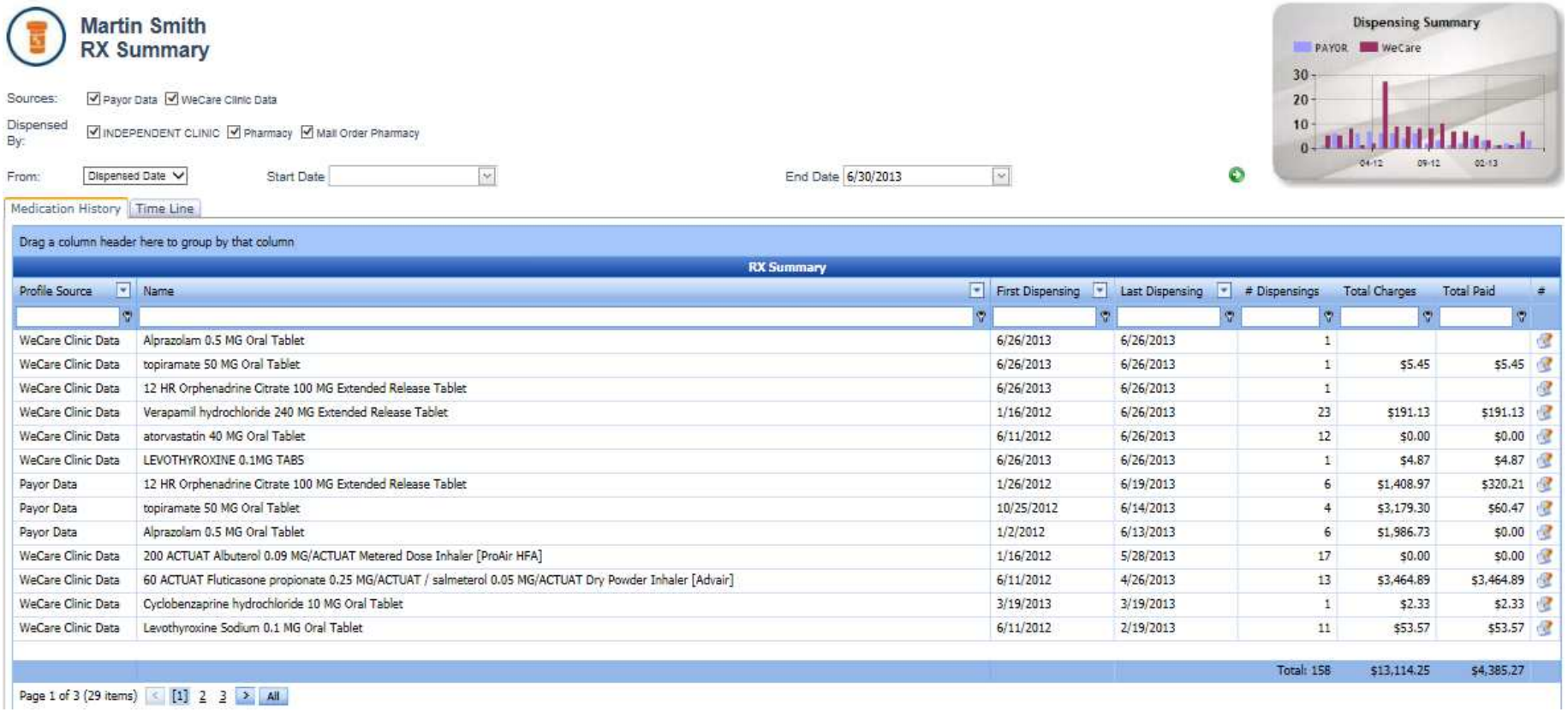
MedWeb: Individual Patient RX Claims Detail



