CareSignal®

Deviceless Remote Patient Monitoring

Community Care Plan

The Health Plan with a Heart

Industry Leadership: Community Care Plan Scales Deviceless RPM to Rising-risk Members

Dr. Miguel Venereo | SVP & Chief Medical Officer, Community Care Plan

Blake Marggraff | CEO & Founder, CareSignal | blake.marggraff@caresignal.health

Agenda

- **CCP's Vision for Member Care**: Value-focused Remote Patient Monitoring, Scalability, Access, and Health Equity
- Introduction to CareSignal & **Deviceless Remote Patient Monitoring**
- **CCP & CareSignal Partnership** to-date
  - Enrollment
  - Current Use Cases & Engagement
  - What's Next

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The Health Plan with a Heart

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Dr. Miguel Venereo

35+ years in the health care/plan industry

Dr. Miguel Venereo

Senior Vice President and

Chief Medical Officer

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About Community Care Plan

Founded by two of the largest safety net hospital systems in Florida.

- Based in Sunrise, FL with 200+ employees
- Accredited by
  - National Committee for Quality Assurance (NCQA)
  - Accreditation Association for Ambulatory Health Care (AAAHC) as a Health Plan
- Member of
  - America's Essential Hospitals
  - Association of Community-Affiliated Plans (ACAP)
  - Florida Association of Health Plans (FAHP)

BROWARD HEALTH®

Memorial Healthcare System

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Mission:

To Build Healthier Communities

Vision:

Be the driving force to
ensure that every community has access to
high quality affordable healthcare

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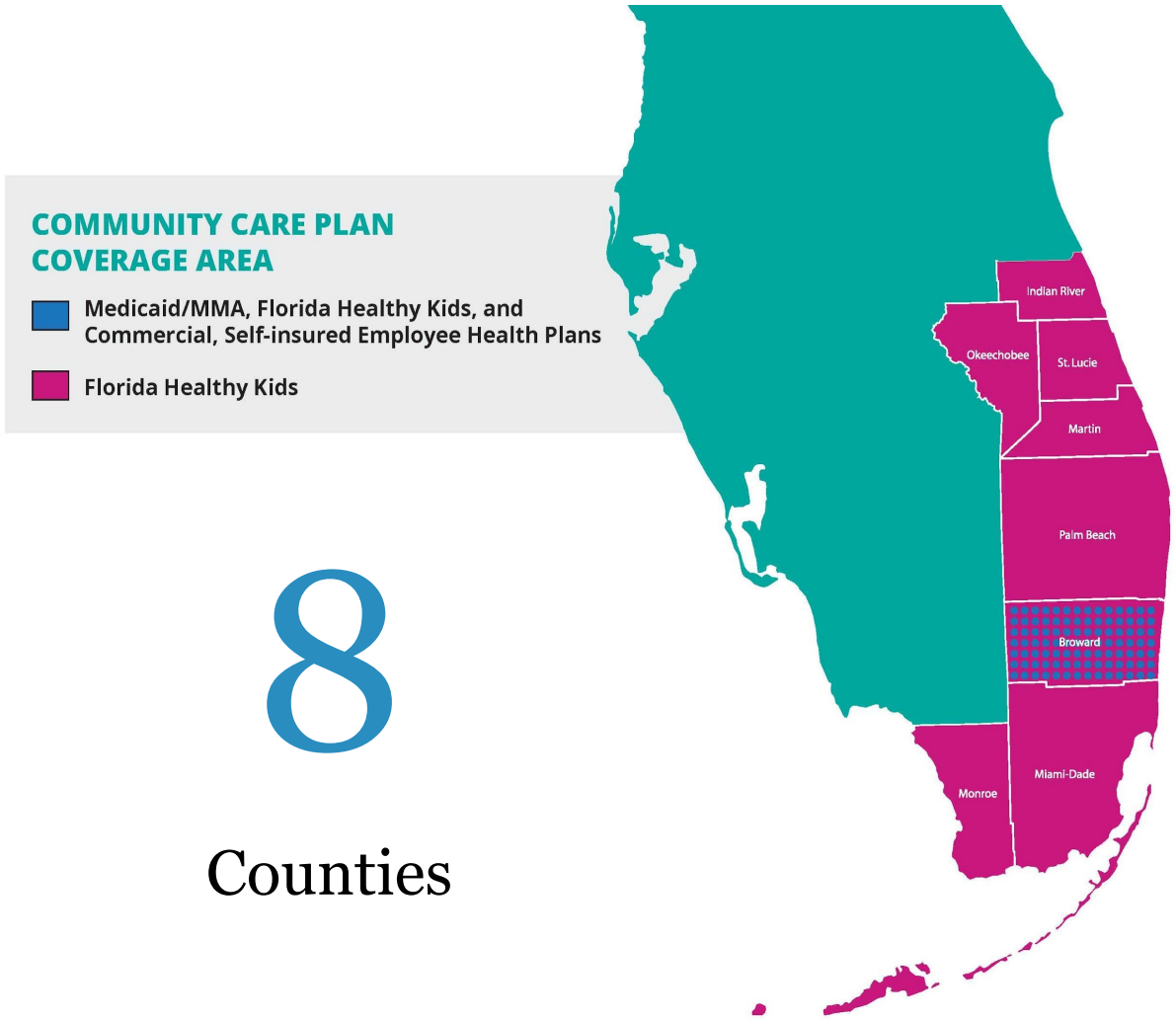
Lines of Business and Membership

100k+ covered lives.



8

Counties

- Medicaid (Region 10) Risk & Capitated
- Florida Healthy Kids (Region 9-11) Risk & Capitated
- Broward Health - PPUC
- Memorial Healthcare System ASO
  - Employee Plan
  - Primary Care
  - Upfund
- Health Care District of Palm Beach

High-Quality Care

Consistently Recognized for Quality.

