Pfizer Health Solutions

Reporting Overview

October 26, 2006

A Unique Care Management Company

Pfizer Health Solutions

Wholly Owned Subsidiary of Pfizer Inc

Breadth of Experience and Implementations

- Operations since 1995
- 78 current client sites
  - Health plans
  - Health systems
  - Physician groups
  - State agencies
- Commercial, Medicare, Medicaid Populations

Commitment to Health Management

- Attend to recognized health care delivery system challenges
- Measure and promote outcomes, partners, and health models

Personnel

- Clinical and technical development, full implementation, and service capabilities
- Measured and compensated based on client satisfaction and success

Pfizer Health Solutions: Experience

Health Plans

- Care management collaborations
- Regional and national health plans
- Focus on care improvement and publishing results

Government (Medicare/Medicaid)

- Comprehensive community care programs (Medicaid)
- Awardee for Medicare Health Support Program (CMS)

International

- UK care management demonstration project
- Italy care coordination project

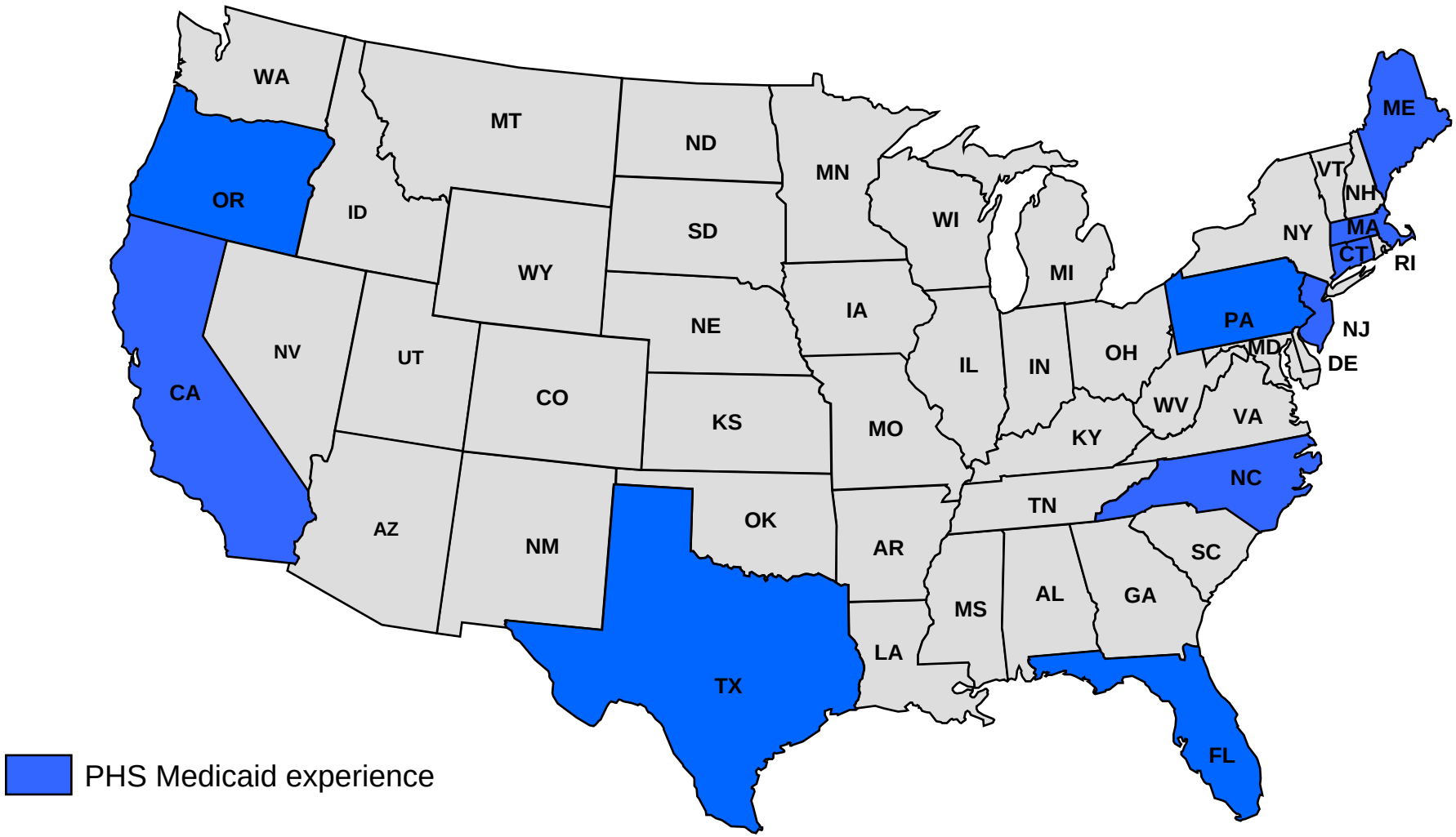
Community

- Community-based health improvement programs
- Hispanic/African-American programs, focusing on diabetes and depression

