ASX ANNOUNCEMENT

ASX:VHL

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Vitasora CCM Patients Continue to Outperform National Benchmarks, Strengthening US Growth Opportunities

Highlights

- **Better results, and still improving:** Patients in Vitasora's CCM program, delivered in partnership with the physicians and care teams of a US Federally Qualified Health Center (FQHC), were already outperforming national health center benchmarks after about six months. After about 12 months, their results had improved again.[1, 2]
- **Diabetes control improves again:** The share of patients with poorly controlled diabetes fell from 13.1% at six months to 6.7% at about 12 months, against a national benchmark of 28.1%. Blood pressure control rose to 82.9%, compared with 67.4% nationally.[1, 2]
- **Small choices, better health:** Vitasora's THRIVE Coaching uses behavioural science, combining Motivational Interviewing and Patient Activation Assessment, to engage patients and build their confidence to make small, everyday lifestyle choices that add up to better health.
- **More care delivered:** Better clinical workflows, the V-care platform and a strengthened US management team lifted Care Coordinator utilisation above 95% and grew monthly billable care minutes by approximately 50%, 262,104 minutes, in October.[3]
- **Building capacity ahead of demand:** Vitasora had 42 active Care Coordinators at late October 2026, with a target of approximately 115 by late Q1 2027. Indicative revenue capacity is approximately US$595 per fully productive Care Coordinator per day.[4]
- **Evidence that opens doors:** These outcomes give Vitasora real-world evidence to bring to existing customers looking to expand services and to new prospects, including opportunities associated with the Treasure Coast Community Health agreement.[3]

Ahead of National Benchmarks at Six Months, and Still Improving at 12 Months

Vitasora Health Limited (ASX: VHL) ("Vitasora" or "the Company") reports further improvements in patient health outcomes through its Chronic Care Management (CCM) program, building on positive clinical results previously reported from its Remote Patient Monitoring (RPM) services. Delivered in partnership with a US Federally Qualified Health Center (FQHC), the CCM program recorded outcomes better than national health center benchmarks after approximately six months of care, with further improvements reported over the following six months. Together, these separate program findings provide further evidence supporting Vitasora's connected care services and strengthen its proposition to existing and prospective US healthcare customers.[1, 2, 5]

The first quality report for the program was produced once patients had already been in the program for about six months, so it is not a pre-enrolment baseline. Even at that stage, CCM patients were ahead of the FQHC's other patients on all 11 reported quality measures, and their diabetes and blood pressure results were already significantly better than historical national averages. The second report, after about 12 months of care, CCM patients results continued to improve and **were ahead of national benchmarks on all 11 measures**.[1, 2]

These results did not come from technology alone. They came from a partnership. The FQHC's physicians lead each patient's care and set the care plan. Vitasora's Care Coordinators, working under their general supervision, stay in regular contact with patients between visits: helping them understand their numbers, working through what may help them improve their health and agreeing on the next small step they feel ready to take.[4]

Reported Clinical Results

Quality indicator	After ~6 months of Vitasora Health CCM	After ~12 months of Vitasora Health CCM	US national average
Poorly controlled diabetes*	13.1%	6.7%	28.1%
Blood pressure controlled	79.6%	82.9%	67.4%
Depression screening and follow-up	70.3%	79.5%	Not supplied

*For diabetes, a lower percentage indicates a better outcome. The six-month figures are outcomes after approximately six months of CCM participation, not measurements taken before enrolment. Data are observational and relate to one participating FQHC.[1, 2]

The diabetes result stands out. At six months on CCM program, only 13.1% of CCM patients had poorly controlled diabetes, already well below the national rate of 28.1%. By 12 months, that figure had fallen to **6.7%,** a reduction of approximately 49% between reporting periods and approximately 76% below the national benchmark. Blood pressure control, already above the national average at 79.6%, rose **to 82.9%.** Depression screening and follow-up also improved from 70.3% **to 79.5**%.[1, 2]

As with any real-world program, these figures should be read in context. They compare successive program-level quality reports from a single FQHC. They do not show patients' outcomes before enrolment, confirm that exactly the same patients were measured in both periods, or prove that CCM alone caused the improvement. The national comparison uses historical benchmarks, not a matched control group.

