Solution Overview:

Acute Care at Home™

Reduce avoidable hospital admissions and readmissions while improving throughput, shortening length of stay, and maintaining high standards of care, safety, and satisfaction **by treating elderly, frail, or medically complex individuals at home.**

The Problem to Solve:

Despite healthcare advancements, systemic inefficiencies and lack of alternative site-of-care options persist, leading to inappropriate care utilization, patient ED boarding issues, and hospital overreliance for many patients.

As a Leader in Home-based Acute Care, myLaurel Aims to:

1. **REDUCE UNNECESSARY BED UTILIZATION**
   By decanting the ED and Observation Units.

2. **GET PATIENTS HOME SOONER**
   By ensuring safe patient discharges, to a soft-landing with care at home, while reducing the length of staypreventing downstream financial penalties

3. **REDUCE READMISSION RATES**
   Preventing downstream financial penalties

The Opportunity to Move Patients to Appropriate Sites of Care

Throughput & Backfill

$4,500

margin per admission

Boarders sit in facility at low reimbursement rates, but can't be moved due to lack of inpatient bed availability or discharge confidence

Moving patients ***through*** the hospital efficiently opens up space for transfer patients

Length of Stay

$3,025

Average adjusted expenses per inpatient day at hospitals

At that rate, one patient staying an unnecessary day at the hospital x 365 days per year totals ***$1.1 million in extra costs.***

*2022, Kaiser Family Foundation.

Patient & Clinician Experience

ED boarding is associated with:

delayed and missed care, medication errors, delirium, higher morbidity and in-hospital mortality, and longer hospital length of stay as well as poor patient satisfaction and increase clinician burnout.

*The Joint Commission Journal on Quality and Patient Safety, 2023

Decreasing the length of stay by one day would add ***$20 million in additional margin***, by accommodating more patients

*2024, KaufmanHall, 425-bed hospital with ave $4,500 margin per admission

Readmissions

11% — 22%

Average U.S rates

*CMS, 2024

How We Solve It

myLaurel utilizes an interdisciplinary care team comprised of field responders, nurse practitioners (NPs), registered nurses (RNs), and physicians (MD/DOs) committed to providing acute and transitional care to highly complex patients virtually and within their homes. This team employs a combination of in-person, telehealth, and telephonic approaches ***to ensure comprehensive care delivery based on each patient's specific needs over a 7— 30-day period of at-risk.***

Trusted by Health Systems, Payers, & Provider Groups

myLaurel™

PEOPLES HEALTH
A UnitedHealthcare Company

EmblemHealth

ilumed

archcare

CENTERLIGHT Healthcare PACE

Ochsner Health

Outcomes

65% DIVERSION IN FACILITY UTILIZATION

For patients in ED that would have resulted in an observation stay and/or admission to avoid hospital visits

[1] Large non-for profit system in southeast I myLaurel Analytics I March 6- June 11, 2024

3:1+ RETURN ON INVESTMENT

Based on partner utilization

77% CONSUMER PREFERENCE

77% of adults over the age of 50 prefer to age in place

1. Ratnayake M, Lukas S, Brathwaite S, Neave J, Henry H. Aging in place. Delaware Journal of Public Health. 2022;8(3):28–31. 11, 2024

89 PATIENT SATISFACTION

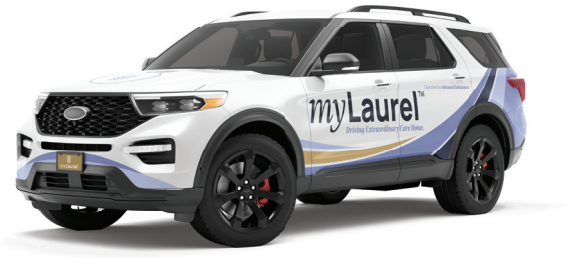
Average net promotor score

*myLaurel Analytics, all partners, inception-July, 2024

85% RECOMMENDED

Of people who have experience with receiving clinical care in the home would recommend it to family and friends.

2. Moving Health Home, August 2021; Methodology: Online interviews among a sample of 2200 adults. Data was weighted to approximate a target sample of adults based on gender, educational attainment, age, race, region. Results of the survey have a margin of error of +/- 2%.



