Atrium Health Hospital at Home

August 22, 2024

Advocate Health Care · Atrium Health · Aurora Health Care · Wake Forest University School of Medicine

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Atrium Health is leading the way in Hospital at Home

Leading the Way with a Swift Launch

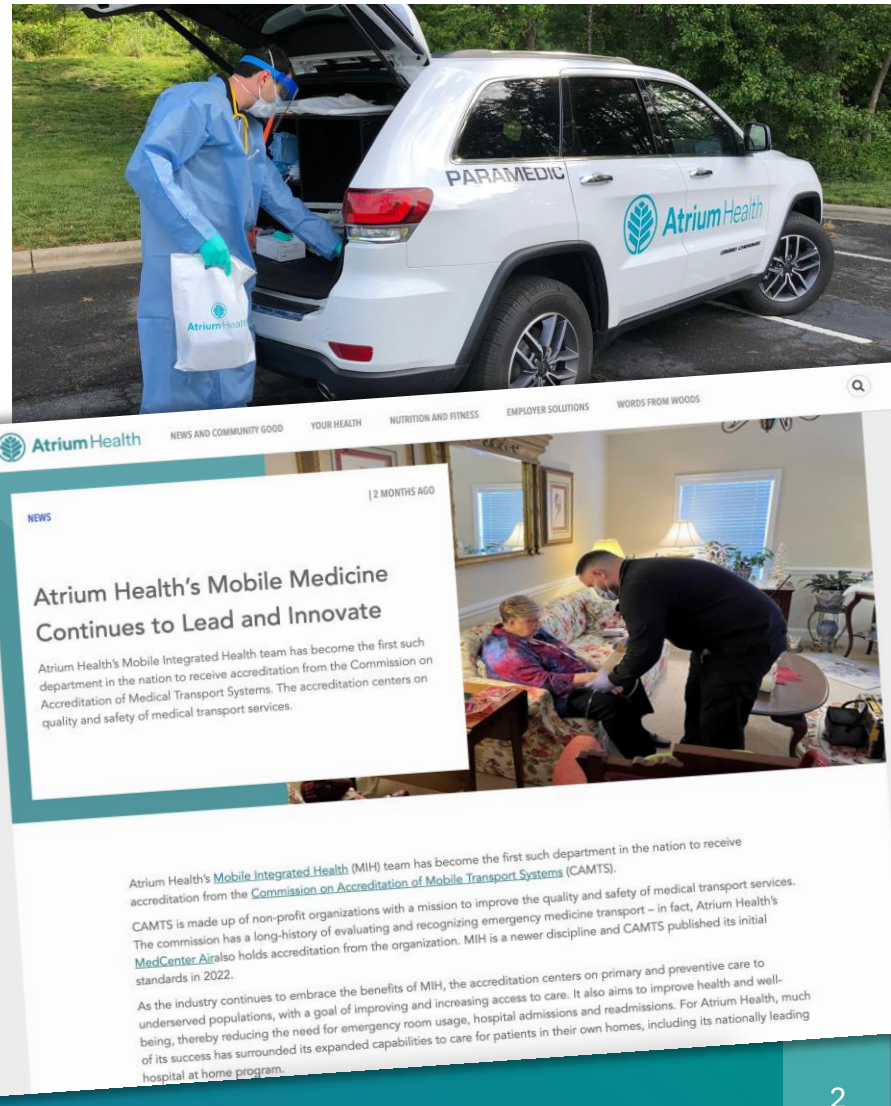
In March 2020, Atrium Health launched its Hospital at Home (HaH) program in response to the pandemic-induced inpatient capacity crisis. It took just 10 days from initial concept to admitting the first patient into the program.

Trailblazers in Efficient Expansion

Harnessing existing resources and expertise from across the System, the program was scaled to serve Mecklenburg and 10 surrounding counties. It provided care without issuing a single claim from March 2020 through March 2021.

Significant Growth and Proven Impact

From the CMS Acute Hospital Care at Home Waiver implementation in March 2021 to today, our program has expanded to 10 facilities, with an ADC of 60 and plans underway to scale to 100 over next 4-6 months.



Achieving key business objectives with Hospital at Home to improve health, elevate hope, and advance healing for all

Reduce
waste and costs for at-risk patients by cutting inappropriate utilization and overall cost of care

Increase
bed capacity by decreasing LOS with earlier discharge to home and reducing admissions/readmissions through home management

