5 ways hospitals can boost capacity through home health

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Post-acute providers play a critical role in relieving pressure on hospital beds—now more so than ever, given that hospitals need to ensure bed availability amid any surge of Covid-19 patients. However, post-acute care organizations—such as SNFs, which are limiting admissions to avoid outbreaks—face challenges of their own accepting discharged patients from hospitals. One way to solve both challenges is to bypass facility-based care altogether when possible in favor of sending select patients directly home with home health.

Not only do home health agencies have the capacity to take on these volumes1, research has also shown that home health outperforms other post-acute care sites on key metrics such as readmissions and overall care costs2. Additionally, within the context of Covid-19, the home setting offers lower risk of infection spread than facility-based settings, due to a lack of direct exposure to other patients.

However, the range and scope of services delivered via home health have long been limited by regulatory and financial barriers. With CMS' recent expansion of the homebound definition and lifting of restrictions on telehealth use in home health, hospitals now have additional incentives to explore non-traditional home health benefits. Our research has identified two roles home health can play in increasing hospital capacity: getting patients out of hospital beds faster and keeping patients from being admitted to the hospital in the first place. Below are five ways—categorized within those two roles—that progressive hospitals are expanding care in the home:

Role 1: Get patients out of hospital beds faster

1. Discharge patients early when possible

> Reducing length of stay by discharging patients early and providing follow-up care at home can create capacity while diminishing the risk of Covid-19 exposure. However, hospitals recognize—and must account for—the potential lack of adequate support and follow-up care among early discharges, which could lead to adverse outcomes, such as readmissions.
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> Michigan Medicine has adopted this approach, while prioritizing patient safety, by discharging certain types of patients early to home health. To ensure patient safety, multi-disciplinary teams determine and prioritize patients who meet clinical criteria for early discharge. For example, postpartum mothers and their newborns are being discharged from the hospital earlier than is typically routine. Before discharge, parents are assigned to home health providers to conduct all the necessary postpartum care either in-person or virtually.

2. Increase the intensity of care delivered in the hospital to enable safe transitions to home

> To further propel safe transitions from hospital to home, hospitals can increase the levels of therapy delivered in the hospital, thereby reducing the intensity of care needed when patients are discharged to home health.
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> For instance, Michigan Medicine is also increasing the levels of therapy delivered in the hospital for patients who would ordinarily need SNF-level care. Patients eligible for this additional therapy include those with

neuropathies, or myopathies, and those who struggle to carry out activities of daily living. Ambulatory rehab staff are deployed to supplement the care delivered by inpatient rehab staff. The additional therapy is delivered while they are recuperating or coming off of oxygen in the hospital.

3. Leverage caregiver capacity to deliver SNF-level care in the home

Patients who are medically stable but need 24-hour skilled nursing and personal care are often referred to SNFs, because home health agencies typically provide intermittent care. But because SNFs are limiting admissions, hospitals can leverage caregiver capacity to deliver the needed 24-hour support.

UnityPoint's SNF-at-home model combines support from the home health provider and the patient's caregiver to provide 24-hour care to patients needing SNF-level care post-hospitalization. To ensure caregivers can safely assist patients with activities of daily living, they receive adequate training from home health clinicians and therapists, which can happen via telehealth.

Role 2: Reduce unnecessary hospitalizations using home-based services

4. Discharge low-acuity patients from the ED directly to home

Not all patients seen in the ED necessarily require admission, even those who need observation or the initiation of therapy. Instead, these patients can receive those services in the home setting with home health.

For example, Starwell Health Care (a pseudonym) is discharging low-acuity patients presenting in the ED directly to home through its Enhanced Home Health program. After ED stabilization, the patient is discharged, and the home health nurse can initiate therapy on the same day or within 24 hours under physician oversight. Starwell conducted a training to ensure home health nurses were well versed with IV initiation procedures in patient homes. A liaison—typically an RN or LPN, with care management experience—coordinates all the necessary care and orders any DME needed directly to the ED so patients can go home fully equipped.

5. Deliver hospital-level care in the home

One bold, though resource intensive, model for reducing reliance on acute-care beds is delivering acute-level care at home through hospital-at-home models. A number of hospitals in the United States already have these programs in place, and research has shown that they are safe and effective alternatives to hospital admissions. Amid the epidemic, hospitals can expand these programs to include more patients who present in the ED or those admitted to the hospital.

For instance, Mount Sinai, Contessa Health, and the Visiting Nurse Service of New York are expanding their hospitalization-at-home program to increase the number of patients they can take care of. In addition to those presenting in the ED for acute care, patients eligible for the program now include those who are stable and nearing the end of their hospital stay but still need acute-level services like intravenous antibiotics, as well as Covid-19 patients stable enough to remain at home.

The successful management of low-acuity acute and post-acute care needs of patients in the home presents a good option for reducing unnecessary hospital days and avoiding risky transitions to facility-based care—and it can be achieved through a coordinated approach between hospitals and their home health partners.