Representatives Adrian Smith (R-NE) and Debbie Dingell (D-MI)

Bringing Rehabilitation, Integrated Delivery, and Greater Extended (BRIDGE) Care at Home Act

Hospital overcrowding, patient and caregiver choice and increased capacity for post-acute care make post-acute recovery at home an urgent need. Tens of thousands of patients are unnecessarily stuck in the hospital because there are not enough beds in skilled nursing facilities (SNFs) or home health providers in their area, thereby creating back-ups among patients in the ER waiting for admission. At the same time, patients and caregivers want the option to recover at home. This legislation will allow Medicare beneficiaries who qualify for a SNF stay to receive post-hospitalization services at home.

Medicare Skilled Nursing Facility: The legislation will expand Medicare's post-acute options by creating a five-year waiver of certain skilled nursing facility (SNF) requirements to allow for a demonstration of SNF at Home. Details of the waiver are below.

Patient Choice and Flexibility: Not only would the waiver create an immediate and necessary expansion of post-acute capacity, patients and caregivers want it. A survey found that 86% of all adults and 94% of Medicare beneficiaries prefer care at home after hospitalization. In fact, patients and caregivers showed a "substantial willingness" to pay extra for quality home-based care.

Decrease in Care Gaps: Home-based care expands options in rural and urban areas and changes the power dynamic between patients and health professionals. Medical providers become guests in a home rather than part of the "system." This leads to a greater ability to build trust and communication.

- **People recover faster in the home -** A 2021 study by the National Institutes of Health (NIH) found that at-home patients had a 26% lower risk for readmission.
- **Receiving care in the home can be less stressful for the caregiver -** A case-study found that 96% of caregivers found in-home care less stressful than a previous experience. Benefits cited included comfort, reduced transit time, minimized infection risk, improved sleep and nutrition, animal companionship, among many others.
- **An at-home care option frees up hospital's limited facility capacity** - The Minnesota Hospital Association found that patients spent 65,000 more days in inpatient hospital beds than needed.

How will it work?

As part of the hospital discharge planning process, beneficiaries who qualify for skilled nursing benefits would be given the choice to recover at home with traditional SNF services. Patients become eligible based on an assessment tool that includes consideration of an individual's place of care preferences, functionality, medical conditions, and questions regarding care and family caregiver concerns. Hospitals and SNFs can directly participate in the waiver and furnish or arrange (such as partnering with home health) for SNF-at-Home services in the beneficiaries' home.

Traditional SNF Services Available at Home

- Daily skilled nursing care as needed.
- Daily physical and occupational therapy as needed.
- Daily speech-language pathology services as needed.
- Custodial care as needed.
- Non-emergency transportation.
- Clinically appropriate meals.
- Remote patient monitoring.
- Home adaptive equipment.
- Respite care and caregiver supports, education, and training.
- Medication management and patient supports.
- Care coordination, discharge planning and transition supports.

Moving Health Home
An Alliance to Advance Home-based Care Policy

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. For more information, visit https://movinghealthhome.org/.