Welcome everyone. My name is Yasmine. Welcome to our 2nd, webinar in our, uh, fall healthy brain webinar series.

Healthy brain webinar series is presented by the health matters program at the University of Illinois, Chicago in partnership with national task group, put on intellectual disability and dementia practices, and is funded by the Centers for Disease Control and prevention.

The healthy brain webinar series, um, the contents are so lead the responsibility of the author and do not represent the official views of the CDC.

A couple of other, um, announcements are not offered for the webinars each live webinar will be recorded and available to view on YouTube channel. You will be emailed once that is up.

It's usually in, about a week and please use chat box for comments and questions. There will be about 10 and 10 to 15 minutes after the presentation for question and the answer.

I wanted to introduce our speaker today. Um, they will be talking about improving access to home hospital for people with intellectual and developmental disability.

Aaron Shad bolt started her career as an acute care. Um, float nurse and then transition to a hospice case manager.
She went on to earn a masters of nursing from Webber State University in Ogden, Utah in 2010, and has been in nursing leadership since she launched the Mayo Clinic home hospital program, Clara, Wisconsin in 2020.

and has transitioned into a role as the senior director of post acute care for ascension healthcare, working to increase access. ascension healthcare working to increase access

To home hospital care to those throughout the country.

Today Aaron will talk about home hospital care has become a growing sector in the acute care world and significant work is being done to insure equity in accessing the services.

This presentation will describe how a fellow in the Institute for developmental disability nursing worked to solve barriers for those with intellectual and developmental disabilities in accessing home hospital care in rural Wisconsin.

Aaron. Welcome. We're very excited to.

Have you here.

Thank you so much for having me. Are you able to hear me okay?

Yes, all right well, we will go ahead and get started. Welcome everybody. Um, I hope that I'm able to share some background for you on home hospital and some of the work that.
We were able to do it mail clinic, um, to help improve access and some of the ongoing barriers that I see, um, that still need to be solved to move the program forward in terms of, um.

20 "Erin Shadbolt" (2917561600)
00:03:12.930 --> 00:03:22.380
Equity, so I was super fortunate that I happened to get an E mail 1 day. Um, that was.

21 "Erin Shadbolt" (2917561600)
00:03:22.615 --> 00:03:30.355
Talking about this nursing fellowship through the Institute for intellectual developmental disability nursing.

22 "Erin Shadbolt" (2917561600)
00:03:31.405 --> 00:03:52.105
I've always have an interest in just generally improving equity and access and healthcare.

23 "Erin Shadbolt" (2917561600)
00:03:52.380 --> 00:04:04.825
And in my work in the home, as a hospice nurse, I had taken care of a wide variety of people that I had seen were not able to access equitable health care. And I was a.

24 "Erin Shadbolt" (2917561600)
00:04:05.245 --> 00:04:16.645
Business, so, for those people, it was resulting in them approaching the end of their life. So this was something I was really passionate about and I'm just so grateful for the opportunity to go through this fellowship.

25 "Erin Shadbolt" (2917561600)
00:04:17.035 --> 00:04:36.805
Um, when I was at Mayo Clinic, I was a nurse administrator, and I was over the home hospital program at Mayo Clinic, that program's called advanced care at home. It's actually called that at a few different systems.

26 "Erin Shadbolt" (2917561600)
00:04:37.035 --> 00:04:22.165
And so I'm gonna talk a little bit about the work that I did there and kind of how that journey went.

27 "Erin Shadbolt" (2917561600)
00:04:22.380 --> 00:04:24.180
For the program.

28 "Erin Shadbolt" (2917561600)
00:04:25.165 --> 00:04:36.805
So, the initial goals of the project was really ensuring appropriate identification of home hospital candidates that have intellectual and developmental disabilities.

Um, and that included input from those that would be served. So, 1 of the foundations of the program that, um, that I went through was really this idea of, you know, nothing for us without us.

And how do we gather the voices of people that will be impacted by the services.

Solving for the relationship between home hospital and community services so I'll talk a little bit more about that, but it is an ongoing challenge to implement the home hospital program in a facility setting,

or for people that have Medicaid and then a caregiver respite program development.

So, a little bit of background about the ACH program.

And really, I just want to start with Y, so male clinic launched their home hospital program in July of 2020. our program development was separate from the pandemic that just happened to be, um.

to be um

Good or bad timing, maybe, depending on who you ask, but this was really part of the vision that Dr.
um, the CEO of Mayo Clinic had to really cure connect and transform, so creating a platform that would allow people all over the world to access male clinic level hospital care in the comfort of their homes.

Um, really working to create capacity to drive affordability and to expand the male clinic reach.

The care delivery model is delivered in partnership with medically home. Um.

For those of you, that are unfamiliar. There is a few, pretty large vendors in the home hospital world.

Um, 1 is medically home, but there are several others such as dispatch health and and medically homes model includes a remote monitoring, um, center.

That is the command center as well as in home technology and then a supplier network and the supplier network includes all of these things that you can see in the outer ring.

So really have the patient in their home connected through technology to the command center and the command center is coordinating all of these different services that go into the home.

And as you can see, it's a pretty extensive suite of services and it mimics closely the services. That you can get in in the hospital setting.

This is what the medically home technology looks like. And this is a pretty typical setup we usually talk to patients about, you know, where do you spend most of your time, or where is it convenient for
you to access the technology? So that can be the kitchen.

47 "Erin Shadbolt" (2917561600)
00:07:20.813 --> 00:07:34.614
It can be the bedroom, it can be, you know, next to the recliner. Really? Wherever people have the space and are most likely to be the medically home model includes a tablet. The tablet is locked down. So that.

48 "Erin Shadbolt" (2917561600)
00:07:34.799 --> 00:07:47.669
Only interface that you can see is this 1 here in this picture so it has a schedule, um, with some upgrades. They now, um, patients can see the schedule for upcoming days.

49 "Erin Shadbolt" (2917561600)
00:07:48.174 --> 00:08:02.934
They can press a button to talk to their team, which initiates a video call to the command center. Um, and then there's also a place where they can enter their vital signs, or see what their vital signs were access education or take a photo.

50 "Erin Shadbolt" (2917561600)
00:08:03.234 --> 00:08:17.604
Um, there is also a set of emergency backup equipment, so the medically home Mayo Clinic model of home hospital is a pretty high acuity model. So the technology includes a.

51 "Erin Shadbolt" (2917561600)
00:08:17.669 --> 00:08:32.544
Um, backup power supply that can run an oxygen concentrator for several hours a phone. So you can see this phone here. If you pick that up at dials, direct to the command center that's in case something were to happen to the tablet.

