



MEDASSURANT™



DATA-DRIVEN IMPROVEMENTS IN HEALTH CARE™

EFFECTIVE STRATEGIES FOR DELIVERING SMART CARE IN THE  
PHYSICIAN'S OFFICE

*Care Continuum Alliance*

*September 8, 2011*

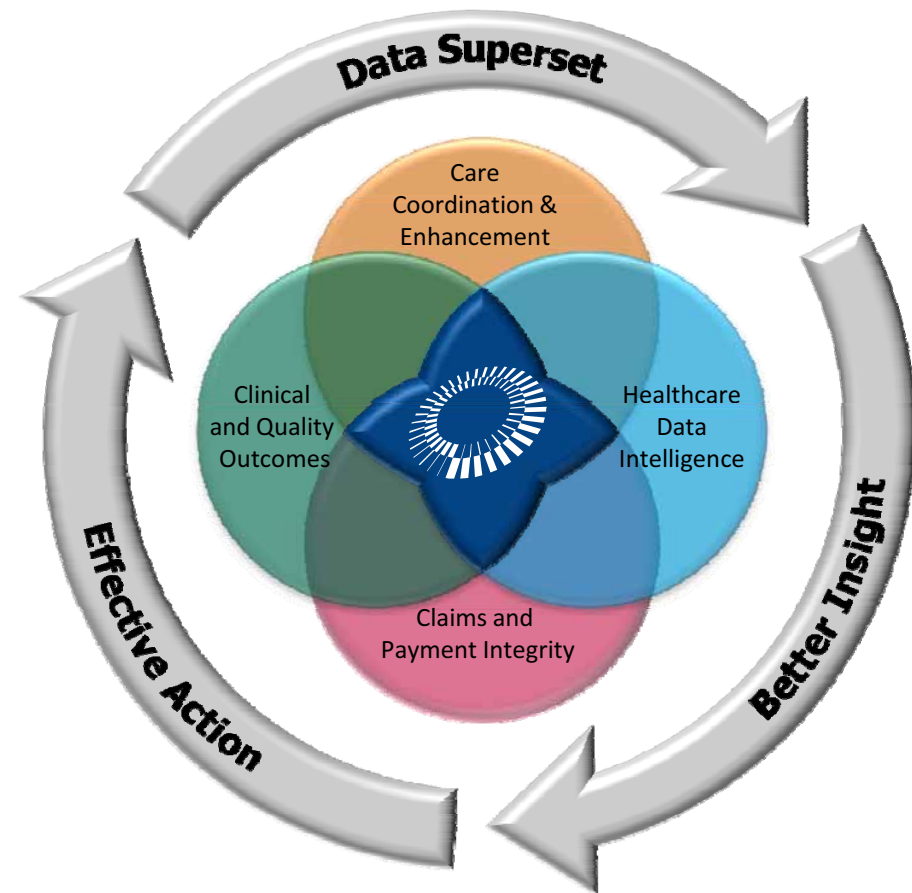
# Discussion Objectives



Care enhancement programs can be used to enhance quality improvement programs, lower unnecessary utilization, and increase risk score accuracy.

Strategies to remember from today’s discussion:

- Use data-driven analytics to identify, stratify, and prioritize
- Develop a Plan of Care that reinforces evidence-based care and the physician’s treatment plan
- Conduct face-to-face and telephonic interventions to support health status improvement
- Integrate care enhancement program with quality improvement and risk score accuracy initiatives
- Achieve optimal clinical outcomes that drive unnecessary utilization and cost improvements



# Introduction – Our Company



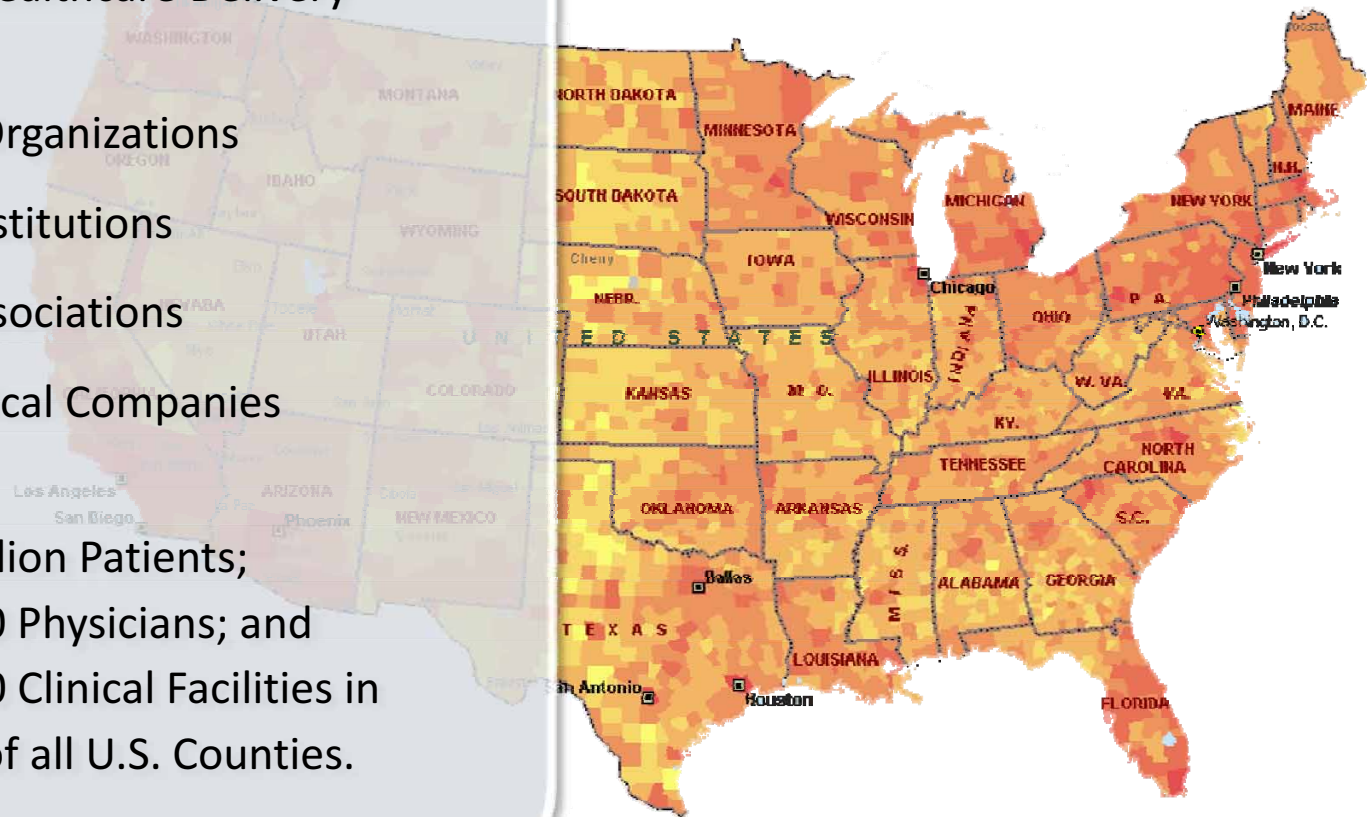
- Founded 1998
- ~4,300 Employees
- Headquartered outside of Washington D.C., in Bowie, MD.
- Applying deep analytics and proprietary datasets to enable advanced health care solutions, driving meaningful and measurable improvements in clinical and quality outcomes, care enhancement, and financial performance within the entire health care community.



