Investment Thesis Report: Hospice Care

March 2024

FCA | VENTURE PARTNERS

Contents

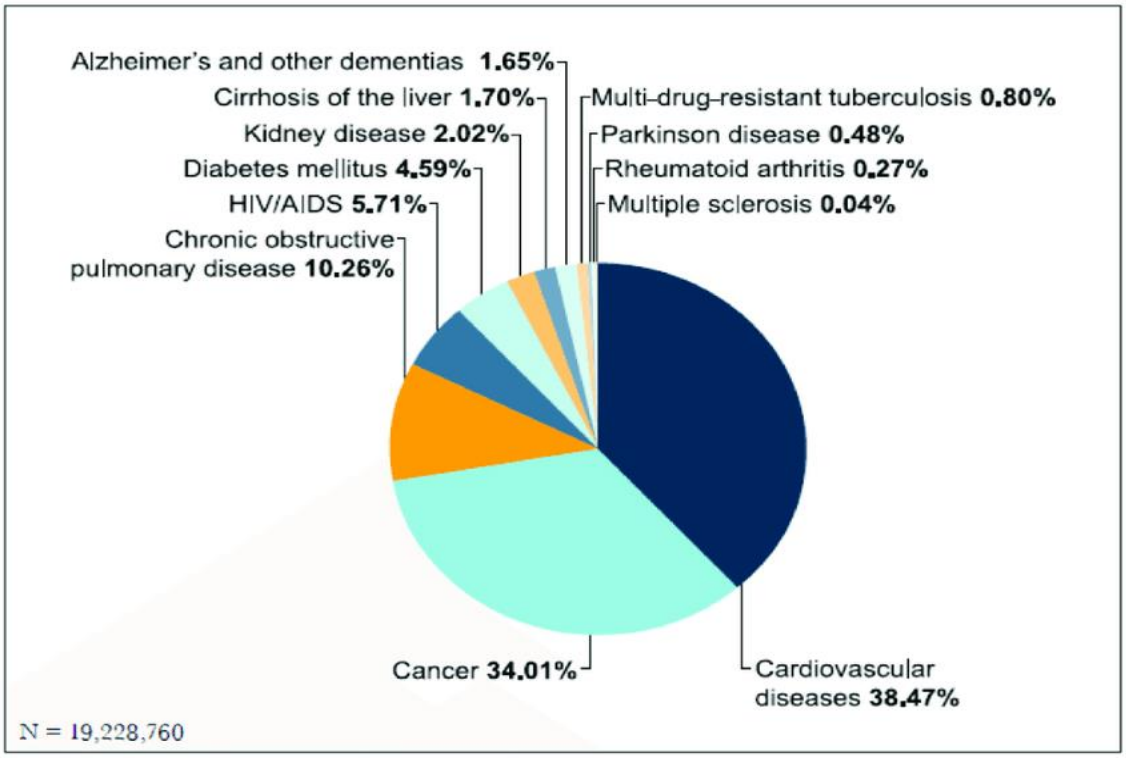
Abstract

Hospice care is a specialized approach to healthcare that focuses on providing comfort, support, and dignity to individuals with terminal illness and their families. This form of care is designed to be a 6-month plan agreed upon by the patient, and/or family if given the right to make medical decisions on their behalf, focused on providing comfort when curative treatment is deemed no longer possible. This form of care delivers patients and families with the emotional and physical support needed at the end of life. Hospice care, a palliative care branch, originated in early 1950s in England. The idea took off in the early 1970s when Dr. Elisabeth Kubler-Ross interviewed 500 terminally ill patients and drafted a book on their struggles. In her book *On Death and Dying*, Dr. Kubler-Ross states, “It is only when we truly know and understand that we have a limited time on Earth - and that we have no way of knowing when our time is up - that we will begin to live each day to the fullest as if it was the only one we had.”[1] Dr. Kubler-Ross makes a strong push for people at the end of their lives to be cared for in a setting and environment in which they are familiar. Before a patient can be considered for hospice, two physicians must sign off that the patient has a terminal illness and has six months or less to live. Hospice care consists

of four levels including routine home care with regular visits from hospice care providers, general inpatient (GIP) care if pain or other symptoms cannot be managed at home, continuous home care for more intensive short term support if someone qualifies for GIP but wishes to remain at home, and respite care in a hospice facility as a temporary solution to give caregivers a rest. While the treatment differs between the different levels of care, hospice care generally provides holistic end of life care focused on a patient's mental, emotional, social and spiritual health, comfort medicine to relieve pain and ease other symptoms, medical equipment to make bed rest easier, short-term care in a facility if care cannot be administered in a home, and support for family caregivers. Hospice is comfort care without curative intent; the patient no longer has curative options (chemotherapy, surgery, dialysis, antibiotics, etc.) or has chosen not to pursue treatment because the side effects outweigh the benefits. Hospice patients can "revoke" hospice care at any time without any penalty and then decide to reenroll later if their illness progresses.

