
2023 VIZIENT CONNECTIONS SUMMIT
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SEPT. 18–21, 2023
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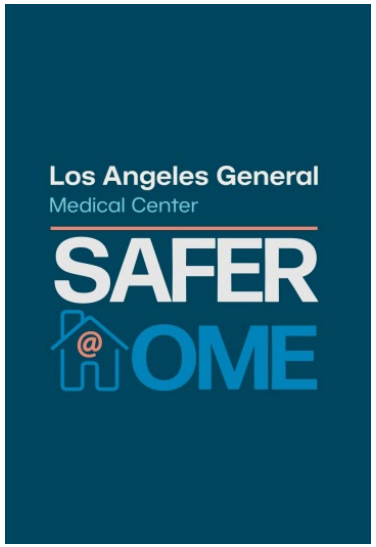
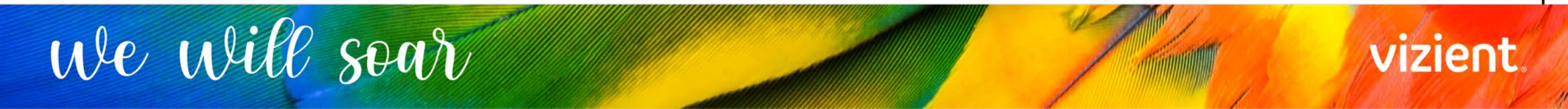



NYU Langone Health

# There's No Place Like Home: Serving Acute Care Patients Where They Belong



# Panelists

**Christopher Lynch, MD,** Medical Director, Safer at Home

**Nikole Swain, RN, BSN,** Nurse Manager of Discharge Lounge, Safe Patient Handling Team, Clinical Equipment

**Meixine Song, RN,** Nurse Manager, Call Team

**Los Angeles General Medical Center, Los Angeles, CA**

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**Eve Dorfman, DNP, RN, NEA-BC,** Vice President, Operations

**Jeanmarie Moorehead, EdD, MA, RN, NEA-BC,** Senior Director, Home Health Operations and Home Hospital Program

**Faith Lynch, DNP, RN, CNN,** Senior Director, Dialysis Operations

**Jenna Blind, DNP, RN, CPHQ, Alumnus CCRN,** Director of Education, Professional Development, and Quality Improvement, Home Health Care and Home Hospital Program

**NYU Langone Health, Mineola, NY**
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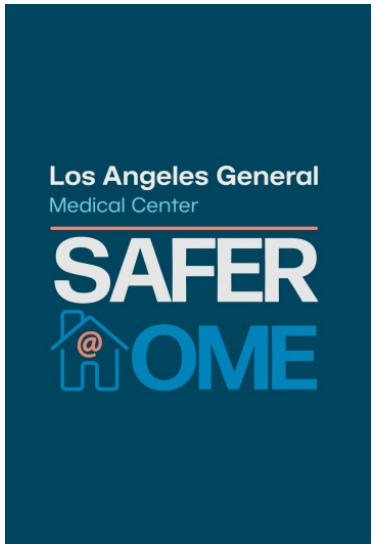
# Learning Objectives

- Discuss CMS home hospital requirements and reimbursement.
- Describe successful strategies to implement a home hospital model, including performance metrics to measure outcomes.

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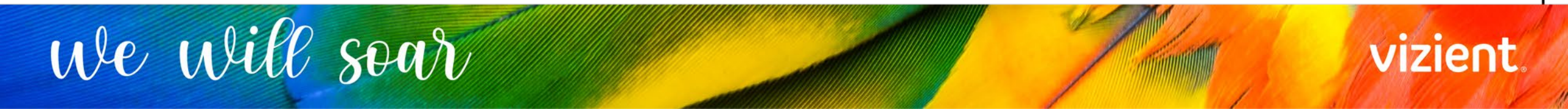

