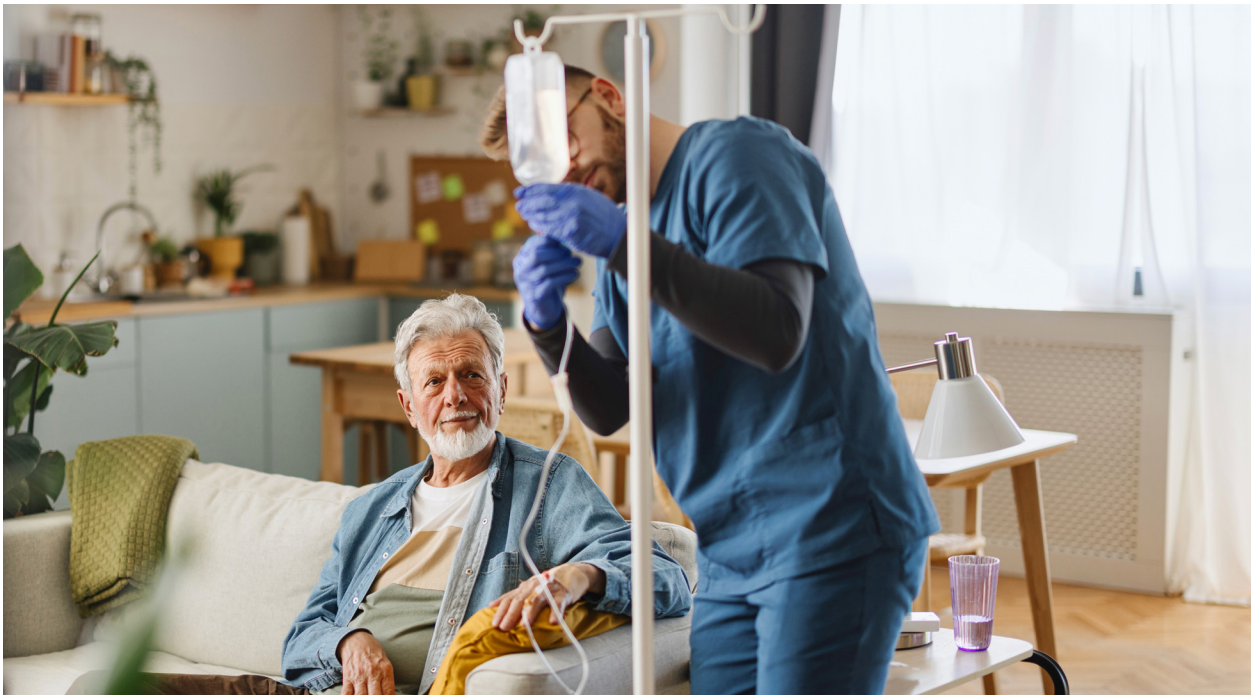
ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT | AHA Data & Insights

Hospital at Home

Navigating Risk Outside the Traditional Hospital Setting



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Executive Summary: Hospital at Home Overview

Introduction

Since the 1990s, the **Hospital at Home (HAH)** model has offered an innovative way for patients in the U.S. to receive acute care services in the comfort of their homes. Its adoption accelerated during the COVID-19 pandemic, prompting the **Centers for Medicare & Medicaid Services (CMS)** to launch the **Acute Hospital Care at Home (AHCAH)** program in November 2020. These programs are designed to deliver hospital-level care at home, aiming to improve patient outcomes, enhance patient care experience, and reduce overall health care costs.

Benefits

HAH offers a variety of benefits for patients and health care organizations, including:

- Enhanced patient comfort and satisfaction
- Reduced hospital-acquired infections, delirium, and pressure injuries
- Lower readmission and mortality rates
- Cost savings, potentially 30% or more[1]
- Increased family involvement and personalized care

Understanding the Risks

HAH programs offer many benefits, but they also introduce distinct risks that must be carefully managed. Here's a breakdown of the key risk categories:

Clinical Risks: Effective implementation depends on rigorous patient selection criteria, clear informed consent processes, and ensuring that staff are well-trained in delivering acute care in home settings.

Challenges to Emergency Preparedness: Programs must address potential environmental hazards, ensure rapid response to patient deterioration, and maintain safe home care environments.

Technology Risks: Success relies on dependable remote monitoring systems, strong cybersecurity measures, and seamless integration with electronic health record (EHR) platforms.

Operational Risks: These include navigating insurance coverage limitations, clarifying scope of practice for home-based care, ensuring accurate marketing, and establishing robust performance tracking systems.

Legal and Regulatory Compliance: Programs must also adhere to CMS Conditions of Participation and comply with state-specific licensing and waiver requirements when HAH is delivered under a hospital license.

Summary

The Hospital at Home (HAH) model, which delivers acute-level care in patients' homes, has gained momentum in the U.S. since the 1990s and expanded rapidly during the COVID-19 pandemic with the launch of CMS's Acute Hospital Care at Home (AHCAH) program. Designed to improve outcomes, enhance patient experience, and reduce costs, HAH offers benefits such as increased patient comfort, fewer hospital-acquired complications, lower readmission and mortality rates,

[1] Providers betting big on future of hospital at home. AHA (2024). Retrieved from https://www.aha.org/aha-center-health-innovation-market-scan/2024-04-09-providers-betting-big-future-hospital-home

and significant cost savings. However, successful implementation requires careful management of several risk categories. Clinical risks demand rigorous patient selection and staff training; emergency preparedness must ensure safe environments and rapid response capabilities; technology risks require reliable remote monitoring and cybersecurity; operational risks include properly navigating insurance, addressing scope of practice, and performance tracking; and legal and regulatory compliance requires adherence to CMS and state-specific requirements.

Introduction

The evolving landscape of health care is presenting new challenges driven by shifting demographics and economic pressures. A persistent shortage of clinicians, coupled with an aging and expanding population, is pushing hospitals and care facilities to operate at or near full capacity more frequently. Additionally, patients are increasingly bypassing primary care and outpatient services, opting instead to seek care directly from hospitals. These dynamics underscore the urgent need for innovative and scalable approaches to health care delivery.

Since the 1990s, United States Hospital at Home (HAH) programs have emerged as a transformative approach to health care delivery, offering patients the option to receive acute, inpatient level care services in the comfort of their homes.[2] HAH has been delivered internationally for decades and is defined by the World Hospital at Home Congress (WHAHC) as "an acute clinical service that takes staff, equipment, technologies, medication and skills usually provided in hospitals and delivers that hospital care to selected people in their homes or in nursing homes. It substitutes for acute inpatient hospital care."[3]

This care model can benefit hospitals and facilities by freeing up beds for those who need in-person or immediate access to clinical personnel, and benefits patients by allowing them to be treated within their home environment, away from the hospital setting. In other words, this shift not only can enhance patient experience but can potentially lower health care costs while improving outcomes.

Risk management professionals play a critical role in the successful development and sustainability of HAH programs. Their expertise is essential not only in identifying the full spectrum of risk in the clinical, operational, technological, legal, and environmental arenas, but also in understanding how these risks are uniquely shaped by the home-based care setting. Recognizing both the **opportunities and vulnerabilities** inherent in HAH models allow risk leaders to guide program design and implementation with foresight and precision.

