Shilpa P. Saxena, M.D. – SevaMed Institute & n1Health National Network of Physicians

Shilpa P. Saxena, M.D. is a board-certified family practice physician, based in Lutz, Florida. She serves as Chief of Medicine for the n1Health national network of physicians. She is a fellow and guest faculty member of the Arizona Center for Integrative Medicine, faculty at the Institute for Functional Medicine and a volunteer assistant professor at the University of Miami School of Medicine.

She enjoys reaching out to the Tampa business community to improve the health of corporate leaders and employees, believing that both benefit from health and lifestyle adjustments to reduce stress, improve wellness and productivity.

Dr. Saxena graduated from the University of Florida College of Medicine through the prestigious Junior Honors Medical Program and completed family practice residency training at St. Vincent's Medical Center in Jacksonville.
Back to the Future:
Engaging Patients for Better Outcomes
Objectives

- Appreciate current healthcare obstacles to improving clinical outcomes
- Understand evolution of patient experience and medical industry
- Identify opportunities to change clinical outcomes by expanding clinical management options
- Identify opportunities to improve patient outcomes through targeted behavior modification
Where We Are Today
Let’s Play Doctor

- Symptoms: Stomach pain, bloating, constipation
- Over-the-counter remedy attempt
- See primary care doc for ‘prescription strength’
- Dr’s Orders: Labs, Radiology with another Rx?
- Refer to Gastroenterologist
- GI’s Orders: Colonoscopy + more Labs
- Diagnosis: Irritable Bowel Syndrome
- Trial of stronger meds
- Pt’s concern: “Is this the best I can expect?”
- Dr’s answer: “On a good note, it’s not cancer. But, you will just have to live with this.”
- Dr’s thinking: “Maybe, she’s depressed?”
Imagine The Patient Perspective

- Expectations?
- Informed Choices?
- Trust?
- Commitment?
- Leave happy?

"I don’t want urgent care type service for my chronic diseases.”
The Evolution of Consumerism

Case Example: The Birthday Cake Industry
service

experienc
What Do Providers Offer Today?

service
Our Service Intention
Perception is Reality
Back to the Future: Engaging Patients for Better Outcomes
Patient EXPERIENCE?

DISEASE Prominence?
OPTIONS experience, enter CHRONIC disease

RELATIONSHIP experience, ACUTE disease

RESTRICTIVE experience, MORE CHRONIC disease
First Era

Drugs are Magic Bullets!
More Drugs & More Divisions!

Second Era

Heart & Gastrointestinal

Brain & Nerves

Autoimmune & Lung
The Proposed Solution

Patient Centered Medical Home
Advanced Care Organization

'RESTRICTIVE' experience, MORE CHRONIC disease

‘STREAMLINED’ experience, CHRONIC DISEASE EPIDEMIC
Albert Einstein

“A man should look for what is, and not for what he thinks should be.”

“We cannot solve our problems with the same thinking we used when we created them.”
If left unaddressed, the triggers continue to create more disease.

The Conventional Path

Health

Symptom

MD

Specialists

Rx/Surgery

Rx/Surgery

More Disease

Death
If left unaddressed, the triggers continue to create more disease.
The High Cost of Reactive Medicine

Employees With These Health Problems Can Cost You

Heart Disease = $6,112.00

Depression = $6,667.00

Arthritis = $5,000.00

Diabetes = $5,000.00

Back Pain- Patients spend 60% more on health care costs

Obesity- Absent 2.3 times more than lean employees

* per employee per year
Required PCPs through 2025 to meet utilization needs after the Affordable Care Act passage

2008: 462 million visits  
2025: 565 million visits

2025: 52,000 additional PCPs

- Population growth (33,000)
- Population aging (10,000)
- Insurance expansion (8,000)

Wisdom from Andrew Weil, MD

When asked about the healthcare reform on Larry King Live, he said…

• The real problem is **NOT** an ACCESS issue.

• It’s a **fundamental problem** with the healthcare **focus** itself.

