ASHHRA 46th Annual Conference & Exposition

Physician-Led Health Management

A Unique Opportunity for Healthcare Providers to Transform the Healthcare Industry

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HEALTH CARE HR: Fulfilling Our Promise Preparing for a New Decade of Success
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Topics for Discussion

- Health Management- Current State
- Physician-Led Models- Emerging State
- Your Organization- Taking Action

Why is Health Management Optimization Important?

Costs related to preventable chronic conditions continue to be major cost drivers

- Typically, more than 80% of health care costs are still driven by less than 10%-20% of the claimants
- Employers (67%) cite poor health habits as their top challenge in controlling health care costs while the majority of employees (69%) say managing their health is a top priority
- Only 16% of employees use company programs to lose weight, stop smoking, exercise more and eat healthier
- 30% of employees with heart disease and 22% with diabetes miss more than 10 days of work annually

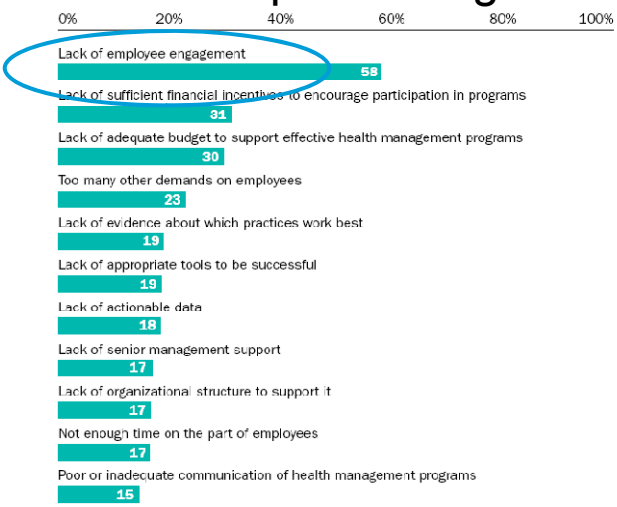
Sources: 2009 14th Annual NBGH/TW Employer Survey
2008/2009 Employee Perspectives on Health Care Survey

Why is Health Management Optimization Important?

Programs are suffering from poor participation despite large investments from employers

- Annual per employee expenditures range from $125 to $200 for health and productivity related programs — more than $1M to the average Employer
- Active participation is generally less than 20% of members identified with chronic conditions or risk factors
- Many employers are paying too much for their low participation, sometimes over $2,000 per active participant per year

Health-Related Behavior: Top Challenges



Employers were asked to identify their top three challenges

Source: Towers Watson NBGH 2010 Survey

Participation Linked to Lower Trends

Median Health Care Trends

Weight Management

Smoking Cessation

Disease Management

Source: 14th Annual Towers Watson/National Business Group on Health Survey

Why is Health Management Optimization Important?

The vendor environment continues to be complex

- No one speciality vendor or carrier has "best practice" internal programs in all areas
- 15 percentage point increase from 2007 to 2009 in purchasing lifestyle behavior change programs through one or more health plans
- 10 percentage point increase from 2007 to 2009 in purchasing lifestyle behavior change programs separately through specialty vendors
- Speciality vendors and carriers are becoming more open to pricing models that support engagement

Source: 2009 14th Annual NBGH/TW Employer Survey

Why is Health Management Optimization Important?

Vendors are not stepping up to the challenge of engaging employees

- Satisfied with low rates of active participation and use of confusing reporting to obscure active participation
- Prefer to use per employee pricing models to protect revenues, even while adversely affecting ROI
- Minimal progress in developing an effective offering of incentives and communication to spur engagement

Care Coordination??

Typical Client Experience

Programs/Vendors

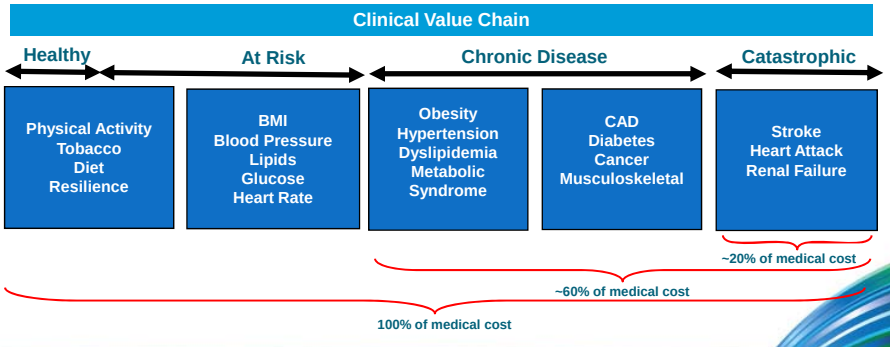
- Health plan
- Nurseline
- Health advocate
- Health portal
- Onsite health center
- Lifestyle Web and phone programs
- Disease management
- Disability
- EAP

Results

- Low participation
- Misaligned incentives
- Multiple sites, phone numbers, employee touch points
- Pay regardless of engagement
- Poor reporting
- Uncertain ROI

Health Management Business Case

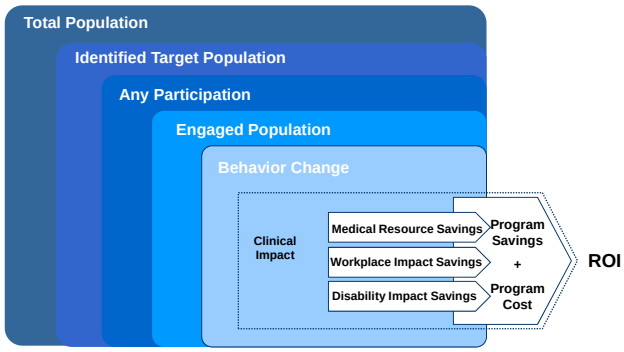
- According to various studies, about 2/3 of a person's medical cost is impacted by their behaviors and environment
- The chronic and catastrophic conditions at the end of the health care continuum can be mitigated by improving wellness on the front end
- A comprehensive population health management strategy must address the critical health risks of each individual, no matter where they are on the health spectrum.