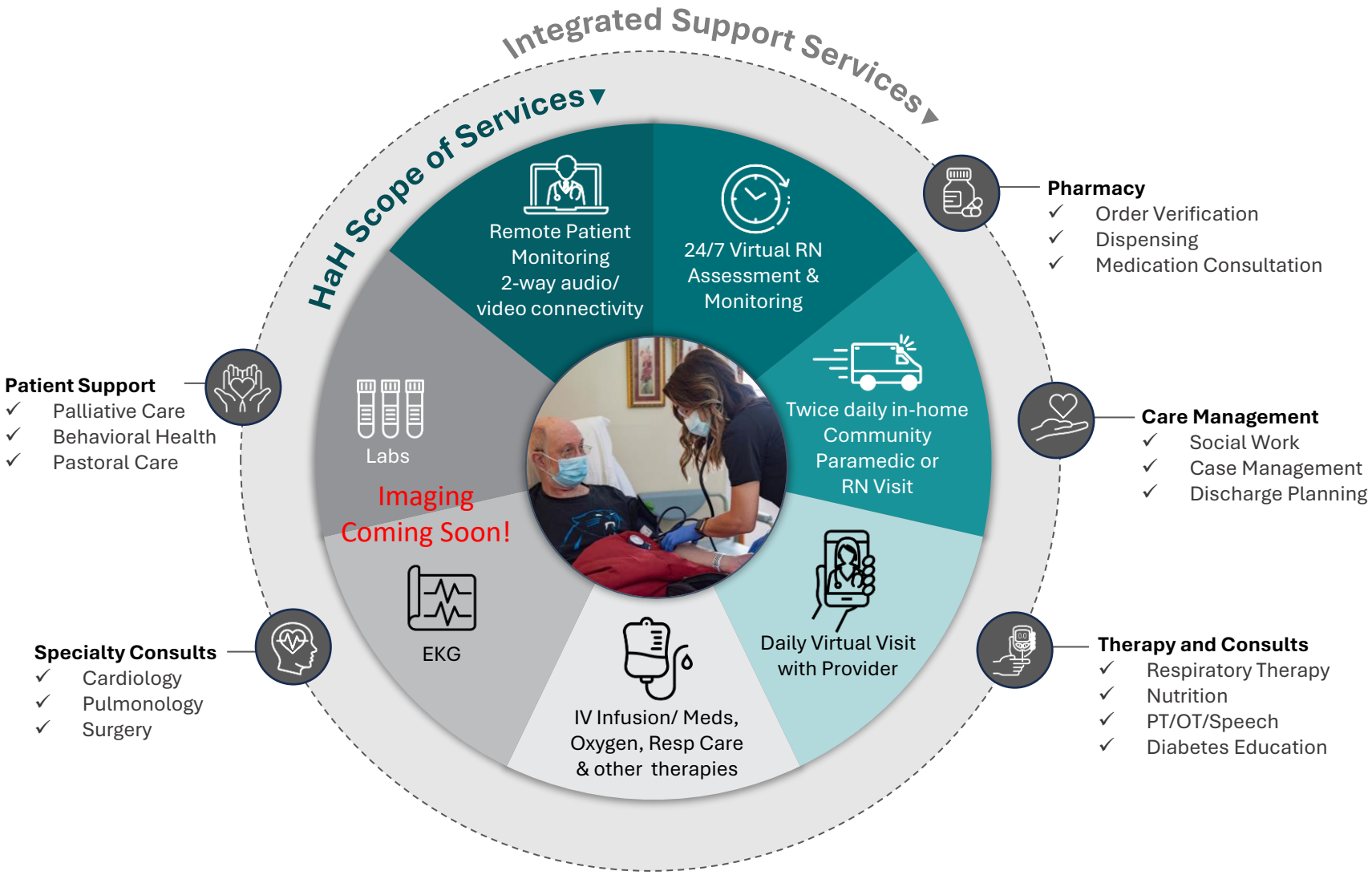
Engage
patients with ”easy-to-use” self-management technologies and timely care escalation

Integrate
clinical programs and resources for seamless care and reduced inefficiencies

Grow
revenue by expanding commercial market share through capacity management

Differentiate
Atrium Health as an industry leader in the market

Patients receive seamless, comprehensive care at home with integrated support



Follow a patient's path from initial identification to discharge

SCREEN

- Identify patients from ED or inpatient unit needing hospital-level care
- Meet eligibility criteria:
  - Clinical
  - Patient
  - SDOH
- Hospitalist conducts in-person H&P

TRANSFER

- Confirm bed availability with PCL
- Provider-to provider handoff
- Write admission orders
- Deliver meds and medical kit
- Secure O2/DME for home

INTAKE

- RN-to-RN handoff
- Nurse performs intake assessment
- Community Paramedic (CP) makes first home visit
- Provider performs intake "H@P" via virtual visit

CARE

- RN assessments and monitoring (2+ daily)
- In-home case by CP (2x daily)
- Daily provider virtual visit
- Virtual specialist consults
- SW, PT, RT, CM, BH, Rx referrals as needed

DISCHARGE

- Stabilized patient is transferred to PCP, specialist and/or Home Health for follow-up
- ALOS 3.5 days

