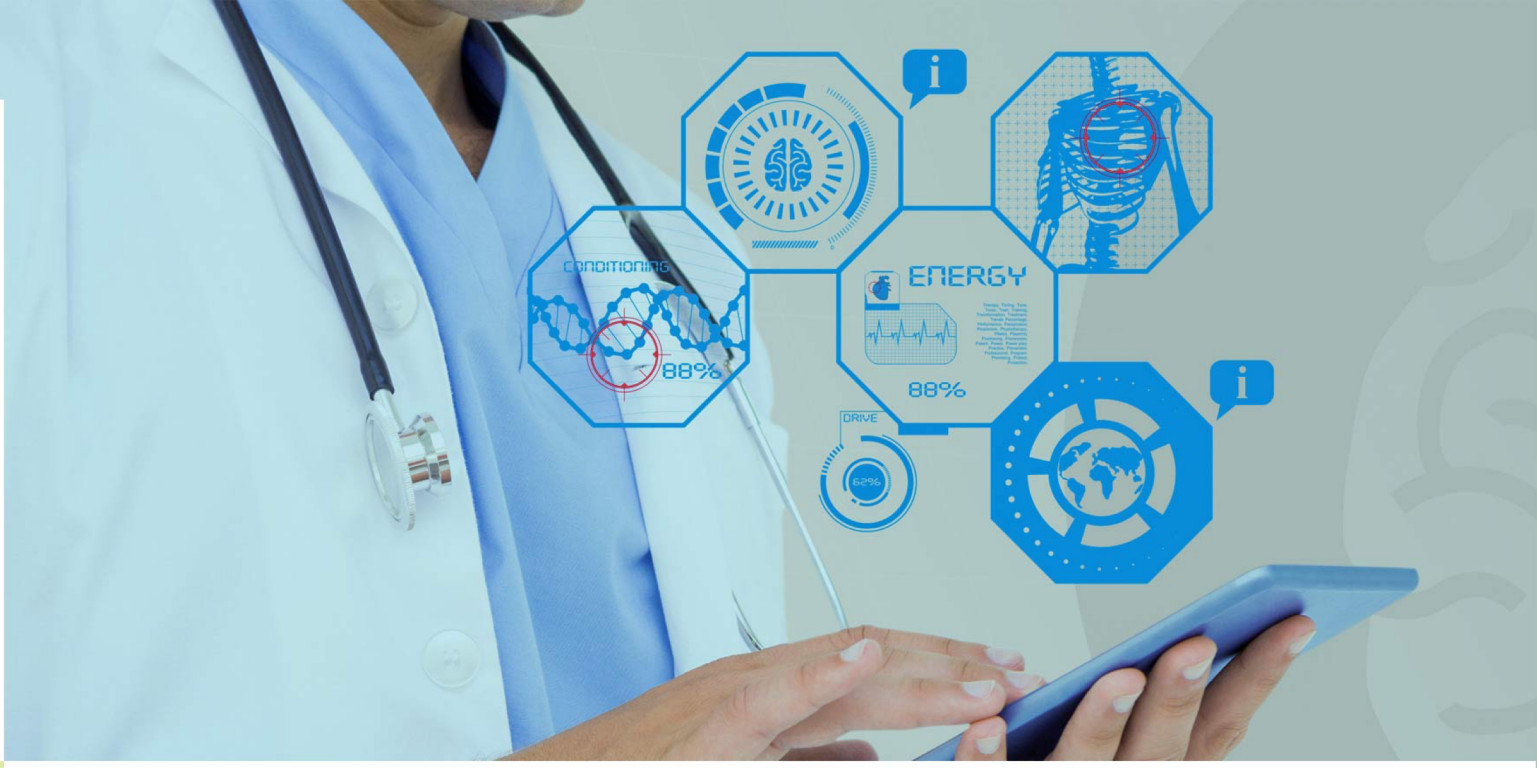
eShift™

Transforming Patient Care



AHTI - connect

Patrick Blanshard

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What do we do?

Our **innovative** solution, eShift, is designed to **reduce readmissions** and allow for **early** hospital **discharge** through a new model of care.

It is a **virtual hospital ward system**, provided within the community and delivered by SaaS.

Through the use of our technology, **patients** can **stay** in the comfort of their own **home** while receiving the proper medical support that they need.

