Andrew Mok:

Hi. Good morning and welcome back to the Barclays Global Healthcare Conference. My name is Andrew Mok and I'll be hosting today's session with Encompass Healthcare. Thanks to the entire Encompass team for joining us this morning. It's my pleasure to welcome Mark Tarr, CEO, Doug Coltharp, CFO, Barb Jacobsmeyer, president of Inpatient Hospitals, April Anthony CEO of Home Health and Hospice and Chrissy Carlisle, Chief Investment Relations Officer. I believe Mark has some opening remarks. Mark, why don't I open up the floor to you. Mark, I think you're on mute.

Steven Valiquette:

Yeah Mark. You fell for the oldest trick in the book.

Mark Tarr:

Okay. Well thank you Andrew. Hopefully everyone can hear me now. I want to appreciate everyone joining us today. I want to start off just some brief recap comments first on 2020 and then probably more importantly, how excited we are with the momentum that we've taken into 2021. But in spite the disruptions of COVID in 2020, we were able to achieve the primary operating priorities that we had set out in 2020 to achieve. Start first with the herb segment, we brought on four new hospitals and a number of those were new States that were excited to have a presence. Both of our operating segments had to implement the new regulatory changes. We had the section GG on the earth side of our business, and of course PDGM on home health. Those were challenges that we successfully faced. We saw the continued growth and the earth side of our business with the Medicare advantage payers and continued to have a chance to show our value proposition that we can achieve. Took it with the COVID patients, where the higher acuity patients, that we could get great outcomes and get those patients back home.

Mark Tarr:

And then we continued to advance our post-acute solutions using all this data that we can now capture through our electronic medical record and data analytics and most notably through our readmission prevention model. It was a busy and successful year on the ERP side in terms of achieving a number of these operating priorities that we had set out. Same thing on home health and hospice. I already alluded to the fact that we implemented PDGM. Once again, the home health and hospice segment had the highest margins in the business. A part of that can be attributed to introducing and new therapy compensation model at the height of the pandemic. We had a chance to continue to roll out and utilize the information with Metalogics care tool and working with our therapists and nurses out there. And then we're excited about the fact that we executed on new national contract with United healthcare, with MA plans there.

Mark Tarr:

We continue to have ample discussions with the MA plans on both of our segments. We have a lot to be excited going into 2021. The fundamentals of our business remain very strong. We were very pleased to see the volumes come back throughout the year and fourth quarter and then that carried over into the first quarter. So for 2021, we'll see eight new hospitals coming on. In terms of our ERP segment, we have 12 new hospitals are planned for 2022. We have a very robust pipeline. That's a combination of wholly

owned and joint venture hospitals. We'll continue to build upon the MA plans and working with the payers to continue to show the value proposition. We've very successfully done that with stroke patients. We think there are other categories of patients as well, such as fractured hips, that we can show the same value or increase values with those patients treated in an ERP versus a nursing home.

Mark Tarr:

And then we're pleased to continue to be involved with the American Heart Association. We'll be co-branding and launching stroke continuing education programs. And so that relationship with AHA has been very positive in terms of positioning the company as the go to site for stroke rehabilitation. It'll be another active year for home health and hospice as well. This is a year where we would say that the reimbursement landscape has greater visibility than at any time in the recent history. We'll continue to focus on capturing market share both organically and through industry consolidation. We certainly with the improvement in the trend lines for COVID, we would expect for the elective procedures to start to take back up.

Mark Tarr:

Particularly those in orthopedic categories that would benefit our home health agencies and increase [inaudible 00:05:31] there as well. And then we're collaborating with two home health care organizations that provide personal care to support the snip and home program. And then finally, we're encouraged to be rolling out a virtual visit platform with national payers capitated programs. We have a full slate of advancements for 2021 that we think are clearly indication of the basic fundamentals and drivers of our business that will lend to the growth and continued need for the services we provide in each one of our segments. So, Andrew, that was very quick recap of 2020 and those areas that we're very excited about in 2021.

Andrew Mok:

Great. A lot to unpack there and you put out on an AK this morning. So to start, I'll ask you to highlight the real time volume friends in that release, including the impact from the February weather disruption in Texas.

Mark Tarr:

Yeah. As I said, we got off to a good start in both our operating segments in 2021. Each segment was at or in the ERP case slightly above pre pandemic levels, particularly for March. Home health got off to a really strong start in January. February, of course the storms in Texas and Oklahoma were impactful for us for that for the seven day time period. We estimated impacted us by 700 admissions. The good news is that, that volume has rebounded. We're seeing a return to normal business and the hospitals are returning back in terms of their volume. We're starting to see the downstream flow from that. We did not have volume impacts from the storms in our hospitals. Although, we had some increased expenses that will be affiliated with that. Whether that's putting up our staff in hotels or having to buy water and other supplies. But it certainly had a short term impact our home health and hospice.

