HealthBlawg :: David Harlow's Health Care Law Blog

Interview of
Wayne Burton, MD, Member, Board of Strategic Advisors,
Center for Health Value Innovation
and
Cyndy Nayer, Co-Founder and President
Center for Health Value Innovation

Part I of II
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David Harlow: This is David Harlow on HealthBlawg and I have with me today two interesting individuals who are going to be speaking with us about value based health benefit design. Dr. Wayne Burton, who is a longtime Corporate Medical Director for JP Morgan Chase and has recently joined the board of strategic advisors of the Center for Health Value Innovation, which is an organization developing and sharing evidence have improved health and economic outcomes, a value based health benefit design. Also with us today is Cyndy Nayer, a Co-Founder and President of the Center who leads the Center's partnership with public and private sector entities using value-based design to improve outcomes. Thank you both for being with us today.

Cyndy Nayer: You're welcome.

David Harlow: I'm interested to hear, as we start, whether you could describe a little more fully, Cyndy, the work of the Center and where you see the largest impact or the greatest impact for your work these days.

Cyndy Nayer: Sure, I'd be happy to, thank you for asking. The Center was founded as an not for profit organization to galvanize innovative employers which would be medical directors as well as VPs of HR, human resources who are doing some very innovative things around getting the better outcomes - both economic and health outcomes - within their employee sector and showing an economic sustainability that would work but what really connected to talk to each other and accelerate the process. As we began to recruit some of those innovators into the space, some of the health plans became very interested in what we were doing. Now we represent a multi-stakeholder group that includes employers, private, public, not for profit as well as for profit, health plans, provider groups meaning health systems, physician organizations, single practices, employee benefits consultants. Some folks call them brokers but many of these folks provide a much wider range of consulting expertise to their employers than just brokering insurance. We include government entities cities, counties and states, we have several not for profit organizations with whom we have a strategic alliance and we are working quite diligently to bring about a change in the focus of the dialog, so what does that mean? When we purchase on unit cost and we use line item vetoes to hold down cost then we're really not focused on the outcome of the patient or the worker. When we instead focus on outcome - improved health - and understand that healthcare is the means to get to improved health, the entire dialogue changes. And so our focus, particularly this year - and this will be our fourth year in existence,

we will be focused very much on outcomes based contracting, outcomes based purchasing. Does that help you understand what we are and where we are going?

David Harlow: Thank you very much. Wayne, I'd be interested in hearing from your perspective - I understand that in your role at JP Morgan Chase you're involved in the patient centered medical home organization and I'm wondering how you see the progress of that initiative? Sort of one demonstration or pilot project among many or, I think, from the perspective of employers who have been using this approach to contracting, it's much more than a pilot. So I would appreciate if you could shed some light on your experience in that arena and where you see that fitting in with other initiatives that employers maybe taking today.

Wayne Burton: Thanks David. Actually we were not involved in patient centered medical home demonstrations but I'm familiar with other companies that are and I believe that the key there is that providing the right care would result in better outcomes for employees and their family members and corporations, and also as Cyndy mentioned, to have sustainability in their cost trends, lesser absenteeism and a more productive workforce.

David Harlow: And do you see other particular types of efforts as being particularly promising or productive today?

Wayne Burton: Yes, I do. The efforts really across the country with looking at outcomes, looking at evidence-based medicine - and one of the hats I wear now is Co-Chair of the National Committee on Evidence-Based Medicine for the National Business Group on Health - is really fostering evidence-based medicine amongst employers and plans and clearly there are many, many efforts going on in that regard. But if we follow the guidelines and latest treatment guidelines that's going to result in better outcomes, and for corporations, employees are going to be in better health, more productive and use less disability time.

David Harlow: Do you see an evolution over time in the development of protocols through evidence-based medicine because historically there has been a lot of objection to the notion of "cookbook medicine" by some frontline providers, and I'm wondering how you respond to that?

