

## Getting them in to win



### Why prevention matters

*“An ounce of prevention is worth a pound of cure.”* It’s a truism that applies now more than ever in medicine. Prevention was a cornerstone for my pediatric practice. Pediatricians utilize periodic screenings and interventions to evaluate, maintain and support the health of developing children. For pediatricians and, to a lesser extent, family medicine physicians, the delivery of these important services is almost reflexive and second nature. Prevention is a concept instilled when training begins. Extending the use of prevention and screening into the lives of adults is not necessarily new; however, practice patterns vary.

The challenge with prevention is that it wasn’t heavily emphasized in the past. Fee-for-service reimbursement kept the focus of medical professionals squarely on the patients presenting at their clinic or facility, mainly for illness management. Prevention, on the other hand, is about more than just the patient in the exam room or in the hospital bed; it’s about keeping whole populations of people healthier and preventing outcomes that include hospitalizations, long-term care or death.



### FEE-FOR-VALUE

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But within the past 10 years important initiatives have reprioritized prevention in the lives of adults. The rise of value-based care has made prevention a hot topic, and, with the Affordable Care Act (ACA), insurers are required to pay for certain preventive services. Prevention is an important bridge between fee-for-service and fee-for-value.

## Why is prevention important?

The National Prevention Strategy of 2011 sees the importance of prevention in these simple, civic terms: “The strength and ingenuity of America’s people and communities have driven America’s success. A healthy and fit nation is vital to that strength and is the bedrock of the productivity, innovation, and entrepreneurship essential for our future.”<sup>1</sup> The Centers for Disease Control and Prevention (CDC) recognizes that preventive services for older adults potentially save lives.<sup>2</sup> A national commitment to provide an infrastructure for prevention is found in the ACA. Beginning in September 2010, the ACA required health insurance plans to cover specific preventive services without charging members a copay or coinsurance. In January 2011, Medicare beneficiaries began receiving annual wellness visits, personalized prevention plans and other preventive services for free. In January 2013, states that offered preventive services at low or no cost to their Medicaid populations began receiving additional funding. And the ACA set up the \$15 billion Prevention and Public Health Fund to invest in programs to keep consumers healthy.<sup>3</sup> Because of the ACA, adults can receive preventive care services at no (or low) cost, including health supervision visits, colorectal cancer screening, mammography for breast cancer, influenza and pneumococcal vaccines, and cervical cancer screening, just to mention a few. In the 21st century, Ben Franklin’s 18th-century notion of prevention is eminently applicable. The “pound of cure” associated with the ounce of prevention can be equated to saved lives, health care cost reductions, and pathways to healthier, happier and engaged citizens.

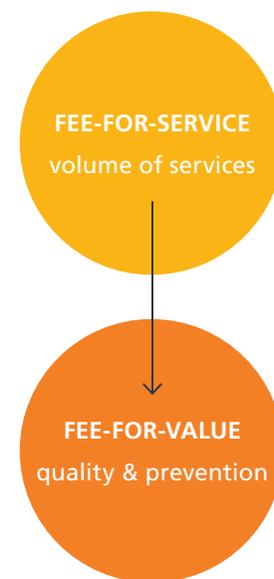
Despite the renewed focus on and the availability of preventive services, only 25 percent of adults 50–64 years of age and less than 50 percent of adults over 65 years of age are up to date in receiving these services.<sup>4</sup> Evidence suggests that in 2006, if 20 preventive services had been used as widely recommended, 2 million more people would be alive — all **without** an increase in cost!<sup>5</sup> Moreover, many of the adults in the two age groups mentioned above are from underrepresented racial, ethnic and socioeconomic groups in the United States. Ethnic and racial disparities are seen in influenza vaccine delivery and colorectal cancer screening, when comparing non-Hispanic Blacks and Hispanics with non-Hispanic Whites.<sup>6</sup> Suffice to say, the impact of the lack of preventive services for most adults 50 and older is a health care burden for patients, communities and the health care system. For certain groups of adults, the impact of going without preventive services is even greater. Instead of preventing unfortunate outcomes by taking advantage of preventive services, many adults over 50 are at higher risk for morbidity and mortality.

An important component of preventive service delivery is paying for those services. Current trends in health care payment may seem to complicate providers’ intention to focus on prevention. While most of today’s health care payment policies and contracts reward volume of services delivered, this legacy approach is shifting toward payment policies that reward quality and prevention. Preventive services outreach and delivery will be critical when fee-for-value ultimately replaces fee-for-service. Preventive services are important as health care systems seek novel ways to replace health care delivery processes currently based on volume with those based on value.

