ESSENTIAL HOSPITALS ADVANCE EQUITY THROUGH HOSPITAL-AT-HOME MODEL

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KEY FINDINGS

- Hospital-at-home initiatives can decrease mortality, lower health care costs, and improve patient satisfaction but historically have operated on only a small scale, due to a lack of reimbursement.
- Providing hospital-level care at home through the Centers for Medicare & Medicaid Services (CMS) Acute Hospital Care at Home waiver has helped manage case surges during the COVID-19 public health emergency (PHE).
- Federal policymakers have shown interest in extending beyond the PHE the hospital-at-home waiver program, which supports more than 200 hospitals in 34 states.
- Essential hospitals across the United States have leveraged hospital-at-home programs to create capacity while also addressing social determinants of health and improving equity.

BACKGROUND

Delivering hospital-level care in a patient's home has been a standard medical practice in the United States for decades. For qualifying patients, hospital-at-home models can replace care otherwise given in an inpatient setting. However, lack of reimbursement from both public and private payers hindered wider adoption of such programs.

In the 1990s, a physician from Johns Hopkins University School of Medicine conducted a pilot study to evaluate the effects of providing acute care in a home setting.[1] A subsequent multisite demonstration study was limited to individuals with a specific set of conditions who were beneficiaries within Medicare managed care or patients of a Department of Veterans Affairs medical center. The demonstration showed promising results—those who participated had lower mortality rates, lower costs, and higher satisfaction, as patients were able to stay close to their support networks with less disruption to their lives.[2]

For more than 25 years, small-scale efforts to implement hospital-at-home programs have varied in scope and practice, but often include:

- management of acute-care conditions;
- daily visits from an acute-care team comprising doctors, nurses, and social workers; and
- use of telehealth to provide care and connect with patients.

In 2014, CMS funded a Healthcare Innovation Award to Mount Sinai Hospital, in New York, to test hospital-at-home programs with 30 days of post-acute transition services. The bundled-payment model included performance-based adjustments tied to cost and quality metrics.[3] In 2017, the Physician-Focused Payment Model Technical Advisory Committee, an independent federal advisory committee that makes recommendations to the Department of Health and Human Services, recommended implementation of the model. The committee also articulated a need for CMS to initiate a Medicare payment model to provide home-based, hospital-level acute care for carefully selected patients.[4] CMS did not act on this recommendation.

CMS WAIVER

The COVID-19 PHE drastically impacted health care access and delivery. As hospitals across the

nation exceeded capacity due to rising COVID-19 hospitalizations, CMS in March 2020 announced the Hospitals Without Walls program, which provides broad regulatory flexibility allowing hospitals to offer services in locations beyond their existing facilities. In November 2020, the agency expanded this effort, announcing the Acute Hospital Care at Home (AHCaH) initiative to aid hospitals reaching capacity, experiencing supply shortages, and treating infected patients.

The AHCaH initiative allows Medicare-certified hospitals to treat patients with inpatient-level care in their homes.[5] This CMS waiver initiative is the first example of payment for this level of care for Medicare fee-for-service and Medicaid non–managed care beneficiaries. As part of the initiative, CMS waived certain hospital conditions of participation (24-hour, onsite nursing services and the immediate availability of a registered nurse) on an individual basis to allow acute hospital care in the home. To ensure patient safety, the AHCaH waiver includes monitoring and reporting requirements, such as:

- having appropriate screening protocols;
- admitting beneficiaries only through emergency department and inpatient hospital beds;
- having daily evaluations, either remotely or in person;
- conducting two in-person visits per day by nursing or integrated health paramedics; and
- collecting and reporting quality metrics.