End-of-life care is a fast-growing market as the number of Americans 65 or older is expected to grow 83% from 52 million in 2018 to 95 million in 2060.[2] This growth will raise the age group's share of the total population to around 25%. In today's culture, death is typically an uncomfortable subject and brings about grief and heartache. However, the mission behind hospice is to make a patient comfortable in their final months and enable a patient's family to feel at ease knowing someone is looking out for their loved one. Hospice care has three main offerings provided to the patient: a comfortable place to live in, usually either a nursing home or their residence, necessary comfort for the family, especially during the bereavement period, and the right caregivers to provide the best care possible given the fatality of the diagnosis.

A common misconception is referring to home health and hospice interchangeably. While these two forms of care do have some similarities, there are several distinctions between the two. Home health is a therapy or treatment provided to a patient in their own home before end-of-life care is administered. Government-sponsored home health care is up to 21 days for 8 hours each day, with the goal of improving the patient's health. Curative treatment measures are provided within this type of setting. If the home health nurse sees no sign of improvement after 21 days, the patient is then considered for hospice care, where the curative treatments end and the focus becomes comfort for end-of-life care. In order to determine a patient's improvement, nurses typically look at weight fluctuations, level of codependence, mental acuity, breathing difficulty, and disease progression. If these metrics are all trending in the negative direction, the nurse then must consider hospice care and defer to other physicians for their assessment. Nurses also use the Palliative Performance Scale (PPS) to assess a patient's health. PPS includes several factors: self-care, intake, activity, evidence of disease, level of consciousness, and ambulation.[3] As shown below, cardiovascular disease and cancer account for nearly ¾ of all diseases for hospice patients.



[4]

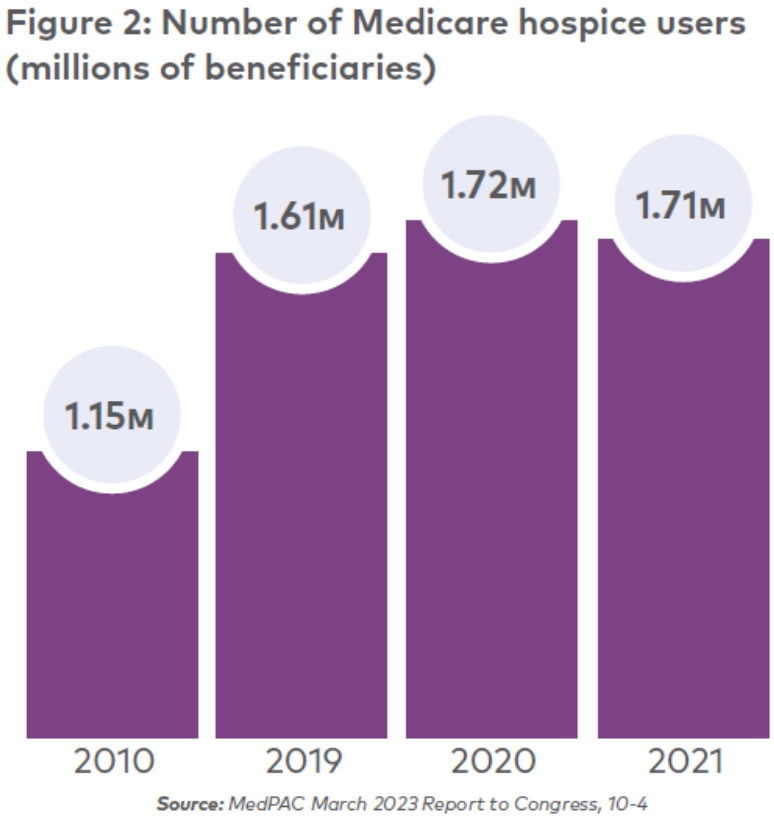
This graph by ResearchGate is a complete list of every patient's disease checked into hospice care by the end of 2018.

Current Advancements

Covid-19 Shifts

Demand for home-based hospice care has grown significantly over the past decade, evident by the number of Medicare hospice users growing by nearly 50% since 2010. As more attention is being directed towards hospice, there is also an increased call for innovation within the historic model. A recent surge of patients and providers is calling for change to the payment methodology, administrative requirements, and overall ease-of-use models of hospice with the goal of bringing down costs for all involved. The original hospice model provided end-of-life

care solely in a nursing home. Patients would stay for up to six months while being surrounded by people with similar terminal illnesses where they could play card games, bingo, or other activities that involve little exercise.