- **Behavioral Health**
- **Keeping Healthy Kids**
- **Keeping Adults Healthy**
- **Living with Illness**
- **Pregnancy Related Care**

Only Medicaid Plan to Achieve Five-Stars in OB for Four Consecutive Years!

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4.59 Stars

Out of 5

AHCA Report Card

4.0 Stars

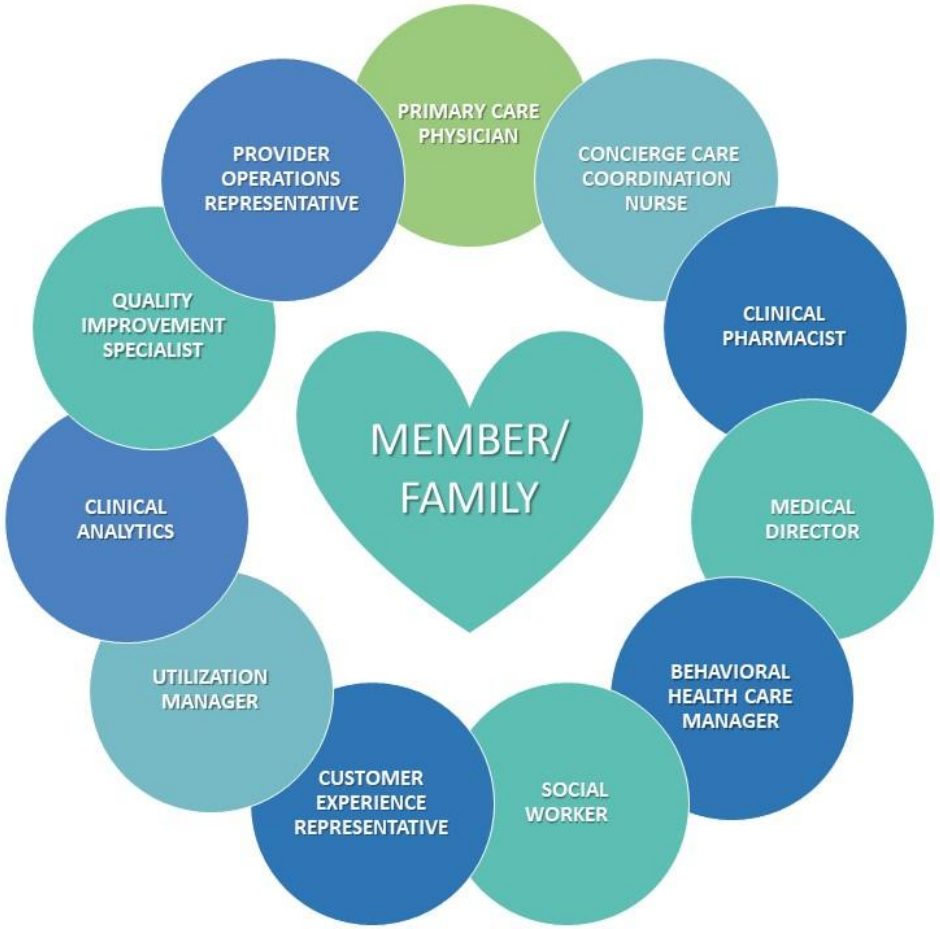
Out of 5

NCQA Report Card

Concierge Care Coordination (C3)

Multidisciplinary and collaborative approach to case and disease management.

Biological



Psychological

Social

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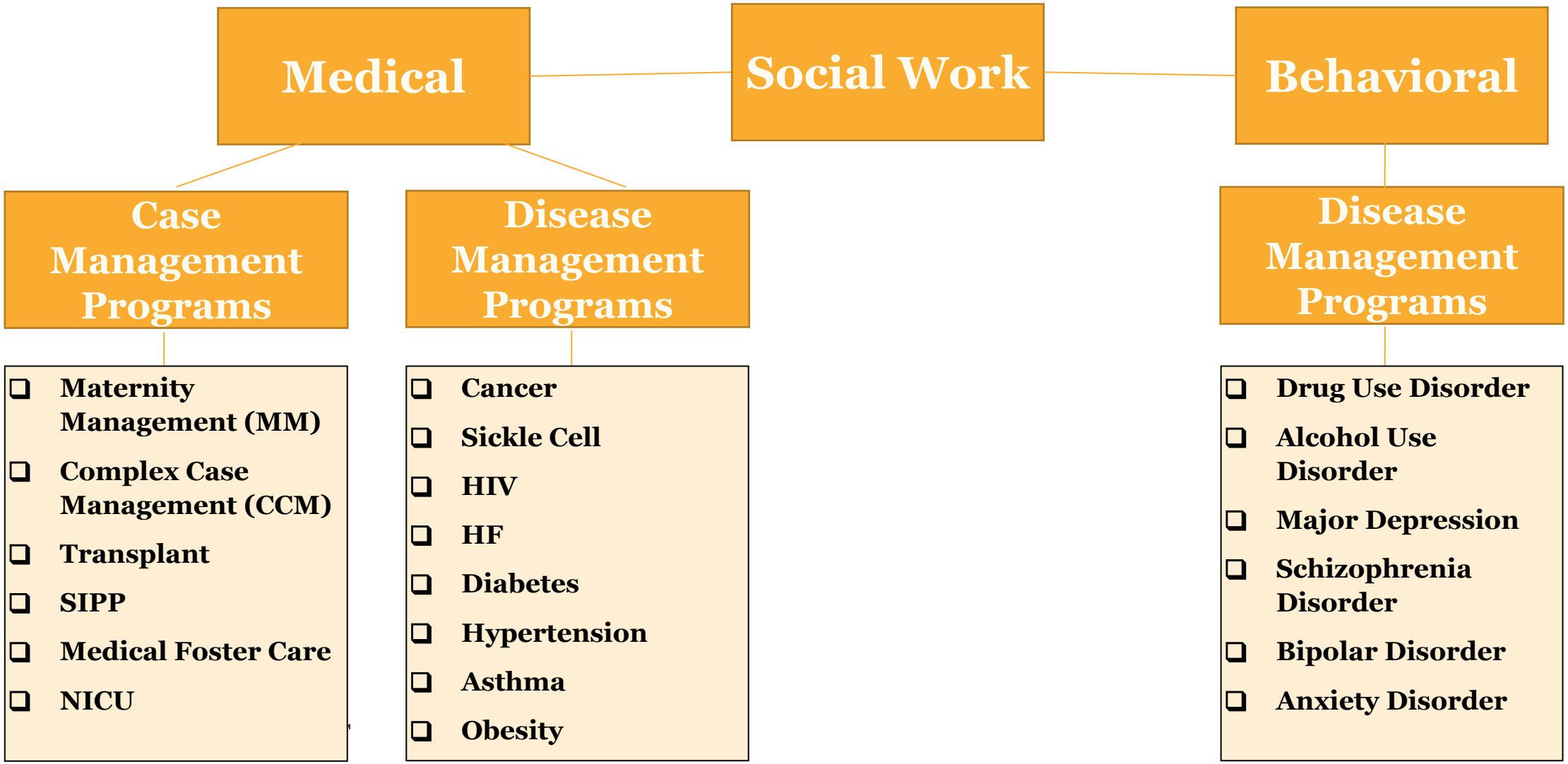
C3 Programs Bio-Psycho-Social Integration

