

COMMENTARY

Advancing the Future of “Care Without an Address”: Recommendations from International Health Care Leaders

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The demand for home- and community-based care will intensify across the world as populations age and technological advancements support innovative delivery approaches. The Future of Health, an international community of senior health leaders, collaborated with the Duke-Margolis Center for Health Policy to identify what priority actions health delivery organizations and policy leaders can take to implement the “Care Without an Address” model — a fundamental paradigm shift where care is centered around the patient in a comprehensive, coordinated manner regardless of location. This article describes recommendations, which the authors derived through a consensus-building exercise and supported with a targeted literature review and an expert discussion group. The four major action areas include: promoting a vision and strategy to achieve Care Without an Address; establishing partnerships with innovative “insurgents” operating outside the traditional clinical setting to build and expand models; investing in the workforce to support new ways of delivering care; and developing standards to ensure high-quality care across sites. However, questions remain as to whether this is sustainable and whether traditional brick-and-mortar institutions, or alternatively new market entrants, will drive this change.

Why the “Care Without an Address” Transformation Is Needed

Across the world, new approaches for delivering care outside bricks-and-mortar clinical settings rapidly expanded during the Covid-19 pandemic. For instance, telehealth rates increased globally¹

(though usage has levelled off,^{2,3} and may decline further) and home-based acute care programs such as Hospital at Home spread broadly to move care out of inpatient facilities.^{4,5}

Care Without an Address modalities are diverse. They can include home visits, assistance with activities of daily living, home-based primary care, as well as technology-enabled remote care and other services that bring care to meet people where they are (e.g., community paramedicine).

Despite the recent growth, there remains a significant mismatch between the need for and supply of services delivered outside of clinical settings. For instance, only 11% of the homebound population in the United States — those with functional impairments limiting their ability to leave their homes to access care — received home-based primary care prior to the Covid-19 pandemic.⁶ Barriers include geographic limitations such as rural location.⁷ Addressing this gap is increasingly important given the aging global population.

Other factors supporting this transformation include patient preference for home- and community-based care,⁸ technological advancements to support new approaches for where care can be delivered, and the fact that delivering care in less resource-intensive settings can enable health systems to reduce health expenditures.^{9,10}

To help close the demand gap, innovators are emerging to make health care more accessible, convenient, and affordable. These organizations are focused on streamlining care delivery through new technologies, systems, or products, such as direct-to-consumer offerings.

As the location of care continues to shift beyond the facility setting, there is a path for traditional brick-and-mortar institutions to support new modalities, aligning or competing with innovative market entrants that are disrupting the traditional hospital-centric care delivery model.

Health delivery organizations, particularly hospitals, are at a crossroads in this shifting paradigm as they consider how to succeed in the emerging Care Without an Address ecosystem. How do leaders of traditional, facility-based institutions galvanize the move to a future where the traditional model is no longer the center of gravity? How can leading health delivery organizations drive this change?

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While there is debate about who should spearhead this transformation — provider, payers, policy makers, or technology innovators — health delivery organization leaders, working in collaboration with all these stakeholders, have a unique opportunity to leverage this momentum to redesign both where and how care is delivered.

[Future of Health](#) (FOH), an international community of senior health leaders — including hospital executives, policy makers, academics, payers, and senior-level health sector leaders — sought to identify how Care Without an Address will reshape traditional institutional-based care and what actions leading health delivery organizations can take to accelerate this transformation. FOH identified four major steps, described below, that health care organizations and policy makers should consider to support this site-of-care shift.

FOH members recognize the need for incumbents to integrate home-based alternatives into the broader care delivery approach to respond to market trends associated with an increasingly aging population and to drive innovation. If they respond proactively, the “first mover” advantage can give health systems the ability to outmaneuver potential competitors and ensure a more secure market position. But this comes with the risk of providing significant upfront capital with no guaranteed pathway to growth.

While the majority of FOH members have implemented some type of Care Without an Address modality — typically telehealth and home-based acute care — further progress is partly limited due to significant workforce shortages and incompatible payment models. Achieving the full potential of Care Without an Address will depend not only addressing these barriers, but also on choosing whether to develop new capabilities in-house or partner with innovators that are in some cases less resourced than traditional care delivery organizations.

As one FOH participant said: “Care Without Address is the biggest threat (to) ourselves. So what do we do? Can we ... eliminate or cut the branch that we sit on? To work against our incentives? We have to.”

This article provides an overview of the current modalities in Care Without an Address, then focuses on immediate steps for health delivery organization leaders to accelerate and expand this transformation.