By collaborating closely with clinical, IT, legal, and administrative teams, risk professionals can help embed proactive risk mitigation strategies into every layer of the program. This includes developing robust patient selection protocols, ensuring regulatory compliance, supporting emergency preparedness, and safeguarding data security. Their involvement ensures that HAH programs are not only innovative but also safe, resilient, and aligned with best practices in patient care and organizational governance.

Although HAH may complement the health care organization's current facility-based or home-based service offerings, HAH is distinct in the acuity and complexity of its services. In this way, it is highly differentiated from traditional home health, ambulatory case management, chronic disease

[2] Pandit, J. A., Pawelek, J. B., & Leff, B. (2024). The hospital at home in the USA: Current status and future prospects. *npj Digital Medicine*, 7(48). https://doi.org/10.1038/s41746-024-01040-9

[3] Montalto, M. (2023). What is hospital at home? *World Hospital at Home Community*. https://whahc-community.kenes.com/definition-of-hah/

management, skilled nursing, or admission prevention programs.[4] The HAH delivery model is unique in that it encompasses patients who would have otherwise been hospitalized, typically at an inpatient level of care. As interest in and growth of the HAH model continues today, this innovative model comes with a unique set of risks and issues that must be understood, planned for, and mitigated.

Hospital at Home and the AHCAH Waiver

The HAH care delivery model gained significant traction during the COVID-19 pandemic, as hospitals struggled with available inpatient bed capacity and staffing challenges. In November of 2020, the Centers for Medicare, and Medicaid Services (CMS) launched the Acute Hospital Care at Home (AHCAH) program, which gave hospitals the ability to treat appropriately selected Medicare and Medicaid patients with inpatient-level care in their homes.[5]

Most HAH programs fall under a hospital's existing licensure, particularly when operating under the CMS AHCAH waiver. This waiver allows hospitals to deliver inpatient-level care in a patient's home, but the hospital remains responsible for the care provided. The program must meet the Conditions of Participation (CoPs) for hospitals. However, state-level requirements vary. Some states have passed legislation or issued waivers to align with the CMS program, while others require additional approvals or exceptions. Today, HAH services are delivered both under the AHCAH waiver and through alternative arrangements with other payor types, including Medicare Advantage, private insurers, and commercial payors.

HAH Benefits

According to the American Hospital Association (AHA), the HAH care delivery model has been shown to reduce costs, improve outcomes and enhance the patient experience. These programs can drive value to patients, providers and payors; it has been reported that HAH may reduce the cost of care by thirty percent or more.[6] Some of the reported reductions that drive quality improvement for HAH, as reported by CMS amongst other organizations, include[7]:

- Compared to similar hospitalized patients, HAH patients experience better clinical outcomes such as lower rates of mortality, delirium sedative medication use, restraints.
- Better satisfaction of patient and family, less caregiver stress, better functional outcomes.[8]
- Cost savings of 19% to 30% compared to traditional inpatient care.
- Lower average length of inpatient stay.[9]
- Fewer lab and diagnostic tests compared with similar patients in acute hospital care.[10]

Patients stand to gain substantial benefits from HAH programs, with many reporting **higher levels of satisfaction** compared to traditional inpatient care. Key factors contributing to this positive experience include the **convenience** of receiving treatment at home, the comfort of recovering in a familiar environment, and the ability to maintain many daily routines and family connections. These elements not only enhance emotional well-being but can also contribute to better clinical outcomes, such as reduced stress and improved adherence to care plans.[11]

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4 Williamson, K. (n.d.). Hospital at home vs traditional hospitalization: What's better for patients? *American Hospital and Healthcare Management.* https://www.americanhhm.com/articles/hospital-at-home-vs-traditional-hospitalization-whats-better-for-patients

5 Eastabrook, D. (2023). Payment concerns not stopping new hospital-at-home programs. *Modern Healthcare.* https://www.modernhealthcare.com/providers/home-health-hospital-at-home-medicare-reimbursement

6 Montalto, M. (2023). What is hospital at home? *World Hospital at Home Community.* https://whahc-community.kenes.com/definition-of-hah/

7 Hospital at Home: Risk Management Implications (2022). Retrieved from: https://www.aig.com/content/dam/lexington-insurance/america-canada/us/documents/25/lexington-healthcare-risk-management-hospital-at-home.pdf.coredownload.pdf

8 Johns Hopkins Medicine. (n.d.). Hospital at home. https://www.johnshopkinssolutions.com/solution/hospital-at-home/

9 Ibid.

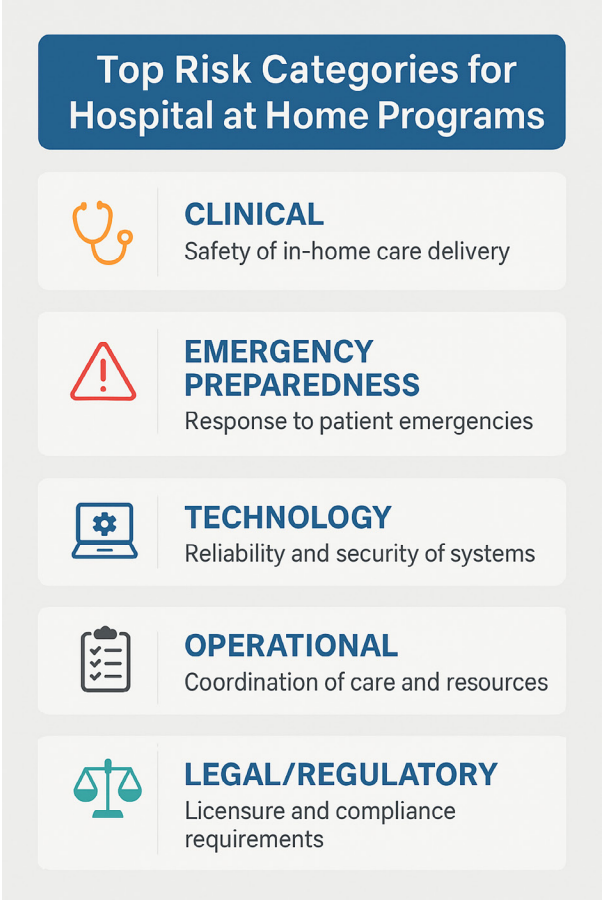
10 Ibid.

11 Williamson, K. (n.d.). Hospital at home vs traditional hospitalization: What's better for patients? *American Hospital and Healthcare Management.* https://www.americanhhm.com/articles/hospital-at-home-vs-traditional-hospitalization-whats-better-for-patients

Understanding the Risks and Insurance Implications

While HAH programs offer significant benefits as detailed above, it is crucial to acknowledge and address the inherent risks associated with delivering acute care in a decentralized system. Managing clinical risks, human capital risks, emergency preparedness, technology and operational risks are just a few of the essential steps toward reducing exposures and realizing the full potential of hospital-at-home programs.

A summary of these exposures, case studies, and recommended mitigation strategies is provided below.