The AHCaH waiver does not change payment or reimbursement—hospitals bill as they normally would under Medicare for an inpatient stay. For essential hospitals, the AHCaH waiver provides an alternative care setting for their patients—often those of lower socioeconomic status, with comorbidities and social needs that impact health outcomes. There is significant interest from hospitals nationwide to engage in this type of care delivery. As of early March, 204 hospitals across 34 states were approved for AHCaH waivers.[6] However, given that the model is authorized through CMS' emergency use power, the waiver is tied to the current COVID-19 PHE and will expire once the PHE ends.

ADDRESSING EQUITY THROUGH HOSPITAL-AT-HOME

Hospital-at-home programs can shorten lengths of stay, lower rates of readmission, improve patient experience, and reduce adverse events.[7,8] Further, they are effective in a variety of settings and patient populations, and their benefits are far-reaching.[9] For some, the hospital-at-home experience takes place in their permanent residence; for others, care might be delivered in a group home or an informal shared living situation. Delivering care where patients live is as varied as the people and neighborhoods served by a hospital providing the care.

Providing hospital-level care at home has not only been an essential tool to handle case surges during the COVID-19 PHE, but this type of care delivery also can improve access and equity outside of a public health crisis. Hospital-at-home programs offer a new vehicle for integrating nonmedical, social needs (e.g., internet access, nutritious food) into acute care.[10] The ability to provide care in the home presents a unique opportunity to treat a patient's clinical diagnosis while addressing social determinants of health that can impact outcomes.

ESSENTIAL HOSPITAL CASE STUDIES

The MetroHealth System: Leveraging Technology

In Cleveland, The MetroHealth System has treated more than 900 patients through its hospital-at-home program. The concept of providing care for patients where they are most comfortable was envisioned before the COVID-19 pandemic and formalized during the PHE.

CMS approved MetroHealth's hospital-at-home program in April 2021 under the AHCaH waiver. Leveraging a Federal Communications Commission grant, the health system purchased tablet computers and remote patient monitoring kits for patients in the program and provided access to broadband to mitigate the digital divide and ensure connectivity.[11]

MetroHealth acknowledges this type of care delivery is a long-term commitment, requiring ongoing infrastructure to continue growing the program's capacity. For example, when patients are "discharged" from the hospital-at-home program, a care team of diverse providers across the health system assists the patient in transitioning to post-discharge care,

from connecting them to a primary care provider to ensuring access to respiratory therapy or other necessary services. For marginalized and underserved patients, the successful transition from one level of care to another, or from one setting to another, requires careful attention to patient care goals and treatment preferences, in combination with social needs. Having access to the entire health system allows patients in the hospital-at-home program to stay connected to care and better manage chronic conditions.

UMass Memorial Health: A Focus on Medicaid Beneficiaries

In August 2021, after significant program investments and CMS waiver approval, UMass Memorial Health, in Worcester, Mass., admitted the first patient into its hospital-at-home program. As a health care system with a safety net mission, UMass Memorial cares for more than half of Medicaid beneficiaries in the region, making it imperative its hospital-at-home program provides equitable access to this patient population.

Since the UMass Memorial hospital-at-home program began, 25 percent of its patients have been Medicaid beneficiaries, and the percentage dually eligible for Medicare and Medicaid (typically the most socioeconomically disadvantaged populations) has been about a third more than for all AHCaH waivers nationally, as reported by CMS.[12,13]

Hospital-at-home programs are associated with fewer 30-day readmissions and emergency department visits among Medicaid beneficiaries, indicating hospital-level services in the home might be particularly impactful for Medicaid beneficiaries.[14] At UMass Memorial, the 30-day readmission rate among hospital-at-home patients for whom Medicaid is the primary payer is nearly 75 percent lower than for their counterparts admitted to the hospital's brick-and-mortar facilities. This successful outcome could reflect greater trust between caregivers and patients and families and, in turn, heightened awareness of and attention to challenges posed by social determinants of health.

