OLIVER WYMAN
HEALTH INNOVATION CENTER

A CONVERSATION WITH

LEEBA LESSIN

PRESIDENT & CEO
CAREMORE HEALTH SYSTEM

Conducted by
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SHIVANI SHAH I imagine there are still a few people out there who haven't heard the CareMore story—how an HMO practice focused on Medicare patients learned to drastically reduce healthcare costs by delivering high-quality care to the patients most at risk of running up big medical bills. Could you give us a short overview?

LEEBA LESSIN CareMore's roots are in an internal medicine medical group in Southern California. It was a time when a lot of California HMOs were moving to prepayment models, and this group had an idea: A lot of adverse effects of disease could be avoided with a variety of interventions: social interventions, nutritionists, services at home, better patient education, behavioral health. So they decided to try to deliver services to patients in ways that focused on avoiding the long-term necessity for treatment.

They faced a variety of barriers. They needed to reorient practitioners' attitudes about treatment. They needed to get a lot of the services that they thought were important to be covered in health plan benefit packages, and they needed a vehicle that could be used to tell the story of what they were trying to accomplish for senior healthcare consumers.

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They solved several of these challenges by launching a Medicare Advantage health plan. Prepayment from the federal government through the Medicare Advantage program gave CareMore control over plan benefits and it gave CareMore control over the decisions about what types of services got paid for and what didn’t get paid for, regardless of whether or not those services are covered under Original Medicare. It also gave CareMore an opportunity to engage clinicians who might not otherwise be proactively focused on prevention which improves the health of our patients over the long run. It allowed CareMore to reconstitute physician compensation, job duties, and general expectations for the roles of a PCP and a specialist within the network.

SS One of the things that definitely pops when I think about CareMore and how CareMore manages Medicare patients is the concept of whole-patient care. What are some of the elements of whole-patient care that the CareMore model introduces that we don’t see outside of the CareMore model?

LL First, many people talk about being “patient centered.” But who is that patient? We think each person we serve is the sum of body, mind, and spirit. A good deal of medicine treats the body only. We care about the body for sure, but we also are attentive to mind and spirit. This impacts everything—what types of clinicians we hire and how we train them, who we include in the medical team (family and friends are in!), what we consider a site-of-service (home, a daughter’s home), and so on. Secondly, we are quite assertive about the fact that while diseases and aging processes are real, they do not have to take the toll on people’s bodies and minds that are often extracted in modern medical systems. We think strength can be maintained through nutrition and exercise and we make such services free to all of our members. Not just any nutrition and exercise, but personalized programs that will address the conditions the person is facing. We think the same physical exercise will maintain mental congition. We think depression is a co-morbidity that advances physical decline, so we aggressively intervene. We don’t believe chronic kidney disease needs to lead to dialysis if managed property. We don’t believe diabetics are bound to loose their sight or limbs. In fact we take great pride in the very opposite outcomes. We’re kind of rare in our insistence on keeping people stable, and I also think we’re rare in the extent to which we use nonphysicians to accomplish that. And I’m pretty proud of that part.

SS When people first hear about coordinated team-based healthcare, it’s often misinterpreted to mean, “I’m not going to see a doctor, and therefore I’m not really going to get high quality care. I really want to see a doctor.” How do you respond to something like that?

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LL We certainly hear people express that concern when we describe CareMore. And what we say is that we're teammates with physicians in accomplishing the care that they need to deliver, and that much of what our patients need does not require a physician to deliver it. In fact, for many disciplines, like intensive patient education, physicians are not the best equipped for the role. One of the most common complaints of seniors—of anybody in the healthcare system really—is that their clinicians aren't sufficiently accessible, either in terms of the time that it takes to get an appointment, or how much time the physician spends with them. So we try and emphasize that what we're doing is adding folks who can spend large quantities of time with them. That message resonates well with a lot of seniors, that someone's going to spend focused, quality time with them to deeply understand their health, and we sure do.

