

# Hospital-at-Home Platform — Readiness Checklist

Pressure-test a hospital-at-home or care-coordination build before launch. Engineering guidance, not legal advice — confirm specifics with counsel.

## COORDINATION & MONITORING ENGINEERING

- One shared care plan, not a chat.** The care team and treatment plan are modeled as structured FHIR CareTeam and CarePlan resources with an audit trail — a shift handoff transfers a record, not a scrolled chat history.
- Command center is a clinical ops hub.** Live dashboards rank patients by risk, alerting separates a real deterioration from a dropped sensor, one-tap video reaches any home, and dispatch is wired to field staff with current location and availability.
- The 30-minute loop closes.** Reading → alert → clinician assessment → dispatch fits inside 30 minutes, with platform time budgeted (e.g. ~6 min) leaving the rest for travel. Coverage geography, not screen design, sets where you can safely enroll.
- Device fleet is managed as logistics.** Every kit is tracked, paired to the right patient without on-site IT, ingested reliably over a flaky home connection, and flagged when it goes silent. Reverse logistics (retrieve, clean, reset) is built, not improvised.
- HIPAA availability built in.** Availability is a Security Rule goal (45 CFR §164.306(a)) with a required contingency plan (§164.308(a)(7)) and emergency-access procedure (§164.312(a)(2)(ii)). A dark command center is an outage AND a compliance failure.
- BAA across the whole data chain.** Every reading is PHI from the device onward; the connectivity provider, device vendor, and every integrated system are under a signed Business Associate Agreement (45 CFR §164.502(e)). Encrypted is not the same as compliant.

## THE ONE TEST BEFORE LAUNCH

Simulate a 2 a.m. deterioration for an enrolled patient and prove the loop closes inside the clock: a falling vital surfaces on the command-center dashboard within seconds; the on-call clinician opens video to assess; the decision and a dispatched visit are recorded against the shared care plan; a paramedic can physically reach the home inside 30 minutes from where you enroll; the EHR is updated over FHIR; and every party that touched the reading — connectivity provider, device vendor, integrated systems — is under a BAA. If any step fails, the product is not ready: in hospital-at-home the failure is an acutely ill patient at home with no nurse in the next room.

## CLINICAL FIT, INTEGRATION & COMPLIANCE

- Waiver rules map to features.** Admission only from ED/inpatient bed after in-person physician eval; daily RN evaluation; two daily in-person visits (RN or community paramedic); immediate on-demand audio. Each rule is a system requirement, not a policy footnote.
- Reimbursement framed correctly.** The CMS Acute Hospital Care at Home waiver pays the inpatient rate and was extended through 2030-09-30 (Consolidated Appropriations Act, 2026 — re-verify the law number and date). State and payer rules still vary.
- Deep integration is scoped from day one.** EHR over FHIR (admissions, orders, notes), pharmacy, labs/imaging back, device logistics, paramedic dispatch. Integration count — not the video feature list — sets cost and timeline. Scope from the integration map outward.
- FDA device line is held.** Monitoring hardware is an FDA-defined device (FD&C; §201(h)); software that displays a reading is safe, software that automatically decides what it means may be regulated decision support. Treat the FDA pathway as in scope.
- Devices and connectivity are covered.** Cuff, pulse oximeter, thermometer, scale, single-lead monitor, cellular hub — each an FDA-regulated device, each reading PHI. Battery/connectivity failure is a clinical blind spot, not just an IT ticket.
- Roles and consent are explicit.** Physician, day/night nurses, community paramedics, pharmacist, logistics, and family caregiver each have a typed role under minimum-necessary access. The patient and caregiver know who is responsible at any hour.