NAACOS
Home Based Models
Short Presentation and Panel Discussion

September 21, 2023

Without Mount Sinai at Home…

Typical Episode of Acute Illness in the United States

Admission

Acute Care

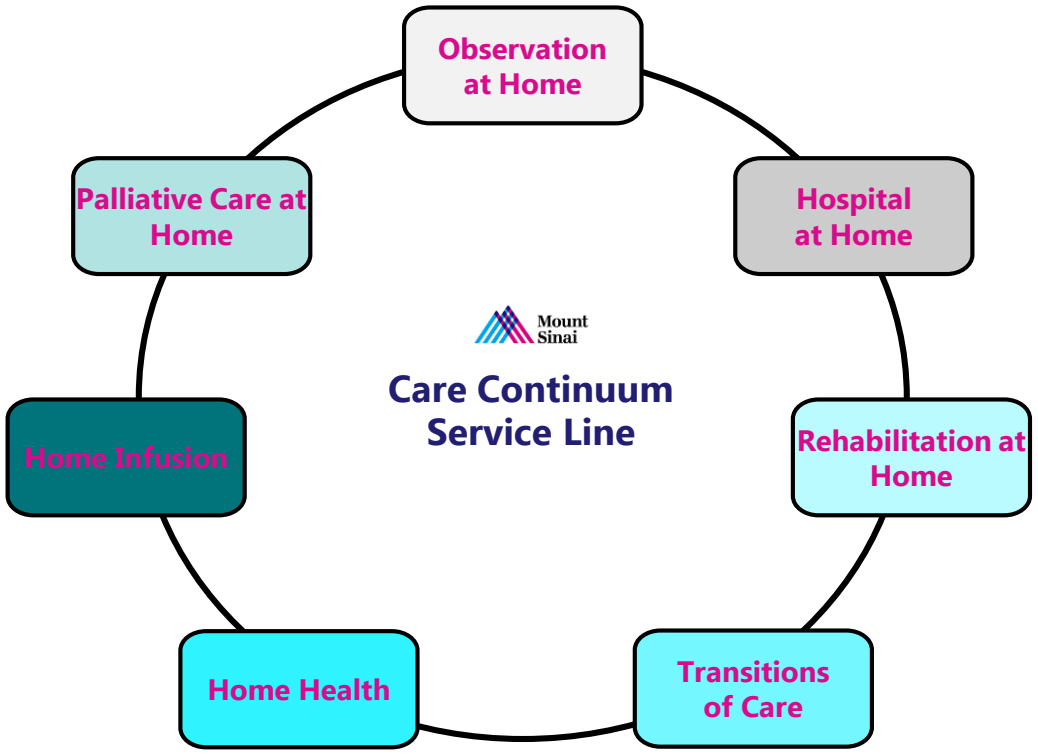
Post-Acute

Imagine the Alternative…

- Nurses coming to home at least 2/d
- Providers rounding daily
- Virtual consults with specialists
- PT/OT
- SW
- 24/7 access to the clinical team
- Community Paramedicine
- Being in patient's familiar environment and around family!

