xealth®
A SAMSUNG COMPANY

Welcome to the Xealth Vendor Directory

Dear Reader,

Welcome to the Xealth Vendor Directory! This resource is designed to help health systems more easily discover, evaluate, and deploy digital health solutions that support their healthcare delivery needs and meaningful outcomes. As the digital health landscape continues to grow, identifying the right partners has become increasingly complex. This directory brings together a curated ecosystem of trusted solutions already connected to the Xealth platform. Each partner is aligned to key organizational priorities, such as improving patient engagement, reducing clinician burden, and enhancing operational efficiency. Because these solutions are pre-integrated with Xealth, organizations can move from evaluation to implementation quickly, often within weeks, while managing their digital ecosystem through a single platform. We hope this directory serves as a practical guide as you navigate the evolving digital health landscape.

Feel free to contact Paige Stocks, Vice President of Partnerships, at paige.stocks@xealth.io.

Table of Contents

Remote Monitoring & Virtual Care

Specialty Programs

Patient Engagement

Diagnostics & Assessments

Care Management

ADAPTIVE TESTING
TECHNOLOGIES

www.adaptivetestingtechnologies.com

Adaptive Testing Technologies CAT-MH® and K-CAT® provide validated computerized adaptive mental health measures that rapidly identify and measure conditions across populations. The platform enables measurement-based care, improves clinical decision-making, and supports scalable workflows.

Solution Capabilities

DATA COLLECTION

WORKFLOW AUTOMATION

CLINICAL DECISION SUPPORT

POPULATION HEALTH MANAGEMENT

Key Features

- **Computerized Adaptive Mental Health Assessment:** Delivers rapid, precise screening and dimensional severity measurement across multiple domains, including depression, anxiety, mania / hypomania, psychosis (adult only), substance use disorder, post-traumatic stress disorder, attention-deficit/ hyperactivity disorder, social determinants of health (adult only), conduct disorder (child only), oppositional defiant disorder (child only), and suicidality.

  Clinicians, health systems, and patients benefit from a reduced assessment burden and improved clinical insight. Computerized adaptive testing (CAT) and multidimensional item response theory (MIRT) dynamically select the most informative questions in real time.
- **Measurement-Based Care & Longitudinal Monitoring:** Tracks symptoms over time to help providers identify improvement or deterioration earlier and make more informed treatment decisions. Standardized severity scores, trend data, and outcomes reporting support collaborative care and VBC initiatives.
- **Validation Clinical Decision Support:** Provides validated severity classifications and diagnostic probability indicators that support care planning, triage, and referral decisions. Strong concordance with structured clinical interviews helps clinicians identify patient needs quickly and confidently.
- **Pediatric & Family-Based Assessment Workflows:** Supports paired or independent youth and caregiver assessments through the K-CAT® platform. Integrated reporting combines multiple perspectives to provide a more complete picture of symptom presentation and functional concerns.
- **Rapid Administration Across Care Settings:** Assessments can be completed on any internet-enabled device across clinical, community, educational, telehealth, and justice settings. Most modules take just 1–3 minutes, with comprehensive assessment batteries typically completed in under 10 minutes.
- **Flexible Integration & Deployment:** Supports EHR-integrated and standalone deployments across healthcare and public-sector organizations. Assessments can be prescribed through Xealth, with results returned directly to the patient chart for seamless clinical workflows.
- **Actionable Reporting & Population-Level Insights:** Generates actionable reports for clinical interpretation, risk identification, operational monitoring, and program evaluation. Severity classifications, probability indicators, precision metrics, and longitudinal outcomes help clinicians and population health teams improve individual care and program performance.

Benefits

Adaptive Testing Technologies clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient outcomes
- Strengthen the digital front door
- Support value-based care
- Support population health management

Measurable Impacts

Outcomes vary by organization, population, and implementation model. Customers have reported:

- Reduced screening and assessment burden for both staff and patients through computerized adaptive interviews that typically require approximately 1–3 minutes per module and under 10 minutes for a comprehensive assessment battery
- Increased clinical capacity for measurement-based care, longitudinal monitoring, triage, and data-driven treatment adjustments between appointments without significantly increasing provider workload
- Improved identification of depression, suicidality, anxiety, substance use, ADHD, and other behavioral health concerns through validated adaptive assessments with strong concordance to structured clinical diagnostic interviews
- Earlier identification of high-risk patients and emerging behavioral health concerns, enabling more proactive intervention and care coordination
- Enhanced visibility into behavioral health drivers of high utilization patterns, including frequent emergency department use and other complex care needs
- More standardized behavioral health workflows across providers, clinics, and care settings through scalable, repeatable assessment protocols
- Faster access to actionable clinical insights, including severity classifications, probability indicators, percentiles, and longitudinal symptom trends to support treatment planning and operational decision-making
- Greater ability to support value-based care and quality initiatives through standardized outcome measurement, population-level reporting, and ongoing symptom tracking over time
- Improved patient engagement and completion rates compared to traditional fixed-length assessments due to shorter administration times and reduced survey fatigue

Clinical Guidelines and Standards

- National Committee for Quality Assurance (NCQA)
- Evidence-based / peer-reviewed protocols

Solution Type

- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Diagnostics & Assessments:** Solutions supporting risk assessments, diagnostics, and screening tools.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.

RESULTS YOU CAN EXPECT

Case Study

A large university health system integrated the K-CAT® and CAT-MH® into their EHR through Xealth in an integrated behavioral health workflow. This enables the collection of assessment data prior to appointment dates, allowing the primary care physician to make referrals to appropriate services that ensures proper triage of high-needs patients. The automation of the creation and dissemination of assessments allows this data to be collected with no burden on the health system.

Security, Compliance, and Certifications

HIPAA Compliant

HITRUST Certified

Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)

Business Model and Reimbursement

- Medicare reimbursable
- Medicaid reimbursable
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Self-service model (largely independent after setup)

ANDOR®

www.andorhealth.com

Andor Health's ThinkAndor® platform delivers multimodal agentic AI for virtual care, helping health systems reduce readmissions, scale workforce capacity, and improve outcomes. Integrating natively with Epic and 15+ EHRs, Andor combines AI-powered workflows with managed clinical services across the full care continuum.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

- Multimodal agentic AI platform combining observation, documentation, voice, and workflow orchestration across the full care continuum enabling clinicians to automate high-burden tasks without leaving existing workflows.
- Native EHR integration with Epic, Oracle Health, and 15+ other platforms, enabling seamless clinical workflow embedding without separate logins or manual data entry.
- Virtual nursing capabilities that extend bedside care capacity, reduce documentation burden, and drive earlier discharges addressing workforce shortages without requiring additional hiring.
- Remote Patient Monitoring (RPM) supporting chronic disease management for CHF, COPD, diabetes, and hypertension, with automated patient outreach and billing support.
- Transitional Care Management (TCM) delivered turnkey through Psynergy Health at no cost to health systems. Andor assumes clinical and financial risk while billing payers directly.
- AI-powered clinical decision support and population health analytics that surface at-risk patients for proactive intervention across enrolled populations.
- Flexible deployment models including subscription, managed services, and outcomes-based revenue-share, allowing health systems to adopt based on their operational and financial preferences.

Benefits

Andor clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Strengthen the digital front door
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

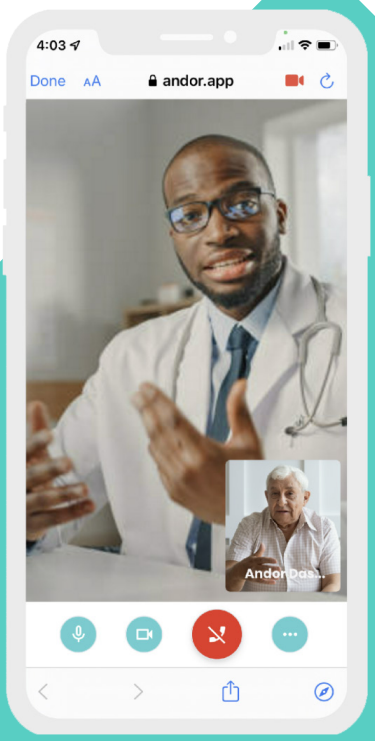
- 63% reduction in hospital readmissions (Ballad Health — peer-reviewed)
- 40% reduction in readmissions
- $5.7M in savings per 13,000 patients
- 44% annual ROI (Orlando Health — peer-reviewed)
- 800 open nursing positions eliminated
- 20,000+ hours returned to bedside care (Sentara Health)
- 70% increase in early discharges (Sentara Health)
- 30% reduction in health system patient leakage (Ballad Health)
- Ranked #1 virtual care platform by Black Book for 4 consecutive years

Clinical Guidelines and Standards

- CMS-aligned programs

Solution Type

- **Patient Engagement:** Solutions supporting education, communication, patient tools, and engagement platforms.
- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Diagnostics & Assessments:** Solutions supporting risk assessments, diagnostics, and screening tools.
- **Supply Chain & Logistics:** Solutions supporting the delivery, coordination, and management of medical supplies and products.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.



RESULTS YOU CAN EXPECT

Case Study

Ballad Health deployed Andor Health's ThinkAndor® platform for transitional care management and virtual nursing across its rural health system.

The program delivered a

63%

reduction in hospital readmissions

30%

reduction in health system leakage

Andor's Synergy Health clinical team managed operations at zero cost to Ballad, enabling measurable outcomes without incremental staffing.

Awards, Accolades, and Certifications

- #1 Virtual Care Platform — *Black Book Rankings* (4 consecutive years)
- Most Commonly Adopted AI Tool — *AJMC*
- Outcomes published in *New England Journal of Medicine, Annals of Emergency Medicine*, and *AJMC*
- 2026 Top of KLAS for Virtual Care Platforms (Non-EHR), *Frost & Sullivan*
- 2025 North American Transformational Innovation Leadership Recognition for Excellence in *Acute Care Virtual Health*

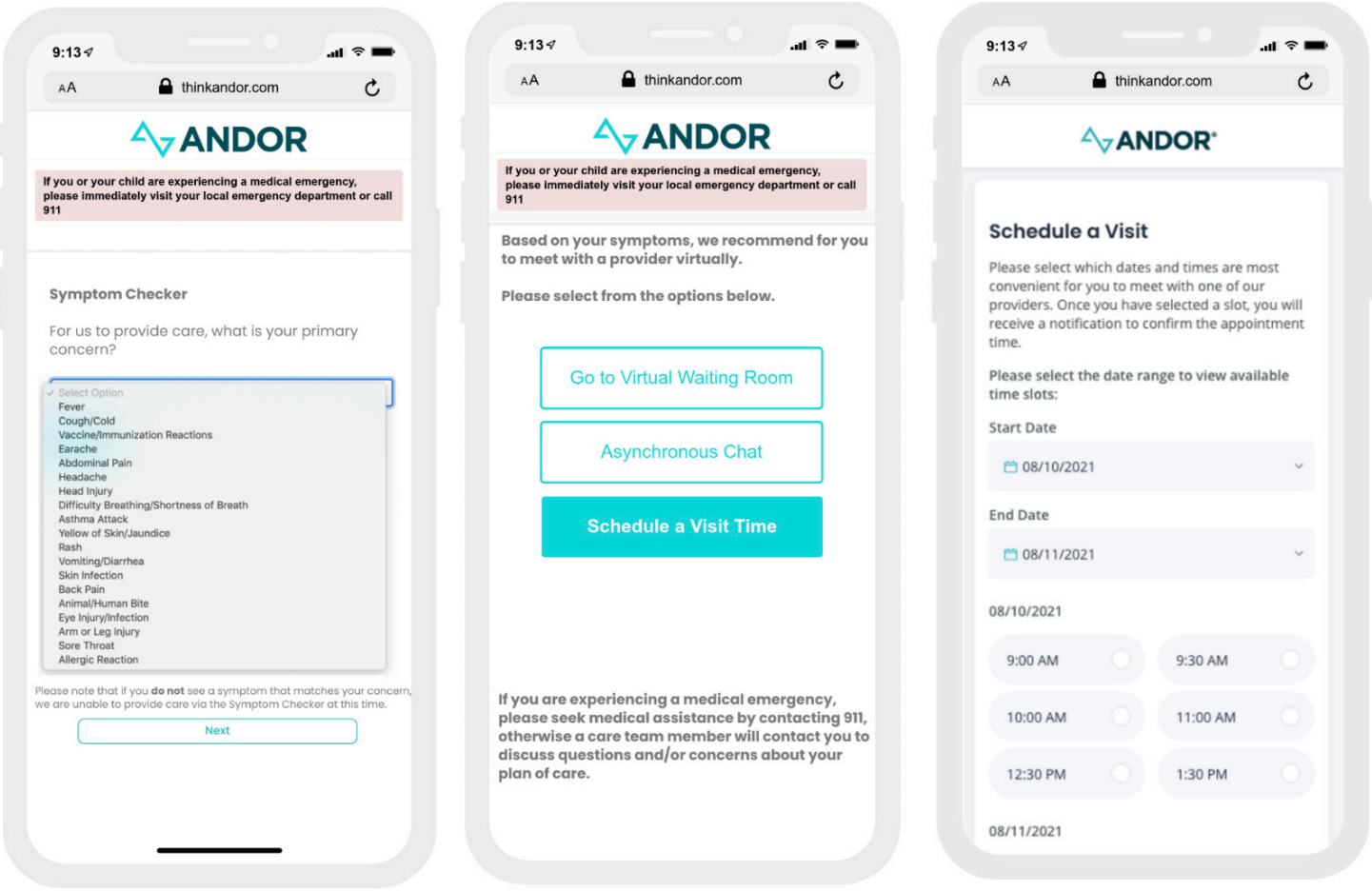
Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

HITRUST Certified

ISO 27001 Certified



Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange
- Operates alongside clinical workflow (not embedded)

Business Model and Reimbursement

- Medicare reimbursable
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)
- Self-service model (largely independent after setup)

BABYSCRIPTS™

www.babyscripts.com

Babyscripts offers a remote patient monitoring program that enables at-home blood pressure management during the prenatal and postpartum period, supported by dedicated care managers and a zmobile app companion. The Babyscripts program enables health systems to scale personalized maternity care.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

Babyscripts myJourney digital companion app supplements and extends the provider's reach by offering 24/7 personalized patient support throughout the prenatal and postpartum journey, improving the quality of appointments and overall care through:

- **Clinical-grade education:** Provides trusted information to inform patients about risk, help them anticipate needs, answer common questions, and prepare them to ask questions that are more comprehensive during appointments.
- **Checklists:** Engage patients in their care and increase adherence to quality measures such as vaccine compliance and appointment attendance
- **Automated risk detection:** Surveys, assessments, and manual data collection connect patients to available resources and benefits, and create a referral source for remote patient monitoring (RPM).
- **Tracking tools:** Enable patients to measure blood pressure and weight, follow a baby's growth, and meet personal health and wellness goals.

Key Features Cont.

Babyscripts myJourney Blood Pressure RPM is designed for high-risk patients and supported by a care management layer. The system enables patients to track their blood pressure readings at home with support from care managers. Readings are recorded via the myJourney app and an internet- or cellular-enabled blood pressure cuff, which syncs with their provider's system. This integration allows for continuous monitoring and immediate feedback. If a patient's blood pressure reading falls outside the parameters set by their healthcare team, the app alerts the patient, the care manager, and the healthcare team, facilitating timely medical intervention.

- **Babyscripts myMentalHealth** allows providers to remotely monitor their pregnant and postpartum patients for behavioral risk and deliver effective interventions via mental health assessments (PHQ2/9 and/or EDPS) deployed at designated times throughout pregnancy and postpartum.
- **Automated workflows:** Patients are connected to mental health services and resources depending on their survey responses, while clinically validated content within the platform facilitates patient awareness and mental health self-support.

Benefits

Babyscripts clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Strengthen the digital front door
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

Peer-reviewed research and internal analyses document significant improvements:

- **Earlier detection of preeclampsia.** Remote blood pressure monitoring shortened time to detection by 13 days and reduced postpartum hypertension readmissions to near zero at Cone Health.
- **Elimination of racial disparities.** A randomized control trial showed at-home blood pressure monitoring resulted in ~92.9 % blood pressure ascertainment for both Black and White patients versus 58.4 % with in-office surveillance. This trial was conducted in a majority Medicaid population.
- **Improved postpartum visit adherence.** Patients using Babyscripts were over twice as likely to attend postpartum visits within 30 days, and 64% within 60 days versus 44% for controls.
- **Financial sustainability and ROI.** A sample of a commercially insured patient population showed Babyscripts improved practice profit margin on reimbursement revenue by 43%.
- **Mental health engagement.** A midpoint analysis found that remote mood screening resulted in significantly higher rates of adherence in the first and second trimesters as compared to standard methods. At week 14, 38% of patients using Babyscripts had completed an Edinburgh Postnatal Depression Scale (EPDS) survey, compared with 10% of patients in the control group. At week 30, 36% of patients using Babyscripts had completed an EPDS survey, compared with 21% of the control group.
- **Improved weight management.** Engagement with the Babyscripts mobile app was associated with a 217% increase in adherence to the Institute of Medicine gestational weight gain guidelines and an increase in postpartum weight loss.