Partner Testimonial

*"**Patient care is our top priority, especially for those who are frail, elderly,** or have complex needs. Our partnership with myLaurel gives patients access to high-quality care that allows them to discharge from the hospital and safely transition to the comfort of their homes. **This relationship is a win-win for patients and our caregivers**, as it frees up bed capacity for new patients while allowing those who are ready to continue their recovery from the comfort of home."*

— Medical Director of Hospital Access and Throughput
Not-for-profit system in southeast

Why We're Unique

myLaurel™

01 /// Flexibility

The myLaurel care model is tailored and based on patient need, allowing us to match visit frequency and intensity.

02 /// Expansion of your care with network integrity

All patients we see are direct referrals from the hospitals we serve. We are fully integrated into your clinical teams, operating off the same playbook. Our primary goal is to provide your patients a soft landing and timely access to post-acute care and then tuck them back into your system.

03 /// Clinical expertise & capabilities

Uniquely built to care for patients in their home.

myLaurel possesses a broad scope of capabilities, including real time diagnostics (e.g blood tests, 12-lead EKG), therapeutics (e.g IV, IM medications, oxygen and IV fluid via our in-home care team), labs/mobile imaging, prescriptions via tele support, and care coordination - with a supportive hand-off to your home health and/or primary care team.

04 /// Scale

Designed to help you serve a larger funnel of patients versus other post-acute models - with the flexibility in co-design of who we treat.

Partnering with myLaurel enables expanded capacity and efficiencies immediately without the extensive resources, time, overhead, training, and logistic configuration of facility planning or pursuing your own in-home post-acute model.

05 /// Complex patient care

Elderly, frail, complex, comorbid - this is our area of expertise.

06 /// Speed to value turn-key implementation

Clients are up and running in 90 days or less. We bring the resources, diagnostics, formulary, supplies, and operations bundled and ready to execute, with a single internal champion needed from your side to get going.

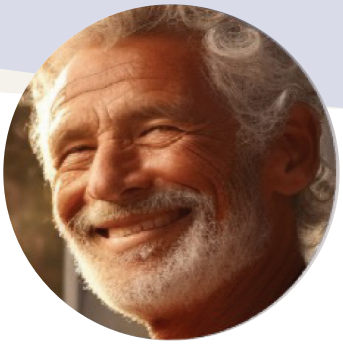
07 /// Outcomes based contracting

We put our fees at risk for readmission while under our care, aligning our clinical team more closely with our hospital partners.

08 /// Did we mention 3:1+ ROI?

Patient Journey

Meet Frank: 93 year old male



IP admitting diagnosis: Pneumonia
History: lung cancer complicated by bilateral pleural effusions, mild aortic stenosis, CKD 3a, GERD, and polymyalgia rheumatica

1. PATIENT IDENTIFICATION

Frank presented to the ED with diarrhea, weakness, and worsening dyspnea on exertion. On exam, the patient was febrile, hypoxic, had crackles on the left base. X-ray showed a left lower lobe pneumonia.

2. PATIENT TRANSITION & COMMUNICATION

Frank was placed in observation and treated with IV antibiotics.
The O2 saturation improved but because of co-morbidities the patient required additional IV antibiotic doses before transitioning to orals.

3. HIGH-ACUITY IN-HOME PHASE

Frank received 2 more days of in home IV antibiotics as well as O2, nebulizer treatments. PHQ9 was positive at 11.

GAD/SDOH screening and caregiver strain assessment were negative.

Medication reconciliation revealed both an ACE and ARB were active meds, the ACE was discontinued.

4. CONTINUOUS CARE PHASE

RN coordinated with the PCP's office for a referral to a psychologist.

The RN initiated goals of care conversation - completed with the PCP in the next in-person appointment.

The family contacted myLaurel regarding increased shortness of breath and yellow sputum; an additional Acute Care at Home visit was dispatched, **preventing a return to ED.**

5. TRANSITION OF CARE PHASE & OUTCOMES

Consulted with PCP regarding depression and goals of care
Referrals made for DME and HHA.