• Health- “care reform” should highlight **low cost solutions for healthier outcomes**
We Don’t Prioritize Behavior Change

Three times more obesity in less than one generation!
What Patients Need
Back to the Future:
Engaging Patients for Better Outcomes

Engage in the
WHOLE
The truth is, doctor, I've lost faith in western medicine!
THINK Outside the Box

ROOT CAUSE APPROACH

THERAPEUTIC PARTNERSHIP
Treat the Cause
Protect Health
More good years.
The Body as a Connected Whole!

Third Era
More Time to Engage the Patient
To dispose a soul to action we must upset its equilibrium.

`Eric Hoffer"
Back to the Future:
Engaging Patients for Better Outcomes

How We DISENGAGE Patients?
Case Example: Diabetes
FEAR of FUTURE EVENT
Behavior Change Requires TIME
What Inspires Change?

freedom

connection

NOT fear & isolation
Back to the Future: Engaging Patients for Better Outcomes

How Can We ENGAGE a Patient?
Bidirectional Focus

PUBLIC HEALTH FOCUS

PERSONAL HEALTH FOCUS

OUTSIDE In

INSIDE Out
Therapeutic Partnership
Man has free choice... to the extent that he is rational.
Treat the Cause
Education Beyond Medication
Back to the Future: Engaging Patients for Better Outcomes

Meet KEVIN & NICOLE
The Possession of Understanding

RECOMMENDATIONS
• Disease-focused
• What we provide based on our understanding

INFORMED CHOICES
• Takes into account their needs and goals
• What they make based on their understanding

‘good service’

EXPERIENCE

Buy IN

EXPERIENCE

health
James Prochaska, PhD

Unique perspective on CHANGE

- Occurs over time
- Nonlinear
- Recycles or regresses
- Individualized pace
- Usually burst vs. consistent (years in precontemplation and then change in weeks/months)
James Prochaska, PhD
Transtheoretical Model for Change

**Precontemplation**
- not thinking about or intending to change a problem behavior or initiate a healthy behavior (in the near future)

**Contemplation**
- becomes aware of a desire to change a particular behavior (typically defined as within the next six months)
Transtheoretical Model for Change

**Preparation**
- action is intended in the near future (typically measured as within the next thirty days)

**Action**
- marks the beginning of actual change in the criterion behavior (typically within past six months)
Transtheoretical Model for Change

**Maintenance**

- successfully attained and maintained behavior change (for at least six months)

**THE GOAL**
What People Really Want

Health

Symptom

MD

Specialists

Rx/Surgery

Rx/Surgery

Death

More Disease

n1health
A Common Root Cause Timeline

• Abdominal pain, bloating & constipation
• Detailed functional integrative medicine assessment
• Rule out and then eliminate food triggers
• Incorporate 5R as GI system corrective therapy
• Moderate to complete resolution

Education Beyond Medication
Behavior Change

freedom

Did not want to be bound to finger stick blood sugar checks the rest of his life

connection

To a team dedicated to helping him achieve his health goals
What Patients Really Want

• Therapeutic Partnership
• Root Cause Approach
• Emphasis on prevention and reversal of disease
• Expanded options for management of disease
• PERSONALIZED FREEDOM & HAPPINESS
Back to the Future: Engaging Patients for Better Outcomes

Meet SUE
Timeless Advice for Current Crossroads
The Dalai Lama, when asked what surprises him most about humanity, answered…

“Man. Because he sacrifices his health in order to make money. Then he sacrifices money to recuperate his health. And then he is so anxious about the future that he does not enjoy the present; the result being that he does not live in the present or the future; he lives as if he is never going to die, and then dies having never really lived.”
How We Create Experience

n1Health SevaMed Institute
- Fitness Center
- Teaching Kitchen
- Online Education

HUB Events
- Community Education

n1Health Corporate Health
- Executive Physicals
- Employee Wellness

Group Visit Toolkits
- Shared Medical Appointments

The Ingredients Matter:
- India
- Educational Cookbook
A Short History of Medicine

2000 B.C. - "Here, eat this root."
1000 B.C. - "That root is heathen, say this prayer."
1850 A.D. - "That prayer is superstition, drink this potion."
1940 A.D. - "That potion is snake oil, swallow this pill."
1985 A.D. - "That pill is ineffective, take this antibiotic."
2000 A.D. - "That antibiotic is artificial. Here, eat this root."

