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CARE AT HOME

1. Health Systems Can Lead Charge On Moving Care To The Home

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REPORT #1

HEALTH SYSTEMS CAN LEAD CHARGE ON MOVING CARE TO THE HOME

Delivering care at home is the next frontier. Health systems are uniquely positioned to lead this transition, rather than letting other entities leapfrog them.

Delivering the right care, at the right time, in the right place is an oft-cited goal for healthcare providers. The desire to meet these aims is commendable but defining the right place is a constantly moving target. We've seen care transition from the hospital to ambulatory sites, retail locations, and, most recently, the virtual space. Charting that journey over the next decade, we see delivering care at home (C@H) as the next frontier. Health systems are uniquely positioned to lead this transition rather than letting other entities leapfrog them.

This article looks at the current C@H landscape. In the other two articles, we will examine where and how to start thinking about the financial implications, and offer considerations to ensure a successful launch of C@H.

CARE AT HOME IS HAVING A MOMENT

Evolving market dynamics are causing healthcare stakeholders to broaden the aperture of care at home beyond traditional home health services, which are mainly geared toward lower-complexity care. A changing payment landscape, evolving consumer preferences, and technological advancements allow us to think differently about the home as the site of care. Home now has the potential to incorporate a suite of offerings across the care continuum to include longitudinal care (home-based primary care, behavioral health), chronic care (infusion, dialysis), discrete ancillary services (urgent care, imaging, labs, therapy) and acute and post-acute care (Hospital at Home, observation, emergency care, and skilled nursing).

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Exhibit 1: An expanded scope of care at home modalities

	**Acute** Hospital at home, observation at home, ED at home
	**Longitudinal** Home-based primary care, home-based serious mental illness/behavioral health
	**Discrete/ancillary** Home-based urgent care, physical therapy, occupational therapy, speech therapy, labs/imaging
	**Post acute/transitional** Skilled nursing at home, home health
	**Chronic** Home infusion, dialysis, home care, specialty Rx
	**Comfort care** Home hospice, palliative care at home

Source: Oliver Wyman Analysis

Several market tailwinds are fueling this expansion. Most notably, a payment landscape that increasingly acknowledges the value care at home can provide. More than 300 hospitals have been approved to participate in the Acute Hospital Care at Home program, which the Centers for Medicare and Medicaid Services launched during the COVID-19 pandemic. Under the program, CMS reimburses providers at parity for the equivalent hospital admission shifted to the patient's home. The waiver is set to expire at the end of the year, but legislation is moving through Congress to extend it through 2029. Following CMS' lead, early experiences with other payers have shown a willingness to reimburse home-based hospital-level care, although often at a lower rate compared to facility-based care. And because care at home offers the opportunity for risk-based providers, government payers, and private payers to reduce the total cost of care and improve outcomes, we expect home-based payment models to keep evolving, structured in a way to encourage participation, while also generating savings.

Care at home also benefits from a growing evidence base around quality of care. Several studies have shown clinical outcomes for home-based hospital care are equivalent or superior to facility-based. In one trial comparing H@H programs with inpatient settings, home-based patients reported fewer lab orders, imaging studies, and consultation orders, increased activity levels, and decreased frequency of readmissions. Additionally, a study conducted by CMS evaluating patients admitted under the AHCAH waiver found hospital-at-home patients had low mortality rates and minimal escalations back to the brick-and-mortar hospital.