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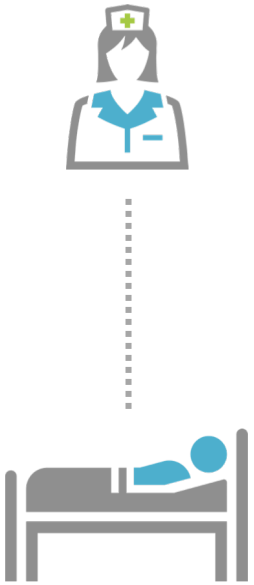
Our solution

Traditional Model



Inefficient

Cannot be scaled

Costly

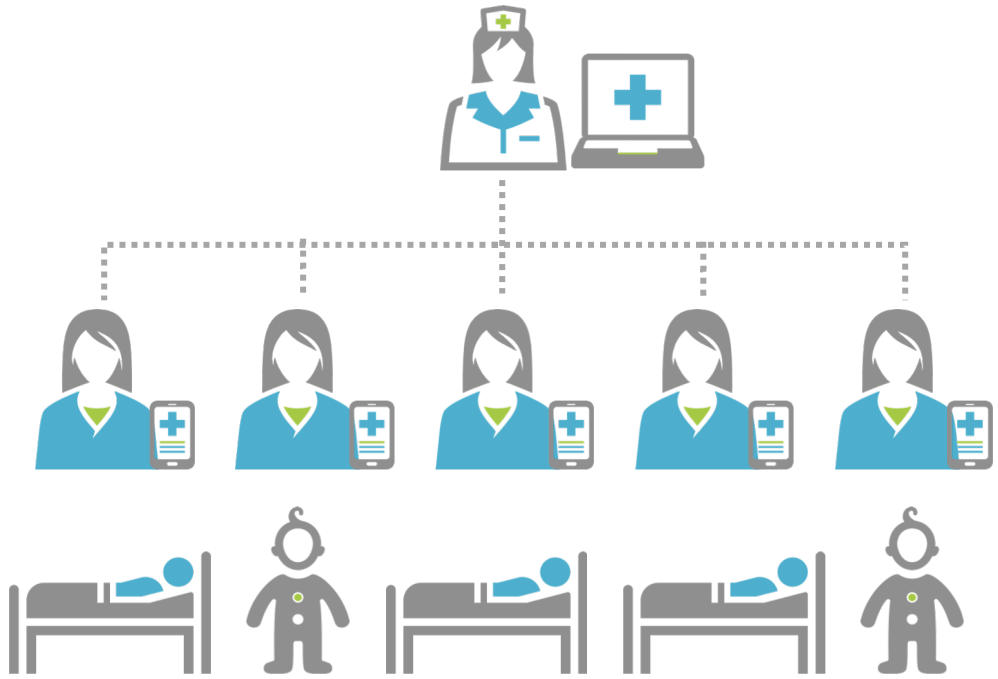
VS

eShift Model

Efficient

Scalable

Cost-effective



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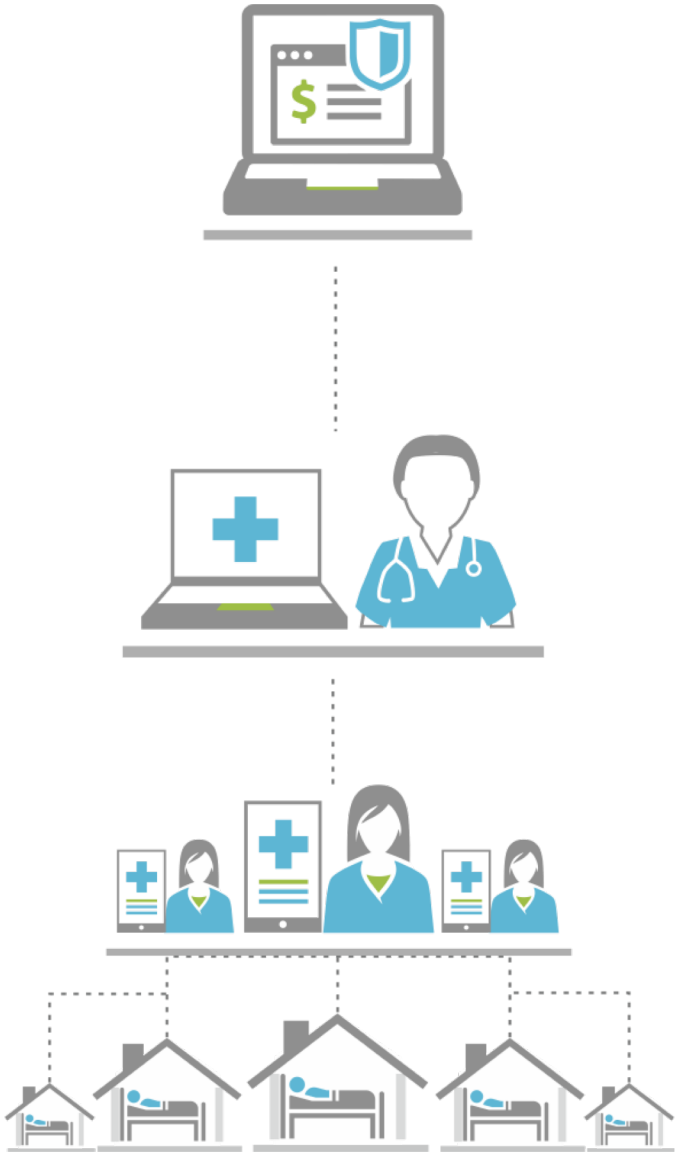
How do we do it?



