CONGRATULATIONS!
2021 INNOVATIONS AWARDS FINALISTS

Aetna Kidney Support
Leading the Change in Kidney Care

Cigna
Distress Screening for Whole-Person Health

Kaiser Permanente
Community Resource (CRS) Evaluation

Navitus
Personalized Member Transitions (PMT) Program

Premera
Telehealth Addiction Treatment with Boulder Care

US-Rx Care
Fiduciary PBM Services
Guiding Members Through Smoother Benefit Transitions

Personalized Member Transitions Overview
Facing Member Transition Challenges

• Benefit transitions can be confusing for members, resulting in member dissatisfaction and gaps in care

• Gaps in care can lead to poor health outcomes and drive up costs, especially in the case of chronic conditions

20% of prescriptions are never filled\(^1\)

50% of filled prescriptions are taken incorrectly\(^1\)

28% of patients fail to refill a prescription on time\(^2\)

22% of patients take a lower dosage than prescribed\(^2\)

Personalized Member Transitions turn benefit transitions into positive experiences
Eliminating Onboarding Stress With Personalized Member Transitions

• Provides high-touch, personalized onboarding and transition experiences for:
  • New members and clients
  • Formulary changes
• Minimizes member disruption by proactively communicating with patients and prescribers
• Helps members navigate the complex health care system with personalized support
Making Transitions a Positive Experience for All

- Creates a positive and seamless member experience when switching to a lower-cost formulary product
- Improves member satisfaction with plan benefits while reducing complaints
- Enhances speed to fill, preventing gaps in therapy for chronic diseases
- Makes the transition process smoother for plan sponsors
“Navitus made my job so much easier and less worrisome. They assisted us in ensuring our significant formulary change went smoothly. Navitus has lived up to its promises.”

Wendie Carlson
Chief Human Resources Officer,
West Tennessee Healthcare
Guiding Members and Providers
How Personalized Member Transitions work

Step 1: Identification
Clinical Transition Analysis identifies members on maintenance medications that will not be covered

Step 2: Member Letter
Member receives clinical transition letter

Step 3: Member Outreach
CEC clinician contacts the member to discuss formulary alternatives

Step 4: Provider Outreach
CEC clinician contacts the provider to obtain new Rx
Creating a Better Approach to Member Transitions

Plan Sponsor Benefits

• Personalized Member Transitions turn member transitions into a positive experiences with guidance and support
• This increases member satisfaction while reducing gaps in care
• With Personalized Member Transitions, members will be happier and healthier
Thank You.
Reference List


DISTRESS SCREENING FOR WHOLE PERSON HEALTH

Dr. Bhuvana Sagar
National Medical Director

Alysia Swanson RN BSOM CCM
Clinical Program Sr. Advisor
Distress is the unpleasant experience of a mental, physical, social, or spiritual nature. While an expected part of receiving a cancer diagnosis, untreated distress is a problem identified in clinical practice that affects coping, functioning, health decisions, and overall health. The National Comprehensive Cancer Network (NCCN) has developed clinical practice guidelines to support distress screening.

Distress Screening was designed as a standalone screening assessment to accompany existing assessment protocols for Cigna's URAC and NCQA-accredited case management solutions.
HOW IT WORKS

• Cigna Case Managers practice “active listening” while screening
• Customers measure distress on a scale of 0 (no distress) to 10 (severe distress)
• Problem-focused resource guide:
  ✓ How to conduct distress screening
  ✓ Caregiver and nutritional support
  ✓ EAP
  ✓ Grief and bereavement
• Connects customers with support, programs, and resources to help with a wide variety of challenges including financial, social, clinical - even transportation
• Case Managers (Cigna Oncology nurses) collaborate with the treating Oncologist as needed to share distress screening results and the implemented case management interventions
RESULTS – DISTRESS SCREENING WORKS!

