Acute Hospital Care At Home Program Frequently Asked Questions

What resources are available to organizations interested in treating Acute Hospital Care at Home patients?

At the bottom of the FAQ is a link to a large group of health systems currently providing this care which is developing free materials to assist with creating programs and meeting the requirements of the waiver. There are also links to several private firms which could be used to support your program.

Waiver Applications

1. **Is the acute hospital care at home program required to be part of a hospital?**

   A program does not have to be physically administrated within a hospital, but a hospital must accept responsibility for the program in order to satisfy the Conditions of Participations for this level of patient care. Additionally, the program must be integrated within a hospital to a sufficient degree to ensure that rapid escalation of care is seamless.

2. **Who can I contact with questions?**

   We encourage our partners to take advantage of the list of resources compiled by CMS and found below.

3. **Did all of these services have to be provided to the 25 patients who we have enrolled in order for our program to be considered experienced**?

   Not all services need to have been provided to 25 patients in order to be considered experienced. CMS anticipates that a variety of diagnoses will be treated by hospitals in their Acute Hospital Care at Home programs, and the expectation is that at least 25 patients who qualified for inpatient admission have been treated in a high quality manner prior to the waiver request.

4. **Would a program be considered if it has served a significant number of patients that varies between 1-2 in person visits a day? What is the flexibility level?**

   If a program has served inpatient acute care patients in the past with only 1 in-person visit per day and has done so with high quality results, these cases would be counted toward the 25-patient experience level. However, regardless of the hospital's past policies, each hospital acting under this waiver must comply to the requirements in the request template.

5. **Scenario: Our Hospital at Home Program has cared for over 80 patients within the past 2 years. We admit our patients directly from their homes into our H@H program. We use an accepted leveling process to determine level of care. Would we be considered the first or second waiver request?**

Experience treating inpatient-level patients with an accepted patient leveling process can be used to qualify for the expedited/experienced waiver request pathway. If approved, your hospital will need to adjust its admission policies to meet those listed on the waiver request template.

6. **If my hospital system has multiple hospitals providing acute hospital care at home, should I submit a waiver request for each hospital?**

   Yes. CMS monitors inpatient care at the hospital level, and a separate waiver request is required for each facility. However, if the services are run by the same group within a health system, CMS understands that each request could appear very similar.

7. **Does my organization have to report to OASIS to participate in the Acute Hospital Care at Home initiative?**

   No, this program is designed for patients who meet acute inpatient or overnight observation admission criteria for hospital-level care. The patient's home is considered part of the hospital during the admission.

8. **Is there a deadline for applying for waiver requests?**

   No, there is not a defined deadline. However, this waiver is only in effect for the duration of the COVID-19 Public Health Emergency.

Admission and Location of Care

1. **Do all patients need to enter the Acute Hospital Care at Home program from brick and mortar hospitals?**

   Yes, all patients must enter Acute Hospital Care at Home from either an Emergency Department or an inpatient hospital setting.

2. **Does the patient's home in Acute Hospital Care at Home meet the hospital physical structure requirements in the Hospital Conditions of Participation?**

   The Life Safety Code and Health Care Facilities Code flexibility guidance applies to alternate care sites. However, any of the temporary locations or alternate care sites would need to be approved by the hospital's state. It is important for hospitals to work with their states to determine if this model would be meet the licensure requirements for individual states.

3. **Does "at home" include people living in assisted living or nursing home facilities?**

   Many existing Acute Hospital Care at Home programs provide this level of care in assisted living but this waiver is not intended to be used by nursing home facilities. If care is provided in these facilities by a hospital, the hospital must work with the facility to ensure that there are not

duplicate state or federal payments to facilities while a hospital is being paid for inpatient level care.

4. **Could the initial in-person provider exam be performed by the inpatient hospitalist or ED physician before patient is transferred to home?**

   The in-person provider exam may be performed by the inpatient hospitalist or admitting provider prior to the patient being transferred home. The in-person evaluation should be performed by the same provider completing the admission History and Physical exam documentation and admission orders and should be consistent with existing hospital policies.

5. **Do you plan to expand this program to patients who meet observation criteria?**

   This waiver is intended to extend flexibility to patients who meet inpatient admission criteria, although it does not preclude treatment of observation status patients to the extent allowed by prior Public Health Emergency waivers.

Daily Operations and Staffing, including Patient Monitoring

1. **Are there any EHR documentation requirements?**

   Documentation should be consistent with existing hospital policies for inpatient admissions.