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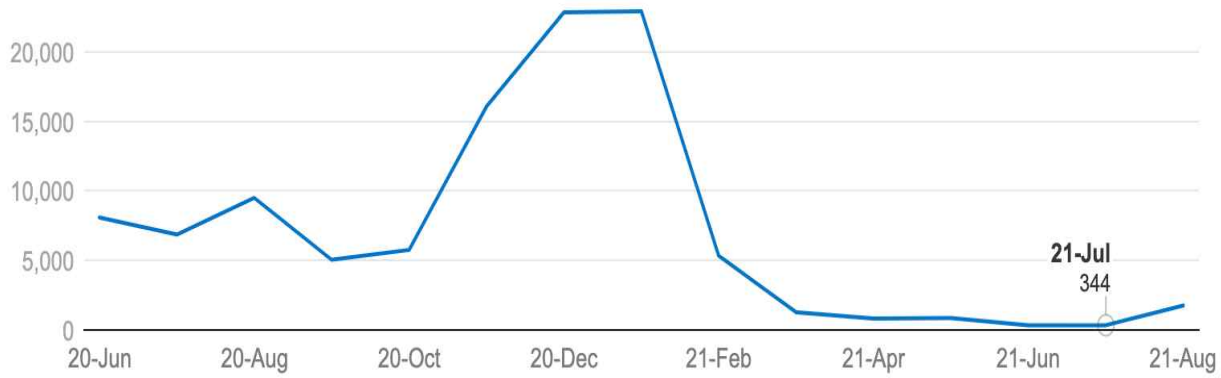
As shown in the graph above by National Hospice and Palliative Care Organization, the number of Medicare hospice users has grown significantly since 2010 yet remained relatively flat since 2019. The growth in hospice numbers slowed in 2020 and reversed course in 2021, in large part due to the Covid-19 pandemic which urged people to stay at home since hospitals, senior living facilities, hospice facilities, nursing homes, etc. became hotbeds for spreading the disease due to the confined nature and weakened immune systems of the patrons. In 2021, the number of hospice patients decreased and this trend has continued as more patients are requesting at home hospice care.



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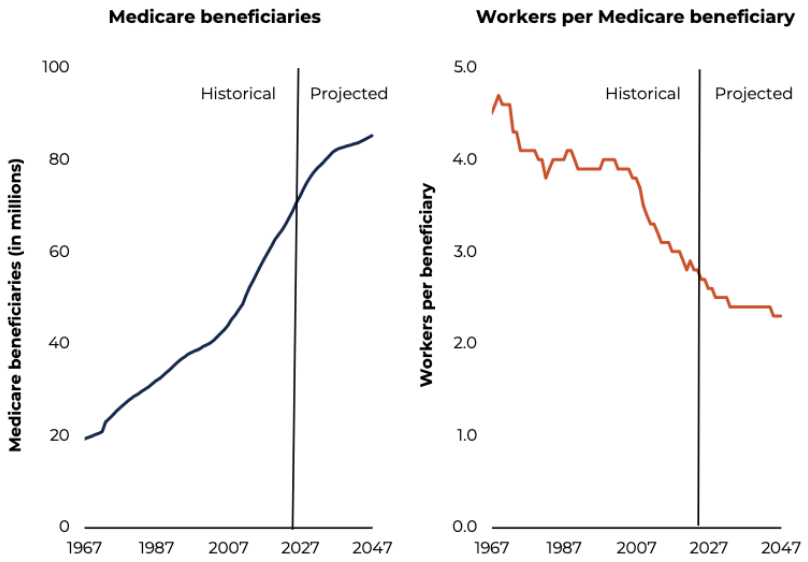
This graph by KKF examines the death toll of nursing home residents across the US from June 2020 to August 2021.

Between December 2020 and January 2021, the second wave of the COVID-19 virus, nursing homes saw 22,000 deaths (340% increase from just 2 months prior) among patients all over the U.S. The trend of hospice care delivered in the home, which began as a result of the pandemic and associated factors such as the nursing shortage and labor costs increasing has continued in the years following. This shift out of the acute or outpatient facility was well-received and appears to be a win-win-win for the providers, payers, and technology companies as new and innovative virtual care solutions can fill many of the historical care gaps caused by in-patient-only care models. Telehealth, virtual care solutions used to deliver care, is a large part of the "care at home" movement. Immediately following the pandemic, telehealth usage grew by 80x and has become a crucial aspect of providing care in today's society, ranging from dental to complex pulmonary medicine. Hospice has also adopted many of the emerging telehealth solutions and innovative technologies in order to extend high quality outside the four walls of a hospice facility or nursing home. For example, remote patient monitoring ("RPM"), a type of telehealth in which healthcare providers monitor patients outside the traditional care setting using

digital medical devices, has become a pivotal aspect of today's healthcare system. RPM is currently used by nearly every hospice facility as a way to monitor patients' health while they are in the comfort of their homes. RPM also gained popularity due to the nursing shortage, which made it difficult to send nurses into patient's homes on a daily basis. RPM has become the most viable tool to show a patient's progression and overall health while in hospice.[7]

