THE REMOTE PATIENT MONITORING INNOVATION CHALLENGE FINAL SHOWCASE

11.18.20

ADAPTATION HEALTH

CHCF

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CHANGING THE WAY THE WORLD TACKLES POVERTY

HEALTH EQUITY VENTURES

Welcome to the Remote Patient Monitoring Innovation Challenge Showcase

Today you will hear from six companies that were identified through a highly competitive national search process and selected for their efforts to provide technology solutions that make scalable, effective, and culturally responsive remote patient monitoring (RPM) possible for health care providers serving populations enrolled in Medicaid and other safety-net programs. The competition prioritized companies with solutions capable of monitoring data related to cardiometabolic conditions, especially diabetes, hypertension, and heart failure.

This webinar offers the selected companies the opportunity to share their innovative solutions with you and a national audience of safety-net leaders. You will hear from each company, as well as a panel of safety-net provider experts. The event will highlight unique RPM-enabled strategies and partnerships emerging in response to COVID-19, which has disproportionately affected populations served by the safety-net.

For more information on the Challenge, visit adaptationhealth.org/rpm-challenge.

Agenda

9 am - 11:30 pm PT, November 18, 2020 | Invite others to RSVP through Zoom

All times listed are in Pacific Time

9:00 AM	9:25 AM	Opening Remarks and Expert Provider Panel
9:25 AM	9:45 AM	LucidAct Health
9:45 AM	10:05 AM	Rimidi
10:05 AM	10:25 AM	CareSignal
10:25 AM	10:45 AM	Certintell Telehealth
10:45 AM	11:05 AM	Alertive Healthcare
11:05 AM	11:25 AM	Memora Health
11:25 AM	11:30 AM	Closing Remarks

Recordings of all individual presentations will be posted and available following the event.

Project Partners

Thanks to our Challenge sponsors, three investors dedicated to scaling innovations in the safety-net:

California Health Care Foundation — ***www.chcf.org***

ACUMEN CHANGING THE WAY THE WORLD TACKLES POVERTY — ***www.acumen.org/america***

HEALTH EQUITY VENTURES — ***www.healthequityventures.com***

*Join the conversation on Twitter using **#RPMChallenge***

Expert Panel

The Showcase will start with a panel featuring the following experts and moderated by Ella Schwartz.

Dr. Christine Braid

Medical Director of Virtual Care Services, Dignity and Vice Chair of Family Medicine Department, Mercy Medical Group

Dr. Edgar Chavez

Chief Executive Officer and Founder, Universal Community Health Center

Dr. Danielle Oryn

Chief Medical Informatics Officer, Petaluma Health Center and Chief Medical Officer, Redwood Community Health Coalition

Ella Schwartz

Senior Program Investment Officer, California Health Care Foundation

Characteristics of Showcased Solutions

> *"When COVID-19 hit, the biggest concern among our community health center members was how we would stay connected with our patients, especially those that aren't as tech savvy. Having remote monitoring technologies that we could scale up quickly and affordably, and be confident our patients could access and use easily, was essential to our response."*
>
> **- Dr. Danielle Oryn**

Six innovative companies were selected based on their ability to meet the following criteria:

- Experience working with safety-net and Medicaid populations
- Culturally responsive, effective patient engagement and health education accessible to patients less comfortable with technology and/or whose first language is not English.
- Integration with provider electronic health records and timely provider workflows and clinical decision support
- Easy and intuitive patient set up and registration process and cellular and Wi-Fi enabled devices
- Leadership, founder(s), and Board represent the communities receiving care and services and practice diverse, equitable, and inclusive hiring practices and principles informing product design

Simplest Remote Patient Monitoring solution for senior patients

LucidAct Health is a leading remote patient monitoring solution company specifically designed for the senior population in Medicare and Medicaid programs. Our technology is designed for a less tech savvy client base and automatically transmits device data to the care team's system without a smartphone or wi-fi. In addition, our AI technology can match patients' SDoH needs with local resources, identifying and facilitating access to meet the social needs of our patients.

