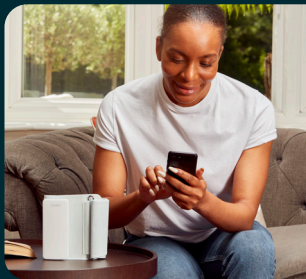




Care at Home: Healthcare's New Cornerstone



Healthcare providers are increasingly developing and implementing care-at-home initiatives – but efforts have been siloed. A comprehensive and integrated care-at-home strategy is key to improving capacity and access issues, managing cost and market pressures, and navigating operational and workforce challenges. This approach can also provide better, more accessible care experiences.

This white paper offers guidance on building an enterprise strategy for care at home, based on the experiences of experts providing consulting and enabling care-at-home services across the continuum.

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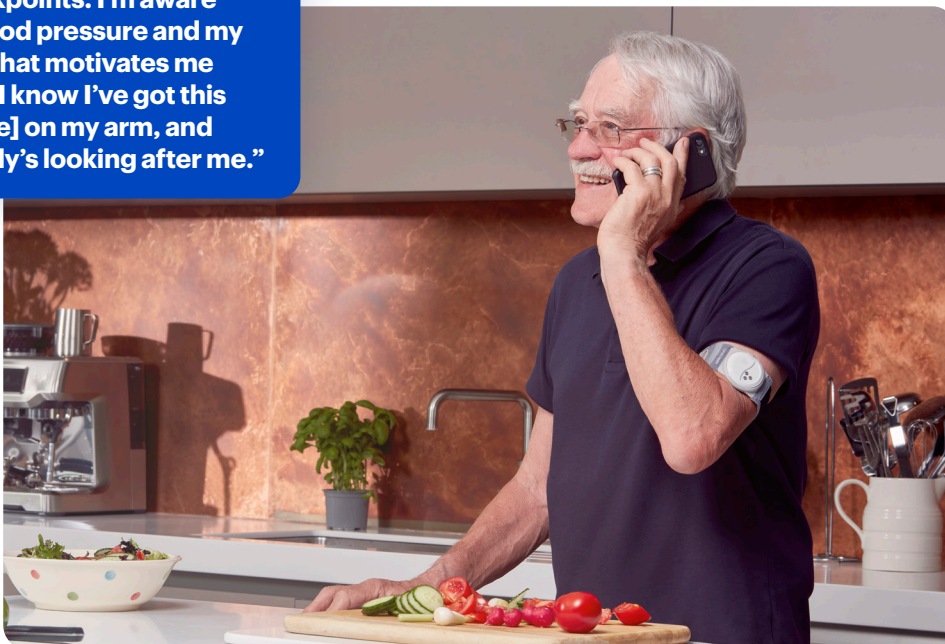
When Paul Knop went to the doctor after struggling to breathe while exercising, he received a startling diagnosis of congestive heart failure. But enrolling in Baptist Health Heart Failure Clinic's home-based healthcare program has given him confidence in his ability to manage and improve his condition.

"It makes me conscious of my health," says Paul, who is remotely monitored through the Current Health-powered program. "Every day when I get up, I know what I have to do; I go through my checkpoints. I'm aware of my blood pressure and my weight. That motivates me because I know I've got this [wearable] on my arm, and somebody's looking after me."

Being in the program has helped him lose 30 pounds, lessening the strain on his heart. When sensors indicate concerns about his blood pressure or heart rate, nurses call Paul—giving him the sense of security he needs to live life to the fullest. "There's nothing holding me back," he notes. "I can do whatever I want to do. I'm being looked after all the time. I think it's great because if I didn't have that, who would be checking on me? I feel good about that. It's the best thing that's happened to me."

For people like Paul, avoiding unnecessary hospitalization while enjoying the benefits of being "seen" by healthcare professionals more frequently than is typical with in-office visits is a major plus of the growing care-at-home model.

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Consumer Demand for At-Home Care

The category increasingly known as care at home encompasses significantly more than just hospital at home models.

It spans a spectrum of innovative virtual and hybrid care delivery models—including remote monitoring for chronic conditions, and in-home services that may have traditionally been delivered within facilities (labs, pharmacy, infusion, etc.). Technological advances such as telehealth, remote monitoring, and intelligent alarms have made it easier to deliver a variety of healthcare services remotely.

