Hospital at Home

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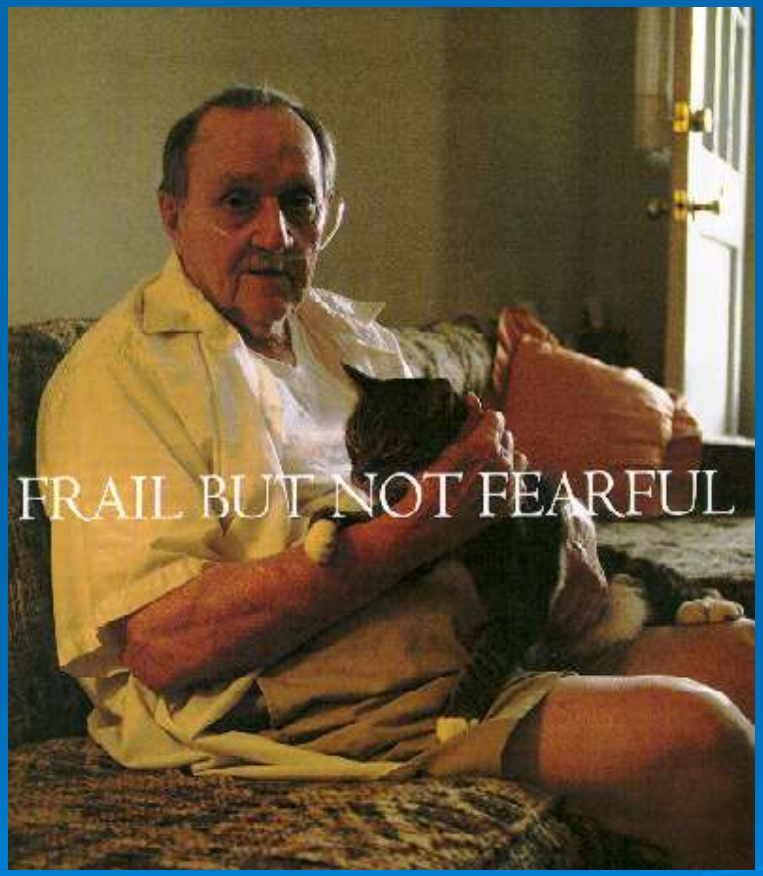
Outline

- Why Hospital at Home and what it is
- Hospital at Home at Presbyterian Health Systems
- Lessons for other health systems

Why We Need Hospital at Home



- Walter, 82, lives with his cat
- COPD, Hypertension, CHF
- Multiple medications
- Multiple hospital admissions

Walter's Gripes About Hospital Care

- "I can't get nebs on time so I end up on the tube"
- "Food stinks"
- "Wake up in middle of night and can't get to bathroom"
- "No one talks to me"
- "I get confused –get tied down"
- "I always come home with a completely new set of medicines"

- Walter got sick again – "I WON'T GO TO THE HOSPITAL"

How Hospital at Home Can Help

Homeward bound

Snapshot of the Hospital at Home process

Assessment

Patient presents to ED. Clinicians determine patient has acute illness that could be treated at home. Patient chooses home-care option.

Transport

Patient transported home accompanied by nurse or physician with appropriate medications and equipment, including oxygen, if necessary.

Home care

Nurse remains with patient in

Discharge

Nurse provides instruction about medications, follow-up care, sends letter to primary care physician.

Source: *Watch* interview, 5/8/06; Naik, *Wall Street Journal*, 4/19/06; Leff et al., *Annals of Internal Medicine*, December 2005.

Hospital at Home basics

- Hospital at Home: a substitutive program for inpatient hospitalization
- Patients meet inpatient criteria
- Diagnoses: CAP,CHF,COPD, Cellulitis, UTI / urosepsis, DVT/stable PE, N/V/Dehydration
- Patients receive MD,RN, Home Health aide and telehealth visits. IV infusions, O2, labs, ECG, x-rays performed in the home.

Johns Hopkins Hospital At Home National Demonstration & Evaluation Study

Johns Hopkins University
School of Medicine & Public Health

Fallon Community Health Plan, Worcester, MA
Independent Health, Univera Health, SUNY Buffalo
Portland Oregon Veterans Administration Medical Center

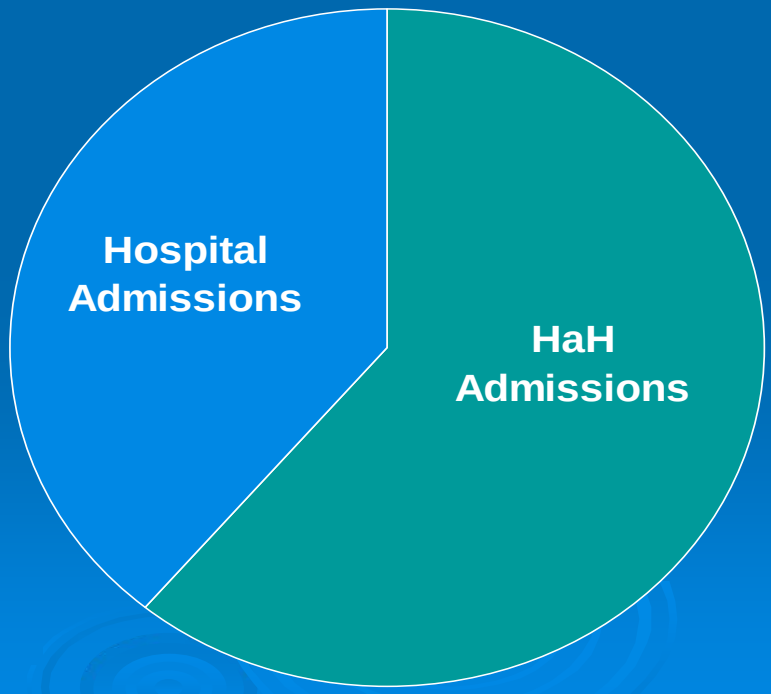
Annals of Internal Medicine 2005;143:798-808

