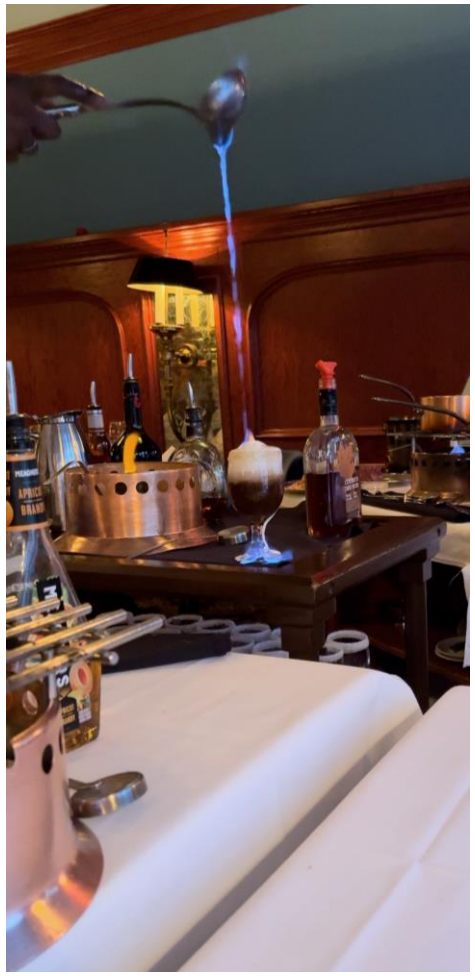
No New Buildings Prescribing the Home for Life with Hospital at Home

Scott Willits, ACP, CP

MIH/CP Advocate, Researcher, & Gary's Assistant

Home Health or Health at Home



Home Health or Health at Home

WORLD HOSPITAL AT HOME CONGRESS™
27-29 March 2025 | Vienna, Austria

HaH is:

- Subject to regulatory and governance obligations;
- Care hospital directed and/ or by specialist physician/s;
- Episodic;
- 24/7;
- Fully responsible for the patient – provides all medical, nursing, allied care; observation, diagnostics and therapeutics during the episode at home.

HaH is not:

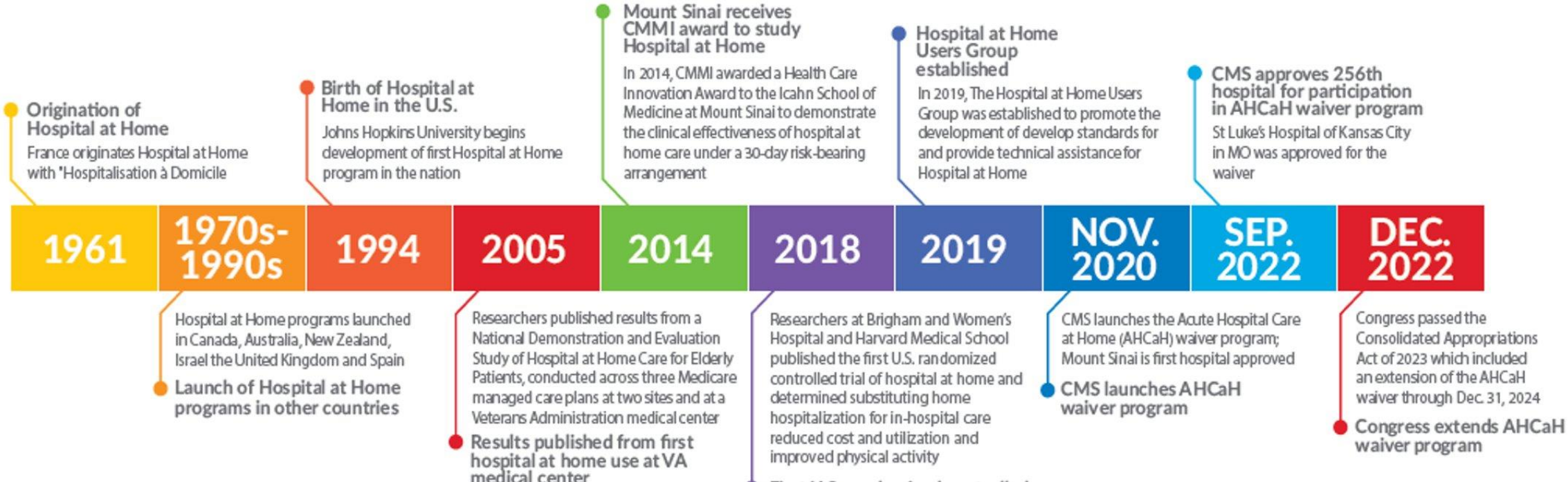
- Outpatient care (thus, not self-administered intravenous treatment, and not OPAT);
- A hospital prevention program;
- A community-based chronic disease management program;
- Solely virtual care or remote telemonitoring;
- Day facility-based treatment;
- Primary home care;
- Community nursing or standard skilled home health care;

