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Health & Productivity Program

A Team Approach to Healthcare Plan Management

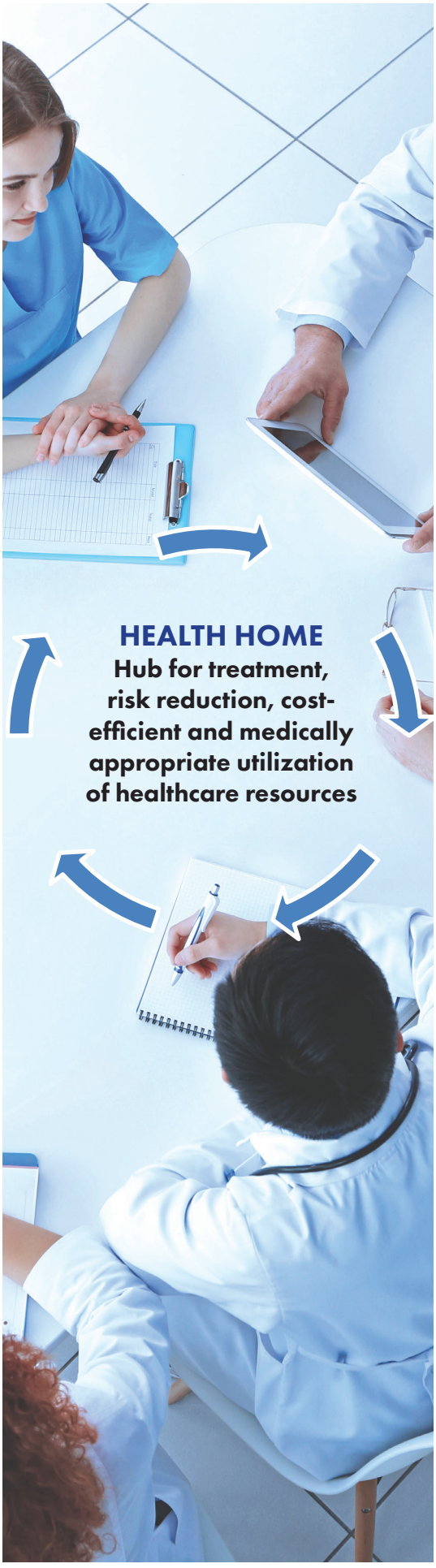
The Health & Productivity Program

is an analytically driven, Primary Care focused program that enables a health plan and the Health Home Provider to bring employee medical and prescription drug management to a whole patient, treatment-specific care level.

Hospitals are primarily focused on patient care and as a result, not as proficient at managing their own population when analyzing medical claim trends and chronic disease management. Further limiting their success, many hospitals have outsourced their wellness programs as well as lab and blood screenings. Due to outsourcing, member data does not populate the hospital's electronic medical record, thus losing valuable employee data. A process is needed that allows for improved medical and population plan management along with quicker analysis of trends to enable plan changes and improved member health initiatives year over year.

Health & Productivity Team

With the **Health & Productivity Team solution**, we bring together hospital administration, human resource and benefits administration staff plus providers, nurses, dietitians and pharmacy professionals that gather in a structured, regularly scheduled forum to identify and implement health improvement and cost saving opportunities. This is accomplished through clinical and financial goal setting as well as implementation of action plans based on detailed analysis of claims data. This analysis not only determines high claim risk and chronic disease management review, but more important, provides the Team with tools needed to focus on "well care" as opposed to the traditional sick care approach.



Health Home

At the core of this program is the primary care practice, or **Health Home**. We use the term Health Home because this is where the members' Primary Care Practitioner (PCP) as well as health data are centrally housed, allowing the member 24 hour access to their vital medical health information through the electronic medical records system.

Through the Health Home, each adult member is required to have an annual preventive exam and specific PCP recommended screening and diagnostic tests based on the members' health conditions and chronic disease management requirements.

Together, the PCP and member evaluate and determine those additional supports needed to ensure long term health and productivity. With the trusted guidance of the PCP, the member will actively participate in creating and formalizing an action plan that determines additional staff such as specialists, dietitians, behavioral health and other professionals needed to help the member win the game of improved outcomes.

In addition, when members have high cost or medically complex conditions, the **Health Home** works with providers to facilitate transitions between local providers and from local providers to high quality, cost-effective, out-of-area specialists if necessary.

Essentially, the concept of the **Health Home** allows customized medical action plans to be developed for improved patient outcomes, which will over time reduce plan costs by a) eliminating or reducing larger claim costs due to monitoring and b) early intervention.

Health Ownership 365

Member engagement is a vital component of a successful Health & Productivity Program. By introducing the concept of **Health Ownership 365**, we create a culture of "take responsibility, take charge" health and wellness for the adult members of the health plan.

Based on the principles of **Health Ownership 365**, the PCP and the member develop an ongoing Care Plan that addresses any moderate to high-risk areas of concern. The **Health Home** works intensively with at-risk patients for compliance with their Care Plan.

In addition, the member has access to an online Personal Health Chart which displays the medical services and cost of treatment for all providers treating the member. To facilitate coordination of care, all treating providers have access to the members' online health record. With the use of the patient portal, members can locate providers, communicate directly with their **Health Home**, access self-management tools and search for important health information.

Actionable Analytics

Utilizing claims data derived from third party administrators, claims payment systems and hospital electronic medical records, the **Healthy & Productivity Team** will gain insight into who makes up their population from a demographic and health risk perspective. This analysis allows for identifying and mitigating potential high-cost encounters, encouraging and incentivizing primary care screening visits, improving and maintaining chronic condition care, and preventing inappropriate emergency department visits and advanced imaging to improve patient outcomes and reduce costs.

The analytical goal of the **Health & Productivity Team** is not solely to improve health outcomes, but to increase value through improving quality and reducing cost. Employee value is multi-dimensional, dictated by the quality of care they receive as well as the effectiveness of the plan design to create an equitable and comprehensive benefit program. By recognizing these dimensions, a more comprehensive, symbiotic relationship is built. Taking an interest in employees' well-being adds value for the employer by being both proactive and cost-effective through reducing the effects of presenteeism and absenteeism, improving health and increasing productivity. This takes an individual-centric, people-first approach to the population health of plan members in the analyses to critically understand the community's health needs, identify how those needs are being met, and uncover as well as work to close gaps in care.

These analyses aid in the benchmarking of health services achievements defined by the team's unique goals. It aims to develop both quantitative and qualitative methods for collecting and reporting health and financial benchmark outcomes to team members and stakeholders. Through combining, analyzing, and sharing the organization's performance data, outcome measures can be interpreted, and actionable assessments can be implemented through this multidisciplinary approach.

A coordinated Team approach is essential in today's fast-paced and analytic driven world. Keeping the patient and the PCP at the center of healthcare helps to improve outcomes as well as provide a lower cost of care on a per member, per month basis.

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