inHealth
Forging Healthier Populations

FIVE-YEAR CASE STUDY

2024

Using evidence-based interventions and a holistic health approach, inHealth generates tangible outcomes:

- Sustained lifestyle and behavioral changes
- Meaningful engagement in personal health management
- Greater savings in healthcare costs

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Our Approach is
Evidence-based

Wellbeing

- **Higher Health Awareness**
- **More Primary Care Engagement**

Research on workplace wellness found the benefit of Health Risk Assessments for participants in raising overall awareness of health and encouraging primary care engagement (JAMA, 2019).

Primary Care Physician

- **Annual Wellness Visits**
- **Preventive Screenings**

Research found Primary Care Physician administered Annual Wellness Visits encouraged preventive screenings and lowered healthcare utilization. (American Journal of Managed Care, 2021).

Healthcare Utilization

- **Less Inpatient Care**
- **Less Outpatient Care**

The same research found disproportionately higher savings in the sickest patient populations (top quartile of the population).

Reduced Healthcare Cost

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SYSTEM PROFILE

- Nationally recognized, multi-state health system
- Fully integrated with multispecialty physician group (500+ providers)
- 19,500+ employees
- 28,000+ members in the self-insured health plan

Year One

- Increased engagement with employees
- Managed costs within the self-funded plan
- Created a brand to provide direct to employer services
- Improved health outcomes in the employee population

Different from trends experienced by many of its peers:

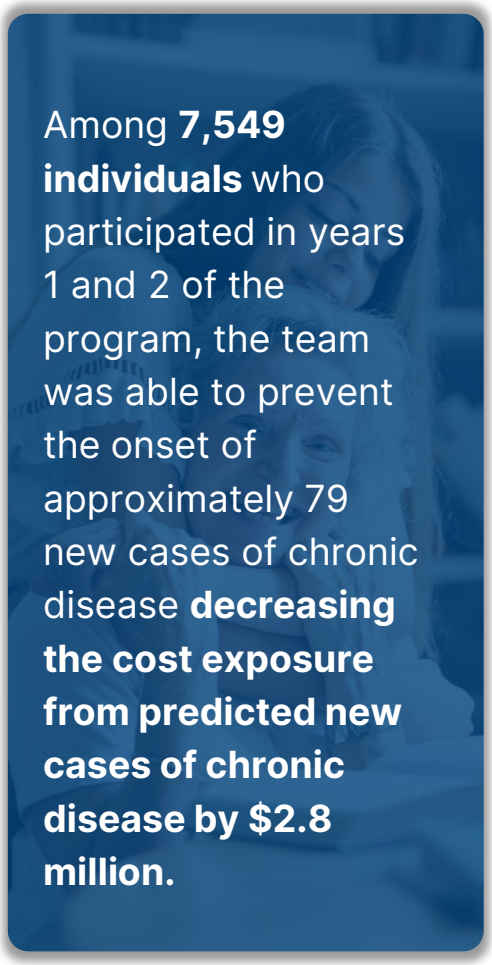
- Nearly $90 million in medical and pharmacy savings
- Employee Per Member Per Month (PMPM) costs approximately $150 per month less than other healthcare provider plans measured
- Cost of predicted chronic disease cases fall by over $3 million among screening participants

A customized approach to improving employee health

During the first year, employee screening participation rocketed from 15% with an outsourced program to 69% in when the program was insourced.

Combining health risk assessment and biometric screening data with claims and clinical information, gives the organization a baseline of its health plan population, predicting new and emerging instances of chronic disease and their associated costs (over 5 years). This process crystalizes opportunities for intervention.