Value Enhancement

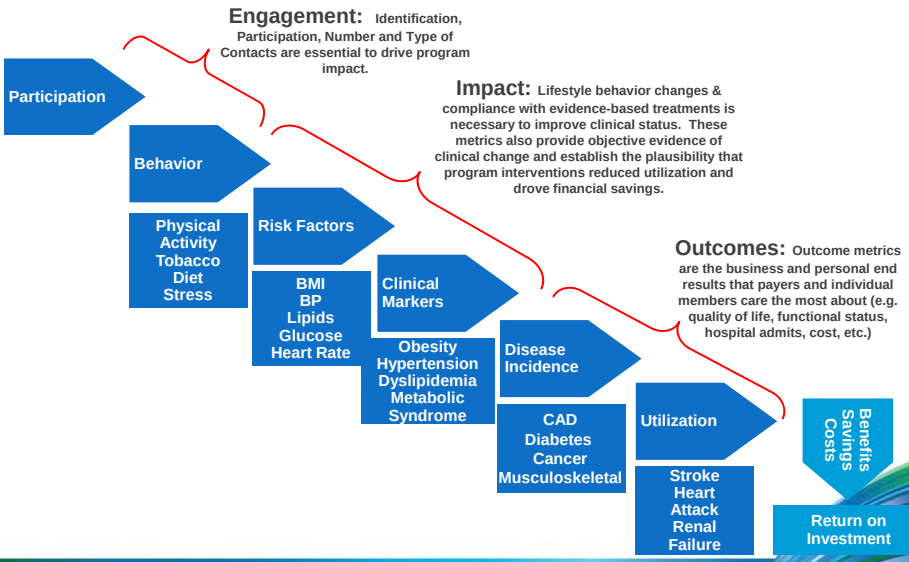
Is My Health Management Performance Optimized?

Keep the End in Mind:
Total Health Management Value Chain



- Right fees
- Right partners
- Right incentive design
- Right reimbursement model
- High engagement
- Best measures and results

Health Management Value Chain



Fair Value Analysis

Operational Data	
# months	12
# employees	4343
# members	10338
# Members with Target Disease(s)	1207
# Enrolled Participants	936
# Active Participants (completed assessments, cumulative)	113
# Engagement Activities (completed calls, cumulative)	278
Monthly Program Fee (estimated)	$20,000
Operational Efficiency Metrics	
Participation Rate	77.55%
Engagement Rate	9.36%
Engagement Activities Per Enrolled Participant Per Month	0.02
Engagement Activities Per Active Participant Per Month	0.21
Fees- Per Active Participant Per Month	$177
Fees- Per Enrolled Participant Per Month	$21
Fees- PEPM	$5
Cost per Engagement Activity	$863
Fair Value Analysis	
Fair Value Cost per Engagement Activity (hourly)	$150
Average Time (hours) per Engagement Activity	1.0
Fair Value Cost per Engagement Activity	$150
Approximate Overpayment Per Engagement Activity	$713
Total Overpayment	$198,300
Additional Number of Engagement Activities Required for Fair Value	1322

Findings from Four Demonstrations

- No effects on adherence or self-care
- Only 3 of the 20 programs reduced hospitalizations or gross costs (4.5% reduction in MCC admissions)
- No effects on mortality
- Scattered modest effects on quality indicators:
  - CHF: MCC reduced preventable hospitalizations
  - Diabetes: Telemedicine improved HbA1c, cholesterol, blood pressure; MCC reduced preventable hospitalizations
- Patients love the programs

Adapted from Vince Kuraitis, Better Health Technologies, LLC http://e-caremanagement.com/

Why Doesn't Call Center DM Work Better?

- Changing patient behavior is HARD:
  - Limited use of behavior change models
  - No incentive for physicians to communicate
- Some patients too ill, others not at short-run risk:
  - But targeting is not the major problem
- Programs don't collect timely hospitalization and Rx info
- Usual care providers are minimally engaged
- Programs led by marketers, not clinical experts:
  - Ineffective use of available data
  - Unfamiliar with unique needs of the elderly
- Contact info poor in population-based models
- Improvements in quality of care don't guarantee better patient outcomes in short run

Adapted from Vince Kuraitis, Better Health Technologies, LLC http://e-caremanagement.com/

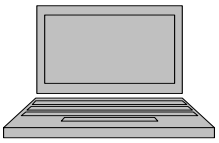
Call Center Models

Current disease management industry models vulnerable

Call Centers

Peripheral Physician Involvement

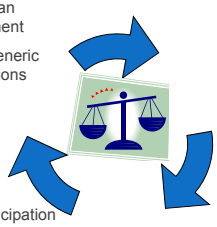
Limited, Generic Interventions



Telephone, Fax, or Mail

Claims Data (Old and Inaccurate)

Lack of Integration



Poor Participation and Engagement

Low Consumer Trust

Unproven Health Outcomes

Multi-site, International Employers

Long Implementation

Unproven ROI

Case Study

Regional Health System

Fair Market Value Assessment

Contract Negotiations

- We conducted a fair value analysis comparing fees to active participation in disease management (DM)
- DM fees were based on employee counts only; effective fees per active participant per month were more than double the per participant fees seen in the industry
- Contract review revealed pricing on a per employee per month basis without performance guarantees related to contact with a nurse or health coach
- Towers Watson negotiated a contract provision to reconcile fees to active participation levels every six months
- The vendor owed the client one-sixth of the fees for the first six-month reconciliation

For Group Discussion

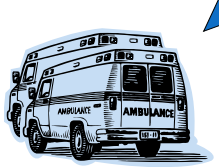
- How effectively are your employees utilizing your health and wellness programs to manage their health?
- What accounts for this level of engagement?
- What could you do to improve it?

