Bridging Two Worlds: Utilizing Remote Patient Monitoring to Succeed in FFS and Position for VBC

Blake Marggraff | CEO, CareSignal – a Lightbeam Company | bmarggraff@lightbeamhealth.com

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Best Outcomes

- Discuss optimal patient populations and technologies for which investment will yield FFS and long-term value-driven ROI
- Explore sustainable care management processes & case studies enabled by Deviceless RPM for increased capacity for VBC-based care contracts
- Investigate the real-world challenges, opportunities, & impacts of this paradigm shift across provider types

Current Drivers of Value-based Care

1. State-based initiatives are driving healthcare reform forward
2. Consumers are growing increasingly dissatisfied with existing models of care delivery
3. Influx of outside investors in both the technologies and strategies of value-based care

Medical Economics®

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"Value-based care is steadily gaining ground across the health care industry. With payers, providers, investors, patients and technology companies joining in the effort, **there are no signs that value-based care adoption will slow down.**"

https://www.medicaleconomics.com/view/what-s-driving-the-transition-to-value-based-care-

Key Areas to Leverage Technology for Value-based Care

1. Reduce Avoidable Utilization, Especially in High-cost Sites (e.g. ED)
2. Identify the Appropriate Next Site of Care Post-Discharge
3. Optimize Skilled Nursing Facility Length of Stay
4. Continue to Focus on Readmissions

HealthTech

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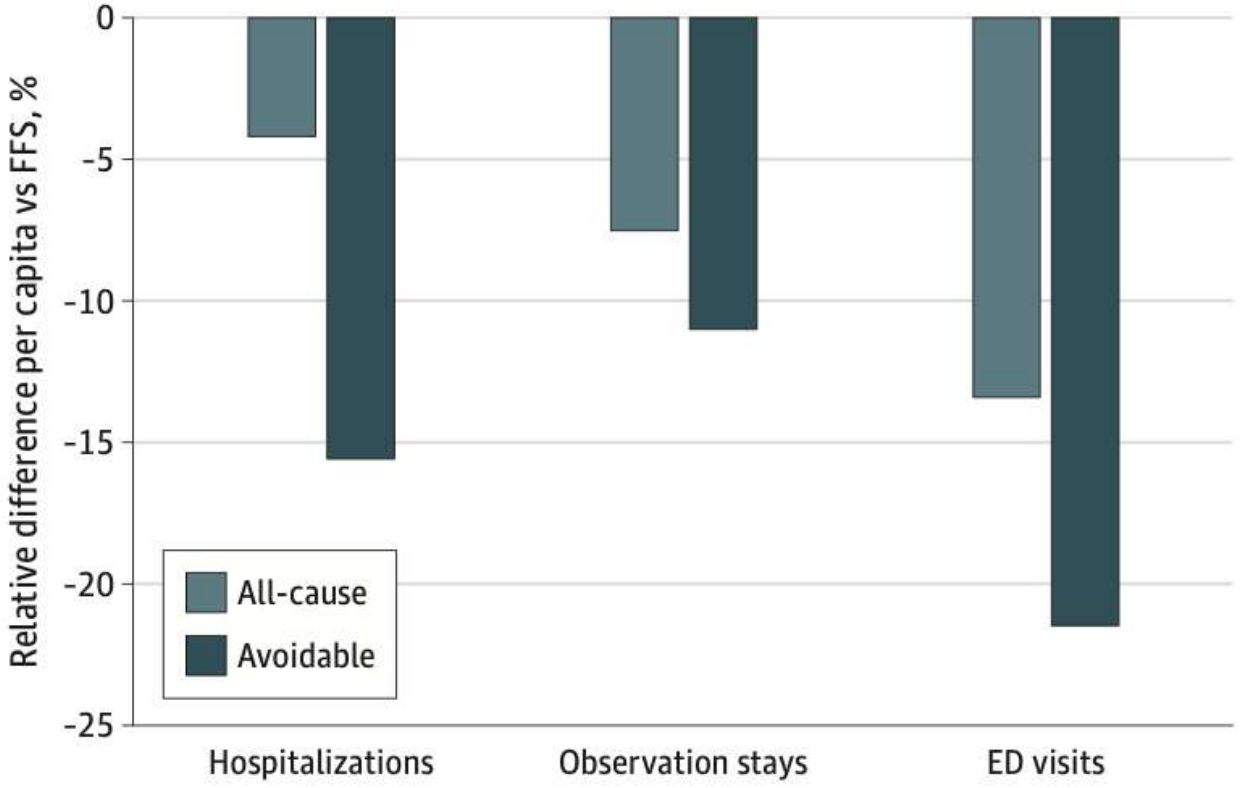
"**Technology is a key driver behind achieving true value-based care.** It has the power to break down silos, connect provider workflows, increase efficiencies and share insights into the patient journey."

https://healthtechmagazine.net/article/2022/05/5-ways-leverage-tech-hospital-success-under-value-based-care

The Impact of VBC Is Significant and Sustained

Figure. Percentage Differences in Adjusted All-Cause and Avoidable Acute Care Use for Medicare Advantage Beneficiaries Cared for Under 2-Sided Risk vs Fee-for-Service (FFS) Payment Models



JAMA Network | Open™

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March 17, 2022 “Analysis of Value-Based Payment and Acute Care Use Among Medicare Advantage Beneficiaries”

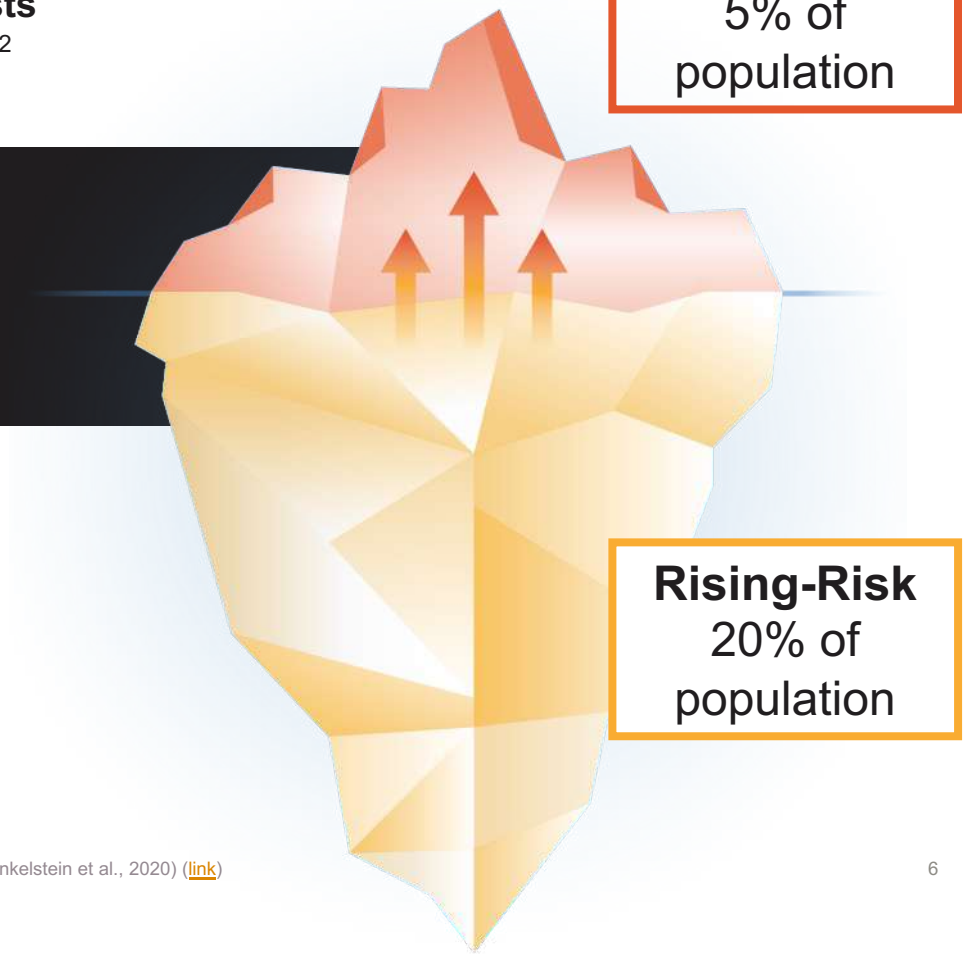
Bending cost curve requires proactive management of high- and rising-risk patients

