Kidney Health Management

For Your Patients

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Agenda

- Healthmap Program Overview
- Healthmap Engagement Process
- Results
- Questions

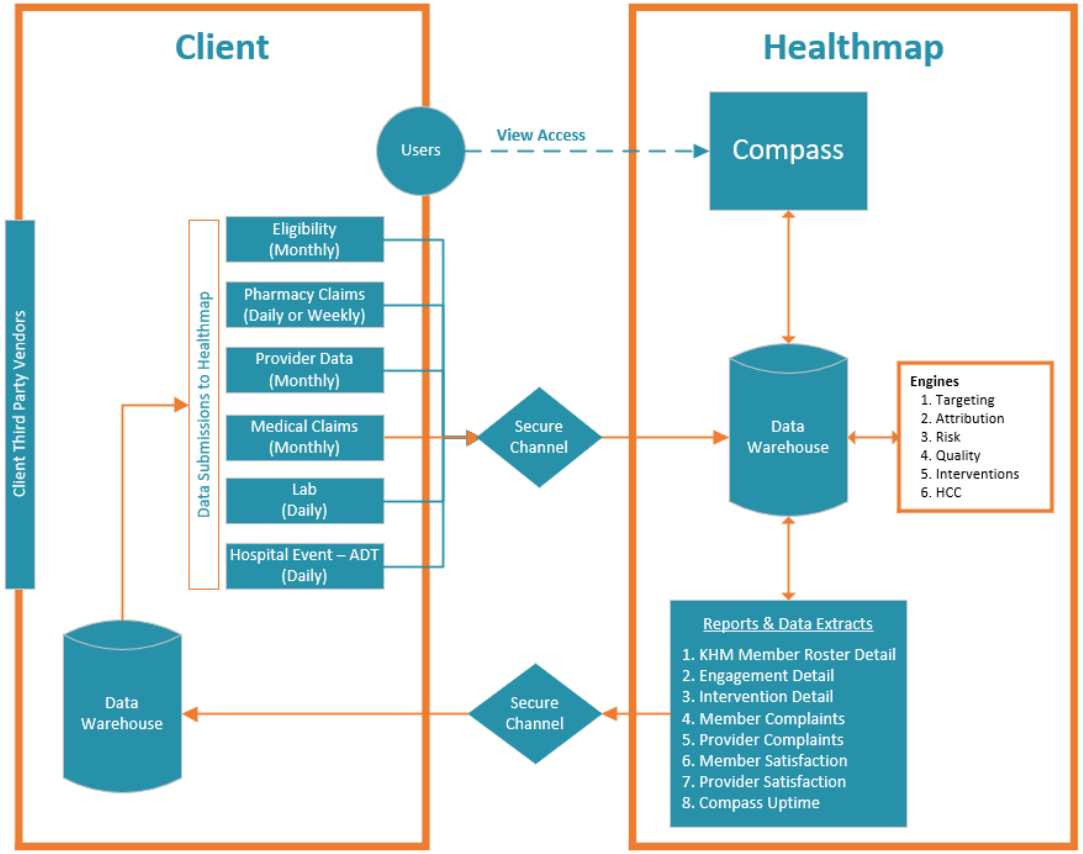
Healthmap Program Overview

KHM Program Framework

Value Proposition	Industry Problem	Healthmap Solutions
Early Patient Identification	Chronic kidney disease (CKD) affects ~15% of U.S. adult population, but ~90% are unaware of their condition	Apply proprietary analytics and "move upstream" to identify patients early in their CKD progression and establish a treatment pathway based on their risk and stage of disease
Member Engagement	Member engagement is critical for any clinical program and can often times serve as a key limiting factor for program success	Healthmap may provides a "feet on the street" approach and engages directly with providers in each local market
Slowing Disease Progression	Fragmented nature of kidney care (i.e., multiple comorbidities and hence healthcare providers) has contributed to worsening health outcomes for patients	Engage with patients and their team of providers to deliver proactive and coordinated care via actionable and timely data and clinical insights
Planned Dialysis Starts	Historically, ~75% of ESRD members have "crashed" into dialysis – planned starts are associated with better outcomes, including higher rates of home dialysis and non-CVC vascular access	Coordinate early referral to nephrologists and assist patients in a planned dialysis approach.
Optimize Renal Replacement Therapy	Opportunity to improve patient quality of life by emphasizing home dialysis, transplant, and conservative care, as appropriate	Empower patients with improved education and accessibility.
Admission/ Readmission Management	Patients with kidney disease, particularly those with multiple comorbidities, are at higher risk of adverse events	Proactive engagement with patients and providers to avoid unnecessary admissions.