# Introduction – Our Clients



- Hundreds of Health Plans
- Integrated Healthcare Delivery Systems
- Regulatory Organizations
- Academic Institutions
- Physician Associations
- Pharmaceutical Companies
- Touching:
  - 118 Million Patients;
  - 295,000 Physicians; and
  - 185,000 Clinical Facilities in
  - 99.8% of all U.S. Counties.



# An Integrated Approach Leads to Improved Outcomes



A more comprehensive and gap-specific patient profile leads to integrated interventions and greater outcomes across quality improvement, unnecessary utilization reduction, and risk score accuracy.



Health Care Profile for Ms. Jones	Programs Impacted			
	Risk Adjustment*	Quality Improvement**	Disease Management	MedAssurant Integrated Solution
Previously diagnosed with diabetes	✓			✓
Overdue for an HbA1c lab test		✓	✓	✓
Lacking glaucoma screening		✓	✓	✓
No podiatry visit for 12 months			✓	✓
Poor blood glucose control		✓	✓	✓
Inconsistent Metformin refill rate			✓	✓
Suspected diagnosis of COPD	✓			✓
No Beta-blocker post MI			✓	✓
Missing breast cancer screening		✓	✓	✓
Recent hospital discharge			✓	✓

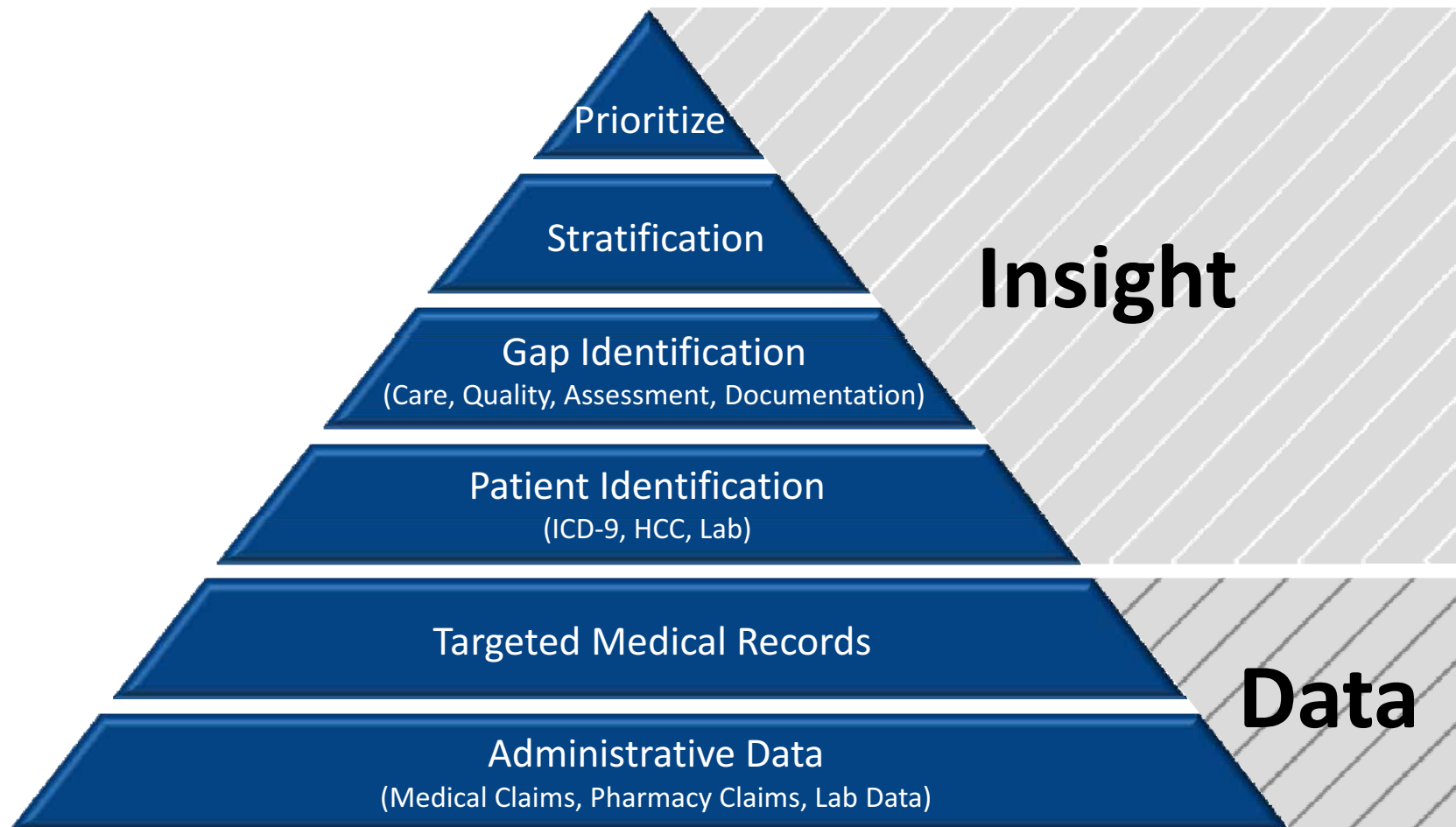
\*Risk adjustment performed to improve HCC and CRG accuracy