The NEW ENGLAND JOURNAL of MEDICINE

"Our findings may also reflect fundamental challenges with the strategy of targeting superutilizers: **many patients whose medical costs are high today will not be as high in the future**."[2]

Each year, 1 in 5 rising-risk patients become expensive, high-risk patients.[1]

Adding more staff is not sustainable



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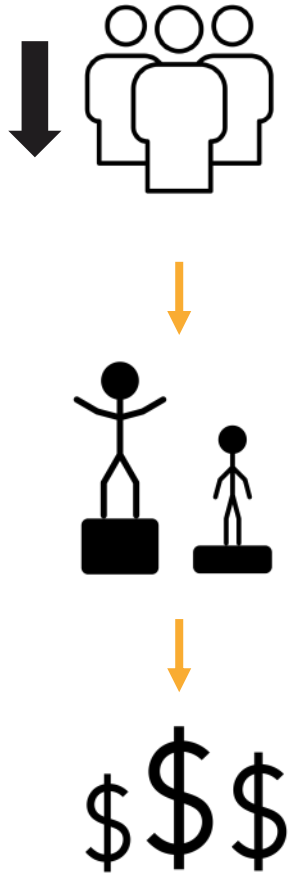
 [1] Advisory Board Report (link) · [2] Hotspotting Study (A. Finkelstein et al., 2020) (link)

Nursing Shortages Inhibit Health Transformation

Racial Disparities in Stroke Readmissions Reduced in Hospitals With Better Nurse Staffing

February, 2022

Carthon, J. Margo Brooks; Brom, Heather; McHugh, Matthew; Daus, Marguerite; French, Rachel; Sloane, Douglas M.; Berg, Robert; Merchant, Raina; Aiken, Linda H.

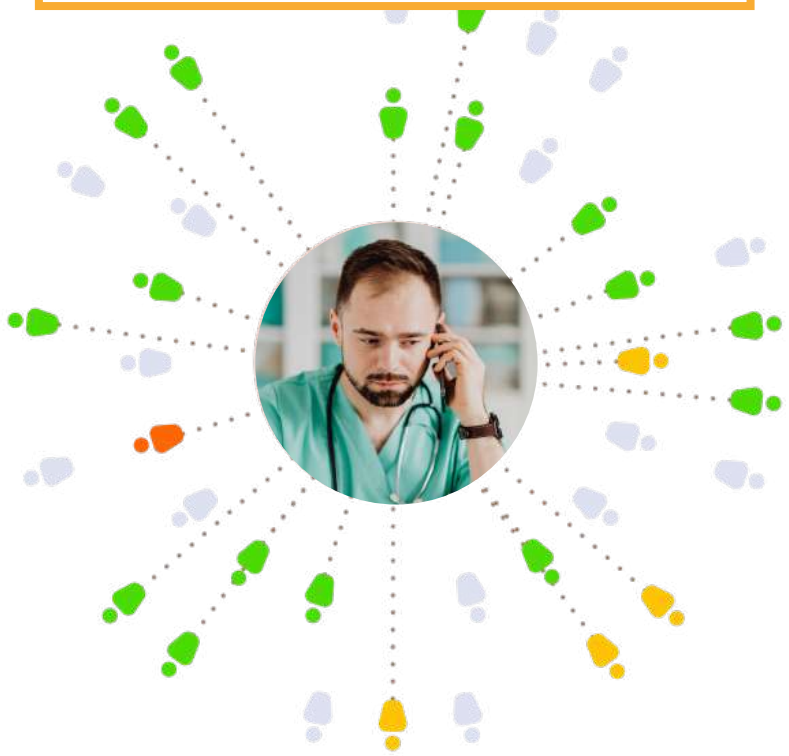


Readmission risk changed from **not significant** to **27% higher than white patients** when nurse staffing ratios became worse.

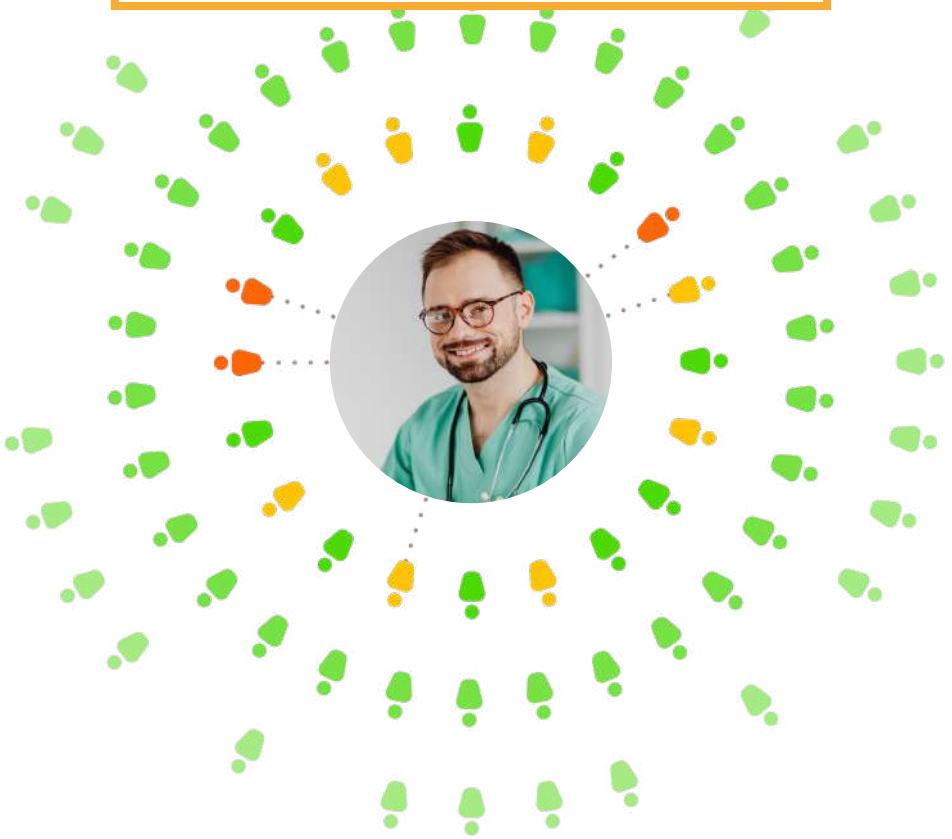
Care Management for Rising Risk: a Paradigm Shift

Do more with less by automating routine outreach & providing top-of-license care

Before CareSignal
Manual outbound outreach



After CareSignal
Automated inbound insights



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Deviceless Remote Patient Monitoring

Affordable | Accessible | Scalable

- **No new devices required**
  No apps, downloads, or passwords
- **Accessible for all patients**
  Promote & elevate health equity
- **Clinically validated**
  13+ Peer reviewed publications
- **30 Programs | One Portfolio**
  Pre-built & evidence-based
- **Engagement powered by AI**
  Predict & prevent drop-off
- **White-labeled for patient/member**
  High-quality, credible experience

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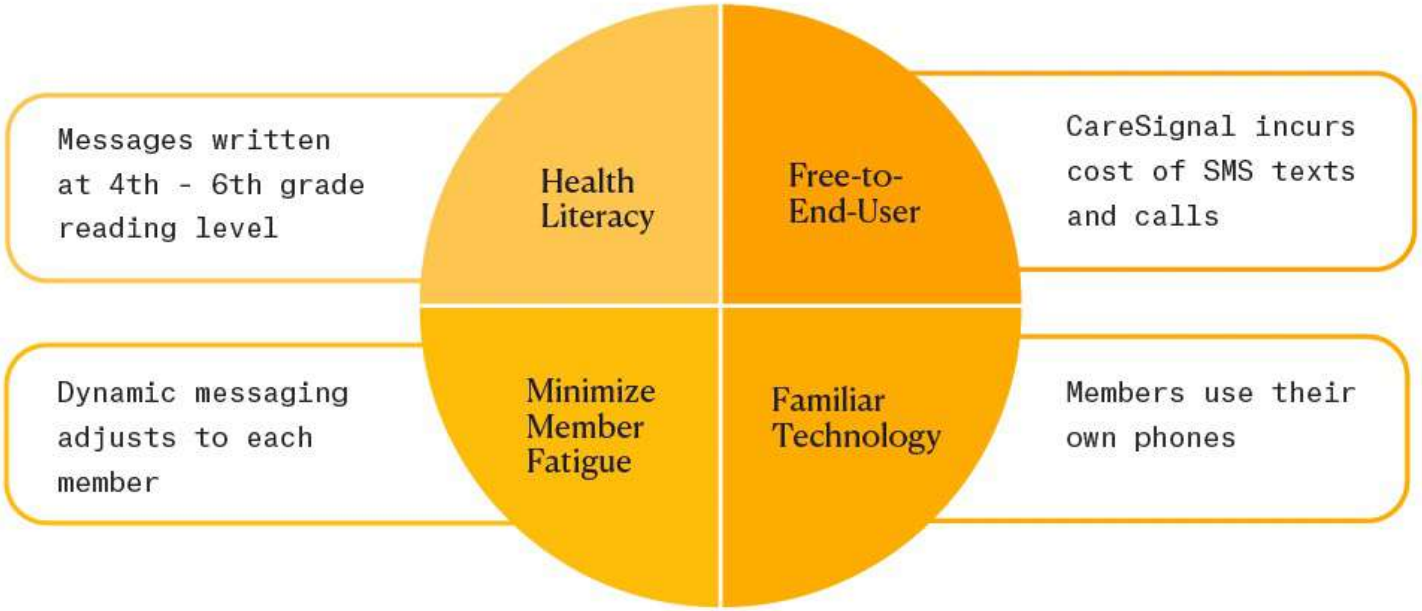
Deviceless Remote Patient Monitoring

