CREATING EQUITY IN HOSPITAL AT HOME PROGRAMS

ELIMINATING SOCIAL AND CLINICAL BARRIERS TO PARTICIPATION

INTRODUCTION

Hospital at Home (HAH), sometimes referred to as Advanced Care at Home or Hospital Care at Home, delivers acute care inpatient services to patients in the home setting. These programs exist under the hospital license. With the COVID-19 health emergency, waivers were put in place to expand these services to Medicare and Medicaid patients. This created a rapid expansion of programs and currently 124 hospital systems operate HAH units across 278 individual hospitals in 37 states.[1]

The home is an optimal place to provide care, and HAH programs produce numerous benefits.

- Less sedating medication use and delirium[2]
- Lower length of stay[2]
- Better mobility and more engagement in ADLs on discharge[3]
- Lower readmission rates[4]
- Lower cost to deliver care[5]

In addition, this space is a very intimate space to take time and engage patients. When patients are on with a clinical staff member, that is their time alone with them. Families can participate and ask questions as well. Patients feel educated, informed, and involved in their home space. OHSU patients in Hospital at Home consistently score above their counterparts in the brick-and-mortar setting. This trend is seen in other programs.

'HOSPITAL AT HOME' ECOSYSTEM

OTHER SERVICES

- Nutrition
- Oxygen
- Medical Equipment
- Medications
- Meals
- Physical Therapy
- Virtual Visits by :
  - *Chaplains*
  - *Wound Care Specialists*
  - *Directions*

WHAT ABOUT HEALTH EQUITY?

In all digital health, concerns exist around equity, and concerns around equity and Hospital at Home have been both vocalized the media and researched. One review of studies pointed out concerns that older patients were excluded, a group many programs promote to serve with large benefits. That same review noted most studies lacked clear identification of gender, education, race, ethnicity and culture to fully understand the impact on equity of access and results.[6]

Hospital at Home programs have noted that they can view into a patient's home for their care, interact with family caregivers directly, and help prevent readmission. Unfortunately, these studies often have small sample sizes and a limited patient group – 30 readmissions tracking on COVID-19 patients with a sample size of 20 showing no change in readmission[7], 405 veterans of which 399 were men showing mild improvement in readmission[8], and caregiver outcomes have showed mild improvement in qualitative analysis without link to health outcomes for the patient.[9]

These findings in research create a need for more nationally reported metrics that include gender, income, education, race, ethnicity and demographic information. They also require all programs to make equity a strong focus in every effort to make sure their programs create strong impact on the health of the community.

OHSU HEALTH EQUITY STRATEGIC PLANNING GOALS

1. EQUITABLE HEALTHCARE DELIVERY

PRIORITY :

CREATE A VIRTUAL UNIT THAT STRIVES TO ADDRESS ALL SOCIAL FACTORS POSSIBLE TO SERVE PATIENTS SAFELY IN THE HOME.

DESCRIPTION :

ALIGNING WITH OHSU MISSION OF VALUE EQUITY, ACCESS, INCLUSION, AND INTEGRITY, HAH WILL REGULARLY ASSESSES WHO WE EXCLUDE, WHY, AND WHAT RESOURCES CAN BE ENGAGED TO EXPAND CARE TO THEM

EFFORTS :

HOUSING INSECURITY
Patients may not have a residence or it may not be appropriate for care. HAH added temporary residence options at no cost to help treat patients who may not live in the service area or have a fixed residence.

GEOGRAPHIC RANGE
HAH has tripled its geographic area it serves to serve patients in more remote areas.

SUBSTANCE USE DISORDER
HAH has begun to consider patients with recent Substance use. This is an ongoing discussion with the Inpatient Medicine Addiction Team (IMPACT) and the OPTIONS DC group who care for this vulnerable population.

INTERPRETER SERVICES
Interpreter Services (IS) translated home packets into 'big five' languages. IS and marketing have translated other materials and work with options for screening and care of patients who are hard-of-hearing and visually impaired.

EXPANDED ACCEPTED PAYOR LIST
OHSU Hospital Finance has worked to expand payor list to include as few exclusions to payor as possible. They have engaged hesitant payors directly.

2. INCLUSIVE CLINICAL EXPERIENCE

PRIORITY :

CREATE A VIRTUAL UNIT THAT STRIVES TO OFFER HOSPITAL LEVEL CLINICAL EXPERIENCE IN ALL HOMES

DESCRIPTION :

COMMUNITY RESOURCES SERVE PATIENTS IN A WAY THAT MIMICS ACUTE CARE AVAILABILITY. OHSU PATIENTS ARE COMPLEX AND NEED NON-TRADITIONAL HAH SERVICES AVAILABLE URGENTLY.

EFFORTS :

DIALYSIS EXPANSION
This expansion in response to an Oregon Health Authority Waiver provides capacity relief for other patients and expands program services to often chronically-ill, low-income patients.

BLADDER SCANNING
This allows paramedics to respond quickly for patients with renal and urological conditions.

CONSULT SERVICES
Consult Services are engaged regularly by HAH as part of planning to expand patient access to the program. In-advance appointments and workflows are shared with services to increase their buy-in to the program and create a complete hospital level experience for more patients.

CONTINUOUS INFUSIONS, TPN, AND TUBE FEEDING
This service expansion has significantly increased the hospital level experience in the home and allows OHSU to offer their services to patients more appropriately matching their average acuity.