Physician-Led Health Management Models

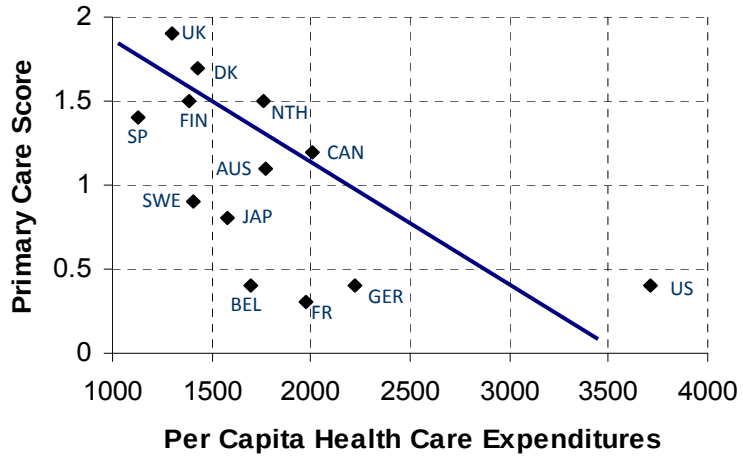
Staff Efficiencies
Physician Revenue
Physician-Directed
Evidence-based Care

Web-based,
patented,
FDA-cleared,
EMR-compatible
decision support

Patient Convenience
Patient Engagement
Improved Outcomes
Lower Costs



Primary Care Score vs. Health Care Expenditures, 1997



Starfield B. Is US Health Really the Best in the World? JAMA. 2000;284:483-485.

Patient Centered Medical Home

The following principles were written and agreed upon by the four Primary Care Physician Organizations – the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.

Principles:

- Ongoing relationship with a personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated care across the health system
- Quality and safety
- Enhanced access to care
- Payment recognizes the value added

This is *NOT* a Gate-keeper Model of Care it *IS* a Coordination of Care

Accountable Care Organizations

- **Key Features**
  - Local Accountability
  - Shared Savings
  - Performance Measurement
- **Multiple Potential Configurations**
  - Multi-Specialty Group Practice
  - PCP Groups, Specialty Groups, one or more Hospitals
  - PCP Groups, Specialty Groups, Hospitals, Home Health, Mental Health
- **Critical Design Issues**
  - Organizational Management and Leadership
  - Scope of Providers and Services
  - Relevant Performance (cost and quality) Benchmarks
  - Distribution of Shared Savings

Medicare Physician Group Practice Demonstration

- **Design**
  - 10 large multi-specialty groups- 5,000 physicians with 224,000 Medicare patients
  - Usual Medicare FFS + bonus payments based on quality targets (required) and cost (if CMS savings exceeds 2% compared to randomized control group)

Physician Group Practice Demonstration Quality Measures			
Diabetes Mellitus	**Congestive Heart Failure**	**Coronary Artery Disease**	**Preventive Care**
HbA1c Management	Left Ventricular Function Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	Left Ventricular Ejection Fraction Testing	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Beta-Blocker Therapy – Prior MI	Blood Pressure Control Plan of Care
Lipid Measurement	Blood Pressure Screening	Blood Pressure	Breast Cancer Screening
LDL Cholesterol Level	Patient Education	Lipid Profile	Colorectal Cancer Screening
Urine Protein Testing	Beta-Blocker Therapy	LDL Cholesterol Level	
Eye Exam	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy for Patients HF		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

- **Results**
  - End of Year 2, all 10 groups achieved performance targets for 25 of 27 quality measures (5 groups achieved targets on all 27 measures)
  - Most groups reduced overall costs compared to controls; 4 groups exceeded the 2% savings threshold
  - A total of $16.7 million in performance payments were distributed for Year 2

Key Drivers for Advancing the PCMH into Practice

- **The Payment System for Primary Care must be fundamentally changed**
  - Coordination of care activities, disease management, and enhanced access (such as e-mail correspondence with patients) must be reimbursed
- **IT systems and practice infrastructure must change**
  - advanced EMR's, registries, interoperability of reports, e-prescribing, etc. must be in place to coordinate and deliver high quality care
- **Quality process assessments and outcomes must be standardized and transparent**
  - NCQA-criteria for advanced medical homes

Direct Employer-Provider Relationships can Improve Quality and Reduce Costs

- **Preferred Networks**
  - Can be formal or informal
  - Based on health plan's "high performance networks"
  - Based on employer based health services building off community referral patterns with development of affiliated high performance provider relationships
- **Direct Contracts**
  - Hospital rebates proportionate to market share movement
  - Case rates and domestic medical tourism steerage
  - Limited high performance provider network
  - Broad quality and cost based networks directly with community physicians, hospitals and other providers

Direct Employer-Provider Relationships can Improve Quality and Reduce Costs

- **Advanced provider relationships**
  - Pay for Performance
  - Medical Home – Primary Care and Condition Specific
  - Condition specific Accountable Care Organizations (cycles of care)
  - Comprehensive Accountable Care Organizations
  - Collaborative Care Organizations- health management vendor-provider integrated care management
  - Employer-based Onsite Health Services
- **Design Requirements**
  - Supporting benefit design and effective communications
  - Integrated with – and supportive – of entire spectrum of health management vendors

Case Study

Employer PCMH Pilot

Program Delivery Model Assessment

Enhance Provider Revenue

- Younger population in suburban area, no access to care issues but quality is variable
- Employer wants to gain control over health care costs and set goal to achieve zero percent trend
- Patient-centered medical home pilot with several community based primary care practices
- Provider payment structure is combination of fee-for-service and capitation with potential for bonus based on achievement of quality thresholds
- Feasibility model projects mature savings of 4.5% on expected spend and a 5-year ROI of 1.7x
- Model also suggests trend reduction of 1.0-1.5% each year
- Pilot scheduled for go-live in January 2011

Dartmouth-Hitchcock Medical Center

- **Academic Medical Center**
  - 9000 employees
  - 900 physicians
  - Multiple sites
  - 11,000 dependents
- **Our vision:** Achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for our nation.

