The "When, Where, and How" of Shared Operations

nawhc

NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

The 6th Annual Forum

Before we start -

- How many employers in the audience?
- Who has an employee health site?
- How many hospitals or hospital-sponsored programs present?
- Anyone using a “near site” strategy?
- Who’s using a “shared site” strategy?

On-site clinics are not simply "clinics"

- The "on-site concept" implies the development of a program – not a place.
- The design and the development of an "on-site" program impacts every aspect of the benefit design strategy.
- The on-site clinic, in and of itself, probably is not a cost-effective decision for most employers.
- The on-site clinic, as part of a larger strategy, definitely provides ROI and VOI.

Staff model HMO?

- Full risk on a defined population.
- Staffed by dedicated providers.
- Manages care, contracting, claims, and prevention (intervention).
- Uses stop-loss insurance to reduce risk.
- Makes its own rules.

What do we know about "on-site" service delivery?

- On-site clinics are not just "clinics."
- On-site clinics do not have to be "ON" site, and they can be "shared."
- We use the term "clinic" to describe many forms of programs.
- On-site clinic vendor/partners come in many shapes and sizes.
- Capital is often an overlooked factor.

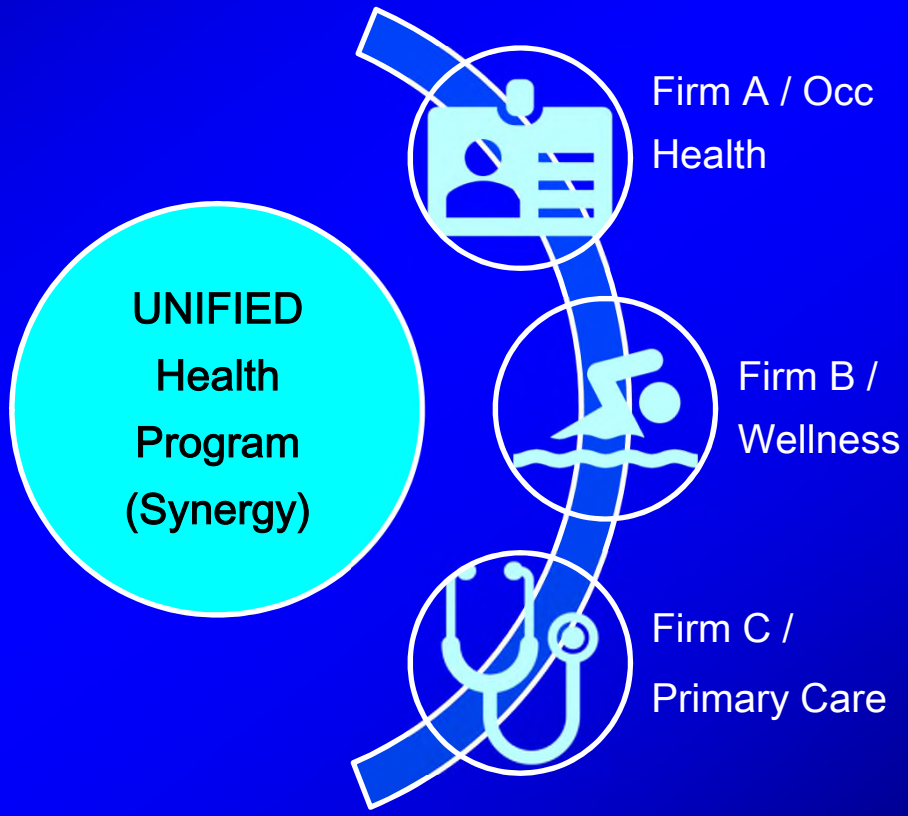
"On-site?"

- Started as an 'innovative idea' – now it is a "proven benefits strategy."
- "Proven" only if it is done correctly.
- On-site and "near site" – equivalent in fundamentals, except for location.
- Single employer or "shared" are not equivalent – very different.

Employer managed care can have many "sites"

- Once the program is defined, it can be delivered from many locations.
- The clinic operations can be near-site, shared, virtual, UBER design, or a combination of these.
- Many parts of the traditional on-site program can be useful to any beneficiary, whether they use the clinic service or not.

Why form a JV?


