Ziegler Link·age Funds

Ziegler·Linkage Fund Family

Active portfolio company profiles

Ziegler Link·age Funds

All Current Portfolio Companies

Aaniie
Formerly Smartcare Software

Access
TeleCare

Alix

arena

At Home
Harmony

BLUESTAR
TELEHEALTH

Bluestone

Cascala

COACHCARE

cosán

CURANA
HEALTH

embodied
labs®

K4 CONNECT

LainaHealth

LifeSite
Life's Information. All in One Place.

Lifespark

MyTown
HEALTH PARTNERS

payactiv

PRECISE
BEHAVIORAL

PS
SALON & SPA

SEASON

shiftkey
+
OnShift

SOCIALLY
DETERMINED

STRATEGIC
HEALTH CARE

TCARE

ThirdEye®
HEALTH

TSOLife

VIRTUSENSE™

Vynca

Ziegler Link·age Funds

Detailed Overviews

Aaniie® Care

The industry's most complete, all-in-one, AI-enabled home care platform.

HCBS & Personal Care • CCRC & Senior Living • Private Duty Nursing • Multi-Site & Franchise

Aaniie: At a Glance

Aaniie empowers senior living communities to expand beyond traditional resident services by enabling HCBS revenue growth opportunities for senior living. The all-in-one AI-enabled platform makes it easy to launch and manage on-demand personal care and home- and community-based services (HCBS), helping residents age in place while creating new revenue streams. With the ability to integrate with PointClickCare, schedule care throughout your community, and coordinate services 24/7/365, Aaniie connects care teams, residents, and families in one seamless workflow. Real-time care coordination, secure communication, dynamic scheduling, and operational automation help communities improve resident satisfaction, simplify administration, and grow with confidence.

Trusted by:

LIFESPACE COMMUNITIES®

Sun Health™ COMMUNITIES

Life Care® Services
An LCS Company

MONTEREAU®

To learn more about how Aaniie can help your community thrive, contact:

Rob Lipps
EVP, Sales & Marketing
608.338.8026
rob.lipps@aaniie.com

Kristin Cummins
Vice President of Sales
773-558-3709
kristin.cummins@aaniie.com

Or visit **Aaniie.com** for more information.

Alix

Losing someone leaves behind a long and complex to-do list.

For most, it's uncharted territory.

When someone passes away, they leave behind more than just memories. A home to manage, accounts to close, legal steps to take, and more. It's a long and unfamiliar list, and most families are navigating it for the first time.

That's where Alix comes in.

What is Alix?

Alix is a service that helps families after loss, taking care of estate settlement and the many responsibilities that come with it.

Alix works with estates of all types and sizes. Our Settlement Specialists handle the legal, financial, and personal details with clarity and care to ensure nothing gets missed.

How we help

Alix takes care of estate settlement end-to-end, including:

- Asset discovery & account transitions
- Probate & court filings
- Creditor notices, bills, subscriptions, & obligations
- Insurance & benefits claims
- Home, vehicle & personal property disposition
- Tax filings & required estate accounting
- Final distribution & estate closure

When you're trusted to handle an estate, trust Alix to get it right.

Estate settlement involves hundreds of tasks across banks, courts, insurers, and government agencies, often spanning a year or more.

Learn more about Alix and why families trust us to handle every step.

Arena for Senior Living: The New Era of Senior Living Workforce Intelligence

The Evolution: From Predictive Hiring to Ecosystem Stability

Historically, the senior living industry knew Arena Analytics (www.arena.io) as a point-of-application tool to screen applicants and reduce turnover.

Today, Arena.io delivers comprehensive, end-to-end **Workforce Solutions powered by a national dataset of over 4 million real career outcomes**, enabling us to make the most accurate predictions possible about individuals in your talent ecosystem. Our active, agentic ecosystem transforms your entire employment market:

- **Solves Frontline Shortages:** Drives proactive talent discovery to fill critical clinical and operational gaps with candidates likely to stay and thrive, and interested in your organization.
- **Eliminates Ghosting:** Flags and minimizes interview and onboarding no-shows.
- **Dynamic Talent Rerouting:** Guarantees an equitable experience that automatically routes candidates to ensure they land in the exact role where they are most likely to thrive, regardless of what position they originally applied for.
- **Community Workforce Development:** Arena partners with regional organizations to cultivate entirely new labor pipelines, introducing and welcoming compassionate, non-traditional talent who may have never previously considered a career in long-term care.