Each member is assigned a dedicated C3 nurse.



Innovative Programs

Always seeking innovative ways to engage members and improve outcomes.

1:1 Text Messaging

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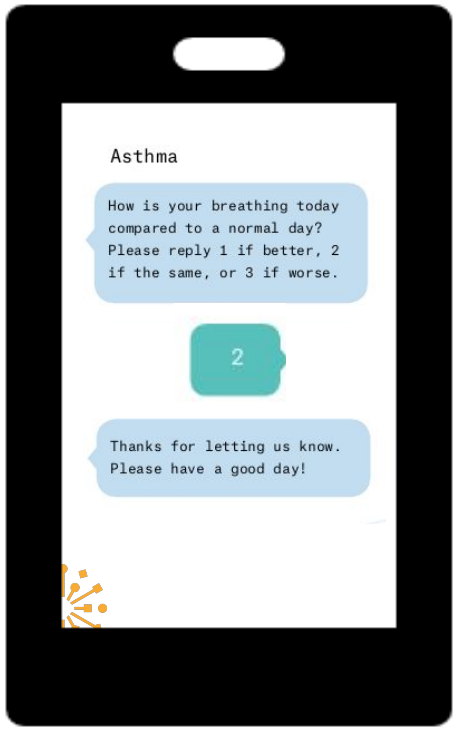
Deviceless Remote Patient Monitoring™