But what about during this time of transition?

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The ACA famously allowed for Medicare to follow the lead of some commercial payers and set up an Accountable Care Organization (ACO). The ACO focus conforms well to Medicare’s various value-based purchasing initiatives, which restructure payments for health care based on quality.<sup>7</sup> Perhaps less well-known are the provisions it makes for all consumers to receive free preventive services. Because of this additional benefit, providers may have an easier time easing into value-based care. Here’s why:

Using a cohort of more than 451,076 patients,<sup>8</sup> I ran some numbers against an active deidentified patient database. Exactly 42.3 percent of the cohort, or 190,805 patients, had not had an adult preventive service visit recorded in 24 months. That represents a significant gap in care.

Regardless of whether an organization is running on fee-for-service or fee-for-value contracts, there was a sizable population of patients *not* getting the care they needed. Financially, the health care organization is missing out on revenues from reimbursement for providing necessary preventive services. Just how much money was being left on the table for this cohort? It’s difficult to be exact, but we can estimate.

We were able to segregate the data based on the payer information attached to each patient. We found that 61,864 of the patients were commercially insured, 17,723 of the patients were Medicare beneficiaries and 5,730 of the patients were covered by Medicaid. Interestingly, 102,777 of the roughly 190,000 — more than half of the deidentified patient data provided by multispecialty clinics for this cohort — did not have their insurer recorded. Medicare pays about \$172 for HCPCS code G0438, Initial Adult Well Visit. Commercial payers, on average, pay \$73 for 99213, Level 3 Office or Other Outpatient Visit, which is the typical CPT code used for an adult well visit. Medicaid typically pays about \$38 for a 99213 code.



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Payer type	Number of patients	Well-visit reimbursement	Total
Commercial	61,864	\$73	\$4,516,072
Medicare	17,723	\$172	\$3,048,356
Medicaid	5,730	\$38	\$217,740
<b>GRAND TOTALS</b>	85,317		\$7,782,168

Table 1 estimates what well visits for this cohort are worth, based on their payer.

For about 85,000 patients — less than half of the patients who hadn't had a well visit in 24 months — a health care organization could increase their revenue by more than \$7.7 million. If we're conservative and double that amount to account for the approximately 102,000 patients for whom insurance coverage wasn't recorded, the value for preventive services for this population is more than \$15 million.

It's unreasonable to think that a provider could recoup all that money, but what if a health care organization could get a third of that population in for a well visit? What would that mean for the finances of a health care provider and, more importantly, for the health of the patients they serve?

It would be naïve to think that health care organizations can transition to fee-for-value structures overnight.<sup>9</sup> Health care organizations need to rethink patient assignment and provider attribution and access to care policies; focus more on quality of care and the use of evidence-based medicine; implement population health management programs; and install health information technology resources that make reporting and the dissemination of data on patient outcomes more readily available.

It would be equally naïve to think that health care organizations could transition from fee-for-service to fee-for-value without placing any emphasis on prevention prior to such a transition. The good news is that prevention not only pays under fee-for-value; it pays under fee-for-service. Preventive services and screenings are now — and will continue to be in the future — important drivers of clinical, financial and operational strategies that help organizations not only transition to fee-for-value health care organizations but also achieve the goals of the Triple Aim: improve the patient experience, improve population health and lower health care costs.<sup>10</sup>

However, health care organizations have trouble identifying just who within their patient populations have (or have not) received preventive services.

What tools do health care organizations need as they begin to reprioritize preventive and screening services?

### Role of population analytics

An essential step a health care organization must take as it focuses on prevention is to know which patients need services. This can only be accomplished with data combined with population health analytic technologies. Initiatives that apply population health analytics to identify patients with debilitating and costly chronic conditions are important. However, in addition to prioritizing patients with chronic conditions, health care organizations must develop parallel strategies to identify patients, in particular adults, who have **not** received well visits and preventive services.

When I was a first-year medical student in 1984, my biochemistry professor helped me understand diabetes with a simple sentence: "It's starvation in the midst of plenty." Simply put, for diabetic patients, there is normally plenty of glucose in the blood stream, but none of it gets into cells to energize metabolic functions. Without insulin, cells starve despite having the energy source right there! Insulin is needed to get glucose into cells.

