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Using Metrics to Lower Health Care Costs and Enhance Productivity

A Conversation With Nancy Blough, Executive Vice President of American Health Data Institute

By Cathleen O'Connor Schoultz

Keeping employees healthy and at the top of their game, and slowing down spiraling health care costs, are objectives near the top of every company's "must-do-somehow" list.

The only way to lower costs is to keep employees healthier and, many say, come up with an alternative to fee-for-service payment of medical providers. Nancy Blough told BNA in an interview that the right numbers will lead the way. Recent advances in technology—even in the past three years—make it easier for companies to "marry" exactly the right data sets to create a foundation for their health care and wellness plans, and to, in turn, measure the effectiveness of the programs they have established, Blough said. She is executive vice president of American Health Data Institute, based in Ft. Mill, S.C.

BNA: Can you really use metrics to lower health care costs and enhance productivity, and if so, how?

Blough: Yes, you can. You look at key indicators such as workers' compensation claims, disability payments, medical payments, pharmacy claims, absenteeism, and productivity rates. You can measure the indicators of how employee health issues are affecting other factors and how those health issues can be improved. For example, how many days are people losing to illness and how much of the illness could be prevented or taken care of more effectively?

BNA: Can you give an example?

Blough: Well, let's look at common (or acute) issues, say people getting colds and ear infections.

BNA: When you say "common," do you mean as opposed to chronic?

Blough: Yes, These can result in time lost from work to get checked out and maybe even being off of work entirely. A lot of companies seeing these types of problems have brought clinics into the workplace so that employees can see a physician—or a physician's assistant or nurse practitioner even more frequently—at the work place to keep themselves healthier in the first place and get treated promptly when they're not.

BNA: Are you seeing more of this—having health care on the premises?

Blough: Yes, mainly large employers—this fits perfectly for a large employer. A clinic on site would be able to take care of both prevention and routine care. Typically they have the ability to fill a prescription too, so you can get people on their medications.

BNA: And I guess you reduce the working sick?

Blough: Yes, that's the second area—not just the absenteeism but the presenteeism—where employees are at work and sick and so not as productive.

BNA: And probably making other people sick in some cases?

Blough: Indeed infecting the workplace. And if a company is watching its illness or sick days as a key indicator or metric, it may ask "How much can we save on this in order to justify any kind of intervention?" Companies that measure productivity closely tend to be large ones. They know what their productivity should be and if employees are sick at work it's going to reduce the productivity.

BNA: Can you explain the mechanism a little more? They are watching their productivity so they can tell it's reduced, but how can they connect it to the sickness and sick days?

Blough: Once you get the data sets into an electronic "warehouse," you can marry them however you like. Every employee has a unique alphanumeric identifier, so a company can compare that employee's claims information to number of sick days, absenteeism, pharmacy records, including whether they are taking their medication for any chronic illnesses.

And if they've got some kind of productivity standards—and most large companies do—let's just say someone who pays claims can do 15 an hour on average, and a person out a lot for sickness who also has a chronic disease is only paying 10 or nine claims an hour. That at least leads you to ask why that person's productivity is lower. Is something going on from an illness burden perspective that we should know about?

BNA: Wouldn't you have a privacy issue there?

Blough: No, first of all much of the data is not private, such as workers' comp and disability. Even so, the company is only using the data in the aggregate. You do not know who the individual is by name but only by the unique identifier. . . . Someone at the company knows who the individual is, even data concerning medical claims. But since medical information is covered by [the Health Insurance Portability and Accountability Act], you have to do it as prescribed by law. Employers do this already. They have

to know who the large claimant is when they go out and shop for medical insurance, for example. HIPAA protects the ability of companies to get the information they need to be able to manage a health plan. It just can't be someone who can take a personnel action. You might use an outside consultant for this, or your privacy officer. But it couldn't be someone in HR who also takes employment actions. Access to data in the medical bucket is given on a need-to-know basis—and you better have a good reason to know. Putting together metrics to find out what kinds of services we need to offer folks to keep them healthy certainly is one of the reasons you can use that aggregated data in the law.

BNA: So you use employee data to design a plan and then again to see if it's working?

Blough: Yes. One key indicator of the state of a company's medical plan—and studies have confirmed this—is workers' comp claims. Companies will find the claims go down if they are managing the medical side better. Accidents happen when you're not paying attention. It can be an employer safety issue, but accidents also happen when an employee is impaired. If you're in pain or you're not taking your insulin, it's hard to focus.

BNA: How do you measure the interaction with productivity?

Blough: You'd look to see whether the claims payer who is not as productive is the same person who is out sick more, has a chronic condition, who didn't fill a prescription.

BNA:How could you tell if someone filled a prescription?

