

Health & Productivity Transformation in a Coal Mining Culture

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Care Continuum Alliance
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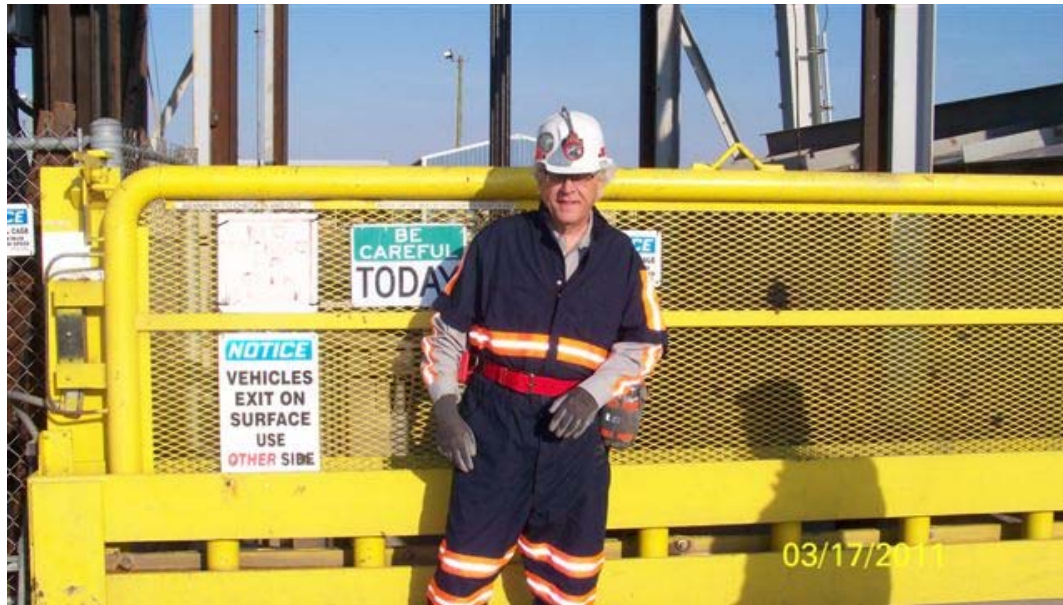
ORGANIZATION

- Background
- What was done? Process
- What was achieved? Outcomes
- What's next? Learnings

BACKGROUND

About Alliance Resource Partners, L.P.

- ARLP is a diversified producer and marketer of coal to major United States utilities and industrial users. ARLP, the nation's first publicly traded master limited partnership involved in the production and marketing of coal, is currently the fourth largest coal producer in the eastern United States with mining operations in the Illinois Basin, Northern Appalachian and Central Appalachian coal producing regions. ARLP operates nine mining complexes in Illinois, Indiana, Kentucky, Maryland and West Virginia and is also constructing a new mining complex in West Virginia. In addition, ARLP operates a coal loading terminal on the Ohio River at Mount Vernon, Indiana.



Epidemic in Coal Mines

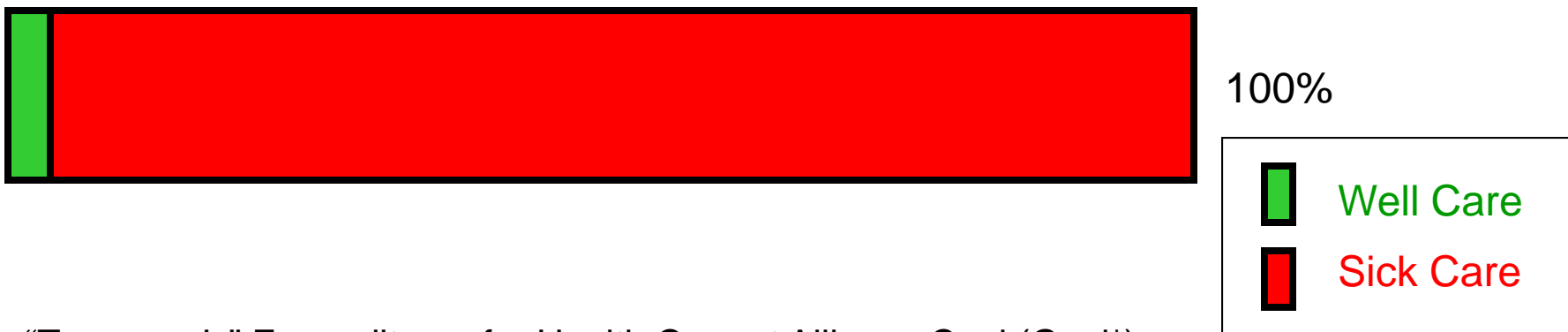
(It is not what you think)

- An ERISA plan was set-up, with authority in the HR department
- Early epidemiological analysis of health care claims data also: Highest costs were end-stage CVD disease, but low prevalence of risk factors for CVD disease.
- We suspected a poor health awareness at the member level and poor penetration of primary care at the professional level.
- Major TPA/Insurance Carrier was unable to provide a good answer to our suspicion.
- Carrier data was inadequate
 - Found we were unable to retrieve most provider names and were unable to get accurate cost information for CPT codes and other procedures.
 - Most providers (over 80%) were listed at “Network providers”
 - Claims costs were totaled for all procedures, and total costs were distributed evenly for each procedure
- In conclusion, carrier was unable to provide to us these data accurately so we were unable to engage in evidence-based decision making.
We were asked to ‘trust,’ but we were not able to ‘verify.’

PROCESS

Health Care = Sick Care + Well Care

Today's Expenditures for Health Care at Alliance Coal



"Tomorrow's" Expenditures for Health Care at Alliance Coal (Goal*)



How? Increase efforts on Primary & Secondary Prevention

Source: 2006 Presentation at Alliance Coal

Grand Strategy

- We wanted to increase primary and secondary prevention ...
- We needed to have data to be empowered, we needed complete data to engage in evidence-based decision making:
 - To see how our aware our employees and families were of their health
 - To see the accurate costs of procedures
 - To see the names of providers treating our members
- We wanted to be a part of the community of health care; not just a disinterested employer.
- We wanted our employees to have easy access to health care
- We wanted to promote a culture of trust between us, providers, employees and their families

