
HOSPITAL LITIGATION

The Hospital Room Is Now a Living Room

Liability Questions in Hospital-at-Home Care

BY MICHELLE CARROLL · FOUNDER & CEO, LEXCURA SUMMIT

A few years ago, “hospital at home” was a pilot program at a handful of academic centers. Now it’s a line of business. CMS opened the door in November 2020 with its Acute Hospital Care at Home waiver, which lets hospitals treat inpatients in their own homes and bill Medicare as if the patient were in a hospital bed. By mid-2025, roughly 400 hospitals in more than 140 health systems had been approved. Then, on February 3, 2026, the Consolidated Appropriations Act extended the waiver through September 30, 2030, and told CMS to collect data on readmissions, mortality, staffing, and transfers back to the hospital.

The published research has mostly been encouraging for carefully chosen patients. I don’t want to suggest otherwise. But when something goes wrong in a patient’s house, the facts look nothing like a hospital case. There’s no nursing station down the hall, no bed alarm, no rapid response team two floors away. Somebody has to drive there. That changes almost every question an attorney would normally ask.

HOW THE WAIVER WORKS

The details vary by program, but CMS’s waiver has built in a common core:

- Patients come in through the emergency department or from an inpatient bed. They can’t be admitted directly from home.
- A physician or advanced practice clinician evaluates the patient before home care starts, and every day after that.

- The patient gets two in-person visits a day, from a registered nurse or a mobile integrated health paramedic, plus whatever other services the plan calls for.
- The hospital provides an immediate, on-demand audio connection to the care team.
- The hospital has to be able to get someone to the house within 30 minutes in an emergency.
- The hospital tracks and reports safety and quality data.

Everything else is up to the hospital: who's eligible, the clinical protocols, when a patient goes back to the hospital, what technology is used, and which vendors handle paramedic response, infusion pharmacy, labs, imaging, and equipment.

That last point matters for litigation. In a hospital-at-home case, you aren't only reviewing a chart. You're reviewing a program, and the program's own rules are often the best measuring stick you'll have.

A FICTIONAL CASE

He's 76, with heart failure, and he comes to the ED short of breath with swollen legs. He's offered a hospital-at-home admission and says yes. His wife, 74, is his only caregiver.

At home he gets IV diuretics, remote monitoring of vitals and weight, and nurse visits morning and evening. On the third night he gets up to use the bathroom, feels lightheaded, and falls. His wife calls the program. A paramedic arrives 40 minutes later. He has a hip fracture. Labs drawn afterward show low potassium.

WAS HE THE RIGHT PATIENT?

This is where I'd start. Every program has written eligibility criteria, some clinical (diagnosis, severity, stability, how likely it is he'll need something only a hospital can provide) and some about the home itself: is it safe, is there reliable phone and internet, is there a capable caregiver, can the patient call for help?

Get the criteria and get the screening document for this patient. Then ask the obvious questions. Was his fall risk assessed? In the hospital he might have had a bed alarm and a nurse helping him to the bathroom. What replaced that at home? Did anyone look at the house: stairs, rugs, the path to the bathroom at night? Was his wife's ability to help him actually evaluated, or just assumed? Was his cognition checked?

WHAT WAS BEING WATCHED, AND WHO WAS WATCHING?

Remote monitoring platforms collect a lot of data that never makes it into the clinical notes. Find out what devices he had, how often they transmitted, what alert thresholds were set, and who was on the other end. The alert logs and the responses to them may tell you more than the nursing narrative.

Then think about the treatment itself. IV diuretics can drop potassium and blood volume. Anyone giving them in a hospital would be checking labs and watching for orthostatic symptoms. When were his labs drawn? When did the results come back, and who looked at them? Did anyone check orthostatic vitals? Had he mentioned feeling dizzy on an earlier visit? These are the same questions you'd ask about a hospital patient. The difference is that the answers depend on a courier, a lab vendor, and a nurse who's only there twice a day.

FORTY MINUTES

The waiver's 30-minute emergency response is a program standard. Here it wasn't met, so reconstruct the timeline minute by minute: when his wife called, who answered, what was assessed over the phone, when a responder was dispatched, where the responder was coming from, and when they arrived. Call logs and dispatch records usually belong to a contracted service, so you may need to request them separately.

Also look at what happened during the wait. Was his wife told not to move him? Did someone stay on the line? Did the program's protocol say to call 911 instead of sending its own paramedic?

WHEN SHOULD HE HAVE GONE BACK?

Every program has criteria for sending a patient back to the hospital. It's worth asking whether he met any of them before the fall: rising heart rate, falling blood pressure, worsening kidney function, new dizziness. If the program's own criteria pointed toward readmission and he stayed home, that's a very different case from a sudden, unpredictable event.

TOO MANY RECORDS, IN TOO MANY PLACES

Nurse notes, paramedic notes, virtual physician visits, device data, pharmacy delivery logs: they may live in four or five systems, some connected to the hospital's EHR and some not, and they won't all record time the same way. Building one reliable timeline is most of the work. Collect every source, place each event in time, and flag where the sources disagree. Don't let a gap in one vendor's records be mistaken for a gap in care.

WHAT WERE THEY TOLD?

Patients choosing hospital-at-home care should understand what they're giving up: no one in the house overnight, how to reach the team, and how long help might take. Pull the consent form and any written materials the family received. Did he and his wife know that help could take half an hour or more? Were they told what to do if he got lightheaded?

CAUSATION, FAIRLY

The question isn't whether the home was as safe as a hospital. Falls happen in hospitals too. The question is whether this program did what his condition and its own rules required, and whether any gap caused the harm. Would closer lab monitoring have caught the potassium in time to change treatment? Would orthostatic checks have led to precautions? Would a bedside commode or a clear instruction to his wife have prevented the fall? Would a faster response have changed the outcome of the fracture itself? Some of those answers may favor the program. They belong in the analysis either way.

RECORDS TO REQUEST

- The hospital-at-home program's eligibility criteria, clinical protocols, escalation and readmission criteria, and emergency response policy
- The patient's eligibility screening, home safety assessment, and consent documents
- All clinical notes: nursing, paramedic, physician and APP (in person and virtual)
- Remote monitoring data, alert thresholds, alert logs, and response documentation
- Lab orders with collection and result times
- Call center logs, dispatch records, and response times from every contracted vendor
- Pharmacy and medication delivery records
- Vendor contracts showing who was responsible for what
- The hospital's quality and safety data submitted to CMS for the program, if discoverable

SOURCES AND REFERENCES

- CMS, Acute Hospital Care at Home program and waiver materials (QualityNet)
- Consolidated Appropriations Act, 2026 (signed Feb. 3, 2026); Baker Donelson, "Medicare Telehealth Waivers Extended for Several More Years"
- Healthcare Dive, "House passes bill extending hospital-at-home waivers for five years" (Dec. 2025) (approved-hospital counts as of July 2025)
- H.R. 4313, Hospital Inpatient Services Modernization Act (119th Cong.)

This newsletter is educational and doesn't constitute medical or legal advice. The case is fictional. Program requirements vary by hospital; always obtain the specific program's documents.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a hospital-at-home case and need one timeline built across the hospital, its vendors, and its monitoring platform, measured against the program's own rules, we'd welcome the conversation.

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