Employers

- Pfizer employee health program
  - Promote health and wellness
  - Attract/retain employees
  - Improve productivity and manage costs

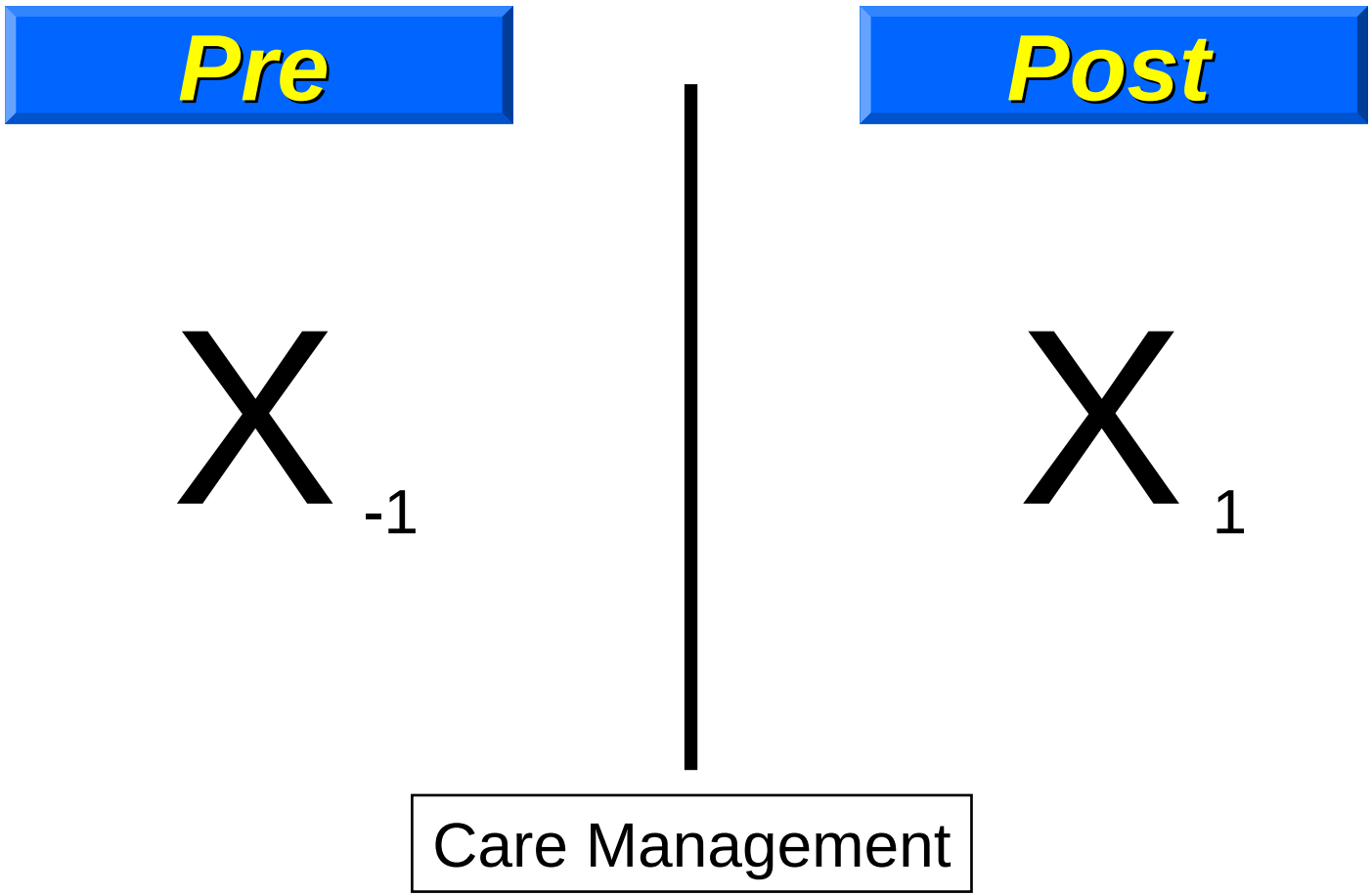
Breadth of DM Experience



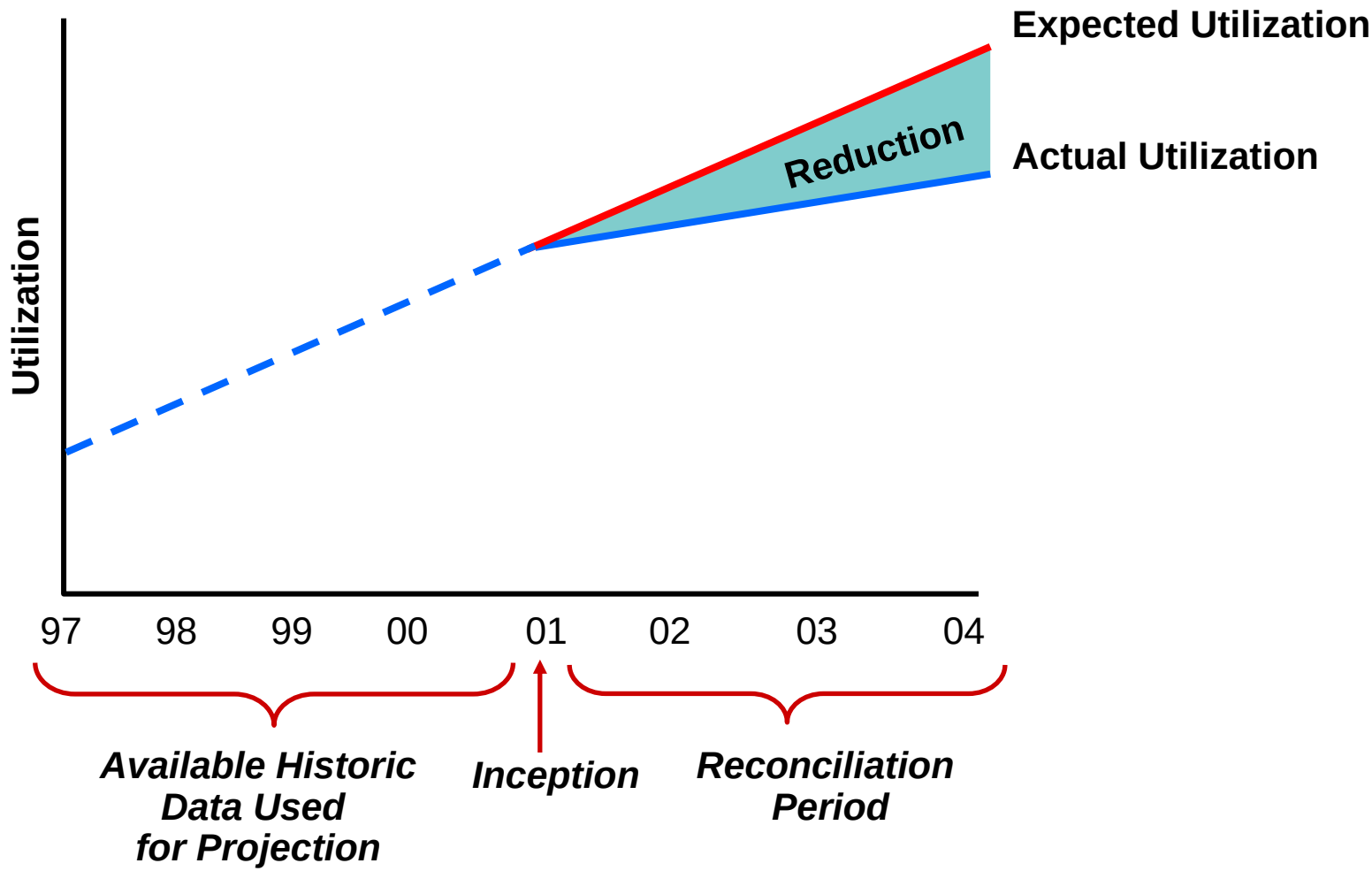
Reporting Challenges in Medicaid DM

- Lack of standards
- Disparate data sources
  - Lab data
  - Current inpatient data
  - Self-reported
  - Claims
- Overburdened providers
- High churn rate of eligible population
- Imperfect contact information