UNIFIED
Health
Program
(Synergy)
Firm A / Occ
Health
Firm B /
Wellness
Firm C /
Primary Care

On-site or near site?

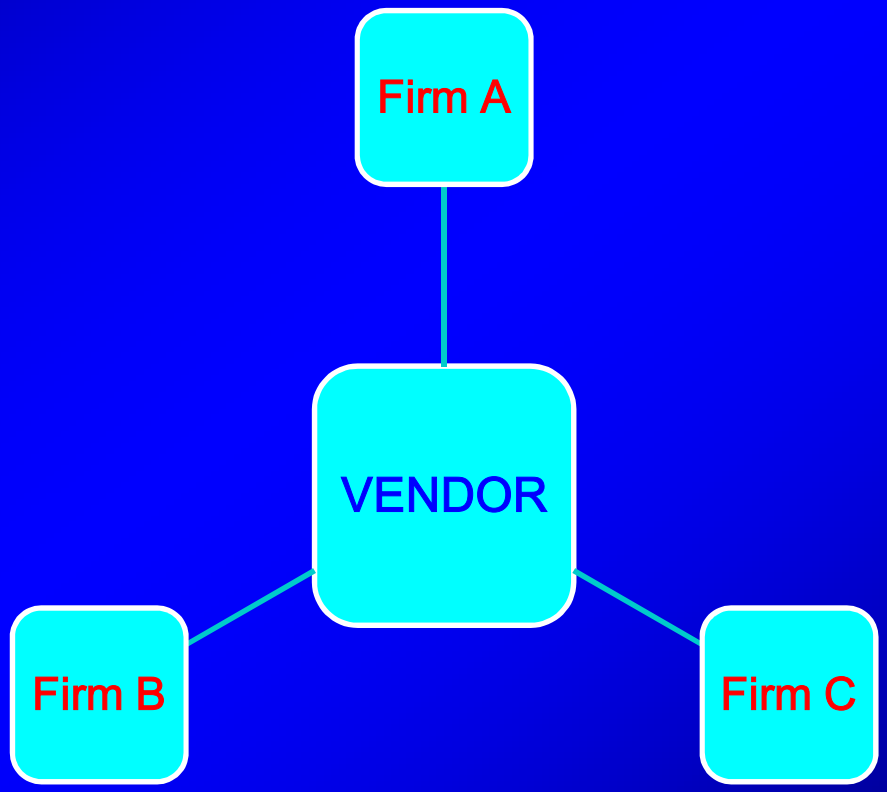
- Access? Proximity? Cost?
- The perception of independence?
- Partnership and branding?
- Relationship to safety and worker's comp / occ health?
- Potential for confusion and disenfranchised programming?

Near-site? Off-site ?

Vendor/partner role?

- Expertise?
- Infrastructure?
- Staffing?
- Capital?
- Project management talent?
- Links to other area programming?
- *Downside – limited goals or vision?*

Vendor Market Consolidation



Why do a JV or shared operation?

- This can be an issue of scale.
- A firm might cover costs of existing marginal capacity.
- Similar firms with different programs might unite to develop cross-connecting services.
- Expansion of patient and beneficiary access.

Size and scale?

- Firms not large enough for a dedicated clinic can reach scale by joining with another firm.
- A clinic struggling with volume can find other partners who want to combine resources.
- *Downside? Program complexity increases exponentially.*

Criteria?

- Combined program should have +/- 1,500 employed beneficiaries (and related lives).
- Program should have central management.
- Program should be protocol driven.
- Program should have benefits clearly above standard market offerings.

Marginal capacity?

- Modestly sized programs generally have unused capacity.
- Mature programs have a refined definition of capacity.
- Program capacity can be shared at marginal cost.
- *Downside? Program complexity increases exponentially.*

Size and scale?