Wayne Burton: Well, David, you're right, and I'm a physician and an internist and so I'm aware of the concern amongst providers about so-called cookbook medicine. Part of the concern is the different guidelines that are out there and different rules and there are a number of efforts now across the country for groups to get together and have common guidelines and common metrics to measure - specifically by the major health plans - because the providers, if they are trying to abide by different rules, it's very difficult knowing which rules they are going to be rewarded for, so to speak, in one plan versus another. The other point that you make, and it's an important one, is we certainly don't want to see cookbook medicine. Evidence-based medicine means doing the right thing for patients realizing there is variation, and realizing that treatment does have to be modified based on the particular patient, the particular medical conditions and comorbidities and so forth.

Cyndy Nayer: So David if I could amplify what Wayne is saying and also do a little bit of the background on Wayne so that everybody knows that the JP Morgan Chase Medical Directorship

is certainly one of the hats that he wears, but Wayne has been diligently cataloging and publishing and researching the connectivity between poor health, disability days (defined as workers comp or unscheduled absence), comorbid conditions - for instance, people who have depression typically don't manage their other health conditions very well if the depression is not managed well. These are the kinds of research and calls to action that Wayne has made a career of, and that's one of the reasons we're so excited to have him on board because he kind of rounds out a lot of the work that we're doing. Having said that, and to his point of evidence-based medicine - not using that as a cookbook, but really just as a starting point as the concept of treating and triaging patients and workers and families has grown and the amount of information that we know about managing health is exponentially larger than what we do 5 to 10 years ago and will continue to grow. Evidence-based guidelines, evidence-based medicine give us a place to start that changes the variability between practice patterns. So it says first start here, and once you see that doesn't work or once you have at least considered this guideline - then again, putting your patient first, not the guideline first, the patient first - think about what you might want to massage, change, do better for that patient. And most of us will do better close to an evidence-based guideline, but there are also many of us that will not, for a variety of reasons. And human beings are human beings because we are different by nature and different by how we approach our health management. For all of those reasons, what Wayne has said and the work that Wayne has done supports and amplifies the whole concept and focus on outcomes. So the evidence-based platform is where you start, but what we really want to see are communities of health. And that's what an employer wants as well, because when we have healthy workers, we also have healthy purchasers and we have healthy users who make appropriate decisions of the kinds of healthcare that they will use as well as the kinds of other products that they will use in a community and that's part of the sustainability factor of America. That's really it's a big picture but it's about seeing how we might do it more efficiently and quite frankly more innovatively which is what we're known for.

David Harlow: Sure. Now at what points in the process in terms of designing and implementing these approaches are you also doing measurement to ensure that there is a significant impact?

Wayne Burton: David, I think there are at least two ways we are approaching it. Ideally, you're designing the outcomes measures at the start of a particular program or intervention and that's best of all possible worlds, but we realize that in many cases that's not always possible. So that much of the very good research now is taking a look back at what had been done, carefully analyzing the data that's available and then seeing the effect of a particular intervention.

David Harlow: And have you collectively been at this long enough to be making changes to the approaches based on the measurements and outcomes observed?

Wayne Burton: From the employer side I've been involved in it for over 25 years. And so we had the opportunity to look at programs prospectively. For example, a lot of our work has been done at the work site where we have interventions for diabetes and asthma and migraine headache and prospectively we look at how these educational programs and disease management kind of programs have impacted the health and well being of our employees that participated - including they have economic impact - but as Cyndy said our role is to first show that that can improve the health of our employees and if you improve the health then the cost will follow.

Secondly, we've looked at really thousands of workers as we put in programs like wellness programs that can address health risk and we know now from a lots and lots of research, our own and many others, that if health risks are modified through lifestyle programs and other interventions that with those reduced health risks that healthcare cost trends will modify, that there will be less absenteeism, and in fact now we know from the past several years there is improved on the job productivity – so-called presenteeism.