How FOH Developed Its Recommendations

The Future of Health (FOH) was established in 2018 as an initiative by Sheba Medical Center in Ramat Gan, Israel, and incorporated in 2022, with headquarters in Washington, D.C. FOH is an international community of more than 50 members driving health care technology development, venture funding, insurance, and risk management across the world.

Every year, the FOH executive committee selects three topics and considers how health delivery organizations can advance health and health care within each topic. In 2022, Care Without an Address was one of the topics selected by the executive committee. The Duke-Margolis Center for Health Policy collaborated with FOH to assist with qualitative research and analysis.

Research activities included a targeted review of key themes from peer-reviewed and gray literature and qualitative analysis of three discussion groups with health care experts — including academic researchers, providers, health delivery organization leaders, payers, and commercial vendors — to understand areas of consensus and disagreement among FOH members.

Expert-focused discussion groups were conducted virtually between June 2022 and August 2022. The annual summit took place in October 2022 in Jerusalem, Israel, featuring discussions and priority-ranking exercises to refine recommendations, in which several of the authors participated. This paper synthesizes topics and actions that FOH leaders identified as important for advancing Care Without an Address.

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Current Status of Care Without an Address Models Among FOH Members

FOH members have launched a variety of Care Without an Address modalities. Multiple members are implementing technology-enabled services such as telehealth and remote patient monitoring. Some members are offering home care services (e.g., infusion), home- and community-based services (e.g., assistance with daily living), and community paramedicine models (e.g., assessing patient safety and screening for chronic diseases).

Reasons for implementing Care Without an Address modalities varied, driven in part by local market demands, technological capabilities, and financial considerations. Members noted that while the shift to deinstitutionalization could reduce inpatient revenue in the short term, there are long-term financial rewards for lowering the use of acute care for non-acute patients and providing care closer to the home, where patients want to be.

Key barriers FOH members face in implementing Care Without an Address modalities include insufficient staffing, change management issues (e.g., physician resistance), and unsustainable reimbursement models.

These modalities are often organized and delivered as stand-alone services. Integrating the various subsegments, including physical, mental, and social needs, into a comprehensive ecosystem can provide a seamless experience for the patient. However, limited instances of full-scale integration across modalities exist.

One example of integration is Beth Israel Lahey Health’s Continuing Care program, which includes home care, hospice, palliative care, assisted living, and skilled facility services. These initially existed as discrete service lines that Beth Israel Lahey eventually consolidated into the Continuing Care platform. That platform supported the organization’s efforts to implement a new Hospital at Home program.

Action Steps for Speeding the Transition to Care Without an Address

To foster systemwide transformation and achieve person-centered care, FOH members identified four key action areas that health delivery organization leaders and policy makers should prioritize.

Promote a Vision, Strategy, and Action Plan for Care Without an Address

It is paramount that health delivery organization leaders define a vision for how their institutions will deliver Care Without an Address. This vision should serve as a North Star for care transformation efforts and galvanize staff to overcome conservative views slowing adoption of new care modalities. Leaders can demonstrate the value of new care modalities and their ability to improve traditional care models, clarify how services will be integrated into the larger care ecosystem, and identify how the health system will foster collaborative partnerships with outside organizations. Health delivery organization leaders should then garner buy-in across key stakeholder groups. While patient satisfaction with digital health and home- and community-based care is often high, enthusiasm may be less widespread among physicians and other health professionals.

Reasons for the lesser support among health professionals include concerns about increased administrative and technological burdens (e.g., poor design interface, Internet access issues, intensive learning curve); skepticism that these new modalities will lead to comparable or improved outcomes; lack of comfort in treating patients without face-to-face contact; and concerns with long-term financial sustainability (e.g., fear of lower income associated with reduced in-person visits). Additionally, some providers may feel that these new modalities change the provider-patient relationship, because patients gain new options for where, when, and how they receive care, no longer being limited to seeing providers on their home turf.

The ways in which FOH members have addressed these concerns demonstrate potential paths forward for other health systems. One approach is to involve providers in the design of new programs, which can increase physician satisfaction with new modalities like telehealth.¹¹

For example, during the early stages of the pandemic, Jewish General Hospital of CIUSSS du Centre-Ouest de l'Île de Montréal in Canada tasked physicians and nurses with setting up a Hospital at Home program to prevent surgical bed closures during the surge in hospitalizations. With access to upfront resources and autonomy in designing the program to meet clinical needs, hospital staff succeeded in setting up the program in 3 days.

