Altitude | VBCExhibitHall.com Educational Webinar Series

ALTITUDE CARES · WEBINAR, AUGUST 26 2026

A Friday Follow Up to Avoid the Weekend Admission

An AI clinical case review of transitions of care, and how AI-enabled services can drive outcomes

PRESENTER

Brett Ives, NP, DrPH

Chief Clinical Officer
Altitude

brett.ives@joinaltitude.com

INTRO

A transitions of care has to survive two steps

Getting seen is the first one. Being seen properly is the second.

FAILURE ONE

Does anyone follow through?

On paper the handoff is complete — a summary sent, a follow-up booked, a number to call. In practice the week after belongs to no one, and the follow-up is in a clinic she cannot reach.

FAILURE TWO

Are the right things done?

Contact is not a complete visit. Her EF sits in an outside PDF nobody opens, eighteen medications are reconciled from the bottles, two of four pillars are left for someone else.

THE RESULT

Patient comes back

Not because anyone was careless. Because no one owned the week after, and the visit she did get was working from a partial picture.

THE CASE - MS. R

75F · heart failure (Stage C HFrEF), diabetes, hypertension, history of falls

REFERRED FOR	ENGAGED IN	HOW
Heart Failure	2 days	Phone, then Zoom visit

KEY HISTORY

- Recent admission three weeks prior
- Acute on Chronic HF exacerbation (NYHA 3) — **over 20 lb** weight gain in the week before
- Symptoms — SOB, cough, and lower extremity edema
- Homebound, mobility issues and fear of leaving the house
- Psych and pain med polypharmacy
- On **2 of 4** HF guideline pillars
- No PCP visit in **three months**

THE CASE

The plan, and how it differed from last time

Rising weight was picked up on the Tuesday, her daughter reached on the Thursday, and she was seen at home on the Friday — before the weekend.

−8 lb
WATER WEIGHT · 36 HRS

By the Monday check-in she had diuresed roughly eight pounds and was breathing noticeably better. No ED visit, no ambulance, no admission. Once she was stable, we started a third GDMT med

FACT ON THE CHART	THIS TIME	HER LAST EXACERBATION
5 lb gain in a week	Diuretic doubled Friday, weights daily	Unobserved until she was breathless
Polypharmacy w 2 sedating, diabetes med held	Reconciled by a clinician, two changes made, diabetes med restarted, and both of them taught why each med matters	Not identified
Home-bound, no PCP in 3 mo	Seen at home in 3 days, mobile PCP arranged	Clinic follow-up booked, no show
2 of 4 GDMT pillars	Third pillar started once she was stable	Titration deferred indefinitely
Where it ended	No admission. At home, stable, engaged	Hospital Admission

REFLECTIONS

The clinician wasn't better. The set-up was.

Our own software ranked what mattered most for this patient and surfaced deprescribing guidance before the visit. The clinical decisions stayed with the clinician.

01 **The most important clinical actions were ranked**
Weight trend, med list, gaps and access barriers pulled into one read instead of four systems — then ordered by what would change her trajectory first.

02 **The polypharmacy was already worked through**
Eighteen medications checked against her regimen and falls risk, with deprescribing guidance on the sedating drugs and the held diabetes med flagged.

03 **Contact actually landed**
The daughter was reached on Thursday, and the slot offered was one they could take.

04 **The visit came to the patient**
She was homebound and afraid to leave the house — a clinic appointment was not going to happen.

05 **Follow-through had an owner**
Weights, labs and the Monday check-in were tracked to completion, not left as instructions.

FROM ONE CASE TO A PROGRAM

Three questions this raises

That visit went well. Whether it goes well for the next thousand patients depends on three things, and the rest of the talk takes them in order.

01

How can a whole clinician base practice this consistently?

One clinician did this well. The question is whether early, middle and late-career clinicians reach the same outcome.

02

How do you power it at scale?

Two different problems: reaching more patients than a clinician has time to manage, and not losing quality across many conditions.

03

What is this clinical and economic impact when this is done?

Where the clinical and economic impacts show up

POLLING QUESTION

Where is your organization using AI today?

A Clinical documentation / scribing

B Clinical decision support

C Administrative functions

D Patient outreach or engagement

E None of the above

PART 2

Consistency of Care

Ensure every clinician, regardless of capability, gets the same result

PLATFORM

Altitude Platform

Both were at work in the case. Perform is the clinical intelligence inside the workflow. Extend is the clinical group that works from it.

Altitude Perform

Clinical intelligence inside the clinical workflow.

