ADVOCATE HEALTH

Building a scalable hospital at home program for urban and rural markets

Matt Anderson MD, MHA
Chief Physician Officer, NC/GA Division
SVP, Clinical Transformation

ADVOCATEHEALTH

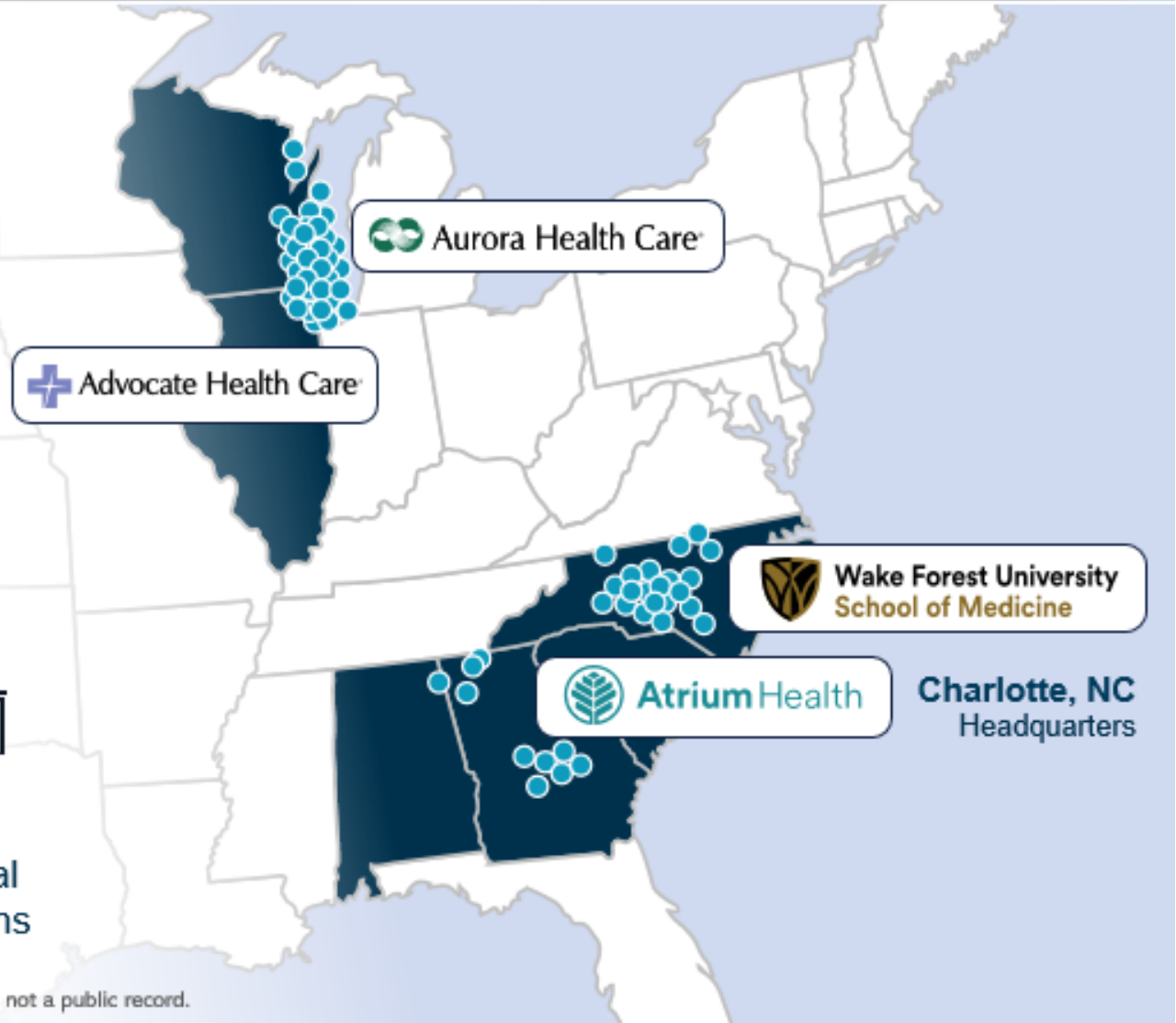
Serving over **6 million** patients across 6 states

1st in Community Benefit ($6.2B)

