ENGAGING THE CARE COMMUNITY USING MOBILE TECHNOLOGIES

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Value Based Reimbursement Creates Multiple Challenges

- Financial Impact
  - Readmission Penalty (2016: 0 to -3%)
  - Hospital Value-Based Purchasing Adjustment Factor (2016:-2 to 2%)
  - Medicare Access and CHIP Reauthorization Act (2025: -9 to27%)
  - OPPS Quality Reimbursement (2015: -2 to 0%)
  - Non-Preferred Provider Cost
- Clinical Outcomes
  - Post d/c support limited to managing only high risk patients
  - Lack of on-demand patient data
  - Lack of identifying Preventative Care compliance failures
  - Utilization of Non-Preferred Providers
  - Lack of patient compliance
- Customer Experience
  - Conflicting Care Plans
  - Post d/c support failures
  - Limited connectivity and engagement of resources
  - Inexperience and knowledge in navigating through convoluted and confusing maze of care options

Percentage of Medicare health care spending associated with chronic conditions is 84 %

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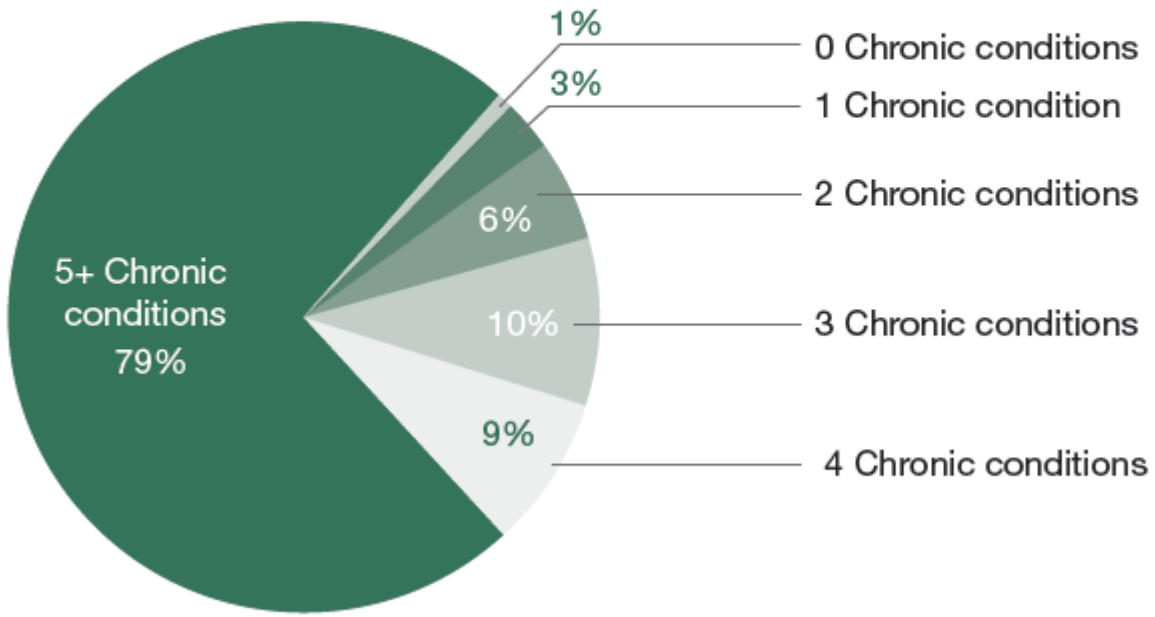
Chronic Disease Is a Major Cost Driver

Two-Thirds of Medicare Spending Is for People With Five or More Chronic Conditions

