ARKANSAS
HOSPITALS
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STRONGER

ST. BERNARDS
Brings Healing Home

2021 Annual Meeting Week
Virtual Highlights

Bringing Healing Home:
Hospital without Walls Programs Rethink Care Delivery

By Vincent Turner Jr., FACHE

The latter half of 2020 stretched Arkansas hospitals to their limits. Steady surges of COVID-19 patients made available beds, especially those providing intensive care, scarcer each minute. While providers acted quickly to accommodate the rapid influx of persons needing isolated care, these demands forced extra shifts upon clinical and support staff as well as logistical and care challenges upon administrators.

Despite the presence of a global pandemic, hospitals still operated under federal care regulations unreflective of the challenges surrounding them. Seeing this rigidity, the Centers for Medicare and Medicaid Services (CMS) reevaluated what constitutes a "hospital." In fact, Seema Verma, who was CMS Administrator at the time, astutely noted that COVID-19 had created a new level of crisis response.

"Our job is to make sure that CMS regulations are not standing in the way of patient care for COVID-19 and beyond," Administrator Verma said.

CMS initially announced the Hospital without Walls program just as the pandemic reached Arkansas. Through this program, CMS authorized additional bed capacity and broad flexibility for hospital services beyond existing care structures. Ambulatory surgery centers, inpatient rehab hospitals, hotels, and dormitories would all play a role meeting this demand. While the initial expansion helped overflowing hospitals, many of these structures did not provide ideal patient environments. Meanwhile, hospitals themselves needed even greater flexibility. Consequently, the agency's challenge involved fostering a care model that benefitted patients, caregivers and providers alike. In November 2020, CMS announced the follow-up program, Acute Hospital at Home, giving approved hospitals

unprecedented regulatory flexibility to treat eligible CMS patients in their own homes.

Based on our telemedicine capabilities as well as our access to home care services, we at St. Bernards immediately saw an opportunity to improve patient care throughout our 23-county service area in Northeast Arkansas and Southeast Missouri. We applied for a CMS waiver on behalf of our flagship hospital, St. Bernards Medical Center (SBMC), receiving it in early January 2021.

We named our program St. Bernards Acute Health at Home (SBAH), forming the first hospital at home system in Arkansas. SBAH began with 10 beds that provided 24/7 care, logistics and patient monitoring. Further replicating acute hospital settings, we installed a system to field patient and family questions while caring for patients' social needs.

SBAH Admissions began with SBMC patients – those arriving at the Emergency Department or those holding inpatient status. A St. Bernards navigator would identify potential hospital at home candidates before sending a list to the SBAH team, including a hospitalist, for further vetting. Our team would then verify whether it could care for a CMS patient at home, looking at both inclusion and exclusion criteria. For example, inclusion criteria required patients at least 18 years of age, clinically stable, living in a safe home environment in Jonesboro, and surrounded by social support mechanisms. Exclusion criteria indicated that patients could not need cardiac monitoring or intensive care services, and they could not have domestic violence concerns.

With eligibility secured, patients and their families voluntarily agreed to a referral, initiating the hospital at home transfer process.

To ensure hospital-level care, each SBAH patient would receive daily physician rounds via telemedicine technology brought into the home. An APRN or RN would complement those rounds, making two in-person visits that provided guaranteed, tangible contact. The care team would also include pharmacists, case managers, social workers and continuum of care navigators, while using physical, occupational and speech therapists as needed. Ultimately, with patients healing from the prime environment of home, we anticipated better experiences, outcomes and reduced healthcare costs.

Our initial admissions began shortly after receiving CMS approval. The length of stay averaged two to three days during this time – valuable hours for the patients to heal at home and opportunities for SBMC to free-up capacity.

SBAH IN ACTION

Two patient examples particularly stand out: the first patient arrived at SBMC's Emergency Department on April 14, 2021. SBMC admitted the individual to in-patient status under a diagnosis of pneumonia, hypertension, generalized weakness and hemoptysis with a sinus source. Six days later, SBAH received the patient. We dispatched an RN for an in-person visit that same day, taking vitals and providing medical education during our time in the home. The following day, April 21, included an in-person RN visit and physician

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A case holds the telemedicine gear that allows at-home patients to interact with providers remotely. An in-person RN attends to assist with each virtual visit.

telemedicine visit. Our physician immediately recognized a mental status change with the patient and initiated a transfer back to SBMC for further evaluation. At the hospital, providers determined the individual needed in-patient rehabilitation. We discharged the patient to a partner provider, simultaneously arranging follow-up appointments with the individual's primary care, ENT and pulmonology physicians during the process.

The second patient also arrived at SBMC's Emergency Department, admitted as in-patient on May 17, 2021. Providers diagnosed pneumonia and hypertension and transferred the individual to hospital at home care one day later. That same day, an SBAH RN made an in-person visit, taking vitals, providing medical education, obtaining a urine analysis, administering intravenous antibiotics and drawing blood. The patient received two in-person RN visits and one physician telemedicine visit per day May 19-20. Our SBAH physician ordered a chest X-ray for the patient at St. Bernards Imaging Center, discharging the patient from SBAH the same day. Meanwhile, we arranged follow-up appointments with the patient's primary care physician and Population Health coordinators.

Based on these seamless care transitions, SBAH has unlimited potential. We plan to fine-tune each process – from the initial patient screening to discharge. In addition, as more hospital at home programs come online, we will borrow and share insights that make each program better. Lastly, as technology rapidly advances, we must ensure physicians, nurses and patients can access up-to-date, reliable, and cost-effective tools. Doing so will sustain SBAH's successes – patients will feel a closer tie to their providers, and providers can more accurately monitor and diagnose patients.

SBAH is nearing its one-year anniversary, and we have received extraordinary participant feedback. We often hear how healing at home reclaims families' time together without visitation concerns for other loved ones. Most importantly, patient care never suffers; if anything, it improves because of the environment. There truly is no place like home.

Perhaps one day, we, as health care providers, will even wonder why capacity concerns existed. It is our hope, and it is our goal.

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