Employee Benefits Webinar Series

Insights to Impact

Elevating Ideas. Empowering Decisions.

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CLINICIAN GUIDED CARE NAVIGATION

Hylant’s Proprietary Health & Care Navigation

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2:00-3:00 p.m. ET

www.hylant.com

Hylant's Care Navigation Solution

PROBLEM:

Existing carrier led population health & care coordination solutions deliver low engagement and modest results.

SOLUTION:

Through a people-centric approach, leveraging powerful data analytics, we identify and work closely with members to proactively close **gaps in care** and empower them to achieve optimal health and well-being.

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Member Engagement and Participation

A growing body of evidence shows that people with higher patient activation (i.e., the knowledge, skills, and confidence to become actively engaged in their healthcare) have better health outcomes.

Effectively engaging members in their care is essential to improve health outcomes, improve satisfaction, reduce costs and even lead to a more satisfied workforce.

Populations and What to Consider:

- **Identify potential barriers**
  - Location relative to accessing care
  - Recognizing the various segments of the population
  - Vulnerable populations
- **Customize the information**
  - Develop effective delivery methods of communication/outreach
- **Avoid information overload**
- **Provide clarity and guidance**
  - High number of stakeholders providing health information with many mixed messages

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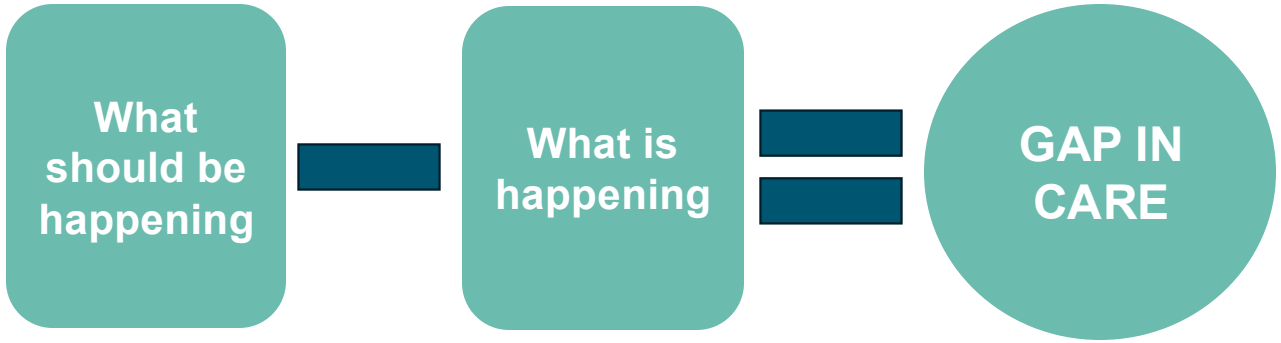
Programs to improve clinical outcomes through care navigation are not new, but they are not engaging enough patients to get meaningful improvement.

This is different!

Our proprietary program enables members to be actively engaged in their own health – improving their outcomes.

Year one results of 43% engagement with high opportunity members is simply unheard of – but we delivered!

Gap in Care



- Statin prescription following a heart episode
- Prescription is missing from patient's claims file
- Physician didn't write one or the patient didn't fill it

Nearly half of patients with atherosclerotic cardiovascular disease (ASCVD) were not being treated with a statin, and a quarter were not on a high-intensity statin in a large cohort of insured patients, according to a study published May 2 in the Journal of the American College of Cardiology.

*A "**gap in care**" is created when the care provided to a patient is inconsistent between recommended best practices and the care that is actually provided.*

HealthDirect Clinicians

30+
Years experience

2.5M+
Patient visits

2k+
Health clinics created

60+
Countries

Clinicians overseen by a board-certified primary care physician with general and emergency room practice experience, specializing in population health and care navigation since 1992.

Improved outcomes are at the heart of the portfolio of services. Employer-based experience includes primary care worksite health centers, occupational health, and telehealth solutions.

Our Approach to Underlying Causes

- Employers are matched with a **dedicated care navigator team.**
- Each member only interacts with their **personal Care Coordinator** and/or **Nurse Navigator.**
- **Meaningful engagement is defined** as a direct action to close **gaps in care.**
- **Financial incentives are aligned** with meaningful engagement.

