

Hospital at Home: Risk Management Implications



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The inpatient hospital environment is costly and can subject the patient to a greater risk for infection, falls, delirium, functional status decline and death.ⁱ In certain cases, patients may refuse to be admitted to the hospital. As early as 2008, some health care organizations recognized a need to implement a hospital at home model to care for patients who have conditions that require hospitalization and are stable enough to be treated at home. The programs were reported as successful citing cost savings, improved patient outcomes and greater patient satisfactions. However, due to reimbursement challenges, there has been little traction in implementation of similar programs across the country, until recently.

In November 2020, Centers for Medicare & Medicaid Services (CMS) launched the Acute Hospital Care at Home (HAH) program, which gives hospitals the ability to treat appropriately selected patients with inpatient level care in their homes.

Under the HAH program, hospitals must apply for a waiver and adhere to screening and safety protocols. Specifically, the waiver grants an exception to §482.23(b) and (b)(1) of the Hospital Conditions of Participation, which require nursing services to be provided on premises twenty-four hours a day, seven days a week and the immediate availability of a registered nurse for care of any patient.ⁱⁱ There are currently 110 systems, 245 hospitals in in thirty-six states participating in the HAH program.ⁱⁱⁱ

Requirements

Currently, there are more than sixty medical conditions approved under the HAH program including, but not limited to acute issues and acute exacerbations of chronic issues, such as asthma, congestive heart failure, pneumonia, and diabetes. Referrals may come from several sources, such as emergency services departments, specialty clinics and community paramedics. Patients are connected to a care team via a combination of in-person visits, video visits, and biometric monitoring platforms.

The CMS waiver approval process requires that the hospital provide or contract for specific services including pharmacy, infusion therapy, respiratory care (e.g., oxygen therapy), diagnostics (e.g., laboratory, radiology), patient monitoring capabilities and requirements, transportation, food services (e.g., meal delivery as needed), durable medical equipment, physical/occupational/speech therapy, social work services and care coordination procedures.^{iv}

Other requirements generally include, but are not limited to:

- At least one daily visit is required from a physician, nurse practitioner, or physician assistant. The visit can be remote after the initial in-person history and physical exam is performed in the hospital or Emergency Department (ED).
- There must be at least two in-person visits by registered nurse or a Mobile Integrated Health/Community Paramedicine (MIH/CP) each day. Two sets of vital signs must be completed daily. If both in-person visits are performed by a paramedic, an additional daily remote registered nurse visit is required to develop a nursing plan.
- The hospital must be able to provide immediate, on-demand remote audio connection with a HAH team member who can immediately connect the appropriate nurse or physician.
- There must be local resources available to provide in-home appropriate emergency personnel response to a patient's home within 30 minutes, if needed.
- Only patients that are evaluated in the ED or inpatient hospital are eligible.
- The hospital must develop and/or use patient selection criteria.
- The hospital must agree to voluntarily provide volume, escalation rate, and unanticipated mortality data to CMS.
- The hospital must establish a local safety committee (like Mortality and Morbidity team) to review reported metrics.
- Implement the use of an accepted patient leveling process to ensure patients require an acute level of care.^v

According to the American Hospital Association (AHA), the HAH care delivery model has been shown to reduce costs, improve outcomes and enhance the patient experience.^{vi} These programs can drive value and it has been reported that HAH models can reduce the cost of care by thirty percent or more.^{vii} Some of the reported reductions from CMS include:

- Seventy-four percent reduction in inpatient-induced delirium
- Pressure sores/other complications from inactivity (patients have improved mobility at home)
- Thirty-day readmission rates (twenty-three percent inpatient versus 7% HAH)
- Skilled nursing facility admissions and emergency department visits
- Mortality rates
- Patient and caregiver stress levels^{viii}

Patients can also benefit significantly and have reported greater satisfaction, citing convenience and being able to recover in their own environment.^{ix}

Services

In general, HAH services include certain types of patient monitoring, diagnostic studies (e.g., electrocardiograms, x-rays, echocardiograms), treatments (e.g., oxygen therapy, intravenous fluids, intravenous antibiotics), and other services (e.g., respiratory therapy, pharmacy services, skilled nursing services). The structure of the program can vary from hospital to hospital. For example, some hospitals run the program out of the ED and admit eligible patients to their homes. Others may focus on a specific patient population. Some programs provide in-person physician visits and others meet the minimum requirement and provide virtual physician visits.^x

As mentioned above, HAH programs have been shown to benefit both the patient and the hospital. However, providing acute care to the patient in his/her home is not without risk. Patient harm and adverse events associated with missed/delayed/incorrect diagnosis, failure to timely identify deteriorating condition, and equipment failure may occur. Contributing factors may include lack of teamwork, communication failures, documentation errors, and incomplete or lack of patient assessment. Key risk management considerations to explore include proper patient selection, the patient's home environment, nursing competency, interdisciplinary team communications, and virtual physician/provider-based care, integration of technology, and patient discharge.

