Maximizing Your Disease Management & Health Promotion Dollar

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Perspective

DISEASE MANAGEMENT – A DEFINITION

According to DMAA (Disease Management Association of America), "Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant." DMAA states that disease management:

- Supports the physician or practitioner/patient relationship and plan of care
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies
- Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.

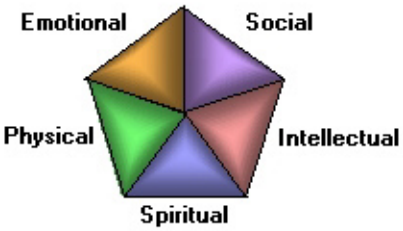
Disease Management Components include:

1. Population Identification processes
2. Evidence-based practice guidelines
3. Collaborative practice models to include physician and support-service providers
4. Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance)
5. Process and outcomes measurement, evaluation, and management
6. Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling) [1]

[1] http://www.dmaa.org/definition.html

HEALTH PROMOTION – A DEFINITION

According to the American Journal of Health Promotion (AJHP), "Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices. Of the three, supportive environments will probably have the greatest impact in producing lasting change." (*American Journal of Health Promotion, 1989,3,3,5*).[2]



Physical	Fitness. Nutrition. Medical self-care. Control of substance abuse.
Emotional	Care for emotional crisis. Stress Management
Social	Communities. Families. Friends
Intellectual	Educational. Achievement. Career development
Spiritual	Love. Hope. Charity.

Disease management is a target component of health promotion. DM concerns itself with a segment of the population identified with, and being treated for, a defined disease (an impairment of the normal state of the living animal or plant body or of any of its components that interrupts or modifies the performance of the vital functions[3]).

Disease management without health promotion is the same as a city having excellent fire fighting skills and no strategy for fire prevention; they must go hand-in-hand as a single unit; DM/HP.

[2] http://www.healthpromotionjournal.com/
[3] http://unabridged.merriam-webster.com/

In today's world of DM/HP there are many excellent programs, qualified vendors, and dedicated health professionals. There is also a treasure chest of data validating the health and economic importance of managing disease and maintaining a healthy lifestyle. As a result, the associated benefits of lowered operating costs, high productivity, dedicated employees, and positive community image clearly positions DM/HP in the same category as other business essentials, i.e. equipment maintenance, appearance of buildings & grounds, marketing & sales, and healthcare claims & administration. Or, does it?

To get a handle on where DM/HP sits on your organization's priority scale, take the following survey (respond honestly; not according to how you wish it might be…)

Employee DM/HP: Where Does it Fit?

1

<u>Your Personal View of Importance:</u> Rank Order (1 – 5)

- ☐ Equipment Maintenance
- ☐ Appearance of Buildings & Grounds
- ☐ Employee DM/HP (Administration & Programming)
- ☐ Marketing & Sales
- ☐ Healthcare Claims & Administration

2

<u>Top Management's View of Importance:</u> Rank Order (1 – 5)

- ☐ Equipment Maintenance
- ☐ Appearance of Buildings & Grounds
- ☐ Employee DM/HP (Administration & Programming)
- ☐ Marketing & Sales
- ☐ Healthcare Claims & Administration

3

Budget Allocation: Rank Order (1 – 5)

- Equipment Maintenance
- Appearance of Buildings & Grounds
- Employee DM/HP (Administration & Programming)
- Marketing & Sales
- Healthcare Claims & Administration

4

Annual Expense: Rank Order (1 – 5)

- Equipment Maintenance
- Appearance of Buildings & Grounds
- Employee DM/HP (Administration & Programming)
- Marketing & Sales
- Healthcare Claims & Administration

5

Measurable Positive ROI: Rank Order (1 – 5)