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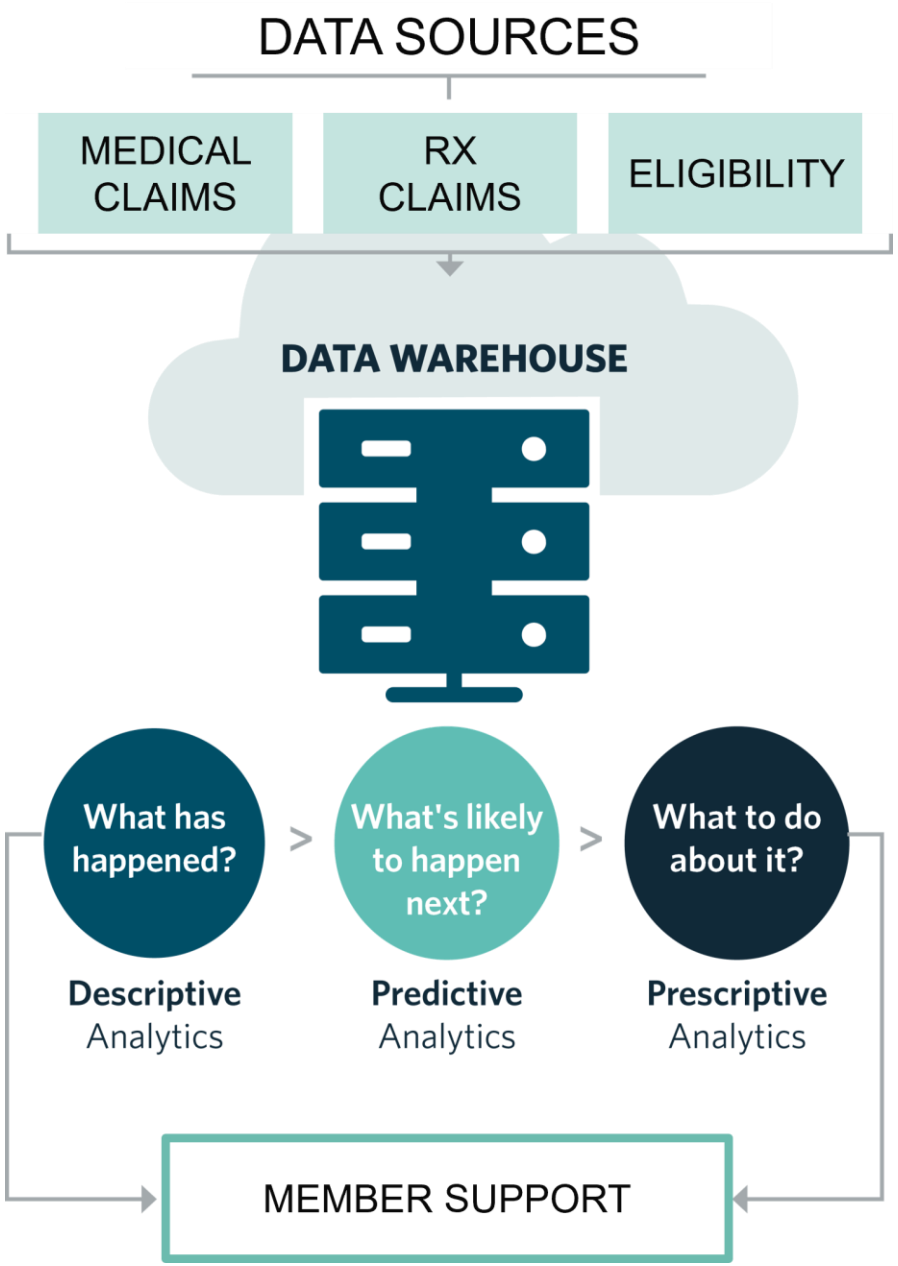
Access *Your* Data

Data Drives Decisions

- Member risk stratification
- Coachable opportunities
- Chronic condition management
- High claimant trends
- Patient steerage opportunities
- Preventive care opportunities

Identify:

- Cost drivers
- Gaps in care
- Member support opportunities



HealthDirect Strategy

Custom navigation built to support your benefit programs

Maximize member opportunities to reduce members from becoming

High-Cost Opportunity

Close **gaps in care** & steerage to high-value care for members with

Chronic Conditions

Support members through their care journey to enhance the

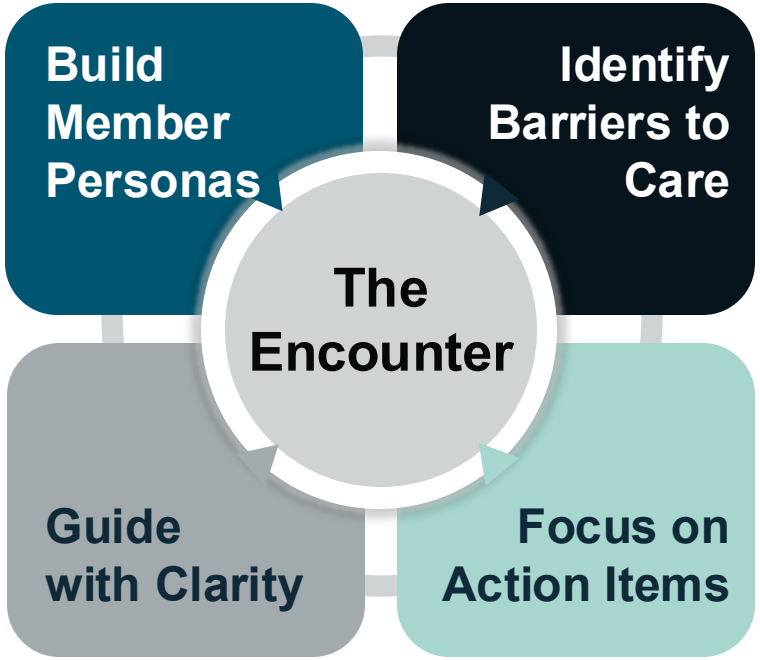
Member Experience

Maximizing Engagement

How to Engage a Disengaged Population?

100% OUTREACH

- Learn & Embrace the Culture
- Become Familiar
- Build Personal Relationships
- Add Unique Value
- Never Give Up on Anyone
- Share Transformational Stories



Outbound and inbound encounters

Impactful Population Engagement

MINIMAL OPPORTUNITY

Stable overall health but may have small **gaps in care**, such as preventative measures