54% of customers reported mild or higher distress

Screened customers are 16% more likely to be referred to internal and external resources

Top problems reported:
1. Fatigue, pain, nausea
2. Treatment decisions
3. Insurance/financial
4. Worry

Medical

- $6,840 PMPY lower IP costs*
- 10.4% less likely to have 1+ IP visit
- 14.7% fewer average # IP visits

Behavioral

- $18.72 PMPY higher costs (driven by those with highest SDI scores)
- 1.3x more likely to submit a claim
- 6x more CM engagements (18 vs. 3)

Case Management

- Engagement rates are six times higher than unscreened customers
- Engage 73 days longer (184 vs. 110 days)
- 2.5x more likely to achieve goals (40.4% vs. 20.3%)

Case Management

- Engagement rates are six times higher than unscreened customers
- Engage 73 days longer (184 vs. 110 days)
- 2.5x more likely to achieve goals (40.4% vs. 20.3%)

*IP results driven by acute visits. No difference in overall TMC, facility outpatient costs, professional visit costs, or ER utilization/costs. Outcomes were not significantly influenced by SDI scores.
The Premera-Boulder Care Care Partnership

Addressing critical deficiencies in the treatment of opioid and alcohol use disorders
The Challenges in Addiction Care

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>40 million people in the US struggle with a substance use disorder (SUD)</td>
</tr>
<tr>
<td>Phone</td>
<td>Few people get care</td>
</tr>
<tr>
<td>Nurse</td>
<td>There is a severe, chronic provider shortage</td>
</tr>
<tr>
<td>Virus</td>
<td>COVID-19 has taken a toll</td>
</tr>
<tr>
<td>Barn</td>
<td>Rural populations have been hit hard</td>
</tr>
<tr>
<td>Hand</td>
<td>The stigma persists</td>
</tr>
</tbody>
</table>

## Substance Use Disorders in the US

**Opioid Use Disorder (OUD)**
- Drug overdose is the *leading cause of accidental death for people under 50.*
- 3M people in the US struggle with OUD
- 130 people die every day due to opioid overdose
- 1000 emergency dept. visits per day are due to opioids

**Alcohol Use Disorder (AUD)**
- Alcohol is the *third-leading cause of preventable death.*
- 28.3M people in the US struggle with AUD
- 261 people die every day from alcohol-related causes
- ~42% of people with OUD also have co-occurring AUD
COVID-19 Has Only Intensified the Crisis

13% of US adults started or increased substance use to cope with stress or emotions related to COVID-19 as of June 2020 (CDC)

29% increase in drug overdose deaths in the US in 2020, compared to 2019 (CDC)

Increasing overdose rates during the pandemic (As compared to the same months in 2019).

ODMAP data from The Washington Post. Note: Percent growth references the 1,201 agencies reporting to ODMAP by January 2019.
The Role of Telehealth in SUD Treatment

Addresses workforce shortage
Extends access to the 80% of communities in the US that don’t have a single buprenorphine prescriber.

Accessible 24/7
Patients can access care anytime, anywhere through secure video, phone, and messaging.

Reduces stigma
No need to show up to a clinic, which can be a deterrent to seeking care.
The Partnership

Premera is the first health plan to partner with Boulder Care to offer long-term virtual support and treatment for SUD.

<table>
<thead>
<tr>
<th>Eliminates access barriers</th>
<th>Empowers patients</th>
<th>Delivers high quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>by delivering care 24/7</td>
<td>with a broad suite of recovery services and delivers low barrier care with health equity in mind</td>
<td>member experience and retains 3 out 4 patients in care at a year</td>
</tr>
<tr>
<td>through secure video and messaging on mobile app and offering treatment within 48 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Solution

Connects patients to SUD treatment through the Boulder Care digital platform and an easy-to-use mobile application.

Provides digitally secure treatment to members from the convenience of their own home.

Delivers individualized care plans, therapies, coaching, and monitoring privately to members through secure video and texting.

Provides a comprehensive approach to addiction therapy that includes medication assisted treatment (MAT).

Assists patients who have additional psychiatric disorders that Boulder Care does not address and connects them with nearby behavioral health care.
How the Program Works

Three components:

- Public health interest
- Program administration
- Populations served
Measuring Success for Premera

Net Promoter Score of 91.

58% 6-month retention rate in OUD medication treatment.

