PREMIER
SPECIALTY PHYSICIANS

HOSPITAL IN THE HOME

Creating a Medical Neighborhood

HOW DO WE DEFINE 'HITH'

Treating clinically acute patients in the comfort of their home after their episodic event while managing all additional comorbidities during a typical 30 to 60-day length of stay (diagnoses dependent)

Akin to the CMS Hospital without Walls Initiative yet with private payor(s)

WHERE DID THIS BEGIN?

Hospital at Home®

- Johns Hopkins 1995 (https://www.hospitalathome.org/about-us/history.php)

FOCAL POINT

Commercial Payors and CMS

- Neglect in the post acute space
- Direct admits
- Clinically acute patients
- Physician oversight and NP face-to-face
  - (transitional care)

WHERE IS THIS PROGRAM HEADED?

- Physician Owned Hospitals/ASCs
- Hospital Systems
- Private Equity Groups
- Expansion Into Multiple States
- Value Based Care

PHYSICIAN OWNED HOSPITALS, ASCS AND HOSPITAL SYSTEMS

Discharge

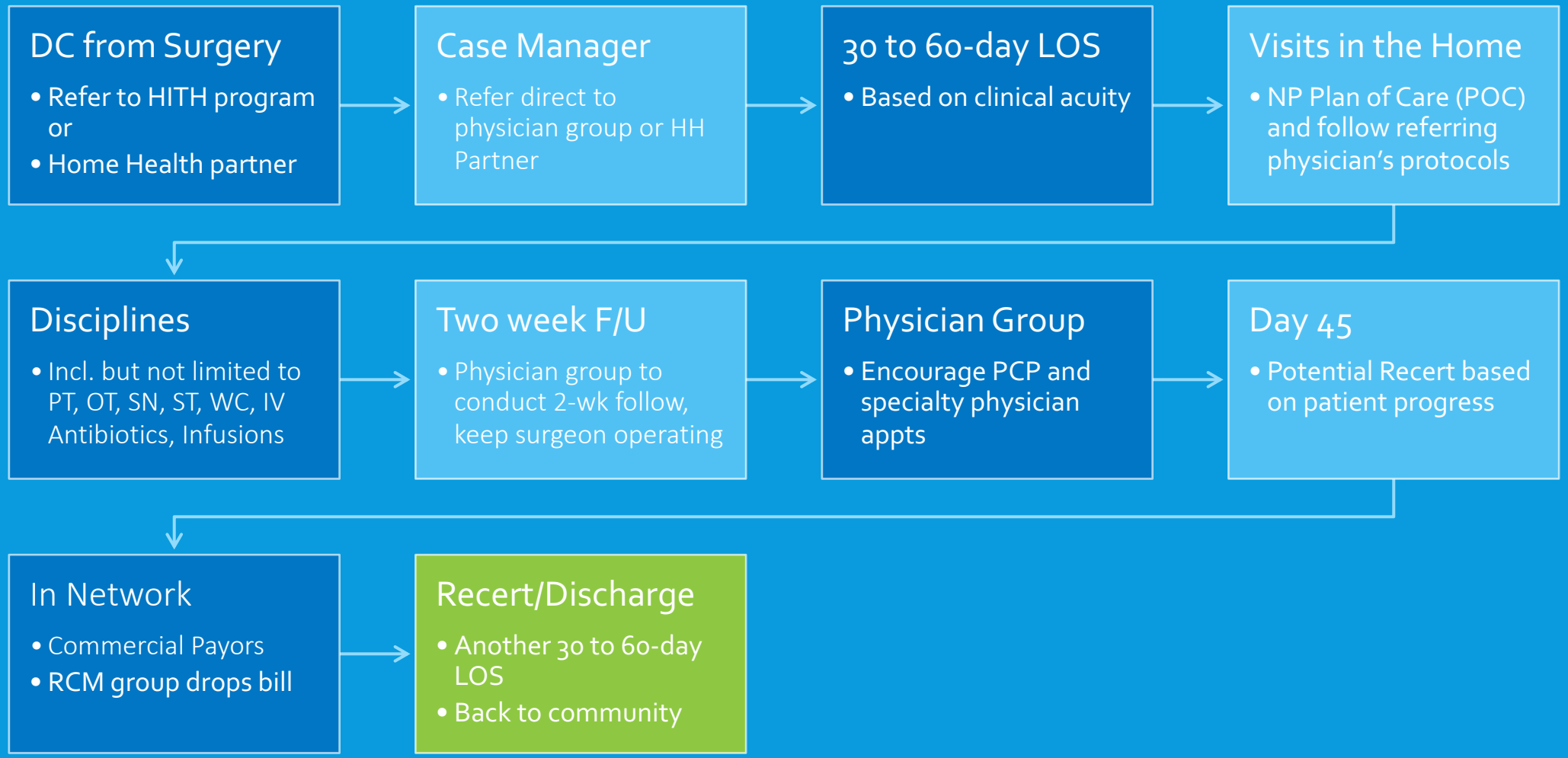
- Post surgery, patient discharges from the hospital or ASC and needs care
- Do *not* send to an LTACH, IRF or SNF
  - Transfer home (some exceptions)