52 "Erin Shadbolt" (2917561600)
00:08:32.544 --> 00:08:44.604
And people aren't able to get through, or if people just don't want to connect through a video call for privacy reasons, they can connect through a phone call. Instead there is a personal emergency response device support on the wrist.

53 "Erin Shadbolt" (2917561600)
00:08:44.694 --> 00:08:47.634
Um, usually that is located in the bathroom.

54 "Erin Shadbolt" (2917561600)
00:08:47.669 --> 00:08:52.379
So there is, you can see this little box there is a call, um.
The thing to call to the command center through that as well and then there's Bluetooth enabled vital sign equipment.

The supplier network, um, looks like this. So, again, like, I mentioned Mayo Clinic, we have a command center.

There's a software platform provided by medically home that's called Sasha, and that helps the command center, coordinate the supplier network to deliver care to the patient's home.

The program at Mayo Clinic allows for people to live 30 miles from the home.

Site of the program, um, and.

A implemented a waiver program in.

I think it was maybe late 2020, um, that allowed for home hospital programs to start to build Medicare directly for the services. Most of the time you'll just hear it called the CMS waiver.

And what it says is that a patient has to have a, um, sort of an index, er, or hospital stay at an identified hospital.

And so, for the program and Eau Claire, male clinic, the identified hospital was the unclear hospital and patients could be served in a 30 mile radius from that hospital. But the command center was actually in Jacksonville, Florida for our program.
be able to.

65 "Erin Shadbolt" (2917561600)
00:10:17.429 --> 00:10:31.014
To people within that 30 mile radius from the hospital so, you know, community pair medicine and which is a cute rapid response career services, some medical equipment, home, health,

66 "Erin Shadbolt" (2917561600)
00:10:31.044 --> 00:10:35.214
AIDS homecare services. So that includes therapy and nursing.

67 "Erin Shadbolt" (2917561600)
00:10:35.519 --> 00:10:47.309
Infusion therapy Labs, medical meals. Um, those actually, in the male clinic model are provided through the hospital, um, cafeteria as freshly.

68 "Erin Shadbolt" (2917561600)
00:10:47.309 --> 00:10:52.709
Fresh frozen meals, mostly, um, and then there's medical waste and.

69 "Erin Shadbolt" (2917561600)
00:10:52.709 --> 00:10:58.289
Kind of all of these, um, pieces of the supplier network that can be delivered.

70 "Erin Shadbolt" (2917561600)
00:11:00.054 --> 00:11:04.914
For the journey of the patient in the advanced care at home program.

71 "Erin Shadbolt" (2917561600)
00:11:04.944 --> 00:11:12.294
Like I mentioned with the CMS waiver, patients have to visit the emergency room,

72 "Erin Shadbolt" (2917561600)
00:11:12.324 --> 00:11:26.814
or have a brick and mortar hospitalization at the index facility which for us is the clear hospital. That's important. Because in the region where we're surveying, Mayo Clinic actually has 5 hospitals here.

73 "Erin Shadbolt" (2917561600)
00:11:26.814 --> 00:11:29.394
There's 4 critical access hospitals 3 of which.

74 "Erin Shadbolt" (2917561600)
00:11:29.489 --> 00:11:44.274
We're actually within 30 miles of the nuclear hospital, and then Neil Clare hospital. So this was kind of an ongoing challenge is, we would
have people that were appropriate for the ACH program. They actually were in the, er, in Menomonie or the Ian Bloomer.

Instead of the Claire, those patients were unfortunately not eligible for the home hospital program. So, for patients that were identified in the emergency department as being a potential candidate for advanced care at home, that was called a hospital.

And those patients would go straight from the, er, home, and they would get acute phase care, which is inpatient level care again this is being paid for under the CMS waiver. So, patients have to meet inpatient criteria.

They have to go through usual utilization management leveling. So, it looks just like, in patient level of care, they get nursing and therapies, frequent clinician visits, and in home diagnostics and then around day, 3.

Those patients would be transitioned to restore to phase where they would get continued rehabilitation, help with medication, management, patient, education and transition back to their primary care provider. Not every patient would qualify for sort of care.

Um, and about halfway through the model. Mayo Clinic actually phased out this restored phase of care.

For bricks and mortar patients, so these are patients that maybe came in and they really were too sick to go home right away. Um, a good example of this is somebody that comes into the hospital with and they actually have signs of being septic.

We generally don't want to take patients that are actively set to
comb. So, for those patients, we would usually culture the wound where we thought the was start antibiotics and once those signs of sepsis had improved, or were trending the right direction.

Then we might bring patients home that was called reduce length of stay.

Um, this is just an example of kind of the difference in care between a typical hospital patient and a patient that is in a home hospital program, like advanced care at home.

So, the hospital is such an interesting environment because we, um, you know,

we pretty much take away usual schedules and we very much schedule things based on convenience for the hospital operations. Uh, it's not really.

Anybody's fault, it's just the way that it works. So, your physician starts rounding at 7, which means that your Labs need to be really run at 6.

and I would say 60 am is probably a little bit late in a typical hospital for your lab draws a lot of times. Those are gonna start at 4 or 5 in the morning and so.

Um, then you have your physician visit and that's going to be between 8 and 11 or maybe later. It just really depends on what is going on in your physician's world. You know, you're gonna watch TV. You're gonna wait for an X, Ray.

We're probably not gonna let you get up and move around very much. We don't really love people to walk too much in the hospital, because we don't want you to fall. Um, so we're gonna do a sponge bath in bed,
um, at 40 P. M.

91 "Erin Shadbolt" (2917561600)  
00:14:42.804 --> 00:14:45.114  
you might push the call button hoping to talk. talk

92 "Erin Shadbolt" (2917561600)  
00:14:45.119 --> 00:14:53.369  
You're physician again, the physician might come by at 5, or they 
might say, you know, your physician will come by and to you tomorrow.

93 "Erin Shadbolt" (2917561600)  
00:14:53.694 --> 00:15:05.544  
Any dinner at 60 PM, and then at 11, the hospital is quite enough for 
you to go to sleep, except at midnight we're going to come in and 
check your vital signs. So you're not going to sleep for that long.

94 "Erin Shadbolt" (2917561600)  
00:15:05.544 --> 00:15:12.894  
Whereas in the home, we have a very patient centric schedule, um, the 
way that, uh,

95 "Erin Shadbolt" (2917561600)  
00:15:12.924 --> 00:15:23.244  
it's usually sort of operationalize is we usually start visits in the 
home actually around 5 or 6 in the morning because some people are 
morning people and they're already up. up

96 "Erin Shadbolt" (2917561600)  
00:15:23.369 --> 00:15:33.209  
And that's when they want to get their day going. So we do that for 
those people. And for people that say, I don't get up until 11, then 
we're not going to come see you until 11.

