EXECUTIVE **SUMMARY**

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Why a whole-listic approach can bend the healthcare cost curve.

Many employers are missing opportunities to reduce, or avoid altogether, the most expensive medical claims. How so? By adopting a narrow view of how to support individuals with chronic conditions and failing to engage the majority of the population early in the decision-making process. But an approach that treats the 'whole' person represents a promising avenue for employers to stem rising costs and improve outcomes.

Patients don't complain about chronic conditions like diabetes so much as voice their frustrations about symptoms, according to Carolyn Young, vice president and chief actuary at Accolade, an on-demand healthcare concierge for employers, health plans and health systems. In fact, she said the fastest-growing cost concern can't be attributed to a single condition at all. Rather, it's ill-defined claims involving a collection of illnesses or injuries that are hard to categorize. The trouble with traditional disease management and case management programs, she went on to explain, is that they focus only on the diagnosis vs. what is driving the costs.

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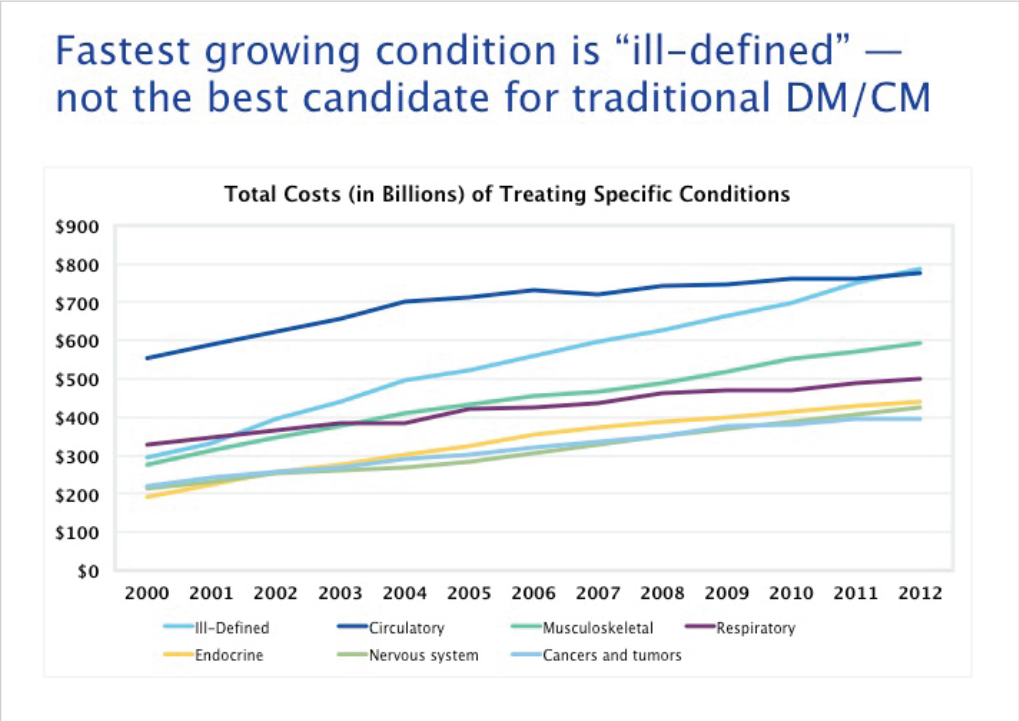

Her comments were made during a recent webinar sponsored by Accolade and hosted by Source Media. The online presentation, Taking a Whole-istic Approach: How to Address Individualized Care Needs Across the Entire Population, also featured Donna Snow, a registered nurse and VP of clinical solutions at Accolade.

While health plan members with chronic conditions tend to cost double or triple those without such illnesses, Young explained that the amount related to these conditions is "actually a small part" of what is spent.

One example is diabetes. Approximately 20% of diabetics account for 80% of the condition's spend in a typical employee population, mirroring the Pareto principle. Accolade has traced nearly half of non-diabetic care to acute conditions that could be completely unrelated to diabetes, almost 30% for non-acute needs and 14% for other chronic maintenance. A similar phenomenon has played out across its book of business for asthma, COPD and congestive heart failure, among other conditions. Overall, the top 1% of high-cost claimants account for 20% of the spending, top 5% nearly half and top 20% almost 80% of all bills.