2nd Largest with an Integrated Medical School

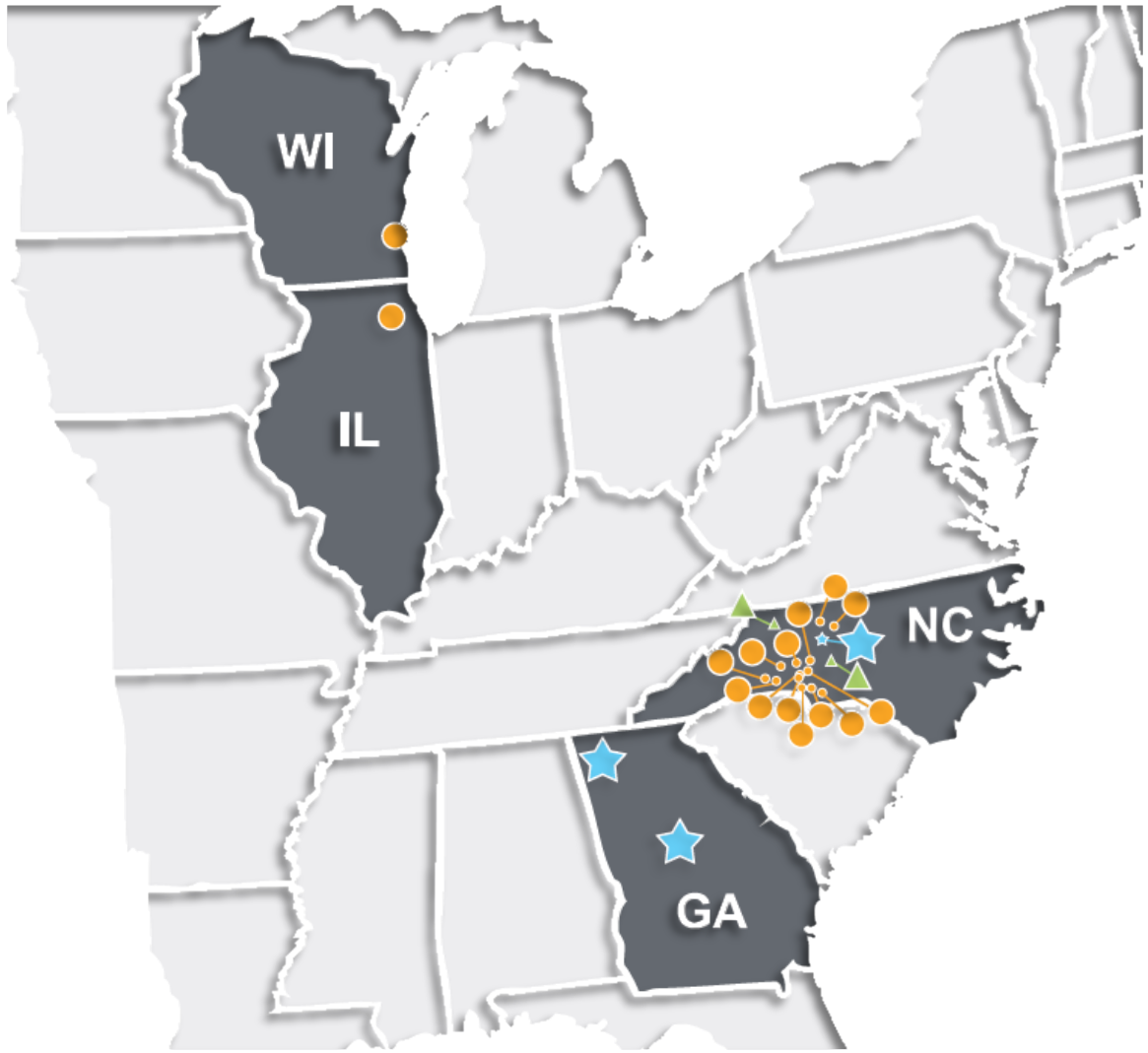
3rd Largest Not-For-Profit

$38B	AA	6M	167K	69
Revenue (Annualized YTD)	Bond Rating	Unique Patients	Teammates	Hospital Locations



Advocate Health is Leading the Way in Hospital at Home

- 4 major metropolitan areas in 4 states
- 18 waivered hospitals
- Patient care area covers 7,500 square mile
- 50% of patients cared for in rural zip codes



ADVOCATEHEALTH

Key Stats

Developing into a virtual hospital rather than just a single unit

31,000+

Patients served across Enterprise

26,000+

Patients within GCA, program to date.

