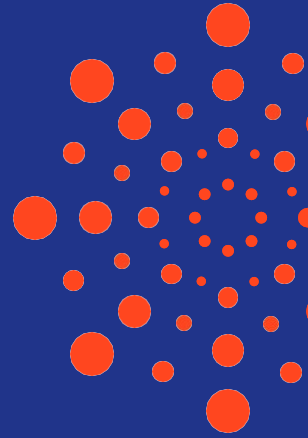




Scaling Access to Care in An era of
AI & CMS ACCESS

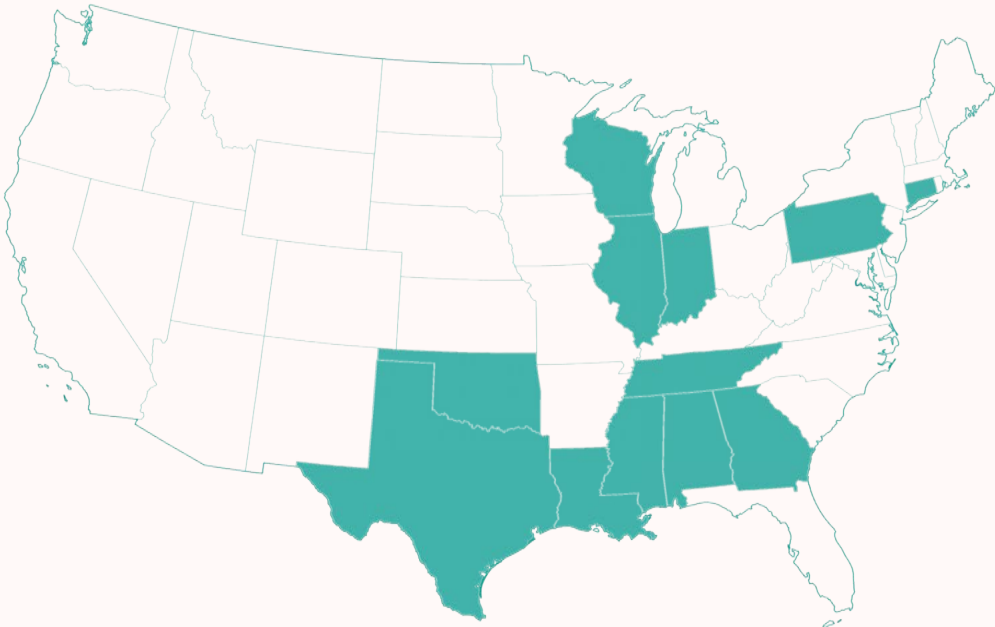
NAACOS Preconference Workshop
Trust, Transparency, and
Technology

10.13.26



Nearly a million patients supported, working alongside our clients' own teams

Guidehealth partners with ACOs, IDNs, IPAs and other healthcare delivery partners to make great healthcare affordable for all.



An embedded partner: our people and our AI, working inside the practice.



Healthguides, nurses and pharmacists, with Rose, our conversational AI.

CUSTOMERS



EMPLOYEES



INNOVATION



TRUST IN OUR AI



TRUST IN OUR PROCESS



TRUST IN OUR AI



Trust, Transparency, and Technology: Evaluating Digital Health Partners

ACCESS expands how, when and where we deliver care coordination for chronic conditions

✓ **Early Cardio-Kidney-Metabolic (eCKM)**

Qualifying Conditions:

- Hypertension; or 2 of:
- Dyslipidemia
- Overweight (BMI $\geq$ 25) with central obesity (waist >40 "[M], >35 "[F])
- Pre-diabetes

✓ **Cardio-Kidney-Metabolic (CKM)**

Qualifying Conditions:

- Diabetes
- Chronic kidney disease (stage 3a/b)
- Atherosclerotic CV disease (ASCVD)

✓ **Behavioral Health (BH)**

Qualifying Conditions:

- Depression
- Anxiety



Chronic Musculoskeletal Pain (MSK¹)

Qualifying Conditions:

- Musculoskeletal pain >3 months

✓ Approved tracks for Guidehealth

The ACCESS program targets patients with high-impact, highly modifiable clinical profiles

Patients can be enrolled in multiple tracks where clinically appropriate – e.g., eCKM and BH

Improved condition management in these tracks can slow progression into more complex disease states

Note: Beneficiaries may be directly solicited and, to participate, are required to enroll; collectively, these tracks apply to the majority of Medicare beneficiaries

1. Defined broadly to include conditions affecting bones, joints, muscles, and connective tissues

A great list isn't enough

The hard question is the next touch: who makes it, how, and when.