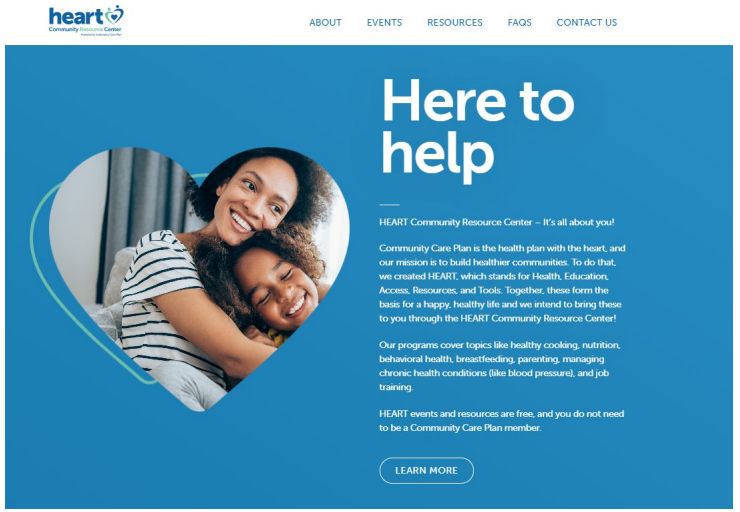
Telehealth

TELADOC

Blueberry PEDIATRICS

Events & Resources

heart Community Resource Center
Powered by Community Care Plan

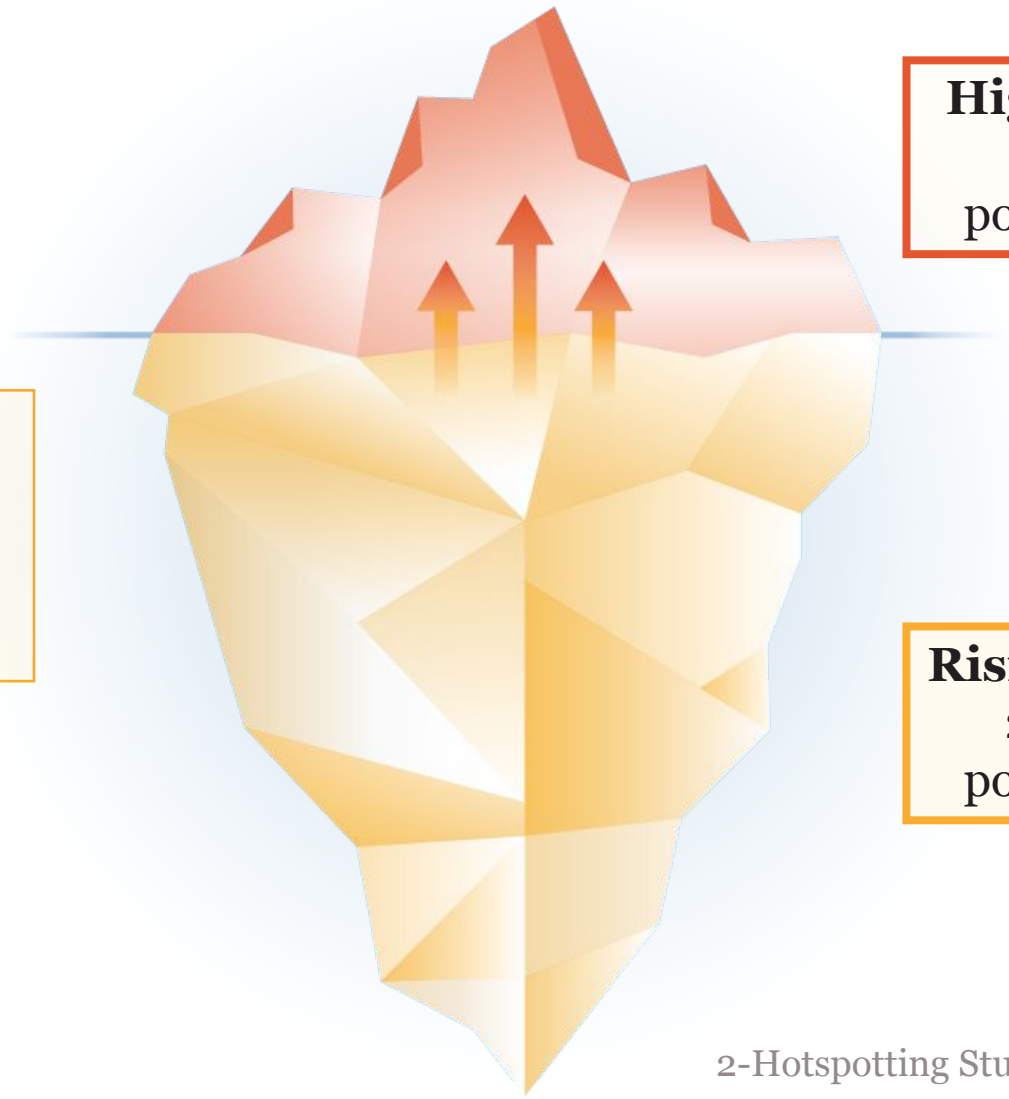


www.OurHeart.org

About CareSignal

Value-based Care Success Hinges on Rising-Risk Management

Rising-risk management: the key to ROI



High-Risk: 5% of population

Rising-Risk: 20% of population

The NEW ENGLAND JOURNAL of MEDICINE

Our findings may also reflect fundamental challenges with the strategy of targeting superutilizers: ***many patients whose medical costs are high today will not be as high in the future.***[2]

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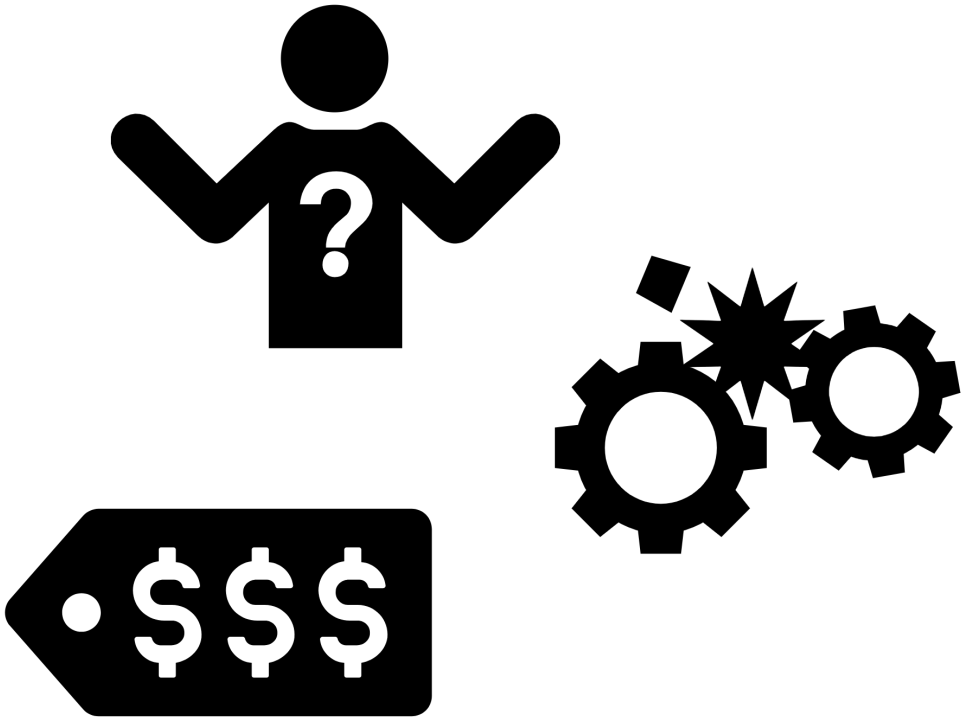
1- Advisory Board Report (link)
2-Hotspotting Study (A. Finkelstein et al., 2020) (link)

Weaknesses of Device-based RPM

- Not Accessible
- Unreliable Data Transmission
- Challenging to Operationalize and Scale
- Limited to Chronic Conditions
- Not suited for Value-based Populations



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Deviceless Remote Patient Monitoring
Accessible, Scalable, & Clinically Actionable

- ☑ Any channel, or via caregiver
- ☑ Any literacy level
- ☑ Works after prepaid ‘minutes’ are gone
- ☑ No tech hurdles, logins, or support

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Deviceless RPM: Covering *30+* Conditions

Deviceless RPM

Quantitative
Patient-Reported Biometrics

Blood Sugar, Blood Pressure, Weight

Qualitative
Symptomatology

Chronic Conditions	Behavioral Health	Maternal Health	Social Determinants of Health
Breathing, Swelling, Dizziness	Feeling Low Mood	Trouble Breastfeeding	Help Finding Food Next Month