\*\*Quality improvement initiatives to improve CMS Five-Star Quality Ratings and Managed Medicare incentives

# Data-Driven Analytics Provides Insight



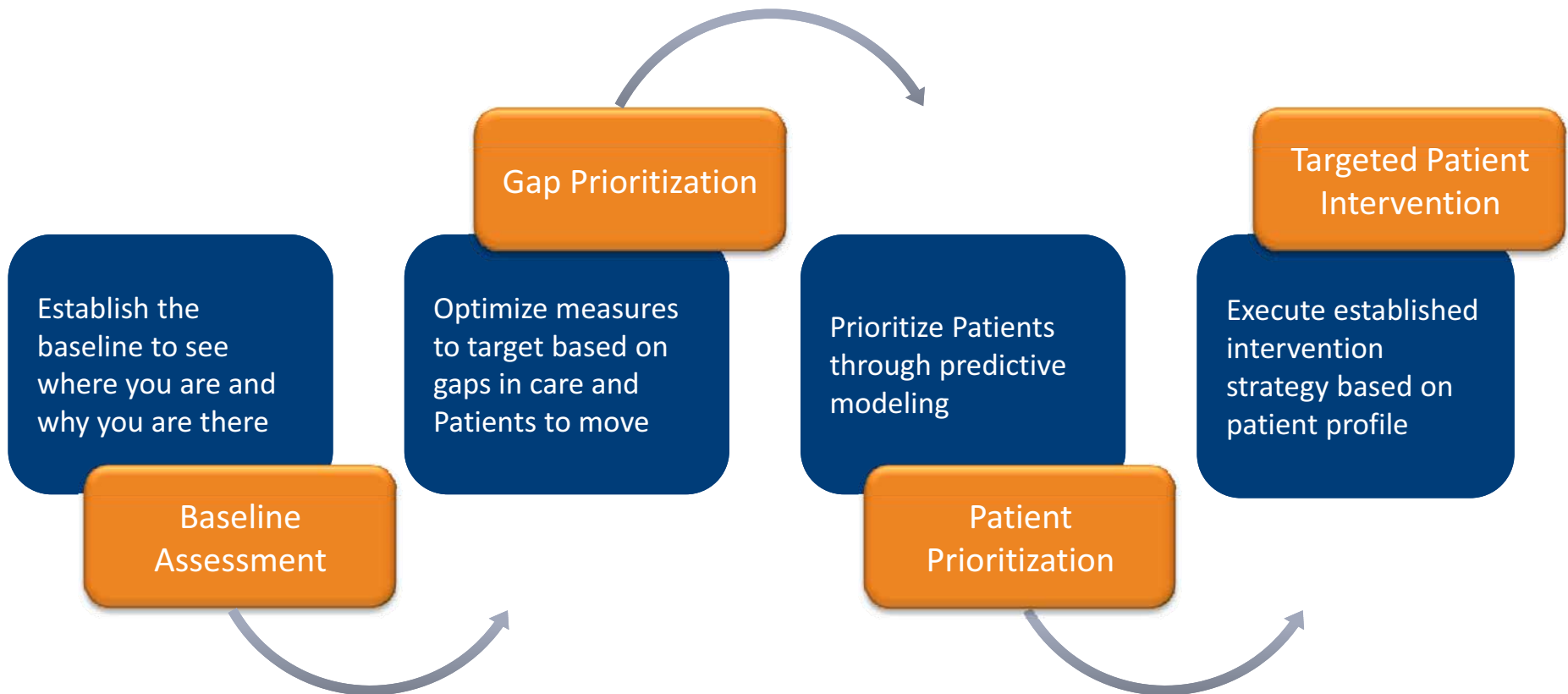
A data superset serves as the foundation for precise, clinically-proven predictive modeling to identify optimal patients and gaps, then perform detailed stratification and prioritization. With this insight, intervention strategies are strategically scheduled and delivered.



# Analytics Direct the Outreach Strategy



Analytics are key to determining which measures to prioritize, which patients (and their physicians) to target, and how these decisions affect ROI.



