Wellness on the Run

Care When Members Need it Most – *Innovations in Care Management*

Welcome

Today's presentation will begin shortly.

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Agenda

- Total Population Health / Total Well-Being
- Engagement
- Primary Nurse Model
- New Technology and Data Analytics
- Q&A (15 minutes)

Our care management strategy

Anthem engages members along the wellness continuum… from the very healthy to those needing immediate support.

Healthy	At risk	Chronically Ill	Critically Ill
Wellness programs	Health risk management	Disease management	**Case management**
Life management	**Behavior change**	**More informed health decisions**	

Anthem BlueCross BlueShield

The Total Well-Being Approach

Our Total Well-Being health care strategy increases connections, is focused on shortening the distance between members and care—and delivers outstanding results.

It's an approach that's geographically based

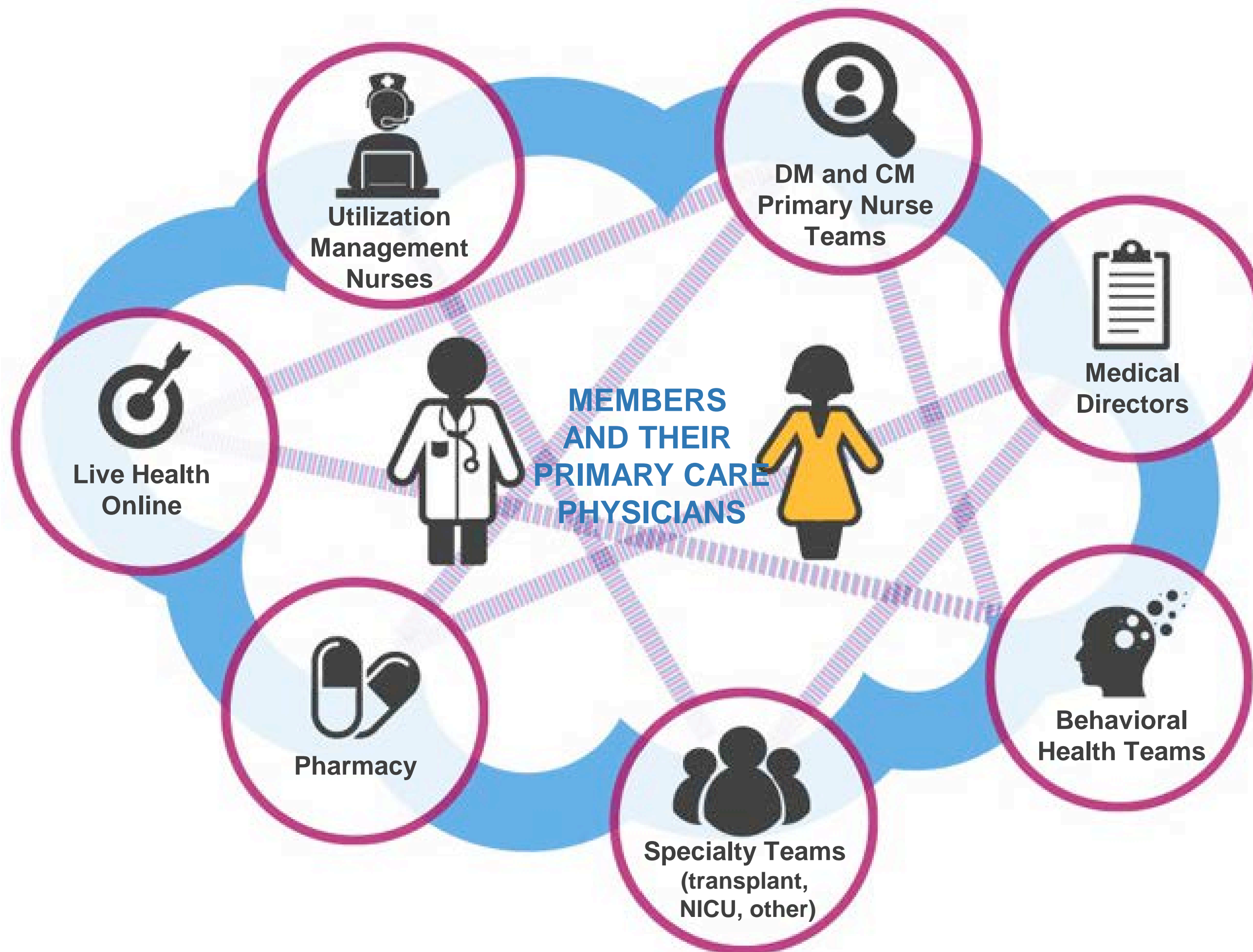
That centers on members

And targets high costs of care

By creating opportunities for our team-centered approach to help members get the most from local resources, we're ensuring right care, the right provider, and the right resource—at the right price.

Total Population Health Management

We're connecting primary care practices and Anthem health management teams for better results.



Dedicated team of case management and disease management nurses along with designated utilization management and behavioral health teams work in concert with primary care physicians **for active health management of your entire population.**

Engagement

—the difference between **speaking to** and **talking with.**

We're invested in creating **engagement opportunities at every touch point in the health care landscape.**

Flexible

- Bringing members flexible solutions that get the job done—wherever they are.

Mobile apps

24/7 NurseLine

Click-to-chat

Capable

- Solutions with access to all Anthem claim, service, and clinical systems
- Addressing all types of health care issues
- Staffing and logistics customized to meet employer's specific goals

Online Parenting Resources

Integrated Care Management platform

Integrated

- Fully integrated with Anthem services
- Provides customized integration and vendor feedback opportunities
- Addresses all member enquiries