Clinical Guidelines and Standards

- National Committee for Quality Assurance (NCQA)
- CMS-aligned programs
- American Heart Association (AHA) guidelines
- USPSTF guidelines; Evidence-based / peer-reviewed protocols

RESULTS YOU CAN EXPECT

Case Study

Babyscripts education and remote patient monitoring were deployed among a health system and affiliate clinics, leading to:

10%
increase in pediatric repatriation

2
fewer in-person prenatal care visits on average per pregnancy, freeing up provider time for additional visits

85%
compliance with blood pressure RPM

92%
patient satisfaction

Awards, Accolades, and Certifications

- Best In Remote Monitoring, Top Reviewed (AVIA Marketplace, 2024)
- Digital Health 150 (CB Insights, 2020)
- Top 50 Remote Monitoring (AVIA Marketplace, 2023)
- Remote Diagnostic Tool or Device Quarterfinalist (UCSF Health Awards, 2021)
- Top 5 Condition-Specific Platforms, Remote Monitoring (AVIA Marketplace, 2022)

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange

Business Model and Reimbursement

- Medicaid reimbursable
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)

Brightside Health

www.brightside.com

Brightside Health is a technology-enabled virtual system of care delivering comprehensive mental health nationwide. Using data-driven care models, measurement-based outcomes, and evidence-based treatment, we provide psychiatry, therapy, intensive outpatient program, and suicide prevention programs across all acuity levels.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

WORKFLOW AUTOMATION

CARE COORDINATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

POPULATION HEALTH MANAGEMENT

Key Features

- **Proprietary Measurement-Based Care & Outcomes Monitoring:** Brightside equips health systems and clinicians with continuous visibility into symptom severity, suicide risk, treatment adherence, and clinical outcomes through standardized assessments and longitudinal analytics, supporting higher-quality care, earlier intervention, and population health management.
- **Integrated Virtual Behavioral Health Services:** Brightside delivers psychiatry, therapy, suicide prevention, and virtual IOP through a unified care model that expands behavioral health capacity, improves access to timely care, and supports seamless coordination across health system referral pathways.
- **PrecisionRx Clinical Decision Support:** Brightside's proprietary PrecisionRx platform analyzes more than 200 patient data points and uses machine learning models to support personalized medication selection, symptom monitoring, and treatment optimization. This helps clinicians improve prescribing accuracy, accelerate symptom improvement, and proactively identify patients at risk of poor response or clinical deterioration.
- **Evidence-Based Clinical Pathways:** Brightside supports consistent, high-quality care delivery through standardized, evidence-based treatment protocols, measurement-based workflows, and continuous quality monitoring designed to improve outcomes and reduce variation in care.
- **Health System Integration & Operational Enablement:** Brightside supports Xealth, FHIR, API, and other referral workflow integrations that streamline provider referrals, simplify operational coordination, and enable scalable behavioral health partnerships across ambulatory, specialty, and acute care settings.
- **Nationwide Access to High-Quality Virtual Care:** Brightside delivers comprehensive mental healthcare across all acuity levels through a scalable, technology-enabled care model available in all 50 states. Our approach combines evidence-based care, measurement-based outcomes tracking, and rigorous quality standards, including Brightside's Mental Health Quality Scorecard, which evaluates 62 indicators across 10 domains to ensure consistent, high-quality care delivery at scale.

Benefits

Brightside Health clients can:

- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Strengthen the digital front door
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination
- Other

Measurable Impacts

- Rapid access to care, with 92% of initial appointments within 5 days
- Strong patient engagement, with 79% of patients remaining active after 3 months, and approximately 75% completing a follow-up visit within 30 days
- Demonstrated operational scalability and referral growth, including engagement across large ambulatory networks, facilities, and payers
- Measurable clinical outcomes through evidence-based, measurement-based care, including reductions in depression, anxiety, and suicidal ideation, supported by peer-reviewed research and continuous outcomes monitoring

Clinical Guidelines and Standards

- NCQA (National Committee for Quality Assurance)
- CMS-aligned programs
- Evidence-based / peer-reviewed protocols

Solution Type

- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.

RESULTS YOU CAN EXPECT

Case Study

Brightside takes a structured, partnership-oriented approach to implementing and managing care collaboration. In one large health system partnership, integrated referral workflows, real-time data exchange, and coordinated operational governance enabled scalable patient onboarding, streamlined provider workflows, and sustained program growth across multiple service lines and referral sources.

Awards, Accolades, and Certifications

Recognized by leading healthcare and consumer publications including *Fortune, Healthline, Forbes, Verywell Mind, Everyday Health, CNET*, and *Medical News Today* for excellence in virtual psychiatry, therapy, anxiety and depression treatment, teen mental health, suicide prevention, and insurance accessibility.

Developed the Mental Health Quality Scorecard, a first-of-its-kind framework measuring 62 indicators across 10 quality domains, achieving a 92% quality score and advancing transparency and accountability in virtual behavioral healthcare.

Peer-reviewed publications, including *JMIR Mental Health, JMIR Formative Research, BMC Psychiatry, Frontiers in Psychiatry, Journal of Clinical Psychopharmacology, Journal of Affective Disorders, Healthcare, Cureus,* and *Psychotherapy Research. Research* topics include precision prescribing, suicide prevention, measurement-based care, AI-supported clinical decision-making, telepsychiatry outcomes, and virtual IOP effectiveness.

Accredited by The Joint Commission (TJC).

Holds HITRUST r2 Certification, is HIPAA Compliant, and aligns with leading industry security frameworks.

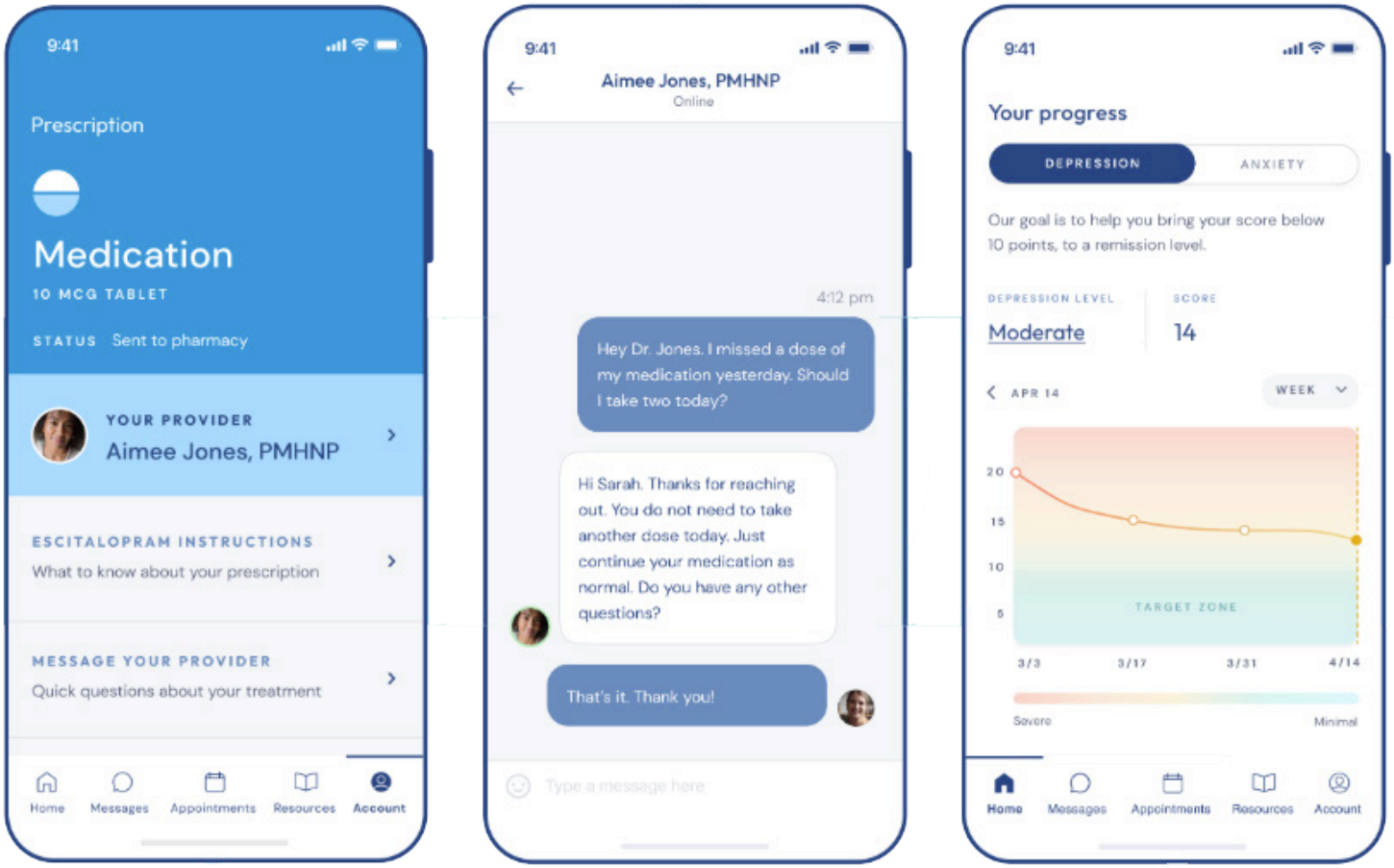
Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

HITRUST Certified

Other



Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange

Business Model and Reimbursement

- Medicare reimbursable
- Medicaid reimbursable
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)

CADENCE

www.cadence.care

Cadence delivers a comprehensive remote patient care platform that combines cellular-enabled remote patient monitoring, a 24/7 NP-led clinical care team, and deep Epic integration to support patients with chronic conditions. The solution improves clinical outcomes, reduces total cost of care, extends provider capacity, and generates sustainable fee-for-service and value-based care revenue for health systems.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

- **Remote Patient Monitoring (RPM):** Cadence provides cellular-enabled blood pressure cuffs, weight scales, and glucometers that automatically transmit patient data without requiring Wi-Fi, Bluetooth, or a smartphone. Patients receive continuous monitoring while providers gain visibility into daily vitals directly within Epic.
- **24/7 Clinical Care Team:** Cadence's multidisciplinary team of nurse practitioners, registered nurses, medical assistants, and physicians delivers proactive patient outreach, medication management, symptom assessment, and clinical support around the clock, extending provider capacity while reducing clinical burden.
- **Epic-Native Integration:** Cadence integrates directly with Epic using FHIR and HL7, enabling embedded dashboards, automated order workflows, clinical documentation, charge capture, and real-time data exchange without requiring providers to leave their existing workflow.
- **Guideline-Directed Medication Management:** Cadence's NP-led team uses evidence-based clinical protocols to support medication titration, laboratory ordering, and chronic disease management for conditions such as hypertension, heart failure, and type 2 diabetes, with provider oversight maintained through the EHR.
- **Automated Alert Management:** The platform continuously analyzes patient data and generates condition-specific alerts for abnormal readings. Cadence's clinical team triages and resolves the vast majority of alerts, escalating only when provider involvement is needed.
- **Advanced Primary Care Management (APCM):** Cadence supports proactive care planning, care gap closure, care coordination, social determinants of health interventions, and 24/7 patient access for Medicare populations, helping health systems extend primary care services beyond traditional office visits.
- **Patient Engagement and Support:** Patients receive onboarding, education, appointment reminders, weekly summaries, and ongoing communication through SMS, phone, and email. The app-less experience improves accessibility and supports sustained engagement across diverse patient populations.

Benefits

Cadence clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Strengthen the digital front door
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

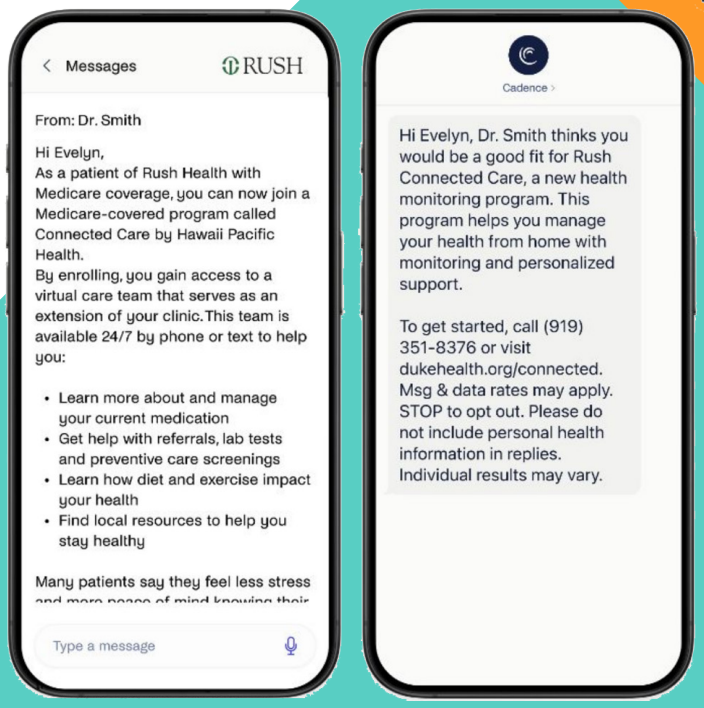
Cadence has demonstrated a 70% relative increase in hypertension patients achieving blood pressure control, a 107% increase in heart failure patients on all four pillars of guideline-directed medical therapy, and a 27% reduction in hospitalizations. Across participating health systems, Cadence has delivered approximately $1,300 in average annual cost savings per patient, while supporting high patient engagement and satisfaction, including a 4.9/5 patient satisfaction rating.

Clinical Guidelines and Standards

- CMS-aligned programs
- American Diabetes Association (ADA) guidelines
- American Heart Association (AHA) guidelines
- Evidence-based / peer-reviewed protocols

Solution Type

- **Patient Engagement:** Solutions supporting education, communication, patient tools, and engagement platforms.
- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.



RESULTS YOU CAN EXPECT

Case Study

Providence partnered with Cadence to deliver remote patient care for patients with chronic conditions.

The program achieved a

43% increase

in patients achieving blood pressure control

107% increase

in heart failure patients on all four pillars of guideline-directed medical therapy

$2,432

reduction in total cost of care per patient per year

4.9/5

patient satisfaction rating

Awards, Accolades, and Certifications

Cadence has been recognized by the Peterson Health Technology Institute (PHTI), which identified Cadence's medication management approach as a standout digital hypertension solution and highlighted its clinical benefits, potential long-term savings, and population health impact.

Cadence was also named #4 on LinkedIn's 2025 Top Startups in the U.S., becoming the only remote monitoring company included on the list.

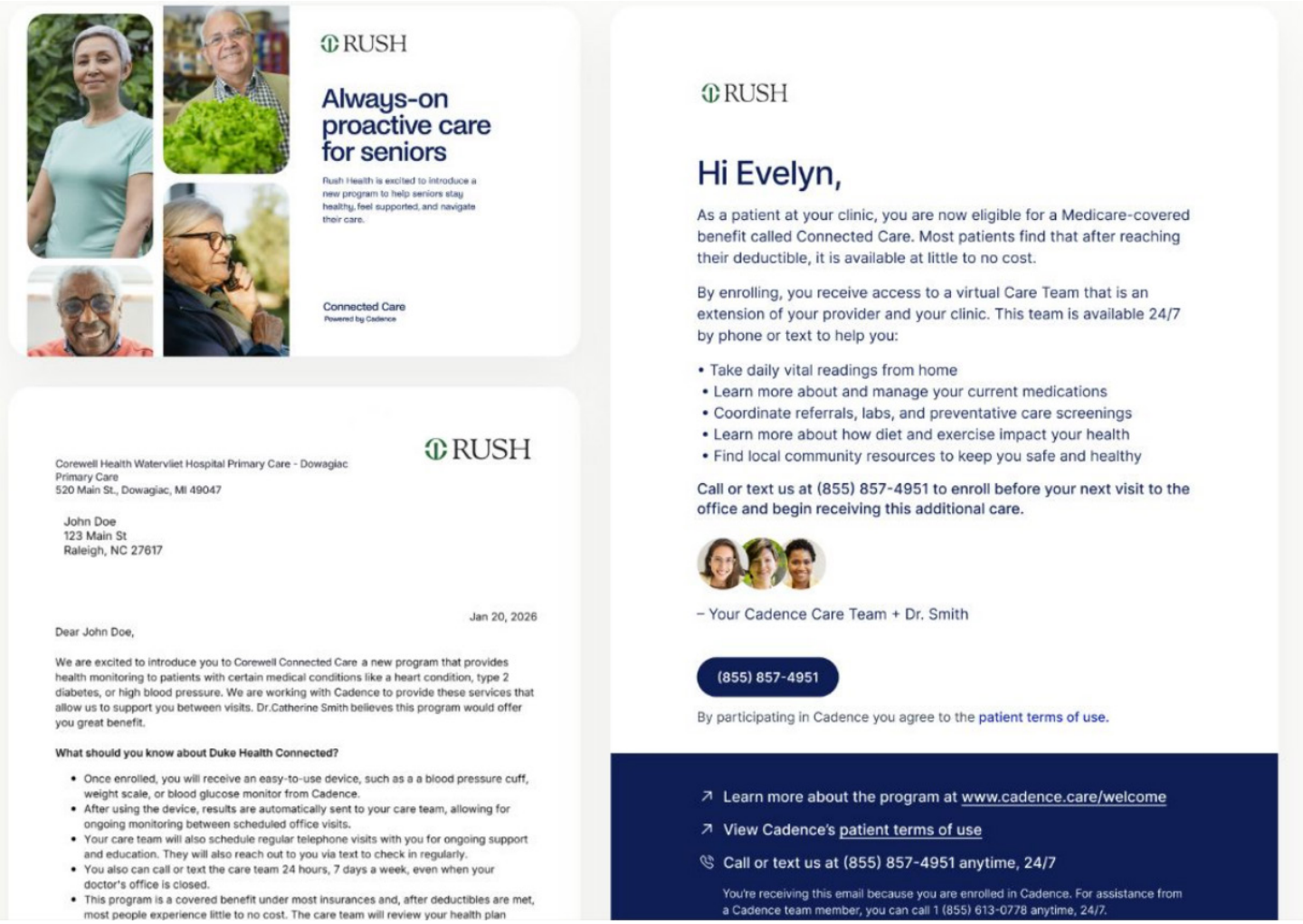
Additionally, Cadence maintains SOC 2 Type II compliance and operates as a HIPAA-compliant organization.