3. EXEMPLAR OF HEALTH JUSTICE

PRIORITY :

CREATE PROCESSES FOR THE OHSU SYSTEM AND SERVICE LINES TO MAKE HOSPITAL AT HOME A CONSIDERATION FOR EVERY PATIENT

DESCRIPTION :

HAH PATIENTS FEEL COMFORTABLE BEING THEMSELVES AT HOME, AND WE STRIVES TO BE A FIRST CHOICE FOR PATIENTS TO RECEIVE CARE. ASK "WHY SHOULDN'T WE SEND THIS PATIENT HOME?"

EFFORTS :

PATHWAY FOR CYSISTIC FIBROSIS
Strong pathways create strong consistent care. The Pulmonary team created a pathway that included their consult physicians and Respiratory therapist rounding daily.

GENDER AFFIRMING CARE
HAH served its first GAC post-surgical patient in November. OHSU TransHealth and HAH are currently in discussions to create a post-surgical pathway for more patients. At present, such surgeries are difficult to schedule due to capacity issues.

'DIRECT ADMISSIONS' USING WORKFLOW
OHSU developed a direct admission workflow with Mission Control. This allows outpatient providers to use the direct admission process and assessment on site to admit patients who then can be transferred to HAH to complete their care. 20 patients have been admitted via this pathway.

FORMULARY
OHSU gives feedback into the paramedic response formulary to ensure emergency response in the home mimics the hospital setting. The limits risk and increases who can be served safely.

PATIENT STORIES
OHSU captures patient stories to promote the program to more patients effectively.

OHSU REGULARY ASSESSES THE DATA OF WE SERVE TO ASSURE THAT THE DIVERSITY OF THE GREATER OHSU PATIENT POPULATION IS REFLECTED IN HOSPITAL AT HOME

ACTIVE AND FUTURE EFFORTS

- OHSU HAH has requested dedicated FTE from Social Work to provide more support to patient who need it.
- HAH is engaged with numerous groups around OHSU to ensure data is being collected and consolidated around care outcomes and patient satisfaction.
- HAH is creating standardized nurse training. This will include training on equity and trauma informed care. While there is system-wide training, the home is a unique space with unique situations. The goals is focus on real life examples and solutions.
- HAH has begun to work with services to "lead with yes". This outlines clear clinical criteria for admission into the home. This limits subjective judgements on what may or may not be appropriate in the home. This subjective judgement often targets patients on their perceived ability to care for themselves rather than the know system capabilities.

OUTCOMES

Using data: How do you incorporate information that helps you follow health equity as you improve your Hospital at Home program? HAH programs need to work to establish connections with those in the system that track outcomes already to add an equity lens to their outcomes. Hospital and hospital systems are complex.

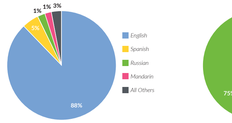
FOLLOW WHO YOU SERVE

PAYOR BREAKDOWN

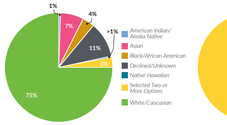
26%	HMP / PPO
26%	Managed Medicare
24%	Medicaid
24%	Medicare

Most HAH programs collect general information on payor and census for CMS per the waiver. Other information like age can be easily extracted. Demographic information on patients can help track the effects of initiatives.

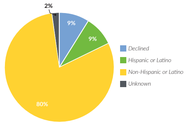
LANGUAGE



RACE



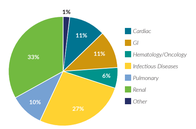
ETHNICITY



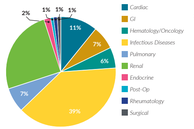
Oregon Health Systems collect Race, Ethnicity, Language and Disability (REALD) information per requirements of Oregon Health Authority. Having this information for HAH patients is helpful for planning around equity. Assess efforts for positive or negative effects on your equity goals as you adjust your capabilities and screening.

FOLLOW THE EFFECTS OF WHAT YOU DO AND PROMOTE

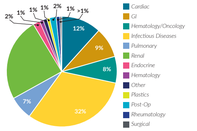
DIAGNOSIS : FIRST 100 PATIENTS



DIAGNOSIS : FIRST 100 PATIENTS



DIAGNOSIS : ALL PATIENTS

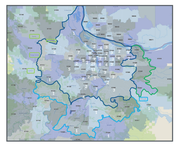


Follow the progression of diagnoses as you advance the system. OHSU HAH has seen a shift in patient populations. The first hundred patients largely reflected community need for dialysis chair placement. The second hundred patients reflected capacity relief needs. Current total patients reflect a more capable system to serve a diverse diagnosis group.

PATIENT DAYS SERVED
(CONVERTED TO BED AVAILABILITY BASED ON ALOS OF 6.5 DAYS)

- TOTAL DIALYSIS PATIENT DAYS : *1148 (BED AVAILABLE FOR 176 PATIENTS IN B&M)*
- ALL PATIENT DAYS : *2382 (BED AVAILABLE FOR 366 PATIENTS IN B&M)*

ADMISSION BY ZIP CODE



ROOD PAVILLION ADMISSIONS
● HOME LOCATIONS

Promotion is key to health equity. Show data in creative ways to teams and patients to demonstrate the strength of the program. Encourage consistent patient referral and then return to working with screening and clinical capability to enhance equity.