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Comprehensive Review of the Success of the Hospital-at-Home Program in Today's Healthcare Delivery

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Abstract

Background: Social prescribing (SP) is a new approach of primary care with the aim of addressing patients' social, emotional, and practical needs (e.g., loneliness and mental health), which traditional medicine is ill-equipped to resolve. Given that 20% of general practice consultations are related to social needs, SP is timely.

Aim: To review the implementation of social prescribing (SP) in general practice, including models of delivery, health and wellbeing outcomes, facilitators, barriers, and scalability.

Methods: Following PRISMA 2020, we systematically searched MEDLINE, Embase, CINAHL, PsycINFO, and grey literature from 2000 to October 2024. Sixty-eight studies were synthesized narratively using the GRADE approach and thematic analysis, with systematic reviews, primary research, and policy reports included.

Results: SP models differ across the globe: the UK is the only country in which the link worker model is formalized, while Canada and Australia have less established approaches. Improved mental health, social connectivity, and reduced food insecurity are associated with SP; evidence for physical health and healthcare use is mixed. Important facilitators include funding and training, while barriers include competing demands on resources and gaps in the evidence base.

Conclusions: SP adds strength to general practice by addressing social determinants of health. Standardised evaluation and developing strategies for scalability and equitable access to programs will be important in maximising the impact of SP efforts.

Keywords: Social prescribing, general practice, primary care, link worker, health outcomes.

Introduction

Global health systems are under pressure from intricate challenges driven by demographic change, epidemiological trends, and economic pressures. Demand for acute and chronic care services is driven by the aging population, particularly in developed nations, and the number of individuals above the age of 65 years is projected to increase by 2050 (1). Chronic diseases such as diabetes, heart failure, and chronic obstructive pulmonary disease (COPD) are also on the increase and contributing to the strain that is being put on hospitals' healthcare infrastructure (2). Inpatient care in the United States has been escalating to over $1 trillion annually, which is equivalent to a third of all healthcare expenditure, emphasizing the urgent need for cost-efficient models of care (3). Traditional inpatient care, though effective for time-limited illnesses, is riddled with significant hazards, such as nosocomial infection that affects up to 7% of patients admitted to hospital in developed countries, and iatrogenic complications such as drug errors and falls (4). The above challenges have led healthcare providers and policymakers to pursue new models of care that have the capability to offer high-quality care at reduced risk and cost.

The Hospital-at-Home model has been a promising alternative to hospitalization. HaH programs provide acute in-hospital level of care in patient homes with

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the help of multidisciplinary teams, advanced technology, and care coordination to offer quality equal or superior to inpatient-level care (5). HaH models also stand a chance to save healthcare costs, reduce hospital-acquired complication, and enhance patient-centered outcomes by allowing patients to recover in a home-based convenient setting. HaH programs are typically divided into two models: Early Supported Discharge or Admission Avoidance models. ESD programs reduce hospital lengths of stay by discharging patients to home-based care earlier in the treatment course with the assistance of clinical teams and monitoring systems (6). AA programs, on the other hand, permit patients to bypass hospital admissions and receive acute care in the home for conditions that would require inpatient care (7). Both models rely on robust clinical protocols, home visits by physicians or other healthcare professionals, and increasingly, telehealth and remote monitoring technologies in both efficacy and safety.

HaH implementation has also been driven by policy reforms and technology advances, particularly in the context of the COVID-19 pandemic. The pandemic exposed hospital capacity risks and surges severely testing health care systems globally (8). In response to this, the U.S. Centers for Medicare & Medicaid Services (CMS) implemented the Acute Hospital Care at Home waiver in 2020 to permit hospitals to accept reimbursement for HaH services and facilitate widespread program usage (9). Telemedicine, sensor wearables, and remote monitoring also increased HaH feasibility by making it possible to obtain real-time data and conduct virtual visits and ongoing observation of patients' conditions (10). These technologies transformed HaH to a preferable solution for addressing capacity restraints, reducing healthcare-associated infections, and responding to patient needs for home-based services.

