

CASE STUDY

How an Enhanced Home Health Program Creates Hospital Capacity

Using home health to manage low-acuity patients after ED discharge

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Overview

The challenge

Amid the Covid-19 pandemic, health systems need to create capacity to prepare for the surge in demand for acute care. While most systems are adopting a home first approach for discharge, doing so without the proper structure and support for patients could lead to poor health outcomes such as increased lengths of stay and hospital readmissions.

The organization

Starwell Health Care¹ is a not-for-profit medical system based on the East Coast. Starwell currently comprises Starwell Hospitals and its provider network, a home health agency, the clinical programs of the Starwell School of Medicine, and eleven affiliate hospitals and hospital systems across the state.

The approach

Starwell Health Care created an Enhanced Home Health program to manage patients presenting in the ED with low-acuity conditions. Instead of being admitted for observation or initiation of therapy, those patients are discharged directly to home with support from a team of home health clinicians. The program liaison identifies patients eligible for the program in the ED and coordinates follow-up care. RNs conduct in-person visits under the supervision of a physician—providing hospitalist-like functioning in support of the patient’s PCP—who conducts virtual visits to monitor the patient’s progress, guaranteeing timely follow-up within 36 hours of the patient’s discharge from the ED.

The result

Starwell has observed high patient engagement and is collecting data to quantify the reduction in care costs and improvement in health outcomes. A number of payers in the market have expressed interest in the program as well as a willingness to increase reimbursement and cover virtual visits. As of June 1, 2020, this program has treated 61 patients. Out of those 61, just four have returned to the ED, with only two of those having a hospital admission.

1. Pseudonym.

Approach

How Starwell discharges patients from the ED to their Enhanced Home Health program

To create capacity and reduce the risk of patient exposure to Covid-19 in the hospital, Starwell created an Enhanced Home Health program to deliver in-home care to low-acuity patients presenting in the ED. Instead of being admitted for observation or initiation of therapy, they are discharged directly to home after stabilization in the ED. Starwell convened a group of 10 specialists to determine the patients most suitable for the program. A nurse liaison embedded in the ED identifies and enrolls eligible patients, trained Covid-19 Response RNs then conduct in-person visits under physician oversight.

The three program components

Below are three components necessary to launch a high-value home health program for low-acuity patients presenting in the ED:

01 Embed liaisons in the ED to identify patients

02 Upskill clinicians to deliver complex in-home care

03 Incorporate advanced-level clinician oversight

01 Embed liaisons in the ED to identify patients

Identifying the target population is a critical element for successful implementation of the Enhanced Home Health program. Starwell convened a group of 10 specialists to determine the types of patients that would best be served by the program. Each clinician then identified the patient subtypes under their respective specialties that could safely be treated in the home.

Patient eligibility

The team uses the following factors to determine patient eligibility.

CLINICAL	HEALTH AND FUNCTIONAL STATUS	Patients presenting in the ED requiring hospital admission for ongoing monitoring or initiation of treatments but stable enough to receive care at home.
	CLINICAL CONDITIONS	COPD, Pneumonia, Complex Wound care, CHF, and Covid-19.
NON-CLINICAL	HOME SAFETY	Home environment conditions such as safety, fall hazards & accessibility needs
	SOCIAL DETERMINANTS OF HEALTH	Patient access to family or caregiver support, mental health status and access to food

ED-embedded nurse liaisons identify and enroll patients

Another crucial step is figuring out how to identify and enroll patients into the program. Starwell embeds a care liaison in the ED to work with physicians to identify patients most appropriate for the program.

Currently, Starwell’s program has hired a team of seven full-time liaisons who cover both of their hospitals 24/7 via a central phone number for all Continuing Care Services, including Enhanced Home Health. They have prior experience in case management and are able to help patients navigate care. They work to schedule in-person nurse visits and virtual follow-up care with the physician.

To ensure appropriate ED discharges, the liaisons coordinate expedited oxygen deliveries to allow for appropriate ED discharges. Liaisons also order any DME needed prior to patient discharge. As some patients have expressed concerns with allowing home care staff into their homes, Starwell is utilizing DME proof of delivery waivers to facilitate contactless delivery of ready-to-use equipment.

