CareMore

CareMore RESULTS

Clinical Model of Care

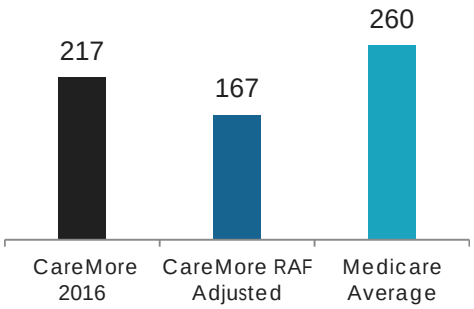
CareMore

STRONG ACUTE MANAGEMENT and WELL-COORDINATED CARE TRANSITIONS

Hospital Outcomes

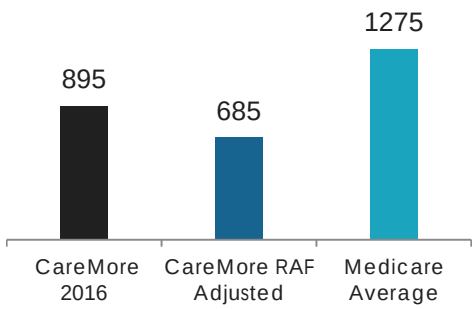
Extensivist Physicians

Inpatient Admissions



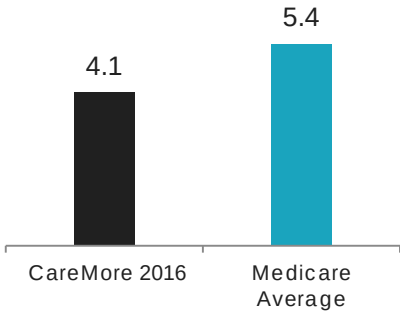
Case Managers

Inpatient BDK



Disease Management Programs

Inpatient LOS



CareMore 2016 Hospital Metrics. Admissions and days are rates per 1,000 beneficiaries. Inpatient LOS is in days. Readmissions are 30 day acute hospital readmissions. Medicare averages from most recent data available, U.S. Department of Health and Human Services. (2017, March) 2015 data.

RESULTS as COMPARED to MEDICARE FFS AVERAGE

CareMore vs. **Medicare Average**

- **17% fewer** admits
- **30% lower** bed days
- **24% lower** length of stay

CareMore RAF Adjusted vs. **Medicare Average**

- **36% fewer** admits
- **46% lower** bed days

RAF average = 1.2979 CareMore 2016, RAF Adjusted is (CareMore 2016) /1.2979
RAF average calculation (Member count per contract) X (Contract RAF score) / (Total Member Count)

