REDESIGNING CARE FOR THOSE WHO NEED IT MOST...
Our Mission

To address the complex problems of aging while protecting the precious financial resources of our members and the federal government.
Our Philosophy of Health Care

- Older patients require **overtly coordinated** care with a care path that takes into account their multiple conditions and treats them **simultaneously**

- A physical and human **focus of care** is required to create care coordination and a setting where care habits of patients can be sustained.

- Clinicians in key roles must be **confident generalists**, persistent and deliberate, with competence as clinical decision makers, communicators and team players.

- All providers of service have a **buy-in for the system of care**, not just their individual capabilities.

- A complete care continuum requires equal **attention to medical, social, psychological and pharmacological needs** of the patient.

- An **explicit approach to care** is required for each chronic condition, for high-frequency acute episodes, and for end-of-life.

- An **obsessive attention to detail** in both micro matters (individual care) and macro matters (care programs) permits optimal outcomes

- A **willingness to thoughtfully challenge the status quo** provides windows of insight into clinical innovation and care pattern redesign which can optimize patient health and comfort, and conserve financial resources.
Challenging the Status Quo

- Health care systems should be about improving quality, not maintaining it
- At least 35% of health care costs for the chronically ill can be avoided
- Prepayment (Capitation) is freedom, not risk
- Primary Care is a “team sport” not an “individual sport”
- For aging adults, Primary Care should be an outbound activity, not an inbound activity
- A high percentage of physician services can be provided by non-physician clinicians
- Benefit design should lead with patient access and compliance considerations, not actuarial risk considerations
- Patient compliance is more our problem than the patient’s
- We have a responsibility for the financial well-being of our physician and hospital partners
- Many patients fare better with less complex health care interventions
Healthcare cost and quality problems are concentrated....not widespread

85% of Beneficiaries = 25% Spending
15% of Beneficiaries = 75% Spending

23 Million Beneficiaries
- Spending $1,130 each
- Total Spending = 5%

(26 B)

16.1 Million Beneficiaries
- Spending $6,150 each
- Total Spending = 20%

(104 B)

7 Million Beneficiaries
- Spending $55,000 each
- Total Spending = 75%

(391 B)

Healthy
Stable
Sick
mostly 1 + Chronic Illness
Progressive Illness
Sickest
mostly 3 + Chronic Illness

2010 Medicare Spending Projection = $522 B
46 Million Beneficiaries
Spending Per Beneficiary = $11,347

ESRD, CANCER
CareMore Spending
CHF, DM
Average Spending

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The CareMore Model
The Essentials of CareMore’s Model

Chronic Care Management

Acute Care Management

Predictive Modeling & Early Intervention

Operating Principles

- **Clinical Control** - CareMore extensivists determine when a patient requires proprietary services and programs

- **Speedy Deployment** - Proprietary services and programs can be deployed within minutes

- **Efficient Allocation of Clinical Resources** - The model replaces physician labor with skilled, allied health professionals such as NPs, MAs, therapists and dieticians

- **Early Intervention** - Proprietary resources and predictive modeling allow for early intervention to prevent acute episodes

Redefining Primary Care

Secondary Prevention

Redefined Acute Care Episode
CareMore’s system functions in parallel with community physicians

**Non-Frail Population**
- Primary Care Physicians
- Provider Relations
- Continuous Frailty Assessment Tools

**Frail & Chronically Ill Population**
- Primary Care Physicians
- Case Managers
- Home Based Services
- CareMore Extensivist
- Specialists

- Close monitoring of non-frail members to proactively identify at-risk members and aggressive management of chronic conditions to prolong the onset of frailty
- Intensive management of frail and chronically ill members, identified through predictive models, data scans, PCP referrals or member self-identification
The CareMore Solution – A New Model of Care

- Predictive modeling
- Integrated IT infrastructure
- Longitudinal patient record
- Evidence-based protocols
- Point-of-care decision support