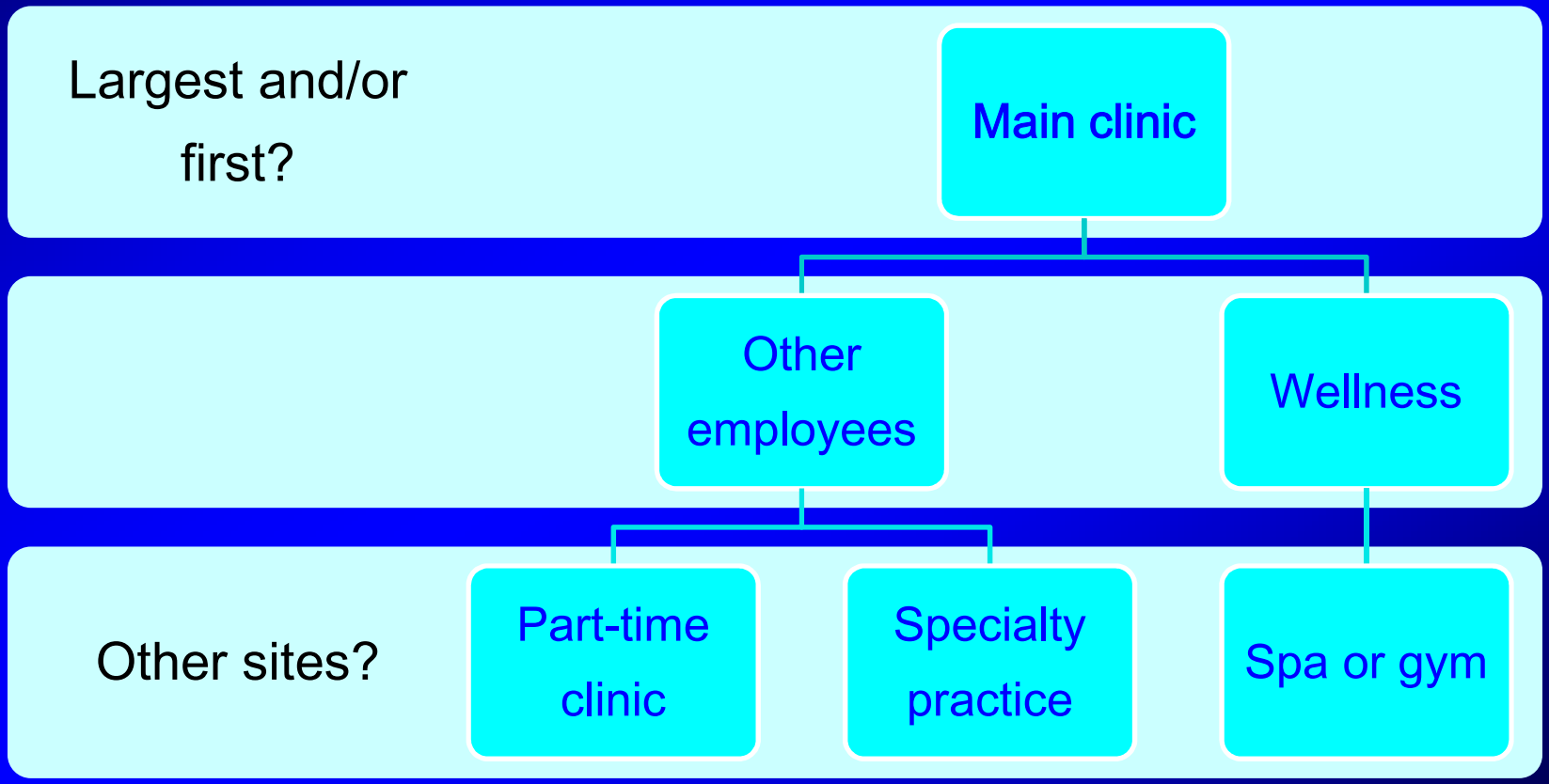
Number of Employees	*500*	*1,000*	*2,000*	*3,000*
Dependents	1,000	1,000	2,500	4,500
Covered Lives	1,500	2,000	4,500	7,500
Program Visits	3,000	4,000	9,000	14,000
Capture Rate	50%	70%	60%	60%
Program Scale (Providers)	.75 FTE	1.5 FTE	3.0 FTE	4.0 FTE
Program	Shared	Shared	Shared Host	Focused

Other reasons?

- Sometimes – a grouping of already connected industries or businesses.
- Maybe – a vendor that is consolidating market power.

Downside?