The larger challenge came in gaining support for the concept from the broader CIUSS clinical community, as physicians were reluctant to refer patients to the new Hospital at Home program. To address this, health system leaders held regular meetings with physicians, nurses, and division and department chiefs, and involved senior leadership including board members. These meetings, in conjunction with vocal support from the provincial Ministry of Health, began to break down most barriers.

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Health delivery organization leaders also must invest in the infrastructure necessary to support Care Without an Address. This is a common barrier to entry, because extending a health system’s footprint into home and community settings requires significant resources. This includes data systems that allow for timely sharing of patient data across care settings, technology that supports remote patient monitoring, and a workforce trained to use new technologies.

One approach to limiting upfront costs is repurposing existing infrastructure. For example, Beth Israel Lahey Health leveraged its long-standing Health at Home program to support a Hospital at Home program. Its approach reorients the existing Health at Home workforce (e.g., hospitalists) and community paramedics to facilitate Hospital at Home. This also serves as a way to enhance coordination and care continuation rather than implementing a separate service line.

Partner with External Innovators

The relationship between health care incumbents and external innovators exemplifies the crossroads that many health care organizations face. As disruptors of the status quo, innovators could represent a competitive threat to incumbent institutions, because they are unburdened by legacy business models and the fixed capital costs of hospital-centric health systems. Yet most FOH members believe this perspective is wrong and even counterproductive.

First, incumbent health delivery organizations on their own generally lack the expertise and infrastructure needed to deliver and pay for care outside the clinical setting. Second, incumbents and innovators come to the table with unique but complementary capabilities that could lead to synergistic collaboration in meeting patient needs.

Although incumbent institutions are typically less experienced in home-based care, they have significant resources, infrastructure, and capabilities to support nimbler but less-resourced innovators. And while innovators often can focus solely on scaling a specific service line, incumbents are more mature players that have the natural advantage of existing patient, provider, and payer networks to quickly scale.

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FOH members highlighted several considerations in building partnerships between incumbents and innovators and otherwise advancing Care Without an Address. First, partnerships should focus on accelerating an innovation's time to market. It can take 2 years for hospitals to contract with a digital health company and bring a new product to market. Yet, as the pandemic demonstrated, care delivery changes that normally took years were deployed in a matter of weeks.

Sheba Medical Center, Israel's largest hospital, launched a virtual and home-based hospital, Sheba Beyond, within a matter of days due to the exigencies of the pandemic. Sheba rapidly implemented the virtual hospital model by partnering with innovators that were developing technology systems, such as TytoCare, to bring care to patients.

For example, Sheba Beyond partnered with a network of nursing homes in Raanana, Israel. It had nursing home staff conduct patient exams using TytoCare's digital technologies — including a digital stethoscope, otoscope, thermometer, and tongue depressor. That enabled Sheba Medical Center's supervising physician to provide technology-enabled hospital care to patients residing in a nursing home.¹²

Different permutations of innovative partnerships — contracting with a third-party entity, acquiring a third-party entity, or developing capabilities in house — occurred at health systems worldwide. The operational assets and expertise of incumbent health delivery organizations influence partnership needs and strategies. Additionally, there may be more of a role for contractual partnerships during initial implementation, and that could diminish as health delivery organizations gain experience and learn to innovate in house. Strategic best practices should be synthesized into a playbook to accelerate future collaborations.

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A second consideration in partnerships is that health delivery organizations should build on their data infrastructure to drive delivery innovation and support care coordination as non-facility-based care grows. The shift to Care Without an Address is already ushering in a new information frontier as new data sources (e.g., patient-reported data) and new ways of capturing data (e.g., remote patient monitoring) are brought online. Hospitals can now use patient-generated data to remotely assess a patient's risk status for hospitalization, potentially avoiding downstream complications.

For example, Sheba Beyond leverages an array of new technologies and data sources to support virtual hospital care across the continuum of care, from preventive services (e.g., remote patient monitoring tools that can anticipate patient deterioration) to post-discharge support (e.g., tools that support patient medication adherence).

Whether health delivery organizations develop these capabilities in-house — as Sheba did — or partner with external innovators, they must ensure that collecting and sharing information

supports the patient's journey across the care continuum. And they must do so without jeopardizing data privacy or worsening the problem of information silos.

A third consideration is that health delivery organization leaders should advocate for policy and payment reforms that reduce impediments to Care Without an Address. In response to the pandemic, many countries authorized temporary regulatory flexibilities that helped advance Care Without an Address, such as expanding scope of practice regulations and reimbursement for virtual care. Yet policy makers remain concerned that permanently authorizing these flexibilities at parity with facility-based treatments may increase total health spending without leading to improvements in patient health.