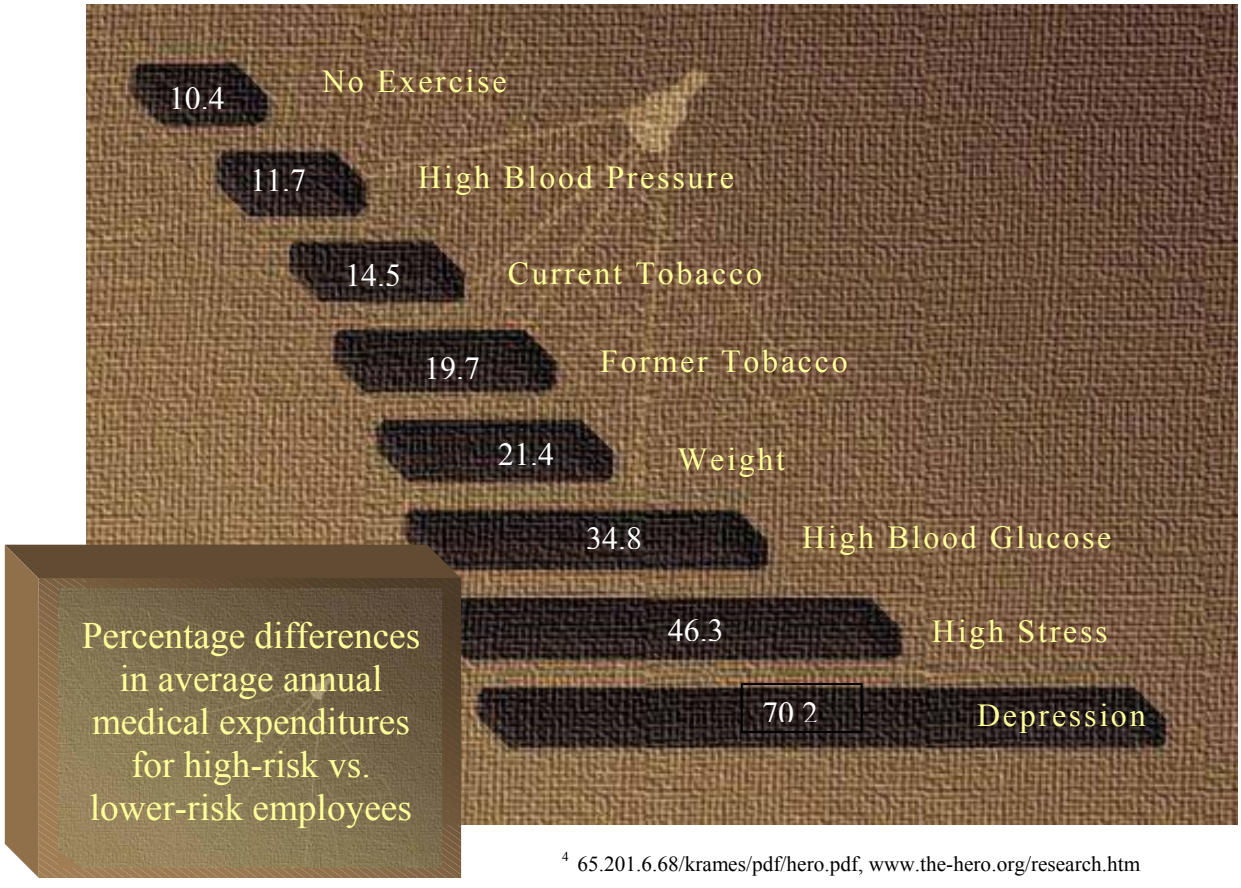
- Equipment Maintenance
- Appearance of Buildings & Grounds
- Employee DM/HP (Administration & Programming)
- Marketing & Sales
- Healthcare Claims & Administration

After carefully considering and responding honestly to the 5 areas, what have you learned? Anything incongruent? If your answers are "nothing" and "no," go back and answer the questions *honestly* this time.