Arena is a direct partner in the applicant and employee experience, driving immediate engagement, expanding recruiter capacity, uncovering hidden talent pools, and unlocking internal mobility. This shifts your operations from reactive hiring to true workforce stability, protecting your business through solid, consistent care ratios and strong, deeply supported caregivers who stay.

Our Performance Guarantee: We tie our success directly to the health of your communities. If our solutions do not deliver a minimum 10% optimization in early workforce stability within the first 12 months, your organization retains the contractual right to request a refund of related licensing fees.

SELECT ARENA CLIENTS FROM THE ZIEGLER LINK·AGE COMMUNITY

Asbury Anticipate More · FellowshipLife Enrich · Transform · Empower · Jennings · McGregor

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To learn more about how Arena can support your workforce, please reach out:
Kelly Russell | Chief Growth Officer | kelly.russell@arena.io | 508.397.9902

Full Model

Bring your healthcare team home.

At Home Harmony brings an innovative, holistic home-based care model to address the complex needs of aging adults.

We offer coordinated home-based care, pharmacy packaging and delivery, and chronic care management to your home for your safety and convenience.

Plus, it's all covered by Medicare.

Thrive at home with true in-home healthcare.

MORE TIME WITH PROVIDERS

Harmony healthcare providers, which include nurse practitioners and physician assistants, spend extensive time with you. Plus, you'll have a dedicated nurse care concierge to listen to your care needs and help coordinate your care in between in-person visits.

MANAGE YOUR MEDICATIONS

Our pharmacist meets with you, reviews your prescriptions and how and when you take them, and develops a customized packaging and home delivery plan so you can easily manage your medications and doses independently.

COORDINATE COMPLEX CARE

After the first visit, we create a Harmony plan customized to your needs. That can include home-based primary care ***plus*** coordinated pharmacy, chronic care management, remote patient monitoring, care aides, and even specialized dementia care.

833.533.7177

athomeharmony.com

At Home Harmony

Bluestone

Embedded Primary Care + Integrated Care Management for Senior Living

Closing the gap between where seniors live and the care they need — improving outcomes and protecting operator P&L.

Top 5 MSSP Nationally for 3 Consecutive Years	**17%** Total Cost of Care Savings vs. Benchmark	**18K** Patients Actively Served	**1,000+** Senior Living Communities	**20+** Years in Geriatric Care

The Care Model

Primary Care Provider

One dedicated PCP per community. Not rotating, not remote. Providers know residents by name, offering true continuity of care and lasting relationships with residents, families and staff.

Dedicated Care Manager

One person per community for everything outside the medical visit: chronic condition management, family coordination, transitions, dementia and behavioral health support, palliative care and more.

Bluestone Bridge

8.2 / 10
Average Community Satisfaction Rating

Our proprietary platform connects community staff to Bluestone care teams in real time — reducing response delays, eliminating care gaps and giving operators live visibility into resident care activity without adding headcount.

Why Operators Partner With Us

Better census & length of stay — Clinical confidence retains residents and supports new move-ins.

Fewer avoidable hospitalizations — Proactive care keeps residents healthier in place.

Reduced staff burden — Your team stops absorbing clinical coordination gaps.

Higher family satisfaction — Faster response times and a dedicated Care Manager families can reach.

Provider continuity — Residents keep the same team. No relationship rebuilding after turnover.

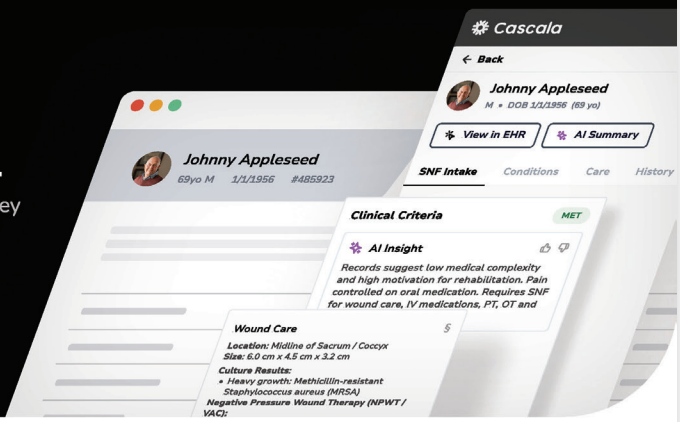
Aligned incentives — Our MSSP model ties success to outcomes, not to visit volume.

