



## **AGENDA**

### **State and Public School Life and Health Insurance Board Quality of Care Sub-Committee Meeting**

**August 14, 2018**

**1:00 p.m.**

**EBD Board Room – 501 Building, Suite 500**

- I. Call to Order.....Margo Bushmaier, Chair*
- II. Approval of June Minutes.....Margo Bushmaier, Chair*
- III. Choosing Wisely Update/Cost Drivers..... Mike Motley, Izzy Montgomery, ACHI*
- IV. Naturally Slim Update ..... Sandy Schenck, Naturally Slim*
- V. Diabetes/Plan Update..... Allie Barker, EBD Registered Nurse*
- VI. Kannact..... Krishna Rao, Mike Pohl, Kannact*
- VII. Director’s Report ..... Chris Howlett, EBD Executive Director*

#### ***Upcoming Meetings***

***September 11, 2018, October 9, 2018, November 13, 2018***

***NOTE: All material for this meeting will be available by electronic means only [ASE-PSE BOARD@dfa.arkansas.gov](mailto:ASE-PSE@dfa.arkansas.gov). Please silence your cell phones. Keep your personal conversations to a minimum.***

# State and Public School Life and Health Insurance Board

## Quality of Care Sub-Committee Minutes

### August 14, 2018

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Date | time 8/14/2018 1:00 PM | Meeting called to order by Margo Bushmiaer, Chair

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#### Attendance

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##### Members Present

Michelle Murtha - Vice-Chair

Cindy Gillespie

Margo Bushmiaer - Chair

Pam Brown

Dr. Arlo Kahn

Dr. Terry Fiddler

Dr. Namvar Zohoori

Zinnia Clanton

Melissa Moore - Teleconference

Dr. John Vinson - Proxy - Dr. Dwight Davis

Chris Howlett, EBD Executive Director, Employee Benefits Division

##### Members Absent

Frazier Edwards

##### Others Present:

Eric Gallo, Rhoda Classen, Jamie Levinsky, Jasmine Bridges, Drew Carle, Shalada Y. Toles, Allie Barker, Terri Freeman, EBD; Dwight Davis, UAMS; Mike Motley, Elizabeth Montgomery, ACHI; Sandra Wilson, AHM; Treg Long, ACS; Jessica Akins, Takisha Sanders, HA; Kristi Jackson, ComPsych; Wayne Whitley, ARDOT; Marc Watts, ASEA, Sandy Schenck, Naturally Slim

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#### Approval of Minutes by: Margo Bushmiaer, Chair

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##### MOTION by Brown

I motion to approve the June 12, 2018 minutes.

Murtha seconded. All were in favor.

##### Minutes Approved.

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#### ACHI Updates by: Mike Motley, Elizabeth Montgomery, ACHI

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Mike Motley and Elizabeth Montgomery presented a review of diabetes related questions from the previous meeting, an overview of healthcare plan quality measurement, a review of the quality of care indicators for EBD member, and plan management options for EBD members with diabetes.

Choosing Wisely is a national initiative to promote conversations between patients and physicians about choosing care that is evidence based, medically necessary and cost efficient. These recommendations come from provider specialty societies. Since 2012 when this was launched, there have been over 555 recommendations made. Act 1089 of 2017, is the piece of legislation from emerging therapies, but it also included Choosing Wisely offering a framework for patients to consider.

There were preliminary results presented, including some of the most common wasteful, low-value services, and when looking at the EBD members enrolled in 2016, 65,135 had at least one of these low value services. Motley explained that over the next few months, they would like to break down these services maybe two at a time.

Discussion:

- Dr. Fiddler Does that mean that they just decided to do lab testing because it was a good return on the money and very little risk to the patient, or because it was a low-risk patient?
- Montgomery This is looking at individuals going through low risk surgery that have had these tests. Part of the overall arch and goals of the initiative is to question what has been done in the past and what is the best use of resources and what is the best for the patient. It had accounted for so much unnecessary spending.
- Brown There used to be protocol of testing done on a large population that came to the hospitals. Since Choosing Wisely came about, it has started classifying these tests and things differently.
- Murtha (On Slide 13) Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.
- Bushmaier What is the practice?
- Dr. Kahn They are talking about specifically, low-risk patients that are going to have eye surgery. If you look at each one of these, there are inclusions and exclusions before you can actually understand what they did.
- Montgomery That is part of our plan to take these a couple at a time, to look at the recommendation and move through the logic of how it ended up here and what that means with the EBD plan.
- Dr. Zohoori **Just out of curiosity, do you have one that lists prescribing pain medications and opiates?**
- Motley I don't recall, but we can go back and look.

Clanton Have you done this over prior years?

Motley This is actually year 2016, but we are setting a baseline by looking at this now and will continue doing that going forward.

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**Naturally Slim by: Sandy Schenck, Naturally Slim**

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Schenck presented an update on the pilot program after the first 10 weeks. The average BMI for our participants is 35.7, right in the middle of the obese category, so we reached the right population. Collectively, the ASE and PSE population lost 11,000 lbs, and 76% of people in the program have increased their physical activity.

Discussion:

Dr. Kahn You use the term active participants and participants. Can you please explain what those mean?

Schenck Participants are anyone that was accepted, and active participants are the ones that on a weekly basis log in, weigh in, answer questions and watch some of the content.

Dr. Kahn What success have you had in other states to find out results from the people that dropped out?

Schenck When we have the benefit of biometric screenings, we can track it. Most of what we track is the Metabolic Syndrome Reversal. 40-50% sustained reversal of Metabolic Syndrome over 10 years. We are tracking waist circumference.

Kahn Do you plan on contacting people in the EBD population that have dropped out over time?

Schenck We will administer a post program survey at six months and a year. It is a voluntary survey, so if they dropped out they may not complete the survey. If they do the Catapult screening, we can track over years.

Howlett The recommendation from the Benefits subcommittee was to start a second phase with 3,000 on ASE and PSE, with the waiting list taking priority. It also includes the Non-Medicare eligible retirees. In addition to that, taking this first pilot population and following them through this second phase to get more data and better results that can help guide further decisions and questions.

Gillespie I think a Phase 2 is a good idea, and it is important to do it quickly. The first group will become mentors to those who come along next which will also keep them more engaged which I think is a positive as well.

Howlett One thing to be cognizant of from the responsibilities you have accepted by being on this sub-committee as well as we go into the remainder of this year and into 2019; part of Wellness, this committee, and the Board, and even Benefits, we are reviewing activities from 2018 in 2019 for the 2020 recommendation around BMI. This is the secondary piece after the tobacco piece. This committee can let the Benefits recommendation go to the Board or make one of their own.

Dr. Fiddler I also think the question lies: can we afford to do it, or can we afford not to do it?. If you feel good about what you are doing, and we can afford it, then phase two should come in. That would be my recommendation.

Dr. Kahn I think we cannot afford to do nothing. This not only applies to EBD but to the entire country. Obesity consumes 4-8% of our gross domestic product. That is as much as we spend on Medicare or defense. I think a good recommendation would be that we would like to see Naturally Slim accounting for each person enrolled and what happened to each of them. We need to see the data to see if this is working. **I would suggest that we recommend continuing with the pilot, with the provision that we need to see data that allows us to know what has happened to every participant in the program.**

Brown Would that be to include the additional people? Is that an additional 3,000?

Howlett It would be an additional, and you would bring the waiting list over.

Brown I think we need to do that as well, continue the current and add.

Gillespie The program runs for 10 weeks, but you are in it for a year in these phases. If they did not complete going through all of the online program in the first ten weeks, can they continue to catch up?

Schenck Yes.

Gillespie The ten weeks is not a hard cut off, and the next time we see data the numbers should be higher to account for these that go back and complete the ten weeks.

Howlett As long as the video library is accessible, they can go back and catch up, and the log in is good for the rest of their life.

Dr. Zohoori How much did this cost?

Howlett We do not have the total cost, but the average cost was \$280 per person. The max for the first round was about \$560,000.

Gillespie There is no single program that is going to be a silver bullet around all of this, and I know we are doing complimentary programs. **Would it be possible over**

**the next months when people begin to talk about increasing their activity, we offer some programs to promote exercise?**

- Howlett We have explored that and looking at discounts at different fitness clubs or gyms, and I agree.
- Gillespie If it is appropriate to circle back with the participants in the pilot, could we make sure they know about other programs available?
- Dr. Zohoori This would be great to integrate with worksite wellness at agencies and schools.
- Bushmaier I have heard three things. Recommendation is to move to phase 2, to have more information and accountability in our reports for each participant, and to add the additional 3,000 participants.
- Howlett What about the non-Medicare eligible retirees? You could agree with the Benefits committee but add the component that Dr. Kahn added about the data going down to the membership data. That way we are not in conflict. Just add that we need more of the required data as it becomes available, and we can start having that to you next month.
- Dr. Zohoori **How many non-Medicare eligible retirees are there?**
- Howlett I do not have that, but I can get it. I am not saying include them all, but we should allow them on the waitlist. They would now have the ability to participate. The additional would be adopting that and Dr. Kahn's request on how to drill down on the subsets of data.

**MOTION** by Gillespie

I make a motion to approve the Benefits sub-committee's recommendation as stated.

Brown seconded. All in favor.

**Motion Approved.**

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**Diabetes/Plan Update by: Allie Barker, EBD Registered Nurse**

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Allie Barker, EBD RN, reviewed the impressive results from Naturally Slim and how the program helped to decrease the risk of developing metabolic syndrome. However, there is still a large subset of our population that are desperate for a more hands-on touch, long term management of chronic disease and conditions.

ACHI reported back in May that 11% of our member population has a diagnosis of Type 2 Diabetes, and these 15,000 members cost the plan \$110 million in medical claims from 2016-2017. our current

Utilization Management provider is managing a group who provide free supplies to the member for participating in our voluntary diabetes management program. These costs add up to:

From January 1-July 31 of 2018

- \$266,708.31 on test strips
- \$184,172.89 on needles and pen tips
- \$29,575.52 on syringes
- \$15,162.68 on lancets

If we assume this trend to hold true, we are on track to spend near \$1 million dollars on diabetic supplies.

These are the facts and dollar amounts that led our leadership team to request information on programs that can provide resources and tools to not only improve the health and overall well-being of our members but also to prevent unnecessary claims cost.

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**Kannact by: Krishna Rao, Kannact**

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Kannact gave an overview of their patient centered model that is designed and proven to engage participants. They have behavior change programs for chronic and pre-chronic conditions. In this program, you coordinate with a dedicated coach to create a personalized care plan. They have easy online enrollment, supplies shipped directly to your home and you will have 24x7 support to communicate on your schedule. Kannact also has a population reporting back to the health plan as early as month three, and they coordinate with other programs. They provided a transition schedule of what to expect from the program setup, enrollment, engaging with the coach and ongoing monitoring, and the claims billing set-up details.

