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Validate your health ROI to the CFO: SHPS explains how

By Bruce Shutan

Benefit managers are constantly approached by care management vendors promising a return on investment (ROI) on every dollar spent, but they need to consider several caveats along the way to developing a measurement strategy that makes sense.

For example, it's imperative to know what part of net savings and medical trend will shape ROI. The trouble is that vendors often over-promise on results, particularly if there's a built-in incentive to make numbers appear as good as possible. Look no further than the common practice of placing fees at risk for failing to meet certain targets.

There's no escaping the fact that ROI will depend on workforce demographics, as well as which programs and methodologies are in place, according to Chris Ryan, chief strategy and marketing officer for SHPS, a carrier-neutral provider of integrated care management solutions.

"We've seen situations where all the care management vendors are claiming significant savings, but the health care trend continues to rise at a double-digit rate," he says. "At the end of the day, the CFO has to be able to take those numbers to the bank."

Assessing carrier metrics

The challenge is to make sense of annual ROI claims when multiple vendors are involved. It's anyone's guess about the extent to which each vendor's metrics can be traced back to the effectiveness of a particular program. If a disease management participant with chronic heart disease is also using a smoking cessation program, and then is assigned a case manager because of hospitalization for a catastrophic event, "you don't necessarily have any way of tracking the portion of cost savings attributable to each vendor's intervention," Ryan cautions.

Health care metrics need to account for the entire approach to care management rather than a specific program, which means avoiding a silo mentality when carving out health and wellness, disease management, case management and utilization management to multiple vendors.

"Each vendor may be providing an ROI but, in fact, you

don't know if they're all claiming credit for the same savings," he says, noting the importance of starting with an actuarial trend analysis to gauge each vendor's true contribution to the program. "Unless the vendor has a 360-degree view of your health care program and interaction with each participant, it will be difficult for them to provide accurate outcomes for each program and which components are driving the ROI."

The art of integration

SHPS offers integrated care management programs that use a holistic approach when treating each participant, regardless of whether they've called into SHPS' 24-hour nurse-line, enrolled in its disease management program or are under the watchful eyes of a SHPS case manager.

"The personal nurse advocate knows what the participant is eligible for, who has talked to the participant, when the conversation took place and the clinical status of the participant," Ryan says, adding how various interventions are linked to medical outcomes.

The approach is built around a comprehensive health strategy that ties program delivery with metrics and it synchronizes participant communications to ensure that key messages are clear, motivational and linked to incentives, even when claims data is from multiple carriers. "Integrated delivery can provide substantially greater value than each program alone," he says.

Ryan stresses the need to produce metrics that are prospective and not simply retrospective, providing an indication of which plans should be tweaked and strong linkage or co-variance between certain programs, as well as better understanding of the future health risks of each individual and the aggregate population.

Another key component when formulating a care management measurement strategy is the ability to tie behavioral changes to claims and case data to demonstrate that people are adhering to their prescribed treatment regimen.

Need for incentives

Still, the fact remains that the appropriate application of evidence-based medicine occurs only about half the time. With

doctors typically spending just five to 10 minutes with each patient, they may not have access to full medical records or have the time and expertise to stay current on all the latest treatment developments.

Another problem is that patients usually don't know the right questions to ask of their doctor, which he says is something a care management or advocacy program can provide in addition to initiating contact with doctors to help elevate the level of care.

Ryan says employers clearly can overcome these obstacles, noting how critical it is to link plan design and financial incentives to care management, particularly in the context of the health care consumerism trend.

"An integrated care management program linked closely with financial incentives will provide individuals with the tools they need to better manage their health," he observes. "There are many ways you can create very effective systems that will change behavior. Where you get into trouble is buying a consumer-driven health plan off the shelf and host of other programs that you try and integrate. It often doesn't work, and the result is participants are overwhelmed by different messages and vendors who don't share data with one another."

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Reprinted from BenefitNews.com, March 27, 2006. One State Street Plaza, New York, NY 10004



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