

## **A Community Health Partnership**

Communities, and more specifically employers, have spent years struggling to manage rapidly increasing health care costs. They have attempted to restrict overuse of medical services (utilization management, health maintenance organizations, and gatekeeper models) and to share the burden of providing coverage (premium contributions, co-payments and deductibles. For purposes of this discussion, the term employer is defined as public and private sector business and industry, finance, education, city and county government. Please refer to Attachment A.

Despite these efforts, the cost of providing health care benefits to consumers, employees and their dependents continues to increase. The Kaiser Family Foundation and the Health Research and Educational Trust found that in 2008, the average annual premium for employer sponsored health care was \$4,704 for single coverage and \$12,680 for family-coverage, more than 115 percent jump since 1999. Despite or because of the high cost of providing health care, an estimated 46 million Americans are uninsured, and that number is likely to climb as the economic crisis continues. Talk of reform is resurging. As Congress drafts structural changes to the overall health care system, benefit plan design change initiatives at the employer level are being examined as well.

One approach, a community focused, value-based health benefit design, is attracting attention. This concept focuses on the individual and works to maximize his or her overall health and quality of life. It embraces the core value of community accountability. Please refer to Attachment B.

### **Managing the Costs of Aging and Chronic Conditions**

Communities are facing the potential for even greater health claims costs as aging consumers contend with illnesses and chronic conditions, and younger individuals enter the workforce less healthy than previous generations. Chronic conditions, if not prevented or controlled, can lead to costly emergency room visits and hospitalizations, surgeries, complications and the onset of related diseases.

The true cost of a health condition to any employer-involves both direct medical expenses and indirect workplace costs. Direct expenses involve the claims costs for medical and pharmaceutical interventions. While direct costs can be high, they can pale in comparison to indirect costs relating to lost time and productivity due to unscheduled absences, short and long term disability, workers compensation and absenteeism (a decrease in job performance due to a health-related condition). For example for every one dollar paid on a workers compensation claim, the employer will incur four dollars in indirect costs.

### **Value-Based Health Care**

Value-based health benefit design is a holistic, consumer centered approach that focuses not on the actual dollars being spent, but on how the dollars being spent work to improve consumer's health. For employers, healthier and more productive employees result in a better return on health care investment, positively impacting a business's bottom line.

The first step is to create a culture of health within a community - a positive environment that supports and encourages physical, emotional and financial health among consumers. For

employers, healthy, satisfied employees are valuable assets, and successful companies offer them the means to attain an enhanced quality of life. City and County government, community leaders in the sectors of finance and education, and senior management in business and industry must champion the cause and be active participants in the endeavor.

### **Consumer Education and Accountability**

With this type of value-based system, the consumer receives educational resources and tools combined with health improvement, programs such as disease and case management, personal care coaches and wellness programs. The goal of the community health partnership is to help healthy individuals maintain, at-risk individuals improve and ill individuals manage their health. Attachment C references potential consumer education initiatives through interdisciplinary collaboration.

Consumers are encouraged to become the primary person responsible for their own health. Through education, support and tools, they understand their diagnosis and course of treatment and subsequent plan of care. They become part of their medical team and participate in decision-making. They are aware of the costs of services and are encouraged to choose high quality care. Healthcare providers can help by providing nurse advice lines, a case manager or a health coach to assist consumers on their medical journey. A study through the Kaiser Family Foundation indicates that function outcomes consistently improve and lower costs are incurred when the consumer actively participates in their healthcare decision-making.

Focusing on chronic conditions such as diabetes, asthma, hypertension and high cholesterol, the city of, Asheville, NC, implemented a value-based initiative in 1996. Employees with these conditions received intensive education and were teamed with pharmacists to ensure prescription compliance and improve health outcomes. While the city saw an increase in claims costs for prescription drugs, an analysis of the diabetes care program showed a decrease in mean per patient per year prescription and insurance claims costs, declining from \$7,082 before program implementation to \$4,651 in the fifth year. On the average, the number of sick days taken per employee per year decreased from 12.6 to six.

### **Health Benefit Design and Reallocation**

Value-based initiatives may involve a redesign in benefit plan cost-sharing levels to incent individuals to seek proper treatment and effective therapies, and to comply with medical advice. Benefit coverage levels may be changed to provide no-cost health equipment or supplies to manage chronic conditions. As an example, an employer can reduce the copayment for a maintenance prescription drug to encourage an employee to adhere to prescription directions. Pitney Bowes Inc., Stamford, CT., moved prescription drugs used to treat chronic conditions to a lower cost-share tier and saw improved refill rates.