The broader availability of care-at-home technology has occurred in parallel with growing consumer awareness of remote and at-home care during the first years of the COVID-19 pandemic. With care-at-home models, individuals can receive convenient, accessible care in the comfort and familiarity of their own homes without worrying about mobility, transportation, or proximity issues. For older adults—and especially those who are living alone—these efforts help them age in place, maintain independence, and feel safer.

Nearly 50% of people are basing their healthcare decisions on convenient locations and more than 50% of people say that convenience is their second-most important driver for brand choice. Additionally, 77% of people 55 and older want to age in place, 78% of Baby Boomers use technology to access medical information, and telemedicine services among seniors increased 300% during the pandemic.¹²

Types of Care-at-Home Use Cases

Depending on system infrastructure, reimbursement policies, technological capabilities, and patient population needs, an at-home care strategy can include the following programs.

Telehealth/virtual visit capabilities, which enable remote consultations between healthcare providers and patients through video conferencing or phone calls, allowing for virtual assessments, diagnoses, monitoring, and follow-up visits

Remote patient monitoring programs, which use connected devices in the home to monitor vital signs (such as blood pressure, heart rate, glucose levels, or oxygen saturation), collect patient health data, and transmit them to healthcare providers, who can remotely monitor patients' conditions and intervene when necessary

Home health services, which are typically prescribed based on patients' specific needs and can include wound care, medication management, rehab/physical therapy, and assistance with activities of daily living provided by nurses, therapists, aides, or other healthcare professionals

Hospital-at-home programs, which deliver acute-level care to patients in their homes with hospital-level monitoring, diagnostics, and treatment for conditions such as pneumonia, cellulitis, or exacerbation of chronic disease

Palliative and hospice care programs, which provide comprehensive, compassionate care for individuals with serious or terminal illnesses and strive to manage their pain and symptoms, provide emotional and psychosocial support, and enhance the quality of life for patients and their families

Pharmacist home visit programs, which provide medication management, specialty drug infusion services, education, and counseling to patients at home and can allow pharmacists to review medications, address medication-related concerns, ensure adherence, and optimize drug therapy.

¹ 2021 Healthcare Consumer Trends Report - NRC Health

² We've entered an unprecedented market for aging in place | Rock Health

Drivers Toward a Comprehensive Care-at-Home Strategy

Fast Facts

About 80% of U.S. hospital beds were in use at the end of 2022³

Hospital expenses increased by 17.5% from 2019-2022⁴

Major acquisitions of home health companies in the past year: CVS bought Signify for \$8B. Optum is buying Amedisys for \$3B^{5,6}

1 in 2 people cite convenient locations as the primary driver for their healthcare decisions⁷

Nearly 25% of inpatients experience adverse events in hospitals⁸

The care-at-home point of view for hospitals, health systems, and other healthcare providers is becoming increasingly clear. Multiple pain points are driving toward adoption of a more comprehensive care-at-home strategy.

The biggest factors are hospital and facility capacity limits, staffing shortages, and financial and market pressures, in addition to:

- **Value-based care models and the need to pursue growth**
- **Patient access barriers due to geographic location, facility closures, mobility limitations, transportation issues, and long waits for in-person appointments**
- **An aging population with a growing need for chronic condition management**
- **Risk of hospital-acquired infections that result in longer hospital stays, higher out-of-pocket costs, and 90,000 deaths each year⁹**

While many healthcare providers have been taking a piecemeal approach to care at home, investing in singular programs that address one or two pain points, those truly benefiting from these programs are taking a more strategic approach. To get the most out of their investments, leading organizations are creating comprehensive care-at-home plans that address short- and long-term challenges to future-proof their enterprises.

An enterprise care-at-home strategy should include a clear roadmap that prioritizes the services that will address the biggest current pain points and then add on programs that will enable organizations to realize long-term visions. In Guidehouse's work with several health systems on comprehensive care-at-home strategies, the initial focus is on post-acute care and improved acute care progression to address hospital capacity challenges, while moving toward a more robust continuum of care strategy supported by an end-to-end care-at-home technology infrastructure.

