Moving Health Home

An Alliance to Advance Home-based Care Policy

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September 13, 2022

Virtual Hill Briefing – Hospital at Home: A View from Across the Health Care Industry

ABOUT US

Moving Health Home (MHH) is a coalition made up of stakeholders working to change federal and state policy to enable the home to be a clinical site of care.

Today, we have an opportunity to shape the future of health care as policymakers, thought leaders, providers, health plans and patients absorb the lessons and experiences of the COVID-19 pandemic.

@movehealthhome

www.movinghealthhome.org

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Survey Says: Bipartisan Support for Increasing Access to Clinical Care in the Home

A national survey, conducted by Morning Consult on behalf of Moving Health Home, speaks to the widespread support by adults for receiving care in their homes from across the care continuum.

Americans Are Comfortable Receiving Care in the Home

70% of those surveyed are comfortable with care in the home citing that familiarity helps alleviate anxiety.

Americans Are Confident in the Quality of Care in the Home

73% of adults are confident in the quality of receiving care in the home.

85% of caregivers are confident in the quality of receiving care in the home.

88% of adults were satisfied with the clinical care services they received in the home.

Americans Prefer and Would Recommend Care in the Home

85% of people who have had experience with care in the home would recommend it to family and friends.

Americans Support Expanded Access to Care in the Home

66% of consumers say it should be a priority for the federal government to increase access to clinical care in the home.

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AGENDA

View From Across Industry

- Biofourmis
- Advocate Aurora Health
- Compassus
- DispatchHealth

View from Capitol Hill

- Jay Gulshen, Health Advisor at House Ways & Means Health Subcommittee

biofourmis

Powering Personalized Predictive Care

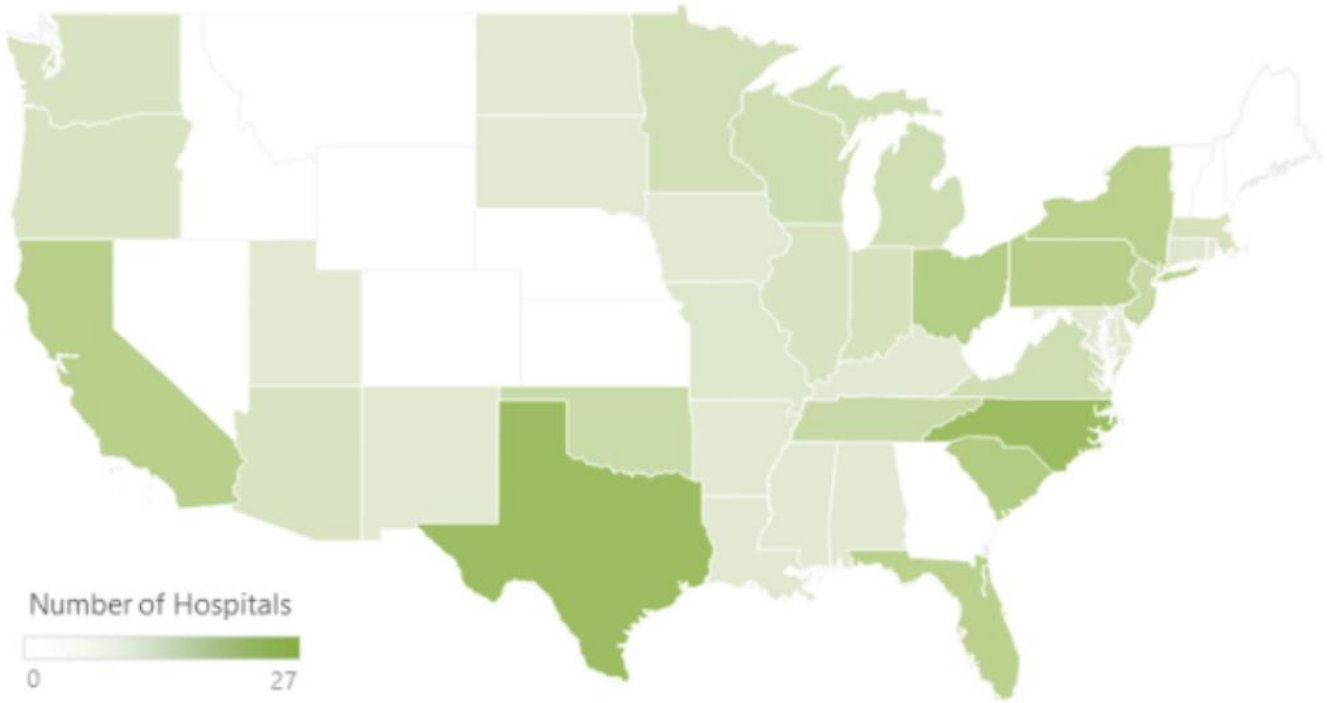
Maulik Majmudar, MD
Chief Medical Officer and Co-Founder

Bloomberg CNBC Forbes Pink Sheet Informa Pharma Intelligence mobihealthnews MedCity News FierceBiotech TechCrunch BUSINESS INSIDER The Boston Globe NIKKEI ASIAN REVIEW

National Distribution of Hospitals Granted CMS Waivers[7]

