

Employee Health

March/April 2009

Quality Matters is a newsletter from The Commonwealth Fund. Published bimonthly, the newsletter explores issues of quality and efficiency in health care.

Past issues of *Quality Matters* are available on The Commonwealth Fund Web site at www.commonwealthfund.org/Publications/Newsletters/Quality-Matters.aspx

Published March 19, 2009

Welcome to Quality Matters, a bimonthly roundup of news and opinion on quality and efficiency, information technology, performance improvement initiatives, and policy innovations.

In Focus: Taking a Fresh Look at Employee Health	1
Case Study: State of Maine Ranks Providers Based on Quality	5
Quality Matters Podcast: Increasing the Value of Health Care	12
News Briefs.....	12
Recent Publications of Note	14
Editorial Advisory Board and Team.....	18

In Focus: Taking a Fresh Look at Employee Health

***Summary:** During the current economic recession, employers may be willing to try new techniques to improve the quality and efficiency of care employees receive under their health benefit plans—especially if they have the potential to lower insurance premiums. This article looks at tools such as tiered networks and employee financial incentives that may improve health care quality while lowering costs.*

By Sarah Klein

Until recently, the main weapons available to employers who wanted to control rising health care costs have been tools that shift costs to employees and wellness programs that help employees take better care of their health.

The cost-shifting approach, which includes the use of higher copayments and deductibles to encourage employees to consider the cost of prescription drugs and medical services, may encourage employees to spend less—but not necessarily spend more wisely. Unless they have reliable information to distinguish between high- and low-value services, they may be discouraged from spending on needed care as well as unnecessary services. That could lead to higher medical costs in the long run, as their untreated conditions progress into more serious illnesses.

Wellness programs, which typically combine employee health

assessments with disease management interventions tailored to identified health risks, signal to employees the importance of prevention and screening. The disease management portion of these programs has proven more useful in increasing the rate at which providers adhere to recommended clinical guidelines (such as screening diabetics for blood glucose control). They also appear to improve measures of disease control, suggesting that employees are receiving more appropriate care for some chronic conditions. [1] But their financial value to employers remains to be seen. One recent study suggested that it would be hard to recoup the cost of such programs with a working-age population in a short time frame, because there would be few opportunities to prevent the high-cost admissions and emergency department visits that drive such savings. [2] Return on investment may take as long as four years, longer than most employers are willing to wait.

"What employers are saying is, 'We want to know we are going to have an impact based upon what we are spending within the next nine months—or we can't do it,'" says Cyndy Nayer, president of the St. Louis, Mo.-based Center for Health Value Innovation, which promotes value-based benefit design programs. She hears that sentiment from executives in all industries, and from businesses both small and large.

Limited Success to Date

Companies that narrowly and aggressively target wellness programs to specific high-risk conditions such as cardiovascular disease and diabetes have achieved modest reductions in health care costs. A program designed for the Minnesota-based employees of BAE Systems Inc., a defense and aerospace firm, combined risk assessments for chronic diseases such as diabetes and heart disease with online and telephonic health coaching. It led to an

annual 3.3 percent reduction in medical costs over three years, about half of which was attributable to lower-than-expected hospital admissions. The savings on medical costs represented a 2:1-to-3:1 return on investment. [3]

But finding other tools to improve quality or increase efficiency has been challenging for many employers. "We've had a relatively short list for quite a while," says Helen Darling, president of the Washington, D.C.-based National Business Group on Health, which represents large employers on health policy issues. Among those are benefit designs using high-deductible plans and tiering for drug classes to encourage the use of generics.

"We have already picked the low-hanging fruit, which is diabetes," adds Paul Fronstin, senior research associate for the Washington, D.C.-based Employee Benefit Research Institute.

New Approaches to Benefits

In an effort to identify other options, *Quality Matters* asked researchers, employer groups, and businesses what employers could do to control costs and improve the value of health benefits. Here are some of their suggestions.