Host model


Largest and/or first?
Main clinic
Other employees
Wellness
Other sites?
Part-time clinic
Specialty practice
Spa or gym

True partnership

Firm A

Firm B

Firm C

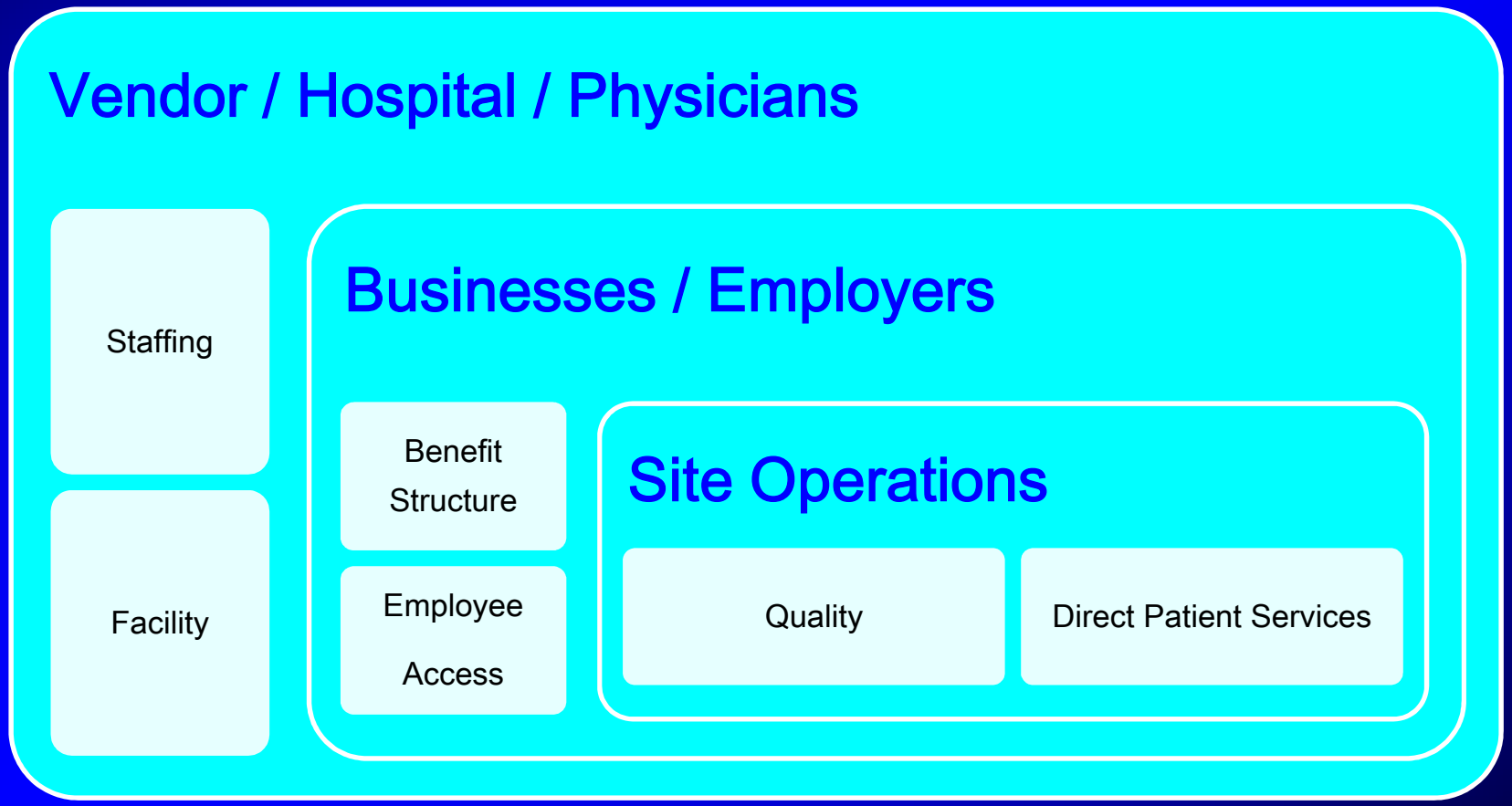
Clinic One

Clinic Two

