Hospital AT Home USERS GROUP

# Who's In, Who's Out?
## Deciding Which Patients Are Right for Your Hospital at Home Program


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AAHCM AMERICAN ACADEMY OF HOME CARE MEDICINE

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**Webinar**

January 28, 2021

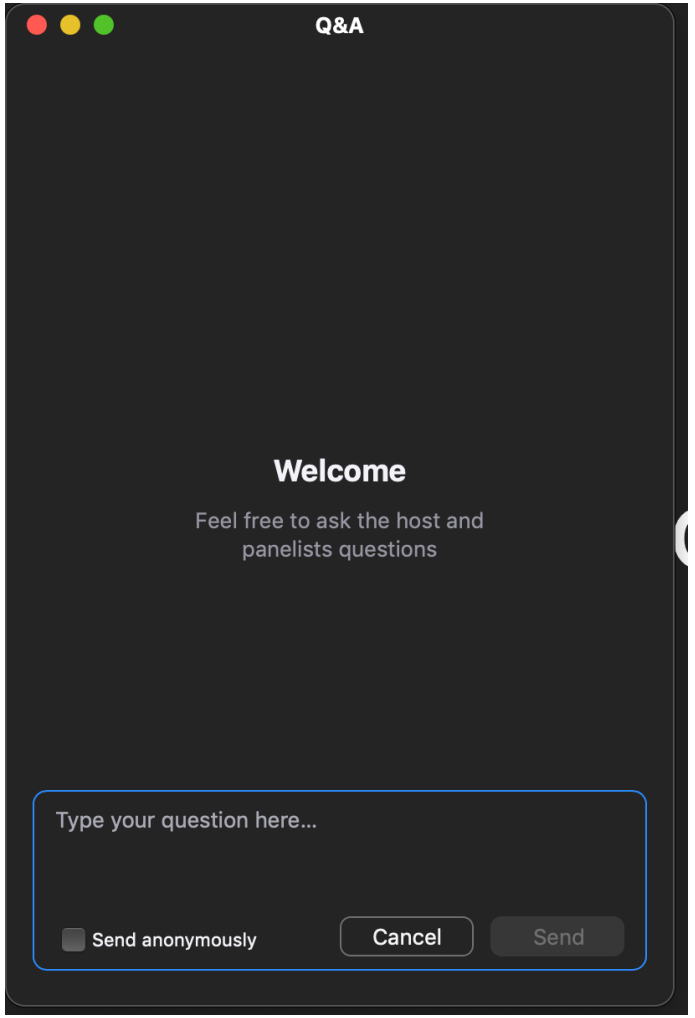
# We appreciate the generous support of


The John A. Hartford Foundation

Hospital at Home USERS GROUP

# ZOOM Webinar Housekeeping

- Please submit your questions via the Q&A option.
- Due to the large audience for today's webinar, everyone has been placed on mute.
- If you have any technical issues, please contact Gabrielle Schiller (gabrielle.schiller@mssm.edu) or send her a message via the Zoom chat feature.



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# Hospital AT Home USERS GROUP

Web: hahusersgroup.org

Tw: @hahusersgroup

# The HaH Users Group Webinar Series

- Issues in Strategic Engagement (See TA Center for slides & recording)
- Who's In, Who's Out? Deciding Which Patients Are Right for Your Hospital at Home Program (Today)
- Tech Matters: Building the Right Digital Platform for Your Hospital at Home Program (Next Tuesday, 2/2)
- Efficient, Effective, Excellent: Issues in Hospital at Home Logistics and Operations (2/9)
- On Time, Every Time: Delivering Hospital at Home Ancillary Services (2/16)
- How Are We Doing? Evaluating Hospital at Home Quality and Safety (2/23)

## More information coming soon…

# Today's Webinar

## Who's In? Who's Out?

## Deciding Which Patients Are Right for Your Hospital at Home Program

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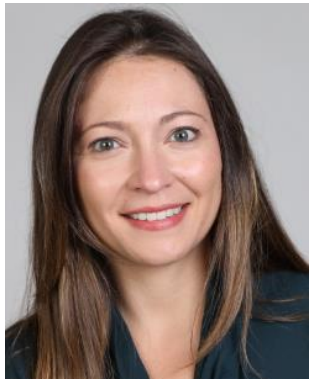

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# Learning Objectives

- Determine how your target population will shape your criteria
- Identify the domains that must be considered when evaluating patients for Hospital at Home care
- Develop customized criteria based on your program's structure and capabilities

