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EXECUTIVE BRIEF · MEDICARE

MEDICARE VALUE-BASED CARE

Medicare VBC is won between visits.
Your care team can't be everywhere.

Whether you manage Medicare Advantage members, run an MSSP ACO, or are moving from ACO REACH to LEAD, performance depends on patients your team rarely sees, and headcount doesn't grow with attributed lives.

WHAT WE HEAR FROM MEDICARE VBC LEADERS

01 · REHOSPITALIZATIONS

Patients go quiet after discharge.

A missed medication or worsening symptom often surfaces as a return trip to the ED.

Shows up in: **total cost of care, readmission measures**

02 · CHRONIC CARE & QUALITY

Control slips between visits.

Blood pressure and A1c drift for months. Gaps get chased at year-end, if they get closed at all.

Shows up in: **STARs, quality scores, avoidable utilization**

03 · WELLNESS VISITS

Eligible patients never schedule.

Missed AWVs mean missed screenings, open gaps and an incomplete picture of risk.

Shows up in: **preventive care, gap closure, risk accuracy**

SAME PRESSURES. DIFFERENT CONTRACTS.

MODEL	WHAT'S ON THE LINE	WHERE IT BREAKS DOWN
Medicare Advantage incl. D-SNP	STAR ratings, medical cost and member retention.	Hard-to-reach members, including dual-eligibles, carry the most gaps and cost.
MSSP ACOs	Shared savings against a benchmark, gated by quality.	Avoidable admissions erode savings; lean care teams can't cover the full panel.
ACO REACH → LEAD LEAD begins 2027	Shared savings against a benchmark, gated by quality.	Rewards sustained engagement with high-risk beneficiaries, not one-time outreach.

THE FLORENCE APPROACH

Reach every patient. Focus your nurses on the ones who need them.

Florence is a clinically validated care management platform that stays in touch with patients by text, between visits, and brings your care team in only when needed.

- **No app, password or broadband**
- **Works on any mobile phone**
- **Extends your existing care team**

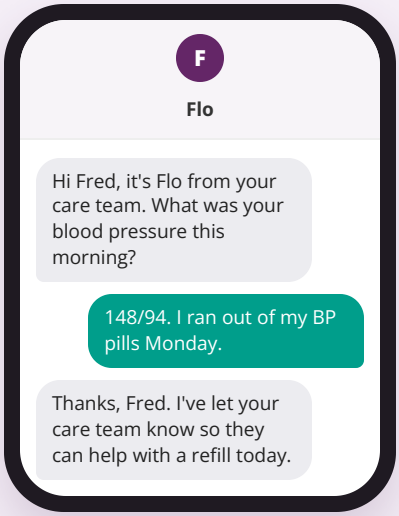
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How Florence works

CLINICAL OUTBOUND

Clinically validated texts, on protocol

- Transitions of care & post-discharge
- Heart failure, COPD, CKD
- Hypertension & diabetes
- Annual wellness & screening outreach



INTELLIGENT INBOUND

Every reply read and acted on

- Interprets and categorizes responses
- Monitors readings and trends
- Identifies SDOH barriers and risk signals
- Triages and escalates when needed

Your care team Escalation only when needed, with the context to act. *Illustrative conversation.*

Collect vitals & symptoms · **Deliver AWV & screening** · **Support medications** · **Identify SDOH** · **Provide feedback & education**

Proven where Medicare performance is decided

REHOSPITALIZATIONS

41–56% ↓
Heart failure readmissions vs. usual care, plus 66% fewer emergency attendances (n=103 vs. 824)[1]

70% ↓
COPD emergency admissions, with 57% fewer bed days (n=148)[2]

CHRONIC DISEASE & QUALITY

30% ↓
Uncontrolled blood pressure in a Medicare/Medicaid D-SNP population (n=353)[3]

66%
Of D-SNP members engaged within seven weeks; 57% submitted a blood pressure reading[3]

WELLNESS VISITS

18% ↑
Increase in AWV show rates within about four weeks of outreach (20,144 members engaged)[4]

6.4% ↑
Increase in well-child visits within about four weeks of outreach[4]

PATIENT IMPACT EXAMPLES

20 → 4
urgent visits for an 85-year-old COPD patient[5]

13.5% → 6.9%
HbA1c for a 68-year-old diabetes patient[6]

95%
of heart failure patients would recommend Florence (n=41)[1]

1. Satchithananda D, et al. Smart with Your Heart: Final Evaluation Report. NHS Test Beds Wave 2, 2020.
2. Nils Michael C, et al. Home and Mobile Health Monitoring Evaluation: Economic Case Studies. Scottish Government, 2019.
3. Generated Health. Highmark D-SNP Programme, 2026.
4. Generated Health. Equality Health client data: 20,144 members engaged across AWV, well-child and lost-to-care outreach.
5. Individual Florence patient outcome. Results vary by patient.
6. Derbyshire Community Health Services NHS Foundation Trust. Diabetes case studies, 2017.