CareMessage

2024 Impact Report

A year of increased innovation and health equity success.

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Letter from the Founders

2024 has been a truly transformational year, during which we achieved key milestones towards becoming the largest organization in the United States dedicated to building technology that delivers measurable improvements in health equity.

Through this first impact report, we showcase our current focus and impact. We share our revamped theory of change, framework for health equity, stories from our community, and key projects. As we look to the future, we believe we can continue to improve health equity, and one day scale to impact the 90 million people in the United States who live at or below 200% of the Federal Poverty Level.

Some key wins this year include our addition of Artificial Intelligence into our suite of products, our expansion into clinical data storage and analysis, and our renewed ability to measure the impact of our diabetes interventions in re-engaging patients in their care.

Alongside our partners in the healthcare safety-net, we remain committed to creating a world in which all people have a fair chance to be healthy through increased access to care, improved clinical outcomes, and addressed social drivers of health. We are grateful for each of you who have contributed to our journey, and look forward to those who will join us in the years to come!

With gratitude,

Vincet Singal

Co-founder and Chief Executive Officer

Cecilia Corral

Co-founder and Chief Strategy Officer

Low-Income Populations, Left Behind in Healthcare Technology

THE PROBLEM

In the United States, **life expectancy for low-income populations is 10-15 years less** than high-income populations. As new technologies have emerged they have not been designed with these populations in mind, widening a digital divide that negatively impacts health equity.

The United States spends more on healthcare than any other nation in the world, yet we see worse life expectancy outcomes. This includes a significant disparity for low-income populations. **Low-income populations have a life expectancy 10-15 years shorter than high-income populations**, with even greater disparities among certain racial and ethnic groups.

Technology has the potential to improve outcomes and advance health equity. However, even with the wide adoption of technologies like electronic health records (EHRs), these fall short in meeting the needs of the people who need it most. For example, patient portals integrated with EHRs are often thought of as a key solution to patient engagement. However, some studies show **patient portal adoption rates as low as 20%** for low-income populations. One example of why this happens is they often do not support languages beyond English, which are critical for this population. Without an approach that centers low-income populations in the design and adoption of technology, we risk increasing health inequities.

Over 90 million people in the United States live at or below 200% of the Federal Poverty Level (FPL), which is the usual cutoff for social services. In 2024, this equates to a family of four making less than $62,400 per year. At this income level we cannot treat health conditions without addressing social drivers of health, i.e. non-medical factors like food and housing that impact someone's ability to improve their health. Our populations often have to make tradeoffs like attending a preventive care visit or missing out on their wages for that day, which can be the difference between paying their rent that month or falling behind.