Organisational change through our technology:

- ✓ Cascading delegation
- ✓ Virtual support teams are constructed with one remote registered clinician supervising and directing a team of 4+ onsite care technicians.
- ✓ Each technician provides care to one patient and updates their medical charts in real-time.
- ✓ Technicians provide live observation of patients and perform delegated interventions under direct supervision of the remote clinician.
- ✓ The supervising clinician is supported by physicians, members of the broader healthcare team & data analytics
- ✓ Our solution can cover shifts or short, episodic clinic-style visits

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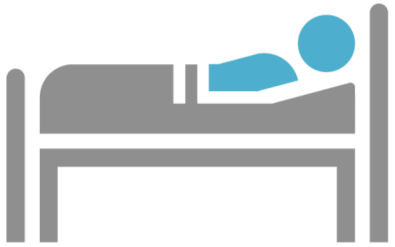
Current Pathways

Palliative Care



Hospital replacement and readmission prevention

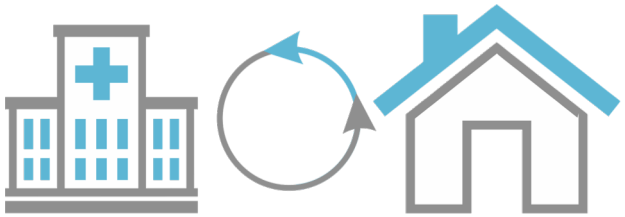
Complex Care
Pediatrics

Early discharge and readmission prevention

COPD, CHF, AMI
Pneumonia,

Post Acute Stroke
Rehabilitation,

Early discharge and better long-term outcomes



Hospital-to-Home pathways support:

- Grand rounds and board rounds led virtually from Hospital
- Delegation from Physician/expert to licensed clinician
- Registered clinician delegation to assistant (Technician)
- Integration with incumbent EMR and RPM via HL7

