CareMore

CareMore RESULTS

Clinical Model of Care
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 = \( \frac{1.2979 \times \text{CareMore 2016}}{\text{RAF Adjusted}} \)

RAF average calculation: (Member count per contract) X (Contract RAF score) / (Total Member Count)

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.

Judicious Utilization

Skilled Nursing Facilities

<table>
<thead>
<tr>
<th>Extensivist Physicians</th>
<th>CNF Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareMore 2016</td>
<td>97</td>
</tr>
<tr>
<td>CareMore RAF Adjusted</td>
<td>75</td>
</tr>
<tr>
<td>Medicare Average</td>
<td>68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Managers</th>
<th>CNF Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareMore 2016</td>
<td>1184</td>
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<tr>
<td>CareMore RAF Adjusted</td>
<td>912</td>
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<tr>
<td>Medicare Average</td>
<td>1792</td>
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</table>

<table>
<thead>
<tr>
<th>Disease Management Programs</th>
<th>CNF LOS</th>
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<tbody>
<tr>
<td>CareMore 2016</td>
<td>12.2</td>
</tr>
<tr>
<td>Medicare Average</td>
<td>26.5</td>
</tr>
</tbody>
</table>

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

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.

RAF average = 1.2979
Admit RAF Adjusted = (CareMore 2016) / 1.2979
BED RAF Adjusted = (Admit RAF Adjusted) X (CareMore 2016 ALOS)
RAF average calculation (Member count per contract) X (Contract RAF score) / (Total Member Count)
# Hospital Readmissions

<table>
<thead>
<tr>
<th></th>
<th>CareMore Overall</th>
<th>COPD Program</th>
<th>CHF Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Hospital Readmissions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CareMore 2016</td>
<td>13.7%</td>
<td>15.4%</td>
<td>14.8%</td>
</tr>
<tr>
<td>CareMore RAF</td>
<td>10.6%</td>
<td>21.0%</td>
<td>19.1%</td>
</tr>
<tr>
<td>Medicare Average</td>
<td>16.7%</td>
<td>20.0%</td>
<td>21.9%</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>COPD on Oxygen Readmissions</th>
<th>CHF Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareMore in program</td>
<td>27% fewer readmits</td>
<td></td>
</tr>
<tr>
<td>CareMore not in program</td>
<td>23% fewer readmits</td>
<td>14% fewer readmits</td>
</tr>
<tr>
<td>Medicare Average</td>
<td>21.0%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

 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)

 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.

 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)
Effective Diabetes Management

Diabetes Program A1C Results
New in Program with A1C > 9

- A1C < 7
- A1C 7-8
- A1C 8-9
- A1C > 9

100%

40.2%

24.5%

21.5%

13.8%

Initial A1C

Last A1C

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.
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

**Comprehensive Diabetes Care**

- Eye Exam: 81% (CareMore), 69% (Medicare Avg.)
- Hba1c Screening: 94% (CareMore), 93% (Medicare Avg.)
- Hba1c >9: 12% (CareMore), 27% (Medicare Avg.)
- Monitoring Nephropathy: 97% (CareMore), 95% (Medicare Avg.)

**Lower rate is better**

Medicare averages from most recent data available, NCQA (2017) Report Cards.
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

RESULTS FOR PROGRAM PARTICIPANTS

48% fewer hospital days | 36% fewer admissions | 23% fewer 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)
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

<table>
<thead>
<tr>
<th></th>
<th>In Program</th>
<th>Not in Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareMore in program</td>
<td>571</td>
<td>921</td>
</tr>
<tr>
<td>CareMore not in program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Average</td>
<td></td>
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</table>

COPD on Oxygen Inpatient Days
Bed Days/1000

<table>
<thead>
<tr>
<th></th>
<th>In Program</th>
<th>Not in Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareMore in program</td>
<td>2207</td>
<td>4236</td>
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<tr>
<td>CareMore not in program</td>
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</tr>
<tr>
<td>Medicare Average</td>
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<td></td>
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</table>

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

COPD on Oxygen Readmissions

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<th>CareMore in program</th>
<th>CareMore not in program</th>
<th>Medicare Average</th>
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<tr>
<td>In Program vs. Not In Program</td>
<td>15.4%</td>
<td>21.0%</td>
<td>20.0%</td>
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<td>In Program vs. Medicare Avg.</td>
<td>27% fewer readmits</td>
<td>23% fewer readmits</td>
<td>5% more readmits</td>
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</table>
Comprehensive End-Stage Renal Disease (ESRD) Program

RESULTS FOR ALL ESRD PARTICIPANTS vs. MEDICARE ESRD
40% fewer admissions | 59% fewer hospital days

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

• Hospital Outcomes

• Skilled Nursing Facilities

• Hospital Readmissions

• Comprehensive Diabetes Care

• Comprehensive End-Stage Renal Disease Program