vitalincite

Population Health Solutions

Healthcare Providers Are Empowered to Manage the Other Side of Healthcare: Their Own

A healthcare provider organization realized the importance of providing top care and decided it was time for some changes and to take control of their benefits plan. With that, the group hired a benefit advisory firm, who specializes in using healthcare data to drive plan design. One of the first steps in taking control was switching from a fully-funded to self-funded structure, which opened the opportunity to gain access to data and have more control over their plan design. Using data, the Employer and the Benefit Advisor quickly learned members were not taking full advantage of preventative medicine, rates of ER utilization and polypharmacy risk were climbing, and medical and pharmacy spend was increasing higher than national trends. Together, they strategically used data to roll out several strategies that have had a significant impact on plan spend and improving members' health.

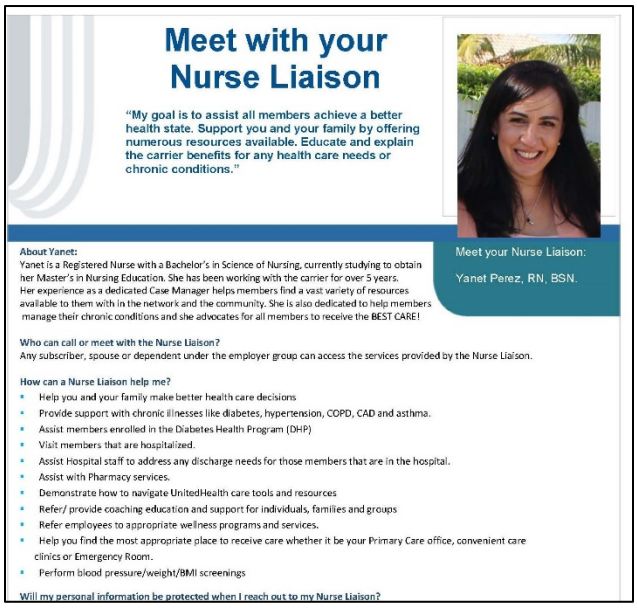
On initial examination of the data, the group quickly learned that although this group was comprised of healthcare professionals, it was clear they were not taking time to care for themselves and prioritizing their own preventative care (**Figure 1**).

Figure 1: Preventative Medicine Compliance, Pre-Wellness Campaigns

	Adult Physical			Two Year Mammogram*		
	2014	Vital Incite Book of Business	Best in Class in One Year	2014	Vital Incite Book of Business	Best in Class in One Year
% Compliance	47%	38%	79%	35%	59%	79%

The first strategic approach was to incentivize annual physicals with a premium credit to encourage primary care and in turn better identify the population's risk for future planning. The group noticed an immediate impact with a 22% increase in annual physical compliance and a 13% increase in overall primary care utilization in the first year. However, they did not expect a coinciding rise in chronic disease identification and in turn increased costs associated with these diseases.

To address these increasing trends and higher demand for care, the advisors worked with their carrier to implement a Nurse Liaison and Health Coordinator. The Benefit Advisor and the Employer devoted significant effort toward ensuring their employees and family members understood their roles so members would be more likely to take advantage of their services. The carrier team used the Vital Incite data to identify the at-risk populations to focus efforts and resources, as well as be available to help with any individual needs. The Nurse Liaison has a blended role of connecting virtually and in-person with members to direct them to high-quality, cost-efficient providers, help improve disease management, coordinate care on complicated cases and provide health coaching to



Meet with your Nurse Liaison

"My goal is to assist all members achieve a better health state. Support you and your family by offering numerous resources available. Educate and explain the carrier benefits for any health care needs or chronic conditions."

Meet your Nurse Liaison:

Yanet Perez, RN, BSN.

About Yanet:
Yanet is a Registered Nurse with a Bachelor's in Science of Nursing, currently studying to obtain her Master's in Nursing Education. She has been working with the carrier for over 5 years. Her experience as a dedicated Case Manager helps members find a vast variety of resources available to them with in the network and the community. She is also dedicated to help members manage their chronic conditions and she advocates for all members to receive the BEST CARE!

Who can call or meet with the Nurse Liaison?
Any subscriber, spouse or dependent under the employer group can access the services provided by the Nurse Liaison.

