Confidential Information

This communication contains confidential information governed by the written confidentiality provisions contained in our license agreement and/or NDA. It is intended only for the individuals or the entity to which it was originally sent. Please do not copy or forward.

Website: www.lightbeamhealth.com

Lightbeam Health Solutions

Realizing the Quadruple Aim in Value Based Care

November, 2023

VBCExhibitHall.com

Educational Webinar Series

Presenters & Overview

Erin Page

President, Government
Value Based Care, Lightbeam

Dr. Kent Locklear

Chief Medical Officer,
Lightbeam

Value-based care entities often feel like they are behind the curve, always reactive, lacking insights and resources to be proactive.

Value-based care experts, Erin Page and Dr. Kent Locklear will cover the 4 key pillars to a winning value-based care strategy and how they connect seamlessly to achieve the quadruple aim.

The webinar will cover proactive strategies for reducing cost of care, optimizing risk adjustment, and improving quality and patient experience.

Evolution of Value-Based Programs and CMS

Medicare has experimented with numerous value-based programs since the passage of ACA in 2010.

CMS wants every Medicare beneficiary in a value-based care model by 2030.

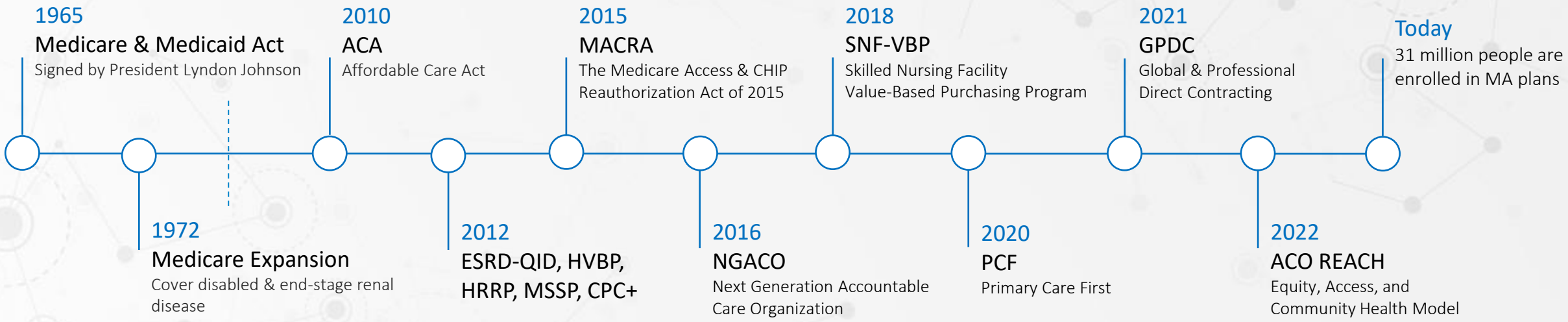
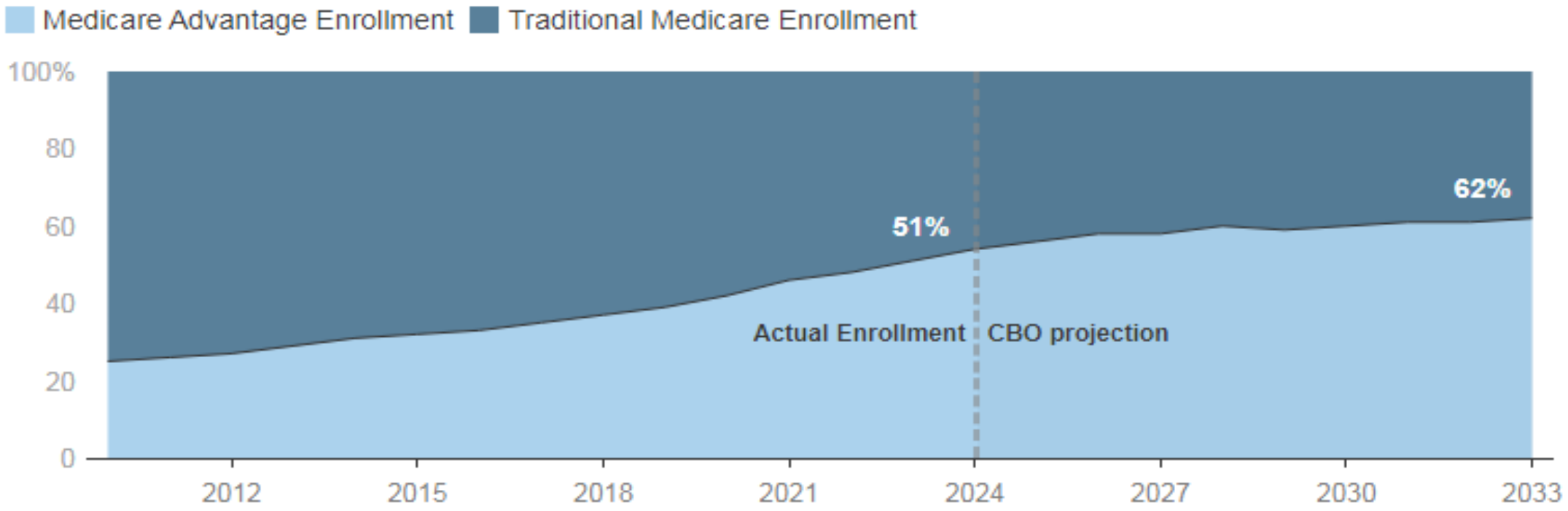