Myth or Reality

No Place Like Hospital at Home

Hospital at Home (HaH) was introduced as a model of care over 50 years ago, and has spread across the world since then. The implementation of HaH in the U.S. began at Johns Hopkins School of Medicine in 1994. In November 2020, the Centers for Medicare and Medicaid Services (CMS) launched the Acute Hospital Care at Home (AHCaH) waiver program. As of March 2023, this waiver has enabled over 275 hospitals across 115 health systems and 37 states to adopt HaH programs in the U.S. with the following goals: to improve clinical outcomes, reduce hospital readmissions, improve patient safety and experience, and prioritize patient choice.[1]

HISTORY OF HOSPITAL AT HOME



Myth or Reality

Deloitte. Services Industries Careers

Article

Hospital at Home – A model with a future

Home care has been firmly established in Switzerland for some time. Organisation
Spitex provide a comprehensive range of home care services. In contrast, the conc
Hospital at Home is still in its infancy. How will this change in the coming years? We have
explained this in a white paper based on specialist literature and insights from various expert
discussions.

NSW GOVERNMENT NSW Health

Careers Public Healthy living

Home > System sustainability and performance > Hospital in the Home (HITH)

System sustainability and performance

Hospital in the Home (HITH)

MAY 17, 2022

Hospital at Home receives National Excellence in Patient Experience Award

Hospital At Home

HOSPITAL IN YOUR HOME

Swiss HOSPITAL at HOME Society

Hospital In The Home
HITH Society Australasia Ltd.

Building hospital at home

Hospital At Home

Innovative 'Hospital at Home' initiative helps to save NHS more than 2,000 hospital bed days in south west London

Will hospital-at-home system be better for Irish patients?

Stephen Donnelly announces rollout for next year of a 'virtual ward' programme for patients of two public hospitals

This U.K. team brings hospital care into homes. Could more of these programs help Canada?

Convincing Canadians that hospital-at-home care is viable is an 'uphill battle,' says one expert

Jonathan Ore · CBC Radio · Posted: Mar 23, 2023 5:45 PM EDT | Last Updated: March 28

