Addressing Rising Risk with Chronic Care Management

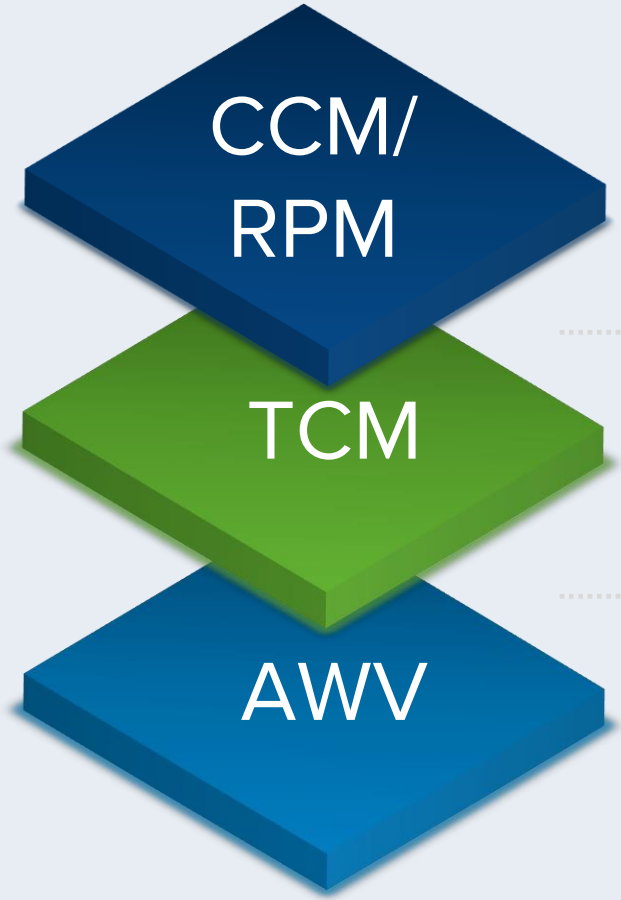
SIGNALLAMP HEALTH

Inc. 500 — America's Fastest-Growing Private Companies

Remotely-Embedded, Personalized Care Management

PraxisCare

Service Lines



Self-Funding

Fully funded via reimbursements with a monthly group Net profit

Foundational

Patients enrolled in CCM/RPM are easier to engage for TCM & AWVs and manage longitudinally

Transitional Care

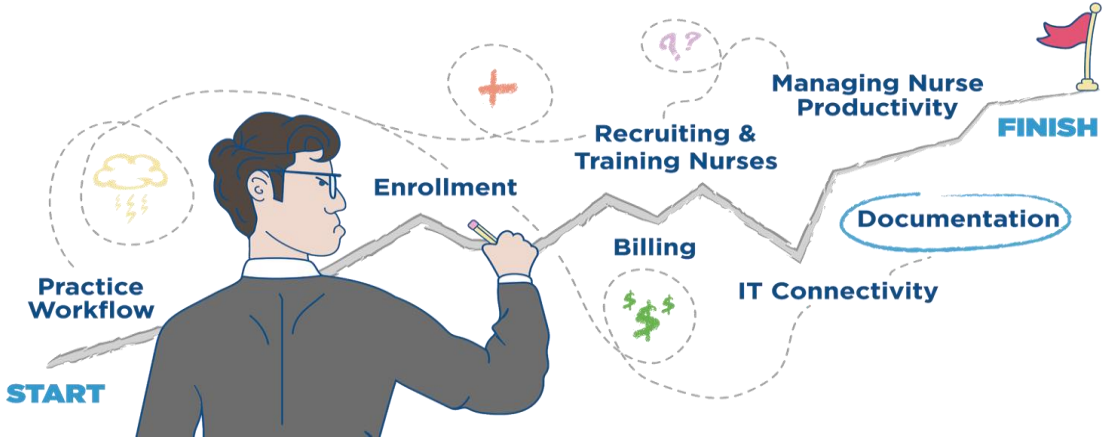
Signallamp allows you to easily expand nurse capacity to meet fluctuating TCM needs and guarantee 100% outreach within 48 hrs

Annual Wellness

Signallamp can help schedule AWVs and/or help to augment capacity to perform AWVs, making office visits more productive and helping to close HCC coding gaps

HOW THE SIGNALLAMP MODEL WORKS

Signallamp's Data Driven Nurse Model Delivers Efficient, Quality Execution at Scale



salesforce

amazon web services | CHANGE HEALTHCARE | Remote Patient Monitoring | Custom Mail Merge API | talkdesk | ChartCheck