A Unique Opportunity to Transform

- **Self-insured**
  - Invest our money using the best evidence available to support population health
- **Reform health care**
  - Service mix focused on improving health
  - Delivery methods
  - Provider compensation
  - Patient incentives

Transformed Health Care

Organizational Readiness

- Alignment with organizational vision and goals
- Commitment to Patient Centered Medical Home
- Embarrassing patient/visitor complaints and observations
- Rapidly escalating medical costs driving business imperative to do something
- Existing, albeit fragmented health improvement, disease management resources, occupational medicine resources
- Research and data driven academic medical center
- Human resource support for more comprehensive program

Baseline Inventory of Employee Health Services

- Health plan services
  - Web portal for health information and HRA with very low utilization
  - 100% coverage for USPSTF A and B services
- Five internal service groups (FTEs)
  - Health Improvement (2.5 + 1 admin)
  - Employee Assistance Program (1.0 + 0.5 admin)
  - Occupational Medicine (0.35 MD, 3.2 RN, .8 LNA, 1.6 NP, 3.2 admin)
  - Safety and Environmental Programs (3.0 + 1.0 admin)
  - Care Management (2.0)

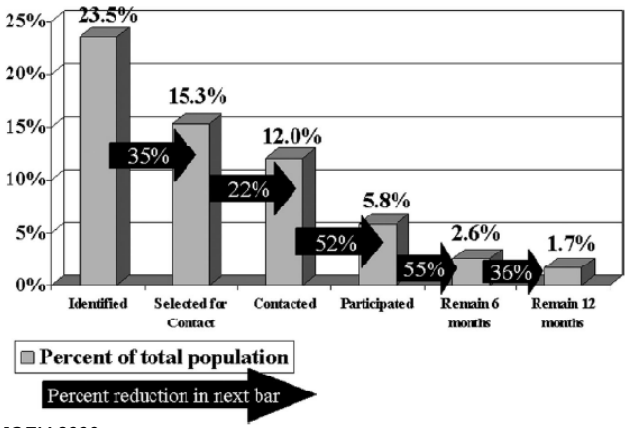
Baseline Work Environment

- Cafeteria and food court – typical large portioned, high fat American food
- Stairwells unattractive
- No on-site health club
- Beautiful rural campus with walking trails
- Few bike racks

Population Health Risk Assessment: *Not* the Healthiest Population

- DHMC employees share a similar burden of health risks as national employee benchmarks
  - Half lead sedentary, inactive lifestyles
  - Nearly half have elevated blood pressure
  - A third have cholesterol > 200
  - A quarter have a BMI of more than 30
  - Almost one in ten smoke
  - Nine percent have high blood glucose levels
  - 68% report significant health problems

Participation in Disease Management Programs

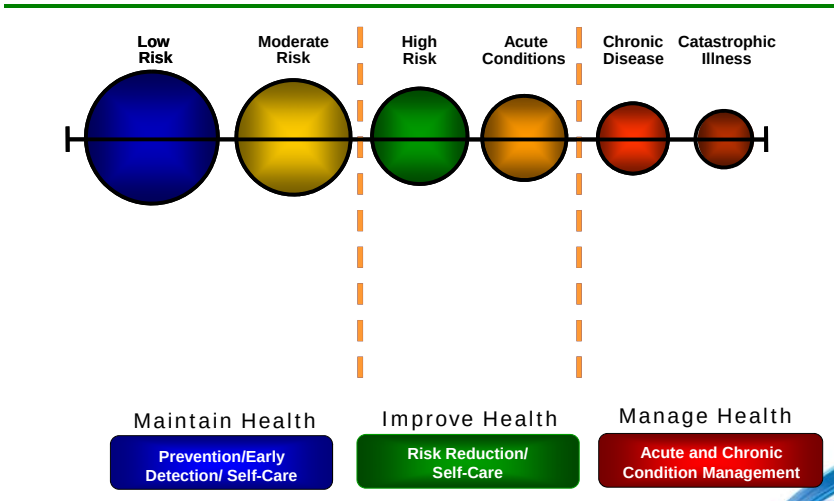


Lynch et al. JOEM 2006

Failure of Co-Sourcing Condition Management and 24 Hour Nurse Line

- Health plan phone calls generated multiple complaints to DHMC president
- Only a few handfuls of plan members engaged with condition management
- < 10 people used 24 hour nurse line
- Primary care providers at best did not engage, many angry about health plan involvement
- Co-managing complex care with D-H care managers hampered by lack of coordination

Build Programs for Varying Needs



Live Well/Work Well: A Comprehensive and Integrated Program of Health Promotion and Protection

- Create and engaging, safe culture of health
  - Enhance work environment, HR policies and benefit design to support health promotion
- Deploy a suite of expanded and integrated services
  - Occupational medicine
  - Safety and environmental programs
  - Care management
  - Health coaching
  - Behavioral Health
  - Work ability program
  - Primary care for employees

Health Coaching Team

- Coaching, Support, Education and Resources related to lifestyle related diseases
- 6 Team members include nutrition, weight loss, smoking cessation, and physical fitness specialists
- Serve all locations including face to face, telephonic, e-mail, and resources regularly embedded in key practices

Behavioral Health Team

- Personal, family and/or workplace relationship problems
- 7 x 24 telephonic availability
- Team of 6 includes MSW, and 2 PhD psychologists, a part-time psychiatrist for medication consultation and a dialectical therapist to assist with workplace conflict

Integrated D-H Primary Care

- Purpose
  - Employee/dependent focused care in high volume practices (GIM and FM)
  - Just in time acute care access and coordinated chronic and preventive health care
- Dedicated Resources
  - 1.0 FTE care coordinator– embedded in GIM
  - 1.0 FTE care coordinator – FM and non- D-H community practitioners
  - 1.0 FTE APRN embedded in GIM and 1.0 APRN in FM evaluated by population health metrics (not RVUs)

D-HELP Team: Centralized Care Coordination

- Purpose
  - Facilitate/coordinate care of unassigned new and existing employees/plan members
  - Assure evidence based continuity of care at hospital discharge
  - Enhance engagement of ee's with PCPs through collaboration with D-H medical home care coordinators and non-D-H practices for targeted conditions
- Resources
  - 1.0 FTE care coordinator
  - 1.0 FTE patient data registrar (Super registry – HRA, Claims, Hospital Discharge, Medical Record)
  - Care gap tool

