



15 YEARS
OF LEADERSHIP
IN VALUE-BASED
PURCHASING

National Business
Coalition on Health

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NBCH Marks 15 Years of “Healthy” Progress

By Jerry Custer

It is hard to believe that I am already half way through my second term as chair of the Board of Governors of the National Business Coalition on Health (NBCH). It has been an honor and a privilege to serve in this capacity. With time going by so rapidly, I will take this opportunity to report on the “health status” of NBCH today. This year, NBCH is proud to celebrate 15 years of advocating for employers and business-health coalitions. Having been involved with the coalition movement from the humble beginnings of NBCH in 1992, I can personally attest to the fact that we and our member coalitions have come a long way.

Over the years, we have made tremendous strides. NBCH has become a strong and zealous force for value-based purchasing, uniquely positioned in Washington to advocate for employers’ demands that the system deliver quality and affordable health care to workers, their families, and retirees.

As evidence of our increased success and visibility, NBCH President and CEO Andrew Webber contributes to a number of high profile organizations that share many of our goals for health care reform, such as the National Quality Forum, the Quality Alliance Steering Committee, and the Consumer-Purchaser Disclosure Project. He also serves on the boards of the Leapfrog Group and Bridges To

Excellence (BTE), among others. In these roles, he has validated NBCH’s important function advocating for viable and lasting reform. There is little disagreement that NBCH and these other organizations are bringing forth the issues that need to be addressed on the health care agenda in Washington.

In addition to gaining increased visibility, NBCH has developed a number of strategic partnerships with BTE, for example, and most recently with HealthMap Rx, a pharmacist-coordinated, patient-self management program formerly known as the Asheville Project. These alliances allow members to take leading roles in their communities to implement projects that serve to foreshadow the models of health care reform that are to come.

Within the next 15 years, we hope to see a pay-for-performance system like that of BTE in place nationwide so that physicians and other providers are rewarded for providing quality care. We also hope that within the coming years, the HealthMap Rx model, in which consumers and health care providers have a strong partnership, is commonplace. We applaud these and other efforts that reward better performing doctors for improving outcomes and consumers for taking a more active role in managing their health.

By working to fulfill the role employers and coalitions designed for us in the early 1990s, we are fostering

the kind of health care reform that purchasers and employers envisioned at the end of the last century. Today, there is great momentum behind our ideas, and although there is still much more to do, the improvements we've seen just in the past few years are remarkable. ■

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Value-Based Purchasing Gains Government Endorsement

By Andrew Webber

This year, NBCH recognizes 15 years of leadership in value-based purchasing. In addition to celebrating our own anniversary, we are marking another important milestone this year: 2007 was the year value-based purchasing achieved cabinet-level endorsement.

Secretary of Health and Human Services Michael O. Leavitt introduced the government's Value-Driven Health Care Initiative earlier this year, embracing the tenets of value-based purchasing as a strategy for advancing health care reform. The federal government's significant recognition has catalyzed a reticent community of health plans, providers, purchasers, and consumers. Recognizing that the federal government is the nation's largest health care purchaser, these stakeholders have begun to form partnerships and loose coalitions to implement a specific agenda that can transform the health care delivery system into a market that works for everyone.

These partnerships have begun to form spontaneously around the country, growing out of a need to address the critical issues related to the cost and quality of health care. In addition, and perhaps more important, these partnerships are aligned behind the cornerstones of value driven health care. It's rewarding to note that when these groups need a coordinator, employers quickly emerge as the vested voice of reason.

True to our mission, NBCH supports these partnerships by helping them to organize, offering them strategies for reforming their local markets, and providing them with access to industry experts and colleagues in other markets who can offer advice and counsel.

We plan to foster the development of these local partnerships so that they have a voice in the national debate about health care reform and a role in transforming health care in their communities.

After the federal government, employers and business-health coalitions represent the largest group of organized purchasers of health care services. Their collective voice has leverage that can encourage health plans to operate more transparently, convince physicians of the value of performance measurement, and persuade consumers to choose doctors who offer high quality and efficient care.

In the coming year, we hope and expect that access to health care for the 47 million Americans who now are uninsured will be one of the most important issues in the presidential campaign. But we also expect the candidates to address the other important issues of health care quality and affordability. NBCH is committed to making the employer's voice heard on these issues by advocating for better care and more reasonable pricing.

Employers and business-health coalitions can and should play a critical role in reforming the health care system and guaranteeing that the system that emerges from this national debate is one we all want and can afford. We welcome the important leadership of the federal government and the employer-purchaser community on the issues of quality and affordability as all stakeholders begin to embrace value-based purchasing. ■

Andrew Webber is the president and CEO of the National Business Coalition on Health, in Washington, D.C.

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“Business-health coalitions are encouraging health plans to operate more transparently, convincing physicians of the value of performance measurement, and persuading consumers to choose doctors who offer high quality and efficient care.”

Niagara Group's Data Show Hospital Quality Rising

Performance measurement effort helps hospitals reduce mortality rates

For employers developing standardized performance measures, Bruce Boissonnault has some advice: Don't change what you measure as ice cream shops change the flavor of the month and always remember who your audience is.

Boissonnault is the president and CEO of the Niagara Health Quality Coalition (NHQC), an employer-led, nonprofit multistakeholder corporation whose audience for public reporting is primarily patients (meaning consumers) and quality improvement professionals.

"It can be tempting to chase funding every time a grant comes out to measure something new," explains Boissonnault. "We have not followed such a strategy because our board members believe doing so would be unfair to consumers and our provider collaborators. Our employer members believe changing directions and measures in response to the shifting winds of opinion, instead of building long-term quality measurement strategies based on what is important, could signal that we do not fully know or care what matters to our audiences. Providers will—and should—ignore measures if they believe such measures are the flavor of the month that will be gone in two years or less. Moreover, some senior community leaders may tire of involvement in organizations that continually shift measurement priorities."

NHQC publishes the New York State Hospital Report Card, which is one of the nation's most respected hospital quality report card efforts. NHQC also operates www.myHealthFinder.com, an independent, advertiser-free source of consumer information to help individuals and communities make better health care decisions. The coalition accepts no funding or advertising revenue from the providers it grades and its Web site gets as many as 3 million hits per day and as many as 15,000 discrete users per hour for extended periods.

Report Card Data

Since 1998, NHQC has been publishing hospital quality data in Western New York. In 2001, it began publishing the New York State Hospital Report Card. In addition to publishing quality and value metrics, NHQC uses these measures in provider collaborations to foster improvements in health care delivery. "We have documented statistically significant improvement as a result of our public reporting and community dialogues," Boissonnault says.

As a result of NHQC's efforts, hospitals in Western New York have been collaborating with each other since 1998. "When we started, NHQC results were among the nation's worst when compared with that of other regions in a national database using identical measures," he comments. "By 2005, Western

New York was among the nation's best regions for patient-centered care based on our initial set of annually published measures. Recently, the Quality Subcommittee of the National Committee on Vital and Health Statistics invited NHQC to present a report on the effects of our work. NHQC presented research concluding that publication of the New York State Hospital Report Card is plausibly responsible for significant improvements in certain clinical outcomes.

8 “One of the keys to our success is that the compensation of a large number of hospital CEOs is tied to our measures,” Boissonnault adds. “If hospital CEOs’ compensation is tied to a measure, you don’t need other pay-for-performance incentives because you already are making quality a priority at the top of the hospital system.”