2. **Are there requirements for the remote monitoring (i.e. Blood Pressure, Electrocardiogram, Oxygen Saturation)?**

   A minimum of two sets of in-person vital signs are required daily and remote monitoring should be consistent with existing hospital policies and standards of care. Remote monitoring can be continuous or intermittent, and the intensity should be appropriate to each patient's management needs.

3. **Are there different expectations of provider assessment if the visits can be remote? Do you require the type of technology that allows a provider to listen to lungs/heart etc.?**

   Assistive technology, including auscultative transmission of heart and lung exams, can be used as needed, although it is also acceptable to verify these parts of the exam with the nurse and exclude them from the physician daily exam if they are not indicated based on the patient's condition. If this part of the exam being conducted by a physician/APP is indicated based on the clinical evaluation of a team member, it should be performed via technological transmission or in-person examination. Provider assessments should be consistent with the existing medical staff policies for requirements for physical assessments.

4. **Can virtual visits count as in-person visits to meet the twice a day in person visit requirement?**

   There must be at least two in-person visits daily. If the required daily RN visit, (remote or in-person) determines that both required in-person visits may be completed by a Mobile Integrated Health paramedic, if deemed consistent with the optimal plan for the patient's care.

If the team RN determines that an RN should see the patient in-person, one of the two daily in-person visits must be performed by an RN.

5. **Can the two required in-person visits be completed by an APP in addition to an RN/paramedic?**

   The two in-person visits can be completed by an APP, but they do not substitute for the role of an RN in the patient's care and must cover the expected care delivered by an RN, including the establishment of an appropriate nursing plan for the patient.

6. **Does the allowed use of Mobile Integrated Health paramedic for visits require that the paramedic be part of a MIH program? Alternatively, can a person who has a paramedic credential who works for EMS agency, but is not part of a MIH program be used?**

   The paramedic needs to be recognized by an official body as being Mobile Integrated Health/Community Paramedicine (MIH/CP). Some states use specific licenses for MIH programs to recognize the additional training required to be considered MIH. Additionally, MIH paramedics must receive constant medical direction if not abiding by a protocol. The paramedic used in the MIH role needs to be employed or under contract with the hospital to provide the MIH service. The hospital is responsible for the services and care provided by this team member. There may be scenarios where a formal certification is not available or easily obtained in certain areas - in this case, please reach out to AcuteHospitalCareAtHome@cms.hhs.gov to discuss your particular circumstance.

7. **Can other ancillary services (PT/OT/SLP/Social Work) provide visits virtually or do they need to be in person?**

   These services can be provided in a manner that meets the individual needs of the patient and consistent with their plan of care. Aspects of their care may be performed virtually or in-person based on the patient's needs and condition.

8. **Can therapists from a partner or contracted home health agency deliver therapy services?**

   Yes, they can. If therapy services are provided by therapists who work for a partner home health agency, the services should not be delivered as part of an episode of home health care. They should be supervised by the attending (MD or APP) overseeing the care plan for the Acute Hospital admission and documented in the hospital record.

9. **Are patients allowed to self-administer their medications?**

Patients can administer their own medications, if that is not in violation of the policies of the hospital overseeing the Acute Hospital Care at Home program.

Emergency Contact with Patients

1. **Can phone contact meet the emergency audio connection criteria?**

   Yes, audio communication can meet this criterion as long as there is immediate connection to the Acute Hospital Care at Home team as described in the waiver request template.

Medicare Payment Policies/Acute Admission Criteria

1. **How does the two midnight rule fit into the process and expectations for levelling?**

   This waiver addresses Hospital Conditions of Participation relating to nursing services for inpatient admissions. It does not alter or affect leveling expectations.

2. **This waiver would require significant resources to provide care. How will this be reimbursed and is this at an increased rate to cover initial costs?**

   Medicare inpatient payment policies and rates have not changed as a result of this waiver. Medicare inpatient payments to a hospital will be the same as they would have been if the care was provided in a traditional inpatient setting.

3. **Given that we will be reimbursed under the DRG, are we able to bill our standard room & board (or bed) charge for each day the patient is admitted under Hospital at Home?**

   Medicare inpatient payment policies, billing requirements, and cost reporting requirements have not changed because of this waiver. Hospitals should bill appropriately for services provided consistent with the existing Medicare policies and requirements.

4. **Do patients require levelling every 3 days, or just at the time of admission?**

   This waiver does not change any requirements other than the specific Hospital Conditions of Participation noted. An accepted levelling process needs to be used and all other requirements are expected to be met.

5. **Will the waiver be applicable to the Medicare Advantage (MA) beneficiaries?**

   Nothing in this waiver prevents Medicare Advantage beneficiaries from being treated with this level of care, if the local MA plan is in agreement.