145-155

Average Daily Census

2/3 of the cost

Brick and mortar stay

200+ Teammates

Virtual

In-person

Hybrid

100+ bed hospital

Medicine

Surgical

HemOnc

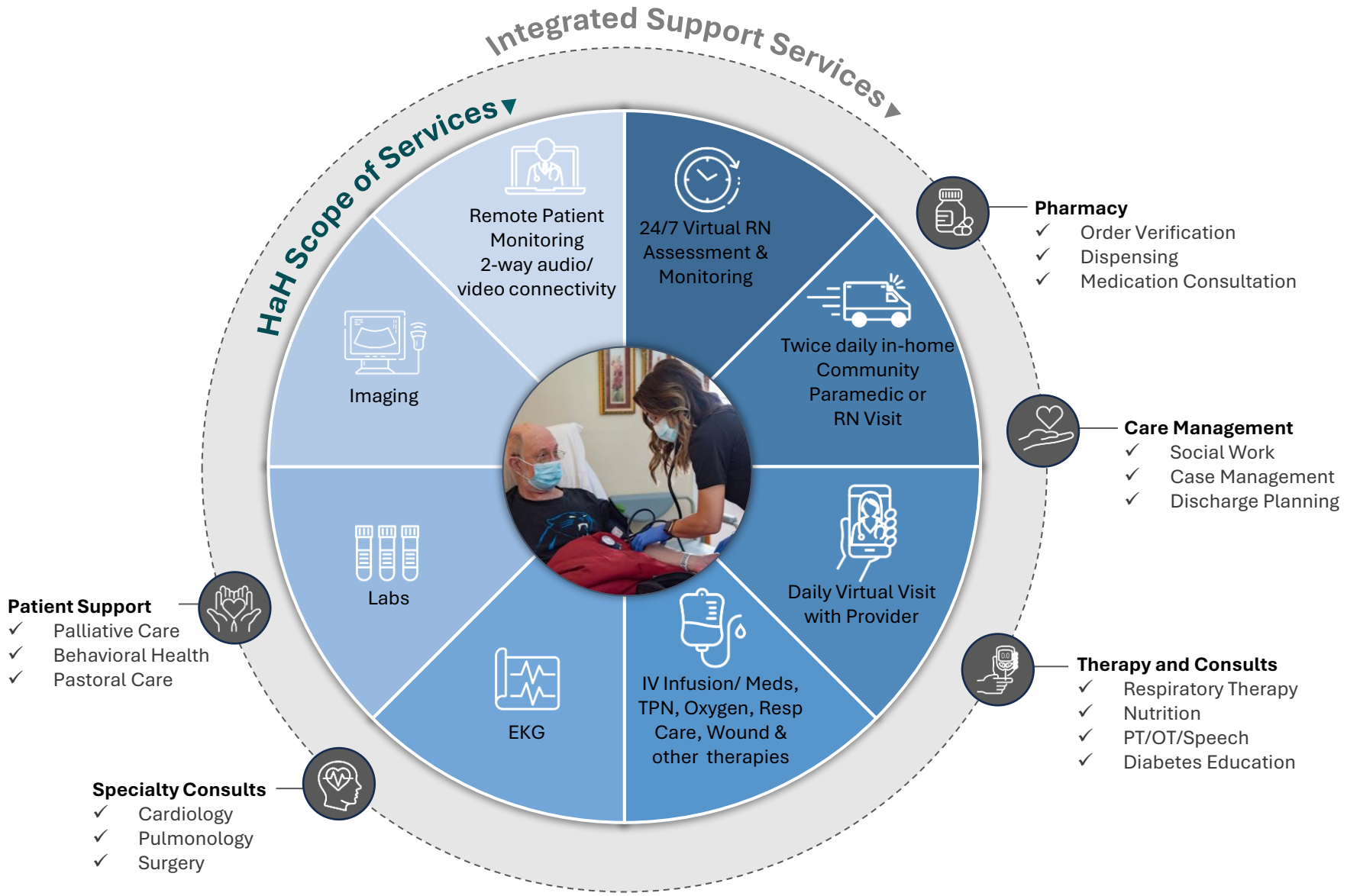
ADVOCATE HEALTH

By providing hospital level care in the comfort of home, our Hospital at Home program is redefining care:

For You	For Us	For All
Patient Benefits	*System Benefits*	*Population/Community Benefits*
Comfort and Familiarity: Patients get care where they prefer… at home… increasing their sense of safety and control.	**Capacity Management:** Increases capacity at brick-and-mortar facilities by avoiding admissions, readmissions and reducing LOS.	**Sicker, Aging Population:** Addresses the unique care needs of the growing aging population who are experiencing multiple chronic conditions but wish to "age in place".
Risk Reduction: Patients face lower risks associated with traditional hospitalization (e.g., falls, infection, delirium, insomnia, etc.)	**Cost Savings:** Potential for lower direct variable cost of care. Significantly lower capital costs than brick-and-mortar construction Very low Post-Acute SNF utilization	**Reducing Health Inequities:** Holistic, whole-person care helps to reduce health inequities and improve access.
Addressing Social Needs: Team can assess and address SDOH, which impact 80% of patients' well-being. in the context of the patient's real life		

ADVOCATE HEALTH

Patients receive seamless, comprehensive, inpatient care at home with integrated support



ADVOCATE HEALTH

Day in the life of a patient

A Typical Hospital

6 AM	Blood draw for daily labs
8-11 AM	Physician visit
11-1 PM	Watch TV & wait for x-ray
2 PM	Sponge bath in bed
4 PM	Push call button to speak to physician
5 PM	Physician stops by
6 PM	Dinner is served
11 PM	Hospital is quiet enough to fall asleep

Hospital at Home

9 AM	Blood draw for daily labs
10 AM	Physician video visit
10-12 PM	Children stop by to say hello
12 PM	X-ray
2 PM	Shower with the help of aide
4 PM	Use iPad to connect with physician
6 PM	Enjoy home-cooked meal
9 PM	Fall asleep in your own bed

ADVOCATE HEALTH

Four Components Work Together To Enable Care

MEDICAL INSTITUTION

Software Platform

Command Center

CARE DELIVERY NETWORK

PATIENT HOME

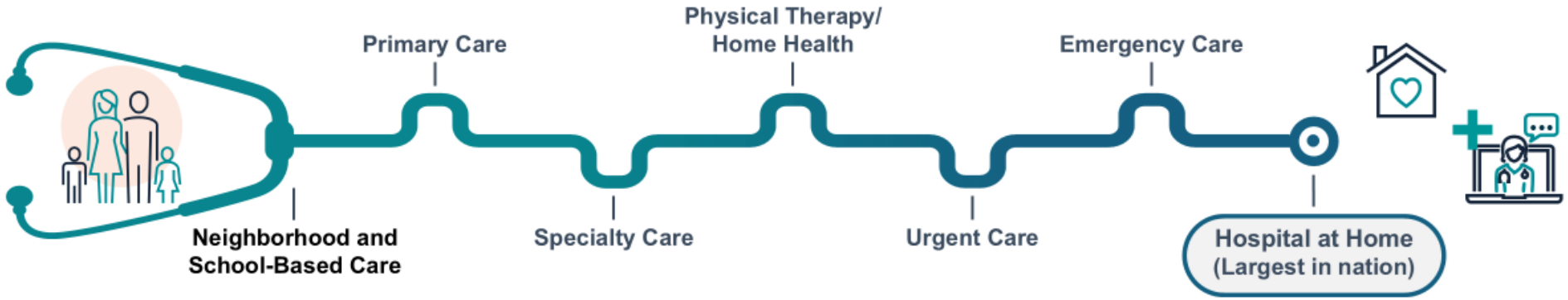
Home Technology

1 **Unlimited** 2 **50 mi radius** 3

ADVOCATE HEALTH

ADVOCATEHEALTH | VIRTUAL HEALTH

As the **leading-edge innovator** in integrated virtual health, we are **reimagining access** while delivering system value through **47 unique virtual health services** at **259 service sites** across **10 states**



FIRST & BEST CHOICE

National Leader in Hospital-Level Care at Home

Advocate Health has the largest adult hospital at home program, averaging 130 patients daily. In February 2025, Advocate Health Levine Children's Hospital launched the nation's first pediatric hospital at home program, caring for over 100 patients since its launch.