1. Employers can drive health system efficiency by developing and promoting information about the value of services offered by providers and then combining this with financial incentives that encourage employees to use those services that are of higher value. Self-insured employers can do this by using networks of providers, including both physicians and hospitals, which are segmented, or "tiered," according to their performance on quality measures. (This issue's Case Study, on Maine's Employee Health & Benefits program,

presents such an example from the public sector.)

The health benefits plans of Gulfstream Aerospace Corp., a Savannah, Ga.-based subsidiary of General Dynamics, presents another example of physician tiering. The company designated local primary care physicians as "distinguished quality physicians" if they met evidence-based care standards for diabetes and women's health. [4] Another criterion to qualify for this designation was to maximize the prescribing of generic drugs, such that generics are prescribed to patients at least 50 percent of the time. Physicians who met these standards and others would receive a bonus equivalent to 20 percent of office visit charges billed that year for Gulfstream employees and their dependents.

In the tiering program's first year, only 10 percent of local primary care physicians qualified for designation, and the company paid a mere \$18,000 in bonuses. But by 2007 (three years after the program started), 44 percent of local primary care physicians qualified, and the bonuses reached roughly \$250,000. Robert Holben, Gulfstream's director of compensation and benefits, said, as of 2006, the program produced a 21 percent decrease in the average medical costs of diabetic employees covered by the plan.

To encourage employees to seek recommended care and thus help physicians receive the designation, the company promised to lower office visit copayments from \$15 to \$10 if their providers qualified for the designation. For example, for women over the age of 40, that might mean getting a mammogram once a year. The company's health program also includes features such as smoking cessation and fitness classes. The program has broad support from Gulfstream's management, which made no cuts to the

program this year despite a companywide cost-cutting effort.

2. Employers may have a dramatic impact on cost and efficiency by rewarding providers for delivering care that does not include high rates of potentially avoidable complications. Algorithms designed to detect those rates are available free of charge from Washington, D.C.-based Prometheus Payment Inc., a nonprofit devoted to creating new models of payment for health care. They enable employers to determine whether the care provided by a particular provider to treat chronic and acute conditions included potentially avoidable complications. [5] For diabetics, such potentially avoidable complications might include hospitalization or an amputation. The rate of these incidents can be used as a proxy to evaluate the quality of care.

Many employers would be surprised by what such data analysis reveals, says Francois de Brantes, national coordinator for Prometheus Payment. "People are going to the emergency department when they have benign hypertension because their blood pressure isn't monitored consistently. Things like that happen every single day of every single month. Those are avoidable complications," he says. "Until you understand that, and you understand how much money you are sucking out of your coffers and into avoidable costs, you are fiddling at the edges."

de Brantes estimates that 30 percent of fee-for-service payments for acute myocardial infarction and 60 percent of fee-for-service payments for diabetes are for such complications. [6] The Prometheus tool can be used to evaluate providers or how well insurers manage those providers. "Once employers grab on to this they are not going to let it go," he predicts.

3. Several sources also suggested that employers think more broadly about health, to identify the ways in which their companies' products advance—or inhibit—public health. Food processors, in particular, may need to think about the long-term impact their products may have on the public. Corporate leaders must also promote healthy lifestyles, if they want employees to change their eating and exercise habits. "It's cultural. It's not programmatic," says Paul Keckley, executive director of the Deloitte Center for Health Solutions, which has been studying consumer attitudes toward health. "There's an unspoken expectation that people don't smoke, that people are going to walk at noon, or they are going to work out on weekends. They talk about being at the gym and it doesn't reflect some discount someone got for them," he says. "It's part of the culture that says if you pile up a lot of French fries on your plate in the cafeteria, this company is going to look at you cross-eyed."

4. Some employers believe financial incentives to encourage healthy behavior by employees will help, too. Safeway Inc., a nationwide grocery chain based in California, has been offering employees a discount on insurance premiums if they maintain a body mass index of 30 or less, do not smoke, and keep their blood pressure at less than 140 systolic/90 diastolic with or without medication. To qualify for the discount, employees also must keep their cholesterol levels within certain guidelines if they have two or more of the following risk factors: they are a man over the age of 45 or a woman over the age of 55; they smoke; they have hypertension; or they have a family history of premature coronary heart disease, including heart attacks or strokes. [7] The insurance rebate for each of these criteria is

calculated separately, but if an employee and his or her spouse both meet all four measures of the voluntary program, they would save \$1,560 per year on an annual premium of \$4,628.