Clinical Risks

Building the Right Team: Assessing Readiness and Structuring Care Delivery

The difference between a hospital care team and an HAH care team lies primarily in the setting, structure, and delivery methods of care, although both teams aim to provide high-quality, patient-centered treatment. When considering HAH, evaluate your team's and organization's readiness for starting such a program.[12,13] Determine early on which services will be obtained internally and which will require coordination with contracted service providers.

HAH programs can provide a wide range of therapies and clinical services that are typically delivered in a hospital setting but adapted for safe administration in the home. These include:

- **Medical Therapies**
  - Intravenous (IV) therapies: Antibiotics, fluids, and medications administered through IV lines.
  - Blood transfusions: In select programs with appropriate safety protocols.
- **Rehabilitative Therapies**
  - Physical therapy: To help patients regain strength and mobility after illness or surgery.
  - Occupational therapy: To support daily living skills and home safety adaptations.
  - Speech therapy: For patients recovering from stroke or neurological conditions.
- **Cardiopulmonary Therapies/Cardiac Monitoring and Rehabilitation:** For patients with heart failure or post-cardiac events.
- **Respiratory Therapy—Oxygen Therapy:** For patients with respiratory conditions like COPD or pneumonia.
- **Diagnostic and Monitoring Services**
  - Lab tests and blood draws: Performed at home or via mobile services.

[12] Read, P. (2021). On time, every time. *Unity Point.* https://hahusersgroup.org/wp-content/uploads/2021/02/On-Time-Every-Time.pdf
[13] Creating equity in hospital at home programs. (N.D.). OHSU. Retrieved from: https://www.cms.gov/files/document/creating-equity-hospital-home-programs-eliminating-social-and-clinical-barriers-participation.pdf

- Mobile imaging: X-rays and ultrasounds conducted with portable equipment.
- Remote patient monitoring: frequent tracking of vital signs like heart rate, oxygen levels, and blood pressure.
- Temporary return of patients to facility settings for advanced diagnostics or procedures that cannot feasibly be performed in the home.

- Pharmacy and Medication Management
  - Medication reconciliation and delivery
  - STAT medication administration
  - Pain management and palliative care
- Supportive and Holistic Services
  - Wound care and post-surgical care
  - Nutrition support and meal planning
- Social Work and Behavioral Health Support
  - Obtaining community support or resources

These therapies are coordinated through a combination of in-person visits and virtual care managed by a centralized command center, ensuring patients receive timely, hospital-level care in the comfort of their homes.[14]

Several of these categories are set by the AHCAH waiver as minimum requirements, whereas other categories help by offering reliability and redundancy of service provision, in order to address more complex or acutely ill patients quickly and at the care level needed for the severity level.

HAH programs offer a wide range of benefits; however, the breadth of services offered through the HAH model also presents a challenge: ensuring that each component is delivered with the same level of safety and clinical rigor typically found in inpatient settings. This can become especially complex when trying to maintain consistent quality across all services.

Additionally, the demand for highly trained professionals to implement and oversee these elements can outpace the available workforce, making it challenging to staff the program with the appropriate level of expertise.

Risk Management Takeaways:
From a risk management perspective, it is essential to ensure that the scope and scale of an HAH program are aligned with the organization's capacity to support it—both in terms of clinical resources and staffing infrastructure. Overextending the program without adequate support can compromise patient safety, care quality, and regulatory compliance.

To mitigate these risks, organizations should adhere to industry's best practices in several key areas:

- Credentialing: Ensure all team members, including contracted providers, meet appropriate licensure and certification standards for home-based acute care.
- Education: Provide comprehensive onboarding that covers the unique demands of delivering hospital-level care in a home setting.
- Ongoing Training: Establish continuous professional development programs to keep staff updated on protocols, technology use, emergency procedures, and evolving regulatory requirements.

By aligning program design with organizational readiness and investing in workforce competency, risk professionals can help create a resilient and high performing HAH model that prioritizes safety, quality, and sustainability.

[14] Mayo Clinic Staff. (n.d.). *Hospital at home: Overview*. Mayo Clinic. https://www.mayoclinic.org/departments-centers/hospital-at-home/sections/overview/ovc-20551797

Patient Assessment and Admission Exclusion Criteria

Effective patient assessment and clearly defined admission exclusion criteria are critical components of a successful HAH program. Clinical decision support systems, predictive modeling, augmented intelligence and/or artificial intelligence streamline patient identification and support equitable access to care. In addition to clinical eligibility, a thorough evaluation of the home environment is essential to confirm its suitability for safe care delivery. Continuous monitoring throughout the admission ensures that patients remain appropriate for HAH care, while exclusion criteria safeguard against admitting individuals whose clinical or environmental conditions exceed the program's capacity. Importantly, these assessments must be audited regularly to prevent bias and ensure that safety concerns do not inadvertently restrict access for underserved populations with high Social Drivers of Health (SDoH) risk.

Structured clinical pathways, algorithms and set criteria[15,16] for admission into HAH programs are essential and should serve as the foundation for patient intake into the HAH program. The algorithms used for HAH patient identification are increasingly automated and involve clinical decision support, predictive modeling or artificial intelligence to facilitate patient entry into the HAH program.[17] The care team will also assess the home environment prior to and during the HAH admission to determine if it offers a safe setting for care delivery.

Patient assessments for HAH are most effective when performed before admission to the HAH program and monitored continuously through the admission to ensure the patient continues to meet eligibility criteria.

Clinical Exclusion Criteria
These relate to the patient's medical condition and acuity:

- **Hemodynamic instability** (e.g., unstable blood pressure or heart rate)
- **New or worsening oxygen requirement** not manageable at home
- **Acute deterioration** or rapidly changing clinical status

Behavioral and Cognitive Exclusion Criteria
These relate to the patient's ability to participate in care:

- **Delirium or significant cognitive impairment** without 24/7 caregiver support

Social and Environmental Exclusion Criteria

- **Unsafe home environment** (e.g., hoarding, lack of utilities, safety hazards)
- **Safeguarding concerns** (e.g., abuse, neglect)
- **Geographic inaccessibility** (e.g., outside service radius or difficult terrain)

If clinical concerns arise indicating that a patient may require a higher level of care than can be safely delivered in the home, or if the home environment fails to meet the safety standards established by the HAH program, the patient will not meet the eligibility criteria for admission to

[15] Hospital at home: Success factors & challenges. (2022, June 7). *Association of Community Cancer Centers.* https://www.accc-cancer.org/acccbuzz/blog-post-template/accc-buzz/2022/06/07/hospital-at-home-success-factors-challenges

[16] Creating equity in hospital at home programs. (N.D.). OHSU. Retrieved from: https://www.cms.gov/files/document/creating-equity-hospital-home-programs-eliminating-social-and-clinical-barriers-participation.pdf

[17] Improving patient selection and prioritization for hospital at home through predictive modeling. (n.d.). *National Center for Biotechnology Information.* https://pmc.ncbi.nlm.nih.gov/articles/PMC10148353/

the HAH unit. Additional examples of clinical concerns may include ICU-level care, uncontrolled behavioral health, septic shock, and cognitive impairment that impact safety.

