Population Health Management & Productivity: The Robin Hood Approach™

"Reinvesting savings from reducing the cost of care for the chronically ill into prevention and lifestyle change programs that will yield returns in health and performance gains"

April 8th 12:30  --  Ray Fabius, MD

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Today’s Agenda

• What is Population Health Management?
• What are key tenants to successful application of Population Health Management?
• How can Population Health Management Impact Productivity?
• Paying for Population Health Management in a zero sum game: The Robin Hood Approach™
**Population Health Management**

**Application Tools**

- **Well**
  - No Disease
    - Health Risk Assessment
    - Targeted Risk Reduction Programs
      - Risk Modeling
    - Incentives
    - Competitions
    - Ergonomics
- **At Risk**
  - (Obesity High Cholesterol)
    - Health Risk Assessment
    - Targeted Risk Reduction Programs
      - Risk Modeling
    - Incentives
    - Competitions
    - Ergonomics
- **Acute Illness/Discretionary Care**
  - (Doctor Visits Emergency Visits)
    - Nurse Advice Line
    - Web tools
    - Consumer Directed Health Plan
- **Chronic Illness**
  - (Diabetes Coronary Heart Disease)
    - Disease Management
    - Incentive Design
    - Self Management Training (Health Coaching)
- **Catastrophic**
  - (Head Injury Cancer)
    - Case Management
    - Decision Support
    - Predictive Modeling

15% members = 85% cost

85% members = 15% cost

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### Population Health Management Approach

<table>
<thead>
<tr>
<th>Healthy (Unknown)</th>
<th>At Risk</th>
<th>Acute / Episodic</th>
<th>Chronically Ill</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HRA/ Biometric Testing and Administration</td>
<td>• Health Coaching</td>
<td>• Scheduled/ Walk-in Visits</td>
<td>• On-Site Disease Management</td>
<td>• Emergency Response</td>
</tr>
<tr>
<td>• Lunch and Learns</td>
<td>• Patient Education</td>
<td>• Emergency Reponses</td>
<td>• Integrated DM</td>
<td>• Case Management</td>
</tr>
<tr>
<td>• Immunizations</td>
<td>• Program Management</td>
<td>• Referral Management</td>
<td>• Health Coaching</td>
<td>• Pharmacy Care Management</td>
</tr>
<tr>
<td>• Screenings</td>
<td>• Health Advocacy</td>
<td>• Pharmacy Care Management</td>
<td>• Patient Education</td>
<td>• Rehabilitation Management</td>
</tr>
</tbody>
</table>

### Face to Face with Trusted Clinicians
- Telephonic Coaching & Care Management
- Provider / Member Portal Content & Tools

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Seven Dimensions of Wellness

- Social
- Physical
- Emotional
- Career
- Intellectual
- Environmental
- Spiritual

Source: http://www.undstudenthealth.com
Swenson, John A., M.D.
The 5 Secrets of Population Health Management

- The Power of the Trusted Clinician
- The Value and Influence of a Culture of Health
- Producing Lasting Behavior Change
- Enhancing Outcomes through Integration
- Improving Population Health Status
Rating of Relationships

- Financial Advisor: 43%
- Pharmacist: 48%
- Co-Worker: 51%
- Spiritual Advisor: 56%
- Doctor: 78%
- Family: 95%

Source: Magee, J., *Relationship Based health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan*. 2003
The Secret Ingredient

The Trusted Clinician

The Doctor or Nurse or Pharmacist who works in your neighborhood or goes to work with you
The Power of The Trusted Clinician

Higher rates of engagement & retention

- Peer – reviewed publication
- DMAA best article of 2007
- Improved engagement & retention rates with integrated program
- Engagement rate related to depth of relationship
- Proven research influencing the marketplace
- Retention rate article will be in October issue of JPHM

![Graph showing engagement rates and retention rates for different categories of DM programs.](image)
How do Trusted Clinicians generate value?

Behavior Change

Improve lifestyle

Increase compliance
The Trusted Clinician’s Focus:
3 Levels of Wellness

Primary
- Lifestyle Change
- Immunizations
- Seat Belts

Secondary
- Compliance with guidelines
- Screenings
  - Cancer
  - Blood pressure
  - Cholesterol

Tertiary
- Compliance with Care
- Disease Management
How Does Population Health Management Effect Productivity?

- Health care – self-insured
- Workers Compensation
- Disability
- Absence
- Presenteeism
- Poor performance
How can you create a Culture of Health inside your company?

- Infrastructure
- Data
- Programs
- Assessment
- Integration
- Reproducibility
How can you create a Culture of Health inside your company?

