



Leaders in Executive Health

An Interview with
Deborah McKeever, President and Chief Operating Officer;
Susan Spear, M.D., Senior Vice President-Medical Affairs; and
Jack Segerdahl, Executive Vice President and Chief Financial Officer,
EHE International

EDITORS' NOTE In 2001, Deborah McKeever joined EHE International as Senior Vice President and Chief Administrative Officer and was named President in September 2003. Between 1979 and 2001, McKeever was with UM Holdings Ltd. where she held a number of corporate positions including Vice President of Administration.

Dr. Susan Spear is also Chairperson of the Medical Advisory Board at EHE International. Prior to her current position, she was the Executive Vice President, Physician Partners Company, physician management and contracting body for New York-Presbyterian Healthcare Network, as well as Assistant Clinical Professor at Columbia University.

In 1997, Jack Segerdahl joined EHE International as Senior Vice President and Chief Financial Officer. Additionally, Segerdahl serves as a member of the EHE Office of the President. Prior to joining EHE, he served as CFO of NewsBank Inc. and Perrier Group of America.

COMPANY BRIEF EHE International (www.eheintl.com) has been a recognized leader in employer-sponsored Preventive Healthcare Plans (PHP) since 1913. The plans are specifically designed for the early identification of preventable disease and risk factors; clinical management of health findings; referral resources; and personal coaching intervention programs of adverse lifestyle behaviors linked to poor nutrition, physical inactivity, and smoking. PHPs are available nationally and are specifically designed for self-funded/CDHP medical plan designs.

What is it about EHE International that has helped it to remain so consistent in its success and what makes it a leader in this space?

McKeever: Next year, EHE International will celebrate 100 years in business. It has done one thing from the day it was founded, and that is to focus on prevention through the early detection of disease and the identification of health risk behaviors.

I often say that "an apple a day" wasn't such a bad idea. The original newsletters of the company speak to obesity and smoking dating back to the '20s.

Spear: We have been consistently successful because when a patient comes to see us, he feels we have provided something valuable. What that is has changed over time.



Deborah McKeever



Susan Spear, M.D.



Jack Segerdahl

The good news is that we have a very robust program that includes initially spending a half day with our physicians – far more time than a patient normally gets to spend these days – running through a series of tests and procedures, all of which occur in a convenient and condensed way.

But where they truly get value from the program is through what we offer them over the course of the next year, and that has changed enormously, even over the past few years.

Through those programs, which focus on health education, health counseling, health coaching, and motivational behavior modification, the patient ends up feeling he has gotten something very valuable. That's the good news.

The bad news is that no one seems to have figured out how to solve these enormous problems our society faces – the single biggest one being obesity and the health ramifications of that. So the more programs we provide to challenge obesity, the better off we all are. We have a long way to go to solve that problem, but we are committed to resolving it over the long run.

Segerdahl: At some point, everyone needs the health services we offer and they certainly have options in fulfilling that need whether it's from a primary care physician or a group like ours. But consistently, the health of an individual is of concern to them at some point and over a 100-year period, a certain number choose us.

McKeever: What we do know is that once people come to us as part of their health care, we have a very high repeat rate because they hadn't realized how unique our approach is.

We like to think we offer an exceptional experience, but we often hear that people either dismiss preventative medicine or didn't know it was available.

Is it challenging to show what makes EHE unique and are you competing with a number of outlets?

Segerdahl: We don't have a lot of competition in what we do, the way we do it, and the scope we do it in an employer market on a national basis. I wouldn't count primary care doctors because certain patients go to primary care for their preventative direction and some doctors do a thorough job and some don't. The general population is not always sure what to expect and don't know what all the tests are, especially compared to the full scope of what we do.

There are a number of fine places where you can go and get the service we provide. However, an employer with employees nationwide would have to send their people to Raleigh or Baltimore for care at those facilities. We are the only one able to service a national employer with the same level of service from New York to San Francisco. And we are the only one that can provide that service to a corporation.

McKeever: Most of those other programs also don't provide any sort of ongoing follow up. So even if they don't have national coverage, the kinds of programs we offer to patients for the duration of the year after they come for the exam is unique.

In terms of value at the corporate level, is there a certain size that an organization should have in order to take advantage of what you offer?

Segerdahl: We have large and small companies, so it runs the gamut.

McKeever: On the large scale programs, ours is a self-insured product. If you're self-insured, it's a perfect match.

You also are focused on research. What is the importance of what you do in regard to harvesting information and research based on that?

Spear: In addition to a medical advisory board that sets all of the clinical protocols for what we do, we have a full-fledged research board called the Life Extension Research Institute. Its members are national experts in epidemiologic preventative health research from various academic institutions throughout the country.

They take our enormous wealth of clinical data to evaluate; there is no other comparable clinical data resource available to them in terms

of the numbers of people we see, the variables that we can control for, and the number of years in which we see people repeatedly. We collect all of that data electronically so it's easy and interesting for them to look at things in a number of ways, controlling for one variable and studying another, and coming up with interesting results.