One of the most challenging aspects of the coalition’s initiatives is identifying the best ways to obtain needed data to produce the desired performance reporting measures. “Identifying the source data for our measures became one of the first hurdles in NHQC’s early years,” Boissonnault explains. “We had several meetings with all the various stakeholders, including the employers, physicians, hospital administrators, and others, to identify meaningful, appropriate data sources for our proposed quality and cost measures.”

In these discussions, some NHQC-member providers proposed last-minute changes to the measures. “After researching these last-minute proposals, we determined that the proposed changes could have undermined the scientific validity of the entire NHQC reporting structure for this care,” he adds. “Worse, the proposed changes to methodology would

Stroke Mortality Data Attract Attention

One of the significant data points among the reams of numbers the Niagara Health Quality Coalition publishes on its Web site (www.myHealthFinder.com) involves acute stroke mortality.

“The state risk-adjusted mortality rate for acute stroke is 11%,” explains Bruce A. Boissonnault, the coalition’s president and CEO. “This rate for all hospitals in New York state shows a lot of variability, which is something we noticed when we published these rates. In 2004, the second year after we started publishing these rates, we noticed that one of the designated stroke centers in New York state had worse outcomes on a risk adjusted basis than some of the other hospitals that were not designated as stroke centers. Being designated as a stroke center is important in each region because it means the community has agreed that ambulances should drive an extra 20 minutes to get the patient appropriate stroke care.

“Worse outcomes for these centers, raises the question: Why are we diverting ambulance patients as much as 20 minutes to go to hospitals where their outcomes are no better or statistically

worse than the state average? We knew there were many ways to fix problems like these,” Boissonnault says. “We could get business, hospital, health plan, and physician leaders in a room and ask about it, or we could go to the media.

“Instead, staff met with a chief medical officer from the most challenged of the stroke center hospitals. He said he knew about this flaw and had been trying to get it fixed,” Boissonnault says. “The problem is a failure to have a radiologist on duty 24 hours a day, seven days a week. Physicians need radiology to know if a bleed or a blockage is causing the stroke. If a patient arrives on a Sunday night and no one’s in radiology until Monday morning, the patient who was driven 20 minutes out of the way on a Sunday night waits for several hours for a radiologist. In the meantime, the patient could suffer brain damage or die. The chief medical officer met with the hospital CEO and the problem was fixed within a week. These data can drive significant improvements in health quality and outcomes quickly, and you might actually save lives as well.”

have altered the results to favor one large category of hospitals. To be clear, this recommended change also would make the data more useful to the hospitals’ quality improvement staff. To regain lost momentum, we directed the discussion toward identifying our audience. One audience for our measures is the quality improvement staff of the providers we grade, many of whom were in the room.

Identifying the Audience

“After more thorough evaluation, however, it was unanimously agreed that our ultimate audience for all of NHQC’s published measures would be the patient or consumer who also was adequately represented,” Boissonnault continues. “In the end, all of the stakeholders voted unanimously not to alter the measures to favor the interests of the providers’ quality improvement needs because such a course would undermine this information’s usefulness to patients and consumers.

“Since that early meeting more than a decade ago, providing information that is useful to patients and consumers has been our first priority, and represents the compass we follow in all such deliberations,” Boissonnault adds. “A leader in the quality movement, W. Edwards Deming, advised against compromising when it would undermine the integrity of key measurement systems. The employer majority on the NHQC board agrees.”

While NHQC focuses on providing measures important to consumers, coalitions operate in a world where there is a wide array of audiences for quality measures including patients or consumers, employers, health plans, government, vendors, and others. “That’s why the search for universal (or perfect) measures

tends to oversimplify reality, and often can make quality improvement efforts worse and not better,” Boissonnault concludes. “It sounds great to say, ‘Let’s all agree on the best health care measures,’ but different audiences have equally legitimate, but often vastly different, information needs. Thus, NHQC’s policy focus has been to promote widespread access to de-identified billing and discharge databases so

users can make their own assessments and tailor their own analyses. At the same time, NHQC works collaboratively with government-endorsed initiatives to select and refine measures of particular importance to NHQC’s members.” ▶

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• AT A GLANCE •

Niagara Health Quality Coalition

The Niagara Health Quality Coalition is a nonprofit multistakeholder corporation that serves the communities in western New York state. The coalition represents more than 2,000 business members and a variety of provider, insurance, consumer, and government leaders statewide.

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Mid-America Coalition Demonstrates Value of Collaboration

Group works with public health agencies, health plans, providers, and others on a variety of initiatives

The Mid-America Coalition on Health Care (MACHC) in Kansas City, Mo., has a long history of working closely with public health agencies. The collaboration between a business-health coalition and public health agencies is not unusual but the extent to which the Mid-America coalition works with these agencies is certainly atypical. Over the years, MACHC has found that the collaborators actually have a lot in common because all aim to improve the health care system.

Since 1978, MACHC has worked closely with local and regional public health agencies in Missouri and Kansas, and in recent years it has worked closely with the federal Centers for Disease Control and Prevention (CDC) in Atlanta. MACHC representatives have worked with state and regional health officials on such issues as illness prevention, patient safety, nosocomial infections, hospital quality, and caring for the indigent and uninsured.

Sustainable Change

“In some ways, we’re not a typical business-health coalition,” says William L. Bruning, MACHC’s president and CEO. “We cannot guarantee our members that they will save money on health care costs every year, because we don’t buy health care or pharmacy benefits collectively. Our model is to create small, incremental, replicable, and sustainable change

in the health care delivery system. Our members believe that because they are paying for health care, they are paying for everything that is dysfunctional in the system. Therefore, if we can make improvements in any aspect of the system, our members will save money over time.”

Two of the coalition’s most significant projects involve improving the care of patients with depression and with cardiovascular disease (CVD). The coalition also recognizes that in addition to paying for such high cost and prevalent conditions as depression and CVD, employers also pay for administrative complexity. Therefore, the coalition has initiatives in place to simplify the administration of health care.

One attempt at simplifying administration involves working with the Workgroup for Electronic Data Interchange (www.wedi.org), an organization seeking effective and efficient information exchange by developing an electronic patient identification card, among other efforts. For the patient ID card initiative, MACHC is working with health plans and the Kansas City chapter of the Medical Group Management Association, an organization in Englewood, Colo., for physician office managers. The collaborators are developing an ID card that a patient can swipe through a card reader in a physician’s office at the point of care. Such a card would help physicians verify patients’ eligibility and speed claims processing.

“Our own study suggests the reason physician claims are rejected 50% of the time is because the patient identification is incorrect,” Bruning explains. “And, because one study suggested 15% of those claims are never resubmitted, employers ultimately will have to pay for that. We developed best practice guidelines for the design of Patient ID cards that WEDI has adopted nationally.”

The State of Kansas plans to adopt the electronic card format for all of its 88,000 employees and 360,000 Medicaid recipients in 2009, and MACHC aims to have four Kansas health plans adopt these cards as well. It also is working with UnitedHealthcare to test electronic card readers in physicians’ offices.

“By helping physicians verify eligibility, we will improve claims submissions, which helps everyone,” says Bruning. In fact, the coalition discovered a problem with physician claims when it launched a program to improve care for patients with depression. In 1999, the coalition did a Behavioral Risk Factor Surveillance System (BRFSS) survey of employees to identify health conditions and risk factors. “When the employers saw the results, they decided to develop a program to improve the identification and treatment of patients with depression in the workplace,” he says. “Our partner was the American Psychiatric Association.