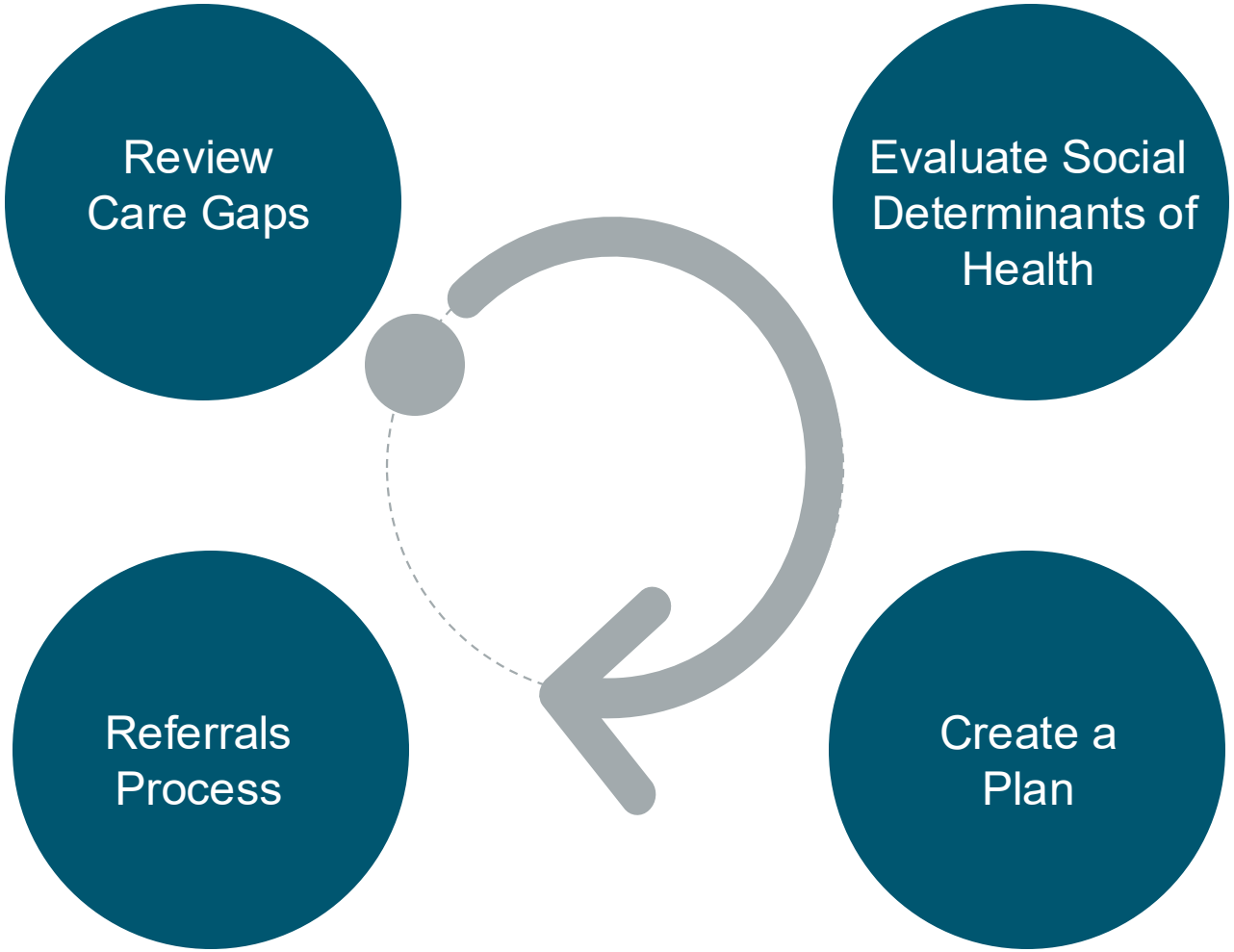
MONITORING OPPORTUNITY

Emerging health concerns or diagnosis that could require increased medical management

ELEVATED OPPORTUNITY

Ongoing health concerns requiring continuing care management, such as specialized interventions or advanced treatment plans

HealthDirect Care Navigation



Opportunity Stratification

Leverage powerful data analytics to identify member opportunities and “movers” that have not yet become high-cost claimants.

Outreach

Communication strategy to engage members via email, phone calls, and onsite wellness programs.