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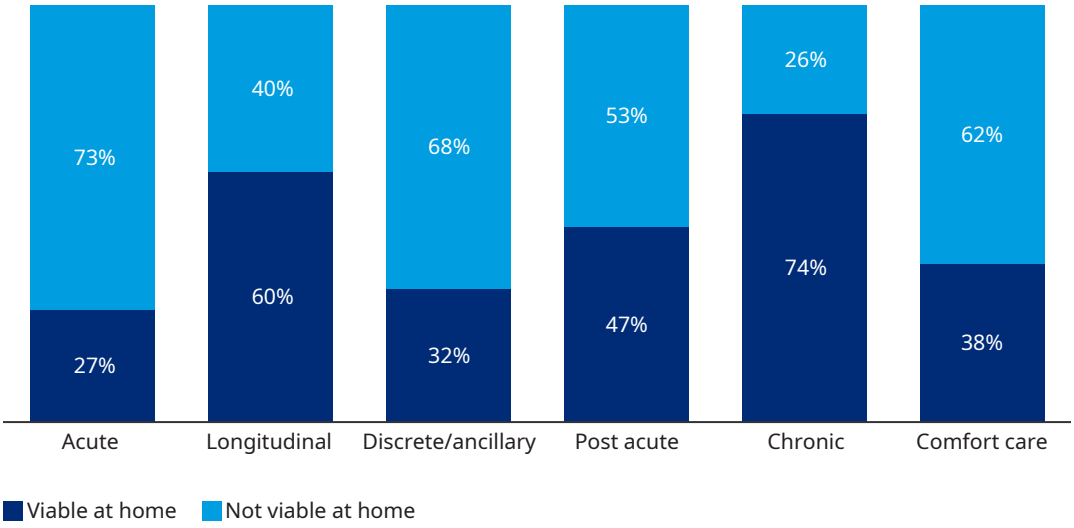
At the same time, patients are becoming more comfortable with receiving care at home — 78% of adults said they would be interested in getting follow-up care for a medical procedure at home, according to a Partnership for Quality Home Healthcare survey. Hospital at Home patients also rate their physicians, comfort, and admissions process higher compared to patients in an acute care setting. More convincing than survey figures are the patient testimonies themselves. Patients frequently cite better sleep, and more control over their care experience as benefits offered by receiving care at home rather than a facility.

Finally, thanks to advancements in technology, the scope of services that can be done at home, across the continuum, continues to expand. A recent Oliver Wyman analysis showed that up to 40% of medical spending can clinically be provided at home today (see exhibit 2). Projecting to 2035, we predict that up to 60% of hospital admissions will be feasible to be cared for at patients' homes.

Exhibit 2: Revenue opportunities from care at home



Note: Projections of potential revenue in 2025 generated by care clinically viable to deliver at home for commercial and Medicare populations. We estimate that 39% of total revenue can come from care that's moved to the home in 2025; 61% won't be viable for care at home yet.

Source: Oliver Wyman Analysis

PROVIDERS HAVE AN OPPORTUNITY TO EXPAND CARE AT HOME

Taken together, these market dynamics present health systems with two options: continue to focus on the traditional way of providing care or embrace care at home as the next frontier and help shape the evolution of care delivery. Historically, health systems have ceded the role of site of care innovation to other players, including payers, big tech, retailers, and venture-backed firms. They shouldn't fall into that trap here. We believe health systems are best positioned to lead the shift of care into the home.

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First, local health systems have built a high level of trust in their communities which is essential to generating adoption of C@H services in the first place. Furthermore, health systems can more seamlessly integrate data and coordinate care. The slow crawl to interoperability is still creating data vacuums when patients get care from other providers. By adding care at home to their service lines, health systems can ensure that a comprehensive ecosystem of services is offered to a patient with data flowing easily from one provider to another.

Additionally, health systems have the assets and knowledge that can be used as a starting point to develop care-at-home capabilities. Yes, each of these assets will have to be reconfigured, and knowledge re-applied. For example, a hospital pharmacy will need to learn how to dispense medications in a patient-friendly manner versus dispensing to automated machines and clinicians, but with the right change management approach, health systems can leverage their capabilities to build high-quality care at home programs tailored to their community's needs.

Finally, the care-at-home opportunity for health systems comes during ongoing cost pressures which are forcing them to think creatively about how to serve their patient population's needs in the most cost-efficient manner. For providers, care at home can serve as the capacity pressure release valve some of them require and help them avoid costly capital outlays — after all, the average system capital outlay per additional inpatient bed is nearly $2 million. Additionally, once a care-at-home infrastructure has been developed, health systems could use that infrastructure to begin offering new previously untapped sources of revenue, including home infusion or home dialysis.