97 "Erin Shadbolt" (2917561600)  
00:15:33.654 --> 00:15:46.164  
So, we usually 1 of the 1st, things in the morning, that happens is 
the nurse or community paramedic is going to come by and they're going 
to get the lab draw for the daily Labs. They're also going to do a 
basic assessment.

98 "Erin Shadbolt" (2917561600)  
00:15:46.584 --> 00:15:55.764  
And then there's going to be a physician video visit, probably at the 
same time that a nurse practitioner, or the nurse or paramedic are in 
home, seeing people in person.

99 "Erin Shadbolt" (2917561600)  
00:15:56.664 --> 00:16:08.574  
Visitors are, of course, allowed and welcomed in your home. Um, we
don't really have control over that, but we do ask people to not really leave their home while they're in the acute phase of their hospital state.

100 "Erin Shadbolt" (2917561600)
00:16:09.084 --> 00:16:11.784
We'll have an X, Ray, somebody will come to the home.

101 "Erin Shadbolt" (2917561600)
00:16:11.814 --> 00:16:25.344
Do the X, Ray uh, we'll have an aid come and help you shower in your home if maybe you haven't showered before and you need additional support then maybe we have an occupational therapist come and make sure that you have all the equipment and supplies that you need.

102 "Erin Shadbolt" (2917561600)
00:16:26.069 --> 00:16:40.319
Um, you can connect to the physician using the iPad at 40 P. M. you can eat food at home, or we'll bring you food if that's what you want and then you'll sleep in your own bed and we don't check vital signs at night in the home hospital.

103 "Erin Shadbolt" (2917561600)
00:16:42.269 --> 00:16:55.554
Um, so who is a candidate for, um, this gets into some really important implications when we start to talk about access for people with intellectual and developmental disabilities um,

104 "Erin Shadbolt" (2917561600)
00:16:55.614 --> 00:16:59.844
and even those with physical disabilities. So, the criteria is that.

105 "Erin Shadbolt" (2917561600)
00:17:00.119 --> 00:17:11.309
They have to have the right diagnosis, and we actually are at a place within the Mayo Clinic program where it's more like, you need to not have the, the wrong diagnosis. So.

106 "Erin Shadbolt" (2917561600)
00:17:11.309 --> 00:17:24.449
There's some diagnoses that we don't take into the program, um, for a variety of reasons, but it's pretty limited right now. 1 example would be somebody that is dependent on HEMO dialysis.

107 "Erin Shadbolt" (2917561600)
00:17:24.804 --> 00:17:35.904
Um, for kidney failure, dialysis has some just very specific Medicare billing implications and we don't have a good way to manage that yet.

108 "Erin Shadbolt" (2917561600)
Um, so I, I think we'll get there, but we're just not there today, clinical stability. So, essentially, we need to think that you're not likely to need to be escalated to the ICU. You're not likely to need continuous telemetry monitoring.

And usually, we don't like to admit people to home hospital if we think that within the next 12 to 16 hours, they have something that they need to come into the brick and mortar for.

So, there's a lot of things that we do in the hospital that we can't do at home scans MRIs we can.

Do basic X, Ray, we can even do some pretty advanced ultrasound in your home, but we can't do scans. So if we know that you need a scan today, you're probably not going home with the home hospital today.

We're gonna wait until, after you have that done.

Um, geographies, so you need to live within 30 miles of the hospital. Social determinants. So, um, each program is a little bit different, but for the male clinic program, they have a social stability screening tool that asks questions like.

Are their weapons in the home if there are weapons to agree to secure them? Are there animals in the home?

Do you agree to secure your animals? Do you have running water? Do you have working electricity? Do you have heat or air conditioning depending on the weather?

Um, do you have access to support, um, to be able to move functionally in your home? Essentially, we're really screening to make sure that you have a safe recovery environment.
Um, but what you find is that what a safe recovery environment is looks really different to.

Every person that assesses that, and then payer. So, um, there has been a variety of changes to this as the Mayo Clinic program has moved along.

Um, you know, there there, almost 2 and a half years into their program. Now, at Mayo Clinic.

Initially, there was a very limited payer, um, group now it's much broader, including most commercial insurances, most Medicare advantage plans, all primary Medicare.

But at least in my state, I'm in Wisconsin. Um, Medicaid is not a payer. Our Medicaid system chose not to, um.

Sign up for the waiver, and I'm not sure that full process, but, uh, the home hospital.

Program is a benefit is not something that's allowable under Medicaid.

In Wisconsin, so we kind of go through this list of criteria. We come up with a list of, you know, 5 to 10 patients in the hospital every day.

And then, are we reach out to the patient's position and say, hey, do you agree that? These patients might look good and if they say, yes, then we reach out to the patients, talk about the program and make sure that they will be interested in going home.
And then everything's arranged, and patients can go home with the home hospital. Um, there are times when patients may opt out and they can come back to the hospital.

Anytime 1 of the things that we've gotten better at over time is preparing people for what it really looks like.

In the home on 1 hand, it's really nice, because it's much more limited interruption than in your hospital room.

On the other hand it feels very disruptive to have people coming to your door every hour or 2 during the day to provide care.

So, we do have to sort of prepare people, but it it really is hospital level care and it's a lot of people coming to see you to provide hospital level care.

So, I did a, uh.

Evidence review for this project really trying to get an understanding of, you know, Where's the current literature and understanding of.

The home hospital model of care hospital care in general for those with, um, and then any connection between.

The home hospital model and care for those with id'd,

which I didn't find any literature around that I did find some pretty good information or at least the beginnings of what I think is going to become a good pool of information.
Um, around use of, like, Tele visits and, um, oh.

Uh, like, uh, telehealth devices for people with id'd. So the current knowledge review for the home hospital home hospital's actually.

Been around for quite a while in the U. S. since the late 1990. S. and longer than that, um, internationally. So there is quite.

Quite a lot of literature, if you go and look for articles around home hospital, I just wanted to share some of the more recent and well known authors, um, on the subject. So, um, Dr left in 2008.

Really did 1 of the 1st, um, what's considered a really nice review of the program and the and the outcome so he describes at the home hospital environment is less stressful for family.

Members of those that were hospitalized. This was kind of regardless of the amount of care that those families ended up taking on when their loved 1 was in the home hospital. And I thought that that was kind of interesting in 2018. Dr.