As of August 23, 2022

WAIVERS GRANTED BY STATE



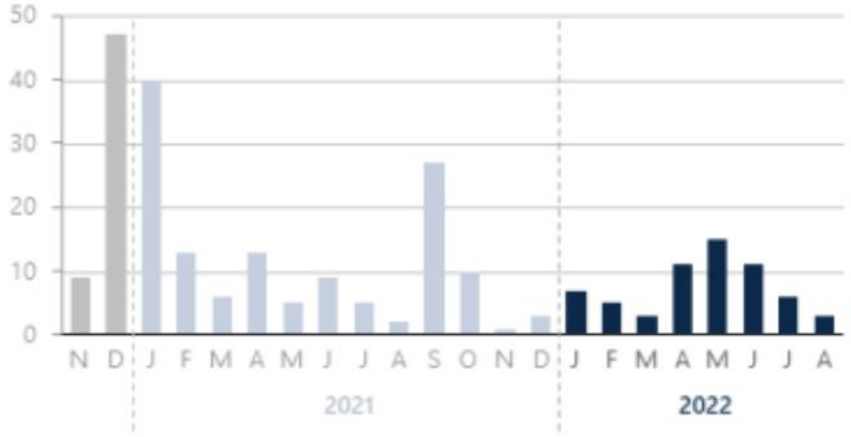
KEY PROGRAM STATISTICS

251 Unique Hospitals

36 States

111 Separate Systems

WAIVERS GRANTED BY MONTH



Acute Care at Home: Strong Evidence, But Limited Adoption

Strong Evidence	Adoption Barriers	Slow Growth

70% Reduction in RE-HOSPITALIZATION

38% Reduction in COST OF CARE

Annals of Internal Medicine

1. Physician Awareness & Acceptance
2. Complex Implementation
3. Limited/ uncertain Reimbursement
4. Technology Platform

2
Hospitals have treated
more than 2,000 patients

<5%
Hospitals have
CMS Waivers for H@H

Program Operations

1 Program Design

- Clinical Model
- Operation Protocol
- Stakeholder Engagement
- Supply Chain Development

2 Patient Identification

- Perform clinical screening
- Conduct social screening
- Obtain patient consent
- Initiation HaH admission process

3 Admission

- Onboarding (evaluation, transportation, etc.)
- Provide admission kit
- Patient education

4 Care Delivery

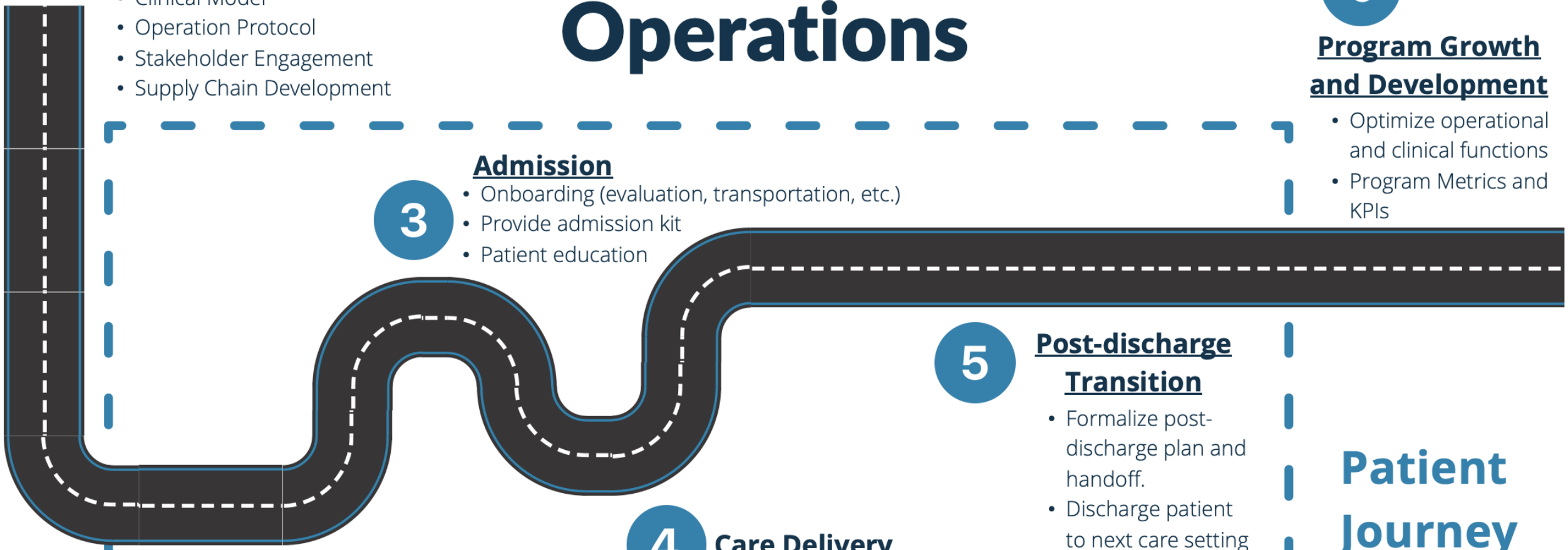
- Provide daily in-home care (evaluation, medication administration, etc.)
- Monitor patient remotely
- Scale through virtual capability

5 Post-discharge Transition

- Formalize post-discharge plan and handoff.
- Discharge patient to next care setting
- Collect and process equipment