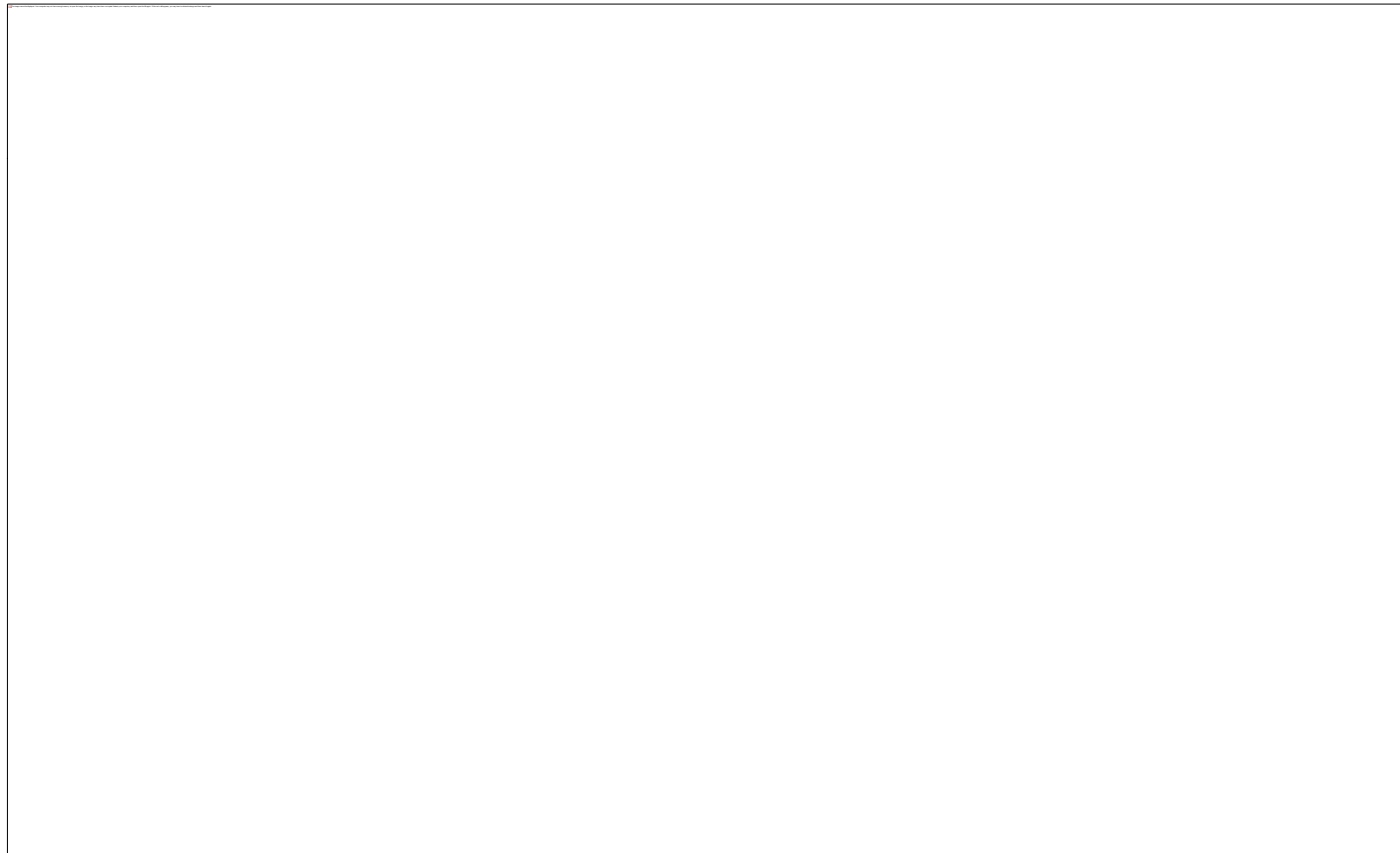


# Comprehensive Patient Intervention Approach

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A care enhancement program needs to be focused on providing the resources, tools, education, and coaching to stabilize and improve patient health.



# Map for Improved Health – Plan of Care



The Plan of Care captures and promotes adherence to evidence-based guidelines of care. Our nurses use the Plan of Care to work with patients and their physicians to set goals, change behavior, and learn to manage their conditions.

## Areas included in the Plan of Care:

- Vital signs (e.g., blood pressure, body mass index),
- Missing labs values relevant to the patient's condition (e.g., HbA1c, LDL),
- Missing lab values relevant to medications and impact on organs (e.g., kidney, liver),
- Utilization gaps (e.g., no recent record of physician visit),
- Personal choices and self-care habits (e.g., diet and exercise), and
- Other relevant data (e.g., smoking status, whether the patient has an asthma action plan).



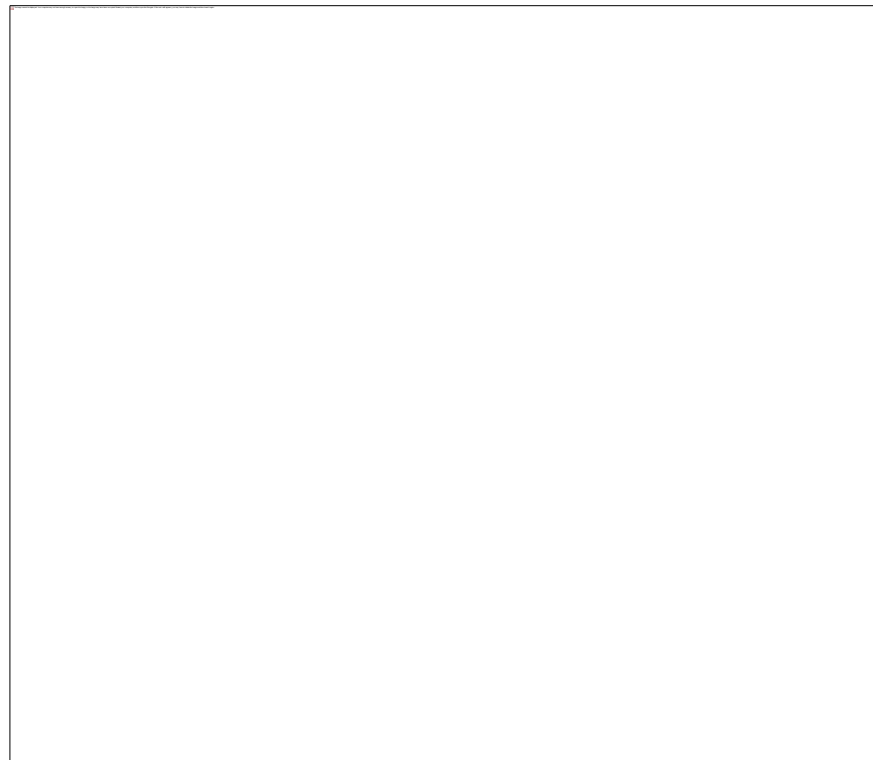
# Patient Behavior Change Gains Commitment

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Apply behavior change methodologies when supporting patients as they strive to improve their health, change lifestyle choices, and create new healthy habits.

