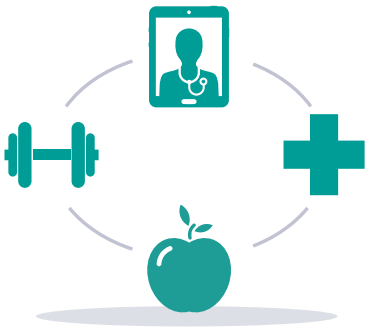
Experience Holistic Health Management with Optima Health

Health Management is a key component to the total health plan package we offer. We make a positive impact on health through a member-centric approach that flexes to fit the needs and goals of each individual.



Optima Health resources work in tandem across the organization to accomplish our Total Population Management approach—encompassing telehealth, utilization management, preventive health services, health promotion and wellness programs, health coaching, chronic disease management and lifestyle management.

We focus on improving health by quickly identifying members who need our help the most, delivering personalized outreach, collaborating with them and their providers, and addressing all their health needs. Our registered nurse case managers, social workers, and coaches cultivate health literacy, ease service access, and empower members to take an active, informed role in their health.

67%
case management engagement rate[1], **415%** higher than average health plan engagement rates.[2]

Our ultimate goal: ***deliver better health outcomes for our community***.

[1]*2021 Optima Health Commercial Book of Business Case Management Engagment Report*
[2]*2016 Agency for Healthcare Research and Quality Study*

Proactive Case Management

Identify

We integrate a wide range of data to **produce a holistic picture** of each member. We know where they are on their health journey, where they are headed, and how we can help. We target members who are rising-risk or at-risk for utilizing significant healthcare services or developing a health condition. We also connect with members who are currently managing a chronic health condition to help them stay on track.

Outreach

We intervene sooner with **personalized outreach**. Eligible members receive outreach via phone call and/or letter inviting them to participate in programs that fit their health needs. Case managers perform an initial risk assessment, which captures their medical, psychosocial, and financial barriers to care.

Assess

Assessment results help us determine the extent of the member's case and the right level of case management. We also address social determinants of health that may be barriers to care. Members may be low-risk, moderate- to high-risk, or complex-risk. These risk levels inform the nature and frequency of our engagement and allow us to **better impact each member's health**.

Engage

Member engagement is key to improving treatment adherence and achieving better outcomes. By the time our case managers reach out, they are ready to talk through immediate actions members can take to prevent future health issues. Case managers connect with members to develop a care plan and set health goals together with their providers. In 2021, Optima Health achieved a case management **engagement rate of 67%**—415% higher than average health plan engagement rates.

Impact

Optima Health produces **meaningful outcomes** for both members and employer groups. By tracking members over time, we can compare how effectively we engaged them in case management—if we provided the help they needed to avoid predicted high-cost health events such as inpatient admissions. We then make adjustments to our approach as a part of our commitment to continuous improvement.

Quality imbues every function of Optima Health—from customer service to clinical care to digital innovation. Quality flows through our systems, our policies and procedures, our strategic priorities, and our daily business. From new hires to senior leadership, quality is an expectation for all team members. We systematically monitor, report, and deliver quality performance across the organization.

Advanced analytics for better outreach

Our robust clinical platform powers our case management processes. This cloud-based care coordination and workflow management system connects claims, utilization management, wellness, and gaps in care reporting. A holistic picture of member health feeds our individualized approach to care. Our advanced analytics allow us to target outreach efforts based on member risk and impactability and develop and execute effective care plans.

Provider collaboration for better outcomes

The success of patient-centered, integrated programming depends in large part on becoming a partner in care with the practicing physician. Because Optima Health is part of an integrated care delivery system, our relationship with providers is built upon our understanding of the provider perspective in care delivery. Taking an active partnership with providers based on mutual goals and mutual respect allows us to drive effective quality of care and total cost of care initiatives.

Digital outreach for disease prevention

Closing gaps in care is a major initiative at Optima Health. We use claims and utilization data to identify and outreach to members with preventive care gaps and their providers.