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So it goes with health care organizations. Many have plenty of patient health data. However, the data are sequestered in multiple health information applications. Time and again, I have heard health care informaticists and leaders bemoan their inability to get data out of their health care information technology investments. They are drowning in data but starving to understand how they all fit together. Health care organizations want to know how all of the data they have collected paint a comprehensive and longitudinal picture of the patients' care and outcomes. They are hungry to take data and make information and knowledge so they can manage populations better.

Population analytics systems that aggregate data from multiple health data sources (clinical, claims, scheduling, census, socio-demographic, pharmacy) into a single patient record can help health care organizations thrive in the ever-evolving health care world. Population analytics systems bring data from disparate health data investments and platforms so they can be utilized to identify populations of interest, segment those populations based on a variety of criteria (demographic, clinical, risk stratification), identify gaps in care (e.g., who has not been screened for colorectal cancer), and even make predictions to avoid disastrous or costly outcomes. Population analytics is key for preventive and screening services and a vital resource to support the transition to fee-for-value.

With knowledge of patients who need well visits and preventive services, health care organizations can address financial, operational and clinical imperatives for their organizations. Financially, health care organizations can find patients at risk, while at the same time improve revenues for delivering preventive services. The risk avoidance is found in the evidence that preventive services help save lives. The financial gains for preventive services can be found in growing commitments from payers (Medicare, commercial plans and Medicaid) to reimburse providers for taking time to provide these services.

Preventive services and screening delivery in a fee-for-value model allow health care organizations to identify those at risk to incur higher-cost health care services. With data from population analytics systems, health care organizations have opportunities to identify healthy patients (and collaborate to keep them that way) and also identify those with simmering chronic conditions and intervene proactively. Either financial model gives health care organizations an opportunity to establish and maintain relationships with healthy patients who may indeed need illness and disease management at some time in the future. Providers can begin to focus on interventions to maintain healthier lifestyles that prevent costly illnesses and morbidity and mortality.

multiple health data sources



single health data source

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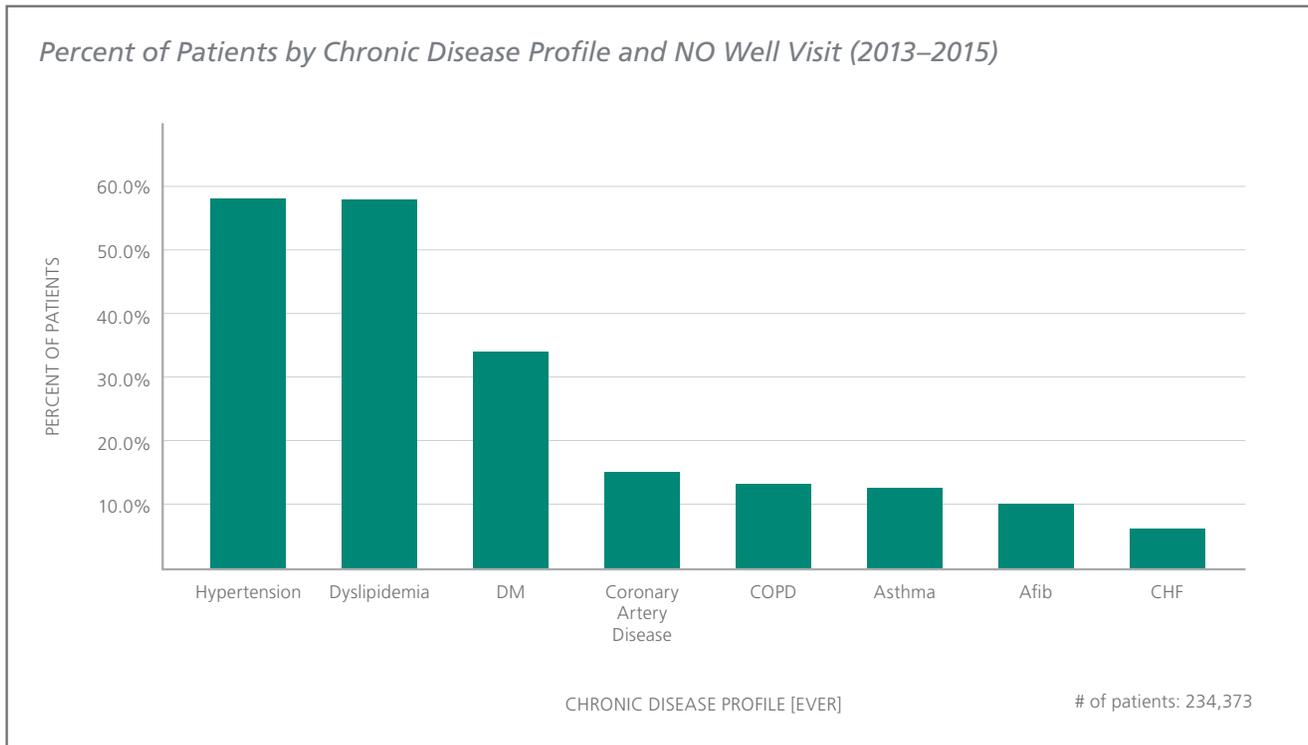
Arguably, increasing consumer awareness of the importance of well visits and preventive services raises concerns about access to care. Indeed, health care organizations will have to accommodate patients they identify needing these important services. They will have to rethink how they deploy resources (human and capital) to prepare to deliver quality well visits and preventive screenings. Thus, modifications in ambulatory services operations will be tested in a health care culture that is working to prioritize prevention. The use of community health workers, flexibility in office hours (it stands to reason that many consumers who aren't accessing preventive services are healthy and working) and other introductions of non-health-care site delivery of preventive services will be required. Health care organizations will find value in investments in nurse practitioner and physician assistant personnel who will become vital team members to provide care to healthy populations. These clinicians (as well as non-clinical "primary care extenders"<sup>11</sup>) can be focused on prevention, wellness, chronic care management and minor illnesses. Care management teams certainly should be leveraged for preventive services, especially for chronic and complex populations. But clinical care managers could also play a role in managing health care extenders and communications campaigns that encouraged utilization of free preventive services by other populations.

