Wellness & Population Health

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Geisinger
Health Plan

Aligning services to meet needs

Health Coaching

Chronic Condition Management

Case Management

Advancing Illness & Special Needs

PRIMARY PREVENTION - CLOSING GAPS IN CARE – PHARMACY-SPECIALTY BASED SERVICES - SUPPORTED BY DATA ANALTYICS

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ProvenHealth Navigator

Serving as the foundation for population health

Patient-centered Primary Care	• PCP-led team-delivered care, all members functioning at "top of the license" • Enhanced access; services guided by patient needs and preferences • Member and family education & engagement
Population Health Care Management	• Population identification, segmentation and risk stratification • Chronic disease and preventive care optimized with EHR, clinical decision support • Care manager as core member within care team • Automated interventions triggered by gaps in care
Medical Neighborhood	• 360° care systems – SNF, ED, hospitals, home health, pharmacy, etc. • Physician profiling; preferred provider relationships • Transitions of care, community services integration
Performance Management	• Patient and clinician satisfaction • Cost of care, utilization, efficiency • Quality metrics, addressing variations in clinical care
Value-Based Reimbursement	• Bridging the journey between FFS and pay for value • Embracing payment models that support population accountability • Payments distributed on measured quality performance

Expanding the focus of Case Management

Remote Telephonic	**Primary Care**	**Technology – Assisted**	**Specialty**	**Facility**
• Telephonic based RNs, Social Workers (SW) and Community health assistants (CHA)	• Embedded RN CMs (advanced medical home) • Linked to SWs and CHAs • Access to EHR • Seen as part of the practice care team	• Bluetooth scales for HF and ESRD • Interactive Voice Response (IVR) for TOC • In-home video connectivity	• Oncology • High-risk OB • High-risk Pediatrics • "Transitions" for high-risk children • COPD, HF, and ICU embedded RN CMs	• Inpatient Hospital • Emergency Department • Skilled Nursing Facilities

Individualized care team

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Tele-monitoring tools

Bluetooth scales	Managing HF	Transmits daily weight to EHR
Nurse sees weight in real time	Diuretic titration protocols	Trending
Interactive Voice Response (IVR)	Outbound calls post discharge	HF IVR
Bluetooth blood pressure cuff		

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ReDS™ Technology

See-through-wall technology

Radar (RF) monitoring and imaging

Military see-through-wall technology

ReDS™ System technology

Direct, absolute, safe and actionable measurement of lung fluid

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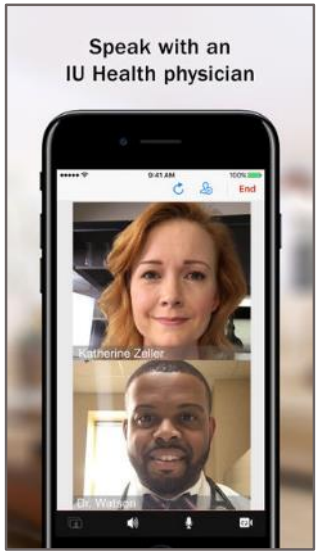
At home telehealth program: current state

Community Health Worker deployed to patient's home with iPad



Community Health Worker calls the Provider via secured Skype connection

Provider assesses patient remotely (i.e. wound assessment, edema, etc.)

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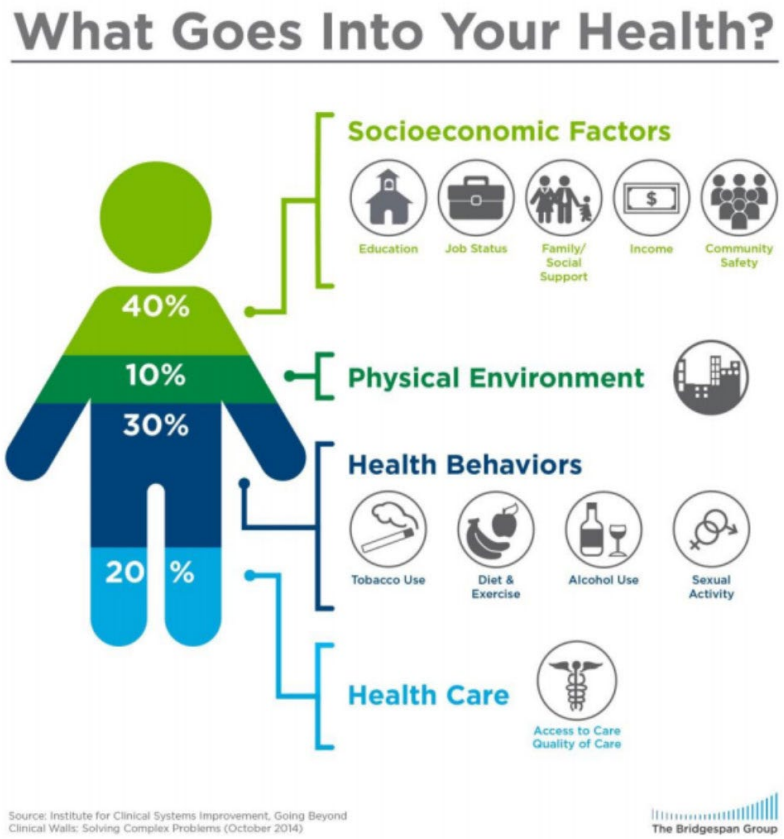
Multiple factors impact health