In addition, our artificial intelligence-enabled predictive modeling technology helps us detect members who are at risk for developing a health condition like diabetes or hypertension. We use this information to engage identified members earlier and faster in preventive healthcare through digital education campaigns.

Ensuring satisfaction for member engagement

Safeguarding satisfaction is one of our driving forces. We measure overall member satisfaction using a Net Promoter Score (NPS). NPS gauges customers' willingness to recommend us to friends or family. Scores range from -100 to 100 and those higher than 0 are typically considered good. The Optima Health 2021 NPS was 20.4, showing we go above and beyond for our customers.[4]

100%

of members were satisfied or very satisfied with their case management experience[3]

We measure member satisfaction with physicians, hospital providers, and Optima Health using our Consumer Assessment of Health Plans Survey. We share the results across the organization to increase awareness of customer experience and drive improvement opportunities. Survey results also help us design provider education, outreach, and collaboration efforts.

[3] *2020 Optima Health Case Management Survey*
[4] *2021 SPH Analytics, Optima Health NPS Member Satisfaction (Commercial)*

We make the most of every interaction to ensure our members receive the care they need.

Cardiovascular Disease Management Program

The Optima Health Cardiovascular Disease Management Program provides members with the support they need to manage this very complex condition. Coronary Artery Disease (CAD) is a disorder that causes the major blood vessels surrounding the heart to become damaged or diseased. Congestive Heart Failure (CHF) occurs when the heart muscle doesn't pump blood as well as it should. Our overall program goal is to help members establish good self-management practices that improve outcomes, prevent complications, and reduce acute hospital admissions.

Members are eligible for the program if they are in active treatment for CAD.

Key aspects of the program:

- Case managers reach out to eligible members to invite them to participate and perform an initial risk assessment.
- Case managers complete a comprehensive health assessment of the participant, including screening for social determinants of health.
- Case managers work together with members and their providers to develop an individualized care plan, which includes measurable goals such as:
  - annual visits with their primary care physician (or more frequently as needed)
  - annual testing for LDL cholesterol levels and blood pressure
  - nutrition and activity plan
- Members and their providers can access the care plan 24/7 through the secure portals on optimahealth.com.
- Case managers engage members as frequently as every two weeks but no less than every three months to review and update the care plan.
- Case managers reach out to members at least annually or more frequently based on changes in the member's condition or needs.

Diabetes Management Program

The Optima Health Diabetes Disease Management Program provides care coordination and ongoing education for members with diabetes and those at risk of developing diabetes. Diabetes is a disease in which the body cannot use food for energy. Diabetes does not go away with treatment but can be controlled. Our overall program goal is to help members build skills to maintain optimal health habits over the course of a lifetime by providing members:

- access to nationally recognized diabetes education classes through Sentara Healthcare and other facilities
- low-cost to no-cost diabetes self-testing blood glucose meters and affordable blood glucose testing supplies
- access to a strong network of dietitians and appropriate benefit design to ensure access to individualized nutrition counseling
- a network of exercise facilities at reduced pricing

Members are eligible for the program if they are in active treatment for diabetes.

Key aspects of the program:

- Case managers reach out to eligible members to invite them to participate and perform an initial risk assessment.
- Case managers follow up with members and their providers to develop an individualized care plan, which includes measurable goals such as:
  - annual visit with their primary care physician (or more frequently as needed)
  - twice yearly A1c testing
  - annual urine microalbumin and LDL cholesterol testing, a dilated eye exam, and regular foot exams
- Members and their providers can access the care plan 24/7 through the secure portals on optimahealth.com.
- Case managers engage members as frequently as every two weeks but no less than every three months to review and update the care plan.
- Case managers reach out to members at least annually or more frequently based on changes in the member's condition or needs.

