



@Home Care Models: Key Highlights and Considerations

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Introduction

Although the concept of @home care models has been around for years, the industry's use of these models has grown significantly since the COVID-19 pandemic as another means to leverage technology to expand access to care. Accelerated by the CMS "Hospital without Walls" initiative, healthcare providers have increased flexibility on where patients can be treated while also receiving similar reimbursement.¹

As a result, these models have continued to gain traction as healthcare organizations realize the benefits of such programs. Due to the emergence (and likely continued growth) of these models, the HIMSS LTPAC Committee created this guide to provide insight into a couple of home-based care models and their benefits. This resource will provide an overview of the importance, functionality, and impact of these models on various stakeholders.

While the authors acknowledge that the healthcare environment is evolving and new care models continue to emerge, this resource will specifically address the following @home models:

- **@Home Hospital:** Acute hospital care delivered at home, including daily monitoring by a medical team and how this differs from home health.
- **@HomeSNF:** Skilled nursing facility (SNF) level of care provided in the home.

Benefits and Efficiency

One of the reasons for the growth of these care models is the ability to treat patients by leveraging health IT without compromising care. Providers are seeing several benefits from implementing these types of models. Some of these benefits include:

- Better health outcomes

¹ [Hospital at home: emergence of a high-value model of care delivery - PMC \(nih.gov\)](#)

- Less stress on patients; increased happiness and satisfaction
- Lower readmissions
- Reducing capacity constraints and freeing up facility space to care for more complex patients
- Reduced risk of infection/reduction of infection rates
- Increase access to care/increased equity
- Enhanced clinician engagement with patients
- Allows for continued treatments that may not be able to occur in an inpatient setting
- Decrease transitions of care time
- Beneficial to payers given the potential for fewer ancillary tests and reduction in both 30-day readmissions and ED visits

Types of Care Models

This section delves into the specifics of each model, such as the required technology infrastructure, the type of care provided, and the patient eligibility criteria. These models represent a shift in traditional healthcare delivery, emphasizing patient comfort and safety, while managing hospital resources more efficiently.

@Home Hospital integrates advanced technology to offer a hybrid approach to clinical care models, allowing acute inpatient-level care to be delivered at the patient's home. This model incorporates the benefits of hospital care with the comfort of home, focusing on patient safety, comfort, and effective use of hospital resources. A similar option being implemented by providers is @home continued hospital which shares many of the same features as @home hospital programs. Key aspects of this model include:

- **Technology-Driven Care:** It employs a robust technological backbone, enabling 24/7 monitoring by nurses and paramedics, along with virtual visits by physicians or advanced practitioners, and multiple daily in-person visits.
- **Patient Eligibility:** Designed for patients who meet inpatient hospital criteria but have low acuity. These patients have acute illnesses but do not need critical care.
- **Patient Onboarding:** Patients usually enter this program through the Emergency Department (ED) or physician referrals and are often transferred from traditional brick-and-mortar hospital settings to their homes.
- **Hospital Capacity Management:** This model plays a crucial role in easing hospital capacity constraints. It enables hospitals to focus on more critical patients by shifting lower acuity care to the patient's home.
- **Provision of Ancillary Services:** Provides for all ancillary services (e.g., labs, imaging, oxygen therapy, infusion services, meals, etc.) that would be provided in a traditional brick-and-mortar inpatient setting.
- **Continuation and Initiation of Treatments:** Facilitates the continuation or initiation of treatments like oncology therapies, which might be delayed or interrupted in a facility.

- **Infection Risk Reduction:** By caring for patients at home, the risk of hospital-acquired infections is significantly lowered.
- **Enhanced Recovery:** The home setting allows patients greater mobility, which can accelerate the healing process.
- **Comfort and Familiarity:** Patients benefit from being in familiar, comfortable surroundings. This aspect is particularly beneficial for patients with cognitive impairments, as it provides a sense of security and familiarity, aiding in their overall well-being and recovery.
- **Safety Measures and Equipment:** Incorporates necessary precautions like Personal Emergency Response Systems (PERS) to manage fall risks and ensures the availability of fall mats as preventive measures.
- **Average Stay Duration:** The average length of stay (LOS) is 3-5 days in the acute phase, with an additional time of 30-60 days in the monitoring phase.