Device-Based RPM

Blood Sugar, Blood Pressure, Weight

Chronic Conditions	Behavioral Health	Maternal Health	Social Determinants of Health
✕	✕	✕	✕

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Portfolio: *30+* Evidence-based Programs

Chronic Condition Management

- Diabetes
- Hypertension
- Heart Failure
- COPD
- Asthma

Behavioral Health

- Depression
- Anxiety
- Substance Use
- Opioid Management
- Caregiver Support

Specialty Support

- Social Determinants of Health
- Maternal Health
- Dialysis
- Surgery

Discharge Monitoring

- Post Discharge
- General Medical
- Vital Signs
- Pneumonia

Care Coordination

- Screening Reminders
- Referral

General Programs

- COVID Suite
- Influenza
- Fall Risk
- Wellness
- Medication Adherence

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Thirteen Peer-reviewed Journal Articles
Proven Enrollment, Engagement, Outcomes, and Scale

62% decrease
in COPD hospitalizations

28% drop in PHQ-9
for members with depression

1.15% drop in HbA1c
in 4 months

>2.1x increase post-ED
in follow-up adherence

50% improvement in blood pressure control over 12 weeks

58% decrease
in CHF ED visits

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http://journals.sagepub.com/doi/full/10.1177/1357633X18800211
http://diabetes.jmir.org/2017/2/e15/
https://www.liebertpub.com/doi/abs/10.1089/tmj.2019.0035

CareSignal Results
Proven Enrollment, Engagement, Outcomes, and Scale

Annual Medical Cost Reduction for every 1,000 members enrolled

COPD	CHF	Diabetes
$850k	$3.7M	$625k

Hypertension	Depression
$500k	$2.6M

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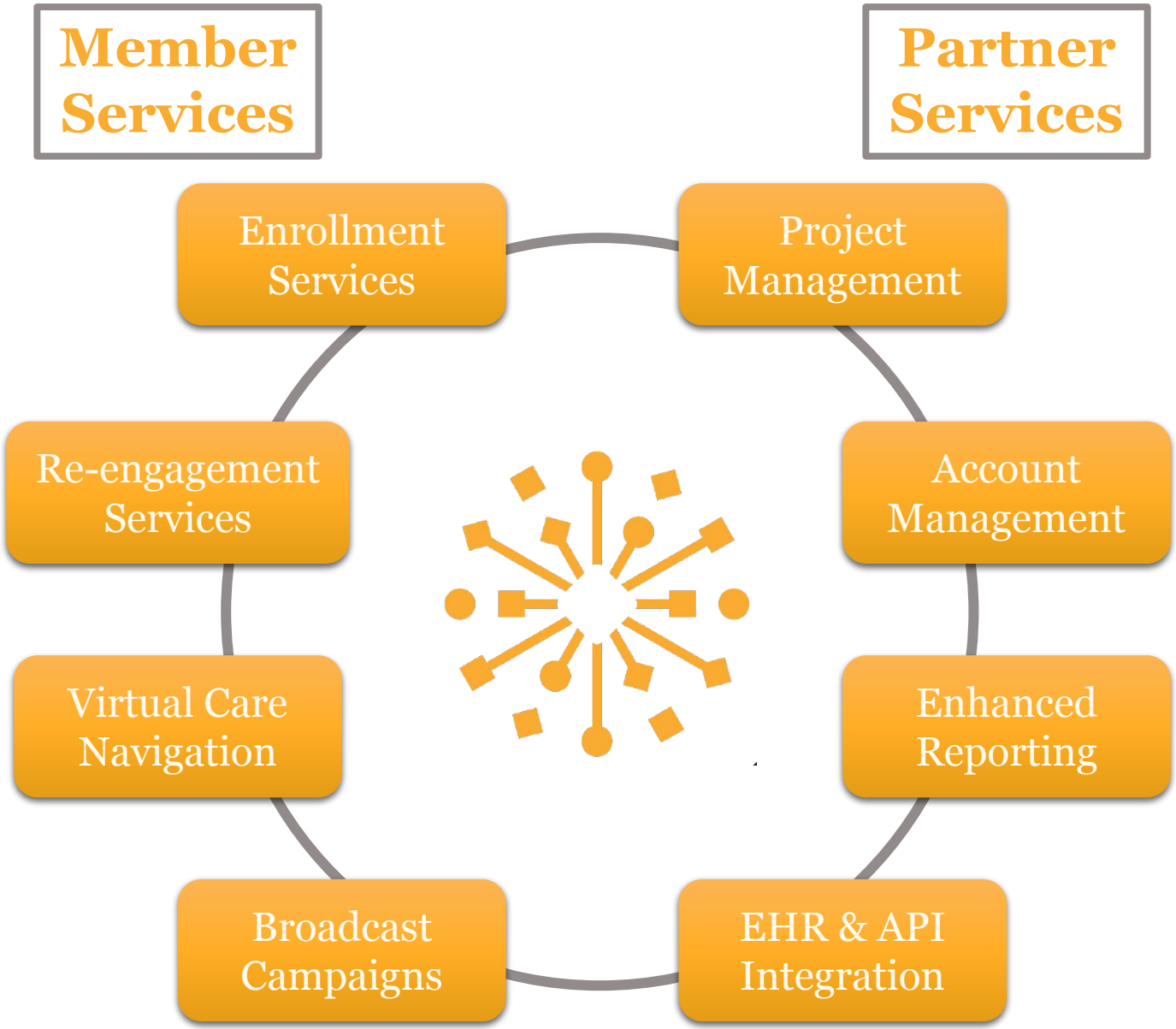
Beyond Technology: Supportive Services to Ensure Success

"The entire team was wonderful. ***The most organized roll out of a project with an outside company*** *I have been involved with. Refreshing!"*