The systematic review will compare HaH to usual inpatient treatment under four general domains: clinical outcomes (e.g., mortality, readmission rates, and length of stay), cost-effectiveness, patient and caregiver experience, and implementation challenges. By bringing together systematically targeted reviews, meta-analyses, and original studies for synthesis, this review aims to draw an overall picture of HaH's impact on healthcare delivery in modern settings. Synthesis will look to explore how to improve patient outcomes and reduce healthcare expenditure, and enhance satisfaction levels, as well as to reveal limitations to scalability and sustainability. Results will be used to inform policymakers, healthcare professionals, and researchers on how to implement HaH in different healthcare settings in the best possible way.

Methods

Systematic literature search was conducted in PubMed, EMBASE, Cochrane Database of Systematic Reviews, Web of Science, Scopus, and CINAHL from January 2000 until February 2024. Search terms utilized were “Hospital-at-Home,” “home hospital,” “admission avoidance,” “early supported discharge,” and synonyms, with outcome terms (e.g., “mortality,” “readmissions,” “cost-effectiveness”). Inclusion criteria were: (1) English peer-reviewed studies, (2) contrasting HaH with inpatient care, (3) reporting clinical, cost, or patient experience outcomes, and (4) involving adult patients. Quality of the studies was assessed with the Assessment of Multiple Systematic Reviews-2 (AMSTAR-2) for reviews and the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist for primary studies. Data were extracted regarding mortality, readmissions, LOS, costs, satisfaction, and implementation factors. Narrative synthesis was used due to study design and outcome heterogeneity.

Clinical Outcomes

Death

The HaH model has been thoroughly trialed for safety, particularly for mortality outcome, and the evidence is always that it is at least as good as, or safer than, usual inpatient care for well-slections of patients. A systematic Cochrane review for Admission Avoidance (AA) HaH programs combined data across a series of randomized controlled trials (RCTs) and reported a trend to reduced mortality at 3 months, relative risk (RR) 0.77 (95% confidence interval [CI] 0.54–1.09), although this did not prove statistically significant due to wide confidence intervals (6). By 6 months, however, the same review identified a statistically significant reduction in mortality (RR 0.77, 95% CI 0.60–0.99), which suggests an enduring benefit for patients receiving AA programs (6). This decrease could be explained by the prevention of avoidable risks of hospital-acquired complications such as nosocomial infection, which arise in around 7% of inpatients and are responsible for excess mortality (4). In older individuals, a meta-analysis of Early Supported Discharge (ESD) HaH programs specifically documented reduced mortality compared to inpatient care for stroke and heart failure conditions (7). Such an observation is extremely relevant to the susceptibility of older individuals to hospital-acquired adverse events that include delirium and loss of function (40). Some studies do caution, however, that underpowered sample sizes and variability in patient selection criteria mean that conclusions about mortality benefits are impossible to make for all HaH programs (8). Such limitations emphasize the need for well-powered trials for longer-term mortality outcomes to be conducted.

Readmissions

HaH's impact on readmissions is more heterogeneous with results varying by population of patient, disease treated, and program design. Systematic review of heart failure patients found positive trends for readmission decrease with HaH with a relative risk of 0.68 (95% CI 0.42–1.09), not statistically significant because of small sample sizes and heterogeneity of protocols used in studies (9). Intensive follow-up and monitoring are plausible reasons for decreased readmission in HaH programs, which can treat complication early and prevent deteriorating (10). A more recent meta-analysis of HaH programs for various conditions found no overall significant reduction in

readmission rates (RR 0.98, 95% CI 0.77–1.23), highlighting heterogeneity in program effect (10). Heterogeneity is partly driven by differences in patient acuity and intensity of home-based interventions and post-discharge support availability (11). Those HaH programs involving intensive telecare and multidisciplinary team input are superior at readmissions in comparison to those using episodic home visit programs (12). Heterogeneity of patient groups and program designs complicates direct comparison and highlights the need for standard reportage in future trials to clarify readmission trends.