Blough: Most companies have a pharmacy benefit manager. They know how often people with high-blood pressure need to fill their prescriptions, so they can tell if a person is not keeping up with their medications for chronic conditions.

BNA: Again, they would know that employee 6699V5 was taking the medication, right, versus Jane Smith?

Blough: Exactly. And when companies know what the issues are they can improve the situation. Maybe at one company the problem is not as widespread, so that company decides it doesn't need to build a whole clinic, but maybe has a nurse practitioner available or a nurse practitioner one day a week. You can back into a solution once you know what your aggregate problems are.

BNA: How does an employer do these measurements?

Blough: There are data companies that will pull all this data from medical claims system here, workers' comp there, disability payments, and so forth—so the employer can get to the level of analysis I'm talking about. The employer uses the data to build

its health care system. This is not pie in the sky. Employers can find out exactly how many people making over $20,000 missed so much work and also had a workers' comp claim, for example. Hit another button and find out how many of those went to the emergency room and how many were hospitalized. Isn't that cool?

BNA: Yes. So these data systems have gotten a lot better recently?

Blough: Yes, when you set up metrics, you have to have a way to monitor them and figure out what to do with them. Technology has caught up over the last three years and gotten very sophisticated.

BNA: I still read conflicting reports on whether wellness can be proved to be effective.

Blough: This is quite measurable. There are companies on the leading edge that have used metrics and wellness successfully. Just last week at a conference for self-insured companies I heard the medical director at Purdue Chicken Farms talk. They studied the data and built their programs around it—and they have kept medical costs flat for five years.

BNA: Wow.

Blough: You have to measure based on what you want your outcomes to be—and let me tell you, prevention is a huge piece of that equation. I don't believe there's the excuse anymore that we can't measure this. Wellness does work but you've got to be knowledgeable about how to measure it—and have the resources to measure it. If you have an unstable population that's coming and going all the time—a revolving door—you're not going to be able to measure it because your variables are always changing. But companies that are fairly stable—and those with groups that are fairly stable—can do these metrics. You definitely can measure the impact of chronic illness and whether those intervention programs are working—that can be an absolute with a stable population—you can track that.

BNA: Amazing.

Blough: At Purdue a physician set up the metrics—he knows when people are getting the care they need or getting care they don't need. And he helped design a health care plan that let people with chronic illnesses get care on a regular basis and gave them access to clinics where it makes sense.

BNA: So the idea is to pay for the problem when it's small, a stitch in time saves nine?

Blough: Yes.

BNA: What's the piece about people getting care they don't need?

Blough: This is not unusual. Say a doctor gets a machine for the office and when people go to the office, they get this test because the machine's

there, whether they clinically need it or not.

BNA: How do you watch for that kind of thing?

Blough: The same way you watch the other side. You watch the claims forms to see what's going on. A lot of large companies are getting into pay for performance arrangements with doctors or other kinds of arrangements other than fee for service. They're saying, "If you take care of my employees the right way, I will pay you what you deserve."

BNA: How do you know what the right number is?

Blough: Again, there are companies out there that can look at medical claims information, and see how efficient a practice's treatment is, and how cost-effective compared to norms written by the medical community. Think about it—you don't want the sickest of the sick going to doctors with the worst scores in both quality and cost-effectiveness. For an employer, not looking at this information is like writing a check and not knowing what you just bought.

BNA: Can you give an example of what a bad outcome might be?

Blough: If you go to the hospital and have to go back for an infection. Normally you wouldn't be expecting two hospital stays—that's an outlier. There are very sophisticated algorithms involved. I'm giving you a simplified example.

BNA: Do employers ever work with doctors to study these issues together or do the two sides have conflicting interests?

Blough: Yes, the two do work together in some cases. Purdue did, for example. I've seen some great partnerships. It's not like doctors are the villains. Some companies sit down with a practice, for example, and say, "We want you to understand our workforce; here are some of the claims I'm seeing come through our system that I'm a little nervous about. . . . I'm not sure my diabetics are being well taken care of." You have that kind of conversation with the local medical community. It's the perfect partnership and it can happen—because they're all working for the same goal. Doctors want to be paid for what they do well but our system because it pays fee for service doesn't always allow them to do that. But you can sit down and work out a different arrangement. There's no law that says you have to pay fee for service.

BNA: Can you give me a hypothetical case?

Blough: Let's say you've got a group of physicians to treat your cardiac patients—you have learned they are high-quality, cost-effective providers in your community through the data. You pay them an amount to take care of that group of people, and they get to manage the care accordingly.

BNA: How does that work better? Is it because they know what they need to do and you let them do it in a sense outside of the picayune limits of the plan? Do they have more freedom to create something innovative?

Blough: Exactly. A group can come up with some very creative approaches as long as the outcome is good. Let the doctors practice the way they say they can for a price you want to pay.