Percentage of Medicare Expenditures



Source: Medicare Standard Analytic File, 2007

Robert Wood Johnson Foundation Study February 2010

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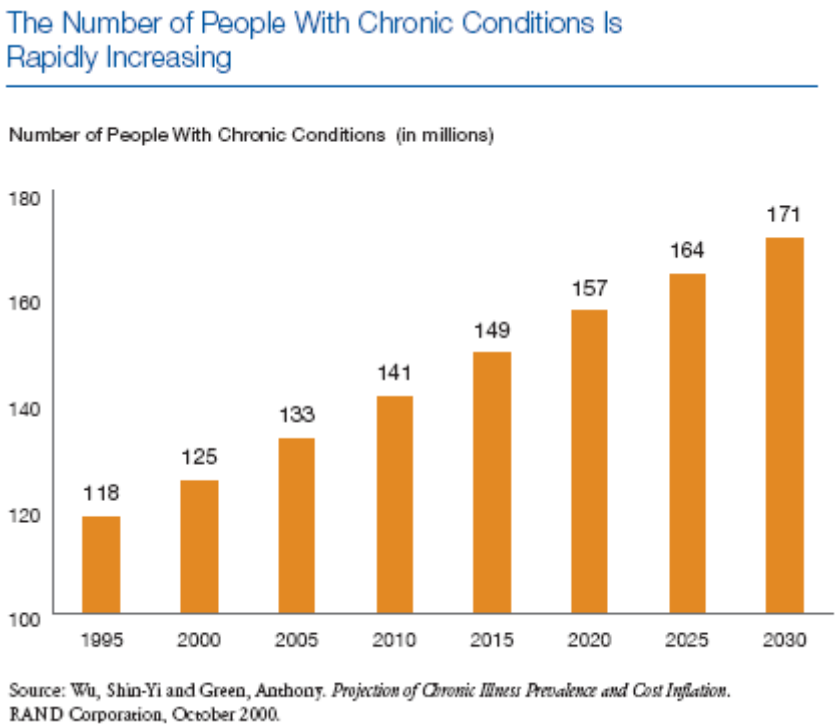
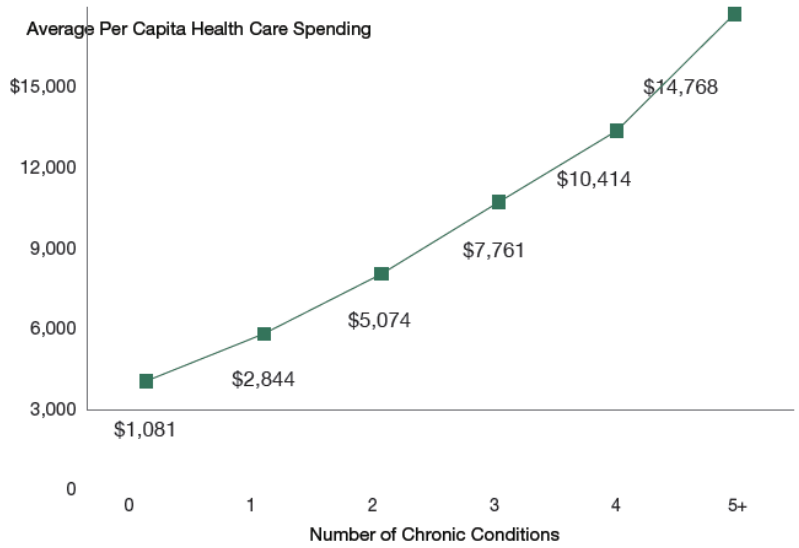
Chronic Disease Management is Important



Source: Wu, Shin-Yi and Green, Anthony. *Projection of Chronic Illness Prevalence and Cost Inflation.* RAND Corporation, October 2000.



Source: Medical Expenditure Panel Survey, 2006

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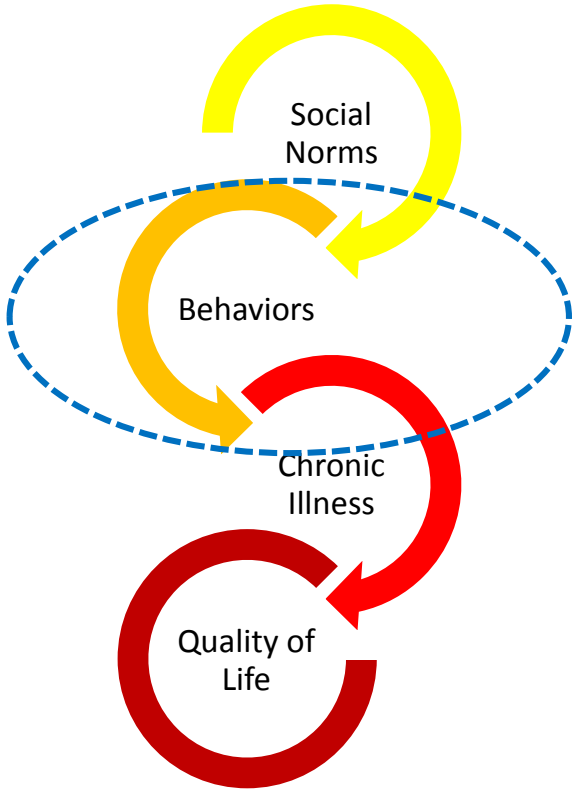
Behavior Change is the Holy Grail of Chronic Disease Management