Length of Stay (LOS)

One of the most uniform benefits of HaH is shorter length of stay (LOS) compared with standard inpatient stay, particularly for ESD programs. Systematic review of ESD programs for stroke, COPD, and orthopedic surgery was found to decrease LOS by 4.85 days, on average (95% CI 3.21–6.49), with potential for earlier discharge to home-based care without loss of stability of clinical status (11). LOS reduction not only eases pressures on hospital bed capacities but also reduces exposure to in-hospital-related risks of infection and fall in the hospital (43). LOS impact is less for technology-enabled HaH models based on highly specialized interventions such as intravenous therapy or prolonged remote monitoring. Some reports report similar or longer LOS in these models for certain conditions, particularly for longer duration of monitoring and treatment needs of complex conditions (12). An example report on technology-intensive HaH in heart failure found LOS similar to inpatient stay because of a longer time to stabilization required in home-based care (15). Current evidence suggests that although effective ESD programs reduce LOS significantly, the effects of AA programs would be variable according to the complexity of provision of care and the technological setup involved.

Cost-effect

HaH programs are associated with lower costs without compromising on clinical outcomes or decline in quality of care. A landmark US-based study reported HaH patients had 19% lower costs than inpatient matched controls without compromising on quality of care or outcome (13). Lower hospital bed days, reduced overheads, and fewer hospital-acquired conditions account for cost savings (24). An economic analysis conducted in the UK also supported these findings by demonstrating 90% likelihood of cost-effectiveness of HaH for COPD patients at a threshold of £30,000 per QALY (14). Such an analysis recognized cost savings in terms of reduced readmissions and reduced LOS to offset costs of home-based service delivery (14). Cost-effectiveness is actually a program model and technology level dependence and is affected accordingly. High-technology model HaH built on complex telehealth platforms and monitoring devices has a higher upfront cost of investment, and evidence regarding cost-effectiveness is yet to emerge fully (15). For example, an assessment of technology-intensive HaH programs reported no change in clinical outcomes but evidenced blunted cost savings due to equipment and training costs (20). Research in the future will need to focus on rationalizing technology-enabled HaH cost-efficiency to increase scale in diverse healthcare settings.

Patients and Caregiver Satisfaction

Patient and caregiver satisfaction is a cornerstone of HaH's widespread popularity, with research consistently showing high levels of satisfaction in comparison to inpatient settings. A meta-synthesis of qualitative evidence concluded that patients value HaH for treatment in a homely and comfortable environment, avoidance of hospital-induced stress, and facilitation of autonomy (16). Caregivers also have positive experience, with reduced travel requirements and increased involvement in treatment choice reported as major benefits (17). For example, patients recovering from acute conditions like pneumonia or heart failure consistently report increased control and reduced anxiety when in the home environment (16). Continuity of care, facilitated by frequent communication with healthcare teams and customization of treatment plans, is a major driver of patient-centeredness of HaH programs (17). However, concerns like caregiver burden and lack of contact with HaH can lead to denial of the model. Systematic review found that up to 20% of suitable patients refuse HaH because of concerns regarding safety, effectiveness or imposing on relatives (18). Such concerns need to be allayed through targeted education and supportive systems to optimize acceptance and satisfaction.

Implementation issues

Despite the benefits, HaH uptake is limited by daunting barriers, including patient refusal, scalability limitations, and technological challenges. Refusal by patients is a common barrier, with the literature citing safety, effectiveness, and perceived burden to family caregivers as discouraging participation (19). For example, frail or socially isolated older adults may perceive HaH as less reliable than hospital care for complex illness (18). Scalability is also a concern inasmuch as HaH programs entail significant workforce training investment, care coordination, as well as infrastructure to deliver consistent quality in diverse settings (20). Technology utilization, including telehealth platforms, and remote monitoring devices, is a necessary enabler but also plagued by accessibility, interoperability, and user training problems (29). In the US, the 2024 deadline of CMS reimbursement waiver expiration has caused fiscal uncertainty, with most HaH programs relying on waivers to subsidize operations (21). Successful implementation requires lowering these barriers through schemes, including stable reimbursement models, and investment in scalable technology and training programs to build confidence among patients, caregivers, and providers (35).