@Home SNF is a home-based approach to SNF care. This model effectively brings SNF-level care into the home, enhancing patient comfort and reducing the strain on hospital resources, characterized by:

- **Technology-Driven Care:** Utilizes a hybrid care approach supported by technology, including 24/7 monitoring by nurses and paramedics, virtual visits by physicians or advanced practitioners, and multiple daily in-person visits.
- **Patient Eligibility:** The focus is on recovery, targeting only patients in the recovery phase, and adapting the care to a home setting.
- **Patient Onboarding:** Patients usually enter this program from a hospital inpatient stay, an observation stay, or the ED.
- **Hospital Capacity Management:** This model can decrease the duration of hospital stays affected by the availability of beds in facility-based SNFs.
- **Continuation and Initiation of Treatments:** Facilitates the continuation or initiation of treatments like oncology therapies, which might be delayed or interrupted in a facility.
- **Infection Risk Reduction:** Lowers the risk of infections commonly associated with facility-based care.
- **Enhanced Recovery:** The home setting allows patients greater mobility, which can accelerate the healing process.
- **Comfort and Familiarity:** Offers a comfortable and familiar environment for patients, particularly beneficial for those with cognitive impairments.
- **Safety Measures and Equipment:** Incorporates necessary precautions like Personal Emergency Response Systems (PERS) to manage fall risks and ensures the availability of physical therapy and related equipment in the home setting.

- **Average Stay Duration:** Typically, the length of stay in this model ranges from 10 to 15 days in the SNF phase and can include additional time in the monitoring phase (30-60 days)

Differences with Current Models

It is important to recognize that these @Home models may be confused with other services provided in the home such as skilled traditional home health. The following section provides a comparison of the @Home models to traditional home health and SNF care.

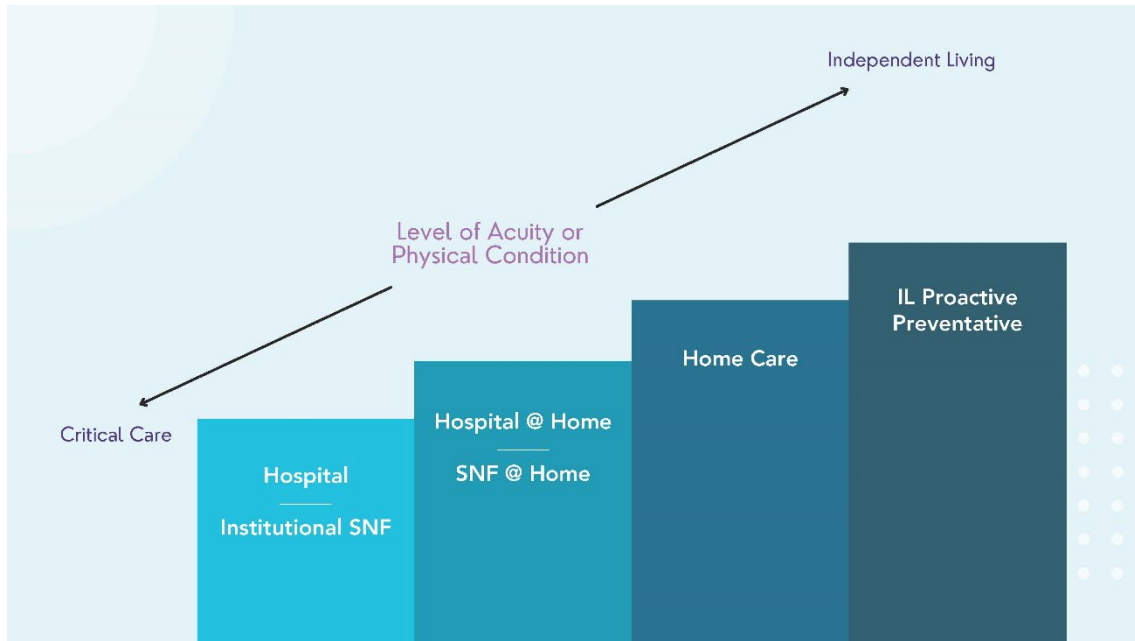


Figure 1: High-level comparison of care settings based on patient acuity

@Home Hospital vs. Home Health

Hospital care in the home is geared towards acute-level care with a shorter duration and more frequent clinician visits, including a mix of in-person and virtual care, and extensive monitoring. Traditional skilled home health care is designed for longer-term recovery, with less frequent visits and a focus on educating patients and families about self-care.

