Intermountain Health

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Committee on Ways & Means

Hearing on Enhancing Access to Care at Home
In Rural and Underserved Communities

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Chairman Smith, Ranking Member Neal, and Members of the Committee, thank you for the opportunity to appear before you today to share Intermountain Health's experience in leveraging technology to provide care in the home, including in rural and underserved communities. As the largest healthcare provider in the Intermountain West, Intermountain Health recognizes the need to support our rural and underserved communities and the opportunity to fulfil our mission by taking the same care found in large urban areas into rural and underserved communities. Over the last four years, Intermountain has dramatically increased its provision of care in the home – through acute care hospital level care at home, telehealth, and remote patient monitoring. I have personally seen patient, family, community, and caregiver benefits of care at home. Our positive experience has reinforced our commitment to increasing access to care at home. That is also why we are so pleased to be here today to advocate for the federal health policy changes needed to enable and support current and future hospital at home and patient needs.

I am Nathan Starr, a Doctor of Osteopathic Medicine. I joined Intermountain as a hospitalist in 2008 following my residency in internal medicine. Intermountain Health is a not-for-profit integrated health care delivery system, headquartered in Salt Lake City, Utah, with regional offices in Broomfield, Colorado and Las Vegas, Nevada. We are comprised of 33 hospitals – which includes our virtual hospital - around 385 clinics, medical groups with more than 4,200 employed physicians and advanced practice providers and a health plans division called Select Health. With approximately $14B in revenue, around 60,000 caregivers and serving over four million patients and more than one million health plan members, Intermountain provides services in seven states: Colorado, Idaho, Kansas, Montana, Nevada, Wyoming, and Utah. In addition to being both a provider and plan, Intermountain is also an innovation hub and has launched multiple companies seeking to address some of health care's most pressing challenges. These include companies focused on value-based care (Castell), generic pharmaceutical drugs (CivicaRx), and interoperability (GraphiteHealth).

Intermountain is committed to improving community health and we are proud to be recognized as a leader in transforming health care by using evidence-based practices and

leveraging health information technology to deliver high quality health outcomes at sustainable costs. Intermountain is committed to accelerating the transition from volume to value. Thus, Intermountain is deeply committed to engaging in federal health policy. Intermountain Senior Vice President for Policy Greg Poulsen serves on the Medicare Payment Advisory Commission (MedPAC), and Intermountain Primary Children's Hospital Chief Medical Officer Angelo Giardino, a pediatrician, serves on the Medicaid and Chip Payment Advisory Commission (MACPAC).

At Intermountain, the focus of our caregivers is on providing high quality care that is accessible and affordable to all by succeeding in our mission to help people live the healthiest lives possible.

Launch of Intermountain's Hospital Level Care at Home Initiative

In the early days of the pandemic, I was asked by Intermountain to develop a new Hospital Level Care at Home Initiative [HLCH] to address bed capacity issues in our larger hospitals. We operationalized this work through Castell, a comprehensive health platform company wholly-owned by Intermountain that is focused on elevating value-based care capabilities with providers, payers, health care systems and accountable care organizations. Castell works to expand on its foundation of lessons learned at Intermountain to offer cutting edge analytics and programs that enable a value-based care program to thrive and utilizing these resources has been a significant contributor to the program's success. In September of 2020, I was named Medical Director for Home Services for Castell, over the HLCH and Housecalls programs. Housecalls in a home-based primary care program for patients with medical and social complexity. In addition, since November 2020, I have served as the medical director for Intermountain Tele-Hospitalist program, which provides nocturnist services (physician night coverage) to five rural hospitals in Utah and consultative services to hospitals across Utah as well as in Nevada and Idaho.

Since 2020 Intermountain's HLCH service has expanded and is available at 16 hospitals across Utah.

These services are offered as an option to Intermountain patients who meet specific clinical and non-clinical criteria who come in through an emergency department (ED) visit or have been admitted to the hospital and can safely complete their hospitalization at home.

HLCH services are provided by in-person caregiver visits by Intermountain Health nurses, as well as remote monitoring and virtual visits by telehealth providers located at Intermountain Health's virtual hospital, which is located in Murray, UT. Intermountain Health's virtual hospital is staffed 24/7 by remote monitoring technicians, tele-nurses, tele-advance practice providers and tele-hospitalists who are available 24/7 to provide digital consultations depending on the patient's acuity.