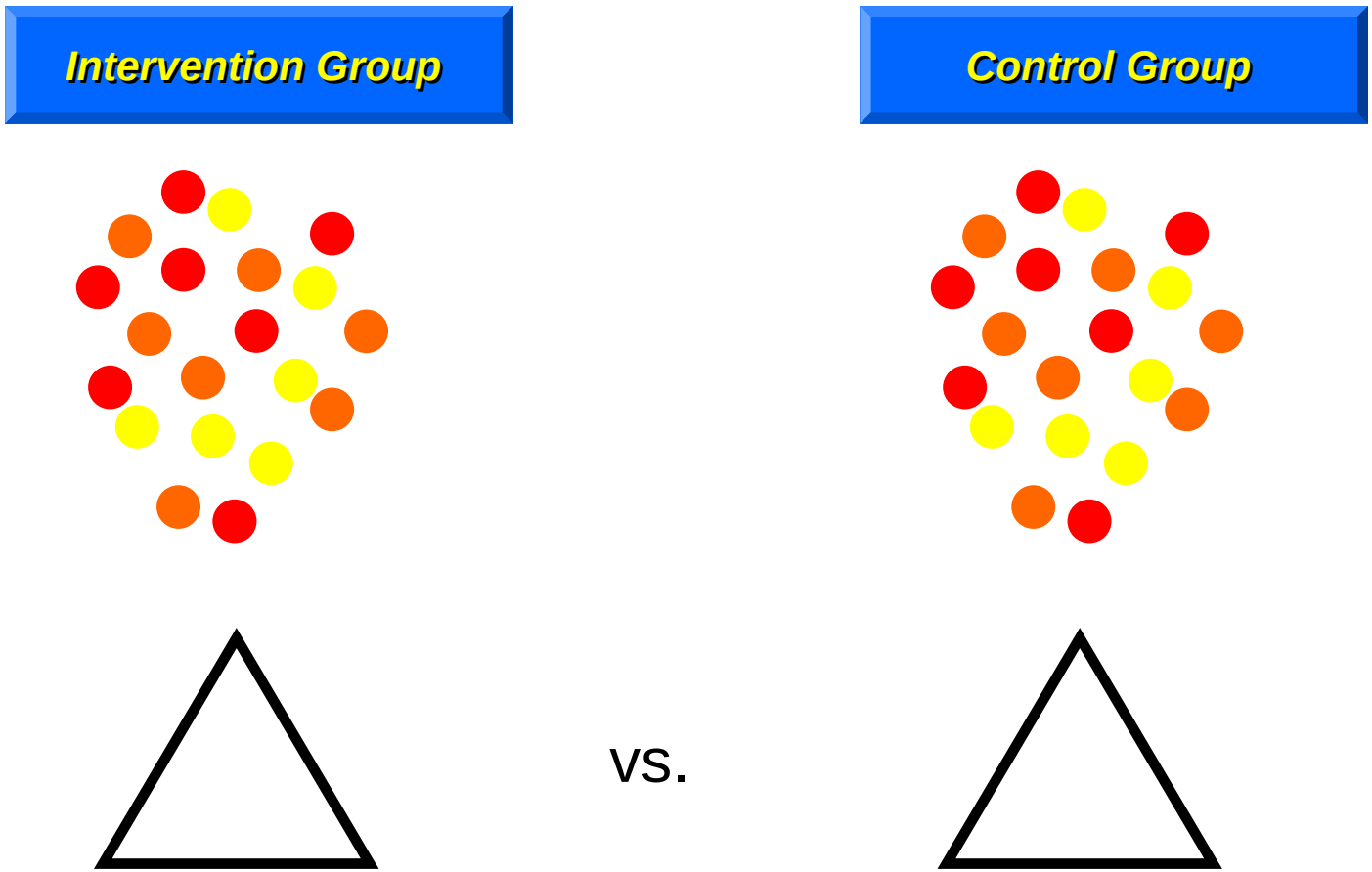
Methodology: Pre/Post



Methodology: Performance vs. Projection

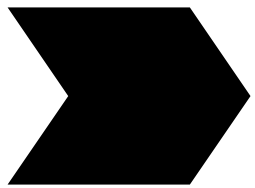


Methodology: Control Group



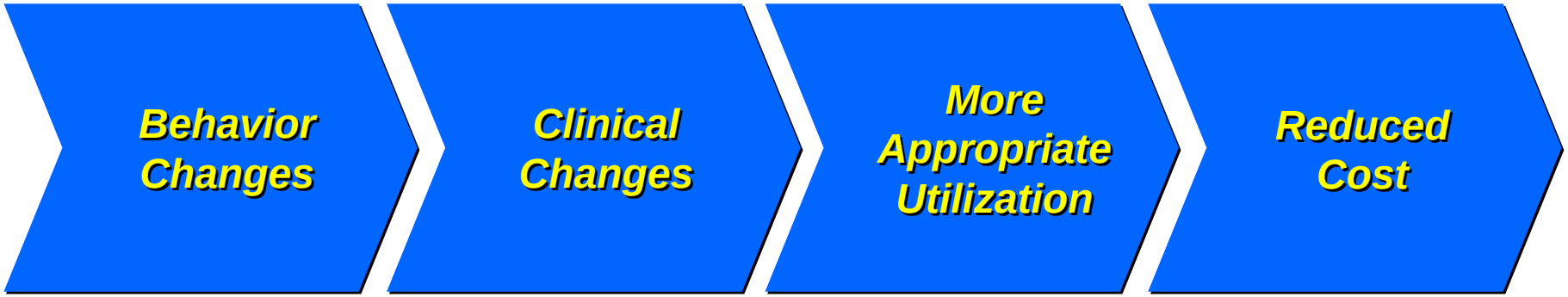
Methodology: Propensity Scores

Care Managed Patient	Propensity Score	Non-Care Managed Patient	Propensity Score
Patient A	1.0	Patient A	1.0
Patient B	1.0	Patient B	0.9
Patient C	1.0	Patient C	0.9
Patient D	0.9	Patient D	0.8
Patient E	0.9	Patient E	0.8
Patient F	0.8	Patient F	0.7