The LucidAct RPM solution has been deployed to more than 3,000 patients' homes. Our entire population is composed of Medicare members—with over 80% dually eligible for Medicaid. LucidAct Health provides a turn-key solution to help Medicaid providers to launch the RPM program successfully. We achieve this through: 1) Delivering home monitoring device kit to the patient's home within 48 hours (Bluetooth-enabled devices: BP cuff, thermometer, pulse ox, weight scale, glucometer) 2) Streaming device data through cellular LTE network to the LucidAct Cloud or physician EMR 3) 24/7 PERS service 4) Remote Vitals monitoring call center and triage services.

LucidAct has 150+ care plan templates built-into our software platform. Our devices have a patient-facing app with health education videos and tools to facilitate communication between patients, family members, and physicians. Patients can also text our LucidAct Bot regarding their SDoH needs—including housing or food support, financial assistance, or emotional support—and our bot will provide assistance through 211.org.

Please contact **gracechen@lucidact.com** for a product demo.

Follow LucidAct Health on LinkedIn.

Featuring Grace Chen, CEO

Grace Chen is the CEO and Co-Founder of LucidAct Health. Prior to LucidAct Health, Grace was the data architect and program director at Stanford Healthcare. She successfully led high profile care transformation programs, including reducing hospital 90/180 days readmission rate for CHF patients, putting in standard processes to reduce chemotherapy wait time for breast cancer patients, and managing the launch of the survivorship program for 10,000 patients by targeting specific needs of cancer survivors. At Sutter Health, Grace led teams and built a smart CHF registry to improve adherence to evidence-based guideline-directed medical and device therapy for high-risk CHF patients. Grace has a master's degree in computer science and 10+ years' experience in the Healthcare IT industry and is an expert in EPIC implementation and advanced data analytics.

LucidAct

Remote Patient Monitoring for Community Health Centers

About LucidAct Health

LucidAct Health is a Bay Area based virtual care technology company. We offer connected telemedicine and remote patient monitoring solution optimized for serving the Medicare and Medicaid Patient populations. Our solution is specifically designed for patients who are non-tech savvy, living in the rural area, or having a cultural/language barrier.

Our Unique RPM Offering

The combination of these 4 key components set LucidAct's RPM offerings apart:

1) Cloud-based virtual care platform with voice, text, email and video call capability

2) Home monitoring device kit: smart gateway hub that automatically reads and transmits measurement data from the prescribed blood pressure cuff, pulse oximeter, thermometer, weight scale, glucometer, and/or spirometer to LucidAct provider portal

2) Certified nurses and pharmacists at our call center

3) 24/7 Personal Emergency Response Service

Patient Experience

We focus on providing the easiest to use devices to drastically improve patient experience and adherence rate. Our devices came with a cellular enabled gateway hub, patients do not need to have a smart phone or go through the trouble of paring devices. They simply plug the gateway hub into the power outlet and take their blood pressure (and other) measurements normally.

Special Value to FQHC and Community Health Centers

LucidAct intelligently spots true-positive alerts to help the call center nurses prioritize outreaches to patients that require immediate interventions, and prevent alert fatigue

Our AI leverages NLP technology to identify and tag patients with SDoH needs

Our AI assistant can automatically search for local resources to meet patients' needs in the following areas:

- Housing
- Rental payment
- Homeless shelters
- Senior Housing
- Soup kitchens
- Food banks
- Hot meals
- Baby food
- Delivered Meals
- Cal-Fresh
- Clothing
- Bill payment assistance
- Crisis interventions
- Transportation
- General relief
- Counselling Services

For a demonstration, or to start a trial, please contact us:

Grace Chen

Tel: 408-677-8895

Email: gracechen@lucidact.com

www.lucidact.com

4701 Patrick Henry Drive, Bld #25

Santa Clara, CA 95053

rimidi

Time for Better

Rimidi's mission is to help clinicians optimize the use of data to enable better clinical workflows, better clinical decisions, better patient engagement, care and outcomes, and ultimately – a better healthcare system.