Innovator of Novel Virtual Care Models

Launched a first-of-its-kind, unified virtual health clinical workforce, scaling clinicians across Advocate Health's seven states. This model leverages our national scale and clinical expertise to provide care when, how, and where patients need it.

Pioneers in High-Quality Virtual Care Delivery

- ✓ **47 Unique Virtual Services** – Spanning the full care continuum
- ✓ **School-Based Virtual Care Leader** – 15,000+ visits in 2024–2025 with a 65% return-to-classroom rate
- ✓ **Teammate Access Expansion** – Discounted virtual primary and urgent care through Advocate Health's health plan

1.7 MILLION
Virtual Health Encounters

8,400
Virtual Health Clinicians

55,000
Virtual Nursing Patients in 2024

50,000+
Virtual Physical Therapy Visits

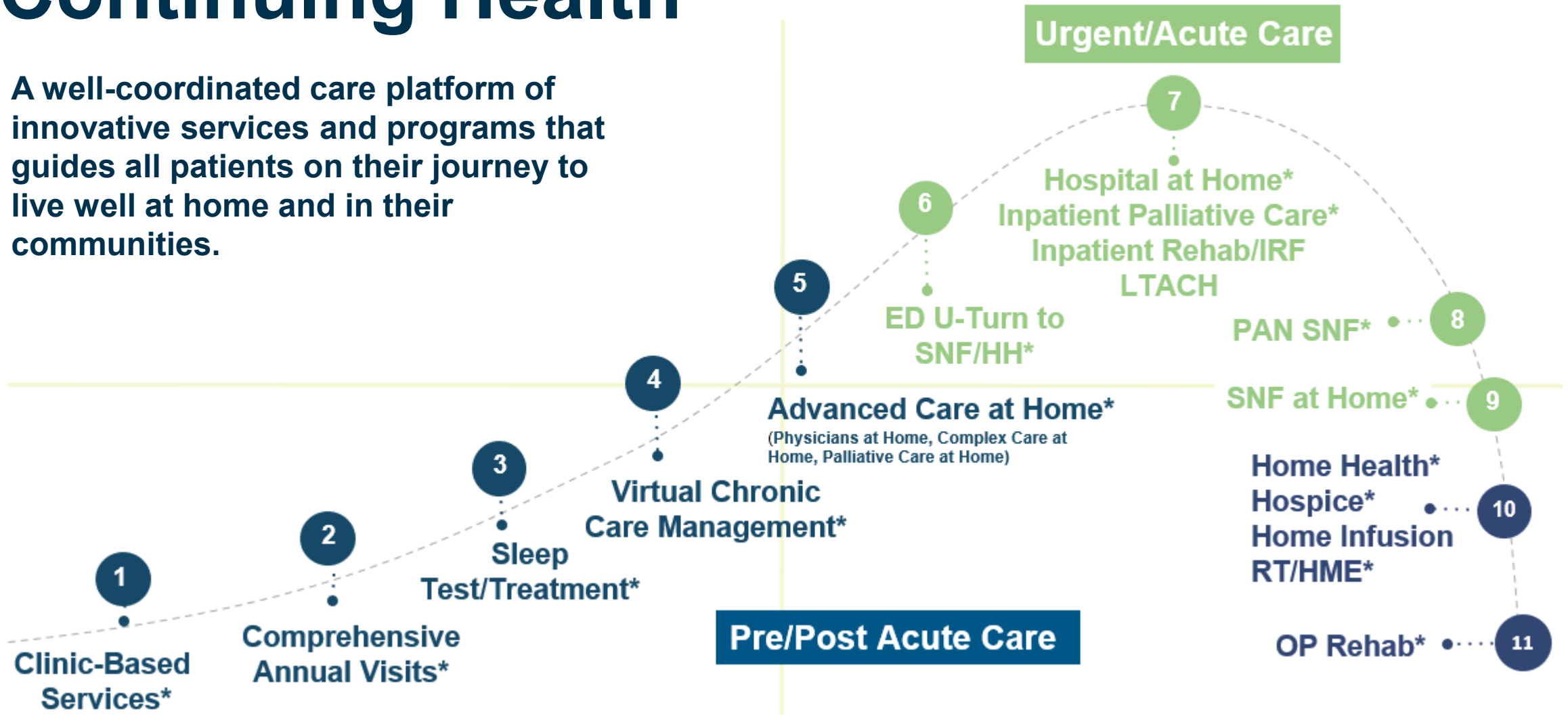
15,000
Patients Remotely Monitored Each Day

26,000+
Hospital at Home Patients Served

Virtual Primary Care | Hospital At Home | Virtual Critical Care | Virtual Specialty Consults | On Demand Virtual Visits | Virtual School Clinics | Employer Clinics | Virtual Sitter | Virtual Nursing | Virtual ED | Virtual Weight Management

Continuing Health

A well-coordinated care platform of innovative services and programs that guides all patients on their journey to live well at home and in their communities.