Dedicated Employee Medical Home Model Practice

- Plan 2012 opening
  - Qualify for NCQA level 3 certification
  - Align financial incentives for employees, providers, and employer
  - Measure value (cost/quality) vs other primary care practices
- Initial panel
  - 1500 – 2000 employees and dependents
- Team (draft -Smallest replicable unit)
  - Providers: Family MD and APRN; part-time psychiatry and CBT psychologist; RN, LNA
  - Admin: Pt data coordinator, care coordinator; secretary
- Function as a distinct team, but integrated with D-H primary care

Work Ability Program

- Healthier employees not necessarily more productive
- Manage stay at work/return to work program for injured and ill employees
- Team of 3
  - RTW coordinator, RN with an advanced degree
  - OT for job site analysis, job shadowing, and identification of alternative duty work
  - Admin support
- EAP facilitates RTW meetings

For Group Discussion

- How many of your employees have a Primary Care Physician who coordinates their care?
- How well does your medical benefit plan incent primary and preventive care services for both employees and providers?
- What are barriers to improving this and how can you address them today?

Taking Action

Fair Market Value Assessment of Current Programs

Start with Fair Market Value Assessment

- Compare active participation and fair value versus best practice
- Make recommendations for improvement that will generally involve contracting improvements and/or delivery model change
- Employers with good performance on this step are good candidates for Impact Metric Review

1 Contract Negotiations

- Pricing model based on engagement
- Performance guarantees

2 Delivery Model Assessment

- Engagement
- Integration
- Vendor roles
- Incentive design
- Communication

3 Impact Metric Review

- Member compliance
- Clinical improvement
- Financial savings

Taking Action

High Gain Questions for your Current Programs

Questions	Consequences	Potential Solutions
Have you ever looked at your fees in relation to active participation or number of calls completed?	Leaving money on the table	Fair Market Value Assessment
Are your employees confused by multiple programs and/or vendors?	Low engagement; low member satisfaction	Delivery Model Assessment
Do your vendors have financial incentive to drive participation?	Low participation and paying for non-participants	Contract Negotiations
Is your vendor measuring what you need to evaluate program success?	Inability to evaluate program and target improvements	Impact Metric Review
Does your executive team trust vendor savings and ROI?	Inability to continue or increase investment in health management programs	Impact Metric Review

Taking Action

Strategic Situation Assessment of Internal Capabilities

Complete an Internal Capabilities Assessment

- What care management and health improvement services are currently being offered by your organization?
- How do these services compare to "best practices" or those of third party vendors?
- How can you optimize internal services and capabilities to serve the health and productivity needs of your employees?

1 Collaborative Management of Employees

- Reduce Vendor Fees
- Improve employee outcomes

2 Identify and Acquire Capabilities

- PQRI Automation
- Care Algorithms
- Reminder Systems
- Patient Registries
- Remote Monitoring

3 Enhance Revenue

- Care Management Fees
- P4P Quality Bonus
- HITECH stimulus funds

Taking Action

High Gain Questions for your Organization

Questions	Consequences	Potential Solutions
Are you capable of reporting clinical outcomes for populations of patients?	Leaving P4P money on the table	PQRI Reporting
Are your patients following up with your clinics at the appropriate intervals and complying with treatment recommendations?	Low engagement; loss of revenue	Evidence-based Care Algorithms
Are you managing your "no-show" rate efficiently with fewest FTE resources possible?	High staffing and overhead costs	Automated Reminder System
Are you capable of connecting to your patients outside the clinic setting?	Low engagement; gaps in care	Remote Patient Management
Are you positioned for population health initiatives on the horizon now?	Loss of HIT stimulus payments and strategic flexibility	Patient Registry

D-H Medical Home – Integrated Model of Employee Health

- Risk Stratification of Registries
  - Gap analysis integrated into registry for stratification
  - Preventive and Chronic Disease registries are in place
    - Mammography
    - Colorectal Screening
    - Prostate Cancer Screening
    - Immunizations
    - Diabetes
    - CHF
    - HTN
    - COPD
    - Coronary Artery Disease
    - Asthma- Pediatrics
    - Seizure Disorder-Pediatrics

D-H Practice Feedback

Team DM report

GIM TEAM REPORTS FEBRUARY 2010

Diabetes Summary	BLUE	GOLD	GREEN	ORANGE	PURPLE	LYME
Count of Diabetic Patients	310	366	377	231	583	284
Type 1	2%	5%	8%	6%	8%	5%
Type 2	98%	94%	92%	94%	93%	95%
Unknown	0%	0%	0%	0%	0%	0%
Pts receiving HA1C test (last 12 months)	92%	91%	91%	86%	88%	90%
Pts receiving LDL test (last 12 months)	76%	79%	81%	74%	78%	79%
Pts receiving Eye Exam (last 12 months)	68%	74%	69%	59%	65%	58%
Pts receiving PCP Visit (last 12 months)	95%	89%	91%	87%	88%	95%
Pts receiving Microalbumin test (last 12 months)	51%	63%	66%	64%	65%	72%
Pts receiving Foot exam (last 12 months)	71%	74%	73%	67%	70%	67%
Pts receiving Pedal Pulse Exam (last 12 months)	71%	73%	73%	66%	69%	67%
Pts receiving Monofilament Exam (last 12 months)	70%	73%	73%	66%	69%	67%
Pts receiving Pneumovax (no time limit)	82%	80%	80%	64%	77%	88%
Pts receiving Influenza vaccine (last 12 months)	61%	60%	59%	48%	57%	60%
Pts receiving BP measure (last 12 months)	94%	98%	97%	95%	96%	98%
HA1C Results Within the Last 12 Months						
Less than 7.0	62%	55%	53%	49%	51%	57%
7.0 to 8.0	24%	25%	24%	28%	30%	27%
8.1 to 9.0	7%	10%	12%	13%	9%	10%
Greater than 9.0	8%	10%	10%	10%	11%	6%
LDL Results Within the Last 12 Months						
Less than 100:	70%	62%	59%	64%	63%	66%
100 to 130:	21%	29%	31%	23%	26%	24%
Greater than 130:	9%	10%	11%	13%	11%	10%
Blood Pressure Results Within the Last 12 Months						
Less than 140/90:	61%	62%	62%	65%	63%	68%
Less than 130/80:	36%	30%	32%	34%	34%	42%
Pts receiving flu assessment (last 12 months)	63%	62%	63%	50%	58%	62%
Pts receiving pneumovax assessment (last 12 months)	9.7	13.1	10.9	11.3	9.3	9.9