Chief Informatics Officer, Physician Group

*"****We had never had such a positive and supportive implementation partnership in such a short turnaround****. Everyone was respectful yet accountable and ensured success at every phase. Bravo!"*

Chief Clinical Officer, BH Network



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CCP & CareSignal Partnership

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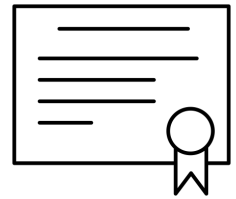
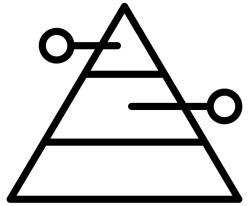
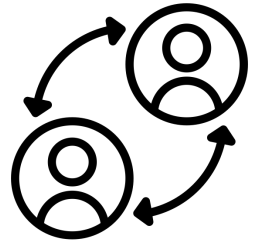
Areas of Alignment

- Care Teams Efficiently Work Top of License
- Reach Rising-risk Member Populations
- Increased Member Engagement through Automation
- Aligning Condition Focus with Value-based Care Quality Metrics







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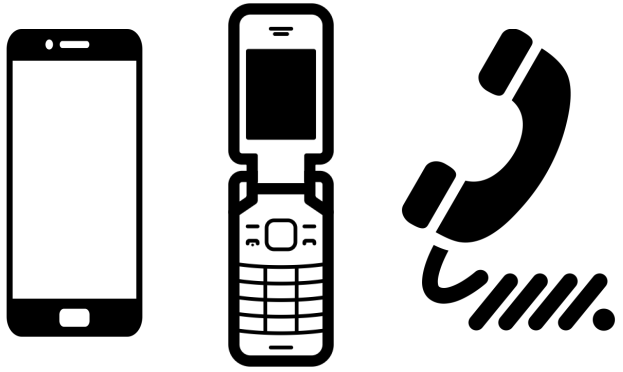
Increased Member Touches Identify Opportunities for Proactive Care Coordination



Automated Touches

28,290

Texts	Calls
22,951	5,339

Alerts Triggered

459

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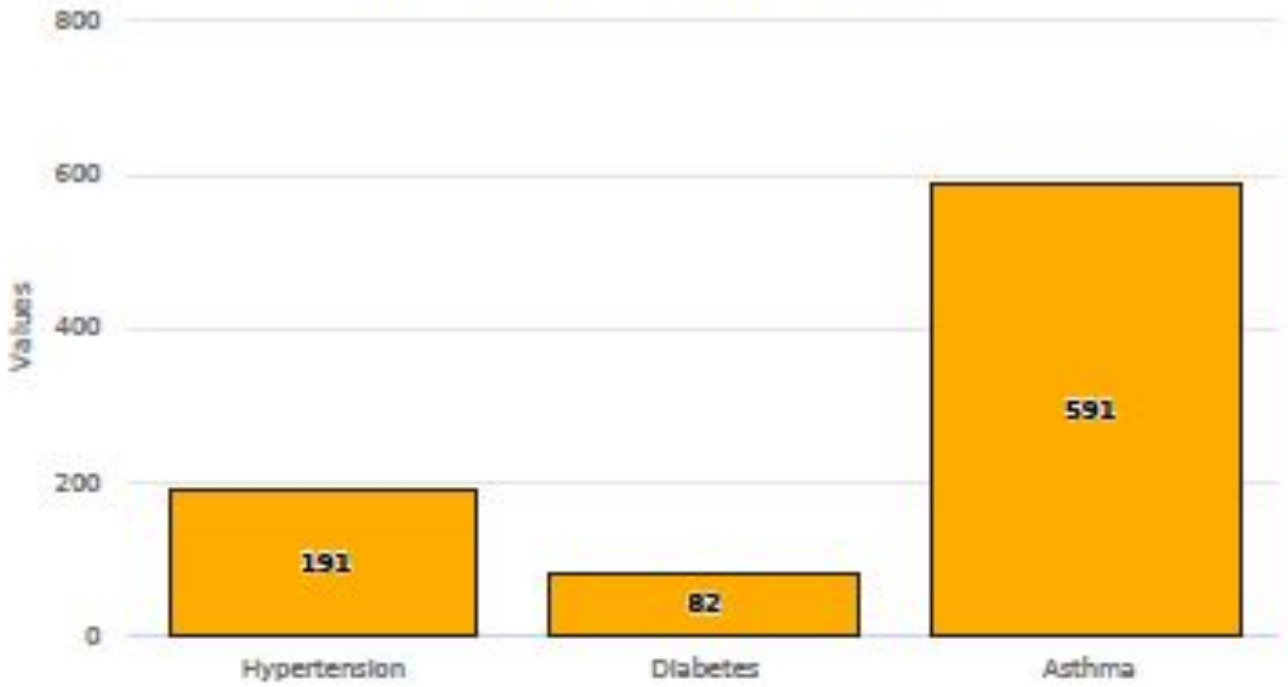
Medicaid Members Supported

- Languages
  - English
  - Spanish
- Conditions
  - Asthma (Pediatric & Adult)
  - Hypertension (Adult)
  - Diabetes (Adult)