Plan Changes: Better Data

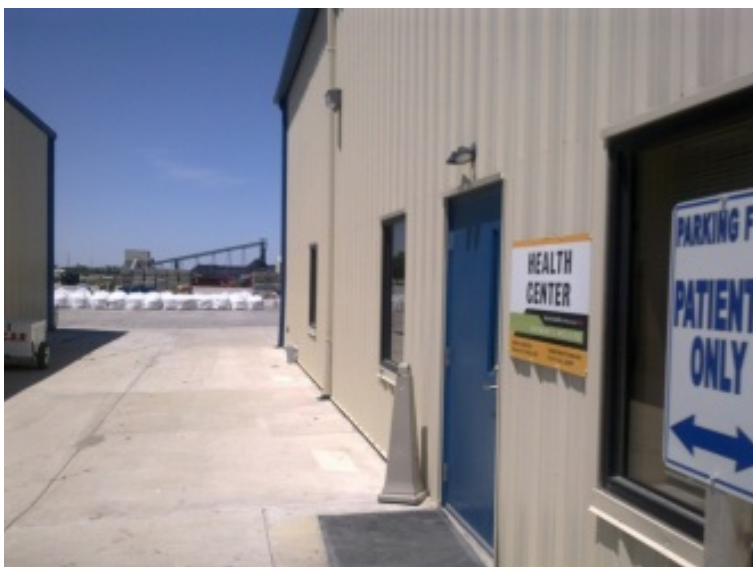
Request for Proposal (RFP) was generated in 2007/8 to ask for an TPA to:

- To see the names of providers treating our members
- To see the accurate costs of procedures
- To allow for direct contracting

Plan Changes: PCP

ON-SITE PCP

- We hired a NP and staff at each site, on salary, provided free targeted drugs, and free primary health care



Plan Changes: Health Checks

Voluntary health risk assessments (HRA):

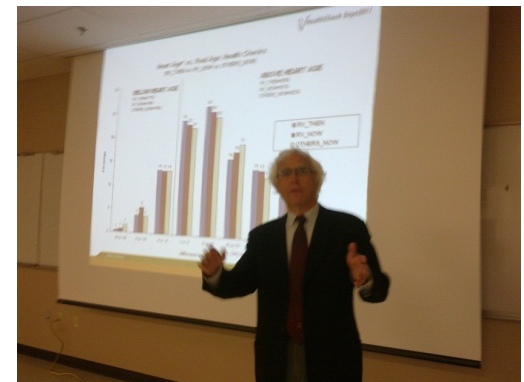
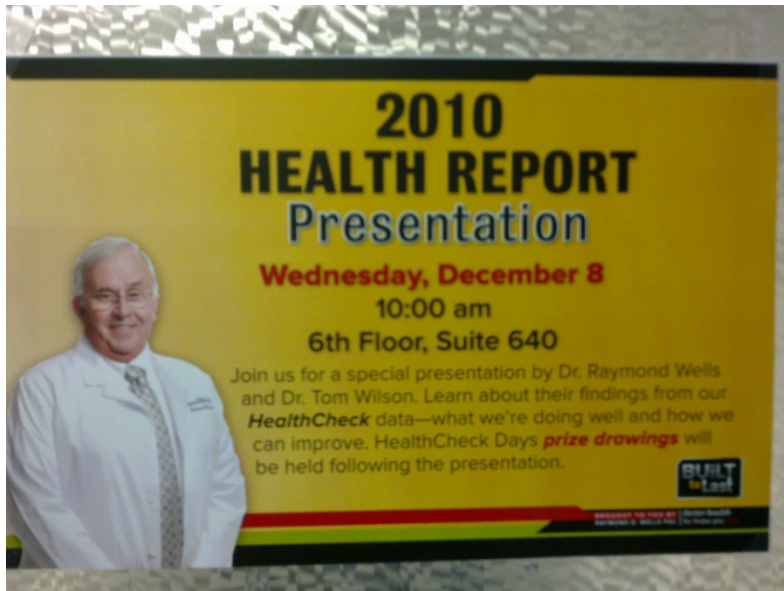
Started out with low participation, but after people found out the employer did not have access to their health information, and no one was fired for being sick. Mine managers began promoting the idea (e.g. with raffles of ATV or big screen TVs); employees gave personal stories of how the information changed their lives, we now have 60% to 90% participation depending on the work site.

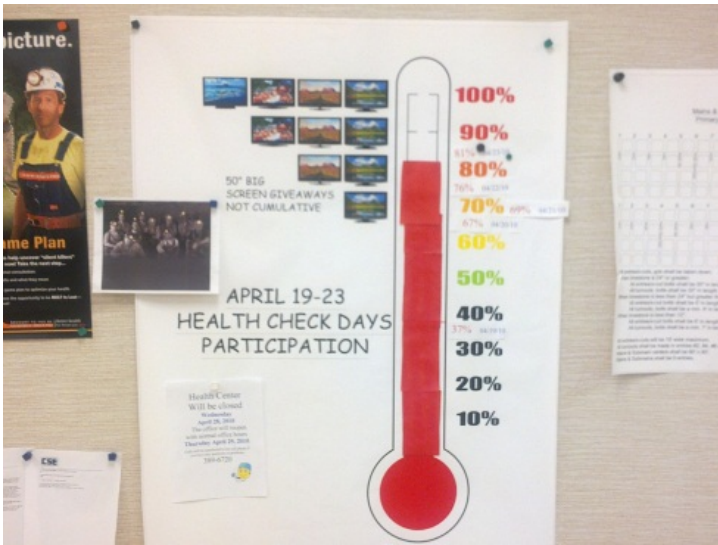
Incentives? None for participants, nurse get rewarded for completing forms.

BUILT
to **Last**



HealthCheck Days **2011**





Estimate prevalence of selected conditions based on claims and nurse-administrated HRA, 2008 (baseline) and 2010

Data source	Essential Hypertension	Hypercholesterolemia
Claims-based assessment (2008)	15%	12%
HRA (2008) - self-report	20%	26%
HRA (2010) – high risk based on biometrics	31%	52%,
HRA (2010) - moderate risk	53%	41%
HRA – combined moderate and high risk	84%	93%

Legend:

Claims, based on evidence of diagnosis in claims data over a one year period, divided by total employee population (n=2,800)

HRA: Classifications based on American Heart Association criteria, based on employees who took the HRA (n=1,803)