Figure 2

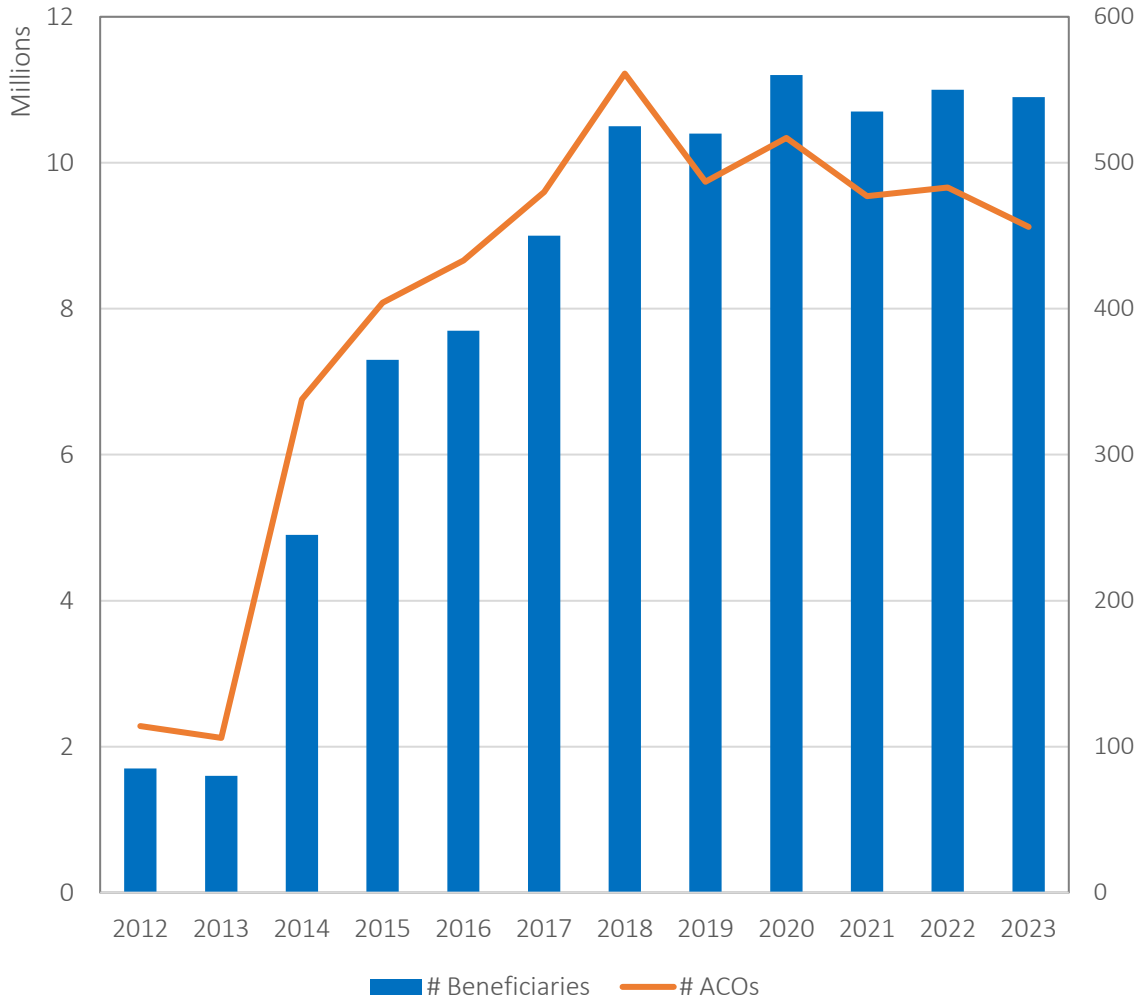
Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