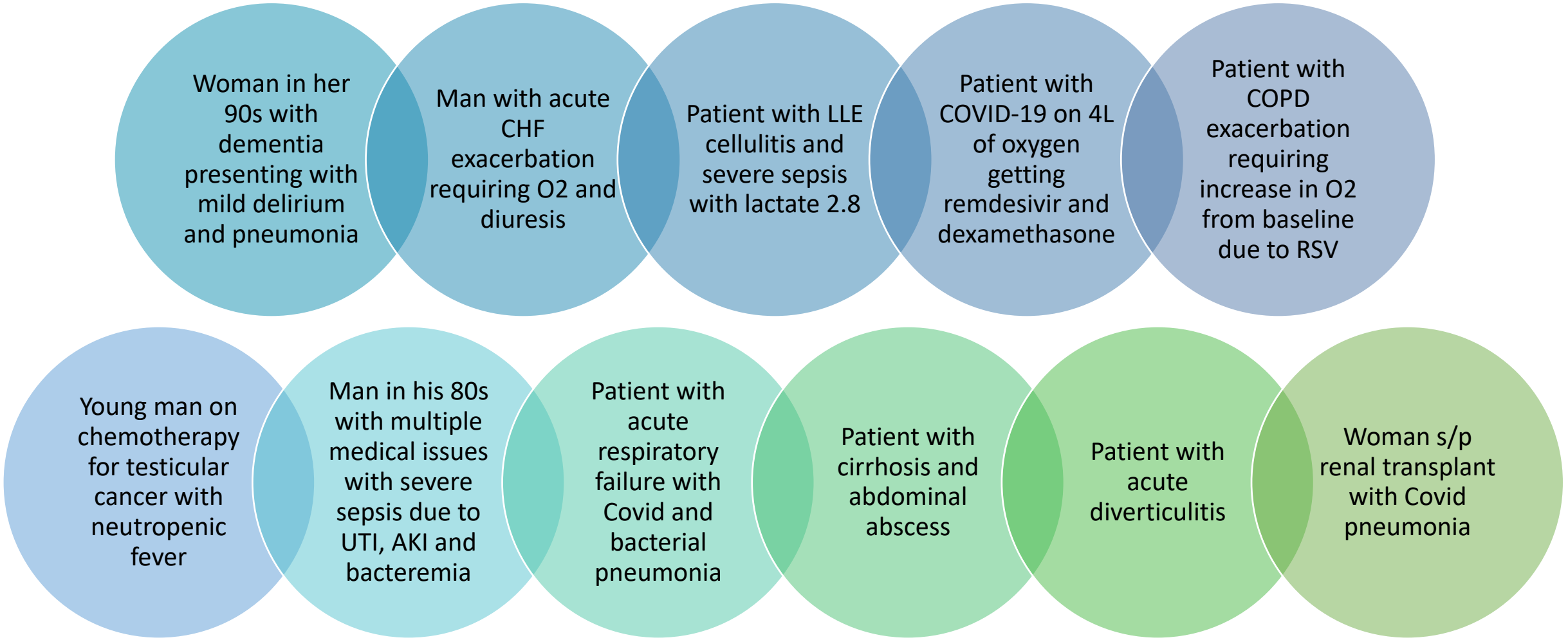
Dr. Dan Lasserson and registered nurse Davinia Newell perform an ultrasound on patient Joan Baxter in February as part of the Acute Hospital At Home program, which is based out of the John Radcliffe Hospital in Oxford, U.K. (Brian Goldman/CBC)

WORLD HOSPITAL AT HOME CONGRESS

State Campaign for Hospital at Home

Hospital AT Home USERS GROUP™

Myth or Reality



Myth or Reality

LOWER READMISSIONS

9 Randomized Clinical Trials assessed 959 adult patients with chronic conditions. Patients who received HaH care had statistically significant lower 30-day readmissions, lower Emergency Department revisits, and lower risk of long-term care readmissions.[3]

FEWER INFECTIONS

Representative HaH programs have reported <1% Hospital Acquired Infection (HAI) rates in 2022, significantly lower than national average of 8.6%.[4]

LESS DELIRIUM

Studies from 2005 through the present report 9% delirium in patients receiving HaH care compared to 24% delirium from brick-and-mortar hospital care.[5]

REDUCED SNF ADMISSIONS

A meta-analysis determined that HaH care led to a statistically significant reduction in patient discharges to a skilled nursing facility (SNF). HaH care was affiliated with a 1.7% SNF discharge rate vs. the 10.4% average brick-and-mortar SNF discharge rate.[6]

LOWER UNEXPECTED MORTALITY

Data suggests that an estimated 3.1% of inpatient deaths are preventable.[7] In a recent paper published on the CMS waiver experience, researchers evaluated nearly 1900 patients who received HaH care from 2020-2021 and found an overall unexpected mortality rate of 0.43%, which is lower than reported rates for traditionally hospitalized patients.[7]

PREFERRED CARE MODEL

A 21-year long longitudinal analysis from 1995 - 2016 assessed patients in 25 systematic reviews with serious medical conditions who had received HaH care compared to inpatient hospitalization. Results showed higher patient and caregiver satisfaction with HaH care compared to traditional inpatient hospital care.[8]

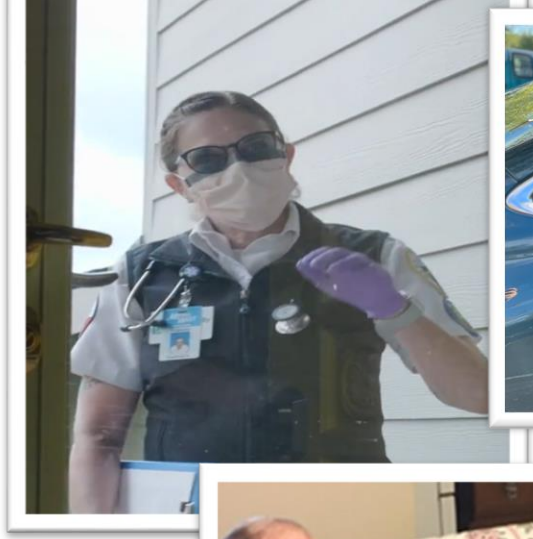
PATIENTS ARE MORE ACTIVE AT HOME

A randomized controlled trial conducted by Harvard Medical School compared HaH care with traditional inpatient care. Results showed improved physical activity in patients who received HaH care vs. brick-and-mortar care and improved patient satisfaction.[9]

