SIMPLY CONNECTED℠

Blue Care Connection®
AN ACTIVE APPROACH TO INTEGRATED HEALTH MANAGEMENT

BlueCross BlueShield of Montana

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
ONE IN TWO AMERICANS LIVES WITH A CHRONIC HEALTH CONDITION that is largely preventable
WHY WE DO WHAT WE DO

IT IS THE RIGHT THING TO DO

PRESERVES AND IMPROVES HEALTH

HELPs CONTROL FUTURE HEALTH CARE SPEND

INSPIRES PRODUCTIVITY AND EMPLOYEE MORALE
60% OF PATIENTS REPORT HAVING NO IDEA ABOUT THEIR COST OF CARE until they received a bill
WE’RE WORKING TO SIMPLIFY CONNECTIONS

between DOCTORS and THEIR PATIENTS

between PEOPLE and INFORMATION

between YOUR EMPLOYEES and BETTER HEALTH
WE BELIEVE health care can, and should, work better
HEALTHY EMPLOYEES MEAN
FEWER COSTLY MEDICAL CLAIMS
LESS ABSENTEEISM
GREATER PRODUCTIVITY
**Integrated delivery model** that ensures faster identification of at-risk members and more active management of member health

**Stronger provider relationships** that maximize opportunities to impact member health and better meet the needs of an evolving delivery system

A **respected brand** that translates into stronger member confidence

A **deep data advantage** and sophisticated analytics that help ensure the right intervention at the right time

**Dedicated and expert staff** offers guidance and support to help members make the best health care decisions
Through predictive modeling and advanced risk stratification, we’re identifying at-risk members earlier, getting them the help they need, even before they know they need it.
CONNECTING WITH YOUR EMPLOYEES ACROSS THE HEALTH SPECTRUM

INTEGRATING MEDICAL, BEHAVIORAL HEALTH AND WELLNESS

Well onTarget® Health Assessment
Biometrics Screenings
Preventive Care Initiatives
Member Portal and Online Tools
24/7 Nurseline

Behavioral Health
Lifestyle Management
Utilization Management
Special Beginnings® Maternity Program
CCEI® Care Coordination & Early Intervention
Condition Management
Case Management

Blue Care® Advisors

<<< Strong provider partnerships in collaborative care initiatives >>>
**Cardiovascular Condition Clusters** Expands to include earlier warning signs – angina, peripheral arterial disease, and atherosclerosis.

**Musculoskeletal Leading Indicators** Focus on low back pain and member education on treatment alternatives to surgery.

**Metabolic Syndrome (MetS) and MetS Leading Indicators** Managing MetS and leading indicators earlier to prevent disease progression to diabetes and heart disease.

**CCEI® Care Coordination & Early Intervention** Targets members at risk earlier to reduce avoidable readmissions, complications, and/or ER visits.

**Early Alerts Initiative** Screening of daily admissions reports for at-risk members. Regression analysis reporting helps identify potential high-cost claimants.

**Care onTarget℠** Comprehensive web-based health assessments for 5 core conditions, click-to-chat with a clinician. Virtual library of condition-specific tutorials.

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**Early Identification, Multi-Condition Approach**

50% of the top 10 services performed are related to heart or musculoskeletal conditions.
MICRO-PREDICTIVE MODELING DRIVES EARLY IDENTIFICATION OF SPINAL FUSION CANDIDATES

COST SAVINGS:

$50,000 per episode of care
Care Coordination & Early Intervention (CCEI®)

Helps prevent or reduce future admissions, avoidable re-admissions and emergency room encounters

Pre-admission counseling and post-discharge planning

Each avoided readmission = $22,000 approx. savings

RESULTS

Engaged: 5.3%
Non-Engaged: 9.5%

CCEI AVOIDS READEMISSIONS
Case Management ENHANCEMENTS

EARLY WARNING SYSTEM

Screening and management of actual and potential high dollar cases

- Advanced analytics
- Daily Admission Reports
- High Cost Claimant report
- Potential High Cost Claimants
- ER alerts report
- Transportation Alerts

MANAGING HIGH COST CLAIMANTS EARLIER AND FASTER

Integrated Grand Rounds

RNs, Medical Directors, Customer Service, Network, Pharmacy, and Behavioral Health staff meet weekly to review cases and identify potential cost containment measures.
Blue Care Advisors provide education and support to moderate and high-risk members with specific conditions, helping them enhance self-management skills to change behaviors, **improve overall health and help prevent or delay disease progression**.
WE BELIEVE
real change happens
one person at a time
OUR HEALTH ADVOCACY MODEL ENSURES DEEP ENGAGEMENT LEVELS.