6 Program Growth and Development

- Optimize operational and clinical functions
- Program Metrics and KPIs



Patient Journey

Clinical Care & Ancillary Services

Non-Emergency Medical Transportation

Hospitalist & Specialists

Field Nurses

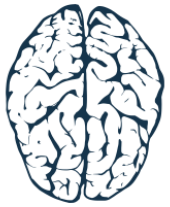
Telehealth

Infusion/Pharmacy

DME

RPM/Tech Kits

Phlebotomy



Mobile Diagnostics

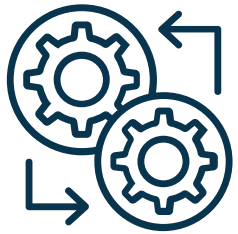
Centralized Support Services

Technology Needs for Scaling

biofourmis

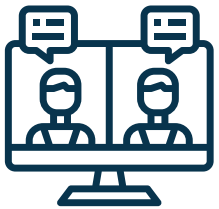
Virtual Specialty Consults

Command Center Tools



3rd Party Integrations

EMR Integration

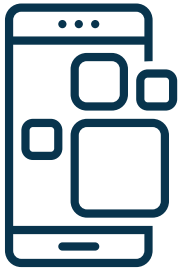


Provider and Patient Communication

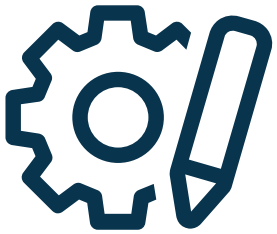
Inventory Managment

Remote Patient Monitoring

Clinical and Ancillary Services



Mobile Application



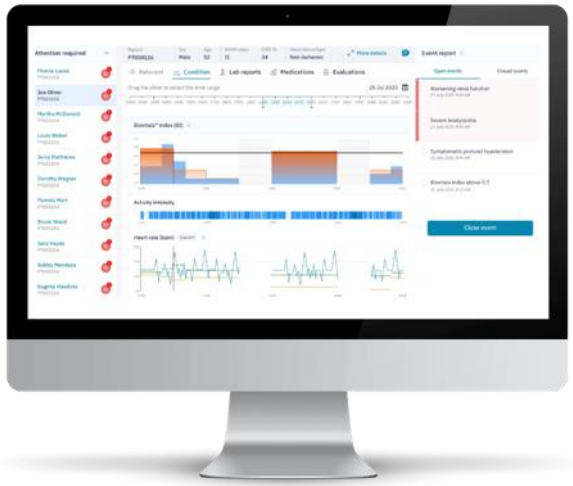
Task Management

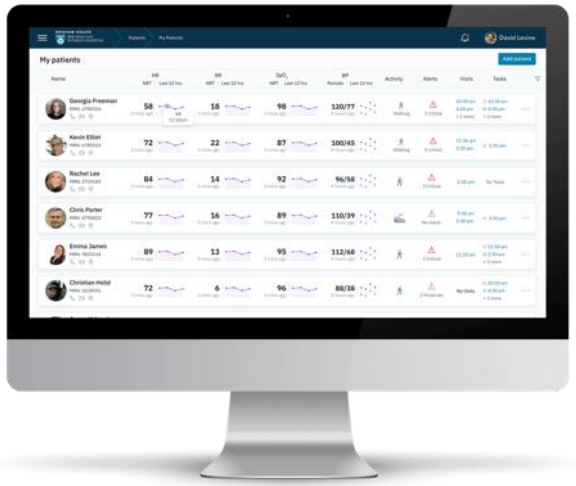
Data and Analytics

A Comprehensive Care@Home Tech Platform

PATIENT ENGAGEMENT

PROVIDER TOOLS TO OPTIMIZE PATIENT OUTCOMES





IMPLEMENTATION SUPPORT

- 24/7 Licensed Clinical Care Management
- Logistics & Operational Support
- EMR Integration

Continuous Monitoring → FDA-Cleared Analytics Engine → Visibility with Integrated Workflows → Turnkey Solution