To reinforce the importance of becoming a stakeholder in medical decision making, some communities and health plans are providing individuals with electronic personal health records (PHRs). PHRs are used to store information from individual and family medical histories and to track an individual's medical conditions, hospitalizations, medical test

results, doctor visits, medications and related activities. Despite security and accuracy concerns, supporters of this technology feel that ready access to the information contained in PHRs will lead to improvements in patient care and community health status.

Some employers are embracing the idea of personal health records. IBM Corp., Armonk, NY, is making them available to employees as a way to reinforce individuals' involvement in their own care and reduce medical errors. A coalition of employers - including AT&T, BP America, Intel Corp. and Pitney Bowes - have joined together to develop a data warehouse to store employee electronic personal health records.

### **Continuum of Care and Access to Quality**

Access to high-quality medical services and providers is imperative in a value-based health care model. Evidence-based medicine identifies the best course of treatment for a diagnosis. Individuals are encouraged to make use of services with high clinical value. Health coaches, navigators and case managers can guide patients through the health care continuum while identifying high-quality providers.

Employers may offer incentives for their workers to visit health providers with a history of positive outcomes. For example, supermarket chain Hannaford Bros. Co., Scarborough, ME, urges employees to seek care at hospitals determined to be centers of excellence by offering a reduced co-payment.

United Food and Commercial Workers Local 1546 in Chicago provides a medical center box pharmacy for its members and their families. Members receive a wide array of medical and dental services, including access to primary care physicians and specialists, lab and diagnostic services and therapies. A managed care department provides access to navigators who assist members needing further testing or hospitalization. The center negotiates directly with area hospitals. Members choosing one of these hospitals have one hundred percent of the bill paid by the plan. Designed to provide easy access to quality health care professionals, the center maintains both the health and productivity of members while being cost-effective for employers.

Some employers are considering a switch to a medical home model that involves an ongoing relationship between a patient and a personal physician who oversees all aspects of his or her care. This coordinated-care approach can eliminate duplicative or conflicting services and therapies, while providing skilled care. One employer making use of this model is the Mayo Clinic, Rochester, MN. Employees who coordinate their care through their primary care physicians are freed from co-payments.

The medical home model is supported through a network of healthcare providers. The network, in turn, is supported by an integrated computer information system to make the health care delivery system more efficient, create a continuum of care, while promoting healthier lifestyles for healthier communities. Stakeholders identify useful system information and streamline support for their efforts. Ultimately, this regional service reporting system is utilized by state and federal entities to provide the basis for meeting health care goals on a larger scale.

The provider of information technology resources must be capable of integrating existing systems and information, to provide a cost effective solution. Choosing this provider must be driven by knowledge of these existing systems, understanding the needs of users, and the ability to bring them together in a manner that serves the needs of the stakeholders.

### **Data Driven**

Value-based medicine begins by using data and technology to identify consumers with established or newly diagnosed chronic conditions or those at high risk to develop such conditions. Data and technology are also used to identify chronic conditions that are costly or responsible for activity restricting problems. Specifically, employers and health plans are analyzing health and prescription claims as well as short-term and long-term disability, workers' compensation and absenteeism rates to identify high cost conditions. This data mining also reveals efficiencies and problems in the health plan's design, providers' clinical outcomes and gaps in individuals' treatments.

Some employers and health plans are turning to predictive modeling a strategy that uses claims data and lifestyle analytics to identify potential catastrophic claims and disease states. Many employers are asking employees to participate in a health risk assessment, a tool that collects an individual's health data via questionnaire and testing. This collected data can assist in identifying needed workplace health improvement programs.