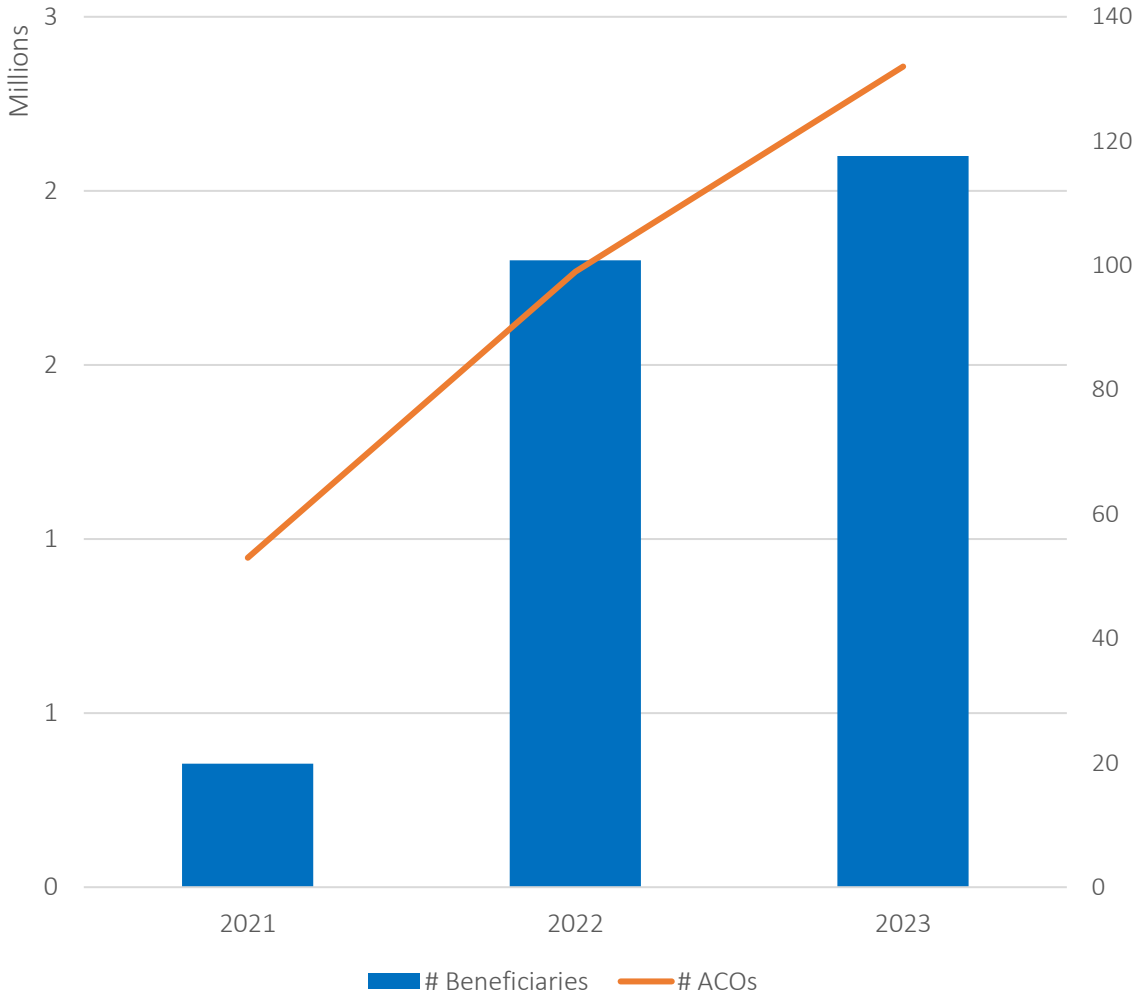
SOURCE: KFF analysis Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023. Enrollment numbers from March of the respective year. Projections for 2023 to 2033 are from the May Congressional Budget Office (CBO) Medicare Baseline for 2023. • PNG