Data Digestion & Operations	*Nurse Outreach & Care Management*	*Employee & KPI Monitoring*
salesforce, Epic, aws, Excel	salesforce, talkdesk	salesforce, ChartCheck

Signallamp Model

Dedicated to the same patient panel & provider every month (no call centers)	✓
Document directly in your EMR (no third-party portals or PDF attachments)	✓
Predetermined clinical workflows, parameters & protocol provided by your clinical team	✓
White labeled, i.e., patient feels as though they are speaking to your local practice(s)	✓
Only RNs and/or LPNs delivering care directly to patients	✓
Nurses licensed in the state they reside and the state where your patients are located	✓
Nurses employed directly by Signallamp (no 1099 nurses)	✓
Nurses located in the US	✓

CCM/RPM Service Overview

Ex. of CCM/RPM Services Delivered by SLH Nurses to *Your Patients:*

- MedRecs
- Depression Screenings
- Fall Risk Screenings
- Referral Management
- Transition of Care
- Scheduling Office Visits & AWVs
- Patient Education
- Care Gap Closures
- RPM Device Setup & Support
- RPM Data Monitoring & Alerts

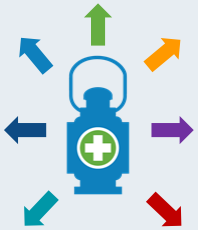
Signallamp Nurses Also:

- Collect social determinants of health and document these in your EMR
- Coordinate w/ CBOs like Meals on Wheels for patients who are food insecure
- Coordinate transportation

Signallamp identifies eligible patients from EMR reports

Signallamp performs outreach to all eligible and documents consent for all patients that opt-in

Signallamp documents patient consent/decline. If patient consents, a branded welcome letter is sent via USPS and/or Portal.



CCM

WORKFLOW

Dedicated Signallamp nurse connects w/patient on monthly basis to help patient manage chronic conditions, adherence to care plan, SDOH, etc. Nurses follow predetermined workflows & preferences to communicate with providers when patients have change in status and/or are outside clinical parameters.

Patient receives first call from Signallamp nurse, who engages patient w/clinical reasons for the program, ties program to care plan goals and builds a custom care plan based on EMR data (e.g., physician notes, diagnoses, etc.)

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Sustainable Model. Long Term Value.

PROVEN

- ✓ Financially Self-Sustaining
- ✓ Remotely-Embedded Nurse Care Model
- ✓ Individualized Care to Patients
- ✓ Proprietary Platform Integrated into Clinical Workflow

TRUSTED

PraxisCare

ProMedica — Your Health. Our Mission.

TGH Tampa General Hospital

Hutchinson Clinic

UPMC — Life Changing Medicine

Yale NewHaven Health

Temple Health

Med Center Health

Finger Lakes Health

Family Practice Center PC

WHY MOVE FORWARD WITH CCM NOW?

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OUT-OF-POCKET COST FOR

SIGNALLAMP SERVICES

$0

PraxisCare is fully funding PMPM fees for Signallamp services for your high-risk population.

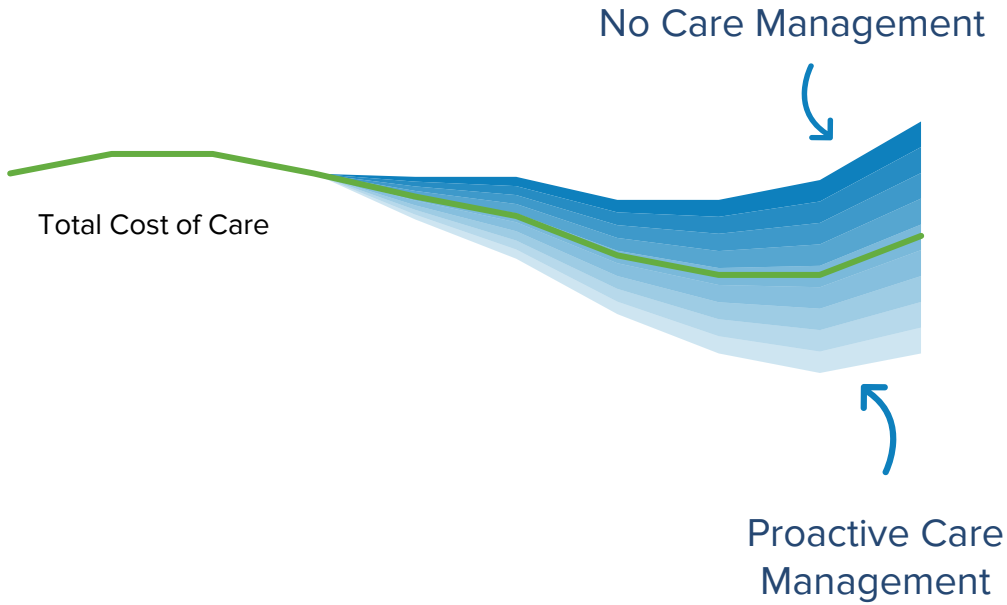
Additionally, you can leverage Signallamp services across your other Medicare populations where we simply leverage existing CPT codes from CMS for CCM & RPM care management services and then **share in the revenue** generated from the services we deliver on your behalf.