The pandemic has been a significant catalyst for remote patient monitoring as a method of care. While hospice care, especially hospice at home, certainly has substantial benefits for both providers and patients, there are some challenges for patients in this care model. Lack of cellular data, digital illiteracy, and access to the internet are significant impediments for patients in rural communities who are already facing inequities in access to medical care. People facing these challenges often see loved ones die months sooner due to caregivers not being close by or nursing facilities being outside a 50-mile radius. Hospice is meant to be a place where someone is given comfort in the last few months or weeks, yet it is difficult for everyone to have equal access to this care. While the overall hospice market has grown since 2010, the hospice market in rural communities has moved the opposite direction. Between 2010 and 2021, the number of rural hospice facilities fell by over 7% from 910 to 845. The primary cause for this was a labor shortage, large hospice care providers could not hire enough caregivers to satisfy the need in these rural areas.[8]

Chart 1-7 **The declining ratio of workers to Medicare beneficiaries threatens the Medicare program's financial stability**

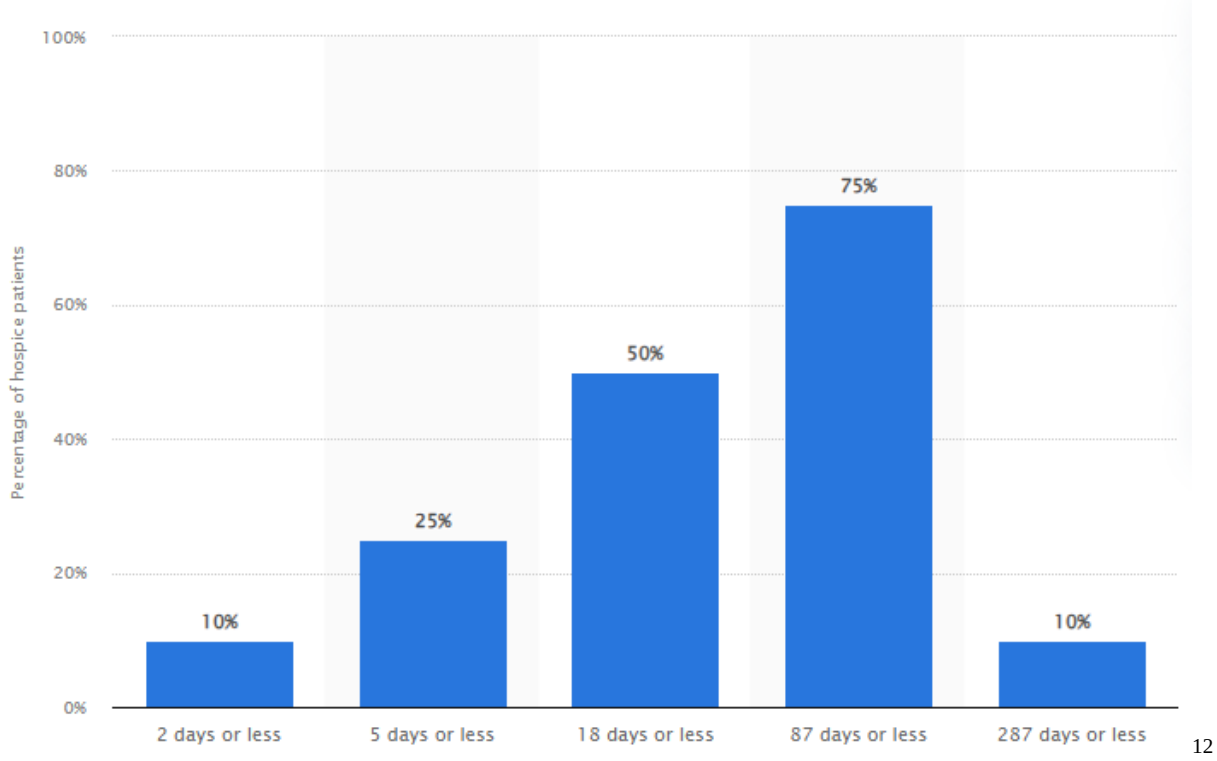


As evident in the chart above, the clinical labor sector is projected to see the worst drop in the workforce over the next 20 years. With the number of Medicare beneficiaries climbing to all-time highs, and the number of workers per Medicare beneficiary on a sharp decline, the spread between the two graphs is the opportunity for technology to come and make an impact on the labor market and improve margins.

Length Of Stays

The length of stay in hospice care is determined by a patient's age and stage of their disease. Patients seen with the least number of days in hospice are those with chronic kidney due to the speed and fatality of the disease once it matures. On average, Chronic kidney disease ("CKD") patients stay 38 days while Alzheimer's patients are seen in care for 105 on average.[10] Most beneficiaries never stay the full six months granted to them by Medicare or Medicaid. If a patient lives past six months, they can still use hospice but must receive an assessment from the medical director of the care facility and an outside doctor's referral that confirms they are

terminally ill. The average length of stay in hospice care for 2022 was 92 days. This number was down ~5% from 2020. In 2022, hospice care saved Medicare $3.5 billion, a 3.1% cost reduction from 2021, according to NHPC.[11] The cost reduction is largely due to the termination of the life-saving measures and expensive therapies in a hospital's high-cost environment.



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This chart from the Federal Registrar shows the length of hospice stays in 2019.

