

Measure, Manage, Engage and Save

An Overview of How Healthcare Performance Management Works

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Executive Summary:

During the mid 1980s, manufacturing giant Motorola developed an internal quality control process it dubbed “Six Sigma,” a method used to identify and eliminate manufacturing defects. The concepts behind the Six Sigma process clarified the role of quality control so well, they were widely adopted across the globe by companies, institutions and governments.

Today, the concepts of Six Sigma are reflected in initiatives designed to streamline a wide range of business processes. In healthcare, many aspects of Healthcare Performance Management reflect the Six Sigma movement. HPM has rapidly become a welcome addition to the corporate arsenal for containing ever-rising healthcare costs.

In many respects, the choice to move to an HPM system is increasingly driven by the frustration companies have experienced with the prevailing model of purchasing insurance through third-party-payer systems. Pursuing this method of providing employee health benefits is a growing challenge. Purchasers are typically in the dark about key cost components. This approach offers no insight on how the health of their workforce affects skyrocketing healthcare cost. And they have little visibility or control over what can and should be done to address the healthcare needs of their employees.

At the center of this problem is not a fundamental lack of claims data but a lack of will to provide data to stakeholders who can benefit most from the information derived. For myriad reasons, insurance providers (carriers) — who receive comprehensive contracts to cover a workforce pool in a healthcare plan — severely limit how much — if any — information is shared with employers who pay their premiums, often citing privacy laws and other risk management concerns. Thus, while paying third-party insurers to assume total responsibility for managing health claims — and risk — may seem convenient, it comes at a price: Employers sacrifice access to vital, aggregated information about employee health.

"One of the first things that must be overcome in the healthcare marketplace is the barrier that the insurance industry places in front of purchasers of healthcare to access meaningful data," says Scott Haas, vice president at the Wells Fargo Insurance Services USA. "In reality, the funding mechanism chosen by any given plan sponsor should be a function of available data being turned into information and business decisions made that are prudent and founded on knowledge. Being fully insured or self-insured should not be a decision driven by the size of an

Self-Funded vs. Full Insured:

Corporations are most familiar with fully insured health plans. Under a fully insured plan, premium rates paid by the company are fixed for a year, with monthly payments based on the number of employees enrolled in the company-sponsored health plan. In this arrangement, the insurer receiving the premiums pays healthcare claims based on the benefits purchased by the company. Individuals who make claims pay deductibles and co-payments according to the coverage that's provided.

In a self-funded program, companies pay claims costs incurred by covered individuals, which vary from month to month. Self-insurance allows employers to use actuarial analysis to determine how much money should be set aside to pay for future healthcare payments. Self-insured companies also pay fixed fees to administer the program and to cover the cost of a stop-loss plan designed to limit the company's expenses in the event of a catastrophic claim. Only companies employing a self-funded benefit program have the information and control available to implement a health-management performance system.

employer group, but rather the chosen risk transfer method based on consideration of all facts related to the group's own situation."

In response, a growing number of corporate buyers of healthcare coverage for their employees are choosing to self-insure, while embracing a new business discipline known as Healthcare Performance Management (HPM).¹ One of the hallmarks of HPM is a data "dashboard" that presents a comprehensive array of information about key trends in the health of the workforce and potential risks. Information like this helps employers answer critical questions, such as:

- What are my company's health plan medical expense trends?
- What areas show the highest potential for costly, future medical risks?

An HPM dashboard also provides insight into the effectiveness of programs that have been implemented to mitigate those risks. This performance data bridges key gaps in the traditional third-party payer system most companies use. It gives executives the tools they need to make more informed purchasing decisions and implement employee health management programs that lead to significant spending reductions, improved health outcomes and productivity increases.

The business discipline of HPM entails learning about and deploying four key elements which, when implemented, lead to better outcomes in terms of employee health and productivity, and in healthcare spending.

To better understand how HPM works, the editors of BizTechReports.Com interviewed experts at the Healthcare Performance Management Institute (www.hpminstitute.org). The institute focuses on the use of business technology and management principles that deliver better and more cost-effective healthcare benefits.

Toward that end, this paper explores the four pillars of HPM, which call on executives to effectively:

- Measure the key cost elements of healthcare spending
- Manage key aspects of healthcare spending and important health outcomes
- Engage employees and family members in material health improvement initiatives
- Save money through cost-avoidance, better workforce health and improved productivity

¹See HPM Institute white paper: "The Role of Healthcare Performance Management in Controlling Costs and Improving Quality in an Enterprise Environment."

