

# Virtua Health Expands Impact of Hospital at Home with Post-Discharge Pathways

## Case Study

Virtua Health Expands Impact of Hospital at Home with Post-Discharge Pathways

## Key results.

**30%**

Reduced unnecessary tests and consultations by 30% with enhanced remote patient monitoring and engagement.

**86.5**

Achieved an 86.5 Net Promoter Score, with high satisfaction reflected in feedback and surveys, praising home comfort, food quality, and personalized care.

**20**

Removed 20 inpatient beds from the capital expansion plan, with a projected 20-24% shift in care to home settings.

## Summary.

Virtua Health, a five-hospital health system operating in southern New Jersey and the greater Philadelphia area, began a hospital-at-home program to transform the traditional hospital care model, enhance the patient experience, and increase inpatient capacity across the system.

This program not only saved significant hospital bed days but also served as a foundation for expanding to transitional care at home, offering a wide range of clinical use-case applications.

# Virtua Health **at a glance.**



## **Virtua Health Network**

Includes 5 hospitals, 400+ care locations, and over 40 ambulatory surgery centers.



## **Program Launch**

Hospital at Home program went live in January 2022.



## **Program Evolution**

Expanded into two models in April 2023, including post-discharge care, treating over 1,500 patients across 60+ Diagnosis-Related Groups.



## **Key Goals.**

**1**

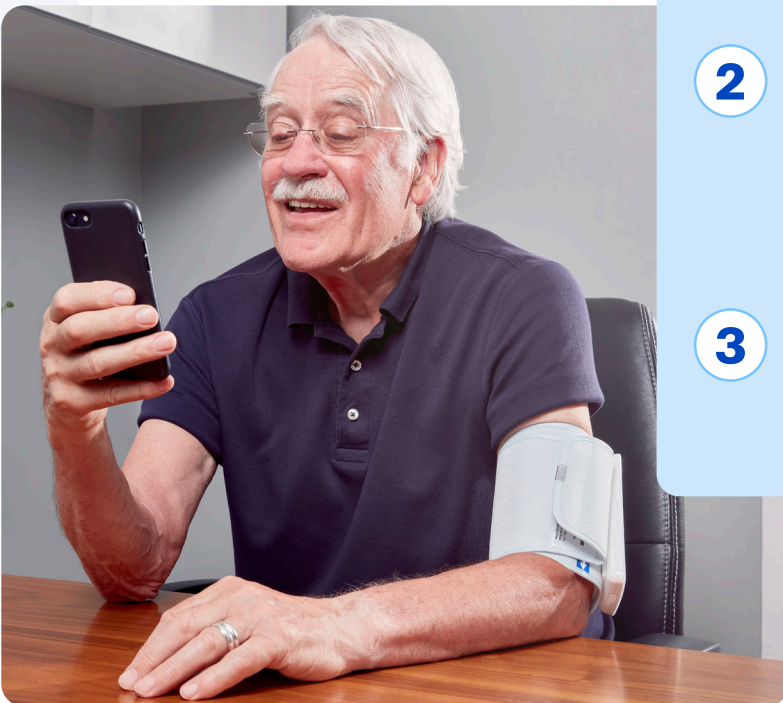
Broaden the scope of home-based care by providing a **24- to 72-hour in-home “Step Down” service.**

**2**

Reduce length of inpatient stays and reduce risk of readmissions to **alleviate the pressure on hospital resources.**

**3**

**Improve patient satisfaction and understanding** for post-hospital care.





# Care-at-Home **Program Overview.**



## **Virtua Health's Hospital at Home Program**

**Virtua Health's Hospital at Home program, launched in January 2022, aimed to provide full acute care in patients' homes as an alternative to traditional hospital stays.**

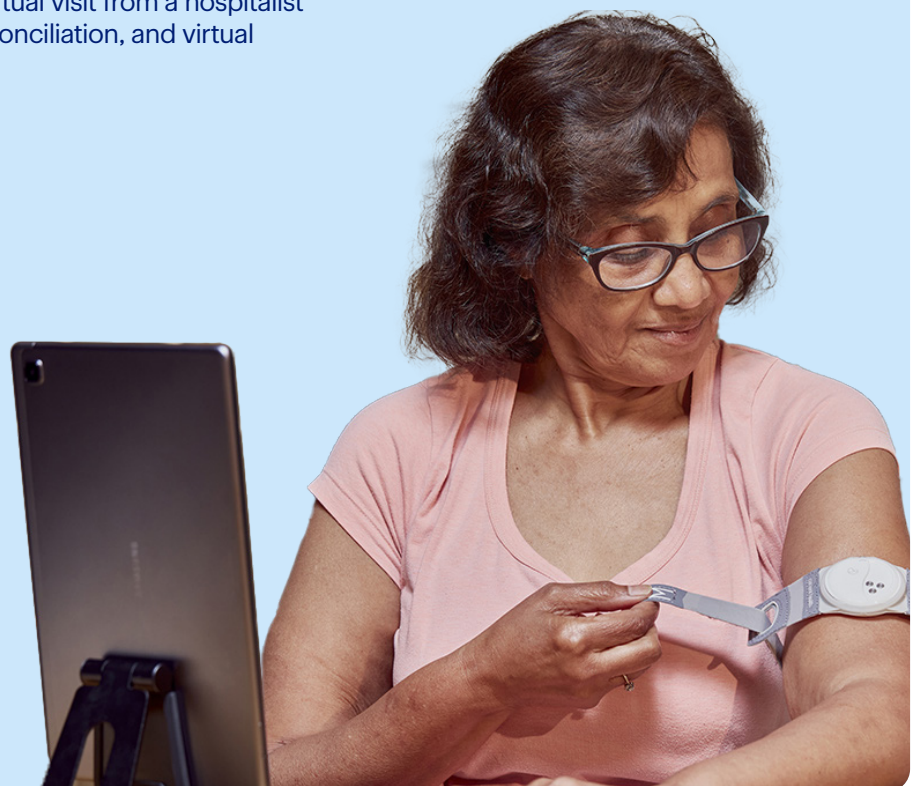
24/7 RN Command Center with daily virtual visits from hospitalists, twice-daily virtual RN visits, and continuous monitoring using remote patient monitoring kits.