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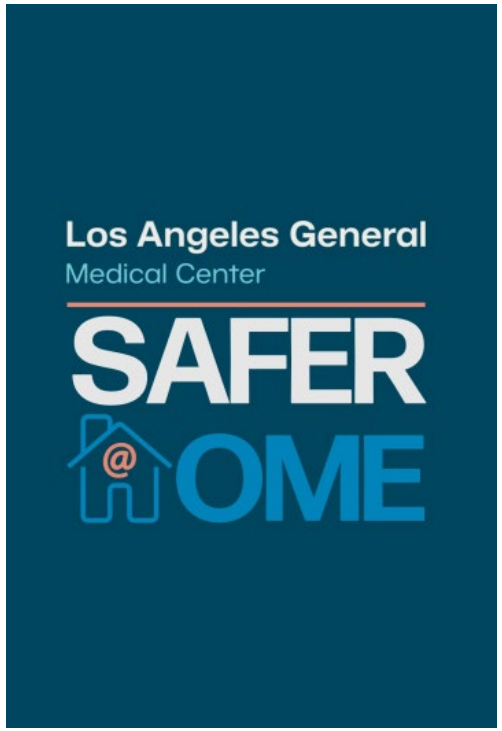
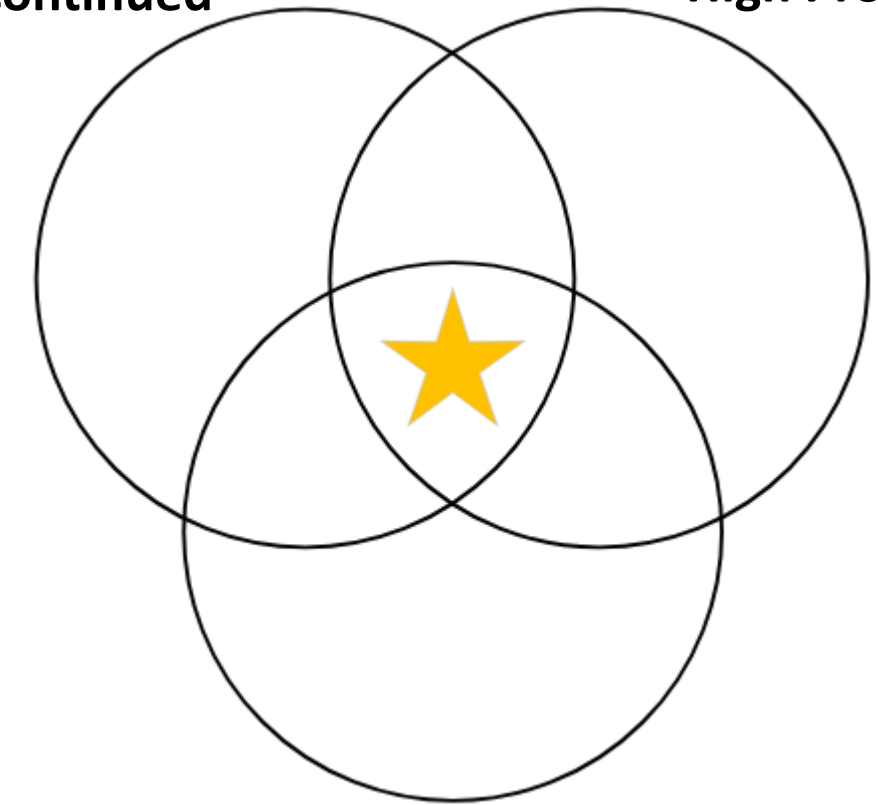



# Los Angeles General Medical Center

# Key Principles for Enrollment

**Patient Requires Admission or Continued Hospitalization**

**High Probability of Treatment Response**



**Low Probability of Rapid Decompensation**

# Safer at Home Pathways

- Infected Diabetic Foot Ulcers
- Cellulitis
- Osteomyelitis
- Pyelonephritis
- Viral Pneumonia
- Bacterial Pneumonia
- COPD Exacerbation
- Asthma Exacerbation
- Decompensated Heart Failure
- “Other”

# Primary Program Components

1.) Referral and Screening with General and Disease Specific Criteria

2.) Enrollment Bundle

- Phone Number Verification
- DME for Home Monitoring
- Education
- Medications in Hand

3.) Protocolized Follow Up

- Nurse Phone Visits with Physician Attending Support
- Standardized Follow Up and Triage
- Concierge Care
- Bridging to Specialty Care