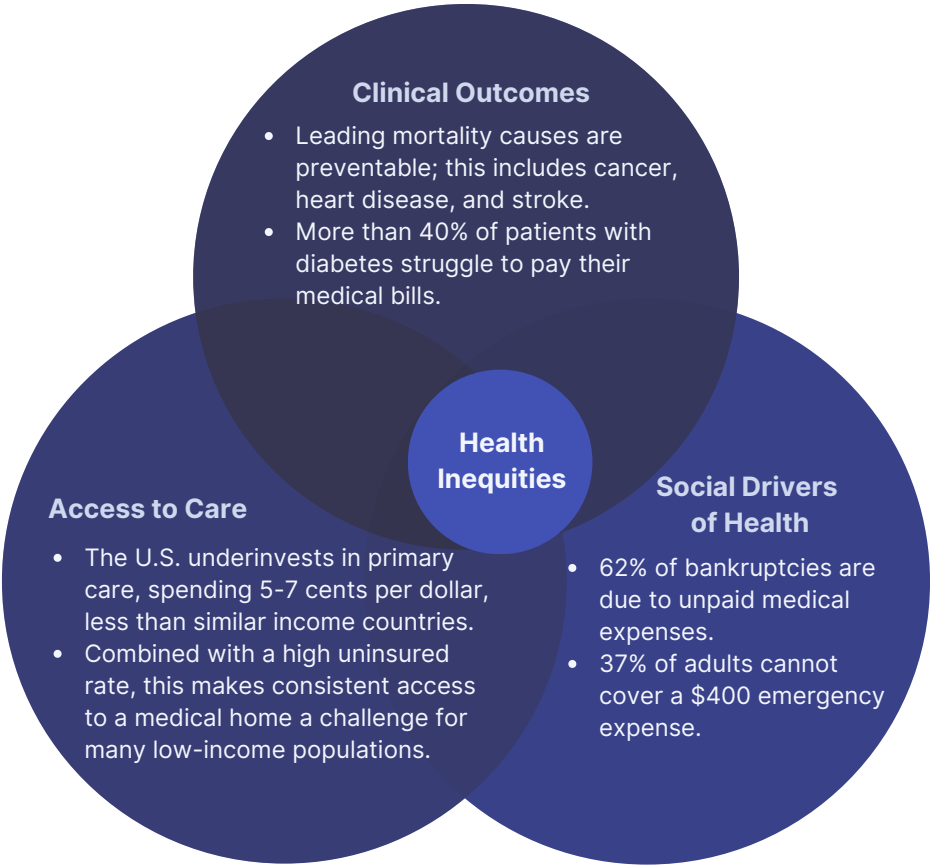
SYSTEMS VIEW

Life expectancy disparities for low-income populations are the result of systems beyond healthcare.

What sets other high-income countries with better outcomes apart from the United States comes down to a few factors including:

- Providing universal coverage.
- Investing in primary care systems.
- Reducing administrative burdens.
- Investing in social services.

While in the United States, we face challenges in a variety of areas:



About CareMessage

OUR THEORY OF CHANGE

Building technology to improve health equity requires a new type of organization.

Our Why

Technology for Health Equity

Low-income populations need equitable access to tech-based solutions that combat, not exacerbate, longstanding healthcare inequities.

Our Who

Experience-Led Design

People who share the lived experiences of low-income populations, or have experience in healthcare, are necessary to design and build solutions that work.

Our How

Revenue Enables Impact

Impact on health equity is our number one priority, and when necessary, we prioritize our non-profit's mission rather than focusing on revenue from our product offerings.

Our Vision

A world where people from low-income populations **achieve health equity through** increased **access to care**, improved **clinical outcomes**, and addressed **social drivers of health**.

Our Mission

Leverage technology to **improve health equity for people from low-income populations**.

Our Goal

By 2028, CareMessage aims to **improve health equity for 5 million people** from low-income populations each year.

HEALTH EQUITY FRAMEWORK

We have selected three core areas where technology has the greatest potential to advance health equity.

Clinical Outcomes

Drive measurable improvements in behavior and outcomes that impact prevention, screening, incidence, and mortality rates for the conditions that disproportionately affect our target populations.

Access to Care

Make healthcare more accessible to low-income populations through tackling availability, affordability, delivery and quality of care.

Social Drivers of Health

Transform the way healthcare addresses social needs through increased and timely screenings, resource distribution, and delivering support to patients in need.

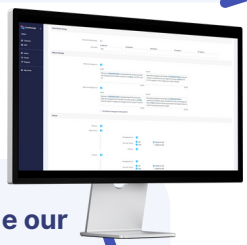
Our Offering

OUR SOLUTION

We deliver a patient engagement platform, designed to improve health equity.

CareMessage blends technology with a human touch, allowing staff to use a web-based application to:

- Engage populations 1:1 or at scale
- Deliver personalized engagement through sequential messaging
- Communicate via text or voice in someone's preferred language

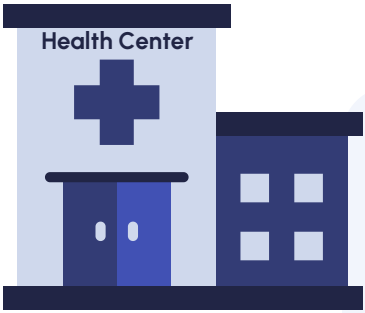


Healthcare organizations leverage our integrations with electronic health records (EHRs) and other data systems to automate and streamline:

- Demographic, Appointment, and Clinical Data Integrations
- Align Organizational & Population Health Priorities with Patient Engagement Strategies
- Implement Scalable Workflow Designs

In addition to our product, organizations can access top-tier services not commonly provided by competitor products:

- Strategic guidance to implement best practices based on our collective insights into what drives patient engagement for safety-net organizations.
- Message templates for one-to-one and population health coaching, backed by our proven results in driving clinical outcomes.
- Hands-on support to scale and maintain operational workflows that are tailored to the unique needs of Federally Qualified Health Centers, Free Clinics, and Tribal Health Organizations.