Care managed patients benchmarked against similar patients

Success Measurements



- Blood glucose self-monitoring
- Foot exam
- monitoring
- Weight and blood pressure monitoring
- Smoking cessation
- Medication adherence
- Asthma self-management

- Hemoglobin A1c
- Lipid profile
- Blood pressure
- COPD symptoms
- Asthma symptoms

- Eye exams
- Micro albumin testing
- ACE/ARB and beta blocker use
- Antibiotic prophylaxis
- Flu shots
- Fewer inpatient visits
- More medical and outpatient visits
- Fewer emergency department visits
- Fewer hospital readmissions

- PMPM changes

Effective and Dynamic Reporting

Program Dashboard	◆ Weekly summary of the activities of the program support team
Operational Reports	◆ Weekly reports of enrollment and other productivity measures
Lab Capture Reports	◆ Monthly reports of lab capture statistics by disease, geography and care manager
Self-reported Metrics Report	◆ Quarterly reports tracking aggregate movement in beneficiary behavior change
Outcomes Report	◆ Annual claims-based and self-report summary of behavioral, clinical and utilization status of beneficiaries, grouped by disease
Ad Hoc Reports	◆ Customized reports requested by AHCA, care team members, supervisors and the program support team addressing specific initiatives

Reporting Metrics

	Source	Target frequency		Methodology	Measure of improvement
		Patient collection	Care manager collection		
1. Diabetes:					
a. Hemoglobin A1c testing	Patient self-report, patient record, home lab kits or claims	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Percent increase in diabetics who obtained an HbA1c semi-annually
b. Blood glucose self-monitoring	Patient self-report	Daily	Semi-annually	Comparing baseline to most recent follow-up	Percent improvement in patients who report checking their blood sugar daily
c. Eye exam	Patient self-report, patient record, or claims	Annually	Semi-annually	Comparing baseline to most recent follow-up	Percent improvement in patients who get an eye exam annually
d. Lipid profile	Patient self-report, patient record, home lab kits or claims	Annually	Semi-annually	Comparing baseline to most recent follow-up	Percent increase in patients who obtained a lipid profile in past year
e. Foot exam	Self-report	Annually	Semi-annually	Comparing baseline to most recent follow-up	Percent increase in patients who obtained a foot exam in past year
2. Congestive Heart Failure					
a. Blood pressure control (BP<130/85)	Patient self-report or patient record	As needed based on patient's clinical status	Quarterly	Comparing baseline to most recent follow-up	Percent increase in patients with BP<130/85
b. Assessment of left ventricular ejection fraction	Patient self-report, patient record, or claims	As needed based on patient's clinical status	Quarterly	Comparing baseline to most recent follow-up	Percent increase with assessment of left ventricular ejection fraction
c. Use of angiotensin converting enzyme inhibitors (ACE-I)/angiotensin receptor blockers (ARB)	Patient self-report, patient record, or claims	Quarterly	Quarterly	Comparing baseline to most recent follow-up	Percent of patients on medication
d. Use of beta blockers	Patient self-report, patient record, or claims	Quarterly	Quarterly	Comparing baseline to most recent follow-up	Percent of patients on medication
3. Hypertension:					
a. Blood pressure control (BP<130/85)	Patient self-report or patient record	As needed based on patient's clinical status	Quarterly	Comparing baseline to most recent follow-up	Percent increase in patients with BP<130/85

Reporting Metrics

b. Lipid profile annually	Patient self-report, patient record, home lab kits or claims	Annually	Semi-annually	Comparing baseline to most recent follow-up	Percent increase in patients who obtained a lipid profile in past year
4. Asthma:					
a. Use of controller medication	Patient self-report, patient record, or claims	Quarterly	Quarterly	Comparing baseline to most recent follow-up	Percent of patients on medication
b. Use of beta agonist	Patient self-report, patient record, or claims	Quarterly	Quarterly	Comparing baseline to most recent follow-up	Percent of patients on medication
c. Asthma action plan	Patient self-report or patient record	Annually	Semi-annually	Comparing baseline to most recent follow-up	Percent of patients with an action plan
5. COPD:					
a. St. George Respiratory Questionnaire	Patient self-report questionnaire	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Improvement in SGRQ scores (Total, Symptom, Activity, and Impact)
b. COPD Symptoms (Cough, Shortness of Breath, Sputum)	Patient self-report or patient record	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Decrease in percent of patients experiencing symptoms
c. Spirometry	Patient self-report, patient record, or claims	Annually	Semi-annually	Comparing baseline to most recent follow-up	Percentage of patients with spirometry
6. ESRD					
a. Vascular Access Care (in conjunction with FL Fistula First Collaborative)	Patient self-report	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Standard care utilization and quality metrics
b. Infection rates	Patient self-report	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Standard care utilization and quality metrics
c. Occlusion rates	Patient self-report	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Standard care utilization and quality metrics
7. Sickle Cell					
a. member is using 3 or more self-management skills to support pain control	Patient self-report	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Standard care utilization and quality metrics
b. Ophthalmology Examinations	Patient self-report, patient record, or claims	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Standard care utilization and quality metrics