Now, for a quick reality check, go back again and take a look at your responses to areas 3 & 4. Now, take another look at area 5 and ask yourself: Why does DM/HP require precision ROI scrutiny while other internal business sectors require little or no analysis? Consider the fact that calculating meaningful ROI for marketing is like nailing Jell-O to the wall and --- while there is a great deal of subjective value associated with nice carpeting, green grass, and expensive artifacts --- organizations rarely tie bottom line dollars to corporate aesthetics. On the other hand, research shows a clear and converse relationship between dollars spent on DM/HP and those spent on healthcare claims and administration. When you add the economic impact associated with undiagnosed stress, absenteeism, and dependant lifestyle, the total ROI for DM/HP grows exponentially. One more thing, given an ageing population, escalating healthcare costs, a shrinking dollar and rapid advances in medicine and pharmacology, we are beginning to experience longer and longer periods of high-cost morbidity.

The next time someone asks you to provide strict ROI data on your DM/HP efforts consider asking them to do the same for the new marble tiles, manicured shrubs, lobby art, and outdoor fountains. Okay, maybe that's a bad idea, but you get the picture.

To demonstrate this point, review the excellent work published by the Health Enhancement Research Organization (HERO Study):[4]



[4] 65.201.6.68/krames/pdf/hero.pdf, www.the-hero.org/research.htm

Another case in point …

An evaluation of the financial and health impact of a large-scale corporate health and wellness program conducted for Johnson & Johnson has shown that participating employees have significantly lower medical expenses and achieve overall health benefits in risk categories such as high cholesterol, hypertension and smoking.

The study conducted for Johnson & Johnson by the Medstat Group of Ann Arbor, analyzed medical insurance claims for 18,331 Johnson & Johnson employees who participated in its Health & Wellness Program from 1995 to 1999. Savings of $225 annually per employee came from reductions in hospital admissions, mental health and outpatient visits. Employee medical expenses were evaluated for up to five years before and four years after the program began. Johnson & Johnson savings averaged $8.5 million annually.

"These results highlight the significant impact that integrating large-scale corporate health and productivity management programs can have on company medical expenditures," said Ronald J. Ozminkowski, lead author of the financial findings, which appear in the Journal of Occupational and Environmental Medicine. (January 2002).

Bottom-line: DM/HP programs have a significant economic and health impact. Period.

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10 Common Concerns Facing Today's DM/HP Professional

1. Participation

"We've got great programs, dedicated health professionals, and supportive management --- so why is participation so low?"

Unfortunately, the "other guy" syndrome is human nature. The norm reminds us that until a measurable event occurs --- a teachable moment --- people deny the need for prevention services. This phenomenon is independent of knowledge and understanding; the cause is emotional. "Yes, I smoke," goes the story, "but I'm going to quit, soon; honest." "Of course I've put on a few more pounds, but this is the way life is. You gain weight, as you get older. One of these days…." "I don't drink any more than most people; besides, I can hold my booze, pretty well." "I know I should get more exercise, but right now, I'm too busy."

The above excuses are all grounded, not in fact, but in desire. The consequences of poor lifestyle choices are all real, however, they are not the person's reality; not, at least, until there is an event. This, the event; the heart attack, stroke, mental breakdown, divorce papers, child in crisis, bankruptcy, onset of type II diabetes, knee replacement, etc., triggers a marked increase in both motivation and activity. The activity is emotionally driven by fear, pain, and the *stark* reality that, indeed, it <u>can</u> happen to me. I am, now, "the other guy." Unfortunately, as the symptoms subside, the newly discovered good health practices seem less urgent and the individual begins to slip back into the world of "should," and "someday" and the cycle repeats.

The bad news is that illness, age, and corresponding disability will increase DM activity. However, incidence of disease and the need to manage that disease is not where we want to see growth. We need to foster growth on the prevention side of HP. To increase prevention participation we need to broaden our target market, focus on all the components of optimal health, and we need to understand the role of lifestyle staging and readiness to change.

2. Segmentation

"Our organization is increasingly diverse. So, with a limited budget, how do we provide programs that are gender specific and accommodate differences in age and culture?"