³ US hospitals are at their highest capacity in a year -- and it's not only due to COVID - ABC News (go.com)

⁴ AHA: Hospitals expenses increased 17.5% from 2019 to 2022 (fiercehealthcare.com)

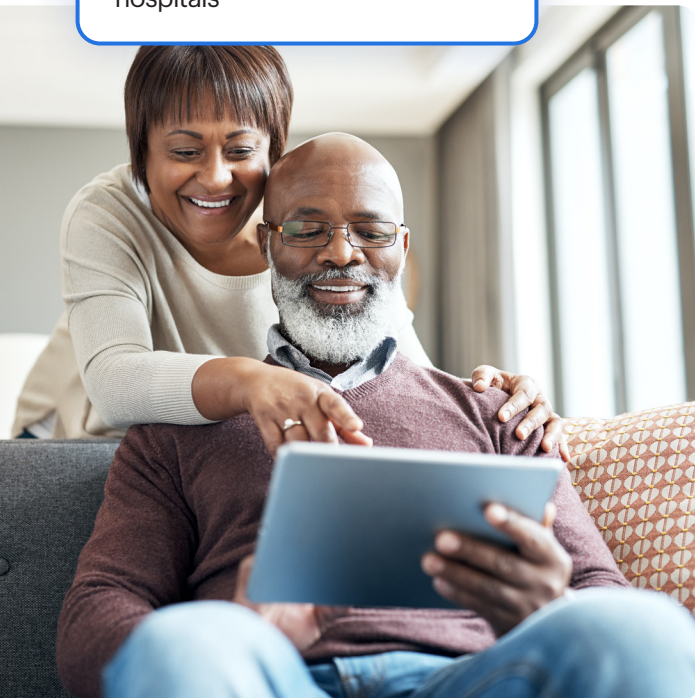
⁵ CVS closes \$8B Signify acquisition | Healthcare Dive

⁶ <https://www.fiercehealthcare.com/providers/unitedhealth-outbids-option-care-health-amedisys-33b-deal>

⁷ 2021 Healthcare Consumer Trends Report - NRC Health

⁸ Nearly 1 in 4 U.S. hospitalized patients experience harmful events, study finds (nbcnews.com)

⁹ Hospital-acquired infections keep rising, wasting billions, finds Leapfrog | Healthcare Finance News



Delivering Value Across the Continuum

For Geisinger Health, an enterprise approach to care at home is delivering value across the continuum.

With a centralized platform, Geisinger runs several different at-home care models, ranging from chronic disease management to acute care at home. This approach allows care teams to step each patient's monitoring and services up or down as needed, while controlling the total cost of care.

Offering care-at-home options can result in improved patient-centered care, better access, cost improvements, and more ways to meet the evolving needs of specific patient populations that can vary significantly by geographic location. By reimagining care delivery with care at home as a cornerstone, hospitals, health systems, and other providers can realize meaningful benefits.

Research has shown that hospitals could realize cost improvements from hospital-at-home models by reducing excess inpatient days, decreasing the volume of clinical testing and consultations, and cutting overhead expenses – all while improving patient satisfaction and avoiding the risk of hospital-acquired infection.



“Geisinger’s care at home model is multifunctional. We focus on the spectrum of chronic disease management within the home. From the highest acuity needs, hospital at home program, to the lowest acuity needs, where we are managing examples like low-risk hypertension. Our patients can communicate with providers effectively, providers can monitor their patients, and both have access to the data to enable them to manage their care better. While helping patients be more connected and empowered, we’re also able to focus on reducing the total cost of care.”

Emily Fry, VP Innovation Operations
at Geisinger

Advantages for Hospitals, Health Systems, and Other Providers

Improved capacity management

Capacity issues took center stage during the height of the pandemic. By providing care at home when feasible, hospitals and skilled nursing facilities can alleviate capacity constraints during times of high demand or public health crises. At-home care can help avoid unnecessary hospital admissions, reduce hospital stay length, and prevent readmissions. It can also help free up hospital beds for patients who require higher acuity care, allowing hospitals to focus on those with more complex needs.

Optimized resource utilization

In light of continued healthcare workforce challenges, shifting care from expensive hospital settings to more cost-effective home-based care can result in the most effective use of resources while yielding cost improvements. Research conducted by Current Health and the Defense Health Agency showed that the presence of a virtual care program yielded facility-level cost savings.

Scalable chronic disease management

Through the use of personalized monitoring, medication management, and lifestyle support in the home environment, care-at-home can help reduce hospitalizations and improve patient outcomes, providing a way to lower the total cost of care.

Better post-acute care transitions

By providing necessary services, rehabilitation, and support after an acute encounter, care-at-home programs can help facilitate smooth transitions from acute care settings to home, shorten length of stay, reduce the risk of complications, ease patient recovery, and improve care coordination.

Expanded wellness and preventive care touchpoints

At-home care can also encompass preventive care and wellness services. By providing health screenings, health education, preventive interventions, and lifestyle coaching, healthcare organizations can proactively address health risks and promote healthier lifestyles.