To facilitate equitable access to Medicaid and dual-eligible beneficiaries, UMass Memorial treated patients living in varied home environments, including single-room occupancy units, group homes, and informal shared living situations. Hospital care in the home provides a unique opportunity to understand patients' social context and to identify barriers to health, such as challenges with medication adherence, worsening memory impairment, and resource limitations. UMass Memorial meets the clinical and social needs of its patient population through the hospital-at-home program by providing food, wirelessly enabled monitoring technology, and video translation services, among other services. Hospital-at-home can be effective beyond the PHE for marginalized patients, including Medicaid beneficiaries.

University Health: Specialized Care at Home

In February 2021, University Health, in San Antonio, received approval from CMS to provide acute, hospital-level care at home. Since the first patient entered the program, the initiative has freed up more than 1,100 hospital bed days using technology that enables patients to stay connected and receive personalized care in the most personal setting: their home.

Patients in the program include COVID-19 patients and those needing neurology, transplant, postpartum, podiatry, and postsurgical care. They have conditions that require hospital-level care but are stable enough to be monitored from home. Patients receive at least two in-person visits daily in addition to telemedicine visits with health care providers. In a nonhospital setting, patients often are happier because they can move about more freely, sleep in their own beds, and receive social support from loved ones. Patients report being less fatigued, more alert, and more engaged in their care—and healing faster, as a result.

As an essential hospital, University Health understands barriers to care exist regardless of the care delivery model. For this reason, internet access is not a requirement: The program equips patients with cellular-enabled tablets and Bluetooth-connected medical equipment that allows for intermittent and continuous remote monitoring of vital signs and patient activity and connects patients to providers for telemedicine visits. Brochures for the hospital-at-home program are offered in English and Spanish to ensure equitable access, and patients are accepted to the program regardless of their insurance status.

Atrium Health: A Data-driven Approach

In the first days of the COVID-19 PHE, Atrium Health, in Charlotte, N.C., rapidly launched its hospital-at-home program, leveraging technology with the health system's mobile integrated health team. The initiative immediately increased hospital capacity, enabling Atrium to provide high-quality care to many patients with COVID-19. To date, the program has cared for nearly 4,500 patients, saving the health system more than 18,000 bed days. The program also has expanded beyond COVID-19 to care for patients with chronic conditions, such as congestive health failure and chronic obstructive pulmonary disorder, as well as acute, episodic conditions, such as pneumonia.

Over time, the health system recognized a lack of templates for how to effectively implement and rapidly scale virtual strategies for providing hospital-level care at home. Through data sharing, Atrium has provided insights and best practices for other hospitals interested in this type of care delivery.[15,16,17] For example, providers need data-driven guidance on who is most appropriate to safely receive hospital-level care in their home. To assist with decision-making, Atrium developed templates for data-driven patient identification and eligibility assessments, patient- and provider-facing information, health information technology integration, and workflows that mirror traditional inpatient care to manage patients in the hospital-at-home program.

Atrium's research highlights the importance of critically evaluating care innovations, such as the AHCaH initiative, and growing its supporting evidence so it becomes a widely accessible, patient-centric, affordable care option for patients.

CONCLUSION

The ACHaH waiver program immediately impacted hospital capacity when hospitals needed flexibility and patients sought alternatives to hospital-based care amid the rise of COVID-19. The long-term benefits of hospital-at-home programs have yet to be fully realized, due in part to the uncertainty providers face in Medicare reimbursement. However, data show these programs can improve quality, lower costs, and increase patient satisfaction. Further, as the case studies in this brief demonstrate, hospital-at-home programs can serve a broad array of patients, including Medicaid beneficiaries and the uninsured. These patients often require management of multiple chronic conditions, as well as social needs that impact their health and well-being.

This level of care must remain available after the end of the COVID-19 PHE. There is bipartisan support for continuation of the CMS waiver program—America's Essential Hospitals supports legislation introduced in March 2022 to extend the waiver program two years beyond the end of the COVID-19 PHE. The legislation highlights the continued success of hospital-at-home programs and the benefits of implementing a permanent version of the program.

Endnotes

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