

THE VALUE OF HEALTH IS DRIVEN BY SUSTAINABLE BEHAVIOR CHANGE

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As the country approaches the end of a year of promised reform that would deliver more health care, bend the trend on costs, and get more uninsured people into the system, weariness and wariness have taken root. The focus has moved from “bending the trend” to insurance reform, but the plan sponsors—most often employers of many sizes and sectors—have a job to do, and they need health and productive employees to do it.

VALUE-BASED DESIGNS DELIVER DIVIDENDS— BUT OVERCOMING NON-ADHERENCE IS KEY

Adherence indicators may well be part of the “holy grail” for ben-

efits design and improved health/economic outcomes. Using a suite of levers, defined as insurance design, incentives and disincentives, the benefits and compensation decision-maker has the power to influence behavior change for desired results. But the arbitrary implementation of iconic models of value-based designs, using these levers to remove cost and access barriers for certain populations, is not without consequences. Value-based designs do work, influencing patient and consumer behaviors in prevention/wellness, chronic care management, and choice of care delivery. But

they must be nuanced based upon data, business strategy, and behavior change constructs. For this reason, many industry leaders believe it is important to reinforce that value-based designs are built on behavior change, and therefore, must include behavior supports (employee assistance programs [EAP] and more) in order to achieve predictability in trend and sustainability in health and performance outcomes.

Research by authors such as Colleen A. McHorney has shown that non-adherence can be predicted through the use of scales that measure commitment (does the patient understand the condition or desired behavior and intervention?); concern (does the patient anticipate side effects of the change that would be uncomfortable?); and cost (is the intervention affordable?).¹

While McHorney’s analysis was focused on adherence to pharmaceutical therapies, the Center for Health Value Innovation’s analysis of the market experiences of over 200 companies appears to line up

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with pharmaceutical-focused indicators. (Figure 1)

This paper will showcase some of the findings of surveys conducted by the Center for Health Value Innovation, building the advanced information for Benefits and Compensation decision-makers in employers of all sizes and sectors. Overcoming resistance to change and securing persistency to lifestyle improvements and care management are fundamental to the health and economic improvement of America's communities. The decisions that Benefits and Compensations directors make will have a profound impact on the organizational, personal, and community viability in the next few years.

OUR EXPERIENCE

The Center for Health Value Innovation has analyzed several market segments this year, most recently the public sector (Cities, Counties, State 2009, www.vbhealth.org). These analyses document the similarities and differences in public entities with mutual goals of health benefits for employees and social responsibility to the taxpayers. The comparison, during this year of health reform, was important to showcase differing approaches and yet similarities in thinking, and actions to drive value.

Throughout the public-sector monograph, the emergence of a risk-management approach that married value-based designs for behavior change with patient-centered care approaches became the theme. By understanding that, no matter what disease or condition was chosen as the "model" for intervention, in order to minimize risk to the organization, the person, and even the public's taxes, they had to create mean-

FIGURE 1

Often, non-adherence to health management may be anticipated through a focus on the "3 C's":

Commitment (does the patient perceive the need and understand the condition?)

Concern (does the patient anticipate side effects that could be uncomfortable?)

Cost (is the intervention affordable?)

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ingful behavior change. By using a value-based approach of waste reduction, chronic care management, and individual health improvement, they could reduce the cost trends sustainably year-over-year. They intuitively used plan design plus incentives/disincentives to overcome resistance to change—and they promoted the patient-centered approach and trust built between the clinician and the patient. (Figure 2)

The consistent answer is a focus on behavior change for improved health and wellness fueled by plan design that supports the changes: A value-based design.

A value-based design uses "levers," or nudges, to guide beneficiaries into the appropriate behaviors for improved health and economic outcomes. The levers have been categorized into three major areas of focus:

1. Individual competency, otherwise known as prevention and wellness.
2. Chronic care management delivered in accordance with evidence-based guidelines.
3. Care delivery choices that are cost-efficient and that promote best outcomes.

FIGURE 2

Similar Approach with Unique Challenges

- Quality improvement effort to develop predictability, alignment in care, and transparency for choice
- Risk management focus to reduce inefficiencies and variability in care and outcomes
- Challenge in plan design v incentives leads to innovative use of levers
- Alignment of incentives between delivery system and consumer decisions
- Communication that is visible, public, and promotional
- VBD + PCPCC = Outcomes that drive sustainable behavior change and predictable, reduced trend

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Fundamental to the value-based designs are a philosophy of investing and supporting prevention and wellness and a culture that promotes shared expectations that access to prevention will be provided, and that beneficiaries will use the access in a wise and timely fashion. There is a second fundamental imperative to value-based designs: Sustainability in reducing the cost trend year-over-year depends upon the communication and support that promotes the desirable behavior change. Overcoming resistance to change is a business strategy that aligns the improved health and performance of the workforce with the improved function of the organization and its personnel.