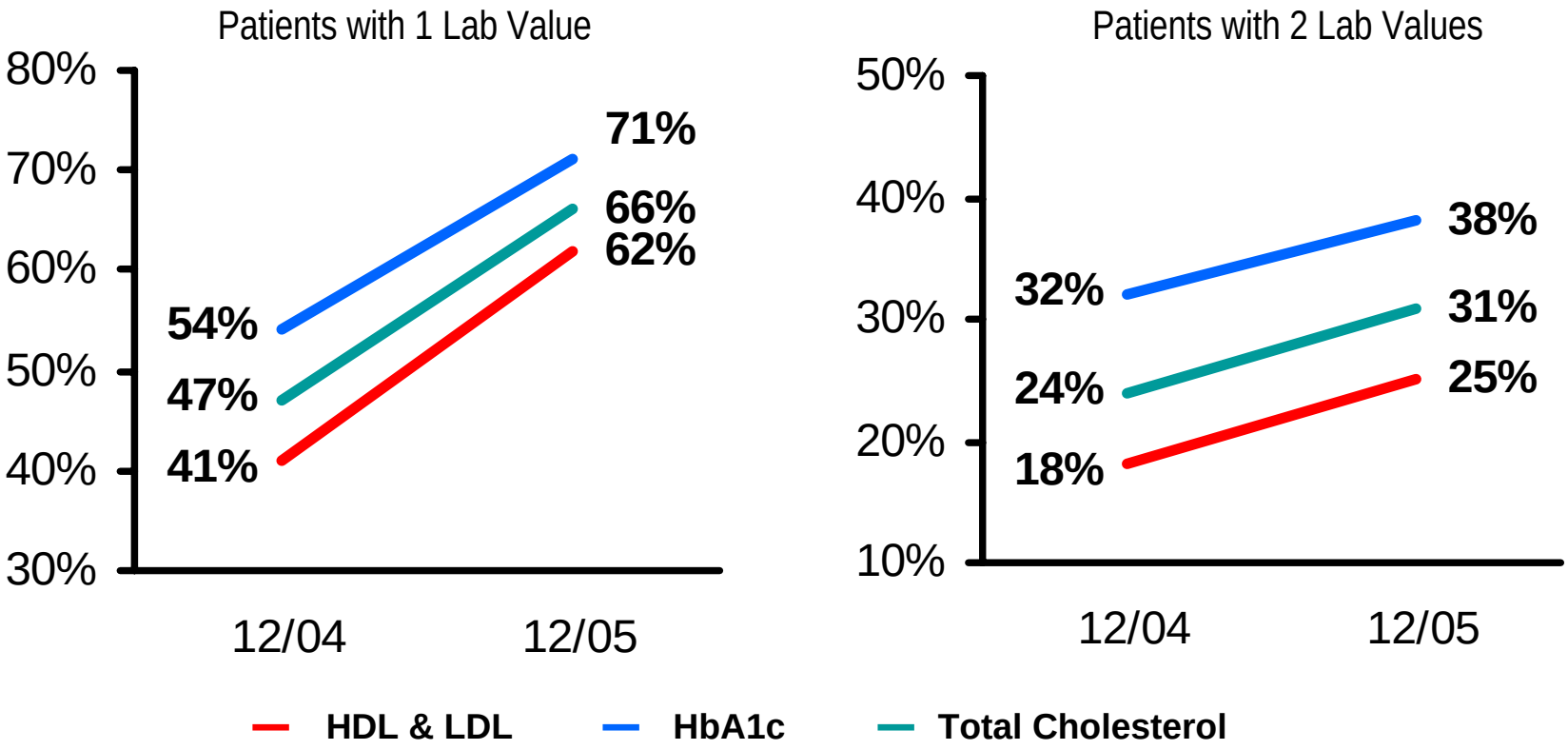
Reporting Metrics

c. member self-sufficiency score (Lorig score)[1]	Patient self-report	Semi-annually	Semi-annually	Comparing baseline to most recent follow-up	Standard care utilization and quality metrics
8. Overall:					
a. Body weight monitoring and / loss	Patient self-report or patient record	Daily	Quarterly	Comparing baseline to most recent follow-up	Percent increase in patients with BMI under 25 and under 30, percent drop in BMI mean
b. Medication regimen adherence	Patient self-report, patient record, or claims	NA	Quarterly	Comparing baseline to most recent follow-up	Decrease in Morisky medication compliance score