Bluestone is actively expanding its operator network. Interested in a partnership?
Email info@bluestonemd.com or visit BluestoneMD.com.

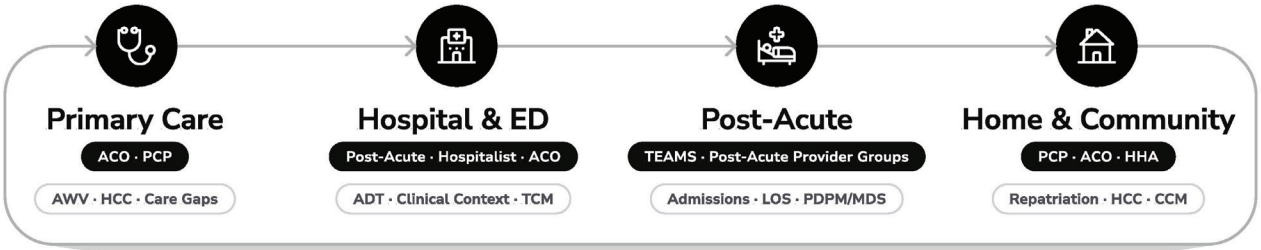
Cascala: AI-Powered Care Transitions

One connected view across every care setting.

Care transitions are the highest-stakes moments in a patient's journey — and where fragmented, delayed, or missing information can put follow-up, documentation, and outcomes at risk.



Cascala retrieves and consolidates available records, surfaces clinically relevant insights, and delivers the right information to the right care team at the right moment.



1. **Record Retrieval:** Regardless of the setting, we gather historical medical records, pharmacy data, and referral documents by partnering with data vendors and HIEs to assemble the full patient history.
2. **Consolidation:** We aggregate all data and surface clinically relevant information by filtering out noise and outdated records - delivering role-specific views with source citations.
3. **Insights:** We surface actionable insights with clinical context specific to the encounter - whether it's a TCM visit, AWV prep, referral and admission review, or inpatient visit summary.

Why It Matters

Transitions are where patients fall through the cracks.

The 30 days following a discharge are the highest-risk window in a patient's care journey. Without timely clinical context, care teams may miss follow-up needs, medication changes, or high risk flags.

Better handoffs support better outcomes.

By consolidating fragmented records and surfacing relevant context across settings, Cascala helps care teams reduce manual work, improve visibility, and coordinate care more effectively.

Documentation accuracy drives performance.

Under CMS V28 and value-based care models, accurate HCC documentation, care gap closure, and complete clinical context are increasingly important.

Cascala

hello@cascalahealth.com
cascalahealth.com

cosán Care Management

CCM & PCM Programs

Cosán extends clinical oversight beyond the exam room — helping patients stay on track while strengthening your practice performance. Unlock scalable, recurring CCM & PCM revenue without adding internal headcount.

Cosán's **care teams** are your eyes and ears between visits — reinforcing care plans, identifying risks early, escalating when necessary, and delivering meaningful insight back to your team.

Practice Benefits

- **Greater Patient Stability**
- **Ancillary Revenue Expansion**
- **Risk Mitigation**
- **Improved Performance**
- **Compliance Confidence**
- **Reduced Administrative Burden**

cosán **Your Plan. Extended. Your Outcomes. Strengthened.**

Close the gap between visits and elevate both patient health and practice performance. Visit us:

www.cosangroup.com/getting-started/

Our Offerings

Chronic & Principal Care Management

- Remote Patient Monitoring
- Functional Health
- Nutrition Support
- Behavioral Health

CURANA HEALTH®

Curana Health® at a Glance

Curana Health is the country's largest and most sophisticated provider-led medical group dedicated to enhancing SNF and senior living performance.

Our services include medical directorships, on-site primary care, behavioral health, remote patient monitoring, regulatory support, and 24/7 provider access, all supported by advanced technology. Through our IE-SNP and ACO programs, our partners can capture the value they generate, while reducing unnecessary readmissions, improving care transitions, and achieving higher patient and staff satisfaction.

40% Fewer Hospital Readmissions and **33% Reduction in Emergency Visits** through medical directorships supported by care teams and advanced technology.

89% Advance Care Planning Completion Rate, improving regulatory compliance and patient-centered care.