Levine, um, published outcomes from a small randomized control trial. randomized control trial

That found that really our outcomes, quality safety and patient experience. We're similar in the home hospital versus the brick and mortar setting. So, home hospital might not be better, but it's not worse than the brick and mortar.
Setting, and then in 2020, as I mentioned, authorized an emergency waiver during the public health emergency so, for those of you that are familiar with this, the is approved through the end of this year.

We've been told in the healthcare world that we'll get a 60 to 90 day notice when the PhD is going to be ended.

There is a lot of risk in the home hospital world that if the public health emergency goes away, this waiver can also go away. And so the revenue capture will go away, which would be very challenging.

Um, because while we all love this model of care and believe in it, it's ideal if you can get paid for the care that you're providing. So, the waiver did set some minimum standards for home hospital programs. Some of the things that were included.

I already mentioned the patients have to come to the, er, or to the hospital.

For a hospital stay before they can be admitted to the program.

There's a pretty extensive application process for hospitals based on whether they have had a previous home hospital program, or whether they're launching a new 1.

The patients that are in the home hospital program, according to the waiver, um, they need to have a visit by provider virtual or in person each day that can be a physician,
or an advanced practice provider like a nurse practitioner or physician's assistant. Um, they need to have a nursing assessment each day. This can be in person or virtual that nursing assessment needs to drive the nursing plan of care.

And then there needs to be 2 in person visits, completed.

To follow through on that nursing plan of care that's created by that nurse assessment.

This can be provided by a nurse, or by a mobile integrated paramedic also called a community paramedic. Um, there's some differences between those 2 terms, but for this presentation, I'm going to use them interchangeably.

So that's kind of where we're at with the current knowledge review of home hospital it exists and the research that's out there is pretty good. There's been very limited, large, randomized, controlled trials and actually kind of, interestingly, male clinic was, um.

In the process of trying to do a large when I left the organization, but there's been sort of multiple challenges because when you approach patients to try to randomize and you tell them that, if they're randomized,

they might have to stay in the brick and mortar hospital. They opt out of the so, um, it's, it's been a challenge, uh, to to kind of gather that data and I think that's been common.

So this is a current knowledge review around telemedicine for those with, with like I said, I didn't find really any literature that talks specifically about the experience of those with ID or the experience providing care for those with,
in the home hospital. But what I did find is especially coming out of the initial year, or 2 of the pandemic. There is some good literature that a, certain to describe what it looks like to provide virtual care.

For people with, so, in a article, they, they talk about that it's possible to deliver accessible and high quality, virtual care for adults with ID, but there's limited research on the topic.

Um, 1, ski in 2021 found that there isn't 1 option. That's better.

For those with ID, but that video and telephone visits can be used to successfully support the care of those with id'd. And then in 2020, there was an article by Tessie. That was kind of a very interesting article.

It was actually talking about, um, the use of 2 way technology so something like a tablet in a home that could help increase independence and a sense of safety in those living at home with ID. So. with id so

Essentially, they took some individuals that had put a, um, a system in place where they could connect to their health team or to their sort of care network.

Whether that was parents, friends, their community and it allowed them to fill more independent in in their home.

Um, I don't remember now which article it was, but 1 of the things that I did find in literature that I thought was interesting. Um, and also it seems like common sense but I want to point it out is that.

The most effective telemedicine for people with and.
I would venture to guess that this is true for all people is that telemedicine is most effective if the provider that is providing the medicine part of the telemedicine visit is familiar with the individual receiving care.

So I think that's a really important piece. That really speaks to kind of that relationship and knowledge of the individual.

And then this is a review of the hospital experience of those with, um, probably not surprising to a lot of those on this call. But McCormick in 2020 found that it continues to be really challenging for people with to feel like they've received respect compassion, communication, and accommodations from acute care providers. Maloney and 2021.

Essentially, what are interventions that we can provide that improves the acute care experience.

The people with what are some of the reasonable accommodations I was care in the home early, discharged home and increase access to family members and caregivers, which,

I think supports this model of care of the home hospital for people with. I also want to just highlight this very, very interesting article that was published in 2020 called how hospital stays resemble. hospital stays resemble

Enhanced interrogation, and essentially, this article took the CIA
enhanced interrogation manual and compared it to a hospital stay.

180 "Erin Shadbolt" (2917561600)
00:29:45.054 --> 00:29:50.874
So we take you out of your clothes and put you in a, in a uniform.

181 "Erin Shadbolt" (2917561600)
00:29:51.179 --> 00:29:54.569
We really, um.

182 "Erin Shadbolt" (2917561600)
00:29:54.954 --> 00:29:57.654
We don't allow you to have any control over the environment.

183 "Erin Shadbolt" (2917561600)
00:29:57.684 --> 00:30:08.694
We ask you the same questions repeatedly, but without anybody really
seeming to care about the answer and then we distort day and time, um,

184 "Erin Shadbolt" (2917561600)
00:30:08.784 --> 00:30:20.484
and often we don't take really many of your preferences into account
and again, this isn't any 1 person's fault. This is the system that
we're all working in, um, as it's set up today.

185 "Erin Shadbolt" (2917561600)
00:30:20.819 --> 00:30:28.469
So, my project was really designed again on this principle of nothing
for us without us. So.

186 "Erin Shadbolt" (2917561600)
00:30:29.934 --> 00:30:39.864
I reached out to patients and caregivers affected by to get input for
the program and there was a couple of really key things that I got
feedback on.

187 "Erin Shadbolt" (2917561600)
00:30:40.194 --> 00:30:52.464
I was I want to know exactly what care I or my loved 1 will be getting
and when so, the convenience of the schedule on the tablet in the home
is is really great for that.

188 "Erin Shadbolt" (2917561600)
00:30:52.974 --> 00:30:57.084
I want to continue my usual activities. So, I already mentioned to you
guys that.

189 "Erin Shadbolt" (2917561600)
00:30:58.104 --> 00:31:09.204
You know, what you do in your own home is sort of your, your own home.
We do sometimes put some limitations like, we don't want you to go up or downstairs, especially if they're particularly steep or slippery.

190 "Erin Shadbolt" (2917561600) 00:31:09.594 --> 00:31:23.124
Um, but for the most part, people can do their usual activities at home, but you can't necessarily go out to a daily visit to a group center. If that's something that you do you can't go to the library every day.

191 "Erin Shadbolt" (2917561600) 00:31:23.124 --> 00:31:27.114
Because technically you're hospitalized, which means you need to be under the care of the.

192 "Erin Shadbolt" (2917561600) 00:31:27.419 --> 00:31:32.369
So, we usually just address that on an individual basis in the plan of care.

