Connections™
Disease Management and Decision Support
-A view from the trenches...

Es Nash, MD
Senior Medical Director
Health Management Programs

Introduction to Connections™ Programs

- Timing is everything-Consumer-directed Health Care- how do DM/DS fit
- Timing is everything-medical management evolution and IBC’s integrated Disease Management/Decision Support
- Integration with member initiatives
- Integration with provider initiatives
- Q & A

Evolution of Healthcare Benefit Models
The Industry is in Transition

Traditional
Discount Focus

Managed Care
Supply Side Focus (Providers)

Consumer Driven Health Care
Demand Side Focus (Members)
What is Consumer Driven Health Care?
(It's More Than Spending Accounts)

Member Engagement
Engage individuals with information, flexibility and choice -- to help them better meet their needs.

Member Empowerment
Collaborative health care management -- if we provide the tools.

Member Involvement
Consumers play a more active role in healthcare process, sharing in decisions and cost.

Entire Package

- Comprehensive consumer-driven package which includes:
  - Medical coverage (health plan)
  - Spending account
  - Web and educational tools
  - Consumer involvement and decision-making
  - Cost-sharing
Member Message:

Consumer-Driven Health Care – Consistent consumer message:

**Member Seeks Care**
- **Care Plan Initiated**
- **Care Plan Defined**
- **Approve or Deny Benefits**

**Member Has Health Problem**
- **Member Sees Physician**
- **Member Expectations Are Formed**
- **Physician Recommends Treatment to Member**
- **Physician Calls for Authorization**

**Treatment Begins**

- **Prevention**
- **Wellness**
- **Pre-NOTIFICATION / PRE-CERTIFICATION**
- **Proactive Outreach**
- **Concurrent Review**
- **Discharge Planning**
- **Case Management** (High Risk Only)
- **Disease Management**

**Past Medical Management Model**

**Member/Patient Experience Over Time**

**Lots of valuable outreach but…**

- **Diabetes outreach - medical / Rx**
- **24 hour nurse line**
- **Diabetes outreach - medical / Rx**
- **Pharmacy initiatives**
- **Asthma management**
- **COPD management**
- **Preventive reminders**
- **CHF programs**
- **CAD management**
DM – the forces converge...

- Consumer-directed health care
- Patient safety focus (IOM reports, Leapfrog Group)
- Accreditation standards
- Government sector interest-federal/state
- Collaborative approach with members/providers
- New medical management models

Connections™ Health Management Programs: Integrated Disease Management and Decision Support

Disease Management

Six key chronic conditions included in IBC Connections™ Program:
- Diabetes
- Asthma
- COPD
- CHF
- CAD
- ESRD as of 6/04
Disease Management  
**The Opportunity:**

IBC has many members with chronic disease and they are costly.

<table>
<thead>
<tr>
<th></th>
<th>KHPE</th>
<th>PC</th>
<th>K65</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated % of members with 1 or more disease</td>
<td>6-7%</td>
<td>6-7%</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>Estimated # with 1 or more disease</td>
<td>43,000</td>
<td>57,000</td>
<td>42,000</td>
<td>142,000</td>
</tr>
<tr>
<td>% of total medical costs</td>
<td>24%</td>
<td>24%</td>
<td>55%</td>
<td></td>
</tr>
</tbody>
</table>

Medical management-“value” to employers

**Current view:**
- Value = control medical costs
- control disability costs
- control worker’s comp costs
- reduce absenteeism
- reduce overtime pay
- reduce “presenteeism”

**Traditional view:**
- Value = control premium costs or medical costs

Estimated ratio: total illness burden to direct medical costs is 3 to 1.

Source: Institute for Health and Productivity Management 8/03

Disease Management  
**The Short Definition:**

“...a systematic, population-based approach to identify persons at risk, intervene with specific programs of care, and measure clinical and other outcomes.”
Help me with the jargon - please!