David Harlow: Presenteeism, I like that. One thing that I've read in your materials is the notion that there are different levers that you can use to effect these outcomes and you've identified them as sort of falling into different categories or different employers maybe at different stages of readiness to employ different approaches. And you mentioned a moment ago the notion that there are a million different measures that people are called upon to report on. And I think the same question arises in terms of the proliferation of different types of interventions that can be taken as well. I often ask people whether we could limit ourselves to a dozen or so outcome measures rather than measuring a couple hundred or thousand different outcome measures and the same goes really on the input side, on these levers. Can we legitimately limit ourselves to a couple dozen levers to manipulate in order to achieve some beneficial outcomes? The more levers we have and the more measures we're trying to follow, the more complicated it becomes the more unadministrable it becomes from my perspective.

Cyndy Nayer: You're incredibly correct. You have no idea of how correct you are, which is why we took 107 levers and rolled them up into basically 15 macros levers but even the macro levers are changing as we're talking right now, they are dynamic. So I think the major focus is to stay on the 3 domains of the levers and understand that innovative employers, innovative health plans will add levers as we learn more. So the three domains are these: prevention and wellness, chronic care management and individual health competency. The last one is a little tricky, so what that means is: how do we teach people to manage their health effectively and link it to both their wealth and performance and these are on a continuum, no one ever deploys only one value based design lever, they are always part of a suite. They are always determined by the state of urgency and sophistication of that employer at that moment when they start and no one succeeds in a value based design without two things. One, an incredible focus on prevention and wellness, an expectation that people will take care of their health. And the second is consistent and ongoing communication. We have several instances where companies thought if they announced a value based design during benefits enrollment people would dive on to it. And within eighteen months they had left the value based design space because it's a complicated message and it takes a while for people to understand what exactly we want them to do. Value based design is not just about moving copays to zero for a drug. It really is about teaching people what part of the highway do we want them to travel on. How do we help them get to their destination, healthier, higher performing, more productive and that's what the levers are about. Think of them as cones on the highway, and as we fix the highway or encounter new bumps we move the cones around to get the cars to move a different direction - that's exactly what a lever does.

David Harlow: So give us an example or several examples of levers, are these financial incentives or these what are they?

Cyndy Nayer: So the iconic moment is financial incentives, you're incredibly correct. The early pioneers, Pitney, City of Asheville did use copay incentives. But sometimes there are others that use a variety of other incentives. I can give you a couple and I know Wayne can give you many more. One example is teaching people to use their personal health record and lowering their insurance premium because they do use their personal health record. Now, why would people, why would a company do that? Because in order to create sustainable behavior change, people have to manage to a goal. Teaching them to use their personal health record teaches them to manage to a goal. Having folks get their flu shot when they have cardiovascular disease or diabetes, and bringing the flu shot on site and if you get it on site giving it to them at a waived copay or low out of pocket expense, that's another kind of a lever. You get the idea, some of them are financial but some of them are really messaging and communication. Wayne, do you want to add to that?

Wayne Burton: Yes, and David, I think one of the questions you brought up is important for corporations - what the focus on in terms of design of wellness programs - and it turns out that for employees if they complete a health risk appraisal and if the health risk appraisal asks questions about medical conditions and health risks and usually it takes at most ten or fifteen minutes to answer those questions. It's a extremely powerful tool to guide the employee and to guide the company in terms of what program should be necessary - and actually, of the health risks there are probably a dozen or less for most corporations that are important, and certainly health risks such as smoking, physical activity and weight are probably at the top of the list for most companies in terms of risk to many individuals. In terms of medical conditions, similarly, yes there is a whole long list of medical conditions that could be addressed. For most companies especially in the United States, in the service industry, for many workers, pregnancy and mental health is usually in the top five or top three conditions, musculoskeletal disorders of one sort or another - probably back pain is one of the most common. So, yes, there are lots and lots of conditions and outcomes that could be focused on in prevention programs, but at the end of the day most companies can focus on a relatively small number and reach the majority of their employees and family members.