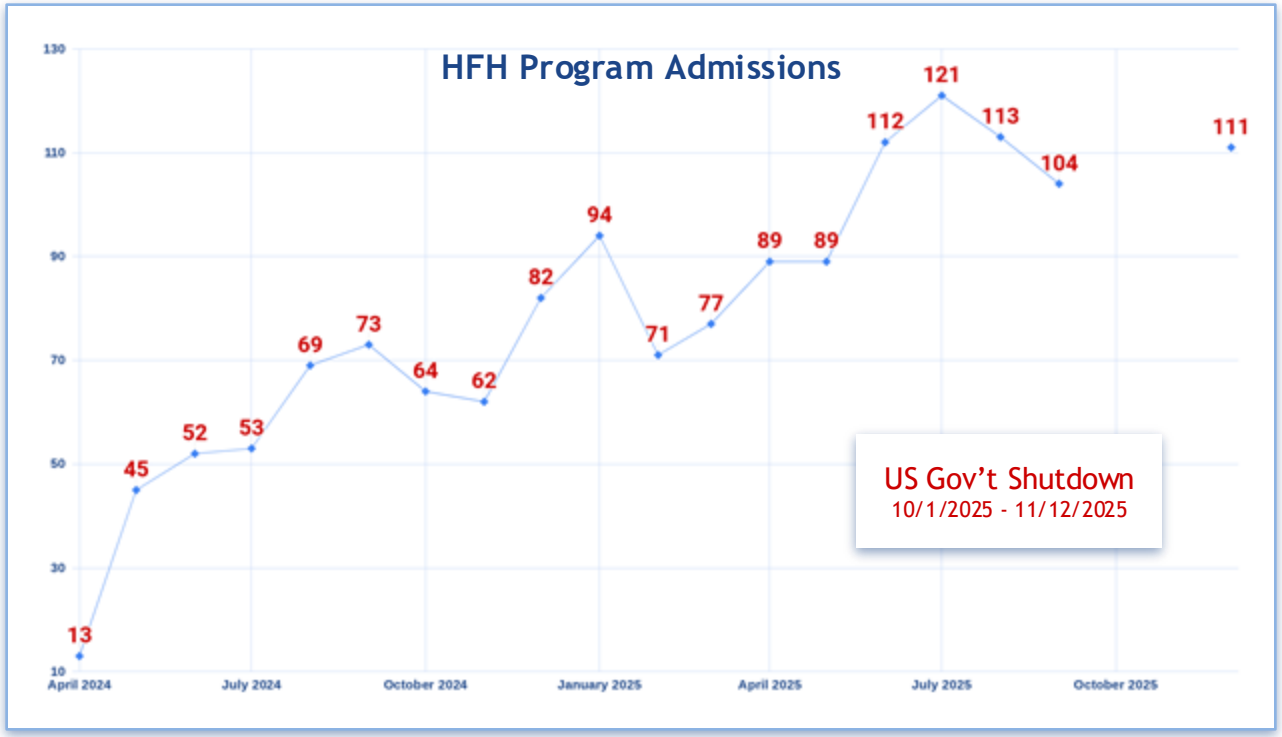
BELIEFS

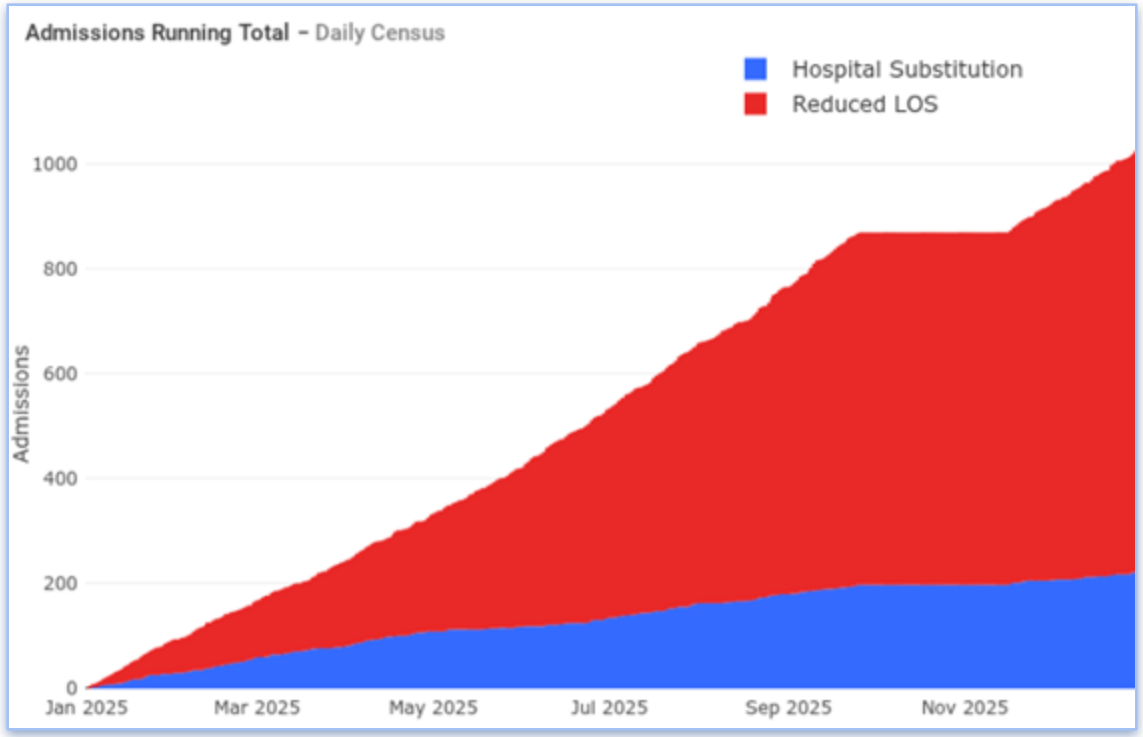
CREATIVE ... I will do my part to make things better.
COURAGEOUS ... I will do the right thing.
COMPASSIONATE ... I am the human experience.
COLLABORATIVE ... I embrace teamwork.
CONNECTED ... I am part of something bigger.

Several different contracted and employed hospitalist / ED groups, high number private admissions, large geographic area

Hackensack Meridian *Health*
KEEP GETTING BETTER

Hospital *From* Home - 2025 Volume





Total Admissions
2024 = **513**
2025 = **1,031**

Saved Bed Days
(since 4/24)
6,853

Average Daily Census
2024 = **9.6** *2025* = **13.84**
Peak Census
2024 = **16** *2025* = **24**

Hackensack Meridian *Health*
KEEP GETTING BETTER

Hospital *From* Home - 2025 Overall Program Metrics

Clinical Outcomes

Discharge Home *(2025)*

HFH Exceeds Hospital 2025 Goals

	HFH Unit	*Hospital Target*
HUMC	97.9%	87.4%
JFKUMC	97.0%	86.5%
JSUMC	97.1%	85.2%
OUMC	98.1%	83.4%
SOMC	100.0%	82.9%

Escalation Rate

9.9%

National benchmark ranges: 7-20%

30-Day Readmission Rate

11.8%

Jan - Nov 2025

Hospital Cohort 30-Day Readmission Rate is **17.05%** *(through 10.31 2025)*

Patient Safety

Serious Safety Events

0

Since Program Inception (4/2024)

At-Home Mortalities

0

Since Program Inception (4/2024)

Hospital Acquired Infections

0

Since Program Inception (4/2024)