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

FDA Cleared (if applicable)



Integration and Workflow Fit

- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange

Business Model and Reimbursement

- Medicare reimbursable
- Medicaid reimbursable
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)

ChronicCareIQ

www.chroniccareiq.com

ChronicCareIQ is a CCM, RPM, and digital engagement software that keeps providers connected with patients between visits. Its red/yellow/green dashboard flags patients trending poorly, while device and EHR integrations automate workflows and reimbursement documentation, to help providers get paid for eligible care work.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

- Early-warning detection helps care teams identify patients trending poorly between visits by analyzing ongoing patient check-ins and monitoring data.
- Patient risk prioritization via a simple red/yellow/green dashboard helps providers focus outreach on the patients who need the most attention.
- Automated patient check-ins help care teams stay connected between visits by collecting patient-reported symptoms, status updates, and care plan feedback through digital engagement channels.
- Remote patient monitoring helps providers track chronic and complex patients by capturing data from connected devices and making key trends visible within the care management workflow.
- EHR integration helps reduce manual work for clinical teams by automating workflows, documentation, and data exchange within existing systems.
- Reimbursement documentation helps providers capture payment for eligible care management work by automatically tracking care activity, time, and required logging for billing.

Benefits

ChronicCareIQ clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Strengthen the digital front door
- Improve financial performance
- Support value-based care
- Improve care coordination

Measurable Impacts

- Providers report scaling patient to care manager ratio by 2.5x, while spending more time with patients, not less
- Reduce hospitalizations by an average of 29.4% by detecting patient deterioration in-between visits
- Generate $103 per patient per month, on average, by automating tracking of reimbursable care activities
- 87% patient engagement after one year

Clinical Guidelines and Standards

- CMS-aligned programs
- American Diabetes Association (ADA) guidelines
- American Heart Association (AHA) guidelines
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Solution Type

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- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
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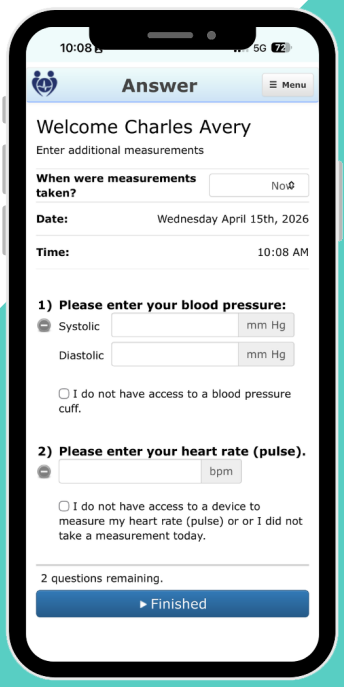
- **Diagnostics & Assessments:** Solutions supporting risk assessments, diagnostics, and screening tools.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.



RESULTS YOU CAN EXPECT

Case Study

Chesapeake & Washington Heart Care, a Southern Maryland cardiology practice, used ChronicCareIQ to improve patient engagement and streamline communication across CCM and RPM programs.

The practice achieved a **12% decrease** in hospital readmissions

650+ active CCM patients

Staff reported less front-desk burden and faster follow-up when patients showed changes in clinical status.

Awards, Accolades, and Certifications

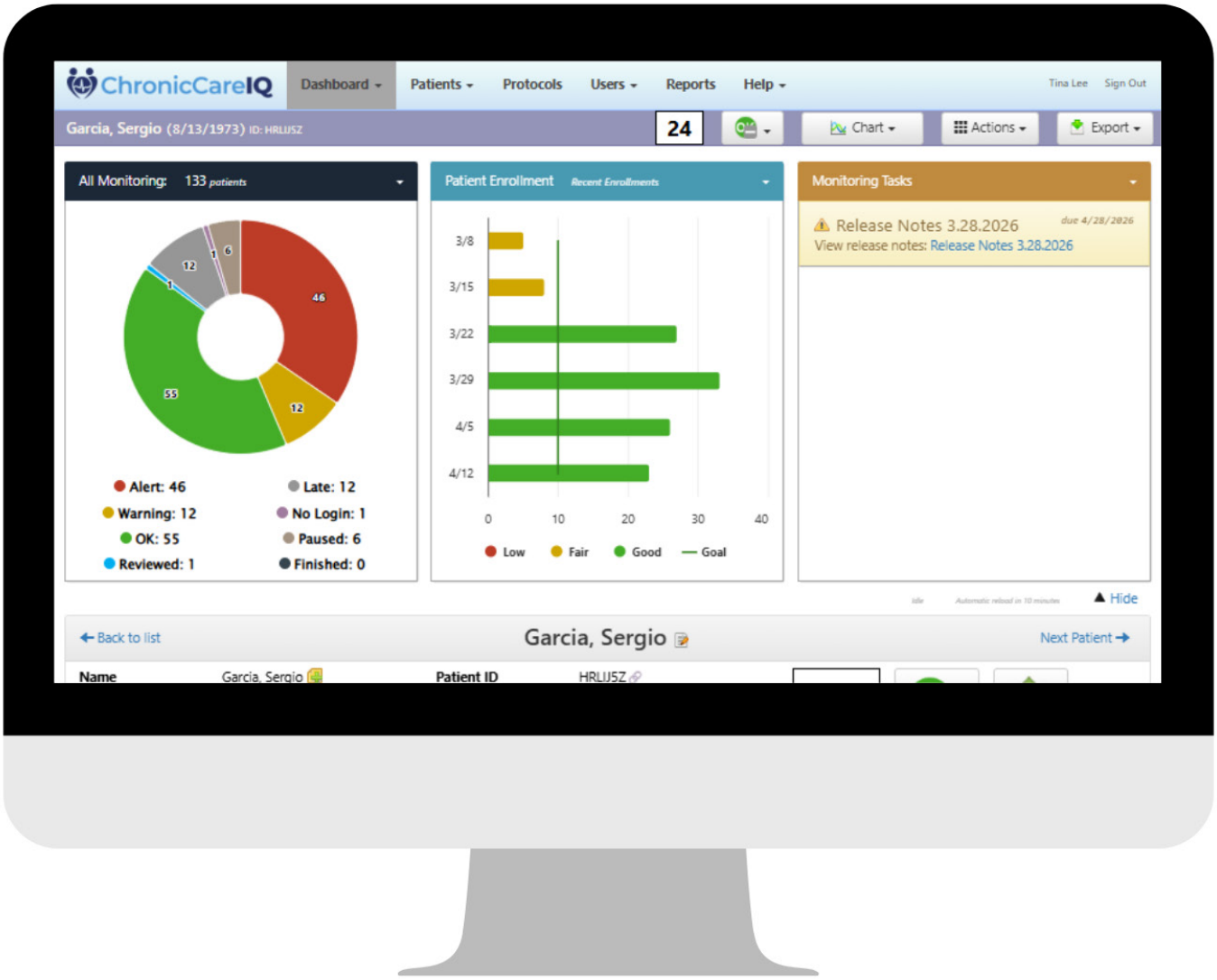
2025 Inc. 5000 America's fastest-growing private companies

2024 Inc. 5000 America's fastest-growing private companies

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified



Integration and Workflow Fit

- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange
- Operates alongside clinical workflow (not embedded)

Business Model and Reimbursement

- Medicare reimbursable

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support

COACHCARE

www.coachcare.com

CoachCare helps health systems extend care beyond the clinical visit through remote patient monitoring, chronic care management, and connected care programs. Combining technology, devices, clinical services, and reimbursement support, CoachCare enables scalable patient engagement and improved outcomes.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

- Full-service Remote Patient Monitoring (RPM) programs combining technology, devices, patient enrollment, monitoring, and clinical support.
- Chronic Care Management (CCM), Principal Care Management (PCM), Transitional Care Management (TCM), and APCM program support.
- Cellular-enabled connected devices including blood pressure monitors, weight scales, glucometers, and more.
- AI-powered patient risk stratification and prioritization tools through CarePredict.
- Clinical workflow integration through EHR-connected experiences, including Xealth.
- Population health dashboards, reporting, and reimbursement tracking.
- U.S.-based care teams providing patient outreach, engagement, and escalation management.

Benefits

CoachCare clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

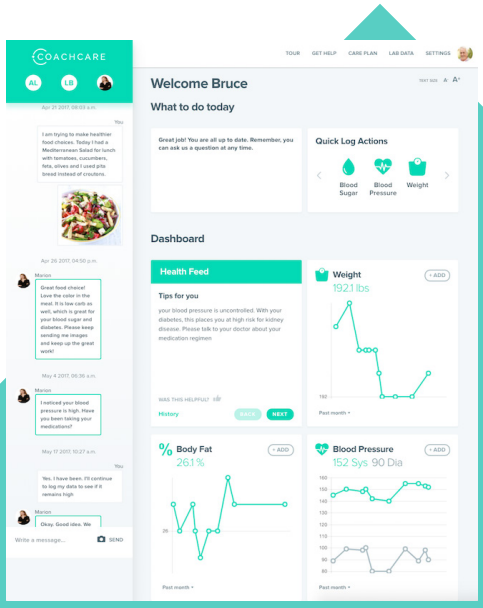
- 50% reduction in 30-day cardiovascular readmissions (Cardiac Solutions)
- 74% fewer inpatient stays, 63% fewer ED visits, and 85% shorter length of stay among monitored patients (health system client)
- $2.4M in documented cost avoidance through proactive remote monitoring programs
- 0% readmissions among 450 advanced heart failure patients during a 6-month remote monitoring program (MercyOne Iowa Heart Center)
- 81 readmissions prevented and 26 GDMT care gaps closed (MercyOne Iowa Heart Center)
- Supports more than 10,000 providers across 1,000+ implementations and 500,000+ patients nationwide
- Expanded provider capacity through outsourced care management and workflow support

Clinical Guidelines and Standards

- CMS-aligned programs
- American Diabetes Association (ADA) guidelines
- American Heart Association (AHA) guidelines
- Evidence-based / peer-reviewed

Solution Type

- **Patient Engagement:** Solutions supporting education, communication, patient tools, and engagement platforms.
- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Diagnostics & Assessments:** Solutions supporting risk assessments, diagnostics, and screening tools.
- **Supply Chain & Logistics:** Solutions supporting the delivery, coordination, and management of medical supplies and products.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.



RESULTS YOU CAN EXPECT

Case Study

MercyOne Iowa Heart Center partnered with CoachCare to remotely monitor 450 advanced heart failure patients as part of a comprehensive chronic disease management strategy. During a 6-month observation period, the program achieved...

0%
readmissions

prevented
81
readmissions

reduced heart failure hospitalizations by
96%

helped close
26
GDMT care gaps

while improving patient engagement and continuity of care.

Awards, Accolades, and Certifications

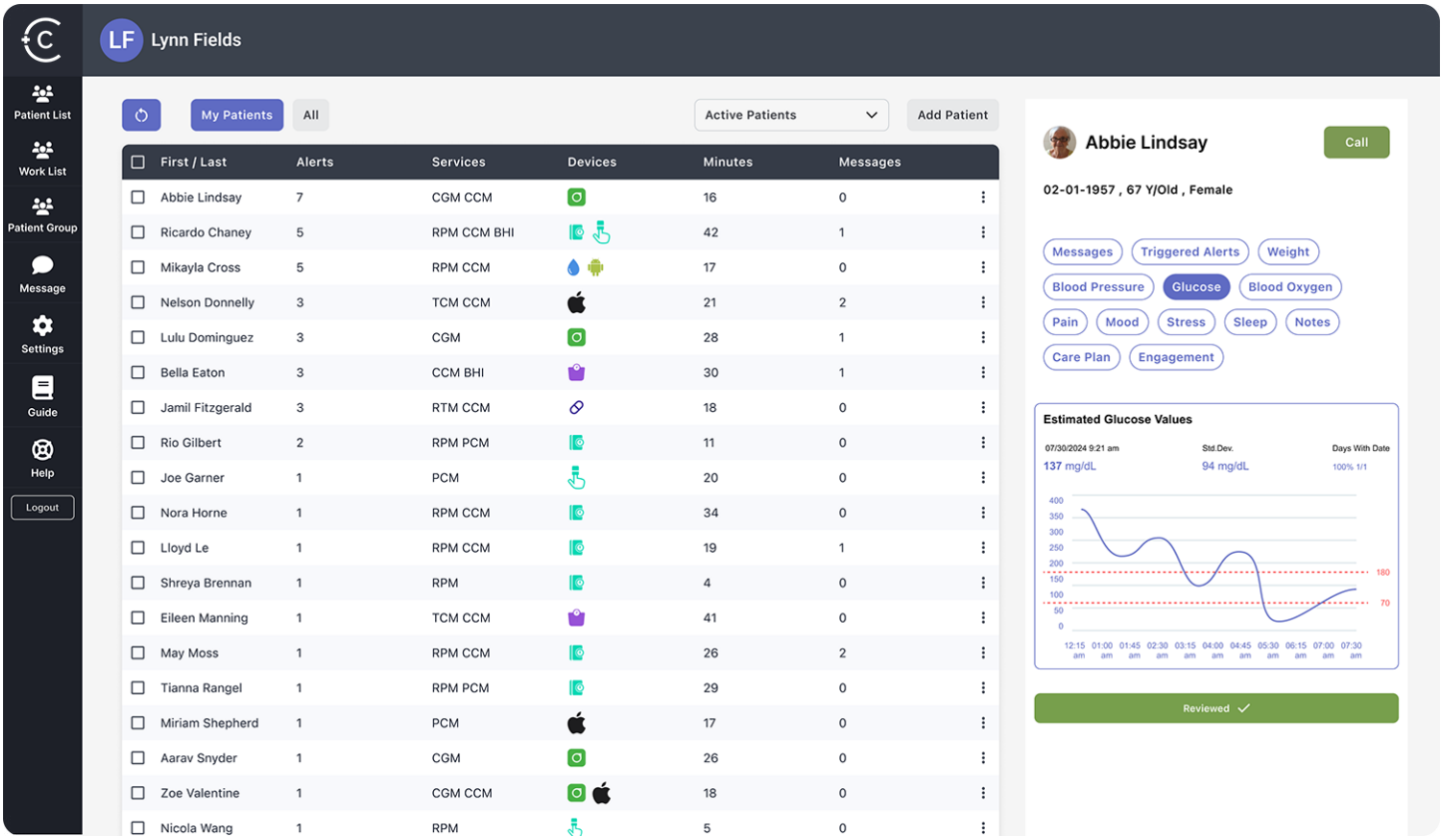
- Founding member of the Remote Monitoring Leadership Council (RMLC)
- TIME World's Top HealthTech Companies 2025
- Epic App Orchard / Epic integration partner
- Trusted by more than 10,000 providers nationwide
- More than 1,000 healthcare organization implementations
- Inc. 5000 Fastest Growing Companies (multiple years) and ranked #11 in Inc. Regionals: Healthcare
- AVIA Marketplace Top 2 Remote Monitoring Company (4.91/5 client review score)

Security, Compliance, and Certifications

HIPAA Compliant

FDA Cleared (if applicable)

Other



Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., electronic health record, dashboards)
- Supports bidirectional data exchange

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support, clinical program support (e.g., nurses, coaches, care teams)

Business Model and Reimbursement

- Medicare reimbursable
- Medicaid reimbursable
- Covered by commercial insurance
- Not reimbursable

www.forcetherapeutics.com

Force Therapeutics is a provider-prescribed digital patient engagement platform that guides patients through surgical recovery with personalized education, remote monitoring, PROM collection, and automated workflows. The platform improves patient engagement, outcomes, and satisfaction while increasing care team efficiency and reducing operational costs.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

- **Standardized and Personalized Gold-Standard Patient Education Pathways:** helping patients prepare for and recovery from surgery, tailored by patient health and risk profile, and decreasing the burden of education for care teams.
- **PROMs Collection and Reporting:** Achieve industry-leading patient outcome capture rates and submit to CMS and registries without care team intervention, enabling regulatory compliance, advanced certifications, improved visibility into patient recovery, and less time spent on manual collection.

Key Features (continued)

- **Actionable Insights for Clinical Teams:** Identify risks early and receive customizable alerts for underperforming patients to prioritize care team resources where needed.
- **Remote Therapeutic Monitoring (RTM):** Facilitate reimbursement through RTM CPT codes for MSK patients, with automated enrollment, in-app communication, built-in clinician timers, and a clear audit trail.
- **Analytics & Reporting:** Real-time executive dashboards, automated registry reporting, and custom accreditation support help leaders ensure compliance, leverage data for payer negotiations, and improve quality performance.
- **Direct Messaging (with patients, between clinicians, and with Force clinical support):** Triage patients remotely and reduce unnecessary call volumes and office visits through secure in-app messaging.
- **Hands-On Support:** Dedicated clinical support experts refine care pathways, help leaders or facilities satisfy accreditation requirements, and provide customizable data extracts to enable quality improvement and research efforts.

