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Agenda

Day One – Monday, September 28, 2026

7:15am – 8:00am
Conference Registration & Networking Breakfast

8:00am – 8:10am
Chairperson's Opening Remarks

8:10am – 8:50am
Building Your Hospital at Home Implementation Plan
This session will guide attendees through developing customized hospital at home implementation roadmaps tailored to their organization's market position, resources and strategic priorities. We'll discuss readiness assessments evaluating current capabilities in home health partnerships, technology infrastructure, physician engagement and payer relationships. Learn about phasing strategies determining whether to pilot at single sites or implement system-wide, selecting initial clinical conditions to target, and building business cases securing executive sponsorship and capital investment. Topics to be discussed will include:
- Organizational readiness assessments and capability gap analyses
- Staffing models, technology infrastructure plans and budget frameworks
- Implementation timelines with phasing strategies and success metrics

Trupti Kotadia
Senior Director, Strategy, Planning & Business Development
NYU Langone Health

8:50am – 9:30am
Physician Engagement and Clinical Champion Development
Physician buy-in fundamentally determines hospital at home program success since emergency department physicians, hospitalists and specialists control patient referrals driving program volume. Many physicians resist hospital at home initially, expressing concerns about losing

oversight of patients, managing acute conditions outside hospital monitoring capabilities, and liability for adverse outcomes in home settings. Building physician engagement requires addressing legitimate clinical concerns while demonstrating hospital at home's safety, effectiveness and benefits for both patients and clinicians. This session will examine identifying and cultivating physician champions who trial hospital at home with their own patients, document positive outcomes, and advocate to skeptical colleagues. The speaker will explore addressing specific physician objections including concerns about patient selection errors, communication gaps between home-based teams and admitting physicians, and reduced reimbursement when patients avoid hospital admission.

Michael Craig, MD, MPH, SFHM
Associate Medical Director, Advanced Care at Home
UNC Health

9:30am – 10:00am
Networking & Refreshments Break

10:00am – 10:40am
Operational Models: Full Hospital at Home vs. Hybrid Approaches
Hospital at home encompasses diverse operational models ranging from comprehensive programs meeting full CMS waiver requirements to lighter-touch hybrid approaches serving lower-acuity patients with fewer resource requirements. Full hospital at home programs provide three meals daily, twice-daily nursing visits and continuous monitoring for patients meeting strict eligibility criteria and remaining home-bound during treatment. Hybrid models serve patients requiring acute-level care but less intensive support, allowing greater mobility and flexibility while still preventing hospital admissions. This session will explore the tradeoffs, implementation challenges and ideal use cases for each approach.

Jane Mericle, DNP, MHS-CL, RN, CENP
Executive Vice President, Chief Nursing Executive & Patient Operations Officer
Nemours Children's Health

10:40am – 11:20am
Bridging Discharge Gaps: Complex Care Transitions and Palliative Care at Home
Patients discharged from Hospital at Home programs often face complex challenges across multiple medical specialties, which traditional outpatient models struggle to address. The emergence of Hospital at Home infrastructure offers an opportunity to reorganize existing resources into adaptive interdisciplinary team structures designed for complex problem-solving in the home setting. Successful implementation of these teams can promote goal-concordant care and address important post-discharge outcomes in targeted patient and caregiver populations.

Ian B. Kwok, MD
Director, Community Outreach/Education | Palliative Care House Call Program
New York-Presbyterian Hospital