- **8 behaviors & risks drive 80% of total costs for all chronic illnesses worldwide**

"Behavior change happens mostly by speaking to people's feelings…" -- Kotter

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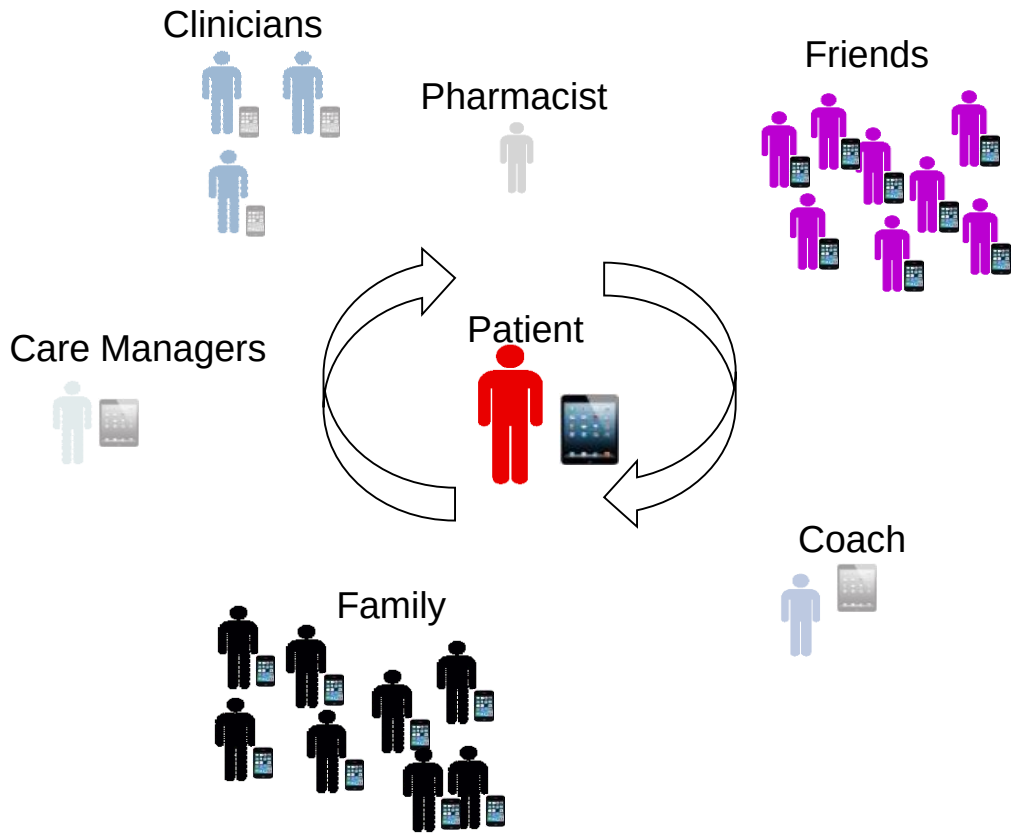
Social Circles Have More Influence on Behaviors than Clinicians



What doesn't work:

- The white coat talk
- Providing 'information' to the patient
- Conflicting instructions from various clinicians

Behavior change fails 68-90% of the time using traditional approaches

What works:

- *Keys to Successful Change 1*
  1. *Relate*
  2. *Repeat*
  3. *Reframe*
- A patients *social support system* is a key factor in defining their risk of readmission.
- Socially isolated individuals incurred *24% higher costs* than socially connected individuals with an equivalent risk.
- At least *39,000,000* non-clinical caregivers in the US.

