FROM CHAOS TO COMPETENCY IN HEALTH BENEFITS

CORPORATE POPULATION HEALTH MANAGEMENT

BY SCOTT CONARD, MD

Trillions of dollars are being spent in America on inconsistent, expensive, confusing health care. An untoward consequence of this expensive care is corporate financial stress, reduced international competitiveness, and employee frustration with erosion of benefits and compensation. This article presents a proactive, employer driven model that utilizes current proven concepts in health care to overcome these challenges and reverse the adverse trends facing employers today.

FROM CHAOS TO COMPETENCY IN HEALTH BENEFITS

CORPORATE POPULATION HEALTH MANAGEMENT

BY SCOTT CONARD, MD

UNDERSTANDING THE CHALLENGE

The cost of health care continues to increase significantly with little relief in sight. Waiting for the system to solve the problem has become untenable for many companies as costs have become prohibitive. While the expenditures for employees using the system are high, waiting in the wings are the employees who follow the "if it isn't broken, don't fix it" mentality. They hold off engaging with the medical system until the last minute; often with the diagnosis of advanced chronic disease like heart failure and diabetes, late stage cancer, or in the emergency department with a heart attack, stroke, or other equally dismal health challenge. These employees literally go from spending nothing to tens of thousands of dollars annually. Of more concern is the subset of these employees who experience a sudden fatality.

Who can address and fix this broken system? The medical community has developed effective strategies – for example the Patient Centered Medical Home (PCMH) for primary care. This model asks primary care doctors to embrace and assume the central role to overcome the chaos and fragmentation so prevalent today. At the writing of this report over 20,000 primary care doctors have successfully re-engineered their practice and gained NCQA recognition. This requires a new management philosophy (team based care), information technology (electronic medical records), patient-experience focus, population level monitoring, and more comprehensive care responsibility (transitions of care and continuity of care). The cost of making this transition is high. Accomplishing this in the setting of static or declining financial resources (compensation at or less than increases in the cost of living) is leading to slow, inconsistent

THE 5/50 PHENOMENON

Consistently when health spend is evaluated, a small percent of the employees – usually 5 – 7% spend the majority of the money – 50-80% in a given calendar year. In addition there is a large group, often over 70% of employees, who fail to spend any money or spend less than $1000 per year.

The challenge is that every 14 – 18 months the employees in the high cost 5% group are replaced by members primarily from the 70% who have failed to keep up with and manage their health risk. Strategies to address this challenge are vital to corporate well-being.

adoption of this model. Research has shown that costs in a Patient Centered Medical Home are significantly lower. However in the fee for service environment this does not result in higher compensation for the primary care provider. Finding effective ways to reward and compensate these providers for investing to a PCMH is an immediate concern. Presently uncompensated services include telephonic and internet availability, transition of care management, continuity of care management, and more staffing for team based care. The time between investing the resources to become PCHM recognized and the development of increased compensation could result in financial collapse of desperately needed resources.

At a higher level, the concept of an Accountable Care Organization has been introduced and pilots have begun nationally. In a well-organized medical community, such as those seen in California or with large groups like the Mayo or Cleveland Clinics this model has been shown to have tremendous potential and effectiveness. Unfortunately for the majority of Americans, access to these systems is limited or impossible and the time needed to develop this level of medical management integration and sophistication is years away at best.

Challenges abound in health care today. On one end of the spectrum the range and sophistication of interventions are seemingly infinite and extremely promising. Demographic trends are driving more need for services with more chronic conditions and higher probability for cancer, heart disease, and other conditions. The medical system has found effective ways to address these challenges but is struggling within the current compensation models to implement the solution. In the meantime corporations are struggling under the stress of continually increasing financial and human resource challenges as employees inefficiently muddle their way through our current system. To summarize “we know what to do, but are not yet doing what we know.” The challenge is to effectively move from the current state to a future state that is known presently, but limited in its current offering. The question is how quickly will leaders within corporations and other health care funding organizations chose to move, how will they move, and how will they know if they are succeeding?

IDENTIFYING THE SOLUTION(S)

The solution to this challenge requires strategies to focus on different groups of employee’s needs. To illustrate this point a corporations population will be considered at three levels; (1) the first group is employees who are not spending any money or less than $1000/year; (2) second are those spending from $1000 to $10,000 annually; and (3) are those spending over $10,000/year. The goal is to get the employees into the right group and over time to develop system and processes to keep them in the lowest group possible. For instance a high risk employee in the 1st group is either not identified (off the radar screen) or is not receiving adequate care and would be best served in the $1000 - $10,000 group. This is contrasted with an employee that is in pain (say neck or back pain) who is bouncing from doctor to doctor getting expensive ineffective interventions and so is in the >$10,000 group but could easily be managed in the <$10,000 group with appropriate care.