“What we learned about depression was staggering. For example, from the employee survey we found that employees didn’t even know they had mental health benefits and so were not using them,” Bruning explains. “We also learned that physicians generally don’t even code for depression because they believed they would not get reimbursed for it. We knew

that perhaps 15% of the population has depressive symptoms but our tests suggested that less than 1% of health plan claims locally bore that diagnosis. We put together a task force of physicians, medical office managers, and health plan representatives and asked the physicians why the diagnoses weren’t showing up. The physician office managers explained that one of the reasons physicians don’t diagnose depression is that when discussing mental health issues with a patient, the patient may start to cry and use too much of the physician’s time. There goes the doctor’s schedule, and he or she isn’t getting reimbursed for that time. Plus, the office managers told us many of them urge their physicians to use other diagnosis codes because if primary care physicians use mental health billing codes the health plans won’t pay the claims.

“Then, we asked the health plans about this problem and they were unsure about their own procedures,” he explains. “From that realization came a project to educate physicians about how to code properly and get paid for diagnosing and treating depression. We educated physicians about how they can code for a visit of greater intensity in certain situations when patients are depressed. We literally taught physicians and their office staff how to code because we had that level of candor among the collaborators about deficiencies in the system. The confounding issue turned out to be that, in the end, the physicians still didn’t change their behavior even though they better understood how to address the issue.”

Improving Heart Health

Another significant effort that MACHC has undertaken is the Community Initiative on Cardiovascular Health and Disease (CICV). This five-year program

involves 14 employers and 400,000 workers, retirees, and family members. Like all of MACHC's efforts, it involves a wide variety of stakeholders including the CDC, and public health agencies in Kansas and Missouri. In addition, it involves the American Association of Family Practitioners, the American Heart Association, regional and national health plans, and pharmaceutical companies. Its focus is on primary and secondary prevention of all aspects of heart disease (including hypertension, high cholesterol, smoking, inactivity, nutrition, and metabolic syndrome).

Cardiovascular disease is the nation's most costly chronic condition. The estimated cost of cardiovascular diseases and stroke in the United States this year is \$431.8 billion.

"The CICV project reflects employers' recognition that cardiovascular disease (CVD) is the leading killer of men and women in the United States, its risk factors are the most prevalent chronic conditions in the workforce, and it is a leading cause of disability," Bruning says. The initiative engages employers in a proactive approach to CVD that includes developing best practices for the workplace and clinical community environments.

Interventions and Outcomes

In the 1999 BRFSS survey that led to the depression initiative, the coalition learned that 27% of respondents reported having three or more risk factors for CVD. "These statistics came back to us in 2004, because we also knew from other research that the number one cause of death in the Kansas City area was coronary heart disease," Bruning says. "And, health statistics showed that 65% of Kansas City area residents over 18 were overweight or obese and that

57% didn't exercise three times or more each week. At that same time, a number of public health officials in Kansas and Missouri were interested in engaging employers on worksite issues.

"We identified our CICV goals as seeking to improve work site cardiovascular wellness and cardiovascular outcomes for employees by focusing on illness prevention," he adds. "We also wanted to reduce health care and lost productivity costs; improve community awareness of how to be a heart healthy consumer; and coordinate employer efforts with clinical projects involving providers, health plans, and public health. We had funding from employers, the Kansas Department of Health and Environment, the Missouri Department of Health and Senior Services, the Sunflower Foundation, and we got some technical and financial assistance from several pharmaceutical companies."

The first phase of the CICV project began in January 2005 and focused on preliminary employer interviews about existing programs, resources, and needs. In the fall of 2005, phase two began with comprehensive baseline assessments, including a leadership survey, a heart healthy lifestyles employee attitudinal survey, employer worksite wellness environment inventory, cardiovascular health plan benefit design survey, and productivity measurements. The coalition compiled the baseline assessments and reported individual and company comparison reports for each employer. One of the most significant findings from these assessments came from the employee attitudinal survey, which confirmed that Kansas City employees wanted employers to participate in their health, a finding at odds with other local and national surveys.

Phase three, implementation, began last year and goes through next year, focusing on development and ongoing support for employers, including specific intervention plans and education forums based on needs from the baseline surveys. While intervention plans for each employer vary significantly, the metrics and objectives are the same for all. “The fourth and final phase will be done in 2009 when we will resurvey

the populations we surveyed in 2005 to compare our results against the baseline data,” Bruning says. “Then, we’ll know how successful this effort has been.”

Clearly, MACHC is working with a wide variety of collaborators and demonstrating that it is possible to have success even when working with so many disparate partners. ▀

• AT A GLANCE •

Mid-America Coalition on Health Care

The Mid-America Coalition on Health Care was founded in 1978 as a Civic Council taskforce that involved bringing together large employers and all health care stakeholders in the bi-state Kansas City region. The mission of the employer-driven coalition is to improve the health of employees, promote community wellness, develop cost containment strategies, and communicate health care information. Its 60 members include employers, hospitals, health plans, physicians, and government and public health agencies.

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ECOH Uses Its Experience to Reform Payment System

Coalition contracts directly with hospitals and physicians

Health plans and business-health coalitions have embraced pay for performance (P4P) in recent years as a way to reward physicians and hospitals for providing high quality and efficient care. While many organizations are just beginning to develop P4P initiatives, The Employers' Coalition on Health (ECOH), a nonprofit coalition in Rockford, Ill., has extensive experience with the strategy. In fact, ECOH has had success in a number of ventures designed to improve the delivery of health care for its employer members.

Its first P4P program began in 1998 when ECOH selected ear, nose, and throat specialists and orthopedists for a centers-of-excellence network. After the project was abandoned due to the administrative burden involved in running the program, the coalition developed a highly successful P4P program to improve diabetes care in 1999. It contracted with two hospitals and two primary care physician groups and asked them to meet specific parameters designed to improve the care of patients with diabetes.

That program has been successful in improving care for patients with diabetes and led to the development of other quality enhancement initiatives with hospitals and physicians in 10 counties in Northern Illinois. These initiatives have helped to control costs and improve health care quality for ECOH's member employers.

Forming Care Networks

"Essentially, we've created two PPO networks for our self-insured member companies," explains Samuel J. Schmitz, ECOH's executive director. "In our networks, we contract with hospitals, physician groups, and the whole gamut of providers, including chiropractors. We have about 51,000 covered lives. If the patient stays in the ECOH network, he or she may pay a lower premium and a lower deductible, depending on the company's summary plan description.

"Each of our 120 self-insured companies has its own summary plan description and they use our networks as the network option for its employees," Schmitz explains. Last year, ECOH agreed to let Destiny Health access its networks, adding about 35 companies and about 1,000 lives to ECOH's offerings. Destiny Health, in Chicago, has developed a wellness-based health plan that provides health insurance and incentives to motivate and reward participants who pursue healthy behaviors.

ECOH does not assume any risk because its member companies are self-insured and pay insurance claims from their own cash flow. In addition, these companies have stop-loss insurance for cases that exceed a certain threshold, typically \$50,000 to \$65,000. The stop-loss insurer pays claims above this amount. "Each company is in effect, its own insurance company," Schmitz explains. "We just provide the network. In

this way, we are a direct contractor, meaning we meet with the physicians and hospitals to negotiate the rates and discuss quality and access.

“The coalition actually has two networks that we developed from the three hospitals in Rockford,” he adds. “Two of the hospitals are in one network and the other hospital is in the second network. In both networks, we have a series of smaller regional hospitals and physicians who provide care in about 10 counties in northern Illinois. Most companies have 80/20 coverage in their plans for staying in-network. The company would pay 80% of the cost of care and the employee would pay 20% up to a predetermined out of pocket maximum. For comparison, getting care outside our network may mean the employer would only cover 60% of the cost and the employee would pay 40% of the total, again up to a predetermined out of pocket maximum.”