While the potential for care at home is great, there are pitfalls to avoid. As health systems consider if and how they should participate in the C@H trend, leaders must also acknowledge operational and economic challenges. Operational concerns include questions on where and how to start — which modalities of care to offer, build/buy/vend options — and the change management implications, particularly with building physicians' level of comfort with C@H models. While C@H models often require a lower labor intensity compared to traditional sites of care, new labor pools will need to be stood up, potentially competing with traditional sites of care for recruitment.

From an economic perspective, providers must evaluate the impact shifting care to the home will have on their existing facility financials. In the near term, fixed cost structures will remain, meaning the system will need to carefully evaluate backfill potential and estimated reduction in cost to deliver care in the home to move forward confidently. We will address these questions in subsequent articles.

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REPORT #2

OFFERING CARE AT HOME IS HARD. HERE'S WHAT YOU NEED TO KNOW

In part two of our series on care at home, we examine several key financial implications as health systems eye actively shifting care to patients' homes.

STARTING WITH HOSPITAL AT HOME AS THE FOUNDATION

The scope of services that can be provided at home is large and growing. For health systems, whether already offering traditional services like home health or considering their first foray into the home, hospital at home (H@H) presents the most attractive starting point. H@H offers the largest addressable spend of all other care modalities and can provide immediate relief for inpatient capacity issues by decanting volume away from the facility. And there's an established reimbursement model through the Centers for Medicare and Medicaid Services' Acute Hospital Care at Home program.

H@H programs include various patient flows with the most common one being an initial emergency department visit followed by hospitalization at the patient's home. Other models may include transfer to home following several days in the hospital, an initial emergent care at home followed by H@H care, post-surgical recovery at home, and other services with medium- to low-acuity conditions that can be safely treated at home. Requiring a comprehensive suite of at-home capabilities, including dedicated clinical and non-clinical resources, a robust technology platform, and contracted services, H@H programs can't be launched overnight. Health systems have to cover most of the upfront costs, including building out or vending technology platforms to reach patient homes and delivering medical supplies, but early adopters like John Hopkins Medicine report savings of up to 30% compared to traditional inpatient care.

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EXPANDING TO OTHER CARE AT HOME PROGRAMS

Once H@H capabilities are built and operable, there is a natural extension into other C@H modalities, including post-acute care, both in terms of care pathways and through leveraging similar resources and capabilities. In fact, a H@H patient can be easily transitioned to a post-acute care at their home using the existing communication and monitoring set-up and they are familiar with how to work with the C@H team. Unfortunately, there is no established payment model yet for H@H in the post-acute space. However, studies have shown that H@H patients have lower rates of readmissions compared to hospital inpatients. And with hospitals subject to payment penalties for readmission rates exceeding 30-day all cause readmissions, the incremental costs of providing transitional post-acute care may be easy to justify financially. On top of that, most markets are experiencing extreme staffing shortages, leading roughly 46% of nursing homes limiting new admissions.

Health systems can take various approaches to building out subsequent modalities based on their strategic needs. Where hospital capacity is challenged, the most logical next step may be to further invest in acute or sub-acute models such as ED or Observation at Home. For systems seeking to enhance their performance on value-based contracts, home-based primary care may offer a strong return. Systems looking for new streams of revenue may find home infusion or home dialysis to be an effective strategy.

Still, health systems should not underestimate the degree to which C@H operations and logistics depart from facility-based care models, and therefore the investment required to build such a foundation. Unlike building another surgical center, hospital wing or urgent care site, C@H programs require new capabilities, operating models, workflows, and technology. Providers are accustomed to centralizing patient care in a physical location and using large-scale, capital intensive equipment and operations to provide care. Operating out of the home means thinking differently about how to serve patients. Consider drug management. Large pharmacies, often situated in hospital basements, send medications to nurses and automated dispensing cabinets at scale. Drugs are then administered by clinicians to patients in a controlled environment. In a C@H environment, these same drugs need to be dispensed on demand, bear consumer-friendly labelling, and be delivered at the right time to the home. The compound is unchanged, but operations are vastly different. All of this requires a new operating model, new assets such as a 24/7 command center, logistics networks, patient and clinician facing technology, and a field workforce.