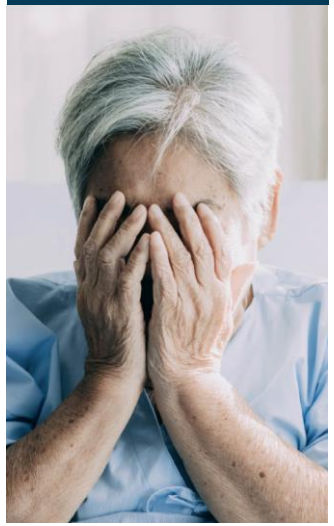
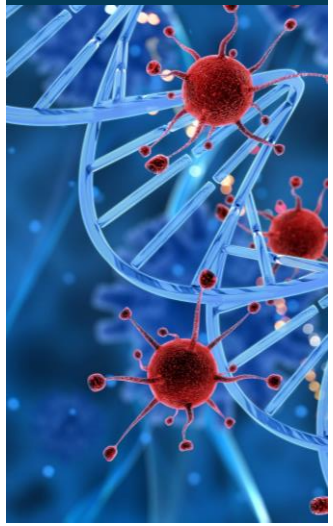
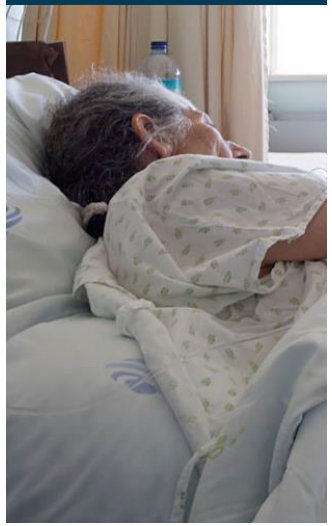
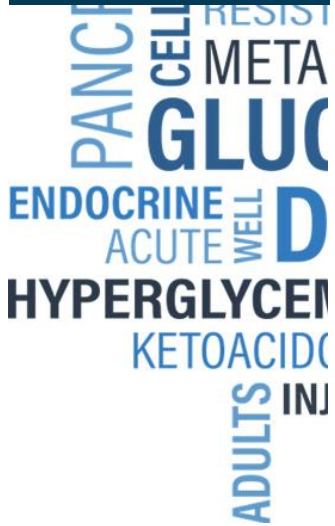
Our HaH program improves outcomes, experience and access through hospital-level care in the comfort of home

Patient Benefits	System Benefits	Population/Community Benefits
Comfort and Familiarity: Patients get care where they prefer… at home… increasing their sense of safety and control.	**Capacity Management:** Increases capacity at brick-and-mortar facilities by avoiding admissions, readmissions and reducing LOS.	**Sicker, Aging Population:** Addresses the unique care needs of the growing aging population who are experiencing multiple chronic conditions but wish to "age in place".
Risk Reduction: Patients face lower risks associated with traditional hospitalization (e.g., falls, infection, delirium, insomnia, etc.)	**Cost Savings:** Potential for lower direct variable cost of care.	**Reducing Health Inequities:** Holistic, whole- person care helps to reduce health inequities and improve access.
Addressing Social Needs: Team can assess and address SDOH, which impact 80% of patients' well-being. in the context of the patient's real life		

We've boosted capacity by caring for more than 11,000 patients – avoiding nearly 45,000 days in facility beds

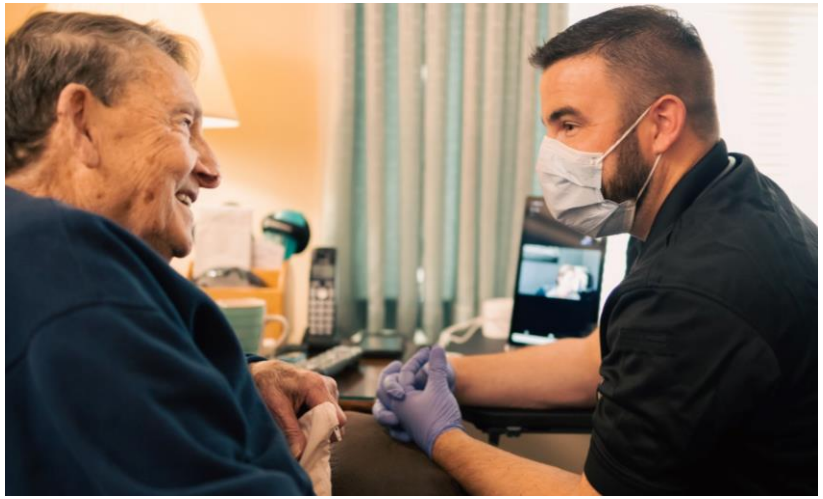
Operations	**Total Patients to Date:** Over 11,000 **Total B&M Days Avoided:** nearly 45,000 **ALOS:** 3.5
Quality	**Readmissions O/E:** 0.78 **Mortality:** <1% **Return to B&M:** 5.0%
Patient Experience	**Overall Rating:** 84.7% *(B&M: 71.8%)* **Likely to Recommend:** 88.3% *(B&M: 75.8%)*

Our approach effectively mitigates the risks associated with traditional hospitalizations