Multi-Specialty Physician practice(s) offer transitional services for the patient

- Physician oversight in the home
- Following referring physician's protocols
- Managing all comorbidities during length of stay
- Instructing/Encouraging patients to attend all appointments with PCP and specialty physician(s)

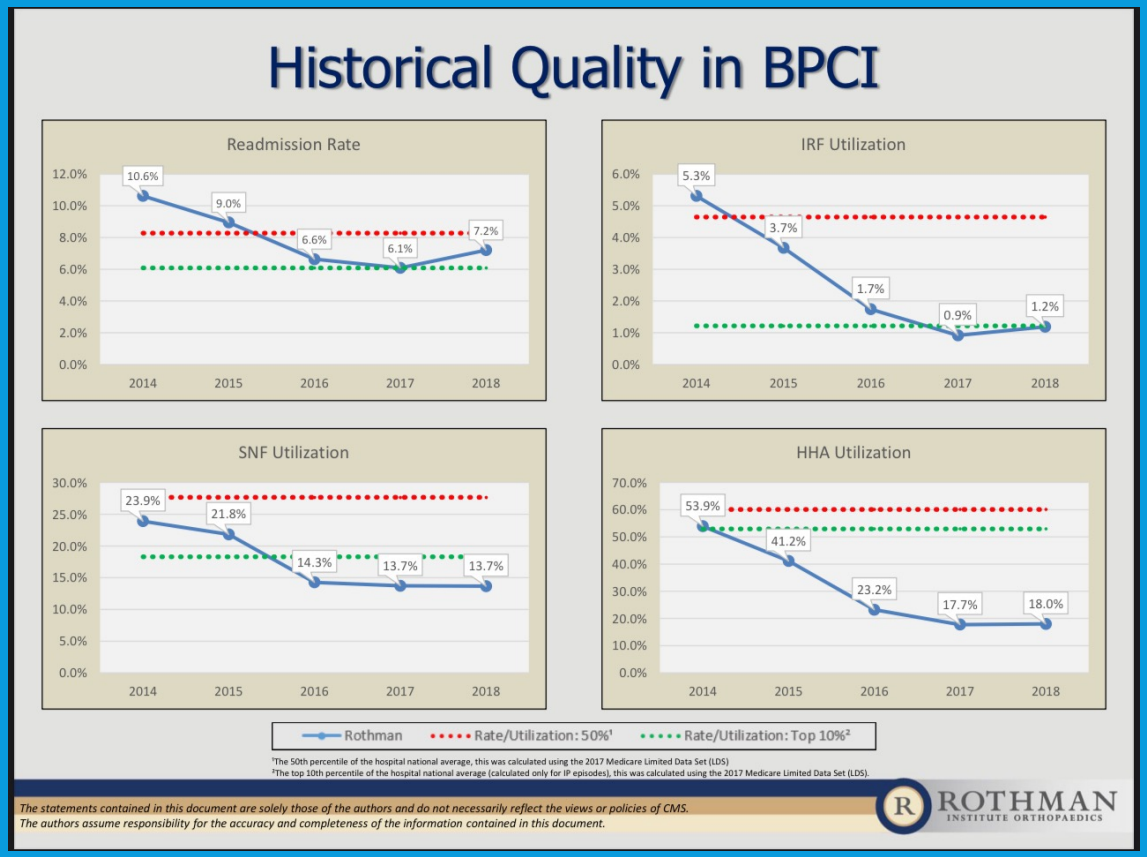
Treatment include but not limited to:

CONTINUUM OF CARE PROCESS



VALUE BASED CARE ORGANIZATIONS

- Bundling
  - Retrospective
  - Prospective
- Savings (most common)
  - Total joint bundles
  - Move patients to lower levels of acuity postoperatively
- Send patients home
  - Increase costs sending to IRF or SNF postoperatively



NEXT STEPS

Further Expansion into Multiple States

Adding commercial insurance payors

Capitated Networks