11:20am – 12:00pm

Staffing Models and Workforce Design for 24/7 Care Coordination

Hospital at Home programs don't succeed or scale based on staffing models alone. They succeed based on how well the workforce is designed, deployed, and evolved over time. This session takes a practical, real-world approach to workforce design for 24/7 care coordination, moving beyond theory to focus on decisions leaders must make from launch through scale. We will walk through how to evaluate insourced versus outsourced staffing models and how organizational goals, such as growth, cost structure, and operational control should guide that decision. Attendees will gain insight into building a multidisciplinary care team beyond traditional roles, including clinical and operational coordinators, technicians, EMTs, and leadership support; and when to introduce these roles as patient volumes grow. The session will highlight the importance of clearly defined roles and responsibilities, while acknowledging the reality that early-stage programs require flexibility and role overlap before transitioning to more structured models. We will also explore how to align staff to work at the top of their license to improve efficiency, reduce burnout, and support retention. Practical strategies for team formation, engagement, and maintaining morale in newly formed and rapidly evolving teams will be discussed. Finally, the session will cover workforce scaling tied to patient census, common staffing bottlenecks that limit growth, and proactive strategies such as PRN staffing, float pools, and leveraging existing hospital-based providers. We will also compare decentralized site-based staffing models with centralized command center approaches, highlighting tradeoffs, efficiencies, and opportunities for scale. This session is designed for leaders seeking a practical roadmap to build, adapt, and sustain a high-performing workforce to support 24/7 care delivery.

Siv Velanthottu, MS, RN
Director
Hospital at Home
Northwestern Memorial HealthCare

12:00pm – 12:40pm

Hospital at Home Management of Diabetic Skin and Soft Tissue Infections (SSTI): Surgical and Non-Surgical Care Pathways

Diabetic skin and soft tissue infections (DFIs) represent a common, high-risk condition traditionally managed through prolonged inpatient hospitalization due to concerns for sepsis, limb loss, and need for close monitoring. This session describes how a Hospital at Home (HaH) model can be leveraged to safely manage both surgical and non-surgical SSTIs, including post-debridement and post-procedural recovery, while maintaining clinical quality and patient safety. We present patient selection criteria specific to SSTI in diabetics, including infection severity, vascular status, glycemic control, and social readiness, and outline standardized HaH care plans incorporating daily nursing assessment, wound and surgical site monitoring, antimicrobial stewardship (including IV antibiotics), glycemic management, and rapid escalation pathways. Coordination models between general surgery, vascular surgery, infectious disease, pharmacy, diabetic educators and HaH clinical teams are highlighted, with emphasis on clear ownership of clinical decision-making across settings. Program outcomes are reviewed, including successful completion of therapy at home, avoidance of inpatient days, readmissions, complications such as worsening infection or need for higher-level surgical intervention, and

patient experience. Common challenges—such as evolving wound status, adherence to offloading, antimicrobial access, and clinician comfort with home-based management—are discussed alongside practical mitigation strategies and lessons learned. This session provides a disease-specific framework for adopting SSTI care in diabetic patients within HaH programs and offers actionable insights to support safe expansion of HaH services into complex infectious and post-surgical populations.

Rohan Dwivedi, PharmD, MS
Director, Home Division Operations
Harris Health

Shazia Sheikh, MD
Medical Director, Hospital at Home
Harris Health

12:40pm – 1:40pm
Networking Lunch

1:40pm – 2:20pm
Family Caregiver Support During Hospital at Home
Family caregivers become essential care team members during hospital-at-home episodes, managing medication administration, monitoring symptoms and coordinating with clinical teams—often without preparation or support. This session explores assessing caregiver readiness and capability before hospital-at-home enrollment, providing caregiver training and education on clinical tasks, respite and relief strategies during intensive caregiving periods, connecting caregivers to community resources and support services, measuring caregiver burden and outcomes, and building partnerships with AAAs and caregiver support organizations to wrap services around hospital-at-home patients.

Diane Mariani, LCSW, CADC
Director, Caring for Caregivers
Social Work and Community Health
RUSH University Medical Center

2:20pm – 3:20pm
Panel: Building the Hospital at Home Business Case and Demonstrating Value to Leadership
Securing funding and ongoing support for hospital-at-home programs requires convincing skeptical CFOs, risk-averse boards and cautious payers that home-based acute care delivers measurable value beyond cost savings alone. Panelists will discuss financial modeling approaches that account for capital investment, operational costs and avoided hospitalizations, strategies for payer contracting and reimbursement negotiations, quality and safety metrics that satisfy executive leadership, addressing concerns about liability and revenue cannibalization, and measuring success through patient satisfaction, market differentiation and clinician recruitment in addition to traditional ROI.