Reads the chart before the visit, answers questions during it, tracks the plan after it.

- Assembles the chart into one read and ranks the actions that matter most
- Drafts the pre-visit note, the prior authorization, the specialist summary
- Hands the follow-through to Extend - transitions of care, disease management campaigns

Altitude Extend

A physician-supervised virtual medical group.

Altitude clinicians use the platform to get patients to goal, faster.

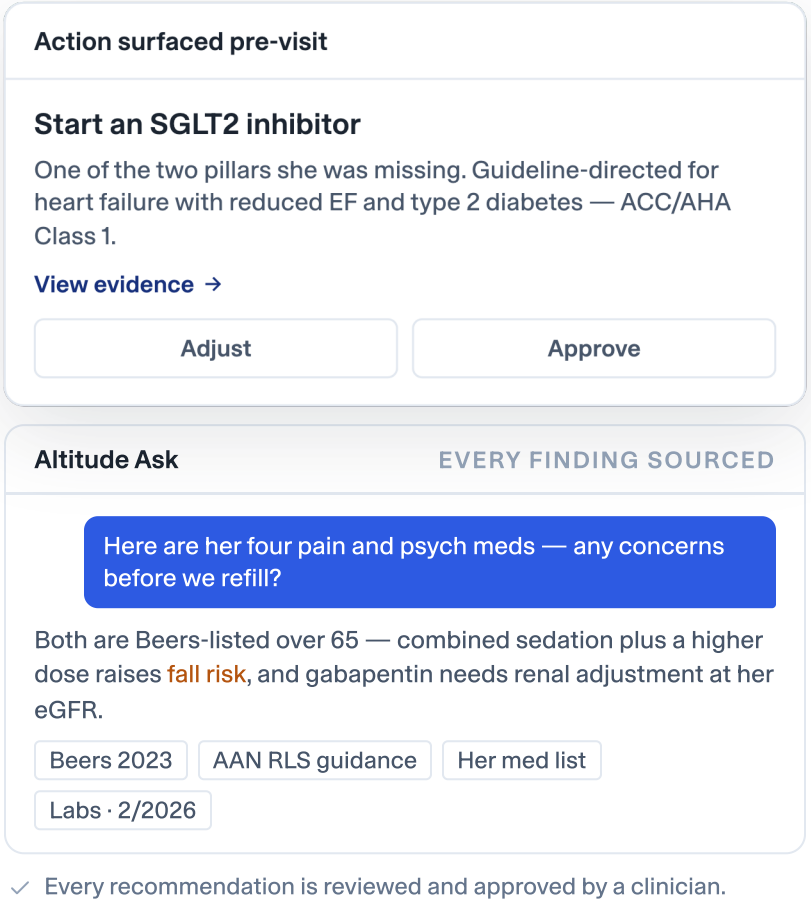
- Continuous condition management to goal or outcome
- Referral, medication and lab loops closed, the referring clinician's authority preserved
- Post-discharge care, disease management campaigns on the PCPs behalf

CLINICAL INTELLIGENCE

Consistent, evidence-based care — every patient, every time

Altitude clinical intelligence puts the latest evidence in front of every Altitude clinician — so care is high-quality, consistent, and reduces time to control of chronic conditions

- **Guideline-directed at the point of care**
  Recommendations mapped to the latest evidence — ACC/AHA, ADA, KDIGO.
- **Consistent across the whole team**
  Every clinician follows the same standardized pathways.
- **Answers questions across the whole record**
  Including outside documents, with every finding traced to its source.
- **Clinician-controlled**
  Intelligence assists — the clinician reviews and decides.



ADOPTION

The same clinical intelligence, made available to practices

Practices use Altitude software to make care consistent across their panels.