d. Smoking cessation	Patient self-report or patient record	NA	Semi-annually	Comparing baseline to most recent follow-up	Percent increase of patients not smoking
e. Flu shot annually	Patient self-report, patient record, or claims	Annually	Semi-annually	Comparing baseline to most recent follow-up	Percent increase of patients with flu shot

Lab Data Collection

Lab Data Collection

Enhanced Clinical Outcomes from Better Data Collection

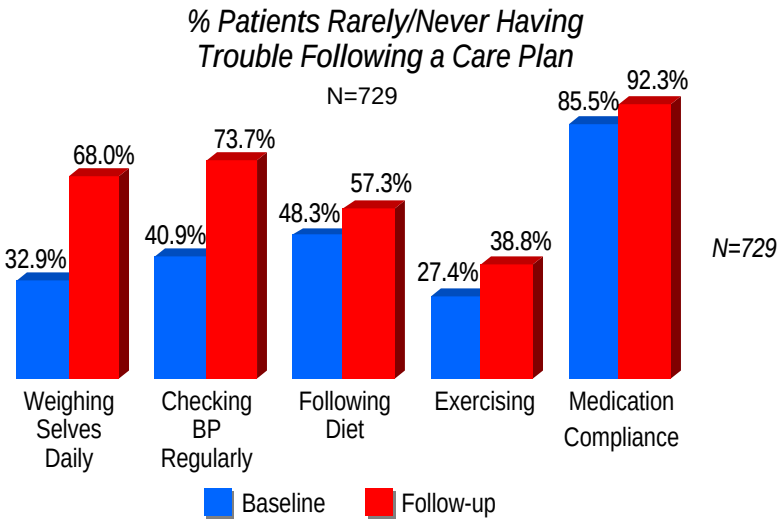


Source: InformaCare

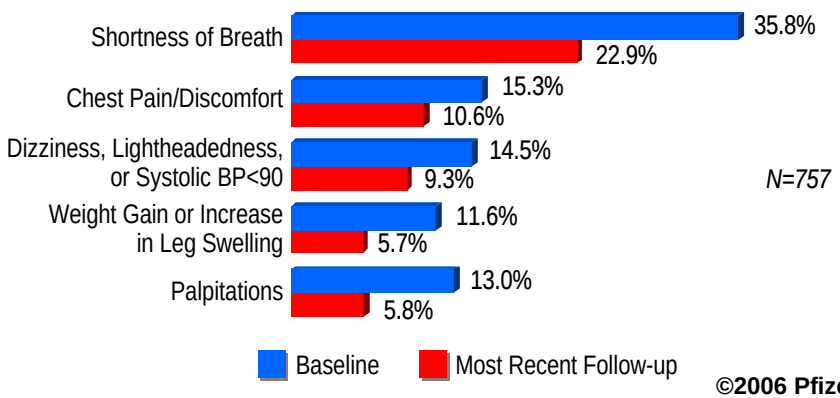
Note: Sample includes only patients who have been care managed for over six months. N (12/04) = 1,546; N (12/05) = 2,462.