To encourage healthier behavior, the company allows employees who don't meet some or all of the measures but who demonstrate improvement over the year to recoup the relevant portion of the insurance rebate. The employee's physician can request a waiver or an alternate standard to the program.

Safeway management believes that 70 percent of all health care costs are driven by behavior, and that obesity is a significant driver of these costs. "If we can't get our arms around that, we don't have a chance of reducing health care costs," says Kenneth Shachmut, Safeway's senior vice president of strategic initiatives, health initiatives, and health reengineering.

Incentives to Move Ahead

In addition to saving employers money, insurance benefits that are tied to quality measures may prove to be more popular with employees than past approaches.

Employers can tell employees, "This time around we are going to give you confidence that this isn't a provider network that was just willing to sign because they had cheap rates. No, this is a provider network that has demonstrated that they were providing high-quality, efficient care and can manage chronic disease better," says Andrew Webber, president and CEO of the National Business Coalition on Health, an association of employer-led health coalitions.

References

- [1.] S. Mattke, M. Seid, and S. Ma, [Evidence for the Effect of Disease Management: Is \\$1 Billion a Year a Good Investment?](#) *American Journal of Managed Care*, 2007, 13(12): 670–676.
- [2.] S. Mattke, S. A. Serxner, S. L. Zakowski et al., [Impact of 2 Employer-Sponsored Population Health Management Programs on Medical Care Cost and Utilization](#), *American Journal of Managed Care*, 2009, 15(2): 113–120.
- [3.] D. McCarthy, K. Mueller, and I. Tillmann, HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda, The Commonwealth Fund, forthcoming; N. M. Thygeson, J. Gallagher, K. Cross et al., [Employee Health at BAE Systems: An Employer-Health Plan Partnership Approach](#), ACSM's Worksite Health Handbook, Second Edition. A Guide to Building Healthy and Productive Companies, N. P. Pronk, ed. (Champaign, Ill.: Human Kinetics, 2009; Chapter 36). T. E. Kottke and N. P. Pronk, [Taking on the Social Determinants of Health: A Framework for Action](#), *Minnesota Medicine*, Feb. 2009.
- [4.] To qualify, physicians must demonstrate that they follow best practices for at least 70 percent of the patients for whom such standards would apply. As the program achieved its goals for diabetes and women's health, it dropped some of those items to measure screening for prostate cancer and use of statins.
- [5.] Prometheus Payment has developed payments models for congestive heart failure, diabetes, acute myocardial infarction, as well as knee and hip replacements, among others.
- [6.] F. de Brantes and A. Rastogi, [Evidence-Informed Case Rates: Paying for Safer, More Reliable Care](#), The Commonwealth Fund, June 2008.
- [7.] Cholesterol levels must be within the following guidelines: high-density lipoprotein (HDL) above 40 mg/dl, low-density lipoprotein (LDL) less than 130 mg/dl, and triglyceride levels less than 200 mg/dl. An employee would be deemed to have a family history of premature coronary heart disease (CHD) if he (or she) has a male relative from his (or her) immediate family who developed CHD before the age of 55, or a female relative from his (or her) immediate family who developed CHD before the age of 65.

Case Study: State of Maine Ranks Providers Based on Quality

***Summary:** A state employee health plan designated hospitals, and later primary care physician practices, that met certain performance criteria as "preferred" providers, and then gave employees incentives to use them. While this initiative appears to have improved the quality of care, its impact on costs has not yet been evaluated.*

By Vida Foubister

Issue

Maine, a state with a relatively modest per capita income, has the fourth highest health expenditure per capita in the country. This is not only a burden for the state's government, but also for companies. "In order for our private sector partners to stay in business in the state, they have to be more competitive," says Frank A. Johnson, executive director of the state's Employee Health & Benefits program.

