Third Eye HEALTH

THE NETWORK EFFECT

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1.800.411.6768
www.thirdeyehealth.net

WHITE PAPER

The Network Effect

How after-hours care holds up at scale: national growth, facility-level consistency and what happens when a nurse calls at 2 a.m.

Executive takeaway

Third Eye Health's after-hours care model is not simply broad, it is repeatable. Across large and small facilities, rising consult volume, and expanding markets, the network continues to deliver fast clinician response, high treat-in-place performance, and operational reliability that matters clinically and financially.

The 2 a.m. Test

It is just after 2 a.m. at a skilled nursing facility in the Midwest: 120 beds, two nurses on the night shift, and a resident whose breathing has changed since the last round. The change is not dramatic, but it is enough to raise concern. Ten years ago, the options were limited: call the on-call physician and wait, call 911 and transfer the resident, or continue watching closely. Tonight, the nurse opens a tablet, and within minutes a clinician familiar with the building is reviewing the resident's chart.

That moment repeats, in some form, every night across more than 1,400 facilities. This paper examines what it takes to make that response reliable at national scale: not only in a single high-performing building, but across facilities with different sizes, staffing patterns, electronic health records, and call volumes.

National Scale, Facility by Facility

Many published proof points in after-hours care come from one facility over a short period. Those results can be useful, but they do not answer the harder question: whether performance remains dependable across buildings that operate very differently. A national network has to prove more than isolated success. It has to show that the same standard can hold across variation.

NATIONAL NETWORK AT A GLANCE

93%
Treat-in-place rate

2 to 5 min
Average clinician response time

1M+
Patient encounters

1,400+
Partner facilities

1,000+
Live EHR integrations

25%
Average reduction in avoidable admissions and readmissions

The tables that follow compare five of the network's largest facilities by bed count with five smaller facilities. The point is not that every building looks the same, it is that response times and treat-in-place rates remain within a narrow, practical range despite major differences in size and volume.

National Scale, Facility by Facility

Across both groups, response times cluster tightly, mostly between 2:08 and 2:49, with one 589-bed facility at 3:08, still within the published range. Treat-in-place rates run from 88% to 98%, but they do not track with facility size. That matters operationally: the model is not dependent on one ideal facility profile. A 35-bed building and a 589-bed building can both receive fast, consistent after-hours clinical support.

Data populated July 2026 from confirmed facility-level performance data. Facility names have been anonymized to letter codes (A–J).nFacility B uses its CMS-certified bed count (360), which differs from its publicly listed size (294).

LARGEST FACILITIES BY BED COUNT

Facility	Beds	Treat-in-place	Response	Monthly encounters
A	589	88%	3:08	118
B	360	95%	2:34	184
C	286	93%	2:08	166
D	220	95%	2:49	268
E	206	95%	2:42	268

SMALLER FACILITIES

Facility	Beds	Treat-in-place	Response	Monthly encounters
F	35	92%	2:42	22
G	80	98%	2:38	212
H	105	98%	2:38	255
I	123	97%	2:34	148
J	137	94%	2:40	77

What Happens When Volume Climbs Fast

A virtual care network is tested most clearly during periods of uneven demand, especially when overnight or weekend volume rises quickly. When call volume rises, clinicians, escalation paths, and support teams must absorb that pressure without making the experience feel slower or less dependable for nurses inside the building.

Between the first half of 2025 and the same months in 2026, average weekly consult volume rose 46.9%, from 7,400 encounters a week to just under 11,000. That number kept climbing through the first half of 2026 alone, up another 16% between January and June.

Every consult runs on a built-in safety net: a clinician who does not respond to a nurse within six minutes gets a direct prompt from the system, and if there is still no response within 15 minutes, the case forwards automatically to another available clinician. A resident is never actually waiting on one person.