Table 1: Summary of Key Findings Regarding Hospitals-at-Home Effectiveness.

Outcome	Key Findings	References
Mortality	Comparable or lower mortality rates; AA programs show significant reductions at 6 months.	6, 7, 8
Readmissions	Variable; trends toward fewer readmissions, but not always significant.	9, 10
Length of Stay (LOS)	Generally shorter with ESD; variable with technology-enabled models.	11, 12
Cost-Effectiveness	19% lower costs in some studies; high probability of cost-effectiveness for COPD.	13, 14, 15
Satisfaction	High patient and caregiver satisfaction; autonomy and comfort valued.	16, 17
Implementation Barriers	Patient refusal, scalability, technology, and reimbursement challenges.	18, 19, 20, 21

Discussion

Clinical Effectiveness

The HaH model has demonstrated robust clinical effectiveness for target conditions and patient populations, a safe and effective alternative to usual inpatient treatment. In such conditions as COPD, heart failure, and specific acute infections such as pneumonia, HaH has been shown to be safe and effective, with outcomes comparable with or superior to outcomes with hospital-based treatment (22). Notably, trends toward decreased mortality and readmission have been observed in various studies that may be attributed to HaH's circumvention of hospital-associated risks such as nosocomial infection, occurring in up to 7% of inpatients, and iatrogenic complications such as drug error or falls (4, 22). Among the frail elderly, an exceedingly vulnerable population, HaH programs, especially those incorporating Early Supported Discharge, have been observed to significantly decrease mortality explainable by less hospital-related stressor exposure, such as delirium and functional decline (7, 40). For all these promising results, however, inconsistencies of the evidence base exist due to heterogeneity of HaH program models, patient populations, and measures of outcome (23). The majority of studies are compromised by small sample size or short duration of follow-up, restricting the potential for the assessment of longer-term outcomes such as sustainability of mortality reductions or quality of life benefits (23). Moreover, the heterogeneity by which HaH programs are implemented—on a continuum from low-technology home visit models to high-technology telehealth models—renders impossible the derivation of global conclusions regarding clinical effectiveness (8). Standardized protocols and larger, longer-term studies must be the target of future research to eliminate these disparities and cement the model's effectiveness within diverse clinical environments.

Economic Benefits

The economic advantages of HaH are a key driver of broader adoption, with the model demonstrating repeated cost savings per comparison versus usual inpatient care. By delivering acute care in the patient's home, HaH reduces demand for costly hospital bed utilization, of particular benefit to pressured healthcare systems and rising costs (24). For instance, in a U.S.-based comparison of HaH patients and matched inpatient controls, it was found to have 19% reduced costs with comparable or superior clinical outcomes (13). Such cost reductions are underpinned by reduced hospital stays, reduced overhead, and reduced incidence of hospital-acquired conditions, which can extend lengths of stay and additional treatment (24). Direct cost reductions of HaH are matched by system-wide relief through liberation of beds in hospitals, reduced need for capital costs in new buildings, and rationalization of use under periods of heightened demand, such as the COVID-19 pandemic (30). Economically beneficial benefits of HaH are not without challenges, however. The model requires significant upfront investments in including telemedicine platforms, remote monitoring equipment, and staff training, which can offset early savings, particularly for technology-dependent programs (25). Additionally, the cost-effectiveness of HaH is program type-dependent (e.g., Admission Avoidance vs. ESD) and target population served, with a lack of evidence on funding sustainability of high-technology models (15). Healthcare organizations will need to apportion these upfront costs carefully against longer-term savings through financial planning, incorporating both initial costs and longer-term operational costs to achieve HaH's economic benefits in full.