Discussion:

- Brown                      If you use this to guide interventions with patient, do you share this with the participant?
- Rao                              We have it online and pdf sharing with the physician. The goal is to be the one in between physician visits.
- Brown                        Do you communicate with the physician?
- Rao                              If there is a serious issue. The report can be viewed online by physician, the patient can print and take with them, or the patient can send a pdf. If there is a high-risk patient, we ask for the escalation point, to send these. We ask for escalation points up front.
- Brown                        If I go to my physician and I come back with Diabetes, and I am on your plan which triggers a program like this, what if my physician wants me to do something different? How will you engage the providers to use this program? Is there a usual way that that's done?

Howlett I would view this program to come along side in support of what the doctor is using as a care plan, both being clinical. There are times that there will be a difference in opinions, but the liability goes to the physician in treating the patient. Generally, the patient follows the doctor's orders.

Brown I am thinking about the equipment that is provided. As a physician, if I don't know that they are provided and I diagnose you with Diabetes. I would call and have supplies sent to your house. How will that work logistically?

Howlett I have answers for that, I will better explain at the end.

Dr. Kahn Are you already a network provider for Blue Cross in Arkansas?

Rao No, not in Arkansas. We are in other states

Howlett It will still be an ITS claim, it is billable as an in-network provider.

Dr. Kahn Now, are you going to explain why we had this presentation?

Howlett Yes. From a plan design, we have a very weak Diabetic program to the point that I don't know we can give you accurate data relative to how the outcomes have reversed or monitored them to a successful managed state or regressed state, regressing back away from the disease. The numbers that we see from Allie's presentation were based on billable claims for those receiving supplies. Let me give you a little history, in 2011 there was a group of the population that was non-compliant and trying to help increase compliance, and they gave them free supplies with no engagement or program. They were grandfathered. Hopefully, the goal would be to transition that grandfathered group, and the rest of the population that are currently receiving supplies we have no control. We have no mechanism in place to monitor them successfully and officially where I can give you true data. We want to look at the population that is currently getting supplies for free and enrolled in the program and find a way to address the grandfathered ones as well as any new starts. The Benefits recommendation was to look at transitioning in groups the current program participants onto Kannact. We will have daily and real time data on the member and outreach to the member. This will be a replacement. We are looking at 6,000 people on the program to be hastily transferred. We could probably transition 1,500 to 2,000 a month, we would monitor that for engagement outcome and look at costs associated with that. We have a recommendation from the Benefits Sub-committee.

Brown Being diagnosed with Diabetes is stressful, so how will they know about the program and to enroll? How do we address this in the rollout? There has been a lot of work with clinics on placing Diabetic educators in the clinics. It should be an

adjunct to that, but at the same time it seems like some duplication. How do we address that in the roll out so the members get the benefit without duplication?

Howlett Presently, I do agree that this is taking place. Other than the education, there is no other follow up. There is outreach from the education piece, but at some point, that wanes. Operationally, we can flag people behind the scenes since there are 30,000 potential pre-Diabetics and 6,000 currently in the program. New starts will be a little difficult. The current utilizers are the ones I believe we are dropping the ball on. I want to see the value of Kannact and that it is meeting the desire of what we are all trying to accomplish with the plan. We can partner with the physicians to create a stop point. I would hate to put a PA criteria on it, but we can. It would at least call for the intervention point.

Brown I think we need to minimize the confusion on the patient's part. Possibly send them notification that you need to enroll in this program once diagnosed.

Dr. Kahn Have you (Kannact) published that study in Texas, and where would I find it?

Rao No

Dr. Kahn That's a concern to me. Why have you not had it published if it was that good?

Rao It's a private company, and we do not want to publish that.

Dr. Kahn There are Patient Centered Medical Homes, and the whole idea behind it is to do exactly what they (Kannact) are doing. A newly diagnosed patient would be referred to this Patient Centered Medical Home, and they have someone develop a personalized education plan. These PCMHs have Diabetic educators, nutritionists, pharmacists, and they don't need anyone else to help them. What I would like to see, if we are convinced that Kannact is the best, then we market them to the providers and recommend them to Kannact.

Howlett We could put that information out there, but we have roughly 14,000 people in PCMH. I don't know that we are getting the best value with the Patient Centered Medical Home. We spend \$2.5 million a year on the PCMH, and there are a lot of different opinions on that.

Murtha Discussing Patient Centered Medical Homes, I can go talk to our experts that do the PCMHs and make sure that this (Kannact) meets the requirements and if this would be beneficial to them. I want to make sure everything will transfer over. I don't want to make anything more confusing for the patient or the provider, and Medicaid is different. I think we need to look into it a little further and do a little more homework on what is out there.

Brown Are they really getting the benefit different than the ones that are not in Patient Centered Medical Home?

Howlett In times past, we see some duplication of services, but if they had checked the services provided through the system they would have caught that.

Brown There are more that are not operating as the PCMH than are operating as PCMH. I just think we really need to think about this before we roll this out with the providers.

Rao All of our coaches are level 2 Diabetic educators. We have psychologists, doctors, and nutritionists, and we operate as a Patient Centered Medical Home. We just go through a coach. We actually work with clinics and have a system. We already partner with clinics, and the continuum of care is our fundamental principal.

Howlett If there was a person that did not want to participate with Kannact or the current program, then he or she would have to pay co-pays. Options are important. I don't want the plan to be dictorial in a lot of respects.

Brown This will give the member the option of going to the doctor and saying my benefits will play 100% of this program and will you work with me on that. That creates more of a collaboration.

Rao We do that today and will gladly help through that.

Brown Then, the physician has to answer to the patient for who is going to pay their co-pays.

Dr. Kahn If EBD will pay for Kannact, then diabetic educators should be covered as well.

Howlett We pay a piece per person toward PCMH.

Brown Just to recap, it is either to move forward with a recommendation to go with the Benefits recommendation or to gather more information.

Dr. Zohoori What was the Benefits recommendation?

Howlett The recommendation was to transition the current utilizors of the program to Kannact as quickly as possible in a phased approach as well as any new starts. The side note is to look at the grandfathered people and how to do that.

Dr. Davis Is the million spend on supplies coming out of the pharmacy program?

Howlett There is a pharmacy piece to that, yes.

- Dr. Davis                    Would those come through Kannact or would they come in through another mechanism outside of the current pharmacy program?
- Howlett                     The pharmacy would waive the co-pay if they are on the program, but I don't know about the grandfathered because I don't know what they are paying. We have to further explore that.
- Dr. Davis                    Would they be adjudicated through the program because we have specific quantity limits on the strips because we saw some people were doing 15 tests per day. I want to maintain those savings on the strips.
- Dr. Kahn                    This committee sounds like it does not agree with the Benefits committee.
- Dr. Zohoori                It sounds like you will save money, but will it improve quality of care? I am not convinced with the company presenting.
- Dr. Kahn                    Another piece is that we don't know how the providers will feel about having something that EBD has imposed on the patients. It doesn't go through the providers. I predict you will get a lot of trouble from the providers.
- Howlett                    We haven't had that problem as long as we were paying. All we have asked for was enrollment into a voluntary program.

**MOTION** by Brown

My recommendation is to gather more information and vet this out a little more.

Murtha seconded. All in favor.

**Motion Approved.**

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**Director's Report by: Chris Howlett, EBD Executive Director**

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One of the pieces in Allie's research is Diabetes Education Empowerment Program, DEEP, that Murtha helped us with. We have Medicare members kicking off with the DEEP program.

**MOTION** by Brown

Move to adjourn.

Dr. Zohoori seconded. All were in favor.

**Meeting adjourned.**

# EBD Quality of Care Subcommittee Updates

**Mike Motley, MPH**  
Assistant Health Policy Director

**Elizabeth Montgomery, MPA**  
Policy Analyst



August 2018

# Objectives for Presentation:

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- **Present background on the Choosing Wisely Initiative and its framework**
- **Review preliminary analysis of the 8 most common low-value healthcare services provided to EBD members**
- **Discuss next steps for further assessment of low-value services and opportunities for improvement within plan**



# Choosing Wisely Initiative Background

- **Choosing Wisely is an initiative of the American Board of Internal Medicine (ABIM) Foundation**
- **Aims to promote conversations between clinicians and patients by helping patients choose care that is:**
  - Supported by evidence
  - Not duplicative of other tests or procedures already received
  - Free from harm
  - Truly necessary

[Source: Choosing Wisely Initiative Website, "About" Section.](#)



- **Recommendations are developed by provider specialty societies**
- **Based on specialty societies' lists of recommendations of tests and treatments that may be unnecessary**
- **Since 2012, over 80 provider groups have published over 550 recommendations**

[Source: Choosing Wisely Initiative Website, "Our Mission" Section.](#)



# Choosing Wisely Background

- **Intended to spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments**
- **Consumer Reports has developed patient-friendly materials based on these recommendations for consumer use**
- **Provider-oriented materials available to assist with patient engagement on these issues**

[Source: Choosing Wisely Initiative Website, “About” Section.](#)



- **Act 1089 of 2017:**

- **Directs the EBD Board to explore evidence supporting opportunities for benefit modification informed by the Choosing Wisely Initiative**

[Source: Act 1089 of 2017, Arkansas General Assembly.](#)



# Assessing Wasteful Services within EBD <sup>8</sup>

- **MedInsight Health Waste Calculator is a tool which identifies low-value services and spending**
- **Examined 42 common treatments deemed by providers to be commonly overused**
- **Two additional states have published reports based on findings from this tool, including Washington and Virginia**

[Source: Choosing Wisely Initiative Website, "About" Section.](#)



- **Washington Example:**
  - Reviewed common wasteful services; 2018 report found that 45% of health care services were determined to be low value
  - Approximately 1.3 million individuals received one of these services
  - 36% of spending on services went to low value treatments and procedures

Source: Washington Health Alliance, "First, Do No Harm: Calculating Health Care Waste in Washington State," 2018.



- **Virginia Example:**

- **Recent analysis of low-value healthcare services revealed more than \$586 million in unnecessary costs**
- **Greatest amount of waste came from low-cost services**
- **Preoperative lab testing for low-risk patients undergoing low-risk surgery accounted for half of unnecessary spending**

Source: Mafi, J., et. al. "Low-Cost, High-Volume Health Services Contribute The Most to Unnecessary Health Spending," Health Affairs, October 2017 vol. 36 no. 10, 1701-1704.