Health outcomes
- Socioeconomic factors: 40%
  - Education
  - Job status
  - Family/social support
  - Incoming
  - Community safety
- Health behaviors: 30%
  - Tobacco use
  - Diet and exercise
  - Alcohol
  - Sexual activity
- Health care and access: 20%
- Physical environment/genetics: 10%



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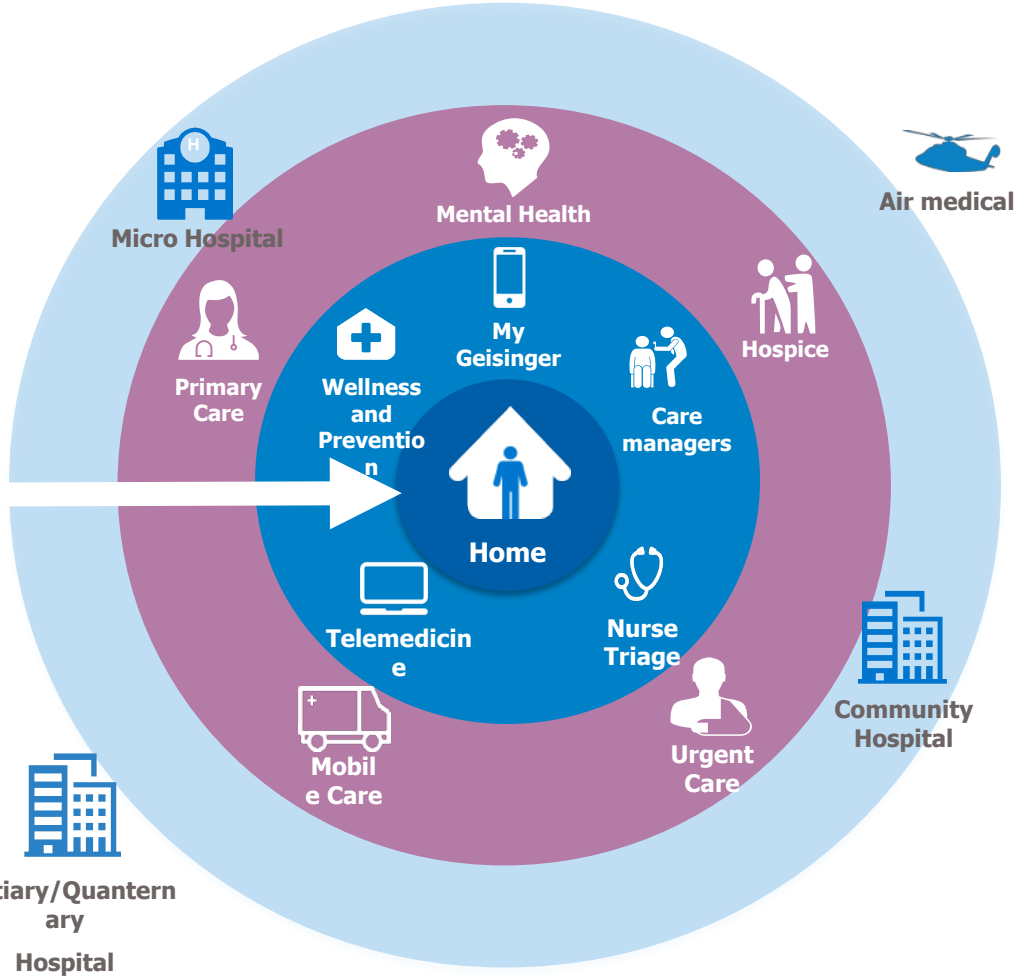
Strategies target members in their communities and homes