95% Satisfaction among residents and caregivers, underscoring the quality and reliability of our care model.

Proven success in addressing critical addressing critical challenges such as polypharmacy reduction, fall prevention, and labor shortages.

SAMPLE PARTNERS INCLUDE:

CIENA HEALTHCARE
Care Initiatives
MAPLEWOOD senior living
BROOKDALE — SENIOR LIVING SOLUTIONS —
BENCHMARK

To learn more about how Curana Health can help your communities thrive, reach out to:

Conor McCaw, *Chief Growth Officer*
773-343-4229 • Conor.McCaw@CuranaHealth.com
Or visit **CuranaHealth.com** for more information.

CH-BD-2026-0463-0625

K4Connect is a mission-driven AgeTech company delivering a connected ecosystem purpose-built for senior living. By unifying technology, data, and experiences, we help communities simplify communication, automate workflows, reduce administrative burdens, and empower staff with the insights needed to enhance care, engagement, and operations.

Fusion^{OS}: The Foundation

Fusion^{OS} is K4Connect's patented integration and data platform, enabling secure, two-way data sharing across systems, devices, and applications. It connects technologies into a single ecosystem while reducing manual work and improving visibility.

K4 Partner Library: The Integration Layer

Powered by Fusion^{OS}, the K4 Partner Library includes 50+ pre-built integrations across clinical, dining, workforce, maintenance, engagement, and smart home technologies, helping communities connect best-in-class solutions faster.

K4IQ™: The Intelligence Layer

K4IQ™ is the AI-powered intelligence layer built on Fusion^{OS} that transforms connected data into actionable insights. By providing a single source of truth, it helps leaders identify trends, improve performance, and make more informed decisions.

K4Community: The Execution & Experience Layer

K4Community brings the ecosystem to life for staff and residents. Team Hub streamlines daily operations for staff, while residents engage through the Plus app, voice, smart home controls, digital signage, TV, and more.

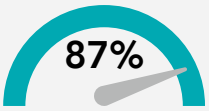
Real Results, Real Impact:

MASONIC VILLAGE

Challenge:
Low resident engagement due to inconsistent updates and time-consuming processes

Solution:
Fusion^{OS} Integrations surfaced in the Plus app

Case Study Results:



boost in resident engagement

2,000+

staff hours saved annually

Visit k4connect.com to learn more, read case studies, and explore our partner integrations.

One Connected Ecosystem

Together, Fusion^{OS}, the K4 Partner Library, K4IQ™, and K4Community create a connected ecosystem for senior living, helping communities operate more efficiently, engage residents more effectively, and make smarter decisions. Ready to connect your community? Schedule a demo to learn more.

k4connect.com/demo sales@k4connect.com 919-297-2921

payactiv

$25.2B
lost in productivity due to caregiver absenteeism

EARNED WAGE ACCESS INSIGHTS

Better Care Begins with Supported Caregivers

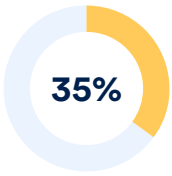
The caregiving industry is facing an unprecedented staffing crisis with an industry-wide turnover rate reaching nearly 80%[1]. High emotional and physical demands, coupled with low wages and limited benefits, are driving burnout and turnover. Many caregivers are working long hours while also managing financial insecurity at home.

This workforce volatility strains every part of the business. High turnover and absenteeism drive up staffing costs, limit admissions, and threaten care quality—undermining profitability and long-term viability in an already margin-sensitive industry.

Earned Wage Access (EWA) for Caregiving Teams

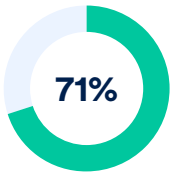
Give your caregivers the flexibility to access their earned wages whenever they need with Payactiv. Senior care providers that offer EWA see lower turnover and greater staff satisfaction—directly improving care continuity and operational stability.