Martin Smith
RX Summary

Sources: ☑ Payor Data ☑ WeCare Clinic Data

Dispensed By: ☑ INDEPENDENT CLINIC ☑ Pharmacy ☑ Mail Order Pharmacy

From: Dispensed Date | Start Date | End Date 6/30/2013

Dispensing Summary
PAYOR WeCare
30
20
10
0
04-12 09-12 02-13

Medication History | Time Line

Drag a column header here to group by that column

RX Summary

Profile Source	Name	First Dispensing	Last Dispensing	# Dispensings	Total Charges	Total Paid	#
WeCare Clinic Data	Alprazolam 0.5 MG Oral Tablet	6/26/2013	6/26/2013	1			
WeCare Clinic Data	topiramate 50 MG Oral Tablet	6/26/2013	6/26/2013	1	$5.45	$5.45	
WeCare Clinic Data	12 HR Orphenadrine Citrate 100 MG Extended Release Tablet	6/26/2013	6/26/2013	1			
WeCare Clinic Data	Verapamil hydrochloride 240 MG Extended Release Tablet	1/16/2012	6/26/2013	23	$191.13	$191.13	
WeCare Clinic Data	atorvastatin 40 MG Oral Tablet	6/11/2012	6/26/2013	12	$0.00	$0.00	
WeCare Clinic Data	LEVOTHYROXINE 0.1MG TABS	6/26/2013	6/26/2013	1	$4.87	$4.87	
Payor Data	12 HR Orphenadrine Citrate 100 MG Extended Release Tablet	1/26/2012	6/19/2013	6	$1,408.97	$320.21	
Payor Data	topiramate 50 MG Oral Tablet	10/25/2012	6/14/2013	4	$3,179.30	$60.47	
Payor Data	Alprazolam 0.5 MG Oral Tablet	1/2/2012	6/13/2013	6	$1,986.73	$0.00	
WeCare Clinic Data	200 ACTUAT Albuterol 0.09 MG/ACTUAT Metered Dose Inhaler [ProAir HFA]	1/16/2012	5/28/2013	17	$0.00	$0.00	
WeCare Clinic Data	60 ACTUAT Fluticasone propionate 0.25 MG/ACTUAT / salmeterol 0.05 MG/ACTUAT Dry Powder Inhaler [Advair]	6/11/2012	4/26/2013	13	$3,464.89	$3,464.89	
WeCare Clinic Data	Cyclobenzaprine hydrochloride 10 MG Oral Tablet	3/19/2013	3/19/2013	1	$2.33	$2.33	
WeCare Clinic Data	Levothyroxine Sodium 0.1 MG Oral Tablet	6/11/2012	2/19/2013	11	$53.57	$53.57	
				Total: 158	$13,114.25	$4,385.27	

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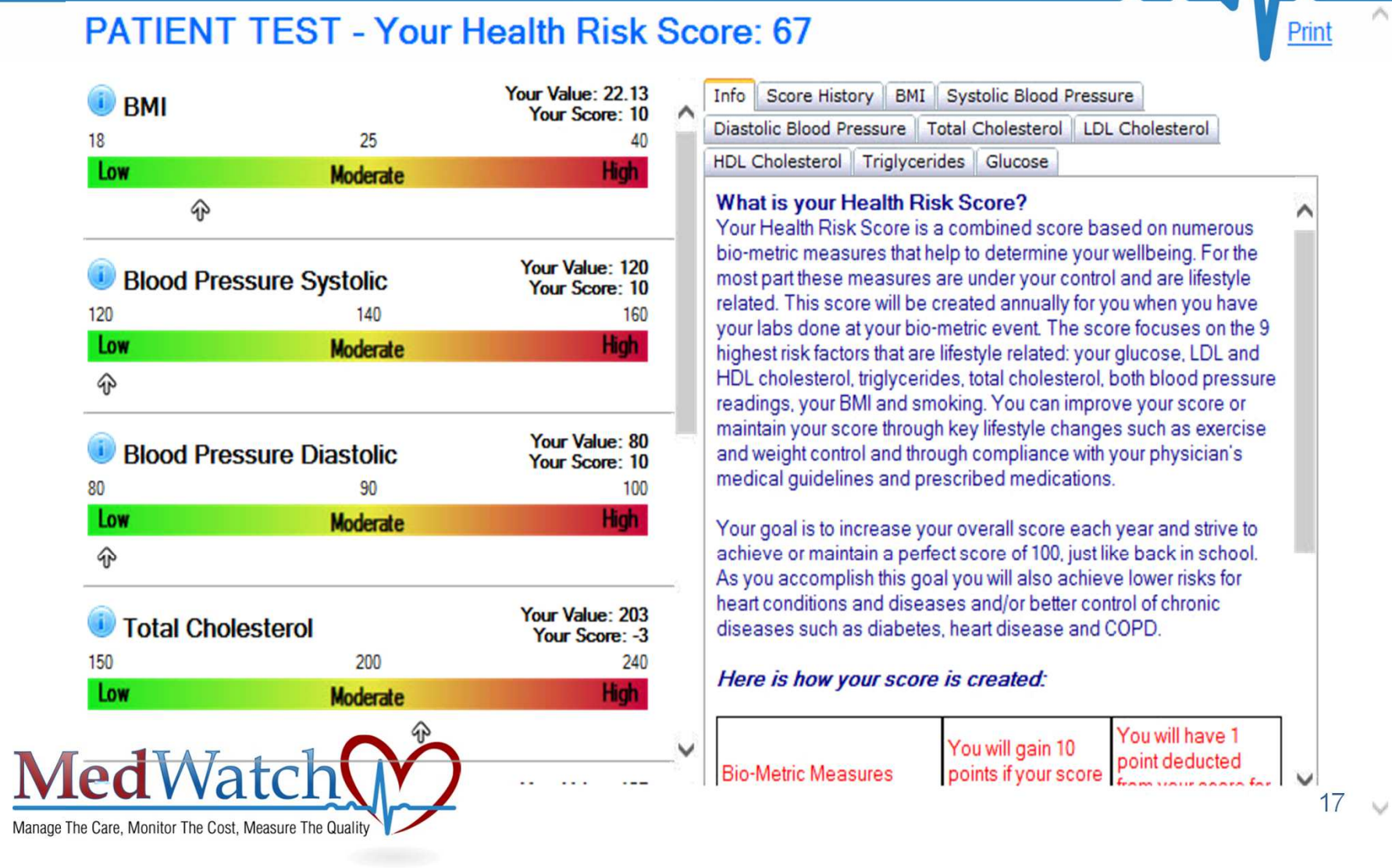
Biometric Results As a Score Card