SS I'm guessing that you can't necessarily take the CareMore style care model and apply it to the population as a whole because the needs are pretty different amongst the populations.

LL I'm not sure I agree. We focused on the Medicare population because there's a lot of disease burden there. It takes a lot of money to build up CareMore type capabilities, and you've got to prove that you're really impacting health. So there's sufficient concentration of disease burden in the Medicare population to put that many resources out there and prove it.

Once that infrastructure is in place, there's no reason not to use it for multiple populations. Now, we didn't use it for other populations in that time that we were expanding and growing, not because we didn't think it would be useful, but rather because we could stay strategically concentrated and that was more important in terms of how our focus went at the time. We wanted the CareMore model of care to expand beyond California. Everybody says healthcare's different in different locations, but the diabetic isn't different, the CHF patient isn't different. The way healthcare is organized in the local community may be different, but that doesn't mean a patient's healthcare needs are different.

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So we thought we would have a shot at expanding our model if we could keep that mantra in mind, that we were not expanding to meet the needs of the local market, we were expanding to meet the needs of the people we would take care of. We did that until the Affordable Care Act changed Medicare Advantage compensation in a way that made brand-new startups less feasible. And so we changed our focus to being about enabling others in the healthcare system to adopt our model in their communities, and everybody we're talking to about collaboration opportunities is planning to use our model for multiple populations.

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SS Are there other barriers you face in terms of scaling?

LL One challenge is having a sufficient number of prepared, CareMore-trained physician leaders. It takes a while to learn to become a physician in CareMore. Most physicians are not trained to be members of multi-disciplinary care teams. And most physicians are not trained to look five years ahead to predict preventive needs and work back to the present to set the patient's course of care. We do and so it takes some time to inculcate our team. We need physicians to be leaders and trainers of others more than doers themselves, which is what physicians are more comfortable with. We need physicians who will take on the specialty teams or hospitals or others that might be combatting the CareMore model for economic reasons. We've got to aggressively find physician leaders who want to do that, and then they have to be immersed in the CareMore model for some period of time.

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The second challenge is making the right decisions at the right time about how technology will be used. There is an explosion of technology going on right now in areas such as home-based monitoring that will transform healthcare in a hands-on sense, but there's also a lot going on technologically on the infrastructure front, in particular, marrying together all the divergent data sources. So we're trying to rapidly expand a particular model while that model is, itself, being altered by technological developments. It creates a challenge for scale, but several other industries—notably telecom—have had to function this way for a couple of decades. We'll figure it out.

SS How do you track success?

LL From an overall business point of view, we track detailed financial performance and gross metrics and efficiency metrics and so forth. But in terms of proof of our clinical model, we track a whole bunch of clinical outcomes, a lot of which I don't know if anybody else is tracking. We track falls, amputation rates and wound healing rates, and percentage of the time someone called us versus calling the ER. We try to track metrics that are indicators of not only whether a program is working but whether people are engaged in it. And we track it comparatively. I mentioned that the needs of of diabetics don't differ based on the market they are in. Thus, we should not expect a diabetic in Richmond to receive a different set of services or accomplish a different level of clinical outcomes than one in San Jose or Las Vegas. Comparative metrics are very powerful.

We love highlighting our amputation rate because it's so low. In some markets it's 80 percent less than the national average. Our end-stage renal disease results are awesome. The average ESRD patient will find themselves in the hospital two to three times a year, and for us it's less than once a year.

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> We said, "OK, here's what you've got to do." They're like, "Oh, that's a lot of work. That would really change our doctors." We were like, "Well, yeah."

We just computed a metric of chronic kidney disease, measured on a scale of one to five. By the time you get to five you're ready for dialysis. In a Medicare fee-for-service population, someone progresses from a three to a five in an average of six years. When we measured our population's progression to dialysis, it was almost a theoretical exercise because the average turned out to be 26 years. And the reason I say a theoretical exercise is that most people of the age that we treat will have succumbed to another disease in those 26 years. So that's a game changer kind of metric for older adults.