Admission criteria is designed to protect patient safety and ensure that care is delivered in a setting conducive to recovery. However, it is equally important to recognize that safety assessments—both clinical and environmental—must be applied equitably and transparently. Regular audits of the patient assessment and admission processes are essential to ensure that perceived risks or assumptions about home safety do not inadvertently exclude underserved populations. A balanced approach is needed—one that safeguards clinical integrity while actively working to reduce disparities in access to HAH care.

Risk Management Takeaways: For risk professionals, it's important to be familiar with the processes used to determine patient assessment and admissions criteria in your HAH program—including how these determinations are generated—and to consistently re-assess the process. It is key to assess the patient's suitability for HAH, and their home environment's ability to meet their needs during their care.

Moreover, be sure a process is in place to continually re-assess and monitor the patient's condition, should there be any significant changes or need to elevate their care (e.g., to the ED).

Case Study

One month after implementation of an HAH unit, a 57-year-old female with Substance Use Disorder (SUD) and end-stage renal disease on hemodialysis (HD) presents to the Emergency Department (ED) with pneumonia. She is considered for HAH admission by the ED providers, but the HAH care team declines their referral due to current clinical operational constraints (lack of reliable transport to and from the dialysis unit, controlled substance prescribing). After evaluating the referral, the new HAH program's admitting clinician is concerned that the patient's SUD will lead to non-prescribed substance use or controlled substance diversion in the home. The patient undergoes facility-based hospitalization, during which time she suffers a medication error, and is discharged to a skilled nursing facility (SNF).

She presents again to the Emergency Department 6 months later for diverticulitis; at this time, HAH unit leadership collaborated with specialists (Nephrology, Addiction Services) to develop HAH protocols and pathways for a) end stage renal disease on dialysis (HD) via transport to and from the hospital HD unit and b) SUD treatment via Medication Assisted Therapy prescribing and virtual specialist consultation in HAH. She passes the eligibility assessment and is admitted to HAH for five days before discharge to Home Health.

Informed Consent

It is imperative for any care setting that the informed consent process is thoroughly and credibly performed with discussion of the risks, benefits, and alternatives with patient and family or home caregiver. Utilizing a shared decision-making model for informed consent is ideal for this setting. This is especially important in HAH programs, where caregivers may be present in the home during the episode of care. Clear expectations should be identified with the patient and their family-caregivers early in the pre-admission process. In light of the uniqueness of providing acute care in the home setting, an informed consent form geared toward the home setting where care is rendered is vital.

Risk Management Takeaways: Keep in mind that informed consent or refusal is not simply about completing a form—it requires a meaningful conversation with the patient, resulting in a shared understanding among the patient, caregivers, and health care providers.

Human Capital

Training and Competency

At a minimum, virtual and in-home clinicians, including nurses, advanced practice professionals, physicians, paramedics, and other health care professionals, who care for HAH patients must be highly skilled in recognizing and responding to subtle clinical changes that may signal rapid patient deterioration. Given the decentralized nature of care, staff must be prepared to adapt quickly to evolving patient conditions, often without the immediate support systems available in traditional hospital settings. These clinicians should have prior acute care experience and must meet the same competency standards through rigorous training and ongoing evaluation as those required for inpatient acute care services. This ensures that patients receive safe, high-quality care regardless of the setting.

Acute care clinical competencies should be completed before rendering care to HAH patients and as regularly as organizational policy requires.

Some examples of acute care competencies include critical thinking, virtual or home-based patient assessment, problem solving skills, experience with telehealth technology, monitoring, intravenous/infusion therapy, infection prevention and control, respiratory care, cardiac care, medication monitoring, medication safety, wound care, gastrointestinal care, identification and management of patient deterioration. These competencies may require procedural adaptation and additional training when combined with virtual care delivery.

Risk Management Takeaways: Of critical importance is ensuring that all virtual and in-home providers possess robust acute care experience and meet standardized competency benchmarks before delivering care. Because HAH settings lack the immediate support systems of traditional hospitals, clinicians must be adept at recognizing subtle signs of patient deterioration and responding swiftly. This decentralized model demands high-level skills in clinical assessment, telehealth technology, and emergency response, all of which must be reinforced through rigorous initial training and ongoing evaluations.

Additionally, procedural adaptations for home-based care—such as infection control, medication safety, and respiratory or cardiac care—require tailored instruction to maintain safety and quality. Regular competency assessments aligned with organizational policy are essential to mitigate risks and uphold care standards across diverse care environments.

The Extended Care Team

In addition to HAH clinicians, patient support in HAH may be offered voluntarily by the patient's family, friends, or caregivers.[18] However, care must be taken to ensure that family and friends are not placed in a role of providing care that instead should be delivered by the medical professional. While the presence and participation of family or caregivers is not required for HAH service delivery, family and caregivers may volunteer to support an ill loved one in their home through provision of assistance for the activities of daily living. Assessing patient and caregiver needs to identify and deploy additional services needed (meal delivery, home health aides, etc.) mitigates the risk of undue burden on the caregiver while enhancing patient safety and experience.

[18] McGowan, K. (2023, July 18). "Hospital-at-home" trend means family members must be caregivers—ready or not. *NPR*. https://www.npr.org/sections/health-shots/2023/07/18/1188058399/hospital-at-home-caregivers-family-stress

The AHCAH waiver application specifically requests that programs address "the process for communicating with the patient support person that the hospital is responsible for providing all patient care needs, including medication administration, transportation, treatments, meals, and patient hygiene" in addition to informed consent.[19] For families and caregivers that choose to participate in a loved one's care plan, these caregivers benefit from training and support to provide required caregiving, as often occurs during transition care planning during a facility-based hospitalization.

Generally, HAH has the opportunity to engage caregivers earlier in the patient's acute care journey. However, without proper training, caregivers may become overwhelmed, struggle to manage complex caregiving tasks, or may recognize signs of deterioration in the patient's condition without appropriately communicating them to HAH clinicians. While this same risk exists for chronic medical management, the acuity and location of HAH places emphasis on the need for early and continuous caregiver engagement. Utilizing orientation checklists for family and caregivers is beneficial. Documentation in the medical record for training provided to family caregivers by the HAH care team is critical.

Risk Management Takeaways: There are two key points for the extended care team. First, it is important to identify the ability of the organization to support the extended care team in order to avoid burnout of the caregivers, regardless of whether that person is a member of the patient's family or a staff member from the HAH program. Providing that support when possible can help reduce unnecessary turnover and stress, build patient safety and enhance the patient's experience (supporting the caregiver is also supporting the patient).

Case Study

An 83-year-old male patient with Parkinson's Disease and moderate cognitive impairment presents to the Emergency Department with urinary tract infection (UTI) and pyelonephritis. He is evaluated by the HAH admitting clinician and transferred to HAH after discussion with the patient's spouse, who participates in consent and is present at home with the patient. His spouse prefers to help cook meals for the patient but feels she cannot support other activities of daily living (ADLs), particularly while the patient is acutely ill. Prior to hospitalization, she relied on other family members and friends to help care for her husband.