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Group Summary At A Glance

Primary Care Visits

Primary Care Visits:

• "Primary Care is health care given by a health care provider, usually specializing in family or internal medicine. Typically this provider acts as the principle point of consultation and coordinates other specialists that the patient may need. A primary care provider may be either a licensed physician or a mid-level practitioner such as a Nurse Practitioner (NP) or Physician's Assistant (PA)."

Emergency Room Visits

Emergency Room Visits:

• "Emergency Rooms (ER) or Emergency Departments (ED) are units housed within a larger hospital system that specialize in evaluation and treatment of acute, often life-threatening, illnesses or injuries. Patients present without appointment and must be triaged, usually by a RN, for level of acuity relative to treatment. Emergency Departments operate 24 hours per day and have, recently, become the primary source of treatment for the indigent.

Urgent Care Visits

Urgent Care Visits

• Urgent Care Centers are frequently free-standing, walk-in clinics focused on walk-in patient with injuries or illness requiring immediate care but not serious enough for emergency room treatment. The scope of treatment is limited as are the hours of operation.

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How Chronic Care Management Impact Cost?

- **Direct medical costs:**
  - 70% of disease is preventable and 70% of the events that occur with the chronically ill are preventable.
  - Help change the life-style of the At-Risk members
  - Help members get control over their chronic conditions and have them understand they can live a full and active life
- **Increase Productivity at work and at home**
- **Transform the members from passive recipients to an active participants:**
  - Link healthcare utilization to costs that directly impact them: "I have a direct connection to the premiums I pay monthly and my out-of-pocket expenses."

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Members Vary in Their Health Habits, Use Data to Target Needed Change