Right Care, Right Place, Right Time

*Available Virtually

ADVOCATE HEALTH

H@H Growth Can Occur Via Scale Or Spread:

Scale: Existing site growth

Volume & Operational Bounds

Growth through role, staffing, equipment additions, etc. and removal of operational barriers

- MIH scope: Paramedics vs RNs
- New Care Team members: Wound Care RNs, Educators
- Alter hours for patient acceptance: ED admits through 11pm
- Add payor sources: Payor agnostic/aware

Complexity & Specialty

Scale up patient acuity and in home capability and/or partner with Specialty services to capture advanced populations

- Add iSTATs, elastomeric balls, midlines
- Enhance med administration protocols/ delivery methods
- Develop specific specialty protocols: Heart Failure in the home, post-surgical, CAR-T, BsAbs, PP HTN, Peds

Spread: Programmatic or Enterprise growth

Geographic Footprint

Expanding into more communities/zip codes to increase patient volumes (considering additional travel time)

- Add zip codes to existing coverage
- Expand into other Areas, States, etc. within System or Enterprise

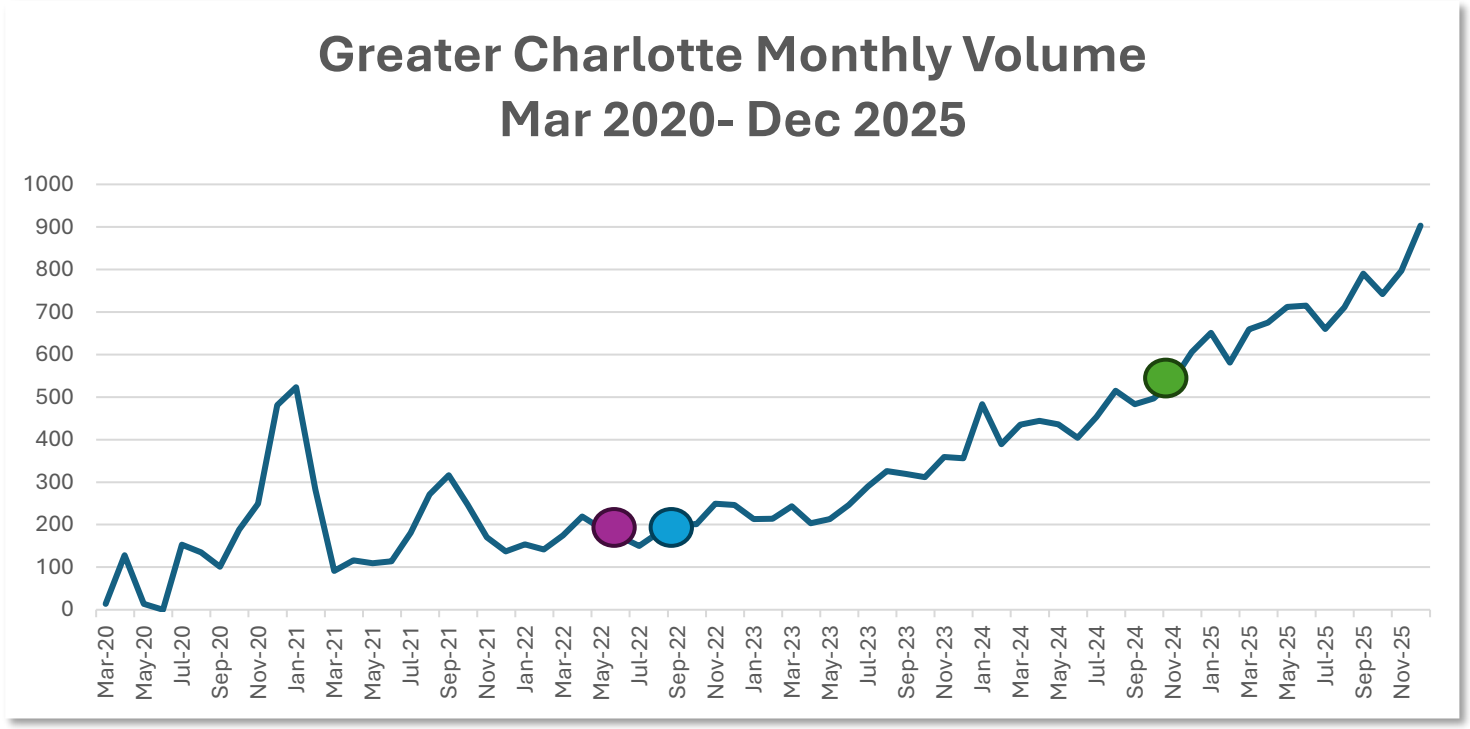
Waivered Facilities

Extending the number of brick-and-mortar facilities for increased patient catchment

- Add facilities near currently waivered locations
- Add facilities in new locations

Our Charlotte Program Has Been Rapidly & Successfully Scaled

- **Upper-level leadership support**
  - Strategy
  - Financial resources
  - Personnel
- **Intra-facility Growth**
  - Maximum HaH capacity
- **Inter-facility Growth**
  - Universal methodology



ADVOCATE HEALTH

Considerations before scale

- Resources & Supply Chain
- Bed Count/ Capacity Gap
- Capital Additions
- Patient sources/ HAH Pathways
- Care Continuum Capabilities