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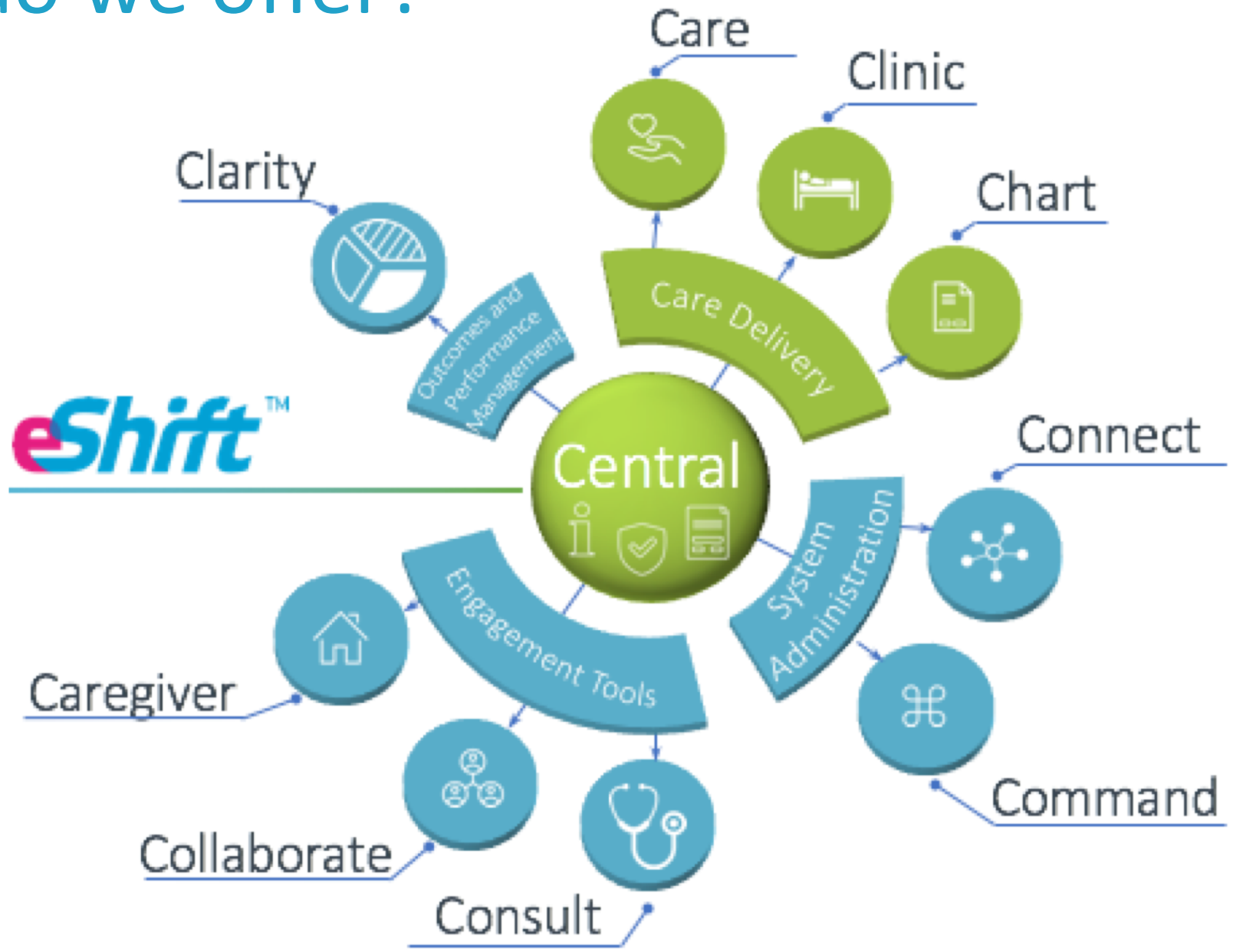
What do we offer?



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Case Study: Adult Complex Care (CC2H Program)

Target population:

- Adult complex care ward is designed for patients with complex care needs at risk of ED visits or recently discharged from hospital as well as patients with COPD/CCF.

How is it done?

- Provided with multiple 1 hour in-home visits on a weekly basis to ensure treatment compliance, education and connection with a clinician to ensure care place adherence.
- Coordinated Care plans are created with direct input from the patient
- Physician is able to consult with patient through video (post discharge)
- All members of CC2H team are present at video conference to discuss patient's progress and care needs
- Tele-triage support personnel and respiratory therapists provided direct access to real-time eShift tools beyond directed care use.

Results:

- Deployed in multiple regions in Canada, the model of care has reduced hospital length of stay by 59%, community length of stay by 81% and achieved overall cost reductions of 47.9%.

Key Results

	Baseline	eShift	% Change to baseline
Hospital LOS	8.1 days	3.3 days	-59.3 %
Community LOS	150 days	28.5 days	-81.0%
30 day Readmission	22.4%	13%	-41.7%
30 day ED Use CTAS 1	81%	0%	-100%
30 day ED Use CTAS 2	72%	6.0%	-92%
30 day ED Use CTAS 3	59%	0%	-100%
30 day ED Use CTAS 4	83%	0%	-100%
30 day ED Use CTAS 5	3%	0%	-100%
Hospital Cost (in patient + readmit + ED)	$12,002	$5,048	-57.9%
Community Care Path Cost	$3,275	$2,901	-11.4%
TOTAL COST	$15,277	$7,949	-47.9%

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