THE LIST: Rising risk | Discharged yesterday | Open gaps

WHAT HAPPENS NEXT IN TRADITIONAL CARE MANAGEMENT

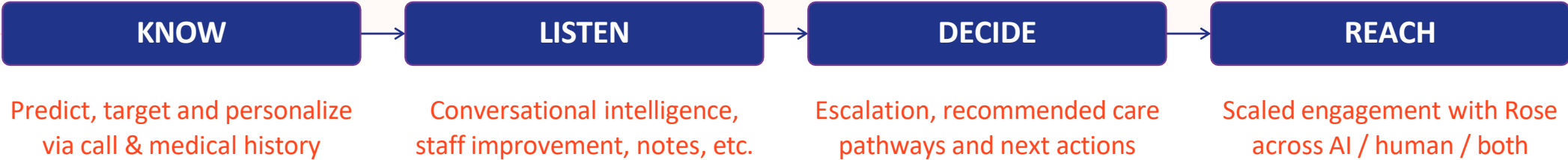
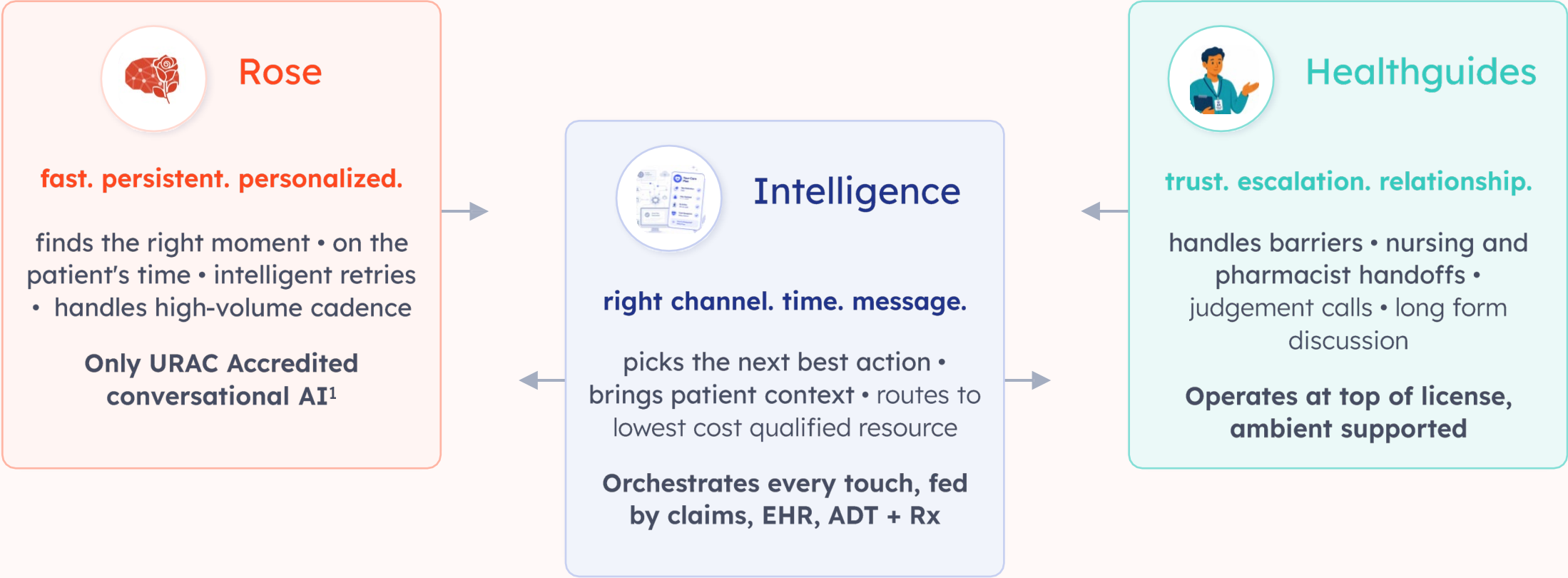
- 1 Calls follow the nurse's schedule**
The team's availability decides when the patient hears from us.
- 2 Three missed attempts become "unable to reach"**
The patient drops out, when a different time or channel could work.
- 3 A care plan becomes administrative work**
A checkbox plan, with documentation repeated in four systems.
- 4 Not enough time with patients**
Too much time spent dialing, and taking notes and not enough with the patient

