OPTUM®

Condition Management

The Optum Condition Management Program provides a fully integrated solution that improves the health and quality of life of participants, while controlling health-related costs.

Through personalized interventions, in-home monitoring and contemporary behavior change methodologies, our experienced clinical staff assist individuals to better manage their conditions through education, empowerment and support.

Our Condition Management Program is NCQA accredited and assists individuals in managing their identified condition, as well as other co-morbidities. We have extensive experience assisting individuals diagnosed with Heart Failure, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Asthma.

Our Condition Management Program:

- Increases compliance and changes behaviors, slowing the progression of disease and development of complications
- Reduces and prevents utilization, including emergency room visits, hospitalizations and medication errors
- Improves quality of life and productivity
- Promotes adherence to national clinical standards
- Provides a support system of nurses and health specialists
- Enables in-home biometric monitoring

OUR EXPERTISE[1]

4+ MILLION
Individuals enrolled

25+ YEARS
Helping people manage their health

1+ MILLION
Individuals assisted with RX adherence

1.6 MILLION
Individuals educated about blood sugars

1.3 MILLION
Individuals supported with action plans

40,000+
Individuals kept out of hospital

1 – Source: 2014 Alere Book of Business Results: Cumulative enrollment through 12/31/13. All data based on legacy Alere Health Book of Business. Alere Health is now part of Optum.

The Optum approach

Our person-centric approach focuses on optimizing an individual's health, regardless of limitations that may exist from their condition and other contributing factors. No two individuals have the same experience with Optum, as all interventions are personalized according to an individual's values, preferences and readiness to engage.

Our clinical staff averages over 20 years experience and includes nurses, health coaches and multi-disciplinary professionals from a variety of healthcare backgrounds who maintain ongoing education. We have the ability to coordinate an individual's care across all contracted programs with Optum, as well as other health programs.

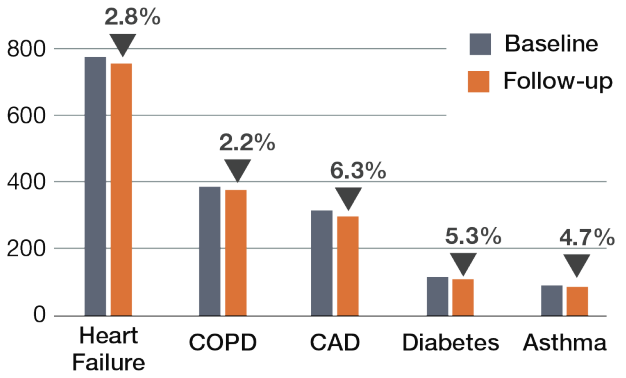
Proven results

Our programs strive to reduce medical service utilization, improve the individual's quality of life and key health numbers, reduce absenteeism, increase productivity and support adherence to treatment plans. By providing the preventive and condition care needed to improve health, our programs can also work to increase HEDIS® measures and CMS 5-Star Quality Ratings.

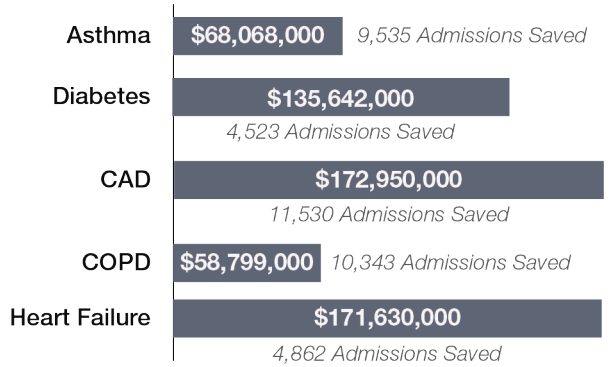
Why the Optum Condition Management program?

- A partner in your strategic vision for health and wellness
- An engaging, meaningful participant-centric experience
- Specialized clinicians and evidence-based interventions
- Configurable program options
- Advanced capabilities in technology and security
- Demonstrated cost savings

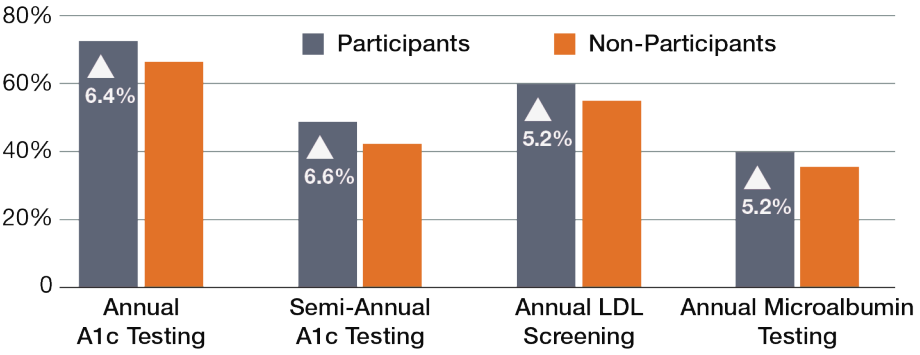
Reductions in total inpatient admissions[2]



Total cost savings[3]



Improvements in diabetes clinical performance[4]



90%+

Participant satisfaction rate[5]

2 – Source: 2014 Alere Book of Business Results: All-cause, per thousand identified members per year.
3 – Source: 2014 Alere Book of Business Results: Cumulative through 12/31/13, based on all cause inpatient admissions.
4 – Source: 2014 Alere Book of Business Results: Diabetes program participants vs. matched sample of diabetic non-participants.
5 - Source: 2014 Alere Book of Business Results: Data on File.
All data based on legacy Alere Health Book of Business. Alere Health is now part of Optum.