Andrew Mok:

Got it. One thing that caught my attention was the incremental expenses from the winter storms, but the volumes were not significantly impacted. What were some of the measures you took to mitigate the volume impact from that storm?

Steven Valiquette:

I'll let the Barb Jacobsmeyer talk first about what we did with our hospitals.

Barb Jacobsmeyer:

The main reason I think we didn't feel the impact on the hospital side, we certainly saw a few days of delay where patients were not able to discharge home from our hospitals. But what we saw is we had saw the same impact in the acute care hospitals. Their patients weren't able to move out. By the time things started to clear up and our patients could get home. We had a large pending referral list to get patients moved into our hospitals from the acute care hospitals. While we had a few days of delay getting patients out, we didn't lose any admissions because those pending needs were happening in the acute care hospital. We refilled and actually filled the discharges once we were able to start moving patients.

Mark Tarr:

Then April, you want to provide some insights from the home health side?

April Anthony:

Certainly health had a little bit more of a near term impact. Those delays and discharges from the hospital, the inability for our clinical staff to get out to physician offices and the physician offices themselves being closed over the holiday resulted in about a 700 admission decline in the month of February. About 30% of our total volumes come from Texas and Oklahoma, which were our most significantly impacted States.It certainly set us back after a really nice start to the year in the first six weeks that, that storm that took about seven days out of February. it was pretty impactful to our February results. We were encouraged by the return to more normalized volumes in the last week of February and feel good about the start that we've seen to March as well. I think we got the rest of the year to recover that. So we feel good that we can certainly do that over time, but impactful in the short period that we had February.

Andrew Mok:

Got it. That's helpful. There's an ongoing debate in the marketplace about how quickly utilization could rebound as COVID cases decline. Is there anything that you would note during the current drop in cases that would suggest a different or accelerated pattern for non COVID utilization. Maybe a rebound in deferred procedures like orthopedic or joint replacement?

Mark Tarr:

Andrew, a number of things that we have tracked and learned over time in a COVID environment in terms of metrics to keep track of. One is, we have seen a significant reduction of our own staff that had to be quarantined due to exposure to COVID. We got as high as 1100 staff at one point during the peak of the pandemic. These were staff that we had to take out of their availability to come and care for patients because they had been exposed. That was down to I think almost 300, a little bit less than 300 this last week or less than that. We've seen a four week decline on staff that have been out on quarantine.

Mark Tarr:

We've also seen a decrease in number of COVID patients that we have both in our hospitals and in our home health service. At the same time, we've been able to increase the number of vaccines for our staff. And so the combination of all the above gives us a great deal of encouragement that we're getting on the other side of this pandemic. And hopefully that will continue to exist and there won't be a surge. But like I said, between the staff that were out or the number of patients we're treating, both of those right now are at multi-week lows. And we find that very encouraging.

Andrew Mok:

Do you have an update on the vaccination rate among your clinicians?

Mark Tarr:

Yeah. So on the ERP side of our business, 43% of our employees have been vaccinated with at least one dose. And then on our home health side, we have 28% of our employees have been vaccinated with at least one dose. With every passing week that just continues to increase as we have access to the increased supply side on vaccines.

Andrew Mok:

And on the patient side, how has the vaccine rollout progressed in the senior living facilities where access restrictions have hampered growth? Can you talk a little bit more about the reopening efforts that you're seeing?

Mark Tarr:

Sure. April, do you want to touch base on that?

April Anthony:

Yeah. We're very encouraged by what we're seeing in the assisted living facilities. They've been pretty proactive and the government has been working strongly with them as well as the pharmacy suppliers to get those vaccines out. Almost all of the ALS that we have worked with have at least had one round of vaccinations for the residents that are willing and eligible for receipt. We're seeing that come online with more and more of them having those complete second doses. And in turn, they're asking that our team members be fully vaccinated to come into their buildings as well. I think we've still got a few more weeks before we'll be at a place where we'll be fully back in, but we're getting awfully close to that and we're seeing steady improvements in our percentage of residents that are being cared for in those assisted living facilities. That's been moving in the right direction. I think the vaccine is going to accelerate that.

Andrew Mok:

Okay. Great. I also wanted to touch a bit on technology. Your technology suite has been a positive differentiator throughout the enterprise. Can you talk about some of the new predictive models you're deploying with respect to readmissions and fall prevention?

Mark Tarr:

Yeah. So Barb Jacobsmeyer has been very involved with that, providing leadership on that. So I'll ask her to weigh in.