- Give your employees the greatest number of free EWA options in the industry
- Reduce financial stress to improve attendance and care reliability
- Empower employees with budgeting, savings, and bill payment tools
- All in an award-winning app built for caregivers



increase in retention among employees who use EWA

of hourly workers want access to on-demand pay



of users say their ability to manage their finances has improved because of Payactiv's EWA[2]

The Advantages of Payactiv

- ✔ Added employee benefit at zero cost to employers
- ✔ No changes needed to payroll processes or cash flow
- ✔ Automated integration with your existing payroll systems
- ✔ Multiple options for employees to access their wages
- ✔ Compliant in all 50 states

Excellence in FinTech 2024 · Tech of the Future 2024 · Certified B Corporation

SALES@PAYACTIV.COM

[1] https://homehealthcarenews.com/2024/07/home-cares-industry-wide-turnover-rate-reaches-nearly-80/?utm_source=chatgpt.com
[2] https://www.payactiv.com/impact

PRECISE BEHAVIORAL

REVOLUTIONIZING BEHAVIORAL HEALTH IN LIFE PLAN COMMUNITIES (LPCs)

Integrated Clinical Services + Digital Monitoring for Life Plan Communities

At Precise Behavioral Health, we are transforming behavioral health care into Life Plan Communities (LPCs) through a fully integrated Behavioral Health Operating System that combines specialized clinical services, digital monitoring, and revenue optimization into one seamless solution.

Our model is designed to help LPCs improve quality outcomes, regulatory compliance, and financial performance, while addressing the growing complexity of behavioral health and geriatric populations. Precise Behavioral Health operates across the entire behavioral health continuum, allowing Life Plan Communities to meet all levels of behavioral health care within the the Life Plan Community.

Precise LPC Behavioral Health Model

Specialized Geriatric Behavioral Health Expertise

- On-site and virtual coverage tailored for LPC environments
- Geriatric-trained Psychiatrists and Advanced Practice Providers
- Expertise in dementia, depression, and complex neurocognitive disorders
- Crisis management and stabilization within the facility

Embedded Crisis Stabilization Capabilities

- On-demand psychiatric support for acute behavioral episodes
- Stabilization within the LPC to avoid hospital transfers
- Coordination with Emergency Departments when escalation is required
- Integration with higher levels of care when needed

Benefits for Life Plan Communities

Precise enables LPCs to:

- Keep residents in lower acuity settings longer
- Reduce ED visits, hospitalizations, and readmissions
- Enhance clinical outcomes and regulatory performance
- Lower total cost of care across the continuum
- Support to appropriately reduce psychotropic use

PRECISE BEHAVIORAL

To learn more:
visit: www.precisebehavioral.com | **email:** info@precisebh.com


PS
SALON & SPA
The Senior Living Industry's Leading Salon Amenity Platform
Professional salon operations, purpose-built technology and actionable data... delivering exceptional resident and family experiences.
UNPARALLELED NATIONAL RESOURCES
1,600+
SALONS
Senior living operations
33
STATES
National footprint
2,500+
PROFESSIONALS
Licensed employees
80,000+
PARTICIPANTS
Resident & family Celebration Accounts
ONE INTEGRATED OPERATING PLATFORM
PEOPLE & OPERATIONS
Staffing, leadership support, training, licensure & compliance
CELEBRATION ACCOUNTS™
Gifting, rewards, appointments & service authorizations
PS
SALON & SPA
TECHNOLOGY & ENGAGEMENT
Connecting residents, families, communities & professionals
DATA & BUSINESS INTELLIGENCE
Actionable insights into participation, utilization & performance
DESIGN & PROCUREMENT
Planning, layout, equipment, procurement & operational design
bd@salonps.com
people • empathy • respect
440-600-0020

shiftkey + OnShift

Simplified workforce management, maximized impact

SAMI optimizes workforce management, offering flexibility and enabling real-time decisions that align with both business goals and resident care. This empowers facilities to increase resident occupancy while maintaining care quality.

Strategic growth and scalability

5x
5x national average census growth rate

77%
77% of SAMI customers increased census

Enhanced financial performance

$1.7M
$1.7 million in annualized savings

$1.3M
$1.3 million average annualized revenue growth per facility

Operational confidence

10K+
Over 10,000 senior care facilities served

45%
45% average reduction in agency usage*

Trusted by leading senior care organizations

Quality Center for Rehabilitation & Healing · LECOM Health · The Delmar Gardens Family · Touchstone Communities

Learn more at shiftkey.com or onshift.com

*These improvements are based on SAMI customer results. Your results may vary.