# Preliminary Outcomes Since Launch (September 2022 - July 2023)

- No Deaths at Home
- Total # Patients Enrolled: 770
- Total Inpatient Bed Days Saved: 2825.03
- Average Bed Days Saved per Patient: 2.32

NYU Langone Health

# NYU Langone Home Hospital

- **NYU Langone Home Hospital** maintains the NYU Langone standards and expectations for clinical excellence and quality patient care and outcomes
- **NYU Langone Home Hospital** was created through robust internal and external collaboration
- **NYU Langone Home Hospital** focuses on patient outcomes and safety rather than rapid growth

# Home Hospital Care Delivery Model

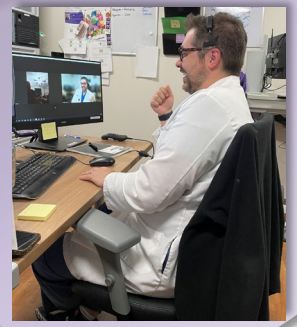
**Candidate Identification & Screening**

**Home Hospital**
*Inpatient Admission*

**Electronic Health Record / Remote Patient Monitoring**

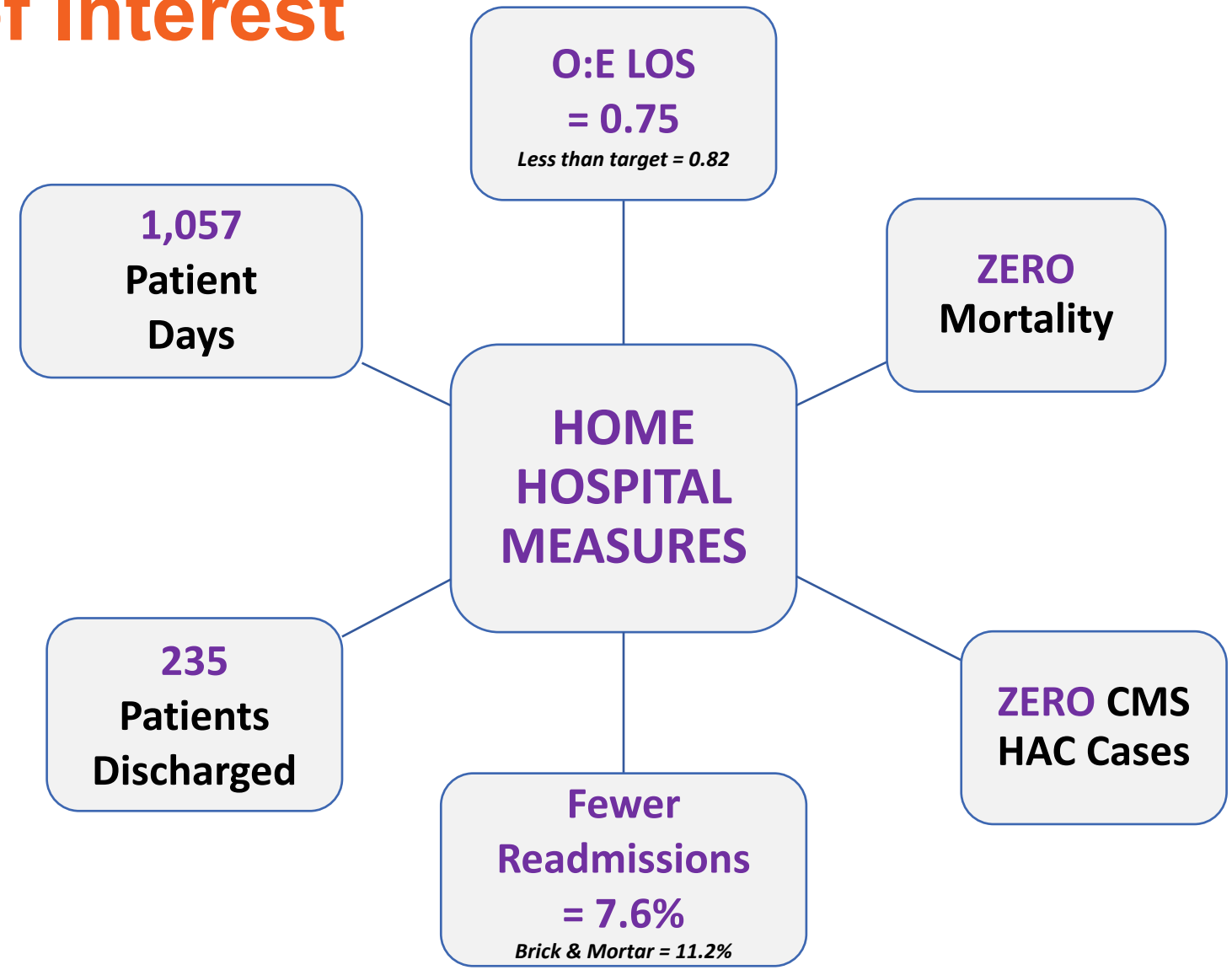
**At–Home Care Delivery**

**Command Center**



**Discharge**

# Measures of Interest



# Measures of Success

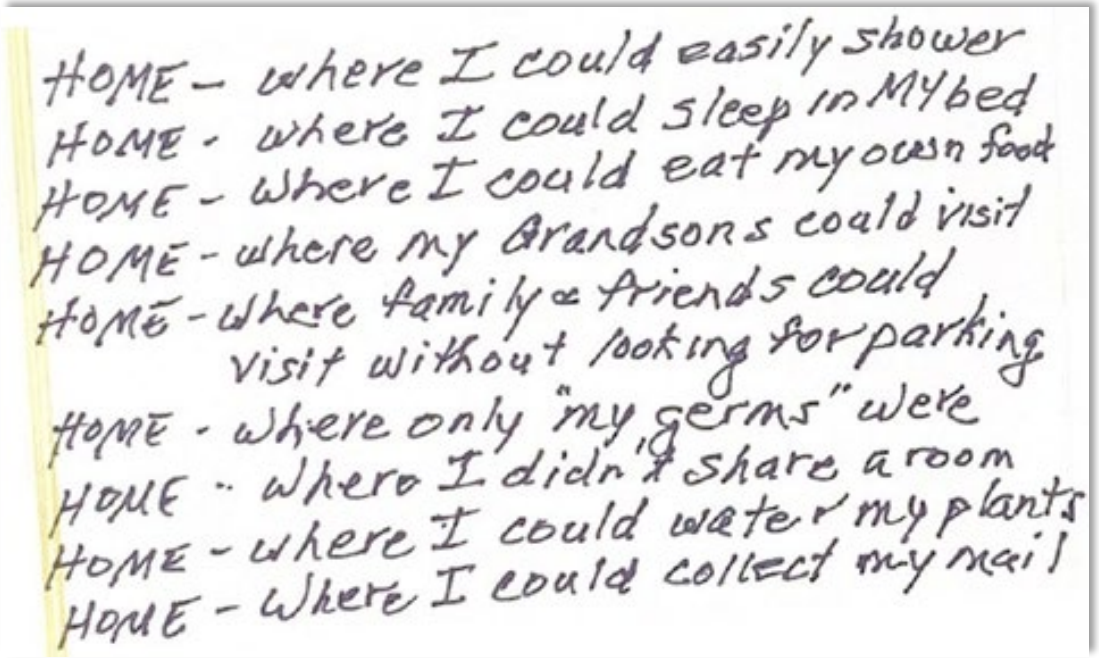
## Patient Experience

- *100% overall rating of care*

## Staff Engagement

- *8 points higher than the organizational average*

## The voice of the patient…



# Panel Discussion

# Lessons Learned

- Executive sponsorship
- Stakeholder buy-in
- Change management
- Social determinants of health
- Build the Team
- Simplify the process
- Adapt in action
- Standardize and integrate

# Key Takeaways

- Success is in the preparation
- It takes a village
- There’s no place like home
- Principles Based Approach
- Concierge Care
- Protocolized, Integrated, Team-Based Follow Up

# Questions?

## Contacts:


NYU Langone Health

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Jenna Blind, Jenna.Blind@nyulangone.org

Los Angeles General Medical Center

Christopher Lynch, clynch@dhs.lacounty.gov



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