Snapshot of Success: CHF

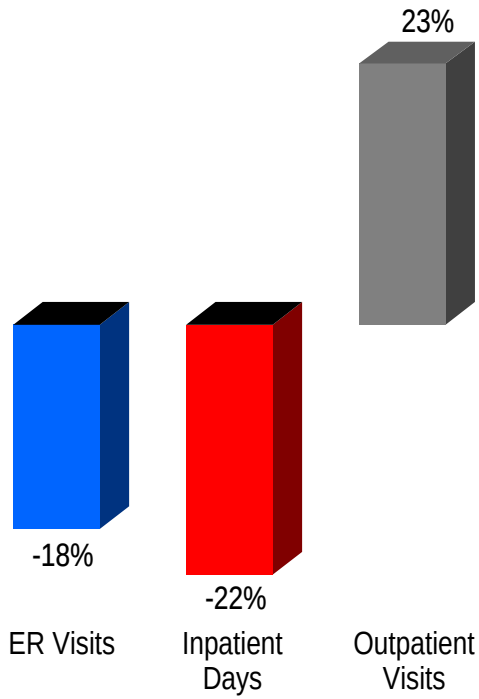
Improved Self-Care Abilities



Reduction in Acute Symptoms



Impact on Utilization



Note: Analyses show results through 12/04

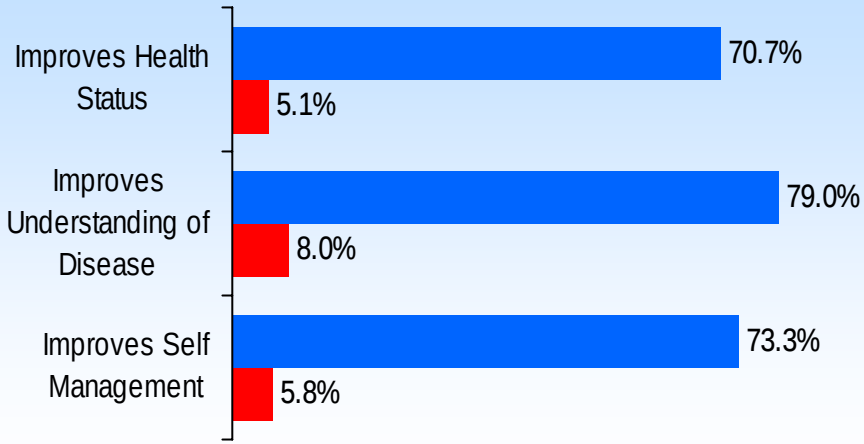
Buy-In from Physicians

Key Physician Satisfaction Indicators

Percentage of Physicians Very or Somewhat Likely to Recommend Program to…

Positive Program Impact on Patients

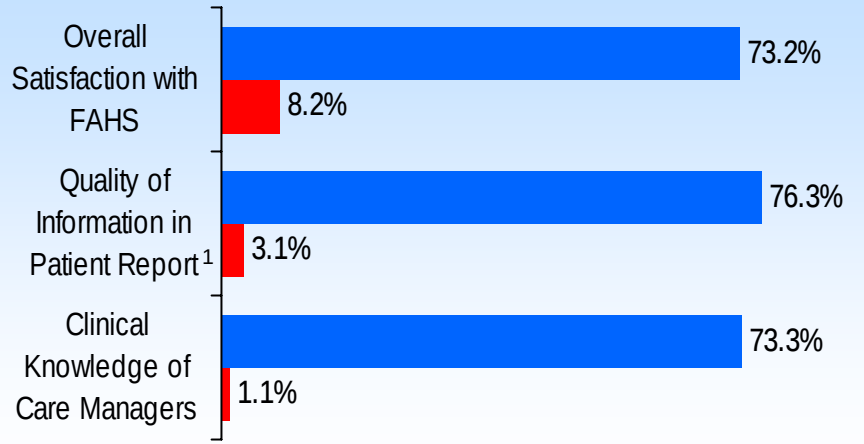
Percentage of Physicians Agreeing or Disagreeing



Strongly Disagree/Disagree Strongly Agree/Agree

High Overall Program Satisfaction

Percentage of Physicians Expressing Satisfaction



Dissatisfied/Very Dissatisfied Very Satisfied/Satisfied

Source: 2005 Provider Satisfaction Survey. N = 181 responding physician who had heard of FAHS.
[1] Patient reports are provided to physicians and reflect either acute care issues or periodic follow-up.

Pfizer *Healthy Directions*: Situation

- > 30 health plans throughout US
- > 100,000 colleagues and dependants
- Limited prior analysis
- Strategic imperative driven by chairman
- Little historic DM
- New program with multiple vendors

Pfizer *Healthy Directions*: Program Description

HRA Health Risk Assessment Personal Medical Data Health Status	**Know Your Health Status**
 Health Portal	**Easy Access to Health and Pfizer Information**
Risk Modification / Disease Management 	**Targeted Action to Improve Health Status**
 Health Advisor/ Advocate	**Live Advice, Navigation, and Issue Resolution Support**
On-Site Services 	**Convenient Access to Health & Wellness Services**
Data Warehouse 	**Understand Pfizer's Status and Measure Progress**

Data Aggregation

Several Health Plans

PBM

Eligibility

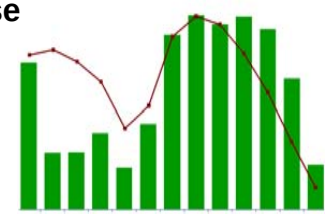
Disease Management

Lifestyle Management

Health Risk Assessment

Potential Others:
-EAP
-Norms
-Job Performance

Data Warehouse



- Manage data transfers from many sources
- Design and implement integrated data warehouse
- Offer reporting tool
- Design and generate regular reports
- Consult on findings; suggest opportunities

Reporting Lessons Learned

- Aggregate data as much as possible—no pain, no gain
- Focus and simplify
  - Reports
  - Findings
  - Internal and external communications
  - Resulting quality initiatives
- Strive for transparency
- Develop ad hoc reporting capabilities