ADVOCATE HEALTH

Inflow For Scale:
Make the Hospital at Home Pathway the Standard of Care

Diagnosis	H@H Exclusion Criteria
CHF	• PCU or ICU level of care • Supplemental O2 needs >6 lpm NC • Suspected or diagnosed ACS • New onset or unstable arrhythmia requiring telemetry • SBP <100 and receiving diuretics • On chronic inotropes until workflow built in
COPD	• Require NIPPV • pH < 7.35 • Impaired mental status or accessory muscle use • Supplemental O2 needs >6 lpm NC
Cellulitis	• If concern for necrotizing fasciitis • Concern for osteomyelitis or septic arthritis needing advanced imaging or procedure • Purulent cellulitis needing I&D • Meets severe sepsis criteria or worse • Ensure doppler ultrasound or advanced imaging is completed if indicated
Pneumonia	• Meets severe sepsis criteria or worse • Impaired mental status or accessory muscle use • Supplemental O2 needs >6 lpm NC • If in-person pulmonary consult is needed, coordinate for patient to wait in HCU until consult is completed. If bronchoscopy is needed, patient can transfer to ACH and return to B&M for procedure once scheduled.
Pulmonary embolism with respiratory failure	• Meets Observation criteria • SBP < 100 • HR > 110 • Impaired mental status • Supplemental O2 needs >6 lpm NC • Needs IR consultation for possible lysis of clot

Diagnosis	H@H Exclusion Criteria
Pancreatitis	• Frequent IV pain control • New hypoxia or pulmonary edema • AKI stage 2 or greater on admission • Risk of alcohol withdrawal • IVF infusing more than 150mL/hr • If pancreatitis is gallstone related, with or without cholangitis
UTI	• Meets observation criteria • Needs assessment for obstruction +/- Urology consult • Needs PCU level of care or higher
AKI	• Needs urgent dialysis • Needs assessment for urinary tract obstruction or procedure • Severe hyperkalemia • Acute respiratory failure
Gastroenteritis	• Meets Observation criteria

ADVOCATE HEALTH

Patient Volume may be the fuel, but consistent resources is the oxygen

You must…

- Identify your pressure points
- Understand interval-leap staffing (increase patient goals correctly)
- Staff and prep for the extremes, not the goal/cutoff/cap
  - Your cap is 22 patients for max ADC
  - But you need to see 22, discharge 8, and admit 8
  - So your touches are 30 + discharge touches + rapid response

Patient Volume	5	12	19	26	31
RNs	1	2	3	4	5
Paramedics	1 truck	1 truck	2 trucks	2 trucks	2 trucks
Couriers	1	2	4	6	8
Physicians	1	1	2	2	3

DELIVERY OPTIMIZATION

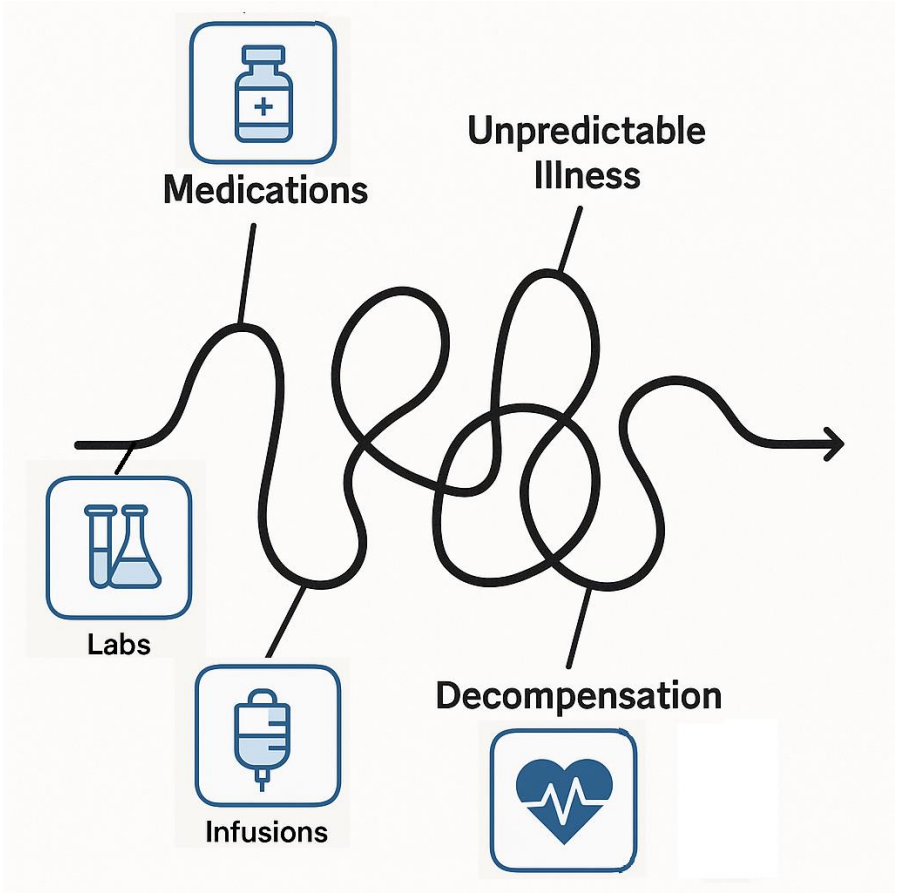
Efficiency comes down to how tightly we manage the logistics, not just better software:

One coordinated command center
Every delivery is dispatched and tracked from a single hub → no siloed hand-offs.

Dynamic routing & scheduling
Stops are sequenced around each patient's window, location, and acuity.

Just-in-time supply staging
Medications, labs, and infusions are staged to arrive exactly when they're needed.

Real-time tracking & re-routing
Live visibility lets us flex the moment illness or decompensation changes the plan.



ADVOCATE HEALTH

Challenges To Scale

Change Management

Delivery Optimization

Future Workforce

Regulatory Environment

Payment Model

ADVOCATE HEALTH

Rural Spread & Scale

Hospital at Home in rural markets: the opportunity, the fit, and how we scale

Why H@H for rural?

