From the ER to your house: Why hospitals are treating patients at home

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BOSTON — An IV bag dangled from a curtain rod, pumping fluids into the patient. A paramedic drew a blood sample as an Olympic women's rugby match blared on the television facing the woman's bed.

Lucia Louis was home. Not that long ago, she lingered in an emergency room, stricken with a painful salmonella infection. Rest in the ER proved elusive. Doors slammed, and a patient profanely told a nurse to shut up. Urine drenched a shared toilet. Louis yearned for her reclining Sleep Number king-size mattress rather than a flimsy hospital bed that made her back ache.

"I'm in the comfort of my home," Louis, 55, said this summer as she snacked on Ritz crackers her husband had brought from the kitchen. "It's peaceful."

She'd opted to receive treatment through a home hospital program operated by Mass General Brigham, among the scores of health systems shifting patients to their homes to be monitored virtually and with daily visits as a way to ease pressure on crowded facilities.

For some seriously ill patients, a hospital is the last place they want to be. A place of healing can instead be a place where they acquire infections, become isolated from family and surrender privacy at a time of deep vulnerability.

The hospital-at-home movement has proliferated during the past decade, reshaping how acute care is delivered and health systems are financed. But nurses and others raise concerns about whether health companies will shutter or gut hospitals and deprive patients of regular, immediate in-person care.

The federal government in 2020 eased regulations on home hospital programs to keep people out of facilities overwhelmed by covid cases. Now, health-care leaders are lobbying Congress for a five-year extension, a decision that could cement the rise of home hospital services — or make them a pandemic relic.

If Congress does not act before the end of the year, patients cared for at home through these programs must be discharged or returned to the hospital on Dec. 31, according to the Centers for Medicare and Medicaid Services (CMS), which oversees these programs.

The 2020 waiver helped home hospital initiatives be financially feasible by making it easier to receive Medicare funding. CMS has given approval to 373 facilities in 39 states to operate home hospital programs under the waiver.

A September CMS report comparing patients cared for in these programs with those treated in hospitals found that the death rate for home patients was lower, the likelihood of acquiring harmful conditions was lower but not enough to be statistically significant, and readmission rates varied depending on the underlying problem. The study had limitations, especially because of the unusual circumstances during the coronavirus pandemic, but the report said the findings were consistent with other research concluding that hospital care can be provided safely at home.

Other studies have shown that patients, usually those being treated for chronic diseases, can have better outcomes and lower odds of being readmitted if they are treated at home rather than at hospitals.

But crucial questions are still being investigated, such as drilling deeper into which types of patients benefit the most and how best to check their progress. Critics worry patients could be harmed while that research continues.

Jay Pandit, director of digital medicine at the Scripps Research Translational Institute, said more studies are needed to examine how to use digital technology and telehealth to monitor patients without jeopardizing their safety. Pandit, who wrote a paper examining hospital-at-home programs, said research would be stymied if Congress let the waiver expire.

“For years, we’ve known people heal and feel better at home,” Pandit said. “We can do this in the right way.”

Leaders of the Mass General Brigham health system, the largest in the state, have pitched their growing home-care program to Congress as an example of why this model should expand nationally.

In hospital offices, staff triage which patients can safely be cared for at home and give them the option to do so. Most accept the offer. Instead of having a call bell, patients wear yellow rubber bracelets displaying a 24/7 hotline number and are given tablets for video calls with hospital staff. They wear devices affixed to their chests and arms to remotely monitor vital signs.

A paramedic or nurse comes in person twice a day, and at least one medical professional considered “advanced,” such as a physician assistant, nurse practitioner or doctor, visits virtually or in person once a day.

A paramedic, Ben Berry, stopped by Louis’s home in Boston’s Dorchester neighborhood on her third day of recovery, replacing her IV line, running a blood sample through a handheld device that returned results in minutes and administering medication. For most of his eight years as a paramedic, Berry was used to showing up after patients called 911 and trying to stabilize them. Now, he gets to help them recover.

He placed a video call to a certified nurse practitioner and held up the phone in one hand while he pressed down on Louis's bare belly with the other, searching for places where she still ached.

Louis recalled her relief in the emergency room when a health worker told her she didn't have to stay at the hospital.

Her husband, Oswin Louis, who replaced medical staff as her primary caregiver, questions why someone would leave the hospital. From his perspective, it's better to receive care in private at such a vulnerable time without burdening family members.

"Leave me in the hospital and go," Oswin Louis said. "I don't want anyone around me."

Critics of hospital-at-home programs say the responsibility to care for patients shouldn't fall on relatives.