# Results

- Of the 42 common wasteful services, 8 measures account for **82%** of low-value services
- The top 8 most wasteful (based on cost) represent at least **50%** of the cost of low-value services
- Among all EBD members enrolled in 2016, **65,135** had at least one of the 42 low-value services



# Findings within EBD Plan

Low-Value Service	Number of Distinct Members with a Low-Value Service	Number of Low-Value Services
Don't prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness or acute otitis externa)	22,230	29,144
Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal	11,122	18,292
Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	10,149	11,235
Don't order unnecessary cervical cancer screening (Pap smear and HPV test) in all women who have had adequate prior screening and are not otherwise at high risk for cervical cancer	10,130	10,238
Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	9,172	15,265
Don't obtain EKG, chest X rays or Pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery	3,428	6,372
Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.	2,201	2,343
Don't perform coronary angiography in patients without cardiac symptoms unless high-risk markers present.	1,023	1,093

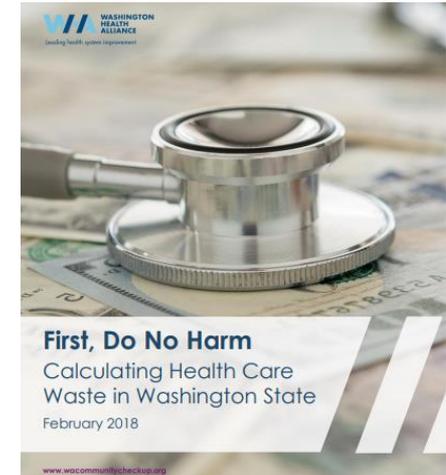


- **Review potential strategies to reduce patient risks and plan costs:**
  - **Tailored member education**
  - **Provider-level education**
  - **Review of prior authorization criteria or medical utilization management practices**
  - **Provider-level assessment of variation**
  - **Review of value-based payment models**



## Washington State

- <https://www.wacommunitycheckup.org/media/47156/2018-first-do-no-harm.pdf>



## West Virginia

- [http://www.vahealthinnovation.org/wp-content/uploads/2018/05/2016-Virginia-Low-Value-Services-Report\\_Final.pdf](http://www.vahealthinnovation.org/wp-content/uploads/2018/05/2016-Virginia-Low-Value-Services-Report_Final.pdf)



# References for Review: Other Publications

- **Health Affairs: *Low-cost, High-Volume Health Services Contribute The Most to Unnecessary Health Spending.***  
<https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0385>
- **NPR: *Unnecessary Medical Care: More Common Than You Might Imagine.***  
<https://www.npr.org/sections/health-shots/2018/02/01/582216198/unnecessary-medical-care-more-common-than-you-might-imagine?ft=nprml&f=>
- **Choosing Wisely: *A Special Report on the First 5 years.***  
<http://www.choosingwisely.org/wp-content/uploads/2017/10/Choosing-Wisely-at-Five.pdf>



NATURALLY SLIM®

# Foundations® Report

Outcomes as of 8/7/18

State of Arkansas  
ARBenefits PSE & ASE

Program Start Date  
05/28/2018



Measurably improve the health  
of ARBenefits employees.

## OUR GOAL

**Objectives:** Achieve measurable weight loss, significant program engagement and receive positive participant feedback for Naturally Slim as a valuable benefit for your health plan members.

**Purpose of this report:**

1. Foundations™ Phase Outcomes
2. Testimonials
3. Next Steps for Participants and ARBenefits

**PARTICIPATION**



# Participation Overview

2,400

## Accepted

Number of individuals that applied and were accepted.

243

## Never Started

Number of individuals that were accepted but never started.

2,148

90%

## Started

Number of individuals that were accepted and started Week 1 of program.

# Started

## Demographic Highlights

48

### Average Age

The average age of the U.S. Workforce is 41

35.7

### Average BMI

Normal: BMI 18.5 to < 25.0  
Overweight: BMI 25.0 to < 30.0  
Obese: BMI  $\geq$  30.0

91%  
Women

9%  
Men

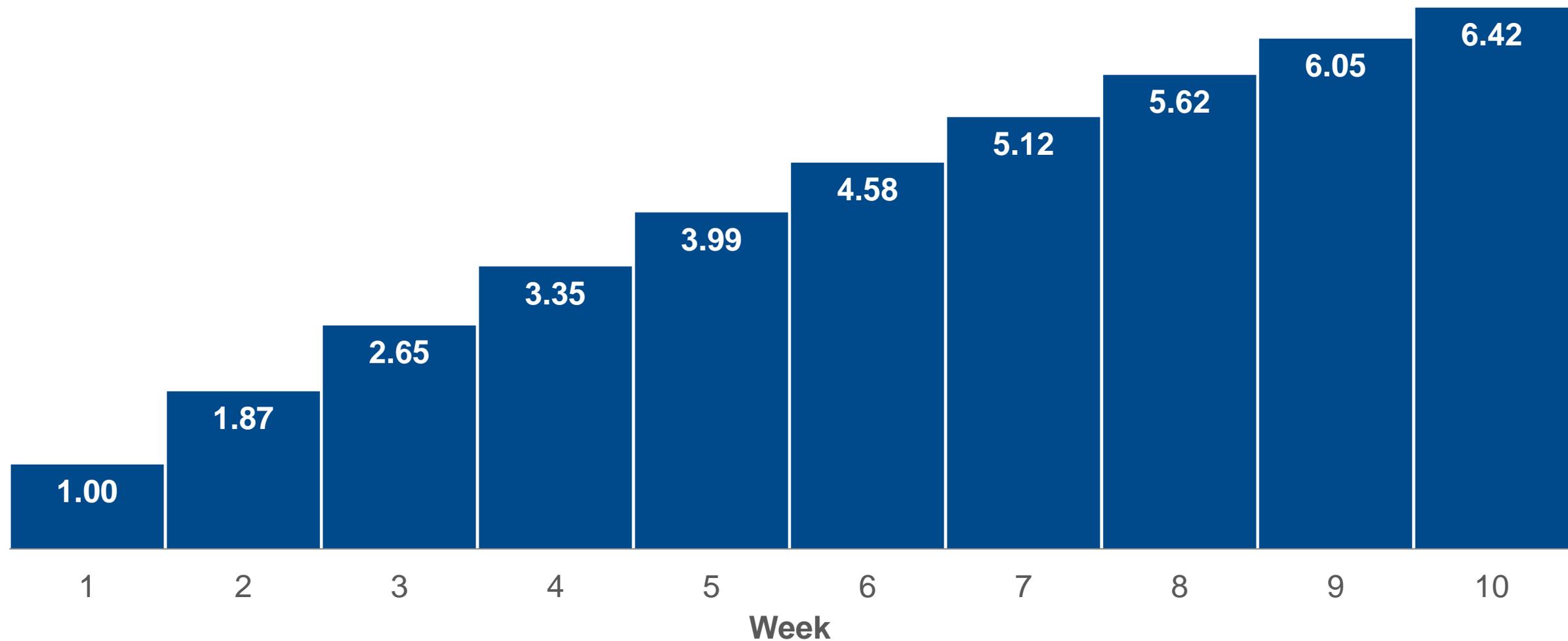
### Participants

On average, male participants lose more weight than female participants.

# Participation Report

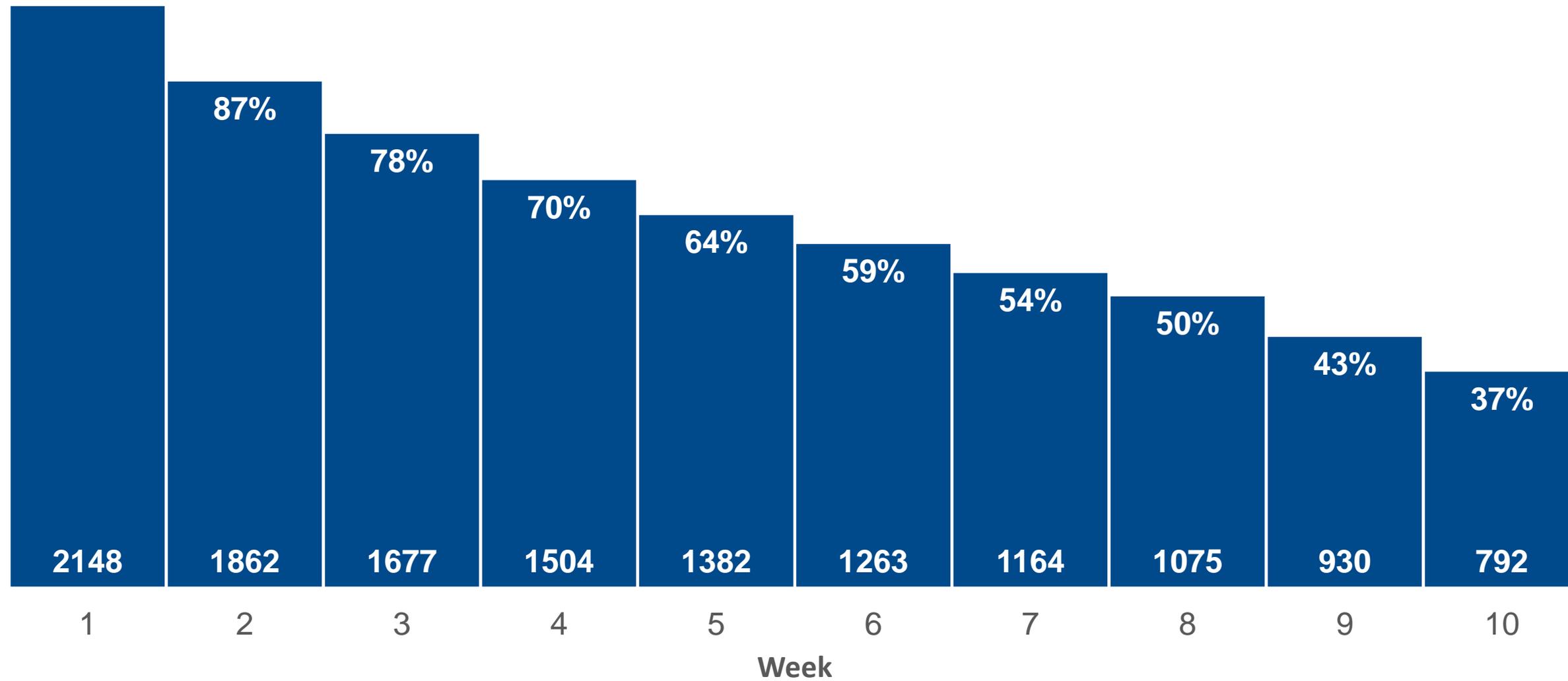
Average total of classes participated per participant per week