Plan Changes: Benefit Changes

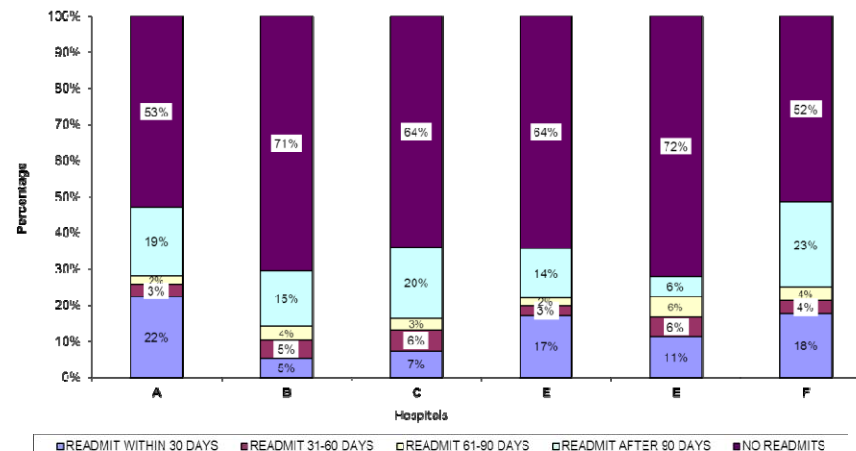
BENEFIT CHANGES

- High co-pay on some drugs, and ED visits and No co-pay on others

Plan Changes: Direct Contracting

- We are creating our own “network” of preferred providers, with direct contracting with our ERISA health plan (independent of carriers and commercial networks)
- Raymond D. Wells, PSC is the first contract.
 - Not discount, a culture of trust, positive relationships., sharing outcomes, better health, collaboration, cooperation.
- Using data to choose other community providers, share data with providers to encourage them to accentuate the positive, eliminate the negative; to direct patients to these providers
- Example of data we present on our own members;

**Admit & Re-Admit ED Rate by 30, 60, 90 & over 90 days:
24 month period (10/1/2008 to 9/30/2010)**



OUTCOMES

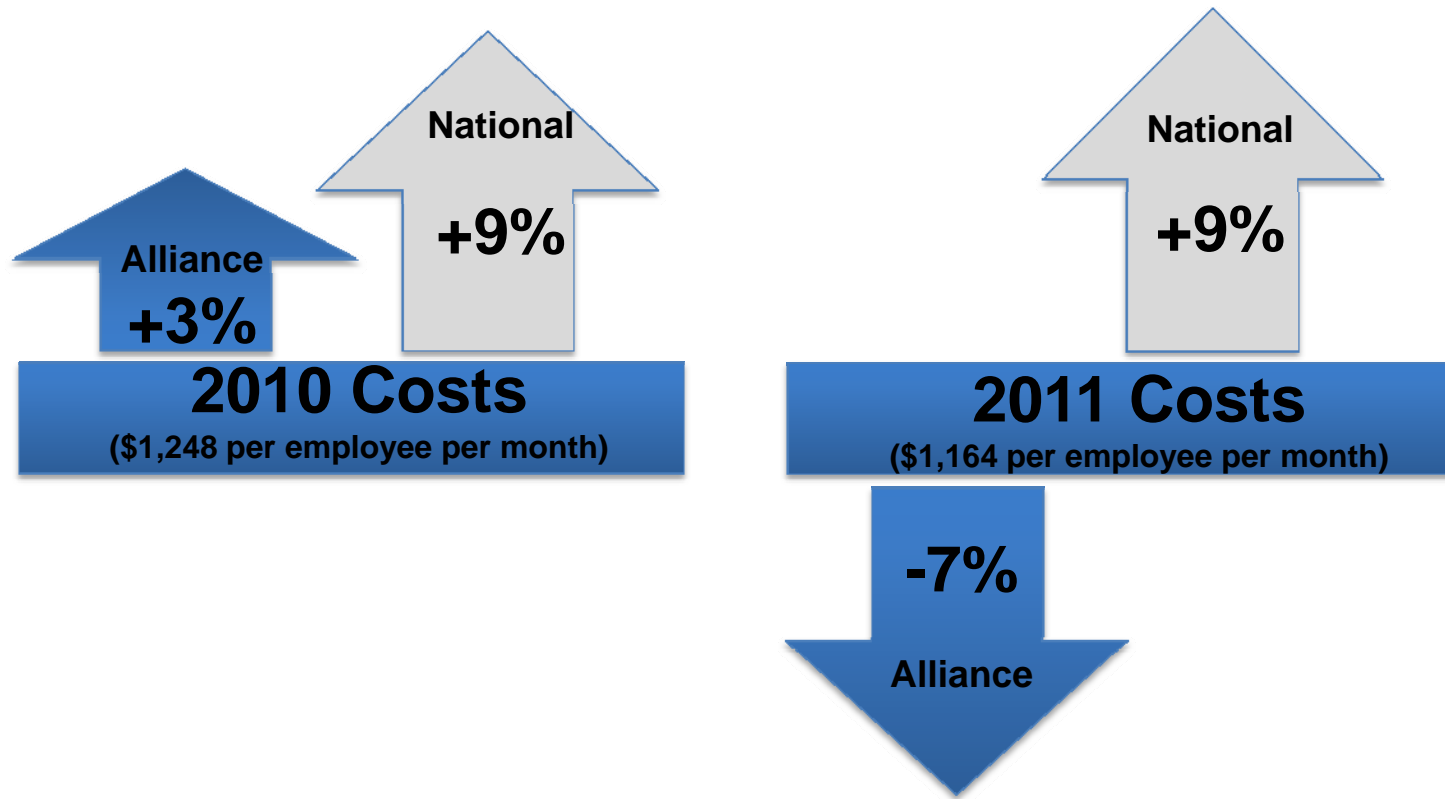
Utilization results

Per Employee Per Month Total Health Care Costs

- 2007 **\$ 927**
- 2008 **\$1,022**
- 2009 **\$1,213**
- 2010 **\$1,248**
- 2011* **\$1,164**

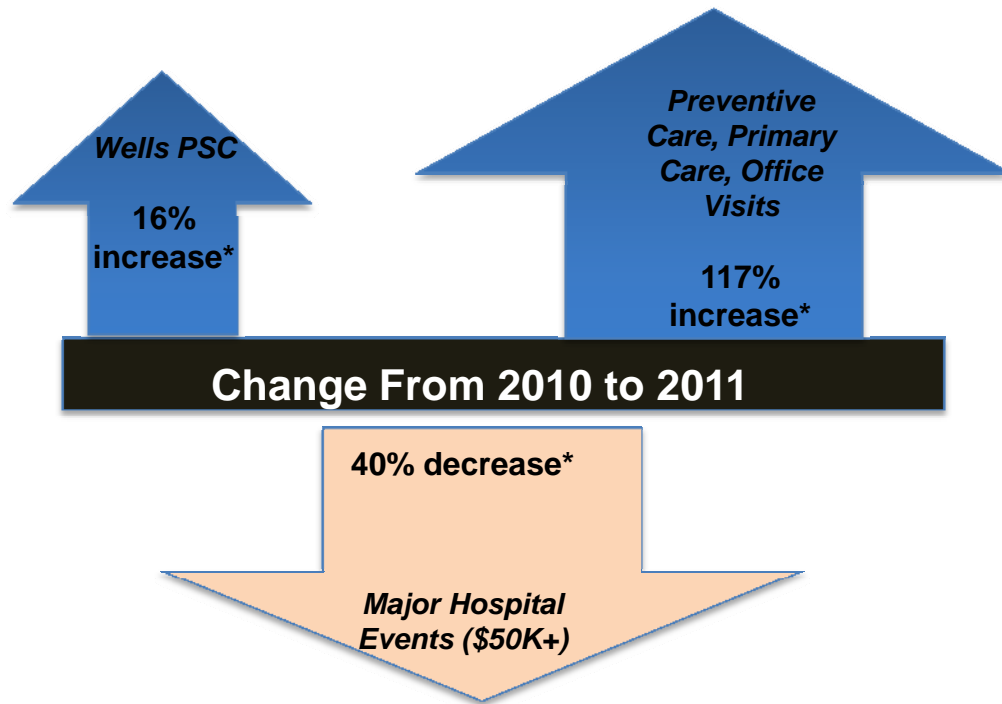
**projected based on 1st 6 months*

Utilization



Alliance health care costs are down for 2011;
significantly better than national trend*