Schmitz offers the example of a patient who sees an orthopedist after experiencing elbow pain. “Normally, that physician might charge \$100 for that visit, but since he’s in the ECOH network, he may be willing to accept \$75 for that office visit,” he explains. “The orthopedist sends the claim to us, and our ‘repricing’ vendor reduces the claim to \$75 and then forwards the new \$75 claim to a third-party administrator that adjudicates the claim on behalf of the member company.”

Performance Data Gathering

Seeking to ensure that employees get quality care, ECOH has been gathering data on physician and hospital performance over the past few years, including patient satisfaction. “If you’re an ECOH

member who goes to an ECOH-contracted hospital, you’ll get a survey in the mail on how satisfied you were with the service,” Schmitz says.

“Our success with the diabetes initiative led us to our project for profiling physicians using cost and quality data. For two years, we’ve been working with physicians to define the criteria we’ll use in our physician report cards,” he adds.

“Our first report card to physicians was based on 2005 data, and we sent that out at the end of 2006,” Schmitz explains. “We spent the first six months of this year redefining the quality metrics for each physician group. The physicians received their second report card this fall, and that report was based on 2006 data. We have not reported the report card data publicly because we’re still refining the quality metrics with the physicians. Currently, we’re working to ensure that we get the measures right first and that the physicians support the process. We’re not interested in ramming it down their throats.

“It’s a slow and deliberate process,” he continues. “In stage one, we collected the data, selected a vendor, and introduced the program. There are dozens of quality metrics, and we asked the physicians to work with us to select the ones they believed were evidence based and made good clinical sense.

“In stage two, we issued the report cards to physicians and medical directors to encourage collaboration among the physicians,” he says. “Research shows that physicians have a strong desire to improve when they see data from their peers even if the data are not shared with the public. So, we expect to see improvement just as a result of sharing the data with physicians.

Physician Education

“Not all the physicians are happy, of course, and we recognize that any physician profiling system is not perfect,” Schmitz adds. “But it’s the best thing we have right now. Our aim with these report cards is to rein in outliers who offer low quality, inefficient care. The report cards give physicians actionable information on specific measures. We hope that because we used a painstaking process, we will get everyone on board when it’s done. Then, we’ll go to stage three, which is scheduled to begin next year and will involve reporting the quality and cost data to the ECOH membership.”

ECOH expects to use the resulting system to fulfill several needs. In addition to using the system for provider education, it can also support public transparency, P4P, and tiered networks. “In that way, our member companies can choose how aggressively they want to use the data system,” Schmitz explains.

Any savings will vary depending on how aggressive the member companies will be in using the data. “Ultimately, we envision that employees of ECOH member companies will check our Web site routinely to evaluate physicians and hospitals based on quality and cost performance,” he says.

• AT A GLANCE •

Employers’ Coalition on Health

The Employers’ Coalition on Health (ECOH) was founded in 1995 by employers in Rockford, Ill., that were seeking to control health care costs through direct contracts with providers and improve health care quality and the delivery of care. ECOH has two networks of providers in northern Illinois: The ECOH Network, has more than 1,500 primary and specialty care providers and 21 hospitals; and ECOH River Valley has more than 1,200 primary and specialty care providers and 19 hospitals.

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Rewarding Hospital Performance

In addition to the physician profiling project, ECOH also has a P4P program for hospitals. “For hospitals that finish in the top 10% of all reporting hospitals nationwide, we offer a financial incentive,” Schmitz explains. “We use data from the federal Centers for Medicare & Medicaid Services (CMS) and thus a hospital can earn a fraction of a predetermined bonus rate for each of the measures (such as administering aspirin upon admission) if they finish in the top 10% of all reporting hospitals for that measure.

“On our Web site (www.ecoh.com), patients can see what ECOH’s data says about one hospital versus another in the area,” he says. “You can see how hospitals stack up on various measures, such as those

from the Joint Commission, the Leapfrog Group, and in terms of patient satisfaction.

Over the years, ECOH took what it learned from its diabetes initiative and built on those results. “Success with the diabetes initiative lead to engaging the doctors in our physician-profiling project,” Schmitz concludes. “And, the hospitals know we’re looking at them too because our board members meet with their boards on issues related to patient safety, quality metrics, and electronic records, among other topics. With projects like these, the collaborative approach is the only way to be successful. In that way, ECOH is a good example of how employers and providers are working together to improve the delivery of care.”

“Our aim with these report cards is rein in outliers who offer low quality, inefficient care.”

Puget Sound Coalition Engages Consumers In Care Quality

Alliance plans to issue the area's first public report on health plan performance

The Puget Sound Health Alliance was founded in 2004 on the principal of fostering collaboration in Washington state. The alliance is reaching its most significant milestone so far when it will release to consumers the region's first public report on health plan performance.

For the report, the alliance will use de-identified claims data from 14 health plans, self-insured employers, and union trusts. The report will allow patients to seek effective and affordable health care by using data that reflect care delivered to about 70% of the insured, non-Medicare population in five counties in western Washington state. The initial report will include measures of care provided for patients with diabetes, heart disease, depression, and low back pain. The data also will show an initial snapshot of the use of generic drugs, antibiotics, and preventive care. The alliance membership includes 162 organizations and 50 individuals, representing more than 1.5 million people in the five county region.

“The cooperation of self-insured employers, union trusts, and health plans is critical to the success of this project,” says Margaret Stanley, the alliance's executive director. “Our first report will give patients, doctors, and others the most comprehensive view of the quality of health care in the region that we've ever had, and future reports will be even richer.”

The alliance's efforts to foster collaboration were recognized earlier this year when Michael Leavitt, secretary of the federal Department of Health and Human Services designated the alliance as the first Community Leader for Value-driven Health Care in the nation. Last year, the Robert Wood Johnson Foundation awarded the alliance a \$616,500 grant under its Aligning Forces for Quality: The Regional Market Project to examine how to improve health care quality in the region.

“When the alliance was formed, the organizers believed that it was not possible for one employer or one health plan acting alone to affect the health care delivery system,” Stanley explains. “The idea was to get the major stakeholders to work collaboratively. Our board of directors includes a majority of purchasers (meaning half plus one) and an equal number of provider and health plan seats and two consumer seats. The goal was to work on quality improvement and cost control, meaning cost control in the context of quality improvement. Cost control is not seen as a competing concept with quality improvement but in fact is complementary to it.

“We learned early that providers wanted to talk directly with employers without having a middleman such as a broker or a health plan filtering the discussion,” she continues. “That happens at our board level, and it

creates a better understanding of opportunities and constraints on both sides. They each understand the other's frame of reference."

In Washington State, cooperation is highly valued. "The collaborative spirit the alliance creates is important," Stanley says. "If a group is made up entirely of employers working together, there can be a tendency to put demands on health plans and on provider groups. Demands are fine and often necessary, but people work better with carrots than with sticks and they appreciate working together on committees and at the board level to find win-win situations to the extent possible.

"Right now, we are working on providing information and aligning incentives, and our biggest effort involves producing a public performance report using ambulatory quality measures," she explains. "We have data from 14 suppliers which reflects care provided to about 1.6 million people. It's a rich data asset for the community. The first report will show results for 16 clinic systems who have volunteered to have their scores made public, which means about 80 medical office sites will be compared in the report.