**Participants completed an average of 6.42 classes**



# Participation Report

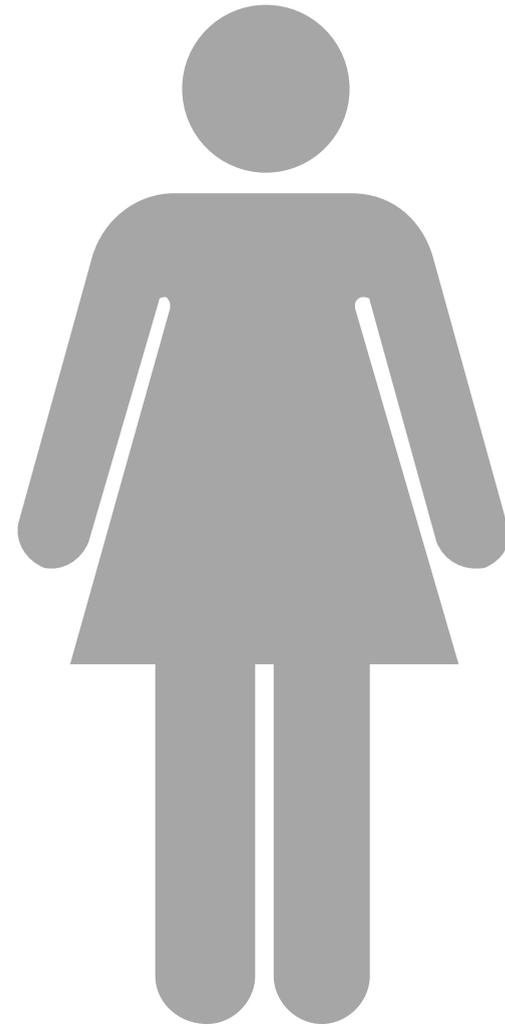
Participation in a Specific Week



# Participation Report: Female vs. Male

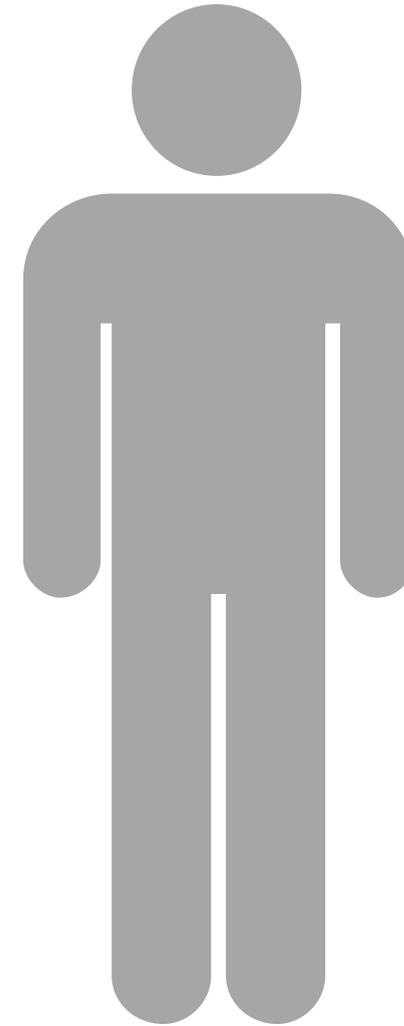
49%

955 Participated in 8 or More Weeks



33%

652 Participated in all 10 Weeks



47%

96 Participated in 8 or More Weeks

39%

80 Participated in all 10 Weeks

49%

1,051 Participated 8 or more Weeks

34%

732 Participated in all 10 Weeks

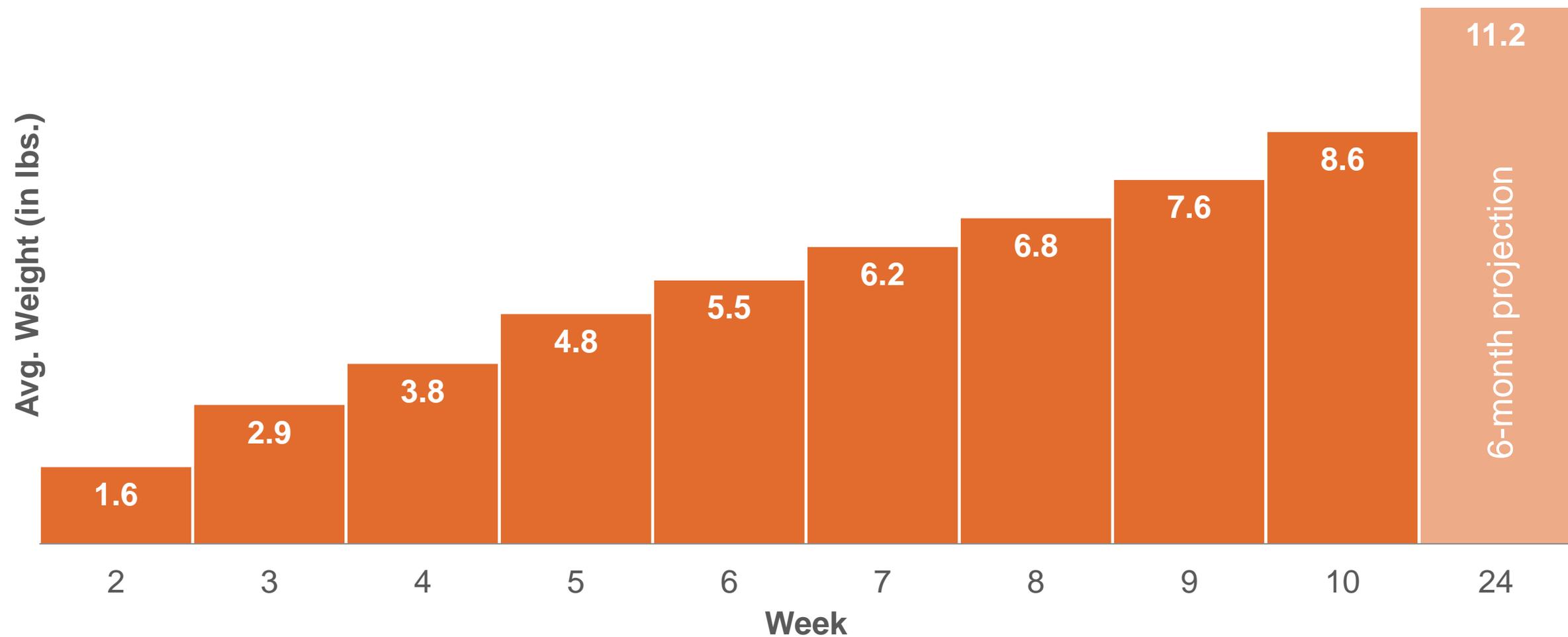
WEIGHT LOSS



# Weight Loss by Week

For active participants

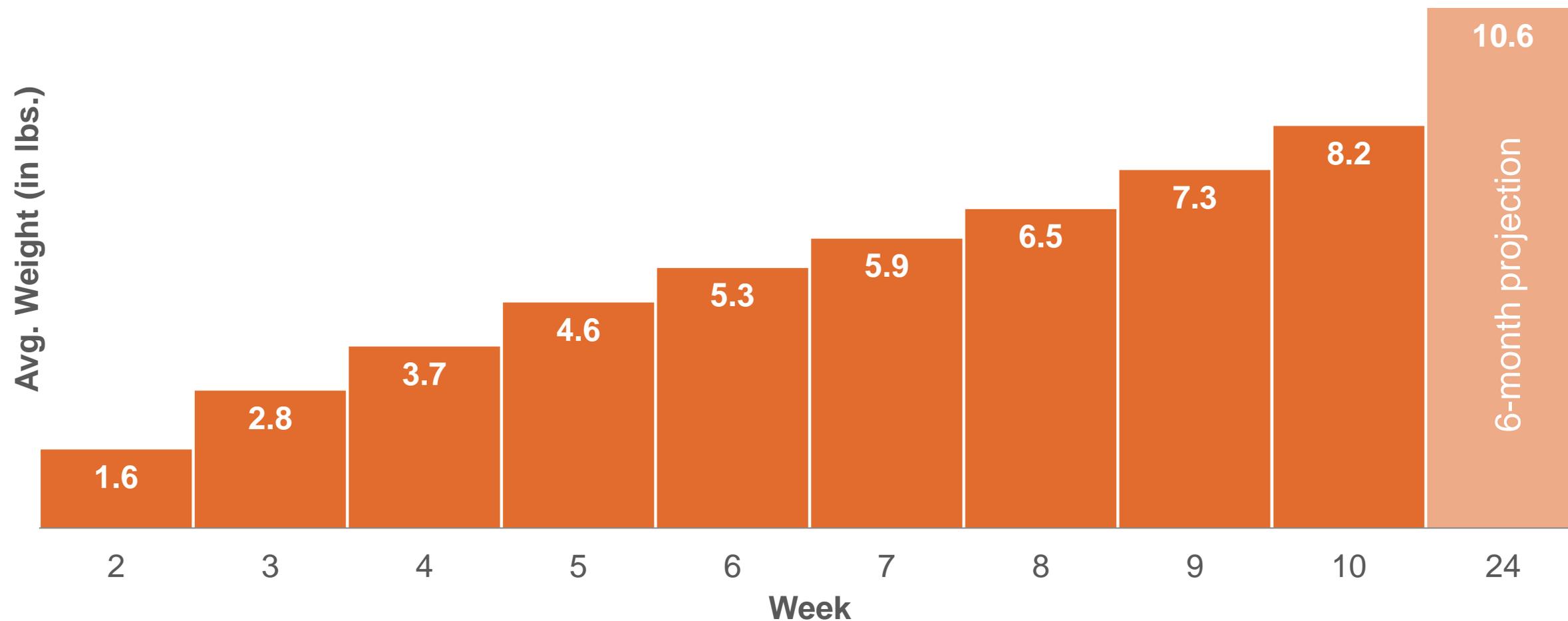
## Total Weight Loss Greater Than 11,000 lbs.



# Female Weight Loss by Week

For active participants

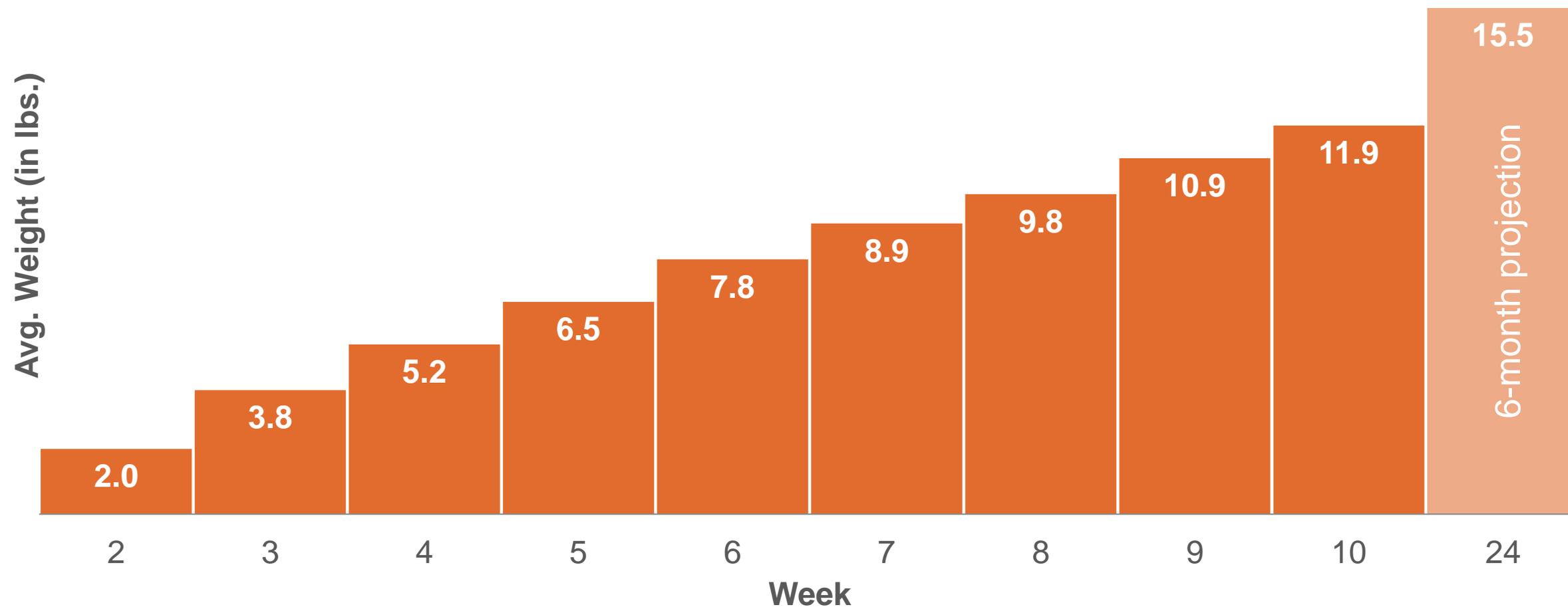
## Total Weight Loss Greater Than 9,600 lbs.