End of Life Care
- Hospice
- Palliative Care

Social / Behavioral Support
- Social Workers
- Mental Health

Clinical Care Centers (CCC)
- Extensivist Management
- Strength Training

Chronic Disease Support
- PCP
- Extensivist
- Case Manager/NP

Risk Event Prevention
- Wound Clinic
- Healthy Start
- Monitoring
- Nutritionist
- Foot care
- Exercise
- Pre-Op
- Coumadin
- Fall

Frailty Support

Extensivist Management

Secondary Prevention
- ESRD
- CAD
- COPD
- Diabetes
- Wound Clinic
- Foot care
- Nutritionist
- Exercise
- Pre-Op
- Coumadin
- Fall

Mental Health

Secondary Prevention
- ESRD
- CAD
- COPD
- Diabetes
- Wound Clinic
- Foot care
- Nutritionist
- Exercise
- Pre-Op
- Coumadin
- Fall

Secondary Prevention
- ESRD
- CAD
- COPD
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- Wound Clinic
- Foot care
- Nutritionist
- Exercise
- Pre-Op
- Coumadin
- Fall
CareMore Care Centers

CareMore neighborhood care centers provide direct services, ensure access to care, and create security and customer loyalty.

- Designed for seniors
- Resource for family and caregivers
- Frequent classes and activities

Care Center Facts
- 4,000 square feet of clinical and 1,500 of therapy space
- Support 5,000 patients
- Located in the heart of the neighborhood
- Typical staffing
  - 2 MDs, 2 NPs, 8 MAs, 1 podiatrist, 1 PT, 1 nutritionist, 1 psychologist, 1 case managers

Clinical Support
- Physician and NP support of chronic and frailty care
- Wound care
- Coumadin management
- Physical therapy and strength training
- Cardiac/pulmonary rehab
- Nutritional training
- Disease-specific group sessions
- Healthy Start

Serves as an anchor to a neighborhood
CareMore model allows for efficient allocation of clinical resources

<table>
<thead>
<tr>
<th>Extensivists</th>
<th>Nurse Practitioners</th>
<th>Case Managers</th>
</tr>
</thead>
</table>
| Conduct pre-operative exams | Chronic Care  
  - Conduct annual health risk assessments and create care plans  
  - Micro-manage chronic conditions and lead interdisciplinary teams specific to a patient’s needs  
  - Provide all wound care (diabetic, ulcerative, post-surgical)  
  - Staff all home wireless monitoring systems  
  - Available for 24/7 telephonic patient consultation  
  - Frailty and Palliative Care  
  - Primary care provider and case manager for home-bound patients  
  - Assume primary clinical role for palliative care patients  
  - Institutional/Custodial/Assisted Living Residents  
  - Make weekly visits  
  - Become first point of contact for facilities and family for ALL care needs | Acute Episodes  
  - Take “ownership” of patient at point of admission  
  - Prepare patient and family for discharge  
  - Dispatch all services necessary to avoid readmission  
  - Long Term Management  
  - “Own” patient for remainder of life  
  - Dispatch home-based services  
  - Facilitate CCC and other necessary visits  
  - Facilitate transportation and other social services |
CareMore RESULTS

Clinical Model of Care
Hospital Outcomes

STRONG ACUTE MANAGEMENT and WELL-COORDINATED CARE TRANSITIONS

RESULTS as compared to Medicare FFS average
22% fewer admits
43% lower bed days
26% lower length of stay
32% fewer readmissions

CareMore 2013 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, 2011 HHS Health Information Warehouse (www.healthindicators.gov).
RESULTS as compared to Medicare FFS average
CareMore SNF admissions are 34% higher but with 40% fewer bed days and 55% shorter stays

CareMore 2013 Hospital Metrics. Admissions and days are rates per 1,000 beneficiaries. SNF LOS is in days. Medicare averages from most recent data available, 2011 HHS Health Information Warehouse (www.healthindicators.gov).
Effective Diabetes Management