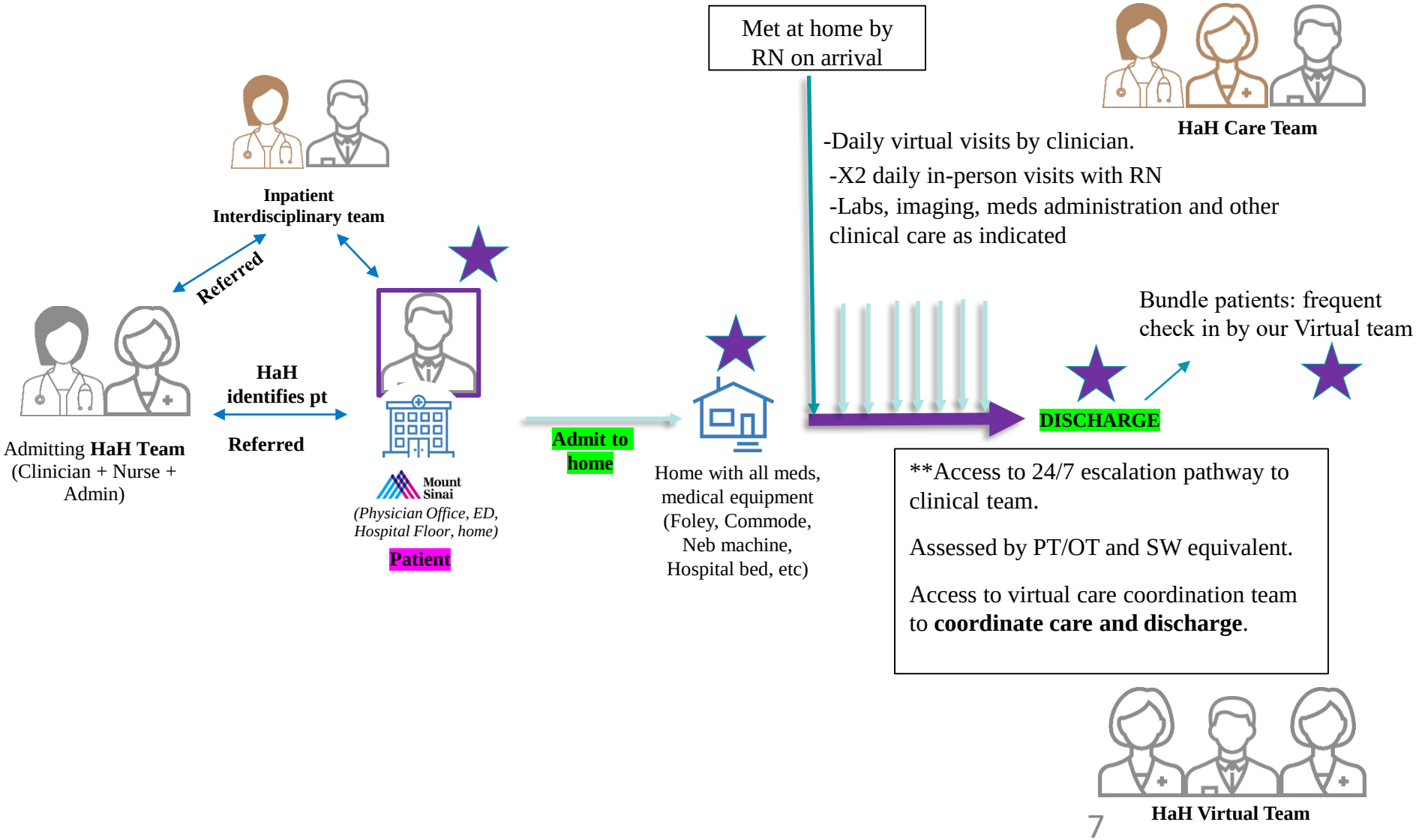
Mount Sinai at Home expanding to provide an integrated home-based model

Current Services Offered Through Mount Sinai at Home or affiliated entity



Hospital at Home

Patient Journey on Hospitalization at Home



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Patients must meet the following criteria to be admitted:

Meet **inpatient** criteria for admission

Have insurance that allows HaH or CHaH

18 years old or older; reside or have place to stay in Manhattan, Queens, Brooklyn or Bronx

Consent to program

Pass the HaH Home/Social assessment by the RCC (Recovery Care Coordinator)

- Adequate home environment and support

Common Eligible Medical Conditions

- Asthma
- Cellulitis
- CHF
- COPD
- Dehydration
- DVT/PE
- General Medical
- Pneumonia
- UTI

Recovery Care Coordinator's (RCC) monitor the ED and floors for eligible patients

Subacute Rehabilitation at Home

Mount Sinai Rehabilitation at Home

Rehab at Home delivers the essential elements of <u>subacute rehab care</u> in the safety and comfort of home

What Rehab at Home provides:

- PT and OT provides in person visits ≥ 5 $days/week$ and ≥ $60mins/day$
- RN 1-2 in-person visits a week; clinician virtual rounding weekly; Virtual nurse rounds daily
- Meds management, Labs, Xray, U/S, ECG as needed
- RaH supplement HHA as deemed appropriate
- 24/7 access to care coordination

Eligibility:

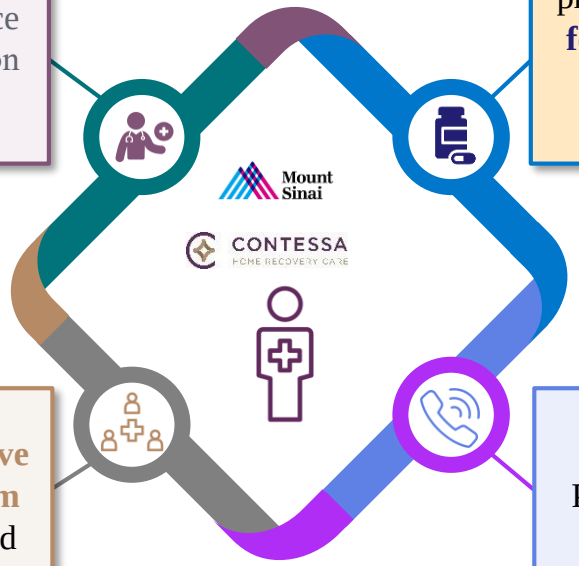
- Healthfirst (all plans accepted)
- Lives in NYC (excluding Staten Island) in a home (not SNF, SRO or shelter)
- Recommended for Subacute Rehabilitation
- Does not need new 24-hr care/

Palliative Care at Home

Additional Support Services are Provided for Patients and Families Improve Management of Complex Care Plans

Collaborative care allows the unique needs of each patient and family to be addressed in the safety and comfort of their homes

The Palliative Care at Home (PCaH) program **collaborates with other treating/managing providers** to enhance the management of the patient's condition in their home



While in the program, the PCaH team will provide **symptom management, support for psychosocial issues, education, and advance care planning**

Once enrolled, **patients and families have access to the full interdisciplinary team** through regularly scheduled in-home and virtual visits and phone calls, as well as for urgent situations

Patients and families will have access to **24-hour telephonic support** from Palliative Care clinicians

Mass General Brigham

Advancing the Future of Healthcare: Healthcare at Home

Lindsay Jubelt, MD
Mass General Brigham

September 2023

System imperative for accelerating Healthcare at Home now

Evolving consumer needs and expectations

Increasing financial and capacity pressures

Technology advancements

Favorable regulatory environment

Changing competitive landscape

Mass General Brigham is a recognized leader in this field, operating one of the largest Home Hospitals in the country

Initial Catchment Area
54 *Neighborhoods across the target Massachusetts region*

90+
Team Members Supporting MGB Home Hospital

40+
Physicians and APPs

20+
Nurses

15+
EMTs and Paramedics

19+
Staff

23
Average Daily Census (June 2023)

1,800+
Home Hospital Admissions Since Jan. 2022

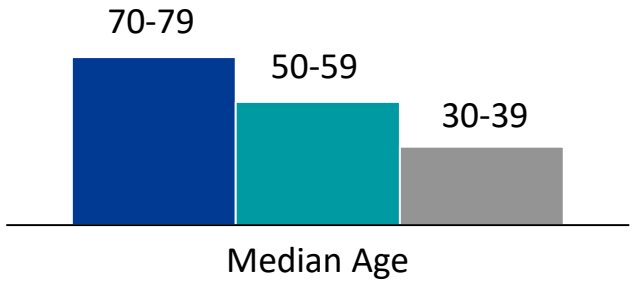
9,300+
Acute Care Facility-Based Bed Days Saved Since Jan. 2022

Mass General Brigham Home Hospital is focused on providing equitable access to acute-level care

We are committed to improving health outcomes for all and eliminating healthcare inequities, and our Home Hospital is advancing our goals around equitable access.