AdvocateAuroraHealth

BY THE NUMBERS

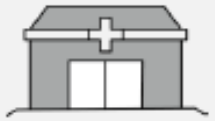
75,000
TEAM MEMBERS

7,000+
VOLUNTEERS

10,000
PHYSICIANS

3M
UNIQUE PATIENTS

27
HOSPITALS



500+
SITES OF CARE

$14B
TOTAL REVENUE**

$2.5B+
COMMUNITY BENEFITS IN 2020

Top 12
NOT-FOR-PROFIT HEALTH SYSTEM

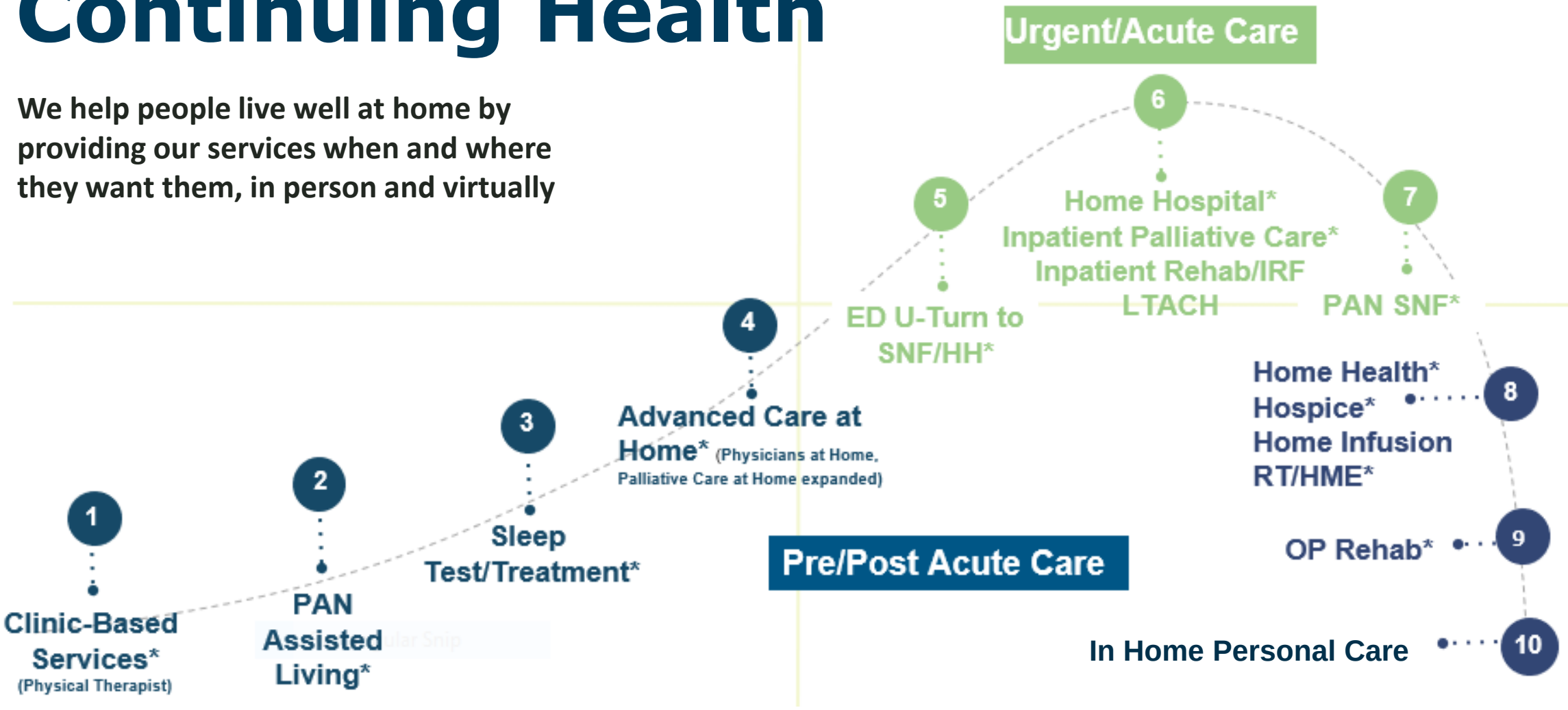
Top 8
*IN HEALTH OUTCOMES

Published July 2022

*Benchmark Health Outcomes Analysis 7/22
**Total Revenue annualized based upon three months ended March 31, 2022.

Continuing Health

We help people live well at home by providing our services when and where they want them, in person and virtually



*Available Virtually

Right Care, Right Place, Right Time

Value Snapshot

Home Hospital Program

The Home Hospital program was launched in response to COVID-19 to keep our most vulnerable patients safe at home while providing the care they need.

- 504 patients admitted to program, which was managed through our Continuing Health Division.
- Eligibility
  - Clinical
  - Payer – MA Plans
  - Support System
  - Safe home environment
- Care was provided by multi disciplinary team – both in person and virtually
  - Advanced Practice Clinicians/Physicians
  - RN/PT
  - MSW
- Additional Services
  - Oxygen
  - Virtual monitoring with equipment that includes a thermometer, a blood pressure monitor and a pulse oximeter.

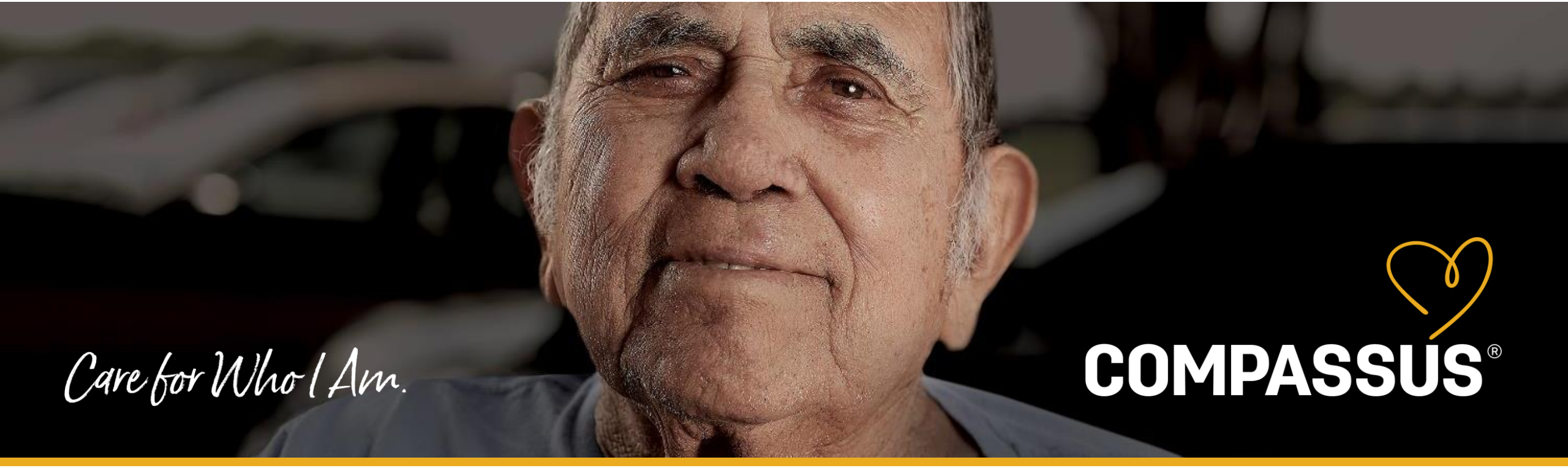
"I felt completely well cared for. My nurse was wonderful. She visited every few days and we developed a great relationship."