# PROGRAM INTROS

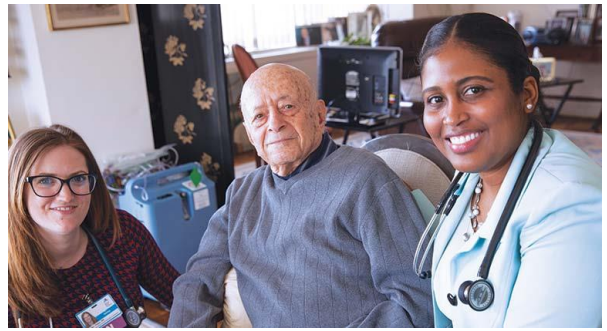
# SNAPSHOT: PRESBYTERIAN HOSPITAL AT HOME

- Established 10/6/2008 Albuquerque, New Mexico
- Integrated health system including 8 hospitals in 7 communities, 915 providers in multiple specialties, and Presbyterian Health Plan
- Hospital-level care in the home for 6 different diagnoses
  - Patients come from the ED or the inpatient floor
- Serving Presbyterian Medical Group members 18 years old and above
- We serve a widespread group of communities near Albuquerque; our providers cover a lot of miles
  - Patients must live within a 25-mile radius of a Presbyterian hospital
- Have served >1400 patients (thru 12/2019)
- Patient satisfaction scores are at 99%
- 30-day re-admission rate: 5.6%, 90-day readmission rate: 6.4%

# SNAPSHOT: MOUNT SINAI HOSPITALIZATION AT HOME

- 2014-2017: HaH program run with support CMMI grant
  - Manhattan-only
  - Recruitment: 1 ED, clinic referrals, home admissions
  - Shortlist of eligible diagnoses
  - Research grant through The John A. Hartford foundation – findings published 2018: shorter LoS, lower ED revisit & readmission rates, lower SNF admission rate, higher patient satisfaction.
- 2017: Re-launched as a joint venture with Contessa Health
  - Started recruiting from 3 additional Emergency Departments; broadened geographic area; expanded diagnoses
- 2020: Launched CHaH (Completing Hospitalization at Home) in response to PHE
  - May 2020: began admitting COVID+ patients
- To date: >1100 C/HaH patients treated in the home
- Our patients:
  - Adults 18+; NYC boroughs; treatment-specific, not diagnosis-specific clinical criteria
  - >95% from ED or IP floor; small number from home/clinic
- 30-day readmission rate: 6.3% (2020 Q1-Q3)
- Satisfaction: 96% would recommend (2020 Q1-Q3)

Mount Sinai



# WHY DO WE NEED INCLUSION/EXCLUSION CRITERIA?

- Hospital-level care
- Staff safety
- Positive outcomes
- Care that aligns with patient goals
- Streamline decision-making process
- Partner satisfaction and trust
- Patient safety, satisfaction and trust
- Maintain quality
- Encourage participation

## RIGHT CARE, RIGHT PLACE, RIGHT TIME

# PATIENT SELECTION: BASIC DECISIONS

## Target population

- Appropriate insurance
- Catchment area
- Age group (e.g., 18+)
- Require hospital-level care

## Referral location

- ED, Obs, Floor, Clinic, Home? Workup/clinical data may vary depending on location, need to design inclusion/exclusion criteria with this in mind
- When and where does patient screening take place?
- Who is making the dispo-to-HaH decision?

## Target diagnoses vs "What's the clinical plan?"

- Adhering to small list of diagnoses may limit pool

# DETERMINE YOUR PROGRAM'S CLINICAL CRITERIA

# WHICH PATIENTS CAN YOU CARE FOR?

## How intensive is your patient monitoring?

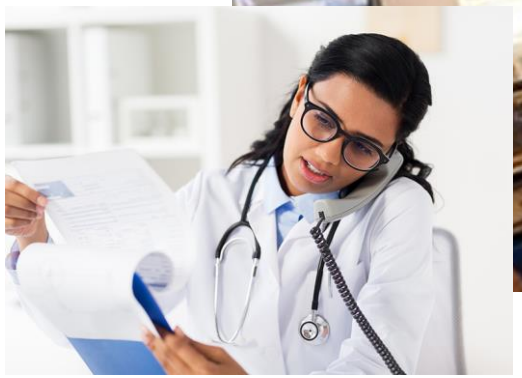
- Do you have telemetry, continuous VS monitoring?
- What is frequency of touchpoints? In-person vs telehealth?
- What is after-hours availability – community paramedicine, urgent RN/provider visits?