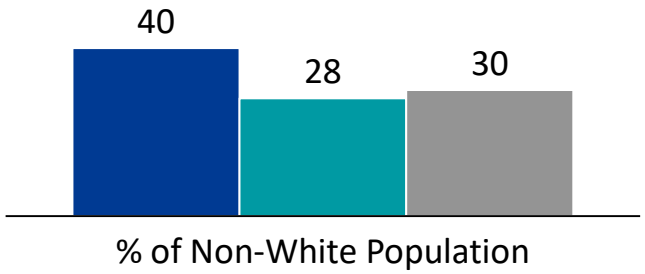
Home Hospital Discharges by Age

The median age for Home Hospital patients is 70-79 years, **older than the median age of the Mass General Brigham inpatient population.**



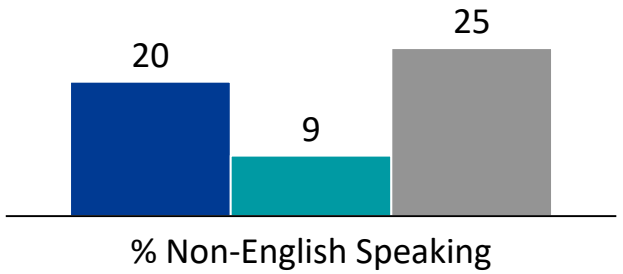
Home Hospital Discharges by Race

Compared to the Mass General Brigham inpatient population, **Home Hospital patients are more racially diverse.**



Home Hospital Discharges by Language

Home Hospital patients are **more likely to be non-English speaking** than the Mass General Brigham inpatient population.



Home Hospital[1] MGB Inpatient Population[2] Boston Metro[3]

[1]Home Hospital Operations Dashboard (October 2022 – April 2023)
[2]Mass General Brigham Inpatient Clinical Data – all MGB locations (10/1/22 – 5/2/23); not limited to Home Hospital DRGs
[3]2020 Census Bureau for Boston Metropolitan Statistical Area (MSA)

*Data is unmatched and is not comparing across DRGs


BLS ALS C/C

Home Hospital delivers financial value through three distinct dimensions

DIRECT REVENUE

- **Medicare** delivers **reimbursement parity** under the Acute Care at Home waiver.
- Medicaid follows CMS guidance under the waiver, offering **reimbursement parity**
- **Commercial** contracts deliver **75 - 85% of their in-facility IP reimbursement**

COST ARBITRAGE

- Digitally-enabled, capital light, operating model, delivers **cost per day savings vs. in-facility care.**
- Through census growth and care model innovation, **HH anticipates continued cost/day reductions.**
- **Avoidance of capital expenditures.**

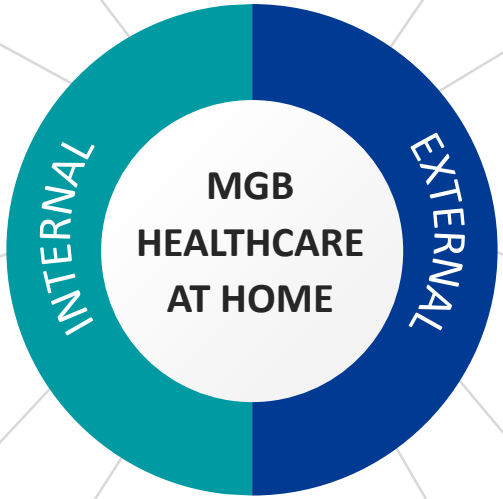
IN-FACILITY CAPACITY

- HH growth has **served over 9,300 patient days** since January 2022 that otherwise would have required an inpatient bed at a MGB facility.
- HH **reduces direct losses on the less acute** HH-eligible population and **creates facility capacity for more acute patients** that yield a positive financial result.

[1] Based on March 2023 HH actual operating costs. Costs comparisons are only based on HH-eligible populations, in-facility vs. all HH

[2] Projected capacity for FY2023 is 77 beds. 47 additional beds at and estimated $2M/bed = $94M. Source: Wentworth-Douglass Hospital capital planning; MGB Real Estate

Orchestrating a complex offering like Home Hospital requires coordination with internal stakeholders, as well as innovative external partnerships.