**"Don't give me
another list.
Help me, do
something, and
keep me informed."**

Practice leadership



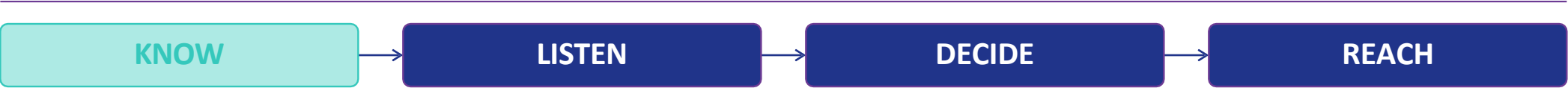
A unique blend of conversational AI, human clinicians, and routing intelligence



Personalization starts with the data you have

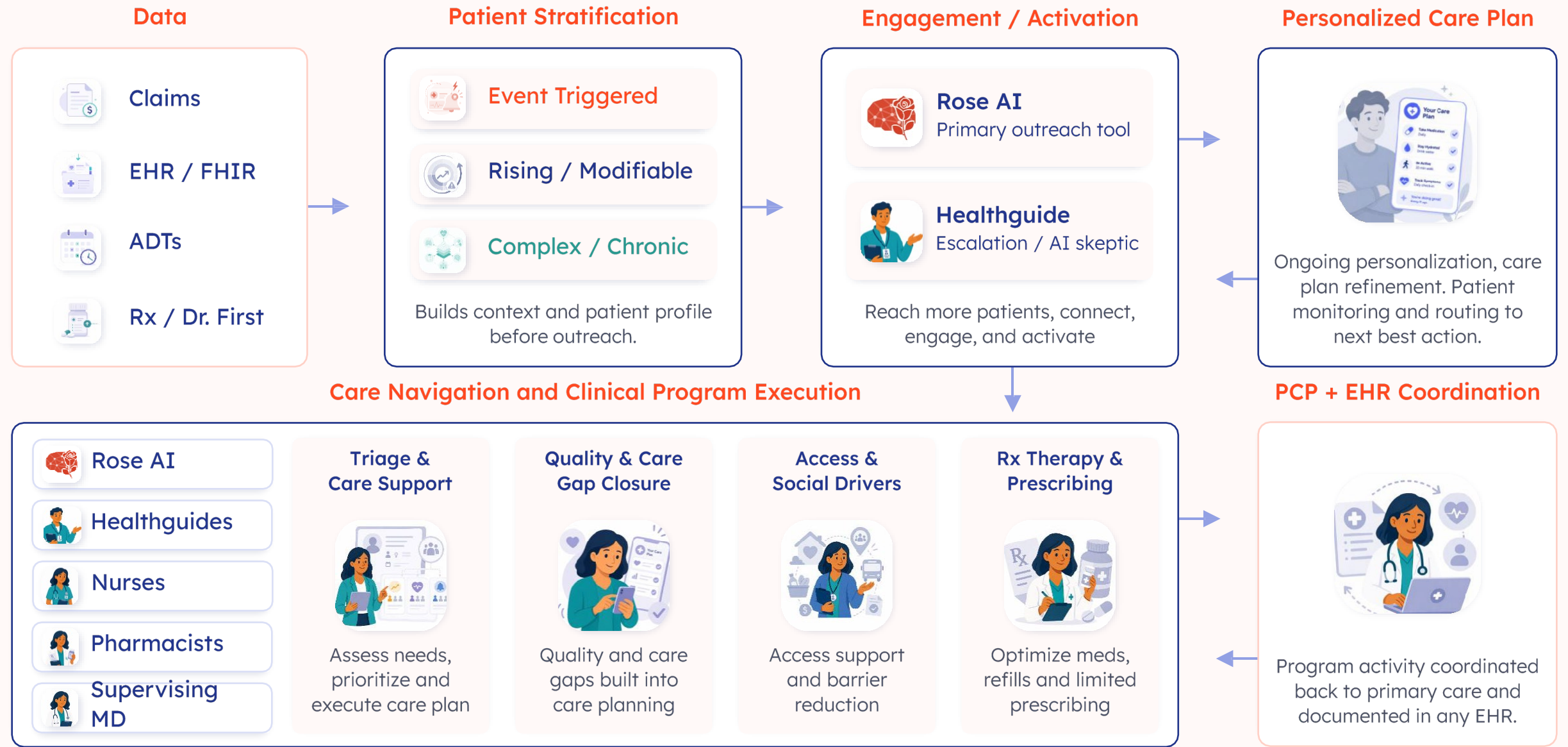
The record tells us who the patient is. We find the right way in, learn how they want to be reached, get in touch with them - and write it all back.