Other innovations could include employers providing on-site well visits and preventive services. Imagine a company with a creative program that each month targets persons born in certain years to have scheduled time away from work (while at work) to receive on-site well visits and preventive services. What a message this sends to employees about commitments to supporting a healthy workforce. Important to any introduction of health care services in nontraditional settings is exchange and sharing of information to patients' primary care providers. Designing novel operational innovations to improve access to well visits and preventive services must include patient information protection and sharing.

Finally, the clinical benefits of improving rates of well visits and preventive services can lead to more healthy outcomes. We know that people with chronic conditions account for 84 percent of national health care expenditures and 99 percent of Medicare expenditures.<sup>12</sup> It is the prevention, identification and effective management of chronic conditions that provide our society with the greatest opportunity for improved health and cost savings. In the privacy and safety of the patient-provider encounter, important relationships can be developed to build collaborations to stay healthy or prevent complications of chronic diseases. A population analytics system that helps health care organizations identify those who need well visit and preventive services, while at the same time understanding unique characteristics of patients (for example, they have other chronic conditions but are not getting important well visits), potentially enhances clinical outcomes for these patients. In addition, population analytics tools must provide ways to help predict avoidable outcomes such as hospitalizations. Population analytics systems can help identify patients with gaps in well visits and preventive services care, identify unique characteristics about patients with gaps (age, ZIP code, race/ethnicity, chronic disease profile) and predict avoidable outcomes. The graph on the next page summarizes just that. There are patients with chronic diseases who also do not have well visits.

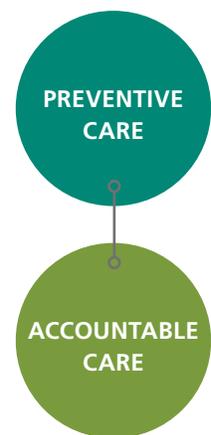
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Prevention provides wins for all stakeholders, regardless of the prevailing payment model. But as organizations transition from fee-for-service to fee-for-value, they can leverage practices around preventive and screening services delivery that will not only benefit them financially in the short term, but also help them understand the operational structures and resources that need to be in place to manage complex conditions in a value-based environment. Provider leaders who may be apprehensive about accepting risks for complex/chronic patients or who know they will eventually need to assume clinical and financial risk should either incorporate or even begin their strategy with preventive services.

Preventive care is important for accountable care. When health care organizations develop strategies to provide preventive care, they show their commitment to healthier and more productive communities. Population analytics systems are important to preventive services rate improvement. They help health care organizations organize data from their different clinical and claims systems into knowledge that can lead to actions to improve financial, operational and, most importantly, clinical outcomes. Health care organizations armed with robust population analytics tools should feel confident in implementing innovative and creative interventions to address the challenges of improving rates of preventive service use by all consumers. In the end, when health care systems provide preventive services and screenings everyone wins.



Preventive care is important for accountable care.

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