01 **Facility-Based Operations:** Patient Progression, System Capacity Coordination, Service Line Expansion

02 **Contracting & Rev Cycle:** Payer contracting for HH encounters; Optimize rev cycle to increase capture

03 **Digital:** New Capability Enablement: Automated Patient Capture, Scheduling, Reporting / Analytics

04 **Human Resources:** Provider and Care Team role definition, Recruitment Strategy and Hiring

05 **Core Hospital Functions:** Pharmacy, pathology, supply chain, biomed, quality and safety

01 **Logistics Orchestration:** Route planning, tracking and optimization

02 **Remote Patient Monitoring**: Platform and resources for 24/7 vitals monitoring

03 **Mobile Imaging:** In-home ultrasound, x-ray capabilities

04 **Courier and Transportation:** Patient transportation and supply delivery services

05 **Food Services:** Providing healthy, secure food source 7-days a week for patients receiving Home Hospital care

Care New England

Integra at Home & Kent Hospital at Home

Ana Tuya Fulton, MD, MBA, FACP, AGSF
Chief Population Health Officer & Executive Chief of Geriatrics & Palliative Care
Care New England Health System

Chief Medical Officer
Integra Community Care Network, LLC

Associate Professor of Medicine and Associate Professor of Psychiatry and Human Behavior
The Warren Alpert Medical School of Brown University

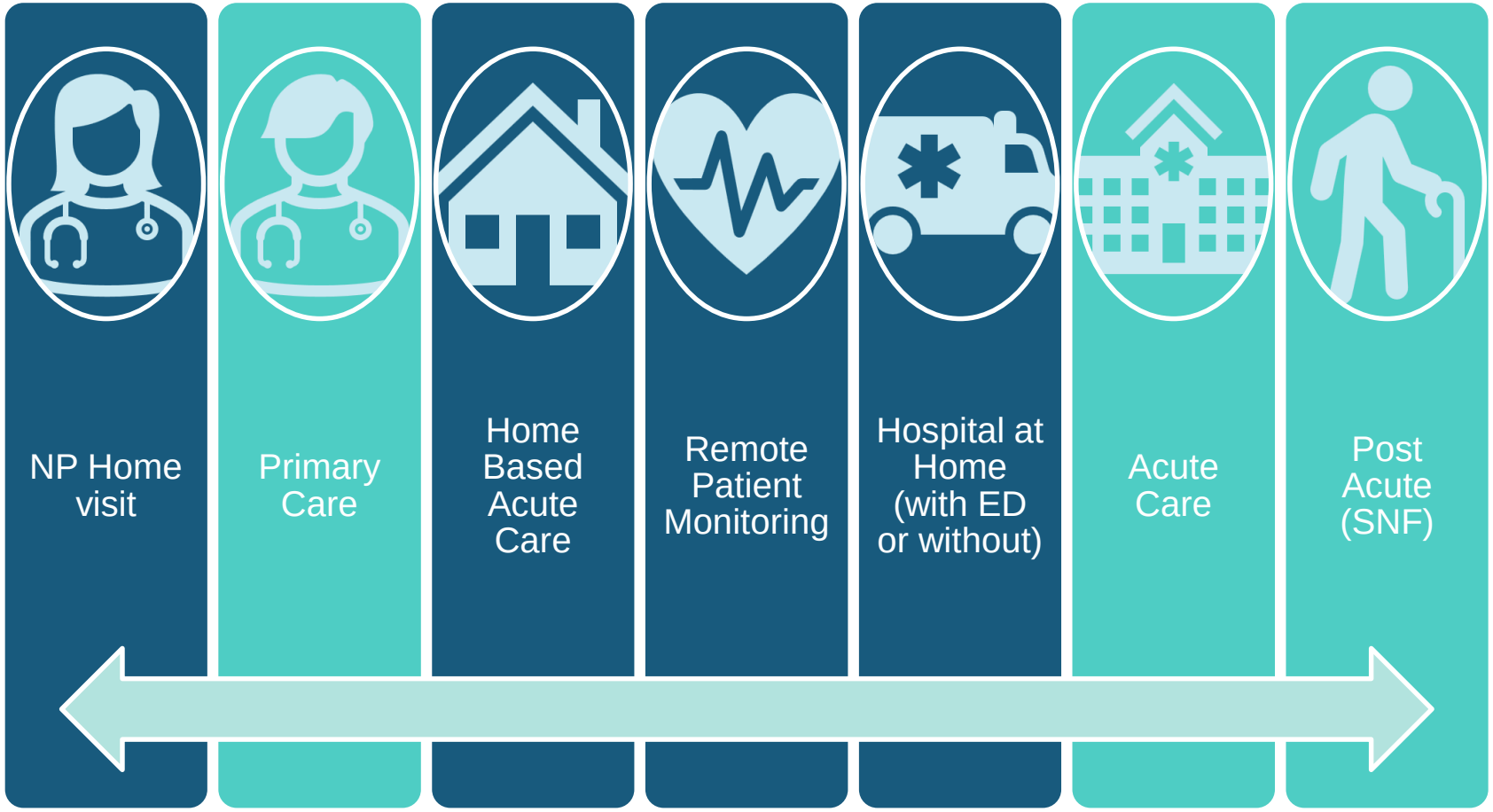
Care New England & Integra – Who are we?