# Male Weight Loss by Week

For active participants

## Total Weight Loss Greater Than 1,300 lbs.



**37% of individuals lowered their  
Diabetes risk.**

\* Refer to “Federal Treatment Guidelines: How much weight loss is clinically significant?” slide in the glossary for further explanation

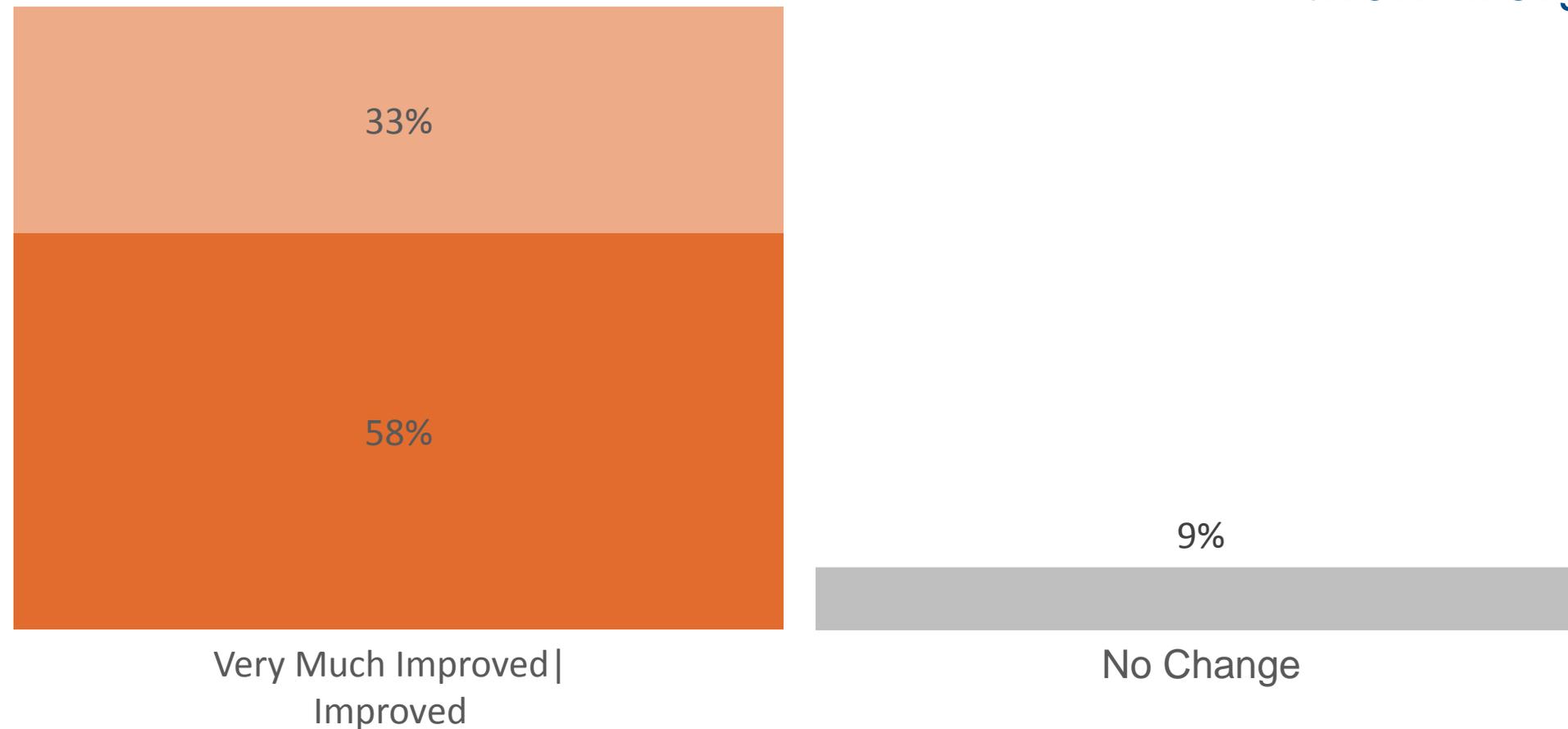
Post  
Foundations™  
Quality of Life  
Survey



# Feeling Weight is Out of Control

How has your feeling that your weight is “out of control” changed compared to before starting the Naturally Slim program?

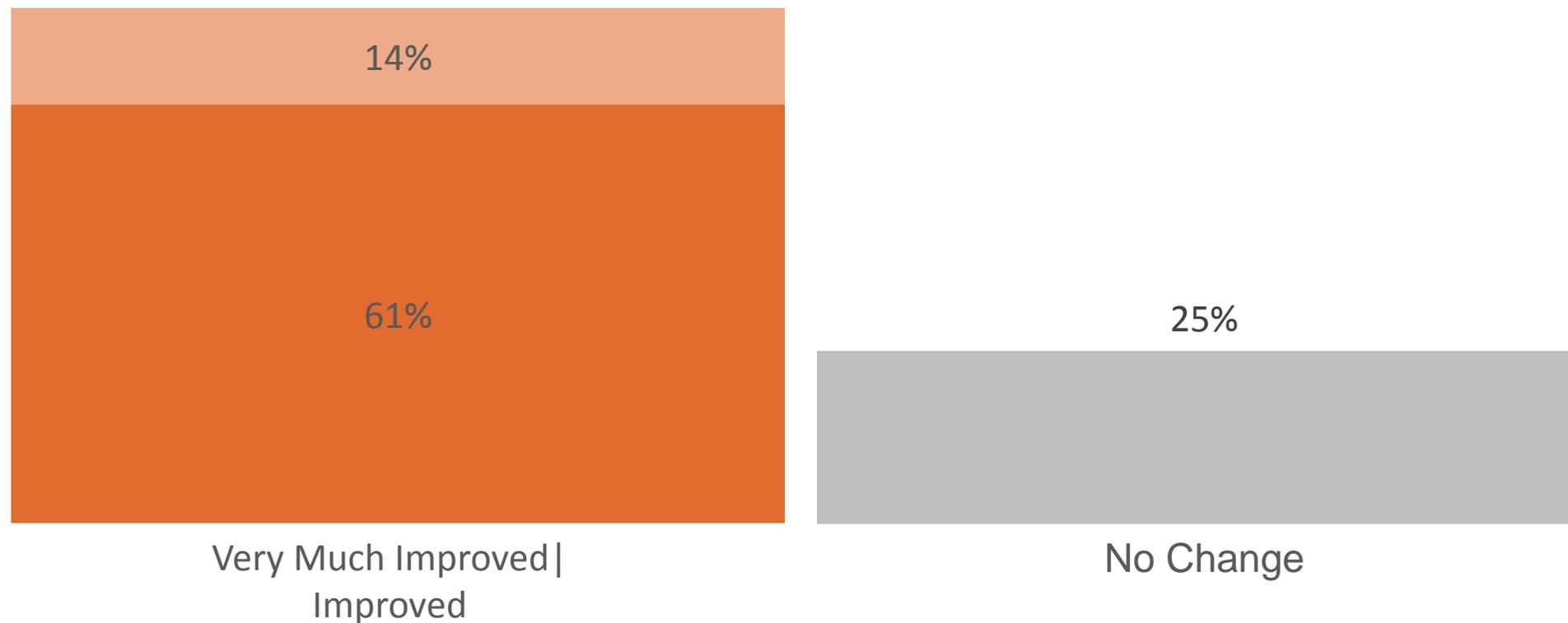
91% of individuals felt more in Control of their weight



# Energy Level

How has your energy level changed compared to before starting the Naturally Slim program?

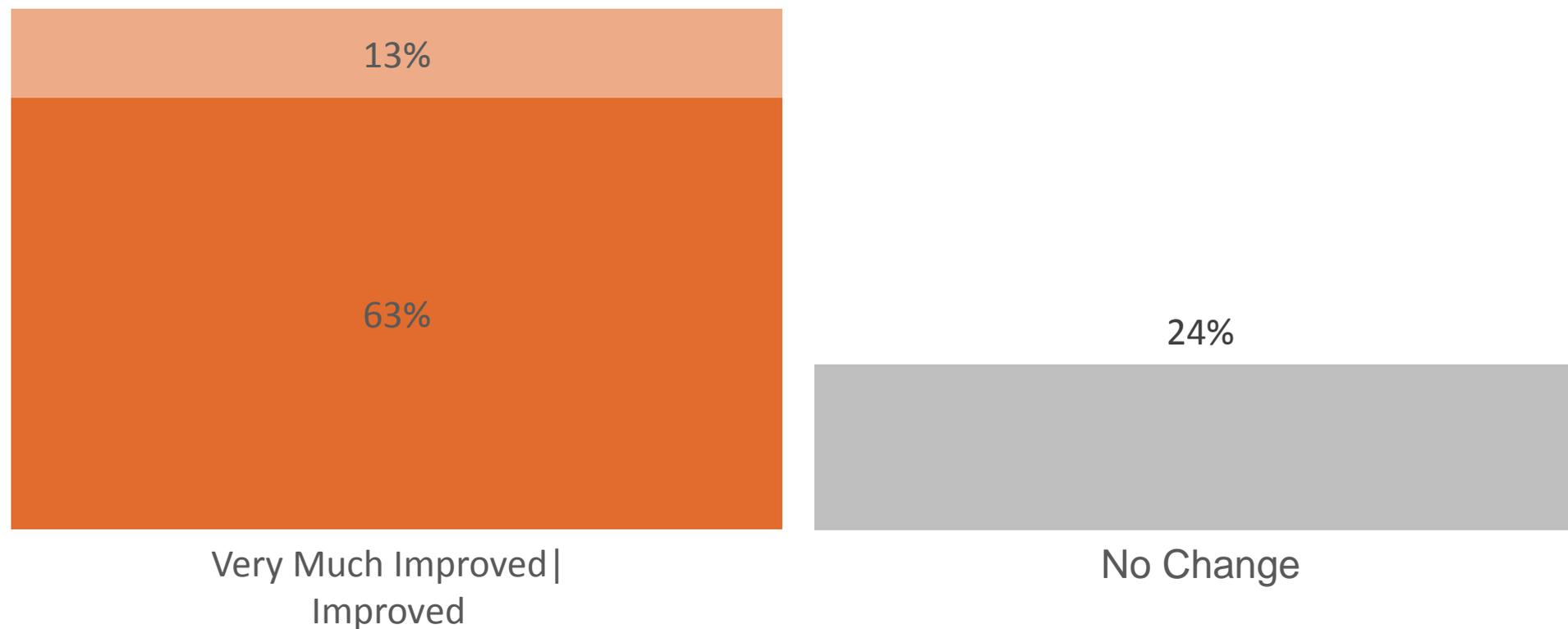
75% of individuals experienced a newfound burst of energy.