Consult volume and missed-page notifications, H1 2025 vs. H1 2026

Metric	H1 2025	H1 2026	What it means
Avg. weekly consult volume	7,399	10,871	Up 46.9% year over year
Missed page notifications (share of volume)	1.48%	0.59%	Fell by more than half despite the surge

The result is a stronger test of scale than volume growth alone. Average weekly consults rose by nearly half year over year, yet missed-page notifications fell by more than half as a share of volume. In practical terms, the network handled more demand while producing fewer signs of delay, suggesting that escalation design, staffing discipline, and operational monitoring helped the network absorb growth.

Where the Network Is Expanding

Today, the network operates across 34 states, with coverage recently added in Georgia, Kansas, Missouri, and Minnesota alongside Colorado, which has been live for some time. Each of these markets came online through the same disciplined process, coverage gaps, provider- group density, and existing customer footprint, rather than which market happened to raise a hand first. As customer demand grows, the long- term goal is national availability across all states.

Partnership Signal

The network's growth also shows up in who chooses to build alongside it. A handful of technology and services partners now extend the platform into adjacent parts of the care journey, and early-market work with regional partners reflects a level of confidence that goes beyond a standard vendor relationship. That activity matters because it shows the network is becoming part of a broader care ecosystem, not simply adding facilities one contract at a time.

Financial Value for Facilities

Beyond clinical measures such as response time and treat-in-place performance, the financial value of after-hours care comes from two distinct sources: direct reimbursement for eligible telehealth encounters, and the downstream costs avoided when a transfer never happens. Facilities that host an eligible telehealth encounter may qualify for the Medicare telehealth originating site facility fee, HCPCS code Q3014, listed at $31.85 per encounter in 2026. CMS pays this fee to the originating site for facilitating the visit, including the staff time required to support the resident at the bedside. The rate is a published CMS figure, not a Third Eye Health estimate, and it applies whether the resident is treated in place or transferred.

At a conservative 25 monthly telehealth encounters, that fee alone represents about $796 a month in facility-level Medicare reimbursement. The amount is modest, but it is verifiable and directionally important: Medicare payment policy increasingly recognizes the labor required to coordinate care outside traditional office settings. A facility's billing team can confirm eligibility and expected reimbursement independently.

The larger financial story is what gets avoided when a transfer never happens.

What Consistency Actually Costs

In 2026, the Medicare Part A inpatient hospital deductible is $1,736 per benefit period, and skilled nursing coinsurance runs $217 a day from day 21 through day 100 (Centers for Medicare and Medicaid Services, 2026). A benefit period resets only after 60 consecutive days outside a hospital or skilled nursing facility. Those figures are national Medicare benchmarks, and they show why consistency itself carries financial weight well before anyone calculates a readmission rate.

2026 Medicare benchmark

$1,736

Part A inpatient hospital deductible per benefit period

2026 Medicare benchmark

$217 / day

Skilled nursing coinsurance from day 21 through day 100

Value-based arrangements reward exactly this kind of reliability: a predictable care experience that holds up at 2 a.m. as well as it does at 2 p.m. The figures above should be read as market context, not as a Third Eye Health-specific savings calculation. They show why clinical consistency and financial performance are increasingly connected.

Source note: Medicare figures are included for market context and should not be presented as a Third Eye Health-specific savings calculation.

Twelve Years In

Scale is most convincing when performance remains repeatable across different facility types, markets, and operating conditions. Fast response times, high treat-in-place performance, thoughtful market expansion, and clear financial context all point to the same conclusion: after-hours support becomes more valuable when it is dependable across many different operating conditions.

> *"Twelve years in, people ask how we scaled the way we did. The truth is simpler than a strategy deck. We answered every night, the same way, for a long time, and the scale eventually caught up to that consistency."*
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> **Dan Herbstman, CEO of ThirdEye Health**

See What This Looks Like for Your Facilities

The facilities represented in this paper vary by bed count, state, electronic health record, and operating reality. What they share is after-hours support designed to remain steady under changing conditions.

Talk to us: info@thirdeyehealth.net