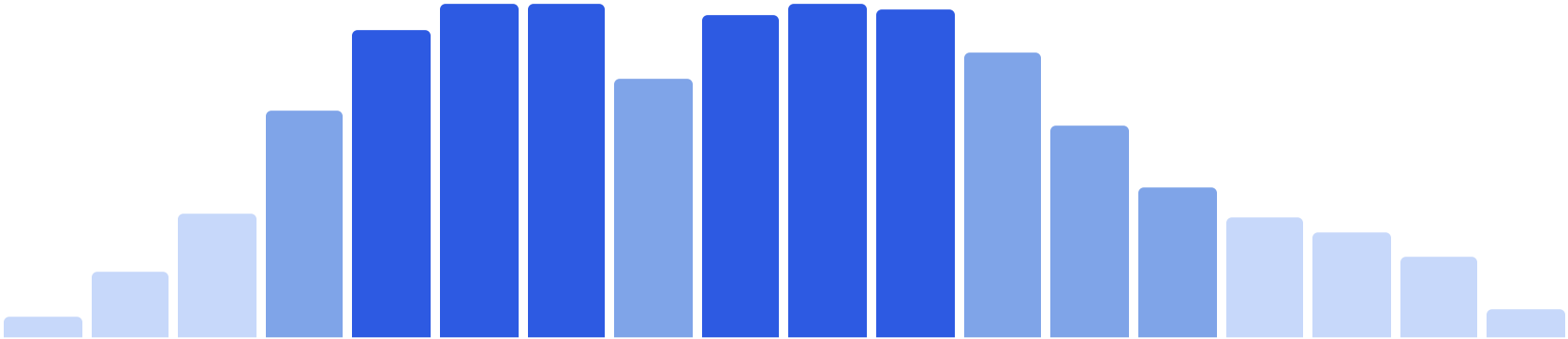
234
unique patients per week

1,320
interactions per week

100%
participation across the enrolled base

THE SHAPE OF THE DAY — INTERACTIONS BY HOUR

Clinic hours shaded darkest



FIRST SESSION BEFORE 6A
The day starts before the clinic does

CONTINUOUS THROUGH CLINIC HOURS
Used inside the visit, not batched afterwards

LAST CLOSE-OUT AFTER 9P
Loops closed same day, not left overnight

CONSISTENCY

Usage differs by career stage, outcomes stay consistent

Each career stage leans on something different. Patients per day rises with experience while interactions per day falls.

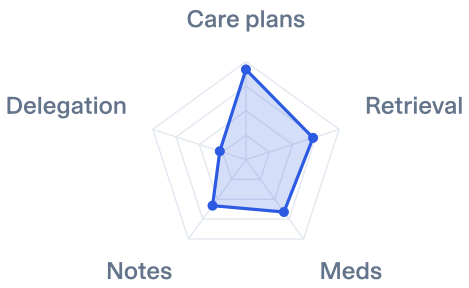
EARLY CAREER

Builds the visit with Altitude

Leans on care-plan, diagnostic, and extend support to work up each patient — trading a slightly lighter panel for depth.

~21 patients / day

58 interactions / day



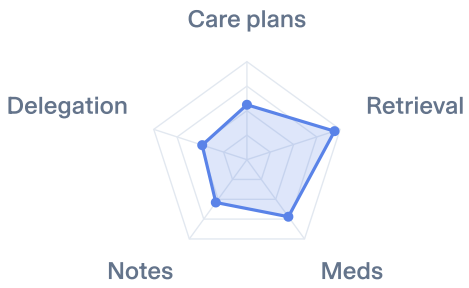
MID-CAREER

Runs the chart through Altitude

Retrieval-first: history, labs, and meds on demand, with coding and calculation folded into the visit.

~25 patients / day

50 interactions / day



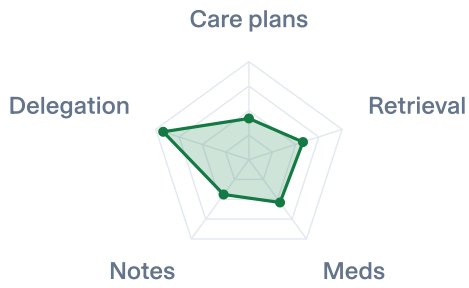
EXPERIENCED

Delegates the busywork

Trusts their own clinical judgment — Altitude handles coding, extension, and retrieval so a bigger panel still closes on time.

~28 patients / day

35 interactions / day



Support Practice Capacity via HF Campaigns

HOW A CAMPAIGN RUNS

01 **Find everyone below four guideline pillars**
Named patients with titration still available, not a report of gaps.

02 **Rank by titration headroom and admission risk**
Most to gain, closest to a hospital bed. Rising risk — like Ms. R's weight trend — moves a patient up.

03 **We work the list**
Our clinicians take the worklist on the practice's behalf, or the practice assigns patients to us. No queue lands on site.

04 **Voice / SMS agent makes the first contact**
Nora books the slot, so the two-week cadence doesn't wait on staff time. Anything clinical escalates.

EXAMPLE — FINISHING GDMT

Typical patient on referral — **2 of 4 on board**:

- ✓ ARNI / ACE / ARB
- ✓ Beta blocker
- MRA
- SGLT2 inhibitor

What we do

Titration stalls between visits — each step needs labs and a slot. We take the patient to **maximum tolerated therapy** on a two-week cadence with at-home labs, then hand them back optimized.

