*Internal analysis results quantify the value of an engagement discipline that provides strategic support beyond direct interactions with members to reduce ER visits and readmit rates.*

# Analysis of the Premier Advocacy model showed measurable benefits even when an inpatient member is not directly engaged

The Premier Advocacy model from UnitedHealthcare is 1 of 3 options (Core, Elite and Premier) employers can choose from to help members navigate their health plan benefits, which may help achieve better outcomes and save on health care costs. A recent case study revealed each model's performance metrics and demonstrated the progressive benefits from Core to Premier based on a concierge, integrated approach with members. See case study at: **uhc.com/advocacy.**

### Premier Advocacy provides whole-person, proactive support

**Key features include:**

- One program that integrates multiple service areas
- Data and insights to proactively identify solutions
- One integrated team of experts to help support employees and their families

## The merits of measuring "on behalf of" support

In addition to the value of direct engagement *with* a member, new analytics measure the results of a care management team's insights and actions *on behalf* of that member. The insights are part of an innovative methodology developed by UnitedHealthcare, featuring the Blended Census Reporting Tool (BCRT) as part of the BCRT Process.

### The BCRT is a bed-day management tool that helps evaluate readmission risk

Using machine learning, each admission is scored to measure the likelihood of readmission to help prioritize outreach

During weekly interdisciplinary rounds and daily census review and intervention, the team uses the scores to amplify care and post-acute planning

**The goal:**

Based on the member's care plan, review more deeply inpatient care to help decrease bed days and avoidable readmissions

The BCRT Process is used in conjunction with interdisciplinary rounds plus daily census review and intervention to help support bed-day management initiatives.

continued

United Healthcare

# The added value of Premier Advocacy

Building on the personalized support of the other 2 advocacy models, Premier incorporates the BRCT Process and includes:

- **Interdisciplinary rounds**
- **Enhanced Premier medical director support**
- **Enhanced inpatient care manager focus**
- **Real-time continuity of care engagement**
- **Head-in-bed transitional care management**
- **Daily census review by Premier medical director**
- **Concierge-like Premier advocate support**

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High-cost claimants are evaluated based on:

1. **Descriptive analytics –** *"Member is a high-cost claimant"*
2. **Predictive analytics –** *"Member is likely to become a high-cost claimant"*
3. **Prescriptive approach –** *"What can we do to avoid the member becoming a high-cost claimant?"*

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This case study captures the impact of the BCRT Process in helping quantify the value of the Premier Advocacy model.

# Methodology

## Purpose

To help measure the impact of participation in the BCRT Process on medical spend and health care utilization at the member level.

## Scope

The research encompassed both client-level and member-level analysis.

## Participants

Members of Premier clients with inpatient admin length of stay ≥7 days (including end-stage renal disease (ESRD), hospice, cancer, HIV and COVID) with 6 months of continuous eligibility during pre- and post-periods.

## Analysis

- Client-level analysis evaluated 18 participating Premier clients and compared them to matched 14 control clients in a year-over-year trend comparison analysis
- Member-level analysis evaluated >5,400 individuals and compared them to matched members (matched on over 80 covariables) in a difference-in-difference (DID) analysis

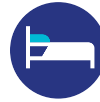
continued

# The differentiated discipline in this analysis yielded statistically significant results

### ER utilization and cost

Both parameters were lower for participants for pre-/post-period comparison for the analysis with ESRD, hospice, cancer, HIV and COVID members included.

| ER counts per thousand members per year (PTMPY) (pre vs. post) | | | |
|---|---|---|---|
| **Group** | **Post-pre** | **DID** | **P value** |
| **Par** | -203.8 | -57.6 | 0.0002 |
| **Non-par** | -146.2 | | |



### Inpatient readmission

Participants also consistently showed a decrease for 30-day and 90-day readmissions compared to non-participating clients for both populations with and without ESRD, hospice, cancer, HIV and COVID members.

| 90-day readmission counts PTMPY (pre vs. post) | | | |
|---|---|---|---|
| **Group** | **Post-pre** | **DID** | **P value** |
| **Par** | 590.6 | -16.6 | 0.0362 |
| **Non-par** | 607.2 | | |

Other parameters yielded reductions in categories that were measurable but not statistically significant.

## Cost-avoidance calculation

A cost-avoidance follow-up analysis revealed that if the members had received services at the same rate as those not managed through the BCRT Process, they may have cost the plan $105 PMPM more than they did.

This savings is regardless of whether the member was engaged in case management following the admit and includes all members with an admit of 7 days or greater (catastrophic/outlier admitters), not just those discussed as part of the BCRT Process.

continued

*Not actual member photo*

## The BCRT Process in action

**Premier Advocacy member profile**

- Seven-month-old infant with B-Cell Acute Lymphoblastic Leukemia
- Nine admissions in 4 months for chemotherapy with >60 days in hospital
- Claims costs >$2.5 million

| Situation | Action | Outcome |
|---|---|---|
| **Readmissions were due to a lack of response to the initial chemotherapy, so reinduction was needed**<br>• During inpatient stays, the case was discussed multiple times in BCRT Process<br>• A specific chemotherapy was requested but only available in adult-sized capsules; alternatives would require repeated infusions in hospital | **The interdisciplinary team determined that a compounding pharmacy could provide the needed chemotherapy**<br>• Although compounded medication is not generally coverable, the team's medical director and pharmacist were able to get it covered under the benefit document as an exception. This resulted in the avoidance of several readmissions to the hospital because the medication could be given orally by the family instead of requiring a series of IVs in the hospital setting. | **The family was able to administer the chemotherapy at home** |

# Demonstrated results

It's worth noting that the analysis from the case review results are not a reflection of an initial lift in Premier-level activation. The participants were composed of clients at various stages of their maturity in the Premier Advocacy model.

Also, the evaluation focused only on the ability of the BCRT Process to positively impact medical spend and health care utilization at the member level. It did not capture the value of subsequent case management and overall concierge-like Advocacy support. As earlier studies[1] have shown, Premier Advocacy helps to:

- Achieve total medical cost of care savings
- Close gaps in care
- Increase program referral acceptance and enrollment
- Decrease repeat and transfer call rates
- Improve employee satisfaction as measured by Net Promoter Score®

More analysis is planned to measure other contributing factors, such as the role of Premier nurses, to elevate the patient experience with the hope of achieving better outcomes at reduced cost. The results will be shared when available.

## Learn more

For more details, go to **uhc.com/advocacy**

[1] 2019–2020 UnitedHealthcare employer study including 387 clients, 4.8M members and $19.2B in medical spend. Analysis completed on a continuous medical enrollment basis. Medical costs risk adjusted for age and gender. Value impact based on comparing clients by the adoption platform features vs. not (e.g., enhanced vs. Core Advocacy). Actual client results may vary based on specific clinical programs the client has or maturity of implementation.

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