CareMore: A model for caring for those at greatest risk
Healthcare cost and quality problems are concentrated....not widespread

- **85% of Beneficiaries = 25% Spending**
  - 23 Million Beneficiaries
  - Spending $1,130 each
  - Total Spending = 5%
  - Total Spending = $26 B

- **15% of Beneficiaries = 75% Spending**
  - 16.1 Million Beneficiaries
  - Spending $6,150 each
  - Total Spending = 20%
  - Total Spending = $104 B

- **ESRD, CANCER**
  - 7 Million Beneficiaries
  - Spending $55,000 each
  - Total Spending = 75%
  - Total Spending = $391 B

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

Progressive Illness

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

Average Spending
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.
CareMore solution - new model of care for those most at risk

- Chronic Disease Support
  - Diabetes
  - COPD
  - CAD
  - CHF

- End of Life Care
  - Hospice
  - Palliative Care

- Social / Behavioral Support
  - Social Workers
  - Mental Health

- Clinical Care Centers (CCC)
  - Extensivist
  - Case Manager/NP

- Risk Event Prevention
  - Pre-Op
  - Palliative Care
  - Foot care

- Frailty Support
  - Fall
  - Coumadin

- Secondary Prevention
  - Nutritionist
  - Exercise

- Secondary Prevention
  - Wound Clinic
  - Healthy Start
  - Monitoring

- CareMore solution
  - Integrated IT infrastructure
  - Longitudinal patient record
  - Evidence-based protocols
  - Point-of-care decision support

- Predictive modeling

- Extensivist Management
  - Strength Training
Expanding the definition of primary care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count/Details</th>
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<tbody>
<tr>
<td>Sees 620 patients in our Care Centers for follow-up and chronic care management</td>
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<tr>
<td>Provides more than 1,917 rides to patients to and from points of care</td>
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<tr>
<td>Makes 56 post-discharge calls to our members</td>
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<tr>
<td>Sees more than 51 new members to assess health, arrange and document personal care plans</td>
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<tr>
<td>Visits 20 homes to provide social and behavioral support</td>
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<tr>
<td>Engages 5 families in end-of-life/hospice planning</td>
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<tr>
<td>Provides 671 strength and exercise training sessions</td>
<td></td>
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<tr>
<td>Makes 220 care visits to patients residing in nursing homes/assisted living</td>
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<tr>
<td>Reads 777 blood pressures from monitors in the homes of hypertensive patients</td>
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<tr>
<td>Reads 750 weights from monitors in the homes of chronic heart failure patients</td>
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<td>Sees 70 behavioral visits, largely for depression</td>
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<td>Cuts toenails for 105 patients at the CCC</td>
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Note: Data as of 11/12/10
The CareMore model produces dramatically improved outcomes for several costly chronic diseases and conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Status Quo</th>
<th>CareMore Redesign</th>
<th>Result</th>
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<tr>
<td>Diabetes</td>
<td>Many patients with out-of-control diabetes were not brought in control through insulin use. Common wisdom was that inability to correctly self administer or improper dosing were driving results. Further, insufficient support in the areas of nutrition and exercise were observed.</td>
<td>Established insulin “starts” and insulin “camps.” At the “start” day, patient is trained in all aspects of self-administration of insulin. At “camps,” patients are brought to the center for a full day to observe all of their behaviors and monitor glucose levels at all points of self care. A personal nutrition counselor was assigned.</td>
<td>Average HbA1c for those attending our diabetic clinic is 7.08, with 7.0 being considered good control. Patients in the clinic are referred for poor control.</td>
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<td>ESRD</td>
<td>Half of all ESRD Admissions were the result of either poor hygiene, poor diabetic control or vascular access limits/clogs. Dialysis centers provided no primary care and patients were referred to the ER. Most ER visits resulted in an admission.</td>
<td>Established a dedicated case manager and nurse practitioner who receive referrals from centers in lieu of ER referral. Primary/preventive care is provided, and all patients are in the diabetic management program, receiving monthly preventive access line inspection and, if needed, cleaning.</td>
<td>50% reduction in hospital admission rate in 5 months 42% fewer admissions than the national average</td>
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<tr>
<td>CHF</td>
<td>PCPs were not collecting daily weights, a leading indicator of change of condition. Self-reported weights were inaccurate. PCPs were not adequately responsive to immediate care needs of patients who require intervention within a few hours of onset of symptoms.</td>
<td>Equip each patient with a wireless scale that sets off alerts if weight gain is 3 lbs overnight or 1 lb per day for more than 3 days. Same-day visit with clinician if alert is triggered. Proactive hospice planning with changes in condition.</td>
<td>56% reduction in hospital admission rate in 3 months</td>
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The CareMore model produces dramatically improved outcomes for several costly chronic diseases and conditions (cont’d)