The board has been around for five years or so and over the course of that time, they have put out many peer-reviewed academic journal articles on subjects from obesity and PSA to colonoscopy in a younger age group. A recent article about health and business travel that the group published in the academic literature was picked up by 50 non-academic journals and newspaper publications, so it had enormous appeal to the general public. It demonstrated the many ways that excessive business travel is bad for your health and we identified which aspects of physical and emotional health are most adversely affected. That allows us to advise our corporate employers and clients about ways to impact that for the better.

What is the strength of the talent you have brought together under the medical board of advisors and how critical are they to your success?

Spear: They are a major factor. We have about a dozen people with expertise in every aspect of clinical preventive medicine from cardiology to rheumatology to gastroenterology to radiology and psychology as well as other areas. If they don't have a specific expertise, they know the people who do, so we can also rely on invited guests in certain fields should it be necessary.

The reason this is so critical is that the purely scientific side in the field of preventative medicine is in a way limited. If we could only utilize the number of practices the U.S. preventative services task force feels it can recommend based on the existing literature, we would have a small and somewhat ineffective program; there is simply not enough data to absolutely prove many things. Everybody is aware of the recent controversies about when, how often, and at what age to do mammograms and PSA tests, for instance.

So we have to use our own judgment in terms of deciding what is worth doing in a program that emphasizes preventive medicine. The hardest decisions are probably what new things not to do, because there is something new coming down the pike weekly. There are many subtler things for which there isn't full-fledged evidence where the judgment of this group becomes critical.

We have a series of procedures that we periodically review and evaluate whether we should continue. We also routinely review anything new that comes along and decide if we should incorporate it.

McKeever: We have been at the forefront of preventative medicine for nearly a century,

and every day we strive to maintain that leadership. For example, we were the first to include C-Reactive and homocysteine testing for cardiovascular disease, and we were early adopters of screening colonoscopies beginning at age 40, as opposed to 50, which remains today's standard. Clinical protocol decisions like this are made by our independent medical advisory board and substantiated by research studies conducted by the Life Extension Research Institute Board.

Is it challenging to establish clear metrics to show the impact of the services you provide, especially when you're focused on the preventive side?

Segeerdahl: We don't guarantee ROI; we don't talk to employers about it because there are so many variables that can influence it. Every company is different and every story is different.

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What you're doing is investing now to avoid future costs. What future costs and future diseases did you avoid because of prevention? Just developing the criteria to get a fix on what that true return may be is challenging. There is a wide range of assumptions that can be made that can swing it to whatever you want it to be.

There are companies in the wellness space, not so much in an exam program like ours, but in wellness or disease management that try to guarantee certain returns. That is not something we're interested in.

Spear: On the other hand, with some of our larger populations, we can demonstrate improvement in the health status of their population over time. What we can't do is a controlled study comparing it to the people in their company who didn't come to us, because we're a business, not a science lab.

So we can show that our program has made people healthier over time, which is a significant accomplishment since the general trend for all of us over time is to get less healthy.

McKeever: We call it as we see it. If you got 25 percent of the population to quit smoking but they all gained 50 pounds and became full-blown hypertensive, what was the return? There are too many variables.

How challenging is the health care debate in terms of what you do and are you optimistic that the dialogue can help us achieve the necessary reform?

Segeerdahl: The 18 months of debate on health care reform seemed to center, unfortunately, on who was to pay for health care, not on the health crisis that the country is facing. I don't know that this has been fully addressed. It's like we're concentrating on which pocket fees are coming out of versus the need to improve the health of the country.

McKeever: It was all about payment reform and not health care reform. But if we would take care of ourselves, we could use our health care resources for the nation's seriously ill.

Spear: Aspects of the philosophical basis for the reforms do emphasize the importance of prevention, in either a carrot or stick way. This country has started to take the obesity crisis more seriously in terms of trying to intervene before people get overweight and there will be ways that become incorporated into the economics of it over time.

McKeever: In the EHE client world, it's a non event. We have a great client list and each one of our clients has a wonderful insurance plan. It's not a matter of access of payment – it's a matter of, I should be taking care of myself.

That's where we play such an important role. We know how to talk to populations to say this is something you need to think about in the management of your health.

Is the medical profession still attracting the best of the best?

Spear: I am exposed to Columbia medical students on a regular basis and the quality of the students is very high and the idealistic quotient remains. A lot of people are still drawn to the medical and health care professions, even though it's no longer seen as a way to get rich. I do have major concerns about what we're expecting of physicians once they start providing care, because there are many settings in which it's extremely challenging to provide good care based on the economic constraints that exist.

McKeever: There is such a shortage of primary care physicians because who wants to work in an environment where they're seeing 40 to 60 patients a day – our doctors see eight or nine to give them the care they need. There are great doctors out there but they are under tremendous pressure to see all these patients.

Spear: The good news for EHE is we get great doctors because they love the way they can practice medicine when they work for us.

McKeever: Yes, the prevention instead of treatment or "apple a day" approach to medicine still holds true after all these years. ●