Quality Of Life

The most important thing a hospice patient typically looks for when trying to find the right provider is the quality of life (QOL). This term refers to a patient's overall well-being. Are they able to lead a normal life or maintain a sense of self? Are they going to be able to keep up socially with their loved ones? Can the patient and family attain a sense of closure when nearing death? These are all frequently asked questions when the beneficiary and family are looking for the right fit. Care companies know this and typically make it their top priority when hiring staff.

They will make sure their caregivers are not only equipped with the right tools but also know how to handle uncomfortable situations in the end-of-life process. The Hospice Quality Reporting Program (HQRP) is a requirement for all hospice providers due quarterly. HQRP is a good tool for deciding the best hospice provider. It reports four different quality measures: Hospice Care Index (HIC), Hospice Visits in the Last Days (HVLDL), Hospice Item Set (HIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS). All four of these metrics measure how a hospice provider should perform for their patients, families, and caregivers. Based on the HQRP, Enhabit, one of the largest and most successful hospice care providers in 2023, received the highest rating in HQRP among customer and employee satisfaction. While most companies strive in quality of life, there have been some cases that have ended up shutting down a business.[13]

Hospice Margins

Nursing Payments

Medicare payments to hospice providers continue to grow as more for-profit hospice companies come to market. In 2021, the number of for-profit hospice care groups increased by 6%, extending a steady trend that has been going on for nearly a decade. Medicare payments exceeded marginal costs to hospice providers by 18%.[14] Between 2010 and 2021, hospice spending grew from $12.9 billion to $23.9 billion, with a CAGR of 5.4%.

Regarding the day-to-day operations of the hospice facility, four main nurses deliver care. Routine home care (“RHC”) nurses spend the most time with the patient. They account for 98.7% of Medicare-covered visits.[15] The three other members of the hospice care team are for more specialized treatment. Continuous home care (“CHC”) nurses are used for brief periods of

crisis and typically visit patients in private residences. General inpatient care ("GIC") nurses provide treatment for symptoms that cannot be managed in another setting. Lastly, inpatient respite care ("IRC") nurses are used to try and stabilize a patient's breathing (normally in late-stage hospice). Payment rates vary drastically between the four: RHC has two per diem rates of $211 for 1-60 days and $167 after 60 days in care, CHC rates are $63 per hour, GIC per diem rates are $1,111, and IRC per diem rates are around $492.[16] In 2020, CMS rebased the payment rates of the three more specialized nurses in accordance with their expertise. This in turn lowered the reimbursement to RHCs both on a relative and absolute basis compared to their peers. As hospice costs increased by 4.2% from 2020 to 2021, facilities are challenged to keep margins positive while also compensating their employees for the care they deliver and the mission they are helping to act out on behalf of the hospice facility.[17]

Shorter hospice stays, typically associated with the costliest patients due to the severe acuity of the disease, are seen most among patients with cancer, genitourinary disease, and digestive disease. Longer stays also attract attention from the U.S. Centers for Medicare & and Medicaid. Exceeding the maximum 6-month stay gets "red flagged" and can trigger an audit. For-profit hospice facilities' margins are significantly higher than their not-for-profit competitors. -- 19% in for-profit facilities compared to 3% in non-profit facilities.[18] Non-profit hospice facilities are not as sensitive to certain costs as their for-profit peers. Both non-profit and for-profit want to provide the best care possible but for-profit hospice companies can spend 300% more on advertising than non-profits. Also, non-profits spend more on visits per day than for-profit.

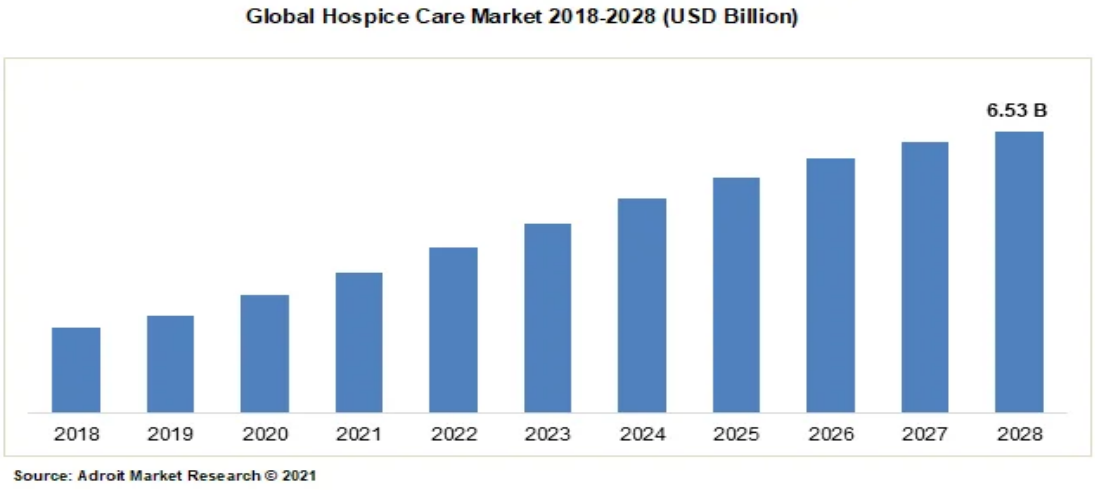
Higher margins are seen in urban areas than in rural areas due to several factors including economies of scale with nurses being close in urban areas, higher overhead costs in rural areas with transportation and recruitment challenges, and greater demand in urban areas allowing for inflated prices.