<table>
<thead>
<tr>
<th>Case Management</th>
<th>Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• One by one approach</td>
<td>• Population-based</td>
</tr>
<tr>
<td>• High cost/high complexity cases</td>
<td>• Data-driven predictive modeling</td>
</tr>
<tr>
<td>• High coordination &amp; navigation needs</td>
<td>• Long-term educational focus</td>
</tr>
<tr>
<td>• Top 1-5%</td>
<td>• Skill transfer/member empowerment</td>
</tr>
<tr>
<td>• Episode-focus</td>
<td>• Designed for all levels of severity / opt-out design</td>
</tr>
<tr>
<td>• Opt-in design</td>
<td></td>
</tr>
</tbody>
</table>

NOT Mutually Exclusive – patient can receive both – referral processes built and working

What is Decision Support?

- DS is a process that supports informed health care decisions by providing members with information on:
  - their condition
  - treatment options, risks and benefits
  - support for identifying their own values and preferences.

Thus the concept of "Shared Decision Making".

What is Decision Support? - examples

- Major DS components:
  - significant medical condition treatment decision support (Health Coach, video, web)
  - Example: I have chronic back pain and my doctor has suggested surgery
  - 24/7 Health Coach symptom and information support
  - Example: my son has a bad bee sting-what can I do? Or I see my doctor for my arthritis next week, what should I ask?
  - Evidence-based health information via web (Healthwise encyclopedia), audiolibrary, video, print
**Shared Decision-Making® Video Titles:**

**General**
- Informed Health Care Consumer
- Peace of Mind Arthritis
- Knee Osteoarthritis Breast Cancer:
  - Treatments for Breast Cancer: Adjuvant Therapy
  - Treatments for Breast Cancer: The Surgery Decision

**Cardiac**
- Coronary Artery Disease
- Living with Coronary Artery Disease

**Pain**
- Low Back Pain: Herniated Disc
- Low Back Pain: Spinal Stenosis

**Gynecologic**
- Benign Uterine Conditions: Abnormal Bleeding
- Benign Uterine Conditions: Fibroids
- Ovarian Cancer
- Prostate:
  - The PSA Decision
  - Benign Prostatic Hyperplasia
  - Prostate Cancer

**Website “Crossroads”: Online tools organized around discrete decision windows**

**Disease Management**
- Traditional "silo" Disease Management
- Integrated Disease Management
- Disease Management and Decision Support

**Decision Support**
- Significant Medical Events (cancer surgeries, back surgery, BUC, etc.)
- 24/7 Symptom Management
- General Health Information

**Better integrated care and greater impact on outcomes**

The Connections® Programs provide both DM and DS in an integrated program.
**Integrated access:**

**Disease Management & Decision Support**

- Program can be accessed directly by member or after physician recommendation 24/7
- Multiple datasets are mined to identify/stratify members for DM or DS outreach
- Interfaces/referrals built for Healthy Lifestyles, case management, Baby Blueprints etc.
- Goal—seamless to members and providers

1-800-ASK-BLUE

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**Healthy Lifestyles**

- Incentives
  - Fitness Program
  - Weight Management
  - Smoking Cessation
  - Alternative Health
  - First Aid and Safety

- Information
  - Personal Health Profile
  - Stress Management
  - Adoption Education
  - Child Safety Education

- Reminders
  - Pediatric and Senior Immunization
  - Adolescent Health
  - Mammography Screening
  - Colon cancer, cholesterol, etc.

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**Connections Implementation Organizational Chart**

*(None of this is easy...)*

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E. Nash, MD

6/2004
None of this is easy...

Intensive Interventions are Targeted to High-Impact Opportunities

High-Intensity interventions- targeted members

- Members with high predicted financial risk will receive:
  - New member outreach call
- Members with high predicted financial risk and/or high clinical need will receive:
  - Flu shot reminder calls
  - Clinical marker calls (e.g., EF <40)
  - Clinical gap calls
  - High Medicare health risk assessment call
  - Member follow-up calls
  - Post-hospital discharge call
  - Referral calls: self, MD, CM, other health plan, etc
  - Patient-specific literature from Health Coach
  - Devices (scales, spacers, etc.)