- Champions
- Rack & Stack
- An environment of health
- Fitness
- Risk Assessment
- Risk Reduction
- Disease Management
- Proof of Concept
- Mainstream success
The **Total Cost of Illness**

Goetzel, et al. JOEM 2004

The chart illustrates the annual cost per employee (PEPY) for various conditions and related costs. The conditions and related costs include:

- **Allergy**
- **Arthritis**
- **Depression**
- **Diabetes**
- **Migraine**

The chart shows the breakdown of costs into different categories:

- **presenteeism**
- **absenteeism**
- **ST disability**
- **inpatient**
- **outpatient**
- **ER**
- **medications**

The total costs vary across different conditions, with depression and diabetes showing significantly higher costs compared to allergy and migraine. The chart highlights the comprehensive nature of the total cost of illness, emphasizing the financial impact of health-related expenses.
Health Risks: Cause Productivity Loss
Top 15 Drivers of Lost Work Time

Source: Kessler’s HPQ – Adjusted to Workforce

- Presenteeism
- Absence
Poor Health Impact on Employee Performance Outcomes

Lost to the workforce
- permanent disability
- early retirement due to health issues
- premature death
- spousal illness

Not at work
- unscheduled absence
- disability
- workers’ comp
- replacement workers

Not doing work on work time
- unscheduled breaks
- unfocused time
- health exams on work time
- information gathering

Not doing well while working
- errors
- complaints
- delays
- team breakdown

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Human Resource Goal: Find People with “The Skill & The Will” But What About Not Being Ill!
### The Robin Hood Effect at Large Manufacturer
**Saving Money Managing the Ill – Reinvesting in Wellness**

This study compares the cost of well and chronically ill active employee and dependent cohorts either cared for by our trusted clinicians at the workplace or receiving care randomly in the community.

We spent $488K more on the well subset we cared for and $692K less on the chronically ill.

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Healthcare Costs</th>
<th>MCD Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute &amp; Preventive Care</td>
<td>Workplace Care</td>
</tr>
<tr>
<td>CHD Meridian Physician Visits</td>
<td>$170</td>
<td>$3</td>
</tr>
<tr>
<td>Community Physician Visits</td>
<td>$331</td>
<td>$379</td>
</tr>
<tr>
<td>Total Physician Visits</td>
<td>$501</td>
<td>$382</td>
</tr>
<tr>
<td>CHD Meridian Rx</td>
<td>$223</td>
<td>$115</td>
</tr>
<tr>
<td>Community Rx</td>
<td>$31</td>
<td>$88</td>
</tr>
<tr>
<td>Total Pharmacy Rx</td>
<td>$255</td>
<td>$202</td>
</tr>
<tr>
<td>Facility</td>
<td>$381</td>
<td>$375</td>
</tr>
<tr>
<td>Total</td>
<td>$1,137</td>
<td>$959</td>
</tr>
<tr>
<td>Aggregate Costs (Savings)</td>
<td>$486,214</td>
<td>$ (691,777)</td>
</tr>
<tr>
<td>Net Aggregate</td>
<td>$ (205,563)</td>
<td></td>
</tr>
</tbody>
</table>
Clinical Outcomes for Health Center Users with Diabetes

Process Indicators Correlate with Outcomes (N = 336)

<table>
<thead>
<tr>
<th>LAB Value</th>
<th>2003 Year 1</th>
<th>2005 Year 3</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1C</td>
<td>9.1</td>
<td>7.8</td>
<td>-14.0%</td>
</tr>
<tr>
<td>HDL Cholesterol</td>
<td>43</td>
<td>47</td>
<td>+9.3%</td>
</tr>
<tr>
<td>LDL Cholesterol</td>
<td>138</td>
<td>108</td>
<td>-21.7%</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>288</td>
<td>201</td>
<td>-30.0%</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>131</td>
<td>126</td>
<td>-3.8%</td>
</tr>
</tbody>
</table>
Analysis of risk factors
predictive modeling indicate a significant reduction in risk of diabetes complications over the 2003-2005 period for diabetics under care

Prevented:
- 3 Amputations
- 2 Episodes of Blindness
- 6 Dialysis Patients
- 44 Heart Attacks & Strokes

Potential future economic impact
• reduced patient morbidity has been estimated at an average of $1,800 of avoided medical costs per patient per year (before inflation adjustment)
• Saved over 6 Million Dollars in direct medical costs alone by preventing these complications*

*Economic impact does not include impact on productivity or disability outcomes
Multiple Trusted Clinicians Working in Concert on Behalf of the Consumer
The Promise of a Medical Home: Integrating Care by “TrustedClinicians”
Today’s Agenda

- Population Health Management is attentive to the full spectrum of care from wellness to catastrophic illness
- There are key tenants to successful application of Population Health Management
- Population Health Management Can Impact Productivity
- Paying for Population Health Management in a zero sum game: The Robin Hood Approach™