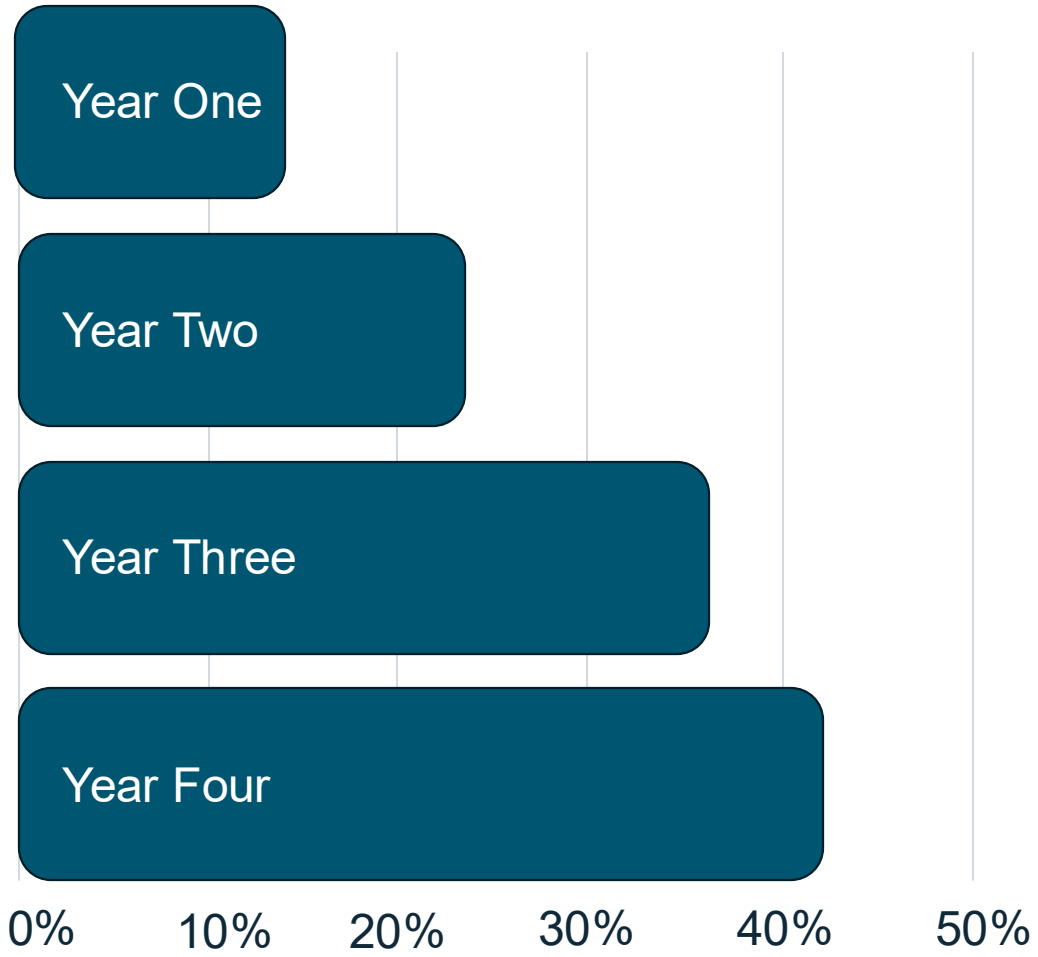
Intervention

Our high-touch approach meets customers where they are, closing **gaps in care** and guiding them through their care journey.

Value Proposition

1. **Better clinical outcomes**
2. **Elevated member experience**
3. **Increased utilization of high-value care**
4. **Positively impacted high-cost claimants**
5. **Lower trend in chronic disease costs** [Diabetes, Cardiac, MSK]
6. **Increased employee retention**

Member Opportunity Projected Engagement



ENGAGEMENT CRITERIA

During the annual measurement period

- Phone conversation with Nurse/Care Navigator
  - Must include education in **Gaps in Care**

And

- Action to close **Gaps in Care** (at least one below)
  - Referral to value-based provider
  - Referral to value-based facility
  - Referral to value-based point solution
  - Transfer of medical records
  - **Gaps in Care** letter sent to member's PCP
  - Reducing barriers to care
  - Treatment decision support

HealthDirect Engagement

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Member Communication

- 100% Outbound Calls
- 100% Outbound Emails
- Outbound SMS
- Inbound Calls
- Inbound Emails
- Appointments Set
- Inbound SMS
- Webinars (Live and Recorded)

Type Within Cases

- Coordinator Appointments
- Nurse Appointments
- Gaps in Care by Type
  - Transfer of Medical Records
  - Physician Referrals
  - Appointments Referred / Scheduled
  - Physician Letters Sent
  - Lab Orders
  - Patient Education