Individual Provider DM Report

Hitchcock Clinic - North	
Chronic Condition Cohort Report	
Diabetes Summary	
Count of Diabetic Patients	90
Type 1	17%
Type 2	83%
Unknown	0%
Pts receiving HA1C test (last 12 months)	93%
Pts receiving LDL test (last 12 months)	83%
Pts receiving Eye Exam (last 12 months)	70%
Pts receiving PCP Visit (last 12 months)	94%
Pts receiving Microalbumin test (last 12 months	70%
Pts receiving Foot exam (last 12 months)	77%
Pts receiving Pedal Pulse Exam (last 12 months	77%
Pts receiving Monofilament Exam (last 12 month	77%
Pts receiving Pneumovax (no time limit)	87%
Pts receiving Influenza vaccine (last 12 months	71%
Pts receiving BP measure (last 12 months)	97%
HA1C Results Within the Last 12 Months	
Less than 7.0	43%
7.0 to 8.0	27%
8.1 to 9.0	19%
Greater than 9.0	11%
LDL Results Within the Last 12 Months	
Less than 100:	59%
100 to 130:	32%
Greater than 130:	9%
Blood Pressure Results Within the Last 12 Months	
Less than 140/90:	61%
Less than 130/80:	28%
Pts receiving flu assessment (last 12 months)	74%
Pts receiving pneumovax assessment (last 12	13.8

D-H Adult Preventative Registries (for Population and Patient Management)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	
1	Divisi	Dep	PC	MF	FSC	Pt Nam	DOB	A	S	Seen by PCP w/I 1-5 year	Last Primary Care Da	I	C	C	H	Pneumo Done	Mammo Done	LDL Done	HDL Done	Colon Test Done	
367	AHS	BED	FAMIL	MORBE	#####	CIGNA M	SAF	7/31/68	41	F	1	4/14/09	N	N	N	N	N/A	Not Done	N/A	N/A	N/A	had ellio
368	AHS	BED	FAMIL	MORBE	#####	CIGNA M	PAF	11/6/71	37	F	3	4/9/07	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
369	AHS	BED	FAMIL	MORBE	#####	MGD CARE (	NEL	3/10/51	58	F	1	6/5/09	N	N	N	N	Done	Done	Done	Done	Done	
370	AHS	BED	FAMIL	MORBE	#####	MEDICARE N	RIC	3/9/14	95	F	1	2/2/09	N	N	Y	Y	Not Done	N/A	Done	Done	N/A	
371	AHS	BED	FAMIL	MORBE	#####	CIGNA M	FOS	11/30/71	37	M	1	8/3/09	N	N	N	N	N/A	N/A	Done	Done	N/A	
372	AHS	BED	FAMIL	MORBE	#####	SELF PAY M	WH	5/13/57	52	F	1	8/20/09	N	N	N	N	N/A	Not Done	Done	Done	Not Done	
373	AHS	BED	FAMIL	MORBE	#####	MGD CARE (	BEL	6/14/78	31	F	1	3/11/09	N	N	N	Y	N/A	N/A	N/A	N/A	N/A	
374	AHS	BED	FAMIL	MORBE	#####	MGD CARE (	MC	5/29/79	30	M	1	4/7/09	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
375	AHS	BED	FAMIL	MORBE	#####	ANTHEM M	CHA	6/1/74	35	M	2	10/1/08	N	N	N	N	N/A	N/A	Done	Done	N/A	
376	AHS	BED	FAMIL	MORBE	#####		NAI	6/8/79	30	F	5	5/13/05	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
377	AHS	BED	FAMIL	MORBE	#####		FLY	9/2/83	26	M	5	8/15/05	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
378	AHS	BED	FAMIL	MORBE	#####	MEDICARE N	WR	5/24/78	31	M	1	4/27/09	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
379	AHS	BED	FAMIL	MORBE	#####	ANTHEM M	SOL	6/20/82	27	M	1	9/4/09	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
380	AHS	BED	FAMIL	MORBE	#####		BUS	5/24/79	30	F	5	7/30/05	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
381	AHS	BED	FAMIL	MORBE	#####	ANTHEM M	BLI	4/12/71	38	M	1	6/24/09	N	N	N	N	N/A	N/A	Done	Done	N/A	
382	AHS	BED	FAMIL	MORBE	#####	MEDICARE N	LED	6/3/44	65	F	1	7/6/09	N	N	N	N	Not Done	Done	Done	Done	Not Done	
383	AHS	BED	FAMIL	MORBE	#####	MEDICARE N	DES	4/21/40	69	M	1	9/9/09	N	Y	N	Y	Done	N/A	Done	Done	Done	
384	AHS	BED	FAMIL	MORBE	#####	ANTHEM M	MC	6/9/83	26	F	1	9/3/09	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
385	AHS	BED	FAMIL	MORBE	#####	ANTHEM M	POI	1/11/58	51	M	1	7/7/09	N	N	N	N	N/A	N/A	Done	Done	Not Done	
386	AHS	BED	FAMIL	MORBE	#####	CIGNA M	WH	4/14/47	62	M	1	3/20/09	N	N	N	Y	N/A	N/A	Done	Done	Not Done	
387	AHS	BED	FAMIL	MORBE	#####	SELF PAY M	NO	5/1/81	28	M	1	3/26/09	N	N	N	N	N/A	N/A	N/A	N/A	N/A	
388	AHS	BED	FAMIL	MORBE	#####	ANTHEM M	COL	7/2/74	35	F	1	8/20/09	N	N	N	N	N/A	N/A	N/A	N/A	N/A	