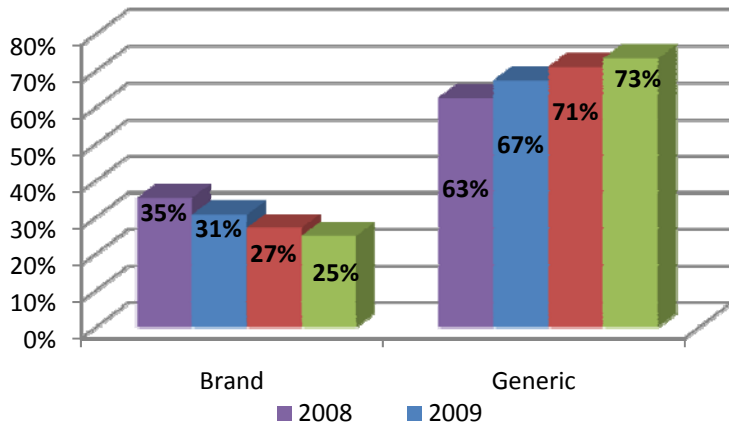
Primary Care



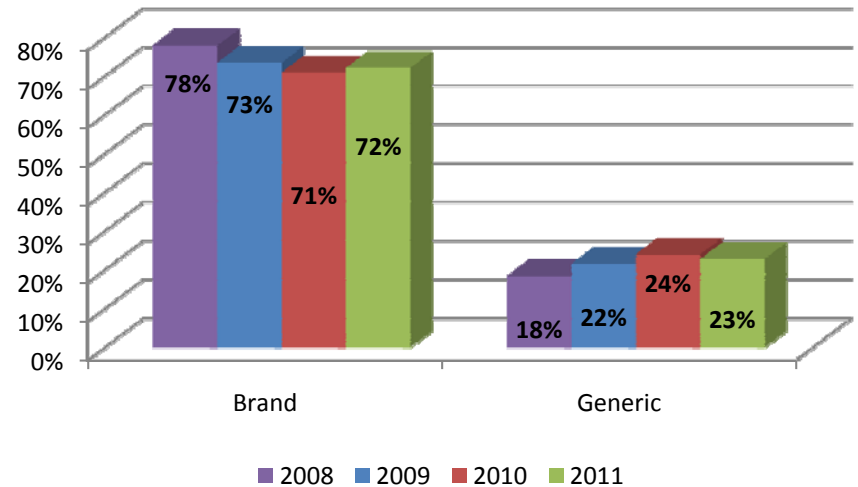
*As percent change in percent of total spend 2011 over 2010