## What are your diagnostic capabilities? How quickly can you pivot your plan?

- Which labs can/can't you do? How long to result? How frequently can you monitor?
- How quickly can you get new meds to the home?
- Do you have capability to do EKG, X-ray, US/dopplers? Line placement?
- Are specialist consults possible?

## What clinical capabilities and ancillary services do you have?

- Foleys, wound vacs, tubes & drains, IV pumps, midlines/PICCs?
- Can you deploy PT, OT, speech/swallow?
- Which DME can you get to the home and how quickly?
- Food delivery for patients with access issues?
- Home health aides?



# Examples of diagnosis-specific clinical criteria

## CAP

**Inclusion**

- S/S CAP: cough, fever, high WBC, dyspnea, hypoxia, CXR tachycardia, tachypnea
- Elderly patients with multiple co-morbidities
- Other organ compromise

**Exclusion**

- Empyema, meningitis, endocarditis, septic arthritis
- Cancer, fibrosis, TB, cavitation
- Immunosuppressed
- Recent inpatient or SNIF
- Renal HD

## CHF

**Inclusion**

- Worsening or new dyspnea or hypoxia
- Impaired usual functional capacity
- Failed outpatient therapy requires IV
- Worsened renal function

**Exclusion**

- Severe arrhythmia
- Decompensated valvular disease
- New CHF may benefit from inpatient imaging/testing
- MI within 6 months special consideration higher risk
- Suspected PE

# WHICH PATIENTS CAN YOU CARE FOR?

## Geographic considerations

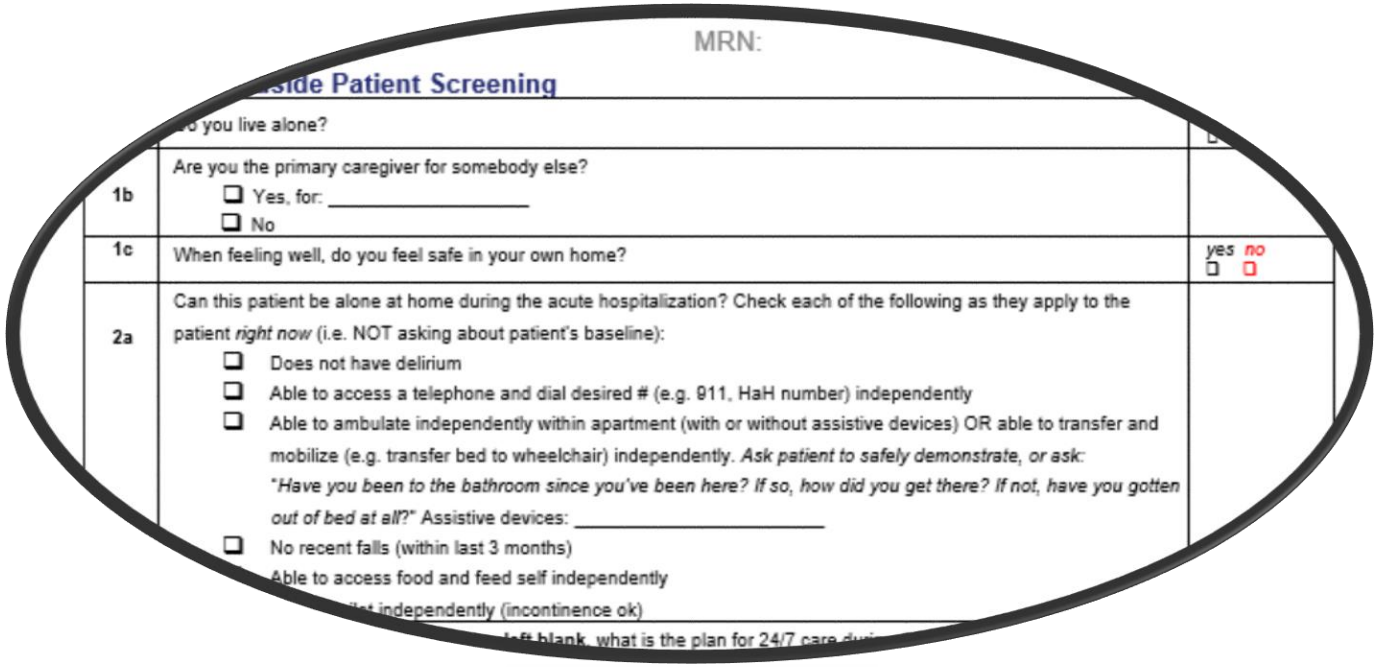
- Patient's distance to nearest ER/hospital; travel time to access higher level of care
- Vendors and ancillary service providers – what are their geographic limitations?
- Staff travel: How will staff get around? Consider time that will be spent in transit.
- Video visits/telemedicine – within service/coverage area? Reliable access? Special equipment needed?
- Logistics:
  - Weather events
  - Weekends and holidays (limits on staffing, ancillary service providers and vendors?)