Member Accessibility



verizon

T··Mobile·

Sprint

CareSignal® a Lightbeam Company

AT&T

boost mobile

metro by T··Mobile·

CareSignal Portfolio & Results

30+ Evidence-Based Programs | One Portfolio

Chronic Conditions
- Heart Failure
- COPD
- Diabetes
- Hypertension
- Asthma

Behavioral Health
- Depression
- Anxiety
- Substance Use
- Opioid Management
- Caregiver Support

Specialty Support
- SDoH
- Maternal Health
- Dialysis
- Surgery
- HIV/AIDS

Post Discharge
- Post Discharge
- General Medical
- Vital Signs
- Pneumonia

Care Coordination
- Screening Reminders
- Appointment Reminders
- Referral

General Programs
- COVID Suite
- Influenza
- Fall Risk
- Wellness
- Medication Adherence

13 Publications
in Peer-Reviewed Medical Journals

62% decrease in hospitalizations for patients with COPD

46% decrease in CHF ED visits

1.15% drop in HbA1c over 4 months

50% improvement in blood pressure control over 12 weeks

28% drop in PHQ-9 for patients with depression

>2.1x increase in follow-up appointment adherence

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Congestive Heart Failure

Inclusion Criteria: LACE, HCC, Diagnosis

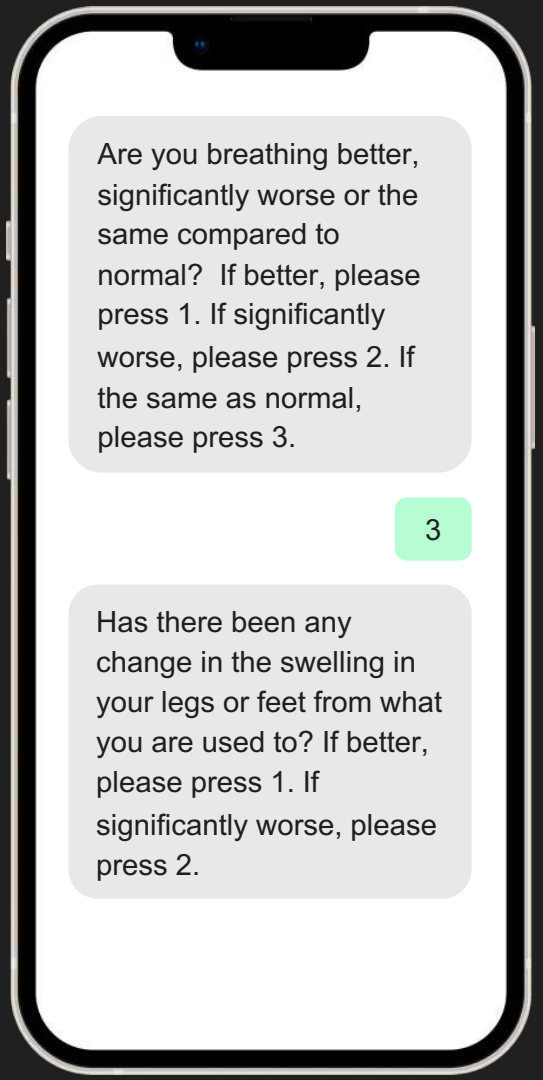
Alert Notifications:

- Worsening breathing
- Worsening swelling
- Excessive weight gain

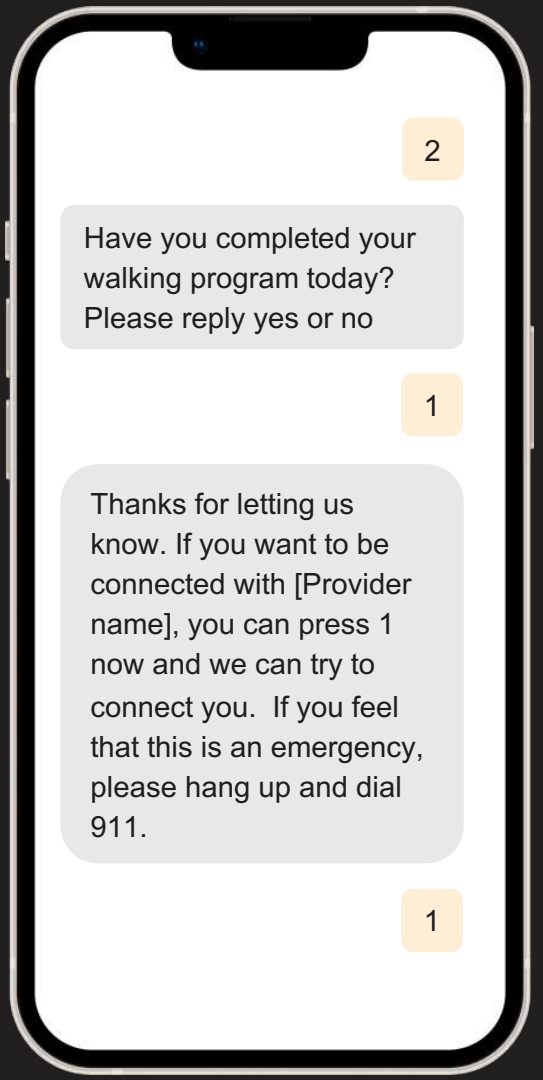
46%

Average Reduction in ED visits (N > 1,000)

Congestive Heart Failure: No Alert



Congestive Heart Failure: Alert Triggered



Alert Triggered

Auto Connect

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COPD

Inclusion Criteria: LACE, HCC, Diagnosis with ED visit within 12 months

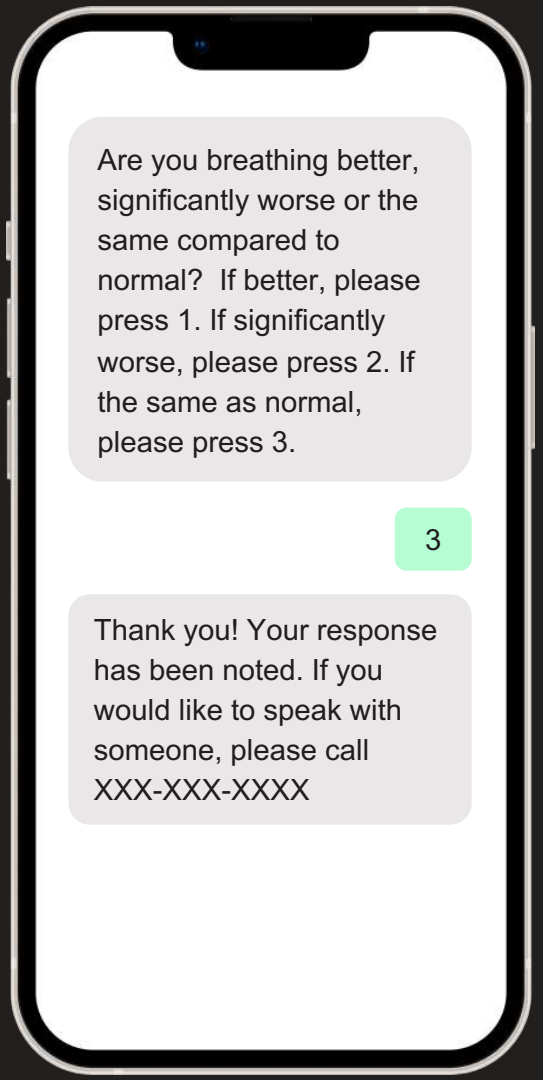
Alert Notifications:

- Worsening breathing
- Worsening cough
- Change appearance of cough
- Risk classification: Danger

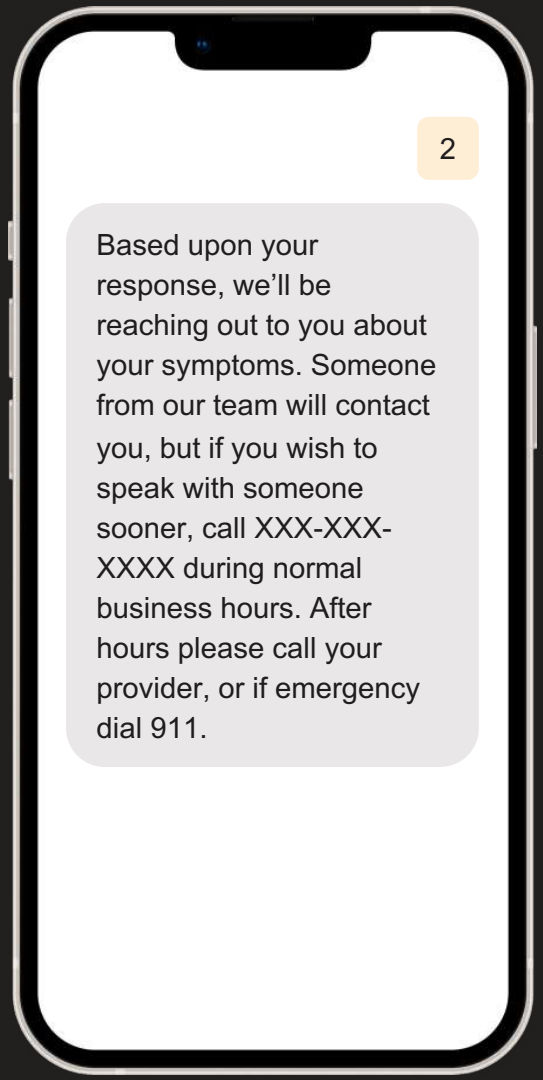
62%

Average Reduction in COPD hospitalizations over 6 months

COPD Example: No Alert



COPD Example: Alert Triggered



Alert Triggered

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Social Determinants of Health

Modules:

- Annual Introductory Screener
- Monthly Check-In Screener(s):
  - Food, Transportation, Employment, Housing, Financial Strain, Safety, Health Insurance, Health Literacy, Utilities, Childcare, Family and Community Support

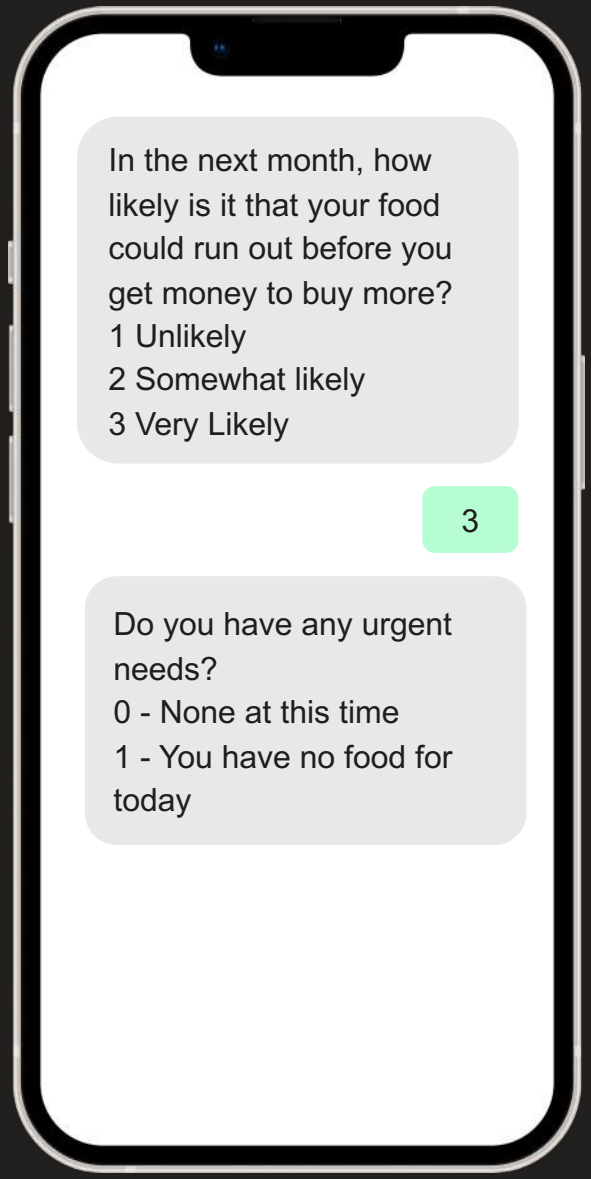
Alerts:

- Alerts are trigged for any urgent need reported

Check-In Screener Features

- Users can text CONNECT to prompt question about urgent needs
- Users get a light-touch reminder each month about the CONNECT feature

Social Determinants of Health:
No Alert



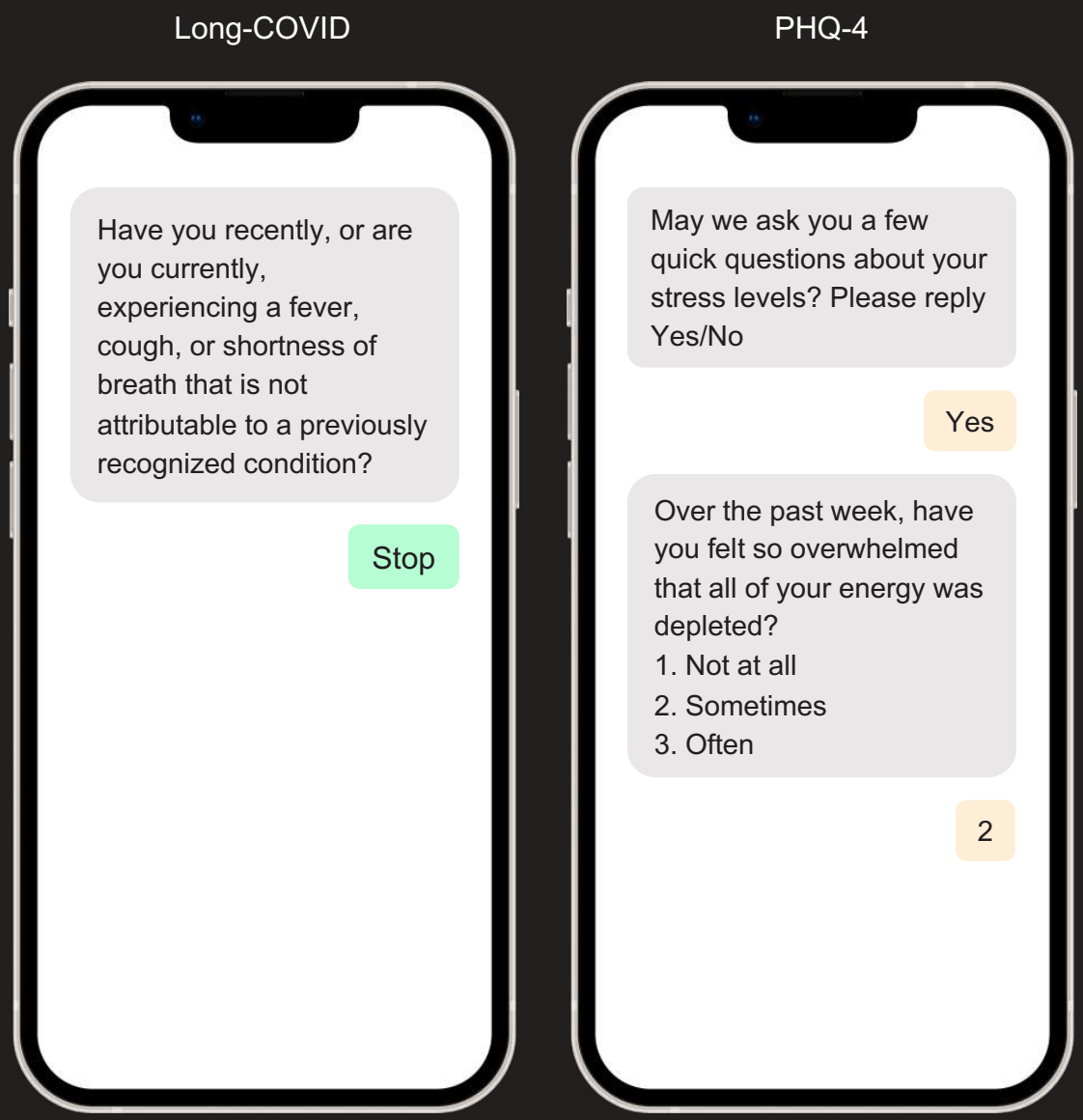
Long-COVID + PHQ-4

Reported Symptoms:

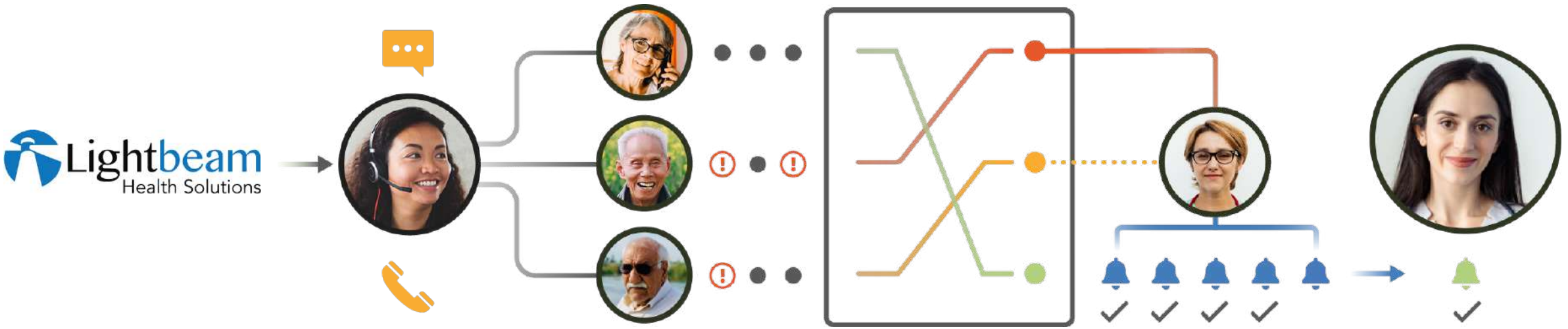
- Feeling worse
- Worsening breathing
- Worsening cough
- Brain Fog
- Fatigue
- Joint or muscle pain
- Fever
- Emotional exhaustion
- Depersonalization
- and more

Users may text:

- Stress
- Tips



Patient Journey with CareSignal & Lightbeam



Lightbeam
Identifies cohort of target patients for CareSignal

CareSignal
Enrolls patients via text, email, mailers, and direct phone calls

Patients
Answer automated SMS and phone call prompts, sending in clinically-relevant data

CareSignal
Categorizes at-risk patients and triggers alerts in real-time

Client or LCS
Care Managers monitor dashboard and follow standard operating procedures

Providers
receive escalations, only as needed

Chronic Care Management in VBC Organizations

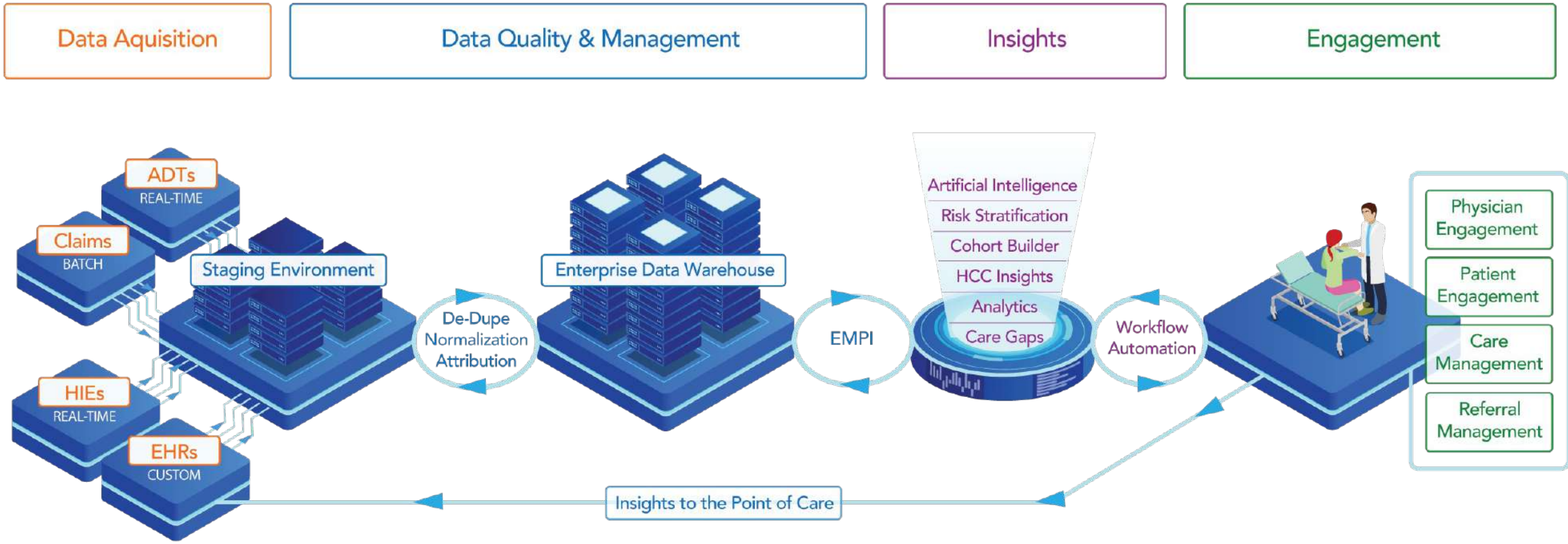
"There is major value in automatically checking in with patients via Deviceless RPM, it is particularly great for patients who are reluctant to reach out to their provider, reaching these patients is most impactful for controlling costs."

"Deviceless RPM helps closely monitor our patients' health and alert nurse care managers to quickly reach out to patients who need help. Through simple phone calls or text messages, our patients can report any changes in their health. By knowing how their patients are doing from week to week, our nurses will be able to prevent avoidable hospitalization.

"This is working out very well for me. I receive the text and reply as soon as I can to it. I honestly appreciate this procedure and feel like these people really do care. It also shows that Christie works as a team." **-Patient**

"It's a fairly painless way to keep a log of general health without having to go in detail, and serves as a reminder that there is help if I need it." **-Patient**

