Issue Brief

Findings from HSC

INNOVATIONS IN PREVENTING AND MANAGING CHRONIC CONDITIONS: WHAT'S WORKING IN THE REAL WORLD?

By Alwyn Cassil

Wellness and prevention strategies are fast becoming a standard feature of employer-based health benefits in hopes of countering rapidly rising health care costs that drive higher insurance premiums. At the same time, payers and health care providers are experimenting with how to improve care coordination for high-cost patients with multiple chronic conditions, an ongoing challenge in the fragmented U.S. health care system. Promoting health and wellness and improving the care of people with chronic conditions offer promise in helping to improve the value of health care and control costs, according to experts at a Center for Studying Health System Change (HSC) conference titled, Innovations in Preventing and Managing Chronic Conditions: What's Working in the Real World? *Panelists explored how effective employer-sponsored wellness and prevention initiatives focus on health improvement as a business strategy and foster work and community environments that help people lower risk factors—smoking, diet, lack of exercise—that lead to disease. Panelists also discussed various models—centered on strong primary care—to improve care for people with chronic conditions.*

Shifting the U.S. Health Care System Focus from Sickness to Health

The prevalence of chronic conditions and obesity continues to increase in the U.S. population, fueling concerns about declining health and rising health care costs. For example, according to HSC's Health Tracking Household Survey, 39 percent of the U.S. working-age population in 2007 had at least one chronic condition, such as diabetes, up significantly from 35 percent in 2003 and 34 percent in 2001. Likewise, the proportion of working-age Americans classified as obese was 29 percent in 2007, up from 23 percent in 2003.

"Yet, we have a health care system that remains focused on episodic acute care and pays too little attention to helping people change unhealthy behaviors and improving the care of people with chronic conditions," said HSC President Paul B. Ginsburg, who moderated the conference.

Health as a Business Strategy

The cost of sickness in America is a threat to the country's economic security, as U.S. businesses burdened by high health care costs struggle to compete globally, according to D.W. Edington, Ph.D., professor and director of the University of Michigan's Health Management Research Center.

"Our whole country just waits for sickness, and then a lot of people make a lot of money," Edington said. "So nobody cares about health except for individuals themselves, and they don't even care, because they think, it's not going to happen to me."

Instead of waiting for workers to get sick, leading companies are shifting their focus from sickness to health, fostering work and community environments that help people lower risk factors—smoking, diet, lack of exercise—that lead to disease, he said. High-risk employees contribute disproportionately not only to health care cost, but also to absenteeism, disability and other costs.

"My advice to Americans is, just don't get worse, because we know the natural flow is to get worse," Edington said, adding, "Where do the high-risk people come from? They weren't born that way. Sixty percent of the people are low risk, and you doing nothing for them, you just wait for bad things to happen. They go from low risk to high risk to disease to high cost. Where's the investment?"

Companies, starting with strong leadership from the CEO and top management, have to integrate health into their cultures if they are going to help people lower risk factors that lead to disease, he said. "Individual behavior change is a good idea, but it doesn't work. You can't change enough people."

And, engaging the wider community is critical, Edington said, "because if the company changes and then people go back into the community, which is unhealthy, it'll destroy that, too, so you need that community change, as well."

Changing the Community

The tipping point to launch a community-wide health improvement initiative in southeast Michigan came in 1999 when local employers faced 40 percent increases in health insurance premiums, according to Amy Schultz, M.D., M.P.H., director of prevention and community health at Allegiance Health in Jackson, Mich.

The hospital system recognized that failure to control health care costs would lead to a vicious spiral of uninsurance, worsening health for the community and higher health costs, Schultz said. Working with Edington's center at the University of Michigan, Allegiance Health developed the "It's Your Life" program, with a key goal of engaging employers and employees in health improvement.

"Our focus was on employers and getting them to recognize the opportunity they have to impact and influence the health of their employees and how that is connected to the success of their business," she said. "And on the employees, getting them to recognize the responsibility they have for their health in the choices that they make."

While the program is now communitywide, Allegiance started with its own employees who, although health workers, had higher than average health risks. When Allegiance initially examined costs trends, about 70 percent of its workforce was low cost, and the next year, the proportion of low-cost workers was 53 percent. "We could see that our population was marching up that trend of higher and higher cost," Schultz said, adding, "We really subscribe to the philosophy of keeping healthy people healthy, really focusing in on that low-risk population and how we can help them maintain and improve their health rather than always fishing those people back out of high-risk categories."