The "Great Melting Pot," as the United States was called at the turn of the last century, consisted, primarily, of Western Europeans, however, today's melting pot is truly international. Asia, Latin America, Eastern Europe and India are the jumping off points for millions of today's immigrants. In addition to diverse cultures, the workplace often houses up to four different generations of workers; kind of a Pearl Harbor meets Pearl Jam mixture of memories, values, attitudes and expectations.

To be effective, DM/HP programs must respect and understand the history and sociology of health and lifestyle practices relative to age and culture. The days of cooker-cutter programs are over --- or, certainly should be. Before throwing programs and activities at your employees you need to identify an individual's needs, interests, beliefs and position in the stage model (Stages of Change, Prochaska, et. al.).

In addition to understanding the dynamics of organizational culture and individual change, research shows a direct correlation between desired outcomes and degree of individual tailoring. The more the individual feels that the program is speaking to him or her the more vested they become in the process. It's the old story of which radio news bulletin grabs and holds your attention:

- Typhoon Strikes the Coast of Japan
- Hurricane Bearing Down on the Caribbean
- Miami Prepares for "The Storm of the Century"
- Funnel Cloud Spotted North of Town: Take Cover, Now!

3. Efficacy

"What expectations should we set for our DM/HP programs and how should we measure success?"

It is important to remember that change is a process, not an event. Certainly, when it comes to the DM aspect of HP, we can look to specific biometrics as one indicator of success. However, in management as well as prevention, the initial key indicator is *participation*. Regardless of anything else, programs must promote and reinforce entry and progression through the continuum of change. *Any* movement along this continuum should be measured and viewed as success.

By limiting success criteria to biometric indicators you not only set your programs up for perceived ROI failure (more about that later) but, by definition, you limit the breath of your program offering to that small segment of the population who is ready for a specific intervention strategy. In tobacco use, as an example, you miss the 85% of smokers who are not ready to begin a formal intervention program but are primed for more education or need assistance in maintaining their non-smoking status. Which tobacco control program is more successful: one that has 30 out 100 attendees tobacco-free at the end of one year, or a program that moves 600 out 1000 tobacco users from the point of NEVER wanting to quit their habit to thinking seriously about changing in the next 30 days? As with so many options, they both have merit. But keep mind that without the pipeline component, you will never have more than a handful of tobacco users ready, willing and able to walk away from their addiction. A successful (efficacious) process includes a strong feeder component. Recruit, measure, and tout participation at all levels of change --- awareness, education, intervention, and maintenance!

4. Reaching Dependents

"We know that a considerable percentage of our healthcare costs are incurred by dependents. What can we do in the areas of DM/HP?

Dependants range in age from birth through retirement years. And, at each age, they can cost your organization time, money and energy. Any DM/HP process that does not include dependants is fraudulent --- not just inadequate --- fraudulent. To presume that your DM/HP efforts will have a significant impact on organizational health and dollars without including dependents is misleading and grossly insufficient. Not convinced? Take a look at your prescription drug utilization and your healthcare claims for your dependant population.

Because of limited direct access, I suggest you take advantage of the 24/7 feature of electronic DM/HP. By using qualified public domain information and carefully selected e-vendors you can greatly enhance the health and lifestyle of your dependent population. In particular, take a close look at programs specifically designed for teens. Teens are huge medical claims waiting to happen. Short-circuit these costs by targeting their unique needs and learning style.

5. Vendor Selection Criteria

"We are bombarded with individuals and organizations selling DM/HP products. How do you sort out the good, bad, and truly ugly?

Twenty years ago, there were a handful of quality programs available through national vendors. Choice was not that difficult. Today, with the advent of the Internet and the flood of scientific data, there are hundreds of vendors anxious to for you to engage their services. Keep in mind that a vendor should be much more than simply a provider of drop-off products and services. They need to be comprehensive, accessible, flexible and experienced. Sound simple? It's not. Due to limited dollars you need as much quality one-stop-shopping as possible. You do not have the time, dollars or energy to have multiple contacts for each of your offerings. Find an experienced multi-component provider and stick with them. They will not only help you with paperwork and sanity, they will also help with triage, crossover, data collection, analysis and strategic planning. Like a good pharmacist, they will also help you avoid unhealthy DP/HP interactions. An excellent provider will have a pattern, philosophy and support network that is consistent throughout their offerings; this will help you, immensely. A good vendor is, at a minimum, equal to one FTE (full time equivalent).