For example, MedAssurant has developed the Stairs to CARE approach to help change patient behavior. The Stairs to CARE mirrors the nursing process (APIE) and incorporates principles from other proven models of behavior change.



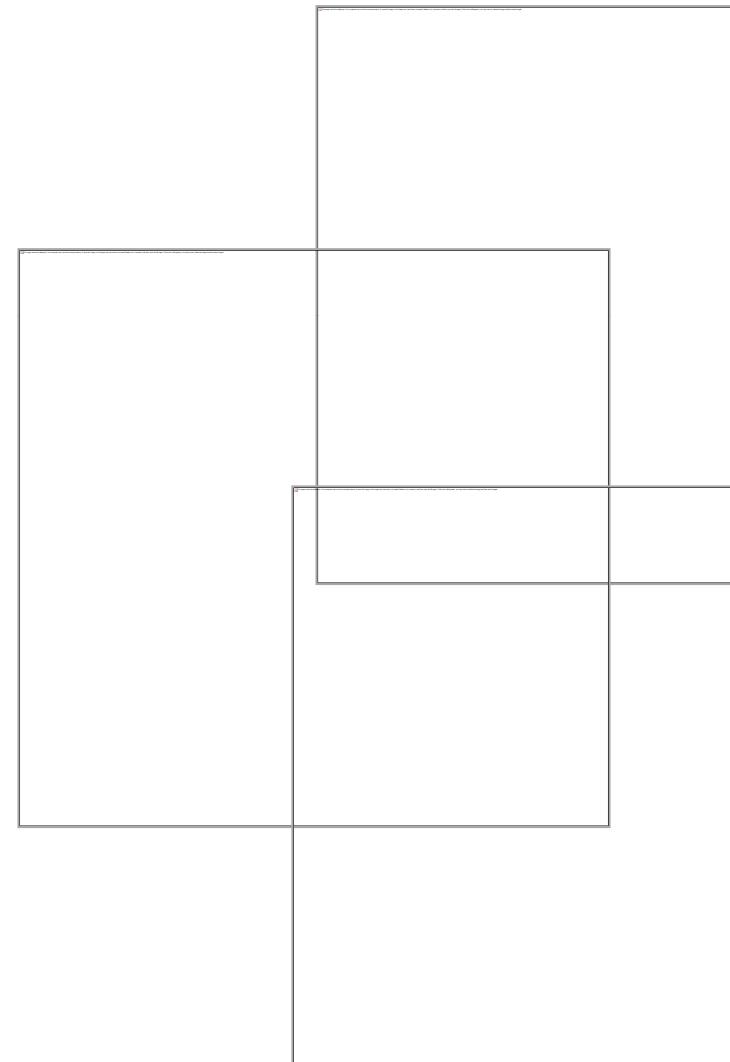
# Support Behavior Change with Targeted Education



Personalized communications support patients as they achieve their goals.

- Send printed educational booklets, regular educational flyers, Plan of Care, screening reminders
- Use principles of health literacy and reader feedback to ensure patients take the desired action
- Reference materials during nurse calls and visits
- Prompt patient to discuss questions with their physician

Compliance with NCQA and CMS requirements for reading level, font, File and Use, etc.



# Targeted Telephonic Patient Outreach

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Telephonic outreach reinforces messages delivered by face-to-face and mail. Nurse-delivered assessments and coaching complements the treatment and education delivered by the patient's physician.

- Welcome calls to gain patient participation in care management program
- Plan of Care development and ongoing support for goal achievement prompts patient self care and behavior change
- Regular coaching calls for patients
- Medication adherence assistance
- Hospital post-discharge support
- Live and IVR telephone outreach to close Five-Star Quality gaps
- Close gaps on telephone and use as supplemental database



# Going Local - Community-based Care Management

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Registered nurses in the community are the bridge between the physician's office and the patient's home.

- Clinic location in geographical areas with heavy patient concentration
- Embedded in a physician location

Advantages of community-based care management:

- Builds on knowledge of community, local resources
- Accommodates aspects of regional culture
- Connects with physicians, medical groups, hospital systems for effective care coordination
- Facilitates a connection between patients and clinicians
- Enhances loyalty to the plan



# Face-to-Face Assessments for Chronically Patients



Face-to-face assessments give insight into the complete patient profile and health status. The visits offer the opportunity for teaching and coaching to help close the gaps in patient health and self management. Nurses have a clear view of:

- Health
  - True picture of health status
- Ability to Self Manage
  - Foot self-care
  - Biometrics
  - Understanding of disease, complications, medication side effects
- Socio-Economic Situation
  - Family and community
  - Food and shelter
  - Medication
  - Transportation



# Decision Support to Aid Providers



Collaboration and communication with physicians is an integral part of delivering coordinated care management. Patient information should be available via paper and online. Tools to support behavior change are important, such as a Plan of Care that is shared between the care management nurse and the physician—with the patient in the center

CCS Advantage™ Plan of Care

Report Date: <<Date>>  
 Member Name: <<Member Name>>  
 Plan Member ID: <<MemberID>>  
 Address: <<Address>>  
 Date of Birth: <<Date of birth>>  
 Gender: <<Gender>>  
 Conditions: <<Condi>>

This is the provider copy of the patient listed above.

The personal Plan of Care do nurse, the patient's health info Care makes it easier for you a your patient to bring the Plan

Topics discussed with a CC

Date Discussed	Topic
<<date>>	•
<<date>>	•
<<date>>	•

Questions for my doctor:

- << system generated>>
- << system generated>>
- << system generated>>

Standard of Care	Most Recent Date Reported	Most Recent Val
A1C Target	<<date>> or None reported	<<value>> or None reported
LDL level Target<sup>100</sup>	<<date>> or None reported	<<value>> or None reported
Dilated Retinal Eye Exam Annually	Last exam: <<date>> or None reported	
Foot check: Every 6 months	Last exam: <<date>> or None reported	<<value>>
Blood Pressure (BP) Recommended target is less than 140/90. Certain diseases, the recommended target is less than 130/80.	<<date>> or None reported	<<value>> or None reported
Height, Weight, BMI	<<date>> or None reported	Weight: <<value>> or None reported Height: <<value>> or None reported BMI: <<value>> or None reported
Diet: Discuss diet restrictions with patient		
Physical activities: Discuss physical activity recommendations with your patient		

CCS Advantage™ Plan of Care

Report Date: <<Date>>  
 Member Name: <<Member Name>>

This section reports your patient's medication or monitoring laboratory needs. The chart below displays his or her in-use prescriptions for the medication and any refill dates. It also indicates remaining supply days based on remaining. A status key is shown for data reporting.