## **Care After Discharge Program**

**The Care after Discharge program, launched in April 2023, was developed to provide a virtual transitional care unit for patients post-discharge.**

24-hour continuous monitoring for the first day leading to a stepped down monitoring period, a virtual visit from a hospitalist within 24 hours, virtual medication reconciliation, and virtual nurse check-ins.



# Solution.

Explore the Current Health Hospital at Home Solution



Virtua Health utilizes the Current Health solution for deep insights into patient health at home through continuous and intermittent monitoring devices and promotes adherence to care plans through patient engagement tools.



**Discover a journey of empowered recovery, from the comfort of home during extended IV treatment.**



"I didn't need that hospital room for two days of IV therapy. Hospital at Home is fantastic. If they offer this to you, go home; you get to sleep in your own bed, settle on your own couch, you get to have the dogs and your family all around you. You couldn't ask for anything better."

**Candy, Virtua Health  
Hospital-at-Home patient**

Watch the video



# Solution.

How Virtua Health runs **Care After Discharge**, ensuring continuous patient support and health monitoring after they leave the hospital.

## Patient Identification

Patients who have been discharged from the hospital but require additional monitoring and care for a short period, typically 24 to 72 hours, to ensure a safe transition to outpatient care.

## Program Enrollment

Patients are enrolled in the program, often after a short inpatient stay, and are equipped with necessary technology, including remote patient monitoring kits, for home-based care.



## Activation Support

A Virtua nurse arrives at patients' homes. They receive comprehensive support, including technology setup and education, ensuring they are comfortable and confident in using the provided equipment.

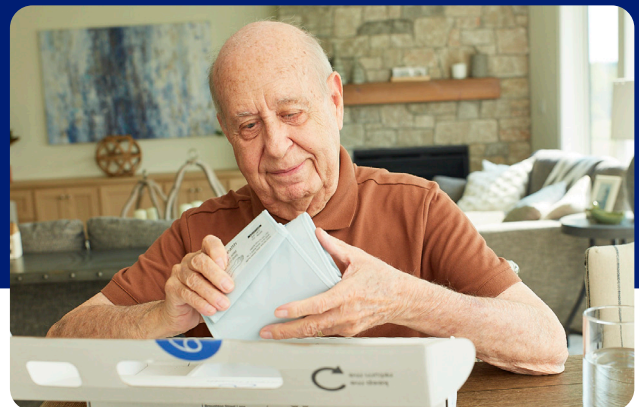


## Monitoring & Care

Patients receive continuous monitoring and care through a combination of virtual visits, remote patient monitoring, and in-home support. This includes medication management and reconciliation.

## Graduation

Patients typically stay in the program for 24 to 72 hours, with the goal of reducing readmissions and ensuring patient preparedness for complete outpatient care.



# Results.

## Hospital at Home.



**2,400** bed days saved with 800+ patients treated.



**3.1 days** average length of stay, which was 1.0+ days shorter than similar patient cohort in the traditional hospitals.



**Expanded into 60+** Diagnosis-Related Groups.

## Care after Discharge.



**1% readmission rate** with more than 700 patients treated. Of these readmissions, **approximately 50% were direct admissions**, bypassing emergency departments, indicating effective monitoring and timely intervention.



**Expanded to all 5** Virtua Health hospitals.

“In 2024, we’re projecting our Care After Discharge program to treat somewhere in the neighborhood of **2,500 to 3,000 patients and that amounts to about 8,000 to 9,000 day reduction in our facilities**. That in itself gets a lot of attention in our organization.”

**Michael Capriotti, SVP of Integration and Strategic Operations, Virtua Health**

## Overall.

# 30%

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# 86.5

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# 20

Removed 20 inpatient beds from the capital expansion plan, with a projected 20-24% shift in care to home settings.

**Discover the impact of Virtua Health's Care-at-Home program**



Watch the video





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