Data Mining & Predictive Analytics

- Healthmap aggregates and normalizes **data from multiple sources** into a patient-centric data warehouse
- Our NCQA pre-validated, proprietary technology, **powered by advanced analytics, artificial intelligence, and clinical guidelines** allows us to:
  - Identify patients early, often before the patient is aware that they have kidney disease
  - Risk stratify patients and to identify patients who are at-risk for progression of their CKD disease stage or at-risk for hospital admission over the next six to 12 months
  - Identify gaps in care and intervention opportunities
  - Identify emerging and rising risk patients



Clinical Intervention Opportunities

- Our engine ingests claims data and recommends clinically proven interventions to slow disease progression and promote preventive care
- Healthmap shares clinical intervention opportunities with onboarded practices
- Care Navigation touchpoints are informed by a combination of claims data and information gathered from direct-to-member interactions

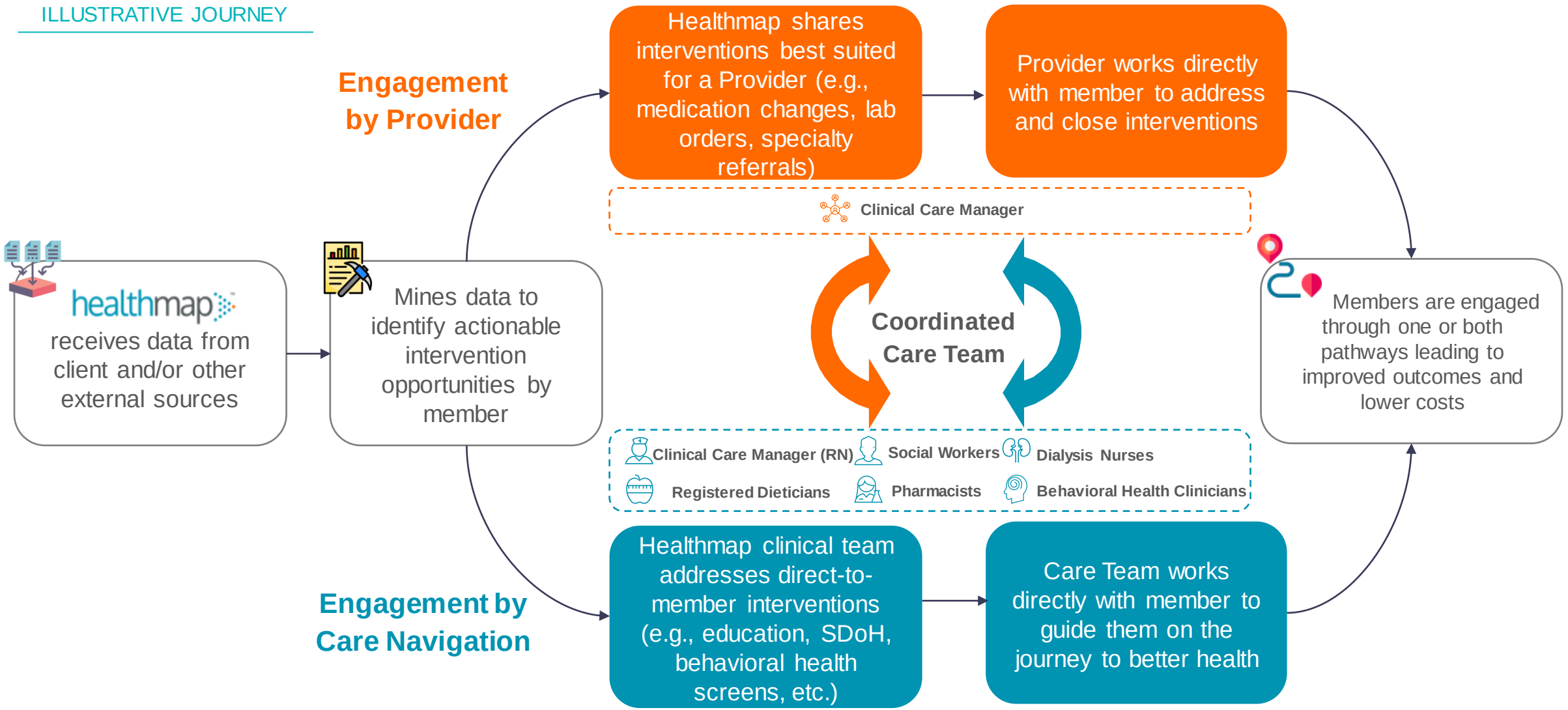
Category	Subcategory	Description
Medication Management	Adherence	Monitor patient adherence with prescribed medication regimen
	Avoid	A medication that should be avoided given patient's stage of kidney disease was prescribed
	Duplication	Two or more medications in same medication class were prescribed
	Interaction	Two or more medications that interact negatively and cause kidney damage were prescribed
Specialist Utilization	Referral	Coordinate specialist referrals
	Compliance	Ensure compliance with scheduled office visits
Lab Testing	Various	Recommend series of lab tests for monitoring of kidney, cardiovascular, and other disease risk
HCC Coding	Various	Promote recapture rate for chronic conditions

Category	Subcategory	Description
Admission/ Readmission Management	Admission	Address avoidable ER visits and inpatient admissions through proactive engagement
	Readmission	Ensure appropriate transitions in care
Condition Monitoring	Hypertension	Ensure proper utilization of medications and real-time monitoring of blood pressure
	Diabetes	Comprehensive patient education program focused on lifestyle management
	Anemia	Patient education about signs and symptoms
	Behavioral	Identify anxiety, depression, and mood disorders
RRT Education	Home Dialysis & Transplant	Empower patients with improved education and assist in developing personal RRT plan
SDoH	Various	Address various social barriers, including food insecurity, transportation and utility assistance