Engagement = Outcomes

Proactive Chronic Care Management Increases Primary Care Touchpoints, Which is a Leading Indicator of Success in Value-Based Care

17%

Volumes of Primary Care Services for the Top 50% of Medicare ACOs Were 17% Higher



Downstream ROI

- → **Improved Performance in Risk & Value-Based Payment Models**: Increasing access to care and engaging patients longitudinally will result in improved quality & outcomes (fewer ED/Admits), leading to lower total cost of care.
- → **Leakage Reduction**: “Stickier” patient relationships, with fewer patients getting procedures outside of your preferred network.
- → **Care Gap Closure**: CCM nurses can help ensure patients come in for office visits, AWVs, etc. These visits increase primary care utilization, improve quality and help ensure HCCs are re-certified year-over-year.
- → **SDOH**: Increased SDOH documentation and coordination of SDOH resources for patients.

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Signallamp By The Numbers

KPIs Averaged Across All Signallamp Clients

60%+

Avg CCM/RPM Enrollment Rate Across All Clients

91%+

Avg Patient Retention Rate of Patients Enrolled in CCM/RPM Across All Clients

97%

% Of Signallamp Clients Where Enrolled Patients Are Attributed to a Value-based Payment Program

93%+

% Engagement of RPM Patients Managed by Signallamp

25%+

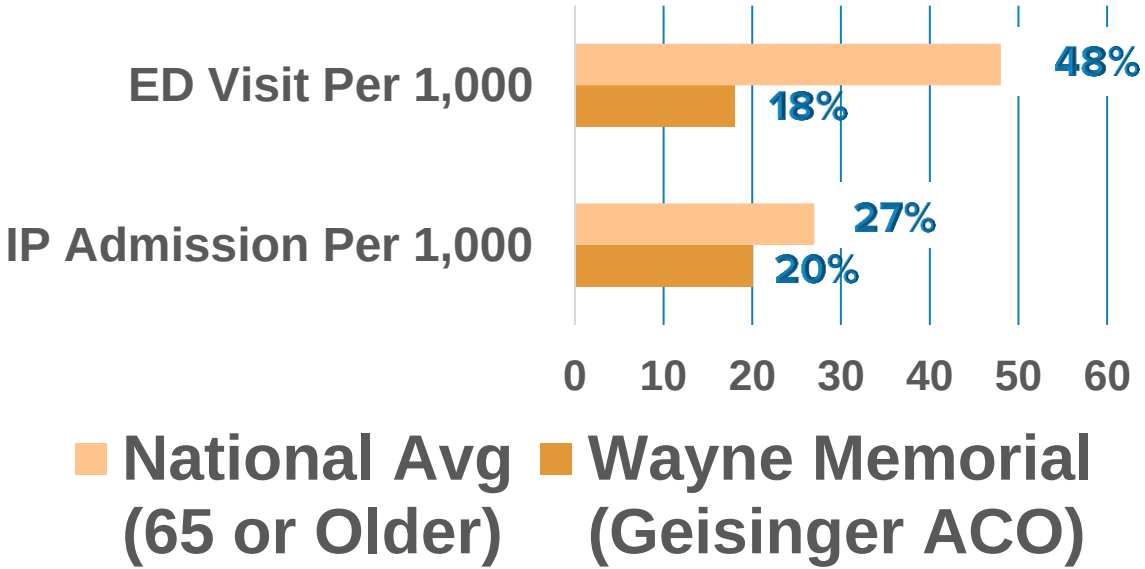
% of Medrecs Performed by Signallamp Where a Medication Discrepancy is Uncovered

50%+

% of Patients Managed by Signallamp 12+ Months That Experience at Least One Acute Exacerbation (Complex)