The solution:
Care closer to home



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Creating a care model in our communities

Supporting those with serious & significant health conditions

Geisinger at Home

Longitudinal Medical Care

- Comprehensive assessment of disease burden
- Condition optimization & management
- Close coordination with PCP/SCPs

Integrated Social & BH

- Social determinants of health
- Behavioral health

Acute Care

- Mobile paramedics
- Case Management
- Home Health

Advanced Illness

- Plan of care
- Symptom management
- Palliative care
- Timely transition to hospice

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New and innovative programs between clinical and community-based partners to impact health

Robust wellness resources for employers

Dedicated wellness specialist

Comprehensive, customizable wellness plan

Incentive program administration

Programs, screenings & presentations

Consumer health education & communications

Reporting and recommendations

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Developing a unique program

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Services snapshot

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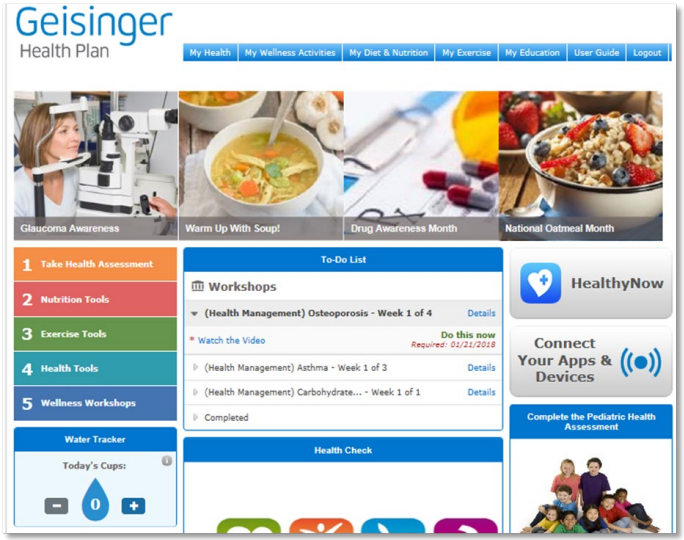
Wellness online resources



- NCQA accredited Health Assessment
- Tracking/logging tools
- Meal planning/recipes
- Exercise plans and examples
- Interactive modules and health education library
- Customizable wellness portal

Example program – participation and design

Registration:

- 78% subscribers registered
- 64% employee participation
  - +12% from 2016 to 2018

Goals:

- 72% of participants reach goal

Personal Health Assessment

Health Screening

Healthy Activities

Goals

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Example program – metric goals

Tobacco

- *Self-reported no tobacco use*
- *If using tobacco, completion of cessation program*

BMI (Body Mass Index)

- *Less than 30, or 5% decrease in weight up to 12lbs.*

Blood Pressure

- *Less than 130/80 mm Hg*

Glucose

- *Fasting blood sugar of less than 100 or A1C < 5.7*
- *Diagnosed with diabetes, A1C of less than 8*

LDL

- *With no risk factors, fasting LDL of less than 160*
- *Diagnosed with diabetes/coronary artery disease, less than 100*