193 "Erin Shadbolt" (2917561600) 00:31:32.934 --> 00:31:43.584
They people told us that they want to know how to access the program and when they could enter. Um, so we created some patient and caregiver guides.

194 "Erin Shadbolt" (2917561600) 00:31:43.584 --> 00:31:58.014
That are actually up in our emergency room at the male clinic hospital here that let people know right away that, as they're being screened, there's an option for them to go home with hospital care at home. We also did a lot of work with our case managers.

195 "Erin Shadbolt" (2917561600) 00:31:58.014 --> 00:32:01.554
In talking to them about the program and letting them know that, um.

196 "Erin Shadbolt" (2917561600) 00:32:02.369 --> 00:32:06.239
They should be talking to patients about this if they qualify.

197 "Erin Shadbolt" (2917561600) 00:32:07.224 --> 00:32:20.244
Fear of the caregiver's ability to manage care again. This is addressed on an individual basis. Most of our patients end up not needing any home health aid support, but we had some people that ended up needing us several hours a day.

198 "Erin Shadbolt" (2917561600) 00:32:20.244 --> 00:32:31.824
And that was something that we work to accommodate and then fear what happens in case of an emergency. So, this really depends on an individual's underlying diagnosis and what's going on.

199 "Erin Shadbolt" (2917561600)  
00:32:32.129 --> 00:32:46.044  
That is likely to create an emergency, but for all of our patients, we had an emergency plans. Good example of this is we took care of hundreds of people with covid 19 to finish up through remdesivir, um, infusions at home.

200 "Erin Shadbolt" (2917561600)  
00:32:46.764 --> 00:33:00.084  
We knew those patients were at high risk of respiratory decompensation. So every single patient got an oxygen concentrator and if they were already on oxygen, then they got the highest oxygen concentrator that we had.

201 "Erin Shadbolt" (2917561600)  
00:33:00.389 --> 00:33:08.069  
So, we have, um, emergency response plans, essentially for every patient. Really? Based on their needs.

202 "Erin Shadbolt" (2917561600)  
00:33:09.419 --> 00:33:16.014  
Project barrier, so, um, care resources for those with are siloed and difficult to navigate.

203 "Erin Shadbolt" (2917561600)  
00:33:16.434 --> 00:33:27.114  
Um, you know, I've been a nurse now for, uh, 15 years, and I've been in leadership in the home care setting for most of that. Um.

204 "Erin Shadbolt" (2917561600)  
00:33:27.419 --> 00:33:35.999  
If if I can't figure it out, I'm really not sure how people that need the services figure it out. I.

205 "Erin Shadbolt" (2917561600)  
00:33:36.534 --> 00:33:50.574  
Have relationships with people and leadership settings. I know people in health care. I know people in the community, and it was so hard for me to figure out really basic information around resources.

206 "Erin Shadbolt" (2917561600)  
00:33:51.144 --> 00:33:53.604  
Um, the Medicaid system, Wisconsin.

207 "Erin Shadbolt" (2917561600)  
00:33:53.879 --> 00:34:07.614
Has multiple levels of bureaucracy, and I was never able to find anyone that could help me answer some basic questions about accessing Medicaid benefits while accessing the home hospital program.

Um, which is really unfortunate and still a barrier that hasn't been solved. And then the electronic health record is not set up for easy identification of those with.

Id, so, for this project, um.

You know, wanting to make sure that we.

Create an access for those with to the program it's important that you can actually identify people with ID. And that's very, very difficult in the, as I found out.

So project outcomes overall, I think my project was a success. We created a toolkit to support ACH access and communal settings.

So, um, at the time of this project with, which was early spring of this year, 12 patients with were served by the program, half of those had heart failure. Most of the rest had infections. We had 1 patient with covid, 19.

Patient and caregiver and staff experience was all very positive.

Um, future opportunities, though.

1 is really working through, um, this partnership with Medicaid to solve for patients receiving Medicaid community services.
So, the big issue is that if patients are receiving Medicaid family services, which in Wisconsin, we have quite a, um.

Really pretty robust family care plan that allows people that would maybe traditionally need to move into facility setting to live independently at home, or to stay in a lower level facility, like a group home,

or an independent living with this Medicaid family care plan, which pays for things like, um, housekeepers, homemakers, um, private duty care,

giving like AIDS and sometimes.

Verses so, for some people that have frequent, like, wraps, for example, they might have a nurse that comes out every other day to do that.

Um, so the issue is, is that when you are a dual eligible, so you're on Medicare and Medicaid, and you go into the hospital.

If your Medicaid Services stop, um.

Because you're in the hospital, Medicare is paying for that for the home hospital program. You're not physically in the hospital you are at home and so to be at home safely, you normally rely on these Medicaid services.

So the question really becomes.

Is there a contractual way for the hospital to pay for these Medicaid
services that you can continue to stay at home and get hospital services? Or should Medicaid kick back in? Because you're at home?

227 "Erin Shadbolt" (2917561600)
00:36:49.559 --> 00:36:53.399
Even though you're receiving hospital level care um.

228 "Erin Shadbolt" (2917561600)
00:36:53.399 --> 00:36:56.819
You know, they, there's.

229 "Erin Shadbolt" (2917561600)
00:36:57.414 --> 00:37:12.174
There is a solution out there, but I wouldn't need to talk to somebody that could answer some of those questions. Um, and honestly, I'm just not sure that Medicaid in our state is resource to start to talk through some of those implications.

230 "Erin Shadbolt" (2917561600)
00:37:12.774 --> 00:37:26.814
I think the other opportunity is continuing to work on creating the respite support for caregivers of those with. So, this is, um, an ongoing challenge. If any of you working in acute care setting, you know, how difficult it is.

231 "Erin Shadbolt" (2917561600)
00:37:26.819 --> 00:37:40.679
To access, um, workers, especially AIDS or housekeepers, or anybody like that. And so trying to create a respite program is really challenging in the current worker environment.

232 "Erin Shadbolt" (2917561600)
00:37:41.184 --> 00:37:49.404
And then we really need some formal studies. So my project was a very basic entry level, um, exploration.

233 "Erin Shadbolt" (2917561600)
00:37:49.434 --> 00:38:00.834
I mean, I manually reviewed every patient's record for potential diagnosis. Like I said, it's very hard to figure out that's how I came up with my count.

234 "Erin Shadbolt" (2917561600)
00:38:00.864 --> 00:38:07.644
But we really need some formal studies and some formal literature in this realm.