# Self-Confidence

How has your self-confidence changed compared to before starting the Naturally Slim program?

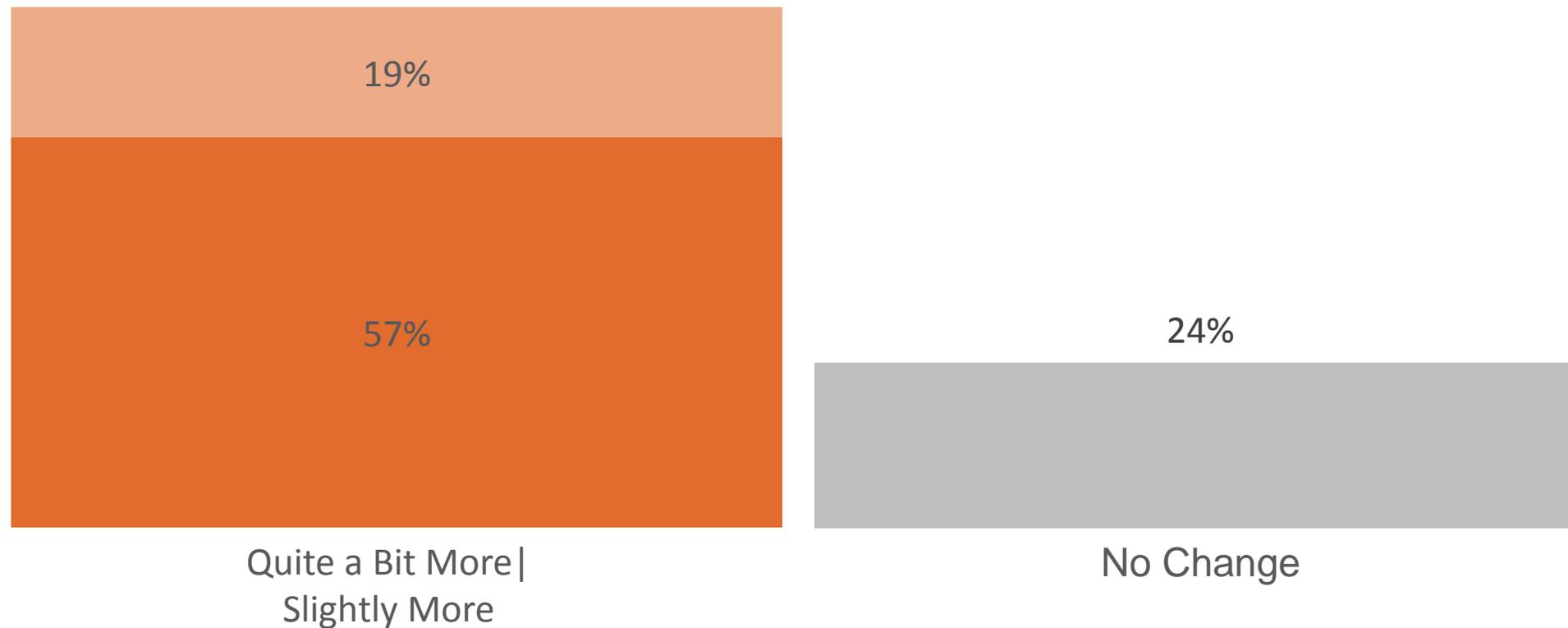
76% of individuals experienced a boost in confidence.



# Physical Activity

How has your level of physical activity changed compared to before starting the Naturally Slim program?

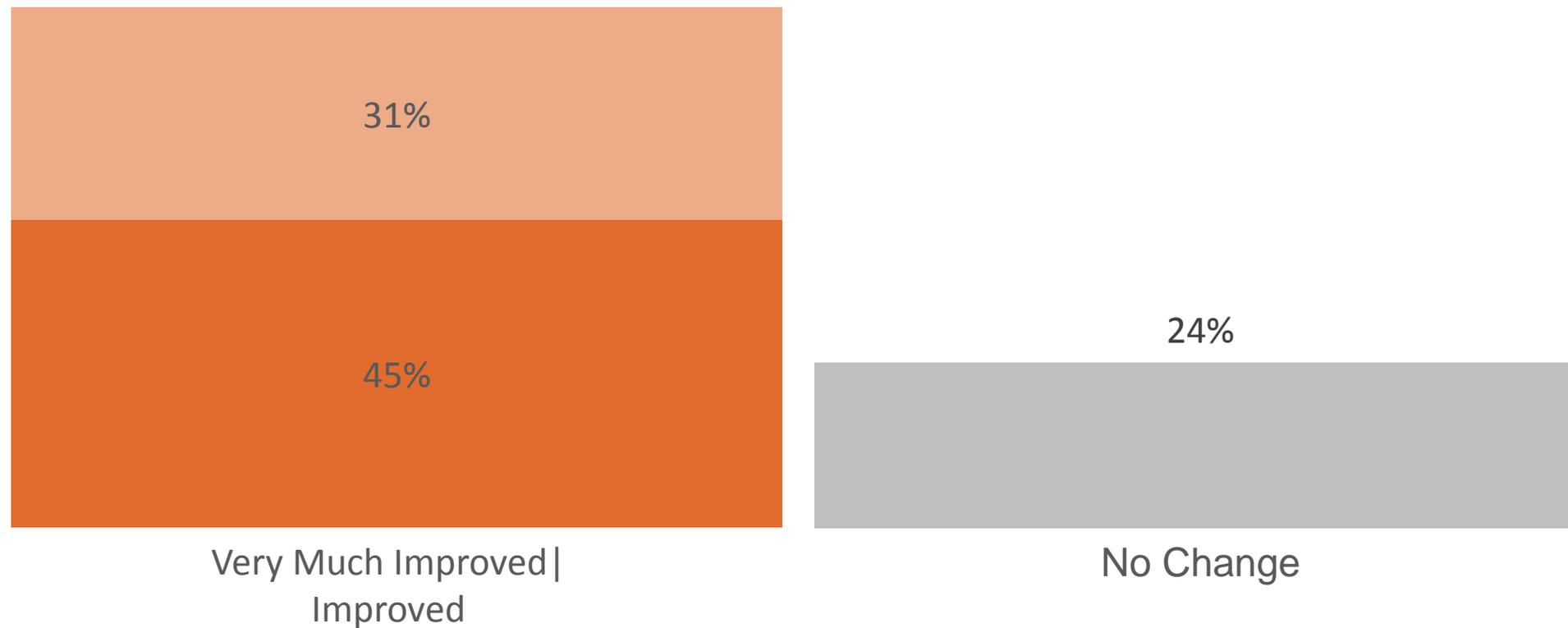
76% of individuals increased their level of physical activity.



# Indigestion

How has your indigestion changed compared to before starting the Naturally Slim program?

76% of individuals' indigestion has improved.



# TESTIMONIALS



Thank you so much for all you do. This has been a life-changing experience and has given me skills for life! I'm so grateful. I'll never be the same!

-ARBenefits Participant

due to change in high blood pressure medication ringing in ears  
has decreased

-ARBenefits Participant

I think my Diabetes is better. I love this program and will continue  
to use it!

-ARBenefits Participant

I'm on cholesterol meds, but, at my recent insurance/employer  
health, it was so much lower I may ask my doctor if I can come off  
the meds.

-ARBenefits Participant

A1C in March was 7.3; A1C in June (after 4 weeks on NS) was 6.5. I still take full dosage of Tujeo at night, but have eliminated Humalog 10 units 3x per day and reduced Metformin from 2000mg/day to 1000 mg/day.

-ARBenefits Participant

This was one of the best things I've been offered. I feel it has literally changed my life. I'm not where I want to be yet, but I met my initial goal and feel this is very sustainable. I would probably never have heard of the program had it not been for my employer.

-ARBenefits Participant

This is a great opportunity. I feel blessed that it was offered by my employer. I hope they offer it to more people who did not get the change to take advantage of it this time.

-ARBenefits Participant

NEXT STEPS



# What's next for participants?



# What's next for ARBenefits?

With an estimated 70%+ of ARBenefits adults pre-diabetic, obese, and/or overweight, leveraging the momentum of the pilot success will be important in engaging those that need our help.

2018



2019



# What's next for ARBenefits?

At no cost, Naturally Slim will create a testimonial video and capture the engagement that has been demonstrated with other State health plans:



## 1. Introduction

## 2. Naturally Slim & Kannact

We've heard impressive results from Naturally Slim and how the program helped to decrease the risk of developing metabolic syndrome. A preventative program like NS, if approved by the board, will continue to improve the overall health of our members by working to decrease the mentioned risk factors.. There is certainly an ROI that could be shown to evaluate plan savings by preventing the progression or development of metabolic syndrome in members. However, there is still a large subset of our population that are desperate for a more high touch/ hands on, long term management of chronic disease and conditions.

3. **ACHI** reported back in May that 11% of our member population has a diagnosis of Type 2 Diabetes. (+23% who are unaware/undiagnosed which would total to an additional 30,000 members affected by T2DM)

- 8,295 T2DM without complications
- 6,695 T2DM with complications

These 15,000 members cost the plan \$110 million in medical claims from 2016-2017

\*\*in addition to these costs; our current UM provider is managing a group who receive free supplies to the member for participating in our voluntary diabetes management program. These costs add up to:

From January 1-July 31 of 2018

- \$266,708.31 on test strips
- \$184,172.89 on needles and pen tips
- \$29,575.52 on syringes
- \$15,162.68 on lancets

If we assume this trend to hold true, we are on track to spend near 1 million dollars on Diabetic supplies.

These are the facts and dollar amounts that lead our leadership team to request information on programs that can provide resources and tools to not only improve the health and overall well being of our members but also to prevent unnecessary claims cost. After using a very specific set of criteria in our search, Kannact stood out in many aspects. To mention a few, they are the only company that can provide raw, Clinical data to the member, provider and EBD in real time. They use a team of MD's, pharmacists, dietitians, psychologists, and nurse coaches to provide a holistic care approach to bridge the gap for these members between physician visits & they provide all of the supplies mentioned above to the members at no additional cost to the plan.

Should the plan choose to transition these members from our current program to Kannact, we could see initial cost savings of \$495,617 on 6 months / \$1 million annually for supplies alone. As time passes, EBD should begin to see a decrease in costs related to multiple provider visits, ER costs, dialysis, inpatient hospitalizations, and other complications/ effects of an un-managed disease state. Kannact also has a targeted approach to identify and engage pre-diabetics which works to de-escalate or prevent the occurrence of T2DM.

I hope this information serves as adequate detail on the instant cost savings a company like Kannact would bring to our plan while providing a proactive program to this underserved population.