Health delivery organization leaders can allay these concerns by working to develop a robust evidence base demonstrating the efficacy and cost-efficiency of new care models, given that the current evidence base, though positive, remains limited.¹³ Policy makers also should ensure that cost savings achieved from shifting care to lower-cost settings — such as moving acute-level care into the home setting — should be shared across the broader health system to help reduce health care spending.

It's essential that health delivery organization leaders support broader adoption of population-based payment models that encourage delivery of care in the manner that achieves the best patient outcomes and experience, agnostic of setting. Volume-based payment models such as fee-for-service are typically facility-centric. Population-based models (e.g., risk-adjusted per-member per-month payments) can give providers the flexibility to deliver care where appropriate based on an individual's need.

For instance, one FOH member was able to pilot a remote monitoring device for its Medicaid population under a per-member per-month payment model. It would have been nonreimbursable under fee-for-service. According to that FOH member, this enabled clinicians to more easily observe children's symptoms, such as wheezing, because the children were calmer at home than in the doctor's office. Clinicians can provide better and more equitable care when they don't have to worry about getting paid for each individual intervention, the participant added.

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Invest in the Care Without an Address Workforce

To achieve the full potential of Care Without an Address, health delivery organization leaders must invest in a workforce capable of responding to new ways of delivering care. For instance, Care Without an Address requires an interdisciplinary and expanded clinical team with everyone working at the top of their license, augmented by emerging digital and analytic technologies. As

FOH previously noted,¹⁴ technological advancements can introduce new efficiencies and support new staffing models that extend the clinical setting and care team.

This has profound implications for what the workforce of the future looks like and what will be needed to deliver comprehensive, person-centered care. At the same time, the pandemic exacerbated workforce shortages, which underscored the urgency of investing in a more productive and diverse health care labor force. While long-term support is needed to rectify the gap between worker supply and demand, there are priority actions that health system leaders can take to bolster the workforce in the near term and equip the labor force to support Care Without an Address.

First, the current and future workforce must reflect the requisite skills for greater productivity and patient impact in delivering care in alternative settings. Health delivery organization leaders should strategically target the cohort of staff willing to adapt and propel reforms, rather than those who are resistant. This can be seen in Beth Israel Lahey Health's approach to leverage its home health workforce to facilitate the Hospital at Home program.

Further, health delivery organizations should leverage nonclinical staff such as community health workers, augmented by remote monitoring technologies and clinical decision support tools, to deliver services at home. That can help maximize the performance of the existing workforce and ensure efficient use of clinical expertise.

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Second, the health care workforce must be equipped to provide equitable, culturally competent care for communities that historically have faced significant access barriers. This will become particularly salient as providers increasingly work with patients in the home setting. It is crucial to make sure family caregivers are not additionally burdened with care responsibilities as care is shifted to home settings.

To help strengthen the provider-patient relationship, leaders can invest in resources that teach professionals how to understand the complex social context of their patient population and respond to the cultural sensitivities and preferences of each patient. This also underscores the importance of hiring health care providers from the communities their organizations serve, which both fosters trust and alleviates workforce shortages by expanding the applicant pool. Incumbent organizations have an opportunity to tap into this applicant pool by collaborating with new market entrants around community engagement and innovative recruitment strategies.

Third, educational reforms can help develop health care teams with the capabilities to deliver Care Without an Address, by relying on competency-based education. The responsibilities and competencies needed for staff to deliver Care Without an Address safely, effectively, and efficiently should be developed and incorporated into clinical and allied health professional training. Medical schools could offer home-based care curricula.

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Community-based certification and degree programs also could help expand career opportunities and standardize training for allied health professionals, community health workers, direct care workers, and family caregivers at a relatively low cost. An example is training for community paramedicine, which is used globally to fill care gaps and bring care to patients, and is associated with reduced emergency department visits, hospitalizations, and costs.¹⁵

The International Roundtable on Community Paramedicine convened representatives from the United States, Canada, Australia, and the United Kingdom and developed a [Community Paramedic Clinician Curriculum](#) that now is used globally. Although community paramedicine programs are limited among FOH members, they are a promising solution for extending the reach of health care providers.

Establish Standards that Ensure the Quality of Care Without an Address Models

Incumbent organizations should lead the way by generating a robust evidence base and performance measures for Care Without an Address. There is currently a dearth of evidence and standardized care delivery protocols in Care Without an Address, which jeopardizes patient safety and undermines future support for transitioning to care outside of facilities. However, there are efforts to enhance research and establish standards across modalities.