– Daniel, patient

AdvocateAuroraHealth

Congressional Ask

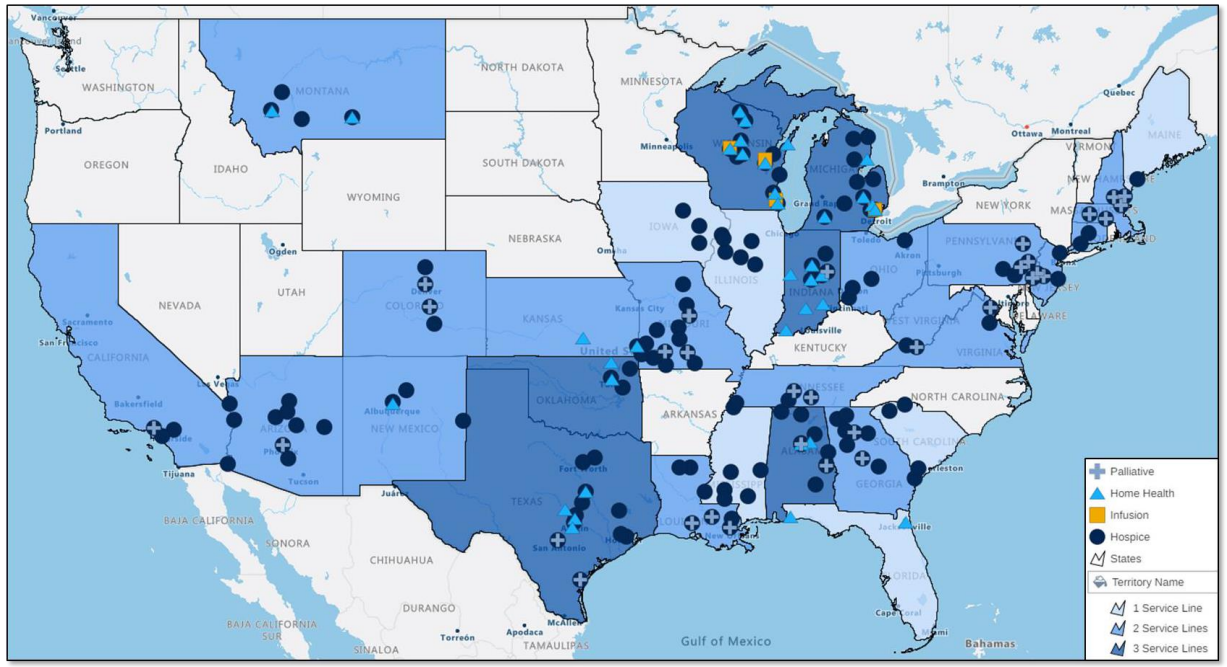
- **Innovation requires regulatory and payment flexibility**
  - **Reimbursement models should enable providers to keep patients in their home, avoiding expensive institutional care such as hospitals and skilled nursing facilities, when appropriate.**
  - **Telehealth, Virtual Health and Remote Monitoring reimbursement flexibilities during the pandemic should be made permanent, which also addresses the strained staffing resources.**



MOVING HEALTH HOME
HOSPITAL AT HOME PANEL

Compassus Overview

Speaker: Jordan Holland, VP Value Based Contracting



SERVICE LINES

- HOSPICE
- HOME HEALTH
- PALLIATIVE CARE
- HOME INFUSION

600+

Hospital at Home patients served to date

Ascension *Together with* COMPASSUS®

Marrying best-in-class acute care with home-based care expertise to advance clinical models of care

Home Health → *Advanced Post Acute Care in the Home* → *Hospital at Home*

Increasing levels of patient complexity, coordination, integration, and technology enablement

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Creating Value for Patients and Partners

