Building Capacity Through Innovation of Ambulatory Care Model

Stanford Health Care at 2026 HaH Users Group Annual Meeting , November 2026

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Learning Objectives

1) Describe how a non-waiver ambulatory Hospital-at-Home model can safely deliver acute-level care in the home setting while alleviating inpatient capacity constraints and reducing hospital length of stay.
2) Identify the key operational, clinical, and interdisciplinary infrastructure components—including standardized clinical pathways, remote monitoring, telehealth, and coordinated care teams—required to build a scalable and sustainable care-at-home program.
3) Evaluate the measurable impact of a care-at-home program using quantitative and qualitative metrics such as average daily census, bed days created, hospital days saved, readmission rates, and patient experience outcomes.

Background

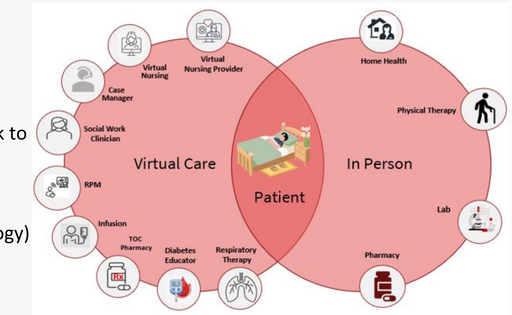
- Hospital leadership identified an urgent need to address hospital constraints and patient access issues.
- Home-based programs are a promising alternative to traditional hospital care and can be a cost-effective approach that maintains high standards of patient outcomes and satisfaction.[2]
- Effective care transitions to home improve health outcomes and reduce healthcare costs by minimizing emergency visits, avoiding readmissions, and shortening hospital stays, while maintaining high-quality care.[1,4,6]
- Telemedicine is a logistically feasible and effective method for detecting and preventing gaps early in the hospital-to-home transition, and discharge planning is a critical time frame to ensure prompt follow-up care.[3,5]
- **Stanford Health Care at Home launched on May 1st, 2025, offering a virtual model of care to support patients in their transition home, with an interdisciplinary team with the goal to increase patient access and support hospital capacity.**

Care Model

Provides **5–7 days** of post-discharge **medical management** and **care coordination** to support **safe recovery** at home and **reduce care gaps** following hospital discharge.

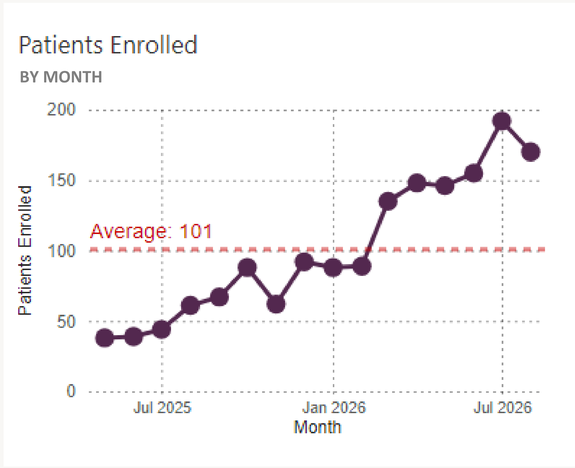
Key Program Components:

- 🩺 Medical oversight and co-management during the post-discharge period
- 💻 1–2 virtual visits with an Advanced Practice Provider (APP)
- ☎️ 24/7 virtual nursing support
- 📋 Dedicated case management and care coordination
- 👥 Daily interdisciplinary care team rounds
- 💗 Daily remote vital sign monitoring
- 🏠 Home Health and rehabilitation services, as needed
- 🤝 Seamless transition back to primary and specialty care providers
- **[NEW]** Inpatient virtual specialty consults (Nephrology)



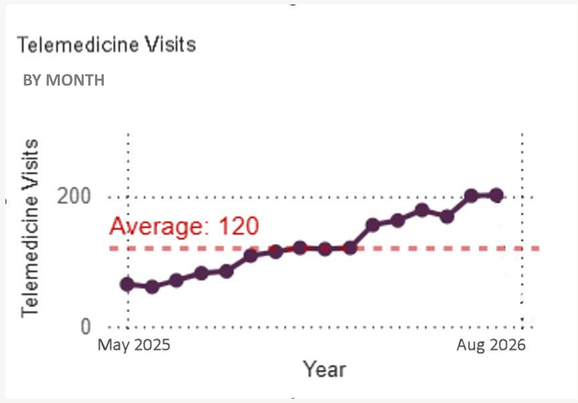
Outcomes

	4 months post implementation	15 months post implementation	Change
Hospital bed capacity created	122	761.08	↑ 6.24x
Average daily census	11.03	48.5	↑ 4.4x



In the first year, we…

…enrolled over 40x the number of patients…



…and more than doubled the number of monthly provider telehealth visits!

Findings to Date

Since its launch in May 2025, Stanford Health Care at Home has demonstrated strong operational performance and rapid growth:

- 1,840 consults completed, resulting in 1,188 patient enrollments and 1,153 completed episodes of care
- Care delivery supported by 1,532 telemedicine visits and 10,714 support encounters, reflecting the high-touch, multidisciplinary model required to safely care for patients in the home
- Average Daily Census grew from approximately 9–12 patients per day in late FY25 to nearly 50 patients per day in FY26 year-to-date, demonstrating successful program expansion and increased utilization
- Created the equivalent of 761.08 inpatient bed days of capacity, helping alleviate hospital capacity constraints while maintaining access to acute-level care
- Saved an average of 0.66 hospital days per patient episode, supporting both patient-centered care and health system efficiency

Together, these results demonstrate the program's ability to scale, maintain strong patient throughput, and create meaningful capacity for the health system while delivering care in the home.

Key Takeaways

- **Align leadership early.** Success starts with alignment across clinical, operational, financial, and executive leadership.
- **Build the right infrastructure.** Establish standardized clinical pathways, leverage remote monitoring and telehealth capabilities, and develop strong partnerships with community-based providers.
- **Start intentionally.** Focus on a well-defined patient population, measure outcomes early, and continuously refine workflows to build provider confidence and support thoughtful growth.
- **Measure what matters.** A robust framework tracking patient experience, quality outcomes, escalation and readmission rates, capacity creation, and financial performance is critical to demonstrating value and sustaining long-term investment.

Acknowledgements:

Stanford Health Care at Home Clinical Operations
Nursing Informatics
General Medicine Hospitalists
General Medicine Advanced Practice Providers
Virtual Nurse Team
Technology and Digital Services
Compliance Team
Finance Team

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