For example, the Community Health Accrediting Partners — an accrediting body for care and services delivered in the home, such as home health, palliative care, and home infusion — is working to [develop a certificate program](#) for home health care that advances age-friendly health systems. Health delivery organization leaders can continue to fill this gap by designing, testing, and documenting ways to improve existing Care Without an Address modalities and standardize clinical guidelines.

As one FOH participant said: “We need objectivity and standardization on quality and accreditation. It’s a little bit of a Wild West right now.”

Leaders should begin with implementing patient-centered and patient-reported quality measures. The transition from facility-based to patient-centric care requires corresponding quality measures that reliably capture patient values, preferences, and goals. Quality standards could be adapted from facility-based care and informed by existing home- and community-based care modalities.

These measures should be informed by patients and their caregivers, to ensure patient-centeredness. Health delivery organizations and policy makers can use these measures to monitor use and assess quality of Care Without an Address services, including telehealth and home-based care referrals. These measures should focus on patient well-being, safety improvements, risk reduction, continuity of care, and health equity.

Policy makers should establish quality standards for Care Without an Address through reforms in national performance measurement and improvement strategies that are site-agnostic, accompanying site-agnostic payment reforms. Efforts should include moving toward new measures that consider functional status, functional outcomes, and patient-reported outcome measures (PROMs).

The U.S. Centers for Medicare & Medicaid Services (CMS) has started to use PROMs derived from patient-reported outcomes.¹⁶ CMS also has started using patient-reported outcome-based performance measures, such as the Functional Status Assessment for Total Knee Replacement in Merit-Based Incentive Payment System Program.

However, health leaders should continue to engage patients and caregivers in measuring the impact of care on outcomes that matter to patients, particularly those who are homebound and have more serious illness, to inform standards for Care Without an Address.

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Surmounting Challenges on the Transformation Journey

Though the shift to deinstitutionalize health care preceded the pandemic, the crisis accelerated innovative solutions for where care could be provided. Nevertheless, it remains an open question whether these solutions are sustainable and whether traditional brick-and-mortar institutions will drive this change.

At the October summit, FOH members considered factors that may impede the success of Care Without an Address. First, macroeconomic volatility and a tightening fiscal environment have created financial headwinds that could lead health systems to deprioritize site-of-care changes. Lower operating margins may become a new normal for health systems facing chronic workforce shortages, higher labor expenses, supply chain issues, increased interest rates, and decreasing inpatient revenue.

On the other hand, these financial pressures create an opportunity for incumbents to recalibrate delivery models that are less dependent on inpatient revenue and responsive to changing patient preferences for home- and ambulatory-based care.

For innovator organizations, the tightening financial environment and an increasingly competitive market could hurt them, potentially decelerating the shift to Care Without an Address. FOH members recognize that innovators are critical partners to successfully expand their footprint

beyond the four clinical walls. Incumbents should evaluate where they can use the expertise of external innovators, rather than attempting to deploy their own processes.

As one FOH member said, “How do we align with the innovators and in a macroeconomic environment where it’s getting very inhospitable and we’re seeing capital dry up? A lot of these companies are going to go away, and I think that’s a net loss. It’s up to the incumbents ... to really reach out to these companies.”

Another big challenge is that adoption of value-based payment models remains limited. While value-based payment models can better support the shift to Care Without an Address, health systems remain largely entrenched in the fee-for-service payment chassis. FOH members believe that payment reform can accelerate Care Without an Address and that policy makers, payers, and providers should continue to push hard for payment reform.

An additional concern is that deinstitutionalization could exacerbate social inequities. While it has the potential expand access to care, it also could entrench and worsen disparities in a variety of ways. Shifting care to the home setting could disproportionately burden households without the capacity to care for individuals in the home setting, as many individuals are unable to pay for home care or lack informal caregiver support. Sending patients back into the home also could exacerbate patients’ medical conditions (e.g., inadequate heating and ventilation systems could trigger asthma) or place patients in danger due to living conditions (e.g., domestic violence).

To address these risks, public programs can strengthen supports for informal and direct care workers. Payers can leverage financing and payment strategies to provide direct financial support and reduce caregiver burden. To evaluate the quality and capacity of care for community-dwelling beneficiaries, standardized home assessments should assess living conditions, patient safety, and caregiver need.

Beyond that, payment models should be linked to quality and performance metrics to ensure that all communities have equal access to high-quality care, whether in the facility, home, or virtual setting.

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