CareSignal + Lightbeam Value Creation



CareSignal + Lightbeam Value Creation

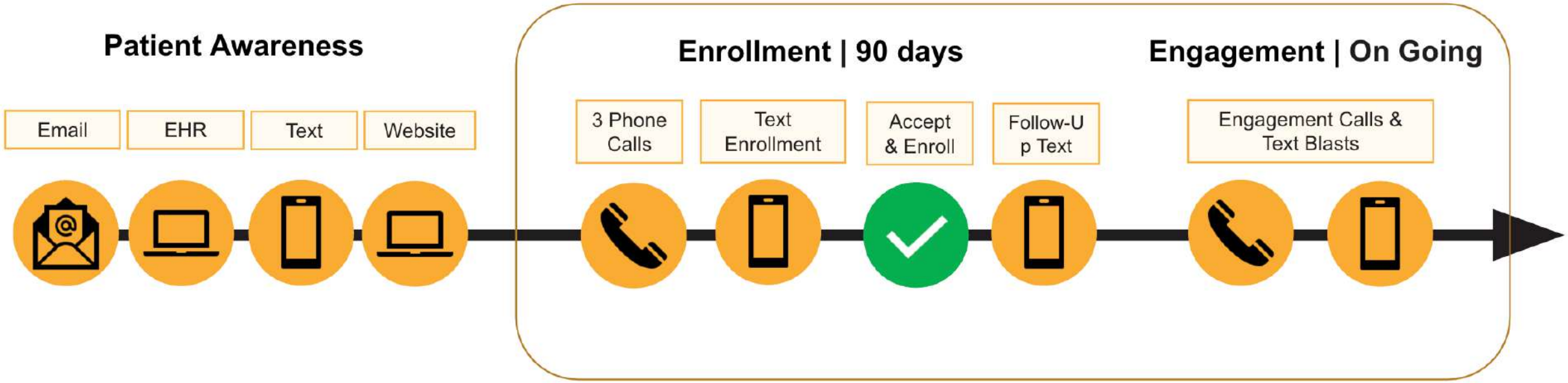
Optimize Quality Scores & Reporting

Increase FFS Revenue – Preventive Programs

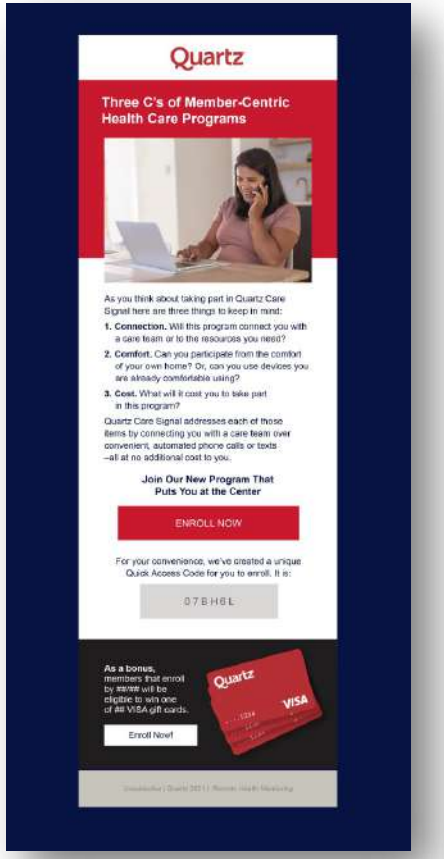
Maximize Shared Savings / Risk Pools

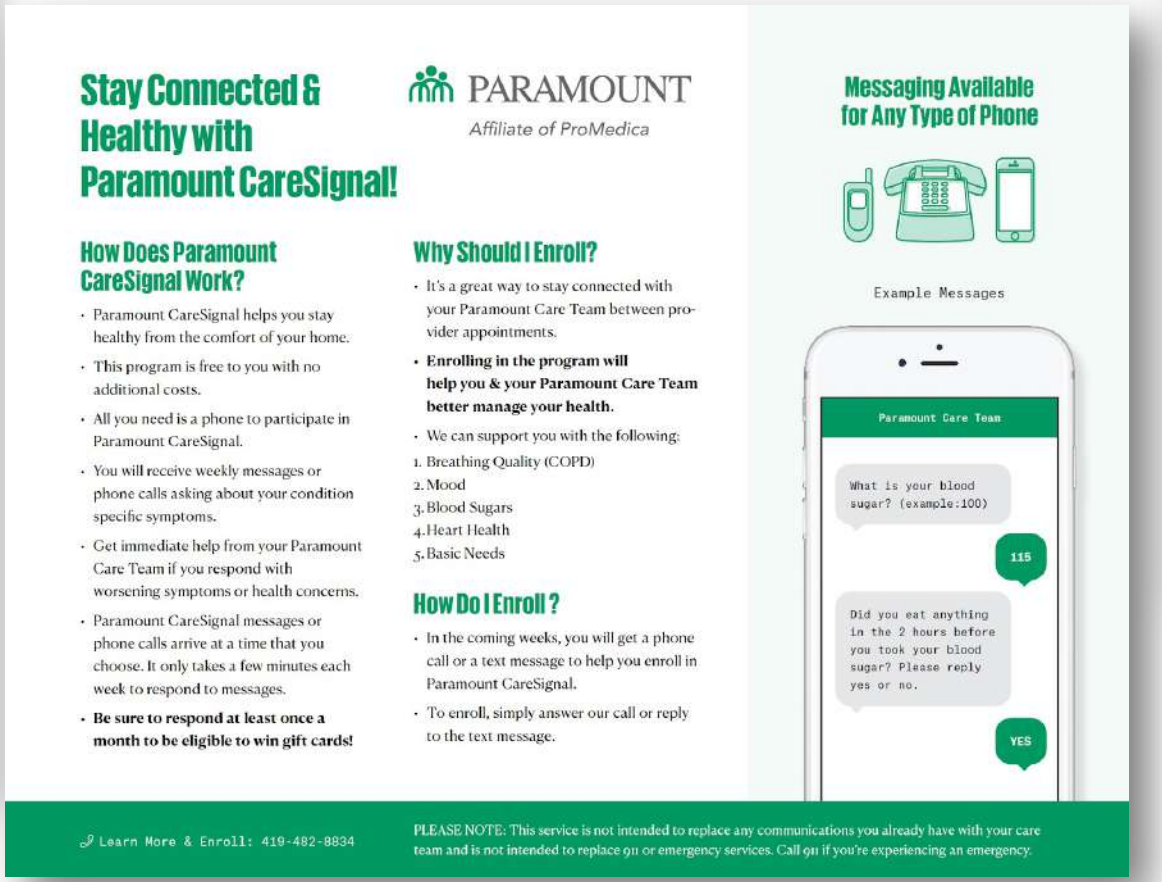
Reduce Unnecessary Utilization

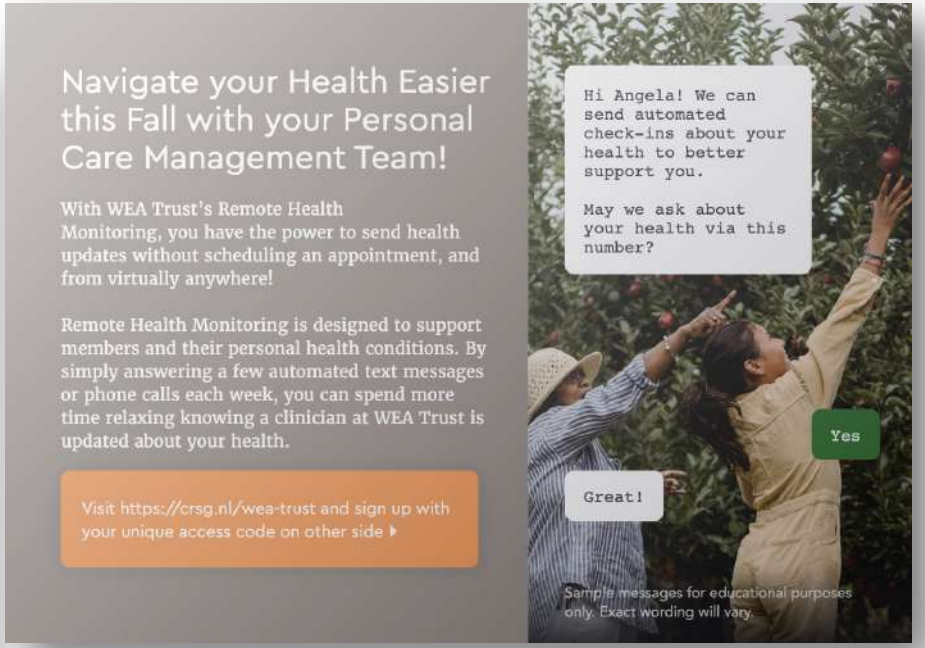
Robust, Cost-effective Enrollment Flow



White-labeled Materials Complement Enrollment

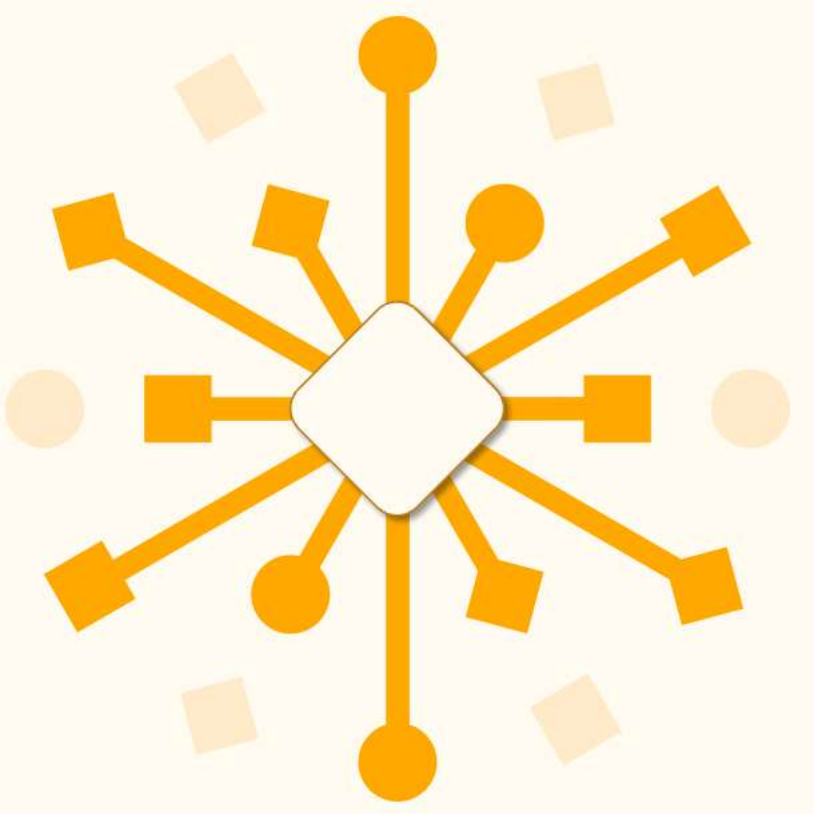






CareSignal Capabilities

Features to Extend Scalability



Two-way Messaging
Security chat with patients

Push Messaging
Send preset messages with a click

Blast Messaging
Deliver content to patients at-scale

CareSignal.AI
Predict engagement, outcomes, and cost

Smart Dashboard
SOPs built into smart queue

Integration
Via HL7, FHIR, or API

Behind the Scenes of One of the Largest RPM Implementations in the US: 35,000 Patients & $32M in Cost Savings

Programs	Asthma	CHF	COPD	Diabetes	Gen Med
ED Visits Avoided per 1,000 Patients	255	329	183	402	475
Relative ED Reduction	-31.8%	-26.4%	-20%	-37.9%	-27.1%
Change in ED Visits Per 1,000 Patients Per Year	803 / 547	1241 / 912	912 / 730	1058 / 657	1752 / 1277
Total Cost Savings	$1.40MM	$17.70MM	$1.55MM	$9.77MM	$2.25MM

Before CareSignal

After CareSignal

Midwest Virtual's Deviceless Remote Patient Monitoring Utilization