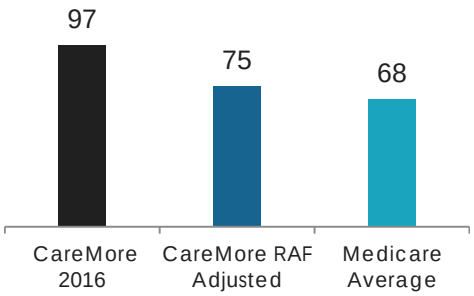
CareMore

JUDICIOUS UTILIZATION

Skilled Nursing Facilities

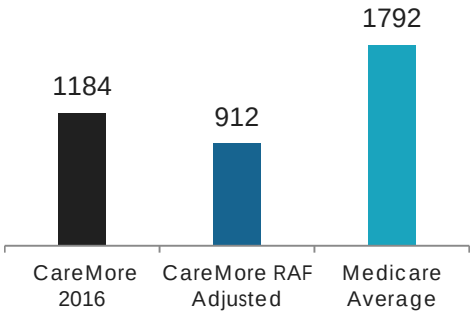
Extensivist Physicians

SNF Admissions



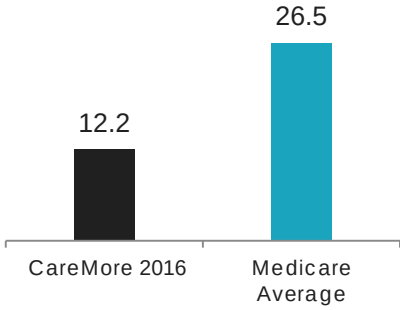
Case Managers

SNF Days



Disease Management Programs

SNF LOS



CareMore 2016 Hospital Metrics. Admissions and days are rates per 1,000 beneficiaries. SNF LOS is in days. Medicare averages are FFS from U.S. Department of Health and Human Services. (2017, March) 2015 data.

RESULTS as COMPARED to MEDICARE FFS AVERAGE

CareMore vs. **Medicare Average**

- **43% more** admits
- **34% lower** bed days
- **54% lower** length of stay

CareMore RAF Adjusted vs. **Medicare Average**

- **10% more** admits
- **49% lower** bed days

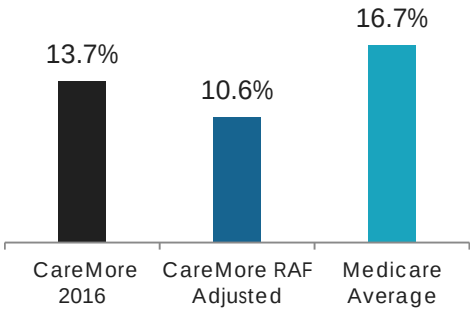
RAF average = 1.2979 CareMore 2016, Admit RAF Adjusted is (CareMore 2016) /1.2979
BDK RAF Adjusted is (Admit RAF Adjusted) X (CareMore 2016 ALOS)
RAF average calculation (Member count per contract) X (Contract RAF score) / (Total Member Count)

CareMore

Hospital Readmissions

CareMore Overall

Acute Hospital Readmissions



RAF Adjusted vs. CareMore
23% fewer readmits

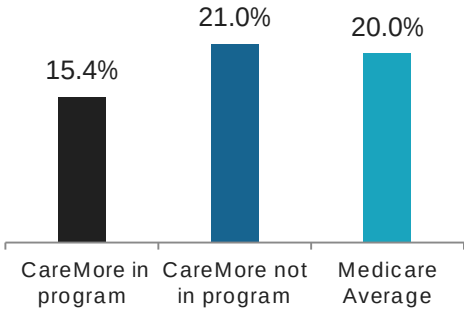
CareMore vs. Medicare Avg.
18% fewer readmits

RAF Adjusted vs. Medicare Avg.
37% fewer readmits

Medicare Readmission rate from most recent data available, Data.Medicare.gov (2015)

COPD Program

COPD on Oxygen Readmissions



In Program vs. Not In Program
27% fewer readmits

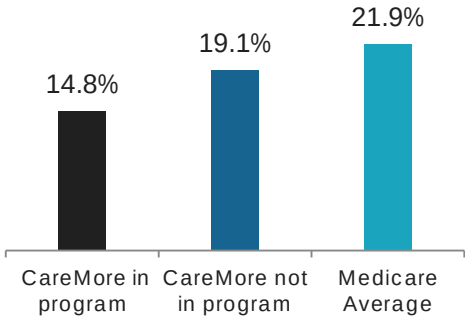
In Program vs. Medicare Avg.
23% fewer readmits

Not In Program vs. Medicare Avg.
5% more readmits

Medicare COPD rate from most recent data available, Data.Medicare.gov (2015) ***NOT based on oxygen use****.*