Rimidi's cloud-based software platform for clinicians enables remote monitoring of chronic conditions across patient populations, with specific use-cases for diabetes, heart failure, fatty liver, cardiovascular disease/hypertension, obesity, and COVID/Epidemic management. Rimidi's electronic health record (EHR)-integrated platform combines patient-generated health data from cellular-enabled connected devices including glucometers, scales, and blood pressure cuffs with relevant clinical data in the EHR to drive patient-specific clinical insights and actions via embedded clinical decision support cards.

Leveraging SMART on FHIR APIs, Rimidi provides clinical data integration, single sign-on and a unified onscreen user experience. The Rimidi platform allows each client to configure alerts, risk scores, and triage status to support their specific protocols, care team structure, and clinical priorities. Rimidi provides visibility of outcomes at the aggregate population level, in various patient registries, and detailed individual patient views. Individual patient views combine patient-generated data from connected devices and patient-reported outcomes surveys with relevant clinical data in the EHR, allowing clinicians and care teams to visualize a patient's progress over time and prompting intervention (i.e. reminders to take blood pressure) when necessary. The platform also offers patient health education courses for diabetes, weight management and fatty liver disease. The platform is integrated with major EHRs, but can also operate stand-alone.

Please reach out to **Kirk Barnes**, our VP of Business Development, or **Lucienne Ide** to discuss how we can help you deploy the right RPM program for your practice.

Follow Rimidi on Twitter, LinkedIn, Facebook or Instagram, and connect with Lucienne on LinkedIn.

Featuring Dr. Lucienne Ide, Founder and Chair

Dr. Ide brings her diverse experiences in medicine, science, venture capital and technology to transforming the delivery of healthcare. Prior to starting Rimidi in 2012, Dr. Ide worked as a physicist at the National Security Agency, Raytheon Systems Corporation and Monarch Capital Partners. She holds a joint M.D. and Ph.D. (pharmacology) degrees from Emory University, and completed her medical training at the University Pittsburgh Medical Center. Dr. Ide serves on the Steering Committee for the Connected Health Initiative which advocates for health policy reform and is Co-Chair of the Health Equity and Access Leadership (HEAL) Coalition. Dr. Ide was named one of the Most Influential Women in Health IT by HIMSS in 2020. She also serves as a Trustee of Middlebury College. Dr. Ide lives in Atlanta with her husband and their four sons.

rimidi

Meeting Patients Where They Are

A virtual, continuous model of care for underserved populations

As early pioneers of SMART on FHIR, Rimidi's apps work directly within your EHR - no separate sign in, no workflow disruption, better clinical efficiency. By offering cellular-enabled devices and browser-based PRO reporting and patient education, Rimidi's holistic solutions are accessible to more patients with as little friction as possible.

Integrated Remote Patient Monitoring for Cardiometabolic Conditions

Rimidi combines patient-generated health data from cellular-enabled connected devices like blood pressure cuffs, scales, and blood-glucose meters with relevant clinical data from the EHR to drive patient-specific clinical insights and actions via embedded clinical decision support cards. The platform enables clinicians to get a holistic view of their patients' health and seamlessly switch between disease-specific views, including diabetes, heart failure, fatty liver, cardiovascular disease/hypertension, and obesity.

Patient Reported Outcomes

We need solutions to bring the patient's voice into the clinical dataset - especially patients in underserved communities impacted by Social Determinants of Health. Rimidi delivers PROs and questionnaires directly to patients on their device in real-time or in an event-driven or data-driven context. Patient responses are visible within the clinician's existing workflow, and allow for visualization of trends over time and incorporation into clinical notes.