864 Total Members Supported Across 3 Conditions



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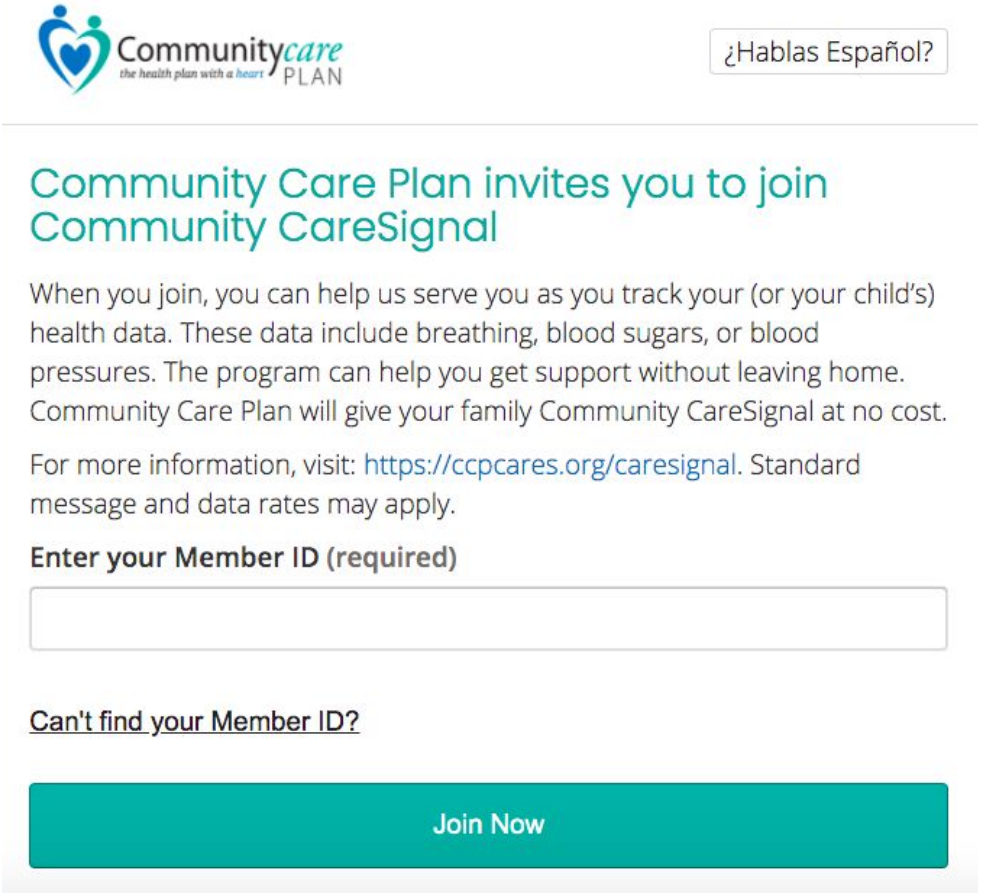
Member Enrollment Process

- Higher enrollment than benchmark for commercial plans
- Pre-education success
  - CareSignal developed pre-enrollment educational texts, flyers, and a dedicated website



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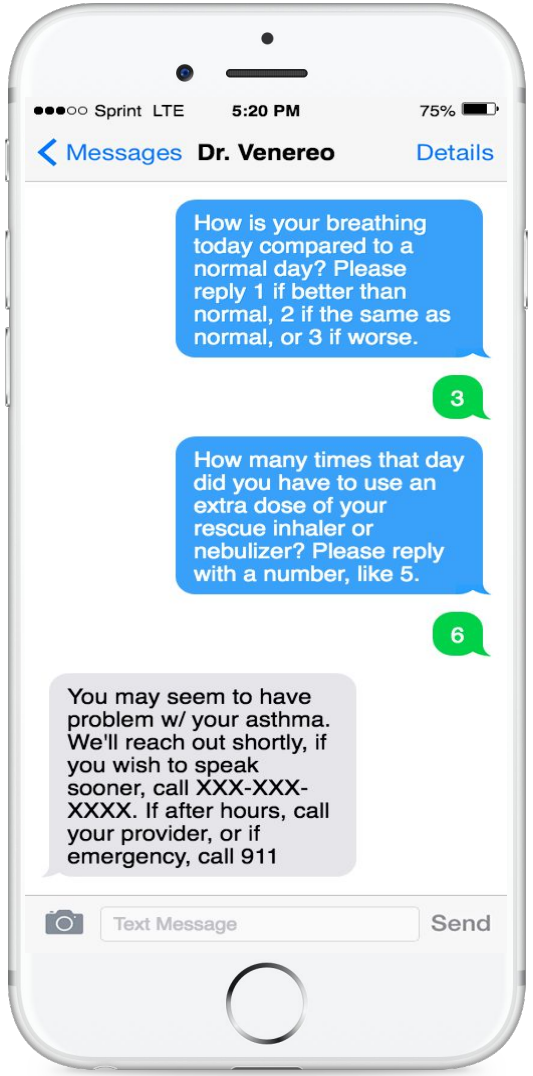
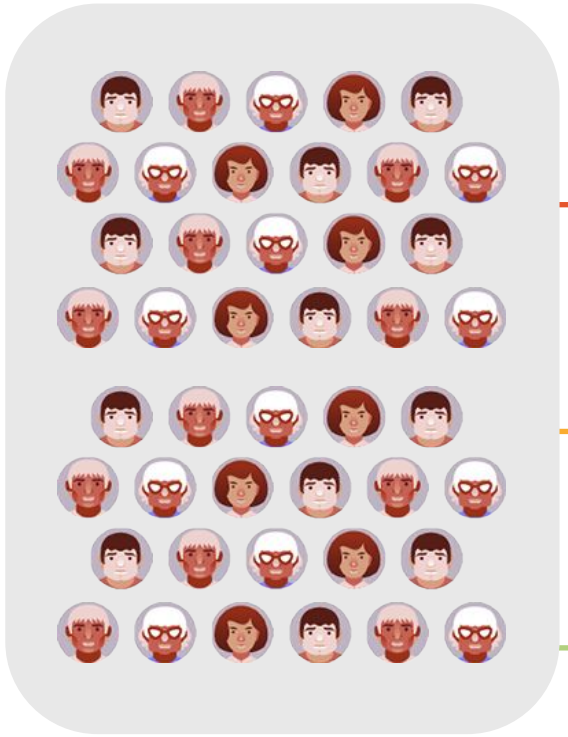
Workflow