"This fall, the first draft of the findings was sent privately to the participating clinics so they can review the results, ask any questions, or raise any concerns they may have," Stanley continues. "Once we have their comments, we'll make any necessary adjustments and then at the beginning of 2008 we will send out the first final reports to clinics, purchasers, and plans, and then we'll publish it for the public."

Reporting health care performance results to the public is an important step toward engaging more

Public Reporting Initiative Is a Collaborative Effort

The Puget Sound Health Alliance's report on health care performance, along with related consumer engagement and quality improvement activities, involves the cooperation of employers, government, doctors, hospitals, unions, consumers, and health plans in the Seattle area.

"With 14 data suppliers providing information to create an all-payer database, never before has this much data been compiled across the region to create a health care performance report useful for the whole community," commented King County Executive Ron Sims, a member of the alliance's board of directors. "With this large volume of data comes greater confidence in the reliability of the results. We are pleased to see so many willing to allow their data to be used for this report which was initially launched with funding through a special grant from the King County Council."

Hugh Straley, MD, the president of Group Health Permanente, in Seattle, said, "This report will be a major step in improving the quality of patient care in the region. The report can be used by physicians to identify best practices for specific types of care and to help patients talk with doctors about effective care and to make more informed decisions."

The initial report to be issued to the public in early 2008 will use claims data to measure certain aspects of care. Recognizing that physicians and other providers want the reports to measure even more aspects of clinical quality and health

outcomes, the alliance hopes to add privacy-protected data from electronic medical records and care registries that a small but growing number of doctors and hospitals are using.

Since 2006, the alliance has been working the Washington State Medical Association and other medical societies and specialty groups to gather comments from physicians, health practitioners, and others in the community on the most effective ways to report the performance data to encourage quality improvement for everyone.

Among the health plans that have contributed to the effort are Premera Blue Cross, Regence Blue Shield, Group Health Cooperative, Community Health Plan of Washington, and Molina Healthcare. Employers and other organizations that have allowed their de-identified health plan data to be included are The Boeing Company, Carpenters' Trust, City of Seattle, First Choice Health, King County, Recreational Equipment Inc. (REI), union trusts, Washington Mutual, and the Washington State Health Care Authority (Uniform Medical Plan).

After publishing the initial report, the alliance plans to update the report periodically with more current data, plus expand the report to cover additional measures and more data suppliers including Medicaid and Medicare.

Milliman, Inc., an actuarial and consulting firm in Seattle, provides the technical services to the alliance to collect, aggregate, and analyze the data.

consumers in how they get and receive health care, says Jill Hodges, the alliance's consumer engagement specialist.

"Historically, consumers have been passive recipients of health care and so we have to find ways to get people more interested in their own care," Hodges explains. "One of our goals is to equip them with information to help them understand the different issues involved with health care quality and variation.

"We hope consumers will use these performance reports to help guide their health care choices in two respects," Hodges adds. "First, the reports will help inform consumers about what kind of care is effective and important for them to receive. Second, we want consumers to use the measures in the reports when they talk with their doctors, to ensure that they get the right care.

"In addition to issuing the performance reports, we are taking other steps to get consumers more engaged in being partners in their health care," Hodges continues. "Our Consumer Engagement Team has developed an initiative involving health risk assessments (HRAs) to help make consumers more aware of their own health conditions. And, we encourage consumers to talk with their doctors or other health care team members about their HRA results.

"We know that patients and doctors want improved communication," she adds. "So one of our jobs is to do whatever we can to foster such communication by working with organizations to promote the use of HRAs and build on efforts of employers such as King County to promote consumer engagement. For example, we're working with the Washington Health

Foundation, which has a program called the Healthiest Business Challenge that encourages employees to use HRAs.

“Our Consumer Advisory Group is helping to ensure that the performance reports are meaningful and understandable to consumers when they are published,” Hodges says. “We have also been exploring health literacy initiatives and learning from community groups about what’s needed to make health information more accessible and useful for patients to take a more active role in their health and health care.

“Currently available information about health conditions is uneven in terms of usefulness and relevance to personal decisions about health care,” Hodges comments. “Some employers have sophisticated wellness programs and materials for employees, but many smaller employers don’t have such resources. By identifying best practices and sharing resources and materials on our Web site for large and small employers, then we can make it easier for all employers to support wellness in the workplace and to provide useful information to workers and their families.” ▶

• AT A GLANCE •

Puget Sound Health Alliance

The Puget Sound Health Alliance in Seattle, Wash., is a regional partnership involving employers, physicians, hospitals, patients, health plans, and others working together to improve quality and efficiency while reducing the rate of health care cost increases across King, Kitsap, Pierce, Snohomish and Thurston counties. Its membership includes 162 organizations and 50 individuals representing more than 1.5 million residents in the five county region.

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Community Initiatives Aim to Improve Care for Patients with Diabetes

NBCH, AHRQ collaborate to develop evidence-based cost calculators for employers

NBCH is developing an evidenced-based collaborative to help employers calculate the costs of diabetes care and to help them improve the care delivered to patients with diabetes.

“The Community Health Value Collaborative for Diabetes is an evidenced-based initiative to make information about quality improvement for employers and other purchasers available in one place,” says Jim Mortimer, NBCH’s project director for the Improving Diabetes Care in Communities collaborative. “A number of employers and coalitions have developed innovative methods of improving care for patients with diabetes. The idea is to put all of this information into one place. In other words, the Web site we’ve developed can serve as a resource for any purchaser or community seeking to improve care for these patients.”

For more than two years, NBCH has worked with the federal Agency for Healthcare Research and Quality (AHRQ), in Rockville, Md., to identify ways for coalitions to improve the quality of diabetes care and prevention. AHRQ agreed to offer consultation on evidence and research and technical assistance and also to help select three NBCH member communities to serve as pilot sites. The three sites are the Greater Detroit Area Health Council, the MidAtlantic Business Group on Health (in Greenbelt, Md.),

and the Memphis Business Group on Health. The Lewin Group, Inc., a national health care and human services consulting firm in Falls Church, Va., is providing technical assistance to NBCH and the three coalitions.

A Costly and Prevalent Condition

Data show that for diabetes, there is clear evidence on best clinical practices, and health systems have developed effective ways to measure the cost and quality of care for patients who have the disease. Diabetes represents 11% of health care expenditures in the United States, and patients with diabetes have medical expenditures that are 2.4 times higher than those who do not have the condition, according to the American Diabetes Association (ADA). After cardiovascular disease, diabetes is the second most costly condition, the ADA says.

“Diabetes is a costly disease, growing rapidly in prevalence,” said NBCH’s Andrew Webber, president and CEO. “As we’re building an infrastructure at the community level to address the disease, credible evidence-based tools, like the one developed by AHRQ, make the urgent business case to employers that investing in better diabetes care will yield a significant return.”

The National Healthcare Quality Report published by AHRQ in 2006 shows that only 48% of adults

diagnosed with diabetes receive three essential tests annually to monitor and treat this condition. AHRQ Director Carolyn M. Clancy, MD, said, “We’re pleased to work in partnership with NBCH and its business and health coalitions to bring evidence-based tools directly to organizations in the front lines of delivering and purchasing health care services. Our hope is that with this information employers and other stakeholders will work together to improve the quality of health care in their communities.”

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Cost Calculators

NBCH’s Education and Research Committee (EAR) is coordinating the initiative with NBCH members and staff. The committee has collaborated with the Institute for Healthcare Improvement (IHI), in Cambridge, Mass., on implementing methods for spreading successful projects, policies, and tools. IHI has developed a “Framework for Spread” based on its experience helping hospitals and clinical teams to learn and apply better ways for organizing and delivering care.