Volume & Throughput

2025 Volume

34% growth

513 admits in 8 mos to 1,031 admits in 12 mos

HFH 2025 Length of Stay

4.3 days

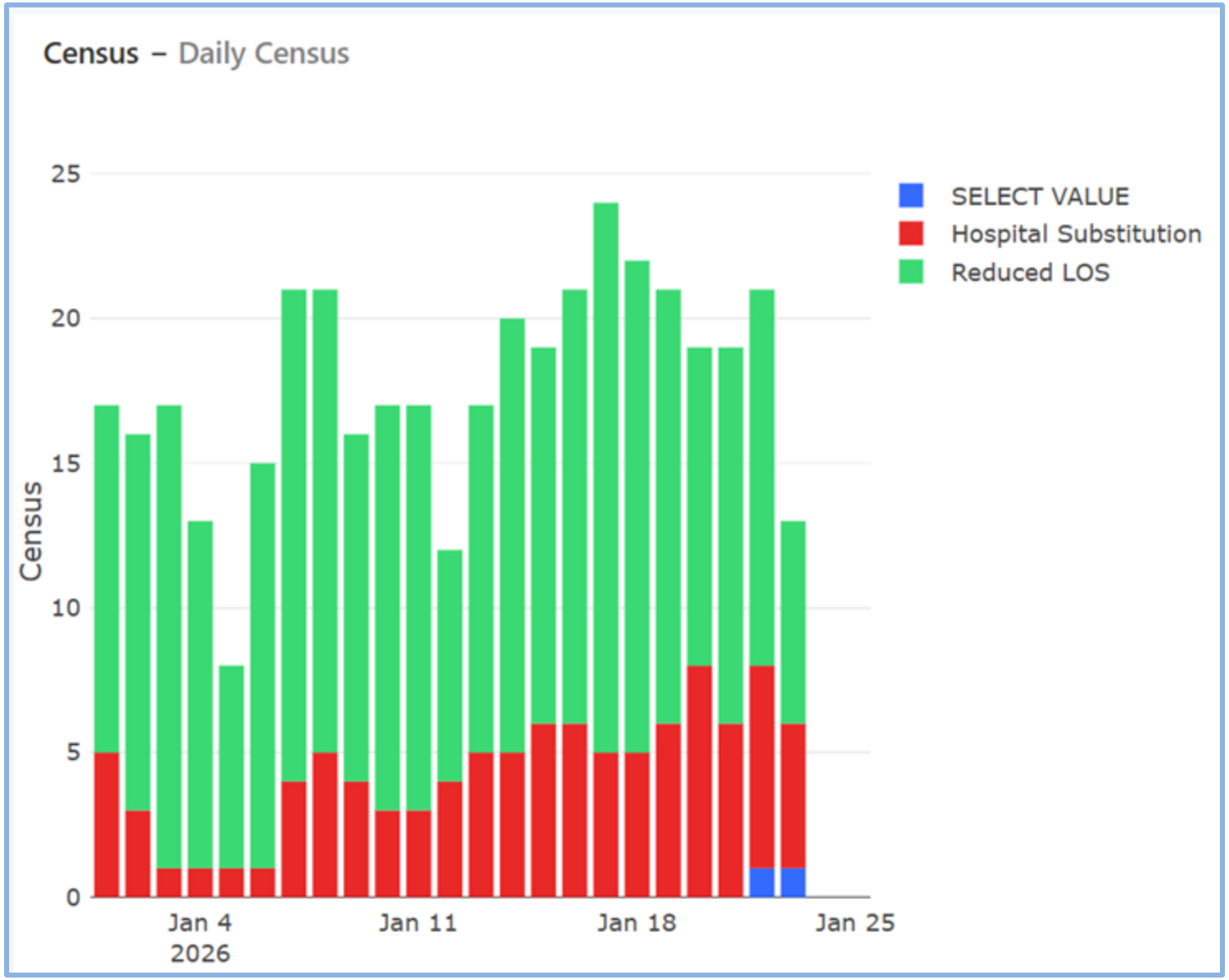
In-Home LOS Mirrors National Trends : 4.5 days

Average 2025 CMI

1.42

vs.