Digital Patient Education

Rimidi developed online health education to expand the reach of patient education for health professionals. Based on proven models, Rimidi developed a video-based digital course accessible via web browser featuring courses in Diabetes Self-Management Education and Support (DSME-S) and Weight Management. The courses are tailored to reflect community demographics and resources most relevant for participants.

For more information visit **Rimidi.com** or email **health@rimidi.com**

CareSignal®

Deviceless Remote Patient Monitoring

CareSignal Deviceless Remote Patient Monitoring engages large patient populations with disease-specific, evidence-based automated texts and phone calls, identifying patients with worsening symptoms and alerting care teams of opportunities for proactive care. With 10 peer-reviewed journal publications, 16,000+ patient-years from patients across the US, and over 30 disease-specific programs (including diabetes, hypertension, heart failure, depression, anxiety and substance use), CareSignal is an accessible and proven solution for underserved populations and their safety-net providers.

Patients use their existing phone to send and receive CareSignal messages. CareSignal works with any phone (landline, cell phone or smartphone). Uniquely, CareSignal is the only solution that has agreements with all major cellphone carriers to provide free-to-end-user messages to patients, meaning patients do not need minutes, cellular data or WiFi to receive or respond to messages. Messages are white-labeled, patients can instantly start engaging with our platform, instead of worrying about learning a new technology.

CareSignal is proud to support dozens of the largest FQHCs, health systems, and payers across the country, bringing scalable Deviceless Remote Patient Monitoring to individuals with chronic, behavioral, and social challenges while driving value for the hard-working organizations tirelessly offering service every day. Thank you for all that you and your teams are doing.

We would love to speak with you! Please email Ann Conrath **(ann.conrath@caresignal.health)** and mention your connection through Adaptation Health.

Follow CareSignal on LinkedIn, try the Interactive CareSignal Demo, and read CareSignal Case Study for CHF and COPD.

Featuring Blake Marggraff, CEO & Founder

As CEO and co-founder, Blake Marggraff leads CareSignal in developing evidence-based healthcare technology to deliver clinical and financial returns for patients and healthcare organizations who have the most to gain. The company's technology has been recognized by the Forbes Impact Summit, the 2018 Prime Healthcare Competition, and the Global Impact Award, and CareSignal's clinical impact is evidenced by ten positive-outcome peer reviewed journal publications. While leading CareSignal, Blake Marggraff was named a St. Louis "30 Under 30" professional and HIMSS 2019 Champion of Health for evidence-based technology.

CareSignal™

Boost proactive outreach by engaging and identifying rising-risk patients–in real-time.

CareSignal™ empowers clinical teams to reduce ED utilization by prioritizing at-risk patients. Our evidence-based portfolio of standardized text messages and phone calls collect and triage patient-generated data for chronic and behavioral conditions.

Achieve impressive outcomes and increased success in value-based care with evidence-based monitoring.