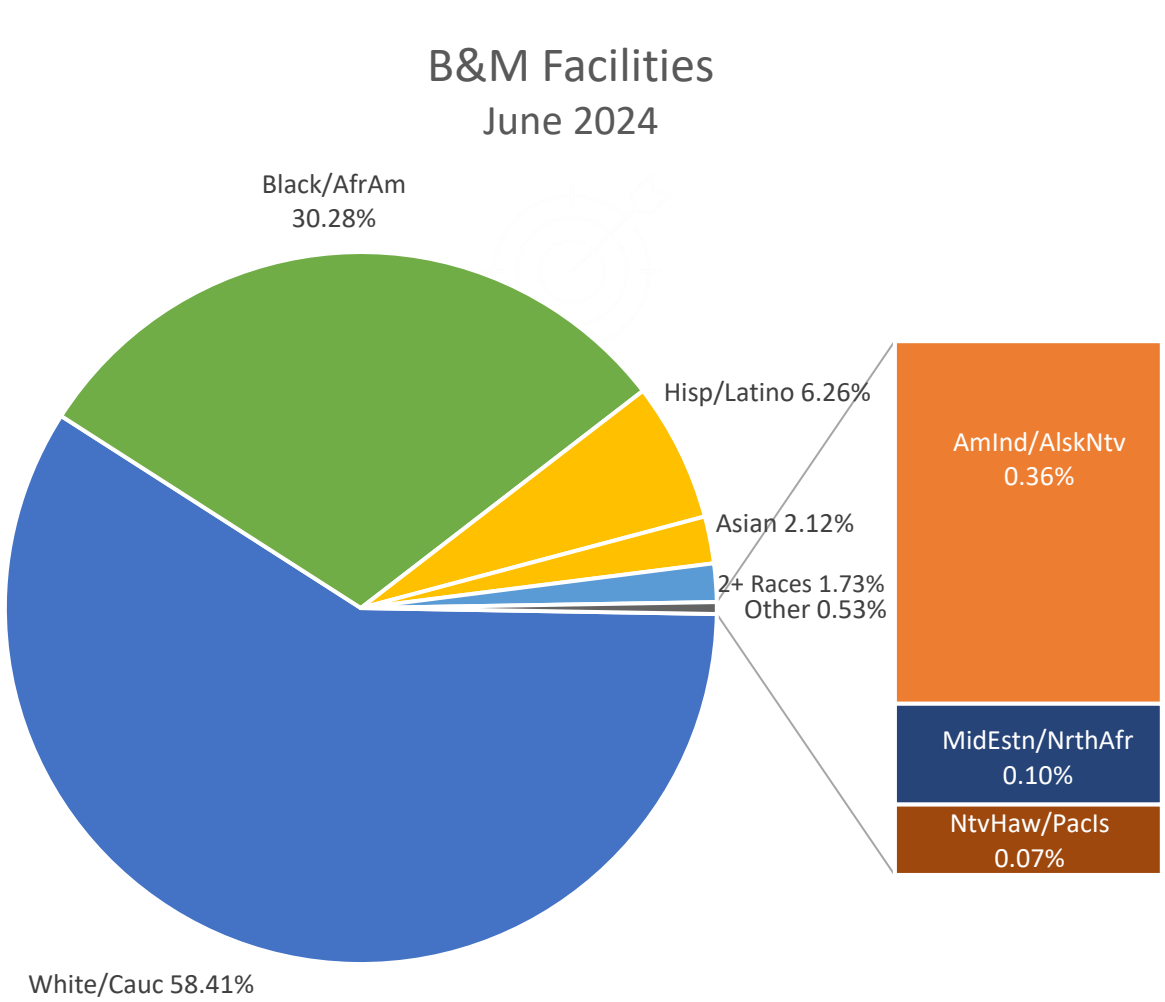
Falls	Delirium	Infections	Insomnia	Immobility	Poor Nutrition	Disease Exacerbation
						