Benefits

Force Therapeutic clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Clinical Guidelines and Standards

- CMS-aligned programs
- Evidence-based / peer-reviewed protocols

Solution Type

- Patient engagement
- Solutions supporting education
- Communication
- Patient tools and engagement platforms
- Care management
- Solutions supporting care coordination platforms, care pathways, and workflow optimization
- Specialty programs
- Solutions supporting condition-specific digital care programs
- Remote monitoring and virtual care
- Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring

Measurable Impacts

- 87% average patient opt-In
- +80% average PROMs collection
- 46 logins per episode (120 day episode)
- 10-12 week implementation
- 95% of patients report “prepared” or “very prepared” for surgery
- +90% of patients report “satisfied” or “very satisfied”
- $387 average savings per patient
- 100% of mandated force clients are THA/TKA PRO-PM compliant

RESULTS YOU CAN EXPECT

Case Study

21,982
THA and TKA patients aged 65 years or older across 6 large hospitals systems and AMCs

91%
opt-in rate

71%
matched KOOS Jr. Compliance at 1Y

70%
matched HOOS Jr. Compliance at 1Y

87%
VR-12/PROMIS Global Preop Compliance

68%
of TKA Patients Met MCID and

57%
Met SCB

79%
of THA Patients Met MCID and

71%
Met SCB

90%
of patients Indicated “Satisfied” or “Very Satisfied” With Procedure

Awards, Accolades, and Certifications

American Academy of Orthopaedic Surgeons (AAOS) PROMs Vendor

Newsweek's World's Best Digital Health Companies 2024

HLTH Digital Health Awards 2024 Best In Class Quarterfinalist

American Association of Hip and Knee Surgeons (AAHKS) Industry Innovation Award 2023

Digital Health New York (DHNY) 100 2021

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

TX-RAMP Certified

Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange
- Operates alongside clinical workflow (not embedded)

Business Model and Reimbursement

- Health system purchases solution directly
- Medicare reimbursable
- Supports CPT/HCPCS-based billing (e.g., RPM, CCM, RTM)
- Provides documentation to support billing

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)

glooko®
BETTER TOGETHER

www.glooko.com

Glooko is focused on improving health outcomes for people living with diabetes. Through our personalized, intelligent, connected diabetes care platform used by more than 4.4 million people around the world, we strengthen connections between patients and healthcare providers and drive patient engagement and adherence via digital therapeutics. By seamlessly integrating with electronic health records (EHRs), providing a unified device ecosystem, and delivering actionable insights, Glooko aims to enhance clinical workflows and improve outcomes for people with diabetes and their care providers.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CLINICAL DECISION SUPPORT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

- Seamlessly integrates with more than 200 diabetes devices and health monitoring apps, including CGMs, BGMs, insulin puvmps and pens, and fitness trackers, to consolidate fragmented data into a single, actionable view.
- Sets the standard for data privacy by protecting sensitive information through hundreds of robust controls and annual third-party audits.
- Clinic dashboard optimizes diabetes population health management and gives care teams quick insights into patient trends and key clinic metrics.

Benefits

Glooko clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Improve financial performance
- Support value-based care
- Support population health management

Measurable Impacts

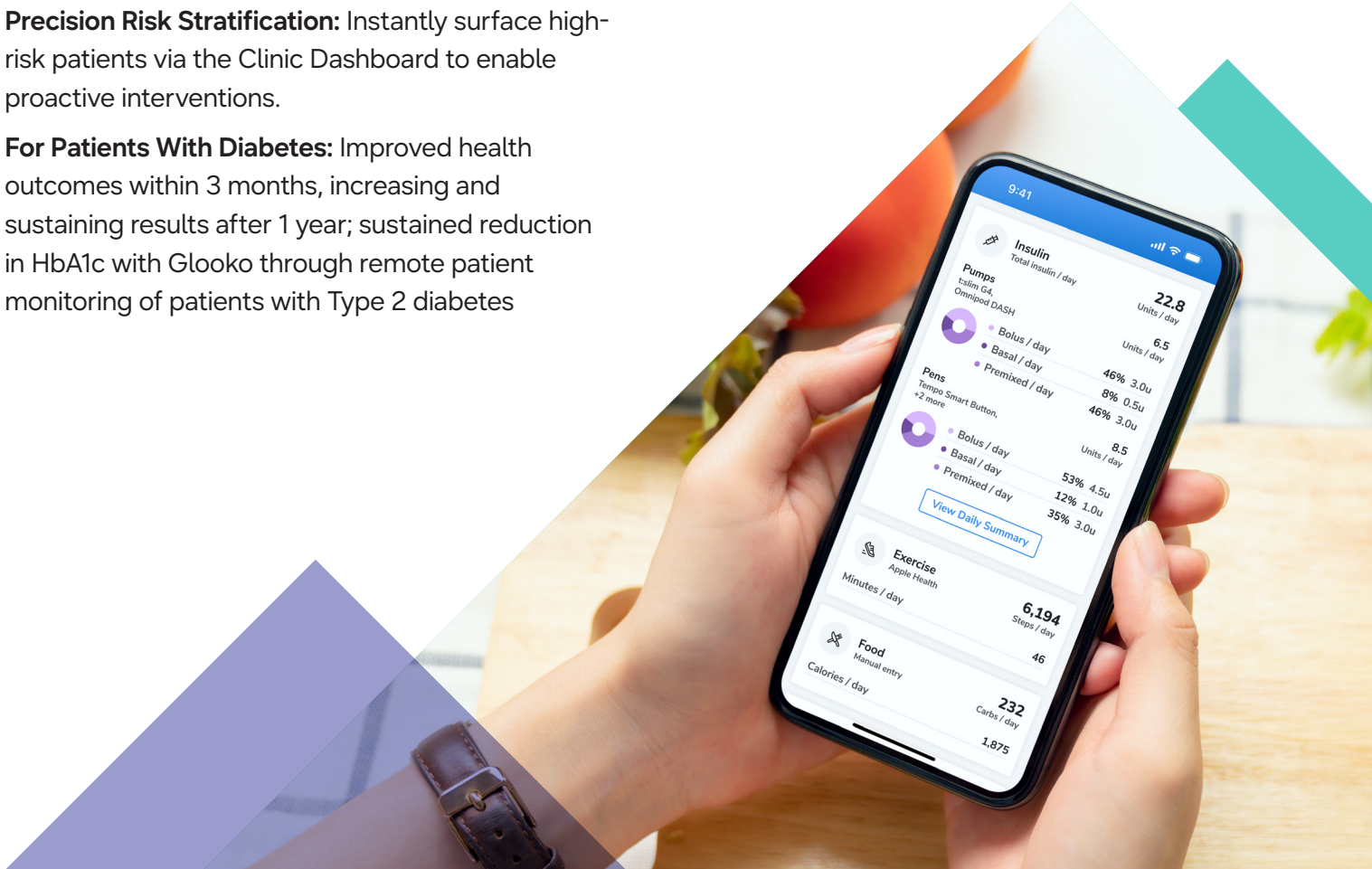
- **Time Reclamation:** Optimize clinical bandwidth with workflows so efficient that one customer reported saving 91 documentation days in a single year.
- **Sustainable ROI:** Advance your ESG initiatives while slashing overhead, with reported savings of $16k–$30k in annual paper costs alone.
- **Precision Risk Stratification:** Instantly surface high-risk patients via the Clinic Dashboard to enable proactive interventions.
- **For Patients With Diabetes:** Improved health outcomes within 3 months, increasing and sustaining results after 1 year; sustained reduction in HbA1c with Glooko through remote patient monitoring of patients with Type 2 diabetes

Clinical Guidelines and Standards

- American Diabetes Association (ADA) guidelines

Solution Type

- Care Management
- Specialty Programs
- Remote Monitoring & Virtual Care



RESULTS YOU CAN EXPECT

Case Study

Large Midwestern university health system

Reduced patient intake time

25 to 10

minutes per patient

91

work days

saved in 2025

Reduced intake Medical Assistants from

3 FTE to 1 FTE

through attrition

Saved

$30k

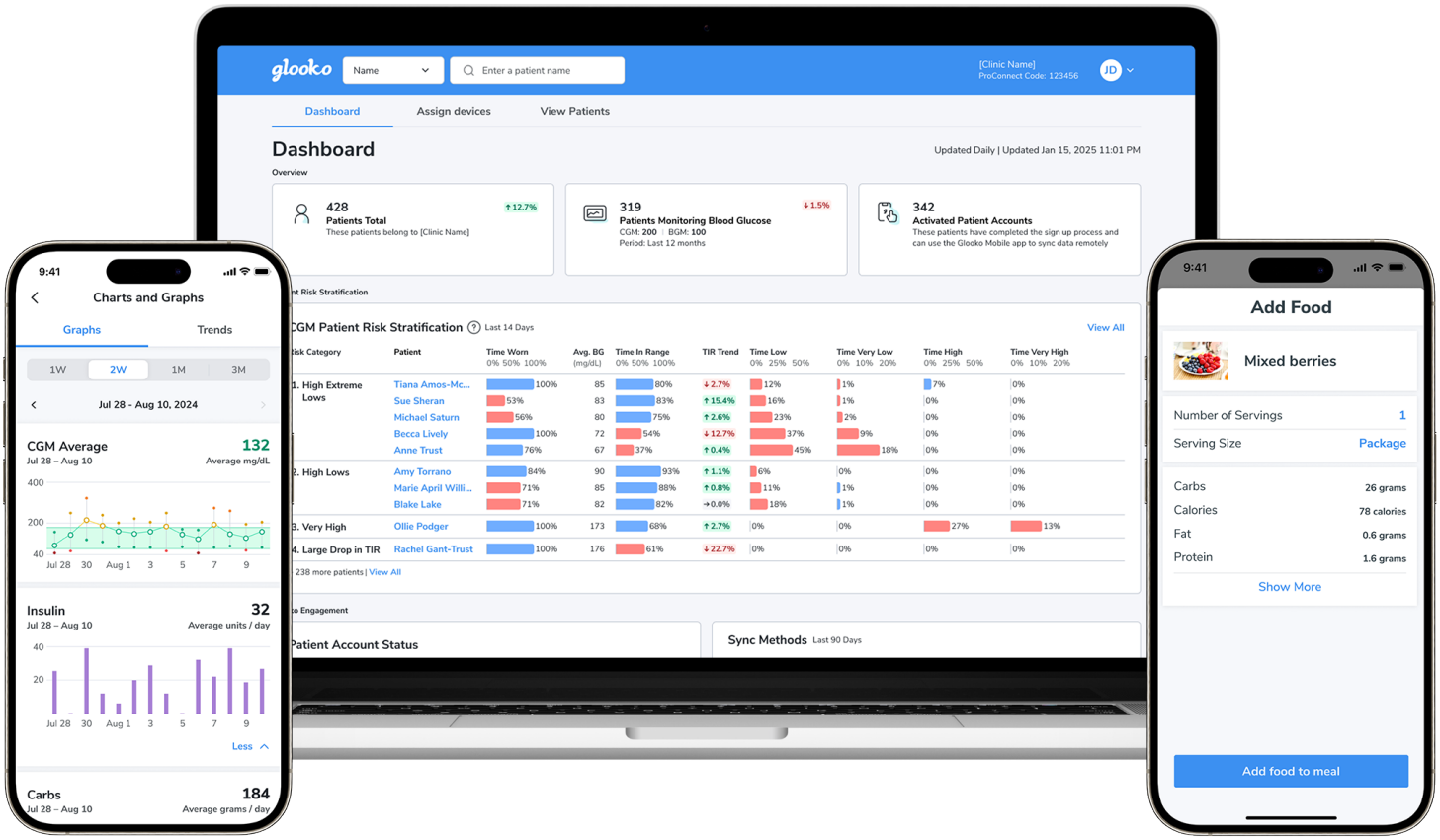
system wide by sending data directly into the EHR

Awards, Accolades, and Certifications

- The Healthcare Technology Report: Top 50 Healthcare Technology Companies of 2025
- 2025 eHealthcare Leadership Awards: Best Population Health, Prevention, or Chronic Disease Management
- Becker's Hospital Review: 2023 & 2025 Telehealth Companies to Know
- "Best Overall MedTech Software": 2026 MedTech Breakthrough Awards

Security, Compliance, and Certifications

- **HIPAA Compliant**
- **SOC 2 Type II Certified**
- **HITRUST Certified**
- **ISO 27001 Certified**
- **GDPR Compliant**



Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Supports bidirectional data exchange

Business Model and Reimbursement

- Health system purchases solution directly
- Not reimbursable
- Provides documentation to support billing

Customer Support and Operating Model

- Dedicated customer success manager
- Ongoing technical support

Glooko offers healthcare providers dedicated customer success managers, U.S.-based support, and expert-led implementation. Backed by an extensive help center, rapid response times, and comprehensive training resources, we ensure care teams at hospitals and health systems have the support they need to provide the highest quality care to people living with diabetes.

Hinge Health®

www.hingehealth.com

Hinge Health is the leading unified musculoskeletal (MSK) solution, partnering with employers and health plans to reduce costs by connecting people to evidence-based care. Through an AI-powered care model and a multidisciplinary care team of experts, we reduce pain by 68% and avoid 1 in 2 MSK surgeries.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

Key Features

- One easy-to-use app that brings together exercise therapy, education, health coaching, and clinical support.
- AI-powered care model with TrueMotion computer vision for real-time movement feedback.
- FDA-cleared Enso device for drug-free pain relief.
- HingeSelect for virtual orthopedic visits and in-person MSK care navigation.
- HingeConnect for data integration, targeted care workflows, referrals, and reporting.

Benefits

Hinge Health clients can:

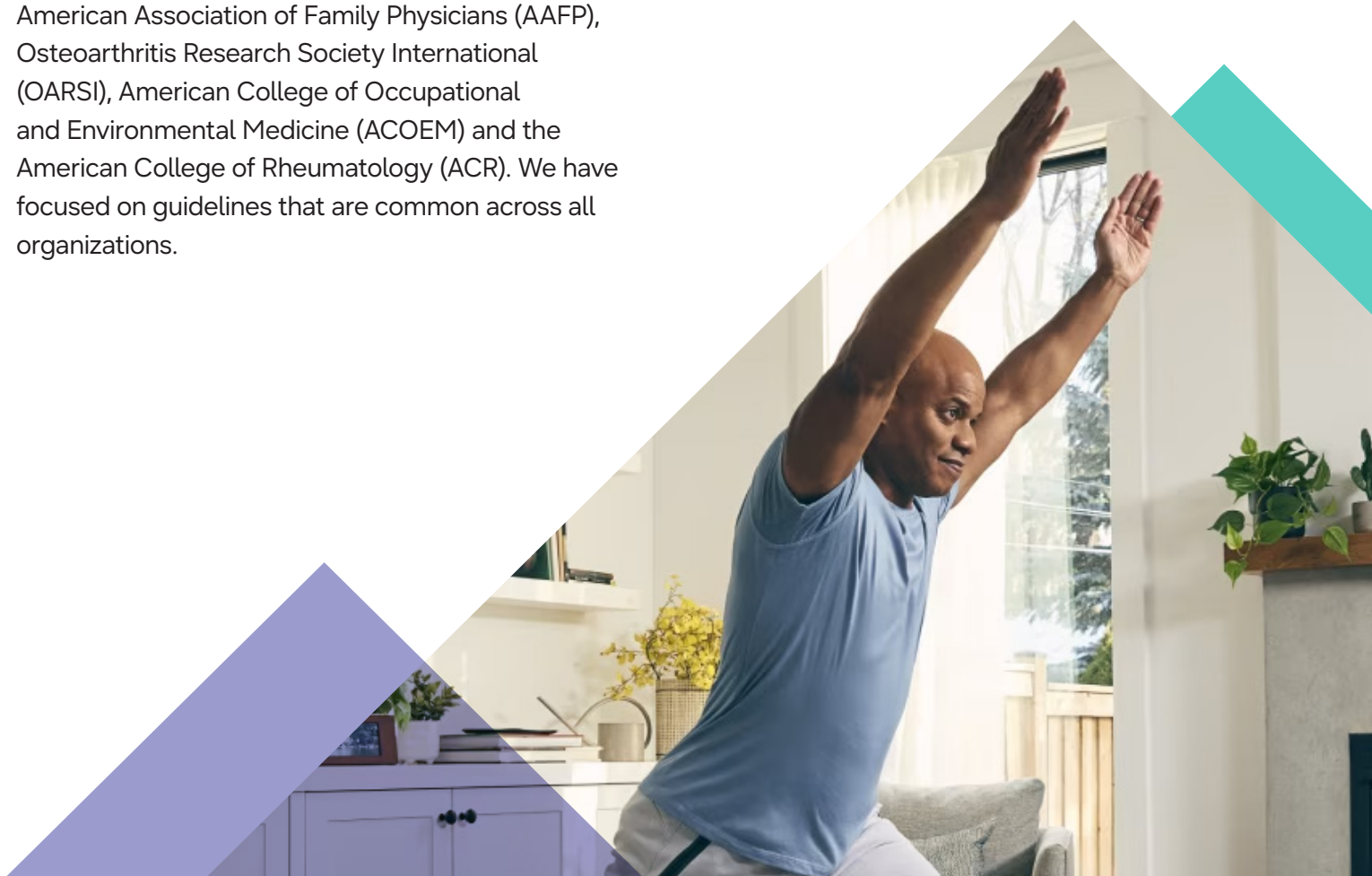
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Improve financial performance
- Support value-based care
- Improve care coordination

Solution Type

- Care management
- Solutions supporting care coordination platforms, care pathways, and workflow optimization
- Specialty programs
- Solutions supporting condition-specific digital care programs
- Remote monitoring and virtual care
- Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring

Clinical Guidelines and Standards

- Evidence-based / peer-reviewed protocols
- Many clinical care guidelines have been utilized in designing the HingeSelect program, including those from American Academy of Orthopaedic Surgeons (AAOS), North American Spine Society (NASS), American Physical Therapy Association (APTA), American College of Physicians (ACP), American Association of Family Physicians (AAFP), Osteoarthritis Research Society International (OARSI), American College of Occupational and Environmental Medicine (ACOEM) and the American College of Rheumatology (ACR). We have focused on guidelines that are common across all organizations.