The HAH admitting clinicians determine the need for Home Health Aide (HHA) services to support the patient's ADLs for 4 hours per day. Additionally, they communicate requests to in-home clinicians to support specific ADLs during their clinical visits to the home, as needed for caregiver support. The patient's wife is surveyed on her level of longitudinal caregiver burden during the HAH episode, allowing physician and nursing leadership to identify additional service supports that may benefit her after HAH. On discharge from the HAH program, the hospital case management and social work team facilitate connection to community-based and in-home caregiver supports.

[19] Centers for Medicare & Medicaid Services. (2025). Acute hospital care at home waiver. https://qualitynet.cms.gov/acute-hospital-care-at-home/waiver

Second, because the extended care team may be outside the standard medical profession (i.e., family or friend), it's valuable for extra attention to be given to 1) what training and ongoing support these individuals receive, 2) their understanding of the patient's condition and 3) how to report any changes in their condition. Document the ongoing training and support provided by the HAH team.

Employee & Provider Safety

Employed and contracted clinicians working in HAH programs deliver care directly in patients' homes, which are often located miles away from the hospital's physical campus. Unlike traditional hospital settings, these clinicians typically do not have immediate access to on-site security personnel or infrastructure. This geographic separation introduces unique safety considerations, particularly when entering unfamiliar environments or responding to urgent situations without the immediate backup of hospital-based resources.

They may encounter problematic home environments and challenging domestic situations, such as intentional or unintentional harm by or to the patient, adverse home conditions (i.e., environmental or family challenges), or other non-caregiving individuals on the patient's property.

Escalating Behavior

To that end, employees should be well trained in de-escalation techniques to work with escalating behaviors from patients, family members, and others in the home environment. Criteria should be outlined for employees to activate their chain of command or when to seek assistance from local agencies such as law enforcement or emergency medical services (EMS).

Additional considerations for enhancing staff safety may include equipping staff with mobile devices that have GPS tracking and emergency alert features; the use of secure communication platforms to maintain constant contact with the command center; check in and check out protocols for each visit; panic buttons, and wearable alarms. Another consideration would be to avoid sending staff alone on visits when feasible.

Risk Management Takeaways: To mitigate these risks, HAH programs should implement comprehensive safety protocols that include:

- Staff Training in De-escalation Techniques: All clinical and support staff should be trained to recognize early signs of agitation and employ verbal and non-verbal strategies to defuse escalating situations. Simulation-based training and trauma-informed care principles can enhance preparedness.
- Clear Escalation Pathways: Criteria should be established for when staff should activate the chain of command or seek assistance from external agencies such as law enforcement or EMS. These protocols should be well-documented and rehearsed.
- Technology-Enabled Safety Measures:
  - Mobile devices with GPS tracking and emergency alert features.
  - Use of secure communication platforms for real-time contact with the command center.
  - Check-in/check-out protocols for every home visit.
  - Wearable panic buttons or alarms for immediate emergency signaling.
- Staffing Considerations: When feasible, avoid sending staff alone into homes with known behavioral risks. Pairing staff or scheduling visits during daylight hours can reduce exposure to volatile situations.
- Behavioral Risk Screening: Incorporate behavioral health assessments into the patient intake process to identify potential risks early. This may include reviewing the history of aggression, substance use, or psychiatric instability.

- Documentation and Incident Reporting: Encourage thorough documentation of any behavioral incidents and ensure that staff feel supported in reporting concerns. This data can inform future risk mitigation strategies and improve program safety.

By embedding these measures into the operational framework, HAH programs can foster a culture of safety, reduce staff vulnerability, and ensure that care delivery remains both compassionate and secure—even in unpredictable home environments.

Emergency Preparedness

Physical Safety in the Home Setting

Given that HAH provides higher acuity and more logistically complex care than post-acute home care visits, it is vital to have a timely process for assessing the patients' home environments to identify and mitigate potential hazards, which may lead to accidents or exacerbate medical conditions. A patient must live in a suitable environment for HAH to be offered, generally with running water, access to a toilet or commode, can be kept at a safe temperature, and is deemed to meet other appropriate social needs.

Since the concept of "home" can vary—especially for individuals who are unhoused or experiencing housing insecurity—it's important to assess the structural suitability of each care environment. HAH services may be delivered in a variety of non-traditional residential settings, including respite care centers, rental units, recreational vehicles (RVs), congregate living facilities, and assisted living communities.[20]

Evaluation of the patient's physical home environment is necessary prior to admission, to determine whether the patient's home will be able to support care management and recovery. This evaluation may be challenging for clinical teams who are not familiar with home-based care, requiring additional training and evaluation. HAH teams may also engage internal or community-based resources to address home "environment of care" concerns as needed, for such services as Meals on Wheels or cleaning services.

Adverse home conditions may include situations that can significantly impact the safety and effectiveness of care delivered through HAH programs. During the intake process, clinicians may encounter a range of environmental challenges that must be addressed before initiating care. These may include **unsanitary living conditions**, such as the presence of pests, mold, or accumulated waste, which can pose infection risks. **Structural hazards** like broken stairs, poor lighting, or lack of running water can increase the risk of falls or hinder the delivery of essential services. **Overcrowding** or **lack of privacy** may compromise patient dignity and interfere with clinical procedures. Additionally, **unstable social environments**, including the presence of aggressive pets, active substance use, or domestic conflict, can pose safety risks to both patients and staff. Identifying and mitigating these conditions is essential to ensure a safe, supportive environment for acute care at home. Moreover, even the most stable home setting may experience temporary instability due to house fires, natural disasters and utility failures.

Considering that falls are a particular concern for patient safety at home, it is crucial to also address this risk systematically during the HAH intake and admission process. Patients are generally more mobile at home, an environment that is subject to less structural control than dedicated clinical facilities. Therefore, mitigating fall risk by conducting initial and ongoing fall risk assessments for the home setting is vital to promote patient safety. A critical component of this evaluation involves identifying potential hazards such as uneven flooring, poor lighting, cluttered

[20] Creating equity in hospital at home programs. (N.D.). OHSU. Retrieved from: https://www.cms.gov/files/document/creating-equity-hospital-home-programs-eliminating-social-and-clinical-barriers-participation.pdf

walkways, and lack of handrails or assistive devices. The assessment should also consider the patient's mobility, cognitive status, and history of falls.

Risk Management Takeaways: Ensure that a comprehensive and effective process is in place for evaluating the patient's home to determine its suitability for supporting safe and effective care management. This evaluation should include a detailed assessment of the physical environment, accessibility, availability of necessary utilities and equipment, and the availability of a reliable caregiver or support system. Addressing these factors proactively helps mitigate risks and ensures that the home setting can adequately support the clinical needs of the patient throughout their HAH admission. Ensure that there is an effective process in place for evaluating the patient's home for its ability to support care management. This includes a thorough fall risk evaluation with clear mitigation strategies.

Technology

Reliability of HAH Technology

The care team will utilize remote monitoring technology and telemedicine platforms to deliver remote HAH care, often linked to other in-home clinicians. The **interoperability** of these technologies—ensuring seamless data exchange and communication across platforms and providers—is essential for successful program implementation. Reliability and effectiveness depend not only on the technology itself but also on its ability to integrate with electronic health records (EHRs), remote monitoring systems, and communication tools used by various members of the care team.