Funding

Home Health vs. Hospice

Healthcare spending in the US is almost double that of all other industrialized countries. The uptick in price can be attributed to several factors. The total number of people aged 65 and older, who are typically the costliest patients, will reach almost 20% of the US population by 2027.[19] These individuals are eligible for Medicare coverage at the age of 65 and can take full advantage of it. Also, the overall inflation in the US is going up, causing the price of goods and services to rise. In the past 20 years, the Consumer Price Index (CPI) has seen the average price of medical goods rise 3.2% annually. This significant increase is .8% higher annually than various goods and services for everyday Americans. All healthcare fields saw an inflation in price due to the Covid-19 pandemic. The clinical labor sector is projected to see the worst drop in workforce in the last 20 years with 10%-20% of nurses stepping out of their roles. These resignation rates are not new for nurses, rather they have been exacerbated due to the stress brought on by COVID-19. The resignations and increase in drug and medical gear are causing inflation to rise all over the country. For inflation to reach the government payers (Medicare and Medicaid), CMS would need to abandon the model they've used for decades with the historical rate settings. The reimbursement rates should not see an increase in rates until 2024 or 2025, according to previous inflation changes by CMS.[20] Technology companies are the only cohort

that are optimistic in this inflated period. These tech companies believe clinicians will rely heavily on them to promote efficiency.[21]



[22]

This is a projection by Adroit Market Research of hospice spending until 2028.

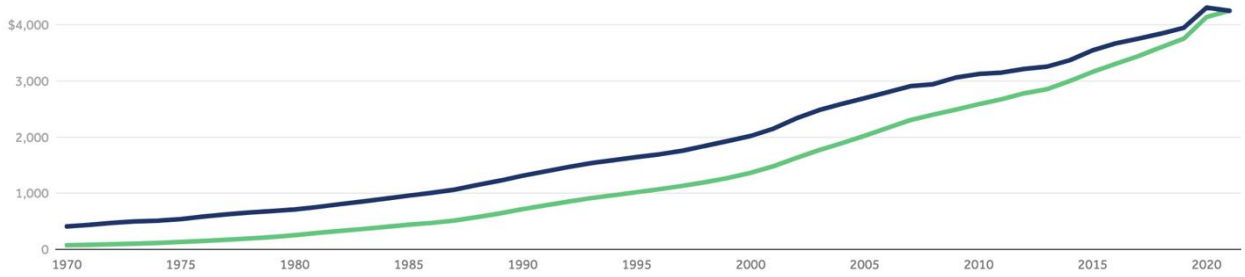
The funding for home health is declining significantly in 2024 due to permanent CMS cuts. The 2.2% cut would be a $375 million hit to the home health industry. This cut was made by the Biden administration who had spoken out about wanting more hospice funding, along with the rest of the party. CMS also implemented a 30-day unit of payment regarding home health Patient-Driven Grouping Models (PDGM). The new PDGM allows for a more patient-centered, clinically driven reimbursement model. It ensures that home health companies align more with the patient's needs rather than their own. This provides much less funding compared to the original 60-day payment model. All these pay cuts in home health are being directly put back into hospice care funding.

Medicare and Medicaid

Medicare and Medicaid are the largest federal insurance programs in the U.S. with 155 million Americans enrolled between the two. There are a few different requirements between Medicare and Medicaid when applying for hospice care. To enroll in Medicare, one must be 65 years or older. For a beneficiary of Medicare to enroll in hospice care, they must get a doctor or hospital to sign off that they need care. Medicare is broken down into four different parts. Part A and B (linked together under the name "Original Medicare") have the most enrolled members of any plan, with 33,948,778 out of the 65,748,297 total enrolled beneficiaries. This accounts for 51% of the total enrolled Medicare beneficiaries.[23] Their benefits allow them to use any hospital doctors in the U.S. who take Medicare and any outpatient and home health care that is covered through this medical insurance. Part C (Medicare Advantage) is run through a private company that offers a "joined" plan between Parts A, B and normally D. Enrolled members in Part C must use specific doctors in a plan network. This can help cut out-of-pocket costs, but it can be harder to find the right doctor on this plan. Part D is set up as a drug coverage plan for members already enrolled in one of the care plans.[24] It covers a wide range of prescription drugs that most Medicare beneficiaries would need to take daily like antidepressants, antipsychotic medications, anticonvulsive medications, and immunosuppressant drugs.