BNA: And do the doctors end up making as much or more money than they would under another arrangement, or do they make less money but they can count on it? How does that work?

Blough: Most of the time, they end up making more because they're doing it right. They're getting volume because they're more efficient. See here's what the employer has to give to that physician—a practice. The physician doesn't have to do things to get fees up to a certain income level. So everybody wins. It's a basic economic principle.

BNA: And I suppose they can renegotiate as they go along?

Blough: If it's a sicker patient population, then the providers can come back and renegotiate. But all things being equal, employers already have the data to have that conversation with the doctors.

BNA: So if the doctors are doing unnecessary tests, in a sense it comes out of their own pockets?

Blough: It does. And that's the right incentive. That's great if you want to buy a machine, but I'm not paying for it every time someone walks in. If that test is necessary we'll pay for it. And that gets rid of all that unnecessary care that doctors are trying to do to make up for how they get paid right now.

BNA: Interesting. You have talked about needing to figure out which groups you need to work with. You said that employers can set up programs to help specific segments of their workforce and their industries—men, for example, or women. You said once that some people are ticking time bombs—certain people with few claims now because they are not going to the doctor. And then the well population can be a risk in the sense that another insurance company— or exchange now—might woo them away. Can you talk about that a little?

Blough: Certain populations present different risks. With males in a manufacturing company, you could see more musculoskeletal issues, especially if they are overweight and over 40—because they're not conditioned.

So there's a metric you can tie right back into productivity and accidents. And the intervention—if you found that to be true—might be some physical therapy and some conditioning, and some weight loss

programs for that population that's been identified so that they can be more productive and healthier and live longer.

BNA: How would you know that they were overweight and out of condition? Would they do health risk assessments?

Blough: Exactly. That would be another one of your baselines. You would have the numbers there to look at in the aggregate. . . . Again I go to my little magic system, I punch in a number say, give me the people musculoskeletal issues that cost over $10,000 last year. Tell me how many of those also have a chronic condition. Tell me how many of those are male and female; tell me how many are over 40; and tell me how many on their health risk assessments had a body mass index of over 28. Guess what? You've now got your targeted population.

BNA: Are you seeing companies doing that now?

Blough: Absolutely. And it's the larger ones. They've figured out they've got to put these pieces together—and tie that all back to productivity measurements. That's how you show that the health plan has a value, not just a cost. The value of keeping people healthy on your health plan, the reason people employers want to offer the benefits because they want a healthy workforce that's productive at the end of the day.

BNA: In that same population, what might some of the women's issues be?

Blough: Part of their profile might be high-risk pregnancies. If I had a female population that was over 35 or 40—who are at greater risk for difficult pregnancies—and not getting pre-natal service, you build a health plan that works for that group. In its pure form, you're building and designing a health plan around the health of your population—what a novel concept!

BNA: Will companies still be able to do that under the new paradigm after health care reform?

Blough: I believe so. One of the provisions actually requires companies to offer preventive services. At least in this area there don't appear to be any landmines for companies. Even at the federal level, people know that the only way to contain the costs of health care is to keep people healthier. And there's a lot about more focus on health care technology.

BNA: Do you think the law's focus on electronic health records will make it easier for companies to get metrics?

Blough: Yes, it will be easier to get better data, so doctors can practice medicine better. If you go to three specialists now, there's no guarantee they've seen each others records or any tests they've done. The electronic records provisions are down the road a bit.

BNA: Do you envision a smart card in the future that will not only tell the doctor what I'm covered for but also that I just had such-and-such test last week?

Blough: Yes, and pharmacy records. Now we're hampering doctors because they don't have access to all the relevant information.

BNA: So can you see records being more searchable?

Blough: Absolutely. And if employers keep pushing for the technology, the best of the best will get into this field. It will be like the evolution and revolution we saw in the banking industry when everything went online. We've learned a lot about securing private information. One might say we haven't because we have identity theft, but not a lot considering all the data passed along these days. The challenge for the medical industry will be greater as far as getting so many individual doctors linked into the system. . . . I've seen some good ideas, though, and some communities have provided grant money for doctors in their area and gotten pilot systems up and running.

BNA: I'm going to jump back in time if you don't mind. You've been in the field a while, maybe 20 years?

Blough: Actually 25! Twenty-five years ago, we learned at our mother's knee that to stay healthy, we need to exercise, don't smoke or drink excessively, and eat lots of fruits and vegetables. That hasn't changed, but unfortunately we're not all doing that. But I think the time is right for wellness—I see a stronger push over the past two years. Plus there are the new tax incentives. Right now the law says companies can get a tax credit for up to 30 percent of their preventive programs, but the secretary of Health and Human Services can increase that to 50 percent without even going to Congress if she decides to.