Populations are activated to improve outcomes:

- Re-engage with their healthcare provider and come in for annual wellness visits
- Improve clinical quality measures like increased screenings
- Drive behavior change to improve wellness practices like exercise or healthy eating
- Connect to local resources for basic needs like food or housing

Health Equity Impact

NATIONAL REACH

In 2024, **417 organizations** engaged **5.7 million people** through nearly **80 million messages** across **45 U.S. States and Territories.**

Of the **5.7 million people** messaged in 2024, close to **5 million people** received one or more messages tied to our three health equity pillars.

Although we have seen existing CareMessage utilization is highly aligned with health equity, this alone is not enough for our 2028 goal. Our aim as we move from breadth to depth is to elevate the measurement of healthcare technologies in their ability to impact outcomes.

Read more about our Quality of Evidence Framework on page 12.

Examples of the types of messages categorized under each pillar, in alignment with our Health Equity Framework

Access to Care

Messaging about the availability, affordability, delivery and quality of care. For example, helping patients get connected to primary care after an emergency room visit.

Clinical Outcomes

Messaging about prevention, screenings, and disease management. For example, to address Maternal Health, organizations delivered health education and virtual classes.

Social Drivers of Health

Messaging about needs assessments, driving awareness of resources, and providing direct case management support. For example, enrollment in food stamps and food distribution.

Examples of messages sent via CareMessage in 2024

We noticed you canceled your appointment, and we want to know why so that we can improve our support in your health journey! This will not impact your patient visits. Text A if work related, B for transportation, C for childcare, D for lack of reminder/did not know about my appt., E for others

Can you take a moment to answer 'Yes' or 'No' to this question: Has our clinic helped you learn more about services, resources, and when to use the emergency room for non-urgent problems?

Hello, this is an application follow up. You previously applied for one of the following programs (Medicaid, Chip, Medicare, SNAP, Gold Card). Did you get approved? Please reply yes or no

During pregnancy you need more water than the average person, at least 8-12 glasses a day. Water plays an important role in the healthy development of your baby such as helping to form the placenta, which is how your baby receives nutrients during pregnancy.

OUR MEASUREMENT FRAMEWORK

We measure impact on health equity based on the strength of the data available.

For the first time, in 2024, we were able to understand the close to 80 million interactions between our system and patients nationwide, showing CareMessage utilization is already highly aligned with Health Equity. This was possible through AI categorization and human review to assign each message a category, and aligning each relevant category with our health equity pillars.

This foundation gives us a roadmap for 2025 to improve the quality of evidence we have to showcase the impact of patient engagement campaigns. In the following pages we will share examples of ways our impact is already moving toward being verified and validated alongside our Quality of Evidence Framework.

Quality of Evidence Framework

DEPTH	BREADTH: Access to Care	BREADTH: Clinical Outcomes	BREADTH: Social Drivers of Health	
Standard	Impact is based on the categorization of outbound messages directly related to our health equity pillars. (e.g. Number of messages about diabetes)			Achieved in 2024
Verified	Impact is based on detailed analysis conducted by us or the customer. (e.g. Number of patients with a reduction in A1c)			2025 Priority
Validated	Impact is based on an external, and independent, evaluation. (e.g. Randomized Control Trial (RCT) proving the reduction in A1c is solely attributed to our program)			

HEALTH EQUITY IMPACT - VERIFIED

Affinia Healthcare increases access to care and **decreases no show rate by 50%** through enhanced language support.

Problem
The organization serves a patient population that speaks dozens of languages. They needed a scalable approach to deliver information about appointments in the languages patients speak, and with the ability for patients to interact in their language.