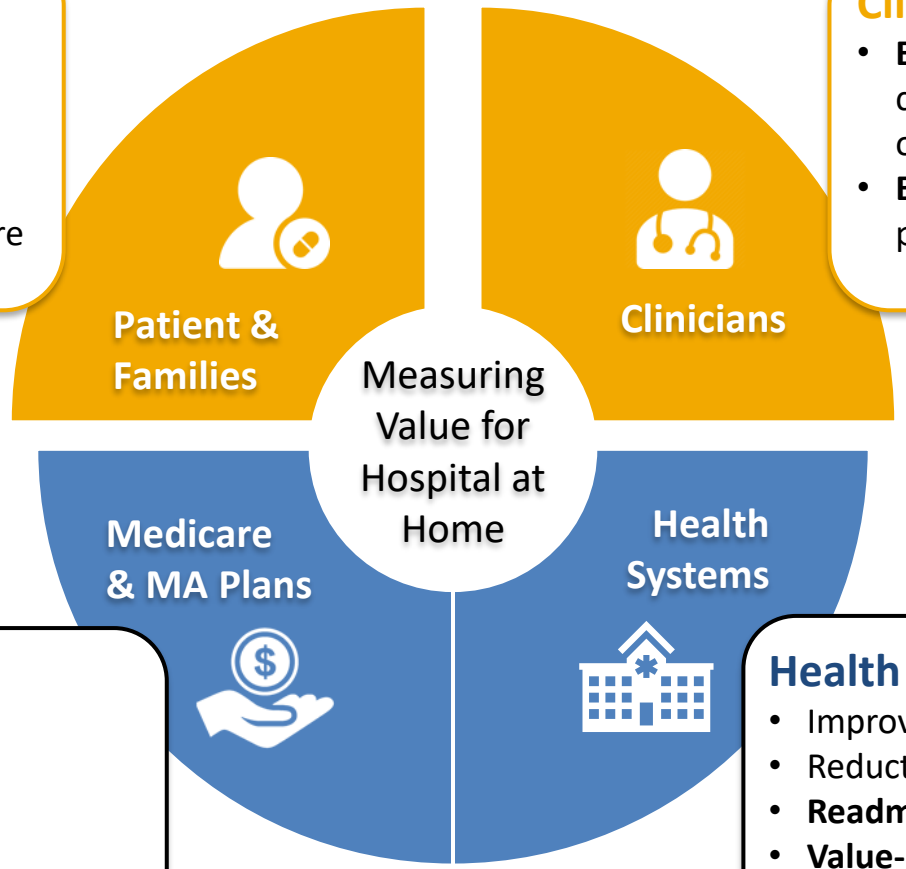
Hospital at Home is a "win-win" for all stakeholders

Patients & Families

- **Improved care continuity** through consistency of care team from acute phase and recovery phase of care
- Increased **days at home**
- Improved **quality outcomes** through care coordination and home-based recovery

100%

Patient satisfaction scores for Nurse kindness, respect, and communication



Clinicians

- **Engage and attract nurses** and other clinicians through new, innovative models of care
- **Enhanced support tools** to optimize patient care

Medicare & MA Plans

- **Total cost of care** reductions
- **Readmission** reductions
- Improved **member experience**

Health Systems

- Improved **ED and IP capacity**
- Reductions in **avoidable days**
- **Readmission** reductions
- **Value-based care** performance improvement

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Hospital at Home | Home-Based Provider Perspective

To support Hospital at Home models of care, home-based providers must recognize key differences in nursing care that require new considerations for hiring, staffing models, productivity, training, and key role responsibilities

Model Differences for Nursing Staff

	Home Health	Hospital at Home
Nurse Experience	• Home-based care experience important; other backgrounds/specializations provide added benefits (e.g., wound care)	• Home-based care AND acute care experience important for success
Visit Frequency & Scheduling	• Visits scheduled based on patient plan of care and need; typically less frequent than daily	• More frequent patient visits with most models requiring two visits per day
Timeliness of Care	• Visits scheduled in advance with more flexible timing	• Minimal advance planning time; required urgent response
Care Coordination	• Care coordination activities supporting patient recovery	• More significant care coordination (e.g., daily rounds, RPM, labs, etc.)

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Key Opportunities

to Advance Home-Based Care

- Create model standardization and a structured Medicare benefit for Hospital at Home to enable opportunities for growth and further innovation
- Support of Choose Home initiative to add post-acute model alternatives (SNF at Home models of care) to fully realize home-based continuum
- Maintain funding for Home Health services that represent “backbone” of nursing to support Hospital at Home care model

