Outcomes Summary



Spiras Health's nurse practitioner-led specialty care-at-home model combines in-person clinical home visits, telehealth visits, digital check-ins, and remote patient monitoring. We target members with progressive, chronic diseases at high risk of incurring avoidable costs. Our personalized, high-touch model has a proven track record of managing treatment plan adherence leading to reduced symptom exacerbations resulting in avoidance of unnecessary ER visits and hospitalizations.

As a value-based care provider, Spiras Health improves clinical, utilization, and member satisfaction outcomes delivering a substantial reduction in the cost of care for members with advanced chronic conditions.

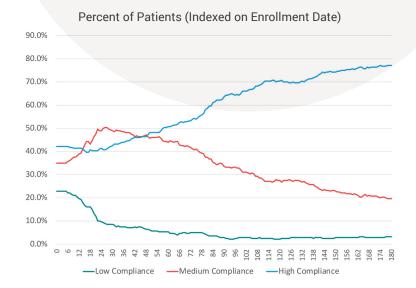
Improving Medication Adherence

Our care model has a strong focus on medication adherence. With patients struggling to manage 8-10 medications, our clinical teams:

- Educate on medication purpose and timing
- · Advise on behaviorial strategies
- Assist with prescription refills and packaging This engagement reduces low compliance and increases high compliance.

Patient compliance rate outcomes measured at 180 days:

- Low compliance reduced by 95%
- High compliance increased by 83%



Resolving Social Needs

Spiras Health works with a deep understanding of people's lived experiences for a true personalization of their care plan. We capture data on race, ethnicity, and gender identity on behalf of the health plan and send that data to the plan to enrich each plans data resources. Our presence in patients' homes allows us to see how each patient is living with their conditions and truly understand their needs. Social care factors can drive as much as 80% of health outcomes¹ and is a critical element in providing whole-person care.

Patient-focused, wholeperson care is realized through assessments of physical, social, and behavioral needs and referring/arranging for needed care.



• Referring behavioral/mental health care from a network provider



• Assisting patients in arranging transportation to a doctor appointment



• Identifying food insecurity and coordinating nutrition resources

• Ordering needed DME to improve safety and independence

Reducing Utilization through Personalized Interventions

Improvement in medication adherence, education on nutrition, activity, triggers, symptom management, and treating acute needs help stabilize the patient's condition. Our monthly in-home visits and 24/7 easy access to a Spiras clinician lead to trusting relationships that foster behavior change and provide regular access to care and support. Spiras clinicians also support early detection and intervention when symptoms do occur and result in avoidance of unnecessary use of ER and hospital. Improved utilization patterns result in significant savings per patient.



40%

Hospitalizations (per 1000)



20%

ER Visits (per 1000)

OUTCOMES:

Documented treatments of exacerbations in-home and exacerbations avoided through improved condition management shifted utilization away from the ER and hospital.

Increasing Satisfaction and Retention

Members are highly satisfied with the care received by their clinicians and report they will stay with their health plan based on their Spiras experience.

95%

of members rated their experience 5 out of 5 with a Spiras clinician "My care from Spiras has been 110%! I am more than satisfied with them! I was surprised at the level of care they were able to provide me. Thank you for all that you have done!"

94%

of members are highly likely to re-enroll in their plan due to care from Spiras Health "We have received great care from Spiras and you all have helped my mother stay hospital-free. We are very appreciative for everything Spiras has done!"



Reimagine value-based care by giving your polychronic members a higher quality of life – at home.

Contact Spiras Health at info@spirashealth.com or visit spirashealth.com.