Medication or Lab

IN ACC or AER (class of medication) refill in the past three months
ACE or AER (class of medication) treatment for three months without kidney test (BUN or Creatinine test)
Stat as a beta-blocker (class of medication) after heart attack
Beta-blocker (class of medication) refill less than expected
Digoxin refill rate and no kidney or potassium lab test
Two or more short-acting beta 2 agonist (SABA) scripts in last three months and no inhaled corticosteroids (ICS)
ICS refill rate less than expected
Spiriva™ refill rate less than expected
Metformin refill rate less than expected
Metformin for three or more months and no kidney lab test (BUN or Creatinine test)
Statins (class of medication) refill rate is less than expected
Statins (class of medication) treatment for three months and no liver lab test
Depression medication refill less than expected
Meat health medication refill less than expected
Fluid pill refill rate less than expected
Fasting glucose (sugar) level with high blood pressure

Program services available:

- Nurse calls
- Letters about your health concerns
- Mailings on health topics and healthy living
- Face-to-face visits with a nurse
- Visit with a specialist in shoe diabetic fitting (for members who qualify)
- Assistance with community resources and referrals
- Access to social workers

A coordinated Plan of Care prompts quality improvement opportunities, such as Metformin safety, and individualized patient Plans of Care.

# CCS Advantage™ Outcomes Summary



MedAssurant’s solutions lead to healthier, more satisfied patients and improved financial outcomes for health care clients.

## Clinical Outcomes Improvement

- **Improved clinical outcomes** for patients in need of higher levels of clinical intervention intensity (based on their individual stratification)
- **17% higher HbA1c testing rates** for patients engaged for six months or more
- **12% higher eye exam rates** for patients engaged for six months or more
- **CMS Five-Star Quality Rating above national average** for all measures related to diabetes

## Utilization & Cost Improvement

- **24%** lower medical costs for patients with chronic conditions
- **30%** lower facility costs, with an **11%** decrease in inpatient admissions by the third program year

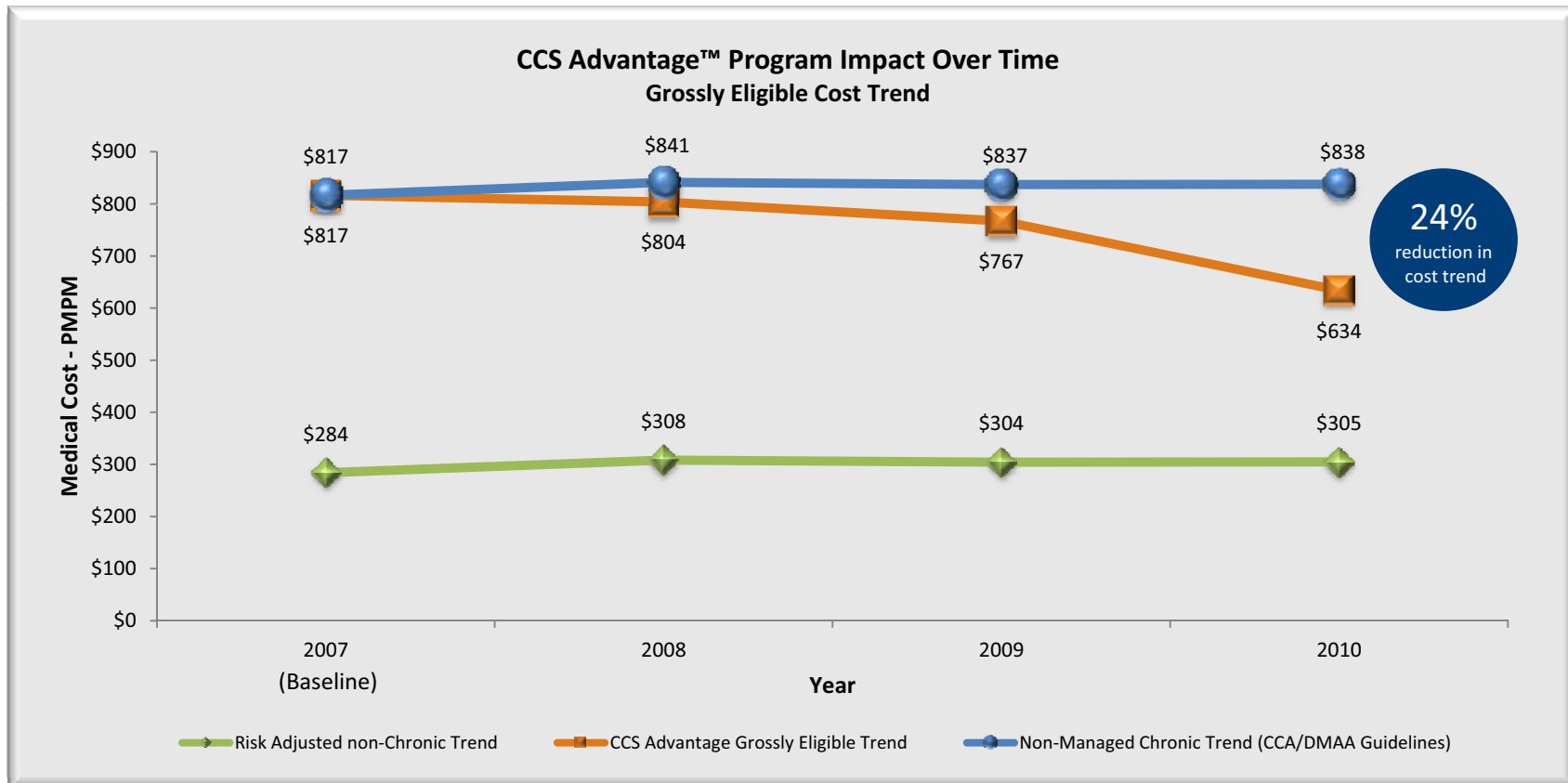
## Engagement & Satisfaction Improvement

- **93%** of patients would likely recommend the program
- **91%** of physicians are satisfied or very satisfied with the program
- **21%** reduced patient attrition

# CCS Advantage™ Results I



Costs for Grossly Eligible patients were 24% lower than the trend after three program years.