TITRATION METHODOLOGY

GDMT optimization — and knowing when to stop

The endpoint is not the maximum dose. It is **maximum tolerated therapy for that patient**, reached quickly and documented clearly.

THE TITRATION LOOP

1. **Establish target and pillars**
   Confirm the four GDMT pillars in play and the guideline target dose for each.
2. **Assess headroom**
   BP, heart rate, potassium, and renal function determine how much room exists to advance.
3. **Step one agent at a time**
   Advance the pillar with the most headroom first — breadth across pillars beats maximizing one drug.
4. **Re-check on a two-week cadence**
   Labs and vitals before each step, so the next decision is made on current data, not last month's.

STOPPING RULES

We stop advancing when the patient reaches target on all tolerated pillars — or hits a hard ceiling:

- Symptomatic hypotension
- Bradycardia below protocol threshold
- Potassium spiking
- Creatinine rise beyond 30% from baseline
- Intolerance persisting after a dose-timing change

The patient moves to a maintenance cadence. Every stop reason is documented and sent to the referring provider — visible, and reversible.

PART 3

How to Power at Scale

Ensure can reach many patients and maintain high fidelity across many clinical pathways.

Altitude Extend Care Model

Altitude Extend is clinician-led, technology-enabled care. Extend adds capacity to a practice, so more patients can be reached and kept close between visits.

Medication management & reconciliation

Reconcile what's actually in the home, then titrate to goal — the lever that moves adherence and control.

Symptom & data monitoring

Capture symptoms, device data, and labs between visits to catch deterioration early.

Risk reduction

Start interventions and medications that reduce risk of short- and long-term complications.

Care coordination

Close referral, lab, pharmacy, and transport loops across every site of care.

Goals / Outcomes

We focus on getting your patients to condition-specific goals or outcomes and reduce the time and barriers it takes to get there.

CAMPAIGNS ACROSS CONDITIONS AND CARE TRANSITIONS

- Hypertension
- Type 2 Diabetes
- Heart Failure
- Chronic Kidney Disease
- Obesity
- Dyslipidemia
- ASCVD
- Atrial Fibrillation
- COPD
- Asthma
- Depression
- Anxiety
- Post-discharge
- Transitions of care

CARE ACROSS 12 SPECIALTY PATHWAYS (LOW-COMPLEXITY)

Cardiology 7 | Endocrinology 7 | Nephrology 3 | Pulmonology 8 | Neurology 8 | Behavioral health 2 | Other 10

The number denotes distinct clinical pathways.

ACROSS PATHWAYS

The Same Campaign Model — Diabetes with CKD

Different pillars, different labs. Identical loop.

HOW THE CAMPAIGN RUNS

01 Find everyone with declining kidney function

Named patients whose eGFR is falling or albuminuria is rising, not a report of gaps.

02 Rank by protection still available

Most to gain from the pillars they are missing, weighted by how fast function is slipping.

03 We work the list

Our clinicians take the worklist on the practice's behalf, or the practice assigns patients to us. Open quality gaps — A1c, eye exam, nephropathy screening — get closed in the same encounter.

04 Voice / SMS agent makes the first contact

Nora books the slot and the at-home lab draw. Anything clinical escalates.

EXAMPLE — KIDNEY PROTECTION

Typical patient on referral — **2 of 3 on board**:

- ✓ ACE inhibitor / ARB
- ✓ Statin
- ○ SGLT2 inhibitor

Cost and access

SGLT2 inhibitors stall on cost and coverage more than on clinical judgment. We check the patient's formulary, run prior authorization, and find copay assistance before the prescription is written, so the barrier is cleared rather than discovered at the pharmacy.

OUR POINT OF VIEW ON AI

AI for reach. Clinicians for judgment.

AI lets us stay in contact at a frequency no care team could sustain; it does not make clinical decisions, and it never hides what it is. Anything clinical, emotionally charged, or simply asked for routes to a clinician with full context.