Referral Type

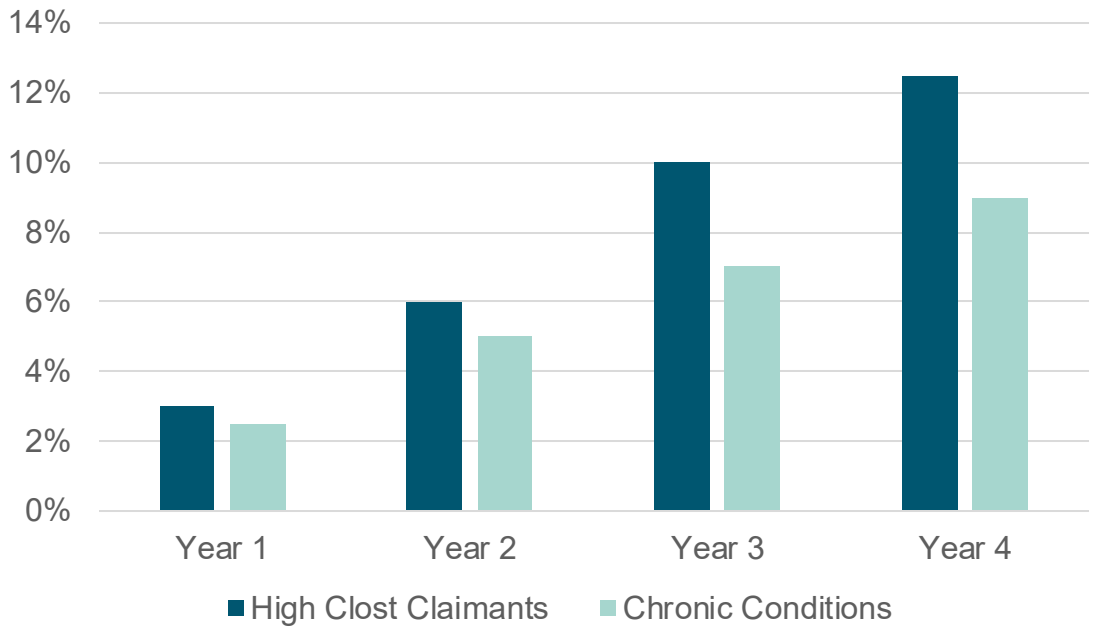
- Primary Care Provider
- Physician Specialist
- Behavioral Health Provider
- Nurse Education / Coaching
- Expert Second Opinion
- Community Resources
- Hylant Advocacy
- Employee Assistance Plan
- Employer Sponsored Programs

Each engagement strategy is customized to the client, their unique population, and blended within their overall benefits initiatives.

Anticipated Outcomes

FINANCIAL

Lower PEPM for engaged participants as compared to similar unengaged risk group



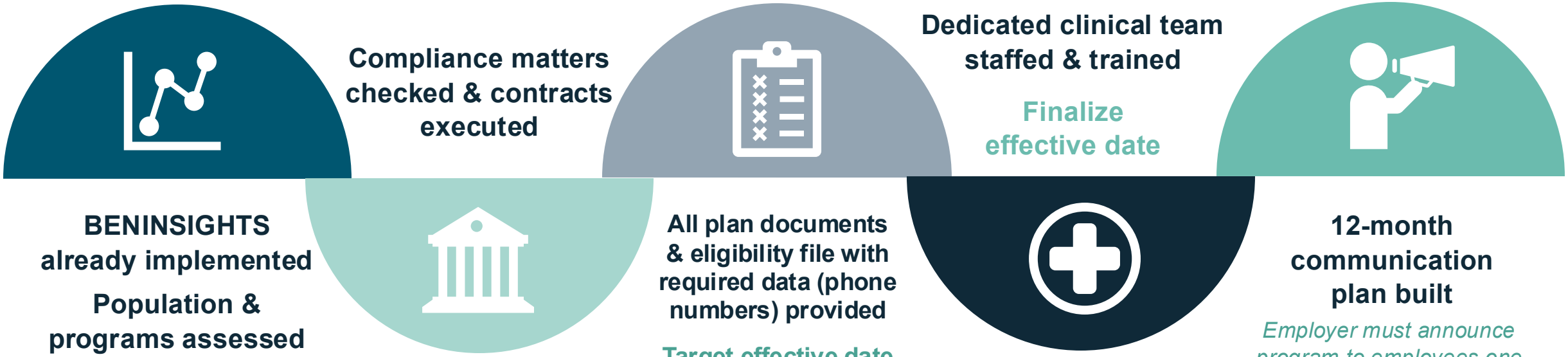
GAPS IN CARE

Annual reduction in **Gaps in Care** for engaged population

17%

Implementation Timeline

Minimum 120 Day Leadtime



INTAKE FORM

BI-WEEKLY IMPLEMENTATION MEETINGS

Average 20-minute time investment

Success Stories

MENTAL HEALTH CRISIS

- A member responded to an outreach call from HealthDirect to accept their offer to help.
- The member and their child were in trauma related mental health crisis.
- The child was in urgent need of affordable therapy. This member is a single parent overwhelmed and unsuccessful at finding an affordable therapist for the child.
- HealthDirect took over the search, identifying a quality in network therapist in their area that took in person and virtual consultations! A virtual visit was scheduled for that day with an in-person session scheduled the next week.
- Through conversations, HealthDirect learned that the parent was seeing an out of network therapist at significant out of pocket cost. HealthDirect booked an appointment for the parent in the same office as the child's new therapist. HealthDirect made the appointments and followed up after to ensure it was a good fit.
- The member was thankful for the help that eliminated the financial barriers to getting care.
- The member is now served through monthly progress calls with their Nurse Navigator to assure treatment plan compliance.