D-H Comparative Benchmarking of Practices

Green Results = top 20% of scores Red results = bottom 20% of scores	Dartmouth-Hitchcock Clinic System Medical Home	Bedford Family Practice	Bedford Internal Medicine	Bedford Pediatrics	Concord Pediatrics	Concord Primary Care Dept	Keene Family Medicine	Keene Island St.	Keene Pediatrics	Keene Walpole	Keene Winchester	Lebanon Family Medicine	Lebanon GIM Lebanon	Lebanon GIM Lyme	Manchester Family Practice	Manchester IMED Pedi	Manchester Internal Medicine	Manchester Pediatrics	Manchester Urgent Care	Nashua Family Practice	Nashua Hudson FP Team	Nashua Internal Medicine	Nashua Merrimack FP Team	Nashua Milford FP Team	Nashua West Coster FP Team	Nashua Pediatrics	Nashua Urgent Care
Monthly Score Up To 9/1/09																											
Service (Provide Patient and Family Centered Care)																											
Outpatient satisfaction - visit overall-percent excellent	50	39	36	62	53	45	51	80	54	54	86	59	55	55	36	60	41	38	61	53	65	46	52	50	42	52	33
Outpatient satisfaction - sensitivity of staff to your needs-percent excellent	49	42	45	58	51	51	53	60	50	71	86	52	58	63	35	60	38	32	44	50	67	33	51	56	21	53	50
Outpatient satisfaction - scheduled appointment when wanted-percent excellent	43	52	32	42	45	38	41	75	43	55	83	46	51	48	31	63	35	25	60	42	43	45	44	29	22	36	40
Access for new patients - Primary Care	74	64	46	90	74	60	75	68	90	87	67	69	62	76	76	89	72	76	100	69	44	72	86	77	55	88	100
Quality (Close the Quality Gap)																											
Outpatient satisfaction - provider explained what was done-percent excellent	54	67	48	68	62	57	56	80	54	71	86	N/A	N/A	N/A	43	60	41	48	53	56	72	56	55	58	50	59	67
Outpatient satisfaction - thoroughness of the care received from the provider-percent excellent	65	61	55	66	71	60	64	80	58	71	86	70	75	65	55	80	60	56	58	63	69	66	63	63	68	67	83
Diabetes outcome composite	49	47	43	N/A	N/A	0	47	47	N/A	46	47	40	40	45	33	32	51	N/A	N/A	55	55	54	70	61	54	N/A	N/A
Diabetes process composite	25	19	18	N/A	N/A	36	19	23	N/A	9	23	23	19	17	21	9	24	N/A	N/A	40	37	36	40	44	40	N/A	N/A
Hypertension	68	65	69	N/A	N/A	77	68	66	N/A	64	73	61	61	68	64	62	70	N/A	N/A	74	72	70	81	77	69	N/A	N/A
People (Build an Empowering Culture) *2009 Employee Survey*																											
Provider and staff satisfaction - top boxes*																				77	88	66	80	90	60	67	85
Provider satisfaction - top boxes*		75	75	75	100	86									45	85	85	86	75	86	75	85	100	75	86	86	
Staff satisfaction - top boxes*		62	62	62	68	56									57	77	77	75	100	77	75	83	77	94	55	87	85
Work well as a team - top boxes*																				76	100	82	61	94	70	73	86
Growth (Create Systems that Work)																											
New Primary Care patients as a percent of total Primary Care visits	4.1	1.8	3.8	2.8	4.4	4.0	3.6	4.2	5.0	4.1	2.6	8.5	5.2	6.6	4.9	4.7	2.1	4.5	2.5	3.6	6.0	5.2	3.2	3.6	4.2	3.6	3.2
Finance (Practice Careful Stewardship)																											
Expense variance to budget	0.7	12.6	-12.6	-2.4	0.0	0.0	0.8	-11.9	6.9	-5.3	10.3	-5.1	-2.6	-2.0	-6.8	-53.3	-7.0	0.0	27.0	0.0	-9.2	-10.2	1.7	8.3	19.2	7.8	###
RVU to budget	-12.3	-20.0	-3.4	-19.3	-25.4	-12.7	-13.7	-17.2	-24.6	-26.4	-14.0	43.5	24.4	41.4	-24.6	20.4	-31.0	0.0	-0.4	-18.0	0.4	-3.4	-17.0	5.5	-51.7	-18.6	14.6
RVU to MGMA Benchmark																											
Fiscal YTD Up To 9/1/09																											
Service (Provide Patient and Family Centered Care)																											
Outpatient satisfaction - visit overall-percent excellent	47	42	50	65	62	44	50	52	41	62	68	54	57	51	38	60	41	40	43	52	60	47	55	51	48	48	40
Outpatient satisfaction - sensitivity of staff to your needs-percent excellent	48	42	48	65	45	45	50	55	45	67	65	54	58	55	35	64	41	40	46	52	52	44	56	54	47	45	41
Outpatient satisfaction - scheduled appointment when wanted-percent excellent	44	41	43	63	59	38	43	41	59	61	62	56	50	49	38	44	38	34	55	49	52	38	48	46	40	39	48