- Real engagement is defined by real clinician contact, not by a checkmark on a mailing list.
- Engagement is when people listen, and then they change behaviors.
- Engagement is when we can teach, learn and inspire others to do better and reach their potential for wellness.

TOUCHING MORE LIVES MEANS BETTER HEALTH OUTCOMES.
BLUE CARE ADVISOR/COACH CALL TIMELINE

Blue Care Advisor’s (BCA) Follow-Up Timeline
(Typical 6 Month Total Engagement)
NOTE: Actual Follow-up Schedule determined by member’s needs

Lifestyle Management Coach Advisor’s Follow-Up Timeline
(Typical 9 Month Total Engagement)
NOTE: Actual Follow-Up Schedule determined by member’s needs
MEASURABLE VALUE . . . TANGIBLE RESULTS

EXPECTED TOTAL SAVINGS $12.18 PEPM

PEPM SAVINGS FOR YOU

$1.88 Preventive Care

$0.44 Lifestyle Management & 24/7 Nurseline

$0.42 Care Coordination & Early Identification

$7.93 Five Core Conditions

$1.51 Complex & Catastrophic (incl. High-Risk OB)
WE’RE PAIRING MEMBERS WITH THEIR OWN PERSONAL COACH empowering them with information and support to make better decisions about their health
**GAP CLOSURE VALUE**

**SUCCESSFUL FORMULA FOR IMPROVING HEALTH STATUS**

Members with a chronic condition and no open targeted gaps are **50% LESS LIKELY** to have a hospital admission or ER visit.

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**Diabetes**
- HbA1C in the past 12 months
- Physician office visit in 6 months
- LDL level in the past 12 months
- Microalbuminuria in past 12 months
- ACE/ARB medication in past 6 months for diabetics with hypertension

**Cardiovascular Condition Clusters**
- LDL level in the past 12 months

**Congestive Heart Failure (CHF)**
- Physician office visit in 6 months

**Chronic Obstructive Pulmonary Disorder**
- Bronchodilator adherence

**Asthma**
- On controller medication

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*Source: Health Care Service Corporation (HCSC) 2012 claims incurred.*
**ALL GAPS MATTER — Just some of the hundreds of gaps**

<table>
<thead>
<tr>
<th>Preventive Gaps</th>
<th>Lifestyle Gaps</th>
<th>Condition-Specific Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of immunizations, mammograms, cervical screenings, colonoscopies</td>
<td>• Physical inactivity / poor nutrition / BMI $\geq 25$&lt;br&gt;• Tobacco use</td>
<td>• No emergency action plan in place for asthma, or condition-specific screenings done</td>
</tr>
<tr>
<td></td>
<td>• Abnormal cholesterol</td>
<td>• Member not following physician's treatment plan</td>
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<tr>
<th>Psychosocial Gaps</th>
<th>Knowledge Gaps</th>
<th>Medication Compliance</th>
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<tbody>
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<td>• Positive depression screen&lt;br&gt;• Inadequate financial, family or other resources&lt;br&gt;• Cultural or religious barriers</td>
<td>• Member does not understand need to track blood pressure readings or how to read&lt;br&gt;• Member does not know how to use peak flow meter</td>
<td>• No beta blocker use with Coronary Artery Disease diagnosis&lt;br&gt;• Asthmatic not on controller meds&lt;br&gt;• Diabetic not taking diabetic meds</td>
</tr>
</tbody>
</table>
IT GETS BETTER

1 in 2 eligible members identified as ready to change enrolls in our programs
We’re Closing the Gaps to Better Care
MAKING A POSITIVE DENT IN YOUR BOTTOM LINE*

49% GAP CLOSURE CONVERSION RATE*

Well-managed members experiencing NO gaps in care for their chronic condition(s).

$534 $1,158 $2,391 $4,553 $6,972 $11,033 $17,733 $23,281

GAP CLOSURE CONVERSION RATE*

3 Conditions 4 Conditions 5 or more Conditions

40% of people who have a chronic condition have more than one.

*ANNUAL SAVINGS PER WELL-MANAGED MEMBER. Source: HCSC claims data from September 2010 - August 2011; 600,000+ members identified with chronic conditions.