Diabetes Program

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

Diabetes Program A1C Results
New In Program with A1C>9

<table>
<thead>
<tr>
<th>A1C &lt;7</th>
<th>A1C 7-8</th>
<th>A1C 8-9</th>
<th>A1C &gt; 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>39%</td>
<td>20%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Average A1c value for program participants
7.08

RESULTS

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

- 17% with excellent control < 7
- 41% with good control < 8
- 61% under control <= 9

CareMore 2012 Program Effectiveness Metrics. Program participants with diabetes whose A1C was > 9 on initial visit to the CareMore Diabetes Program in 2012, compared to repeat A1c testing, reported as Last A1C in CY2012.
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

**RESULTS**
Better control of blood pressure and cholesterol, higher compliance with annual eye exams for program participants

CareMore 2012 Program Effectiveness Metrics. Compliance based on HEDIS Comprehensive Diabetic Care measures for Blood Pressure Control <140/80, Cholesterol Control <100, and Diabetic Retinopathy Screening. Part C Rating 2013 Stars cut-points applied to entire population, both In Program and Not in Program.
Positive Diabetes Wound Outcomes

Diabetes Program
- Diabetic Foot Care with On-site Podiatrist
- Wound Care Certified Nurse Practitioners
- Transportation to CareMore Care Center

Diabetes Program: Amputations PTMPY, Non-ESRD

RESULTS
Amputation rate 65% lower than the Medicare FFS average

CareMore 2012 Program Effectiveness Metrics. Non-traumatic lower extremity amputation rate per thousand members per year, excluding individuals with ESRD. Medicare average is for FFS beneficiaries, not age adjusted, from most recent data available, American Journal of Preventive Medicine, 2005.
Successful Congestive Heart 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**

- 42% fewer hospital days
- 28% fewer admissions
- 30% fewer readmissions

CareMore 2012 Program Effectiveness Metrics. Based on program participants with diagnosis of CHF who received Ideal Life wireless scale (In Program) and individuals who did not (Not in Program).
Routine point of care checks of PT/INR (Prothrombin time/International normalized ratio) at CareMore Care Center

Warfarin medication adjustment

**RESULTS**

for program participants

Higher rates of PT/INR time in therapeutic range

<table>
<thead>
<tr>
<th>Individuals with all PT/INR values within therapeutic range</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Program</td>
</tr>
<tr>
<td>Not In Program</td>
</tr>
</tbody>
</table>

CareMore 2012 Program Effectiveness Metrics. Based on individuals with warfarin prescription in 2012 who had at least 1 CareMore Anticoagulation Program visit (In Program) versus those with no visits (Not in Program). Percentage of time PT-INR in therapeutic range is based on number of therapeutic values over total number of values in 2012.
CareMore 2012 Program Effectiveness Metrics. 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)

**RESULTS**
for program participants
32% fewer admissions
37% fewer hospital days
Comprehensive End-Stage Renal Disease 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 program participants
37% fewer admissions
64% fewer hospital days

ESRD Inpatient Admissions
- CareMore: 1133 PTMPY
- Medicare Avg.: 1811 PTMPY

ESRD Inpatient Days
- CareMore: 4240 PTMPY
- Medicare Avg.: 11800 PTMPY

CareMore 2012 Program Effectiveness Metrics. Based on individuals in the CareMore ESRD Program in 2012. Medicare average is unadjusted 2010 data from United States Renal Data System (www.usrds.org) accessed July 2012.
# Provider Quality Report Card