# WHICH PATIENTS CAN YOU CARE FOR?

## Social and safety considerations

- Home environment and safety of patient and staff:
  - Infestations
  - Access to electricity, water, food
  - Substance abuse
  - Drug activity in/around home; weapons; pets
  - Psychiatric issues
- Home support or ability for self care
  - Baseline status vs now while acutely ill
- Special populations
  - Homeless
  - Group homes, managed care homes
  - Assisted living

# SCREENING TOOLS



MRN:

**Bedside Patient Screening**

| | | |
|---|---|---|
| | Do you live alone? | ☐ |
| 1b | Are you the primary caregiver for somebody else?<br>☐ Yes, for: _____<br>☐ No | |
| 1c | When feeling well, do you feel safe in your own home? | yes ☐ no ☐ |
| 2a | Can this patient be alone at home during the acute hospitalization? Check each of the following as they apply to the patient *right now* (i.e. NOT asking about patient's baseline):<br>☐ Does not have delirium<br>☐ Able to access a telephone and dial desired # (e.g. 911, HaH number) independently<br>☐ Able to ambulate independently within apartment (with or without assistive devices) OR able to transfer and mobilize (e.g. transfer bed to wheelchair) independently. *Ask patient to safely demonstrate, or ask: "Have you been to the bathroom since you've been here? If so, how did you get there? If not, have you gotten out of bed at all?"* Assistive devices: _____<br>☐ No recent falls (within last 3 months)<br>Able to access food and feed self independently<br>...t independently (incontinence ok)<br>...left blank, what is the plan for 24/7 care dur... | |

- Standardized
- Easily accessible
- Update, iterate, refine

# PATIENT CASE: CAP

86 yo woman PMH COPD, dementia, 2L Oxygen NC, CHF, stomach cancer in remission. Failed oral therapy with azithromycin for CAP presenting with worsening cough, fever, SOB, weakness, wheezing and volume overload.

Now WC-bound and requiring 6L NC to keep oxygen saturation at 90%. Husband is main caregiver and does not want hospitalization due to sundowning.

CXR bilateral infiltrates
WBC 12 left shift
GFR from 50 to 34
Cr 1.03 to 1.42
NT pro BNP 4,078

## RIGHT PATIENT, RIGHT TIME, RIGHT PLACE?

# PATIENT CASE: UTI

64 yo man PMH CAD, prior STEMI, OSA, HTN/HLD, NIDDM, p/w dysuria, hematuria, frequency
T 37.4, HR 106, RR 16, BP 127/88, SpO2 99% on RA
WBC: 21
Lactate: 3 → 3.6
CT A/P findings c/w UTI

Overnight in the facility: IVF, broad spectrum antibiotics

In the morning: Lactate 1.66, WBC 16. T 36.4, HR 81

# COVID-19 PATIENT CONSIDERATIONS

- New or known infection? Respiratory symptoms?
- Length of time since symptomatic, expected worsening?
- Baseline co-morbidities, age
- Need for ongoing observation vs. treatment candidate (remdesivir, convalescent plasma, steroids)
- Oxygen needs
- Social screening criteria, assess risk to other household members
    - Anyone at high risk in the home?
    - Able to isolate from others in the home?
    - Able to care for self vs. patient receives care from someone else in the home
- Home health aides and issues with home care reinstatement

# KEY TAKEAWAYS

- Customize your inclusion/exclusion criteria to fit the needs of your program
- Create screening tools (checklists, lists, prompts/scripts) to standardize and guide patient screening -- and keep them updated
- Keep your team on the same page – criteria and screening tools accessible from shared space
- Be agile and flexible; avoid rigidity
- Keep your partners informed on major changes through continuous outreach
- Provider-to-provider communication essential in finding appropriate patients

# QUESTIONS

# Learn More

- Hospital at Home Users Group
  https://hahusersgroup.org/

- Hospital at Home Users Group Tools and TA
  *(Beta version, powered by CAPC)*
  https://www.capc.org/strategies/acute-hospital-home/

# THANK YOU

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**Please make sure to join our next webinar:**

## *Tech Matters*

*Building a Strong Platform for Your Hospital at Home Program*

**February 2, 2021 - 4pm – 5pm ET**

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