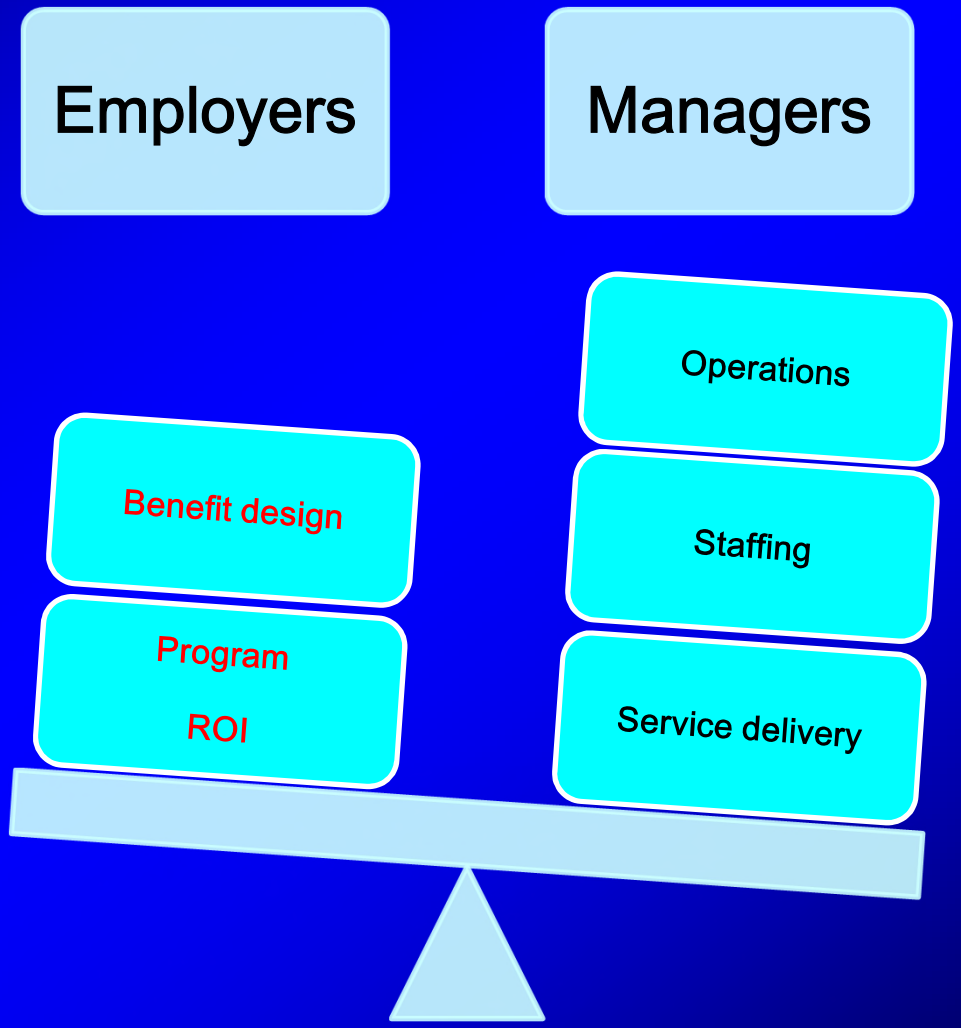
Complexity?

- Matching benefit design.
- Allocating costs.
- Contracting effectively.
- Governance and management.
- Differentiation of product offerings (from the standard marketplace).
- Stifling program innovations.