235 "Erin Shadbolt" (2917561600)
00:38:08.784 --> 00:38:21.834
This is just a quote from a patient so, being a part of the program
truly was a blessing. The program is incredible. And I will certainly
miss the interaction I have with the extremely caring and
compassionate professionals that took care of me during my recovery.

236 "Erin Shadbolt" (2917561600)
00:38:22.554 --> 00:38:37.164
So, the patient experience, like I said, has been great. The last
comment that I just want to make in terms of equity and accessibility
is that there is a lot of conversation right now in the home hospital
community about.

237 "Erin Shadbolt" (2917561600)
00:38:37.164 --> 00:38:38.004
Are we really.

238 "Erin Shadbolt" (2917561600)
00:38:38.664 --> 00:38:52.614
Improving access to health care, or are we making it? Maybe even less
equitable. I told you guys, I live in unclear. Wisconsin. Claire is
population of about 60,000 people. It's fairly rural.

239 "Erin Shadbolt" (2917561600)
00:38:52.614 --> 00:39:04.350
Um, compared to a lot of places, it's not. not

240 "Erin Shadbolt" (2917561600)
00:39:04.350 --> 00:39:06.274
It's not a suburb of anywhere, you know, claire's, the biggest town
for a couple of hour drive. So, um.

241 "Erin Shadbolt" (2917561600)
00:39:06.274 --> 00:39:14.425
We really struggle to provide access in our area to the home hospital
program, because we just have very limited resources.

242 "Erin Shadbolt" (2917561600)
00:39:14.785 --> 00:39:28.855
So 30 might having a patient 30 miles north and a patient, 30 miles
south and patient, 30 miles east and 30 miles west of the hospital.
Really? Limits our resources and makes it very difficult to provide
this care.

243 "Erin Shadbolt" (2917561600)
00:39:28.855 --> 00:39:41.065
Because we don't have unlimited community paramedics or nurses in the
community. So we've seen a lot of success with home hospital programs
in a more urban or suburban area.

244 "Erin Shadbolt" (2917561600)
00:39:41.065 --> 00:39:49.645
It's a real struggle in the rural communities, and we tend to find that those programs are small and somewhat limited in the acuity that they can support.

The other thing that is happening is that many many systems are using AI algorithms to help.

Identify patients and predict likely outcomes.

For people that are in the home hospital program, the, um.

The AI, you know, that's great. Computer learning is really great.

The issue becomes, if we are not really mindful of making sure that we are seeking out and providing access to all different types of people in our programs,

then we start to build computer learning models or AI algorithms that specifically exclude those people.

So, if you've never served a person with, in your program, your algorithm is not going to necessarily include.

Those people moving forward and so that's a real risk to programs as we're starting to build some of our, um, more advanced.

Algorithms to identify patients.

So that is the end of my presentation, I would love to take questions or comments.
Thank you so much Aaron please feel free to put your questions or comments in a chat box in the meantime.

Aaron, can you expand on just what you were talking about with the algorithms so, um, with with the home hospital, how how.

How would you address the issue of access and equity and, um, and just use the user misuse or of the algorithms?

Yeah, that's such a good question. Jasmin and I've had a lot of conversations with people that are involved in some of this work in the home hospital world, and it's not specific to home hospital. That's just the world I'm most familiar with.

I think that there's a few things that are on the radar.

But people are starting to think about 1 is, um, doing a better job coding.

People in the medical record, you know, that's 1 of the ways, then you can be very deliberate about making sure that the percentage of people being pulled into your hospital home algorithm.

That have is equivalent to the percentage of people that are be that are in your hospital in general. So that's 1 of the things that we look at.

Um, when we think about inclusive inclusivity and diversity in home hospital, we want to make sure that it mimics our brick and mortar and we want to make sure that our algorithms kind of mimic that.
I think the other thing that's really important is that as we're working with the, um, information technology people.

Build this that we have a plan for, how do we go back and adjust our algorithms as our capabilities get better. So, uh, a good example of this is the dialysis thing.

So, right now the male clinic hospital program doesn't take people on dialysis. So if we don't go back and change our ai algorithm.

It's never going to feed us patients with dialysis, because those patients aren't in the current algorithm and so.

We have plans every month or 2 to go back and update those algorithms and we need to do the same for people with different socio economic backgrounds for people with different intellectual developmental or physical disabilities for people with different types of mobility as we have increase access to things like home, health, AIDS, and even the Medicaid services, it will be important that we update those algorithms.

Thank you was there a difference between service provision between general population patient versus patient with intellectual disability?

From you there was so, um, there there was a couple of differences and again, this was a pretty small, and it was very manual, but based on my review, um, the.

People that we took care of with id'd generally had more visits per
day. So usually they had additional therapy. So both physical therapy and occupational therapy, um, each day and then many of them.

273 "Erin Shadbolt" (2917561600)
00:44:33.630 --> 00:44:41.850
Had a home health aid, at least once a day and often twice a day more for respite than for, um.

274 "Erin Shadbolt" (2917561600)
00:44:41.850 --> 00:44:56.365
True hands on personal care although certainly personal care was part of what was provided the other thing though. Um, especially with that underlying diagnosis of the infection or heart failure.

275 "Erin Shadbolt" (2917561600)
00:44:56.785 --> 00:45:11.785
Um, this group of patients tended to need, uh, more than the, the minimum, twice, daily nursing or paramedic visits. They tended to need 3 visits today. Um, some of this is because a lot of the IV antibiotics that we give them the hospital.

276 "Erin Shadbolt" (2917561600)
00:45:11.850 --> 00:45:22.290
For every 8 hours, instead of every 12, um, also when we are giving people with heart failure in the home, a lot of times.

277 "Erin Shadbolt" (2917561600)
00:45:22.290 --> 00:45:25.440
You want to give that, you know.

278 "Erin Shadbolt" (2917561600)
00:45:25.440 --> 00:45:35.965
1st thing in the morning, and then early to mid afternoon, but we also like to see those people right before bed. And so some of it was just timing of medications.

279 "Erin Shadbolt" (2917561600)
00:45:36.565 --> 00:45:41.935
But that is another thing that could really impact access to this program.

280 "Erin Shadbolt" (2917561600)
00:45:42.685 --> 00:45:56.035
Is, um, I went to a conference and talked about the home hospital program and listened to some presentations on some other programs in Wisconsin and the other 3 programs that presented are providing 2 visits today.

281 "Erin Shadbolt" (2917561600)
00:45:56.035 --> 00:46:03.775
And they don't take patients that need more than 2 visits a day upfront um, which again kind of limits access.

282 "Jasmina Sisirak" (955846400)  
00:46:07.080 --> 00:46:11.520  
And, and the reason they don't take them is because it doesn't.