62% reduction in risk of COPD related hospitalizations

1.15% drop in HbA1c in 4 months

50% improvement in blood pressure control in 12 weeks

9+ Peer-Reviewed Publications

2x increase in post-discharge follow-up attendance

28% decrease in PHQ-9 scores for patients with depression

18% decrease in CHF-specific hospitalizations

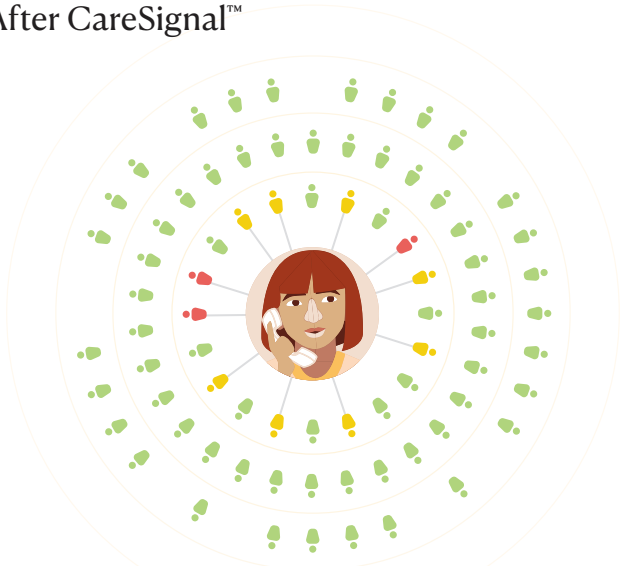
27+ Conference Presentations

Amplify Care Management's Impact

Before CareSignal™

- Cold call patients to identify at-risk patients
- Unsure which patients have rising-risk issues
- Caseload limited by outbound calls
- Difficulty in setting priority with available resources

After CareSignal™



- Algorithms identify at-risk patients without cold calls
- Alerts highlight urgent or emergent rising-risk issues
- Informed outreach helps expand caseload
- Timely interventions can be prioritized with same resources

(314) 272-2586 · Setup a call at https://meetings.hubspot.com/ann-conrath. 4220 Duncan Ave #201, Saint Louis, MO 63110

CareSignal™

Demo: Text "care" to (844) 837-9996
Learn More: https://www.caresignal.health

Our chronic and behavioral tools send automated, evidence-based messages to proactively engage at-risk patients. Patients may also get educational or motivational messages at a frequency that adapts to patient responses. CareSignal™ has clinically-validated technology that is white-labeled so messages look like they're from your organization, creating a seamless patient experience for collecting patient-generated data.

Cardiology

Heart Failure
- Breathing worse
- Swelling in legs
- Weight gain (default 9 pounds)

Hypertension
- Blood pressure
- Hypertensive and hypotensive crisis with symptoms

Endocrinology

Diabetes
- Blood glucose (fasting, preprandial, and postprandial)
- Hypoglycemia and hyperglycemia
- Ophthalmologist appointment reminder
- Supplies: lancets and strips

Wellness
- Tracks diet and weight
- Motivational messages

Pulmonology

COPD
- Dyspnea
- Cough and sputum

Asthma
- Peak flow
- Rescue inhaler use
- Breathing difficulty trends

Behavioral Health

Depression
- PHQ-9 (mood, depressed, sleep, appetite, fatigue, concentration)
- Mood, quality of sleep
- Monitors suicidality

Substance Use
- Stress related
- Follows # of meals, loneliness and sleep hours

Maternal Health

Postpartum Depression
- EPDS score > provider set threshold
- Thoughts of self harm immediately connects patient with 24/7 National Behavioral Health hot line

Breast Feeding
- Breastmilk exclusivity versus mixed versus formula only
- Latching issues, breast pain, milk supply production
- Baby's weight

Nephrology

Dialysis
- Patient indicates they will miss or be late to appointment
- Concerning symptomatology for transitions of care indicated

CVC to Fistula
- Educational messages for patients switching from CVC to Fistula

Post-Discharge

Referral
- Routes patient to downstream provider
- Proactively reminds patient to attend appointment

Surgery

Surgery
- Redness, swelling, pain
- Drainage, odor
- Fever
- Nasal ointment procurement and application
- Scrub care procurement and application reminders for use

Complementary

Basic Needs
- Patient wants a call because of feeling worse
- Patient wants to talk about upcoming bills

Medication Adherence
- Tracks medication refills
- Asks about ability to refill medication

CareSignal™ Platform Features


Real-Time Alerts


Population Health Reports


Intuitive Dashboard


EHR Integration Available

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Closing the Care Gap

As a Management Services Organization (MSO), Certintell partners with health centers and delivers comprehensive primary care-led services to patients through their proprietary telehealth 2.0 cloud-based technology platform and clinical delivery workflows. These health centers receive Remote Patient Monitoring services and hardware at no cost, including a white-labeled telehealth portal, and proactively scheduled telehealth check-ins with their patients — increasing revenue and quality measures for their health center, while allowing Certintell to bill ongoing patient encounters.