	@Home Hospital	Home Health
Patient Criteria	Acute Phase	Recovery Phase
Meets Hospital Inpatient Criteria	Yes	No
Homebound Criteria Needed	No	Yes
Site of Care	Home	Home

Support System Needed (family/friends)	Yes (beneficial, but not required, patient-specific)	Yes
LOS	3-4 days	30-60 days
Monitoring Phase	Included	Not included
Clinician Visit Frequency	Daily	3 times a week (on average)
Technology – Virtual Visits	Yes	May include
Technology – Remoting Monitoring	Always	May include
Care Focus	Provides care to the patient	Teaches the patient/family care methods
Cost	Potentially lower than facility-based care	Lowest cost option

@Home SNF vs. SNF (facility-based)

SNF care in the home is focused on the recovery phase of an illness or injury with a shorter duration, frequent in-person or virtual clinician visits, as well as support from both nursing and therapy services all in the patient's home setting. While facility-based SNF care is also for the recovery phase, it provides around-the-clock nursing support, therapy services, and longer periods of services including the option to remain in the facility setting if further custodial or long-term care is needed.

	@Home SNF	SNF (facility-based)
Patient Criteria	Recovery Phase	Recovery Phase
Meets SNF Inpatient Criteria	Yes	Yes
Patient Exclusions	Needing facility-based custodial or long-term care	None
Site of Care	Home	Facility
Support System Needed (family/friends)	Yes	Beneficial but not required
LOS	Varies (ranges from 5-15 days)	Varies (ranges from 10-30 days)
Monitoring Phase	Included	Not included
Clinician Visit Frequency	Daily	24/7

Technology – Virtual Visits	Yes	May include
Technology – Remoting Monitoring	Always	May include
Care Focus	Provides care to the patient and teaches patient/family about care	Provides care to the patient and teaches patient/family about care
Costs	Lower than facility-based care	Higher than home-based care

Considerations for @Home Care Models

With potentially more providers implementing @home care on the horizon, here are a few key questions organizations should ask themselves² when considering these new care models.

- Does the organization have a clear understanding of the business case and are the financial models associated with the program well understood?
- What are the legal and regulatory requirements (at the Federal, state, and local levels) for implementing a program?
- Has the organization identified program champions and established organizational governance for the program?
- Does the organization understand how the model may impact staffing, training, and support?
- What processes and workflows may need to be established or modified to accommodate the program?
- What external partners (caregivers/specialists, transportation, equipment, etc.) does the organization need to partner and coordinate with to provide services and support for the program?
- Has the organization established patient criteria for @home programs? This includes items such as understanding which diagnoses can be managed well from @home programs, evaluating patients' social drivers of health to ensure programmatic fit, and ensuring a safe home environment exists.
- What are the technology and infrastructure requirements for implementing a program (both at the facility and the patient's home)?

² [Designing and Launching Hospital-at-Home Models: Strategic Imperatives for Health System Leaders - Manatt, Phelps & Phillips, LLP](#)

Summary

Over the past several years, healthcare providers have been increasingly exploring @home care models. And while the CMS waiver program was only extended to 2024, many within the industry believe that a more permanent program will be created.³ While implementing such programs is a large undertaking, the benefits of these programs are promising. As the industry continues to evolve, we hope this short guide provides readers with a better understanding of how hybrid clinical models of care can be facilitated through leveraging of health IT.

³ [Will CMS' Acute Hospital Care at Home waiver program become permanent? | Healthcare IT News](#)