Cost outcomes computations based on Care Continuum Alliance (CCA/DMAA) guidelines. Outcomes analysis is based on client claims data through April 2011.





# CCS Advantage™ Results III



CCS Advantage™, MedAssurant’s fully NCQA-accredited disease management solution, has demonstrated significant quality outcomes above the national average. This is most notable in diabetic measures, which is a primary area of disease prevalence and cost in Medicare Advantage health plans.

CMS Five-Star Quality Rating Measures	2011	
	National	Client
C03-Cardiovascular Care - Cholesterol Screening	3.9	5.0
C04-Diabetes - Cholesterol Screening	4.0	5.0
C06-Monitoring for Long Term Meds	3.9	4.0
C07-Annual Flu Vaccine	3.0	2.0
C08-Pneumonia Vaccine	3.1	2.0
C09-Improving Physical Health	4.4	4.0
C10-Improving Mental Health	1.9	3.0
C15-Diabetes – Eye Exam	3.3	5.0
C16-Diabetes – KD Monitoring	4.0	5.0
C17-Diabetes – Blood Sugar Control	3.2	4.0
C18-Diabetes – Cholesterol Control	3.2	4.0
C19-Controlling Blood Pressure	3.2	4.0
C21-Testing to Confirm COPD	2.1	3.0
C23-Reducing the Risk of Falling	2.9	3.0
C25-Doctors who Communicate Well	3.2	2.0
D17-Blood Pressure Medication for Diabetics	3.1	4.0

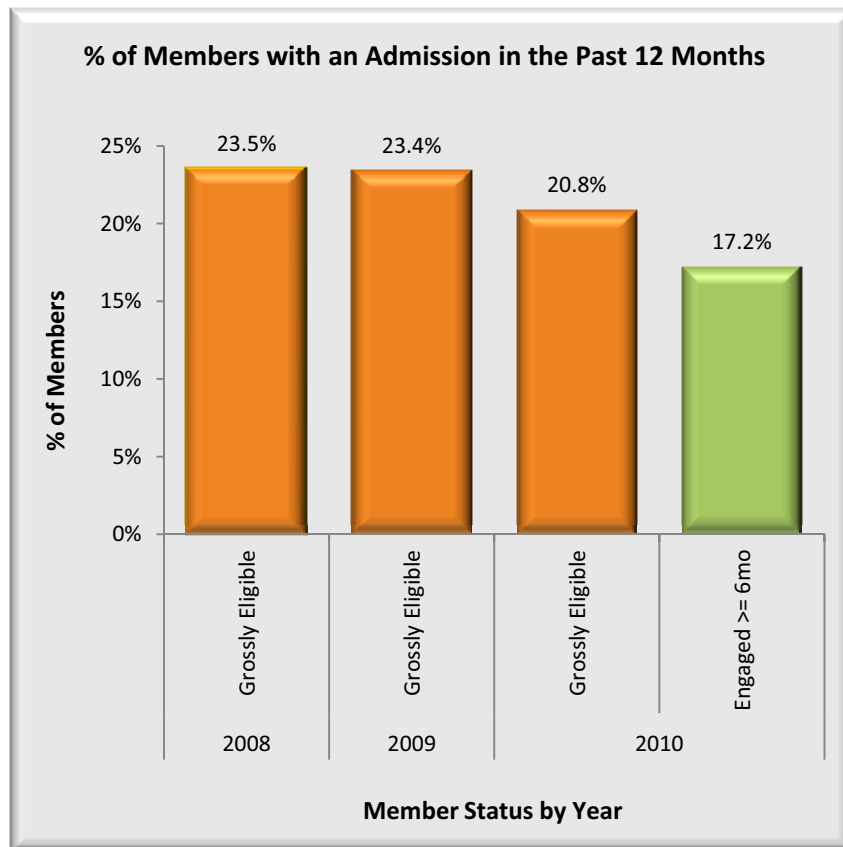
Results based on 2009 Dates of Service  
130,800-member Medicare Advantage plan

 Above National Average (2011)  
 Indicated program-relevant measures

# CCS Advantage™ Results IV



MedAssurant’s advanced chronic care solution (CCS Advantage™) drives lower utilization rates through its stratification, prioritization, and carefully timed intervention process. The percentage of patients with an admission has reduced by 11% (23.4% declining to 20.8%) year-over-year from 2009 to 2010. Patients engaged for at least six months in 2010 showed an even greater beneficial impact. The percentage of patients with an emergency room visit has also trended lower, with a 10% decrease (20.4% declining to 18.7%) year-over-year from 2009 to 2010. Patients engaged for at least six months in 2010 also showed an even greater beneficial impact.