CHF Program

CHF Readmissions



In Program vs. Not In Program
14% fewer readmits

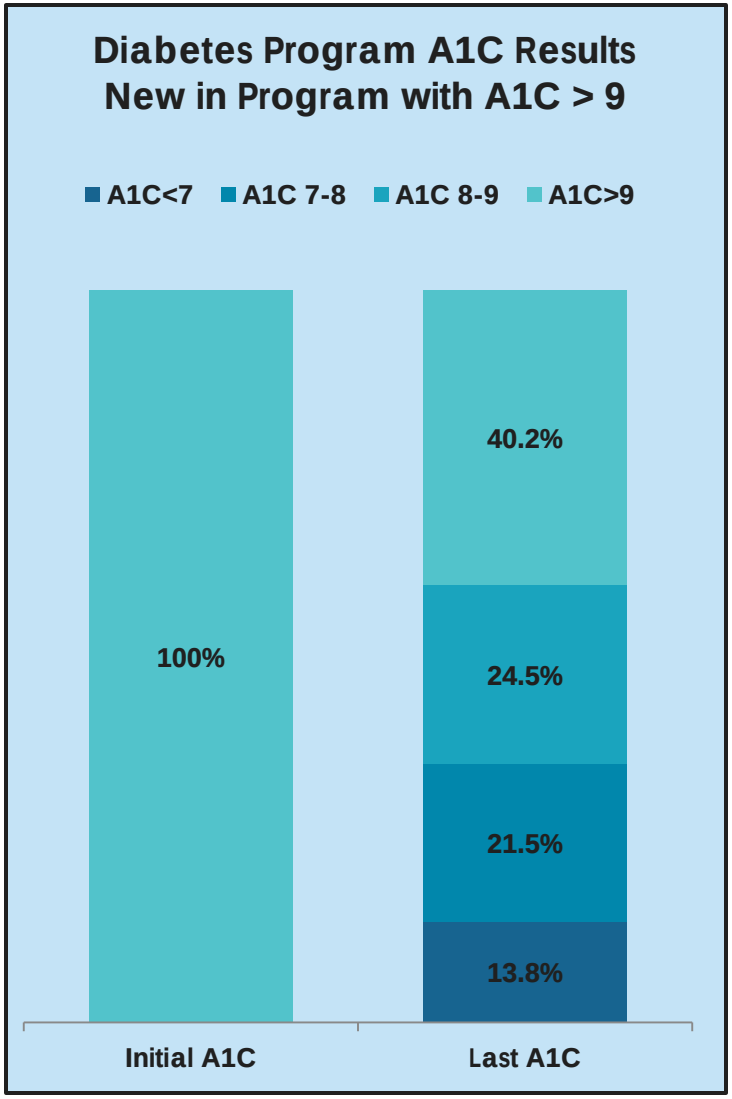
In Program vs. Medicare Avg.
23% fewer readmits

Not In Program vs. Medicare Avg.
11% fewer readmits

Medicare CHF rate from most recent data available, Data.Medicare.gov (2015)

CareMore

Effective Diabetes Management



DIABETES PROGRAM

- Nurse Practitioners
- Registered Dieticians
- Self-Care Education
- Point of Care HbA1c labs
- Insulin and blood sugar testing management

RESULTS

Individuals referred to the Diabetes Management Program for A1c poor control > 9 experienced better blood sugar control.

- **13.8%** with excellent control < 7
- **35.3%** with good control < 8
- **59.8%** under control <= 9