THE RECORD	Analytics from EHR, ADT, Claims and Conversations Claims across payers, clinical data, attribution, risk, open gaps, utilization and ADT events	ONE PATIENT'S ENGAGEMENT CONTEXT Answers after six. Prefers a text first. Trusts her pharmacist more than us. Missing doses because of cost, not memory. Everything writes back to the Care Plan and the EHR.
THE WAY IN	Finding the right way to reach them TransUnion · QR codes in the practice · the care family	
WHAT WE LEARN	Some of it from listening When they answer, and on which channel · their language · who they trust · what they said last time · their care plan in their own words · the Guidehealth Index	



Our Model: Turnkey Patient Engagement, Care Navigation and Clinical Support

Connect with more patients in their context, close care gaps and improve outcomes



Our richest data is unstructured and comes from in the conversation

Rose’s calls and our people’s calls, heard in full, with live ambient support on every call.

Calls	Avg. complexity	Avg. total points	SR	IC	LC	BR	CU	RA	PS	Complexity mix	Total duration	Avg. duration
85	1.37	-0.69	-0.38	-0.30	-0.22	-0.01	0.02	0.24	-0.15	H 2% · M 32% · L 65% · U 1%	11h 27m	8m 05s
85	1.73	-0.20	-0.40	-0.16	0.18	0.21	0.03	0.07	-0.23	H 22% · M 27% · L 49% · U 1%	9h 20m	6m 36s
85	1.52	0.34	-0.41	-0.20	0.43	0.29	0.19	0.19	-0.26	H 4% · M 45% · L 52%	11h 34m	8m 10s
84	1.69	-0.57	-0.42	-0.21	0.00	0.14	-0.12	0.25	-0.25	H 18% · M 32% · L 49% · U 1%	8h 44m	6m 15s
83	1.67	0.13	-0.33	-0.16	0.09	0.11	0.17	0.14	0.06	H 17% · M 30% · L 48% · U 5%	8h 42m	6m 18s
78	1.97	2.17	0.05	0.06	0.54	0.64	0.52	0.32	0.04	H 21% · M 56% · L 23%	14h 48m	11m 23s
78	1.62	-0.86	-0.44	-0.27	-0.05	-0.04	0.04	0.00	-0.14	H 13% · M 36% · L 51%	8h 12m	6m 19s
77	1.43	0.43	-0.39	-0.03	0.04	0.24	0.17	0.11	0.06	H 14% · M 14% · L 71%	8h 44m	6m 48s
72	1.61	0.57	-0.05	-0.03	0.15	0.21	0.09	0.31	-0.08	H 13% · M 36% · L 51%	9h 15m	7m 43s
59	1.80	0.05	-0.38	-0.19	0.22	0.08	0.09	0.28	-0.07	H 14% · M 53% · L 34%	6h 18m	6m 25s
56	1.77	-0.16	-0.15	-0.13	-0.16	0.07	-0.04	0.38	-0.14	H 11% · M 55% · L 34%	8h 36m	9m 14s
51	1.90	0.39	-0.43	-0.12	0.06	0.41	0.11	0.33	0.02	H 24% · M 43% · L 33%	8h 39m	10m 12s
50	1.39	0.29	-0.15	-0.09	0.10	0.31	0.06	0.13	-0.14	H 6% · M 26% · L 66% · U 2%	3h 10m	3m 48s
49	1.74	-0.79	-0.49	-0.44	-0.15	0.18	-0.03	0.21	-0.19	H 18% · M 35% · L 43% · U 4%	4h 42m	5m 46s
48	1.30	-0.19	-0.17	-0.07	0.41	0.03	-0.13	0.11	-0.47	H 6% · M 17% · L 75% · U 2%	2h 18m	2m 53s
42	1.67	-0.62	-0.29	-0.21	-0.07	-0.02	0.06	0.14	-0.24	H 21% · M 24% · L 55%	5h 26m	7m 46s

Find your best people. Hear how they do what they do.
Replicate what works, in scripts, coaching and Rose.