KFF

MSSP ACO Enrollment Year-over-Year



DCE/ACO REACH Enrollment Year-over-Year



Defining the Quadruple Aim

Improve Population Health
Prioritize Management & Prevention

Reducing Cost of Care
Reduce avoidable admissions & utilization while assuming greater risk

Enhancing the Patient Experience
Empower patients to self-manage

Improving the Provider Experience
Implement processes to reduce provider burden

The Low-Risk Path to Value-Based Care

Lightbeam Health Solutions

Reduce Unnecessary Spend

- Identify Cost/Utilization outliers
- Manage High/Rising Risk populations
- Improve patient outcomes of chronically ill
- Transition of Care Management and CCM

Improve Quality Performance

- Provider compensation impact based on QM outcomes
- Automated workflow targeting non-compliant patients
- Morning Huddles
- Integration with providers at the point of care

Risk Adjustment (HCC) and Documentation

- Alert Providers in their EMR of chronic condition and documentation opportunities
- Identify recapture and suspect conditions
- Outreach to chronically ill patients not coming into office
- Retrospective and Concurrent Chart Reviews

Improve Patient Experience

- Proactive outreach for preventive services and access to care
- Quality of Life improvements – less hospitalizations
- Provide more care options within the home
- Improved relations with Care Managers and Providers

Challenges

Lightbeam Health Solutions

- Data Integration & Interoperability
- Stakeholder Alignment
- Patient Engagement
- Risk Management
- Financial Pressures
- Measurement Difficulties
- Infrastructure & Upfront Costs
- Cultural Shift

Key Areas of Focus

Understand the Concept	Ensure that your organization understands the fundamentals of value-based care, including the shift from fee-for-service to outcome-based reimbursement models.
Assessment & Readiness	Conduct an assessment to determine your organization's readiness for value-based care. Assess your current infrastructure, data capabilities, and cultural readiness for change.
Data & Analytics	Invest in a robust data platform that provides attribution mgmt, quality, cost of care and outcomes driven analytics and share the data effectively. This is crucial for identifying areas of improvement and performance.
Quality/Performance Metrics	Define and track key performance indicators (KPIs) and quality metrics. These could include patient satisfaction, panel management, cost of care, HEDIS, STAR, readmission rates, hospital-acquired infections, and more.
Care Coordination	Implement care coordination strategies to ensure that patients receive the right care at the right time at the right site of service from the right providers.
Population Health Management	Focus on managing the health of your patient populations and co-horts, including preventive care, high risk and rising risk populations. Development and manage the provider network of services for the population.
Patient Engagement	Engage patients in their care through education, telehealth, and digital tools. Encourage patients to take an active role in managing their health.

Key Areas of Focus

Provider Incentives	Develop incentive programs for healthcare providers that reward them for delivering high-quality care and achieving positive outcomes and goals.
Payment Reform	Negotiate with payers to transition from fee-for-service contracts to value-based payment models, including both administirative and financial terms.
Continuous Improvement	Establish a culture of continuous improvement. Regularly review data and metrics to identify areas where performance can be enhanced, and costs can be reduced, and overall quality outcomes improve
Patient-Centered Care	Emphasize patient-centered care, focusing on the individual needs and outcomes of patients. This includes access to care, treatment plans, coordination of care and communication.
Collaboration & Partnerships	Collaborate with other healthcare organizations, specialists, and community resources to provide holistic care and address social determinants of health and access needs