Measurable Impacts

- 68% average pain reduction
- 58% average reduction in depression
- 58% average reduction in anxiety
- 67% average reduction in surgery intent
- 61% average increase in work productivity
- 42% fewer participants starting opioids
- 1 in 2 MSK surgeries avoided
- 60% reduction in imaging at 3 months
- 9/10 member satisfaction
- 4%+ engagement
- 2.4x Return on Investment validated by an independent third party across 136 employers and 46 industries

RESULTS YOU CAN EXPECT

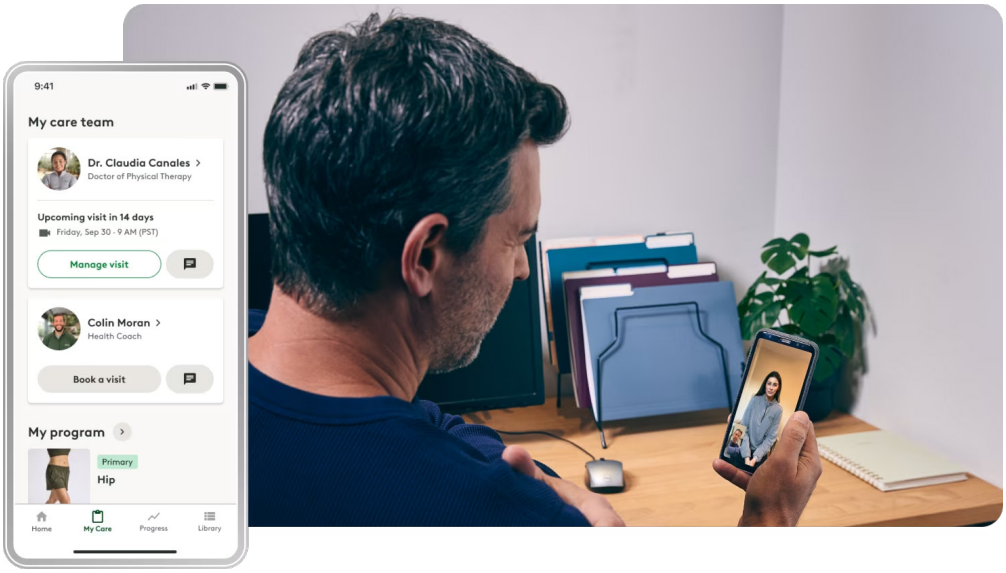
Case Study

Northside Hospital partnered with Hinge Health to expand access to high-quality MSK care through a flexible, digital model that fits into demanding clinical schedules. After one year, they saw an average of:

49%
reduction in pain

66%
reduction in pelvic floor symptoms

3.5x
ROI



Awards, Accolades, and Certifications

- FDA-cleared Enso device
- *Newsweek's* World's Best Digital Health Companies 2024
- 16 peer-reviewed journal articles
- Adoption by 45% of the Fortune 500 and 53% of the Fortune 100
- 5 third-party validated claims studies

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

HITRUST Certified

ISO 27001 Certified

Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)

Business Model and Reimbursement

- Employer-sponsored benefit
- Payer-sponsored
- Health plan offering
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)
- Self-service model (largely independent after setup)

LINUS HEALTH

www.linushealth.com

Linus Health's AI-enhanced digital cognitive assessment platform helps providers detect subtle signs of cognitive decline that may otherwise go undetected for years. Using an evidence-based approach that analyzes how patients complete cognitive tasks—not just the results—our iPad-based platform enables providers to intervene sooner and improve patient outcomes.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

Key Features

- **Advanced digital cognitive assessments:** AI-enhanced automated assessments designed to detect subtle signs of cognitive impairment, with built-in clinical guidance and personalized patient action plans to support next steps.
- **iPad-based testing platform:** A fully digital assessment experience streamlines administration and analysis, replacing manual testing processes with an automated workflow.
- **Clinical decision support and care planning:** Combines evidence-based assessment, reporting, and care planning tools that support cognitive management and aligned reimbursement opportunities.

Benefits

Linus Health clients can:

- Improve operational efficiency
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

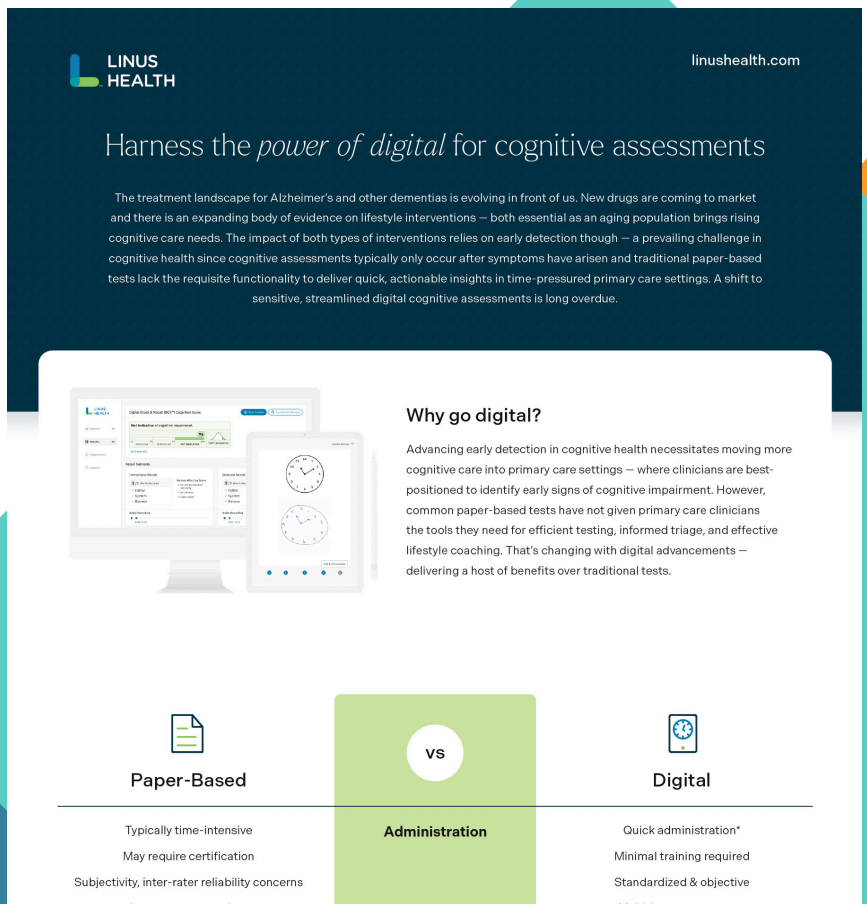
- 500+ assessments completed Q1-Q2 2026.
- Over $2,500 per month increase in billable charges through accurate CPT coding.
- No negative payer trends observed, validating reimbursement consistency.

Clinical Guidelines and Standards

- CMS-aligned programs

Solution Type

- **Diagnostics & Assessments:** Solutions supporting risk assessments, diagnostics, and screening tools.



RESULTS YOU CAN EXPECT

Case Study

A large health system in the Northeast deployed Linus Health's digital cognitive assessment platform. The case study was conducted:

across	and	in
30 clinic sites	**185** providers	**2 weeks** after an initial pilot.

Within a month of launching the platform across their primary care network, the health system conducted more than 1,000 assessments and triaged patients into neurology and care management programs with much greater efficiency than the previous pen-and-paper process.

Awards, Accolades, and Certifications

DiME Seal of Approval

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

FDA Cleared (if applicable)

ISO 27001 Certified

GDPR Compliant

Be your own brain health *advocate*

Did you know? **Nearly half of dementia cases may be preventable** by addressing modifiable risk factors that impact cognitive health. Small changes can make a big difference. Checking in on your brain health now can help you stay healthy for years to come.

Why take a brain health assessment?

As we age, it's normal to experience occasional forgetfulness, but **significant memory or thinking changes are not a normal part of aging.**

What affects brain health?

These modifiable risk factors can impact cognitive health. **The good news?** Many of these risks can be reduced with lifestyle changes, early intervention, and regular health check-ups.

Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Supports bidirectional data exchange

Business Model and Reimbursement

- Medicare reimbursable
- Medicaid reimbursable
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support

medbridge

www.medbridge.com

Medbridge is a hybrid care platform combining home exercise programs, remote therapeutic monitoring, digital MSK pathways, and patient-reported outcomes. It helps health systems engage patients between visits, extend care beyond the clinic, and scale digital care across rehab and MSK service lines.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

WORKFLOW AUTOMATION

CARE COORDINATION

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

Key Features

- **Home Exercise Programs:** customizable programs delivered via print, web portal, or the Medbridge GO app; keeps patients engaged and adherent between visits.
- **Remote Therapeutic Monitoring:** lets care teams enroll patients, monitor activity and symptoms, document, and bill for remote therapeutic monitoring, reducing manual tracking.
- **Digital MSK / Guided Pathways:** progressive, condition-specific programs with assessments, education, and exercises to manage low-to-moderate-acuity patients in independent or hybrid models.
- **Patient-Reported Outcomes:** standardized measures collected digitally to track progress, personalize care, and demonstrate value.
- **EMR-integrated Workflows:** SSO, in-EMR program assignment, automated patient-record creation, and documentation write-back across Epic, Oracle Cerner, athenahealth, NextGen, and Raintree.
- **MyChart Patient Access:** patients reach Medbridge programs directly in MyChart, boosting adherence and supporting MyChart utilization goals.
- **Clinical Education Library:** 2,500+ accredited courses across 15+ disciplines to develop and retain clinical staff.

Benefits

Medbridge clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Improve financial performance
- Support value-based care
- Improve care coordination

Solution Type

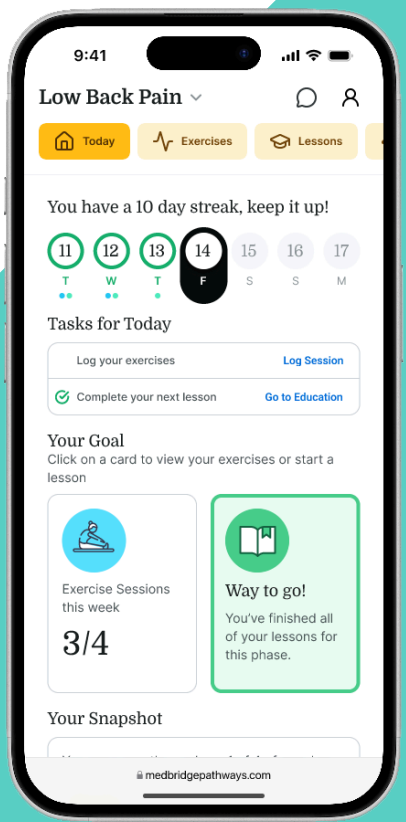
- **Patient Engagement:** Solutions supporting education, communication, patient tools, and engagement platforms.
- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Remote Monitoring and Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.

Measurable Impacts

- 70% of patients report an improvement in pain at 30 days (PROMIS)
- 68% of patients report an improvement in function at 30 days (PROMIS)
- 40% average reduction in pain scores
- 56% average increase in Physical Function
- $1,268 estimated annual healthcare charge reduction for patients with low back pain after just 1 month on Pathways

Clinical Guidelines and Standards

- Evidence-based / peer-reviewed protocols



RESULTS YOU CAN EXPECT

Case Study

19%
improved FOTO* performance (now in the 60th percentile)

15%
reduction in no-shows and cancellations

95%
of Freeman's patients that assigned an HEP** were satisfied with the experience

* Focus on Therapeutic Outcomes
** Home Exercise Program

Awards, Accolades, and Certifications

- 2026 Telly Award - Bronze - General Explainer Branded Content
- 2025 Signal Award Winner - Excellence in Podcasting
- 2024: Better Work Media - Silver Learning in Practice Awards - Excellence in E-Learning
- 2020–2023– MedTech Breakthrough Awards honoring excellence in health and medical technology
- 2020 — Best Patient Portal
- 2021 — Best Digital Health Innovation
- 2022 — Best Overall Patient Engagement Platform Medbridge
- 2023 — Best Remote Patient Monitoring Solution Medbridge

Security, Compliance, and Certifications

- HIPAA Compliant
- HITRUST Certified
- HITRUST CSF Aligned
- GDPR Compliant

Integration and Workflow Fit

- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange

Business Model and Reimbursement

- Health system purchases solution directly
- Employer-sponsored benefit
- Medicare reimbursable

Customer Support and Operating Model

- Onboarding and implementation support
- Ongoing technical support

NEUROFLOW®

www.neuroflow.com

NeuroFlow transforms behavioral health care delivery through comprehensive analytics and technology infrastructure integrated directly into existing EHR workflows. Our solutions enable health systems to proactively identify and stratify behavioral health needs, optimize referral processes, and deliver effective integrated care programs.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

NeuroFlow helps risk-bearing healthcare organizations improve outcomes and reduce costs by surfacing and supporting behavioral health needs that typically go undetected and under-addressed. Our scalable technology and analytics platform provides actionable intelligence that enables payors, providers, and the government organizations to manage populations in a financially sustainable way. Powered by deep expertise in behavioral health and whole-person care, NeuroFlow offers a path to risk predictability and proactive care that helps overcome the systemic challenges in today's healthcare ecosystem.

Benefits

NeuroFlow clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

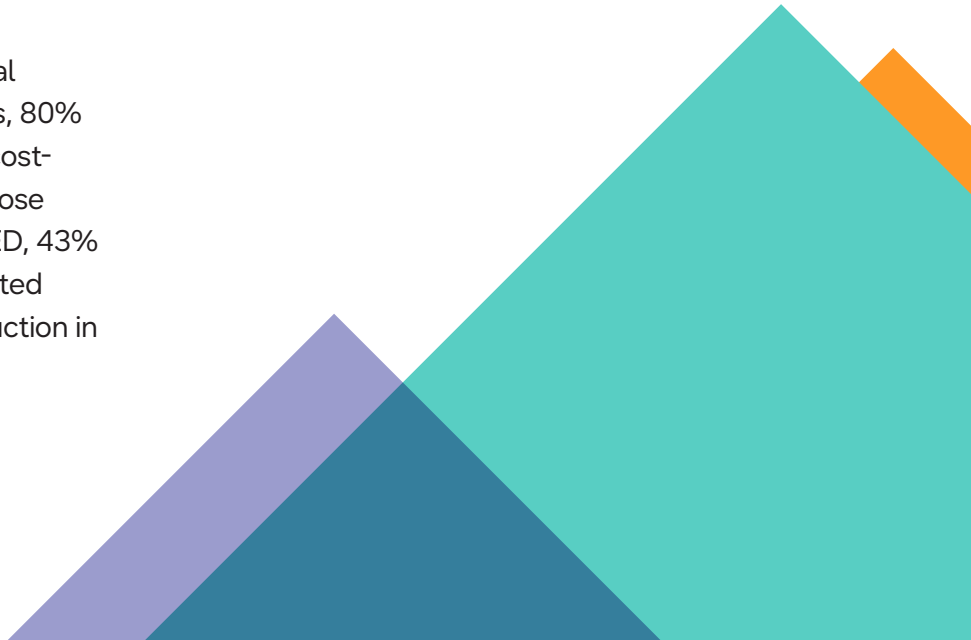
- **Improved Quality & Outcomes:** A large hospital improved its performance and reimbursement for a state quality program by increasing behavioral health assessment compliance 14x after implementing NeuroFlow. Across a health plan's provider network, 7-day follow-up rates after behavioral health ED visits increased 73%.
- **Improved Behavioral Health Access:** Health system patients with access to NeuroFlow's referral management capabilities were 68% more likely to connect with outpatient behavioral health care, with a 36% reduction in days between behavioral health diagnosis and first outpatient visit.
- **Lower Acute Care Utilization:** At a regional health plan and its health system partners, 80% of flagged high-risk patients engaged in cost-effective behavioral health care — and those patients were 33% less likely to visit the ED, 43% less likely to have a behavioral health-related inpatient admission, and drove a $28 reduction in total medical PMPM.

Clinical Guidelines and Standards

- Evidence-based / peer-reviewed protocols

Solution Type

- **Patient Engagement:** Solutions supporting education, communication, patient tools, and engagement platforms.
- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Diagnostics & Assessments:** Solutions supporting risk assessments, diagnostics, and screening tools.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.