FOCUS ON ADHERENCE FOR THE TOTAL HEALTH IMPACT

When most companies consider which value-based design elements to implement, they tend to gloss over the prevention imperative, and they most often do not remove access barriers to behavior change supports. Somehow, the total health management of value-based design becomes fragmented as companies quantify clinical and pharmaceutical use while ignoring the consequences of undermanaged prevention and behavioral health. This, coupled with a lack of continuous communication on the desired actions throughout the year (most communication regarding benefit design happens only at open enrollment), launches the employer into a roller coaster of events that was unexpected and, sometimes, economically unmanageable—all because the focus was on a clinical condition rather than the human

performance improvement that is possible with value-based designs.

A caution to employers and plan sponsors: Pause for just a moment and consider what outcome is sought. Most respond they want a healthy and productive workforce, focused on the product of the company, balanced in the work-life timeframe, and well-functioning in the community. In the work of the Center for Health Value Innovation, these goals can be achieved over time with affordable, accessible health interventions that include prevention, risk management, and, perhaps most importantly, behavioral health support.

BEHAVIORAL HEALTH WAS THE FIRST VALUE-BASED DESIGN

There are two icons in the value-based design arena: Pitney Bowes and Asheville, N.C. Most people know that the 2001 plans and beyond were focused on chronic care management, such as diabetes, asthma, and hypertension. Both models have withstood the test of time and accomplished their goals, although each was deployed with different levers. Pitney did not have a required condition-management in order to receive the lowered co-pays; Asheville's model required participation in the pharmacist counseling and diabetes education in order to receive the lowered co-pays, inherently supporting the clinician (pharmacist, physician, and diabetes educator).

But the actual first value-based design at Pitney Bowes occurred in the mid-1990's when access to EAP and behavioral health was expanded, and results showed

the efficiency. In sum, Pitney learned that improving adherence to health management would require supporting the clinician/patient trust, promoting accessible and affordable care, and including EAP/behavioral health as a means to overcoming resistance to change.

At Pitney in the early 1990s, cost trends began to ease lower as a result of health care universality (education) and provider networks formed on evidence-based guidelines, yet the trends in behavioral health were rising. Pitney then began to benchmark its health management experience against the marketplace.

Pitney's strategy was to benchmark against other same-size employers in the same market sector, and the benchmark showed that EAP/behavioral health expenditures were out of sync with the benchmark. In response, they initiated limited EAP/behavioral health coverage. The result was a rise in clinical health costs for the people who needed the EAP services—in fact, the savings in the reduced EAP access were more than offset by the 37 percent increase in clinical costs and absenteeism.²

Thus began the building of the value-based design that eventually became known as the Pitney model: Reduce access and cost barriers to the very intervention needed for the patient. By early 2002, when Pitney began coordinating the care through the integrated data and service mix, thus minimizing the interference between the patient and physician, real change took root. Better outcomes, better management, and better economic results were sustained.

NEW INFORMATION ON BEHAVIORAL HEALTH IMPACT AT THE WORKSITE

Chronic care, and even preventive care and wellness, require long-term persistence, which sometimes works against the human inclination to waiver. However, the reduction of out-of-pocket expenditures and plan design incentives/disincentives can help people manage their health and chronic care better—just as a sagging economy fosters behavior changes. Nevertheless, studies show that depression and anxiety complicate the management of diabetes, cardiovascular disease, asthma, and cancer by up to 50 percent of those diagnosed with these conditions. Such external factors can cause disruption in the commitment, concern, and cost influences for adherence and persistence. (Figure 3)

Continuous surveys track the market for changes in design, focus, and need. One item that does not change—but is never addressed—is the link between behavioral health and clinical health outcomes. Surveys show that most employers of all sizes recognize that diabetes, cardiovascular disease, asthma, and cancer are potentially high costs for their organizations. In a recent on-line survey on the Center for Health Value Innovation’s Website, 10 companies, representing 26, 542 lives, detailed their health benefit focus (Figure 4):

This chart shows that companies are seeking solutions and considering benefits designs according to the concept of improved clinical and financial solutions—a value-based design. They are emulating leaders in the marketplace, using levers such as

FIGURE 3

Economics and perceived instability can interfere with the commitment, concern, and cost indicators of adherence. EAP and behavioral health supports can “catch” employees who may be at risk and reassure their progress.