Proper Patient Selection

CMS outlines minimum requirements, such as identifying established criteria to determine the patient's level of acuity, whether the patient is capable of self-administering medications, and whether the patient is willing to be engaged in his/her care. Prior to admitting the patient to the HAH program, clinical team members should:

- Evaluate and document the patient's/caregiver's readiness to participate in the program;
- Nurses should evaluate the patient's/caregiver's ability to care for himself/herself at home by asking open-ended questions rather than closed-ended questions;
- Educate the patient/caregiver on his/her role in the process and ask the patient/caregiver to repeat-back key aspects of his/her role in their care at home. For example, the patient/caregiver should be prompted to verbally list his/her medications, the dosage, how/when to take each medication, and the purpose of each medication. In addition, when new medications are prescribed the patient/caregiver should be provided with, educated on and repeat-back side effects to watch for and what to do if side effects occur; and
- Nurses should document the patient's/caregiver's ability to accurately repeat-back key elements of patient education and the information provided. The content of the education and the patient's ability to accurately repeat-back the information should be clearly documented in the patient's medical record.

Patient's Home Environment

A patient must live in a suitable environment to be considered for HAH. A suitable environment includes running water, heat, air conditioning and social needs such as at home support to help with care. General questions about these elements may not be enough to ensure that the patient's home is suitable for the patient to receive care. For example, significant hoarding and lack of sanitation can hamper recovery and may exacerbate the patient's condition. Excessive stale garbage, human or animal feces, and infestations may cause respiratory or other health problems resulting in a less than optimum environment for acute care hospital at home. Consider further evaluation of the patient's physical home environment against the patient's diagnosis, as appropriate, to determine whether the patient's home might hinder care management and recovery. Engage internal or community resources to address significant home environment issues. Some communities may offer, through a non-profit organization, volunteer hoarding

cleaning services. Anticipate patient environment-related barriers to HAH services and proactively identify strategies or services that may be applicable.

Nursing Competencies

The nurse or paramedic must be trained on and pass competencies to care for the acute care patient population, at a minimum. Although some HAH models partner with home health agencies, nurses should be highly skilled at clinical assessment and the identification of subtle changes that can lead to rapid patient deterioration. Some HAH models include nurses with recent critical care experience. At a minimum, nurses who care for patients in their home under the HAH model should have acute inpatient care nursing experience and pass the same competencies that are required for inpatient acute care nurses. Examples of acute care nursing competencies include intravenous/infusion therapy, infection control, respiratory care, cardiac care, medication monitoring/medication safety, wound care, gastrointestinal care, patient assessment/ monitoring, identification and management of patient deterioration, and so on. Acute care nursing clinical competencies should be completed before providing care to HAH patients and on a regular basis, as required.

Interdisciplinary Team Communication

Communication failures has been listed in the top three as a contributing factor in several different types of sentinel events.^{xi} Ineffective communication among health care team members has been cited by several studies as a leading cause of medical errors and patient harm. The patient's medical record serves as an additional mode of communication among care team members, and this is no different in the HAH environment. In addition to patient care-specific documentation, team communications related to the patient's care, should be documented in the medical record. The wise adage applies: If it wasn't documented, it wasn't done.

The HAH structure can create greater vulnerabilities to patient safety related to communication failures due to the virtual component of the program and the lack of formal face-to-face nursing handoff procedures in the presence of the patient. Relevant communication problems encompass communications that are not timely, failure to communicate appropriate information with all relevant team members and communicating content that is not consistently complete or accurate. There are several interventions that have demonstrated effectiveness in improving the quality and timeliness of communications among team members. One organization shared their multi-faceted strategy to address communication. Their strategies include implementing a standardized SBAR (Situation, Background, Assessment, Recommendation) communication format, structured team huddles that are done at the same time each day, multi-disciplinary rounds using a "Daily Goals Sheet," and implementing a formal escalation process.^{xii} These processes can be translated to the HAH model and accomplished even when team members are virtual.

Virtual Physician/Provider Care

According to the CMS rules, physicians, and other approved providers, may evaluate the patients via a virtual platform with a two-way biometrically enhanced video and are not required to complete in-person patient assessments after the patient has been assessed by a physician in the ED or inpatient setting and the patient has been admitted into the HAH program. From the logistics aspect, the virtual patient assessment process may be hindered by connectivity issues. Before the patient is admitted to HAH services, ensure that the patient has the appropriate internet connectivity capabilities to optimize virtual care.