Looked at from a slightly different perspective, there are three tasks that must be accomplished. First to the degree possible, the development of new disease must be prevented or diagnosed early and removed before it becomes a problem. Secondly the disease present in the population must be

managed efficiently and effectively. Finally, the employees must be supported in using the health care system to identify and use the highest quality, most effective, efficient medical providers possible.

How? The backbone of this effort is information – data compiled and presented in an actionable, understandable fashion. Armed with this, an employer can provide resources to "right size" the health care experience – employees getting the *right* care from the *right* provider, at the *right* place, and finally at the *right* cost.

Ironically the greatest challenge in this process may be the employees themselves. Afflicted with the current "I feel fine" epidemic they fail to appreciate that usually while cancer, heart disease, strokes, diabetes, anemia, diverticulosis and numerous other conditions are developing, the person feels "great" – until they fall off the cliff and are now chasing a severe condition with ominous consequences.

What is the key? Becoming informed and appreciating that "I feel fine" and "I am healthy" are not the same thing, and that they must actively investigate their level of health before they feel any symptoms or see any signs is the key. Once they understand what their key metrics mean, which ones to look at, and how often to look, often they will engage.

What is the challenge? The right information presented at the right time to the right person empowered to act on the information to solve his or her issue in the most effective, lowest cost way to go. Now the challenge is how to establish the system and which providers with whom to work.

Turning Data into Information

The first step is to aggregate the data and turn it into actionable information. What are the possible sources of data?

- Medical Claims information is a vital historical record of who has gotten what service from whom and for what. This "look in the rear view mirror" provides a strong foundation to inform probable future needs.
- To look forward and to risk stratify, biometrics often predict future problems. An example of this are the association of weight or body mass index (BMI) with future heart, diabetes, musculoskeletal, cancer, sleep apnea and other significant medical challenges.
- Corporate programs such as those offered for weight loss, stress and other chronic challenges both at a process level (who participated and for how long) and at

DATA SOURCES

Primary care providers get a very limited view of their patients. Corporations on the other hand have the potential to get a comprehensive picture. While the corporation can only view this data in aggregate, the ability to empower others with this data and thus to create an actionable, more complete picture offers tremendous potential. Possible sources of data include;

- Medical Claims
- Biometrics
- Corporate programs (wellness, stress)
- Fitness Assessments
- Health risk assessments
- Medical access information from hospitals and emergency rooms
- Clinical information e.g. from clinics or labs, and/or
- Pharmacy data

a metric level (weight, stress score, cholesterol level, blood pressure) can be incorporated.

- Fitness assessments from annual biometric testing or gym testing may be available at some larger employers.
- Health risk assessments provide important perceived health and wellness information as well as historical health, family, social and other information.
- Visit information from hospitals and emergency rooms has become available to some groups. Examples of this are notifications when patients check into the local ER or hospital allowing groups to ensure continuity and transitions of care.
- Clinical information can be obtained from associated near site/on site or community clinics for the latest weight, blood pressure or other findings.
- Laboratory feeds from major vendors like Quest and Lab Corp are key in moving from process oriented metrics to actual outcomes oriented metrics.
- Finally pharmacy data is available from major pharmacy benefit managers or insurance companies.

While not a comprehensive list of sources these are a good starting place for employers to consider as they move into a proactive mode for their population of employees.

Once these sources are collected and integrated, information can be available wherever it is needed; at the primary care doctor, specialist, hospital emergency room, the trainer at the gym, or the onsite nurse. The accumulation, integration, and the availability of the information reduce waste and inefficiency leading to improved health quality and costs.

The exact format and specifics of how this information is shared is flexible– whether dashboards, iPhone application, on the web or online through an employee or physician portal. What cannot be underemphasized is the importance of making the information available to the employees and their health care support and treatment team in a timely fashion. With the technological advances available today this is not only possible but relatively inexpensive.

Understanding Risk

The risk of the employees can be assessed with the information listed above:

- Are the employees using the healthcare system?
- How many of the employees have been screened for health conditions?
- What are the challenges they are confronting?
- What gaps in care exist (for example mammogram, cholesterol and blood sugar testing).
- What gaps in care exist for those with chronic disease?
- Who is trying to get help for pain or suffering without success?
- Who has seen a primary care provider?
- Who has had a physical?
- Which primary care providers are offering proactive, comprehensive, prevention based care?
- What are the discrepancies in cost within the community?
- Which employees appear to be using the emergency room as their primary care provider?
- Who is going to expensive, ineffective, or out of network providers?