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Exhibit 3: Foundational elements of Care at Home



- **New operating model**
  C@H requires enhanced scheduling, deployment, and coordination capabilities to ensure effective delivery of care
- **New technology**
  New data, software, and hardware tools are needed to enable operations tailored to C@H. Vendor solutions are still evolving, and systems should assess build or vend options across the tech stack
- **Scale**
  Early phase C@H programs can be quick to set-up and learn from. Longer-term financial sustainability requires investments in automation and streamlining workflow to generate scale and spread operating costs

Source: Oliver Wyman Analysis

BUILDING THE BUSINESS CASE FOR CARE AT HOME

How can a system justify all the necessary costs for home-based care, yet still realize financial value? Doing so requires contextualizing the necessary investment against the full set of direct, indirect, and longer-term value drivers:

- Direct value comes from the margin generated by the C@H operation itself. Most of the investment and operating costs are sensitive to economies of scale — technology, virtual care, command center, in-home labor, administrative and overhead, vendor contracts. Our analysis suggests that up to 50% of per unit cost can be saved when comparing a sub-scaled and a scaled operation. Thus, scale is the single most important element to achieving financial sustainability in a C@H program. It can be achieved by pulling several levers, including increasing the addressable volume for a modality — more hospitals, more payers, more insurance segments, more conditions/DRGs — gaining clinician buy-in, and implementing multiple modalities of care to leverage capabilities and share costs.

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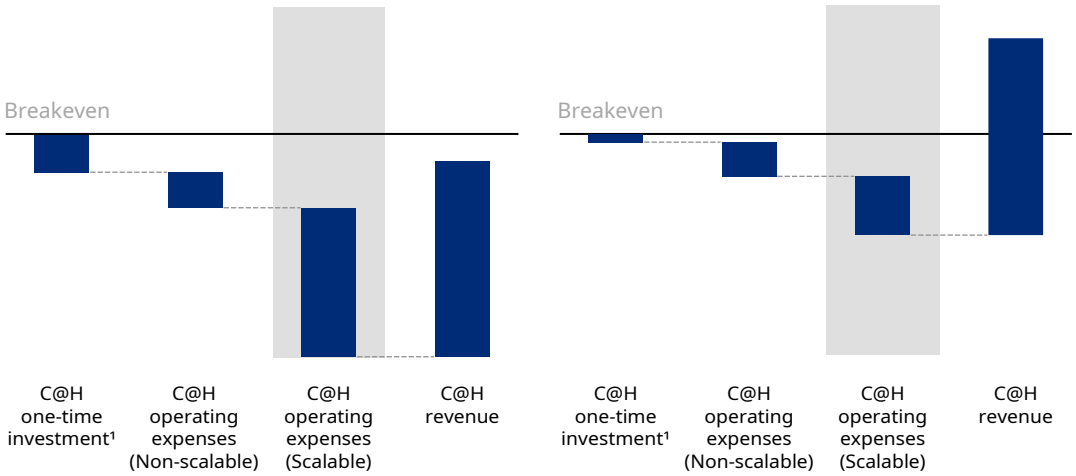
Exhibit 4: The importance of scale to developing a financially sustainable C@H program

Illustrative C@H program economics at sub-scale
Aaverage daily census of roughly 15, costs and revenue per one H@H admit

Illustrative C@H program economics at scale
Aaverage daily census of roughly 50, costs and revenue per one H@H admit

$ margin per one H@H admit



Source: Oliver Wyman Analysis

From technology to in-home labor, each element needed to support C@H plays a role in reducing unit costs. The cost per unit of care changes in different rates for different expense categories, as shown in the table below.