79% of patients report positive sentiments toward their recovery progress in the last 30 days, as part of the CDC-endorsed Health Related Quality of Life (HRQoL) survey.

48 hours median time from new inquiry to clinician visit.
Changing the face of rehabilitation by:

• **Allowing physicians to create personalized programs** in terms of the duration of peer support, dosage of medication, and how long a person stays on medication

• **Providing patients access to a care advocate and a peer recovery support specialist** who support them through the program and sobriety

• **Providing ongoing treatment with no end date** and continued access to Suboxone for as long necessary to mitigate addiction

• **Eliminating access barriers** by reaching patients where they are

• **Providing the medication, resources, and support** to help patients succeed on their own terms, wherever they are in their journey
Questions
Thank you
Public Health Interest

Positively impacts the health and well-being of the community at large by reducing:

- Economic impacts to family systems by providing affordable cost of care
- The strain on traditional health systems
- Absenteeism, turnover rates, and overall employer healthcare costs
- Systemic health disparities stemming from social determinants
Program Administration

Reaching the target audience by:
- Referral to Boulder Care by providers
- Self-referral (available 24/7)
- Providers directing members to self-refer

Unique features for patients include:
- Care advocates
- Peer Recovery Support Specialists for goal setting and housing/transportation/social determinants

Program has no end date
Populations Served

- 2.5 million Premera members ages 18 or older with an established diagnosis of OUD or AUD
- Any member who feels their use of substances has adversely impacted their lives
- Minimal exclusion criteria
- Commitment to providing specialized, high-touch support to members who are often underserved
Boulder Care’s Treatment Approach

Every Boulder patient has a dedicated care team comprised of a **Prescribing Clinician, a Care Advocate, and a Certified Peer Coach**.

Caregivers work together to provide accessible, high-touch care for **opioid and alcohol use disorders** to members by secure message, phone, and video through Boulder’s telehealth platform.
Aetna Kidney Support

• Danée Harrison, Senior Director, New Product Development, Aetna
• Sara Martin, Senior Director, CVS Kidney Care
Danée Harrison
Sr Director,
New Product Development, Aetna

Sara Martin
Sr Director,
CVS Kidney Care
Introducing Aetna Kidney Support:
Helping to delay end-stage renal disease

Identifying
where care is needed through advanced analytics

Identifying
where care is needed through advanced analytics

Unique algorithms
CVS analytics will help us:
• Find members earlier
• Predict chronic kidney disease progression
• Target interventions

Enabling
tailored and meaningful care coordination

Enabling
tailored and meaningful care coordination

Chronic kidney disease-specific nurses and care managers provide support including:
• Ongoing care coordination and education
• Help with diet, medications, comorbidities and needed resources

Empowering
members to choose what’s right for them

Empowering
members to choose what’s right for them

Live, in-person* sessions educate people choose a therapy and:
• Connect those interested in transplant to resources
• Prepare to transition to chosen therapy

Goals
Delay onset of kidney failure
Increase number of transplants
Increase uptake of home modalities
Reduce hospitalizations
Increase percentage of planned dialysis starts
## It’s a win-win: Improved quality of life for members and cost savings for plan sponsors

<table>
<thead>
<tr>
<th>Savings Type</th>
<th>Amount</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>$57K savings</td>
<td>per successful avoidance to dialysis*¹</td>
<td></td>
</tr>
<tr>
<td>$26K savings</td>
<td>per avoided unplanned start to dialysis*⁴</td>
<td></td>
</tr>
<tr>
<td>$20K savings</td>
<td>per avoided admission*⁵</td>
<td></td>
</tr>
<tr>
<td>$132K savings</td>
<td>per year over a 5-year period for each person who has a kidney transplant instead of being on dialysis**²,³</td>
<td></td>
</tr>
<tr>
<td>$4K savings each month</td>
<td>that a start to dialysis is delayed**²,³</td>
<td></td>
</tr>
</tbody>
</table>

*Not everyone will progress to dialysis; of those who progress we assume we can only reduce unplanned starts by 20%. Not double counting between avoided admissions and increasing planned starts; some admission savings included in planned start savings.