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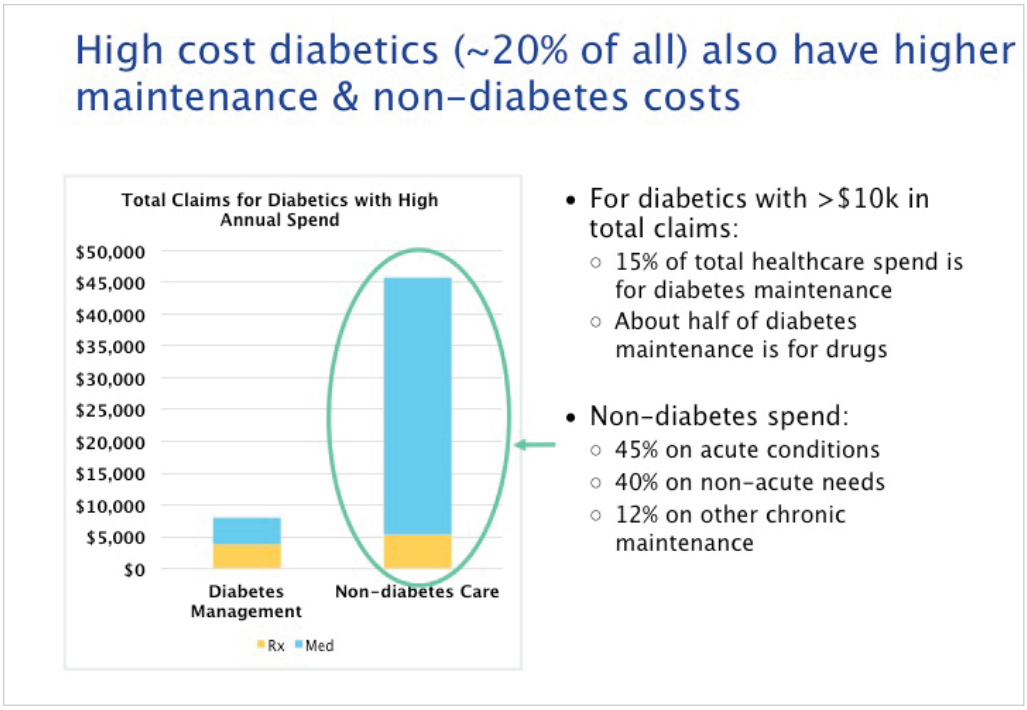


What's telling is that these numbers hold up from one year to the next because of newly diagnosed claimants and/or previously undetected care needs, according to Young. Accolade found that nearly two-thirds of the high-cost population in any given year isn't categorized that way the prior year while about 30% of that number actually had low projected risk in the prior year.

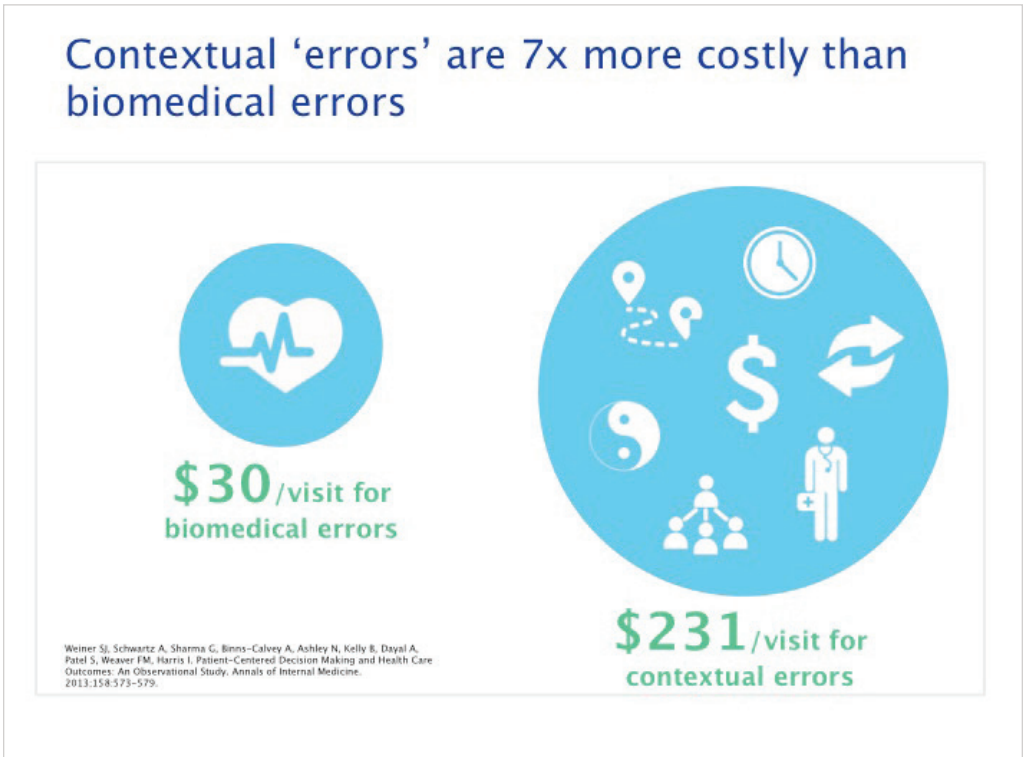
That's why, as Young suggested, "it's so important to focus on the person and not just the condition... What we find is that people are the best predictors of their future healthcare needs. A lot of people will self-identify when they have a care issue, and that's an early and impactful opportunity to change direction or help someone understand their options or know which provider to go to or how to utilize their benefits."