02 Upskill clinicians to deliver complex in-home care

Following the drastic decline in home health volumes due to cancelled elective surgeries, Starwell reallocated their workforce to support the Enhanced Home Health Program. Starwell recruited LPNs to help with the less acute home health patients to allow the RNs to manage higher acuity patients out of the EDs with a caseload of no more than 10-15 EHH patients on caseload at a time. The RNs perform assessments, administer treatments and medications, and provide education to the patient over 7-10 weekly visits on average.

In-person training ensures patients are managed safely

To ensure that patients receive high-quality care, Starwell also developed a training program to upskill RNs, LPN, and PTs with the relevant knowledge and skills necessary. Since RNs are required to deliver an expanded scope of services under the program, Starwell based the training curriculum off of the most common procedures patient groups eligible for the program typically receive. The training consisted of one week of Covid-19 training, and one day of a non-Covid-19 skills refresher.

Over the course of a week, RNs, LPNs, and PTs were trained on Covid-19 infection control measures, including how to don and doff PPE, and when to use appropriate equipment. In case patients required mouth-to-mouth resuscitation, clinicians were issued Ambu bags and isolation kits to decrease the risk of transmission through forced inhalation. The clinicians worked together in simulated scenarios to ensure they were prepared to perform life saving measures if necessary while waiting on EMS to arrive.

Additionally, over the course of one day, RNs refreshed their skills on wound care, peripheral IV infusion, and diuresis protocols. The workshops were hands-on and conducted by advanced level clinicians.



Front-line clinicians

- RNs, LPNs, and PTs trained on new protocols to manage patient at home
- Manages case load of 10-15 patients
- 7-10 visits weekly post-ED discharge

03 Incorporate advanced-level clinician oversight

Finally, to ensure ongoing monitoring of patient care, Starwell Health incorporated advanced level clinician oversight. The program is lead by Master Prepared Nurses and a Continuing Care Medical Director.

RNs directly supervise LPNs and support physicians with developing a plan of care for the patient. They also monitor tests and laboratory results, as well as the patient's condition. Currently one RN supervises four LPNs in the program.

Home health RNs become the Care Manager for the patients care across the health system while the patient is in the Enhanced Home Health program. Collaborating and coordinating services as well as educating patients and caregivers on disease management and Covid-19 self care and isolation protocols.

Physicians monitor patient progress

Typically, physicians refer patients to home health and approve plans of care, but with Enhanced Home Health, physicians provide ongoing medical management and periodic evaluation and assessments in collaboration with the patient's primary care provider, Starwell specialists, and Starwell Home Health agencies.

Starwell is taking advantage of CMS' recent waivers that allow for physicians to bill for virtual visits for home health patients. The physician performs a virtual visit within 36 hours of ED discharge, and again 5-7 days later. Throughout the patient's care episode, physicians conduct 3-5 virtual visits total. This system ensures a consistent timely follow-up from physicians. Additionally, to ensure that patients can receive a visit within 36 hours of ED discharge, the physicians operate on a rotating schedule.



Nurse leader

- RNs directly oversee LPNs
- 1 RN hired to managed 4 LPNS



Physician

- 3-5 visits weekly post-ED discharge
- 10 specialists manage all patients in the program

Results

Early results

While the Enhanced Home Health program is still a pilot, Starwell is currently collecting data on patient satisfaction, reduction in readmissions and overall care costs to prove its value. They are also negotiating with payers in the region to increase reimbursement rates to match the potential program benefits and resource investments.

- **High patient engagement:** So far 61 patients have been referred to the program and only 11 have declined to participate translating to an 82% acceptance rate.
- **Expected improvement in outcomes:** Of the 50 patients they have treated, only four have been readmitted to the ED, and just two of those four were hospitalized. Additionally, over the month of May, 30% of patients have been discharged back into the community with goals met.
- **Engaging payers in reimbursement increases:** Starwell has also engaged various payers in the market in discussions on increased reimbursement given the relative resource intensity of the program. The state's Medicaid program has agreed to increase the visit rates for patients receiving home health care during the Covid-19 pandemic.

Beyond the pilot, Starwell expects to expand the program to other patients presenting in the ED or those discharge early from the hospital. They hope to continue with the program even after the pandemic slows down.

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