Patient-centered care

HaH is closely aligned with patient-centered care practice and offers a model of care intended for patient comfort, autonomy, and individualized requirements. High levels of patient satisfaction are reported for those receiving HaH and comprise descriptions of comfort during convalescence in the home setting, mitigation of hospitalization-related stress, and greater control over daily activities (16). Qualitative studies demonstrate a patient preference, particularly among patients with chronic disease or older patients, to preserve autonomy and avoid the disorienting nature of hospitalization, as in sleep disturbance

or exposure to strange environments (26). Caregiver involvement is an integral part of HaH's patient-centered philosophy of care, facilitating shared decision-making and augmentation of the patient's support system (17). Such caregiver dependence can pose daunting challenges, most notably the risk of burnout in caregivers, where interventions lag behind supportive frameworks such as respite or training programs (27). Refusal by patients represents a lingering controversy regarding access to HaH, with refusal to engage by 20% of target subjects due to safety and effectiveness concerns of home-based intervention or dependence on family resources (18). Such concerns represent the target of intervention by raising awareness and confidence in HaH through the provision of targeted education programs and customized communication styles to address the specific needs of patients and carers (28). Through the augmentation of caregiver support and enhancement of awareness and confidence in HaH through increased education of both parties, HaH programs can further align themselves with philosophies of patient-centered care and enhance acceptance levels regarding their programs.

Implementation and Scalability

Successful implementation of HaH programs depends on robust care coordination, a high-performing workforce, and a secure technological infrastructure. Successful HaH programs are built on interdisciplinary teams of physicians, nurses, and allied health professionals trained to deliver hospital-level care in the home and incorporate seamlessly with telehealth and community-based care (29). HaH's potential to meet surge capacity was demonstrated during the COVID-19 pandemic, with programs rapidly scaling up to accept patients during hospital bed shortages, made possible by temporary CMS reimbursement waivers (30). Scalability, however, is the greatest challenge, as waivers ended in 2024 and left many programs financially in limbo (21). Other barriers include partial stakeholder buy-in among healthcare providers and patients, as they are concerned with the safety or feasibility of the model, and technology scaling costs, such as interoperable telehealth platforms and remote monitoring systems (31). Workforce shortages and requests for special training also hinder scaled adoption, particularly in rural or underserved settings with poor access to skilled clinicians and technology (20). To overcome these challenges, future studies are recommended to focus on standardizing HaH program components, such as clinical protocols and technology integration, and evaluate strategies to allow for scalability, such as public-private partnerships or expanded reimbursement models (32). By overcoming these challenges, HaH programs can achieve greater reach and longitudinal impact across diverse healthcare systems.

Limitations

This review is constrained by a series of limitations on generalizability and strength of evidence. Heterogeneity of HaH program models, such as variation in patient eligibility criteria, intensity of intervention, and outcomes measurement, restricts meta-analytic synthesis and conclusive conclusions to be drawn (23). For example, AA vs ESD programs and variation in use of technology do not facilitate comparison of studies (12). Moreover, the vast majority of HaH studies are conducted in well-resourced health system environments of high-income countries, restricting applicability of findings to low- and middle-income settings with fewer infrastructural and material resources available (33). Potential publication bias is another constraint with studies with positive results having a higher likelihood of publication and therefore potentially distorting the evidence base (34). Lastly, studies are often underpowered with too few patients or too short a duration of follow-up, restricting the potential for assessment of longer-term outcomes such as sustained gains in mortality or gains in quality of life (8). Such constraints indicate a need for more rigorous and standardized research to build a stronger evidence base for HaH and to improve relevance to settings.