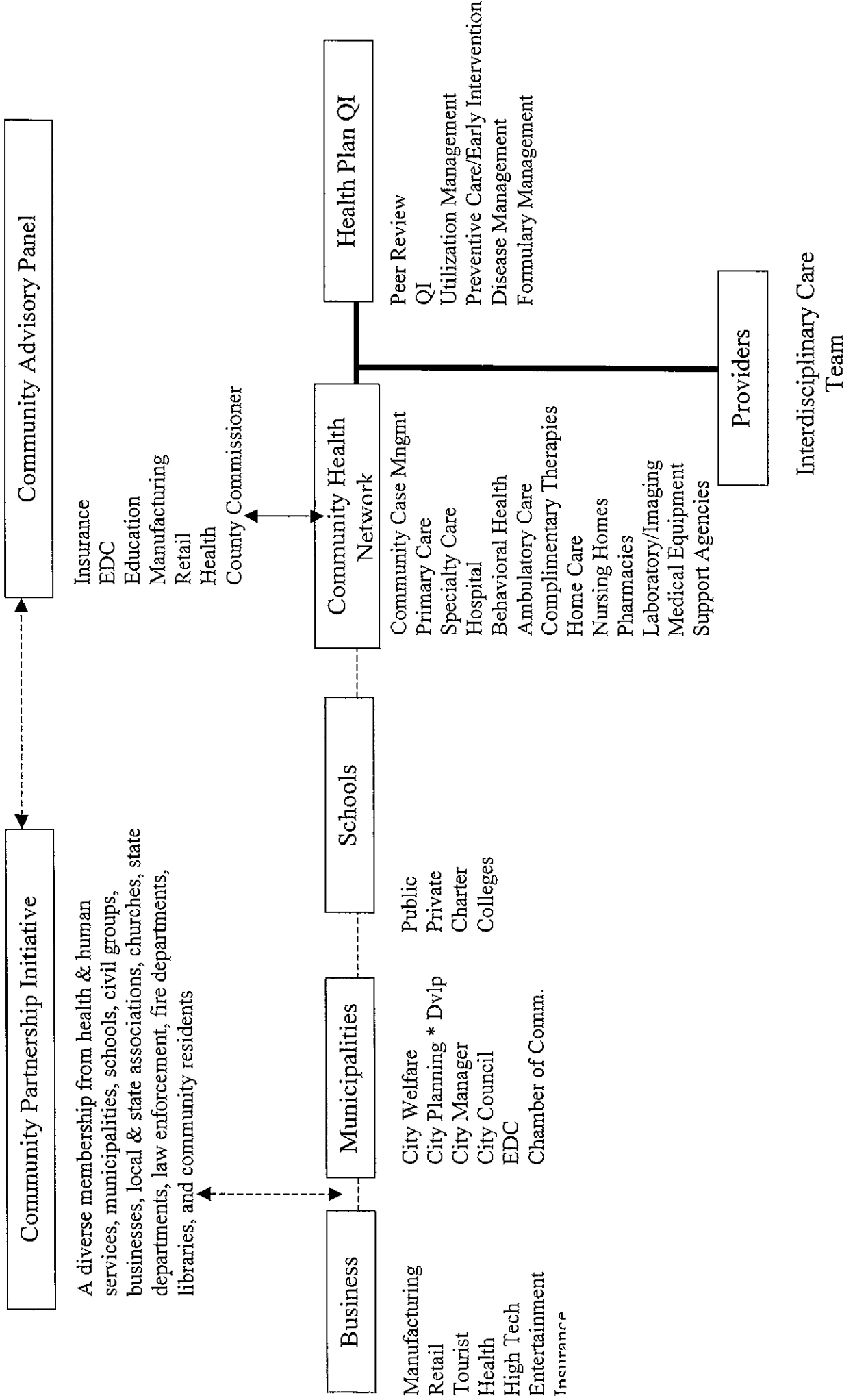
Implementing a value-based health design can be challenging. Communities and employers may see an initial increase in costs as there are changes in the cost-share structure and preventive and care maintenance processes are set in place. As improvement in an individual's health status takes time, seeing a positive return on investment. A value-based design may also cause administrative and employee relations challenges. Communities and employers who have implemented value-based initiatives have experienced positive results in productivity levels and overall employee health. The Franklin Community Health Network publicly publishes the gains it has achieved and the resultant financial impact on local businesses.