To help make information available about the best ways to manage care for patients with diabetes, NBCH has devoted a portion of its Web site to the initiative (www.nbch.org/chvc/). The site contains a collection of models, tools (including diabetes cost calculators), reports on community experience, and links to other sites devoted to improving the care of patients with diabetes and helping to prevent the disease. The evidence-based cost calculators allow employers to quantify the return on investment they could get by delivering better care to employees with diabetes. The site also includes an explanation of how coalitions can get funding for such quality improvement initiatives.

CHVC Site Offers Two Diabetes Cost Calculators

On the Web site for the Community Health Value Collaborative for Diabetes, NBCH offers two Web-based calculators that employers, business-health coalitions, and others can use to estimate the cost of managing the care of patients with diabetes. Employers and coalitions can use the calculators to help make the business case for a program designed to improve the quality of care for these patients.

One tool, called the Diabetes Outcomes Analyzer, allows a coalition or employer to quantify the effect of value-based benefit design on care for patients with diabetes. This tool is made available through a partnership with Pfizer, Inc. It helps users assess the effect of implementing value-based benefit design for diabetic-related pharmaceuticals. For example, a user could calculate the effect of changing its benefit design by revising employee cost sharing levels for medications for patients with diabetes. Some employers that have reduced or eliminated cost sharing for such medications have reported that overall health care costs have declined.

Here’s the link for the Diabetes Outcomes Analyzer:

<https://diabetesoutcomesanalyzer.com/welcome.htm>

The second tool is called the Diabetes Cost Calculator for Employers. The federal Agency for Healthcare Research and Quality (AHRQ)

created this tool with The Lewin Group for employers, purchasers, coalitions, and others to estimate how much diabetes costs them and the potential savings that would result from better management of patients with diabetes. This tool bases its calculations on an employer's industry, location, and size, and then estimates the:

- Number of patients with diabetes
- Annual diabetes-related medical costs
- Annual diabetes-related productivity costs
- Potential savings associated with better management of patients with diabetes.

Then, it estimates savings based on evidence that shows how much could be saved by improving certain parameters in a population, such as blood glucose control. The calculator draws on the best available evidence from peer-reviewed journals and data sources such as the National Health and Nutrition Examination Survey, the National Health Interview Survey, the U.S. Census Bureau, the U.S. Bureau of Labor Statistics, and the AHRQ Medical Expenditure Panel Survey.

Instructions on how to use the AHRQ calculator are available on NBCH's Web site:

www.nbch.org/CHVC/calculator/instructions.cfm

“The site contains a significant collection of experience,” Mortimer explains. “It includes resources such as a report from the EAR Committee on the experience of more than 20 NBCH-member coalitions on purchasers’ quality improvement efforts at the community level. There also is an excellent compilation of data on the community health value collaborative model that purchasers and committees can adapt for their own use.

“Any organization that has tried to develop a quality improvement program knows that each program has to be tailored to the market in question, but that doesn’t mean you have to reinvent the wheel,” Mortimer adds. “It is likely that many other organizations have developed similar programs. The problem is gathering information on these similar initiatives. So, NBCH has cataloged much of the information that is available on a wide variety of programs that have worked in many different markets and made the information available to members. In this way, the site serves as a library of useful information and resources for employers and coalitions.

“At the same time, the program and the affiliated Web site allow member coalitions to network with other NBCH members about what works and what lessons other coalitions and other organizations have learned over the years. In that way, the program and Web site have some utility for a wide variety of users.” ▀

Ohio Group Seeks to Fill Gaps in Care

Employers Health Coalition of Ohio Focuses on Diabetes, Antibiotic Use

In many regions, employers and business-health coalitions find health plans fail to deliver care adequately, particularly for patients with chronic and costly conditions. When they identify these failings, some employer health coalitions deem it necessary to develop programs to fill these gaps in care delivery.

That's the role the Employers Health Coalition of Ohio, Inc., (EHCO) has assumed in Northeast Ohio. Since 2003, the coalition has cultivated the development of the Diabetes Coalition of Northeast Ohio, an organization that aims to improve the quality of care delivered to patients with diabetes through partnerships and collaboration and to increase awareness of the disease, emphasize prevention, and implement consistent, evidence-based care cost effectively.

"It's absolutely critical that when we see a gap in care, we need to fill that gap in our community at least in the short term," says Michael Stull, EHCO's director, external relations.

Pay for Performance

The Diabetes Coalition of Northeast Ohio (DCNEO) is a collaboration of diabetes nurse educators, employers, pharmacists, physicians, public health officials, and representatives of Ohio KePRO

(a Medicare quality improvement organization), among others. It seeks to engage providers, payers, and patients by distributing a diabetes care resource guide to patients and diabetes care flow sheets to physicians. It also sponsors patient education meetings and has implemented the Bridges To Excellence pay for performance program for physicians.

Jeff Schmitt, PharmD, the coalition's director of pharmacy and clinical initiatives, explains that to date the program has helped to raise the awareness of the importance of providing quality care to patients with diabetes. It also has paid \$91,000 in pay for performance (P4P) bonuses to physicians. These two results are important, particularly in Ohio.

"It's hard to get physicians interested in this program, and none of the health plans in this area are doing anything with Bridges To Excellence in Northeast Ohio," Schmitt explains. Last year, in addition to paying \$91,000 in P4P bonuses to 10 physicians, EHCO found that two physicians not eligible for a financial incentive were nonetheless interested in becoming accredited to participate in the BTE program.

All physicians who saw a certain number of EHCO beneficiaries with diabetes were invited to participate. "From our data warehouse, we developed a list of the physicians who see a lot of our patients who

have diabetes,” Schmitt explains. “Last year, we sent out several mailings to them and told them we were establishing a P4P program through Bridges to Excellence. We wanted to know how many were interested in participating so we could budget the money. From a list of 33 physicians, we had 10 physicians participate and become accredited through NCQA, and we had two participate and not become accredited. The two who didn’t pass didn’t receive an incentive payment but six months later we went back to their offices and they subsequently passed. So, that’s a significant result by itself.

“Plus, we had 10 physicians who were eligible for an incentive payment of \$100 for each patient with diabetes who was covered under our prescription drug

plan,” Schmitt adds. “Among all physicians receiving bonuses, the physician on the low end got a check for \$3,500 because he saw 35 of our patients, and the physician who received the most, received a check for \$15,300 because he saw 153 of our patients. The other eight physicians saw varying numbers of our patients.”

Patient Education

In addition to paying bonuses, the program has helped to increase the level of understanding among patients and physicians about the importance of delivering quality care. “Early this year, we purchased a half page ad in some of the Ohio newspapers to recognize physicians for participating in the program

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The Employers Health Coalition of Ohio

The Employers Health Coalition of Ohio, Inc., is a nonprofit coalition founded in 1983 by nine Stark County employers to contain county health care costs. In 1999, the Employers Health Purchasing Corporation of Ohio was incorporated as a subsidiary of the coalition to facilitate group purchasing programs and government lobbying. The two organizations represent more than 130 organizations and more than 1 million lives in eight states: Ohio, West Virginia, Illinois, Wisconsin, Michigan, New York, Nebraska, and California.

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and becoming certified in the BTE Diabetes Physician Recognition Program (DPRP)," Schmitt continues. "In the ads, we listed the physicians' names, their practices, addresses, and phone numbers because we want to motivate patients to see the physicians who have good outcomes.