*Depending on specific clinical need*
Standard-Intensity interventions for all members with 1 or more of the 5 diseases:

- New member letter
- Condition specific booklet (if single condition) or Living Well brochure (if co-morbid conditions)
- Flu / pneumonia postcard
- Specific topic mailings (seasonal allergy, fluid balance)
- Clinical gap mailings
- Comprehensive Decision Support Services, including:
  - Support for significant medical decisions
  - Inbound calls for 24/7 symptom support and health education
  - Web access (the Dialog Center™, Health Crossroads™, and the Healthwise® Knowledgebase)

CONNECTIONSsm Health Coaches*

- Accessible
  - Phone/Internet, 24x7x365
- Dedicated personal coaches
  - Establish relationships
  - Follow up with member and provider
  - Comprehensive and confidential
- Specially trained
  - Licensed experienced clinicians
  - Shared decision-making
  - Behavior modification and listening
  - Treatment options and procedures
  - Certified educators
- Medical director oversight
- Computer support

*Provided by Health Dialog

Health Coaches educate and support individuals, using the principles of Shared Decision-Making® ...

Help individuals understand the importance of participating in the health management process.

Help them develop and implement personal action plans.

Support them as they discussed the implications of the information that they have received.

Help them prepare to discuss their options with their physicians.

Help them understand the importance of participating in the health management process.
Example - Year One Interventions for a Member with Diabetes:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01</td>
<td>New member letter + magnet</td>
<td>X</td>
</tr>
<tr>
<td>01/01</td>
<td>DM booklet</td>
<td>X</td>
</tr>
<tr>
<td>01/01</td>
<td>Living Well brochure</td>
<td>X</td>
</tr>
<tr>
<td>01/01</td>
<td>Health Plan communications + ID card</td>
<td></td>
</tr>
<tr>
<td>01/01</td>
<td>New member outreach call</td>
<td>XX</td>
</tr>
<tr>
<td>02/01</td>
<td>Flu/pneumonia postcard</td>
<td>X</td>
</tr>
<tr>
<td>02/01</td>
<td>Targeted outreach - low back decision</td>
<td>y</td>
</tr>
<tr>
<td>02/01</td>
<td>Flu shot reminder calls</td>
<td>XX</td>
</tr>
<tr>
<td>03/01</td>
<td>Lipid test gap mailing</td>
<td>X</td>
</tr>
<tr>
<td>03/01</td>
<td>High gap score call</td>
<td>X</td>
</tr>
<tr>
<td>03/01</td>
<td>Targeted outreach - joint decision</td>
<td>y</td>
</tr>
<tr>
<td>03/01</td>
<td>High Medicare PRA call</td>
<td>XXX</td>
</tr>
<tr>
<td>03/01</td>
<td>Targeted outreach - women's health</td>
<td>y</td>
</tr>
<tr>
<td>03/01</td>
<td>Diabetes standards of care mailing</td>
<td>X</td>
</tr>
<tr>
<td>03/01</td>
<td>Targeted outreach - men's health</td>
<td>y</td>
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<tr>
<td>03/01</td>
<td>Retinopathy gap mailing</td>
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</tr>
<tr>
<td>03/01</td>
<td>Member follow-up calls</td>
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<tr>
<td>03/01</td>
<td>Post-hospital discharge call</td>
<td></td>
</tr>
<tr>
<td>03/01</td>
<td>Referral calls: self, MD, CM, etc</td>
<td>X</td>
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<tr>
<td>03/01</td>
<td>Inbound calls</td>
<td></td>
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<tr>
<td>03/01</td>
<td>Patient-specific literature</td>
<td></td>
</tr>
<tr>
<td>03/01</td>
<td>Foot care kits</td>
<td>X</td>
</tr>
</tbody>
</table>

How do the “new” Connections™ differ from prior internal IBC programs?

