REDESIGNING CARE FOR THOSE WHO NEED IT MOST...

Healthcare cost and quality problems are concentrated.... and up to half of all costs are preventable

- 40% of Beneficiaries = 25% Spending
- 10% of Beneficiaries = 75% Spending

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

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

Average Spending

CHF, DM

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)

15% of Beneficiaries = 85% Spending
Challenging the Status Quo
The essentials of CareMore’s model

- **Beyond Medical Care** - CareMore explicitly recognizes that health care quality and cost is a complex equation which includes clinical, psychological, social and functional factors.

- **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 assumes that non-physician clinicians can be maximally effective.

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

- **Minimize Fee-For-Service as Payment Method** - Pay clinicians and facilities for time and results.

A Medical Home Co-Op

Healthy  Chronically Ill  Frail

- Primary Care Physicians
- CareMore Extensivist
- Care Center, Hospital, SNF and Home Care Teams
A Replicable Model Enabled by Defined Services, Clinical Roles and Technology

The CareMore model produces dramatically improved outcomes for several costly chronic diseases and conditions

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>ESRD</th>
<th>CHF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status quo</strong></td>
<td>Half of all ESRD admissions were the result of either poor hygiene, poor diabetic control or vascular access limits.</td>
<td>PCPs were not collecting daily weights, a leading indicator of change of condition.</td>
</tr>
<tr>
<td><strong>CareMore Redesign</strong></td>
<td>Established insulin “starts” and insulin “camps”. At the “start” day, patient is trained in all aspects of self-administration of insulin.</td>
<td>Established insulin “starts”. 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>
</tr>
<tr>
<td><strong>Result</strong></td>
<td>Average HbA1c for those attending our diabetic clinic in 2008, with 7.0 being considered good control. Patients in the clinics are referred for poor control</td>
<td>50% reduction in hospital admission rate in 5 months. 42% fewer admissions than the national average.</td>
</tr>
</tbody>
</table>

Status quo

- 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.

CareMore Redesign

- Established an insulin “start”, case manager and nurse practitioner who receive referrals from orders in lieu of ER referrals.

Result

- Average HbA1c for those attending our diabetic clinic in 2008, with 7.0 being considered good control. Patients in the clinics are referred for poor control.

- 50% reduction in hospital admission rate in 5 months. 42% fewer admissions than the national average.

- 54% reduction in hospital admission rate in 3 months.
The CareMore model produces dramatically improved outcomes for several costly chronic diseases and conditions (cont’d)

<table>
<thead>
<tr>
<th>Stroke Prevention</th>
<th>Amputations</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>System Failure</strong></td>
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<tr>
<td>70% of hypertensive patients do not have adequate blood pressure control. This leads to increased stroke and other cardiovascular risks. Blood pressures checked in PCP offices frequently are inaccurate.</td>
<td>PCs have inadequate time/resources to deal with diabetic wounds, which results in specialty (surgical) referrals that delay treatment, increases cost and increases chance of amputation.</td>
<td>Depression is a underdiagnosed problem in seniors. Underdiagnosed depression leads to a variety of health problems and costs including ER visits &amp; unnecessary tests.</td>
</tr>
</tbody>
</table>

**CareMore Redesign**

- Equipped patients with table/17TH with wireless blood pressure cuff. CareMore NPs monitor blood pressure & make appropriate changes according to JNC guideline.
- Designed a wound clinic, staffed with wound-certified CareMore NPs. Diabetic amputation rate for CareMore members is 60% lower than the national average.
- Early diagnosis and then intervention at CareMore’s mental health centers (19% of screened). Reduced hospital and SNF admissions by 60%. Resulted in placement rate of >30% for participants.

**Result**

- 40% 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
- 60% reduction in diabetic amputation rate for CareMore members
- 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

The CareMore model produces dramatically improved clinical outcomes for several costly chronic diseases and conditions (cont’d)

<table>
<thead>
<tr>
<th>Wounds</th>
<th>Nursing Home Quality</th>
<th>Social Intervention</th>
</tr>
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<tr>
<td><strong>Status quo</strong></td>
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</tr>
<tr>
<td>Incidence of serious ulcer or skin lesions (e.g., monthly rate 40/1000) is high. Lack of primary care in facility, lack of timely wound development or exacerbations (for example bed sores)</td>
<td>Patients in institutional settings were being hospitalized at a rate of 5x the general population for untractable conditions, largely because nursing homes do not have skilled clinical staff to make timely interventions</td>
<td>A small fraction of Medicare beneficiaries are hospitalized &gt;10 times per year because of lack of home-based or social support resulting in falls, infections, dehydration, heat stroke and other preventable conditions.</td>
</tr>
</tbody>
</table>

**CareMore Redesign**

- Deployed nurse practitioner teams to nursing homes weekly to proactively tend to skin or create early intervention in patients likely to develop wounds.
- 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.
- 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.

**Result**

- The usual rate per year for development of pressure ulcers for nursing home patients in California is 15%. Only 4% of CareMore’s institutionalized patients developed pressure ulcers.
- Preventive intervention resulted in reduction in bedsores and reduction in falls. Hospital admission rates are 80% less than national norms.
- Reduced hospital and SNF admissions by 60%. Resulted in placement rate of >30% for participants. 

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