SS It's sad that the model isn't already being applied universally across Medicare patients.

LL Remember, we can only do what we do in prepaid arenas. This does not work in a fee-for-service environment. There are lots of things we do that Original Medicare wouldn't pay for. We just had a meeting with a big hospital system in New York—you'd recognize the name—and they were all high on the CareMore model. We said, "OK, here's what you've got to do." They're like, "Oh, that's a lot of work. That would really change our doctors." We were like, "Well, yeah." It's almost a little joke here, you can't change without changing.

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SS CareMore has been one of the earliest and most supportive members of the Oliver Wyman Health Innovation Center, so we're delighted that you're going to be with us at MediFuture. How do you expect MediFuture to be different from other conferences?

LL I think the very tactile approach that you're taking is awesome—bringing people through in groups, facilitating conversation. Adult learning research tells us that if people talk, they remember things, and if they don't talk, they don't remember as well.

SS Have you ever seen something quite like the experiential exhibits that you and some of our other members are preparing?

LL No, and I love the idea, especially for an approach like ours. You can't tell our story in a five-minute speech, so having an opportunity to dialogue with people about it is really cool.

When practitioners first join CareMore, we put them in a training session in which they put cotton in their ears and Vaseline on their glasses so that they can feel what it's like for an older patient to experience one of our care centers. How do we make it easy for them to navigate and easy for them to hear us or see things? We had a whole bunch of design work done on what colors to use in the centers that don't create glare in elderly people's eyes, and all kinds of thoughtful design stuff like that. I don't know if we can go as far as that in Tampa, but we'd like to get as close as we can.

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SHIVANI SHAH

Shivani is a Principal in Oliver Wyman's Health & Life Sciences practice and serves as a Director of the Oliver Wyman Health Innovation Center. She specializes in helping clients develop and execute their value-based healthcare strategies. Her primary areas of focus are in establishing value-based models and developing innovative go-to-market commercialization strategies for both payers and providers.

LEEBA LESSIN

Leeba Lessin has over 19 years of experience in the healthcare and managed care industries. In early 2007, Ms. Lessin joined CareMore Health Plan as President and Co-Owner of CareMore Health Group. Under Ms. Lessin's leadership and vision, CareMore Health Plan grew its membership from 18,000 members to over 75,000 today. CareMore is focused on the proactive identification and management of frail patients, preventive care programs, and efficient cost management, leading to superior care delivery. Leeba is the driving force and heart and soul of CareMore's mission.

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ABOUT OLIVER WYMAN

Oliver Wyman is a global leader in management consulting. With offices in 50+ cities across 25 countries, Oliver Wyman combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation. The firm's 3,000 professionals help clients optimize their business, improve their operations and risk profile, and accelerate their organizational performance to seize the most attractive opportunities. Oliver Wyman is a wholly owned subsidiary of Marsh & McLennan Companies [NYSE: MMC], a global team of professional services companies offering clients advice and solutions in the areas of risk, strategy, and human capital. With 52,000 employees worldwide and annual revenue exceeding $10 billion, Marsh & McLennan Companies is also the parent company of Marsh, a global leader in insurance broking and risk management; Guy Carpenter, a global leader in risk and reinsurance intermediary services; and Mercer, a global leader in human resource consulting and related services.

Oliver Wyman's Health & Life Sciences practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Deep healthcare knowledge and capabilities allow the practice to deliver fact-based solutions.

The Oliver Wyman Health Innovation Center (OWHIC) was created to develop and promote market-driven solutions to the crisis of high cost and poor quality that afflicts the healthcare systems of the developed world. Based on the deep healthcare expertise of Oliver Wyman and drawing on a network of innovative leaders across industries, OWHIC identifies and disseminates the ideas and practices that will transform healthcare. Our goal is to create a healthcare system driven by innovation and the needs and desires of consumers, creating value for companies and the public alike.

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