"*The Akron Beacon Journal* published an article on the front page of the local section with a picture of one of the first physicians we certified," Schmitt adds. "One of our patients took this article to his physician and asked why he wasn't participating. Within a few days, that doctor asked us to certify him. Even though he was ineligible for an incentive payment, he still wanted to participate and became accredited. His interest shows that the program has had an effect on patients and providers."

The physicians in the initial group were invited to participate based on the number of EHCO patients they treat who have diabetes. EHCO identified the physicians through its pharmacy claims database, administered by Caremark. "We choose 35 patients as the minimum, because the incentive was \$100 per patient and we thought \$3,500 was the minimum amount to attract a physician's interest," Schmitt explains. "Then we offered to gather the data from their charts, do the paperwork and pay the fee required to get them accredited. If they meet the minimum criteria, we submit their data to NCQA and pay the accreditation fee to NCQA.

"To date, we have accredited 20 physicians in the Akron and Canton area, and among those 20, 10 were eligible for an incentive payment and 10 were not," he adds. "It's significant that we had a number of physicians who were not eligible for an incentive

and still wanted to be accredited. We had a group of four endocrinologists, for example, who wanted to be accredited even though only one was eligible for an incentive payment. They all passed and all four are now accredited."

Physicians who want to be accredited understand the value of gaining such recognition, in part because EHCO publishes the list of accredited doctors, says Christopher V. Goff, EHCO's CEO and general counsel. "These physicians who are accredited hold themselves to a high standard," he adds. "Plus, we told patients, 'If your doctor is not on this list, you might want to ask why not.'"

Standardized Treatment

One of the most interesting aspects of EHCO's diabetes initiative involves the development of the diabetes care flow sheets for physicians. "The flow sheets contain the most recent guidelines from the American Diabetes Association and help providers in their delivery of care to these patients," Stull explains. "Through BTE, we found that very few physicians use a documented process when treating patients with diabetes. The sheet lists all the tests or procedures that a patient with diabetes should have in a given year. It helps the physicians document when they perform those tests and procedures, such as annual eye and foot exams, and blood glucose testing.

"During our semi-annual patient-education meetings, we hand out the flow sheets to patients," Stull adds. "We tell them that physicians should track this information and that the patients should make sure they get these tests each year. We also distribute Diabetes Resource Guides by direct mail to high

prescribers of diabetes medications or distributors of diabetes-related products. We've printed this guide every year for four years, and this year, we printed 15,000 copies and have distributed most of them."

Antibiotics Awareness

EHCO has a similar patient- and provider-education initiative involving antibiotics. "In 2002, we found that about 80% of physicians responding to a survey prescribed an antibiotic when they knew the patient had a viral infection," Stull explains. "We developed patient care kits and targeted the top providers of antibiotics through our pharmacy database. Through a partnership with Wyeth Pharmaceuticals, we asked the company's field representatives to deliver the kits to physicians' offices. The kits include over the

counter samples of pain relievers, decongestants, and cough medicine and a brochure about the dangers of antibiotic resistance. The kits help to alleviate some of the pressure the physicians feel when a patient wants to leave with a prescription. Instead of writing a prescription, the physician can give out the kit.

"These two programs are examples of where we believe we have to step in and be a catalyst when we recognize that a need isn't being met," Stull concludes. "We'll start something with the intent that one of the health plans or a combination of health plans will subsequently run with the ball. That hasn't happened yet. Until it does, we'll continue to do what we've been doing, which we believe is helping to improve care for employees and their family members." ■

"Through BTE, we found that very few physicians use a documented process when treating patients with diabetes."

College Helps Attendees Introduce Value-Based Purchasing

One participant finds employers engaged in health reform efforts

Many participants of NBCH's College for Advanced Management of Health Benefits find they can apply the lessons learned right away. That was certainly the case for Gena Trujillo, the director of benefits administration for the University of Colorado. After she attended the college in 2004, she started applying the principles of value-based purchasing and then sent three staff managers to the college one year later.

The college offers a three-day course to teach health benefits professionals advanced purchasing strategies particularly those related to value-based purchasing. Offered in various cities each year, the college gives students an opportunity to learn practical ways to apply benefits purchasing techniques and skills to improve the value, quality-cost ratio, and effectiveness of health care services purchased on behalf of employees. Typically, the students are human resources and benefits professionals.

“After attending the college, we started evaluating the issue of value-based purchasing in our benefit offerings,” Trujillo comments. “Before that, we were like most employers and were concerned primarily with the cost of health care programs. Value was rarely part of the discussion. But after attending the college, I was interested in making that shift in how the entire University of Colorado system purchases medical,

dental, life, and disability insurance for about 32,000 employees and dependents.”

“When we went out to bid this year, for example, our request for proposals (RFP) included requiring health plans and providers to meet value-based requirements,” she explains. “We asked health plans about the quality of the networks they offer, and we asked if the hospitals were meeting the patient safety standards of the Leapfrog Group. We also told the plans that we wanted them to complete the eValue8 survey every year, and that is a significant step.

“We’re currently reviewing the proposals we received, and the reaction among health plans and providers has been very positive,” Trujillo adds. “Each plan committed to complete the eValue8 survey, for example. Having plans that will complete the eValue8 survey is significant because that’s something the Colorado Business Group on Health has asked health insurers to do. So, as a member of CBGH, the university was already familiar with the benefits of having health plans complete the eValue8 survey. That’s why I put it into our RFP.”

What Trujillo learned from attending the college was significant because it related directly to what she found through CBGH's programs: that progressive employers are engaging in efforts to reform the health care system. “The college raises the question of ‘How

“In 2008, the College for Advanced Management of Health Benefits will hold three sessions on value-based purchasing: March 3 to 6 in Nashville, June 2 to 5 in Orlando, and September 15 to 18 in Washington, D.C.”

can we respond to the high cost of care and the access issues that we’re facing in the marketplace?’ ” she explains.

32 “In fact, health care reform is happening in part because of the efforts of employers and coalitions like CBGH,” Trujillo comments. “But another important factor in reforming health care involves getting leadership from senior executives. Here at the University of Colorado, senior leadership has been supportive of our efforts to change the dynamics of health care purchasing. In fact, one of our senior leaders will be attending a CBGH conference on wellness, quality, and value-based purchasing this fall. That’s the first time during my tenure that anyone from our institution has engaged at that level.

“One reason leadership support is needed is because even though we are focusing on value-based purchasing, it’s way too early to start seeing results in terms of lower costs,” she explains. “Value-based purchasing strategies are not like increasing deductibles and co-payments so that you get a 5% decrease in overall spending. Our philosophy is that we need to make a difference over time by improving health care quality and having transparency among hospitals, health

plans, and providers so that individuals will have the information they need to manage their health care effectively. By making that information available, and by working with hospitals and providers to deliver quality care, then we will see the effect of our efforts in five or 10 years down the road. Basically, we’re investing in the future of health care rather than seeking an immediate return.

“In addition, we are also looking into reducing absenteeism and presenteeism because health care benefits should be used to help each employee and family member be healthy and productive over a lifetime,” Trujillo adds. “This is a different approach to health care purchasing than we have had in the past. But this job is no longer simply about helping employees to maximize their benefits. It’s about helping to improve the health care we offer in our state and in the country.”

In 2008, the College for Advanced Management of Health Benefits will hold three sessions on value-based purchasing: March 3 to 6 in Nashville, June 2 to 5 in Orlando, and September 15 to 18 in Washington, D.C. ▀

Nevada Coalition Launching Data Collaborative

Strategy took off after coalition representatives attended benefits college

For Mark Goodwin, attending NBCH's College for Advanced Management of Health Benefits helped change his approach to health care contracting. The director of human resources for Atlantis Casino Resort Spa in Reno, Nev., Goodwin went from simply trying to contain health care costs to working to change the health care system in western Nevada. In part as a result of Goodwin's efforts and the work of the Nevada Health Care Coalition, the coalition is preparing to launch a data collaborative to help all stakeholders in western Nevada to manage health care costs and quality more effectively.