Shift to Generics

Number of Prescriptions



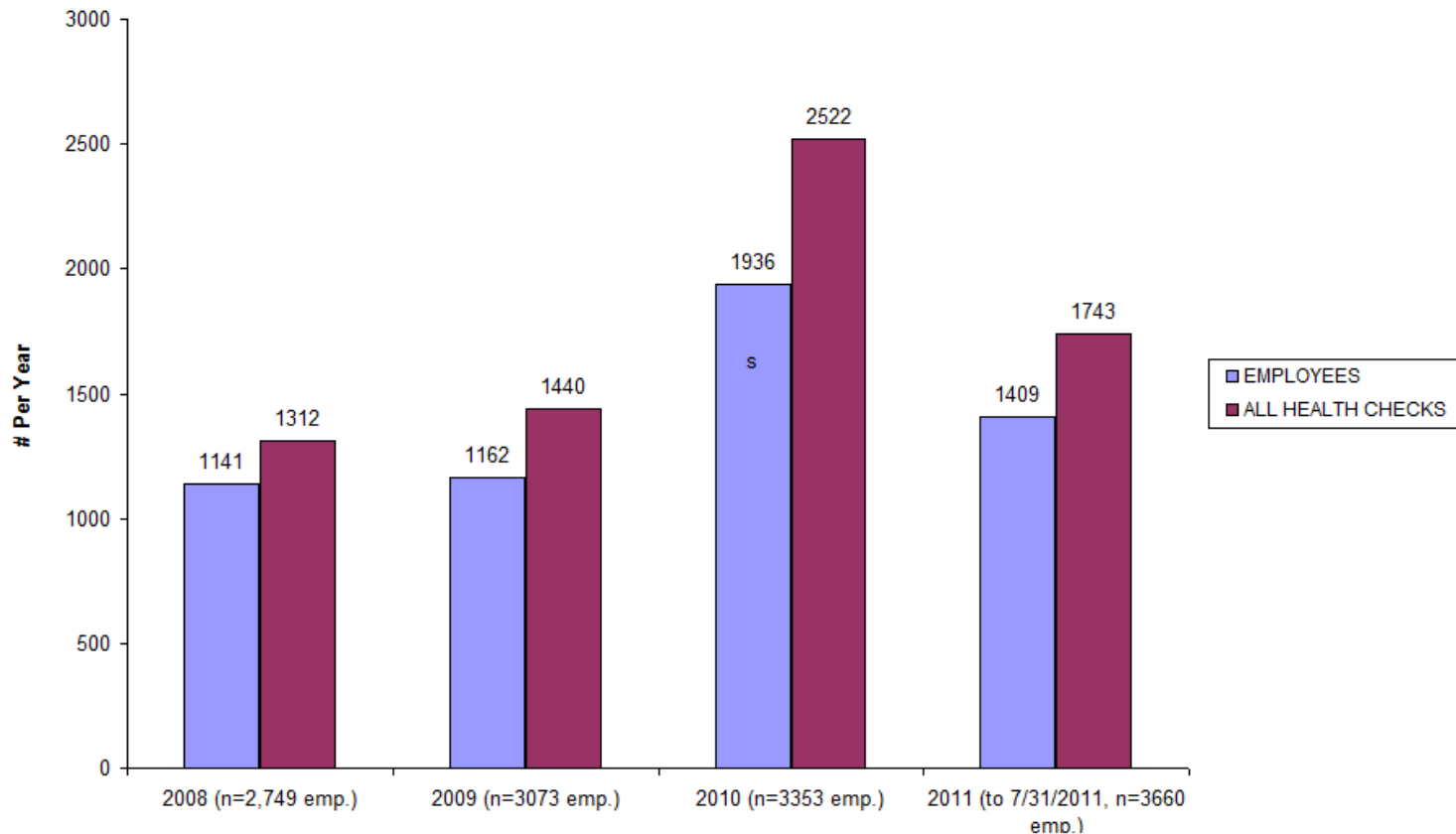
Percent of Plan Cost Brand vs Generic



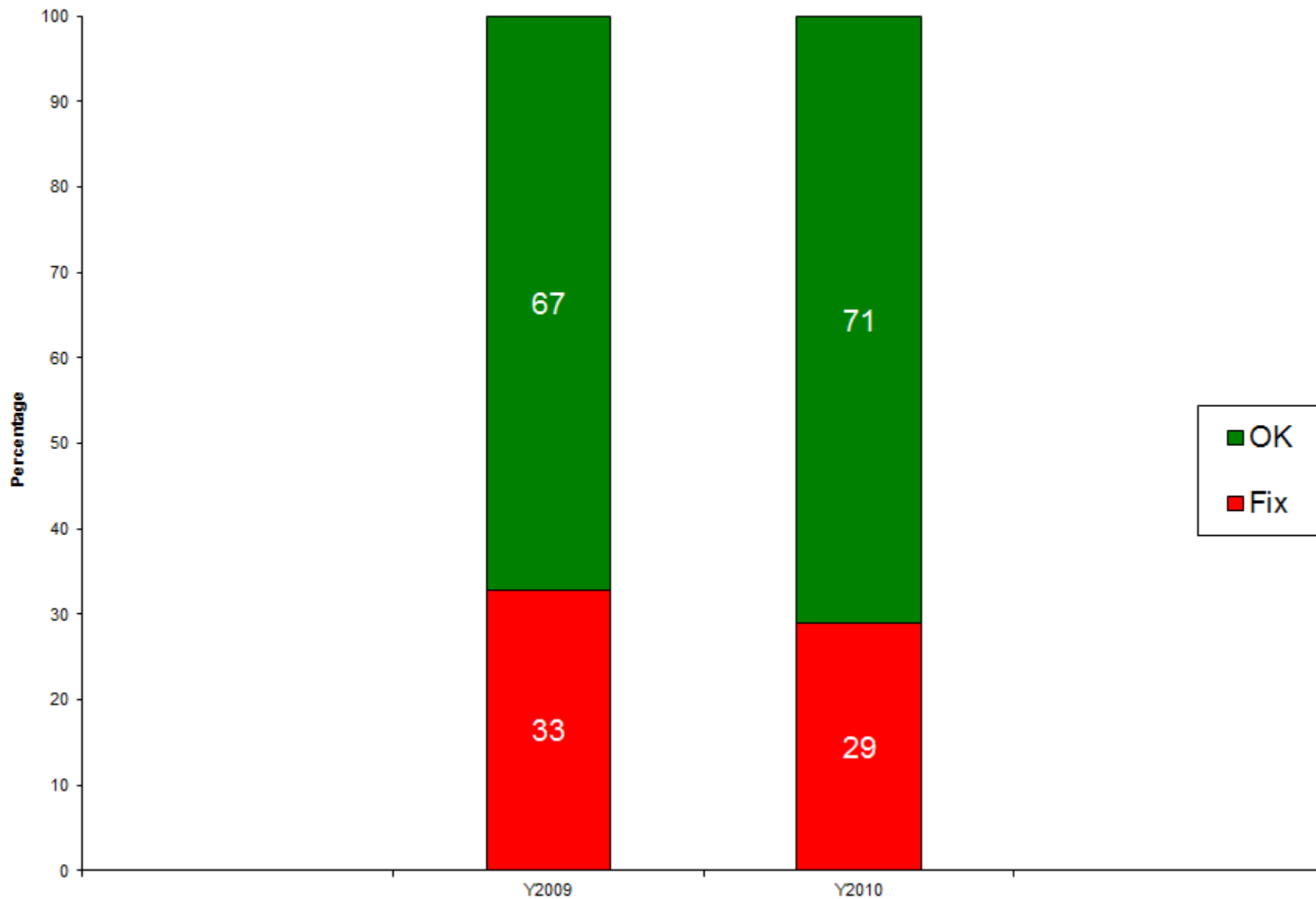