During the call

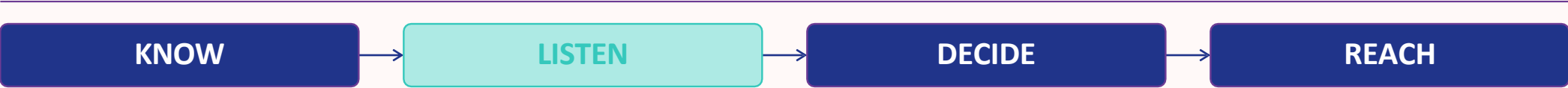
Live ambient support flags conversational gaps, so staff focus on the patient, not the script.

After the call

The care plan updates in the patient’s own words. The next call changes. Routing learns what worked.

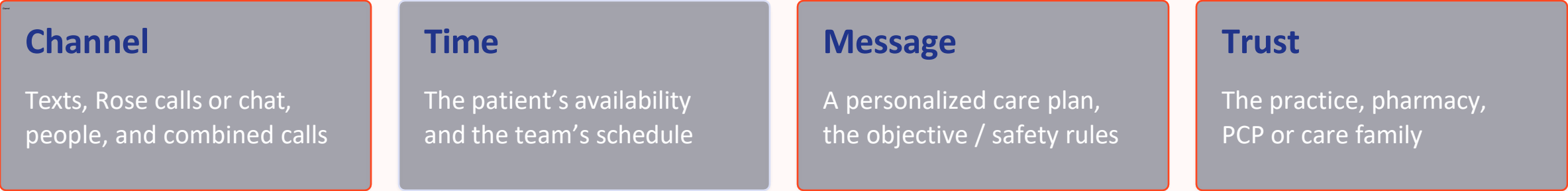
Forgotten care

Non-billable conversations and half-finished plans: gaps in notes, not codes.



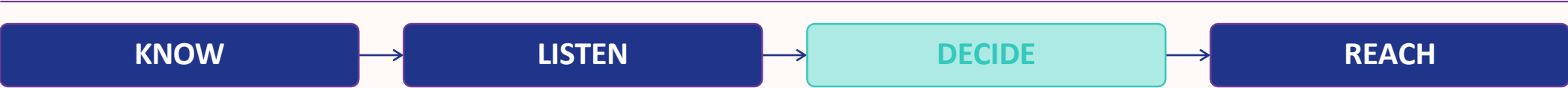
Routing intelligence: every touch is a decision

We route the next patient action to the best channel, time and message as we can, even when that isn't our staff.



Engagement: 30–40% AI alone | 40–50% people alone | 65–75% combined

Also reached 45% previously unable to contact and converted 10% who had declined.

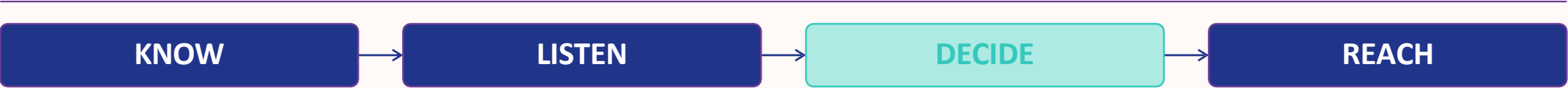


Escalation management becomes critical

For voice AI escalation is an absolute must, but the value extends to human calls as well. As you roll autonomous outreach programs out, be prepared for more activity.



Over-escalation: be prepared for **over-escalation** to start. When we launched, 20% of escalations were false positives, with tweaking, that's come down. **Importantly, targeting 0 true positive misses is critical.**



Your patients need help. You can finally reach them all.

We specifically orchestrate Rose’s context (memory) for each interaction. This allows us to control each call and not surprise patients.

Who: a woman on a blood-pressure check-in

What: 187/95 that day, with new dizziness since her pressure went up, and she felt like she might throw up.