Average A1c value for program participants: 8.11

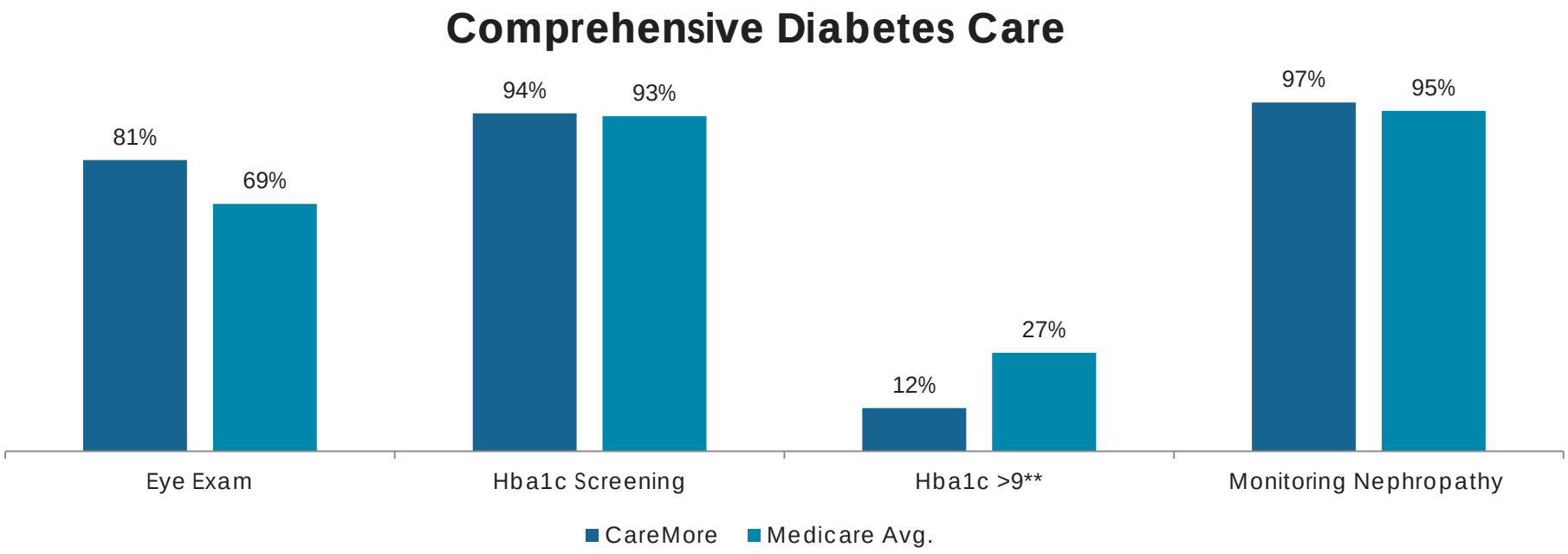
CareMore 2016 Program Effectiveness Metrics. Program participants with diabetes whose A1C was > 9 on initial visit to the CareMore Diabetes Program in 2016, compared to repeat A1c testing, reported as Last A1C in CY2016.

CareMore

Comprehensive Diabetes Care

DIABETES PROGRAM

- Protocols in CareMore EHR for prompt annual diabetes care compliance
- ACE/ARB and statin medication management
- Appointment scheduling for retinopathy screening via CareMore Outreach



**Lower rate is better

CareMore 2016 based on 2017 HEDIS Comprehensive Diabetic Care measures for Diabetic Retinopathy Screening, A1c Screening, A1c >9 and Monitoring Nephropathy. A1c>9 based on 2017 HEDIS MA samples
Medicare averages from most recent data available, NCQA (2017) Report Cards.

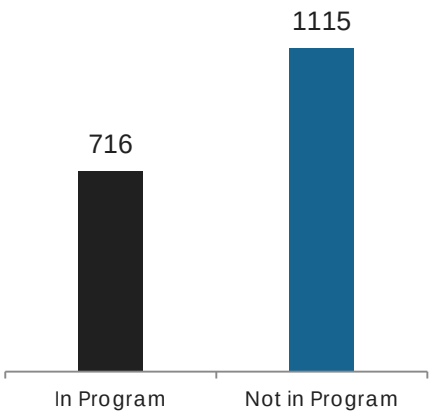
CareMore

Successful Congestive Hearth Failure (CHF) Monitoring

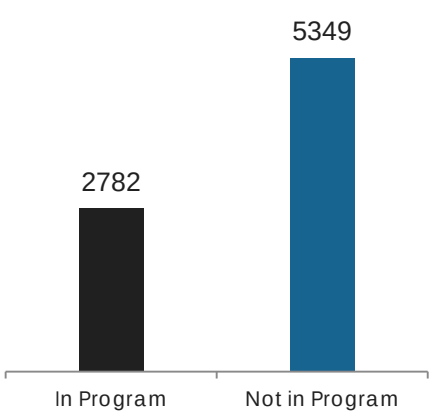
CHF WEIGHT PROGRAM

- Wireless scale for weight monitoring at home provided to members with CHF
- Alerts CareMore Nurse Practitioner to contact member for rapid weight increase
- Same-day appointment at the CareMore Care Center if needed