Key Areas of Focus

Regulatory Compliance	Stay informed about regulatory changes related to value-based care and ensure compliance with all relevant laws and regulations. Annual readiness exercise
Education & Training	Train staff members, including clinicians and administrative staff, on the principles, goals and practices of value-based care. Engage all staff in the success of a value-based care model.
Measure & Report Outcomes	Continuously measure and report on outcomes to stakeholders, including patients, payers, and regulatory bodies, to demonstrate the effectiveness of your value-based care initiatives. Share the success of the organization.
Flexibility & Adaptation	Be prepared to adapt your strategies as you gain experience and as healthcare landscape changes. Flexibility is key to success in value-based care.

Our Solutions

Solutions to Drive Outcomes and Success

Lightbeam Health Solutions

Aligned Incentives

Create compensation models and contracts that align incentives for all stakeholders, ensuring everyone benefits from value-based care's success.

Patient Education Programs

Develop comprehensive programs to educate patients about the benefits of VBC, emphasizing preventive care and wellness.

Risk Stratification Tools

Utilize advanced analytics to identify high-risk patients and tailor interventions to manage and reduce their health risks.

Phased Transition Plans

Implement VBC gradually, allowing providers to adjust to new payment structures over time.

Standardized Metrics

Collaborate with industry leaders, providers, and payers to develop standardized quality and outcome metrics.

Public-Private Partnerships

Engage in partnerships to fund and support the infrastructure needed for VBC, sharing the financial burden.

Training & Development

Invest in training programs for staff, physicians, and administrators to help them adapt to the VBC model and its nuances.

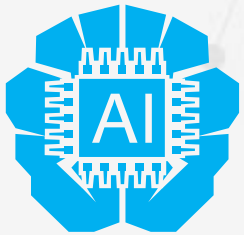
Population Health *Enablement*

Lightbeam Health Solutions

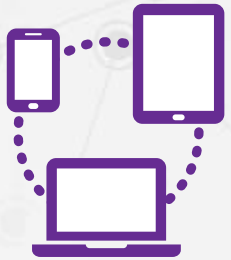
Aggregation + **Analytics** + **Automation** + **Augmentation**

Collect and process data from EMR, Claims, ADT, & HIE and identify opportunities

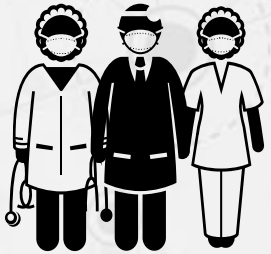
Leverage AI to identify and stratify risk



Transform manual outreach to automated action and inbound insights



Supplement current resources with additional staffing as needed



SERVING	PROCESSING	RESULTS
Over 42 million patients	Over 5 billion claims	$2.5 billion+ in gross savings
Over 170,000 physicians	Over 13 billion clinical data elements	PMPM Savings $125+ CHF & COPD

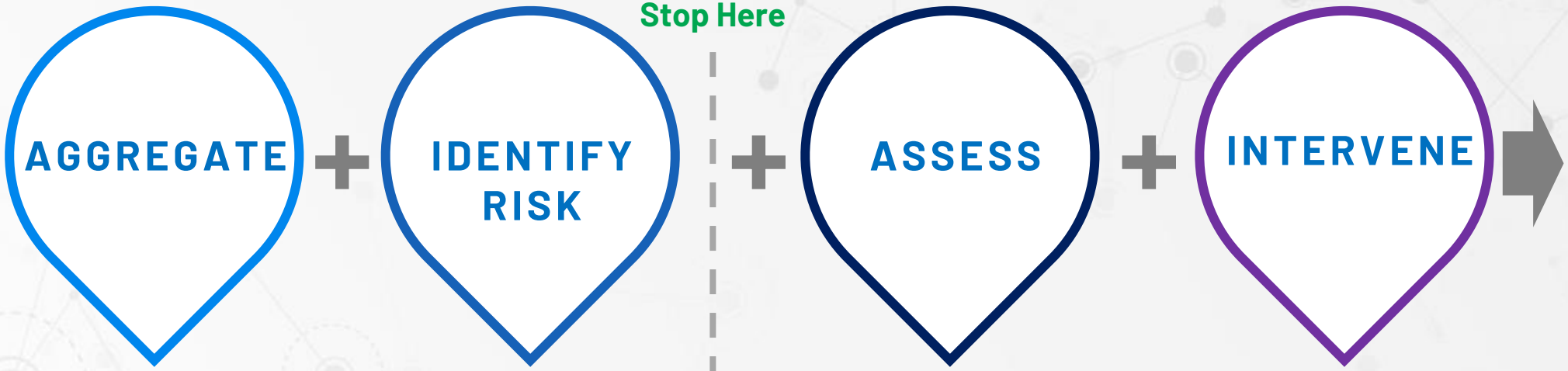
Successfully Navigate the Risk Continuum