## CMGI IPA

### STOUFFER, JOHN E. (10000001515)

<table>
<thead>
<tr>
<th>Program Description</th>
<th>Qualified Members (District or Member Years)</th>
<th>Bonus Threshold</th>
<th>PCP Score</th>
<th>Star Rating</th>
<th>Bonus Amount</th>
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</thead>
<tbody>
<tr>
<td>Generic Rx %</td>
<td>n/a</td>
<td>81%</td>
<td>87%</td>
<td>n/a</td>
<td>$622</td>
</tr>
<tr>
<td>Access Availability</td>
<td>n/a</td>
<td>100%</td>
<td>n/a</td>
<td>100%</td>
<td>$933</td>
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<tr>
<td>Qualified Member Care Center Usage</td>
<td>18 Varies</td>
<td>72%</td>
<td>n/a</td>
<td>n/a</td>
<td>$1,866</td>
</tr>
<tr>
<td>PAHAF Payment</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>HbA1c Control</td>
<td>35</td>
<td>83%</td>
<td>3</td>
<td>$0</td>
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<tr>
<td>Diabetic Retinal Eye Exam</td>
<td>35</td>
<td>57%</td>
<td>1</td>
<td>$0</td>
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<tr>
<td>Cardio LDL-C Testing</td>
<td>1</td>
<td>100%</td>
<td>5</td>
<td>$0</td>
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<tr>
<td>Diabetic LDL-C Control</td>
<td>35</td>
<td>60%</td>
<td>4</td>
<td>$0</td>
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<tr>
<td>Diabetic Nephropathy Screening</td>
<td>35</td>
<td>91%</td>
<td>5</td>
<td>$0</td>
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<tr>
<td>Colorectal Screening</td>
<td>69</td>
<td>49%</td>
<td>2</td>
<td>$0</td>
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<tr>
<td>Breast Cancer Screening</td>
<td>16</td>
<td>75%</td>
<td>3</td>
<td>$0</td>
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<tr>
<td>Glaucoma Screening</td>
<td>157</td>
<td>88%</td>
<td>2</td>
<td>$0</td>
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</tr>
<tr>
<td>BMI</td>
<td>62</td>
<td>89%</td>
<td>5</td>
<td>$0</td>
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<tr>
<td>Adherence Hypertension (By Member Years)</td>
<td>98</td>
<td>n/a</td>
<td>77%</td>
<td>4</td>
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<tr>
<td>Adherence Oral Diabetes (By Member Years)</td>
<td>36</td>
<td>n/a</td>
<td>76%</td>
<td>4</td>
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<tr>
<td>Adherence Statins (By Member Years)</td>
<td>95</td>
<td>n/a</td>
<td>74%</td>
<td>4</td>
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<tr>
<td>Diabetes Treatment (By Member Years)</td>
<td>46.1</td>
<td>n/a</td>
<td>98%</td>
<td>5</td>
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<tr>
<td>High Risk Medications in the Elderly (By Member Years)</td>
<td>240.6</td>
<td>n/a</td>
<td>13%</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Total PCP Bonus Payment:** $3,421  
**Total Potential PCP Bonus Payment:** $4,665  
**Total PCP Bonus Difference:** $1,244
### Hospital Metrics

**JANUARY – JUNE, 2013, BASED ON AUTHORIZATIONS**

**(READMITS ARE BASED ON JANUARY 2013 – MAY 2013 TO ACCOUNT FOR 30-DAY LAG)**

#### Inpatient Acute

<table>
<thead>
<tr>
<th>Metrics</th>
<th>All</th>
<th>SubRegions</th>
<th>Alameda</th>
<th>Santa Clara</th>
<th>Stanislaus</th>
<th>Pima</th>
<th>Maricopa</th>
<th>Clark</th>
<th>Virginia</th>
<th>New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits PTMPY</td>
<td>228</td>
<td>228</td>
<td>252</td>
<td>205</td>
<td>219</td>
<td>313</td>
<td>153</td>
<td>168</td>
<td>180</td>
<td>217</td>
</tr>
<tr>
<td>ALOS</td>
<td>3.9</td>
<td>3.8</td>
<td>4.2</td>
<td>4.2</td>
<td>3.7</td>
<td>3.5</td>
<td>3.6</td>
<td>3.5</td>
<td>4.1</td>
<td>3.9</td>
</tr>
<tr>
<td>BDK</td>
<td>893</td>
<td>857</td>
<td>1,048</td>
<td>871</td>
<td>812</td>
<td>1,083</td>
<td>556</td>
<td>583</td>
<td>646</td>
<td>887</td>
</tr>
<tr>
<td>BDK Goal</td>
<td>1,058</td>
<td>1,171</td>
<td>1,235</td>
<td>1,008</td>
<td>1,191</td>
<td>1,148</td>
<td>863</td>
<td>814</td>
<td>919</td>
<td>1,001</td>
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</table>