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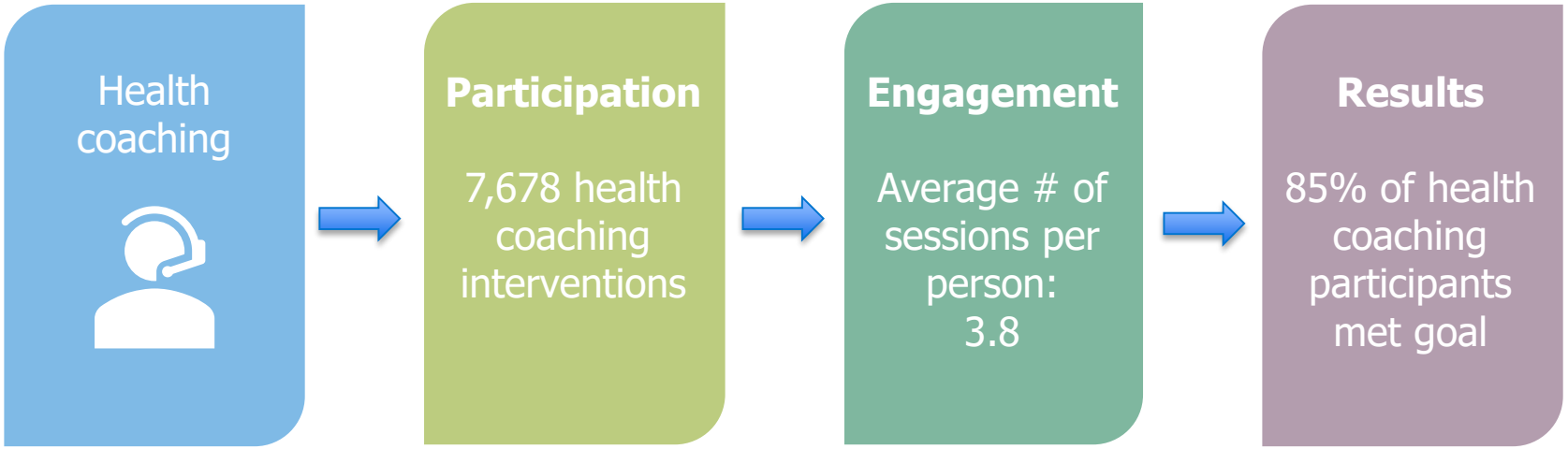
Example program – health coaching efficacy



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Example program – key clinical outcomes

Body Mass Index (BMI)

36,994 lbs. lost in 2018

112,125 lbs. lost since 2015 (54% sustained)

41% of participants with a BMI > 30 lost weight

Pre-diabetes

1,983 (59%) of participants in pre-diabetic range decreased to normal blood glucose

12.9% of population in pre-diabetic range (33.9% national avg.)

Blood pressure

24% increase in participants meeting recommended AHA blood pressure range

Tobacco cessation

59% of tobacco users enrolled in a tobacco cessation program (30% reported quit)

27% decrease in self-identified tobacco users

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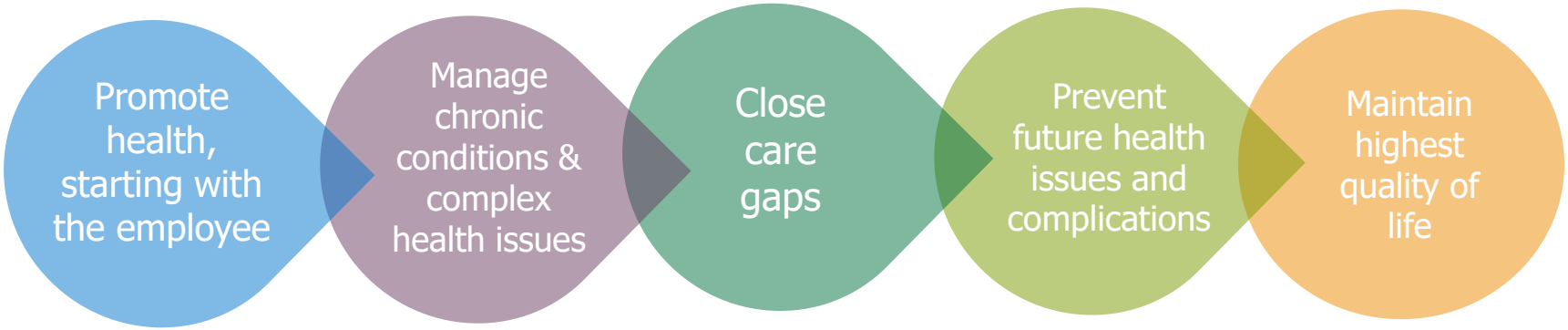
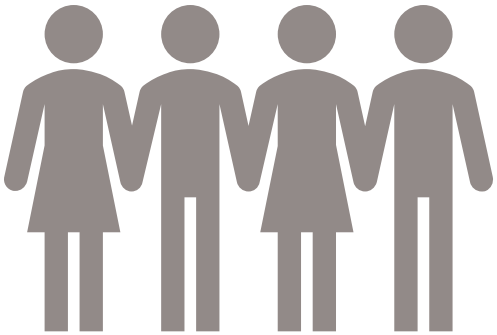
Together with the help of our broker partners…





For healthier, happier employees

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Questions?

"Nothing *looks* as good as being healthy *feels*"

- Anonymous

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