HLCH also has access to consultations as clinically needed, including infectious disease, wound care, dieticians, and other hospital-based specialties. Some common diagnoses

that are seen include pulmonary embolisms, Covid-19, pneumonia, heart failure, cellulitis (bacterial skin infection), pyelonephritis (kidney infection), diverticulitis, gastroenteritis, dehydration and acute kidney injury, electrolyte deficient states, and complications of cancer treatment such as infections.

Since inception, HLCH has provided high-quality care to over 1,200 patients. Half of these patients are admitted directly to HLCH from the hospital ED, diverting a traditional inpatient admission altogether and keeping a bed open for more acute patients. The other 50% of patients have been transferred from an inpatient admission unit to finish their hospitalization in their home.

HLCH is working with Intermountain Health's strategy office on projects in Utah's rural communities where providers are scarce and resources to rebuild old hospitals are limited. The goal is to offset some of the projected beds needed with HLCH and to be able to provide more inpatient care to the rural communities by serving them in their homes. With the realization that some patients will always require a traditional hospital stay, there is an important opportunity to serve some key health care needs of rural, underserved, and vulnerable populations through HLCH and virtual acute care.

HLCH Statistics:

- >1,200 patients cared for (top 10% in program size)
- Zero serious in-home safety events.
- Average 7.5% 30-day readmission rate (compared to 9-11% for hospitals)
- Press Ganey Patient Satisfaction Likelihood to Recommend Score 85%
- Length of Stay - 3.2 days – similar to patients staying in hospitals.
- Over 4,000 bed days saved for hospitals

To illustrate the benefits of HLCH, I want to share a few brief patient stories:

A young male patient developed muscle breakdown after a new, intense gym workup, putting him at risk of kidney failure. He required admission for continuous IV fluids and monitoring of his kidney function. However, he lives in a multi-generational home and his role and responsibility was to watch younger family members after school so other family members could work outside the home. If he were in the hospital, there would be significant added stress to him and his family. We treated him at home, and he was able to fulfill his role in supervising younger family members.

An elderly male was treated at home for COVID. His second day home he was dizzy with a low blood pressure. We reviewed his medications and discovered that he was taking a blood pressure medication that no one seemed to know he was taking. We stopped the medication and gave him some fluids and his blood pressure and dizziness resolved.

A middle-aged male with diabetes was admitted with a leg infection. Once home, we discovered that his diabetes was poorly controlled because he needed to take his insulin very early in the morning due to his work. We adjusted his treatment regimen to fit his life and allow him to better control his diabetes.

A middle-aged female had a weakened immune system as a side effect of needed medications. She developed pneumonia and low oxygen levels and required hospitalization. In the past, she had acquired new infections while in the hospital. We treated her at home, and she healed quickly as her stress level was much lower than it had been in a hospital environment.

These are just a few of the stories from patients who were successfully treated through HLCH.

Telehealth and Remote Patient Monitoring

Intermountain Health has invested heavily in taking care to patients in their communities and homes through its telehealth and remote patient monitoring programs.

Telehealth Programs

Intermountain Health's Virtual Hospital is rapidly growing in number of specialties and communities served. We offer over 50 telehealth services in nine states (AZ, CO, ID, KS, MT, NM, NV, WY and UT) and with over 40 clinical partners, including 55 facilities from outside Intermountain Health. Many of these facilities are remote, critical access hospitals. Since 2016, we have completed over four million interactions, including over 79,000 transfers for patients requiring a higher level of care. Below are some program examples.

Stroke: Comprehensive virtual stroke evaluations and recommendations by stroke neurologists. We are supporting 38 hospitals with more than 16,000 patients served.

Crisis: Emergency Department (ED) virtual crisis evaluations for patients with mental health issues in all system Eds with 45% of patients able to transition home with outpatient support.

Patient Safety Monitoring: Monitor patients in hospital who are confused or at risk for falls via video which frees up hospital staff to cover other patient care duties. We've monitored over 3500 with no increase in falls or safety concerns.

Neonatology: Virtual evaluation and care of neonates at lower-level units by experienced neonatologists. This virtual care has yielded significant reduction in transfers and admissions, keeping babies and parents together in their communities.

Critical Care: There is a nation- and global-wide shortage of intensive care physicians. Via telehealth, we provide critical care support in hospitals without an intensivist, even in small community and rural hospitals. This helps keep patients in their community with equivalent care. Additionally, when a patient requires transfer to a higher-level facility, our intensivists help stabilize patients prior to transport, and ensure they are transferred to an appropriate facility by identifying the right level of care needed. This allows us to optimize all of the

available ICU beds. Observed versus expected mortality shows a reduction in mortality for patients who receive our services.