Measure — The Perennial Prerequisite for Effective Management

Among the key provisions enacted by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 were statutes regarding the security and privacy of employee health data. Rather than ease the sharing of data between healthcare service providers by analog or digital means, HIPAA spurred many healthcare providers to hoard and store data rather than risk substantial fines for moving data without patient permission.

Consequently, in a typical enterprise, health benefits decision makers operate in a vacuum. They find it difficult to measure or analyze data that may be hard or impossible for them to obtain on a regular basis. The information that they do receive from full insurance providers is "fragmented," according to Judith Mueller, president of WellNet Interactive. This is true even when a company works with third parties — such as Employee Assistance Program (EAP) providers or wellness companies.

"Most of the time there's no centralized location that takes all of that information and is able to relate it to how the plan is managed overall," she explains.

Organizations that self-insure are allowed to access detailed information (in an anonymous and HIPAA-compliant manner) about the health of their workforce.

Following an emerging set of HPM best practices, these self-insurers can hire one or more third-party healthcare/wellness management providers to assist their employees with health services such as:

- Employee assistance programs
- Chronic disease management programs

- Biometric testing (examining such indicators as cholesterol, blood glucose, etc.)
- Weight management (and other lifestyle management programs, such as smoking cessation)
- Other programs that can proactively improve the health and well-being of a covered workforce

"Access to detailed data turned into information is critical," says George Pantos, executive director of the Healthcare Performance Management Institute.

To understand what is driving healthcare demand and thus costs, Pantos says organizations need this type of information to accurately assess the risk of chronic, acute and potentially catastrophic illness in the workforce.

"It is important for organizations that choose to proactively engage in the management of their health plans — which is arguably one of the fastest-growing line items in a corporate budget — to understand what percentage of employees exercise regularly, what percentage of employees are obese and what percentage of employees have stress-related or cardiac illnesses," he says.

In an organization that implements HPM, data can be housed in a data warehouse that acts as a central repository for analytic applications. Information can also reside in a federated environment.

This means that instead of aggregating information into a central repository that various applications can "mine" for analysis, various tools can dynamically query each application in its native environment.

Done properly, a federated strategy is more timely and less prone to error because it allows analytical tools to access the "native source" of the data.

Once data is gathered, organizations can examine cost trends of:

- pharmaceuticals
- medical treatment
- mental health treatment
- wellness programs
- other key cost elements in healthcare spending

In some instances, third-party data can be blended into the mix for the purpose of comparing one organization's experience to larger demographic populations.

For instance, executives can assess the annual number of catastrophic claims made by employees and determine whether they exceed national, regional or industry averages. Once baseline metrics are in place, organizations can trend the data to measure the success of interventions over time.

Manage — By Optimizing Performance of Self-Insurance Strategies

Raw data about the workforce's healthcare experience is fed into and normalized in an HPM software system — such as a data warehouse — for further analysis.

"That data can tell you an awful lot about the workforce's risk exposure," explains Pantos. Using predictive analytics methods, organizations are able to better assess their future healthcare obligations.

Human resource professionals (or other executives tasked with the proactive management of healthcare costs) are then able to meet with third-party healthcare providers on a regular basis to have much more meaningful discussions about workforce healthcare cost and outcomes trends.

HPM requires that organizations take a much broader look at the impact that

healthcare costs have on short-, mid- and long-term operations.

"Poor healthcare outcomes in a covered pool cost an employer much more than meets the eye," says Alexandra Cha, Ph.D., director of multivariate methods at Healthcare Interactive.

"Ineffective management of healthcare issues manifests itself in terms of loss of productivity, absenteeism, and loss of expertise. ... It costs employers much more than just a claim dollar when they have a sick employee."

That is why risk profiling is not an academic exercise. Corporate decision makers must translate the data that organizations have decided to track and measure, then turn it into an action plan that leads to a healthier workforce with higher worker productivity.

At the enterprise level, the first step is data collection, explains WellNet's Mueller. For organizations that self-insure, gathering that data is relatively straightforward, although it can flow in from multiple sources, particularly in the case of multi-location companies in which worker data is maintained on disparate systems in many different locations.

The second step is analyzing the data with HPM software applications — which are either custom-developed internally or licensed from third-party providers. These applications must have analytical engines tied to a database with querying and near-real-time reporting capabilities.

"The next step," says Mueller, "is to engage in predictive modeling, a process that is relatively new for most organizations. But this will allow executives to forecast with a high degree of certainty the risk exposure of a healthcare plan, and to identify the

categories of risk that are most likely to manifest themselves. You may find, for instance, that 78 or 80 people out of a workforce of 1000 are at a high risk of catastrophic heart illness. This can be extremely costly."