Health Risk Assessment results

Health Checks: 2008-2011 (Employees Only, All).

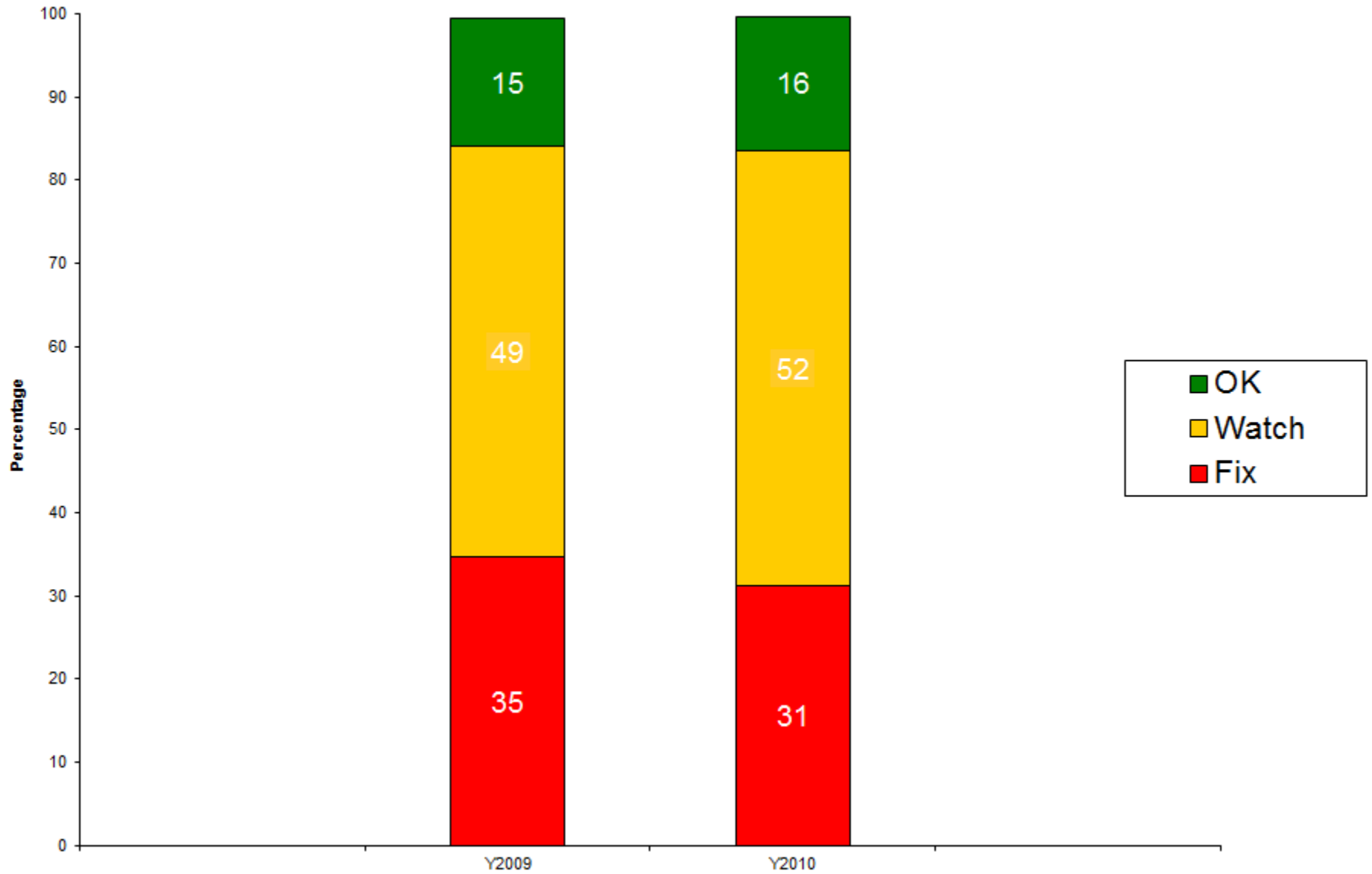
Note: Some individuals have more than one per year.