Infectious Disease: Provide virtual expert Infectious Disease consultations, which has shown reduced mortality, reduced readmissions, and reduced use of unnecessary antibiotics.

Hospitalist: Provide virtual nighttime coverage at rural hospitals for admissions and nurse questions. This is of particular value at rural facilities because the same provider often covers both day and night, leading to burnout and difficulty recruiting and retaining providers.

Oncology: Chemotherapy patients are treated in their communities with video visits from experienced oncologists. Benefits include decreased cost, no need for transportation, which helps with safety for older patients driving and time savings for patients. Patients stay in their communities with family and friends. Typically, in-person infusion times can last up to 12 hours, and if a patient needs to drive hours to get to infusion, each treatment could be a multiday trip.

Here is a testimonial from Clinical Manager Kimberlee Rowlett that speaks volumes:
"I personally have heard numerous times directly from patients that they would have "let the cancer take" them if they didn't have the TeleOncology program in their community."

For 849 patients receiving TeleOncology services in Richfield, Utah, the total drive time saved was 232,626 minutes, total drive distance saved was 280,170 miles, and total CO2 emissions saved was 103,214,628 grams.

Emergency Medicine: We have a new program supporting urgent care clinics who have patients they think need to go to the emergency room. An ED physician reviews data and does a video visit with the patient. The program has found that 94% of patients do not need an ED visit (average cost of $1,400 per ED visit). We are currently expanding into rural areas.

<u>Case Study in Wells, Nevada: Leveraging a Virtual/In-Person Hybrid Model to Bring Care to a Small Rural Community Lacking Health Care</u>

Wells, Nevada is a town of 1,243 people with no local physician or health care. Because of clinic closures, residents must travel 100 miles round trip to receive care. Intermountain Health partnered with city leaders to set up a financially viable option leveraging virtual care. This hybrid clinic opens today, March 12, 2024.

Objectives:

- Help patients avoid unnecessary travel.
- Provide in-town option for routine care, labs, simple procedures.
- Create sustainable financial plan.

Hybrid Model:

- Operated by Intermountain Telehealth and staffed with EMTs.
- City of Wells, NV provides clinic building.
- Operates two days per week with EMTs under the supervision of a virtual primary care provider.
- Primary Care Provider visits clinic monthly for physical exams and procedures.
- Utilize other telehealth care when clinic visit is not needed such as urgent care and behavioral health.

Remote Patient Monitoring

Intermountain Health uses multiple technology platforms to efficiently extend care across our footprint. HLCH is a prime example. Below are some other examples.

COVID mini-kit program:

During COVID, we provided Bluetooth enabled pulse oximeter to patients with COVID with risk factors for severe disease. Over 14,000 patients were discharged home with RPM. Outcomes showed this to be a safe, effective way to monitor patients with COVID at home, and identify patients who needed to come back to the Emergency Department.

Intermountain Health and Omada

As stated earlier, Intermountain Health focuses on innovation and health care transformation and is committed to delivering better care and improving outcomes at lower costs. This pursuit led to a partnership with Omada Health, Inc., a virtual, chronic disease prevention and management company that works with health care systems to improve access, outcomes, and compliance with chronic disease prevention and management. The program offers asynchronous care, dedicated human health coaches, connected devices, an app for tracking, lessons, and access to online peer support groups. The initial partnership launched in 2016 and provided access to Omada's Prevention program to Intermountain's patients followed by it becoming a covered benefit for employees in 2019. The collaboration in Utah expanded in 2020 with launch of an Omada Diabetes Prevention Program (DPP) demonstration project. A significant outcome demonstrated by Intermountain's DPP with Omada is having reduced the conversion rate from prediabetes to type II diabetes (T2D) in under three years from 58% in 2018 to <6% in 2021. Other meaningful results shown among the 6,000+ employees, patients, and community members who have participated in Omada's DPP across the Intermountain Health catchment area include an average satisfaction rate of 85%, engagement above Omada's national benchmarks, and analyses showing net positive savings from the program. These

results led to expanding the partnership again in 2023 through a new risk-based contract administered by Castell offering broader access to Omada's DPP and Diabetes Management program to help support qualifying patients in between provider visits. Early analysis of year one results are showing Omada has positively impacted weight loss, engagement, and hemoglobin A1C outcomes.

