Divert from the Emergency Department and Deploy a Hospital at Home Program

Use this guide to understand how HRS can support EDs, hospitals, and health systems

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HRS Health Recovery Solutions

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How HRS Can Support Emergency Departments, Hospitals, and Health Systems

Around the holidays, emergency departments (ED) are already packed with flu patients and injuries. Combine that with COVID-19 positive patients, and you've got an overwhelming number of patients who need hospital-level care. Hospital beds are at a premium. With no other choice, patients are left in observation status in the ED. Overcrowded EDs are strapped with limited resources and staffing—they need a practical alternative. Deploying a successful hospital at home program can offer a real solution.

This guide explains ways to adopt a hospital at home program using HRS technology.

What Is a Hospital at Home Program?

A hospital at home program is an innovative, cost-effective care model that provides hospital-level care in a patient's home as a full substitute for acute hospital care, while improving patient safety, quality, and satisfaction.

Need This Program for Your ED? Here's What You Need to Know:

Patients who meet established criteria—including COVID-19 positive patients—can be sent home from the ED with an assigned care team and **HRS' PatientConnect** remote patient monitoring technology. At home, patients regularly send vital signs and other biometric readings via the HRS technology for the corresponding care team to monitor.

If a patient requires a virtual visit, the patient can connect with the care team in real time to conduct additional clinical assessments. The care team can get a holistic picture of a patient's condition through HRS—patients answer disease-specific symptom surveys included in the technology, which allows the care team to trend survey answers and biometric readings over time. Also, educational videos delivered through the HRS platform empower patients to learn more about their condition.

What Are the Billing Basics?

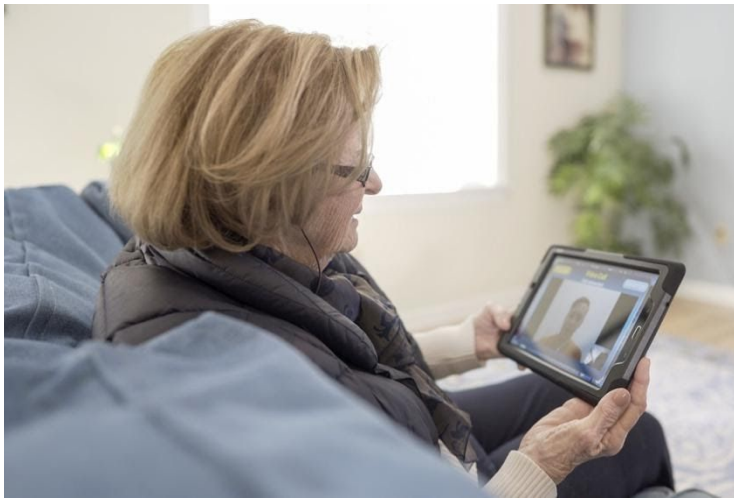
The Centers for Medicare & Medicaid Services (CMS) recently announced a strategy to increase hospital capacity and provide care to patients outside a traditional hospital setting. With the announcement, CMS released the Acute Hospital Care at Home waiver request process, providing acute care hospitals new billing flexibilities to deliver care in a patient's home.

The new model would direct payment to a hospital that has been awarded the waiver and has met the Acute Hospital Care at Home requirements, such as conducting one virtual visit per day between a patient and a registered nurse, and having the patient transmit vital sign readings at least twice per day.

Home health providers can be a critical partner in this program by providing the staffing and technology, but this is not fundamentally a home health program. The Acute Hospital Care at Home program clearly differentiates the delivery of acute hospital care at home from more traditional home health services.

Organizations who have not applied for the waiver can still use home health as a partner to divert patients from the ED by increasing the level of care provided by home health under the existing rules—such as conducting more frequent virtual visits and monitoring biometric data for patients. The home health provider could bill for their services as usual. So, what's the takeaway? **Either option can provide much-needed relief for your organization.**

Examples of Patients Eligible for a Hospital at Home Program:



COVID-19 Positive

Positive COVID-19 test result with mild-to-moderate symptoms requiring less than two liters of nasal oxygen

COVID-19 Negative

Negative COVID-19 test result, but at-risk for COVID-19, presenting symptoms consistent with COVID-19

Other Potential Conditions

Pneumonia, UTI, and wound infections requiring close observation, antibiotic infusion, and/or complex wound care

Example of How to Deploy a Hospital to Home Health Program with HRS:

1. Patient presents to the emergency department with symptoms consistent with COVID-19, including fever, sore throat, cough, and loss of taste or smell.
2. Patient tests positive for COVID-19.
3. Patient's vital signs are stable, pulse oxygenation is greater than 92% with a clear chest X-ray—and there's a willing and able caregiver in the home.
4. The emergency department physician consults with the admitting hospitalist to determine the patient's eligibility for enrollment in the hospital at home program.
5. Once eligibility is established, the hospitalist makes a home health referral, identifying the person as an ED diversion patient. This alerts the partner home health provider to put an agreed-upon process in motion—the patient is enrolled with the **HRS technology platform** and discharged to the care of home health with hospitalist supervision and support. The patient's primary care physician is notified of the patient's condition.
6. The home health nurse meets the patient at home the same day and deploys the HRS technology, including the recommended Bluetooth peripherals for blood pressure, pulse oxygenation, and temperature.

7. Following the managing hospitalist's orders, the biometric parameters and reading frequencies are set within the HRS technology so a patient is aware of how often (and which) biometric readings are required to be sent as part of the patient's care management plan.
8. The patient sends biometric readings and answers COVID-19 symptom survey questions via the HRS platform. To begin, the patient typically sends biometric readings at least twice per day (or as ordered by the physician). The patient also watches the assigned COVID-19 video clips daily within HRS' COVID-19 Recovery Care Plan. Once stable for a minimum of three days, the patient can submit biometric readings one time per day until the patient is ready for discharge.
9. The home health nurse has access to an assigned hospitalist 24 hours a day, 7 days per week for at least 3 days—or until the patient is deemed stable and ready to transition to their primary care provider.
10. The home health nurse completes daily virtual visits with the patient via the HRS platform. An assigned hospitalist also can connect virtually with the patient via the HRS platform to conduct additional health evaluations, write orders, and provide supplementary care, as needed.

HRS offers a Best Practice Virtual Visit Guide for the nurse to reference.

11. Once the patient transitions back to their primary care provider, the patient can complete the home health episode.

Support Your Organization with a Clinically Effective ED Diversion Program

As the U.S. struggles through another dark chapter in this COVID-19 pandemic, our country continues to set new records for cases almost daily. Amid this public health emergency, hospitals, health systems, and home health agencies can create a clinically effective ED diversion program quickly with the help of HRS.

HRS offers **clinical expertise** and a **rapid implementation framework** to help your organization see immediate positive results in the emergency department. Every eligible patient can be treated in the comfort and safety of their own home with HRS technology resources, instructions, and support—freeing up vital hospital beds for patients who truly need them.

HRS' remote patient monitoring and telehealth solutions help emergency departments quickly mobilize efforts during the COVID-19 pandemic.

Reach out today to learn more about how to set up your program.