Success Stories

DIABETES

- A newly diagnosed member with diabetes was released from the hospital, struggling with the next steps in their care journey.
- HealthDirect's Nurse Navigator provided both a nutritional plan and got him scheduled with his PCP to begin the journey towards improved care.
- Prior to the call with HealthDirect, he indicated that he was not going to engage since he was symptom free.
- The Nurse Navigator continues to follow up with the member.

CARDIAC HEALTH

- After hosting a webinar on cardiac health, a member, recognizing her family history of heart disease, realized the importance of seeing a cardiologist.
- HealthDirect assisted her in finding a high-quality in-network cardiologist.
- Her cardiac workup appointment was scheduled, and she was prepared by the HealthDirect team on what to ask, what to expect and how to be her own best care advocate.

Success Stories

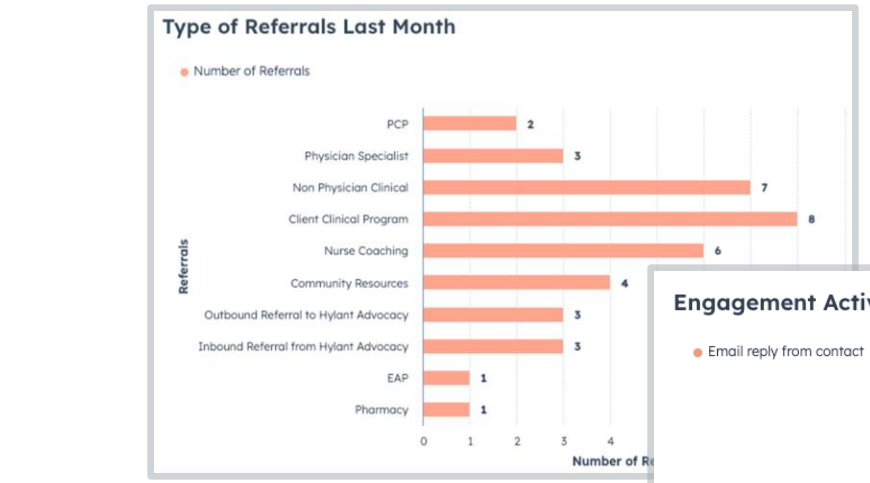
POST-CANCER CARE

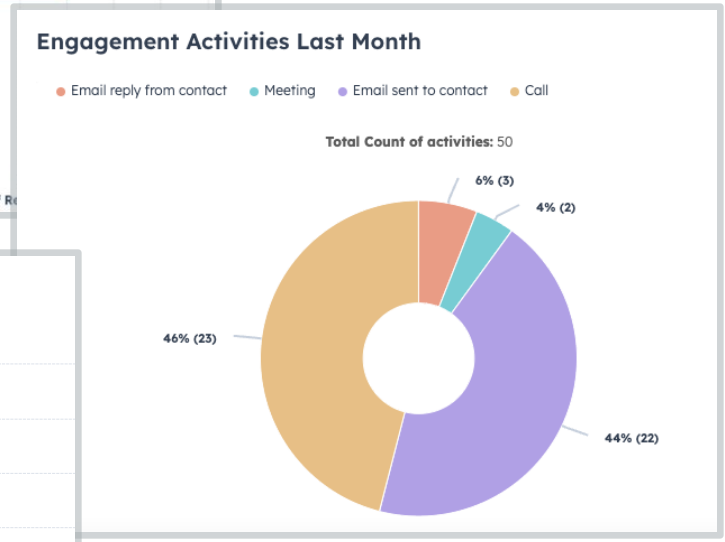
- A high-risk cancer survivor reached out for guidance on healthy eating habits post-chemotherapy.
- The data showed that the member had **not completed essential preventive care** visits, including a mammogram, pap and annual physical due to the rigors of her treatment, and fear.
- HealthDirect collaborated with the member to design a **customized nutrition plan** focused on post-chemo recovery, making it easy for her to adopt healthy habits that aligned with her unique needs.
- HealthDirect also took time to **educate the member** on the importance of preventive care and primary care, explaining how regular screenings, particularly cancer screenings, are potential life-saving interventions for her.
- Understanding the member's exhaustion, HealthDirect extending a helping hand, **scheduling her primary care appointment**, taking the responsibility off her shoulders and streamlining her path forward.
- The member agreed to continue engagement and build up a plan to complete her screenings.
- By addressing both immediate needs and long-term preventive care, HealthDirect supported the member's recovery **AND closed critical gaps in** care.