#### Skilled Nursing Facility

<table>
<thead>
<tr>
<th>Metrics</th>
<th>All</th>
<th>SubRegions</th>
<th>Alameda</th>
<th>Santa Clara</th>
<th>Stanislaus</th>
<th>Pima</th>
<th>Maricopa</th>
<th>Clark</th>
<th>Virginia</th>
<th>New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF Admits PTMPY</td>
<td>97</td>
<td>113</td>
<td>109</td>
<td>102</td>
<td>87</td>
<td>95</td>
<td>97</td>
<td>59</td>
<td>87</td>
<td>79</td>
</tr>
<tr>
<td>SNF ALOS</td>
<td>11.9</td>
<td>11.1</td>
<td>11.8</td>
<td>11.4</td>
<td>11.4</td>
<td>12.9</td>
<td>7.6</td>
<td>11.3</td>
<td>14.7</td>
<td>14.0</td>
</tr>
<tr>
<td>SNF BDK</td>
<td>1,146</td>
<td>1,256</td>
<td>1,289</td>
<td>1,169</td>
<td>988</td>
<td>1,233</td>
<td>736</td>
<td>666</td>
<td>1,277</td>
<td>1,108</td>
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<tr>
<td>BDK Goal</td>
<td>1,266</td>
<td>1,544</td>
<td>1,380</td>
<td>1,219</td>
<td>1,161</td>
<td>1,250</td>
<td>951</td>
<td>1,143</td>
<td>1,214</td>
<td>1,303</td>
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</table>

#### Readmit, Acute Inpatient and Skilled Nursing Facility

<table>
<thead>
<tr>
<th>Metrics</th>
<th>All</th>
<th>SubRegions</th>
<th>Alameda</th>
<th>Santa Clara</th>
<th>Stanislaus</th>
<th>Pima</th>
<th>Maricopa</th>
<th>Clark</th>
<th>Virginia</th>
<th>New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmit %</td>
<td>12.8%</td>
<td>7.8%</td>
<td>16.1%</td>
<td>11.9%</td>
<td>12.4%</td>
<td>16.7%</td>
<td>16.7%</td>
<td>3.3%</td>
<td>11.8%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Readmit % Goal</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>SNF Readmit Dir to Acute</td>
<td>8.1%</td>
<td>6.8%</td>
<td>10.0%</td>
<td>5.5%</td>
<td>10.4%</td>
<td>9.9%</td>
<td>0.0%</td>
<td>8.4%</td>
<td>11.3%</td>
<td>8.3%</td>
</tr>
<tr>
<td>SNF Readmit to Acute (Exc Dir)</td>
<td>12.2%</td>
<td>9.3%</td>
<td>13.2%</td>
<td>13.1%</td>
<td>11.1%</td>
<td>13.7%</td>
<td>0.0%</td>
<td>9.5%</td>
<td>11.3%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Total SNF 30-Day Readmit</td>
<td>20.1%</td>
<td>16.1%</td>
<td>23.2%</td>
<td>18.6%</td>
<td>21.3%</td>
<td>23.6%</td>
<td>0.0%</td>
<td>17.9%</td>
<td>22.6%</td>
<td>21.2%</td>
</tr>
</tbody>
</table>
PROGRAM EFFECTIVENESS:  HEALTHY START PROGRAM MANAGEMENT
Diabetes Clinical Metrics (Examples)

**Diabetes Program: Drop in HbA1C, In vs. Not In Program**
July 2012 - June 2013

**Diabetes Program: Amputations PTMPY**
June 2012 - July 2013

**Notes:**
- Variance is All or New in Program vs. Not In, starting HbA1c ≥8. Min 90 days between labs, In program = min 2 Diabetes Management Program visits in period.