Panelists:
Siv Velanthottu, MS, RN
Director
Hospital at Home
Northwestern Memorial HealthCare

Michael Craig, MD, MPH, SFHM
Associate Medical Director, Advanced Care at Home
UNC Health

3:20pm – 3:50pm
Networking & Refreshments Break

3:50pm – 4:30pm
Suzanne B. Schwartz, MD, MBA
Director – Office of Strategic Partnerships & Technology Innovation (OST)
Center for Devices & Radiological Health (CDRH)
U.S. Food and Drug Administration

4:30pm – 5:15pm
Strategies When Hospital At Home Programs Are Not Available
In the Chicagoland Area, hospital systems are overwhelmed with ER wait times of 8-12 hours and ICU patients holding in ERs for 1-2 days before transfer. Despite dire need for Hospital at Home programs, they have yet to materialize in Chicago likely due to staffing challenges, lack of supportive caregivers and other barriers. As a result, patients are hospitalized for chronic condition exacerbations and discharged earlier due to insurance mandates, leaving them vulnerable to readmissions. Heroes Home Health has successfully integrated services to bridge this gap including visiting physician groups (within 48 hours of discharge), visiting wound care providers, mobile laboratory services, and pharmacy delivery at no cost to patients. These partnerships allow hospitals to discharge patients safely, decrease readmission risk and prevent serious safety events from premature discharges. Heroes Home Health also partnered with Chicago's Department of Aging to expedite homemaker services and provide one-time monetary assistance for medical supplies not covered by insurance. Results demonstrate 81.6% of patients remained in the community after home health discharge (versus 77.7% national average), 4.5% were readmitted for potentially preventable conditions (versus 4.1% national average), and 10.7% were admitted for potentially preventable conditions while receiving home health (versus 10.8% national average). This session will discuss how these partnerships were started, integrated and sustained, including obstacles encountered and strategies for success.
Tricia McVicker, JD, BSN, RN
Agency Supervisor/Director of Nursing
Heroes Home Health

5:10pm
End of Day One

Day Two – Tuesday, September 29, 2026

7:15am – 8:00am
Networking Breakfast

8:00am – 8:15am
Chairperson's Remarks

8:15am – 9:00am
Integrating EMS Personnel into Hospital at Home Models
Emergency Medical Services (EMS) personnel, especially paramedics, are increasingly being integrated into non-traditional healthcare settings, including hospitals, community clinics, mobile health programs, and hospital-at-home models. Their broad clinical training and ability to deliver care in dynamic environments make them valuable members of interdisciplinary care teams. However, effective integration requires a clear understanding of how EMS personnel are trained, how their scope of practice is defined, and how credentialing varies across states. While many paramedics obtain national certification through the National Registry of Emergency Medical Technicians, each state independently determines what EMS clinicians are authorized to do in practice. This leads to important differences in skills, procedures, and responsibilities across states. Understanding these elements will help healthcare organizations better align expectations, optimize workforce utilization, and incorporate EMS personnel into hospital at home settings.
Sarah Rivenbark
Manager, Mobile Integrated Health / Community Paramedicine
Novant Health New Hanover Regional Medical Center

9:00am – 9:45am
Patient Selection Criteria: Identifying Who Benefits Most from Hospital at Home
Successful hospital at home programs depend on selecting appropriate patients who can receive acute care safely at home while excluding those requiring hospital-based monitoring and interventions. CMS waiver criteria provide baseline eligibility requirements, but effective programs develop nuanced selection frameworks balancing clinical appropriateness, social support adequacy, home environment suitability and patient preference. This session examines clinical conditions commonly treated in hospital at home settings. The speaker will explore assessing home environment factors including reliable electricity for medical equipment, adequate space for nursing visits, safe medication storage and family or caregiver presence when required. Learn about developing screening workflows in emergency departments and inpatient units that identify eligible patients early, building patient and family education approaches addressing common concerns, and creating escalation protocols for patients whose conditions deteriorate requiring hospital transfer.
Clare Park, DO
Medical Director – Hospital at Home
URMC Strong Memorial Hospital