RESULTS YOU CAN EXPECT

Case Study

Bergen New Bridge Medical Center, NJ's largest hospital, partnered with NeuroFlow to boost behavioral health screening and Medicaid pay-for-performance revenue. Screening rates jumped from 5.8% to 81.6% in 8 months, exceeding the statewide benchmark. The result:

14x
improvement in P4P compliance

3:1
anticipated ROI

36
at-risk patients identified for suicide intervention in the first three months

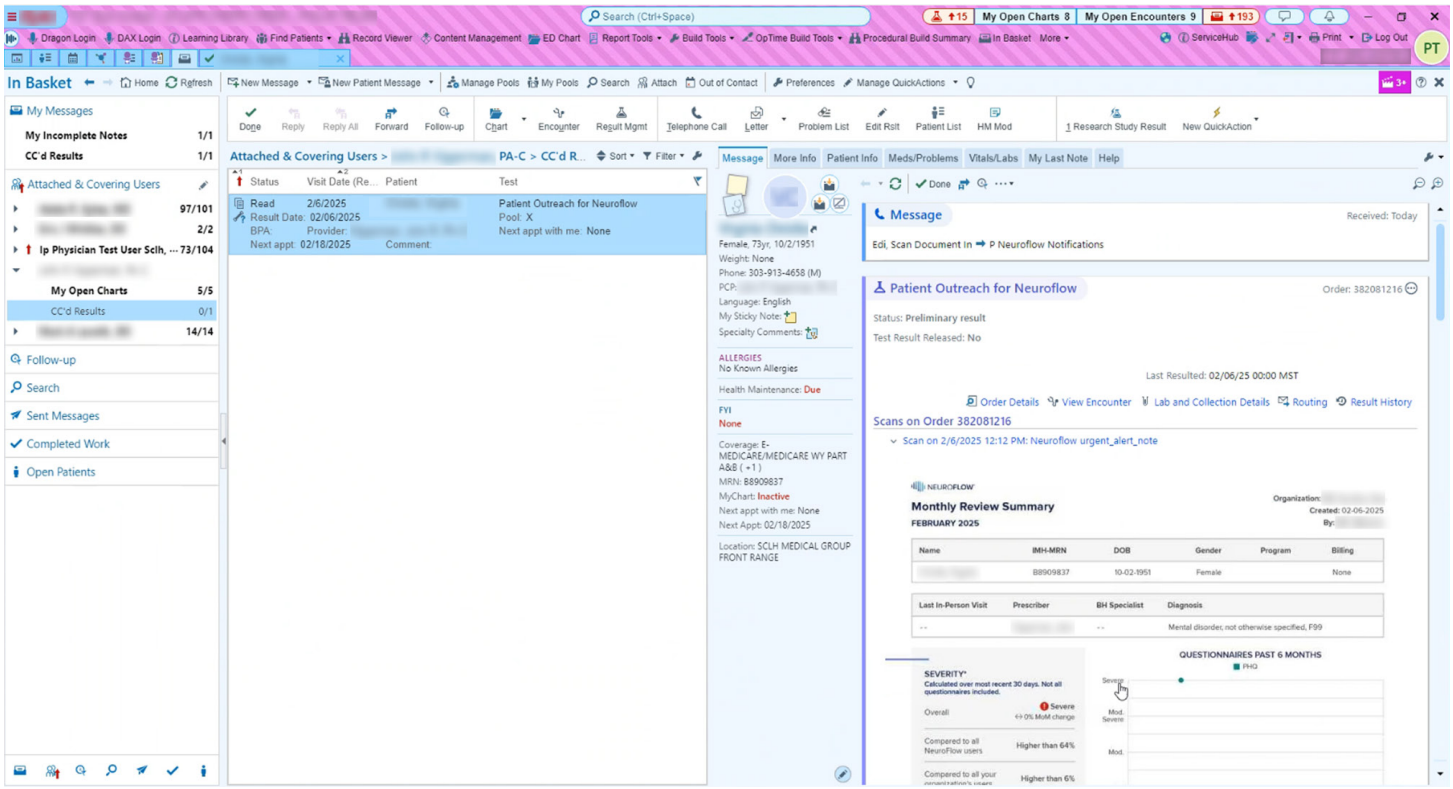
---

Awards, Accolades, and Certifications

- Fierce Healthcare's Fierce 15 of 2026
- Slice of Healthcare's Top 50 Digital Health Leaders 2025
- Time Top Healthcare Companies 2025

Security, Compliance, and Certifications

- **HIPAA Compliant**
- **SOC 2 Type II Certified**
- **HITRUST Certified**
- **HITRUST CSF Aligned**



Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange

Business Model and Reimbursement

- Not reimbursable

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)

patientIQ

www.patientiq.io

PatientIQ is an outcomes intelligence platform that automates patient-reported outcomes collection across health systems, specialty practices, and life science organizations. It turns standardized, comparable data into actionable insight that drives quality improvement, supports value-based care, and operationalizes the patient voice at scale.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

WORKFLOW AUTOMATION

CARE COORDINATION

PATIENT EDUCATION AND CONTENT

Key Features

- **Automated PRO collection in the clinical workflow:** Captures patient-reported outcomes with no added work for clinical staff. Patients are enrolled automatically from electronic health record diagnosis, procedure, or visit data, then surveyed by text or email at the right points in their care.
- **Outcomes visibility at the point of care:** Surfaces patient-reported outcome results in the EHR and in the embedded monitor view, so care teams can track progress and act without leaving their workflow.
- **Intelligent patient engagement:** Keeps patients on track with automated, configurable reminders, reducing manual follow-up for administrators and operations teams.
- **Procedure-specific patient education:** Delivers condition-matched education alongside surveys to improve patient adherence and engagement.
- **Reporting and registry submission:** Captures, aggregates, and exports outcomes data in registry-ready formats to support CMS quality reporting and value-based care, easing the burden on quality and compliance teams.
- **Benchmarking and outcomes analytics:** Normalizes outcomes data and compares it against national benchmarks and peer organizations, giving clinical leaders trustworthy context.
- **Deep EHR interoperability:** Integrates with Epic, Cerner, and 50+ EHR systems through established interfaces, fitting existing systems rather than requiring workarounds.

Benefits

PatientIQ clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Improve financial performance
- Support value-based care

Measurable Impacts

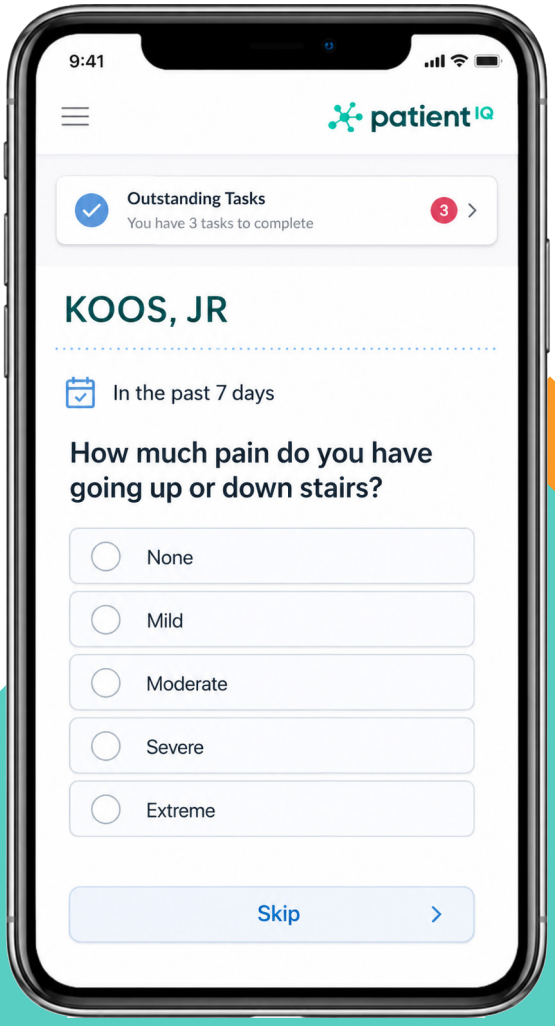
- $2.9M saved by one health system that automated registry participation across 400 surgeons, versus a traditional in-house build
- Live on registry data collection in 60 days, with 1,500+ patients enrolled in the first week
- Baseline patient-reported outcomes collection of 80%, exceeding what manual or EHR-embedded tools typically achieve
- 64M+ patient outcomes collected, 16M+ patients enrolled, and 2.5M+ patients engaged monthly
- Live across 850+ healthcare organizations, 27,000+ providers, and 12,000+ sites of care

Clinical Guidelines and Standards

- CMS-aligned programs

Solution Type

- **Patient Engagement:** Solutions supporting education, communication, patient tools, and engagement platforms.
- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Diagnostics & Assessments:** Solutions supporting risk assessments, diagnostics, and screening tools.



RESULTS YOU CAN EXPECT

Case Study

A major U.S. health system used PatientIQ to earn Blue Distinction for spine surgery, automating American Spine Registry reporting and outcomes collection across 400 surgeons.

PatientIQ went live in

60 days

Enrolling

1,500+

patients in the first week with no manual data abstraction or custom EHR build

The result:

$2.9M

saved versus a traditional in-house approach, plus the alignment to qualify for Blue Distinction

Awards, Accolades, and Certifications

Industry Awards:

- Inc. 5000 #910 — Fastest-Growing Private Companies in America (2025, debut appearance)
- MedTech Breakthrough Award — "Best Patient Experience Solution," 7th Annual (2023, selected from 4,000+ nominations across 17 countries)
- Chicago Innovation Award — 21st Annual (2022, recognized from 365 nominees)

Registry & Industry Partnerships:

- Official technology partner: American Spine Registry (ASR)
- Official registry partner: American Academy of Orthopaedic Surgeons (AAOS)
- Official registry partner: American Association of Neurological Surgeons (AANS)

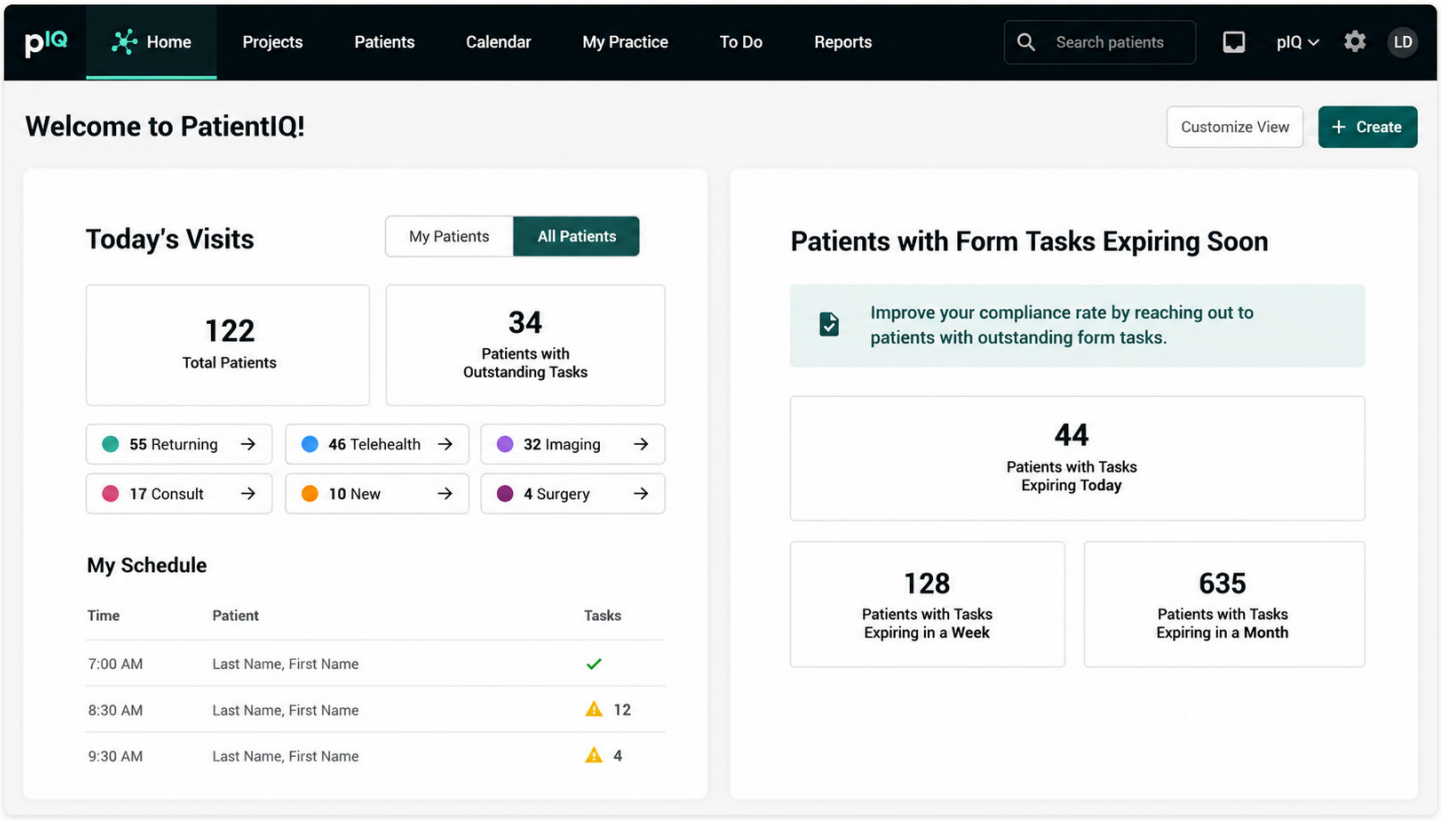
Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

HITRUST Certified

ISO 27001 Certified



Integration and Workflow Fit

- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange

Business Model and Reimbursement

- Not reimbursable

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support

Rula

www.rula.com

Rula delivers high-quality, evidence-based behavioral health care through a national network of 23,000+ credentialed providers, with a one-day median time to first appointment and 71% of patients demonstrating clinically meaningful improvement. With seamless integration into health system referral workflows, Rula helps connect patients to timely behavioral health services and improve outcomes.

Solution Capabilities

ANALYTICS AND INSIGHT

WORKFLOW AUTOMATION

CARE COORDINATION

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

Key Features

- **Rapid referral and care coordination:** Providers and care coordinators refer patients directly to the Rula network, eliminating manual referral coordination and reducing time-to-care to a 1-day median.
- **Epic-integrated referral workflows and closed-loop communication:** Clinicians have visibility into referral status, appointment confirmation, and clinical notes within their existing electronic health record (EHR) workflow, restoring care continuity and eliminating the "referral black hole" that drives provider frustration.
- **Credentialed national provider network of 23,000+ behavioral health clinicians:** Health systems and patients have access to therapists, psychiatrists, and psychiatric nurse practitioners across all 50 states, with broad payer coverage and specialty matching to ensure clinically appropriate care.
- **Measurement-informed care with validated outcomes tracking:** Supports clinical quality improvement and HEDIS performance by tracking PHQ-9 and GAD-7 scores across the patient population, with 73% of Rula patients demonstrating clinically meaningful improvement.
- **Patient-provider matching engine for appropriate clinical fit:** Patients are paired with providers based on clinical need, specialty, modality, language, and demographic preferences, increasing engagement rates and reducing dropout in the critical first weeks of care.
- **Referral analytics and population health reporting:** Operational leaders and population health teams gain visibility into referral volume, conversion rates, time-to-care, and outcome trends, supporting VBC contract performance and continuous workflow improvement.
- **Multi-modal care delivery, including therapy and medication management:** Patients access care through virtual therapy, in-person therapy, psychiatric medication management, and hybrid care models, allowing health systems to address the full spectrum of behavioral health needs from mild anxiety to complex psychiatric conditions.

Benefits

Rula clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Strengthen the digital front door
- Support value-based care
- Improve care coordination

Measurable Impacts

- **Speed to Care:** 1-day median time to first appointment for patients referred into Rula's network, compared to the 4-6-week industry standard for behavioral health access.
- **Symptom Improvement:** 71% of patients demonstrate clinically meaningful symptom improvement as measured by PHQ-9 and GAD-7 score reduction, supporting HEDIS measure performance for Depression Screening, Antidepressant Medication Management, and Follow-Up After Hospitalization for Mental Illness.
- **Clinical Engagement:** Rula achieves unmatched patient continuity within our virtual provider group, where 90% successfully complete their second clinical appointment, 82% of patients progress to complete a third appointment, and 93% of patients report strong therapeutic alliance with their provider,
- **Cost Mitigation:** Connecting patients to timely outpatient behavioral care provides significant downstream financial protection for health system risk-bearing entities, showing an average total medical spend reduction of up to $2,500 per person over 15 months.

Clinical Guidelines and Standards

- CMS-aligned programs
- Evidence-based / peer-reviewed protocols

Solution Type

- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.

RESULTS YOU CAN EXPECT

Case Study

At Stanford Health Care, Rula partners with Xealth to integrate within existing workflows to solve the behavioral health referral bottleneck. By connecting clinicians to a network of more than 23,000 in-network providers, primary care teams seamlessly route patients to personalized behavioral health solutions.

This infrastructure delivers appointments in less than

48 hours

Ensuring

90%

of individuals successfully complete their follow-up care.

Awards, Accolades, and Certifications

"Best Virtual Care Solution" Award (May 2026): Rula Health was named the winner of this category in the 10th Annual MedTech Breakthrough Awards. The independent market intelligence program selected Rula for its innovative digital platform, clinical quality frameworks, and focus on delivering measurable, long-term mental health outcomes.