Before the patient is admitted to HAH, care teams should ensure that the patient has the appropriate internet connectivity capabilities to optimize virtual care. To ensure equitable access to HAH for patients who may not have home internet connectivity, and to mitigate concerns regarding the stability of home connectivity, HAH units may supplement the existing connection with additional broadband, satellite or cellular connectivity (e.g., Sim-card enabled equipment). HAH leaders should conduct team-based simulations of "downtime" procedures for connectivity issues during scheduled or urgent events. HAH teams must continuously test and improve upon new or updated technologies and equipment that impact clinical operational workflows.

The rapid response and proactive maintenance performed by tech support teams are essential for operational reliability, patient safety, and program effectiveness. To deliver reliable, high-quality care in HAH models, health care systems must broaden their understanding of the care team to include IT and tech support teams. Recognizing these roles as front-line operators is essential to sustaining safe, technology-enabled care in the home.

Generally, HAH protocols and procedures should guide timely management of patient care via technology-enablement, including addressing on-demand patient assessment. As an example, a patient may wear continuous monitoring devices that provides real-time telemetry or pulse oximetry results. A critical alert is transmitted to the remote provider; however, a care team member may not be in the home to assess the patient simultaneously. Instead, assessment may occur during an urgent home visit. A process must be in place to provide immediate, virtual patient assessment, in addition to mobilizing rapid in-person assessment and intervention when clinically warranted.

Risk Management Takeaways: Continually reevaluate the reliability and effectiveness of the technology used for patient monitoring and communication. Moreover, it's critical to ensure that users know how to operate the technology and that tech support teams are able to respond in a timely fashion to any challenges that arise.

Technology Security

In addition to ensuring consistent and reliable performance, any remote technology platform used in any clinical settings must also be secure. At a minimum, these platforms should comply with HIPAA security regulations, including the requirement for an annual HIPAA security risk assessment.

Depending upon the sophistication of the technology deployed, risk professionals, in conjunction with information technology professionals, may wish to also seek out such certifications as SOC 2 (System and Organization Controls 2), which was created by the American Institute of Certified Public Accountants (AICPA) to help organizations verify technology security and reduce the risk of security breach.[21] Regular penetration testing should be considered to test points of potential vulnerability in HAH technology systems.

Certification and penetration testing should adhere to the organization's compliance requirements.

Additionally, third-party contractors or caregiver technologies should also meet the minimum requirements aforementioned. Technology risk assessments should include assurances from third-party providers to ensure that they meet defined minimum standards, including completed Business Associate Agreements.

Risk Management Takeaways: As in all your facilities, it's worth keeping on top of your technological security. Breaches can carry major financial penalties and have an impact on patient privacy and undermine patients' and business partners' confidence in the organization.

Virtual Care

According to the Centers for Medicare and Medicaid Services, as part of the AHCAH waiver, physicians and other approved providers may evaluate HAH patients virtually instead of in-person, as long as the patient has been assessed by an admitting physician prior to patient movement into their home setting. While this is not a clinical operational requirement of all programs, it represents an attempt to appropriately balance in-person and virtual acute care.

From a clinical standpoint, gaining a full understanding of a patient's condition through virtual means is similar to other forms of virtual care that have become routine. However, the shift to virtual care models—especially those that rely on in-home clinicians without the physician physically examining the patient, can lead to uncertainty. This hesitation around HAH may mirror the broader concerns physicians have about virtual care in general.

Physicians may also be concerned about the legal risks of providing care for patients in an HAH program.[22]

The American Medical Association (AMA) offers telehealth resources that include guidance on improving patient care and team engagement through team-based telehealth practices. While this content is currently oriented toward outpatient virtual care, it applies well to HAH with the common goals of enhancing team engagement and improving care quality.[23]

Physician Hesitancy

Physicians may be reluctant to join HAH programs for several reasons, despite the model's growing popularity and demonstrated benefits:

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[21] Vanta. (n.d.). What is SOC 2? https://www.vanta.com/collection/soc-2/what-is-soc-2#:~:text=SOC%202%20stands%20for%20System,risk%20of%20a%20security%20breach

[22] Pifer, R. (2022). What's holding up hospital at home? *Healthcare Dive*. https://www.healthcaredive.com/news/hospital-at-home-himss-cms-doctors/620539/

[23] American Medical Association. (2023). AMA telehealth helpful resources. https://www.ama-assn.org/practice-management/digital-health/ama-telehealth-helpful-resources

Change Management and Workflow Disruption: In the article *"What's Holding Up Hospital at Home?,"* the author highlights that transitioning from traditional inpatient care to a virtual or hybrid model demands a substantial shift in clinical workflows. Physicians must adapt to new technologies, remote monitoring systems, and virtual communication platforms—changes that can be both challenging and time-consuming, particularly for those accustomed to conventional hospital-based practices.[24]

Trust and Team Dynamics: HAH care relies heavily on multidisciplinary teams, including nurses, paramedics, and advanced practice providers. Physicians may initially struggle with delegating responsibilities or trusting remote team members, especially when they're used to in-person oversight in hospital settings.[25]

Training and Skill Gaps: Delivering care virtually or in a home setting demands a different skill set, such as conducting video-based assessments and managing care remotely. Physicians may feel unprepared or inadequately trained for these roles.[26]

Concerns About Patient Safety and Liability: Some physicians worry about the risks of managing high-acuity patients outside the controlled hospital environment. Concerns about liability, emergency response capabilities, and the adequacy of home setups can deter participation.[27]

Reimbursement and Program Stability: The sustainability of HAH programs often depend on temporary waivers or pilot funding. Physicians may hesitate to invest time and effort into a model that lacks long-term financial and regulatory certainty.[28]

Cultural Resistance: There can be a general skepticism among some physicians about the effectiveness of remote care, especially for complex or unstable patients. This cultural resistance can slow adoption even when evidence supports the model's efficacy.[29]

Risk Management Takeaways: Providers and staff should be aware of the challenges of evaluating, diagnosing, and treating patients in the virtual care environment. Although more commonly understood than it was several years ago, it remains beneficial to know the limitations of handling patients that aren't directly in front of the provider. Understanding these limitations is not just helpful—it's critical. Providers must be equipped to adapt their clinical approach, ask more targeted questions, and use available tools (such as remote monitoring or digital diagnostics) to compensate for the lack of in-person interaction.

Business Operations

In addition to emergency preparedness, clinical and technology risks, addressing operational risks is paramount for successful implementation of the HAH model.

Claims and Insurance Implications

The HAH model, while promising in its potential to deliver acute care in a more comfortable and cost-effective setting, is still in its early stages of widespread implementation. The CMS waiver program, which enabled broader adoption, did not launch until November 2020, and significant program growth only began in 2022. As a result, available professional liability claims data remains limited.