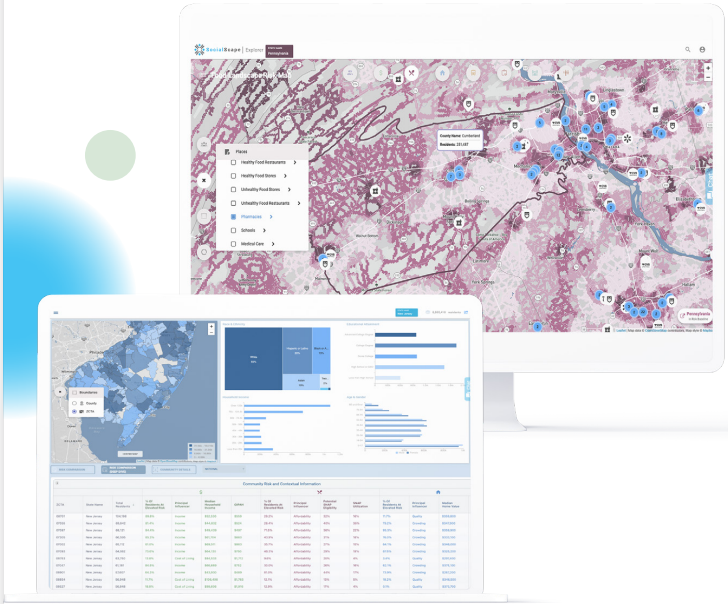
SOCIALLYDETERMINED

Taking on a data-informed approach to address Social Determinant of Health (SDOH) needs

Social determinants of health (SDOH) impact **80%** of health outcomes from acute to chronic disorders.[1] To truly have an impact, healthcare organizations need to go beyond the insights derived from a clinical setting and understand how environmental factors are hindering clinical interventions.

Socially Determined partners with healthcare organizations to provide them with the insights they need around SDOH and health-related social needs (HRSN) to make better community investments, identify strategic vendor and community partners, and provide proactive outreach to members that need it the most.

Our comprehensive data illuminates how and where social risk is having the greatest impact on your communities and members. These insights enable you to identify gaps in existing programs, increase member engagement and retention, decrease overall costs and improve health outcomes.



HOW DO WE DO THIS?

Our SocialScape® platform visualizes a community's risk across seven social determinant of health (SDOH) domains, enabling health plans to identify strategic partners and manage their community investment dollars effectively. For health plans entering a new market or wishing to expand their footprint, it provides insights into the needs of their potential members.

In addition to providing community social risk insights, we also deliver social risk scores for each member across five HRSN domains. This includes detail on the key drivers for each domain, empowering health plans to design tailored interventions and provide culturally congruent benefits to meet members' needs.

1 Greer ML, Garza MY, Sample S, Bhattacharyya S. Social Determinants of Health Data Quality at Different Levels of Geographic Detail. Stud Health Technol Inform. 2023 May 18

Visit our website at **sociallydetermined.com** to learn more and catch up on our latest insights.

TCARE

Supporting Those Who Care

TCARE® combines evidence-based caregiver support, expert care management, and digital engagement to help organizations support and retain the people who care for others. Through personalized guidance, proven clinical practices, and easy-to-use technology, we help reduce stress, improve wellbeing, and strengthen organizations.

Our Approach:

24/7 Access
Personalized resources, tools, and support available anytime they're needed.

Expert Guidance
Ongoing one-on-one support from a dedicated care specialist.

Education & Community
Access to expert webinars, educational resources, and peer connections.

Results That Matter:

35% improvement
in employee retention among TCARE-engaged staff

50% of engaged caregivers
improve their mental health status & reduce their burden scores

90% caregiver engagement
following initial assessment

Average savings of $8,000
per retained (non-leadership) employee

Ziegler | link·age
ZIEGLER LINK·AGE FUNDS

www.tcare.ai | hello@tcare.ai

ThirdEye® HEALTH

AFTER-HOURS INSTABILITY IS WHEN POST-ACUTE RISK SPIKES.

OVERVIEW

Third Eye Health provides clinician-led virtual urgent care during nights, weekends, and holidays so skilled nursing teams can make confident treat-in-place decisions instead of defaulting to hospital transfers.

Designed for skilled nursing and post-acute teams managing after-hours risk without on-site physician coverage.