9:45am – 10:15am
Networking & Refreshments Break

10:15am – 11:00am
Hospital at Home for All
Hospital at Home for All explores how hospital-at-home models can be intentionally designed and implemented to promote health equity rather than reinforce existing disparities. This session will examine the evolution of the hospital- at-home model, discuss the structural, social, and technological barriers that limit access for patients, and highlight practical strategies health systems can use to expand eligibility, adapt care models, and measure equitable impact. Through real-world examples and policy considerations, the talk will emphasize how equity must be a core design principle if hospital-at-home programs are to truly serve all patients.
Nkemdilim Mgbojikwe MD SFHM
Associate Chief Medical Officer
Associate Professor of Medicine
Fox Chase Cancer Center- Temple Health

Stephanie Murphy, DO, FHM
Associate Medical Director, Transitions of Care
Devoted Health

11:00am – 11:45am
Partnerships with Home Health Agencies: Build vs. Partner Decisions
Hospitals launching hospital at home programs face fundamental decisions about whether to build internal capabilities with hospital-employed staff or partner with established home health agencies possessing existing workforce, infrastructure and expertise in home-based care delivery. Each approach offers distinct advantages and challenges affecting implementation speed, program control, quality consistency, financial performance and scalability potential. Topics to be discussed will include:

- Hospital-employed staff models offering maximum control versus partnership approaches
- Implementation speed, upfront investment and operational complexity tradeoffs
- Quality oversight mechanisms and cultural fit considerations
- Financial structures including cost sharing and revenue distribution arrangements

Lia Smith-Pratt
CEO
A Better Solution, Inc.

11:45am – 12:30pm
Introduction to an Innovative Community Resource to Support African American (AA) Caregivers' ADRD Care Choices
This session will focus on learning about the development of a community based program to support AA caregiver's in dementia care decisions for their loved one. Learning objectives:

- Gain insight of disparity in EOL decision focus of African Americans living with ADRD.
- Understand themes of importance in the decision-making framework of AA caregivers of loved ones with advanced dementia.
- Review an innovative resource for supporting caregivers of diverse populations living with ADRD.

Shellie Nicole Williams, MD, FAAHPM
Associate Professor of Medicine
Pritzker School of Medicine
Director ADRD Education for SHARE Network
University of Chicago

12:30pm
Conference Concludes

12:45pm – 2:45pm
Workshop
Beyond the Episode: Building an Integrated Hospital-at-Home & Aging-in-Place Model
As hospital-at-home programs scale under the Centers for Medicare & Medicaid Services waiver extension, organizations must move beyond episodic care delivery and design models that support patients long after discharge. This highly interactive workshop guides participants through building a fully integrated hospital-at-home ecosystem—connecting acute care with housing, caregiving, community services, and long-term aging-in-place strategies. Attendees will actively map their current-state gaps, design cross-sector partnerships, and leave with a customized action plan.

Workshop Format & Experience
This is not a lecture. It is a working session where participants actively build solutions in real time.

- Small group breakouts
- Guided worksheets and ecosystem mapping tools
- Real-world case scenarios
- Facilitated peer discussion and problem-solving
- Live polling and rapid feedback loops

Learning Objectives
By the end of this workshop, participants will:

1. Map the full hospital-at-home care continuum beyond discharge
2. Identify breakdown points in care coordination and transitions
3. Design partnerships with aging services, housing, and community organizations
4. Build a practical, organization-specific integration roadmap

Tara Ballman
Executive Director
National Aging in Place Council

Israel Cross
President

National Aging in Place Council

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