Security, Compliance, and Certifications

HIPAA Compliant

Rula

Patient Name: S. Testpatient

DOB: 03/1998

Referrer Name: Mira Salama

First Visit Date: 04/01/2024

Provider Name: Araiza Fuentes,Paola

Next Visit Date: 03/07/2025

Primary Diagnosis Category: Depressive Disorders

Primary Diagnosis: Major Depressive Disorder, Single Episode, Moderate

Baseline PHQ-9 Score: 24.0

Baseline GAD-7 Score: 21.0

Current Medications: Wellbutrin XL 150 mg oral tablet extended release 24 hr (Take 1 oral tablet every morning x 7 days then discontinue), fluoxetine 10 mg oral capsule (Take 1 oral capsule every morning x 7 days (take with 20mg capsule -own supply)), fluoxetine 20 mg oral capsule (Take 1 oral capsule every morning), Wellbutrin XL 300 mg oral tablet extended release 24 hr (Take 1 oral tablet every morning), fluoxetine 40 mg oral capsule (Take 1 oral capsule every morning- Start after completing 7 days on lower dose)

Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange
- Operates alongside clinical workflow (not embedded)

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)

Business Model and Reimbursement

- Medicare reimbursable
- Medicaid reimbursable
- Covered by commercial insurance

SeamlessMD

www.seamless.md

SeamlessMD is a digital care journey platform that digitizes patient care through automated education, reminders, symptom monitoring, and remote follow-up. The platform is backed by 40+ clinical studies and evaluations and integrates with Epic, Oracle Health, and MEDITECH, including support for MyChart Care Companion.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

- **Broad care plan library:** 75-plus customizable, pre-built care plans covering 150-plus conditions and surgical procedures—including orthopedics, cardiology, women's health, oncology, mental health, and more
- **MyChart-ready content:** Care plan content also available for use in MyChart Care Companion (Epic's only Toolbox partner)
- **Automated patient guidance:** SMS, email, and in-app reminders that guide patients through evidence-based education and daily to-dos, reducing no-shows and improving surgery or treatment preparation
- **Real-time monitoring:** Remote monitoring dashboards and alerts that surface patient-reported vitals, symptoms, side effects, and health status changes so clinicians can intervene earlier
- **Structured outcomes data:** Patient-reported outcome measures (PROMs) and survey collection give care teams longitudinal data on recovery and treatment response
- **Workflow integration:** Turn-key, validated integrations with Epic (including MyChart), Oracle Health (Cerner), and MEDITECH, embedding SeamlessMD directly into existing clinical workflows
- **Outcome reporting:** Analytics and reporting dashboards with configurable, ready-to-use reports for population-level and program-level outcomes tracking

Benefits

SeamlessMD clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Strengthen the digital front door
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

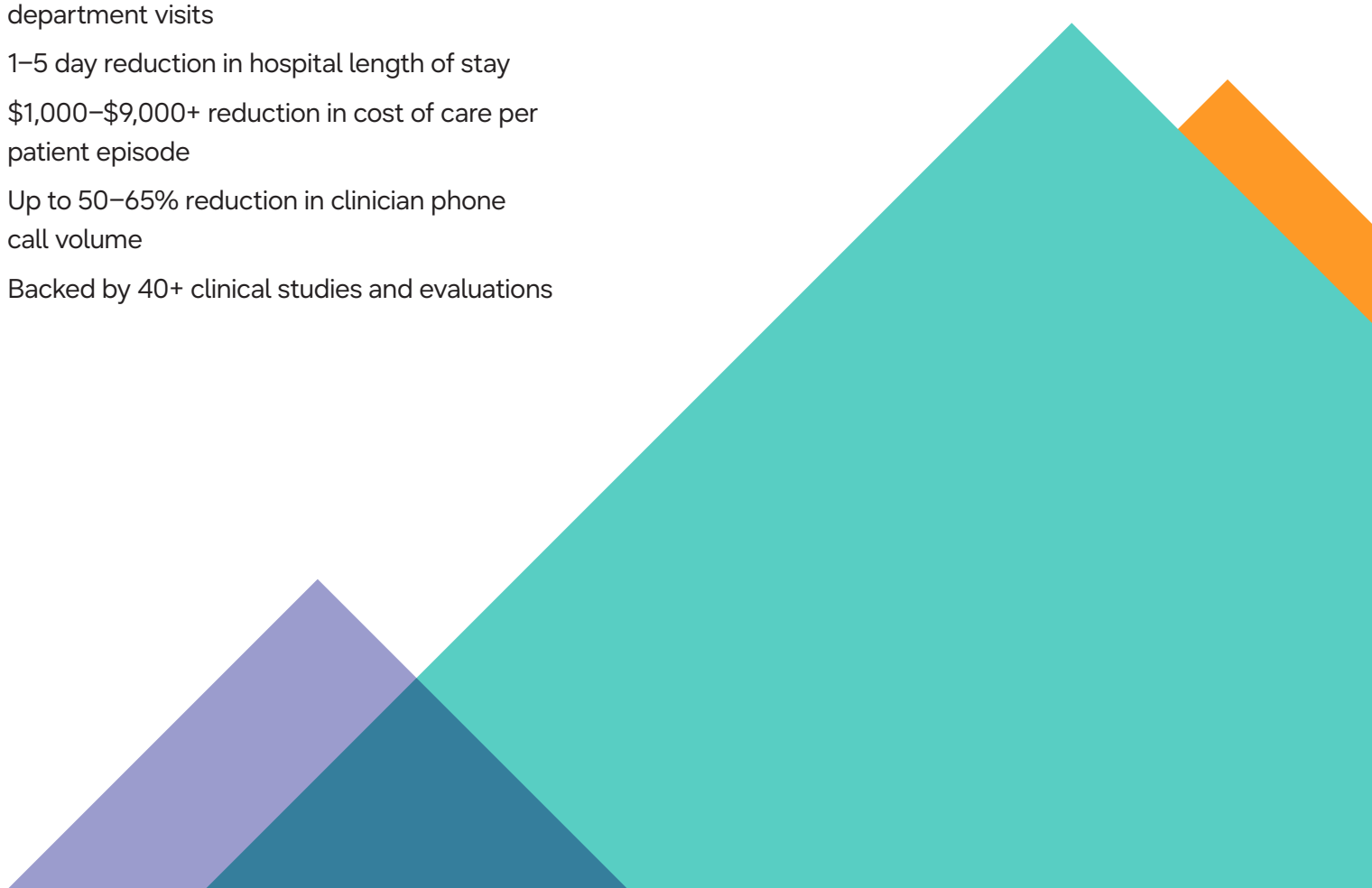
- Up to 89% reduction in hospital readmissions
- 68% to 72% reduction in emergency department visits
- 1–5 day reduction in hospital length of stay
- $1,000–$9,000+ reduction in cost of care per patient episode
- Up to 50–65% reduction in clinician phone call volume
- Backed by 40+ clinical studies and evaluations

Clinical Guidelines and Standards

- Evidence-based / peer-reviewed protocols

Solution Type

- **Patient Engagement:** Solutions supporting education, communication, patient tools, and engagement platforms.
- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.



RESULTS YOU CAN EXPECT

Case Study

University of Rochester Medicine, an eight-hospital academic health system, deployed SeamlessMD for use in hypertension, heart failure (CHF), urology biopsy, endoscopy, colorectal cancer screening, COPD, and stroke programs. SeamlessMD was fully integrated with Epic and MyChart.

In its hypertension program, patients with elevated baseline blood pressure saw a

12.07 mmHg

average drop in systolic blood pressure

5.73 mmHg

average drop in diastolic blood pressure

20%

increase in readings in target range

Awards, Accolades, and Certifications

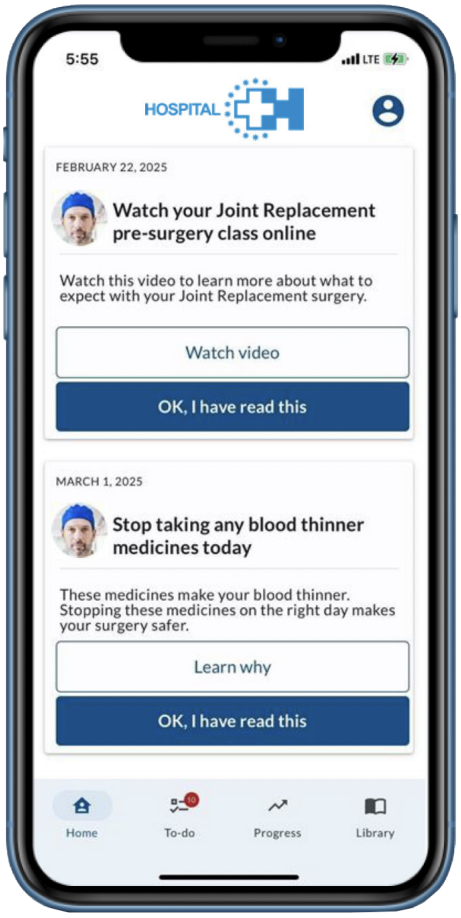
Ranked #1 solution to Improve Outcomes in the KLAS Emerging Solutions Top 20 Report (2023) — the only solution ranked in the top 5 across all four Quadruple Aim categories

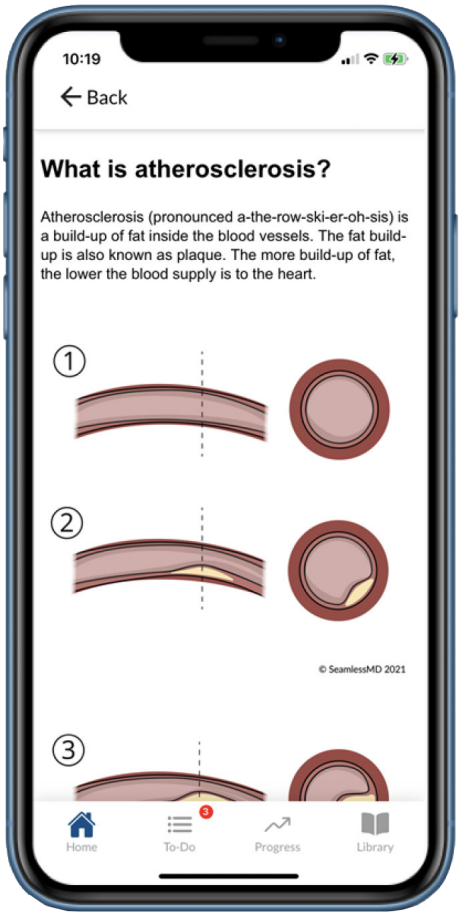
Named a Top-Rated Remote Patient Monitoring Company by AVIA Marketplace, two years running (2022–2023), ranking across all categories: Top Rated Features, Customer Support, Integrations, and Ease of Use

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified





Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support

Business Model and Reimbursement

- Not reimbursable

Stel

www.stel.life

The Vitals Hub transmits patient measurement data via a cellular connection directly into clinical workflows, including native integration with Electronic Health Records (EHRs) via platforms such as Xealth. This makes Stel uniquely suited for elderly, rural, and digitally underserved patient populations who are most likely to fall out of traditional remote patient monitoring programs due to technical friction.

Critically, the Stel Hub is designed as a non-protected health information (PHI) device. It captures and transmits only measurement values. It does not store or process PHI on the device itself, maintaining a strong privacy-first posture in line with HIPAA requirements.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

PATIENT EDUCATION AND CONTENT

Key Features

- Multimodal agentic AI platform combining observation, documentation, voice, and workflow orchestration across the full care continuum, enabling clinicians to automate high-burden tasks without leaving existing workflows
- Native EHR integration with Epic, Oracle Health, and 15+ other platforms, enabling seamless clinical workflow embedding without separate logins or manual data entry
- Virtual nursing capabilities that extend bedside care capacity, reduce documentation burden, and drive earlier discharges, addressing workforce shortages without requiring additional hiring
- Remote Patient Monitoring (RPM) supports chronic disease management for congestive heart failure, chronic obstructive pulmonary, diabetes, and hypertension, with automated patient outreach and billing support.

Benefits

Stel clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Expand access to care
- Strengthen the digital front door
- Improve financial performance
- Improve care coordination

Measurable Impacts

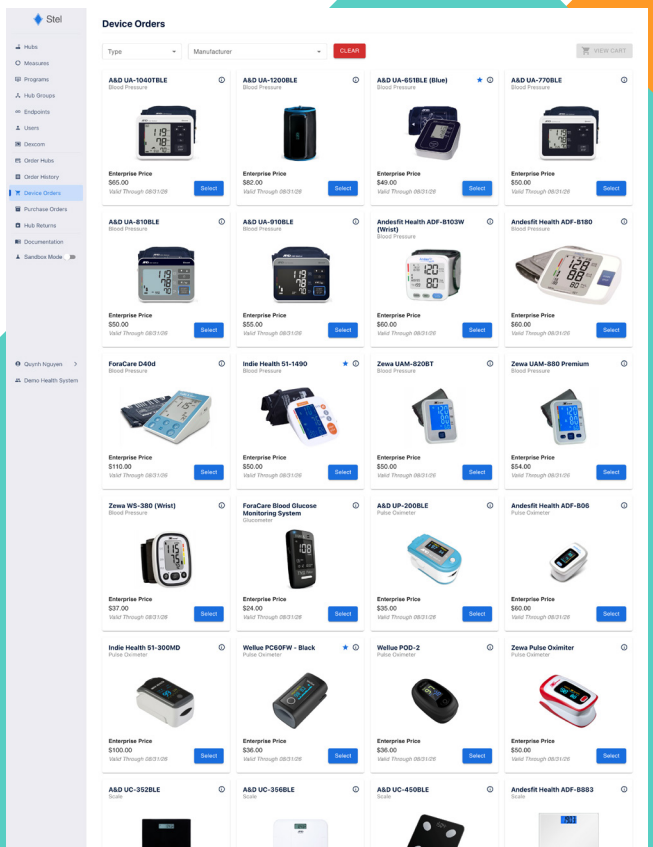
- $412,472 in direct cost savings and 376 hospital days saved across a 56-patient post-discharge hospital-at-home pilot, with 88% of patients successfully weaning off oxygen by follow-up.
- 11,000+ patients at Lehigh Valley Health Network (LHVN) transmit millions of vitals into Epic flowsheets — no app, no Wi-Fi, no tech support required.
- 92% patient retention rate at Tampa General Hospital, alongside resolution of more than 1,200 medication discrepancies.
- 3x more results submitted by LVAD patients using the Stel Hub versus traditional self-reporting (phone/email/portal), with measurable reductions in transcription errors and staff workload (ODI/DiMe V3+ validated).
- $20M PCORI-funded Yale Pressure Check study integrated Stel as its home monitoring backbone, targeting hypertension equity in minority and low-income communities across multiple sites.

Clinical Guidelines and Standards

- CMS-aligned programs
- American Diabetes Association (ADA) guidelines
- American Heart Association (AHA) guidelines
- Evidence-based / peer-reviewed protocols

Solution Type

- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.



RESULTS YOU CAN EXPECT

Case Study

Over **11,000** LVHN patients transmitted millions of vitals without needing app stores, Wi-Fi, or tech literacy; they simply measured near a Stel Hub and the data appeared directly in their flowsheets. LVHN also integrated continuous glucose monitoring into Epic EHR workflows as part of this connected care rollout.

Tampa General Hospital achieved a **92% patient retention rate** using Stel's RPM program and resolved more than 1,200 medication discrepancies.

Orthodynamics Company (ODI) deployed the Stel Vitals Hub for left ventricular assist device (LVAD) patients requiring weekly prothrombin time/international normalized ratio home monitoring. Patients using the Hub submitted over 3 times the number of results compared to those using traditional self-reporting methods (phone, email, or portal entry). The study found the Hub reduced patient and staff workload, supported timely testing compliance, and eliminated transcription errors.

https://aws.amazon.com/blogs/industries/stel-lifes-integrated-connected-care-empowers-healthcare-providers/

Awards, Accolades, and Certifications

University of California, San Francisco / Digital Health Hub Foundation - 2022 Rising Star

Consumer Electronics Show 2023 - Featured Digital Health Success Story

Stel Life was featured as a CES Success Story in 2023, gaining direct access to digital health trailblazers and showcasing the full range of its wireless RPM system.