Barb Jacobsmeyer:

On the readmission front, we did get that rolled out to all the hospitals by the end of 2020. That's been really critical because as you know in the past, we focused on our react model, which was to help prevent the patients to have to go back to the acute care hospital while they were with us. But a big cost to payers and to acute care hospitals as it relates to their readmission is really that readmission that happens after we get the patient home. The deployment of the readmission prevention really takes into account other types of variables for the patient that affects them once they get home. The readmission prevention allows us to notify whether it's our home health or another home health of a patient's risk for readmission after they get home.

Barb Jacobsmeyer:

That really helps that home health focus on getting out to see that patient within that first 24 hours and try to help front load visits because that patient's most critical time is usually that first week at home. And what we find is that a lot of the home health do have the ability to have some risk mitigation efforts as they start to diagnose and evaluate the patient. But that many times it takes those first few days of visits to get that information into their system. This predictive analytics allows us to notify them at the time they're leaving our hospital that they're high risk. We're going to be able to monitor what does that readmission look like and how much are we able to decrease that readmission after the patients leave our hospital? So we're really excited about that.

Barb Jacobsmeyer:

Like I said, that got out to all of our hospitals by the end of 2020. On the fall prevention piece, we're really just at the stage now what we're going to be developing and piloting that. But that will have an impact on readmissions because we've had over 12,000 falls in our hospital in the last year. And those are things as the patient enters the rehab hospitals, one of the goals is to help them become more mobile. Becoming more mobile they're at greater risk of falls. And there are some times those falls actually create a need for a readmission. And that obviously increased costs to the payers as well.

Barb Jacobsmeyer:

A lot of the current systems out there to predict a patient's fall risk have been developed and are more for the patients in the acute care hospital. If we use those models in our rehab hospitals, almost everyone of the patients are at a fall risk. It really doesn't help us focus and identify those patients at greatest risk. So we'll be starting to model this predictive model in our hospitals and refine it just like we did with reacts, just like we did with the readmission prevention, with the goal of having something that we can roll out to all of our hospitals by the end of this year.

Mark Tarr:

Andrew, just as a reminder, we made a pretty substantial investment a number of years ago with Cerner corporation to work collaboratively on developing an electronic medical record that is specific to what we do in a rehabilitation hospital. That's been fully deployed now for use. So what we are able to do now is capture that data over 400 plus thousand discharges now since we've had the system. We're able to collect that data, do data analytics, create these predictive models that Barb just touched based on. We're really starting to see the benefit of that investment made several years ago.

Andrew Mok:

Okay, great. Let's transition to the home health segment now. Throughout 2020, new referrals lead to nice market share gains from SNF diversions, but the next leg of SNF market share gains will likely come from the higher acuity patients. How do you think about that opportunity set for home health and what investments are you making in this area?

April Anthony:

I'd be happy to jump in there and talk a little bit about that. We're I think excited about what's happening with SNF diversion. We've seen it really accelerate obviously throughout the course of the pandemic, but at the same time we recognize that the SNF and home model, although a catchy phrase, doesn't have a full reimbursement model around it yet. We're certainly seeing the opportunity to take higher acuity patients into the home and under the current diversion strategies, we're seeing that those patients, if they have a reasonable caregiving network, can come home and that home health can support their acuity of those patients under the current model. There are other patients that as you really think about the broader scale of this SNF at home model are going to need a different kind of reimbursement model. Something that covers non-skilled care, home delivered nutrition, a variety of different things that we don't have in the model today.

April Anthony:

I think we're working with payers who are willing to come up with innovative ways to create those models when it comes to the traditional Medicare model. I don't think they're quite there yet, on being ready to the innovate a SNF at home model. But we're seeing a lot of the payer relationships where they've got a strong interest in finding a new alternative to that. I think we're going to find lots of opportunities and that when we can put together the right structure of both reimbursement and access to those home-based services, SNF at home model has the potential to make a huge difference in the daily cost of care. Under our current home health model, our average reimbursement per day runs right around $50, even a little bit less than that. You take that clear to the nursing home at 450, there's a place in the middle where I think a SNF home model could work really effectively.

Andrew Mok:

What needs to happen on the regulatory side to facilitate that shift upward? What do you need to see from CMS here?

April Anthony:

I think it's honestly less of a regulatory change and more of a reimbursement change. It's not that we necessarily need some freedom to care for these more acute patients. We can handle the skilled components of that care. It's just that we need reimbursement to support the non-skilled components of that care. Today, we can do that when families have the personal financial resources to do it. But as you know, that's an expensive undertaking to bring in a non-skilled caregivers for a block of hours each day. And so many families can't afford that alternative. And until the government steps in and says, Hey, there's a model where we can see savings between the 450 a day for nursing and the 50 we're currently paying for the skilled portion, then I think there starts to be a much broader opportunity. It's less of a regulatory issue and more of a reimbursement issue.

Andrew Mok:

Got it. That's helpful. COVID has also accelerated long-term trends toward virtual care broadly. How do you think about the role of telemedicine within home health specifically? Where are you seeing the greatest levels of adoption and where are you seeing the greatest levels of resistance to telemedicine?