Client Expectations:

1) Improve outcomes for chronic patients through increased engagement and evidence-based coordinated care
2) Increase quality measures by assigning Certintell services to Medicare and dual-eligible patients
3) Significantly increase revenue through underutilized telehealth visits scheduled by Certintell

A nation free of disparities in health and health care.

The leading health indicators have demonstrated little improvement in disparities over the past decade, according to recent analyses of progress on Healthy People 2010 objectives. Significant racial and ethnic health disparities continue to permeate the major dimensions of health care, the health care workforce, population health, and data collection and research.

There needs to be strong strategies in place that will accelerate national momentum toward reducing racial and ethnic health care disparities.

Follow and and connect with Certintell on Twitter, Facebook, and LinkedIn.

Featuring Benjamin Lefever, Founder & CEO

Benjamin is a healthcare industry veteran with 20 years of experience of working with patients, hospital systems and community health centers, including developing sales, operations, and technologies.

certintell® TELEHEALTH

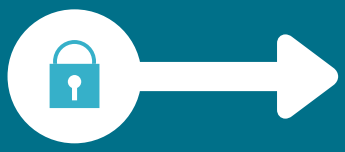
Virtual Chronic Care Partner for FQHCs

Your health center partners with Certintell to improve health outcomes for Medicare and Dual-Eligible patients. Once the patient eligibility file is provided, Certintell begins their proprietary clinical workflows, starting with Health Risk Assessments, for each eligible patient. Certintell's Medical Director oversees a staff of nurses and Certified Clinical Health Coaches as patients are enrolled into additional services based on health factors, including Remote Patient Monitoring and Care Management Services.

CARE MANAGEMENT & PROACTIVE TELEHEALTH VISITS

Step 1

HEALTH CENTER PARTNERS WITH CERTINTELL



Step 2

Step 3

CERTINTELL SCHEDULES TELEHEALTH VISITS FOR YOUR AVAILABLE PROVIDERS:

- ✓ Improve Patient Visits & Health Outcomes
- ✓ Increase Health Provider Job Satisfaction
- ✓ Implement Value-Based Care Workflows

PATIENT-CENTERED CARE SERVICES

- HEALTH RISK ASSESSMENTS
- REMOTE PATIENT MONITORING
- CARE MANAGEMENT SERVICES
- TRANSITIONAL CARE MANAGEMENT

CERTINTELL.COM – INFO@CERTINTELL.COM – 1-800-946-9143

certintell® TELEHEALTH

Accelerate Value-Based Care with RPM & More

REMOTE PATIENT MONITORING

RPM

- PATIENT-CENTERED CARE PLAN
- MONTHLY ENGAGEMENT
- REAL-TIME READINGS
- CLAIMS & COMPLIANCE DONE BY CERTINTELL

- GLUCOMETER
- BLOOD PRESSURE CUFF
- BODY WEIGHT SCALE
- PULSE OXIMETER
- THERMOMETER
- ELECTROCARDIOGRAM

Enable out-of-the-box care for complex patients to improve their health in the comfort of their own home and reduce avoidable hospital admissions.

TELEPHARMACY PROGRAM

HEALTH CENTER PATIENT ACCESS

340B Rx

PARTNERSHIP BENEFITS

- 340B SAVINGS STAY AT FQHC
- AUTOMATE PRESCRIPTION REFILLS
- SPECIALTY MEDS ARE PRESCRIBED
- PATIENT ADHERENCE & HEALTH IMPROVES WITH MEDS HOME DELIVERY

SPECIALTY CARE SERVICES

If your patients need a Specialty Provider, we have you covered via telehealth:

- DERMATOLOGY
- NEUROLOGY
- RHEUMATOLOGY
- PAIN MANAGEMENT

Contact us for complete list of specialties.