Small Choices, Better Health: How THRIVE Coaching Works

Most people living with a chronic condition already know they should take their medication, check their blood pressure or watch what they eat. The hard part is doing it, day after day. That is where Vitasora's approach is different. Rather than simply collecting readings and documenting care, THRIVE Coaching draws on behavioural science to help patients act. Clinical data and regular conversations show a Care Coordinator when a patient may need support, and the Care Coordinator, working under the general supervision of the treating provider, reaches out to engage them.

Two well-established techniques sit at the centre of the Vitasora-Way model. Motivational Interviewing helps Care Coordinators explore what matters to each patient and what is holding them back, rather than relying on instructions and reminders. Patient Activation Assessment gauges how much knowledge, confidence and capability a patient has to manage their own health, so coaching can meet each person where they are and help them become more active in their own care.[4]

The aim is not a dramatic overhaul. It is a series of small, achievable choices that patients feel ready to make and can keep making: taking medication as prescribed, checking blood pressure regularly, changing one meal, going for a short walk, keeping a follow-up appointment. Over time, those choices add up. The FQHC results are consistent with what this model is designed to achieve, although an observational analysis cannot isolate the effect of any single intervention.

A Genuine Partnership with FQHC Physicians and Care Teams

FQHCs care for some of America's most underserved communities, and many of their patients live with more than one chronic condition. These health centers also work within their own reimbursement rules, clinical workflows and quality reporting requirements, overseen by the US Health Resources and Services Administration (HRSA).

Vitasora has built its model around that reality. Its Care Coordinators act as an extension of the health center's own team: working with its physicians and staff, following its workflows and connected to its electronic medical records through vCare. That partnership is designed to give more patients consistent support between appointments in a way that fits how the health center already works. The latest results give Vitasora strong evidence to share with existing customers considering broader adoption and with prospective customers evaluating its model, although outcomes alone do not guarantee future contracts or enrolment growth.

Clinical Evidence Across Vitasora's Connected Care Portfolio

The latest CCM findings complement previously reported RPM results from a separate US primary care practice. Between July and September 2026, the RPM analysis reported an 8.5 mmHg reduction in average systolic blood pressure across successive reporting periods. At the final measurement, 303 of 435 assessed patients (approximately 70%) had systolic readings below 140 mmHg. Patients receiving at least 20 minutes of Thrive coaching had larger observed reductions than those receiving less coaching.[5]

The CCM and RPM findings relate to different patient populations and observational analyses, rather than a combined clinical study. Together, they provide evidence of favourable reported outcomes across two core service lines, supporting Vitasora's discussions with healthcare providers about expanding existing programs and introducing new services.[1, 2, 5]

Operating Model Established; Now Focused on Scaling

Behind these results is significant investment in US clinical leadership, recruitment and training, care delivery processes and the integrated vCare platform. The strengthened US management team has changed how Care Coordinators are allocated, how patients are engaged and how care is documented, and those changes are now showing up in productivity.

The Company is delivering substantially more patient care. Care Coordinator daily utilisation rose from approximately 65% to more than 95%, and monthly billable care minutes grew approximately 50%, from 175,324 in September to 262,104 in October. Importantly, this growth came from the existing customer base, before patient enrolments begin for Treasure Coast Community Health and other new clients.[3]

vCare supports clinical workflows, patient prioritisation, Care Coordinator allocation, documentation and billing. It integrates with customers' electronic medical records, it is designed to support more patients and flexible deployment of appropriately qualified clinical staff without a proportionate increase in central overheads. Billing conversion and claims processes continue to be optimised.