**Commercial estimates for dialysis events based on 4x Medicare. Individual results may vary.

Kim is in remission from breast cancer, and has been working with Aetna care management. She has now been flagged as less than 18 months progression to dialysis and identified as someone who will benefit from Aetna Kidney Support.*

Kim is warm transferred from the care management nurse to the CKD (chronic kidney disease) nurse. The nurse does a deep-dive on kidney disease with Kim, providing education and care coordination.

The nurse manager notices Kim is on multiple medications and engages the Rx support program, consulting with a pharmacist to help manage medication.

The care manager speaks with Kim on the phone monthly, and flags Kim for face-to-face support (less than 12 months from dialysis).

The KCE focuses on building a relationship with Kim and her family, and discusses renal replacement options. The KCE helps Kim align treatment with values and life goals.

The KCE calls the physician’s office to coordinate care and discuss in-home dialysis.

Kim is able to continue with her social life and spend time with family.

*For illustrative purposes only. Does not reflect events experienced by an actual member.
Community Resource Specialist Evaluation

Cindee DeWitt
Program Manager
The **Community Resource Specialist** Role at KP Washington

Evolved from the LINCC study

- **Funded by the Patient-Centered Outcomes Research Institute, 2014 – 2016**
- **Included patients as partners in designing the study and the CRS role**

CRSs are members of the primary care team

- **Interact with patients as social needs surface during care**
- **Provide information, connection, referral to serves, and coaching**
CRS is now part of the **standard staffing model** in primary care

**CRS staffing**
- 26 CRS staff members
- Working in 30 medical centers
- Based on 1 CRS/ 20,000 patients
- Primary care departments and recently added to oncology

**CRS competencies & qualifications**
- WA state DOH Community Health worker training
- Motivational Interviewing
- Understanding of socioeconomic, environmental, and cultural factors that impact health
- Strong computer, communication and organizational skills
- Skilled in providing collaborative, team-based care
- Connection with community orgs

**Patient interactions**
- Nearly **2000** unique patients per month
- Around **3300** patient encounters per month
- In person, telephone, video visit, as well as walk in or warm handoff from primary care team
- All patient interactions are documented in EHR and standard SDOH assessment is completed
Learning Health System partnership to implement & evaluate the CRS role

Quantitative survey to assess impact compared to a control group
- Social needs and self-efficacy
- Coping, symptoms, and functioning
- Engagement and utilization

Qualitative interviews with patients and care teams
- Experience with health system, wellbeing, perceived burden of social need and patient engagement
- CRS impact on care team functioning, team integration
- Contextual factors to inform implementation strategies

- 3,383 members surveyed
- 1,159 completed baseline
  - Single CRS visit (N=384)
  - More than 1 CRS visit (N=354)
  - Control group (N=421)

- Interviews with 25 CRS’s
- Observations with 16 CRS’s
- Interviews 10 primary care team members
- Brief care team survey at 4 clinics
- Interviews with 45 Patients
Key results from the evaluation

A snapshot of our 3 main learnings

1. The CRS role is valued by members & care teams, reflects well on KP, & sets us apart in the market.

   Benefits commonly mentioned by members:
   - Makes them feel cared for
   - Provides a human connection
   - Builds trust
   - Creates a stronger link to the care team

   Care teams: CRS fills an important care gap & benefits members and care teams:
   - 80% - 94% “Having a CRS has allowed me to better use my training and time”
   - 86% - 100% “Having a CRS has improved the care we’re able to give to patients”

   Range of responses across 4 clinics: Fed Way, Olympia, Pt Orchard, & Riverfront

2. Members who had 2 or more CRS encounters reported positive changes & were very satisfied with the CRS—but members may need more than 1 encounter to benefit.

   Members who saw the CRS improved more on self-rated health than comparison patients who did not see the CRS. (No other outcome differences detected)

   Compared to members with 1 encounter, those with 2+ encounters:
   - Had higher efficacy to fulfill care plan
   - Had more trust in their care team
   - Felt more like their care team is on task
   - Felt more of a bond with their care team

   76% of members with at least 1 CRS encounter “agree” or “strongly agree” that they feel supported by the CRS.