Lightbeam Health Solutions

Uncovering both obvious and hidden risks, targeting impactability, and the actions that matter

Lightbeam AI Identifies Which Patients are at Risk, Why, and How to Intervene

Traditional Predictive Analytics Stop Here



Combine structured and unstructured data across the enterprise

Patients with obvious or hidden risks and factors that put them on an accelerated path to a poor outcome

Surface both WHY the patient is at risk and IF that risk can be changed - prioritizing those that are modifiable in terms of health improvement and cost avoidance

Enable ACTION by proposing prioritized and clinically validated interventions that can best change patient outcomes

Clinical & Financial Results

Reduction in Readmissions

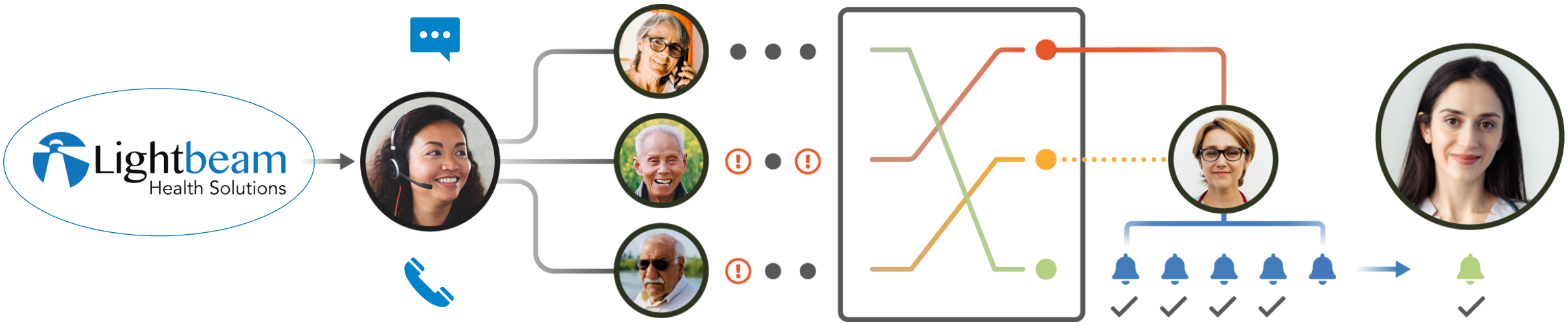
Reduce Care Manager Call Time

Identify More Avoidable Utilization Events than EHRs

Cost Savings

Enabling Insights to Action

Lightbeam pairs the best population health analytics with the best Deviceless remote patient monitoring technology to help providers move seamlessly from insights generation to patient engagement.



