bright spot

cost | payment/incentives | care across settings

Hospital At Home

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About our organization

Presbyterian Healthcare Services (PHS) is an integrated delivery system in the state of New Mexico with 8 hospitals, a 600+ multi-specialty physician group, and a health plan with over 400,000 members. It is a non-profit system which serves the healthcare needs of over one third of the state's population.

The problem we were trying to solve/the challenge(s) we faced

With ever-increasing challenges around the delivery of quality healthcare at an affordable cost, PHS has determined that it needs to be a leader in the creation of innovative healthcare delivery solutions. Lower reimbursement rates for Medicare and Medicaid, an aging population with a higher burden of chronic illness, and bed capacity issues at several hospital facilities created a gap in the ability to provide quality and affordable inpatient care services. An innovative program was created to provide an alternative to hospitalization for specific acute illnesses, which would otherwise require a 2 – 4 day inpatient hospital stay. This program leveraged multiple care delivery resources including expanded home care services, physician home visits and tele-monitoring to allow quality care to be provided in a patients' home. This program is called "Hospital at Home".

Our bright spot – the successful program, result, or process we want to share

A pilot of this program was started in mid-2009, and to date a total of 469 patients have been entered into the program. Cost savings of approximately $2000 per "hospitalization" have been realized with quality outcomes better than those attained in the hospital for the same diagnoses. Readmission to a higher level of care within 30 days is only 6.18%. This has occurred while maintaining patient satisfaction at high levels.

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The biggest hurdle

A concern from both physicians and patients about the ability to safely provide hospital-level services in a patient's home had to be overcome. Therefore, the pilot was begun within our integrated system for Presbyterian Health Plan managed Medicare and Medicaid members only. This allowed barriers to be proactively addressed in regards to appropriate patient identification, entry criteria into the program, and patient consent. In addition, patient cost-sharing and health plan reimbursement methodologies were able to be addressed early on through an integrated approach. Lessons learned there are being used to further expand the program.

Aha moment or lesson learned

Creating a streamlined easy to manage process for identifying and then enrolling patients into the program was critical. ED physicians and nursing staff were concerned that it took more time to admit a patient into this program than to simply admit them to the hospital. This "pain point" was addressed by streamlining the admission process through intervention by an on-call nurse liaison. In addition, clear cut admission/exclusion guidelines and a solid communication plan helped to effectively address this issue.

To share generously (or steal shamelessly), what advice do you offer?

It is critical to start the program with highly aligned "partners" including a hospital, home care agency, and health plan. A physician champion is very important for effective adoption and communication with ED staff.

Multiple additional opportunities are being explored including expansion to provide palliative care services in lieu of hospitalization and the potential to accept patients with more significant illness as transfers out of the hospital after an initial 2 -3 day stay. This program can also become an effective part of a readmission reduction initiative for patients with chronic illness at high risk for readmission such as CHF and COPD. PHS is in the process of requesting CMS reimbursement for this program, as well as from other private payers.