1.31 in 2024



Improving ED - HFH admissions:

- Alignment on key diagnoses
  - Respiratory / Viral
  - ID / Cardiac
  - Care of Older Adult
- Obs to Inpatient Conversions
  - New ‘step’ in care path
  - Brought forth by ED
- Emphasis on Hospitalists
  - Early in triage process
  - Direct rounding / outreach

HFH Strategic Focus - 'Expanding Definition of Early'

HFH Total Length of Stay	ED vs Inpatient Admissions	HFH B&M Time*
HFH Avg - **6.36 days** B&M Avg - **6.19 days**	ED Admissions - **21.7%** vs. Inpt. Admissions - **78.3%**	Patients admitted to HFH in less than 48 hours: **45.02%** Patients admitted to HFH in greater than 48 hours: **54.98%** *Average dwell time 2.44 days*

***Admissions within the first 48 hours dramatically change the P&L and ROI by decreasing inpatient expense attributed**

Would you admit this patient?

Case 1

Patient case – ED presentation

Clinical Snapshot

- KA, 75-year-old male
- Presented to ED on Saturday
- Chief Complaint
  - **Fever, chills, rigors** x 1 day
- Local symptoms
  - **New pain and drainage,** right foot wound
  - **Erythema** spreading up leg

Vital signs (ED)
- T: **39.3°**
- BP: 126/63
- HR: **111**
- RR: 23

- PMH
  - Parkinson's disease
  - Epidermolysis bullosa with chronic foot ulcers
  - Peripheral neuropathy
  - PVD
  - COPD
  - GERD
  - Carotid artery stenosis,
  - HFrEF (EF 45%) s/p AICD
  - CAD s/p CABG ×2

Key Diagnostics
- Imaging (Xray)
  - Soft tissue gas
  - Unable to r/o OM
- Lab Findings
  - WBC:**14.2**
  - PLT: 130
  - LA: **4.4**
  - SCr **1.15**
  - LFT WNL

Sepsis 2/2 severe soft tissue infection with possible osteomyelitis in medically complex patient with recent critical illness

Patient case – ED management

ED Course

Sepsis management
- Bundle completed in ED
- Hemodynamics stabilized

Lactate Trend (mmol/L)
4.4 → **2.0** → 1.7

Microbiology
- Blood cultures **Gram-positive cocci**
- 2/2 sets (aerobic only collected)

Antibiotics initiated
- **Cefepime** 2 g IV Q8H
  - Due **0330** / **1130** / **1930**
- **Metronidazole** 500 mg IV Q8H
  - Due **0300** / **1100** / **1900**
- **Vancomycin** (pharmacy-dosed)
  - 1.5 g IV Q24H, over 90 minutes
  - Due 1650
  - Trough prior to dose #3

Disposition Planning:
- Patient anxious about postponing his wedding (planned for Monday) due to hospitalization.
- Advanced Care at Home consulted Saturday PM
  - Eligible based on: insurance coverage, geographical location (25 minutes from campus)

Question 2:
What would you do for this patient?

Admit to Hospital at Home

Admit to BAM for anticipated admission to HaH within 24 hours

Admit to BAM for anticipated admission to HaH >24 hours

This patient is not a candidate for HaH

Patient case – happy wife, happy life

Transition to Advanced Care at Home

Clinical Summary

- KA, 75 year-old-man
- Sepsis with MRSA bacteremia
- Source: SSTI (suspicious for osteomyelitis)
  - MRI ordered

Microbiology and Cardiac Workup

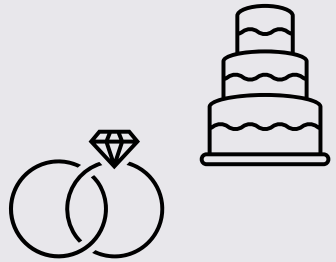
- Blood cultures: MRSA, repeats collected
- TTE no vegetation visualized
- TEE required for definitive evaluation

Care Transition and Antimicrobial Plan

- Consented to ACH Sunday
- **Cefepime** + m**etronidazole** → **piperacillin/tazobactam**
  - Continuous infusion (changed daily)
  - Elastomeric pump
- **Vancomycin → daptomycin**
  - Daily IV push

Advanced Care at Home

- Wedding guests notified → home converted to venue for Monday
- Antibiotic delivery and administration consolidated to avoid interference with wedding festivities
- TEE rescheduled to Tuesday
- MRI (to rule out OM) rescheduled to Tuesday
- Discharged with home health