Healthy Well
- Eat Right
- Healthy Lifestyle
- Few Claims

Unhealthy Well
- Unhealthy Diet
- Unhealthy Lifestyle
- More Claims

Chronically ILL
- Least Healthy
- Highest Cost
- Require Attention

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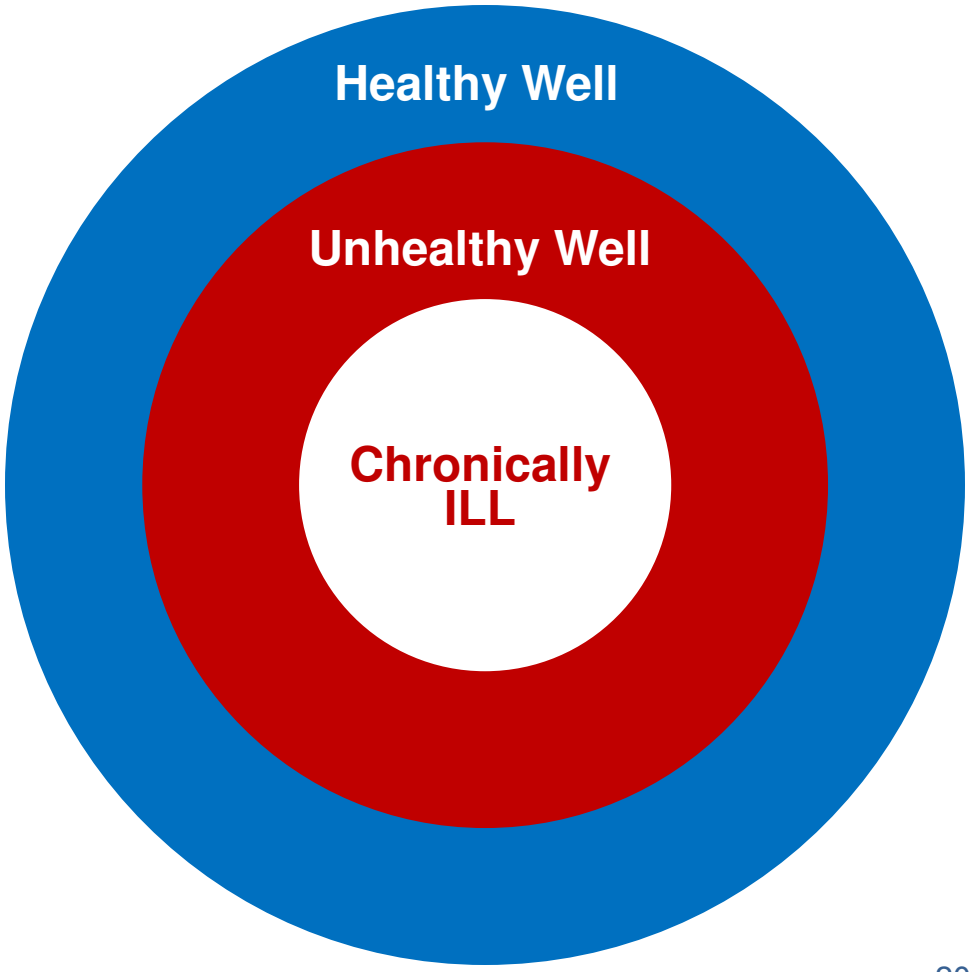
Living Well



What we don't know about our own Health and Numbers?

Condition	Prevalence	Undiagnosed
High Cholesterol	22%	47%
High Blood Pressure	23%	35%
Diabetes	8%	50%
Anemia	3%	50%
Liver Disease	10%	70%

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Living Healthy
A Biometrics & HRA Program

Living Informed, Knowing Your Numbers

Making sure your:

- **Healthy Well stay Healthy**
- **Healthy Unwell & Chronically Ill**
  - Know their Numbers
  - Seek Help

Providing:

- **Onsite Biometrics**
  - Off-site biometrics & other opportunities to know your numbers
- **Health Risk Assessments**
  - On-line & Paper
- **Extensive Score Cards and Reports on your health status and the plan's**

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Living Well
With Chronic Conditions

Living Well . . .
with Chronic Conditions and Lifestyle Coaching

Before Chronic Conditions exist, tell-tale symptoms and markers reveal the trends of your Unhealthy Well towards costly, yet preventable Chronic Conditions.

- **Coaching & Counseling can reverse these trends and provide support for:**
  - Hypertension
  - Hyperlipidemia
  - Pre-Diabetes
  - Obesity
  - Smoking Cessation

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Living Well
With Chronic Conditions

Living Well . . .
with Chronic Conditions and Lifestyle Coaching

- Asthma
- Congestive Heart Failure
- Coronary Artery Disease
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)

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Living Well
With Chronic Conditions

Living Well . . .
with Complex Conditions and Lifestyle Coaching

- Amyotrophic lateral Sclerosis (ALS)
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Cystic Fibrosis (CF)
- Dermatomyositis
- Gaucher's Disease
- Hemophilia
- HIV
- Systemic Lupus Erythematosus (SLE or Lupus)
- Multiple Sclerosis (MS)
- Myasthenia Gravis (MG)
- Parkinson's Disease (PD)
- Polymyositis
- Rheumatoid Arthritis (RA)
- Scleroderma
- Sickle Cell Disease (SCD)
- Epilepsy (Seizures)
- Crohn's Disease
- Ulcerative Colitis
- Hepatitis C
- Cancer

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Kidney Care and Dialysis Program: Program Highlights

GOAL:

To effectively case manage CKD, ESRD and dialysis patients in order to obtain substantial savings to the plan by decreasing risks, delay onset of dialysis treatments and/ or transplantation while providing support and education to patients and if dialysis occurs, controlling the costs.