Figure 3 Source: Nayer, © Mahoney Center for Health Value Innovation 2009. Reprinted with permission

reduction in premium for wellness exams, reduced out-of-pocket costs for pharmaceutical treatment, and others. But these companies seeking new methods for “bending the trend” have missed the impact of under-diagnosed and under-managed depression and anxiety, particularly in this economic downturn when so many are deserting their care management regimens.

These results are similar to the results from a recent survey from the American Psychiatric Association’s Partnership for Workplace Mental Health.³ Five hundred and fifteen companies responded, representing 350,000 employees [75 percent of respondents have workforces

larger than 100 employees]. Key facts from the survey:

- 90 percent provide mental health coverage
- 31 percent say depression is the major cost driver in their workforce; the next largest condition is back illness at 14 percent
- Two-thirds of respondents said less than 3 percent of their workforce suffered from mental illness. This is in direct conflict with the Substance Abuse and Mental Health Services Administration (SAMHSA) findings that over 8 percent have mental illness (Substance Abuse and Mental Health Services Administration,

FIGURE 4

Do you cover prevention and wellness at 100% pre-deductible?	Yes (10 out of 10)	100%
For what conditions do you reduce or waive out-of-pocket expenses?	Diabetes Asthma Coronary Artery Disease [CAD] Congestive Heart Failure [CHF] Chronic Obstructive Pulmonary Disease [COPD]	43% 14% 14% 14%
Note: multiple answers from any of the respondents were acceptable		
Do you reduce or waive out-of-pocket expenses for EAP, behavioral health or substance abuse?	Yes [2 out of 10]	20%

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FIGURE 5

Cost-Based or Financial Design	Value-Based Design
<ul style="list-style-type: none"> • Focused on line-item costs 	<ul style="list-style-type: none"> • Focused on Outcomes
<ul style="list-style-type: none"> • Short-term timeline 	<ul style="list-style-type: none"> • Long-term commitment
<ul style="list-style-type: none"> • Applies to the entire population 	<ul style="list-style-type: none"> • Focused on at-risk population

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National Survey on Drug Use and Health: National Findings, 2003).

- Despite the fact that 31 percent identify mental illness as a major cost driver, only 11 percent provide reminders and recommend screenings for mental illness

There is a wide disconnect between what employers know is driving their costs (unresolved mental illness) and what they are doing to promote better mental health. This drives an even wider disconnect between the behavior change needed for lifetime improvement of health management skills and choice of lifestyle, care provider, and even adherence to treatment for life-threatening conditions.

A CALL TO ACTION

The levers of value-based designs, and their categorical “buckets” of prevention/wellness, chronic care management, and care delivery, have been shown to produce sustainable, replicable lowered costs trends (Center for Health Value Innovation, www.vbhealth.org).

The difference between a value-based design and a financial or cost-based design is the focus on outcomes. A cost-based design considers line-item approaches to reducing costs to the organization within a one-year time period. It is usually a price-first consideration and cost-shares often increase based upon the cost of the service.

A value-based design uses a total health management approach and an investment philosophy to develop an insurance plan, incentives, and disincentives to nudge employees to the desired choices and behaviors. (Figure 5) The investment timeline is a longer-term commitment, with inklings of improvement appearing around the 15-month mark—with trend reduction and reliability occurring between the second and third year. It is an outcomes-focused consideration, rewarding better behaviors across the system. It is not homogenous, but rather population- and segment-focused to promote prevention, identify early risk, and monitor care coordination over time.

FINAL THOUGHTS

Benefits and Compensation Designers would do well to broaden the lens that is often used in order to create designs that improve the health outcomes of the workforce. In order to achieve sustainability and predictability, the inclusion of EAP and behavioral health supports as integral to behavior change will speed the reduction in total spend. Creating a culture that anticipates non-adherence and promotes the education (commitment), resolves the fear (concern), and increases the access and affordability (cost), will sustain behavior change over time. Creating a culture of health, beginning with a culture of shared responsibility for health management, demands a broader focus that includes behavioral health as a total health management and value-driven strategy.

NOTES

1. McHorney, Colleen, A.; *The Adherence Estimator: a brief, proximal screener for patient propensity to adhere to prescription medications for chronic disease*; Current Medical Research and Opinion; January 2009, Vol. 25, No. 1, Pages 215-238.
2. Rosenheck, et al.; *Health Affairs*, Vol. 18, Issue 5, 193-203; September/October, 1999; Copyright © 1999 by Project HOPE.
3. Employee Benefit News; *Innenworkings Survey: A Look at Mental Health in Today's Workplace*; 2007; http://www.workplacentalhealth.org/employer_resources/26739AZSurveyReport.pdf