AI CARRIES

- Assembling the chart into one read before a visit
- Surfacing the actions that matter most, and the interactions to watch
- Chasing weights, labs, refills and no-shows to completion
- First contact and scheduling on a campaign

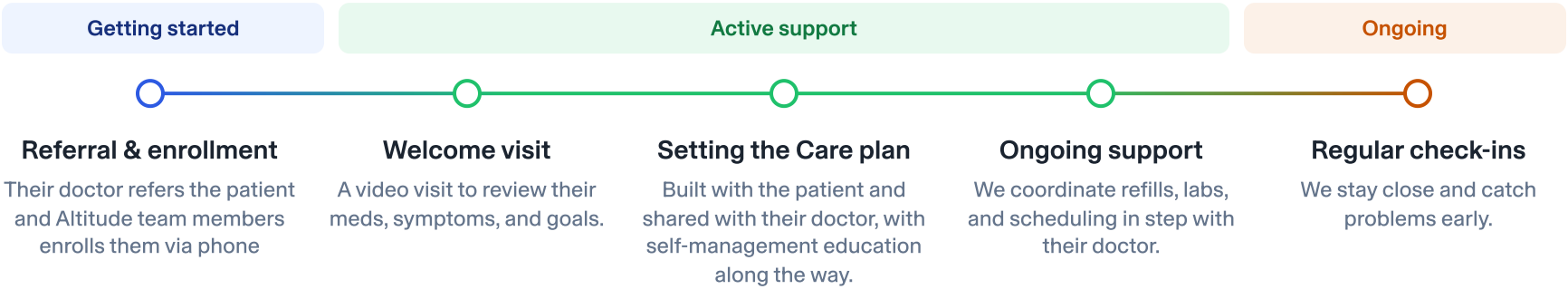
A CLINICIAN IS PRESENT

- The visit itself — and every clinical decision in it
- Any question the patient or caregiver asks about their care
- Anything a threshold or an agent escalates
- The relationship with their own doctor, which we reinforce

THE FULL EXPERIENCE

A standing relationship, a discrete care cycle

Every step is coordinated with the patient's own doctor — we reinforce their plan, we never replace it.



BY DESIGN We plan for presence — where in this journey a clinician is with the patient, and where the work can be carried for them.

CONVERSION

Engagement Approach

Referrals only create value if the patient actually engages. Five things drive our conversion rate.

01

We call on their doctor's behalf

Outreach is attributed to the referring practice, so the call is expected and trusted — not a cold call from a vendor.

02

Persistent, multi-channel

Repeated attempts by phone and SMS at varied times of day, rather than one call and a voicemail.

03

Nothing to download

No apps, no logins, no portal setup — senior-friendly by design, which removes the biggest drop-off point.

04

A visit within days

We get patients to their first virtual visit quickly, while the referral is still fresh in their mind.

05

Care from home

No navigating transportation. Patients consistently tell us this is the part they value and need most — many have limited mobility or no reliable transport.

PART 4

Impact

Drive clincal and economic outcomes

POLLING QUESTION

The priority use case(s) driving your organization's investment decisions in AI capabilities is/are:

A Clinical capacity &/or productivity gains

B Administrative cost reduction

C Quality of Care improvement

D Reducing Total Cost of Care

Clinical Impact

Medication optimization

Reconciliation against what is actually in the home, guideline therapy finished under protocol rather than flagged, and deprescribing where the regimen is doing harm.

Improved medication adherence

Fills confirmed at the pharmacy, barriers worked, and patients taught why each medication matters.

Patients brought to goal

Uncontrolled members reach target and stay there — the outcome every downstream measure depends on.

Quality gap closure

Control measures closed through treatment, not another outreach campaign.

Avoidable utilization

Fewer admissions and ED visits — especially post-discharge.

THE RETURN

Economic Impact

Four sources, reviewed independently. Three come from getting patients to goal faster; the fourth comes from who has to be in the loop.

01 · CODING

Coding accuracy

Conditions documented and coded correctly at the point of care, rather than reconstructed after the fact.

02 · MLR

Reduced time to control

Every month a patient spends uncontrolled is a month of avoidable utilization. Shortening that window moves the loss ratio.

03 · QUALITY

Quality gap closure

Gaps closed through treatment rather than another outreach campaign — the measure and the outcome move together.

04 · OPEX

Clinicians practice at top of license

The platform absorbs the operational work and routes only what needs clinical judgment to a clinician.

From one patient to the platform

WHERE THE PATIENT IS NOW

- No admission since.
- Feels better, less drowsy and unsteady.
- Follows the in-home PCP
- Three of four GDMT pillars on board.

WHERE THIS LEAVES US

- Drive consistent care and similar outcomes, regardless of clinician capability / career stage
- Deliver the standardized evidence-based care, regardless of which conditions
- Reach more patients than a PCP has time for

Altitude

Questions

Thank you

Altitude

Thank you

Brett Ives, NP, DrPH
Chief Clinical Officer
brett.ives@joinaltitude.com

Prabhjot Singh, MD, PhD
CEO
prabhjot@joinaltitude.com