Next: alerted daughter, admitted to hospital

Who: a man on a refill reminder for his statin

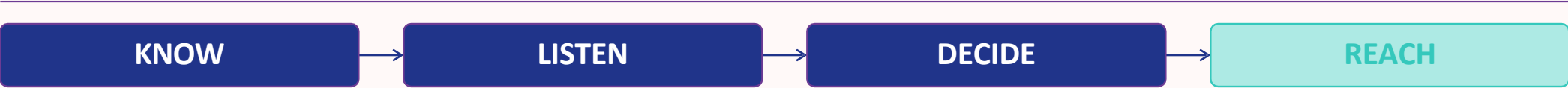
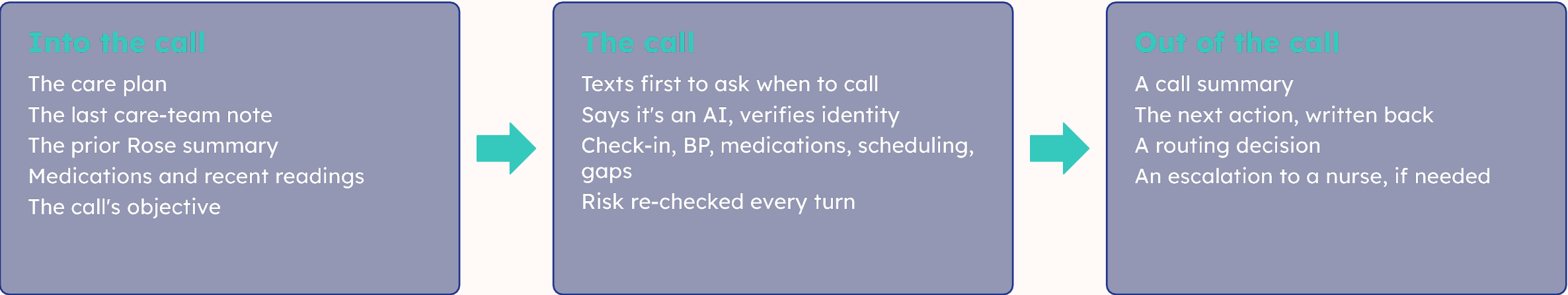
What: asked about the pickup, he said “I need my breathing stuff real bad,” and yes, serious trouble breathing right now.

Next: nurse callback doctor’s visit scheduled

Who: a man on a prescription refill call

What: constant pain since a bypass two years ago, his pain pills being cut back, and he can’t afford the ambulance..

Next: nurse callback, care team on next steps



How to Refer Patients & Partner with ACCESS Program Providers

Each of the 100+ vendors have been approved across one or multiple tracks – the programs they design are unique within those tracks, using their particular method of technology and care coordination with clinical oversight.

ACOs are encouraged to select a few core partners and establish consistent referral paths to drive continuous and impactful enrollment.

1 Identify

Review your eligible patients who could use guidance, education and resources between appointments. Patients can self-enroll too.

2 Reach out

Start to consider partners who best align with your population priorities and demographics.

Complete the form at guidehealth.com/access explore referrals to our programs.

3 We connect

Guidehealth routes you to the right team member and supports your patient. Secure, HIPAA-compliant updates keep you informed.

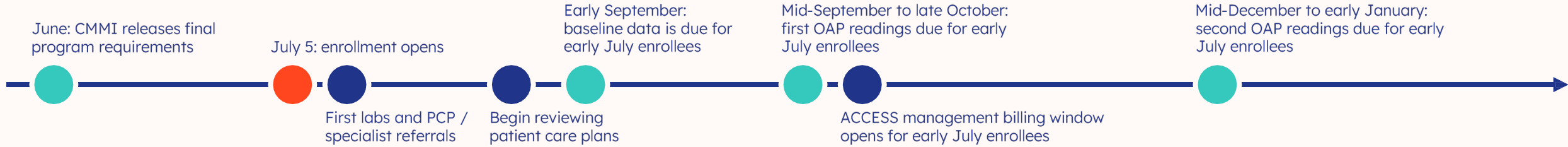
You can b

Questions on eligibility or workflows?
access@guidehealth.com

Co-Management Payment: An HCPCS codeset with allowed amounts for providers for reviewing ACCESS care updates from the provider.

ACCESS participants can test and iterate models over the next 2 quarters

● Data and reporting



Final preparations

ACCESS participant:

- Identify patients and collect initial baseline data
- Final compliance capability checks
- Create patient intake forms
- Engage providers

Health systems:

- Engage providers

Build first cohort panel

ACCESS participant:

- Start provider referral and patient outreach campaign
- Identify patients with no PCP or infrequent primary care utilization and schedule PCP visits
- Launch ACCESS-tailored AI agent outreach
- Order labs needed to plug biomarker baseline gaps
- Begin medication management protocols and start virtual visits for early titration

Health systems:

- Allot lab and provider appointments for under-affiliated ACCESS patients
- Start billing for ACCESS referrals

Assess program efficacy

ACCESS participant:

- Evaluate biomarker changes against control groups
- Adjust care and medication management protocols to improve clinical impact
- Run patient experience surveys and aggregate provider feedback
- Assess ongoing patient engagement and implicit churn (“unable to reach”) rates and compile documentation to meet disenrollment standards

Health systems:

- Help review and revise care plans
- Submit first bills for ACCESS patient management