From the physician care aspect, it can be challenging to obtain a complete picture of the patient's condition without laying hands on the patient. Physician uncertainty has been cited as a top barrier to adoption of HAH programs. Physicians are concerned about the legal risk and providing the same quality of care that patients receive in the hospital.^{xiii} The American Medical Association (AMA) offers telehealth resources that include guidance on improving patient care and team

engagement through team-based care in telehealth practices. The content is aimed at outpatient telemedicine and the content translates to the HAH model and shares the common goals to enhance team engagement, improve quality measures, and improve the quality of patient care.

The AMA resource focuses on a three-pronged approach to include:

- Visit redesign to include delegated and shared care responsibilities, individual caregivers functioning at the level of their qualifications, real-time documentation, and team member skills and training.
- A focus on population health to include the use of system and community resources to achieve and maintain optimal health and well-being of the patient population.
- In-between visit redesign that emphasizes a team approach.^{xiv}

The HAH team should include skilled professionals who consistently communicate and collaborate to ensure that the goal of providing high quality patient care is achieved.

Integration of Technology

The role of technology in HAH spans from supporting remote visits and facilitating remote patient monitoring, to enhancing team coordination. As such, there needs to be continuous evaluation of the interoperability and integration capabilities, as well as other considerations for necessary use in HAH-focused care. Additionally, team-based simulations should be conducted to test new technologies and new equipment that impacts the workflow. Another consideration regarding the role of technology in HAH is how patient assessment might be accomplished on demand. For example, suppose a patient is using a telemonitoring device that provides real-time blood glucose monitoring. A critical blood glucose level is reported to the provider through the device and a care team member is not in the home to evaluate the patient. Either the reading is incorrect (possibly determined through patient assessment) or the reading is correct, and the patient requires immediate intervention. Thus, HAH programs need a process in place to provide immediate patient assessment and intervention when a care team member is not in the patient's home. Prior to admitting your first HAH patient, proactively anticipate the scope of on-demand patient assessment and care needs and develop protocols and procedures to guide timely management.

Patient Discharge

Transitions in care naturally present a vulnerability to patient safety. Patient discharge is one such vulnerability. As with inpatient admissions, in order to set the patient up for a successful transition, the patient's care plan should clearly outline goals and measures of success to guide appropriate discharge from HAH, other than transfer to a higher level of care (emergency services, inpatient admission). HAH discharge planning should:

- Anticipate the patient's needs and provide additional support care or continued care, as indicated.
- Provide patient teaching, including follow-up appointments, when to call the provider or 911.
- Document the scope of teaching to the patient/caregiver and their ability to "repeat back" or "teach back" the information provided.
- Conduct a final patient assessment and ensure that documentation reflects how the patient has met the established goals in their care plan.

Conclusion

HAH programs can be beneficial to both the patient and the hospital. Regulatory guidelines provide minimum necessary requirements and hospitals should consider implementing additional measures to further promote patient safety. Implement an ongoing evaluation of your program for vulnerabilities associated with patient safety and identify opportunities to improve and enhance your HAH program.

Additional Resources:

- The American Hospital Association (AHA) provides a wealth of resources related to HAH to include webinars, briefs, and other resources. The AHA resources may be found here: <https://www.aha.org/hospitalathome>
- The Clutter Image Rating (CIR) tool may be used, as indicated, to evaluate the patient's hoarding severity before the patient is admitted to HAH. The International OCD Foundation's Clutter Image Rating (CIR) tool: <http://www.philadelphiahoarding.org/resources/Clutter%20Image%20Rating%20Scale.pdf>
- Institute for Healthcare Improvement "SBAR Tool: Situation-Background-Assessment-Recommendation" tool: <https://www.ihl.org/resources/Pages/Tools/SBARToolkit.aspx>
- American Medical Association (AMA) Telehealth Quick Guide resources and tools: <https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide>

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^v Ibid.

^{vi} American Hospital Association. *Hospital-at-Home*. Retrieved 07-18-2022 from <https://www.aha.org/hospitalathome>.

^{vii} "Hospital at Home" Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers. *The Commonwealth Fund*. Retrieved 07-19-2022 from <https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance>.

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^x American Hospital Association. (2020). Creating Value by Bringing Hospital Care Home. *Value Initiative Issue Brief*, 1-7. Retrieved 07-18-2022 from https://www.aha.org/system/files/media/file/2020/12/issue-brief-creating-value-by-bringing-hospital-care-home_0.pdf.

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Lexington Insurance policyholders may direct additional questions to Lexington Healthcare Risk Management at riskmanagement@aig.com.

Author:

Caroline Bell, RN, BSN, JD, CPHRM, DFASHRM
American International Group, Inc. (AIG)
Lexington Healthcare Risk Management Consultant

Contributing Editor:

Moira Wertheimer, Esq., BSN, CPHRM, FASHRM
American International Group, Inc. (AIG)
Lexington Healthcare Client Service Product Management Lead

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