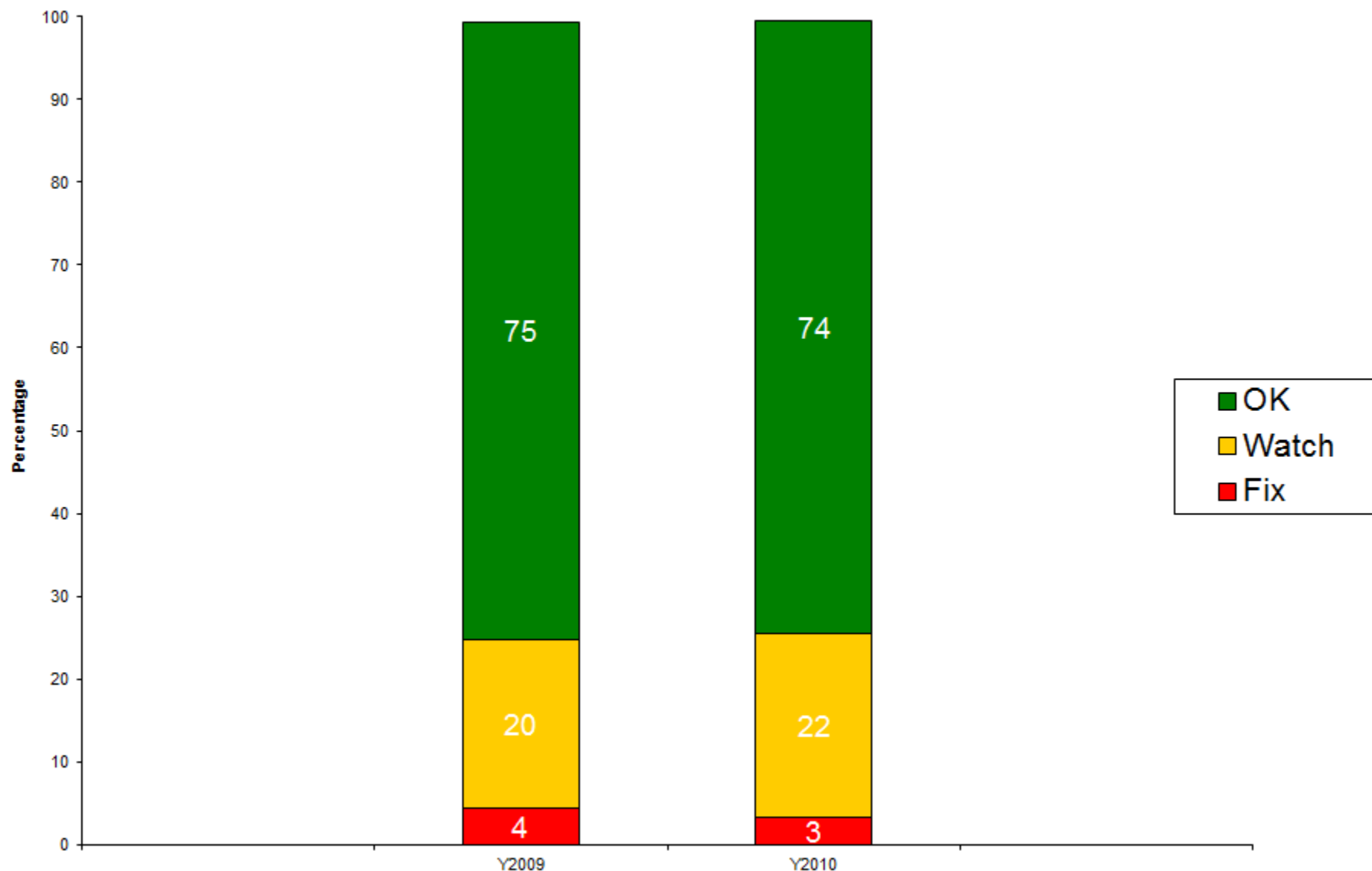
Smoking Risk: 2009-2010



Blood Pressure Risk: 2009-2010



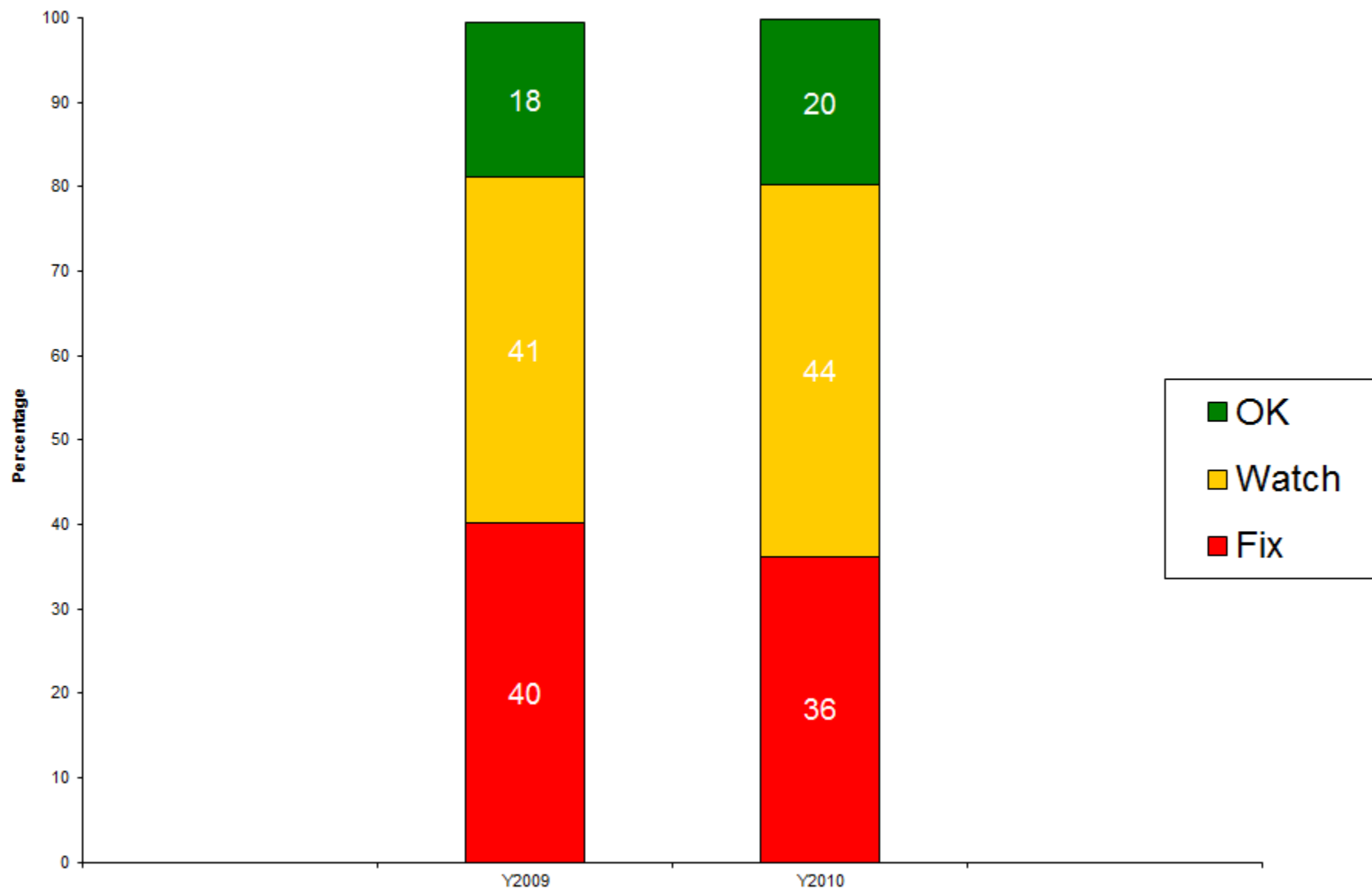
GLUCOSE/DIABETES Risk: 2009-2010



CHOLESTEROL Risk: 2009-2010



BMI/OVERWEIGHT Risk: 2009-2010



Basis of Risk Scores

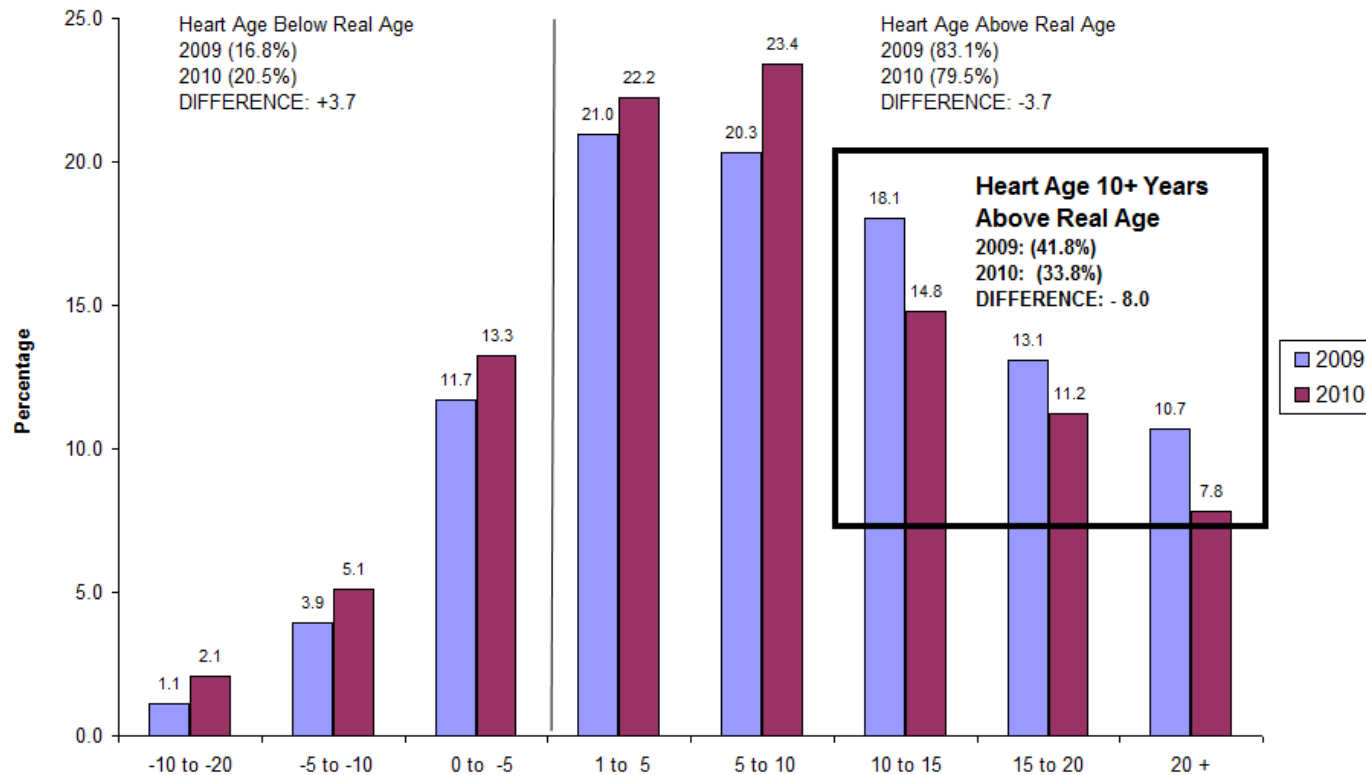
*Opportunity Levels: OK, Watch, & Fix or * [green], ** [yellow], *** [red]*