- **Four** acute care hospitals – 3 Academically affiliated – Brown - Kent, W&I, Butler, South County
- Certified home health & hospice agency – VNA of CNE
- Ambulatory behavioral health organization - TPC
- IPA + Employed medical group (120 sites) – Integra + CNEMG
- Integra Community Care Network
  - Integra is responsible for ~ 160,000 covered lives
  - MA, MSSP, AE – Medicaid, Commercial, Medicare/MA

Our “why”

- Complement care provided by the PCP
- Provide intensive services for our most vulnerable patients
- Keep patients in their homes – treat in place
- Fill in the gaps – give our team more tools
- Integra-branded and staffed solution in the same EMR rather than a disconnected approach often provided by payer solutions

Our new continuum of services…



Goals for Integra @Home

Providing a patient-specific anticipatory foundation

Providing early warning signs of potential exacerbations

Development of an agile response mechanism

Ability to respond on a timely basis

Continuum of services for added flexibility

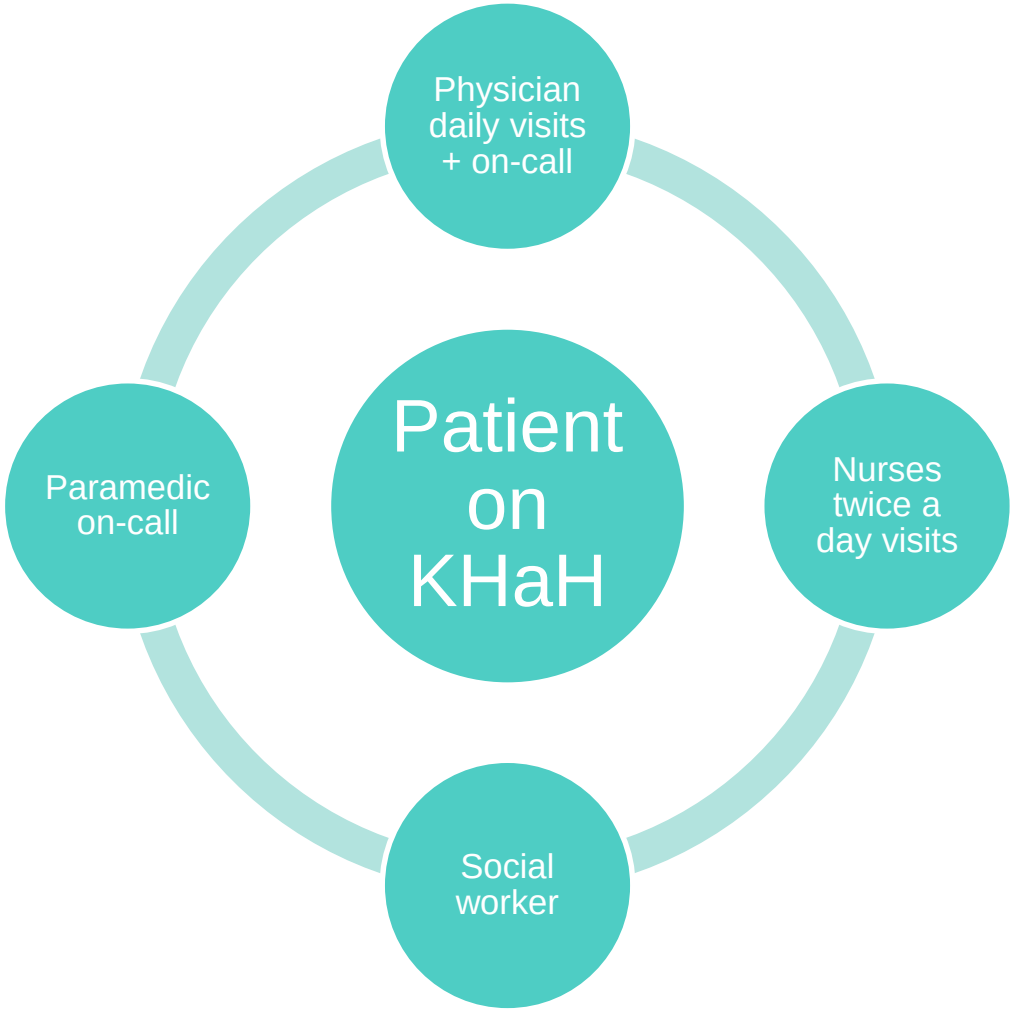
Prevent unnecessary and unwanted ED/Inpatient episodes