Healthmap Engagement Process

Our Engagement Approach

ILLUSTRATIVE JOURNEY



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Provider Engagement Model

Clinical Care Managers: Healthmap Solutions **Clinical Care Managers** are responsible for developing and maintaining long-term relationships with physicians, physician office staff, and Healthmap members that are engaged in Healthmap's Kidney Health Management program. Clinical Care Managers' responsibilities include:

- **Managing provider relations:** focusing on provider outreach for program review and onboarding activity and identifying practice preference for working with Healthmap.
- **Serving as a clinical practice liaison:** working with the onboarded provider for routine member panel reviews that include identifying care gaps and intervention opportunities, admission notifications, and coordination of in-office/clinical visits.
- **Interfacing with members:**
  - Providing a multidisciplinary approach to nutrition, pharmacy management, behavioral health, and social determinants of health (SDoH) for holistic care
  - Delivering longitudinal coordination across the care continuum and care continuity to the member's provider care team
  - Reinforcing member education and compliance
  - Facilitating closure of barriers to care and addressing SDoH

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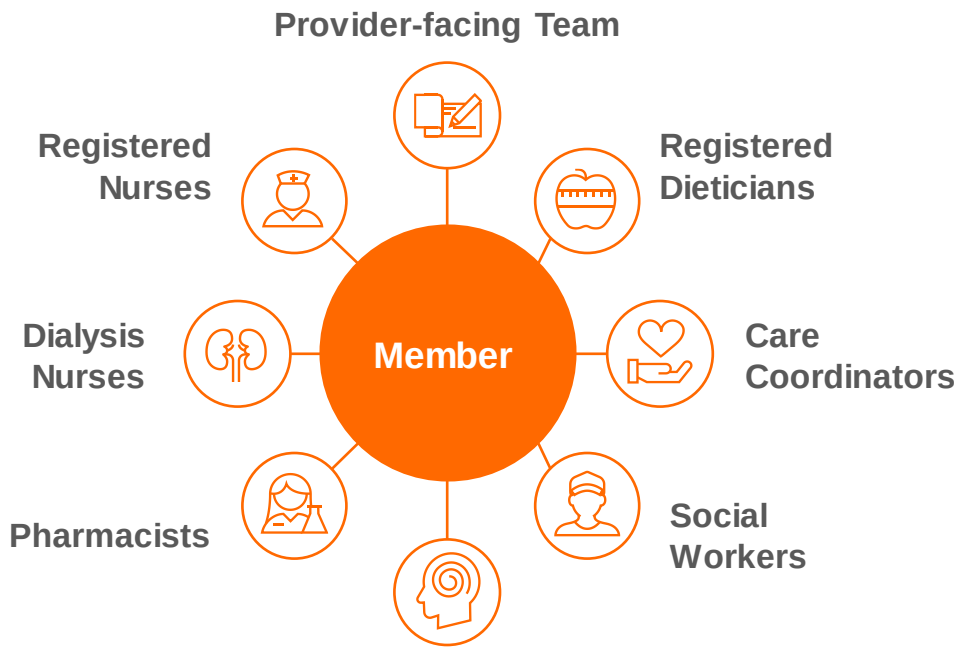
Care Navigation Engagement Model

In addition, a select cohort of members will also receive high-touch, individualized care from a Healthmap Care Navigator (primarily Registered Nurses)

Holistic, Customer-Centered Care



Care Navigation Touchpoints

Personal Health Assessment (PHA)

Components of Healthy Action Plan (HAP)

- Medication Review
- Comorbidity Management
- Nutrition & Lifestyle Management
- Transportation Assistance
- RRT Education & Assessments
- Behavioral Health Screening
- Social Determinants of Health

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Results

Healthmap Performance

Metric	Healthmap Impact	Healthmap Value Proposition
Gross Savings	**Reduction in Medical Expense**	• Savings are due to reduction in inpatient spend, as specifically designed by our Kidney Health Management (KHM) program
Inpatient Utilization	**Reduction in Admits & Readmits**	• Proactive engagement to avoid unnecessary hospitalizations and ED visits • Assist with transitions in care and deliver readmissions instructions and interventions.
Home Dialysis Rate	**New Dialysis Starts in the home**	• Assist patients in a planned dialysis approach. • Early referral to nephrologist.
Dialysis Crash Rate	**Reduction in Dialysis Crash Rate**	• Ensure proper nephrology care and/or vascular access • For every crash avoided, there is a corresponding reduction in cost of initiating dialysis.
Engagement Rate	**Increased Engagement with Providers & Members**	• Ability to drive intervention closures highly contingent on engagement in KHM program • Engagement is defined as members attributed to onboarded providers and/or engaged directly with a Healthmap Care Navigator

Questions?

THANK YOU