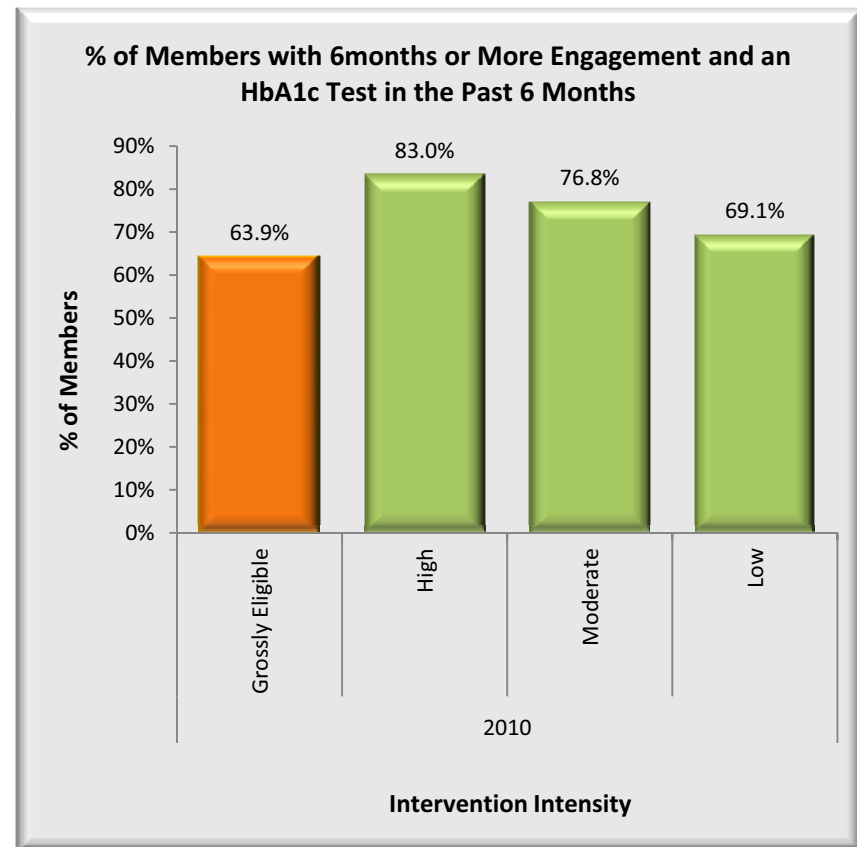
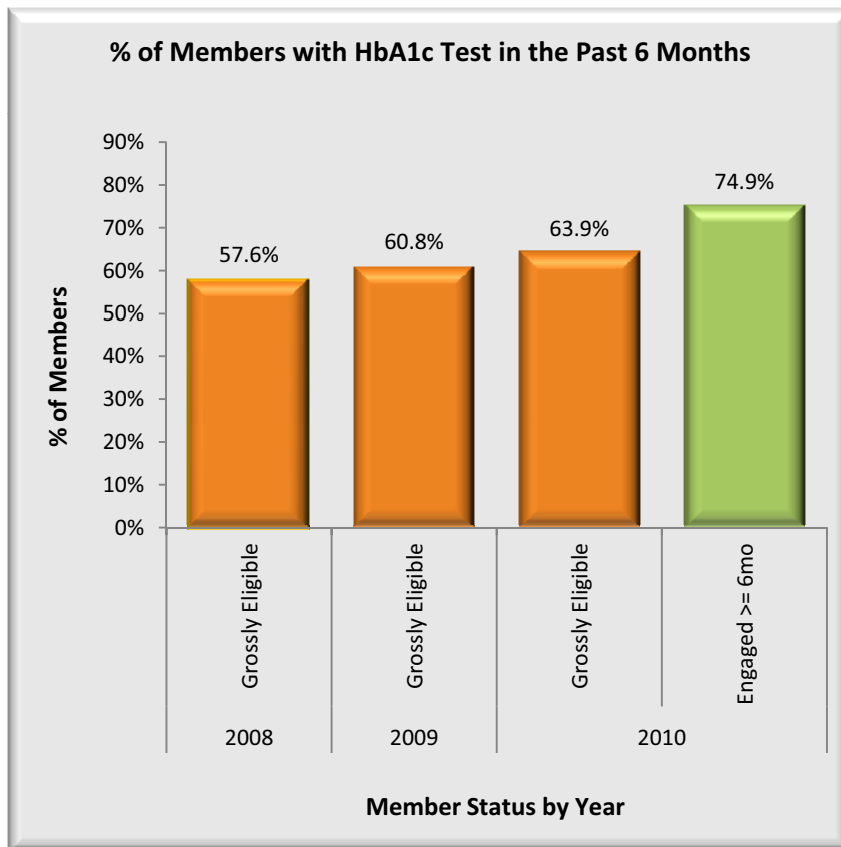


Medicare Advantage population of approximately 118,000 patients. The program was initiated in late 2007. Performance presented is for the three full years 2008, 2009, and 2010.

# CCS Advantage™ Results V



In 2010, the percentage of patients receiving an HbA1c test was 17% higher for engaged patients (of six months or more) compared to Grossly Eligible patients. In the same year, 83% of patients in the high intervention group had an HbA1c test.



Medicare Advantage population of approximately 118,000 patients. The program was initiated in late 2007. Performance presented is for the three full years 2008, 2009, and 2010.





## Jason Z. Rose

Vice President

MedAssurant

## Questions?

[jrose@medassurant.com](mailto:jrose@medassurant.com)

301.809.4000 ext. 1531

Find us on:





# MEDASSURANT<sup>TM</sup>

MedAssurant Inc. is a leading technology-enabled healthcare solutions provider focused on the importance of healthcare data and its ability to drive dramatic, objective improvement in clinical and quality outcomes, care coordination and enhancement, and financial performance throughout the healthcare community. Proprietary healthcare datasets, aggregation, and analysis capabilities, combined with a national infrastructure of leading-edge technology, clinical prowess, and deep human resources empowers MedAssurant's advanced generation of healthcare assessment and improvement through highly informed solutions. Driven by a mission to improve today's healthcare landscape, the employees of MedAssurant proudly apply care, ingenuity, and dedication to delivering a new approach to healthcare touching more than 100 million Americans – one driven by data and insight – one resulting in meaningful action. Please visit [www.medassurant.com](http://www.medassurant.com) for more information.

Corporate Headquarters:  
4321 Collington Road  
Bowie, Maryland 20716 USA  
301-809-4000

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