Inpatient Admissions



Inpatient Days

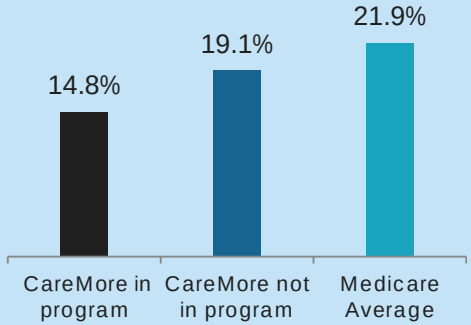


RESULTS FOR PROGRAM PARTICIPANTS

48% fewer hospital days | **36%** fewer admissions | **23%** fewer readmissions

CareMore 2016 Q4 Executive Summary. Based on program participants with diagnosis of CHF who received Ideal Life wireless scale (In Program) and individuals who did not (Not in Program).

CHF Readmissions



In Program vs. Not In Program
14% fewer readmits

In Program vs. Medicare Avg.
23% fewer readmits

Not In Program vs. Medicare Avg.
10% fewer readmits

Medicare CHF rate from most recent data available, Data.Medicare.gov (2015)

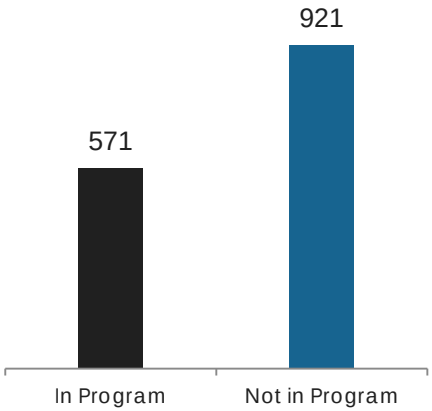
CareMore

Proactive Chronic Obstructive Pulmonary Disease (COPD) Management

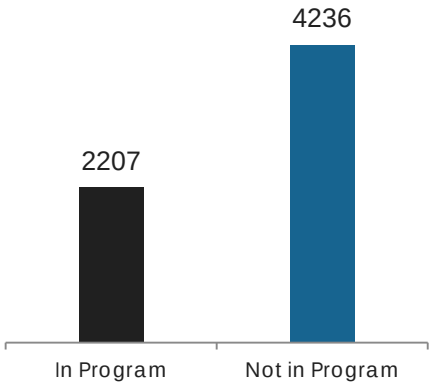
COPD PROGRAM

- COPD Management and Self-Care Education with Nurse Practitioners and Dieticians
- Medication Management – routine and rescue meds
- Smoking Cessation Class for all smokers interested in quitting

COPD on Oxygen Inpatient Admissions
Admits PTMPY



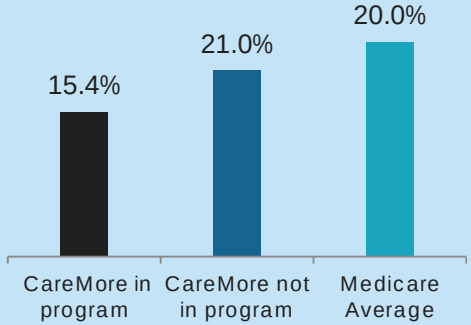
COPD on Oxygen Inpatient Days
Bed Days/1000



RESULTS FOR PROGRAM PARTICIPANTS
38% fewer admissions | **48%** fewer hospital days