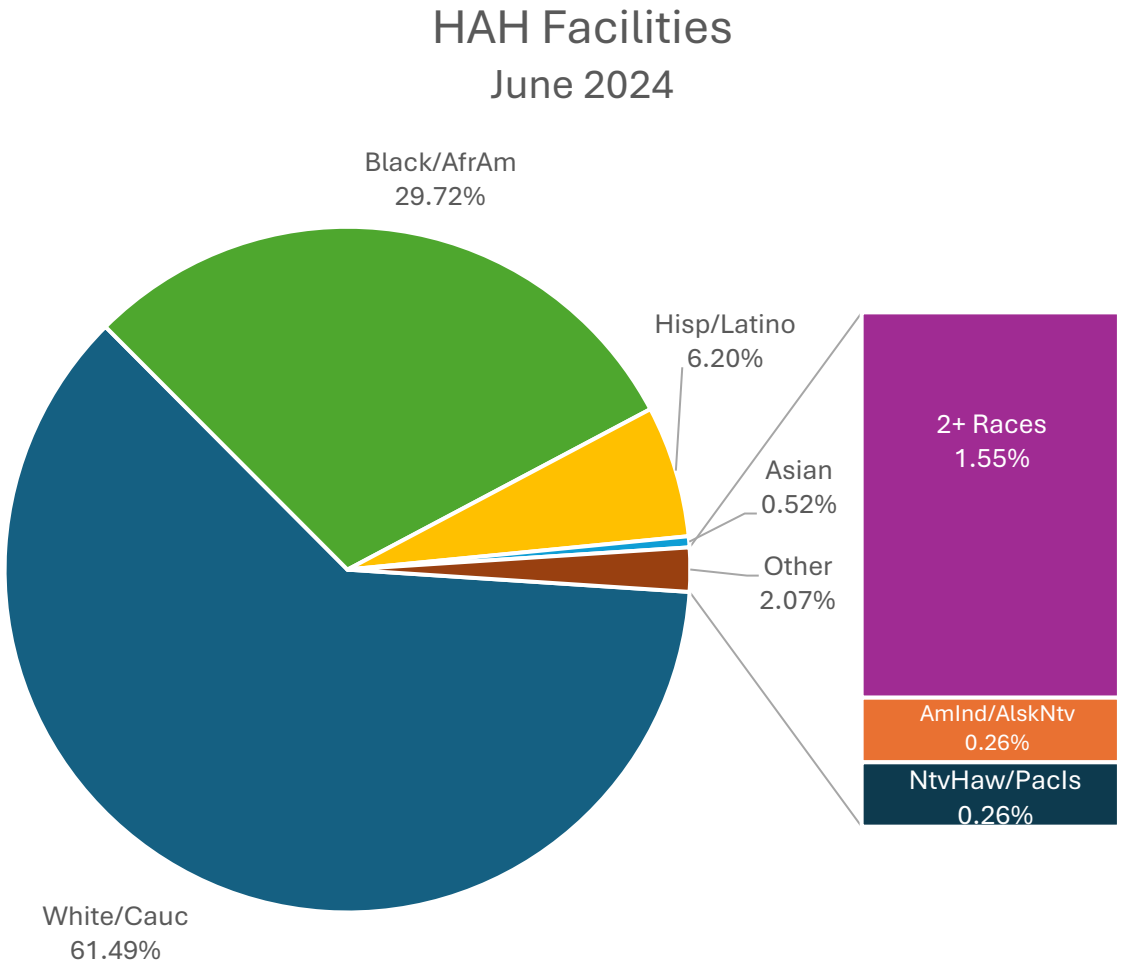
Hospital at Home Case Mix Index (CMI) is commensurate with general medicine in an acute facility

	Hospital at Home	Acute Facility (Gen Med)
2021	1.73	1.36
2022	1.39	1.28
2023	1.28	1.27
Overall	1.42	1.31