COMPASSUS®

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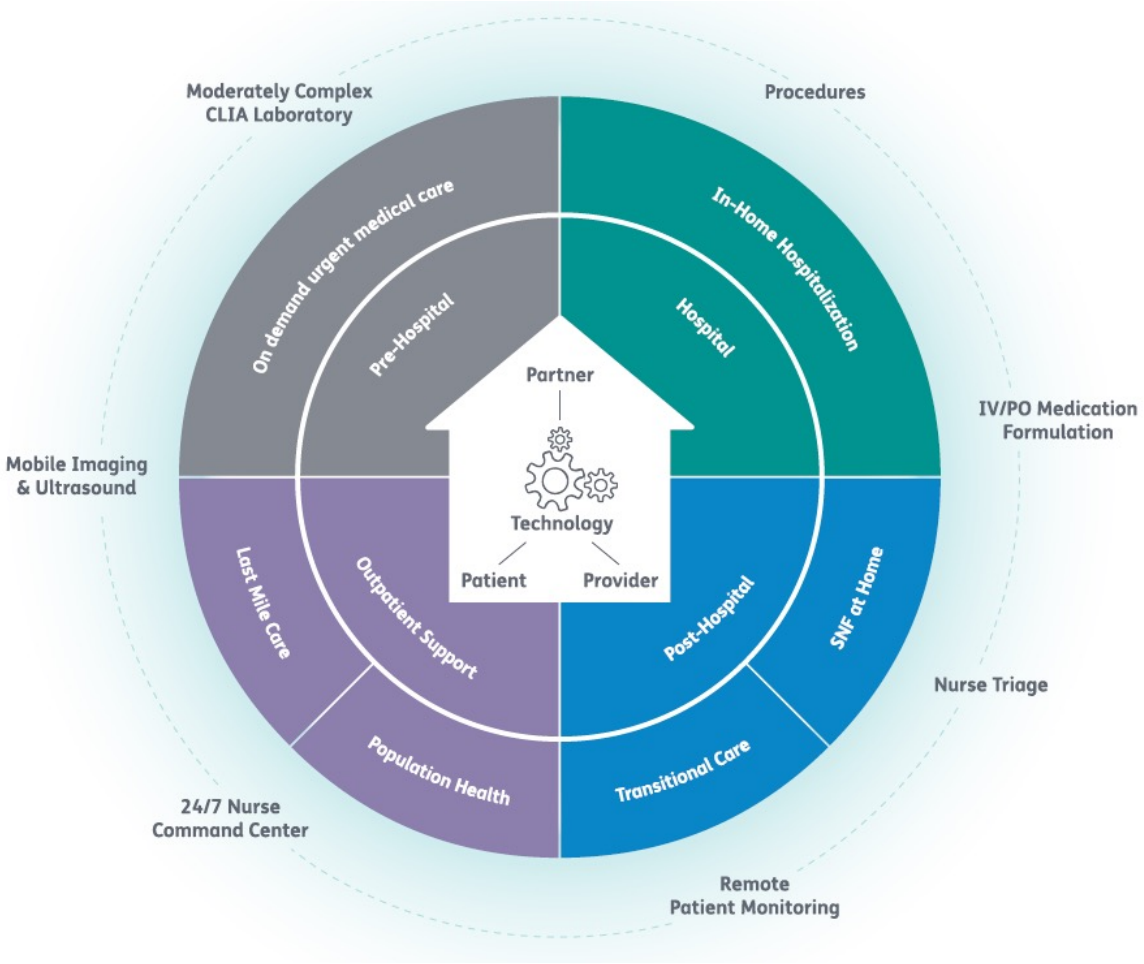
Home Is Where Your Health Is™

