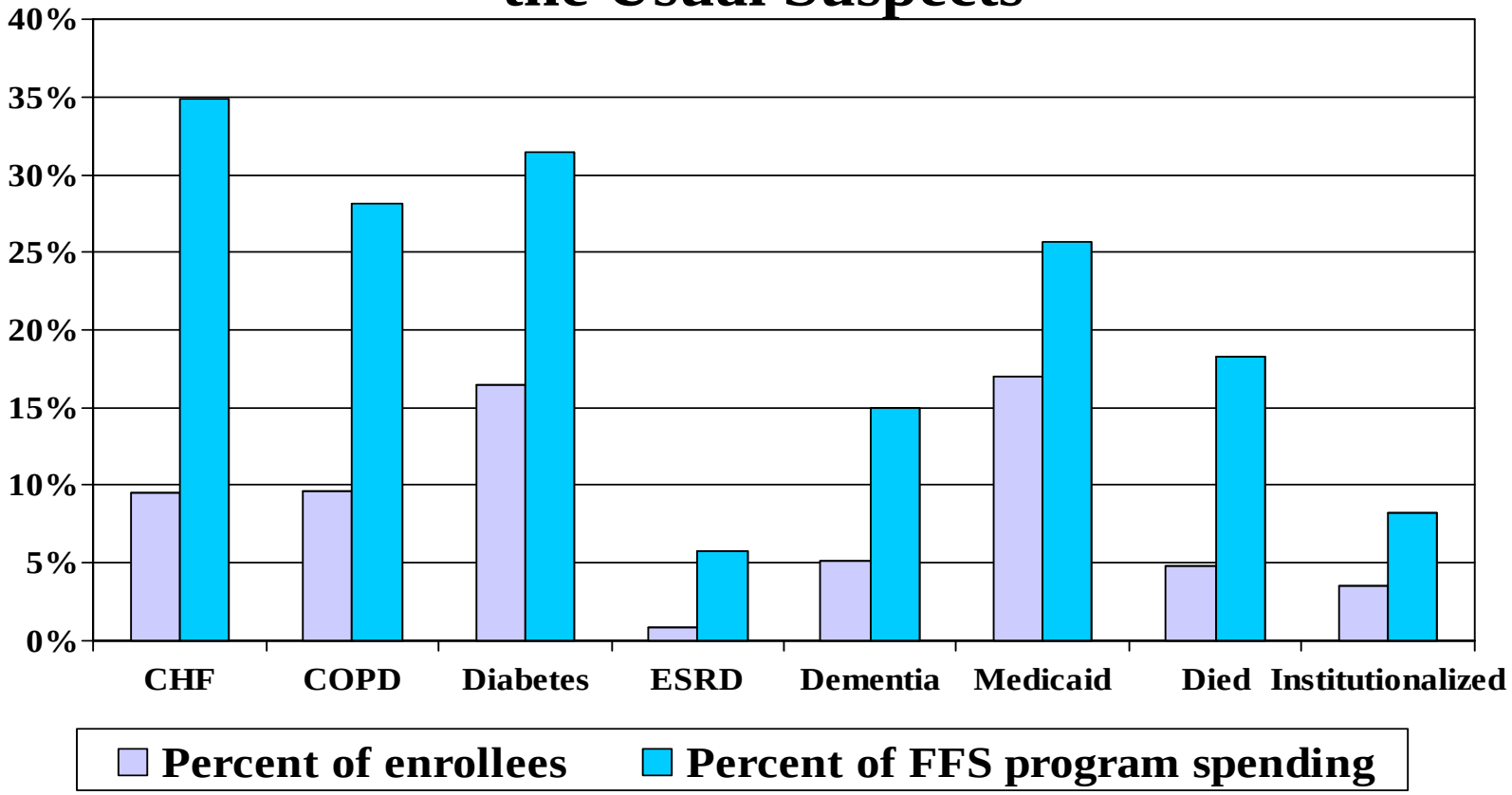
Member Selection for Care Management

Readmissions and Avoidable Admissions

Medicare Medical Management: "Round up the Usual Suspects"



Source: C. Hogan and R. Schmidt, MedPAC Public Meeting, Washington, DC, 18 March 2004. Based on a representative sample of FFS enrollees and all their claims. Beneficiaries may be in multiple categories. Spending is for all claims costs, including treatment of beneficiaries' co-morbid conditions.

1

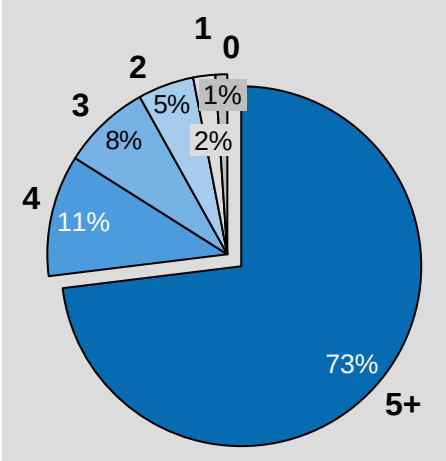
Members in Transitional Care Management

- Age = 76 (65-99)
- Chronic conditions = 7 (3-14)
- Prescribed medications = 8 (4-14)
- Average of 4.6 problems per patient
- Nurses addressed 32 different types of problems with 173 patients

Care Management Focus

73% of Medicare spending is on people with five or more concurrent chronic conditions