Solution
In 2024, the organization enabled CareMessage's 60+ languages to support their Appointment Reminders and appointment lifecycle messaging. This provided the opportunity for messages to go out in the patient's language as well as the opportunity for patients to respond in their language. The CareMessage system automates the translation and parsing of patient responses into their English equivalent so staff can review the entire conversation.

Success
Since the expansion of languages to their patient population, the organization has seen their **no show rate decrease by 50%**! Tailored language support enables greater access to information for non-English speakers.

About Affinia Healthcare
Affinia Healthcare is an FQHC in Missouri. For more than 100 years, Affinia Healthcare has been providing primary and preventive health services to the residents of St. Louis. It serves over 40,000 patients, of whom over 80 percent are racial and ethnic minorities.

Contributing Team Members
Kim Ngo
Trish Izzo

HEALTH EQUITY IMPACT - VERIFIED

Physicians CareConnection **enables 64% of patients with a missing A1c** to return to care.

Problem
Health Coaches were making manual phone calls to patients who did not show up for their 3-month diabetes checkups. It became difficult to reach patients, and **2 to 3 hours per patient per week** were spent trying to re-engage them. The staff had a goal of 3 callbacks a week and were also texting from their EHR (athenahealth).

Solution
Physicians CareConnection leveraged our new product, Automated Gaps-in-Care Journeys, to automate data extraction from its EHR. Patient segments were created based on appointment and clinical data, and were paired with the right patient engagement strategy to bring them back into care. For example, they automatically targeted patients who visited the clinic in the last year, where their last A1c>8, between the ages of 18-75, with no upcoming appointment. Patients were sent a prompt to come back in for care.

Success
From May to December 2024, **64% of the patients who were messaged came back into care**. The average number of messages sent before someone came back in was three. Additionally, the updated A1c values for the patients who came back in showed **27% of them had a reduction in A1c**.

About Physicians CareConnection
Physicians CareConnection is a Free Clinic in Ohio. Physicians CareConnection is an affiliate of the Columbus Medical Association, is a volunteer-based, charitable organization that helps coordinate care for vulnerable adults in Central Ohio.

Contributing Team Members
Darryl Belcher
Andrea Halko

HEALTH EQUITY IMPACT - VERIFIED

Urban Health Plan **reduces A1c by 1.1 points** through diabetes education and health coaching.

Problem
The Urban Health Plan Quality Improvement (QI) team has a strong focus on improving population health, and was seeking ways to lower A1c levels for its patients with uncontrolled diabetes.

Solution
The QI team enrolled their patients into our 25-week Diabetes health education program, and since Nov 2024 they've had 8,439 patients complete the program (a high completion rate of 88%).

Success
In an analysis of A1c data for initial cohorts, the team found:

- Average A1c at the start of the program was 10.7
- Average A1c at the end of the program was 9.6 (**Reduction of 1.1**)

Patients who replied to the messages saw a greater reduction:

- Average A1c at the start of the program was 10.8
- Average A1c at the end of the program was 9.4 (**Reduction of 1.4**)

Additionally, patients expressed satisfaction with the program and even asked to be re-enrolled.

About Urban Health Plan
Urban Health Plan is an FQHC in New York. Urban Health Plan is one of the largest federally qualified health center systems in New York State serving communities in the Bronx, Corona, Queens, and Central Harlem. The organization serves more than 89,000 patients.

Contributing Team Members
Kim Ngo
Ariana Belsky

HEALTH EQUITY IMPACT - VALIDATED

CareMessage continues to be cited in a variety of research publications, strengthening the rigor through which we evaluate impact.

The following is a selection of publications by independent researchers who have tested the use of CareMessage in a variety of settings. Given the length of time it takes from running an intervention to publication, we are highlighting studies published prior to 2024.

Health Equity Pillar:
Clinical Outcomes
Category:
Diabetes, Group Visits

Health Equity Pillar:
Clinical Outcomes
Category:
Diabetes, Community Health Workers

Health Equity Pillar:
Access to Care
Category:
Appointment Reminders

Visit **www.caremessage.org/learn-more/clinical-publications** to learn more.

