Report to the
Joint Commission on Health Care

State Employee Health Insurance

Early Identification and Preventive Care of Chronic Diseases

Virginia Department of Human Resource Management

September 2011

Report on Early Identification and Preventive Care of Chronic Diseases

Purpose

Senate Joint Resolution 325 (2009) directed the Joint Commission on Health Care to examine ways in which early identification and preventive care could improve patient health while reducing health care costs. The COVA Connect program was described and JCHC members approved the following request:

> By letter of the Chairman, request that the Department of Human Resource Management report to JCHC (after July 2010) regarding the costs and benefits of the recently implemented COVA Connect pilot program.

Background

The subject program was implemented July 1, 2009 (FY 2010), the first report period required by the resolution. This period represents the baseline year. The important evaluation context of the impact of the program is as follows:

- The research literature suggests it takes 3-5 years to realize any material return on investment and observe positive health improvement metrics within a population.
- When focusing on improvements in preventative practices within a population, you may actually see an increase in costs in early years due to additional compliance with annual physical examinations and or recommended preventative screenings (such as mammograms and or colonoscopies).
- Year one is much too soon to evaluate the efficacy of a program in which the focus is on preventive health practices.
- Best practice recommendations suggest use of year one as a baseline, then track and collect the data until at least year three before attempting to draw meaningful conclusions.

Baseline Year FY 2010 Report

This initial report will describe the key components of the program.

Optima Health has developed and implemented a total population management model designed to accomplish the following:

- Early Identification of members with modifiable health risk
- Population stratification into risk profiles with specific interventions for each risk grouping
- Collaborative Engagement of the member in developing a plan to modify such risk
- Innovative Programs to support the risk modification plan and improve likelihood of success
- Measurable Outcomes to evaluate the success of the program and allow for improvement

Total Population Management is defined as a program initiated by an assessment of medical and behavioral need, focusing on prevention, risk reduction, self-care management and coordination of services.

The fully integrated Clinical Care Services Model is comprised of clinical professional and non-clinical staff including registered nurses with diverse clinical backgrounds, respiratory therapists, licensed behavioral clinicians, health education specialists, dietitians, certified tobacco cessation specialists, social workers, and non-clinical Health Advocates trained to support self-management plans, trained to offer all of the following services:

- medical care and utilization management

- disease management
- behavioral health management
- pharmacy management
- health & prevention education and biometrics
- Employee Assistance Program (EAP)

Members are assigned to a primary resource within this model to prevent duplication of contacts and confusion for the member. A member may be identified for the program based on any of the following:

- Presence of chronic illness such as (but not limited to) hypertension, diabetes, hyperlipidemia, coronary artery disease, congestive heart failure, respiratory illness, complex joint/muscle disorders, sickle cell disease, depression, major psychiatric disorders, and chronic pain
- Frequent utilization of the emergency room
- Acute or unplanned hospitalization
- Presence of specific medications indicating complex or high risk conditions
- Members who are pregnant are also identified by the program and offered our population-focused pregnancy program.

Optima staff members use evidence-based guidelines of care and actively work with the member to develop a plan of care. Goals are set and members receive follow-up coaching to evaluate progress and offer ongoing support, management and coordination of services.

Evidence based outcomes measures are the hallmark of a successful health management strategy. The results of the program offered and the effects of changes in the environment must be part of a continuous quality improvement program. Measures of success rely on a high level of organizational engagement, as well as a high level of employee or member engagement. [i]

Demonstration of Return on Investment (ROI) in such programming generally requires three to five years. [ii] The program underway with the Commonwealth of Virginia completed its second year in June of 2011 and data will be available in late 2011. When available, a comparative data set will be completed for FY 2010 and 2011, and initial observations will be included in the 2011 report. Data included will be metrics such as year over year(s) number and rate of interventions, compliance with coaching, the overall risk stratification of the population, etc. However, we would caution that meaningful conclusions on the overall effectiveness of the program will not be available until at least the 2012 report cycle.

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[i] Edington, D., Zero Trends: Health As A Serious Economic Strategy. Health Management Research Center: 2009.

[ii] Serxner S., Gold D., Meraz A., Gray A. Do Employee Health Management Programs Work? Am J Health Promot. 2009 Mar-Apr; 23 (4).