~Author Unknown
Melissa Miller, Director, Employee Benefits & Services – NextEra Energy Companies

Melissa serves as the Director of Employee Benefits and Services for the NextEra Energy companies. Her areas of responsibility include the design, implementation, administration, compliance and accounting for the health and welfare, retirement and time-off programs providing value to NextEra’s 14,000 employees and 4,600 retirees across 26 states and in Spain and Canada.

Melissa previously held a variety of roles in employee benefits, labor, and HR Mergers & Acquisitions. She joined Florida Power & Light Company, the electric utility subsidiary of NextEra Energy, in 1995, where she began her career on the employee services helpline.

Melissa earned a Bachelor of Science degree in business management, finance and marketing from Florida Atlantic University, and completed her Master of Science degree in business administration at Florida Atlantic University.
Private Exchanges
One Employer’s Perspective

April 2014
Private exchanges continue to evolve in the market as a viable solution for employers to deliver health plan benefits

What is a Private Exchange?

• A marketplace of group health insurance and other related products offered by employers to its employees
  – The employer contracts with the private exchange and selects the products to offer employees

• The majority of private exchanges are hosted or sponsored by large benefit consulting firms or major insurers

• They typically provide administration platforms and participant websites and decision support tools

• They differ from the public exchange which are state or federally managed for individuals and small employers with subsidies for those with lower incomes

Private exchanges do not release an employer from its obligations under ERISA, insurance laws, COBRA, HIPAA and health care reform
Each private exchange varies with respect to delivery models, carriers, provider networks and plan design

**Private Exchanges**

- **Private exchanges deliver health plan benefits using:**
  - Best-in-market carrier model
  - Multiple carrier side-by-side model

- **The network of providers may be broad or smaller high-performing networks that can better leverage cost and quality efficiencies**
  - Some private exchanges require the high-performing network to be the only network option where they are available

- **Medical plan designs are standardized and have metallic plan names that align with the value of the plan**
  - Platinum, Gold, Silver, Bronze

- **Prescription drug, dental and vision plan designs are also standardized with varying design options**
Private exchanges have the potential to offer more choice to employees and drive competition among carriers

**Private Exchanges – Value Proposition**

- Private exchanges claim to add value to an employer’s ability to deliver health plan benefits to employees by:
  - Providing employees more choice of health plans and/or carriers
  - Leveraging purchase power by combining with other organizations on the exchange
    -- Claims experience for pricing is based on NextEra’s claims, not spread across other participating employers
  - Leveraging administrative technology and bundling of plan management services (communications, compliance, vendor management)
  - Providing employers with the ability to shift focus from managing health costs to managing the health and productivity of its workforce
Be sure to evaluate the critical components of each exchange alternative

**Evaluating Private Exchanges**

- **Fully Insured Vs. Self-Insured**
- **Best in Market Vs. Multi-carrier**
- **Inclusion of Ancillary Benefits**
- **Networks**
- **Formulary**
- **Tools / Resources**
- **Flexibility in Premium Structures**
- **Flexibility in Incentive Designs**
- **Wellness & Care Management**
A fully-insured approach allows an employer to pay a fixed premium to cover claims, administration, taxes and fees.