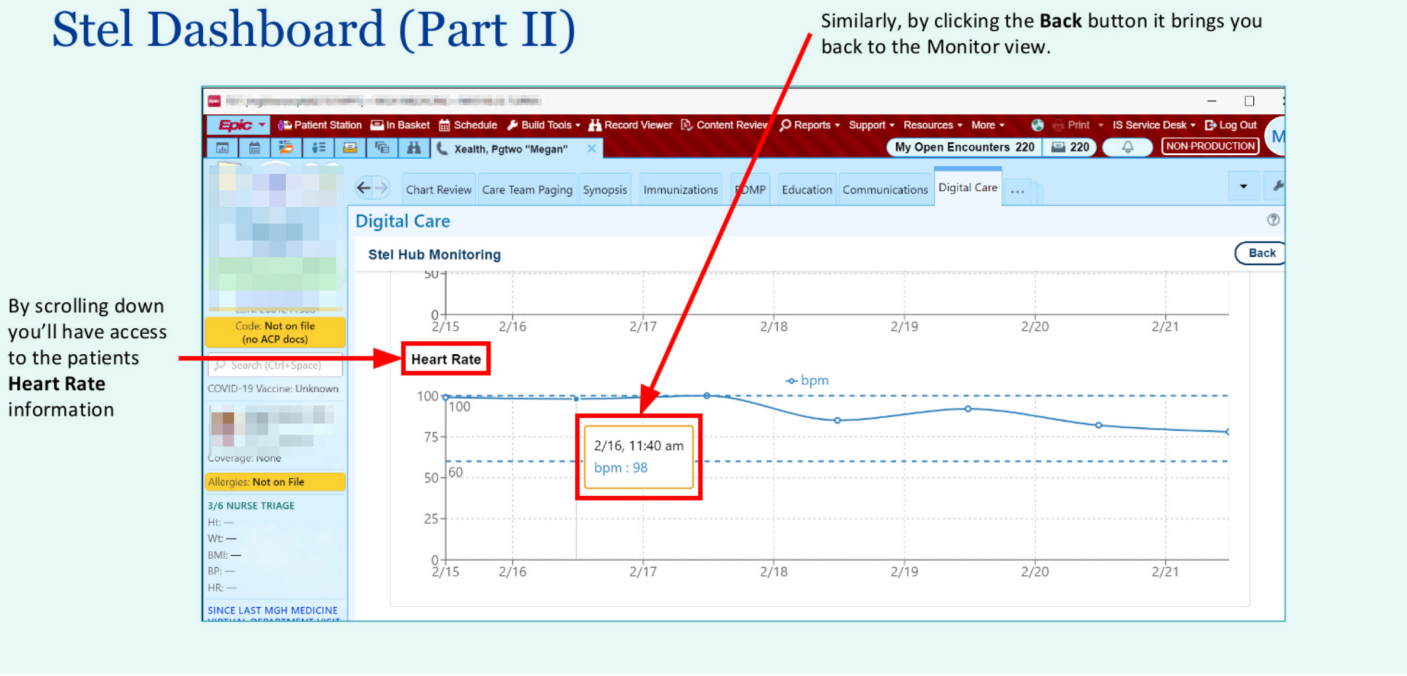
Stel Life is an official Amazon Web Services (AWS) Partner, recognized for building its connected care solution on AWS infrastructure.

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

Stel Dashboard (Part II)



Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)

Business Model and Reimbursement

- Not reimbursable

Customer Support and Operating Model

- Onboarding and implementation support
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)

TIDEPOOL+

www.tidepool.org

Tidepool+ is a clinical diabetes management platform that aggregates data from 90+ devices into Electronic Health Record (EHR)-integrated workflows via Xealth. Our TIDE Dashboard surfaces at-risk patients for proactive outreach, while built-in remote patient monitoring billing support ensures the care teams deliver is recognized and reimbursed.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

POPULATION HEALTH MANAGEMENT

Key Features

- **TIDE Dashboard:** Surfaces patient risk stratifications (hypoglycemia, time in range (TIR) drops, high glucose, low CGM wear) so care teams can prioritize outreach across a full panel rather than reviewing patients one by one.
- **EHR Integration:** Embeds in-context patient data directly into over 90 EHRs and Xealth-integrated systems, reducing portal switching and supporting documentation at the point of care.
- **RPM Billing Support:** Captures reimbursable remote monitoring activity within existing clinical workflows, enabling revenue capture without added administrative burden.
- **90+ Device Connections:** Aggregates continuous glucose monitoring, pump, and blood glucose monitoring data from major diabetes device manufacturers into a single view, eliminating manual data collection.
- **Population Health Workflows:** Enables team-based, proactive care across large patient panels with tagging, outreach tracking, and cohort-level visibility between visits.
- **Summary Reports & Discrete Data:** Generates ambulatory glucose profile-standard reports and structured data outputs for provider review, patient education, and documentation.
- **Dedicated Implementation Partnership:** Each customer receives a Clinic Success Manager, custom onboarding, and ongoing support — backed by HIPAA compliance, SOC 2 Type II, and ISO 13485:2016 certification.

Benefits

Tidepool clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Expand access to care
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

- 1.1% A1c reduction and 8.8% increase in TIR in the Stanford 4T Study for new onset pediatric patients (Kim et al., *npj Digital Medicine*, 2024)
- 147% increase in clinic capacity through workflow efficiencies (Ferstad et al., *Pediatric Diabetes*, 2021)
- 86% reduction in provider screen time (Scheinker et al., *NEJM Catalyst*, 2022)
- 1.59% A1c reduction and 13.4% increase in TIR in a community health center diabetes care management program using CGM + RPM (Reddy et al., ADA 2026, submitted)
- 89.5% of patients highly engaged with CGM data in the same community health setting

Clinical Guidelines and Standards

- National Committee for Quality Assurance (NCQA)
- CMS-aligned programs
- American Diabetes Association (ADA) guidelines
- Evidence-based / peer-reviewed protocols

Solution Type

- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.

RESULTS YOU CAN EXPECT

Case Study

A federally qualified health center implemented Tidepool+ as the foundation of a structured diabetes care management program, integrating CGM and RPM for an underserved patient population.

Care teams used the TIDE Dashboard to monitor patients between visits, identify those falling out of range, and coordinate timely outreach — replacing reactive, visit-driven care with a proactive, population-based model.

Results:

1.59%
reduction in A1c

13.4%
increase in TIR

89.5%
of patients highly engaged with their CGM data (defined as reviewing glucose readings more than 5 times per day)

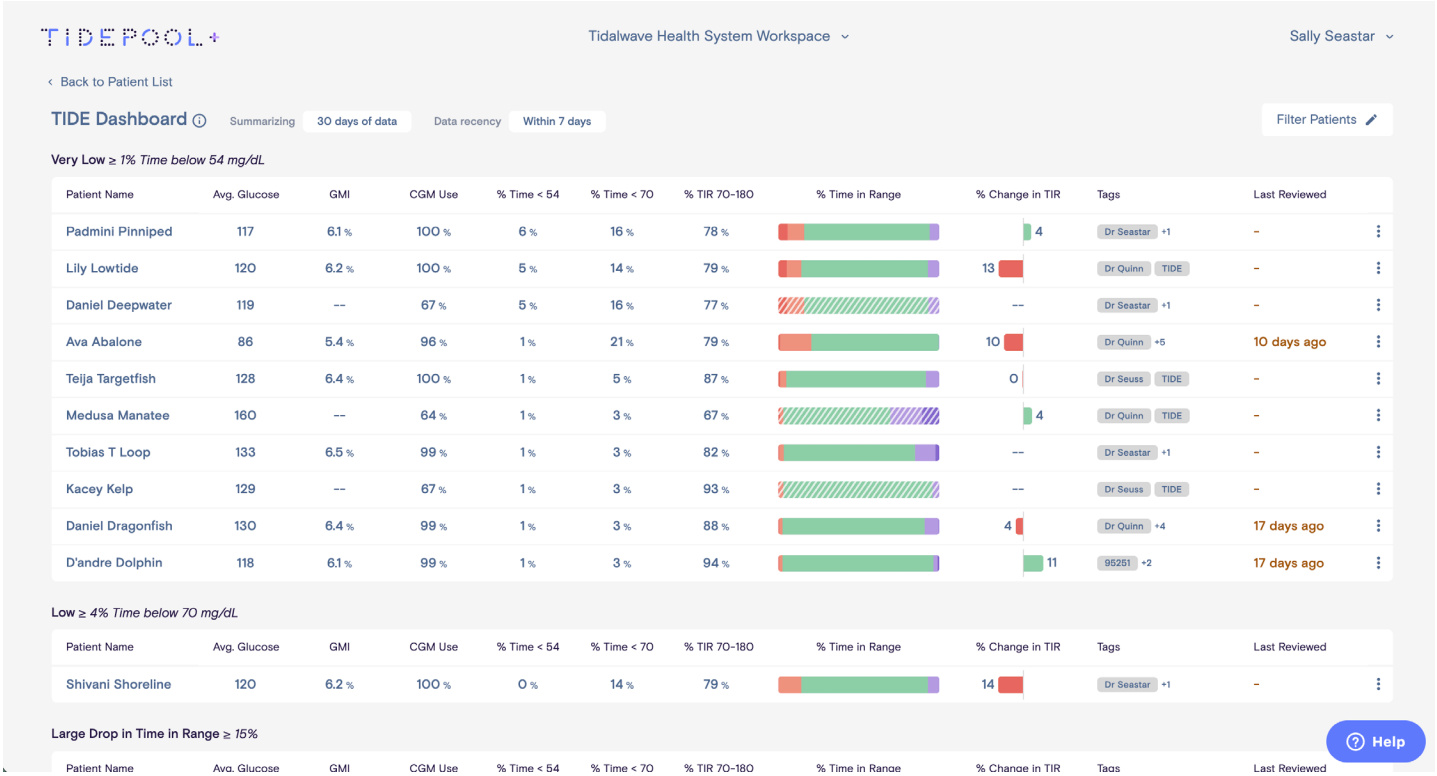
The program demonstrated that connected, data-driven diabetes care is achievable across diverse populations — not just in academic medical centers. High patient engagement alongside meaningful clinical improvement points to a model that works both for the care team and the people they serve.

Source: Reddy S, Henry K, Heidenreich M, Lucas SA, Reddy S. Using CGM and RPM in Safety Net Clinics: Feasibility and Impact. Submitted abstract, American Diabetes Association 86th Scientific Sessions, 2026.

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified



Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)

Business Model and Reimbursement

- Medicare reimbursable
- Medicaid reimbursable
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support

VeeOne HEALTH

www.veeonehealth.com

VeeOne Health delivers a "Virtual Care-as-a-Service" platform that bridges the gap between acute hospital settings and longitudinal post-acute care. By unifying RPM and subcapitated workflows natively within the EHR, we eliminate time-tracking and reduce readmissions and length of stay to optimize value-based revenue.

Solution Capabilities

DATA COLLECTION

ANALYTICS AND INSIGHT

BIDIRECTIONAL COMMUNICATION

DEVICE INTEGRATION

WORKFLOW AUTOMATION

CARE COORDINATION

CLINICAL DECISION SUPPORT

PATIENT EDUCATION AND CONTENT

PATIENT SELF-MANAGEMENT TOOLS

POPULATION HEALTH MANAGEMENT

Key Features

- **Enterprise Virtual Care Across the Continuum:** Unlike point solutions focused on a single care setting, VeeOne Health's Virtual Care-as-a-Service (VCaaS) platform connects acute hospital workflows with longitudinal post-acute care. A single platform supports inpatient virtual care, specialty consults, Hospital at Home, and remote patient monitoring across the enterprise.
- **Native EHR Integration & Clinical Workflow:** VeeOne Health integrates remote monitoring data, alerts, and clinical documentation directly into enterprise EHRs, helping care teams work within their existing clinical workflow. Bidirectional integration reduces reliance on separate applications while supporting care coordination and documentation.
- **Hospital at Home Infrastructure:** The platform provides the clinical infrastructure to support CMS Acute Hospital Care at Home programs, combining continuous biometric monitoring, scheduled virtual rounding, and 24/7 clinical escalation. Hospitals can extend acute-level care into the home while maintaining coordinated oversight.
- **Value-Based Care & APCM Automation:** VeeOne Health automates key operational requirements for value-based care programs, including CMS Advanced Primary Care Management (APCM). Built-in workflows support care transitions, SDOH screening, remote monitoring, and revenue optimization while reducing manual administrative work.
- **Intelligent Monitoring & Clinical Escalation:** Continuous physiologic monitoring and automated clinical alerting help identify early signs of patient deterioration. Integrated escalation workflows and secure virtual communication enable timely intervention across inpatient and post-acute care settings.
- **Cellular-Enabled Connected Care:** Integrated 5G and IoT connectivity allows monitoring devices to function without patient-owned Wi-Fi or smartphone pairing. Out-of-the-box connectivity supports reliable data collection, virtual communication, and patient engagement across diverse care settings.

Benefits

VeeOne clients can:

- Improve operational efficiency
- Reduce clinician burden
- Improve patient engagement
- Improve patient outcomes
- Enhance patient experience
- Expand access to care
- Support service line growth
- Strengthen the digital front door
- Improve financial performance
- Support value-based care
- Support population health management
- Improve care coordination

Measurable Impacts

By bridging the gap between acute and post-acute longitudinal workflows, our platform yields measurable impact across four core pillars:

Financial Performance & Value-Based Revenue Optimization

- 4.5x return on investment: Independent health systems deploying our capitated Advanced Primary Care Management and Remote Patient Monitoring "code-stacking" workflows generate substantial net-new revenue streams without incurring additional clinical staffing overhead.

Acute Care Utilization & Total Cost of Care Reduction

- 28% reduction in 30-day hospital readmissions: By providing continuous 24/7 care team access, automated transition tracking, and proactive remote physiological monitoring, we successfully stabilize high-acuity chronic disease panels post-discharge.
- 18% decrease in avoidable emergency department visits: High-fidelity, cellular-backed biometric data streams catch physiological decompensation early, allowing clinical staff operating under general supervision to intervene before a crisis occurs.
- Average 12.4 mmHg drop in systolic blood pressure: Longitudinal data across high-risk hypertensive panels demonstrated an average reduction of 12.4 mmHg in systolic pressure and 6.2 mmHg in diastolic pressure within the first 6 months of continuous physiological data tracking.

Operational Efficiency & Clinician Time Reclamation

- 2.5 minutes saved per patient alert review: Deep bidirectional enterprise EHR integration eliminates siloed third-party software logins, allowing clinical staff to review alerts, update care plans, and complete documentation within their daily charting workspace.

Patient Onboarding, Access, and Clinical Engagement

- 92% active patient compliance rate: Utilizing out-of-the-box 5G/IoT cellular connectivity bypasses the technical friction of patient-owned Wi-Fi or smartphone pairing, dropping device abandonment rates to less than 8%.

Clinical Guidelines and Standards

- CMS-aligned programs
- ADA (American Diabetes Association) guidelines
- AHA (American Heart Association) guidelines
- USPSTF guidelines
- Evidence-based / peer-reviewed protocols

Solution Type

- **Patient Engagement:** Solutions supporting education, communication, patient tools, and engagement platforms.
- **Care Management:** Solutions supporting care coordination platforms, care pathways, and workflow optimization.
- **Specialty Programs:** Solutions supporting condition-specific digital care programs.
- **Diagnostics & Assessments:** Solutions supporting risk assessments, diagnostics, and screening tools.
- **Remote Monitoring & Virtual Care:** Solutions supporting remote patient monitoring, virtual care delivery, or device-connected monitoring.

RESULTS YOU CAN EXPECT

Case Study

A major health system deployed VeeOne Health via Xealth to manage patients with chronic disease directly within the EHR workflow. The remote patient monitoring program successfully captures and reports daily weights to the care team, allowing them to identify early fluid retention and intervene earlier. This seamless integration reduced avoidable readmissions and helped save an average of $1,400 per patient. Following this program rollout, the same system expanded to power the in-hospital virtual care continuum. By unifying inpatient specialist workflows, acute virtual rounding, and care-at-home models, the system achieved comprehensive care coordination, reduced total cost of care, and streamlined post-acute transitions.

Awards, Accolades, and Certifications

Frost & Sullivan North American Entrepreneurial Company of the Year Award for Transformational Healthcare: VeeOne Health was commended as an industry pioneer for its suite of physician-led technologies, which successfully address systemic gaps in legacy telehealth and care coordination platforms, and interoperability.

Intel Technology Collaboration Highlight: Recognized as a key ecosystem partner alongside Intel for pioneering high-acuity, agile inpatient virtual healthcare deployments in leading national networks (such as Banner Health) to optimize critical care resource allocation.

Gartner Market Recognition: Gartner—the world's leading research and advisory firm—recognized VeeOne Health's comprehensive Virtual Care-as-a-Service architecture, highlighting the platform's ability to successfully deliver end-to-end, enterprise-scale longitudinal care and high-bandwidth IoT interoperability across health system networks. This placement highlights VeeOne Health's operational maturity, architectural flexibility, and readiness to help risk-bearing healthcare organizations transition seamlessly from legacy time-tracking tools to sub-capitated, automated advanced care models.

Security, Compliance, and Certifications

HIPAA Compliant

SOC 2 Type II Certified

ISO 27001 Certified

Integration and Workflow Fit

- Prescribed and managed within the Xealth platform
- Data and insights returned to clinical workflows (e.g., EHR, dashboards)
- Supports bidirectional data exchange

Business Model and Reimbursement

- Medicare reimbursable
- Medicaid reimbursable
- Covered by commercial insurance

Customer Support and Operating Model

- Onboarding and implementation support
- Dedicated customer success manager
- Ongoing technical support
- Clinical program support (e.g., nurses, coaches, care teams)
- Self-service model (largely independent after setup)

A better way to discover and deploy digital health solutions

The Xealth Connection Community helps health systems identify, evaluate, and implement trusted digital health solutions. With a curated ecosystem of partners already integrated with the Xealth platform, organizations can move faster and make more confident decisions.

Focus on what matters most

Solutions aligned to your top priorities

Evaluate with ROI in mind

Clear value across outcomes, efficiency, and experience

Deploy faster

Pre-integrated solutions, live in weeks

Decide with confidence

Transparent capabilities and real-world results

Join the Xealth Connection Community

www.xealth.com/company/partners/