Using a health coaching model, each employee has access to one-on-one assistance "to talk about where people are in their readiness to change, help them set goals, identify barriers, lots of referrals to other resources, providing a lot of support, and helping them evaluate progress and reset goals as needed," Schultz said.

Initially, particpating Allegiance employees received a $200 credit toward their health insurance, but the paycheck reduction in premium payments wasn't sufficiently visible to employees, and the health system switched to gift cards. After a few years, about 70 percent of Allegiance's 3,000 employees participated, and the health system added a premium differential where nonparticpating employees pay an additional 20 percent of the employee-only premium, or about $1,200 a year. Spouses covered by the system also must participate or pay higher premiums, and about 95 percent of the eligible population now participates, Schultz said.

Allegiance also added health track programs focused on smoking cessation and weight control, for example, and added requirements for age-, gender- and disease-specific recommended screening tests. Schultz stressed that helping people change unhealthy behaviors has to be targeted and customized to each individual, saying, "We really want to reach people where they are at."

By 2008, Allegiance saw its proportion of low-risk employees grow from 48 percent to 63 percent. "So rather than following the natural flow, where we would expect to lose people out of that population year after year, we've grown that population pretty significantly, which is we're on our way to achieving that cultural change," Shultz said.

Dismantling Silos

About a decade ago, facing cost pressures, North Carolina Medicaid officials decided to get more directly involved in how care was provided to Medicaid patients to improve quality and control costs, said L. Allen Dobson Jr., M.D., the state's former Medicaid director and now chairman of North Carolina Community Care Networks.

"When we went to the communities, we found…that we didn't have any real coordination at the local level, providers were just fragmented, and, worse yet, is that we had

created all these silo programs in the public sector that didn't really contribute to the overall health of the community," Dobson said.

Out of the disarray, Community Care of North Carolina (CCNC) was born— community-based networks of primary care providers that focus on quality, utilization and cost-effectiveness for patients enrolled in Medicaid and the Children's Health Insurance Program.

CCNC now has 15 networks with about 3,500 primary care physicians and a little more than 1,200 medical homes managing care for about 1 million patients. Each network has a medical director, a clinical coordinator, a steering committee, case managers and clinical pharmacists who help manage total populations. The networks receive per member, per month payments of $3 from the state, while each primary care physician receives $2.50 monthly per patient to serve as a medical home. North Carolina also has more generous Medicaid payments than many states, with payment rates at 95 percent of Medicare fee-for-service payments, a plus in attracting primary care physicians to care for Medicaid patients, Dobson said.

"We give the medical homes and the communities the resources, and we include as many of the resources that we have. So, if you are in a rural area, you may have a doctor and a pharmacist and a public health department as your entire health care system—that's it—and maybe a safety net hospital, maybe not, depending on the county," Dobson said. "In Charlotte, you have lots of health care resources, and the problem is different. It's not how to get resources to the community. It is how you make them all work together in a coherent fashion for a population."

Statewide priorities include asthma, diabetes, congestive heart failure, pharmacy management, dental screening, emergency department use and case management for high-cost, high-risk patients. "We allow our networks flexibility to really go in and look at their own needs and create change," he said.

The state's efforts to improve care coordination have more than offset the costs of operating the networks, Dobson said, adding, "The lesson learned here is small things taken to scale equal big dollars.

Our Legislature has been extremely smart because they have allowed reinvestment of some of these savings. It's not taking money out of the system; it is lowering the rate of growth."

Putting Patients in the Center

Three targets—improving quality, efficiency and patients' experience—drove Geisinger Health System's development of ProvenHealth Navigator, an integrated approach to managing the care of complex, chronically ill patients, said Janet Tomcavage, R.N., M.S.N., vice president for health services at Geisinger Health Plan.

Spread across 42 counties in central-northeastern Pennsylvania, the Geisinger Health System is an integrated delivery system with 750 physicians practicing in more than 40 community sites; three acute care hospitals; and a health plan with 227,000 members and contracts with 80 hospitals and 17,000 providers.

"What we're trying to do is take what a health plan does well and move it out to the community where the practices and patients are instead of keeping it centrally located, which has been the typical approach to disease management, case management in the past," Tomcavage said.

Initially, Geisinger started with a small group of Medicare Advantage patients and three primary care sites, conducting a baseline assessment of each practice and looking at where there were gaps in patient care and identifying populations within the practices' patients.