COVERAGE

5pm-8am Mondays though Fridays and 24/7 Weekends + Federal Holidays

TECHNOLOGY

HIPAA & SOC 2 Compliant Messaging, Image Capture, and Video Calling

CARE COORDINATION

Manage care transitions and provider communication between all teams

PERFORMANCE

93% treat-in-place means fewer unnecessary transfers, less overnight escalation, and cleaner handoffs to the day team

WORKFLOW

Simple, repeatable workflow built for after-hours clinical teams and facility staff

EHR INTEGRATION

Full bidirectional EHR access with notes and order flowing directly back into the center EHR

When a nurse faces an acute change in condition after hours, they can immediately reach a licensed clinician who can see the resident, review the chart, and guide next steps in real time.

HOW IT WORKS

- Virtual Urgent Care provides acute care during nights and weekends at the touch of a button, with providers experienced in emergency medicine successfully treating patients in place 93% of the time
- Care transitions are overseen by care coordination nurses who collaborate with providers, health systems, and clinical staff to ensure proper care transitions during virtual interactions
- Virtual Care Platform offers integrated secure chat messaging, image sharing, and video calling with your post-acute EHR, along with reporting and analytics

1.800.411.6768 **119 S Western Ave Unit 1, Chicago** **www.thirdeyehealth.net**

PROACTIVE YOU

Proactive health intelligence that identifies cognitive and physical decline

Continuous, automated insights into gait, balance, frailty, daily activity, and functional trends help clinicians intervene earlier while keeping the experience simple for seniors and low lift for therapists.

Universal access

Serve seniors with smartphones and seniors without smartphones. SMS-friendly workflows broaden access and reduce friction.

Data + Surveys + Exercises

Track gait speed, step length, daily steps, activity patterns, and pain/function surveys, along with recommended exercises in one connected RTM workflow.

Virtual Care Visits

Complete live phone or video check-ins, document clinician time, and support Medicare-B RTM claims.

3M+	$50B+	~ 90 days
falls-related ED visits annually	annual U.S. spend on falls	highest-risk post-discharge window

Why ProActive You matters for senior care

Keep residents visible between therapy visits and after discharge without adding burden to patients or staff.

Reduce falls risk
Identify mobility decline earlier so clinicians can intervene before a fall or functional setback.

Support longer, safer stays
Help seniors remain independent longer and support safer length of stay across senior living settings.

Enhance quality of life
Keep monitoring passive, senior-friendly, and practical for day-to-day care delivery.

- **Works with or without a smartphone**
- **Real-time alerts** that enable proactive care and timely intervention
- **Supports RTM workflow** for engagement and reimbursement
- **Seamless documentation** with automated functional assessments

Built for RTM workflow, reimbursement, and compliance

From passive monitoring and survey tracking to phone/video check-ins, billing, and operational visibility.

How its works in practice

01 **Enroll & order** — PT/OT assesses mobility or fall risk and initiates the RTM order — no physician referral required.

02 **Passive monitoring** — Background tracking captures movement trends, activity patterns, and survey data with minimal patient effort.

03 **Evidence based alerts** — Early-warning alerts surface mobility decline while SMS-friendly outreach helps maintain engagement.

04 **Interact & bill** — Clinician reviews the dashboard, completes a phone or video check-in, documents time, and bills RTM.

2026 Medicare Part B RTM codes

Approximate national average reimbursement

Code	What it covers	Rate
98976	Initial setup (one-time)	$21.71
98986	Device supply (monthly)	$38.76
98979	Treatment mgmt 10-19 min	$28.06
98980	Treatment mgmt 20+ min	$63.77
98981	Add-on mgmt (each +20 min)	$41.80

Approximate per-patient monthly totals
98986 only: $39.76
98986 + 98979: $65.80
98986 + 98980: $93.52

ProActiveYou RTM ● **Request a demo at proactiveyou.com**

VSTAlert Go

A MOBILE, AI-POWERED FALL PREVENTION SOLUTION

Up to 85%	30-65 sec	95% fewer	27/7
Reduction in Resident Falls	Early Warning Before Exit	False Alarms vs. Legacy Systems	Continuous AI Monitoring

How VSTAlert Go Works

1. **Sensor detects intent**
A small mobile sensor placed in the room identifies when a resident intends to exit their bed or chair - 30-65 seconds before it happens.

2. **Instant Staff Alert**
An alert is sent immediately to staff devices, hallway notification lights, and the central nursing console - routing to the right team.

3. **Staff Arrives, Patient Is Safe**
A care team member arrives before the resident stands unassisted. VSTAlert Go continues monitoring around the clock.