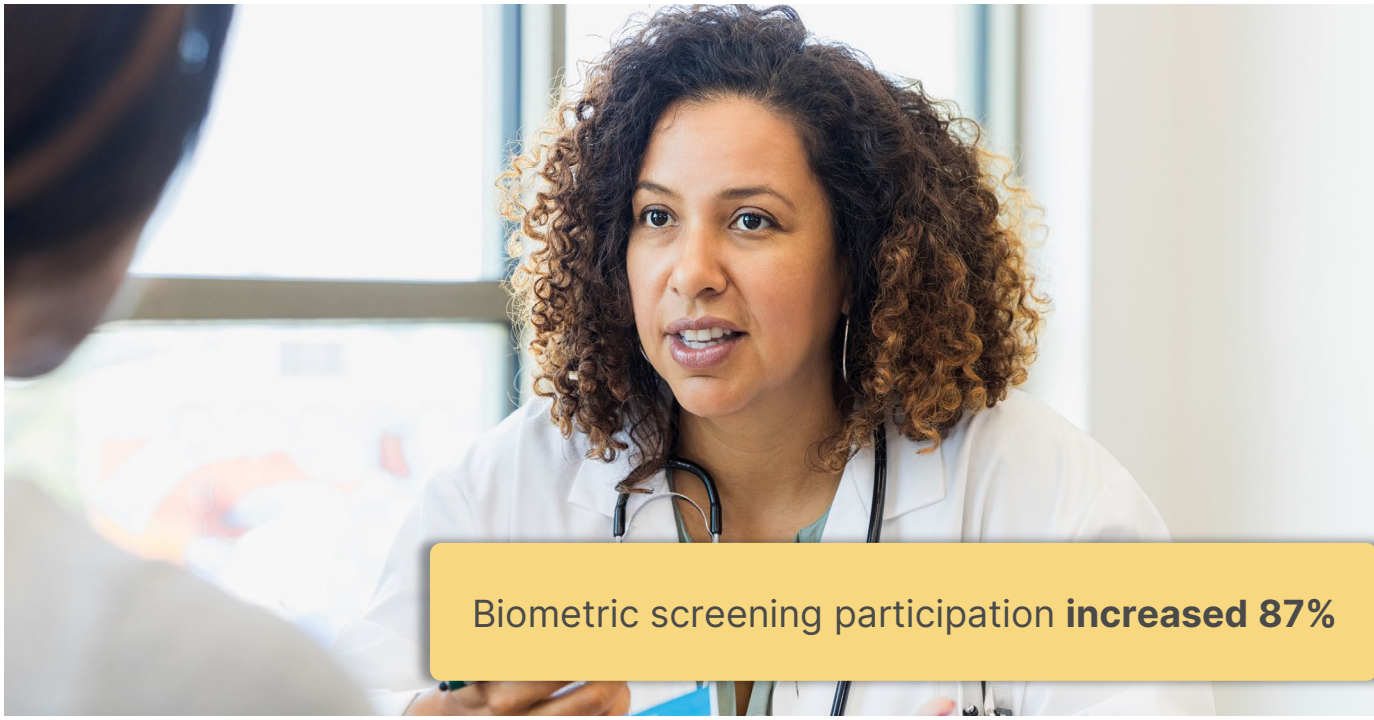
87% of the **health system** group weight management program (717) successfully reduced their weight.



Among **7,549 individuals** who participated in years 1 and 2 of the program, the team was able to prevent the onset of approximately 79 new cases of chronic disease **decreasing the cost exposure from predicted new cases of chronic disease by $2.8 million.**

Year 2: Let the data drive improvement

Leveraging the achievements of its inaugural year, **inHealth** concentrated on amplifying engagement, reorienting the direction of care coordination, and refining rewards and measures grounded in analytical findings. By modifying the reward framework, the necessity for participants to complete their biometric screenings was eliminated, instead making it a prerequisite for accessing additional incentives.



The team launched a monthly newsletter that averaged over 8,000 employee interactions with each edition. Wellness leaders introduced a teaching kitchen program and highlighted employee testimonials in organization-wide communications.

With almost 9% of the employee health plan population classified as high risk, the organization began to increase its focus on care management - shifting the nursing team perspective from a disease management program to holistic personal health management.

Year 2: Highlights

- 87% of the reward-eligible individuals screened during the year
- Adjusted healthy lifestyle incentives to address largest risk factors
- Designed a value-based diabetes care program
- Shifted from disease management to holistic personal health management for high-risk individuals
- Outperformed peer healthcare provider health plans by $44.7 million

Year 3: Turn obstacles into opportunities

In year three the team transitioned screenings from on-site to screenings with a primary care physician. Nurse care coordinators saw an increase in engagement and increased connection with other organizational resources like pharmacy.

New cases of diabetes were the greatest driver of emerging cost. The health system and **inHealth** designed and launched a diabetes value-based program, covering all out-of-pocket expenses on prescribed diabetes medications and testing supplies for individuals with any type of diabetes, pre-diabetes, or insulin resistance provided they meet and maintained the program requirements.