"It was pretty amazing that most sites had no clue of who their practice of Medicare patients was at their site," Tomcavage said. "They didn't know who was assigned to their panel or not assigned on any given day…. So, again, taking health plan data from a central repository and moving it out to the practice was very enlightening to the practice."

The goal is for the primary care practice to assume responsibility for identified patients "24 hour a day, 7 days a week, regardless of where the patients happen to be," she said. "So, if they are in a nursing home, the primary care team knows it and is managing the patient, even if the provider is not the direct provider of care."

"The role of government and probably industry…needs to be more directive at what this health care system needs to look like versus sitting back and hoping it will reform itself and just paying the bill."

—L. Allen Dobson, Jr., M.D., North Carolina Community Care Networks

"We very much believe in the patient in the center. Everybody says that, but it's very difficult to make happen. It doesn't happen overnight. It doesn't happen intuitively."

—Janet Tomcavage, Geisinger Health Plan

"You need to provide analytic tools to the provider, so they can make better decisions—a list of your diabetics that haven't had a hemoglobin A1C, a list of the patients that are not following your prescription, here's the other doctors that are writing scripts for your patients, that kind of thing."

—Stephen E. Saunders, M.D., APS Healthcare

This Issue Brief is based on an HSC conference—*Innovations in Preventing and Managing Chronic Conditions: What's Working in the Real World*—held April 8, 2009, in Washington, D.C. A full transcript of the conference is available at *www.hschange.org*.

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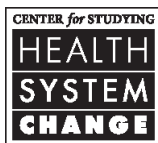L. Allen Dobson Jr., M.D.
North Carolina Community Care Networks

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Each practice has a nurse case manager paid for by the health plan but located in the primary care site and who provides direct access to high-risk patients and their families. The health plan also wanted to transform primary care from a transaction focus, fueled by fee-for-service payments, to a value focus. To that end, the health plan recognized that a new payment approach was needed.

"We didn't want any barriers to keep the practice from being able to make the change that they needed," Tomcavage said. "So we put dollars to the primary care providers up front and to the practice itself, and then we built a model around an incentive program that was based on efficiency but rewarded based on quality." The intensive focus on improving patient access and care coordination has paid off in significant declines in the rates of inpatient admissions and readmissions, she said.

The health plan has reinvested savings and, as of 2009, the Geisinger ProvenHealth Navigator program was in 25 primary care sites with 35,000 Medicare Advantage patients and 15,000 commercial members enrolled.

Targeting the Costliest Patients

While children constitute the bulk of Medicaid enrollees, the aged, blind and disabled adult population constitutes the majority of Medicaid spending, according to Stephen E. Saunders, M.D., M.P.H., chief medical officer, APS Healthcare, which contracts with scores of state Medicaid programs to operate disease management programs. And while many children are enrolled in Medicaid managed care plans, the disabled adult population typically remains in Medicaid fee for service, which is unmanaged, he said.

"These are a group of adults that have a high prevalence of chronic disease and a high prevalence of…serious mental illness issues," he said. "So that's really where a lot of states have focused their so-called disease management or total health management in Medicaid."

While traditional disease management programs have targeted patients, APS designs programs that also reach out to providers, Saunders said, adding, "What we try to do is work with the providers…to help identify gaps in care, gaps in medication management, gaps in laboratory management. That can be done by providing feedback and information back to providers in terms of patient profiles and other kinds of mechanisms."

To address gaps in care, APS gives Medicaid providers access to the electronic record used by the firm's nurse-health coaches so that providers can see the care plan developed with the member and the member's medication list.

"What we find often in Medicaid, unfortunately, is sometimes you have more than one prescriber or multiple prescribers for the same patient, and Dr. A doesn't know that Dr. B is prescribing even sometimes the same drug or the same class of drugs," Saunders said.

Physicians also receive incentives to get involved with the care plan and are rewarded if they meet certain quality benchmarks. For example, in Missouri, the state allows physicians who review patients' care plans to bill an extra $25 a month per patient. The state also provides up to $5,000 annually to each physician who meets defined quality metrics for patients—physicians can earn all or part of the bonus depending on how they do on individual quality measures, Saunders said.

The approach has reduced emergency department use and inpatient admissions, saving the state an estimated $150 million annually by reducing the growth in spending per Medicaid enrollee, he said.

"You need to develop your payment incentives to be in line with what you want to happen," Saunders said. "So what these states have done is they continue to pay the provider on a fee-for-service basis as they always have…. Then, on top of that, they provide this pay for performance and incentives, or pay for participation, over and above that." ∎