April Anthony:

Yeah. I think we're certainly encouraged by what telemedicine can do. But we also are quick to recognize that in our population, there's not really a one size fits all kind of approach to telemedicine. That you've really got to figure out how are you going to make it impactful? How are you going to do it in an intentional manner that ensures the patient outcomes are realized? I think we're seeing really a multi-channel approach. Sometimes it's two way video calls. Sometimes it's just telephonic interventions with patients who don't have two-way video capabilities. Sometimes it's text messaging using the Cincy app that we've recently adopted. Sometimes it's a combination of all of that. Sometimes it's home-based sensors and in-home telemonitoring devices. There's just all kinds of different combinations. And what you've got to do is find the right combination for that patient based on their acuity, based on their ability, based on their mental status, just a whole host of factors that determine what the right combination is.

April Anthony:

I think where the innovation is going to come is that we're going to start to see over time that instead of admitting a patient and designing a care plan that's a hundred percent visit based. You're going to start to see care plans be much more of an evolutionary thing where you start with a visit based approach. You add in some combination of telemedicine that fits for that patient. And then you start responding on an as needed basis, an exception basis to the care. And so your face-to-face visits instead of planned or just observation and assessments, start to become the things that are done as a response to what we're learning through the telemedicine alternatives. And then we start incurring face-to-face visits when they really fit, when they're really needed. So that we're getting the most bang for the buck out of the face-to-face encounters, and in turn the most efficiency out of the telemedicine opportunities that we have through that multi-channel approach.

Andrew Mok:

Great. That's a nice segue into the home health segment performance and Metalogics. In the back half of 2020, the home health segment delivered meaningful margin expansion. Can you flesh out the drivers of the cost improvements, including the impact of Metalogics? What were some of the unexpected outcomes from that rollout?

April Anthony:

Yeah. Well, one of the primary drivers certainly of the margin improvement was our cost per visit. If you lower visits, but you don't manage your human resources well and cost per visit goes up, you really don't accomplish anything. You give the patient less care and you just spend the same amount of money to do it. I think what we proved to be really adept at in the second half of the year as volumes were shifting and moving rapidly, it was creating a cost structure with our employee base to make sure that we were bringing our cost per visit down. We did that through innovating our therapy compensation model. We leaned into some of those same resources into our nursing model and we did a really efficient job of managing cost per visit. Along the way as we deployed metalogics, it really got it officially deployed by the end of the second quarter. But because a lot of that deployment was happening in the

midst of COVID, I think it was a little bit less an immediate adoption just because people were so distracted with all of the other COVID related issues.

April Anthony:

It took us into the third and fourth quarter to really begin to see much in the way of gains in that. But you will notice as you look at our visits episode, that we began to see some improvement in third and fourth quarter regarding visits per episode. I think we've still got a pretty good runway of improvement that we'll see from Metalogics tool in the really each quarter of 2021. I think you're going to continue to see migration in our visits per episode and we're moving cautiously because we want to make sure that our outcomes are not affected. We want to make sure that our patients are getting all that they need. We're taking a bit of an expeditious approach to cautiously moving toward what we think is a great new opportunity on visits per episode. And the combination of improving visits and lowering cost per visit is going to create a nice margin uptick. I'm proud of the balanced way that we approach that this year.

Andrew Mok:

That's great. We're just about up on time here. Maybe last question. We're now one year into the pandemic. Can you speak to the lessons you've learned in managing to the crisis and how your organization is better prepared to deal with the next crisis? Maybe start with Mark

Mark Tarr:

Andrew, first of all, I'm very proud of the way our organization responded to the crisis. We were very responsive to the acute care referral sources. We never hesitated in taking COVID patients, either in our hospitals or home health agencies. We proved that we could treat these patients and treat them well and be a valued part of the post-acute continuum. I think it's obvious to all that not all parts of the post-acute continuum was able to perform with COVID patients. In particular, the skilled nursing facilities were very challenged with that higher acuity patients.

Mark Tarr:

I think that the one that tailwinds we take away as an organization is this good will that we continue to develop with our referral sources and the fact that we showed the quality that we could provide in an environment that a really high acuity patients. I think that clearly we learned to diversify our supply chain for PPE supplies. We did that in the middle of last year. I think that we've also seen the continued resiliency of this organization and its ability to mitigate challenges thrown at it, whether those are regulatory or whether those are pandemic, whether those are cost or pricing changes in the marketplace. I think our organization has a lot to be proud of in terms of the way we handled ourselves in 2020 and what we can apply to 2021.

Andrew Mok:

Wonderful. We're in overtime now so let's end it there. Thanks again to everyone for joining and please enjoy the rest of the conference.

Mark Tarr:

Thank you. Appreciate it.