Risk Stratification
Identifies cohort of target patients for Deviceless RPM

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

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

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

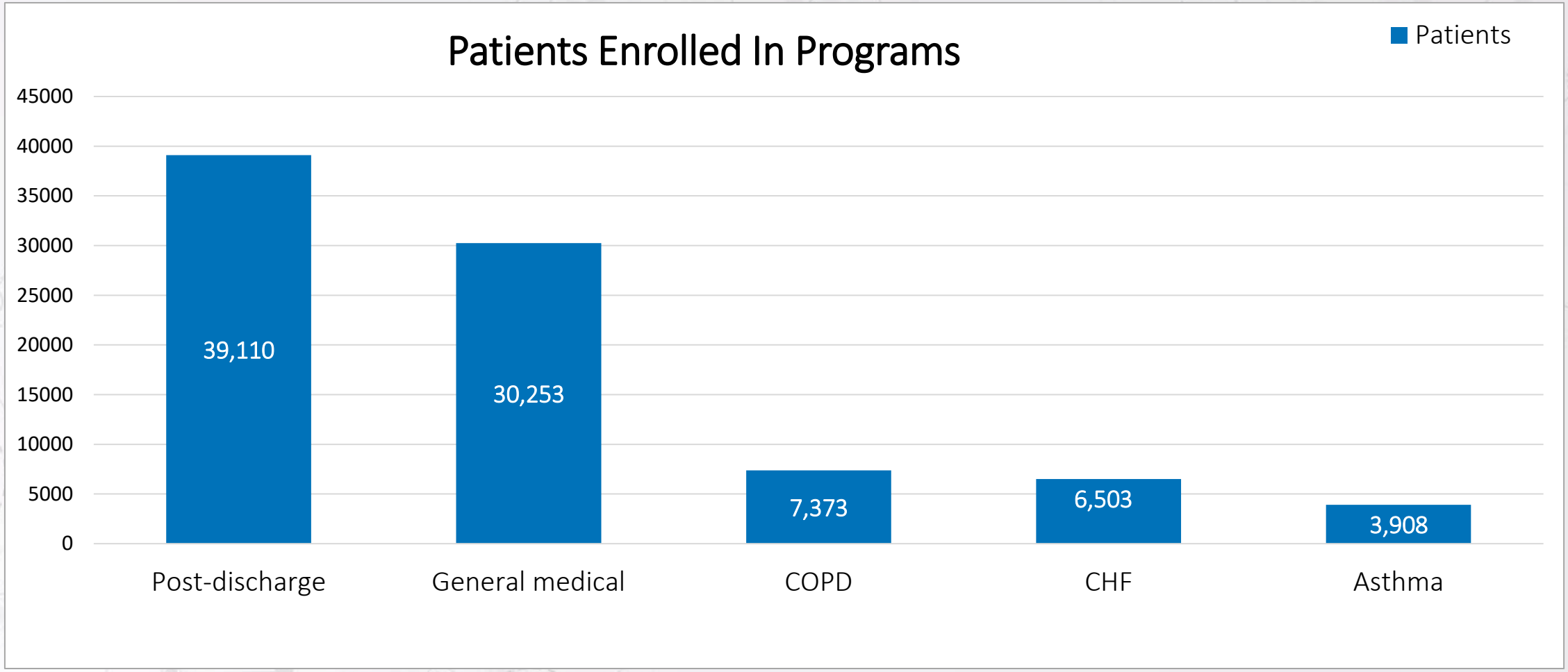
Lightbeam LCS or Client
Care Managers monitor dashboard and follow standard operating procedures

Providers
receive escalations, only as needed

Client Results

Client Success: Midwest Health System

Over 54,000 Unique Patients Enrolled (2020-2022)



Scalability / Reach

Elimination of cold calls increases efficiency

Patients can connect with the team when they need help

Allows team to manage broader population without adding FTE (promotes top-of-license work)

Provider-based team able to resolve patient issues in the moment, while keeping PCP updated

Care team caseload = 1:800

Typical care manager caseload = 1:150*

~ 5x increase in care team capacity

*based on data from AHRQ

Total Cost Reduction of $53 Million

Savings from chronic conditions:

$49,189,643

Savings from prevented readmissions:

$4,430,790

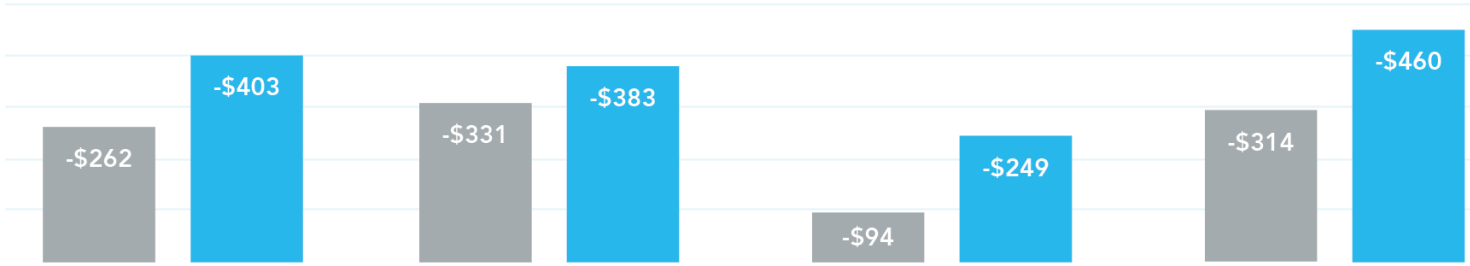
Total: $53,620,433

Client Success

Reduced Utilization in High-Cost Conditions for an Overall $141 PMPM Reduction

Programs	Overall	Asthma	CHF	COPD
PMPM Reduction	**$141**	**$52**	**$155**	**$146**
Total Patient Months	**348,122**	**86,566**	**119,017**	**143,996**

PMPM Pre-Post Difference



Total Cost Savings	**$49.18MM**	**$4.51MM**	**$18.49MM**	**$21.03MM**

The intervention group's PMPM reduced more than the control group

Client Success

1.95% Absolute Reduction in the 30-Day Readmission Rate

Type	Intervention Readmission Rate (15,146 Discharges)	Control Readmission Rate (4,501 Discharges)	Absolute Reduction	Relative Reduction
30-Day	8.31%	10.26%	1.95%	19.01%

Total Readmissions Prevented: 295. Savings of $4,430,790

The difference in the readmit rates between intervention and control group was statistically significant, $X^2=16.5$, $p<.01$

Source of readmission cost= https://www.hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp

Client Success

Over 20,000 Patients Reported High Satisfaction with Care & Communication

Care Satisfaction: *You are getting the best possible care from Midwest Health*

N = 24708
Average = 7.71

1 - Strongly Disagree — Strongly Agree - 9

Message Frequency: *Messages from Midwest Health are sent at just the right frequency.*

N = 22767
Average = 7.72

1 - Strongly Disagree — Strongly Agree - 9

Improved Communication: *These messages improved communications with Midwest Health*

N = 23466
Average = 7.64

1 - Strongly Disagree — Strongly Agree - 9

Patients Feel Connected & Cared For

Quotes from Patients

"The ***information that they provide is very helpful.*** *they return your call promptly. very courteous of your question fully."*

*"****I don't ignore symptoms.*** *I am more apt to take my medicine at the same time every day."*

"A friendly reminder that we are ***connected to Medical Services that can help at any time****."*

"At times ***reminds me of issue I'd forgotten*** *but didn't feel warranted call to doctor."*

"That ***they are concise and short*** *on the fact that their text messages and not phone call because I'm hearing impaired."*

"Shows Midwest Health is ***interested in monitoring feedback*** *for continuing improving. Good job!"*

"That someone contacts you and tries to help. ***It makes my overall feeling about Midwest Health a lot more positive****."*

"They are a ***direct line to the care team*** *if a health issue flares up. Less red tape for me if I need more care."*

Client Success: Esse Health

Scaled Care	Improved Quality	Lowered Costs
1 RN Could Reach 15x More Medicare Advantage Patients	46% reduction in CHF ED visits (n=1,018) 31% reduction in COPD ED visits (n=214)	Lowered PMPM Costs by $257

Client Success: Kootenai

Lightbeam Health Solutions

KootenaiCareNetwork

- 12% decrease in total medical PMPM expenditures
- 16% decrease in total professional PMPM expenditures
- 13% decrease in total inpatient PMPM expenditures
- 26% decrease in hospital admissions per thousand patients
- 15% decrease in ED visits per thousand patients

Q & A

For More Information Scan the QR Code *or visit Lightbeamhealth.com*

Stop by our VBCExhibitHall.com Virtual Booth

[Visit the Lightbeam exhibit booth]

Contact Us

Info@lightbeamhealth.com gschmitt@TheExhibitHalls.com