Exhibit 5: Major cost categories and their impact on reducing unit cost (scalability)

Cost category	Percentage of total cost	Sensitivity to scale
Technology	~35%	High
Command center	~20%	High
Non-clinical labor (leadership, admin)	~10%	High
In-home labor	~20%	Medium
Support capabilities	~15%	Low

Source: Oliver Wyman Analysis

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Indirect value is driven by using newly available facility space as volume is shifted to home. Hospitals are largely a fixed cost operation. As admissions are decanted to the home, significant costs remain unchanged, such as building and equipment maintenance. However, if a system can backfill capacity with new volume, ideally with a higher margin case mix such as elective surgeries, it can significantly benefit from any new volume leveraging the already existing cost structure.

- Longer-term value drivers include three potential sub-elements:
  - Capital spend avoidance from building or renovating physical capacity once volume can be decanted at scale to the home. With the capital cost of a new acute care bed nearing $2 million, savings can be meaningful.
  - Enhanced performance on value-based care, whether by incurring lower cost per admission or improving outcomes — lower complications and re-admissions.
  - Margin from new services the system is not providing today such as home dialysis or infusion. Overall, we see the bulk of value potential as being concentrated in the direct and indirect value categories, with the longer-term value drivers category being meaningful yet secondary.

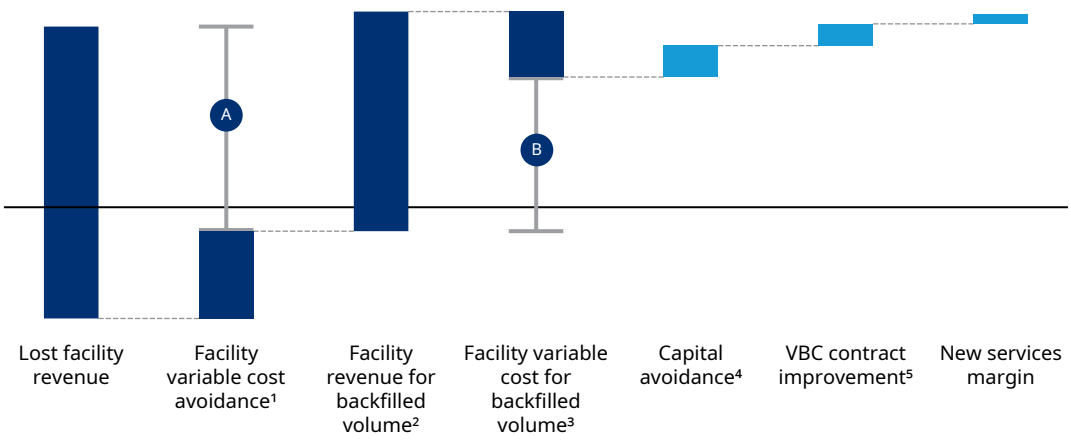
Overall, we see the bulk of value potential as being concentrated in the direct and indirect value categories, with the longer-term value drivers category being meaningful yet secondary.

Exhibit 6: Economic impact of a scaled C@H program

CONTINUES FROM EXHIBIT 2

Illustrative economic impact of a scaled care at home program
Average daily census of 50

Economic impact at the facility **Long term economic impact**



A Fixed cost in facility remains constant even if volume shifted to home (in short term)

B Margin on 75% of volume backfilled in (A); may be larger depending on mix (for example, surgical cases)

Source: Oliver Wyman Analysis

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Although the case to offer C@H is universal from a clinical and patient experience standpoint, the business case may not balance out for all systems. We expect the business case to be resoundingly strong for systems with strong payer partners and in markets with sufficient demand. There are several critical elements to launching the program that warrant special attention, including how to leverage vendors to accelerate capabilities, and how to engage clinicians to ensure buy-in. We will explore the keys to success for these elements in the final article of this series.