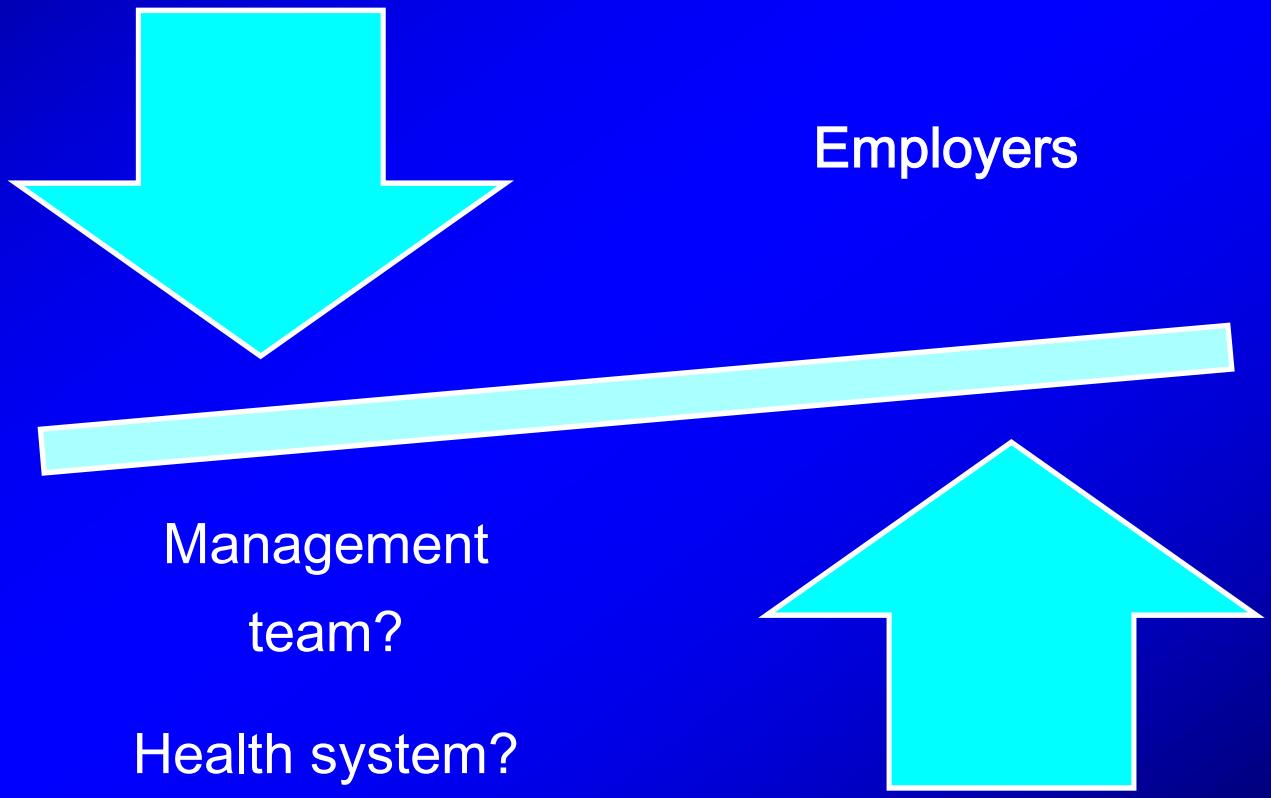
How is the clinic managed?



Find a balance quickly



Natural dichotomy?



Work from a template

- Defined scope of work, holding the sponsors responsible long term.
- Defined contract performance, holding the contract term as leverage.
- Written goals and timelines.
- ROI and VOI established benchmarks.
- Routine and regular meetings with clear expectations for reporting.

Employer	FIXED COSTS	VARIABLE Lives Covered *40%* *$1,600,000*	VARIABLE Process Measures *60%* *$2,400,000*	Total VARIABLE	Total Program Cost
A	$130,000	250	1,100	$511,308	$641,308
B	$180,000	600	1,200	$699,505	$879,505
C	$250,000	1,100	1,300	$952,655	$1,202,655
D	$75,000	260	400	$259,149	$334,149
E	$290,000	800	1,550	$914,353	$1,204,353
F	$160,000	685	1,000	$663,029	$823,029
Totals	***$1,085,000***	3,695	6,550	$4,000,000	$5,085,000

VARIABLE [Operations] ***$4,000,000***

Prepared by the La Penna Group, Inc.

Global considerations

- Be concerned about a vendor that is simply consolidating market position.
- Define the goals and any scope of work carefully.
- Do not combine confusing benefits programs.

On-site programs can fail

- If nothing is projected, no wonder it is not managed.
- The “vendors” themselves will kill the program.
- Programs need justification among and in a variety of audiences.
- The key metric is acceptance and engagement – not cost/benefit.

Summary?

- Employers and employees are in a position to impact quality and cost.
- The on-site model can be successful in many forms.

Value? Quality? Cost?

- Measure what you can.
- Hold partners and vendors accountable.
- Link measurements to actions.
- Focus on access, reporting, guidelines, compliance, communication, and consumer satisfaction.
- Plans and consensus before contracts!

What if . . . .

- There is a need to curtail contracts?
- A vendor elects to not participate?
- A partner business bows out?
- Goals and objectives are not met?
- There are multiple benefit platforms?

- What happens when there is a failure to achieve program goals?
- Can a JV be undone?

Closing comments?

Questions?