6. **Is there forthcoming information on billing/coding?**

   All billing and coding requirements remain the same as those for inpatients treated at other alternative care locations operated by the hospital during the PHE.

7. **Should claims be submitted as inpatient for the full length of stay until dismissed from the Home Hospital setting and will it be paid based on the DRG?**

All billing and coding requirements remain the same as those for inpatients treated at other alternative care locations operated by the hospital during the PHE. Medicare inpatient payment policies and rates have not changed because of this waiver. Medicare inpatient payments to a hospital will be the same as they would have been if the care were provided in a traditional inpatient setting.

8. **Which DRG's are applicable to this program?**

   DRG's which are appropriate for the level of care and the clinical condition of the patient are applicable. Medicare inpatient payment policies and rates have not changed because of this waiver.

Reporting and Data Collection

1. **If our acute hospital care at home program provides services to more than one hospital, are we required to report our quality metrics separately?**

   Yes, similar to above, each hospital is required to report its required data at the hospital level. The hospital is legally responsible for care of the patient, regardless of contractual arrangement.

2. **Given that a hospital POS will be used to submit charges, is CMS able to track admissions or access data about these patients, other than our monthly submission?**

   CMS is evaluating methods for tracking admissions as this initiative progresses. Full data collection details will be available soon, and they may include ways of tracking admissions for future analysis.

3. **A patient in our program was sent back to the ED to rule out cardiac chest pain, then returned back to her home to continue care after tests were negative. She was later discharged from inpatient care without further incidents. Does this count as an "escalation" in our reporting measures?**

   No, this would not count as an escalation. An escalation requires that a patient be transferred to a different unit of the inpatient stay (i.e. from home to hospital floor/ICU).

Resources for Programs

While numerous organizations have experience with providing acute hospital care at home, most hospitals do not. However, CMS believes there are innovative systems which currently have the infrastructure and teams to take part in this initiative and seeks to provide resources to assist if needed. This will be updated as needed.

Implementation assistance can be separated into those based in academia vs the private sector. CMS does not endorse any of the organizations providing these resources; this listing is for informational purposes only.

Health Systems and Academia-based Resources

Hospital at Home Users Group: https://hahusersgroup.org/sites/
Support for Hospital at Home (and similar) groups aimed at sharing resources, disseminating best practices, and expanding the reach of programs. Material is publicly available and free. The site Includes links to a large number of health systems currently providing this type of care.

Hospital at Home consulting group through Johns Hopkins Medicine -

http://www.hospitalathome.org/develop-your-program/toolkit.php

Hospital at Home offers expertise and technical assistance to help institutions evaluate whether they should adopt the program as well as to support the implementation and reduce start up timelines.

Detailed research publications

Randomized Controlled Trial describing the Brigham and Women's Hospital model :

Levine DM, Ouchi K, Blanchfield B, Saenz A, Burke K, Paz M, Diamond K, Pu CT, Schnipper JL. Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020 Jan 21;172(2):77- 85. doi: 10.7326/M19-0600. Epub 2019 Dec 17. PMID: 31842232.

Case-control study showing decreased ED visits, readmissions, SNF admissions in 30-day post- acute period with improved patient experience and no difference in death rates:

Federman AD, Soones T, DeCherrie LV, Leff B, Siu AL. Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences. JAMA Intern Med. 2018;178(8):1033–1040. doi:10.1001/jamainternmed.2018.2562

Publication by Johns Hopkins School of Medicine regarding acute hospital care at home for selected patients:

Leff B, Burton L, Mader SL, Naughton B, Burl J, Inouye SK, Greenough WB 3rd, Guido S, Langston C, Frick KD, Steinwachs D, Burton JR. Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients. Ann Intern Med. 2005 Dec 6;143(11):798-808. doi: 10.7326/0003- 4819-143-11-200512060-00008. PMID: 16330791.

Private Sector (Listed Alphabetically)

Biofourmis - https://www.biofourmis.com/home-hospital/
Biofourmis advertises that it uses patient physiology data and advanced analytics to improve clinical outcomes with its clinically validated, predictive platform.

Contessa Health – https://contessahealth.com/solutions/health-systems/

Contessa advertises a Home Recovery Care program which claims a "turnkey solution" to assist health systems provide acute hospital care at home.

Conversa Health - www.conversahealth.com/

Conversa advertises a Virtual Care and Triage platform that automates communication between care teams and their patients to drive better engagement, greater efficiency and better patient outcomes.