CERTINTELL.COM – INFO@CERTINTELL.COM – 1-800-946-9143

Alertive HEALTHCARE

Healthcare within Reach

Alertive is a clinically-validated digital healthcare service designed to transform the management of chronic conditions. Our platform monitors physiologic data, makes actionable treatment recommendations, improves medication adherence, and, in turn, generates revenue for healthcare systems.

Conceptualized and designed by physicians, our innovative digital medicine technology enables health systems to continuously monitor patient data and deliver seamless, integrated care.

To learn more please email Dr. Rama Aysola at **raysola@alertive.com**

Follow Alertive on LinkedIn.

Featuring Dr. Rama Aysola, Head of Business Development

Rama Aysola is an internal medicine physician with extensive experience in clinical operations and workflow in diverse care settings in New York, Chicago, and Phoenix. Previously, Rama was the regional president for the nation's largest medical scribe company with oversight of business development and operations for a $50 million region. Rama is a Los Angeles native and undertook his medical training in New York City.

Alertive
HEALTHCARE

Headquarters

2220 76th Ave SE,
Mercer Island, WA 98040

Founders

Pioneers in clinical and remote care utilizing pharmacology and physiology.

Nirav H. Shah M.D,
Chief Executive Officer

Jorge Sanchez M.D.
Chief Medical Officer

Noah Manders
Chief Technology Officer

Rama Aysola M.D.
Sales and Business Development

Daniela Ordonez
Account Management

Sarah Sutton Ph.D
PR and Marketing

Michael Jue
VP of Sales

Healthcare within reach

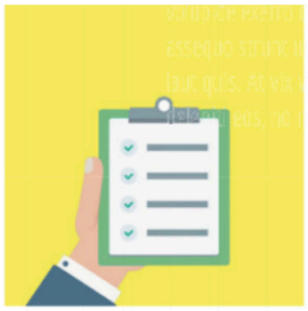
Alertive Healthcare is a digital healthcare company known for its state-of-the-art remote monitoring solutions. We are committed to making healthcare more accessible, cost-efficient, and affordable for clinics, hospitals, and payers. To achieve these goals, we fascilite communication with care teams to monitor patients between visits, monitor physiological data, and interpret data to enable physicians to make better decisions. Alertive was developed for doctors by doctors and medical technologists and we are driven to help patients live healthier and happier lives.

Product highlights

Alertive's platform can be modified to monitor patients with multiple conditions, including:

- Kidney disease: Alertive can reduce the rate of progression to dialysis in patients with renal impairment and in dialysis.
- Lung disease: Our platform can help monitor lung disease and oxygenation to prevent exacerbations and
- re-hospitalizations.
- Hypertension: We improve patient outcomes in expedited time frames by lowering the risk of stroke and heart failure by 50%.
- COVID-19 : Our platform can help monitor and contact trace for COVID-19. We can expedite early treatment and warning by up to 2 days in asymptomatic patients.

Remote Monitoring



Improved Outcomes

Actionable Analytics

Alertive
HEALTHCARE

How we make care easier

The Alertive difference

51,125
Total blood pressure readings analyzed

11.5mm Hg
Average blood pressure reduction in refractory hypertensives

4.7mm Hg
Average decrease in blood pressure

MEMORA HEALTH

The Operating System for Care Delivery

Memora Health has developed the most comprehensive end-to-end platform for patient communication and continuous remote monitoring. We provide health organizations with the infrastructure necessary to virtually deliver care, including a suite of intelligent remote monitoring devices (blood glucose, blood pressure, activity, SpO2, weight scale) along with an automated, SMS-based communication system for symptom triage, patient-reported outcome collection, and intelligent surveys for providers to comprehensively assess which patients are at-risk. Memora embeds this combination of qualitative and quantitative performance data into the EMR, allowing providers to track patient progress and report back on value-based arrangements in real time. Generated from over 93 million patient interactions that have taken place on the Memora platform, we have developed comprehensive engagement models that optimize how to engage different types of patient personas and have helped health systems reduce readmissions by 16%.