6. Follow-On Programming

"Most of our employees have multiple risk factors. What should they do first and how do we help them maintain momentum once they get started?"

After some basic data collection, you probably have an idea as to what is most important --- and therefore, should-be-first --- on someone's list of disease prevention and management needs.

So, what?

Need is only a part of the decision process. Interest, access, learning style and belief in success are critical factors to consider when beginning a change program. Hypertension, diabetes and high blood pressure may, indeed, signal the need for weight loss for someone who is morbidly obese. However, if distress is blocking visions of success maybe a good stress reduction/management program is the way to go, first. On the other hand, maybe someone has recently lost a close friend or relative to lung cancer and their teachable moment has arrived. If finances are in runaway mode, perhaps financial responsibility is the first step (yes, this is part of comprehensive DM/HP --- check your VISA charges if you doubt this…). There are a number of factors that influence the whens, whats, hows, and whys of DM/HP. The more barriers you can remove --- and the more control you give to your employee --- the more likely the individual is to begin a program, stay with it, and springboard their success into other areas of change.

7. Resources

"Funds are limited. How do I provide comprehensive services without adequate resources?"

Look around. Borrow from other departments. Use the graphics person to help you with a promotion campaign, tap the IT folks to help develop and maintain a database, and pick the brain of your VP of sales to help you develop the right pitch. A frequently spoken lament is: "I can't do it all!" Of course you can't and if you try you will fail.

8. Budgeting & Funding

"I seem to be on the short end when it comes time for resource allocation. Any ideas?"

Budgeting and overall funding will be covered in detail in future articles. In brief, it is important that you keep your budget request reasonable, measurable, and tied to the corporate mission. Also, find a champion; someone in senior management who inherently recognizes the full value of a solid DM/HP program. And, most important, the tone, structure and presentation of your budget request must look and read like any other business unit's budget. In other words, conform to the basic principals of business.

9. ROI

"My boss is a numbers person and wants to know how much everything costs and what kind of return we can expect from our investment."

I'm tempted to refer back to my "company carpet" comment, however, I will resist. Certainly, management must believe there is value in what you're doing and you need to show realistic numbers. And, the best way to do this is by extrapolating data collected from a business similar to yours. As shown earlier in this paper, national leaders like Johnson & Johnson and the companies studied in the HERO study (Chevron, Health Trust, Inc., Hoffmann-LaRoche Inc., Marriott Corporation, State of Michigan, and State of Tennessee) have already demonstrated both the costs of high risk employees and the ROI associated with comprehensive DM/HP programs. To collect financial support data refer to authoritative resources such as the American Journal of Health Promotion for detailed studies. In reality, if someone wishes to shoot down any project based upon the inability to pin ROI to the penny, it can easily be done. It usually boils down to the fact that management either believes in the extrapolated data position --- and in the intuitive logic of DM/HP --- or they don't.

10. Costs

"Costs are always an issue. How can we deliver quality services and watch our dollars, at the same time?

Cost is always an issue and it should be. The good news is that it is currently a buyers' market and you do have room to negotiate. Unit price is one way, however, I recommend you use your leverage to expand services more than lower price. As mentioned earlier, you should find a vendor who is willing to provide more than drop-off products and services. All vendors should provide an open-line support person who will, in effect, become your staff person, someone who will guide you step-by-step with the introduction, marketing, delivery, and evaluation of whatever product or service you may purchase. Price is usually fairly fixed, however, service is another matter. Most top-notch vendors appreciate a client who is sincerely focused on using their products to the best of their ability. It makes you both look good. To sweeten the deal, offer to be a reference and an advocate.

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