Employer reporting

Member dashboard

Gaps in Care Analytics

Engaging members through nurse care support

Our nurses are the member's direct contact for Care Management Support

Teamwork

Working with a trained professional team to help members with specific needs

Care Management

Enrollment & Referrals into care management programs

Active Dialogue

Discussing a medical diagnosis and available treatment options

Communicate

Working with member on understanding their health plan

Coordinate

Coordinating benefits before/during/after hospital stay

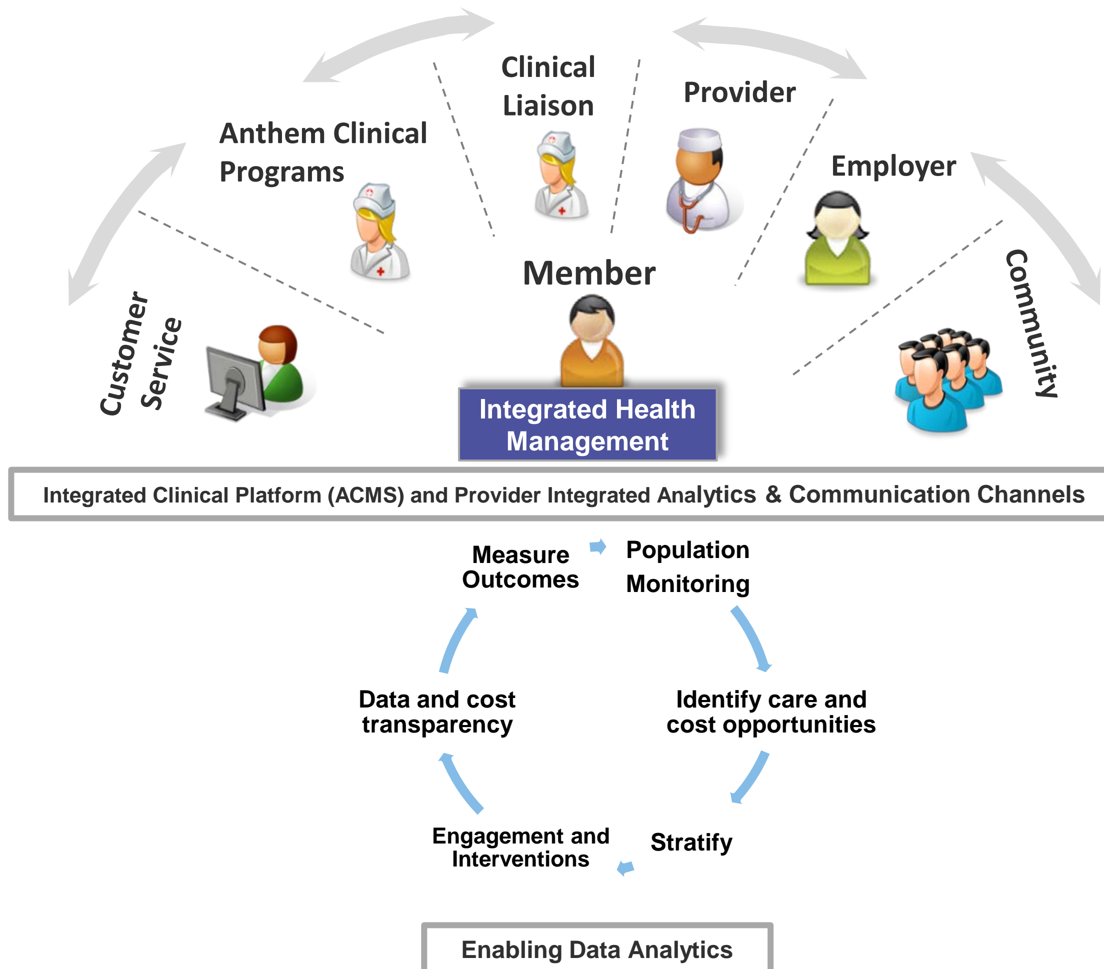
Case management: Our goals

The goals of the case management program are:

- Support the most critically ill members
- Seek to identify, reach and engage members:
  - On a predictive basis before significant health care use
  - During significant health care events
- Coach and educate members to optimize care and contain costs

Total Population Health Solution

Integrated Ecosystem



Engaging
Integrated health management across all consumer touch points.

Partnering
Provider collaboration and innovative delivery driving increased value.

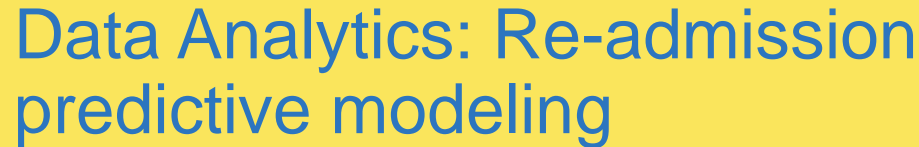
Actionable Insights
Technology, data and analytics make smart health care decisions easier.

Giving Care Teams more points of data, and a "big picture" view of member health

Using analytics to identify, and close, gaps in care

Gaps in Care Analytics are run on 100% of our members. These opportunities are run continually and:

- Are completely accessible to nurses who use them to develop a better picture of members' health and develop health coaching plans.
- Are displayed in our care management system, helping staff provide timely, personalized communication to both members and providers, and improving health outcomes.



Data Analytics: Re-admission predictive modeling

Re-admission predictive modeling helps to reduce chances of readmission

- Proprietary model uses diagnosis, utilization history, clinical indicators and other data
  to predict readmission likelihood
- An extension of our existing predictive modelling successes.
- Proactive pre/post-admission outreach to members designated as high readmission risk
- Lowers chances of readmission; lowers costs and supports at-risk members

New technology in case management

Interactive telephonic outreach to members

- Reaches more members in a timely and efficient manner
- Offers live transfer to a nurse for any reason during normal business hours (next day otherwise)
- Helps offer additional support during member important transitions
- Four types of calls – pre-admission, post-discharge, post-graduation, high-cost

Video chat

- Provides case managers the ability to better connect with members
- Members truly appreciate the face-to-face interaction
- Available in most markets

Q&A

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  Our Enhanced Personal Health Care payment innovation model

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  Strategies to help employees with work-life balance

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Like "Wellness on a Dime" which gives ideas on how to do wellness on a small budget.