dispatchhealth

Hospitalists Without Walls: Scaling Capacity to Admit Patients from Home to Home

Manuel J. Diaz, MD FHM, Anna Barth, MHA, Lindsay McGuiness, MSN BSN RN, Patrick Kneeland, MD SFHM

Background

- "Hospital at Home" (HaH) models of care have existed for over 20 years in the U.S.
- Recent demand for healthcare value, advances in relevant technologies, and the ongoing global pandemic have driven renewed attention to HaH models, including from the Center for Medicare and Medicaid Services (CMS), and have spawned several p-ilots within the U.S.
- These models have had desirable impacts on readmission rates, care-acquired adverse events, patient satisfaction, and cost.
- Despite this, adoption and scaling of these models remains difficult due to multiple factors: complex logistics, cumbersome supply chain management, coordinating the appropriate clinical workforce, and lack of a workable payment model.

Purpose

- To innovate a scalable a model for hospitalists to provide safe and high-quality advanced care in patients' homes.

Episode-specific Value Goals

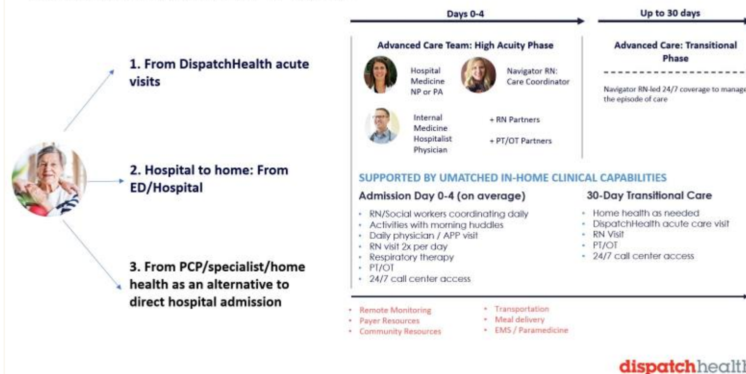
Unnecessary Emergency Department Visit Avoidance
Unnecessary Hospital Admission Avoidance
% Discount of Hospital Admission Payment
Unnecessary Post-Acute Facility Utilization Avoidance

Patient-centric Impact Goals

Hospital-Acquired Deconditioning Avoidance
Hospital-Acquired Condition Risk Reduction
Goal-concordant Clinical Care Planning
Patient and Family-centric Experience of Care

Description

- DispatchHealth: In-home medical practice model now seeing patients in more than 40 US cities.
- Leveraging existing practice infrastructure, Advanced Care Hospital Substitution launched in 2019 in DEN Market.
- Standardized protocols built to manage complex logistics (just-in-time imaging, medication supply chain, supplemental oxygen, DME, skilled providers: RNs/PT/OT/).
- Scaling facilitated by centralization of support resources.
- 350% Episode Growth in 2022.
- 140% Episode Growth in 2023.



Key Lessons

- Ability to deploy RN-centric care model in the home facilitates scale by enhancing ability to manage high-acuity patients.
- Management and coordination of an interprofessional team in a combination of local, in-person roles and centralized, remote roles provides pathway to scalable clinical workforce.
- Developing a central command center to manage clinical operations is critical to effective scaling.

Outcomes

- 8.7% 30-Day Hospital Readmission Rate
- 4.5% Unanticipated High Acuity Phase ED Escalation Rate
- 0% Unexpected Mortality
- 0.2% Serious Safety Event During Episode
- >$5000/patient-episode medical cost-savings compared to brick-and-mortar admission
- +93 Patient NPS Score

Conclusions

- Hospitalists are uniquely positioned to design, lead, and innovate in providing advanced care in the home.
- Our model leverages an existing mobile in-home practice infrastructure and to identify and treat appropriate patients.
- Co-evolution with payer partners has facilitated the expansion of this program to offer patients safe, effective, health care solutions in their home which allows for scaling when deployed in addition to "traditional" waiver-type HaH clinical models.

We bring the power of the hospital to the comfort of home