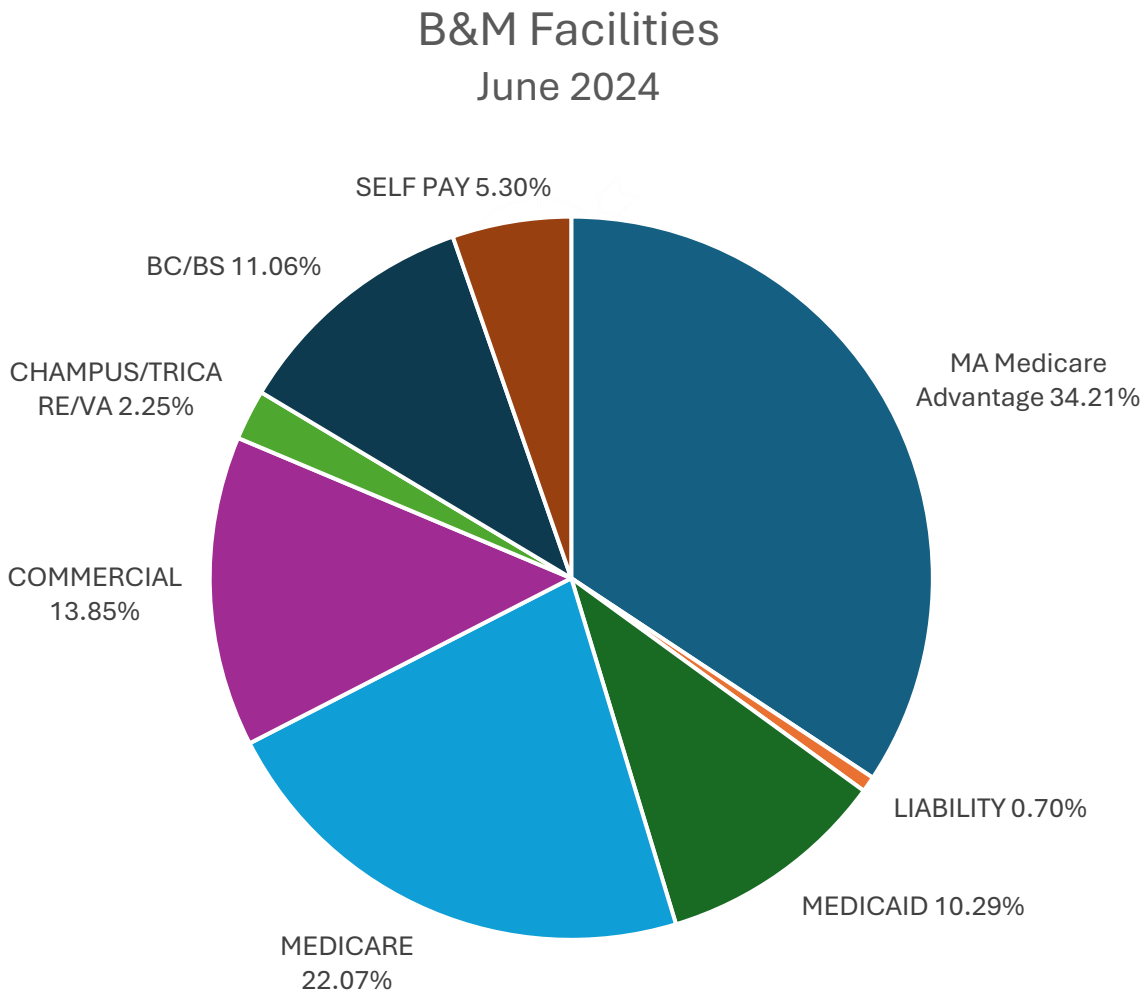


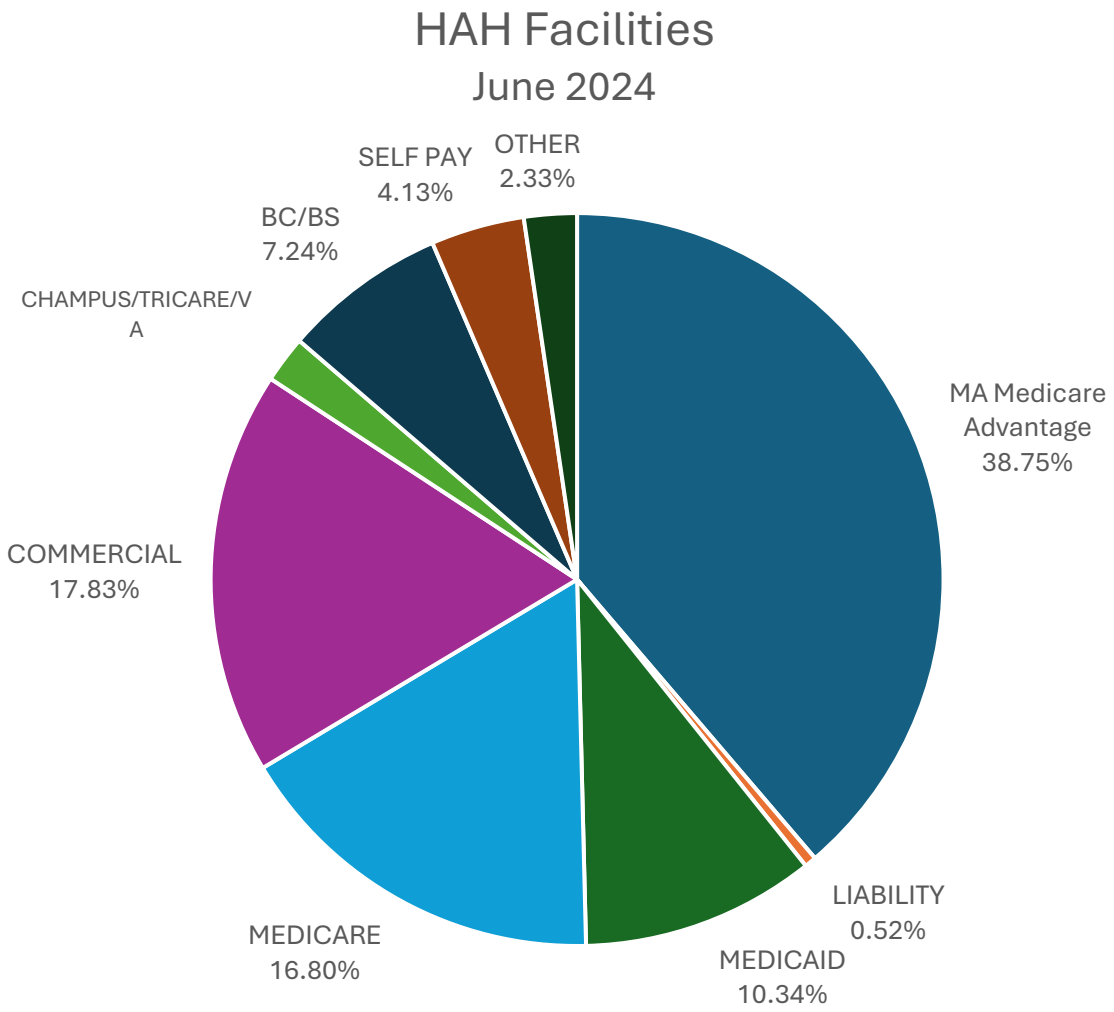
Atrium HaH ethnic/racial mix similar to brick-and-mortar





Atrium HaH payer mix closely mirrors brick-and-mortar





The HaH team uses tech-enabled tools, clinical judgment and dialogue with patients to screen, identify and enroll participants