2016 - 2021

35,959
Total Number of Patients Enrolled

2.9MM
Total Automated Patient Touches

2.0MM
Total Automated Text Messages

963,900
Total Automated Phone Calls

80,000
Proactive Alerts Raised

19 Programs
Currently Utilized by Midwest Virtual

BROTHER BILL'S helping hand

Social Welfare Board

Greater HICKORY Cooperative Christian Ministry — Serving our community since 1969 — HOPE. HELP. HEALING. FOR ALL.

Shepherd's Clinic

HEAL the CITY

> "The Americares platform has infused another layer of communication between the patient and provider team that allows for real time problem solving and action steps."
>
> - Linda Judah, Executive Director

Social Determinants of Health Needs Identified

Health Literacy	Employment	Community Support	Food
196	344	447	1,066

Total Needs Identified

2,053

Patient Satisfaction · Most CareSignal enrollees agree that they are getting the best possible care from [Clinic Name].

Communication · Most CareSignal enrollees agree that their communication with [Clinic Name] has improved.

The Five Clinics' Impact

Total Automated Touches

87,917

Total Alerts Triggered

272

Engagement

Total Patients Engaged in the Diabetes Program

585

of Patients Remain Engaged after 10 Months

78%

Diabetes Outcomes

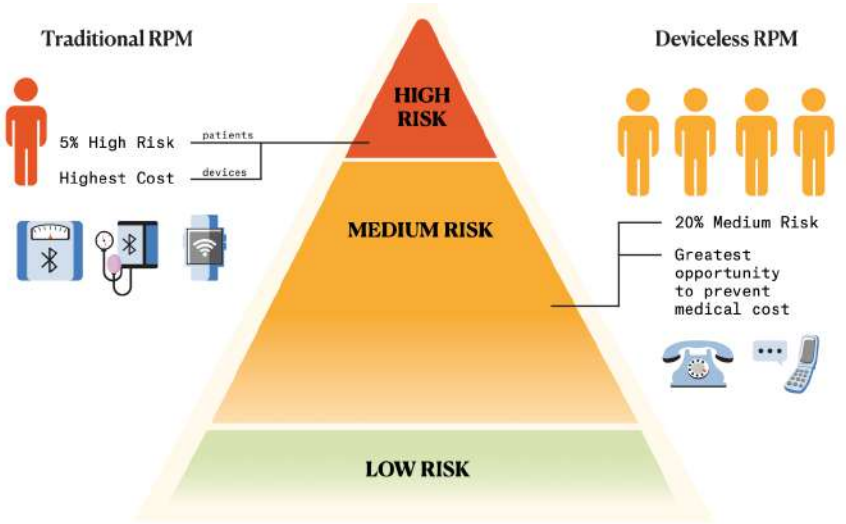
Reduction in eHbA1c >8% at baseline (n=81)

1.8%

Reduction in eHbA1c >9% at baseline (n=51)