CareMore 2016 Executive Summary. Based on individuals who receive supplemental oxygen at home who had at least 1 CareMore COPD Program visit (In Program) versus those who did not (Not In Program)

COPD on Oxygen Readmissions



In Program vs. Not In Program
27% fewer readmits

In Program vs. Medicare Avg.
23% fewer readmits

Not In Program vs. Medicare Avg.
5% more readmits

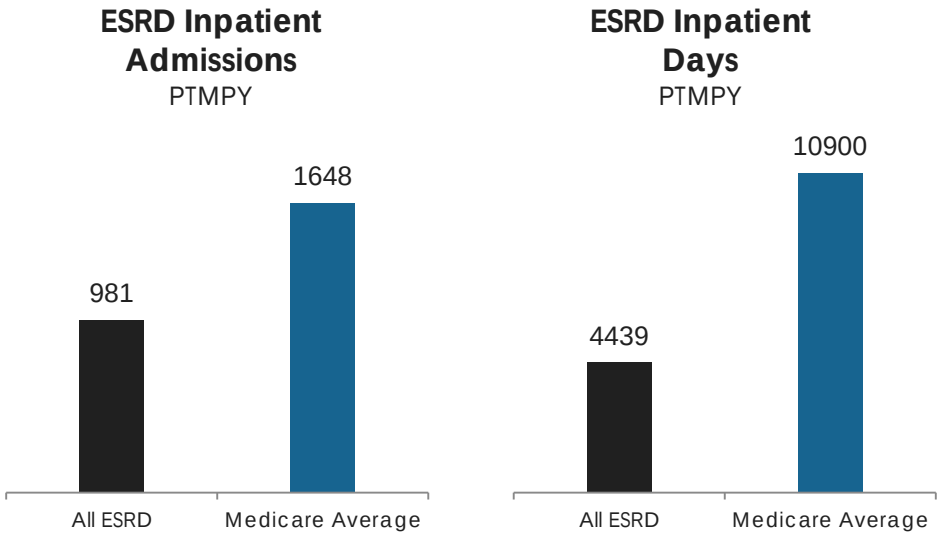
Medicare CHF rate from most recent data available, Data.Medicare.gov (2015)

CareMore

Comprehensive End-Stage Renal Disease (ESRD) Program

ESRD PROGRAM

- ESRD Management NPs and Dedicated Case Manager
- Dialysis Access Line Inspection and Cleaning
- Close collaboration with nephrologist and dialysis center



RESULTS FOR ALL ESRD PARTICIPANTS vs. MEDICARE ESRD

40% fewer admissions | **59%** fewer hospital days

CareMore 2016 Executive Summary. Based on individuals who receive supplemental oxygen at home who had at least 1 CareMore COPD Program visit (In Program) versus those who did not (Not In Program)

CareMore

RESOURCES

- Hospital Outcomes
  - U.S. Department of Health and Human Services. (2017, March). 2016 CMS Statistics. Retrieved June 21, 2017, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2016_CMS_Stats.pdf Pages 33-34
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  - Medicare Enrollment - Centers for Medicare & Medicaid Services. (n.d.). Retrieved August 3, 2017, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2015/2015_Utilization.html
- Hospital Readmissions
  - Data.Medicare.gov (2017, April 26) Readmissions and Deaths - National. Retrieved June 21, 2017, from https://data.medicare.gov /Hospital-Compare/Readmissions-and-Deaths-National/qqw3-t4ie
- Comprehensive Diabetes Care
  - NCQA (2017) Report Cards. Retrieved August 1, 2017, from http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2016-table-of-contents/diabetes-care
- Comprehensive End-Stage Renal Disease Program
  - USRDS (2016) Retrieved June 22, 2017 from 2016 USRDS Annual Data Report Volume 2: ESRD in the United States https://www.usrds.org/reference.aspx G. Morbidity and Hospitalization Tables G.1 and G.6