Medicare Cost Distribution by # of Chronic Diseases



Top Five Medicare Conditions

Heart Disease

Diabetes

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Renal Failure

Dementia

Engagement Opportunity

- Engagement in chronic disease program "matures" and shows impact – a process that develop over years vs. weeks / months
- Allows for ROI on prevention (e.g., Hypertension, Osteoporosis, Blood Sugar Management)

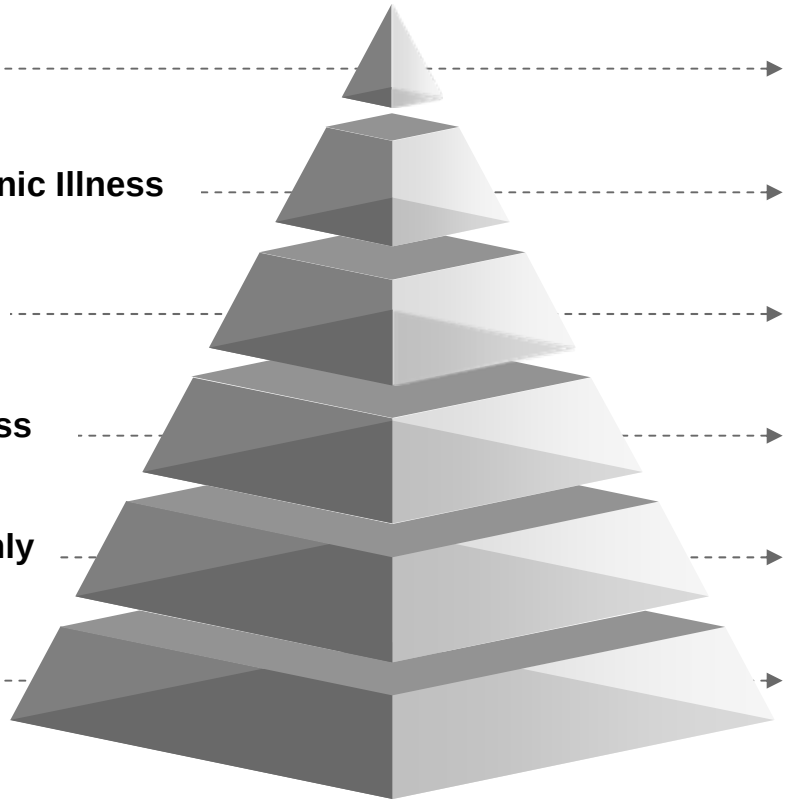
Programs That Show Impact

- Multiple chronic conditions
- Advanced illness
- Modifiable risk factors
- Transitional care
- Pharmacy management
- Ongoing follow up
- Ongoing risk evaluation

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7
Potential Impact on Avoidable Acute Utilization	22%	29%	34%	-	-	-	-

Long-term Contract - A “Real” Care Management Opportunity

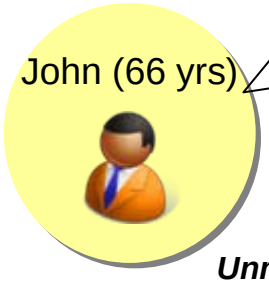
Illness Pyramid



Care Management Model

	Typical	*Ideal*
End of Life Advanced Chronic Illness	▪ Care management focus ▪ Short-term Impact	▪ Early engagement for advanced directives and planning ▪ More effective case identification
Chronic Illness	▪ Some engagement	▪ Long term impact focus (e.g., osteoporosis) ▪ 3-5 year Potential
Reversible Illness Risk Factors Only	▪ Minimal engagement ▪ Mailings	▪ Identify and engage on specific risk factors ▪ Impact potential in 3-7 years
Wellness, Life Satisfaction	▪ Minimal engagement ▪ Impact not demonstrated	▪ Impact lifestyle through actual engagement (smoking, obesity)

How Value Will Be Created: Example of Metabolic Syndrome



I am in a bad shape… I have -

- Hypertension
- High cholesterol
- High triglycerides
- Obesity
- Borderline sugar

… and this can get worse

- ✓ **Multiple chronic conditions**
- ✓ **Terminal illness**
- ✓ **Modifiable risk factors**
- ✓ **Transitional care**
- ✓ **Pharmacy management**
- ✓ **Ongoing follow up**
- ✓ **Ongoing risk evaluation**

Unmanaged progression → ~ 3 yrs ***~ 3 yrs*** ***~ 3 - 5 yrs***

	1 Pre-Diabetic	2 Diabetic	3 End Organ Failure	4 End-of-Life
Anne's Interventions	• Define health goals • Customize plan to modify risk factors • Review medications • Work with member on adherence with continuous feedback	• Onsite annual health risk assessment • Care coordination with PCP • Monitor Blood sugar, A'C, etc. • Continuous feedback	• Care coordination to assure care completion • Long term case management • Holistic management	• Follow up, education, and support • Choices, options, psychosocial support
John's Impact	• Progression to Diabetes is **delayed by ~ 10 years**, OR • Diabetes **does not occur** in Johns' lifetime!	• Progression to organ damage is **delayed by 10 years**, OR • Organ damage **does not occur** in John's lifetime!	• Organ damage is managed and **does not progress** • Organ damage **does not result in Terminal Illness!**	• Long term engagement facilitates Compassionate Care • Effective impact on Advanced Illness