Current Health - https://currenthealth.com/
Current Health advertises that it provides a single, enterprise platform to capture patient health at home using state-of-the-art monitoring to meet the needs of all patient populations.

Dispatch Health - https://www.dispatchhealth.com/

Dispatch Health advertises that it can hire, schedule, supply and manage Emergency Room trained practitioners that can work with existing clinical models to address high acuity medical needs.

Locus Health - https://www.locushealth.com/

Locus Health advertises that it provides a tailored remote monitoring, patient engagement and navigation platform and partners with health systems to make care management at home a reality.

Medically Home - https://www.medicallyhome.com/

Medically Home advertises that it works with leading health systems that are looking to develop a new care model by shifting volume out of the brick-and-mortar hospital and creating additional bed capacity.

Twistle - https://www.twistle.com/
Twistle advertises that it automates patient-centered, HIPAA-compliant communication between care teams and patients to drive better outcomes.

Vivify - https://www.vivifyhealth.com/

Vivify advertises that it can help launch and scale comprehensive, effective remote care programs for chronic and post-acute care as well as wellness management.

Example of published Inclusion and Exclusion criteria

Levine DM, Ouchi K, Blanchfield B, et al. Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020;172(2):77-85. doi:10.7326/M19-0600
https://www.acpjournals.org/doi/pdf/10.7326/M19-0600

Inclusion

Clinical

Aged ≥18 y

Primary or possible diagnosis of any infection, heart failure exacerbation, COPD exacerbation, asthma exacerbation, chronic kidney disease requiring diuresis, diabetes and its complications, gout exacerbation, hypertensive urgency, previously diagnosed atrial fibrillation with rapid ventricular response, anticoagulation needs (e.g., venous thromboembolism), or a patient at the end of life who desires only medical management

Exclusion

Social

Not domiciled

No working heat (October–April), no working air conditioning if forecast >27 °C (June–September), or no running water

Receiving methadone requiring daily pickup of medication

In police custody

Resides in facility that provides onsite medical care (e.g., skilled-nursing facility)

Domestic violence screen positive (39)

Clinical

Acute delirium, as determined by the Confusion Assessment Method

Cannot establish peripheral access in ED

Secondary condition: active nonmelanoma/prostate cancer, end-stage renal disease, acute myocardial infarction, acute cerebral vascular accident, or acute hemorrhage

Primary diagnosis requires multiple or routine administrations of controlled substances for pain control

Cannot independently ambulate to bedside commode

As deemed by on-call physician, patient likely to require any of the following procedures: computed tomography, magnetic resonance imaging, endoscopic procedure, blood transfusion, cardiac stress test, or surgery

For pneumonia:

Most recent CURB-65 score >3 (40)

Most recent SMRT-CO score >2 (41)

Absence of clear infiltrate on imaging

Cavitary lesion on imaging

Pulmonary effusion of unknown etiology

Oxygen saturation <90% despite 5 L of oxygen

For heart failure:

Has a left ventricular assist device

GWTG-HF (42) (>10% in-hospital mortality) or ADHERE (43) (high risk or intermediate risk 1)

Severe pulmonary hypertension

For complicated urinary tract infection:

Absence of pyuria

Most recent qSOFA score >1 (44)

For other infection:

Most recent qSOFA score >1 (44)

For COPD:

BAP-65 score >3

For asthma:

Peak expiratory flow <50% of normal: exercise caution

For diabetes and its complications:

Requires IV insulin

For hypertensive urgency:

Systolic blood pressure >190 mm Hg

Evidence of end-stage organ damage

For atrial fibrillation with rapid ventricular response:

Likely to require cardioversion

New atrial fibrillation with rapid ventricular response

Unstable blood pressure, respiratory rate, or oxygenation

Despite IV β and/or calcium-channel blockade in the ED, HR remains >125 beats/min and systolic blood pressure remains different from baseline <1 h has elapsed with HR <125 beats/min and systolic blood pressure similar to or higher than baseline

ADHERE = Acute Decompensated Heart Failure National Registry; BAP-65 = elevated Blood urea nitrogen, Altered mental status, Pulse >109 beats/min, and age >65 y; COPD = chronic obstructive pulmonary disease; CURB-65 = Confusion, Urea, Respiratory rate, Blood pressure, and age ≥65 y; ED = emergency department; GWTG-HF = American Heart Association Get With the Guidelines-Heart Failure; HR = heart rate; IV = intravenous; qSOFA = quick Sequential [Sepsis-related] Organ Failure Assessment; SMRT-CO = Systolic blood pressure, Multilobar chest radiography involvement, Respiratory rate, Tachycardia, Confusion, and Oxygenation.