**Stroke Prevention**

**System Failure**
70% of hypertensive patients do not have adequate blood pressure control. This leads to increased stroke (and other cardiovascular) risk. Blood pressures checked in PCP offices frequently are inaccurate.

**CareMore Redesign**
Equipped patients with labile HTN with wireless blood pressure cuff. CareMore NPs monitor blood pressure & make appropriate changes according to JNC guideline.

**Result**
- 48% of patients had >10mmHg drop in blood pressure.
- Patients with SBP>160 or higher had average SBP drop of 23 mmHg.
- Patients with SBP b/n 150-160 had average SBP drop of 19mmHg.

**Amputations**

**System Failure**
PCPs have inadequate time/resources to deal with diabetic wounds, which results in specialty (surgical) referrals that delay treatment, increase cost, and increase chance of amputations.

**CareMore Redesign**
Designed a wound clinic, staffed with wound-certified CareMore NPs.

**Result**
Diabetic amputation rate for CareMore members is 60% lower than the national average.

**Depression**

**System Failure**
Depression is an underdiagnosed problem in seniors. Underdiagnosed depression leads to a variety of health problems and costs, including ER visits & unnecessary tests.

**CareMore Redesign**
All new CareMore members receive a comprehensive health exam that includes PHQ-9 & dementia screen.

**Result**
Early diagnosis and then intervention at CareMore’s mental health centers (19% of screened).
The CareMore model produces dramatically improved clinical outcomes for several costly chronic diseases and conditions (cont’d)

<table>
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<tr>
<th>Wounds</th>
<th>Institutional</th>
<th>CIT¹</th>
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<td>Inactivity and some staffing issues (one monthly visit/60 days), lack of primary care in facilities resulted in wound development or exacerbation (for example, bed sores).</td>
<td>Patients in institutional settings were being hospitalized at a rate of 5x the general population for untreatable conditions, largely because nursing homes do not have skilled clinical staff to make timely interventions.</td>
<td>A small fraction of the Medicare population is hospitalized &gt;10 times per year because of lack of home-based or social support, resulting in falls, malnutrition, dehydration. Most live alone and suffer from dementia or other mental illnesses.</td>
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<td>Deployed nurse practitioner teams to nursing homes weekly to proactively tend to skin or create early intervention in patients likely to develop wounds.</td>
<td>CareMore sends a nurse practitioner to the nursing home once a week to keep patients stabilized. If an acute event emerges, an NP is available 24x7 for telephonic consultation and in-person visits if needed.</td>
<td>CareMore assembled a team of clinical social workers, mental health professionals, lawyers, physicians, and NPs who assume a home-based, multi-disciplinary care approach for these patients.</td>
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<td>Only one new wound developed in over three years and more than 600 patients. The usual rate per year for development of pressure ulcers for nursing home patients in California is 13%.</td>
<td>Preventive intervention resulted in reduction in bedsores and reduction in falls. Hospital admission rates are 80% less than national norms</td>
<td>Reduced hospital and SNF admissions by 60%. Resulted in placement rate of &gt;30% for participants.</td>
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¹ CareMore Intervention Team, which includes the Company’s expert team of providers