Signallamp Services Reduce ED & Inpatient Utilization

ED & IP Utilization Performance %



64%

Population Managed by Signallamp Experienced ED Visits Per 1,000 Rates 64% Below National Avg

Clinical Outcomes

UPMC

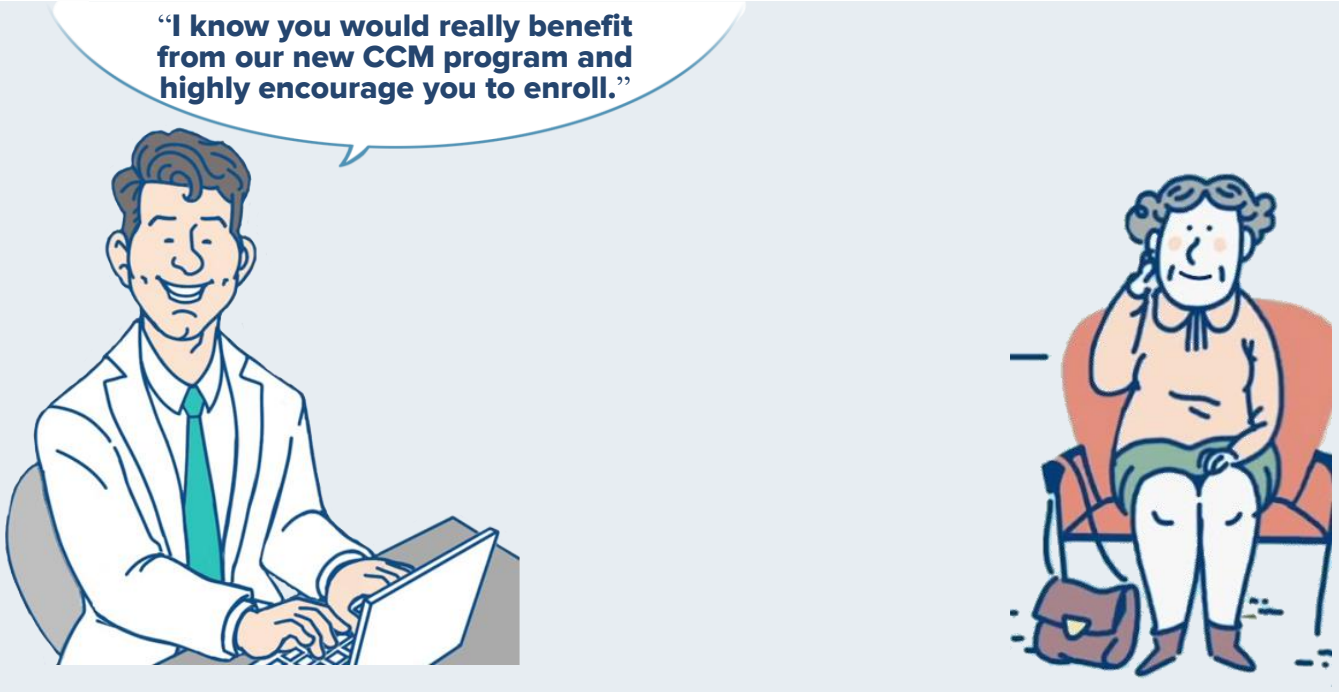
Based on early analysis, **Statistically significant lower 7-day readmission rates (1.6% compared to 8.5%)** for patients enrolled in the Signallamp program

CCM encounters up 50%+ in 2022 compared to internal CCM program before Signallamp partnership.

UPMC
LIFE CHANGING MEDICINE

HOW DO I PREPARE FOR CCM?

Secure Support From Providers



The leading indicator of operational success of a CCM program is provider support & engagement.

Additional Pre-Launch Considerations

Your dedicated Signallamp project team will consult with you and provide best practice guidance on all onboarding requirements.

WHAT DOES A TYPICAL CCM PROJECT LOOK LIKE?

CCM Project Milestones

PRE-LAUNCH	GO LIVE	POST-GO LIVE
Provider Profiles	Enrollment Outreach	
EMR Eligibility Export	Nurse Care Management	
EMR Access	Patient Interventions: Nurse < > Practice	
Finalize EMR Workflows		EMR Workflow Optimization
Practice Kickoff		Quarterly Practice Meeting
		Ongoing Data/Reporting
Ongoing Project Touch Points (Pre-Launch/Weekly, Post-Go Live/Biweekly)		

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THANK YOU!

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