Elements of our enhanced diabetes management program:

- Access to the Diabetes Prevention Program through Sentara and other locations for members at risk of developing diabetes
- Automated phone messaging to members identified with diabetes gaps in care to include medication adherence reminders, annual lab testing, foot and eye exams, and additional electronic reminders to providers alerting them to patient gaps in care related to diabetes

Partners in Pregnancy Program

The Optima Health Partners in Pregnancy Program provides members with information and support in making good choices throughout their pregnancy. We are dedicated to providing guidance, support, and education to all expectant members. Partners in Pregnancy provides access to experienced pregnancy and childbirth nurses, clinical case managers, licensed social workers, and service coordinators to help members:

- maintain good health throughout their pregnancy
- develop a healthy nutrition and activity plan
- maximize their benefits and resources
- locate important resources, classes, and services on pregnancy and parenting
- coordinate prenatal care and appropriate risk screenings
- understand timely health tips, which are mailed directly to their home

Members are eligible for the program beginning in their first trimester of pregnancy.

Key aspects of the program:

- Partners in Pregnancy case managers reach out to eligible members to develop a pregnancy management plan within the first three months of pregnancy (by 14 weeks).
- Case managers follow up with members to develop an individualized care plan, which includes measurable goals such as:

visit with their obstetrician within the first three months of pregnancy, or by 14 weeks

visit their doctor for a postpartum checkup within six weeks after delivery

nutrition and activity plan

- Case managers re-engage members at least once a month to review and update the pregnancy care plan.
- Members and their providers can access the care plan 24/7 through the secure portals on optimahealth.com.

Respiratory Disease Management Program

The Optima Health Respiratory Disease Management Program provides members with the support they need to keep their asthma and/or Chronic Obstructive Pulmonary Disease (COPD) under the best possible control. Asthma and COPD are ongoing diseases of the airways in the lungs. They cannot be cured but can be controlled. Our program goal is to help members establish lifestyle management practices that prevent damage to the lungs.

Members are eligible for the program if they are in active treatment for asthma and/or COPD.

Key aspects of the program:

- Case managers reach out to eligible members to invite them to participate and perform an initial risk assessment.
- Case managers follow up with members and their providers to develop an individualized care plan, which includes measurable goals such as:

  - annual visit with their primary care physician (or more frequently as needed)
  - nutrition and activity plan
  - annual influenza vaccination, as appropriate

- Members and their providers can access the care plan 24/7 through the secure portals on optimahealth.com.
- Case managers engage members every two weeks if needed, but no less than every three months to review and update the care plan, while assessing for any changes in the member's condition or needs.

We embrace the expertise of specialized care partners, which act as an extension of our teams, to provide enhanced health management for members with certain health risks or complex conditions. We are reporting the following achieved or projected returns on investment and cost savings for our book of business.*

**Results are illustrative and not a guarantee of savings. There may be additional costs for these programs.*

Diabetes Prevention and Weight Management

Projected **three-year risk reduction of 54%** for members who lose at least 5% of their body weight[5]

30,580 lbs lost

by 4,151 members since the start of the program

54% achieved 5% or greater weight loss[5]

Oncology Utilization Management

Return on investment of at least 3:1 through claims and authorization savings[6]

Transplant Case Management

Total cost savings of $3.2 million for dialysis through Centers of Excellence, by earlier identification of renal disease[7]

Virtual Diabetes Management

A1C reductions for members with A1C>8 by 1.5mg/dL and A1C>9 by 1.2 mg/dL[8]

Rare Chronic Disease Management

Return on investment of 4.72:1 and total net savings of **$9.7 million**[9]

Neonatal Intensive Care Unit (NICU) Case Management

Average length of stay **three days below** Optima Health baselines[10]

Return on investment of 6.3:1, per member savings of more than **$14,000**, and total net savings of approximately **$1.1 million**[10]

[5]2021 annual diabetes prevention and weight management report, [6]2021 annual oncology report, [7]2021 annual transplant case management report, [8]2020 virtual diabetes pilot program report, [9]2021 annual rare chronic disease report, [10]2021 annual NICU report

We identify strategies, deliver solutions, and develop a longitudinal plan to improve health outcomes and costs.