- Rural access is collapsing — **182 rural hospitals** closed since 2010 and **46% run at a loss**, widening care deserts.
- H@H keeps acute care **local**, easing the long travel behind worse rural outcomes.
- Proven in rural: comparable cost & readmissions, more patient activity, strong preference *(JAMA, 2025)*.
- Tailwinds: CMS waiver **secured through 2030** + **$50B** state rural funding — and we run the **largest H@H program in the U.S.**

Where it works — and where it's harder

Works well when:

- A waivered hospital anchors patients within a serviceable radius
- Reliable connectivity + remote monitoring, with EMS backup
- Predictable medical acuity and local RN / MIH capacity

Harder when:

- Very low density and long distances stretch care orchestration
- Broadband or EMS gaps, or unsuitable home settings
- Thin local workforce or no nearby anchor facility

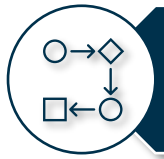
Rural scale challenges → how we solve them

- **Wide geography:** virtual command center, remote monitoring & MIH visits, drone (Zipline) delivery, Care Hotel option
- **Workforce gaps:** cross-train existing staff, regional pooling, a rural workforce coalition
- **No local waivered site:** partner with Critical Access & Rural Emergency Hospitals and CMS; scale within footprint (Stanly, GA, AL, WI)
- **Financial fragility:** lean on the AHCaH waiver + state RHTP funds; disciplined proformas, ramp to 15 ADC

Sources: Chartis Center for Rural Health (2025); JAMA Network Open (Levine et al., 2025); CMS Acute Hospital Care at Home; Advocate Health rural strategy & H@H program updates.

ADVOCATE HEALTH

Considerations before spread



Standardization in spread methodology & process

Quality and safety

Technology

Efficiency

Sustainable Financial Performance

ADVOCATEHEALTH

Success comes from a spread methodology

	1 Current State Analysis	2 Future State Modeling	3 Site Selection
Activity	•Conducting an in-depth analysis of program qualifying cases in divisions to guide expansion: •**Data Analysis**: capacity and utilization •**Geographical Analysis** •**Regulatory Analysis:** Bed licensure, CON, Medicaid, Pharmacy Boards, Community Paramedic	•Gather input from relevant department leads. •Create models •**Financial**: Revenue, expenses and assesses •**Human Capital:** Required staffing based on census •Have the executive team review the assessment before final site selection.	• Evaluate modeling and current state analysis • Select site in division
Outcome			
	Realtime snapshot of division hospitals to determine readiness and ability to take on H@H program	Detailed financial and resource modeling to determine potential impact of program at selected sites	Division confirms site for expansion

ADVOCATE HEALTH

Implementation Process Components

Phase 1: Implementation Planning

- Finalize and Approve Proforma
- Implementation Preparation
- Gap Analysis
- Existing and New Partnership Contract Analysis

Duration Phase 1

1-2 months

Stage Gate

- *Validate organizational stability*

Phase 2: Implementation Build

- Complete Finance Involvement
- Engage Compliance, Legal
- Engage IT
- Engage Government Relations
- Assess and Build Infrastructure (Digital and Physical)
- Internal Marketing & Communication Plan
- HR Collaboration
- Pre-Workflow and Workflow
- Training Materials
- On-Site Training
- Internal Education Plan

Stage 1

2-3 months

Stage 2

2-3 months

Duration Phase 2

4-6 months

Stage Gate

- *Validate implementation build for readiness*

Phase 3: Go Live

- Soft Go-Live
- Ramp-Up
- Post Implementation Optimization

Duration Phase 3

2 months

Gap Analysis

Gap Analysis for Market Assessment Across Sites					
Area of Assessment	**Current Capability (Per Site)**	**Desired State / Standard**	**Identified Gap**	**Actions Needed**	**Expected Timeline**
Pharmacy Workflow (First fill, refills, discharge meds)		Streamlined, standardized medication workflow			
Admission Process		Consistent, efficient admission protocol			
Transfer Process		Standardized patient transfer system to H@H.			
Billing Processes		Centralized or standardized billing procedures			
Patient Transportation (all types)		Integrated, on-demand patient transport			
Care in the Home (RN vs Paramedic)		Defined home care staffing model			
Remote Patient Monitoring (RPM) (Current Health)		Expanded RPM with support logistics			

Implementation Process Components

Phase 1: Implementation Planning

- Finalize and Approve Proforma
- Implementation Preparation
- Gap Analysis
- Existing and New Partnership Contract Analysis

Duration Phase 1

1-2 months

Stage Gate

- *Validate organizational stability*

Phase 2: Implementation Build

- **Complete Finance Involvement**
- **Engage Compliance, Legal**
- **Engage IT**
- **Engage Government Relations**
- **Assess and Build Infrastructure (Digital and Physical)**
- **Internal Marketing & Communication Plan**

Stage 1

2-3 months

- HR Collaboration
- Pre-Workflow and Workflow
- Training Materials
- On-Site Training
- Internal Education Plan