Product Innovation

PRODUCT RELEASE

CallerID for Voice Messaging to enhance patient experience and improve voice messaging impact.

Problem
Often times people will not pick up the phone for their reminders due to not knowing who is calling and the volume of spam voice calls.

Solution
We implemented an automated CallerID to display the name of the clinic on all voice calls without the need for the patient to have the number saved on their phone. This builds greater trust with patients, ensuring they know who is calling them.

Success
Since the release of this feature in September 2024, we have seen an increase in the volume of people who have answered their calls in comparison to previous years. Oct 24 (40%) vs. Oct 23 (33%)

Next Steps
We continuously monitor changes in text and voice messaging regulations in the United States. This year we will continue to invest in our messaging infrastructure to improve the way we keep up with regulations while improving patient experience.

Contributing Team Members
Danilo Peres
Matus Kliment

PRODUCT RELEASE

AI Response Assistant to enhance conversational experience for patients, save staff time on easily understood responses, and surface insights.

Problem
7.4% of patient responses did not fit the expected criteria. Within these messages, we found examples of patients trying to seek help, often unrelated to the topic of the outbound message from the clinic.

Solution
Leveraging Generative AI, our team developed an AI categorization layer to support assigning unstructured patient responses to structured data. This approach enables the AI to be segmented to categorization only, while the organizations continue to control the workflow logic. This limits potential harm due to any AI inaccuracies or hallucinations. Alongside the categorization layer, organizations are provided with a dashboard to track the AI's categorization accuracy, and the ability to turn the assistant on or off at any time.

Success
This feature was in private beta for 5 organizations over the summer and was expanded to our entire customer base in the Fall of 2024. We've seen a reduction in error responses for patients, a reduction in the volume of messages staff have to review, and an increase in the staff's capability to address more meaningful messages.

Next Steps
AI implementation will continue in 2025. We will be paying close attention to the in-app workflows for clinic staff who are responsible for reviewing inbound messages and handling follow-up.

Contributing Team Members
Raphael Monteiro
Tatiane Guedes
Alexia Yang
Matus Kliment

PRODUCT RELEASE

Diabetes **Automated Gaps-in-Care Journeys** to automate and sustain clinic interventions for improved population health.

Problem
CareMessage customers use our product to address a variety of clinical quality measures tied to gaps-in-care for their patients. The process today can require manual uploading of patient lists, or be lightly automated via integrations with population health management tools that only address screening reminders.

Solution
Through an integration with the EHR, we can automatically identify patients with uncontrolled diabetes and enroll them into messaging programs that bring patients in for lab visits, diabetes management programs, or provide education on disease management. This offers a comprehensive way to tackle all aspects of clinical quality improvement.

Success
This new feature has been proven to quickly and continually re-engage patients. By automating diabetes follow-ups, we ensure thousands of patients receive timely A1c screenings, preventing complications and hospitalizations. Our pilot customers all reported a reduction in staff hours spent tackling diabetes care gaps, an improvement in the volume of A1c measures on file, and an increase in appointment attendance.

Next Steps
We will continue to expand the clinical areas for which we offer this type of automation, for example cancer and immunizations. This ensures we have comprehensive coverage in each clinical area to tackle the entire journey from prevention to disease management.

Contributing Team Members
Steven Han
Renan Campos
Orit Mohamed
Kim Ngo
Paden Hirstwood

PRODUCT RELEASE

AI for Outbound Message Categorization to understand millions of patient interactions.

Problem
With over 60 million outbound messages going out through CareMessage every year, it is increasingly difficult to understand and report on the types of conversations happening between organizations and the people they serve.

Solution
We leveraged Generative AI to start to categorize outbound messages. In particular, we wanted to find the messages most aligned with our Health Equity Pillars to inform future work on clinical data collection and impact measurement.

Success
We have since launched the categorization of all outbound messages via our Messenger (1:1) feature. This has allowed us, for the first time, to understand the topics of messages going out in personalized support to patients.

Next Steps
We are expanding AI categorization to a few areas that were manually categorized in 2024, including group outreach and health education programs. Additionally, we hope to start exploring how we report on these insights internally and to customers. Insights on messaging interactions at this scale can help inform how we evolve interventions and improve patient engagement strategies.