Sample populations and conditions

Chronic Condition Exacerbation

- Congestive Heart Failure
- COPD/ Asthma
- Diabetes
- Hypertensive Urgency

Acute/Episodic Conditions

- Cellulitis
- Pyelonephritis
- DVT
- CAP
- PE

Covid now approx. 5%

Factors	Eligible	Ineligible (Currently)
Clinical	- Requires no more than 4L O^2 per nasal cannula - Resp <24, Systolic BP >90, O^2 sat >92 on no more than 4 L O^2 or decreasing O2 requirement - Requires VS no more frequently than q6 hrs - Not anticipated to need advanced diagnostics or procedure in next 72 hrs - Patient condition stable enough for RN Virtual monitoring, twice daily in-home paramedic visits and physician virtual visit	- Continuous IV infusion - Parenteral narcotics - Hospice - SNF - LTC - > 20 weeks Pregnant
Patient	- Able to comply, Able to transfer from bed to BR, Not confused beyond baseline, Understands the plan of care and consents to receive care at home	- Patient leaving AMA, Patient refusing H@H, < 18 y/o, Lives outside geog. scope, No support in home
SDOH	- Working phone, Available Emergency Contact, Safe / Stable living situation	- No working phone, No emergency contact, Unsafe/ unstable living situation

As leaders navigating uncharted territory, we've reached new milestones and are shaping the future of Hospital at Home

Key Milestones and Updates

Federal Legislation

In collaboration with various coalitions, advocated for and secured a CMS AHCAH Waiver extension through Dec 2024. Key congressional committees are advocating for a 5-year extension, with at least 2 years expected.

We're collaborating with Advocate Government Affairs to influence state and federal legislation supporting Telehealth, HaH and other home-based care programs.

State DHSR and DHHS

Secured temporary licenses for virtual inpatient beds through new legislation supporting HaH through Dec 2024. As a CON state, permanent HaH IP bed licensure will require legislative action.

Corporate Compliance

We will continue working closely with Compliance regarding CMS rules/regs, billing, scope of practice, etc.

Accreditation

The Joint Commission is not currently surveying HaH programs; new standards are contingent on any revisions to the Hospital CofP, which won't be addressed until HaH Waiver becomes permanent through legislation.

Medicaid Coverage

NC is one of only 8 states that cover HaH through Medicaid. Dr. Janelle White (formerly with Atrium Health and HaH advocate) has been named the new NC Medicaid Medical Director

American Hospital Association™

News / Headline

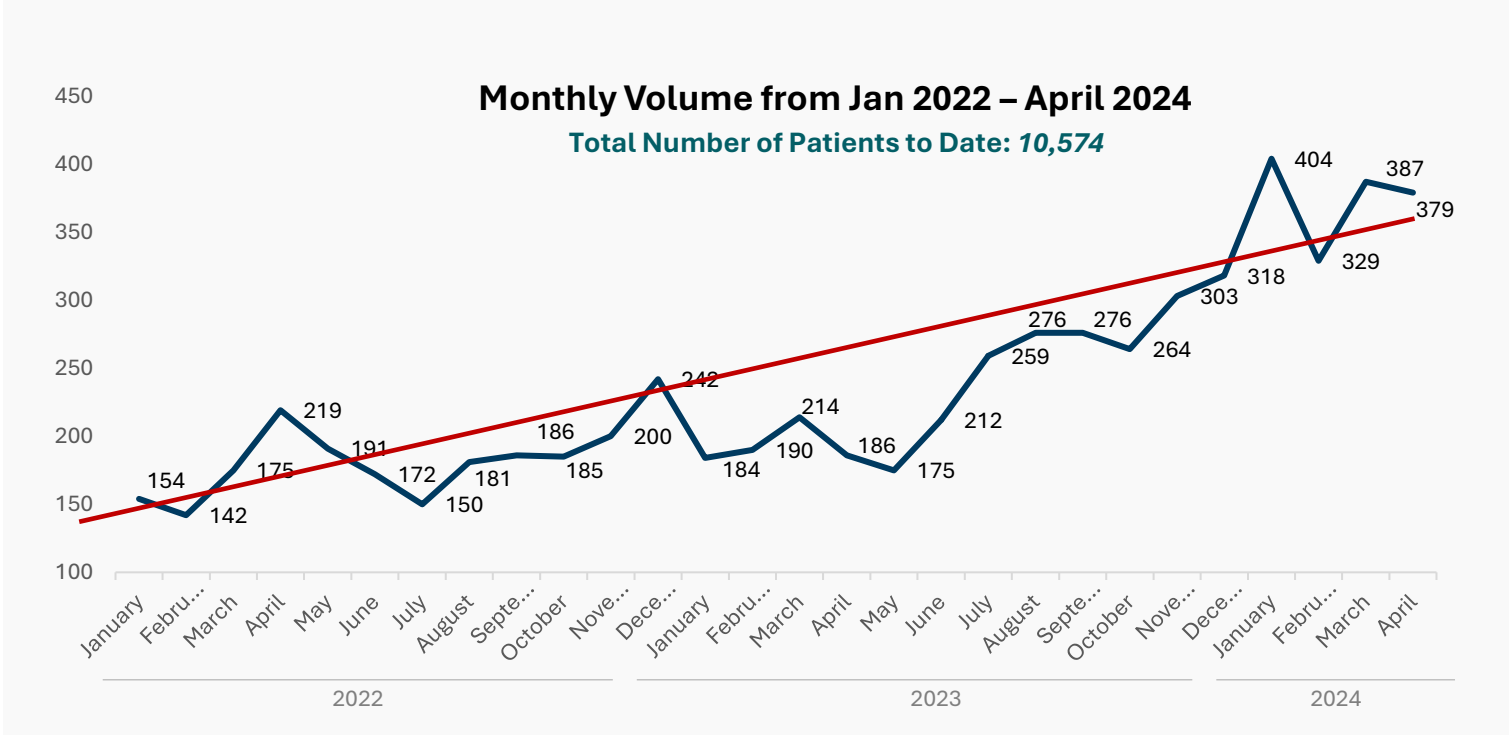
House passes omnibus funding HHS and other programs through FY 2024