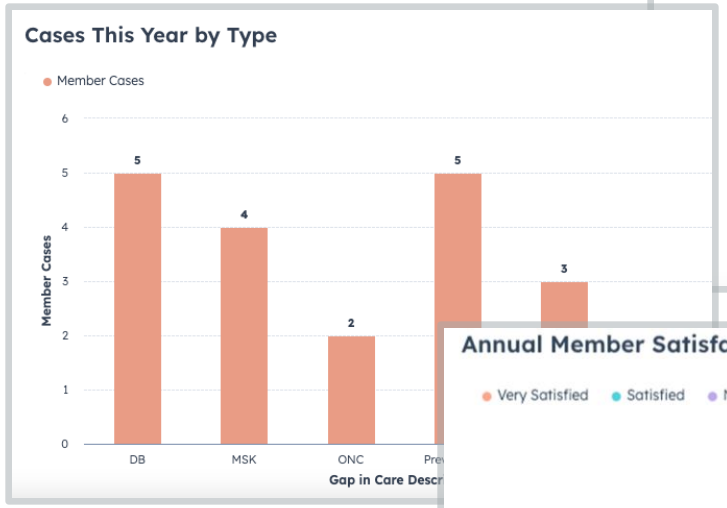
Monthly Reporting Dashboard

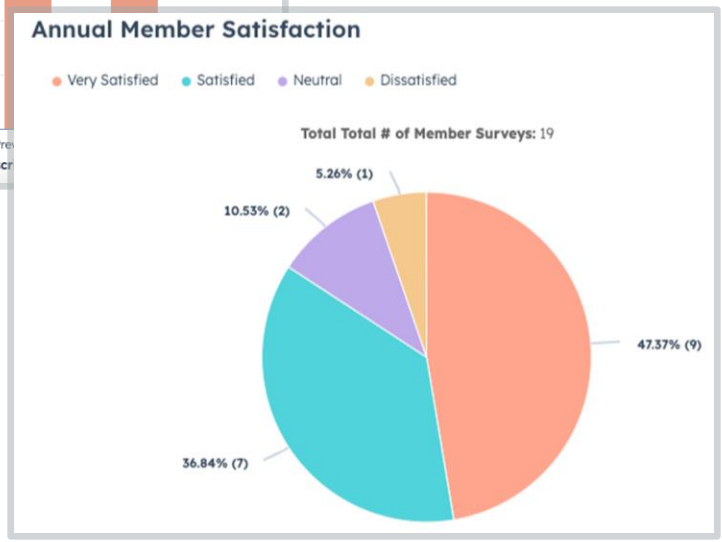
Reporting includes metrics illustrating

- Engagement data
- Member opportunity engagement analysis
- Number of cases & by type
- Number of referrals & by type
- Support activities
- Engagement activities
- Member satisfaction









Committed to Solving Immediate Needs and Anticipating the Next

HealthDirect
CLINICIAN GUIDED CARE NAVIGATION

- **Data Driven -** Use claims data to proactively close gaps in care
- **Proactive Clinical Navigation** – Anticipate and eliminate barriers
- **Personalized Guidance** – Tailored care plans to meet patient's needs
- **Smart Technology –** Seamless communication, records, and support
- **Collaboration** – With providers for more informed care
- **Whole-Person Focus** – Addressing medical, emotional, and social needs

Making healthcare navigation clear, easy, compassionate, and effective.

Working to Improve the Healthcare Journey

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