Transforming the Facility-Based Care Model

dispatchhealth

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



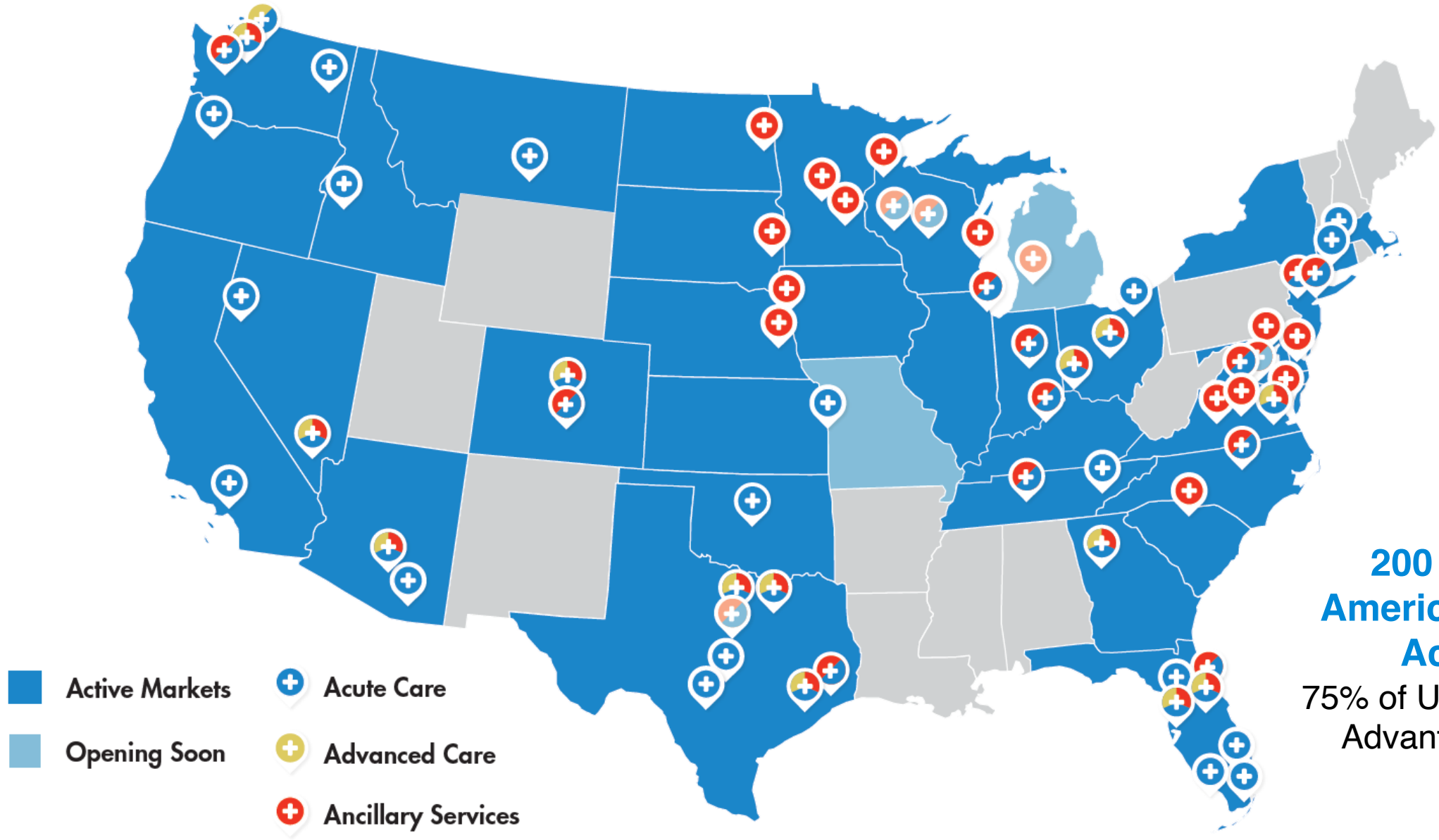
OUR MISSION

We deliver trusted, compassionate care to all in the comfort of home

OUR VISION

Building the world's first decentralized, home-based health system

Strong clinical footprint across the country



200 Million Americans Have Access

75% of U.S. Medicare Advantage Lives

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Differential ability to drive high-acuity admissions

Three key referral sources for Advanced Care model

Account for >95% of Dispatch referrals

1. Admissions from **DispatchHealth mobile ER care teams in the home**
2. Admissions from **PCP or specialist clinics** as an alternative to direct hospital admission

Typical H@H referral channel

3. Direct admissions from **hospital**

All Advanced Care visits managed as 30-day episodes with two phases

Days 0-4

Advanced Care Team: High Acuity Phase


Hospital Medicine NP or PA


RN "Sherpa": care coordinator


Internal Medicine Hospitalist


+ RN Partners

+ PT/OT Partners

- RN coordinating daily
- Activities with morning huddles
- Daily physician / APP visit
- RN visit 2x per day
- Respiratory therapy
- PT/OT
- 24/7 call center access

Up to 30 days

Advanced Care: Transitional Phase

Sherpa-led 24/7 coverage to manage the episode of care

- Home health as needed
- DispatchHealth acute care visit
- 24/7 call center access
- Integrated Plan of Care

- Remote Monitoring
- PCP + Specialist Engagement
- Transportation
- Meal delivery
- EMS / Paramedicine

Transition back to community PCP + specialist care

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Patient Story

80-year-old male

Admitted for CHF exacerbation with hypoxemia and bilateral LE edema

- Hospitalization for respiratory failure, intubation by paramedics in the home secondary to cardiac arrest, defibrillation and ROSC. Patient was designated as DNR / DNI, but paramedics were unaware. Left hospital AMA with no discharge planning or follow up services.
- DispatchHealth acute team visit at family request to assist with shortness of breath and referral for home O2. Room air ambulatory saturation range 78-87% and at rest 89-92%.

  - **Complex Medical History with Multiple Co-morbidities**
    - CHF with EF 8/23 30-35%, ASCVD, COPD
    - IDDM. Episodes of hypoglycemia. HgbA1C 7/27 8.5
    - Neuropathy, likely from DM and daily alcohol, and disturbed gait
  - **DispatchHealth Advanced Care Interventions**
    - Acute team initiated oxygen concentrator on scene
    - Oxygen initiation safety assessment: provided fire extinguisher, working smoke / CO2 detector
    - High-acuity care: POCT lab and send out, BID IV Lasix, Abx for UTI, CXR, daily team rounding, pm nurse visit, nightly RN call
    - OT assessment for safety given decline and addition of trip hazard
    - Adjustment of diuretic, beta-blocker and antihypertensive to level labile B/P and hypotensive episodes
    - Care, support and relationship building with patient and daughter to begin goals of care conversations
    - Patient diagnosed and treated for new onset pneumonia during transition phase

"You are all amazing. We just love that you can come here and help us. He doesn't want to ever go back to the hospital. Thank you for everything you are doing."

- Lives with his daughter, who is also a primary caregiver for a special needs child
- Patient and daughter now connected to his payer's nurse care management to coordinate support
- Due to the trusted relationship we built, the patient decided to transition to hospice care saying, "I'm tired of being a patient and just want to be myself."

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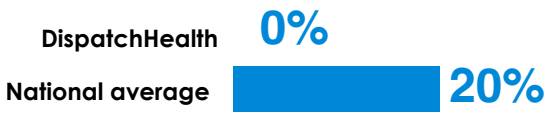
Care Model & Outcomes

Improved clinical outcomes

30 Day Hospital Readmit Rate

SNF Admit Rate



Serious safety event rate: 0%

Unexpected mortality rate: 0%

ED escalation rate: 6%

Increased patient satisfaction

Program Acceptance Rate

(when offered Advanced Care vs. hospitalization)

+98 Patient NPS score

+100 PCP NPS score

75% Patient or family sharing unprompted positive feedback

Additional benefits

Chronic med adjustment	38%
Goals of Care Revision / Goals of Care Conversation	29% / 100%
Intervention on at least one SDOH	67%
Evaluating nutrition, social isolation, fall prevention, pharmacy needs	100%

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Thank you!