Contributing Team Members
Tatiane Guedes
Raphael Monteiro
Matus Kliment

People Behind the Work

OUR TEAM

First company-wide retreat since COVID.

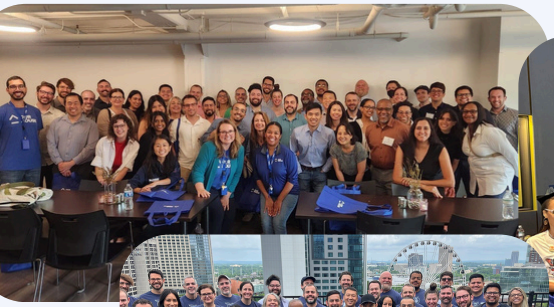
Atlanta, Georgia - May 2024

Our team came together for our first company-wide retreat since 2019. We had a chance to bring together our team members from across the United States as well as team members based overseas.

We spent our first day together realigning around our mission and goals. We visited the National Center for Civil and Human Rights where we underwent trainings on understanding implicit bias and microaggressions.

Our second day was dedicated to department-level activities and bonding time throughout the city. On our third day we had a chance to visit a CareMessage customer, Our House, as well as The King Center. Our House is a wonderful non-profit organization that offers a variety of services to their community, including housing and clinical support. Our team was re-energized by seeing the dignified way in which Our House supports families experiencing homelessness.

We wrapped up our time together with a city scavenger hunt and farewells! We look forward to our time together in 2025!



OUR BOARD & ADVISORS

We welcomed 8 new board members to support CareMessage in our next stage of growth.

Letter from the Chair of the Board

I was pleased to join the Board of Directors of CareMessage late in 2023.

The CareMessage team achieved astonishing impact in its first 10 years. In 2024, the Board of Directors focused on significantly increasing the advice that the CareMessage team can receive from outside advisors. To that end, we have added members to the Board of Directors who can advise on relevant areas including compliance, fund raising for a non-profit, corporate governance, finance and the needs of targeted patient populations. And faced with the fact that CareMessage runs a software as a service business, we have often focused on advisors with SaaS and AI expertise.

We're not done! You can look forward to additional advisors with relevant expertise in 2025. If you have any questions you would like to ask the Board of Directors, please feel free to contact me at kit@kitkaufman.com.

Christopher (Kit) Kaufman

Governing Board

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President, Starling Advisors

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Sarah J. DiBoise
Deputy General Counsel for Healthcare, Stanford University

Uché Blackstock, MD
Founder and Chief Advisor, Advancing Health Equity

Vineet Singal
Co-founder and Chief Executive Officer, CareMessage

OUR DONORS

We raised over $8 M in funding to support our innovation and expansion efforts in 2024 and beyond.

Fundraising Initiatives

2024 and 2025 AI & Data Fund	2025 Interoperability Fund	2024 Customer Impact Fund
This fund continues to cover development of AI and Data solutions. Our work here focuses on measuring Health Equity impact and deepening our impact.	This fund is dedicated to expanding our interoperability capabilities. Our work here is focused on expanding the data systems with which CareMessage integrates to power the right patient engagement interventions at the right time.	This fund was dedicated to subsidizing the adoption of CareMessage for organizations who had a direct commitment to driving a measurable improvement in health equity.

Visit **www.caremessage.org/about-us/donors** to learn more.

Major Donors

ballmer GROUP

J&J Foundation

Patrick J McGovern FOUNDATION

DOVETAIL IMPACT FOUNDATION

Scarlet Feather Fund

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CareMessage is the technology non-profit building the largest patient engagement platform for low-income populations in the United States. Powered by the Health Equity Engine™, the platform enables organizations to combine messaging, data, and interoperability to increase access to care, improve clinical outcomes, and address social drivers of health.

With 20 million patients reached since 2013, CareMessage is the only patient engagement solution proven to improve health equity at scale. The team, many with lived experiences in these communities, leverages a nonprofit model to reinvest revenue into impact. CareMessage is the partner of choice for organizations committed to advancing health equity.

CareMessage

www.caremessage.org