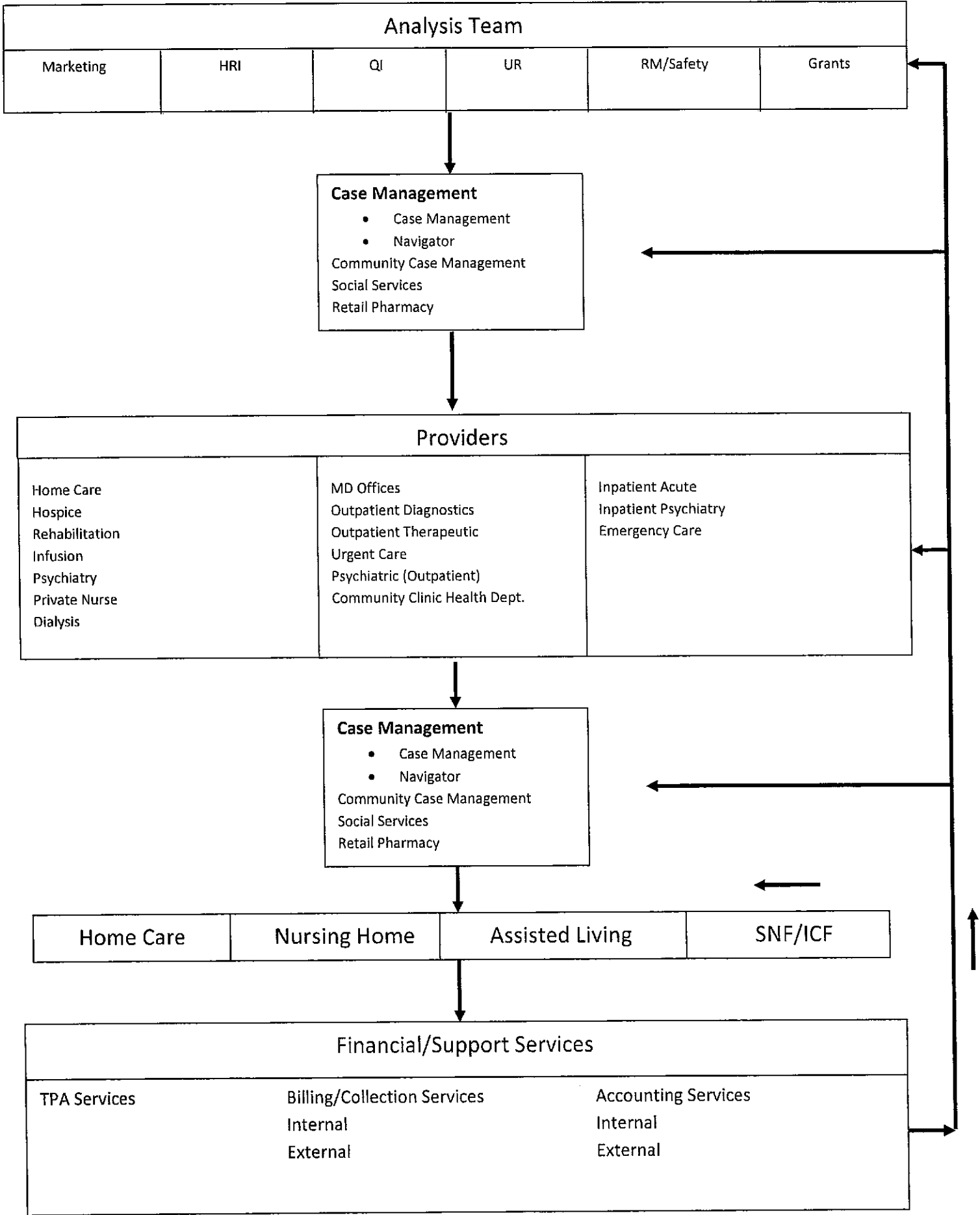
### **Conclusion**

Changing the structure of the healthcare system alone will not change the health care cost and delivery problems facing the United States, let alone Brevard County. County wide provider coordination and health plan design change initiatives are necessary, especially initiatives that focus on achieving and maintaining consumer health and enhanced quality of life. As the current financial crisis drives shrinking workforces, employee well-being and productivity are more important than ever. Preventive care and effective medical therapies lead to declining rates of illness and absenteeism. Challenging economic times require efficient and positive health spending.