Medicaid has the largest number of enrolled between the two at 90 million. Medicaid is a federal and state-funded medical insurance for low-income U.S. citizens over the age of 18. These income requirements are broken down into the three categories of Medicaid but vary from state to state. In Tennessee, Medicaid Waivers / Home and Community-Based Services has an income limit of $2,742 per month for one applicant with an asset limit of $2,000. People applying for this level of medical insurance are normally "at risk" and want home health care.[25]

However, in North Carolina, individuals applying for the same level of care have only a $1,215 monthly income with an asset limit of $2,000.[26] If the applicant meets these monetary guidelines, they can fill out an election statement with a specific hospice care provider and get a doctor to sign off. The main thing Medicare and Medicaid have in common, once you start hospice, you will not be able to receive any prescription drugs or curative treatment from a doctor.



[27]This graph by KKF shows the growing U.S. spending in the medical field over the last 50 years.

In 2021, the United States spent $4.3 trillion on personal healthcare. Medicare and Medicaid make up a staggering 38% ($1.6 trillion) of the total spend.[28] Projections by CMS have shown that spending on hospice care will grow to $54 billion by 2032. Medicare payments to hospice companies have grown steadily. Projections show Medicare will see the highest increase of 7.5% due to the aging population.[29]

Reimbursement Rates

There was been a change in reimbursement rates in 2023 regarding the cap rates. In July of 2023, The Centers for Medicare and Medicaid ("CMS") passed a new rule (CMS-1773-F) to update the hospice payment system. The new rule will go into effect in the fiscal year (FY) 2024 and the hospice payments will grow by 3.1%. That is a $780 million increase from 2023 alone. CMS-1773-F would raise the cap rate per patient from $32,486.92 to $33,494.01.[30] This final

rule establishes, for FY 2023 and subsequent years, a permanent, budget-neutral 5 % cap on any decrease to a geographic area's wage index, so that a geographic area's wage index would not be less than 95 % of its wage index calculated in the prior FY regardless of the circumstances causing the decline. This means, the hospice company will be reimbursed 95% of whatever was generated in 2023, regardless of their losses. For example, if a hospice care provider earns $50,000 in 2024, they will be reimbursed no less than $47,500 in 2025, as a result of the 95% reimbursement rate. This was in response to Covid-19 when many rural and suburban hospice companies took large pay cuts due to being forced into lockdown. Even with the new changes, Medicare remains the largest hospice reimbursement payer. SIA (service intensity add-on) is another reimbursement that Medicare and Medicaid must pay attention to. SIA is a budget-neutral system that pays RHC nurses the CHC nurse rate ($63/hour) for up to four overtime hours. SIA was put into place when RHC nurses felt their pay wasn't nearly what it should be for the number of hours put in.[31] CMS signed off on going away with SIA but later retained the budget program due to the growing rates in FY 2023.

CMS Audits

With the Federal and State governments funding the hospice companies, audits are extensive. There are four phases to CMS audits. Phase 1 starts with an "Initial Engagement and Universe Submission".[32] This is a six-week process that is done before any fieldwork is laid out. The hospice company is notified they have been selected for an audit and must turn over the required documents in their database. Phase 2 is the hands-on "Audit Fieldwork." It normally takes up to three weeks and consists of web-based meetings, with the last week consisting of on-site audit fieldwork. Phase 3 is the conclusion of collecting data about the company. This phase can differ depending on the findings from the first two phases. CMS can draft a breakdown of

the preliminary findings and review them for the final evaluation. Once evaluated, classification occurs. Immediate Corrective Action Required ("ICAR") is findings of inappropriate behavior in the company and requires immediate action to mitigate further risks to enrollees. ICAR counts as two penalty points in the audit scoring methodology. Corrective Action Required ("CAR") states the company lacks the proper medications for enrollees. CAR counts as one point in the audit scoring. Observation Requiring Corrective Action ("ORCA") is the strictest reviewing process that the company being audited will go through. However, these findings are usually less significant and do not count as penalty points. Phase 4 is the longest process of the audit. It typically is a six-month fixing period for the hospice company. Hospice companies have 30 days to submit a non-ICAR corrective action plan ("CAP"). Once CMS has approved CAP, the hospice company has 180 days to validate their changes.[33] CMS or an outside group, with no conflict of interest, will conduct a shortened audit making sure the promised CAP has been met. If the audit has not met the remaining conditions, CMS will require another audit typically conducted through the Division of Compliance Enforcement.[34]

Startup Companies in the Hospice Care Market

In order to understand the hospice market, it is important to understand the innovation occurring in the sector. There are several innovative software technologies, as well as unique care models that are capturing the attention of hospice providers and enabling better care and lower costs. A few interesting early-stage companies focused on the hospice space are highlighted below.

Hospice companies

COMPASSUS

Founded: 1979

Employees: 6,000

Compassus is a network of community-based hospice, palliative care and in-home health services.

Mission to focus on the well-being of each patient under their care with their best quality of life in mind.

Recorded 2022 revenue of $698M, up 42% y/y. In 2019, Towerbrook Capital Partners and Ascension Health purchased Compassus for $1B.