Annals of Internal Medicine | Improving Patient Care

Hospital at Home: Feasibility and Outcomes of a Program To Provide Hospital-Level Care at Home for Acutely Ill Older Patients

Bruce Leff, MD; Lynda Burton, ScD; Scott L. Mader, MD; Bruce Naughton, MD; Jeffrey Burl, MD; Sharon K. Inouye, MD, MPH; William B. Greenough III, MD; Susan Guido, RN; Christopher Langston, PhD; Kevin D. Frick, PhD; Donald Steinwachs, PhD; and John R. Burton, MD

- 61% chose HAH care
- HaH is feasible and efficacious
- High-quality care
- Fewer complications
- Higher satisfaction
- Less caregiver stress
- Lower costs of care



Hospital at Home at Presbyterian Healthcare Services

A healthcare model for the future

- and for now

Presbyterian Healthcare Services

- New Mexico's only private, not-for-profit healthcare system
- State's largest managed care organization providing commercial health insurance, Medicaid and Medicare products to over 450,000 members
- PHS hospitals, physicians, caregivers and insurance plans serve more than 710,000 patients and health plan members and care for one in three New Mexicans
- The Presbyterian Medical Group (PMG) offers 34 locations statewide, has > 500 practitioners, and its clinics provide more than 1.2 million annual patient visits

Why PHS Was Interested in HaH

- PHS as an integrated delivery system has the ability to manage and improve health across the continuum
- Is interested in innovative models of care delivery even those that are disruptive
- Bed Capacity issues in major service area --Albuquerque
- Prevalence of an aging population with chronic disease—CHF, COPD, CAP
- Proof of HaH care being safer for vulnerable chronically ill patients—less falls, less delirium, less infections, etc
- Patient and family satisfaction
- Met mission and strategic objectives to provide high quality, safe and affordable care

PHS HaH Care model

- Substitutive model for hospitalization—an alternative to traditional hospital admission for 3 dx mostly likely to be a source of hospitalization and re-hospitalization: CHF, COPD, CAP—later added Cellulitis, DVT/stable PE, N/V/Dehydration, UTI/Urosepsis.
- Admit patients from ED, home health, clinics and early hospital discharge.
- Must live within 25 miles of ED: ability to return to ED
- Voluntary program
- Provide minimum of 1 MD visit, 1-2 RN visits, 1-2 aide visits daily and 24 hour call coverage
- Telehealth video used to monitor patients
- DME, oxygen, medications, diagnostic services, transportation provided by vendor partners
- Average length of stay 3-5 days
- Discharge to Home Health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Summary of Program performance

- Clinical Indicators
  - All are equal or better than hospital:
    - CMS reportable clinical indicators are at 100 % of pts verifying that have received pneumovax, fluvax
    - Antibiotic timely receipt with CAP are at or better than inpatient performance
    - Receipt of ACE and ARB in CHF are at or better than inpatient performance
- Customer Loyalty
  - 2010 Patient Satisfaction mean score via Press Ganey HaH Hospital CAHPS survey was 94.5 (Q3 2010)
- Financial
  - 2010 HaH variable costs per stay are $1000-$2000 less than comparable inpatient stay costs by diagnosis
    - ALOS 3.5 days
    - Not reimbursed by Medicare
    - Provided to Health Plan patients as a benefit (managed Medicare and Medicaid)
    - Payor Mix is 90-95% capitated ; other 5-10% are Health Plan but not capitated

2011: Improving Access

- ER triage “after hours”
  - RN stationed in ED to to find and coordinate care in Hospital at Home, Hospice or Home Health Care.
  - 2-11pm daily
  - Works with physician (Hospital at Home or Hospice Medical Director) in assessing and admitting patient to above service.
  - Reports nightly—assures follow up on patients still undergoing workup

2011: Medical House Calls

- MD/NP visits for home health patients to prevent ER visits or rehospitalization. Urgent visits < 24 hours.
- Can deliver acute care—IV infusions, labs, x-rays if needed.
- Developing into Medicare “equivalent” of Hospital at Home.

2011: Transition of Care

- Pilot in July 2011for home health patients
- Based on Naylor and Coleman
- Collect data on rehospitalized patients from Hospital at Home
- Develop customized transition of care program.
- Ultimately to coordinate inpatient hospital care coordination.

Our Future in Preventing Hospitalization and Re-Hospitalization

- The value of an integrated health system: a multi-faceted approach to complex patient care
  - Hospital at Home/Medical House Calls
  - Home Healthcare Agency
  - Inpatient and Outpatient Hospice
  - Inpatient and Outpatient Palliative Care

Questions?

HaH Payment Methodology

- Hospital at Home is paid by a DRG (diagnosis-related group), rather than accessing home health benefit.
- Mimics the hospital payment methodology
- Episodic payment methodology started November 1, 2011
- HaH will share DRG payment if patient taken from hospital.