283 "Jasmina Sisirak" (955846400)  
00:46:11.520 --> 00:46:21.150  
The the funding, or it doesn't pay offer it, it doesn't make sense in in that direction. Or or why would that be the case.

284 "Erin Shadbolt" (2917561600)  
00:46:21.150 --> 00:46:30.840  
Yeah, it's really it's a resource issue. So, do you have the resources to provide 3 times a day visits or not? And.

285 "Erin Shadbolt" (2917561600)  
00:46:30.840 --> 00:46:40.440  
It it starts to get really complex to take care of more than just a few patients, but especially if they have more than twice a day visits.

286 "Jasmina Sisirak" (955846400)  
00:46:41.605 --> 00:46:45.895  
Thank you, um, is there so, the 12?

287 "Jasmina Sisirak" (955846400)  
00:46:45.925 --> 00:46:59.515  
I know it's a small number, but with the 12 patients with intellectual disabilities, where they usually, um, at home with family member, or was it with a direct support, professional or caregiver,

288 "Jasmina Sisirak" (955846400)  
00:47:00.205 --> 00:47:05.605  
can you speak a little bit about that? And what was the difference between 30 to 2?

289 "Jasmina Sisirak" (955846400)  
00:47:06.600 --> 00:47:15.330  
Yeah, so location and, um, and is there a need to build capacity among sort of the support people?

290 "Erin Shadbolt" (2917561600)  
00:47:15.330 --> 00:47:19.830  
Yeah, so what ended up happening for us is that.

291 "Erin Shadbolt" (2917561600)  
00:47:19.830 --> 00:47:24.780  
The people that we took on to our program with ended up.
Being people that were living in a home setting, so we were not able to take people that lived in assisted living or group home setting. Um.

For a variety of reasons, but 1 of the biggest reasons is back to kind of that dual eligible. And Medicaid issue is if you are in a group home or an assisted living, and Medicaid is paying for your room and board, which is really common.

Does Medicaid pay room and board if you are technically in an acute hospital state and if they don't then does the hospital pay your room and board and so there is a lot of contracting and stuff with that.

But anyways, we ended up just not taking people and this was during the height.

In many ways, during the height of the covid pandemic and so most facilities weren't allowed allowing extra people in anyways. Um, so for most of these.

People with ID that we took care of, they either lived independently with.

A support community, whether that was privately paid or neighbors or family, or they live with family members most commonly they were living with family members either a siblings, um, spouses or, uh, parents.

That that were their primary caregiver.

Um, and did you see any need to so, how was the role of that
support person? Um.

301 "Jasmina Sisirak" (955846400)
00:48:55.740 --> 00:49:02.550
Kind of like, how was it different? Um, compared to, um, general population.

302 "Erin Shadbolt" (2917561600)
00:49:02.550 --> 00:49:07.950
Yeah, so that was 1 of the really interesting things is that, um.

303 "Erin Shadbolt" (2917561600)
00:49:07.950 --> 00:49:12.240
It the, the experience.

304 "Erin Shadbolt" (2917561600)
00:49:13.350 --> 00:49:16.890
Of the support person.

305 "Erin Shadbolt" (2917561600)
00:49:16.915 --> 00:49:31.645
Really didn't vary based on things like, you know, was was the patient somebody with ID or not it varied more on what was their sort of usual support system. So.

306 "Erin Shadbolt" (2917561600)
00:49:31.920 --> 00:49:38.760
You know, we, we took care of a lot of people that their spouse was their primary caregiver, but that.

307 "Erin Shadbolt" (2917561600)
00:49:38.760 --> 00:49:46.645
They didn't live near children. They didn't. They really didn't have a community. They didn't go to church. They didn't have friends. They didn't talk to their neighbors.

308 "Erin Shadbolt" (2917561600)
00:49:46.945 --> 00:50:00.025
That was a much more difficult experience than the experience of somebody that had a community, had children nearby. You know how to church community um, so.

309 "Erin Shadbolt" (2917561600)
00:50:00.895 --> 00:50:15.715
There actually will probably be some papers coming out on this, because we did do some formal caregiving, um, experience surveying. This is a really interesting area of the home hospital world and I that I'm excited to see more information.

310 "Erin Shadbolt" (2917561600)
Come out on is, what is that experience of the caregiver and how does it differ from the hospital? I think 1 of the common themes as I talked to people, though, is that.

Being the caregiver of somebody that's hospitalized is very challenging.

Even if they're in the brick and mortar, you still feel like you need to be there. Most of the time you still worry, you still feel like the care's disjointed. You still feel like the care could be better than it has. Been you worry about them falling?

Um, and then there's a lot of things like delirium is much worse in the hospital. Um.

You know, people tend to not eat as well. They tend to not be as socially outgoing. They usually can't move around as much.

Like I said, we don't love for people to walk in the hospital and so there's a lot that's really challenging in the hospital setting being a caregiver. And then the other thing is is, like I said, this was during the height of covid.

So, we weren't allowing more than 1 visitor, um, which.

Made it even more difficult because now that primary visitor, and we didn't allow visitors to switch out.

He got 1 visitor and it was your primary visitor. That that person was it they, they were the only person that was able to come to the brick and mortar and provide support to patient to the patient.
So, it was a different time. I think for caregivers, regardless of kind of the patient situation.

Thank you, um, another question. Mm. Hmm.

Let me just look through, um.

When you're looking at different disciplines, what other disciplines should participate in your opinion in the home hospital.

Yeah, that's a really great question. So, um, most home hospital programs are partnered with, um, the services that are available through a home health agency.

Um, we certainly saw the use of a social worker. I think the program could use a dedicated social worker to be honest.

Especially if we want to do a really good job, transitioning people to other community services.

So we mostly access our social workers that worked in our home health and hospice agency for this program.

And that wasn't really good, sort of natural match, because we're trying to access community services, um, for our patients, um, speech therapy, occupational therapy and physical therapy, or just instrumental. It was so important to have them involved. And every patient got at least a physical therapy evaluation. And most of them also gotten occupation.
Therapy evaluation, um.

And that's so meaningful in the home setting, because people often have never had a professional, assess their home environment for equipment or changes to make their home safer.

The other discipline that I just can't say enough about is pharmacy. Pharmacy was such an important and integral part of our program. Um, they really helped keep patients safe and they, they were really crucial for us to try to find ways around barriers to admitting people. So good example is that a common antibiotic that we use in the hospital?

Jason Jason is given every 6 hours that was more often than what we would usually accept, but we worked with our pharmacy team and they were able to set up a continuous Nelson infusion.

So we could take those patients home. So.