Brentwood, TN with 151 locations in 31 states.

Three Oaks HOSPICE

Founded: 2019

Employees: 119

Three Oaks Hospice is a palliative and hospice care service company focused on maintaining the best quality of life for a patients.

Mission to bring peace to all their patients in a family members home or in a senior living facility.

Raised $21M in 2019 from Granite Growth Health Partners, Health Velocity, and Petra Capital Partners to support acquisitions of 3 TX hospice facilities.

Dallas, TX with facilities in 7 states.

VIRTUSENSE™

Founded: 2013

Employees: 61

Virtusense developed solutions to track residents' movements in hospice facilities to prevent falls.

VSTAlert is a new solution that identifies a patient's intent to exit their bed 60 seconds before they get up and alerts the staff immediately.

Has grown employee base by nearly 50% since 2022.

Peoria, IL

electronic caregiver

Founded: 2009

Employees: 168

Electronic Caregiver offers connected care and health plan monitoring at home or in senior living/assisted living facilities.

Addison Care, one of Electronic Caregiver's new solutions, provides care management for chronically ill patients through alerts and 24/7 emergency response

Raised $95M Series A in 2023 at a $544M post-money valuation, bringing the total capital raised to date to $176M.

Las Cruces, NM and partners with patients all over the country.

ENNOBLE CARE

Founded: 2017

Employees: 51

Provides home care, hospice, and healthcare staffing to ensure that a patient is taken care of in every way.

Committed to providing holistic care for a patient to ensure they are as comfortable as possible during end-of-life.

Undisclosed financing in 2021.

Hackensack, NJ

StateServ

Founded: 2004

Employees: 210

Distributes durable medical equipment to hospice and healthcare companies

Specializes in real-time reporting using analytics tools to ensure clinical efficiency through their “always on time” mission

Acquired in 2021 by WindRose Health Investors in a deal valued at $440M

Mesa, AZ

Founded: 2016

Employees: 21

Folia is a patient-driven Health-IOS (Individual Operating System) that enables individuals to easily take an active role in their care.

Folia's rich longitudinal data and proprietary analytic methods provide a vital and missing piece in the emergence of a home-centered, data-driven healthcare ecosystem.

Raised $6.5M seed round in 2021, led Correlation Ventures and Crosslink Capital

Boston, MA

Company Highlights

Compassus— Compassus has achieved success through a commitment to delivering high-quality end-of-life care, backed by a skilled and empathetic healthcare team. The organization's strong community engagement, effective leadership, and adaptability to industry changes contribute to its overall achievements. Compliance with healthcare regulations and a focus on patient and family satisfaction further enhance its success.

Ennoble Care— A provider of home care, hospice, and healthcare staffing services, this company stands out for its commitment to delivering personalized, concierge-like care. The recent acquisition by investors, including Applied Equity Partners and Peterson Partners in a leveraged buyout in October 2021, highlights strong investor confidence. There are plans for expansion into new markets and strengthening their presence in existing ones, responding to the increasing demand for palliative and home-based care with a patient-first approach.

VirtuSense— VirtuSense has achieved success by leveraging Artificial Intelligence (AI) and innovative sensors to accelerate predictive insights in healthcare. Their proactive approach allows physicians, caregivers, and families to prioritize patient-centric care while maintaining affordability and accessibility. By detecting movements and anomalies well in advance, their AI sensors contribute to reducing falls and preventing injuries, providing hospitals with valuable objective metrics to showcase the enhanced quality and value of their services.

Moving Forward

As the trend of providing care outside the four walls of the hospital continues to grow, the hospice space appears to be following suit. While hospice care does not include life-saving measures or treatments, the costs associated with hospice care remain elevated largely due to antiquated technology. The rise of RPM and other technological advancements within medicine should provide more cost-effective opportunities to monitor patients at the end of life. However, even with more innovative technology, the clinical labor shortage, especially in rural communities, serves as the biggest challenge for hospice care providers to scale. There remains ample opportunity for technological advancements that can improve margins on the labor front to be applied to the hospice vertical, as we are seeing this take place in the acute and outpatient space already. With the aging population in the US and the projected number of Medicare beneficiaries to reach record-breaking levels, the hospice space should prepare for significantly elevated volumes over the next few decades. Now is the time to begin implementing new technologies to drive efficiencies with patient onboarding, payments, care delivery, remote monitoring, etc. in order to care for more patients at scale.

FCA Venture Partners is a venture capital firm investing in early-stage healthcare technology and technology-enabled healthcare services companies that improve patient care, reduce costs, and increase efficiency. FCA manages over $250M and invests across the Series Seed to Series B stages. Our firm brings portfolio companies valuable healthcare insights, connections, and board-level experience to accelerate growth and build disruptive and sustainable businesses. Based in Nashville, the epicenter of healthcare innovation, with a strategic network in Charlotte and Winston-Salem, NC, our team has a decades-long track record including more than 60 investments in the rapidly changing healthcare industry.

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