### Fully-insured vs. Self-insured Exchange Considerations

<table>
<thead>
<tr>
<th>Item</th>
<th>Fully-insured</th>
<th>Self-insured</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Budget</strong></td>
<td>Defined budget available 6 months in advance.</td>
<td>Estimated expenses and trended claims available in advance.</td>
</tr>
<tr>
<td><strong>Cost Predictability</strong></td>
<td>Fixed insured rates - Cost varies only by number of employees and dependents.</td>
<td>Cost variability dependent on claims - can only be estimated.</td>
</tr>
<tr>
<td><strong>Client Financial Risk</strong></td>
<td>Full claims risk born by carriers.</td>
<td>Full claims risk born by the employer.</td>
</tr>
<tr>
<td><strong>Carrier Competition</strong></td>
<td>Carriers competing on full premiums - true retail competition.</td>
<td>Carriers compete on ASO fees and consultant estimates of values of financial programs</td>
</tr>
<tr>
<td><strong>Carrier Financial Incentives</strong></td>
<td>With full financial risk, carriers have total incentive to control both Medical and Rx costs since direct correlation to their P&amp;L, but must maintain member satisfaction due to retail competition.</td>
<td>Carriers financials based on ASO fees - Incentives to control costs for employer satisfaction, but has no impact on their financials unless client is ultimately lost.</td>
</tr>
<tr>
<td><strong>Carrier Initiatives such as Accountable Care Organizations and Value Based plans</strong></td>
<td>Carriers at full financial risk for success or failure of new programs and innovations.</td>
<td>The employer has full financial risk for success or failure of new programs or initiatives.</td>
</tr>
<tr>
<td><strong>Impact of a bad claim year</strong></td>
<td>Bad experience may be felt in renewal rates but Carriers have continued retail competition, risk adjustment built into model and pooling of catastrophic claims</td>
<td>Bad claims experience felt immediately as claims are paid.</td>
</tr>
<tr>
<td><strong>Plan Design Control</strong></td>
<td>Limited to the full spectrum of plan designs offered, but designs cannot be adjusted.</td>
<td>Employer has complete control of plan designs.</td>
</tr>
<tr>
<td><strong>Claim Determinations</strong></td>
<td>Carrier is claim fiduciary and has determination risk. The employer can provide input.</td>
<td>The employer can be fiduciary and assume claim determination risk.</td>
</tr>
<tr>
<td><strong>State Mandates</strong></td>
<td>Plans subject to state mandates based only on contract state; not state by state.</td>
<td>Not subject to state mandates.</td>
</tr>
<tr>
<td><strong>Risk Expense Charges</strong></td>
<td>Risk charges reduced or eliminated due to risk adjustment tool.</td>
<td>No risk charges – but company assumes full risk.</td>
</tr>
<tr>
<td><strong>Premium Taxes &amp; Healthcare Reform Fees</strong></td>
<td>Included in insured rates.</td>
<td>Separate cost.</td>
</tr>
</tbody>
</table>
Benchmark

- An employer who elected to implement a private exchange
  - “We first explored private exchanges in 2012 and decided to go live with the Aon Hewitt model for our 174,000 eligible employees in 2014. Our company’s focus is on the consumer first and we believe this move will allow us more time to focus on health and productivity.”
Several large employers have looked at private exchanges but they are electing to take a wait-and-see approach

**Benchmark**

- **Large Employers with more than 10,000 employees**
  - “We are currently monitoring the exchange market, but haven’t taken a deeper dive. We’ve made serious investment in our culture of health, and are not ready to give up that responsibility.”
  - “We looked at the Aon Hewitt fully-insured exchange model, but it’s too soon to consider; we are more likely to take a closer look in future years to avoid Cadillac Tax.”
  - “We aren’t quite ready yet. There’s no real appetite for change; we’re paternalistic and don’t like giving up control. We just don’t feel like exchanges would be a good recruiting tool for us.”
A recent survey by Towers Watson further supports that most employers are taking a wait-and-see approach

**Benchmark**

- **Towers Watson 2013 Health Care Changes Ahead Survey***
  - 37% rate private exchanges as potentially viable alternative for 2014, increases to 57% that see it as a more viable alternative for 2015
  - 95% of respondents are not committed to engaging a private exchange for employees for 2014 or 2015
  - Employers want to see three things primarily before deciding to adopt a private exchange:
    - Evidence that it can deliver greater value than their current self-managed approach (74%)
    - Actions of other large companies in their industry (56%)
    - A private exchange’s ability to provide additional health care plan choices to employees (40%)

* 420 midsize to large U.S. companies – September 2013
While the private employer exchange marketplace is an interesting alternative, the pros and cons need to be considered.

**Private Exchanges – Pros and Cons**

**Pros**
- Provides employees with more plan design choice and in some cases choices of carriers
- Increased competition where carriers compete on price for market share
- Allows employers to focus less on plan design and more on health and productivity
- Purchase power for administration and prescription drugs
- Exchange host owns continued improvement in infrastructure

**Cons**
- Employer loses control over plan design, cost control levers
- Still new in the market with uncertainty of future viability
- In a fully insured model, bad experience may be felt in renewal rates, but good experience benefits the vendor
- Restrictions on premium structure and incentive designs

Exchanges have a variety of great qualities and we will see companies continue to evaluate this very viable alternative.
Matthew Snook, Partner and Senior Health and Welfare Benefits Consultant - Mercer

Matthew has expertise in benefit plan strategy, design, financial analysis/marketing, demographic/statistical analyses and serves as the primary Relationship Manager - Lead Strategy Consultant for larger clients in numerous industries. As Mercer’s primary resource for all media relations and speaking engagement activity in Florida, he regularly appears at local, regional and national conferences focusing on the use of all types of health and welfare benefit programs complimenting and enhancing corporate strategic initiatives.