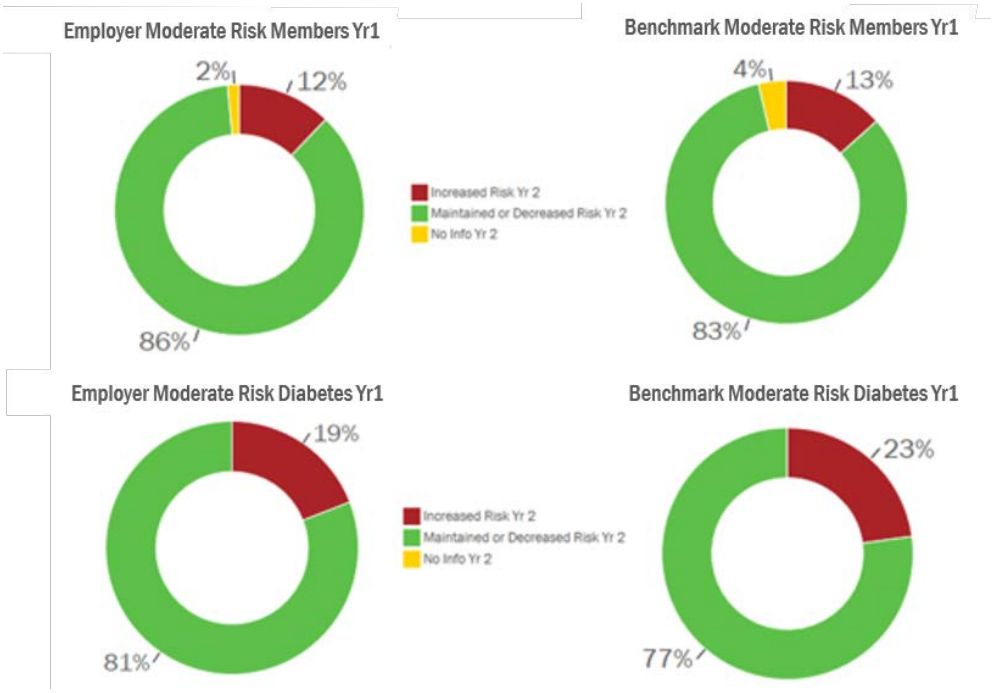
How can a Nurse Liaison help me?
- Help you and your family make better health care decisions
- Provide support with chronic illnesses like diabetes, hypertension, COPD, CAD and asthma.
- Assist members enrolled in the Diabetes Health Program (DHP)
- Visit members that are hospitalized.
- Assist Hospital staff to address any discharge needs for those members that are in the hospital.
- Assist with Pharmacy services.
- Demonstrate how to navigate UnitedHealth care tools and resources
- Refer/ provide coaching education and support for individuals, families and groups
- Refer employees to appropriate wellness programs and services.
- Help you find the most appropriate place to receive care whether it be your Primary Care office, convenient care clinics or Emergency Room.
- Perform blood pressure/weight/BMI screenings

Will my personal information be protected when I reach out to my Nurse Liaison?

improve lifestyle choices. Initially, redirection of care from one costly, less efficient hospital system was critical.

With more identification of risk, the group quickly realized the importance of improving care to help their people manage chronic conditions. They noted an uncontrolled diabetic would cost the plan $9,500 more per year than a controlled diabetic. Of course, as healthcare providers, they realized cost related to disease burden was even greater for their members. Therefore, the Health Coordinator focused on monthly wellness campaigns targeting lifestyle management education as well as providing health coaching to members in their chronic condition care program. Between 2017 and 2018, the group began seeing an improvement in risk management compared to the prior year and is now controlling chronic conditions better than benchmark (**Figure 2**).