   Members with 1 CRS encounter:
   - Struggled more with things like food security, self efficacy, trusting the care team
   - Were much less satisfied than members who had 2+ encounters

   The new CRS dashboard in Epic helps track whether members’ needs are met and helps ensure follow up.

3. Members have a lot of unmet social needs the CRS role can help address & many need significant support to overcome barriers to accessing resources & the stigma of asking for help.

   59% of members surveyed endorsed 1 or more social needs. Of those members:
   - >90% would like help meeting those needs
   - Nearly 25% had 3 or more social needs

   But our comparison group did not get access to the CRS despite being good candidates for the service (e.g., struggling to fulfill their care plan, endorsed social needs)

   “I worked with a woman who had a young kid. She was staying in the car and I gave her the resource to call for housing... and she got housing within that week. I could hear it in her voice, the follow-up call. She was like, ‘I got in, we’re moving in.’” — CRS

   Normalizing the need for help emerged as an important aspect of the CRS role—as did providing motivation and accountability to follow up on plans and resources.

   This benefit for members will likely be even more important in the COVID-19 era.
US-Rx Care

• Leader in *Pharmacy Benefits/Risk Management* services

• Over two decades of service

• Over 5 million lives

• Over $1 billion in drug cost savings generated for clients

• Expertise in all aspects of pharmacy risk including acute, chronic, and specialty medications
Accept Nothing Less

✓ Transparency
✓ Fiduciary Compliant
✓ Risk Management Experience
Typical Path To 50%+ Lower Plan Spend

- Discounts Off AWP -51%
- Rebates -16%
- Copay Assist. -5%
- Clinical Programs:
  - Specialty (45%)
  - Non-Specialty PA (28%)
  - Right Rx (27%)
- Patient Assist. -15%

- 100% 84% 79% 57%
- With no change in benefit design
- With minimal member disruption
- 30% + lower member spend

Cost Savings & Percent of Current Annual Plan Spend
Recent Client Examples

**Georgia County Government**
- 2,930 Covered Lives

**Call Center / Marketing Services**
- 1,280 Covered Lives

<table>
<thead>
<tr>
<th></th>
<th>Annual Rx Spend</th>
<th>Cost Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(000’s) Pre-US-Rx</td>
<td>$3,500</td>
<td></td>
</tr>
<tr>
<td>(000’s) Post-US-Rx</td>
<td>$2,300</td>
<td>34%</td>
</tr>
</tbody>
</table>

| (000’s) Pre-US-Rx    | $2,500          |                |
| (000’s) Post-US-Rx   | $1,500          | 41%            |
Another Client Example

$ Per Member Per Month

<table>
<thead>
<tr>
<th>Period</th>
<th>Plan Paid</th>
<th>Specialty Spend</th>
<th>Member Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-Sep 2019</td>
<td>$60.2</td>
<td>$23.5</td>
<td>$10.6</td>
</tr>
<tr>
<td>Oct-Dec 2019</td>
<td>$55.4</td>
<td>$17.4</td>
<td>$6.4</td>
</tr>
<tr>
<td>Jan-Mar 2020</td>
<td>$56.6</td>
<td>$14.9</td>
<td>$7.1</td>
</tr>
<tr>
<td>Apr-Jun 2020</td>
<td>$54.5</td>
<td>$14.2</td>
<td>$5.8</td>
</tr>
<tr>
<td>Jul-Sep 2020</td>
<td>$48.1</td>
<td>$12.5</td>
<td>$6.7</td>
</tr>
<tr>
<td>Oct-Dec 2020</td>
<td>$35.2</td>
<td>$2.9</td>
<td>$6.5</td>
</tr>
</tbody>
</table>
$2.8 MM Annual Cost Reduction
$4.6 MM Two-Year Cumulative Savings
Coordination and Communication Across The Quality of Care Continuum

Prescribers

Members

Medical & Rx Data

Clinical Service Providers

- Pharmacies
- Diagnostic Facilities
- Other
STOP WASTING MONEY!
Fiduciary Pharmacy Risk Management Services
Thank You!