Non-Clinical Resources are Under-Utilized in the Care Community

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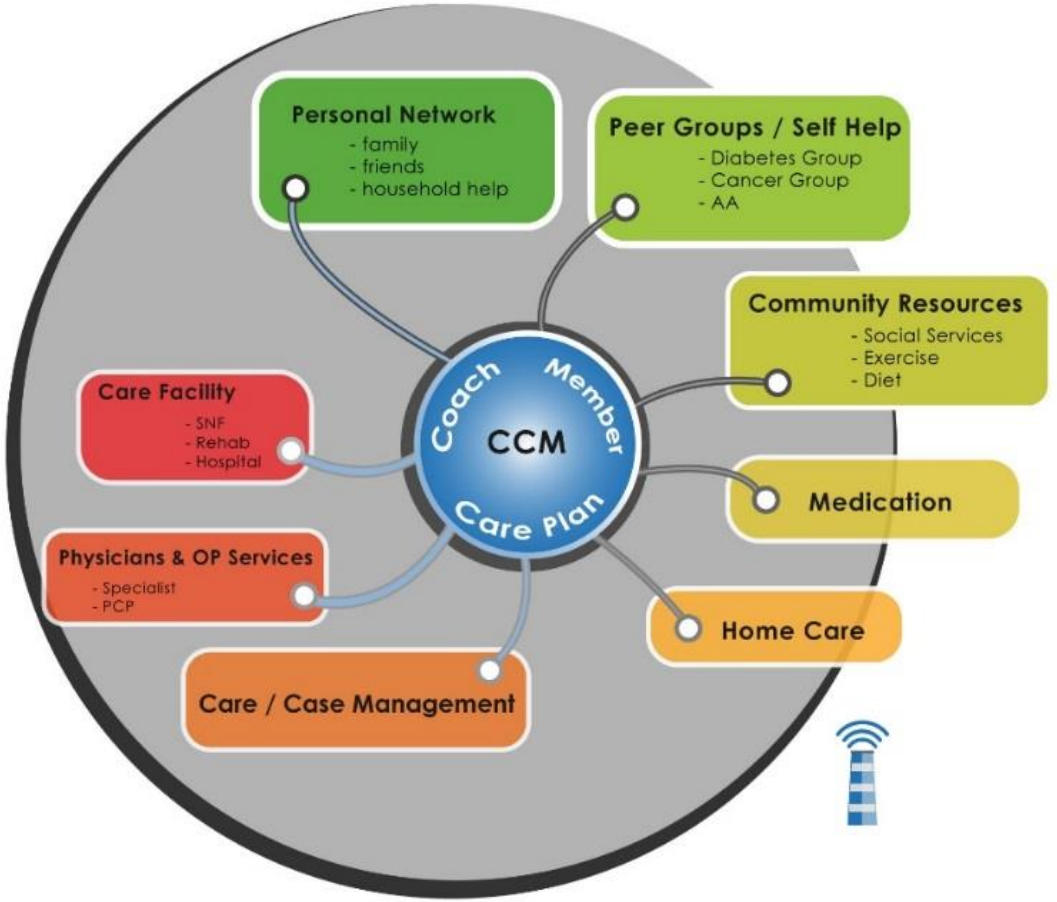
CCM Must Remove Barriers for Care Plan Success To Reduce Risk of Acute Episode

- Personalized Care Plan based on Best Practice Disease Management
- Removal of Real World Barriers Enables Engagement to Care Plan

- Economics Matter:
  - Technology to Support Care Plan Success
  - Involvement of 'Free' and Caring Resources
  - Support by professional coordinators to remove barriers



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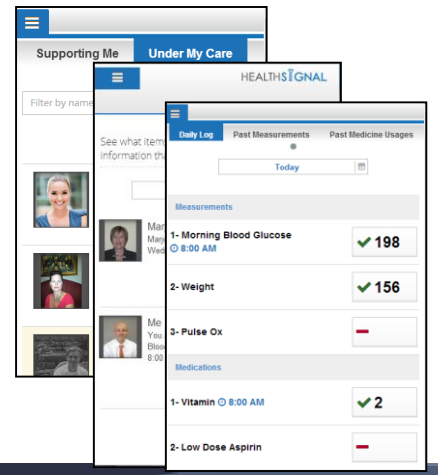
Mobile Engagement Technology For The Entire Care Community To Support and Remove Barriers

Chronic Disease Engagement Technology

- **Mobile** technology
- **Personal Health Record / Lifestyle Management Tool** for data generated at home
- **Engagement Tool** for patients, friends and family supporting chronic disease patients
- **Support** for infrastructure needs
- **Early intervention** alerts



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CMS Supports Chronic Care Management

- Elements of CPT Code 99490
  - Established patient relationship via AWV
  - 20 minutes of Non-Face to Face time every Month
  - Medication monitoring
  - Coordination/continuity of service
  - Personalized Care Plan
  - 24/7 access to healthcare providers
  - 24/7 access to medical records and provide them as needed
  - Facilitated care transition
  - Schedule appointments / transportation
  - Coordinate with community-based services
  - Use of Technology to connect with patients and social support

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