Better alignment for value-based care organizations

Care-at-home models complement accountable care organizations, Medicare Advantage programs, and other value-based models that strive for high-quality care delivery across the continuum of care while controlling costs.

Ultimately, these models offer significant business growth opportunities for meeting consumer-driven demand by expanding care delivery through care-at-home solutions that don't carry the typical infrastructure, equipment, staffing, and other costs of in-facility care.

Across types of care-at-home programs, data and workflow integrations play a key role in driving adoption and scalability. Care at home must integrate with the EHR at key junctures: patient enrollment and discharge, patient records, vitals and notes, billing, and a dashboard view of all the patients on the service. Integrated data and workflows are vital for scaling the program as well as reducing redundant work and delivering a good provider experience.

Ideal Candidates for Care-at-Home Strategies

While leaders across the healthcare ecosystem need to have care-at-home initiatives in their strategic plans, there's a sense of urgency for certain healthcare providers to make them a cornerstone.

1

Large academic medical centers at full capacity

A Guidehouse analysis shows that academic medical centers are treating more patients across the U.S. each year. This drives up their case mix index and average length of stay, as well as operating expenses, which rose 123% between 2008 and 2020, according to Medicare cost reports. Yet revenues flow in unpredictably, and academic medical centers incur a higher average adjusted cost-per-case than other hospitals. Developing or enhancing their hospital-at-home programs and involving hospitalists in emergency department operations and emergency patient care decisions at an early point can provide capacity relief while reducing that uncertain gap between operating expenses and revenues.

2

Rural hospitals with limited patient access

With the COVID-19 pandemic accelerating pre-2020 rural healthcare challenges, it's become clear that the gap between urban and rural health outcomes is increasing. Factors such as shrinking populations, hospital closures, provider shortages, increased competition with urban and suburban amenities, and shifts in payer mix all contribute to this bottom-line realization: Evolving healthcare trends have rendered the rural healthcare delivery model unsustainable. While some organizations have seen success through concerted efforts at changing that model, more sustainable change could be achieved by investing in at-home care for the rural communities chronically facing access obstacles.

3

Specialty service line providers

Oncology, kidney failure, and transplantation care programs are just several of many natural matches for care-at-home strategies. Keck Medicine of USC is on the forefront of this revolution, having developed a virtual care solution for USC's gastroenterology service line, among other innovations. Through the Center to Stream Healthcare in Place—a multi-institutional partnership Keck leaders helped to establish—the academic health system and the school of medicine are developing convenient wearable devices that collect information with a clinical level of rigor and enable clinicians to provide “care in place” by remotely monitoring patients wherever they are, checking in with them, and giving them medical advice.

Care-at-Home Models in Action

1

Investment in a future-focused, highly technological model for at-home care has positioned Palomar Health to realize substantial cost, quality, and efficiency improvements. The health system worked with Guidehouse on the enterprisewide transformation initiative, which included gaining CMS Acute Care at Home waiver approval in three months, aligning acute and ambulatory workflows, and implementing the program in six months. **“We’ve seen the impact not only in decreased readmissions and happy patients and families, but also in reduced cost of care for those with chronic illnesses,”** said Sheila Brown, former Palomar Health COO.

2

With support from Current Health, Atrium Health runs a large hospital-at-home program, relying on continuous monitoring technology that allows providers to capture the full picture of patient health and adjust care plans according to real-world factors. This model strengthens continuity in care, patient and family education, and support for clinicians’ data-driven view of patient health. **“We’re able to monitor vital signs continuously, at all times, just like you would in a hospital setting,”** says Manny Mill, an Atrium Health community paramedic. **“We can get an EKG if needed, draw labs, and give medication. Anything you can do in a hospital setting, you can do here.”**

3

Keck Medicine of USC (University of Southern California) worked with Guidehouse on a beyond acute strategy that **identified multiple initiatives to improve hospital capacity and throughput by more efficiently transitioning patients through the care continuum**, including a post-acute care collaborative and attaining the CMS waiver for an acute hospital-at-home program.

4

Baptist Health worked with Current Health to adopt an at-home care program for its heart failure clinics, empowering patients to take control of their condition in the convenience of their own homes. **This approach has resulted in zero congestive heart failure-related readmissions among participating patients.** The Kentucky-based health system’s program represents part of a larger strategy to reinvent the patient experience.