> Interventions targeting the 9% of the high-risk, high-cost members on the plan drove $2.2 million in annual health plan savings

Managing the 9% of the plan that is high-risk, high-cost plan members

	Managed	Unmanaged
PMPM costs	**$3,425**	$4,082
ED Visits per 1,000	**1.83**	4.14
Inpatient admits per 1,000	**18.54**	31.96
Average length of stay (days)	**3.04**	4.52

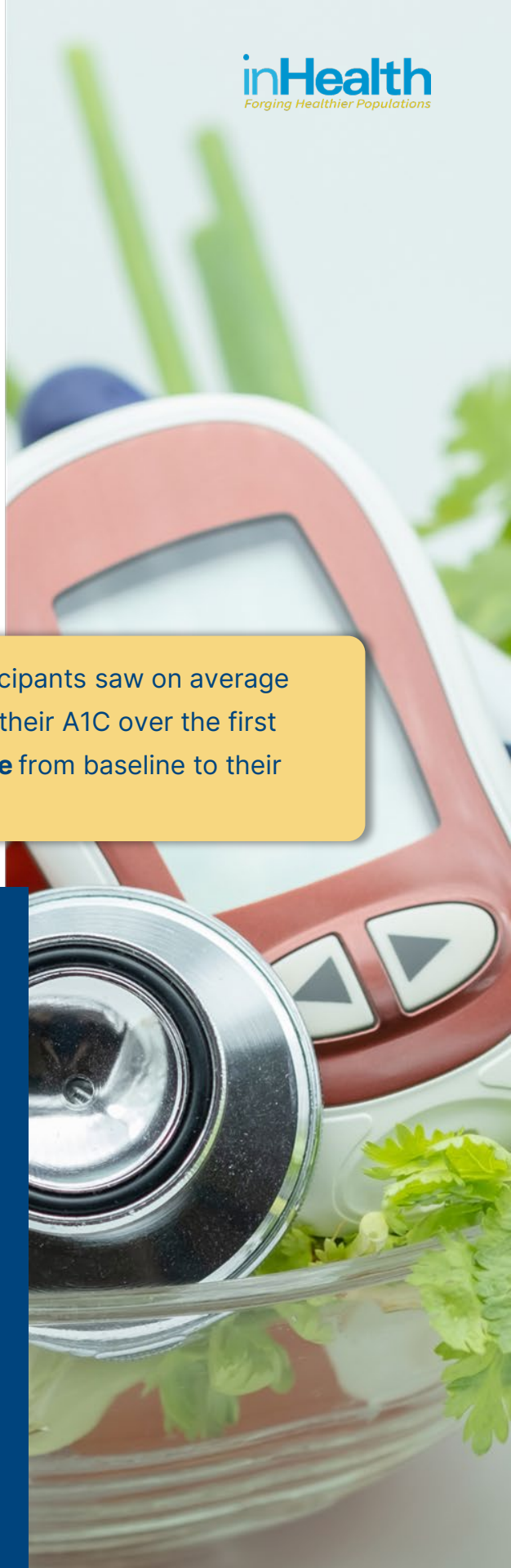
Year 4: Building and implementing specialized interventions

Pharmacy interventions expanded to include mail order, alternative lower cost drug options, and transition to in house specialty pharmacy.

Using the CDC assessment, opportunities for nutrition improvement were identified. The health system started a nutrition committee to add healthier food options in vending machines and cafeterias.

In Partnership with their EAP, the health system launched a new program, delivering an emotional wellbeing series with 6,000+ participants to date.

Diabetes program participants saw on average a **13% improvement** in their A1C over the first year and a **7% decrease** from baseline to their first recheck.



Our Population Health Model provided a $6.50 to $1.00 return on investment; 23% better than the national average.*

*Society for Human Resource Management data, 2022

- Farmers Market Bags with Fresh produce and recipes
- Teaching kitchen hosted by an executive chef and a registered dietician
- Discounts to healthy restaurants offered across the Health System

Year 5: Leveraging services by expanding footprint into the surrounding community

- **1:1 Health Coaching** | 25% reduction of potential chronic condition future risk
- **13-week Weight management program** | to date since program inception 20,000 lbs. have been lost
- **6 Week tobacco Cessation Program** | 65% of participants either quit or cut back
- **Diabetes Management Program** | participants dropped their A1C by an average of 13%
- The wellbeing team launched free health and wellness virtual workshops with advice on how to adopt and maintain a healthy lifestyle
- Leveraging the success of years one through five, the health system began expanding its footprint into the surrounding community through direct to employer offerings.
- Inclusion of press release in Becker's Healthcare Review.

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Population Movement Summary

25.9% of participants decreased their risk classification leading to a projected savings of $2,518,725

Decreases due to :

- Glucose Management – **45%**
- Blood Pressure Management – **33%**
- Weight Management – **15%**

Nutrition Committee formed and implemented:

- Catering menu
- Approved labels in cafeteria
- Farmers Market pilot successful

- Employee Population achieved 90% HRA participation
- Annual Wellness Visits almost doubled to 61%
- Participation in programming grew to 73% (up from 43% in 2020)
- Medical claims Per Member per month were 18.4% below benchmark
- $480K total spend reduction from prior year (0.4% decrease)