# Attachment B COMMUNITY HEALTH PARTNERSHIP

## Governance Structure





**Analysis Team**

Marketing	HRI	QI	UR	RM/Safety	Grants
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**Case Management**

- Case Management
- Navigator

Community Case Management  
Social Services  
Retail Pharmacy

**Providers**

Home Care Hospice Rehabilitation Infusion Psychiatry Private Nurse Dialysis	MD Offices Outpatient Diagnostics Outpatient Therapeutic Urgent Care Psychiatric (Outpatient) Community Clinic Health Dept.	Inpatient Acute Inpatient Psychiatry Emergency Care
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**Case Management**

- Case Management
- Navigator

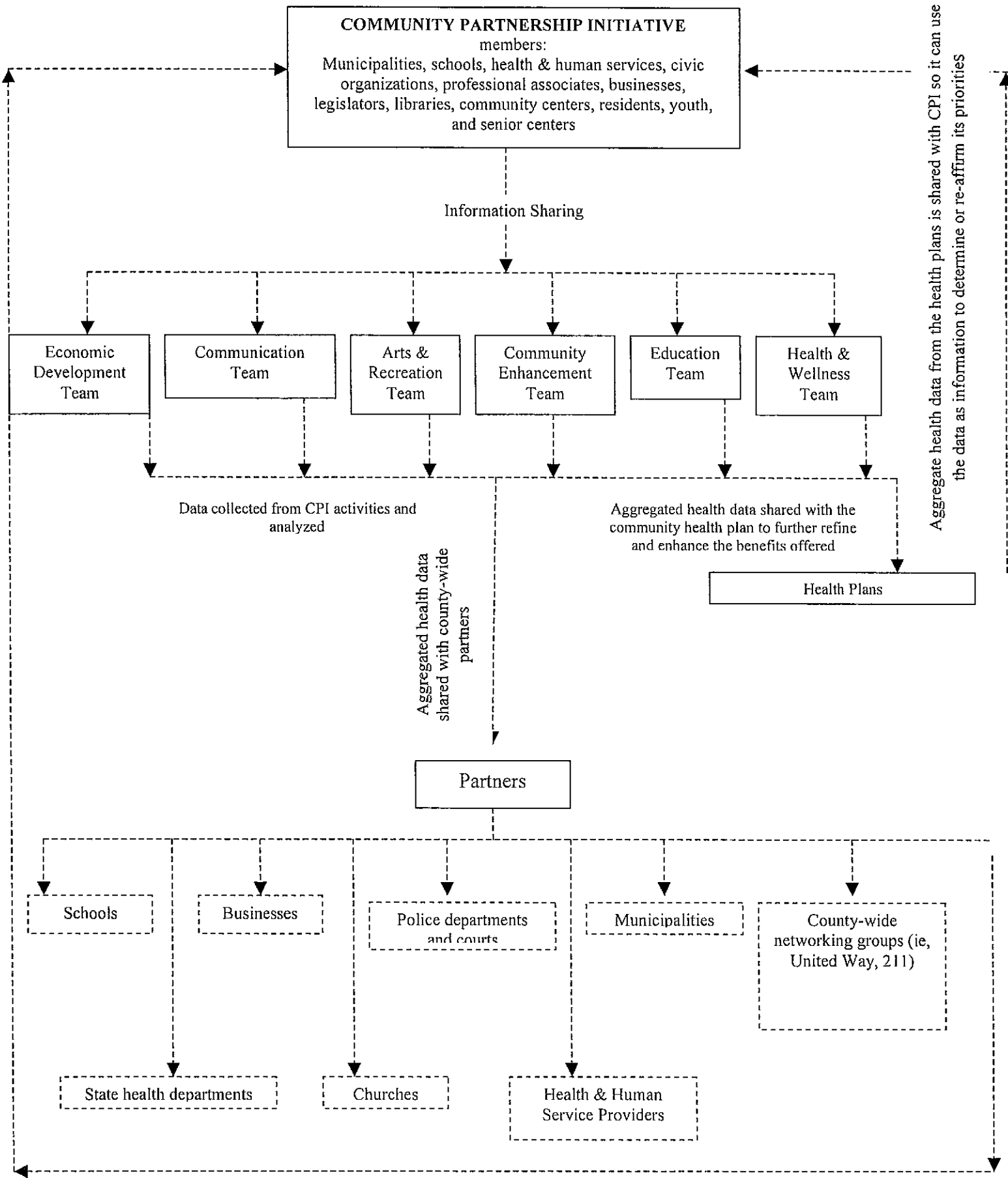
Community Case Management  
Social Services  
Retail Pharmacy

Home Care	Nursing Home	Assisted Living	SNF/ICF
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**Financial/Support Services**

TPA Services	Billing/Collection Services	Accounting Services
	Internal	Internal
	External	External

# Attachment A Brevard County Model



Coordinated information shared back to CPI to determine or re-affirm its priorities