Introduction: CEO Krishna Rao & Director of Marketing, Mike Pohl



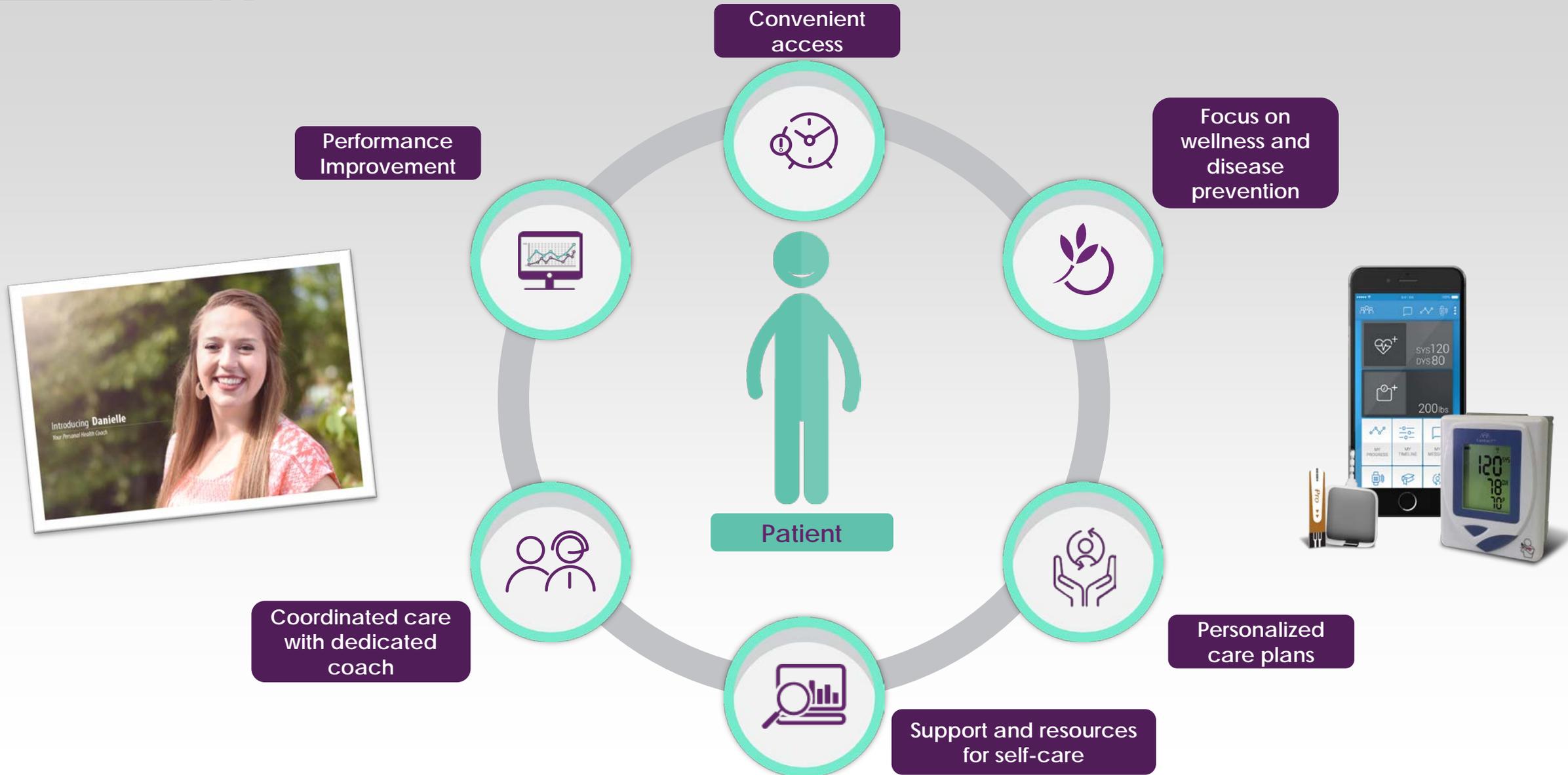
Kannact

**Patient Centered Care –**  
*Designed and Proven to*  
**Engage Participants**

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**Behavior Change** Programs for  
Chronic and Pre-Chronic  
Conditions

# Key Elements Of Kannact Patient Centered Care



## Client Description

Self-Insured Employer:

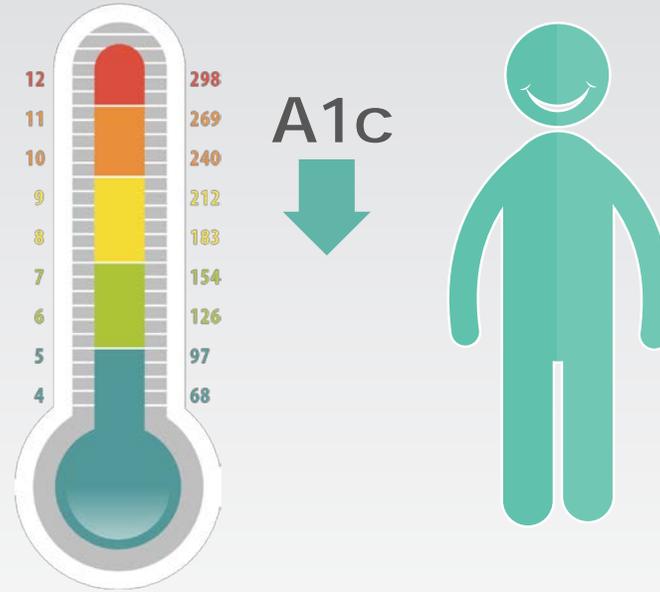
Large City in Texas

Business with 10K employees

80% were engaged and adherent

Significantly reduced blood glucose in 90% of the population!

## Participants Experience

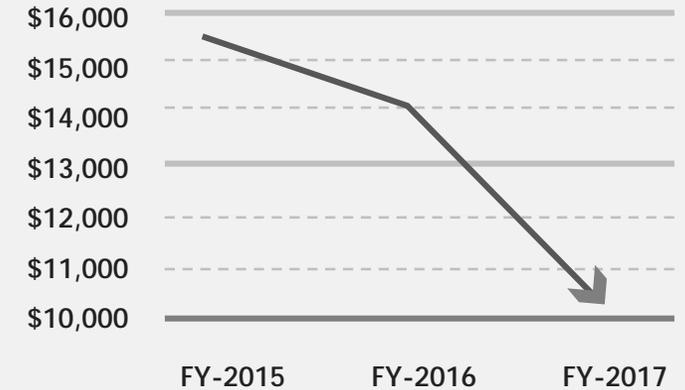


Outcomes for Diabetes patients **improved 37%**

Glucose levels dropped 35 mg/dl or **HbA1c improved by 1 point**

## Impressive Client Results

### Average Cost of Care



Cost dropped \$15.2K to \$10.3K **(32%)**



# Convenient Access

## Easy Online Enrollment



- ◆ Customized State of Arkansas landing page
- ◆ Enroll in under 5 minutes
- ◆ Support staff available on email and phone
- ◆ Engaging content, videos and emails to introduce the program

## Supplies Shipped Directly to Home



- ◆ Tracked and delivered automatically as needed
- ◆ Unlimited supply
- ◆ No cost to participant

## Communicate on your schedule



- ◆ 24 x 7 Support
- ◆ Multiple different methods (secure text, phone, email)
- ◆ System and coaches in English and Spanish
- ◆ Access all program data on smartphone



# Focus On Wellness & Disease Prevention



- ◆ Diagnosis/Procedure Codes
- ◆ Hospitalization/ER visits

**MEDICAL  
CLAIMS  
HISTORY**



- ◆ Medication Possession Ratio
- ◆ Medication Compliance

**PHARMACY  
CLAIMS  
DATA**



- ◆ Weight/Height (BMI)
- ◆ Blood Pressure
- ◆ Blood Glucose

**HEALTH  
DATA**



- ◆ Nutrition Management
- ◆ Appropriate Activity
- ◆ Family & Support System
- ◆ Level of Disease Knowledge
- ◆ Level of Sleep & Stress

**BEHAVIORAL  
ASSESSMENT  
DATA**

# Data



# PARTICIPANT



# Profile



Medical Claims



Rx Claims



Biometrics



Health and Behavior Risk Assessment



DIABETES

HYPERTENSION



85% adherent to oral diabetic

+6 Months non-adherence to hypertension Rx



A1C 7.5

BMI 34

BP 138/93



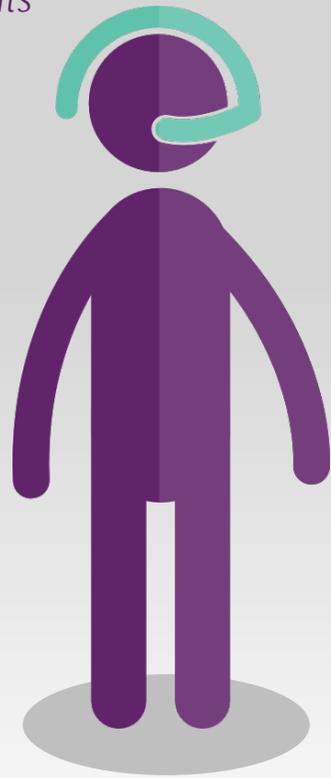
High-stress work environment

Average sleep 6 hours/night





# PERSONALIZED CARE PLANS



Guided by the coach and medical team





# Support & Resources for Self Care



Ability to take measurements anytime anywhere – automatically logs, charts, and reports data



Participants learn how the biometric data is tied to their behaviors and habits



Accurate data allows the coaching team to adjust guidance in real time



Platform tracks wearable activity data from any device



Learning modules are adaptable to the participant's style of learning, and current knowledge level



## Coordinated Care with Dedicated Coach



*Coach conducts Health and Behavior Risk Assessment and is guided by pharmacists and clinicians*

*Personal coach creates relationship, accountability and helps build **new skills** in dealing with :*