Stage 2

2-3 months

Duration Phase 2

4-6 months

Stage Gate

- *Validate implementation build for readiness*

Phase 3: Go Live

- Soft Go-Live
- Ramp-Up
- Post Implementation Optimization

Duration Phase 3

2 months

Implementation Process Components

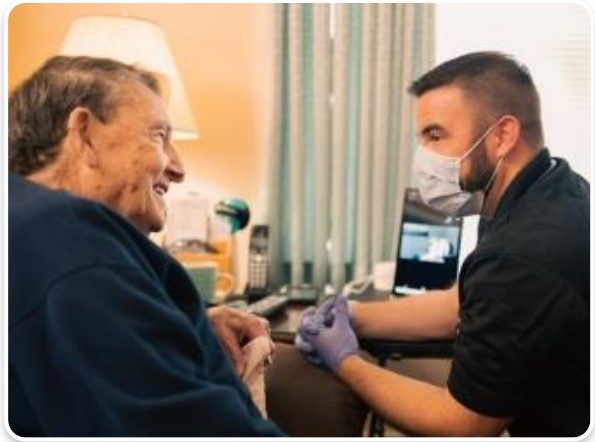
Phase 1: Implementation Planning	• Finalize and Approve Proforma • Implementation Preparation • Gap Analysis • Existing and New Partnership Contract Analysis	**Duration Phase 1** **1-2 months**
Stage Gate	• ***Validate organizational stability***	
Phase 2: Implementation Build	**Stage 1** (2-3 months) • Complete Finance Involvement • Engage Compliance, Legal • Engage IT • Engage Government Relations • Assess and Build Infrastructure (Digital and Physical) • Internal Marketing & Communication Plan **Stage 2** (2-3 months) • HR Collaboration • Pre-Workflow and Workflow • Training Materials • On-Site Training • Internal Education Plan	**Duration Phase 2** **4-6 months**
Stage Gate	• ***Validate implementation build for readiness***	
Phase 3: Go Live	• Soft Go-Live • Ramp-Up • Post Implementation Optimization	**Duration Phase 3** **2 months**

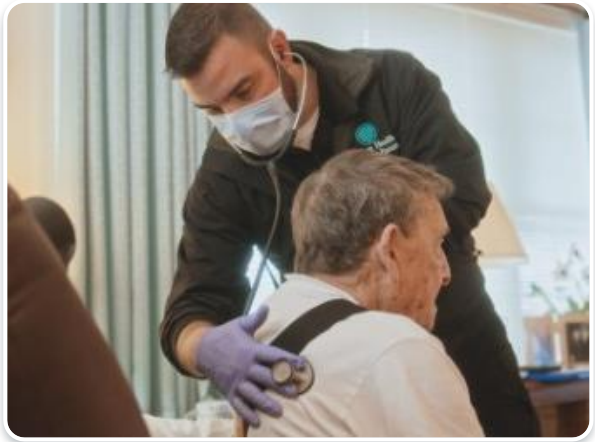
…supported by comprehensive enterprise resources.

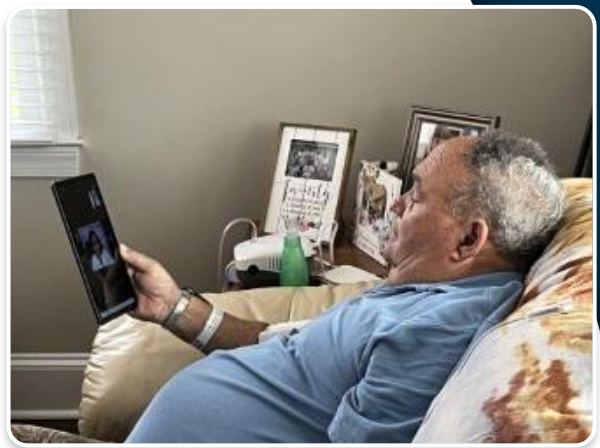
- Unified clinician care team
- Centralized enterprise virtual nursing team
- Unified logistics and supply chain structures
- Industry leading Mobile Integrated Health (MIH) team
- Transformational care continuum platform

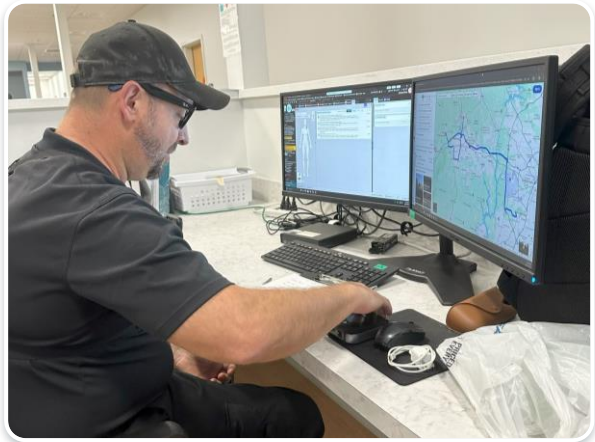
ADVOCATE HEALTH

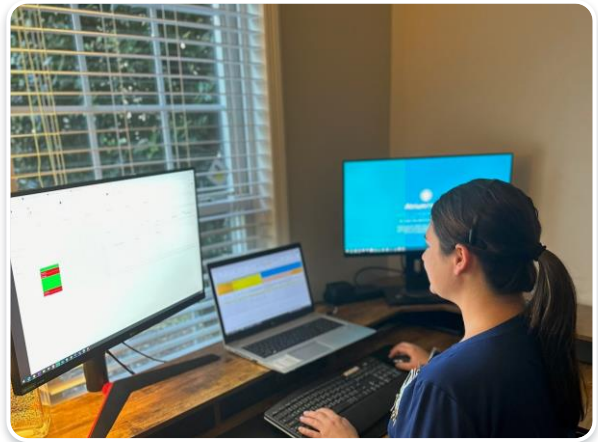
A day in the life.











1. Daily readiness
2. Morning visit
3. Virtual nursing
4. Afternoon visit
5. Team-based care
6. Repeat to discharge

ADVOCATE HEALTH