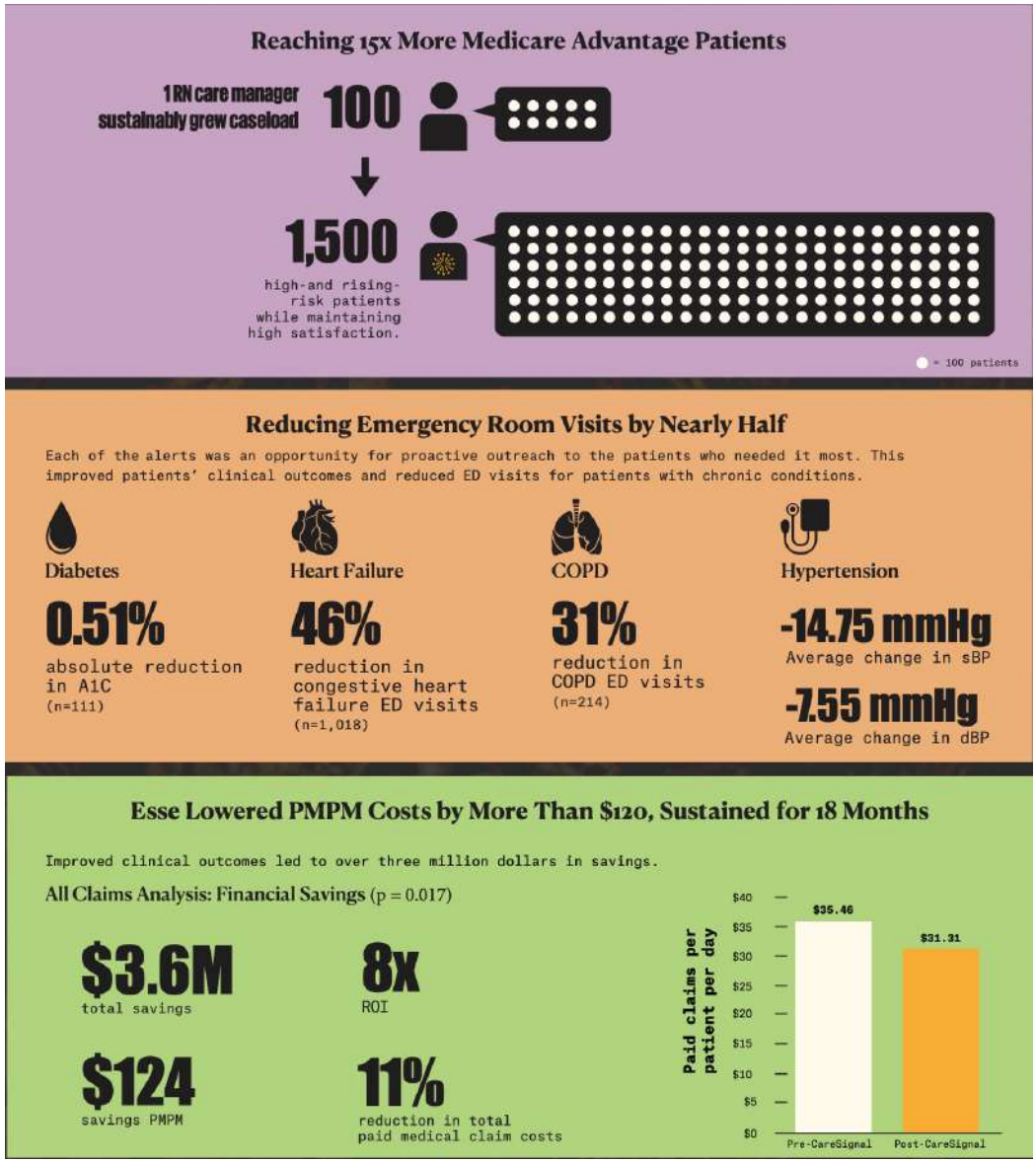
2.5%

Case Study



"Now we've been able to wrap our hands around a whole group of people who otherwise might not have gotten all those touches that they received with the platform. We've been able to scale the outreach dramatically without an increase in staff, and that's really important. High-risk care management is inherently a reactive model. By extending care management into the rising-risk patients, we are becoming more proactive. Now we can say, 'Hey, there might be a problem developing. Let's reach out to the patient instead of waiting until he goes to the ED.' It's helped us manage rising-risk patients who might not have perceived a need for a care management team before."

– Carla Beckerle
Vice President of Clinical Programs at Esse Health



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3 Hours
Average Time from List Sent to First Call

30 Days
Post-Discharge Monitoring Program

Programs Continue Beyond Post-Discharge Monitoring

Linda Jenkins
46, Patient

Patient is Discharged

Daily ADT List Sent to CareSignal

Patient gets Enrollment Call within 2–24 HR

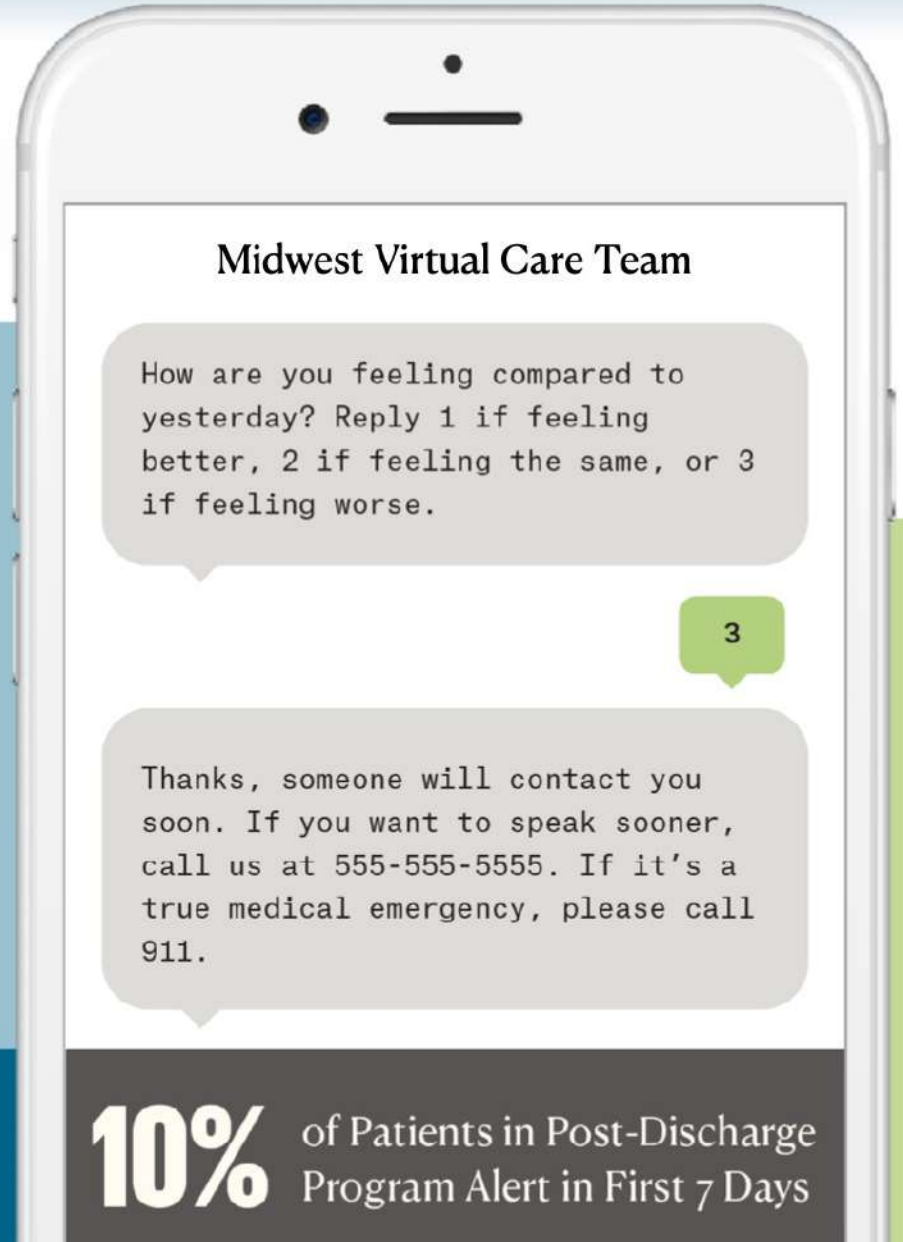
Epic EHR "FYI Flag"

CareSignal Engagement Specialists Enroll Patients

140
Enrollment Calls Per Day

57
Patients Enrolled Per Day

13,883 Total Patients Enrolled in Post-Discharge Program



10% of Patients in Post-Discharge Program Alert in First 7 Days

Linda enrolled in another relevant program after Post-Discharge

General Medical
N=9,477

Condition-Specific
N=1,059

Most Common Programs

- Asthma
- COPD
- CHF
- Diabetes

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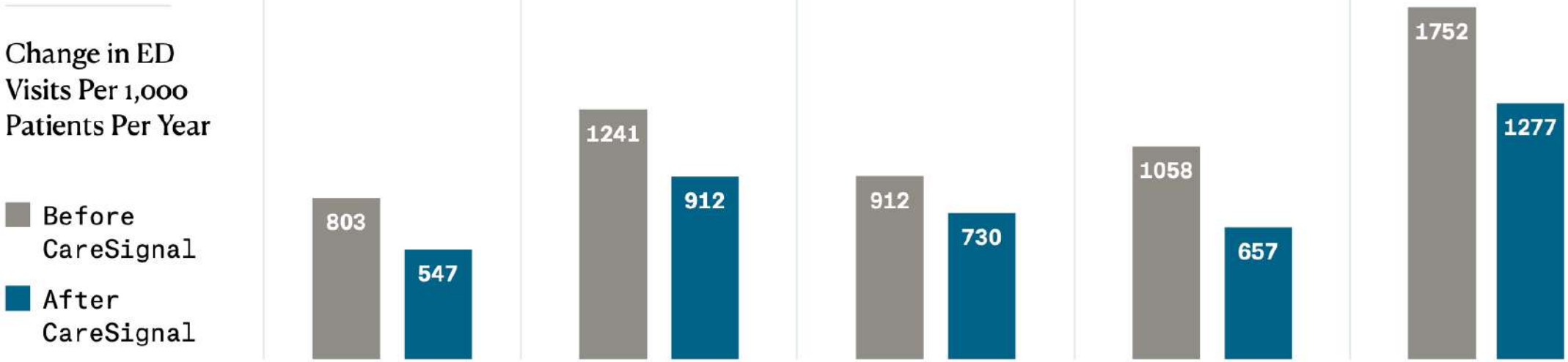

Total Cost Savings	$1.40MM	$17.70MM	$1.55MM	$9.77MM	$2.25MM

This is Jamie.

We help care managers like Jamie improve patient care *while* reducing workload.

Experience how automated, evidence-based SMS and IVR interventions enable Jamie to improve outcomes for any of her patients:

Chloe
Depression

Start Journey

Sharon
Heart Failure

Start Journey

Antonio
Diabetes

Start Journey

Adam
Asthma

Start Journey

Visit

try.caresignal.health

Q&A

Stop by our VBCExhibitHall.com Virtual Booth

Visit the CareJourney exhibit booth

Bridging Two Worlds: Utilizing Remote Patient Monitoring to Succeed in FFS and Position for VBC

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