Program Overview

- “Virtual” 10 bed inpatient unit of Kent Hospital
- CMS waiver allows hospital level of care to be delivered at home
- Hospital at Home ≠“home care”
- Minimum of 2 in person RN visits and 1 MD visit each day
- 24/7 monitoring, on-call RN, MD
- Services include: Oxygen, IV medications, lab testing, mobile imaging, tele-consults, meal plan

Program Overview

- Dedicated physician medical direct and nurse operations leader
- 3 physicians dedicated to hospital at home
- Dedicated social worker and care manger
- Dedicated nurse coordinator and 2 nurses in the field



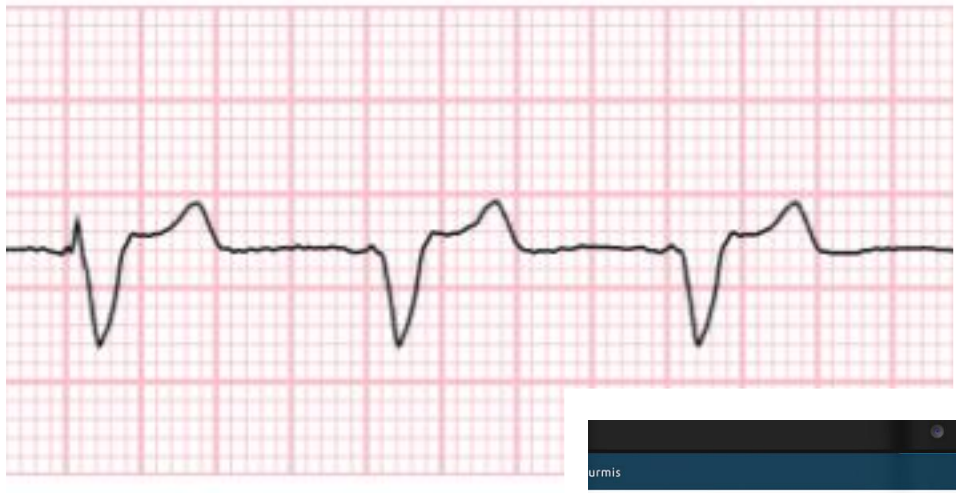
KHaH patient categories

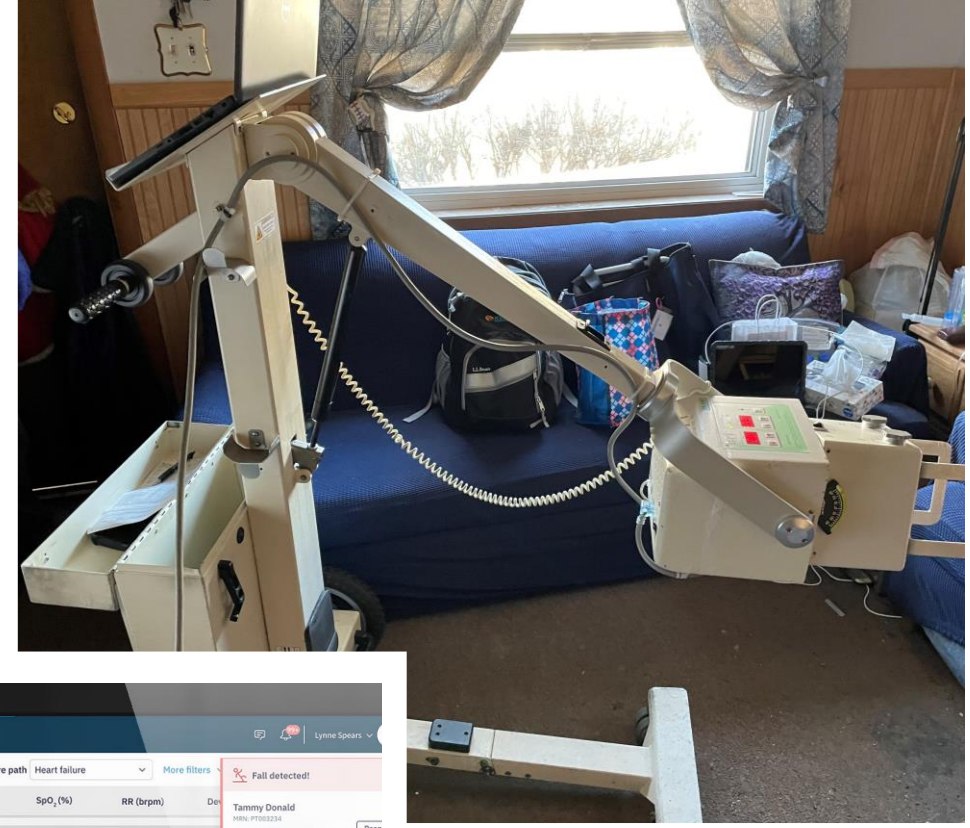
Lower acuity, stable patients who still require obs/inpt status hospital needs that can be met at home

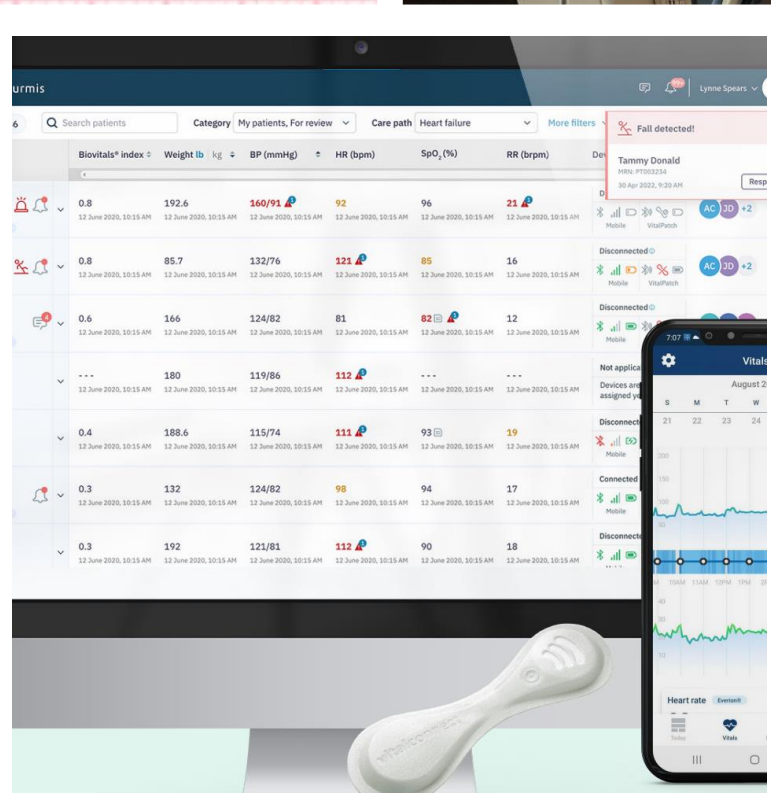
“Step-down” for floor patients who were initially higher acuity or more complex

Older adults who are at risk for hospital adverse events (delirium, etc.) and have a safe home environment, good caregiver support


VitalPatch
Connected
Tablet



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