Figure 2: Risk Migration Following Introduction of Wellness Campaigns



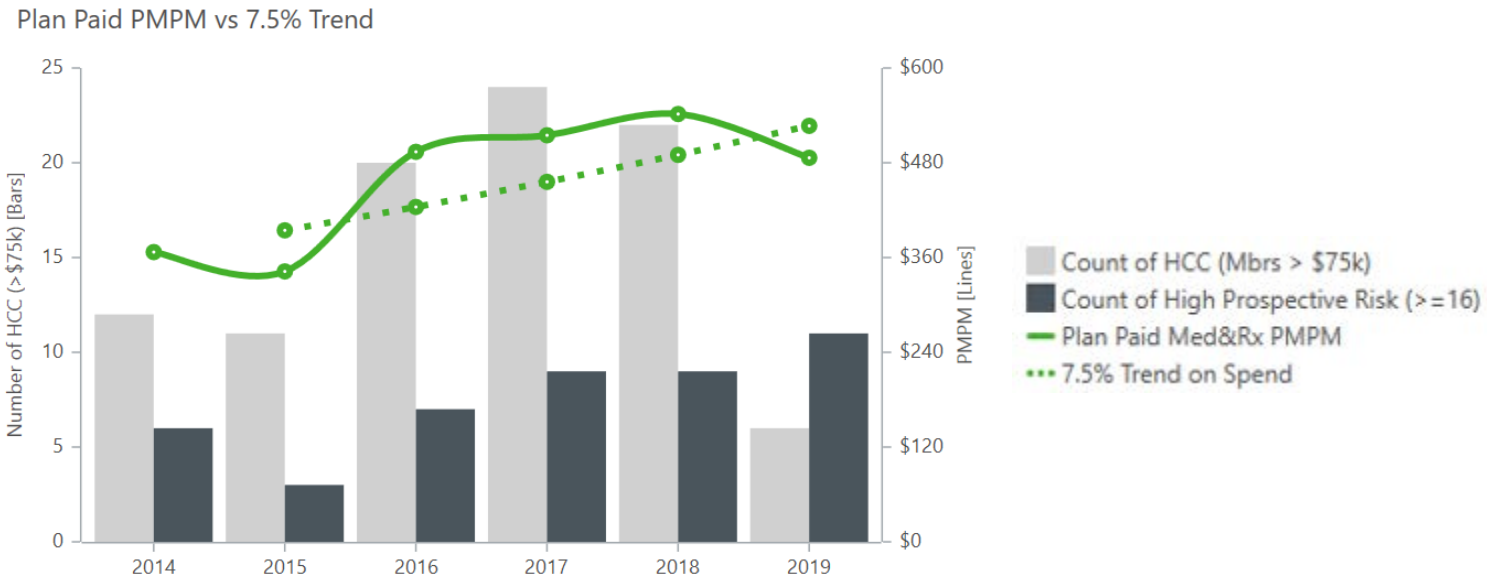
With better disease identification and increased care compliance, pharmacy costs were increasing, and the data illustrated that members were on more expensive medications than typically seen. In the fall of 2017, the group did a deeper pharmacy analysis. The analysis identified several opportunities for potential savings and provided transparency into pharmacy costs the providers had never seen. While results of this review were being presented, the providers were shocked to see the cost of some medications they regularly prescribe in their own practice. Now empowered by cost awareness, they felt comfortable making formulary changes that would still provide the appropriate therapeutic opportunity at a price that was not going to harm their ability to provide strong benefits. The providers, given this new level of understanding, were motivated to restructure their pharmacy benefits, but quickly realized they had to change their pharmacy benefit manager (PBM) to create the best strategies. The new PBM had the ability to provide a tighter formulary that maximizes rebates and co-pay assistance opportunities, as well as create stronger prior authorization programs. In the

first four months of 2019, the group has already seen a 24% reduction in pharmacy spend compared to the first four months of 2018.

The Employer now finds themselves **empowered** realizing that the better the plan is structured, the more benefit the organization can provide to their employees. Certainly, who better to create stronger strategies than healthcare providers themselves. Given that, the group is now working on narrow-network strategies. In 2019, the advisors helped construct the first step in narrow networks by setting up a tiered network program that introduced higher co-pays/co-insurance when procedures were performed at outpatient hospitals, but more efficient options were available. At the same time, the group realized that making things more complicated for busy healthcare providers would require more demand on their time. To help manage this demand, the advisors added a concierge healthcare navigator service. This navigator provides members a personal resource that directs them to cost-efficient yet high-quality providers.

The Employer and the Benefit Advisor have achieved their goals to date and are now running better than the national trend (**Figure 3**), while improving preventative care compliance to 64%, improving the use of quality care and health of their population. Their next steps are to expand their top tier network to expand the impact of their strategies.

Figure 3: Financial Progress of Plan



The Employer understood how imperative it was to create a plan that would help improve the health of their population and their partnership with the Benefit Advisor, who understood how to use data to identify and act on that information, was critical to their success. As healthcare providers, the objective view of their plan spend and health needs of their population empowered them to create strategies quickly and allowed them to respond to the needs of their population. Without that transparency, the providers and advisors would have been slow to respond or identify the needs of the population. Both the advisors and providers were concerned about improving the health of their population but trusted the numbers and are using data effectively to provide a sustainable win-win solution for their company and employees.