Case 2

Patient case – ED presentation

Clinical Snapshot	

• 73 YO Female
• Presented to ED
• Chief Complaint
  • **Progressive SOB**
  Other symptoms
  • Fevers
  • Productive cough
  • Rt sided chest discomfort
	Vital signs (ED)
	• T: **38.2°**
	• BP: Stable
	• HR: **110s**
	• RR: 20s
	• On 4L

• PMH
  • COPD/Asthma on 2L at baseline
  • Insulin dependent DM with peripheral neuropathy
  • CAD, stents in 2018
  • HFpEF
  • Class III obesity
	Key Diagnostics
	• Imaging (Xray)
	  • **Right sided pleural effusion**
	• Lab Findings
	  • Leukocytosis

ED Course **Patient decompensated requiring 6L of O2 and with concern she may require BiPAP** MICU team evaluated and did not recommend BiPAP or intubation	

Question 3:
What would you do for this patient?

Admit to Hospital at Home

Admit to BAM for anticipated admission to HaH within 24 hours

Admit to BAM for anticipated admission to HaH >24 hours

This patient is not a candidate for HaH

Case 3

Patient case – ED presentation

Clinical Snapshot	

• 63 YO Female
• Presented to ED
• Chief Complaint
  • **Progressive SOB**
  Other symptoms
  • Fevers
  • Productive cough
  • Rt sided chest discomfort
	Vital signs (ED)
	• T: afebrile
	• BP: stable
	• HR: stable
	• RR: stable
	• Not on O2

• PMH
  • Class III obesity
  • COPD
  • CKD IIIa
  • HTN
  • Insulin dependent DM
  • PVD
  • Lt. BKA
	Key Diagnostics
	• Imaging
	  • **CTA with bilateral acute lobar and segmental Pes w/o RH strain**
	• Lab Findings
	  • BNP >22,000
	  • Elevated D-Dimer

ED Course **MICU consulted, did not recommend ICU level care**	

Question 4:
What would you do for this patient?

Admit to Hospital at Home

Admit to BAM for anticipated admission to HaH within 24 hours

Admit to BAM for anticipated admission to HaH >24 hours

This patient is not a candidate for HaH

Q&A

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NHaHQR Interest Form

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...

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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

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Information/ Research

OFFERING OBSERVATION AT HOME SERVICES: PAYMENT PATHWAYS AND FEASIBILITY

Last updated: March 2024

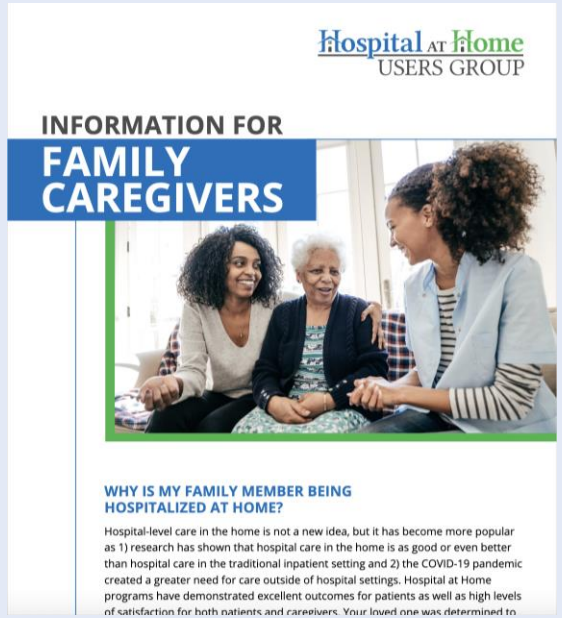
In January 2024, members of the HaH Users Group assembled to discuss Observation at Home. Dr. Anthony Wehbe of SENA Health described how they are implementing Observation at Home for their health system partner, Inspira Health.

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



https://www.hahusersgroup.org/technical-assistance-center/

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