Protection That Goes Where You Need It

Resident Privacy First

VSTAlert Go uses infrared light — not cameras — so residents retain full privacy. Sensor scans are automatically anonymized. Residents are never under video surveillance.

Key Product Features

Sensor Technology
- Infrared-based, privacy-safe monitoring
- Detects bed & chair exit intent
- Works in any lighting condition

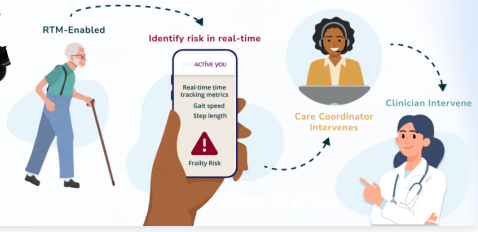
Transportable Hardware
- Small device wheels into any room
- Wi-Fi or cellular connectivity
- Rapid room-to-room redeployment

Intelligent Alerting
- Mobile app, hallway lights & nurse console
- Reduced false alarms with AI precision
- Routes to the right care team instantly

ProactiveYOU Integration
- Connects individual wellness data
- Tracks balance, gait & mobility trends
- Family & care team visibility dashboard

AI- Powered Fall Prevention

Wherever Residents Go



Vynca

Serious Illness Management Solutions

Vynca is a health technology and services company transforming how care is delivered to people living with serious illness. Through specialty palliative care, advance care planning, and intelligent care software, we help patients experience More Quality Days at Home™, while delivering measurable cost savings and quality improvements for the health plans and systems we partner with.

15 STATES CURRENTLY OPERATING

12 EXPANSION STATES PLANNED

Medicaid-focused, with experience across Medicaid, Medicare, Medicare Advantage, Commercial, and ACA plans.

Specialty Palliative Care

Your trusted partner in caring for patients with serious illness.

For over 10 years, Vynca has provided hybrid palliative care to patients with life-limiting illnesses, improving the lives of over 15,000 patients. We partner with health plans, health systems, and providers to improve patient quality of life while reducing avoidable healthcare utilization.

Vynca's intensive, home-based palliative care provides an extra layer of support alongside the existing care team, helping plans and providers reduce avoidable ED and inpatient utilization.

Benefits:

- Extend reach into the home and community
- Assist with symptom management between office visits
- Coordinate care to reduce fragmentation and noncompliance
- Identify and treat 'rising risk' to prevent costly acute exacerbations
- Facilitate advance care planning discussions
- Lead to earlier, more appropriate hospice initiation

A Care Model That Delivers Meaningful Results

- **95%** – Patient satisfaction score
- **81%** – Symptom burden reduction after 6 weeks
- **79%** – ACP document completion (vs. 28% nationally)
- **43%** – Reduction in ED visits
- **52%** – Reduction in inpatient admissions
- **3x** – Longer hospice stay than national average
- **53 days** – Median hospice length of stay following Vynca services (vs. 17-day national average)

Advance Care Planning (Acp) Software

Ensuring care choices are honored — when it matters most.

Vynca's ACP Software is a comprehensive digital platform that enables individuals, providers, and care teams to create, store, access, and share advance care planning documents.

For Patients & Families

Provides reassurance that care preferences are documented and honored — empowering individuals to take control of their decisions and relieving caregivers from the burden of making life-altering choices in a crisis.

For Clinicians & Care Teams

Easy to use with seamless integration into existing workflows. Immediate access to up-to-date ACP documentation with clear, actionable insights — no searching for forms, no uncertainty at the point of care.

What Makes Vynca ACP Different

- Digitally transforms a paper-based process — modernizes outdated ACP documentation systems
- Simple & intuitive — eliminates complexity for both patients and clinicians
- Seamless remote signing — mobile access for easy document completion and verification
- Built-in QA & error prevention — ensures only active, accurate documents are available
- Instant access for care teams — real-time updates eliminate uncertainty and delays

Measurable ROI for Health Plans

<20%
Of qualifying patients currently have access to palliative care (significant market opportunity)

$3,494
Net monthly savings per patient

3:1 ROI for health plans

I needed support, I needed more advocacy. I needed to know someone had my back. Vynca made a world of difference. If your illness has become your life, Vynca coordinates everything. They gave me back time.

Toni, Vynca Cancer Patient

Let's Work Together

Connect with us to reduce healthcare spend, improve outcomes for seriously ill patients, and partner in the future of serious illness care.

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Contact us

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