Another important benefit of this partnership is that Omada uses cellular technology for the devices its program uses, rather than less-widely available wifi networks, with the intent to have the program work in rural, suburban and urban areas. Omada health coaches also personalize the program by addressing social risks and other potential barriers to enable an individual to successfully achieve the best health outcomes.

Home Infusion:

Intermountain's Homecare Pharmacy is licensed in 7 states and has locations in South Jordan and St. George Utah. They provide infusion (IV) and enteral (tube feed) services to patients across Utah and the Intermountain West. This includes IV treatments for infections, cancer, heart failure, hospice and immunodeficiencies. On average, Intermountain's Homecare Pharmacy has 1,500 active patients receiving infusion services, many of them in rural areas. Intermountain's Homecare Pharmacy has been vital for the success of HLCH and our TeleOncology programs by delivering IV therapies to patients across our geography.

Future Opportunities

Historically, the hospital is the center of a health care system. However, a patient's home and community are the center of a patient's health and wellness. Over and over, we have seen the benefit of moving care into a patient's home. What is so exciting about this work is the impact we can see from individual patients and their stories. To truly understand someone and their health, nothing is more valuable than seeing them in their home and community. Hospital at Home, telehealth and technology like remote patient monitoring have opened up a new world of possibilities that are only beginning to be envisioned.

Addressing Barriers to Enhancing Care at Home in Rural and Underserved Areas

On behalf of Intermountain Health and the Moving Health Home Alliance to which we belong, we urge you to pass the "Expanding Care in the Home Act" introduced by Ways & Means Committee member Congressman Adrian Smith and Congresswoman Debbie Dingell. This legislation, HR 2853, would remove barriers currently limiting patient access to care in the home, which is often the preferred site of care for patients, caregivers, and providers. It would ensure home-based care is a viable option for patient care and scalable for providers.

We also urge a five-year extension of the current waivers to the Acute Hospital Care at Home initiative. CMS launched this initiative in November 2020 in response to challenges faced by hospitals following the spread of COVID-19. The initiative, which is currently set to expire at the end of 2024, allows certain hospitals to treat patients at home with in-patient

level care. It is important to ensure a five-year extension so there is enough time to invest in and expand hospital at home programs and allow time to continue to study the clinical outcomes and cost impacts, which thus far have demonstrated very positive results. Indeed, evidence shows that home-based acute care delivers the same or better outcomes with lower costs than facility-based care. Lower costs can be attributed to both a lower cost of care in the home and cost savings from reductions in readmissions.[1][2][3] Intermountain is setting goals for growth in HLCH admissions for multiple hospitals who either run at capacity or are going to be rebuilt due to age. The message we received from our CEO Rob Allen was very simple: "Grow!".

Barriers/Issues/Problems:

CMS Acute Care at Home Waiver tethers patient care to a specific hospital, making it more challenging to use the resources of a health system to efficiently run programs.

CMS Acute Care at Home Waiver allows for little flexibility in care delivery, which often makes care more expensive. For example, every patient requires two in-person visits daily, even if one visit with additional telehealth visits would provide the care a patient needs.

Provider licensure and credentialing for telehealth across state lines is very expensive and cumbersome.

Payers have variability in covering telehealth encounters which can greatly affect rural areas with limited options for care.

Acute Hospital Care at Home has two patient populations- patients admitted from the emergency department to home, and patients transferred home to complete their hospitalization following an admission to the hospital. Each population would benefit from a distinct reimbursement structure as the opportunities for cost savings do not fully overlap.

Protecting against fraud and waste by ensuring patients are receiving an appropriate level of care, not more than what they need.

Medicare coverage for home infusions is often incomplete, requiring many patients to get infusions in hospitals or skilled nursing facilities, typically at a higher cost and with great burden to the patient and their families.

Conclusion

Hospital at Home is a safe, effective model of care that benefits patients, health care systems, hospitals, and payers. There are many Hospital at Home programs functioning across the country, all identifying solutions to problems that are particular to their communities. The CMS Waiver has been key to the expansion and stability of Hospital at Home. Many states and payers use the Waiver as a basis for their successful programs.

[1] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2685092
[2] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780783
[3] https://www.acpjournals.org/doi/10.7326/0003-4819-143-11-200512060-00008

But the current version of the waiver is not a finished product. We need additional time to continue to collect data and create the best long-term model.

Thank you for your attention to these very important topics and the opportunity to testify.