** 190,779 out of 387,391 members converted from poorly managed between June 2011 and May 2012 to well managed through November 2012. Reflects outcomes for 6.9 million ASO BCC members.
A PROVEN APPROACH

WITH BLUE CARE CONNECTION, EVERYONE WINS

5% LOWER HOSPITAL ADMISSIONS per 1,000

8% LOWER HOSPITAL DAYS per 1,000

2% LOWER ER VISITS per 1,000

Data provided is for members with one or more core conditions (asthma, diabetes, CAD, CHF or COPD)
BCC vs. Non-BCC ASO Accounts (excluding ERS, FEP, Medicare Primary) – Service Dates from January 2011 through December 2012
Connecting your employees to the strength and power to live healthier lives
WEIGHT MANAGEMENT
63%
lost six percent of body weight

TOBACCO CESSATION
29%
of members report they stopped smoking

METABOLIC SYNDROME
34%
reduced or eliminated medication usage
NEARLY 1 IN 3 ADULTS WITH A MEDICAL DISORDER HAS A MENTAL HEALTH CONDITION

We’re managing the whole person to enhance overall treatment effectiveness, improve outcomes, and achieve better results.

Source: Robert Wood Johnson Foundation, Mental Disorders and Medical Co-Morbidity, February 2011
MANAGING THE WHOLE PERSON ACHIEVES BETTER RESULTS

THE VALUE OF BEHAVIORAL HEALTH INTEGRATION

16% DECREASE IN ER VISITS AFTER CASE MANAGEMENT ENGAGEMENT

$1.05 MILLION ENGAGEMENT VALUE

27% Potential days avoided acute IP ALOS reduced by 2+ days

Dollar Impact = $10,194,198
Cost Avoidance = $1.63 PEPM

= ~10% of total behavioral health spend

READMISSIONS 12% to 9%

SIMPLY WHOLE
Members with Behavioral Health and Core Medical Conditions

$93  LOWER PMPM
$1,100 / member / year

-7% total PMPM, -19% medical PMPM

HIGH COST CORE EXAMPLES

20% lower PMPM ($263) for members with diabetes and a BH condition engaged in medical DM = more than $3,000 per year

4% lower ($58) for members with CAD and a BH condition are = approx. $700 per year

Source: HCSC internal data.
MOBILE HELPS MEMBERS MANAGE THEIR HEALTH

**DIABETES CARE MANAGEMENT**
Better self-management with Rx reminders, preventive information, diet tips, and general information

**MATERNITY CARE MANAGEMENT**
What to expect, pregnancy basics, checkups, screenings, vaccinations, a contraction timer, nurse outreach (enrolled members in Special Beginnings®)

**CORONARY ARTERY DISEASE (CAD) CARE MANAGEMENT**
Diet, exercise, fitness, and basic care management tips

**FIVE** text messages sent *every minute*
Smart Phone App

Find Doctors App

- Redesigned Interface
- Faster results
- Locate providers
- Link to map and directions
- Add to contacts
- Locate urgent care facility using GPS location

For iPhone® and Android™ phones.

More than 2,500 Find Doctors app downloads / month
• A calendar informing moms of **what to expect** during each week of pregnancy.

• A **library of articles** to help moms stay healthy and informed throughout their pregnancy.

• Information on **vaccines and tests** that moms will encounter during pregnancy.

• Educational **videos from a cross disciplinary panel of experts** on pregnancy.
CONDITION MANAGEMENT NOW MEETS MEMBERS WHERE THEY ARE … ONLINE

Many videos tutorials offered in Spanish
Interactive Health Tutorial

EXAMPLE for Low Back Pain

Many available in Spanish
Our wellness strategy just got smarter, faster, better.
We asked consumers what it would take to get serious about wellness. And then we did what they said.
Our Wellness Suite

- ondemand client website
- Healthy Worksite consultation*
- Member personalized communications

- Weekly utilization reporting
- Aggregate and member-level reporting

- Events and seminars*
- Health fairs*
- Workplace challenges
- Wellness Coordinators*

- onmyway™ Health Assessment
- Personal Wellness Report
- Biometric screenings*
- One-on-one coaching

- Well onTarget portal
- Self-directed eCourses
- Trackers
- Health articles
- Fitness Program
- Social networking
- Text messaging
- Life Points

- Dedicated coaching
- Goal-setting tools
- Multiple modalities
- Online and telephonic support

*Buy-up dependent
Workplace competitions and wellness coaches inspire employees to new levels of performance.

Online tools let you set goals and track your progress.

Life Points reward employees for progress.
THE DIFFERENCE IS PARTNERSHIP AND IT IS POWERFUL

- Best success achieved with strong client leadership message and sound communication strategy
- Strong drivers for members to engage
  - incentives or disincentives
- Wellness Consultant and Wellness Plan
- Clinical Account Consultant
Alternate views

(PENCIL CONTINUUM HAS BEEN VERY POPULAR)
Well onTarget®
Health Assessment
Biometrics
Preventive initiatives
Member portal and online tools
24/7 Nurseline
Lifestyle Management
Utilization Management
Condition Management
CCEI® Care Coordination & Early Intervention
Case Management
Special Beginnings® maternity program
Behavioral Health Management
Blue Care® Advisor coaching

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