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REPORT #3

WHAT IT TAKES TO SUCCESSFULLY LAUNCH, SUSTAIN CARE AT HOME

BE STRATEGIC ABOUT ENGAGING VENDORS

At its core, C@H includes three key modules:

1. Telehealth hardware and software in the patient's home and with clinicians that facilitate two-way audio/video/text communications

2. Remote monitoring sensors and connected devices that allow clinicians to keep track of patient's vital signs and other metrics

3. Command center technology that facilitates the orchestration of in-home resources deployment and virtual care provision A variety of platform vendors can support all three modules across the breadth of a C@H operating model, including building the required integrations to the electronic medical record, with varying degrees of sophistication

However, health systems should be aware that vendor solutions are evolving. This is especially apparent when it comes to supporting multiple initiatives simultaneously. Even if working with a platform vendor, health system leaders should expect to invest in workflow automation and logistics optimization to scale operations that are critical for program economics. Many systems that operate C@H programs today are still using burdensome manual workflows. For example, each admission to a H@H program requires multiple phone calls, messages, and emails to vendors to initiate and coordinate delivery of equipment and services to the patient's home, including telehealth kits, durable medical equipment, connected devices, oxygen, and more. This manual orchestration extends throughout the episode and applies to deploying clinicians, medication, and other contracted services.

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Regardless of whether and where systems opt to build or rely on a vendor, investment will be required to streamline and automate workflows and support scaling in H@H and into other modalities.

Some health systems have adopted and integrated point solutions with their EMR, such as telehealth and remote monitoring. This approach presents a low-cost option to get started but health systems should apply lessons learned from previous experiences of adding disparate technologies on top of their existing tech stack.

At the outset, we expect most health systems will rely on trusted vendors for specific in-home services such as mobile labs, imaging, DME, and in-home nursing. As programs scale up, various elements can be brought in-house. Program operators who aim to handle these needs internally from the outset must be clear on service fulfillment expectations and the unique aspects of certain C@H modalities. For example, home health nurses may need clinical upskilling to feel comfortable caring for hospital level acuity patients. From an operational standpoint, scheduling approaches may need to be adjusted for home health nurses to accommodate the flexibility some higher acuity models require. These challenges can be overcome, but operators should not expect a simple plug-and-play approach of existing capabilities into a modern C@H operation.

THE IMPORTANCE OF GETTING CLINICIAN BUY-IN

Scaling C@H can't be done without clinician buy-in and support, so it is important for systems to invest time and resources in stakeholder education and engagement.

Providing care at home, particularly acute care, is still relatively new — this, along with the inherent challenge in launching any new program, may result in sluggish adoption from clinicians. However, there are several strategies systems can employ. First, passionate leadership along with a sturdy governance and engagement structure is critical. Having a clinical champion with a consistent, disciplined message to referring providers will help to make sure the program takes root and doesn't languish post-launch.

As a part of the engagement process, leadership should also use reliable data that illustrates success from their program. These feedback loops provide opportunities to reinforce and reiterate the potential for C@H but can also help bring the program to life.

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Finally, making the process for clinicians to admit into the C@H program as frictionless as possible will go a long way to establishing a steady pattern of referrals. This process will vary by system, but common tactics include proactive flags in the EMR to identify potentially eligible patients, embedded administrative support in the ED and on inpatient floors, and easy communication channels with C@H clinical teams. The referral and enrollment process to home should be designed as a push from the site of care versus a need for the C@H program to constantly pull patients in.

Launching a successful care at home program requires a wide breadth of clinical, operational, and technological capabilities. Regardless of whether those capabilities are vended or built, they will take time to initiate and run smoothly. The same is true for gaining clinician buy-in. Leaders should be realistic about timing and early expectations while remaining diligent in laying the groundwork for a successful program.

In sum, C@H presents a unique opportunity for health systems to take the reins on the next frontier of care delivery innovation. Before launching a program, health systems need to think through a myriad of clinical, financial, and operational questions, but few care models can offer the same potential for achieving the triple aim of better outcomes, better experience, and lower cost.

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For more information, please contact the marketing department by phone at one of the following locations:

Americas	Europe	Asia Pacific	India, Middle East & Africa
+1 212 541 8100	+44 20 7333 8333	+65 6510 9700	+971 (0) 4 425 7000

AUTHORS

Ran Strul
Partner
ran.strul@oliverwyman.com

John Caison
Engagement Manager
john.caison@oliverwyman.com

Zoe Kreutzer
Senior Consultant
zoe.kreutzer@oliverwyman.com

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