1. Proactively Monitor



2. Triage



3. Risk Stratify

- **High** — 3+ Alerts triggered, Weekly Outreach
- **Rising** — 1 – 2 Alerts triggered, Actively Monitor
- **Low** — No Alert, Passively Monitor

Aligning Programs & Quality Measures

Quality Metric	Measurement Methods	Relevant CareSignal Programs	CCP Benchmark
Diabetes	HEDIS Metric	Diabetes	Average Decrease ≥1 percentage point HbA1c
Asthma	HEDIS Metric	Asthma	Asthma Medication Ratio ≥75th Percentile
Hypertension	HEDIS Metric	Hypertension	≥ 30% brought to controlled, defined as <140 SBP and <90 DBP

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Member Story

Enrolled: CareSignal Member Engagement Specialist team calls member, gets verbal consent and enrolls into CareSignal Deviceless-RPM program for asthma
Symptom Monitoring: Member receives weekly messages on phone asking them to report symptoms.
Eligible for Disease Management: Member reported being awakened by asthma symptoms and had 4 PCP visits for asthma-related symptoms within last 12 mo. Member identified as someone who could benefit from disease management.
Enrolled: CCP Case Manager contacts member, gets verbal consent and enrolls in CCP Disease management progra for asthma to closely monitor member asthma status while continuing CareSignal's RPM program for asthma.
Asthma Alerts: Member alerted through CareSignal asthma program.
Intervention: C3 care management intervened to provide education to empower caregiver to help manage disease.
Whole member health:
- **Medication and Provider Appt.** With asthma under control, attention shifted to medication adherence for ADHD medications. During asthma assessment with C3 team identified need for member support in getting medication and psychiatrist appt. Intervention: C3 team partnered with behavioral health and pharmacy teams to facilitate both.
- **Bills support:** With medication challenge solved, attention shifted to social determinants of health. During C3 discussion, member identified need for financial support. Intervention: C3 connected member to social work team who was able to provide support.
Ongoing member engagement and support: Through CareSignal, C3 continues to monitor member asthma symptoms and medication adherence and provide asthma education and address any social work needs.

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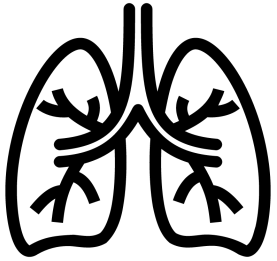
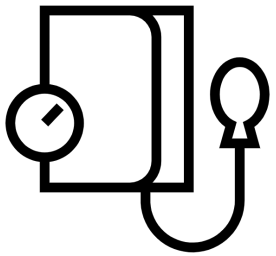
Outcomes: CCP+ CareSignal



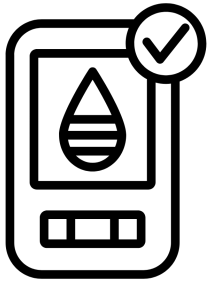
Asthma

- 66% Activation
- 40% Engagement @ 5 months
- 91% of low-risk maintained low-risk status



Hypertension (>160 mmHg sBP)

- 60% Activation
- **82% of members brought to control**
- 50% Engaged @ 5 months



Diabetes

- 70% Activation
- 60% engaged @ 5 months
- 57% of rising-risk members prevented from moving to high-risk status
- **1.35% HbA1c average decrease**

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Member Satisfaction: Experience is Key

Improved Communication · These messages have improved your communication with Community CareSignal.

N = 108

Average = 7.16

1 - Strongly Disagree Strongly Agree - 9

Care Satisfaction · You are getting the best possible care from Community CareSignal.

N = 120

Average = 7.45

1 - Strongly Disagree Strongly Agree - 9

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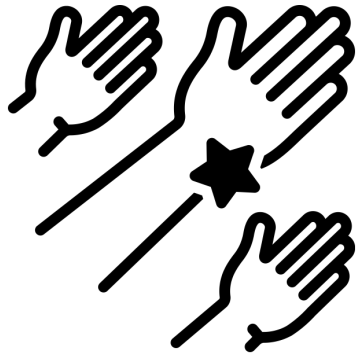
Member Satisfaction: Qualitative Feedback

"This is one of the best I have ever been with. Thank you for having me a customer, thank you so very much the service is awesome."
04/25 –Member

"It helps to show that [Community Care Plan] is trying and using different ways to reach out to their clients (members)."
01/25 -Member



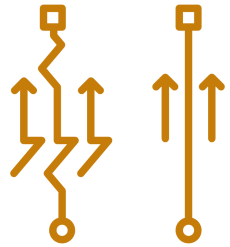
What Makes Our Partnership Unique?
Shared Values. Aligned Goals.

Community Care Plan
The Health Plan with a Heart

CareSignal®
Deviceless Remote Patient Monitoring

Deliver healthcare **equitably**

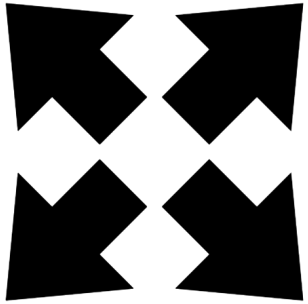
Simplify to achieve accessibility



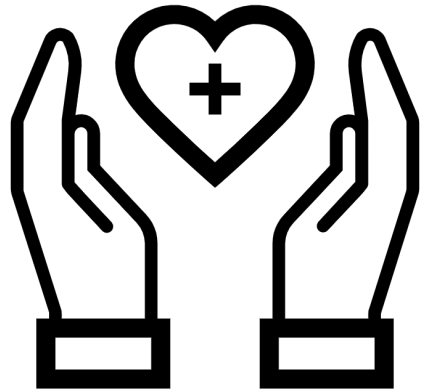
Analyze & act using **evidence**

Align clinical & financial goals

What's Next?



- Potentially expanding into new Medicaid populations
- Potentially expanding to support other conditions (COPD, Behavioral Health)



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