A simulator can then be used to project whether medical claims are generated for this group. There's a 54 percent chance that the plan will have, for example, \$4.4 million in cost exposure in year "X."

The simulator can then be used to examine what savings can be achieved. For example, savings can be projected if more enrollees use less-costly mail order drugs or less-expensive generic alternatives.

Timing is critical. It's better to understand and attempt to ameliorate risks before something happens to your workers. Mueller says that she has seen appropriate responses to such analytics prevent 10 catastrophic claims in one company.

"These were people whose blood pressure was so high that within days or even hours they would have had a massive stroke — and we got them emergency care to mitigate it immediately," she says.

The use of predictive modeling helps organizations better estimate quarterly or annual healthcare spending. It also improves a company's ability to make investments in targeted wellness, EAP and other programs designed to help improve the health of at-risk employees and to boost worker productivity as well.

"When you compile risk profiles that predict which members are going to incur costs in the future, then you can intervene before they incur high cost claims," says Healthcare Interactive's Cha. "In that sense, your risk prediction is not only giving you a

budgeting tool, but it also provides you with enough information to actually avoid the worst-case scenarios in your projected healthcare costs."

HPM also enables organizations to do a much better job of monitoring or administering the performance of third-party healthcare providers. HR administrators, working with financial analysts, for instance, can ask third-party providers tough questions about the:

- Accuracy of claims administration
- Need for duplicate tests
- Usage patterns of money-saving generic pharmaceuticals within their plan
- Whether plan participants are taking preventive steps in managing their own health — such as receiving their annual physical

Engage — Hearts, Minds and Good Pre-Bedside Manner

The core objective of an HPM strategy is to make headway on the cost-reduction goals organizations need to materially improve the health of individual employees and enrolled family members.

The catch is that they must:

- Motivate these plan participants to change their behavior and do it in a way that is compliant with key laws and regulations.
- Make certain that the strategy is clearly advantageous to participants and viewed as acceptable by the workforce.

To achieve this goal, many companies contract with third-party wellness providers to work directly with employees on a confidential basis to craft personalized health-improvement strategies.

The good news is that many employees are open to this form of intervention; they want their employers to coax them into taking better care of themselves.

According to a study of 2,500 workers by Towers Watson, an HR consultancy, two-thirds of employees are, in fact, trying to take better care of themselves. But a similar number of employees feel that their employers could do more to engender a “culture of health.”² In short, employees seem — in overwhelming numbers — open to availing themselves of corporate health-care initiatives that can help organizations cut costs, explains WellNet’s Mueller. That said, engaging employees about their health must be done in strict accordance with HIPAA privacy protections.

Providing people with incentives to participate, while in no way mandatory, is a proven way to popularize these programs. Some wellness programs offer cash incentives to participants who lose weight, quit smoking or even hit the gym three times a week. The key, though, is to set up an array of gateways for identifying employees who need help.

“Once we know who the at-risk people are, no matter how we identify them — whether through health-risk assessments, the biometric screenings or analysis of prescription and medical claims data,”³ says Mueller, “then we can implement a very proactive outreach to each of them.”

Explaining to employees that changing their habits can both improve their health and save the company money is a message that goes over surprisingly well. Workers

will often switch from brand name to generic drugs if asked. In some cases, employers have imposed higher co-pays on participants who ignore this request.

“Where the rubber meets the road is really in the member engagement,” says Mueller. “WellNet sees a 37 percent to 40 percent participation rate when there’s no incentive in place at all for a member to work with one of our care managers. When incentives are in place, however, participation jumps up significantly.”

There are many ways to engage with employees, and over a large population of health plan participants, a tailored mix of communication methods and intervention models will be called for to optimize program participation and, therefore, improved healthcare outcomes, coupled with reduced healthcare costs.

An effective engagement strategy will make available multiple points of contact, including:

- Automated digital healthcare coaching over the Web (in which a profile is set up and progress is tracked by the individual)
- Personal digital health coaching (with a live healthcare professional over the phone and/or the Web)
- Live personal contact with healthcare professionals
- Live group interactions with healthcare professionals and peers

Digital health coaching services are remarkably effective, according to Mueller. “Often these start with a series of health-risk assessment questions — data that is invaluable for building personal or aggregated health risk profiles. Then the program provides a step-by-step program tailored to the employee in areas such as

²<http://www.towerswatson.com/publications/strategy-at-work/1310>

³See the HPM Institute white paper entitled: “Rx Data Analysis Provides Critical Insight for Effective Healthcare Performance Management.”

managing weight, stress or fitness,” she explains.