Roll-Up of D-H Outcome Score Cards

Report Date: 1/1/10

Scorecard Report

General | Scorecard | Chart | Trending Table | Notes | Annotation

Measure	Notes	Status	Trend	Result	YTD Result	YTD Target	Sample (n)	Score(%)
Service (Provide Patient and Family Centered Care)								**95.78**
Outpatient satisfaction - overall experience - percent excellent - 2 mo prior (Manchester Internal Medicine)				43	45	46	76	97.91
Outpatient satisfaction - sensitivity of staff to your needs-percent excellent - 2 mo prior(Manchester Internal Medicine)				49	45	46	74	98.8
Outpatient satisfaction - scheduled appointment when wanted-percent excellent - 2 mo prior(Manchester Internal Medicine)				45	39	42	64	92.07
Access for new patients - Primary Care(Manchester Internal Medicine)				74	75	80	--	94.31
Quality (Close the Quality Gap)								--
Outpatient satisfaction - provider explained what was done-percent excellent - 2 mo prior(Manchester Internal Medicine)				55	56	60	73	94.03
Diabetes outcome composite(Manchester Internal Medicine)				51	51	52	--	98.08
Diabetes process composite(Manchester Internal Medicine)				24	24	30	--	80
Hypertension(Manchester Internal Medicine)				70	70	75	--	93.33
Mammography adult preventative(Manchester Internal Medicine)				67	67	65	--	100
Pneumovax adult preventative(Manchester Internal Medicine)				--	--	--	--	--
Outpatient satisfaction - thoroughness of the care received from the provider-percent excellent - 2 mo prior(Manchester Internal Medicine)				62	64	64	77	100
People (Build an Empowering Culture)								**99.68**
Provider satisfaction - top boxes(Manchester Internal Medicine)				85	85	44	7	100
Providers - work well as a team - top boxes(Manchester Internal Medicine)				100	100	66	7	100
Staff satisfaction - top boxes(Manchester Internal Medicine)				77	77	78	26	98.72
Staff - work well as a team - top boxes(Manchester Internal Medicine)				58	58	57	26	100
Finance (Practice Careful Stewardship)								**0**
Expense variance to budget(Manchester Internal Medicine)				1.0	-6.7	0.0	--	0
RVU to budget(Manchester Internal Medicine)				-17.0	-7.9	0.0	--	0
Growth (Create Systems that Work)								**42.6**
New Primary Care patients as a percent of total Primary Care visits (Manchester Internal Medicine)				2.2	2.1	5.0	--	42.6

D-H Primary Evaluation Questions

Focus on health outcomes, performance, costs and value

1. Health Status & Performance

   Is the program associated with better health outcomes and better work performance for employees and dependents?

2. Health Care Costs

   Is the program associated with more appropriate utilization of health care services and lower health care costs incurred by D-H (the employer) for its employees and dependents?

3. Return on Investment

   Are the investments in the program (i.e., DH expenses per employee for program) offset by the lowering of health care costs (i.e., adjusted health care utilization costs per employee) and or by the increases in health outcomes and work performance?

D- H Secondary Evaluation Questions

Assess "value chain" components likely to generate better outcomes based on context and subpopulation differences

1. Social & Physical Environment
   - Is the program associated with an improvement in a D-H culture of health among employees and a safer healthier working environment?
2. Program Input Components
   - Is the program able to implement state-of-the-art program components that have been shown to make important contributions to better health outcomes, better work performance and lower health care costs in other contexts?
3. Program Process Elements
   - Is the program able to engage and activate employees and dependents in key activities that are associated with better health outcomes, work performance and lower health care costs?
4. Influence of Context and Personal Characteristics on Outcomes
   - Does the program work better in some work settings within D-H than in others? Does the program work better for some types of people than others, (e.g., people at high vs. low risk for large health care costs)?

Formal Organizational Assessment Tools

- Dimensions of Corporate Wellness
  - Key informant interview
  - Based on CDC key elements of a corporate wellness program
    - Organizational culture and leadership
    - Program design
    - Program implementation and resources
    - Program evaluation
    - Scoring summary benchmarked

Where is Your Organization?

	Just Getting Started	Started but not Hitting all Cylinders	Organized but Uncertain of Impact	Best Practice, Need Business Outcomes
Focus	Undetermined	Healthy activities with some health risk interventions	Health risks and conditions, but limited cost management	Health and Productivity management
Programs	Need to clarify	Generalized but not coordinated	Organized and targeted but unsure of health impact	Multiple integration programs tailored to individual
Participation	Uncertain	Low to moderate	Moderate to high	High
Engagement	Need to define	Not focused strategically	Aligned with organization	Coordinated incentives, organizational alignment
Measurement	Need to determine strategy	Measurements in place, but need data integration	Comprehensive evaluation strategy	Advanced evaluation strategy with defined data
Business Outcomes			Programs and processes not connected with financial outcomes	Need quality improvement and better financial outcomes

For Group Discussion

- How well does clinical leadership in your organization understand the concerns and needs of employers in your service area?
- What barriers exist in your organization to fully integrating your clinical resources with your employee health and wellness strategy?
- Where can you start today?

What Health System Employers Can Do Now

- **Assess Current Programs**
  - Assess and trend the health and productivity of your workforce
  - Determine vendor fees as a function of level of engagement of members in your programs
  - Review vendor contracts for incentives and alignment with your goals
  - Monitor ability of members to access primary care services in a timely fashion and develop strategy to address gaps
  - Educate members, vendors, and all stakeholders on the value of primary care
  - Promote primary care to members and report on PCP utilization
  - Ensure benefit design incents PCP utilization

What Health System Employers Can Do Now

- **Develop Internal Capabilities**
  - Establish a measurement plan with feedback to providers to evaluate impact of interventions
  - Restructure physician payment in support of primary care
  - Develop physician networks built around primary care
  - Provide financial rewards/bonus payments to primary care practices that make appropriate referrals and coordinate care
  - Encourage physician practices to participate in Physician Practice Connections Patient Centered Medical Home and Bridges to Excellence
  - Implement reimbursement for practice services such as secure e-mail, telephone consultations, and remote patient management
  - Provide financial incentives to primary care practices that invest in technology systems and tools to better manage members
  - Require all health management vendors to integrate their services with the member's primary care physician

Selected Resources

- PCMH and ACO
  - http://www.pcmh.ahrq.gov/portal/server.pt
  - http://www.pcpcc.net/
  - http://www.aafp.org/pcmh
  - http://www.transformed.com
- Health and Productivity Tool Kit
  - http://www.acoem.org
- Blueprint for Health: A Framework for Total Cost Impact
  - http://www.acoem.org/hpblueprint.aspx
- National Institute of Occupational Health
  - http://www.cdc.gov/niosh/worklife/default.html#intro

Selected Resources

- Heart Check
  - http://www.nyhealth.gov/diseases/cardiovascular/heart_disease/docs/heartcheck.pdf
- Heart Check Lite
  - http://www.albany.edu/sph/prc/worksites/
- HERO Health Management Best Practice Scorecard
  - www.the-hero.org
- NBGH WISCORE
  - http://www.businessgrouphealth.org/scorecard_v2/index.cfm?event=nonmember.register

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