PROGRAM COMPONENTS:

- Comprehensive case management, chronic condition care management with RN renal specialist and nephrology / transplant physician review and consultation as needed.
- Changes in life style and management of the disease to mitigate the progression.
- Assistance with applying for Medicare part B, suggested plan language to carve out dialysis treatments from PPO and UCR language to protect plan.
- Successful repricing and/or negotiation of dialysis claims, often 85% discount or better with a flat fee rate.

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Disease Management/Life Style Management

GOAL:

To provide a value added personal health education service for members who have chronic conditions and clinical risks from low risk to high risk to effectively manage their health status and decrease plan costs

PROGRAM COMPONENTS:

- Risk Stratification using Biometrics, HRA Results, Claims and/or Rx Data, CM and UR
- Dedicated Total Life Style Coach (TLC) assigned to participant who implements a "Personal Contact Schedule".
- Initial Assessment with participant includes their level of knowledge and understanding of their disease, potential future risks and level of motivation for change.
- Teaching Strategies and plan of care incorporated on an individual basis to provide education, medication compliance, healthy lifestyle behaviors.
- With member permission TLC communicates with PCP.
- In-depth Reporting.

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Success Story

This member was referred to Disease Management from Utilization Management for Hypertension, depressive disorder, proliferative diabetic retinopathy with detachment of the retina, poorly controlled diabetes with insulin, hyperlipidemia, atypical chest pain ruled out, erosive esophagitis and hyperkalemia. Participant was admitted to the ER in for chest pain and found to have all conditions above and referred to DM program.

Initially, his TLC (Total Lifestyle Coach) reached out to patient without success and the participant was then re-admitted to the ER within the month for Hyperpotassemia. The TLC continued to make multiple attempts to engage this participant, sent patient multiple materials on his conditions including basic information on how to manage diabetes and blood pressure. The nurse finally spoke to patient at length and provided much needed counseling on the most basic part of controlling his conditions.

The participant was very appreciative of all of the help provided to him in his native language of Spanish and appreciated all the education on his condition. He credited both his TLC and his doctor for helping him to get control over his diseases. Participant has reported that his blood glucose and blood pressure which were completely uncontrolled 9 months ago are now running in the normal ranges. This participant is receiving dialysis for end stage renal disease three times a week but he has not had a hospital or Emergency room visit in over 7 months now. He is diligent in following his diet per his doctor orders, going to his doctor regularly, closely monitoring both his blood glucose and his blood pressure. Patient has been referred to our Case management department for potential dialysis re-pricing. Savings from No hospital or ER visits in 7 months $26,570.

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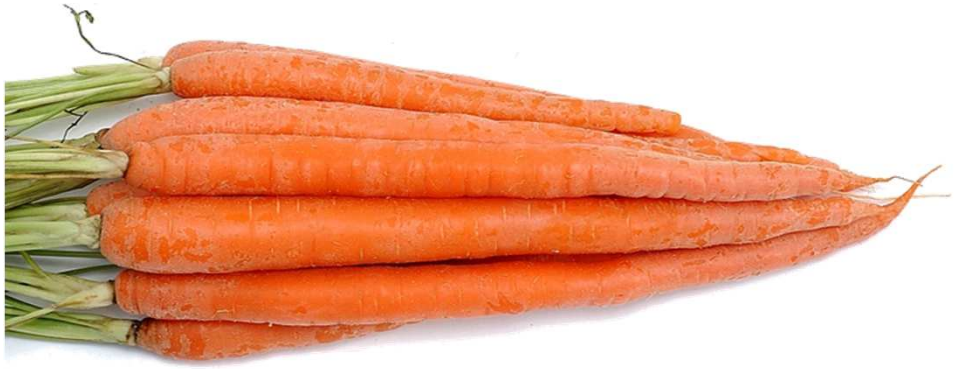
INCENTIVES

Dangle the carrot . . .



Or the stick

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Wellness Program Engagement

- **Commitment from the top: A Culture of Health**
  - Determine the best way to communicate
  - Incentive Development: Ask your consulting partner to help develop a targeted strategy to create incentives that create accountability

- **Key Components:**
  - Biometric Screening and Health Assessments
  - Age and Gender Requirements/Testing
  - Complete health improvement programs based on screenings

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