Pharmacy was very, very important,

and they were important during the acute phase of the hospital at home stay and then they also worked with us to transition people to a home medication regimen that they were going to be successful with.

So, you know, how do you limit the number of times a day? Somebody has to take medication? How do you get them on kind of the best dose with the least amount of side effects? Um, what's the right way to set up...
their med? So that it's easy to remember. So.

339 "Erin Shadbolt" (2917561600)
00:54:31.260 --> 00:54:43.770
They were really, really helpful. Um, the, the other discipline that I had bought a lot about, but really, we hadn't done a great job on implementing with spiritual care. Um.

340 "Erin Shadbolt" (2917561600)
00:54:44.485 --> 00:54:49.285
I and I just, I have a personal connection to spiritual care.

341 "Erin Shadbolt" (2917561600)
00:54:49.285 --> 00:55:04.105
I'm not a religious person, but I, when I had my last child, she was in the special care nursery and I think out of all of the time that anybody spent with me, the 30 minutes, the chaplain spent with me was probably the most meaningful.

342 "Erin Shadbolt" (2917561600)
00:55:04.465 --> 00:55:13.675
And I think that that is a discipline that we really need to find a way to implement in the whole hospital model. Um, to make sure that.

343 "Erin Shadbolt" (2917561600)
00:55:13.770 --> 00:55:15.090
We are.

344 "Erin Shadbolt" (2917561600)
00:55:15.090 --> 00:55:25.350
Providing that holistic care, and also helping people connect to their spirituality and the home setting is really different than the hospital setting.

345 "Jasmina Sisirak" (955846400)
00:55:28.405 --> 00:55:35.935
Thank you Aaron, thank you so much. This is so very interesting. Have you found that many people?

346 "Erin Shadbolt" (2917561600)
00:55:35.965 --> 00:55:50.845
How how familiar are people with the, uh, um, home hospital model in your sort of experience? My experience is probably bias is hanging out with a lot of people in the home hospital community.

347 "Erin Shadbolt" (2917561600)
00:55:51.295 --> 00:55:54.085
Um, I think in larger.

348 "Erin Shadbolt" (2917561600)
Hospital systems it.

People know about it um, do patients know about it? I think it's very hit or miss, but mostly people don't really.

Know about it, and they don't really understand, I think the level of care that actually can can be provided in the home,

and even physicians within our own system weren't always really able to understand how sick people could be and go home safely.

So, um, I think there is a tremendous amount of work to be done on sort of public knowledge and understanding, but I would encourage any of you. If you were a loved one ends up needing to be in.

Hey, stuff um, so I love your presentation. Um, and, you know, I have to admit, I.

Until I heard your presentation with the fellowship, I, I really had never heard of home hospitalization and had never heard of it for people with ID, intellectual and developmental disability.
So I have to wonder if, um.

358 "Beth Marks she, her(s) (UIC)" (3290306816)
00:57:25.110 --> 00:57:38.575
How well, people know about it as an option, and I'm not even sure that people on discharge and I'm thinking of older adults as well and people with intellectual disabilities.

359 "Beth Marks she, her(s) (UIC)" (3290306816)
00:57:39.025 --> 00:57:47.995
Um, how much they even know that they have an option, just for home health after this church went along a home hospital model.

360 "Beth Marks she, her(s) (UIC)" (3290306816)
00:57:47.995 --> 00:58:08.670
And I'm, I'm sort of wondering your thoughts on how we can get this information.

361 "Beth Marks she, her(s) (UIC)" (3290306816)
00:58:08.670 --> 00:58:15.540
Now, just aren't aware of level for people within both, um, older adults and people with disabilities and and people with intellectual and developmental disabilities as an option.

362 "Beth Marks she, her(s) (UIC)" (3290306816)
00:58:15.540 --> 00:58:20.970
And maybe I have slept through all of it and everyone knows about it, but I don't think so.

363 "Erin Shadbolt" (2917561600)
00:58:20.970 --> 00:58:32.580
No, I, I think you're right back. I think it's fairly.

364 "Erin Shadbolt" (2917561600)
00:58:32.580 --> 00:58:38.335
Unknown, especially to the public and like I said, I think, you know, in the acute care setting, I, I would guess most people have heard of it but there is a lot of, um.

365 "Erin Shadbolt" (2917561600)
00:58:38.335 --> 00:58:52.405
Financial implications to launching a home hospital model. So they're very expensive to run.

366 "Erin Shadbolt" (2917561600)
00:58:52.405 --> 00:58:55.540
Especially if you work with a vendor that oversees them, they are challenging operationally because you have people that are up to 30 miles from a hospital, and you need to deliver to visits at a minimum a day to them. Um.
And, you know, for better for worse, if I have 2 patients that I'm looking at for home hospital, 1 of them is a person with an intellectual developmental disabilities, and 1 of them is a person without, and I can only take 1 person into the program.

Who do I choose? And I.

I think that that is a very real challenge right now that we naturally are creating a system in the home hospital world where.

It's creating.

A place where we have to make a decision on, who is going to be.

Easier to take care of in the home.

And who are we going to be able to provide services for and an easier way? So, you know, who is that? That's somebody that has a more stable, more safe home environment. That's somebody that lives closer to the hospital.

That's somebody that can read and write and communicates really clearly. And I'll be honest I worry a lot about that current system and.

How do we create a future system that that doesn't.
Do that, um, but I don't know to answer your question about, how do we make sure everybody knows about potential access to health care in their community.

I don't know if I figure that out go back I will let, you know, you'll be the 1st on my list.

Well, I guess in the meantime, I wonder if this is an option you talk about your network if if you have, like, a list of, you know, the, the hospitals that have it and then just like some really be.

Questions of how can we access it? Um, I, I think we would be happy to just disseminate that on our list. So so people have it in the mindset that this is even an option.

Yeah, that's a good suggestion. Beth, I, I'll have to look because I think that there's a list available on the CMS waiver website. Like, I think you can see the lists of approved waivers.

But the other thing is, there's home hospital programs that are running outside of the waiver. So that adds kind of another level of complexity.

Okay, yes, ma'am. I said we have to wrap it up and thank you. Uh, yes, being a close shop.

We are at the hour Thank you so much Aaron, this was very intriguing. Interesting and informative and please keep us posted, um, you know, in your future endeavors. What happens?

Um, thank you all for sticking with us till the the hour.
I just wanted to put a plug in for than our next webinar, which is Tuesday, December, 6, promoting direct support, professional resilience, synthesizing.

Findings to make an impact. Thank you again, Aaron. Like, I mentioned that the presentation has been recorded and we will be able to put it up.