Mar 22, 2024 - 03:28 PM

The House March 22 voted 286-134 to pass the Further Consolidated Appropriations Act of 2024, legislation that would fund all remaining federal agencies through Sept. 30. The bipartisan bill includes six appropriations bills, including one funding the departments of Labor, Health and Human Services, and Education. The legislation omits other mandatory health extenders previously under discussion, including site-neutral and hospital price transparency provisions. It also would extend through fiscal year 2024 the Conrad 30 waiver program, which waives the foreign residence requirement for physicians holding J-1 visas who agree to stay in the U.S. for three years to practice

Expanding HaH in GCR eases strain on facilities *(still running at 110-115% occupancy)* without the cost/time of new construction

Facility	Budgeted ADC
CMC	682
Cabarrus	391
Pineville	287
Mercy	183
Cleveland	133
Union	125
Hospital at Home	**100**
University	98
Lincoln	66
Stanly	57
Kings Mtn	33
Union West	28



*"We can't build enough beds to cover the need in this **growing market**." (Sr-Level Finance Leader)*

New hospital will grow with Cornelius

BY DAVE VIESER

Atrium officials say they expect to be coming back to the state and the Town of Cornelius in a few years for permission to more than triple the size of the $150 million hospital that will open here 2024.

When completed the first phase of the new Atrium hospital will contain 38 beds.

They could add as many as 100 more beds in the coming years.

"Growth in this area is inevitable and we are poised to move in that direction," said Bill Leonard, facility executive with Atrium Health University City.

Novant Huntersville has 139 beds and is frequently full. It opened in 2004 with 50 beds on 29 acres at Exit 23.

Hospital need is urgent

Atrium officials emphasized the hospitals," Leonard said. "We need this hospital in Cornelius right away."

Details

be two operating rooms in the new hospital, along with other rooms for procedures, tests and lab work.

There will also be a helipad on the new hospital property.

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Cornelius Today

Enabling factors such as ongoing capacity challenges, favorable regulations, and strong leadership drive the program's success

1. **Initial and ongoing capacity challenges**
2. **Robust clinical capabilities and financials**
   - Clinical excellence
   - "In-house" resources and support services
3. **Financials**
   - Payer agnostic
   - System-level POV on financials
   - Positive Contribution Margin
4. **Regulatory support**
   - CMS Acute Hospital Care at Home Waiver
   - Favorable NC Legislative/ Regulatory Conditions
     - DHSR- bed licensure
     - DHHS- Medicaid coverage
   - Favorable MIH Rules and Regs
   - Supportive NC Board of Pharmacy
5. **Leadership support and "ALL IN" mindset**
   - C-suite, managers, clinical, non-clinical
   - Esprit de Corps!

Key lessons in leading and scaling a Hospital at Home program

Leadership and Strategy

Secure C-suite endorsement and active support
Align with organizational strategy
Be intentional, not tentative

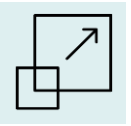
Engagement and Communication

Understand and respond to policies and regulations
Engage stakeholders *(What's in it for me?)*
Communicate constantly and clearly
Share wins to build organizational pride

Design and Growth

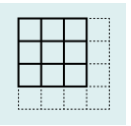
Design thoughtful structures *(Where does it live?)*
Focus on a patient-centered continuum of care
Avoid perfect revenue allocation
Scale effectively to succeed *(If you don't scale, you'll fail)*

Our plan to “Go Big *and* Go Home” includes scaling with tech and infrastructure investments, along with a commercial payer strategy



Scale H@H to make meaningful impact on GCM capacity

- ❑ Scale program to 100 beds (5% of GCM IP beds) over next 4-6 months
- ❑ Launch “Flex Unit” (as an OP service) to provide “hospital-level care” with more operational and billing flexibility

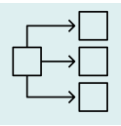


Invest in technology and infrastructure to optimize program

- ❑ Optimize RPM platform and workflows
- ❑ Build enterprise-wide workforce, equipment and supply chain infrastructure

Develop Commercial Payer Strategy

- ❑ Proactively engage payers regarding H@H coverage
- ❑ Develop 30-day Episode of Care/ Bundle payment model among other payer-specific contract options



Define Enterprise Leadership, Structure & Accountability

- ❑ Define Enterprise H@H reporting structure and accountabilities
- ❑ Align and integrate H@H with broader home-based services to create a seamless patient experience and maximize synergies and efficiencies