OPPORTUNITY LEVEL	*	**	***
Body Weight	BMI<25	BMI>=25 to <30	BMI>=30
Cholesterol (mg/dl)	HDL>=59 or LDL<100	HDL>40 to <59 or LDL>=100 to <130	HDL=<40 or LDL>=130
Blood glucose (mg/dl)	<100	>=100 to <126	>=126
Blood Pressure (mm Hg)	SBP<120 or DBP<80	SBP>=120 to <140 or DBP>=80 to <90	SBP>=140 or DBP>=90
Tobacco Use	Non-Smoker (current)		Current Smoker

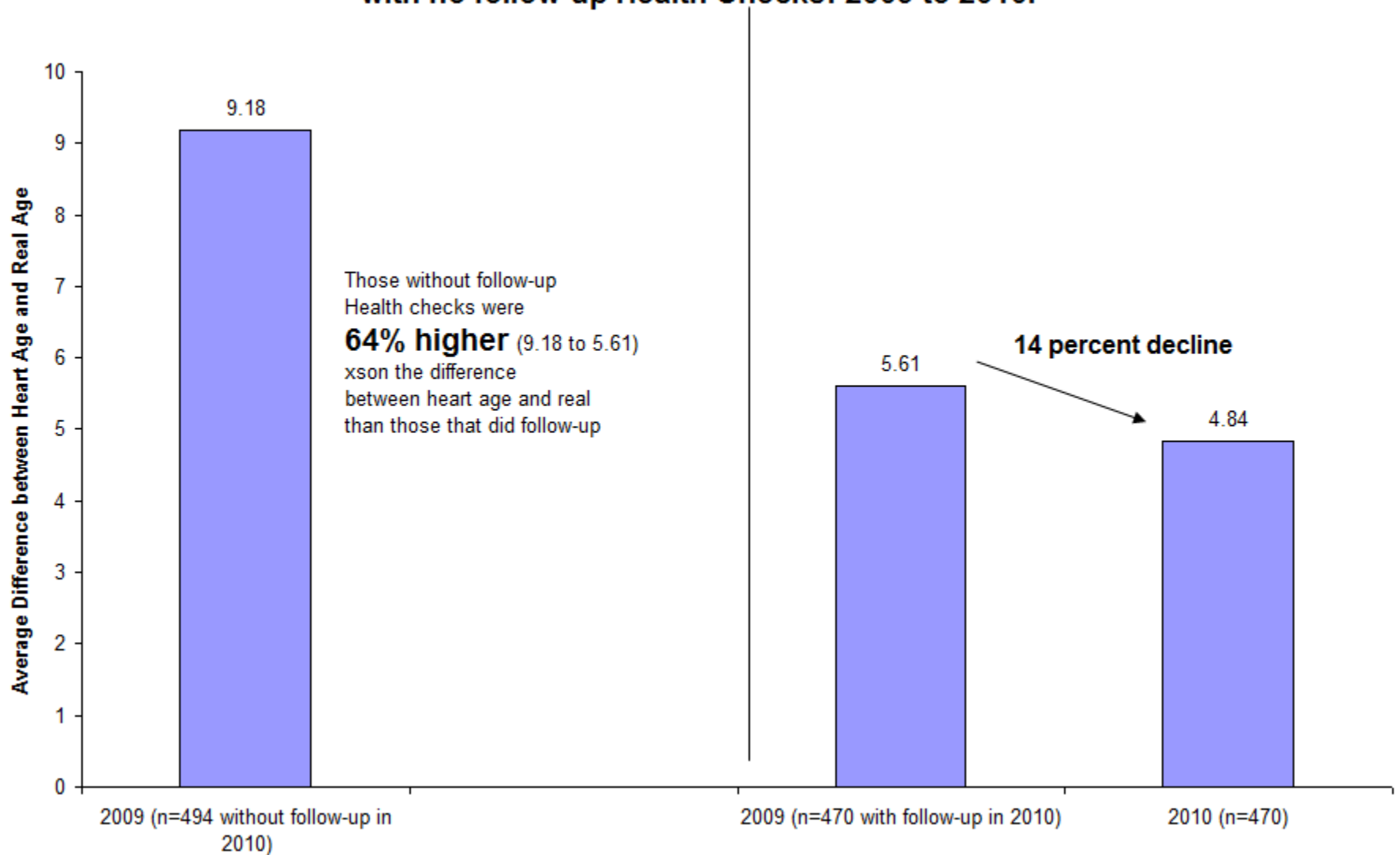
Note: SBP=Systolic blood pressure
 DBP=Diastolic blood pressure
 BMI=Body Mass Index (a function of height and weight)

Framingham Heart Age to Real Age

Differences between Heart Age and Real Age, 2009-2010



Heart Age to Real Age: Employees with Follow-up Health Checks vs. those with no follow-up Health Checks: 2009 to 2010.



Health Risk Assessment Summary

- Number of Health checks increase over time
 - Mostly employees
 - Note: Opportunity to engage many more spouses, where 50% of our cost reside among the 1500 most expensive members)
- 2009-2010 comparison among employees (last Health check per year).
 - Cholesterol “fix” down
 - Blood Pressure “fix” down
 - Tobacco “fix” down
 - BMI/Body Weight “fix” down
 - Heart Age to Real age
 - % with Heart Age lower than real age, up
 - % with Heart Age higher than real age, down
 - Follow-up Health Checks between 2009 and 2010
 - Those with follow-up Health checks, compared to those that did not follow up:
 - lower difference in heart age to real age in 2009
 - show improvement between 2009 and 2010
- Conclusion
 - Health checks are more likely each year to ID risk factors.
 - Overall this leads to lower rate of risk factors and lower heart age
 - Those that engage year after year show improvement
 - Those that engage once have higher risk factors than others and higher heart ages.
 - Opportunity to a) engage more spouses; b) engage more for follow-up Health check

Productivity results

Absences per employee: 2008-2010

Year	Absences (in days)	Employee months	Absence Index (absent days per employee month)	Percent Change in Absences from 2008
2008	17,516	1,440	0.56	0%
2009	18,725	4,804	0.54	-3%
2010	16,824	7,811	0.44	-20%

Source: ARLP, Payroll System, January, 2011

LEARNINGS

Outreach

OUTREACH (IN DEVELOPMENT)

- Encourage more employees to participate in Health Check, and more often
- Pre-cert data in Electronic Portal to make docs aware of upcoming events.
- Transitions of care programs
- Community partnerships.
- Community clinics
- “Culture of Trust”

Conclusion

Engagement with data and a direct relationship with people ... can lead to a culture of trust with providers and employees, and better health at lower costs.

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