Please reach out to our team to learn more, see a demo, or discuss your needs at **memorahealth.com/contact** or **info@memorahealth.com**.

Follow and connect with Memora Health on LinkedIn, Twitter and Facebook.

Featuring Manav Sevak, CEO

Manav Sevak is the CEO and founder of Memora Health. Manav's focus in digital health stems from his background in medicine and training as a computer scientist. Previously, he has worked as a public health researcher at the U.S. Centers for Disease Control and Harvard School of Public Health, and most recently as a computational biologist focused on cancer genomics research at the Broad Institute of MIT and Harvard. He has previously lectured in medical informatics at the University of Pennsylvania and Georgia Institute of Technology.

MEMORA HEALTH

The Operating System for Remote Monitoring

Integrate Data

Unite discrete sources of remote monitoring, secure messaging, and medical device data for a holistic view of patient progress

Drive Reimbursement

Improve adherence to daily transmissions to meet monthly reporting requirements for CCM, TTM, and RPM reimbursement

Monitor

- Blood pressure monitoring
- Weight transmissions
- Blood glucose recordings
- Activity data
- Pulse oximetry data
- Medical device integrations
- CPAP usage
- Brand neutral/open-source

Respond

- Immediate follow-up based on clinically defined workflows
- Reduce unnecessary encounters with auto-triage of false positives
- Qualitative symptom capture + quantitative RPM data = complete virtual care

Adhere

- Reminders and confirmations for data submission
- Meet monthly transmission requirements for CCM billing
- Pre/Post transmission guidance
- NLP-based responses for device troubleshooting

Connect

- HIPAA compliant text, email, phone, and video conferencing
- Asynchronous or live communications
- Provider-to-provider communication
- Notification Routing

2.5hrs
Saved in daily phone calls

6.5x
Patients managed per FTE

$1856
Earned per patient you manage

Learn more at memorahealth.com

About the Project Partners

ADAPTATION HEALTH

Adaptation Health is a buyer-side incubator program developing and building thought leadership and value on behalf of State Medicaid programs and Managed Care Organizations. Through Medicaid Innovation Challenges, we connect state Medicaid agencies, Managed Care Organizations, and innovative vendors to solve deep-rooted problems in public health and Medicaid service delivery. We match market needs and Medicaid priorities against market and product fit to cultivate an awareness of the value that innovations can bring in solving persistent and deep-rooted challenges. To learn more visit www.adaptationhealth.org or contact Kyle Murphy at kyle@adaptationhealth.org.

California Health Care Foundation

The California Health Care Foundation (CHCF) is an independent philanthropy dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

Launched in 2011, the CHCF Innovation Fund invests in emerging companies to bring the best innovations and technology to the providers, health systems, and payers serving Californians, particularly within Medi-Cal, the state's Medicaid program. The Fund invests in mission-aligned, venture-backed technology companies that are well-positioned to scale in California. The Fund makes a direct financial investment in the company and offers grants to safety net partners to support adoption.

To learn more about the Fund and their portfolio of companies, visit chcf.org/innovationfund.

ACUMEN CHANGING THE WAY THE WORLD TACKLES POVERTY

Acumen is changing the way the world tackles poverty by investing in companies, leaders and ideas. We invest patient capital in businesses whose products and services are enabling low-income communities to transform their lives in 14 countries around the world. In the United States, Acumen America invests in early-stage companies across three sectors addressing some of the biggest challenges that face low-income Americans: health, workforce development and financial inclusion.

HEALTH EQUITY VENTURES

Health Equity Ventures is an emerging venture/private equity fund laser-focused on inclusive healthcare innovations. We prioritize investments in underserved populations and underrepresented founders that advance a healthcare system that works for everyone.