Matthew joined Mercer’s Tampa office in 1987 and has 27 years in the health and welfare arena.

Matthew earned a B.S. in Applied Mathematics from Auburn University, a M.S. in Statistics from the Graduate School of Engineering and has successfully completed five of the courses of actuarial study sanctioned by the Society of Actuaries.
Karen van Caulil, Ph.D., President and CEO - Florida Health Care Coalition

Karen van Caulil, Ph.D. is the President and CEO of the Florida Health Care Coalition. The Coalition is a non-profit agency with a mission to improve the quality, transparency, safety, efficiency, and effectiveness of health care for Floridians. This mission is accomplished through education, research and program support to their members and the community at large. The Coalition’s Board members include AAA, Florida Power and Light, Lynx, Walt Disney World, Universal, Lockheed Martin, Orange County Schools, Orange County Government, Miami-Dade Schools and others, representing nearly 2 million insured lives. Karen also serves on the Board of Governors of the National Business Coalition on Health, an influential policy group located in Washington, DC.

Karen has worked in health care for nearly thirty years in both academic and community settings. She teaches graduate level courses at UCF in health services administration and health informatics and lectures frequently on a wide array of topics in the health care field. Karen has actively participated in local, regional, state and national boards and committees for many years. She has worked in Florida for twenty years and has been involved in developing and implementing programs and initiatives geared to increasing access to care and improving quality and cost effectiveness. Karen graduated from Duke University with a Bachelor of Sciences Degree in Biological Sciences. She received a Master’s of Science in Public Health in Health Policy and Administration from the University of North Carolina at Chapel Hill and her Doctorate in Public Affairs from the University of Central Florida.
A Population Health Strategy to Improve Chronic Disease Prevention and Management in Orange County, Florida

Karen van Caulil, Ph.D.
President/CEO

Florida Health Care Coalition
Community Needs Assessment

- Several healthcare stakeholders were undertaking assessments at the same time - nonprofit hospital systems, Florida Department of Health
- Used the MAPP process - multiple data sources
- Diabetes, heart disease, and obesity were common areas of concern in all the assessments
Healthy Orange Collaborative

- MAPP Process -- initial discussions identified strategies and actions that were not felt to be sustainable or significant enough to “move the needle” on the chronic disease issues we were focusing on.

- Looked closely at the local healthcare delivery system and focused on learning about PCMH/medical homes and what impact they could have on chronic disease prevention and management.

- These discussions and research led to our major collaborative strategy - *Encourage and promote development of Patient Centered Medical Homes.*
Why PCMH?

• The Patient Centered Medical Home is a strategy to redesign primary care and specialty care delivery.

• The PCMH model puts the patient at the center of care, and provides more accessible, continuous, comprehensive, coordinated, and culturally effective care.
Action Plan

- Education campaign in partnership with the medical societies - recommended approach is “it’s about the transformation and not just the certification”

- Working with accrediting bodies to develop quality improvement/monitoring metrics - feedback from the field indicated skepticism about whether PCMH accreditation really improved outcomes

- Working with health plans to incentivize the practices to pursue accreditation - grants to assist with the work associated with the transformation; enhanced reimbursement
Action Plan

- The regional extension center working with practices to make the transformation - federal cooperative agreement funds health information technology work with 2000+ small providers in the region

- Consult with major employers on benefit design that steers people to PCMH and accompanying employee education about PCMH - timing critical on these activities because right now there are not enough PCMH’s to support the expected demand
Current work

- Looking at the objectives in each of the healthcare systems’ plans and those identified in the county health improvement plan to set goals for improved health status as a result of the PCMH initiative

- Focus is on diabetes, heart disease, and obesity, but we are also looking at maternal and child health and infectious diseases.

- Identifying data collection and data monitoring activities