- Proportion of the day sedentary: 12% HaH vs 23% in brick-and-mortar hospital
- Proportion of the day lying down: 18% HaH vs. 55% in brick-and-mortar hospital

Community Paramedics.
You Call, We Care.

Formulary Medications	Determinants of Health	Medication Reconciliation
Physical Assessment	**Mobile Integrated Health**	Medical Literacy
Phlebotomy		Resource Referral
Point of Care Testing	Home Environment Assessment	Wellness Exams
Diagnostic Testing	Cognitive Assessment	Follow Up Care
Fall Risk Assessment	Skin Assessment	Care Management



Ms. J.S.

J.S. is a 40 yr. old woman with graft versus host disease (GVHD) of her lungs following a stem cell transplant for Acute Myeloid Leukemia.

Due to her GVHD, she has been admitted and intubated three times.

Though her condition was worsening, and she had been holding out to see her two children graduate.

Soon after she took another downturn and agreed to be DNR but declined hospice.

Ms. J.S.

Then one evening Her sister called as J. was becoming increasingly short of breath.

She wanted to call 911 but knowing her sister did not want to return to the hospital, she was reaching out for help.

After discussion with her MIH team, we agreed she needed a vascular access, and IV ABX.

Treatment Plan:

- Vascular Access
- Q6H IV Antibiotics
- Pain Management (IV Morphine)

Ms. J.S.

2-weeks later, Ms J.S. was enrolled in Home Hospice.

Community Paramedics provided scheduled assessments Q48hrs and remained available for unscheduled, acute responses for patient or family needs.

Community Paramedics were activated three times for increased pain, dehydration, and post-fall evaluation.

Over 10 days, Ms. J.S. remained in the home with comfort and pain management available.

Ms. Cindy-Lou

- Primary Care at Home:
  - A coordinated Community Paramedic in-home visit with the virtual Primary Care Clinician for a wellness physical and general assessment.
- Post Cardiac Discharge Program:
  - A coordinated Community Paramedic in-home visit with the virtual Cardiology Clinician for a wellness physical and targeted assessment every 3-5 days.
- Palliative Care Community Paramedic Program:
  - A coordinated Community Paramedic in-home visit with the virtual Palliative or Hospice Clinician every 5-7 days or same-day urgent visit.
- Hospital at Home:
  - A partnership of a virtual clinical team and local Community Paramedics with 2-3 appointments per day to fulfill the treatment plan.

Ms. Cindy-Lou

67-year-old female.

Retired after 39 years teaching in the public schools.

Fixed income with government assisted living.

Spouse passed away 10+ years ago with no immediate family in the area.

Myocardial Infarction x 3 (2017, 2019, 2022)

Congestive Heart Failure (LVEF <40%)

AV Block, Complete (2022)

Hypertension

Severe Obesity

No history tobacco use

History of alcohol addition, 20+ years sober

Physical activity is seasonal (spring-summer)

Ms. Cindy-Lou

Myocardial Infarction #1 — **2017**

2017-2019 — **9 Admissions for Exacerbated CHF (B&M). ALOS = 22 midnights.**

Myocardial Infarction #2. Enrolled in Post Cardiac Discharge Program x 30 days. — **2019**

2019-2020 — **7 Admissions for Exacerbated CHF (B&M). ALOS = 13 midnights. Enrolled in Post Cardiac Discharge Program x 30 days.**

4 Admissions for Exacerbated CHF (Hospital at Home). ALOS = 8 midnights. Enrolled in Post Cardiac Discharge Program x 30 days. — **2020-2022**

2022 — **Myocardial Infarction #3 + pacemaker. Discharged to Palliative Care Community Paramedic Program.**

Ms. Cindy-Lou

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Bring Health Home,

and Prescribe The Home,

For Life.

"It's about time healthcare comes to you." - J.S.

Scott Willits, ACP, CP