National Nurses United, the country's largest registered-nurses union, asserts that patients are better served in hospitals, where registered nurses and other medical professionals are always down the hallway.

Before the pandemic-era waiver, federal officials required patients treated at home to have a registered nurse on-site at all times.

"Burdening family members with care that should be provided by registered nurses and other health care professionals allows the hospital industry to increase its profits at the expense of patient safety," the nurses union wrote in a 2022 report accusing hospital-at-home programs of being dangerous for patients.

While research has not identified serious safety issues with hospital-at-home programs, advocates of in-hospital nursing point to studies — largely referring to what happens in traditional health-care settings — finding that medical errors are less common when nurses regularly monitor patients.

Nurses also fear that the movement toward home care will accelerate hospital closures and the loss of acute-care beds by providing an alternative with lower overhead and labor costs.

"There is no such thing as a hospital at home," said Nancy Hagans, president of National Nurses United. "A hospital is where you have the health-care setting with everything that's needed to care for a patient. When you send a patient home by themselves, you are cutting corners."

Rep. Jim McGovern (D-Massachusetts), who favors extending the waiver, said he has not seen evidence that hospitals are using at-home programs to gut traditional hospital operations and said Congress could revisit the issue if that happens. Still, he was sympathetic to the nurses' concerns.

"I understand their paranoia and their suspicions because there's a long history of hospital administrations trying to cut cost by cutting staffing," McGovern said. "But it seems to me to be working, and it should be allowed to continue to work."

So far, home hospital programs are usually too small and inefficient to offer a cheaper alternative to acute-care wards, according to hospital leaders and a federal report to Congress.

Nancy Foster, vice president for quality and patient safety policy at the American Hospital Association, said home programs offer other financial upsides: building loyalty among patients who might return to the hospital for elective care, alleviating staff burnout by offering alternatives to hospital chaos and reducing readmissions among long-term patients.

The economics of home hospital care remain a work in progress. Mass General Brigham executives believe that providing care to patients in their homes will ultimately prove more cost-effective, even though the costs are now similar to providing care in hospitals. They expect to realize savings as more patients go from hospital bed to their own bed.

Private insurance plans also reimburse at-home hospital care at rates similar to in-hospital care.

Stephen Dorner, an emergency physician and the chief clinical and innovation officer for the at-home program, said hospital crowding has worsened during the last decade, increasing financial pressures on the system.

One recent afternoon, more than 80 patients languished in the ER waiting for a bed at the system's flagship, Massachusetts General Hospital — something that would have been unheard of when he started the job, Dorner said.

Patients reclined on stretchers in hallways and in front of nurses' stations.

"We need you to lay down. It's a busy hallway," a staff member in scrubs admonished a patient who stood up to walk. People in waiting room chairs were hooked to IV bags.

That morning, two patients were approved to return home for care. Eventually, the system hopes to treat 10 percent of patients at home.

"It would be even more crowded without the home program," Dorner said. "We can't build our capabilities and hire fast enough."

Bringing hospital care to homes comes with its own complications.

Lauren Doctoroff, an internal-medicine physician at Massachusetts General who splits her time between home visits and occasional hospital rounds, wore a cardigan and jeans, sneakers and a yellow surgical mask as she stopped by the home of Paul Costa, who was recovering from congestive heart failure. The 80-year-old hair salon owner was making progress and seemed happier seeing a doctor and paramedic while he sat in his living room. But his home case also presented logistic challenges, Doctoroff explained.

The hospital had to send a car later that day to take him back to the facility for an MRI, which, if he'd been an inpatient, would have been as simple as wheeling him downstairs. His lab work would have been done sooner for the doctor to figure out how to adjust his medication. And when he needed to take a dose of Ativan, a controlled substance that helps ease anxiety, he had to connect with a nurse who monitored him over a video call.

Sometimes, Doctoroff spends more time driving to the homes of patients than seeing them. Patients get disappointed when their conditions deteriorate, forcing them back to the hospital. The program is not a great fit for people who need intensive treatment by specialists or extensive testing to diagnose their condition.

But Doctoroff has noticed that patients with dementia and other cognitive dysfunction find more solace in a familiar setting than a frenetic, destabilizing hospital. Some older patients warmly recall the days of doctors making house visits.

"Patients are much happier. They sleep better," Doctoroff said.

And that's how Costa felt, too, in his home in Lynnfield, a Boston suburb, when Doctoroff visited. It was his wife's birthday, and she didn't have to spend it visiting him in the hospital. He ate macaroni for dinner instead of what he called "gross" hospital food. Going to the bathroom was no longer a "project."

"This is like heaven," Costa said. "The hospital is like hell."