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Lessons Learned from First-Generation Employee Health Strategies

The reluctance of employers to intervene in employee health and lifestyle choices has dissipated over recent years, and been replaced by debate on how to best drive healthy behaviors. Early programs have generally fallen short of their promise, while the burden of healthcare costs has continued to grow. These strategic "failures" have resulted in critical insights that will inform the next generation of programs. This addresses disease management, which is one of the pillars of employee health programs.

What Doesn't Work

The traditional approach to disease management is largely patient-focused and involves telephonic outreach by nurses and other professionals to health plan members diagnosed with a "big five" chronic disease: coronary artery disease, diabetes, chronic obstructive pulmonary disease, asthma and heart failure. The prevailing approach is to prevent exacerbations and complications by using evidenced-based practice guidelines and patient empowerment strategies. Some fundamental shortcomings of this approach are:

1) **Identification of high-risk members**
   - Algorithms for selecting patients often rely on historical information, such as members with the highest healthcare costs. By the time those members are targeted, they have already undergone treatment and their expenditures have regressed to the mean.
   - Selection criteria that depend primarily on medical and prescription claims identify members with well-established chronic conditions and miss early detection opportunities.
   - Targeting specific chronic diseases may lead to providing care in disease silos. In reality, members frequently have co-morbidities that require a whole-person approach.

2) **Call center model**
   Telephonic coaching is conducted from call centers or other remote locations. Attempts to familiarize nurses with account-specific information are hampered by a lack of familiarity with the culture of the community. Similarly, delivery of healthcare differs from one region to another. Distance inhibits coaches' establishment of trust and rapport with both members and physicians.

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3) **Member-centric focus**
Traditional disease management focuses on member self-care. With the plethora of credible health content available online and from various sources, the issue is not necessarily an information gap, so much as a more coordinated effort of the healthcare system. For example, the physician plays a critical role in promoting behavior change. Additionally, the health plan sponsor may need to address access barriers such as deductibles and co-pays for preferred programs or provider network restrictions.

Tell Tale Signs of Ineffective Programs

Both self-insured and fully insured employers may be paying for non-performing programs. Even a sophisticated healthcare system can be surprised by poor performance. In one instance, the health plan had inadvertently turned off the data feed to the disease management vendor. No new members were added to the program for six months, but no one noticed!

What to Look For:

1) **Simplistic engagement metrics**
   - Substantive engagement with a coach is required in order to change behavior. The number of postcards sent to members should not count as engagement. Nor does one call with a coach suffice. Engagement begins when the member actively participates, e.g., agrees to a second call with the coach, requests print/online materials, etc.
   - An average number of at least two to three coaching sessions is necessary to gauge whether the coaches are being accepted and/or getting to the right members.

2) **No physician collaboration or provider referrals**
   - Hourly invoices or reports should reflect time spent discussing cases with physicians. Look for at least 20 percent of total time to be spent with physicians. Customer-centric vendors should be able to provide this information when requested.
   - Reports should include referral counts. Coaches who know the community resources will encourage participation in health and wellness programs, such as EAP, Weight Watchers and so forth, to provide additional support to members.

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3) **Few anecdotal reports from members**
In our experience, delighted members come forward to discuss their experience, notwithstanding the rigorous privacy protections afforded to individuals. If employer representatives (with feet on the ground) do not hear any success stories, it may well be that there are none.

4) **Inconclusive results**
Disease management vendors should calculate results and provide details on their methodology. They should also provide benchmarks and references for the specific standards utilized. This is a complex subject that warrants a dedicated article. Please email us at CammackLaRhette@clcinc.com if you are interested in receiving more information.

For More Information

If you would like more information on this article or the Health Leaders Learning Series, please contact us by email at CammackLaRhette@clcinc.com.

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