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[24] Pifer, R. (2022). What's holding up hospital at home? *Healthcare Dive*. https://www.healthcaredive.com/news/hospital-at-home-himss-cms-doctors/620539/
[25] Darves, B. (2025). Hospital-at-home practice emerging as a growing venue for physician practice. *New England Journal of Medicine Career Center*. https://resources.nejmcareercenter.org/article/hospital-at-home-practice-emerging-as-a-growing-venue-for-physician-practice/
[26] Ibid.
[27] Pifer, R. (2022). What's holding up hospital at home? *Healthcare Dive*. https://www.healthcaredive.com/news/hospital-at-home-himss-cms-doctors/620539/
[28] Ibid
[29] Darves, B. (2025). Hospital-at-home practice emerging as a growing venue for physician practice. *New England Journal of Medicine Career Center*. https://resources.nejmcareercenter.org/article/hospital-at-home-practice-emerging-as-a-growing-venue-for-physician-practice/

However, based on known risk areas, we can anticipate several categories of potential claims. These include failure to meet the standard of care in a home environment, such as lapses in infection control, delayed or missed diagnoses, failure to monitor, and inadequate emergency response.

Other concerns involve insufficient provider credentialing or training, data breaches and cybersecurity vulnerabilities, failure to obtain or properly document informed consent, improper medication management—especially regarding controlled substances—and incidents compromising patient or family safety within the home. These anticipated risks underscore the importance of robust protocols, training and oversight as the model continues to evolve.

The following are illustrative examples of general insurance-related considerations that may arise:

- **Patient Injuries During Care:** Injuries sustained by the patient during the course of treatment may trigger professional liability coverage, depending on the circumstances and standard of care provided.
- **Employee Injuries in the Home:** If a health care worker is injured while providing care in a patient's home, the incident would typically fall under the organization's workers' compensation coverage.
- **Injuries to Third Parties:** If a visitor or guest in the patient's home is injured, the resulting costs would likely be addressed through the patient's homeowner's or renter's insurance policy.

Any claim or allegation arising from care provided in the home setting must be promptly and thoroughly investigated to determine the appropriate course of action. A critical part of this process involves evaluating which lines of insurance coverage—such as professional liability, general liability, or workers' compensation—may be implicated.

Risk Management Takeaways: Given the complexity of coverage terms and potential overlaps, it is often necessary to consult directly with the organization's insurance broker or carrier. Their guidance can help clarify policy language, confirm coverage applicability, and ensure that the claim is managed in accordance with both contractual obligations and regulatory requirements.

Financial Implications

Gaining a comprehensive understanding of the insurance and financial implications associated with the HAH care delivery model is essential for its successful implementation and long-term viability. To ensure appropriate insurance coverage, HAH services must align with the organization's licensure, the individual provider's scope of licensure, and scope of practice. Additionally, the level of care delivered must be clinically appropriate for the home setting. Establishing this alignment not only supports regulatory compliance but also mitigates risk exposure and enhances payer confidence.

Risk Management Takeaways: Clear operational and clinical boundaries are critical to securing adequate reimbursement, minimizing liability, and ensuring the financial sustainability of the HAH model.

Performance Metrics

CMS has outlined quality metrics for HAH that must be reported under the AHCAH waiver. These include patient, volume, and escalation (return to brick & mortar hospital) count, in addition to claims data. However, quality reporting may evolve or vary by program type; clear guidelines from a state-by-state perspective will benefit HAH as it grows. Working with state regulators and understanding state guidelines is essential to this end.

When evaluating HAH programs, it is essential to consider metrics collected both during and after the episode of care. These metrics should align with a comprehensive quality measurement framework that captures inpatient-level care standards, ensuring consistency between admission data and post-admission outcomes.[30]

During HAH	After HAH
■ Falls with injury ■ Medication errors ■ Delirium rates ■ Hospital-acquired infections ■ Serious injury or harm to staff ■ In-episode mortality ■ Escalation (return to brick and mortar hospital setting) rate ■ Clinical, Operational, Technology Incident Rates and Severity	■ 3-day readmission ■ 30-day readmission ■ 30-day ED or observation presentation ■ Days at home ■ Post-discharge patient experience ■ 30-day mortality ■ Program demography, insurance types

Data Limitations

Data limitations present significant challenges in various operational areas for HAH, though this is not unique to HAH. Claims and Enterprise Data Warehouse (EDW) data often lack consistency and completeness, making it difficult to draw accurate conclusions. For HAH, evolving reimbursement structures, varied program frameworks, and diverse reporting exacerbates this challenge across HAH programs. Additionally, data definitions themselves across different systems may vary for metrics that are applicable to all inpatient care, complicating efforts to benchmark and compare performance. Logistics management data is relatively novel for home-based acute care; its integration into existing systems poses unique challenges. Furthermore, access and equity data is crucial for ensuring fair and inclusive practices, but it is underrepresented or inconsistently collected, hindering efforts to address disparities effectively.

Legal/Regulatory/Compliance

AHCAH Waiver Program

While the COVID-19 PHE ended in 2023, the AHCAH initiative continued under the Full-Year Continuing Appropriations and Extensions Act of 2025 (H.R. 1968), which extended appropriations through the end of Fiscal Year (FY) 2025. H.R. 1968 included an extension of waivers and flexibilities associated with the Acute Hospital Care at Home (AHCAH) Data Release initiative until September 30, 2025. Continuation of the AHCAH initiative beyond September 30, 2025, is contingent upon further Congressional action. Regulatory, compliance and risk leaders may consult the CMS AHCAH website for current guidance, as this is an ongoing review with dynamic legislative change.[31]

[30] Levine, D. M., et al. (2025). Practice standards for acute hospital care at home. *Journal of the American Geriatrics Society*. https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.19427?af=R

[31] Centers for Medicare & Medicaid Services. (2025). Acute hospital care at home waiver. https://qualitynet.cms.gov/acute-hospital-care-at-home/waiver

Privacy

As for all patient care, patients' rights must be considered, and the HAH care team must ensure patients have the information and support needed to make informed decisions about their care, while safeguarding privacy and confidentiality. HAH will follow the COPs of their licensed hospital owner. The same rules that apply in the hospital apply in the home setting but may require a nuanced approach to privacy in the home setting. Employees and clinicians may be exposed through direct observation to more intimate details of their patients' everyday lives, as well as in-home social drivers of health. Risk and compliance leaders must ensure that breaches of such information are prevented and if necessary, addressed through established organizational privacy policies and procedures.

Fraud, Waste and Abuse

Although there is not a permanent reimbursement mechanism for Medicare or Medicaid reimbursement of services under the Acute Hospital Care at Home (AHCAH) Waiver, risk and compliance leaders must monitor and address potential fraud, waste and abuse within the HAH system. While many state and federal rules and regulations surround fraud, waste and abuse, the most relevant here are the Federal False Claims Act, the Anti-Kickback Statute, the Physician Self-Referral Law (Stark), Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL).

There are several reasons for assessing the risk around fraud, waste and abuse. First, while health systems may not be being directly reimbursed from Medicare/Medicaid for some of the services provided under AHCAH, they may be reimbursed tangentially for services provided *around* AHCAH services. As such, any of the services "in the stream" of reimbursement could be subject to scrutiny. For example, in some HAH services provided outside of the waiver, services such as pharmacy, imaging and laboratory may be billed separately outside of the Diagnosis Related Groups (DRG) model. As such, each of those services must independently meet the Medicare and Medicaid billing requirements in order to be reimbursed appropriately.