"The college gave me a whole new perspective on the crisis in health care in this country," Goodwin says. "Last year, I was new to our coalition. My focus on the job was on contracting and squeezing out a dime here and a dime there, just as most people do on the employer side. At the same time, our CEO was continually asking me, 'What are you doing about health care costs? Why don't we have any solutions? Health care costs are a crisis.'" Goodwin attended the college in February 2006 with Michael Ginder, the executive director of the coalition.

"By attending the college, I intended to learn some new tricks about contracting," Goodwin explains. "I left there with a totally different idea about possible solutions, and these ideas were completely radical

compared with what most employers are thinking about with regard to the health care crisis. I went from trying to squeeze out savings in our contracts, which of course continues to be a priority. But now, we're focusing on value-based purchasing and how we can use the data we've been gathering over the years.

Now serving as the president of NHCC, Goodwin said the coalition is focused much more closely on quality and value-based purchasing. "Our mantra is quality will affect price," he comments. "We recognize that we can squeeze only so much out of contracting. For the past few years, we have spent a lot of time and resources collecting data on the care that employers deliver here in Reno. Now we want to use the data we've collected to quantify the quality of care that's delivered here."

The data the coalition has collected include information on 40,000 lives from the coalition's employers. The coalition is planning to include data from one of the two major health plans in Reno, adding 50,000 lives to the total. The total number of lives represents almost 25% of the total 400,000 residents of the Reno area. The coalition hopes to add data from the second health plan in the coming months.

"This fall, the coalition is getting ready to introduce a true data collaborative that will include data from employers and health plans and will be a true regional

collaborative,” Goodwin says. “Then, we hope to take our data back to physicians, hospitals, and provider networks to discuss with them the quality of care they’re delivering. Just having those discussions should affect the cost of care.

“If all parties have a vested interest in this project, then we can all use these data to improve how care is delivered,” he comments. “Physicians can learn what their peers are doing to provide quality care effectively. Employers can identify areas of high risk among their workers and family members. And the community can benefit by identifying high risk areas in the population.

“Reno is an unusual market because it’s isolated,” Goodwin continues. “If we can identify community health problems, then we might be able to target programs we can introduce to solve these problems. The data might show that we have a problem with

diabetes in the community, for example. Then we can work with our physicians on what steps they should take. And, we can work with the employers on what benefit designs they can use to address this problem. That’s how we want this collaborative to work.

“This fall, we’re planning to sign a contract with a software provider,” he adds. “We have had all the meetings with the employers, physicians, and the network and hospital representatives. Once we have the software contract in place, we expect it will take about six to eight months before we will see some results. We hope to start getting results to work with toward the end of next year.”

In conclusion, Goodwin says, “For the employers here in Reno, this whole project is exciting. We feel like we have a ray of hope to affect health care in a positive way.” ■

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Nevada Health Care Coalition

The Nevada Health Care Coalition is a purchasing and direct-contracting coalition serving employers in western Nevada.

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President & CEO, HealthCare 21 Business Coalition of East & Middle Tennessee

Jerry Custer

Executive Director, Heartland Healthcare Coalition

Ned Lamkin

President, Indiana Employers Quality Health Alliance

Martha McDonell

Consulting Executive Director, Labor/Management Health Care Coalition of the Upper Midwest

Tim Buko

Executive Director, Lancaster County Business Group on Health

Butch Passman

President and CEO, Louisiana Business Group on Health

Douglas Libby

Executive Director, Maine Health Management Coalition

Cristie Travis

CEO, Memphis Business Group on Health

Marilyn Bell

Executive Director, Michigan Purchasers Health Alliance

William L. Bruning

President & CEO, Mid-America Coalition on Health Care

John R. Miller

Executive Director, Mid-Atlantic Business Group on Health

Member Coalitions, Continued

Larry Boress

President, Midwest Business Group on Health

Ron Meyer

Executive Director, Missouri Consolidated Health Care Plan

Don Crevling

Executive Director, Montana Association of Health Care Purchasers

Michael Ginder

Executive Director, Nevada Health Care Coalition

Dave Knowlton

President and CEO, New Jersey Health Care Quality Institute

Laurel Pickering

Executive Director, New York Business Group on Health

Bruce Boissonnault

President and CEO, Niagara Health Quality Coalition

Robert E. Jones

Executive Director, Northeast Pennsylvania Regional Healthcare Coalition, Inc.

Barbara Prowe

Executive Director, Oregon Coalition of Health Care Purchasers

Peter Lee

President & CEO, Pacific Business Group on Health

Gregory A. Walters

President, Piedmont Health Coalition, Inc.

Christine Whipple

Executive Director, Pittsburgh Business Group on Health

Margaret Stanley

Executive Director, Puget Sound Health Alliance

Paul W. Brand

President, REAL Health Association

Gary Rost

Executive Director, Savannah Business Group on Health

Angie Uthe

Director, Sioux Empire Health Care Coalition

Maya Pack

Manager, South Carolina Business Coalition on Health

Dianne Lawrence

Executive Director, Southeast Missouri Business Group on Health

Louise Probst

Executive Director, St. Louis Area Business Health Coalition

Marianne Fazen

Executive Director, Texas Business Group on Health

Cheryl DeMars

CEO, The Alliance (Wisconsin)

Lisa Gish

Executive Director, Tri-State Business Group on Health

Beverly Rossmiller

Executive Director, Tri-State Health Care Coalition

Barbara Wallace

Executive Director, Virginia Business Coalition on Health

Greg Horstman

Executive Director & CEO, Wisconsin CooperativeRx

Kyle Adamonis

Executive Director, Rhode Island Business Group on Health

Claudia Muse

Executive Director, Western North Carolina Health Coalition

Board of Governors

Carolyn Pare

Buyers Health Care Action Group

Marianne Fazen

Dallas/Fort Worth Business Group on Health

Samuel J. Schmitz

Employers' Coalition on Health

Christopher Goff

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Sue Szymanski

FrontPath Health Coalition

Gary Allen

Hawaii Business Health Council

Jerry Burgess

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Jerry Custer

Heartland Healthcare Coalition

Douglas Libby

Maine Health Management Coalition

Cristie Travis

Memphis Business Group on Health

Michael Ginder

Nevada Health Care Coalition

Margaret Stanley

Puget Sound Health Alliance

Gary Rost

Savannah Business Group on Health

Cheryl DeMars

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Barbara Wallace

Virginia Business Coalition on Health

National Health Leadership Council

Abbott

Alkermes, Inc.

American Medical Association

American Optometric Association

America's Health Insurance Plans

AstraZeneca

Blue Cross Blue Shield Association

Boehringer Ingelheim Pharmaceutical, Inc.

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Eli Lilly & Company

Ethicon Endo-Surgery, Inc.

Genentech, Inc.

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Healthways

Iowa Foundation for Medical Care

IPRO

Johnson & Johnson Health Care Systems

Joint Commission on Accreditation of Healthcare Organizations

Merck & Company, Inc.

Merck/Schering-Plough Corporation

National Association of Chain Drug Stores

National Committee for Quality Assurance

National Pharmaceutical Council, Inc.

Novartis Pharmaceutical Corporation

Novo Nordisk Pharmaceuitcals, Inc.

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