Care Coordinator Recruitment to Support Anticipated Patient Demand

At the end of October 2026, Vitasora had 42 active Care Coordinators, a net increase of 20 since 1 July. The Company is targeting 48 or more during November 2026 and approximately 115 by late Q1 2027, with hiring paced to anticipated enrolments from existing and new customers.[3]

Management estimates that each fully productive Care Coordinator can generate approximately US$595 in daily revenue under current operating assumptions. On the same indicative basis, 10 additional fully productive Care Coordinators would represent approximately US$5,950 in daily revenue capacity. This is a measure of capacity, not a revenue forecast. Actual results will depend on eligible patient demand, staff ramp-up, utilisation, payer mix, billing eligibility, reimbursement and collections.[3]

The next phase is clear: keep growing the Care Coordinator team, enrol more eligible patients from existing and newly contracted clients, and convert more of the care delivered into recognised revenue and cash receipts.

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Vitasora Health Managing Director and CEO, Marjan Mikel, said:

"These results show what happens when a health center's care team and our Care Coordinators work as one. The physicians and staff at our FQHC partner lead the care, and our team helps patients follow through on it every day between visits. Patients were already outperforming national benchmarks at six months, and they kept getting better.

"What makes the difference is how we engage people. THRIVE uses behavioural science to understand what motivates each patient and to build their confidence to make small, practical changes. Small changes, made consistently, add up to better health.

"That track record is opening doors with existing customers and new ones. With our US management team, the vCare platform and a growing clinical workforce, we have the capacity to scale.

"We have built it. It works. Now we scale."

Outlook

Vitasora's focus now is turning demonstrated clinical outcomes into commercial growth: expanding patient enrolment and service adoption with existing customers, winning new healthcare customers and growing productive clinical capacity. The vCare platform and THRIVE Coaching approach are designed to keep care consistent as the Company scales. Management continues to target cash-flow breakeven during H1 2027, subject to execution and collections.

The clinical findings and operating metrics in this announcement are unaudited. October care-minute figures are management estimates subject to final reconciliation. Workforce targets, indicative revenue capacity and breakeven timing are forward-looking and are not guarantees of performance.

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This ASX announcement has been authorised for release by the Board of Directors of Vitasora Health Limited.

References and data sources

1. Participating US Federally Qualified Health Center (FQHC), clinical quality scorecards, March and October 2026. Source of the CCM patient-cohort results, including diabetes, blood pressure, depression screening and the reported 11-measure comparison. These data relate to one FQHC.

2. US Health Resources and Services Administration (HRSA), 2024 Uniform Data System (UDS), national health center clinical quality measures. Historical national benchmarks used for the diabetes (28.1%) and blood pressure (67.4%) comparisons. National averages are not a matched control group.

3. Vitasora Health Limited, September 2026 Quarterly Activities Report and Appendix 4C (30 October 2026), and ASX market update (30 September/2 October 2026). Sources for Care Coordinator numbers, utilisation, billable care activity, indicative revenue capacity, vCare and growth targets.

4. Vitasora Health, THRIVE Coaching care delivery methodology and management descriptions of Motivational Interviewing and Patient Activation Assessment. Describes the intervention approach; the FQHC observational results do not isolate or establish the causal contribution of either technique.

5. Vitasora Health Limited, September 2026 Market Update, slide 18, "The Vitasora Difference: We Don't Just Collect Data. We Act on It." RPM observational blood pressure analysis at one partner US primary care practice, 1 July–16 September 2026; three successive measurement periods, no matched comparison group. The slide reports 303 of 435 patients with final systolic readings below 140 mmHg, an average 8.5 mmHg systolic reduction, and larger observed reductions with 20 or more minutes of coaching.

About Vitasora Health Limited

Vitasora Health Limited (ASX: VHL) provides technology-enabled connected-care services to US healthcare providers. Its clinical teams and vCare platform support Chronic Care Management (CCM), Remote Patient Monitoring (RPM), Principal Care Management (PCM) and Transitional Care Management (TCM), extending care between appointments through patient engagement, clinical coordination and reimbursement support. Learn more at www.vitasorahealth.com.

Forward Looking Statements

This announcement includes forward-looking statements, including workforce targets, anticipated patient demand, revenue capacity and the Company's objective of cash-flow breakeven. Such statements reflect current management assumptions and involve risks and uncertainties. Actual outcomes may differ materially due to recruitment, patient enrolment, utilisation, reimbursement, billing and collections, among other factors. They are not guarantees of future performance. Vitasora undertakes no obligation to update these statements except as required by law.