HPM software can bring together the key stakeholders in an online “social network” that enhances an enrollee’s ability to manage healthcare through interactions with providers and others. The member engagement tool connects each employee with his/her doctor, nurse, care manager and retail pharmacists. On the desktop screen, employees can see their claims history, research a medical condition, chat with the care manager or plan specialist, access electronic medical records and communicate online with doctors. They can even use a special telemedicine feature to consult with local area providers while traveling in other cities.

Save — A Path to Cost Avoidance and Productivity Gains

Implementing an HPM program requires a serious organizational commitment to managing healthcare in a multifaceted way. Although health management isn't a core competency for most organizations, it's typically an overlooked area of potential cost containment. Organizations that undertake HPM embrace three key goals: improving employee health; optimizing health risk management; and targeting significant cost savings.

- **Self-Insure Intelligently.** For many companies, the cost savings will start by self-insuring to remove the costs associated with full-service insurance providers who are fundamentally unincented about making significant progress in healthcare cost reductions. But those cost reductions can only be realized if companies that self-insure effectively manage the range of third parties that will be needed to help administer claims, negotiate for dis-

counts with health providers, contract with networks and implement wellness or EAP programs.

- **Improve Healthcare Effectiveness and Efficiency.** Once those management tools are in place, organizations can use HPM to begin controlling costs by improving the effectiveness of healthcare services to those covered by the plan. "If we can manage the 20 percent of the people that are likely to consume 80 percent of the claims, and we can keep those medical expenses down, chances are that a healthcare plan is going to save money over traditional, fully insured programs," explains WellNet's Mueller.

For many organizations, a cost-benefit analysis is a necessary first step for implementing HPM or wellness programs. Healthcare Interactive's Cha contends that within an employee population, organizations can literally attach a dollar value to the risks and predictive incidences associated with certain diseases.

“If you can help even one participant to avoid cardiac problems, you can save tens of thousands of dollars per year. Armed with these analytical and actuarial insights, executives can make rational investments accordingly,” she says.

- **Digital Collaboration.** Another way HPM can help organizations manage costs is by using technology to reduce redundant tests or unnecessary procedures through improved collaboration. Are an employee's doctors sharing the results of expensive tests such as MRIs — or are doctors in different groups duplicating procedures or tests? HPM analysis can limit expensive mistakes.

- **Improved Productivity.** For some companies, the return on investment will be measured in terms of productivity, not just lower healthcare costs. Productivity gains may well be "the biggest incentive for employers," contends Wells Fargo's Haas. "The healthcare system has to ultimately come back to productivity and the value of productivity to the employer."
- **Healthcare Demand Reduction.** The ultimate underlying benefit of HPM, however, revolves around the notion that the more organizations engage employees in wellness and other health management programs, the greater the chance to reduce demand for expensive healthcare services. "Anything associated with making high-risk employees healthier will drive down cost," says Cha. "That's the core idea behind HPM programs — your organization's commitment will drive down costs, improve employee health and ultimately boost worker productivity."

Conclusion

As healthcare costs associated with traditional benefits management continue to rise — and rise fast — developing an organizational strategy to control these costs will become increasingly important. For private sector organizations, these rising costs represent a direct assault on profitability. For nonprofit and public sector agencies, the healthcare budget line item will divert important resources away from direct, mission-critical activities.

In this report, we have presented an operational framework for harnessing technologies and new business processes to control costs and improve outcomes. The principles that have been introduced can be implemented today and in the future — regardless of the direction that broader policies and government regulations take. A growing number of organizations are embracing this approach.

In the weeks and months to come, BizTechReports.Com will present specific case studies that illustrate both the challenges and opportunities associated with developing and implementing health-care performance management strategies.

About the HPM Institute

The Healthcare Performance Management Institute (HPM Institute) is a research and education organization dedicated to promoting the use of business technology and management principles that deliver better and more cost-effective healthcare benefits for employers who cover their employees. The institute's mission is to introduce and develop a new corporate discipline called healthcare performance management (HPM) — a technology-enabled business strategy that tackles the challenge of controlling healthcare costs and quality in much the same way that enterprises have optimized customer relations, supply chain management and enterprise resource management. HPM provides C-level executives with visibility and control over company healthcare benefits spending trends and risk-management postures, while protecting individual employee privacy. For more information, visit www.hpminstitute.org.

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