Traditional models often rely on claims data to fuel predictive models that flag patients for intervention. Given the lag time in claims processing, she said this can happen late in the process – often with little or no opportunity to curtail costs. The result is that employers rely on negotiated network and provider discounts to manage costs, falling short of better or more appropriate treatment options.

Mindful of costly comorbidity factors, the need to address both mind and body (the 'whole' person) is critical to the success of group health plan management. Individuals with chronic conditions who also suffer from behavioral health problems such as anxiety, depression or substance abuse are more expensive, according to Snow. For example, she said medical costs double for those with both coronary artery disease and a behavioral health condition.

But there are also other key considerations. Saul J. Weiner, M.D., professor of medicine, pediatrics and medical education at the University of Illinois at Chicago and co-founder with Alan Schwartz, Ph.D., of the Institute for Practice and Provider Performance Improvement, conducted extensive research that helps explain these employer challenges.

Their conclusion is that "contextual" errors, i.e., those related to a patient's daily life issues, are seven times more costly on average than biomedical errors at $231 vs. $30 a visit. Young said one example of a contextual error is prescribing care that the patient doesn't understand or isn't going to comply with. This happens if the doctor doesn't pick up on the fact, for example, that the patient just lost his job and doesn't have money to fill a prescription or may not have transportation to get a particular diagnostic test.



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Drs. Weiner and Schwartz determined that the physicians took such contextual issues into account less than 60% of the time, but Young said it's not necessarily surprising how many medical concerns are typically overlooked considering that doctors are trained to diagnose a condition within just eight minutes. Their analysis uncovered a failure to order tests or treatments considered essential for managing medical or contextually complex conditions, and prescribing ineffective care.

BUILDING A TRUSTED PARTNERSHIP

This is where Accolade's concierge model can come into play. "Our health assistants are generally the first and subsequent main point of contact for a member," Young reports, "so it's logical that they're the ones who really know the member, their family, and what 'life issues' they're dealing with as they try to navigate healthcare." This level of contact builds trust with members – typically very early in the process and often before people enter the healthcare system.

The intent behind building this trusted relationship is that it will improve engagement to "better influence care decisions," Snow explained. That includes supporting a partnership approach between doctors and patients, as well as encouraging the practice of self-care and preventive screenings.

A team of Accolade registered nurses engage with health plan members at both a contextual and clinical level, which she said "results in significantly higher engagement than we see in a traditional disease management program." Whereas about 5% of a population engages with a nurse in traditional disease management programs, Accolade's engagement can be as high as 20% to 25% with a nurse and 50% to 70% on a contextual issue. But most importantly, most of these interactions are initiated by the member – perhaps reflective of their trust in health assistants and the value members place on the program.

Success hinges on a 'whole-istic' approach that addresses the medical, contextual and emotional issues facing a member, needed, said Snow, because a patient's "reaction to illness is related to their social, financial, or psychological situation."

Our goal is really simplifying the healthcare experience for members. And when you do this through a service that people value and want to use, you get better outcomes and greater savings.

Indeed, nearly one-third of people responding to a Harris poll conducted for Accolade indicated that financial difficulties contributed to a poor healthcare decision. Twenty six percent blamed stress, anxiety, or fear and 19% cited work-life challenges. In addition, 75% of the survey respondents said it would be beneficial if their healthcare provider understood them and their circumstances – not just their diagnosis or medical issues. However, just 16% of respondents indicated that their doctors take that approach.

Accolade's model, which engages about 70% of the eligible population, achieves flat to negative cost trend. There also are soft measures that burnish hard numbers. For example, Snow cited a 98% satisfaction rate and 70 Net Promoter Score (NPS), which exceeded popular consumer brands such as Google and Amazon that were in the 50 or 60 NPS range – a rare feat for a healthcare company.

The technology platform includes benefits information, medical, behavioral and pharmacy claims, and biometric results, as well as member interaction data. "All of this information is used by our health assistants to guide consumers to help them get the right care at the right time in the appropriate setting," Young said.

Each of these components, when added together, represents a powerful force for change rooted in a 'whole-istic' approach that's built on better results. Added Snow: "Our goal is really simplifying the healthcare experience for members. And when you do this through a service that people value and want to use, they're more likely to get the right care at the right time in the right setting. This means you get better outcomes and greater savings. Everyone wins."

For more information, contact Accolade at inquiries@accolade.com