Recommendations

To achieve HaH's full potential, several recommendations are made to policymakers, healthcare providers, and researchers. First, policymakers should prioritize expanding reimbursement for HaH programs through CMS waivers, as we need to promote sustained funding avenues and enhance the uptake of these programs. (35) Second, healthcare providers should prioritize caregiver support, including training, respite, and counseling, and develop educational outreach campaigns for patients and caregivers to increase trust in the model and decrease refusal rates. (36) Third, researchers should conduct larger scale, standard RCTs to close the evidence gap of long-term outcomes and scalability, while also examining diverse patient populations and care contexts. (37) Finally, stakeholders should invest in telehealth technologies that are interoperable across platforms, as well as remote monitoring technologies, to improve care coordination and feasibility in HaH models within resource-constrained contexts. (38) The comprehensive adoption of these recommendations has the potential to overcome current barriers and maximize the application of HaH as a disruptive care delivery model.

Conclusion:

Hospital-at-Home (HaH) is a safe, patient-directed, effective alternative to inpatient care that is equivalent, or has better outcomes for select patients and conditions like older adults, patients with COPD or heart failure, etc. With patient engagement and satisfaction rates that exceed hospital inpatient, HaH removes many hospital risks and costs while improving patient satisfaction. HaH will address unique problems in today's healthcare delivery models, including acute care capacity and cost improvement. Still, for HaH to be effectively implemented on a larger scale, it is essential to address challenges to scale, such as patient refusals, technical challenges, and payment uncertainty. Policymakers, providers, and researchers will collectively, and as a priority, implement strategies that support sustainable implementation, including policy for long-term payment, support for unpaid caregivers, and standardized research, to maximize the potential of HaH and fundamentally change healthcare's future delivery.

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مراجعة شاملة لنجاح برنامج المستشفى في المنزل في تقديم الرعاية الصحية اليوم

الملخص

الخلفية: الوصف الاجتماعي (Social Prescribing) هو نهج جديد في الرعاية الأولية يهدف إلى تلبية الاحتياجات الاجتماعية والعاطفية والعملية للمرضى (مثل الشعور بالوحدة والصحة النفسية)، والتي لا تستطيع الطب التقليدي التعامل معها بشكل فعال. ونظرا لأن 20% من استشارات الممارسة العامة تتعلق بالاحتياجات الاجتماعية، فإن الوصف الاجتماعي يعد تدخلا مناسبا وملائما في الوقت الحالي.

الهدف: مراجعة تنفيذ الوصف الاجتماعي في الممارسة العامة، بما في ذلك نماذج التطبيق، والنتائج الصحية والرفاهية، والعوامل الميسرة، والعقبات، وقابلية التوسع.

الطرق: وفقا لإرشادات PRISMA 2020 ، أجرينا بحثا منهجيا في قواعد بيانات MEDLINE وEmbase وCINAHL وPsycINFO بالإضافة إلى الأدبيات الرمادية من عام 2000 حتى أكتوبر 2024. تم تلخيص 68 دراسة سرديا باستخدام منهج GRADE والتحليل الموضوعي، شملت مراجعات منهجية، و أبحاث أولية، وتقارير سياسات.

النتائج: تختلف نماذج الوصف الاجتماعي عالميا؛ حيث تعد المملكة المتحدة الدولة الوحيدة التي طبقت نموذج "العامل الرابط" بشكل رسمي، في حين أن كندا وأستراليا لديهما نهج أقل تنظيما. يرتبط الوصف الاجتماعي بتحسن الصحة النفسية، وزيادة الترابط الاجتماعي، وتقليل انعدام الأمن الغذائي، بينما كانت الأدلة المتعلقة بالصحة الجسدية واستخدام الرعاية الصحية متباينة. تشمل العوامل الميسرة التمويل والتدريب، في حين تشمل العقبات تضارب الطلبات على الموارد وفجوات في قاعدة الأدلة.

الاستنتاجات: يعزز الوصف الاجتماعي الممارسة العامة من خلال التركيز على المحددات الاجتماعية للصحة. سيكون التقييم الموحد وتطوير استراتيجيات لتوسيع نطاق البرامج وضمان الوصول العادل أمرا حيويا لتعظيم تأثير جهود الوصف الاجتماعي.

الكلمات المفتاحية: الوصف الاجتماعي، الممارسة العامة، الرعاية الأولية، العامل الرابط، النتائج الصحية.