The questions one could ask are many. What begins to emerge, with the information obtained is where resources need to be invested to support the employees. What emerges is the evidence of the deficiencies in the system - lack of care, fragmented/disorganized care, or significant variability in cost. In addition, the best in class providers for quality and cost can be identified and supported. This results in more employees utilizing and benefiting from their services.

IMPLEMENTING THE SOLUTION

Where to move next depends on the analysis, corporate size, risk

ASKING THE RIGHT QUESTIONS

Once the information is collected what questions need to be answered for the employe questions the right solutions begin to emerge.

- What are the gaps in care?
- Who is not engaged in the system?
- Who is lost in the system?
- Where are employees receiving low quality, fragmented care?
- Who are the best primary care providers in the system?
- What are the discrepancies in cost within the provider community?

VITAL SOLUTION COMPONENTS

Implementing a strategy of health system design, communication and identification of best in class, culturally acceptable interventions leads to reduction or elimination of health benefits cost increases. Necessary components include;

- Convenient high quality primary care
- Value based purchasing of high cost services and procedures
- Quality and cost transparency for employees
- Employee support for health system navigation during complex medical challenges
- Health benefit design to reduce barriers and increase engagement their health and well-being

tolerance, and motivation of the employer. When implemented over three to five years, a company transition from an inefficient challenge, to a well-designed system of care. Financially this change leads from double digit inflation to flat or even negative trends. *At the very least it insures that the money being spent is actually contributing to the health and wellness of the employees.*

The highest priority when considering where to focus resources and energy includes:

1. Primary Care. Identify and deploy a strategy at the locations of primary care - whether at an onsite/near site clinic or working with best in class community clinics
2. Transitions of Care. Support and coordinate continuity through transitions of care from specialists, imaging, and/or hospitals. Often these challenges occur for the employee during their most challenging times – ill or threatened by a serious issue – making the smooth functioning of these functions even more important to effective use of the system.
3. High Cost Procedure Management. For high cost imaging, treatment (radiation, chemotherapy), and/or surgery value based payment results in lower complications and cost. Evidence from the case based compensation initiatives have consistently resulted in 8 – 20% reductions in infections, readmissions, and complications. Paying for providers to practice inefficient and poorly organized medicine is not an option in creating value for employees. The old adage "you get what you pay for" has been proven unequivocally true in medicine.
4. Transparency. A strategy to introduce cost and quality transparency in making health decisions, in particular in a setting where they can receive logistical help with scheduling and coordinating care, allows "just in time" processing. Engaging the system in this manner has been shown to significantly reduce the hassle and cost to employees.
5. Engagement. All of the great processes and systems in the world won't work if employees don't engage. We have the tools to solve the health challenges. We must benefits that encourage and support appropriate use of the health system. We must continually re-invent within a corporation and medical setting. We need to communicate incentives and consequences. Health benefit design to encourage getting biometrics, establishing a primary care relationship, using the quality and cost transparency tools, and utilizing the value based contracts is required. While the advice of a friend or co-worker on the friendliness and perceived competence of medical professionals can lead to the right care being identified, a *data* based, informative, well designed, consistent system of care requires more structure, support and objective criteria. With this at our finger-tips, we are able provide the right care on which to place well-being and healthy life of all. Being incented to engage and use the system must be communicated and supported for it to be used consistently.

CONCLUSION

The significant transition from providing health insurance for employees, to ensuring that employees understand their risk, are engaged, and are empowered with a clear path to utilizing responsive, competent providers may seem daunting . However, trends over the last decade prove beyond a reasonable doubt that relying on the current system to find the answer condemns one to the current increasing cost and lower quality spiral. When corporations are armed with data, and identify and work with motivated, caring primary care and other medical providers, they will be able to lead their employees from expensive wasteful to valuable efficient care. While a new approach, this is occurring

today in a small measure within larger corporations or within collaborations of smaller corporations. Today we are seeing this transition begin as health care professionals and corporate leaders are beginning to work together to take the “baby steps” that are leading to the cure for our very ill and out of control system.

Scott Conard, MD DABFM, FAAFP
Corporate Healthcare Strategist
Converging Health
6211 W NW Highway
Suite 1003
Dallas, TX 75225
(817)691-4970
www.scottconard.com

Executive Assistant and Operations Lead;
Alyce Callahan
Alyce@scottconard.com
Phone: (469) 442-9977

