

# The "Hospital-at-Home" Revolution

FORTIS & PEAK PERSPECTIVES | APPLIED FORESIGHT

The Hospital-at-Home (HaH) Revolution has reached its clinical and regulatory tipping point. What was once a pandemic-era pilot is now a permanent, five-year legislated pillar of the modern health system, following the landmark **Consolidated Appropriations Act of 2026**, which extended the acute hospital-at-home waiver through 2030.

For Fortis & Peak, this is the "**Distributed Hospital**" model—a decisive move from centralized, high-overhead facilities to a decentralized, tech-enabled clinical network that redefines where and how acute care is delivered.

# The Distributed Hospital: A New Paradigm

2026

## Legislative Milestone

Consolidated Appropriations Act extends the HaH waiver through 2030, cementing permanence.

32%

## Cost Savings

Average cost per episode drops from \$10,000 (inpatient) to \$6,800 under the HaH model.

85%

## Staffing Delays Reduced

Blockchain credentialing slashes staffing-related admission delays across virtual bed capacity.

90%

## Lower HAI Rates

Hospital-acquired infection rates are 90% lower in HaH programs versus inpatient wards.

These headline figures represent the core value proposition of the Distributed Hospital model—a system where clinical outcomes improve, costs fall, and capacity becomes virtually unlimited. The following sections unpack the three pillars that make this possible.

# Pillar 1: The Digital Safety Net – AI-Triage & Biometric Fidelity

## CONTINUOUS CLINICAL STREAM

The 2026 HaH model is powered by a **Continuous Clinical Stream**. We no longer rely on twice-daily nurse visits; the patient is under 24/7 autonomous surveillance through a layered stack of intelligent sensing technologies.

### The Multimodal Patch

Patients wear a single, medical-grade adhesive patch combining continuous single-lead ECG, respiratory rate, and skin temperature monitoring. Unlike 2024 wearables, these 2026 devices are **AI-Edge enabled**—processing data locally to filter noise and alert the command center only for true physiological deviations.

### Ambient Fall Intelligence

Radar-based (non-camera) sensors equip bedrooms to detect falls or "near-fall" gait changes without compromising patient privacy. This is critical: falls drive **84% of adverse events** in traditional hospital settings, making passive, privacy-safe detection a clinical imperative.

### Predictive Triage

AI agents in the "Virtual Ward" analyze the delta between a patient's live vitals and their unique baseline. By identifying a **2% drift in oxygen saturation over six hours**, the system can trigger a nebulizer treatment at home 4 hours before the patient would have felt short of breath—turning reactive care into proactive intervention.

# Pillar 2: Clinical Portability – The Blockchain "Passport"

## The Problem It Solves

In 2026, the shortage of specialized clinicians has been solved by **Global Clinical Portability**. Traditional credentialing delays—often months long—are eliminated through blockchain-verified digital identities that are untamperable and globally recognized.

This enables hospitals to "rent" world-class expertise to manage their home-based census almost instantly, scaling virtual bed capacity without bureaucratic friction.

## How It Works

**Verifiable Credentials:** A specialist's board certifications, surgical history, and current licenses are stored as blockchain-verified digital credentials, checkable in seconds rather than months.

**The "Follow-the-Sun" Model:** A specialist in London can monitor a HaH patient in the United States during the US night shift. Because credentials are globally recognized, geographic boundaries no longer constrain clinical expertise.

**The Impact:** Staffing-related delays in HaH admissions have been reduced by **85%**, allowing hospitals to scale their virtual bed capacity almost instantly and respond to patient demand in real time.

# Pillar 3: The "Fortis" Advantage – Neutralizing Hospital-Acquired Risks

## CLINICAL & FINANCIAL FORTRESS

The financial and clinical fortress of HaH is built on the elimination of the hospital environment itself—removing patients from the very setting that generates the most preventable harm. Three distinct risk categories are neutralized at home.

### Decimating HAIs

By keeping patients out of the hospital, HaH eliminates exposure to multi-drug resistant organisms (MDROs). In 2026, HaH programs report a **90% lower rate** of hospital-acquired infections compared to inpatient wards—one of the most dramatic quality improvements in modern medicine.

### The Delirium Buffer

For elderly patients, the hospital environment is clinically "toxic." Lights, noise, and unfamiliarity trigger delirium in nearly **20% of surgical patients**. At home, surrounded by family and familiar routines, delirium rates have plummeted by **60%**, significantly lowering the risk of long-term cognitive decline and nursing home placement.

### Recovery Velocity

Patients are more mobile in their own homes—walking to their kitchen rather than remaining in a hospital bed. This drives **25% faster muscle function recovery**, lower 30-day readmission rates, and consistently high patient satisfaction, with NPS scores for HaH programs above **85**.

# The Fortis & Peak "Distributed Care" ROI

The financial case for Hospital-at-Home is unambiguous. Across every key performance metric, the 2026 HaH model outperforms traditional inpatient care—delivering superior outcomes at substantially lower cost, with elastic capacity that breaks the physical constraints of brick-and-mortar facilities.

Metric	Traditional Inpatient	Hospital-at-Home (2026)
Cost per Episode	\$10,000 (Avg)	\$6,800 (32% Savings)
Length of Stay	5.0 Days	3.2 Days (Targeted)
Patient Satisfaction	65% (Anxious)	88% (Comfortable)
Bed Capacity	Fixed by Physical Walls	Elastic / Virtually Unlimited

The 32% cost reduction per episode, combined with a 36% shorter length of stay and a 23-point improvement in patient satisfaction, represents a compounding advantage. As HaH census scales, the fixed-cost leverage of the virtual infrastructure grows—making the model increasingly profitable at volume.

# Strategic Recommendation: Building the HaH Value Dossier

## PAYER-PROVIDER FRICTION

The biggest barrier in 2026 is **Payer-Provider Friction**. While the waiver is extended, some private insurers are still applying Fee-for-Service metrics to a fundamentally Value-Based model—creating reimbursement gaps that undermine the financial case for HaH at scale.

### → Build the HaH Value Dossier

Fortis & Peak leads by helping clients construct a comprehensive "HaH Value Dossier"—a structured, data-driven case that translates clinical outcomes into the financial language insurers require for full DRG reimbursement.

### → Leverage Real-Time RPM Data

Use the real-time data from your Remote Patient Monitoring (RPM) systems to demonstrate to insurers that your HaH model is not "home health"—it is **Acute-Level Care** that deserves full Diagnosis-Related Group (DRG) reimbursement, not a discounted home-care rate.

### → Prove Clinical Equivalence at Scale

The data is on your side: 90% lower HAI rates, 60% lower delirium incidence, 25% faster recovery, and NPS scores above 85. The strategic imperative is packaging this evidence into a payer-facing narrative that closes the reimbursement gap and unlocks the full financial potential of the Distributed Hospital model.

# About Fortis & Peak Perspectives

"Fortis & Peak Perspectives represent our forward-looking perspective on the forces shaping industries, business models, and competitive advantage. Drawing on deep strategic insight and cross-sector experience, these perspectives go beyond observation to frame what matters most—and what comes next."

Fortis & Peak Perspectives are designed to help executives interpret disruption, anticipate shifts, and make informed decisions with clarity and confidence in an increasingly complex business environment. They are not merely observations—they are actionable frameworks built for leaders who need to move from insight to strategy.



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