Accreditation and Certification Tradeoffs

Accreditation and certification both play important roles in safeguarding quality and credibility, but they come with their own tradeoffs. Accreditation involves comprehensive evaluation of an institution or program to ensure it meets high standards across various aspects, such as curriculum, personnel qualifications, and outcomes. This process demonstrates the organization's commitment to quality and continuous improvement, enhancing the institution's reputation and trust among stakeholders. Accredited programs often enjoy wider recognition and acceptance, which can be beneficial for consumers evaluating their services. However, the accreditation process can be lengthy and resource-intensive, requiring significant time, effort, and financial investment. Additionally, accredited institutions may need to adhere to strict standards and procedures, which can limit flexibility and innovation. In HAH, definition of clinical operational standards of practice is maturing, with practice standards set forth by the Hospital at Home Users Group of the American Academy of Home Care Medicine (AAHCM).[32]

The following offers a summary of accreditation bodies and their currently available accreditation programs:

[32] Read, P. (2021). On time, every time. *Unity Point.* https://hahusersgroup.org/wp-content/uploads/2021/02/On-Time-Every-Time.pdf

Can HAH programs receive accreditation?

- **Centers for Medicare & Medicaid Services (CMS)** does not provide formal accreditation but approves hospitals to participate in the Acute Hospital Care at Home (AHCAH) waiver program
- **Accreditation Commission for Health Care (ACHC)** provides in home accreditation and validates quality and safety for advanced home-based acute care.
- **The Joint Commission (TJC):** While TJC does not have a dedicated HAH accreditation, it offers:
  - **Home Care Accreditation** for organizations providing services like home health, hospice, and infusion therapy.
  - **Hospital Accreditation** for facilities integrating HAH into broader inpatient services.
- **URAC (Utilization Review Accreditation Commission):** URAC does not currently offer a specific HAH accreditation, but it provides programs for:
  - Telehealth.
  - Case management.
  - Health plan services.

On the other hand, certification provides targeted validation of specific skills, competencies, or standards, which can be highly relevant for professional development and differentiation of service providers. The certification process is generally faster and less resource-intensive compared to accreditation, allowing for more flexibility in terms of updating and adapting to new industry standards and practices.

However, certification typically focuses on specific areas or competencies, which may not provide a comprehensive evaluation of an entire institution or program. The recognition and value of certifications can vary widely depending on the certifying body and industry, and certifications often require periodic renewal, involving additional time and costs.

Ultimately, the choice between accreditation and certification depends on the specific goals, resources, and the needs of the organization or individual. Both processes offer valuable benefits but come with tradeoffs that should be carefully considered for HAH programs, clinicians and leaders.

Leadership and Governance

Governance and leadership play a crucial role in the successful implementation and sustainability of HAH programs. Effective governance ensures that HAH programs are aligned with broader strategic goals of the health care organization, while robust leadership drives the adoption and integration of these innovative care models.

HAH leaders must foster a culture of collaboration and continuous improvement, engaging multidisciplinary teams to deliver high-quality, patient-centered care in the home. They are responsible for establishing clear policies, protocols, and accountability structures to manage the unique risks and complexities associated with HAH services.

Additionally, HAH leaders must navigate regulatory requirements and secure appropriate reimbursement frameworks to ensure financial viability for program sustainability. By prioritizing strong governance and visionary leadership, health care organizations can maximize the benefits of HAH programs, ultimately enhancing patient outcomes and operational excellence.

Risk Management Takeaways:
Governance, risk management oversight and leadership are foundational to the safe and sustainable operation of HAH programs. To effectively manage risks, leaders must implement structured oversight mechanisms and foster a culture of safety, accountability, and continuous improvement. Key areas of risk management include:

1. **Patient Selection and Admission Criteria**
   - Establish and enforce clear clinical and environmental eligibility criteria.
   - Use standardized algorithms and escalation protocols to assess patient acuity and home safety.
   - Ensure that exclusion criteria are applied equitably to avoid disparities in access, especially for patients with high Social Determinants of Health (SDoH) risk.

2. **Home Environment Evaluation**
   - Conduct thorough assessments of the home environment, including sanitation, utilities, caregiver support, and fall risks.
   - Engage community resources to address environmental barriers (e.g., hoarding, infestations).
   - Document findings and mitigation strategies in the patient's care plan.

3. **Clinical Competency and Staffing**
   - Require acute care competencies for nurses and paramedics, including training in IV therapy, infection control, and rapid deterioration recognition.
   - Provide ongoing education and simulation-based training for interdisciplinary teams.
   - Align staffing models with patient needs, including virtual and in-person visit capabilities.

4. **Technology and Infrastructure**
   - Implement reliable telehealth platforms with defined downtime protocols.
   - Ensure biometric monitoring devices are functional and supported by 24/7 technical assistance.
   - Develop standard operating procedures (SOPs) for technology failures, including backup communication and escalation plans.

5. **Regulatory and Legal Compliance**
   - Adhere to CMS waiver requirements and maintain documentation for audits.
   - Ensure informed consent processes are tailored to the HAH model.
   - Monitor compliance with HIPAA, licensure scope, and medication management regulations.

6. **Operational Coordination**
   - • Integrate care coordination across pharmacy, labs, logistics, and clinical teams.
   - • Use electronic health records (EHRs) to support daily care planning and documentation.
   - • Establish rapid cycle improvement processes to address gaps and adverse events.

7. **Safety and Quality Oversight**
   - Form a local safety committee to review metrics such as escalation rates, readmissions, and mortality.
   - Track and report quality measures to CMS, including patient experience and discharge outcomes.
   - Promote transparency and learning from safety events to drive continuous improvement.

Conclusion

As HAH continues to gain traction, proactive risk management for HAH becomes as vital as for other care models and service lines. By addressing clinical, technological and operational risks with HAH prior to and during HAH implementation and continuously thereafter for growing HAH programs, health care risk professionals can support safe and effective acute care delivery outside of the walls of the hospital facility.

Operational excellence for HAH programs requires a dedicated approach to the program's design, alongside the technological capabilities and EHR compatibility required to enable this care. Safe practice in HAH applies to a multidisciplinary team of clinicians and operational colleagues, relying on technologies and services that themselves require high degrees of reliability, quality assurance and continuous improvement. Virtual care and technology enablement of HAH, as well as dynamic regulatory and reporting frameworks, will ensure the continued and differentiated need for risk management leaders to engage in this new care model. At the same time, traditional risk management principles apply to HAH programs, just as they do to other innovative service lines. This includes the adaptation of acute inpatient care standards to the home environment, ensuring that safety, quality, and regulatory expectations remain consistent.

Establishing a well-resourced, cross-functional enterprise risk management framework—alongside a structured quality assurance and improvement governance system—is critical during the design phase of HAH programs. These elements ensure that hospital-level care in the home remains sustainable, scalable, and responsive to both risks and opportunities for continuous improvement.

Embracing HAH risk mitigation strategies will enhance patient outcomes and positions health care organizations at the forefront of innovation in patient-centered care. Through diligent risk assessment and mitigation, strategic planning, and continuous improvement, health care providers can confidently navigate this home-based care frontier, redefining the future of acute care delivery. By addressing these challenges proactively, HAH programs can achieve their full potential, offering a safe and effective alternative to traditional hospital care.

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