**“OLD”**
- Referred members - “opt in”
- Designed for sickest 1-5% of chronic illness members
- For episodic case management needs
- Single disease focus
- Retrospective stratification
- No decision support

**“NEW”**
- Includes all members except those that “opt out”
- Population-based - available to all eligible members
- Ongoing Health Coaching
- Co-morbidity management
- Predictive modeling to identify high risk members/ members with clinical care gaps
- Both disease management and decision support

Case management by health plan remains for appropriate members.
Partnering with Providers

- NaviNetSM - electronically links providers with IBC’s systems
- QIPS - PA PCP reimbursement based on HMO membership quality indicators
- QIPS reimbursement methodology extended to hospitals
- Disease management support and reporting benefit physician QIPS

Meetings with key network physicians and facilities provide an opportunity for integration

In the three months prior to program launch, IBC Medical Directors personally introduced the program to >50 key physician groups.

- Provider Advisory Boards
- Dedicated Connections Provider Services Specialists

In the first 6 months of program operation, Connections PSS’s met with 546 IBC network physician practices.

- Dedicated Connections Provider Support Line
  Response by Provider Service Specialist within 1 working day

Provider Communications support the programs and communicate the clinical evidence

Program Flyers
- Provider Communications support the programs and communicate the clinical evidence
- Clinical Evidence
- Meeting Invitation
- Clinical Guidelines
- Clinical Insights
- Videos
- Clinical Evidence

Web-site: www.ibx.com
- Provider portal - Navimedix
- Referral Cards
The SMART™ Registry provides actionable information at the point of care

Practice Report

Peer Comparison Report

Individual Patient Report

IBC May 2004 SMART™ Registry Network Release

- Adult and Pediatric population; includes PA Medicare HMO/PPO and Commercial HMO/POS/PPO members
- Delivered to all IBC participating primary care practices (General Practice, Family Practice, Internal Medicine and Pediatrics)
- Covering services received by patients 1/1/2003 through 12/31/2003
- Number of IBC practices = 2,515
- Number of IBC members with chronic conditions = 150,779
- MD feedback due by August 1, 2004 to be reflected in next Network release in Fall 2004

Attributing PPO Members to PCP’s
(i.e. none of this is easy......)

- Test population of 100,000 HMO members
- Based on claims data, each member is attributed to a primary care provider and a location of care
- Four IBC PCP practices participated in a pilot to test the accuracy and validity of the PPO attribution logic
- Results validated the use of the methodology for the May 2004 SMART Registry

May 2004 SMART Registry Results
PPO Medicare: 79% of currently eligible chronic members were attributed to a PCP and location of care
PPO Commercial: 68% of currently eligible chronic members were attributed to a PCP and location of care.
Connections Kidney Program
24/7 Call Center (1-866-303-4CKP)

- Dialysis Center
- Community Resources
- Ancillary Services
- Health Service Coordinator (HSC)
- Members
- Nephrologist & Other Specialists
- IBC Case Management / Healthy Lifestyles
- Patients and Family
- Hospital/Surgical Center
- Ancillary Services
- Providers

Disease Management/Decision Support Implementation Timeline

- 7/1/2003: PA Medicare HMO & PPO
- 10/1/2003: PA Commercial PPO
- 6/1/2004: Other HMO/POS, PPO, Medicare members*, ESRD program all regions

Integration: Marketing

- Employer, Broker and Member Promotion
- Open Enrollment Direct Mail, Collateral, Seminars, On-Line Demo Capability
- Radio, Print Billboard, Advertising
- Extensive Sale Representative and Broker Training

E. Nash, MD
6/2004
New Medical Management Process
MEMBER EXPERIENCE OVER TIME

Where do we go from here?

- Incentives for healthy behavior & program use
- More information to support consumer decisions (outcomes, provider info, costs)
- Expanded DM & DS Scope
- Sophisticated targeting of members at risk

In Summary...The Health Plan makes it happen:

- Connections™ Programs:
  » Integrated Disease Management (6 chronic conditions) and Decision Support
  » Integration: Medical management, Provider Initiatives, Consumer-directed health care strategy/marketing/promotion
  » Members supplied tools to work with their doctors to make "the right decisions" for them and to improve care of chronic conditions.
Questions?

Thank you for listening!