The Way We Improve Health

We partner with you to develop a solution that meets your financial and healthcare goals. Our programs promote the right care, at the right time to drive the best results. Our experienced staff connects participants to their physicians, as well as the tools, technologies, skills and knowledge they need to make smarter healthcare choices.

Attract & Enroll

Early & Accurate Identification

Partricipants are identified with the following tools:

- Medical & Pharmacy Claims
- Health & Productivity Assessment
- Physician or case manager referral
- Self-referral via Health Portal

Once identified, participants are stratified into the appropriate intervention levels.

Maximized Enrollment & Engagement

We develop an engagement strategy with you utilizing:

- Impactful communications
- Specially trained staff that provide a focused and welcoming experience
- Automated outreach
- Online enrollment opportunities

Coach

We work with individuals to create personalized goals as part of an action plan. For those at a high risk, monitoring devices are placed in the home and report on symptoms. Based on data and feedback, we determine appropriate interventions.

Our registered nurses provide:

- Continual education & communication
- Support in adherence to guidelines and physician care plan
- Promotion of behavior change techniques
- Biometric data monitoring
- Physician alert, status and pre-visit reports

Individuals also have access to an Interdisciplinary Care Team with health specialists including:

- Pharmacists
- Social Workers
- Registered Dietitians
- Respiratory Therapists
- Certified Diabetes Educators

Analyze

We provide clear and timely reporting that demonstrates program value including enrollment, clinical, utilization, financial, quality and satisfaction impacts.

Program reporting provides:

- Monthly, Quarterly and Annual measurement
- An integrated reporting package: operational activities, program progess, performance and impact
- Convenient access with automatic secure email or web portal delivery
- Dedicated analytic support team that will update you on results and trends

TOOLS WE USE FOR ENGAGEMENT

Health Portal

- Mobile responsive for use on any smart phone or tablet
- Participant Message Center
- Personal Health Record
- Nurse Chat
- Newsletters

Phone & Mobile

- Inbound/Outbound calls
- Nurse 24
- Automated Outreach (IVR)
- Text Messaging

Direct Mail

- Postal Notifications
- Select Educational Materials (per member preference)

Strategic Support

- Marketing Resource Center
- Health Promotions Strategist

Condition management pathways

All pathways ensure that a participant has a general understanding of their condition and medication regimen and can recognize and control symptoms. We also monitor for behavioral health issues, body mass index, blood pressure, tobacco use and cessation, and flu and pneumonia vaccinations.

CONDITION	TOPICS COVERED WITH PARTICIPANTS	IN-HOME MONITORING	ADHERENCE MEASURES TRACKED BY CLINICAL STAFF
Heart Failure	• Weigh daily and assess for acute weight gain • Change unhealthy lifestyle behaviors • Avoid salt and learn healthy eating habits • Understand when to seek medical treatment	✓ Available for high risk participants	• Daily weights • Use of recommended medications: ACE/ARB or other, Beta blocker & Statin
Chronic Obstructive Pulmonary Disease (COPD)	• Recognize symptoms of lung infection • Monitor sputum • Understand negative effects of smoking and how to access smoking cessation resources	✓ Available for high risk participants	• Bronchodilator usage • Spirometry testing • Oral corticosteroid use • Written action plan
Coronary Artery Disease (CAD)	• Change unhealthy lifestyle behaviors • Blood pressure • Control cholesterol level with diet and/or medication • Recognize early symptoms of a heart attack and when to seek medical treatment	✓ Available for high risk participants	• Beta blocker use • Statin use • Non-statin antilipemic use • Aspirin use
Diabetes	• Change unhealthy lifestyle behaviors • Recognize and control blood sugar • Improve self-care skills, including adherence to medication regimen, daily foot exams and home blood sugar testing • Complete preventative exams and screenings	✓ Available for high risk participants	• Hemoglobin A1C • Microalbumin • Use of ACE/ARB • Retinal eye exam • Foot exam • Blood glucose testing • Aspirin usage
Asthma	• Identify individual "asthma triggers" and how to manage • Learn medication therapy options and when to carry a "rescue" inhaler • Understand when to seek medical attention		• Use of asthma management plan • Daily controller usage • Short acting beta agonist use • Sleep disruptions due to asthma symptoms

Enhance your condition management solution

In addition to our core Condition Management services, we also offer several solutions to enhance the effectiveness of your programs. We can support further clinical gap closure through our CareAlerts Program, provide clinical assistance for everyday health issues and questions through our Nurse 24 Program, and further engage participants through our mobile responsive Health Portal with virtual coaching.

Our programs can also support populations with unique needs including pediatric, Medicaid and Medicare participants. Contact your Optum representative for further details.

OPTUM®

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