Bringing the Hospital Home & Private Duty Homecare

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Hospital at Home: Patient Care Model of the Future?

Hospital at Home is a pioneering healthcare model that allows for acute hospital-level care to be provided to elders in the comfort of their homes.

Caring for older adult patients in their homes has been shown to improve patient care and reduce healthcare spending. Additionally, at-home visits allow physicians to treat patients where they are most comfortable and assess their living situations. Since the 1940s, the number of physician house calls had continued to decline. In 1998, however, Medicare increased its reimbursements for house calls to about 50%, which incentivized an increase in the number of house calls performed by family practitioners, geriatricians, and internists.

Benefits of a Hospital at Home Program

- Hospital at home programs that enable patients to receive acute care at home have proven effective in reducing complications.

- You find out things in patients’ homes that you never would’ve picked up in the hospital. You also realize the limitations that people have when they’re hospitalized and the patients’ needs when they’re transitioned back home. You see how people function, why things don’t get done, why the system doesn’t work for people, and why things do work out great—easy things you never see working in the physician office.
Hospital at Home Program Outcomes

- Compared to similar hospitalized patients, Hospital at Home patients experience better clinical outcomes: lower rates of mortality, delirium sedative medication use, restraints. Better satisfaction of patient and family, less caregiver stress, better functional outcomes.

- Cost savings of 19% to 30% compared to traditional inpatient care

- Lower average length of stay

- Fewer lab and diagnostic tests compared with similar patients in acute hospital care

- Advances the Triple Aim of clinical quality, affordability and exceptional patient experience.

Which Patients Are Good Candidates for Hospital at Home?

Patients with illnesses including community-acquired pneumonia, congestive heart failure, chronic obstructive pulmonary disease (emphysema), cellulitis, volume depletions / dehydration, urinary tract infection / urosepsis, deep venous thrombosis and pulmonary embolism, as well as others are good candidates for Hospital at Home.

These conditions are treatable in the home, and typically account for a sizeable portion of hospital admissions among older persons. Hospital at Home patients may be admitted from various clinical sites: the home, an ambulatory setting, or the emergency department.

However, not all older patients who require hospital admission for these illnesses are appropriate for Hospital at Home. A patient must meet the medical eligibility criteria to be suitable for Hospital at Home care.

Research suggests that approximately 30 percent of older patients with these conditions are appropriate for Hospital at Home care. These patients require hospital-level care, but are at a low risk of clinical deterioration with proper care, and are less likely to require highly technical hospital-based procedures.
An emergency department or community physician identifies a patient who is sick enough to be hospitalized but stable enough to be treated at home. Narrowly defined eligibility criteria help distinguish patients who need intensive services and/or multiple visits from specialists—and therefore should be treated in hospital settings—from those whose needs may be met at home by visiting physicians, nurses, and other clinical staff. Conditions with defined treatment protocols, such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), community-acquired pneumonia, and cellulitis, are a natural fit.

- The suitability of the home is assessed to confirm it has air conditioning, heat, and running water.
- Responsibility for care is assigned to a physician.
- A greeter meets the patient in the emergency department or elsewhere to discuss the program, arrange transportation, and deliver the biometric and communication devices that will be needed to oversee care.

A caregiver meets the patient at home and a physician—either in person or via video—explains the treatment protocol. Orders are written, care pathways are enacted, and clinical staff, including respiratory therapists, physical therapists, and other caregivers arrive as needed to administer intravenous medications and fluids, provide nebulizer treatments, and conduct tests, including ultrasounds, X-rays, and electrocardiograms. Meals are arranged if necessary. The patient’s vital signs are monitored electronically.

- The physician visits the patient daily, or in some models, communicates with the patient via telemedicine equipment. To capture any decline in the patient’s condition when clinicians are off site, providers monitor patient using telemedicine equipment.

- Once the patient is stabilized and well enough to return to activities of daily living, he or she is handed off to his or her primary care physician. In one model, providers maintain oversight of the patient for at least 30 days, to ensure he or she is keeping appointments and is not suffering any adverse consequences. During this period, the physician provides updates to the patient’s primary care physician.
READY FOR HOSPITAL AT HOME?

Organizations seeking to adopt innovative care models often need to develop new systems and roles while overcoming resistance to change. To successfully implement Hospital at Home you need to ensure that the conditions at your facility are right and that needed resources are readily available.

Ask yourself the following questions:

• Is your local health system experiencing problems from a lack of hospital capacity?
• Does your local health system have established home health care delivery capabilities?
• Do you have physicians with the interest and ability to care for patients in the home environment?
• Does your local health system experience a large volume of Medicare admissions for common problems such as community-acquired pneumonia, heart failure, or chronic obstructive pulmonary disease?
• Does your institution view itself as an innovator in developing and implementing new models or systems of care?

SO ARE YOU READY TO IMPLEMENT A HOSPITAL AT HOME PROGRAM?

• If you answered “Yes” to one or more of the questions on the previous slide, then Hospital at Home may be appropriate for your organization.
There has never been a more exciting or challenging time to provide care at home. With progressive changes in the Post-Acute care environment and need to avoid unnecessary transitions in care, Private Duty agencies will be called upon to help provide ever more aggressive interventions outside the hospital.

Are you prepared?

Advanced care in the home requires a complete interdisciplinary approach.

Understanding The Administrative Burden

- Addressing the Issue of Cost.
  - Can you afford to do this?
  - Can you afford not to?

- On Call Staff: a “Ready to Go” mentality (which means more on-call pay)

- “Ready to Go” staff means having staff ready to care for the sickest of the sick which requires increased education and training.

  - CHF Certifications
  - Wound Care Certifications (Understand RN Delegation Requirements, staff Private Duty Nurse)
  - Ostomy Certifications
Bringing the Hospital Home

The goal is to provide hospital-level care for high acuity patients & conditions at home, thus eliminating the need for ER & hospitalizations.

How do we get there:

- Collaboration with Discharge Planners to ensure all discharge needs are met
  - Meds to Beds Program
  - DME Arrival
  - OTC Medications (Tylenol, Stool Softeners, Etc.)
- Specialty Chronic Disease Programs
  - Not just booklets w/ tear out pages: “Beef Up” chronic disease education so your caregivers know what to expect without panicking.
  - Caregiver Certifications: Dementia, CHF, COPD, Chronic Pain, Etc.
- Care Team Meetings: Allow caregivers to know who to call when things get rough.
- Check List of Care Providers: Home Health, Hospice, House Call Providers, or Palliative/Advanced Care Providers for urgent care visits that come to the patient versus panicking and calling 911.
- Advanced Care Planning: Having the tough conversations and understanding patient goals. Ensuring your caregivers understand fully the differences in Advanced Directives.
Can't MASK our GRATITUDE for everything you do!