Disease knowledge



Lifestyle management



Home biometric testing



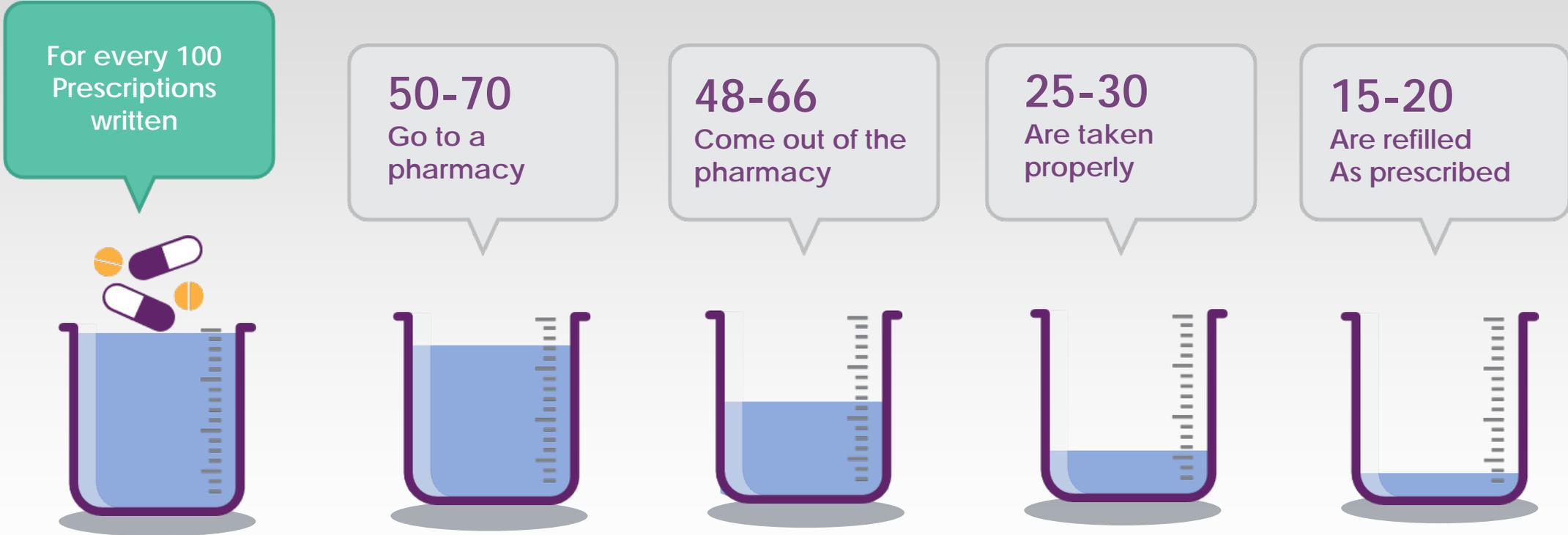
Managing personal plan & goals



# Coordinated Care – Medication Compliance



Medical and Pharmacy claims provide history, and pharmacists guide coach to provide medication compliance support



Source: National Association of Chain Drug Stores, Pharmacies. Improving Health, Reducing Costs, July 2010. Based on IMS Health data





Participants can share portal access to the friends and family that will help them stay on track by receiving health related alerts & notifications





# Performance Improvement

## On-Demand Detailed and Summary Reports to Physicians

Patient Biometric Detailed Report  
March 19 - April 18 2017

Patient: Debra Parker  
DOB: 05/01/1962

Report Generated at 09:02 AM Apr 18 2017  
All times are in Pacific Standard Time

### Glucose Metrics Summary (90 days)

Prescribed Readings Per Day: 1

Glucose Statistics	Breakfast (6 am - 11 am)		Lunch (11 am - 4 pm)		Dinner (4 pm - 9 pm)		Bedtime (9 pm - 6 am)
	PRE	POST	PRE	POST	PRE	POST	
Highest	354			489			
Lowest	354		356				
% within Target	0%		0%				
Reading	354		423				

### Glucose Logging

Date	Time	Glucose (mg/dL)	Reading Context	Insulin (Units)	Notes
04/07/2017	02:24 PM	356	Pre-Lunch		
04/06/2017	11:04 AM	354	Pre-Breakfast		

\* manually entered reading

## Population Reporting Back to the Health Plan

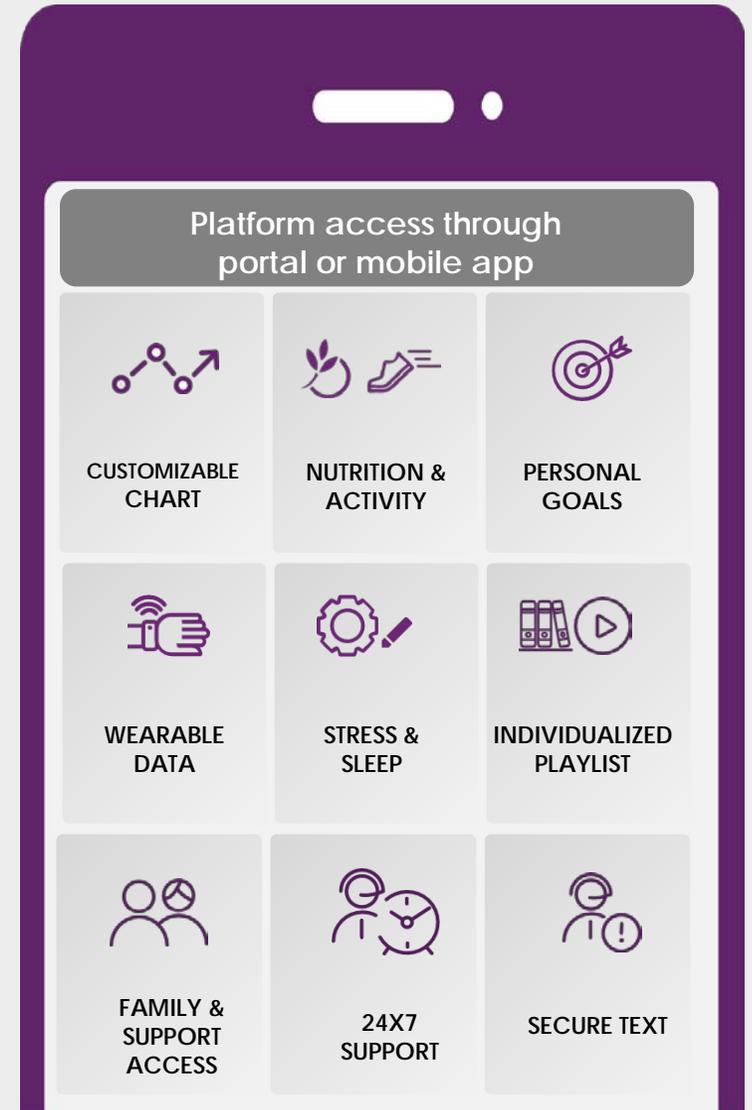
- ◆ Initial Enrollment
- ◆ Month 3 – Early Program Engagement
  - Engagement
  - Testimonials and satisfaction
  - Early outcomes and trends
- ◆ Month 6 – Phase 1 Review
  - Engagement
  - Testimonials and satisfaction
  - Early outcomes and trends
- ◆ Month 9 and ongoing quarterly
  - Health outcomes





# PRE-CHRONIC PROGRAM

- ◆ People with **Pre-Diabetes** are at higher risk for diabetes, cardiovascular diseases, and other chronic conditions
- ◆ Members are identified using a combination of **claims data, wellness data, and HRA**
- ◆ Lifestyle change with an emphasis on activity and nutrition
- ◆ Self-monitoring to create self-awareness about how behaviors are directly effecting health scores



# Coordinate With Other Programs

The Kannact platform **complements other programs** with a holistic approach to chronic care. Our focus will be coordinating in these areas with other State-implemented programs. The Kannact coach works directly with each individual to identify barriers and motivate change.



Mental Health

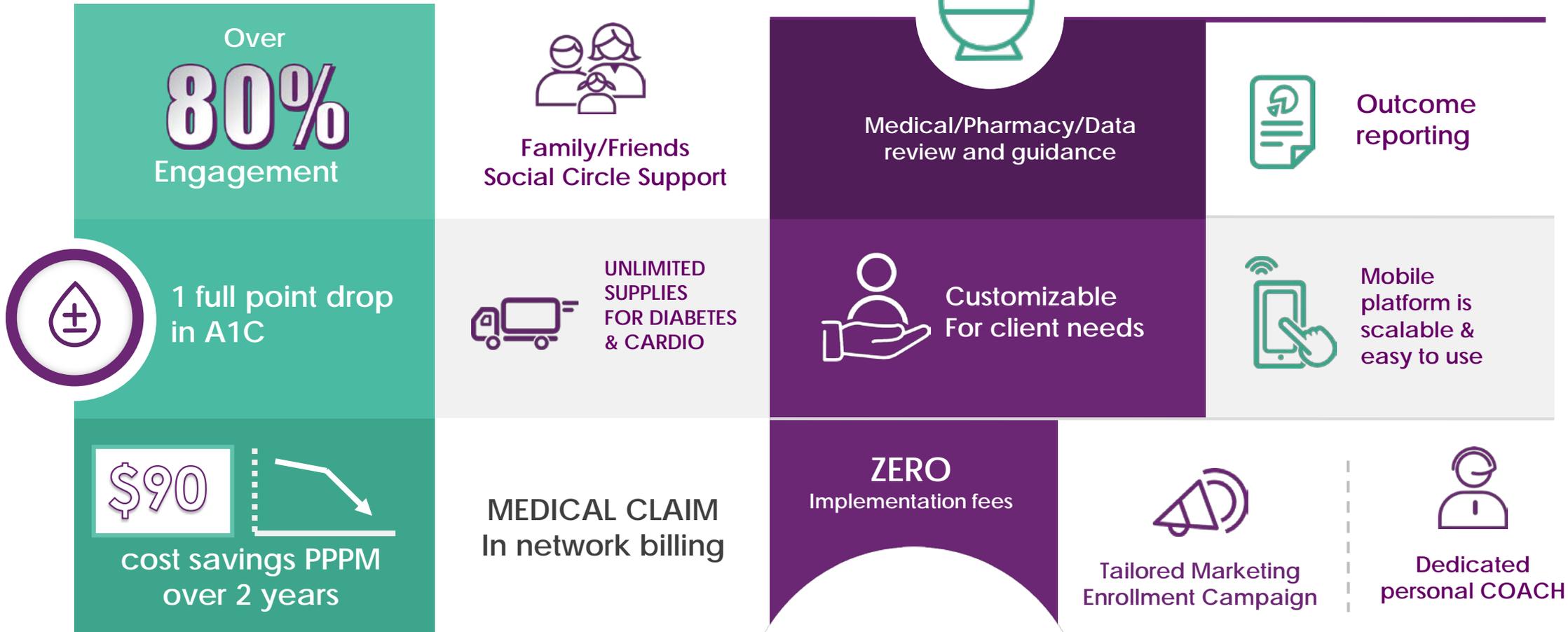


Wellness



Nutrition  
management





# Implementation

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# Transition Schedule

Week 1



## Program Setup

- ◆ In-Network Billing
- ◆ List of Members
- ◆ Claims data
- ◆ Communication materials



## Enrollment

- ◆ Phone call and online enrollment

Weeks 2 - 4



## Engage with coach

- ◆ Claims Data Analysis
- ◆ Assess risk category
- ◆ Create individual plan
- ◆ Ship supplies

Ongoing



## Monitor and adjust for success

- ◆ Biometric monitoring
- ◆ Continually evaluate
- ◆ Intervene as appropriate





## Claims Billing set-up Details

*The following is the detailed information that we provide to the Claims Administrator (CA) to set up the In-network billing. We provide backup codes and modifiers as needed for each CA's specific system needs.*

- CPT code for Chronic Care Program is S0317
  - There are 3 levels of service - each would use a different modifier according to the price of service.
    - Diabetes and Cardiovascular \$79
    - Diabetes \$69
    - Cardiovascular \$59
- CPT code for Pre-Diabetes program is 0488T
  - No modifier – billed at \$49
- Benefit level: pay at 100% with NO employee deductible/copay/co-share
- Benefit plan year max is 12 claims
- ICD10 / Diagnosis codes –
  - E13.00 – Diabetes
  - I99.9- Cardiovascular
  - R73.00 – Pre-Diabetes

Thank You

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