5

An academic, military tertiary referral center instituted same-day discharge to home for care following bariatric surgery. Patients were monitored through the Current Health platform and were shown to be highly adherent (97%). **The program shortened length of stay by 2-3 days and yielded between \$3,000 and \$11,000 cost savings per patient.**

How to Make the Care-at-Home Business Case

1. Clearly state primary goals such as improving patient outcomes, reducing hospital readmissions, increasing patient satisfaction, or optimizing resource utilization.

2. Identify who would benefit from at-home care services, considering disease conditions, acuity levels, and potential cost impact.

3. Assess the market to better understand home-based care demand, identifying existing providers, potential partnerships, and available reimbursement models.

4. Conduct a cost-benefit analysis that covers staffing, technology infrastructure, equipment, training, and ongoing operational expenses while estimating potential cost improvements and revenue generation opportunities.



5. Quantify projected clinical and quality outcomes through reduced hospital readmissions, improved patient satisfaction scores, enhanced care coordination, better care plan adherence, and other metrics and benchmarks.



6. Redesign clinical operations with active involvement of clinicians and physicians, establishing exclusionary criteria while determining standards of care and cross-walking clinical competencies with inpatient care competency requirements.

7. Review pharmacy integration to ensure that medication dispensing, workflows, and evidence-based standards of care meet state requirements, including 340B reimbursement.

8. Analyze reimbursement/financial models to understand rates, payment model options, and regulatory factors that might impact financial viability.

9. Outline a detailed implementation plan that includes necessary infrastructure, staffing requirements, technology integration, care protocols, and workflow processes, then identify potential challenges and develop mitigation strategies.

10. Conduct a thorough risk assessment that covers regulatory compliance, staffing shortages, technology limitations, patient safety, and privacy/security concerns, then develop risk mitigation strategies and contingency plans.

11. Engage key stakeholders (executives, clinicians, payers, patients) to gain support, identifying barriers to adoption and working to overcome them.

Getting the Most Out of Care-at-Home Construction

With growing use cases for care at home, organizations can find a model that aligns to existing strategic priorities and operational needs, whether that is increasing inpatient capacity and throughput or lowering the costs associated with treating chronic conditions. Constructing a cross-continuum enterprise strategy will look different for every organization, depending on their existing services and assets.

With many organizations having implemented care-at-home initiatives over the past few years, building an enterprise strategy may require grappling with slivers of solutions deployed across the continuum of care. Bridging existing care-at-home models to the organization's long-term vision may be a complex undertaking, but enterprise technology with EHR integrations and cost-effective, scalable support services (monitoring, logistics, and technology troubleshooting) should form the basis of that evaluation.

Aligning to the organization's long-term strategic plan, health systems should build a comprehensive care-at-home strategy that phases in the care models and clinical use cases that will meet operational and strategic priorities. With this approach, healthcare leaders can address community needs while strengthening care quality, patient retention, financial performance, and prospects for growth.

In an increasingly complex market, the flexibility of care-at-home strategies to pursue a variety of goals provides healthcare leaders with a powerful tool for safeguarding today's care delivery models while building toward the healthcare we want tomorrow.





From **BEST BUY** Health™

Current Health, a Best Buy Health company, provides an enterprise solution that enables our partners to deliver safe, cost-effective, and scalable care in patients' homes. Our solution unifies remote patient monitoring, telehealth, and patient engagement tools to give a holistic picture of patient health for populations across the acuity spectrum. Collected data feeds into our Clinical Dashboard for real-time insights, that integrate seamlessly with the EHR, enabling risk stratification across entire patient populations, early interventions, and efficient resource management. Powered by Best Buy, Current Health provides reliable services to support programs at every step, with supply chain management, in-home Geek Squad services, and 24/7 tech and clinical support teams, and dedicated implementation experts. We're bringing the best of retail to the forefront of healthcare and provide a secure and viable solution for healthcare organizations looking to make home a primary site of care.

For more information, please visit www.currenthealth.com or email sales@currenthealth.com



Guidehouse is a leading global provider of consulting services to the public sector and commercial markets, with broad capabilities in management, technology, and risk consulting. By combining our public and private sector expertise, we help clients address their most complex challenges and navigate significant regulatory pressures focusing on transformational change, business resiliency, and technology-driven innovation. Across a range of advisory, consulting, outsourcing, and digital services, we create scalable, innovative solutions that help our clients outwit complexity and position them for future growth and success. The company has over 16,500 professionals in over 55 locations globally. Guidehouse is a Veritas Capital portfolio company, led by seasoned professionals with proven and diverse expertise in traditional and emerging technologies, markets, and agenda-setting issues driving national and global economies.

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