Led by its trustee board's belief in value-based purchasing, the state employee health plan began evaluating provider performance

in 2006. It first encouraged enrollees to use hospitals with higher quality care, adding physician ratings at a later stage of the initiative. "The whole idea of focusing on value, clinical outcomes, and how it relates to cost is getting far more attention than it was several years ago," Johnson says.

This process helped a statewide, employer-led health care coalition establish criteria to identify high-performing hospitals and physicians. It also educated plan enrollees about health care quality and the role they can play in holding providers accountable for their performance, generating interest in the public reporting of quality data.

Organization/Leadership

Maine Employee Health & Benefits provides health insurance to state employees, retirees, and their dependents, using [Anthem Blue Cross and Blue Shield](#) as a third-party administrator to process its claims. The Maine State Employees Health Insurance Program is a member of the [Maine Health Management Coalition](#), an employer-led partnership that includes hospitals, health plans, and physicians and aims to improve the value of health care in the state.

In addition to being governed by state law, the health plan is overseen by a 22-member trustee organization composed of labor and management representatives, which gives each party a single vote. Called the State Employee Health Commission, it must reach consensus on vendor selection, benefit design features, and the health plan's overall plan strategy.

Frank A. Johnson serves as executive director of Maine Employee Health & Benefits.

Target Population

Maine Employee Health & Benefits has nearly 40,000 covered lives, which includes about 30,000 active state employees and their dependents and 10,000 retirees and their dependents. The average age of employees is 47; these employees work throughout the state in a wide range of jobs.

Among the retirees, almost half (about 4,500) are not eligible for Medicare, most of whom are younger than 65 and others who do not qualify for other reasons. They are instead enrolled in the program's point-of-service plan. These non-Medicare retirees "influence our plan expenses considerably," says Johnson. While they make up about 14 percent of the point-of-service population,

they consume about 30 percent of its expenses.

Implementation

Though the State Employee Health Commission embraced the principles of value-based purchasing, it was initially unable to enter into contracts that did not adhere to the state's geographic access standards. Established by the Bureau of Insurance as part of the Health Plan Accountability Act, the intent of these standards was to ensure plan enrollees had adequate access to provider networks. However, the standards impeded the ability of self-insured groups and health plans to differentiate health benefits based on quality measures. This changed in 2005, when the legislature amended the statute, giving the Commission a waiver to develop and implement tiered provider networks and tiered benefits that adjust payments based on the quality and efficiency of care. As a result, state employees have begun to select physicians and hospitals based on their performance, encouraged by financial incentives for choosing high-value providers.

The pilot project grew out of this exemption and has progressed in several phases: the first phase was implemented July 1, 2006, the second phase July 1, 2007, and the third phase October 1, 2008.

Key Measures

The State Employee Health Commission chose hospital quality and patient safety as its initial focus, because health plan payments to hospitals make up more than 50 percent of plan expenses and comparative data were available on hospital performance. The measures used to identify "preferred hospitals" were chosen by the Maine Health Management Coalition's Pathways to Excellence Hospital Steering Committee,

which included representatives from the Coalition, Maine Hospital Association, and the Maine Quality Forum—a government organization created through the Dirigo Health Reform Act in 2003 to improve the quality of health care. Hospitals were tiered in this first phase of the project based on their performance on three measures:

1. [The Leapfrog Group's](#) safe practices survey, which assesses performance on a series of National Quality Forum–endorsed patient safety practices that apply to all hospitals.

2. Maine Health Management Coalition's [medication safety survey](#), which assesses the protocols and practices in hospitals related to the safe use of medications. In 2008, the survey focused on five elements: how prescriptions are double-checked; how medicines are given; how medicine is stored; use of bar code scanning technology to confirm patient identity and medication information prior to administering medications; and established systems to identify and follow patients with poor renal function. The survey was designed by a committee of hospital pharmacists—under the direction of the Coalition's former executive director, who was also a hospital pharmacist—as Leapfrog's computerized order-entry ratings do not apply to most hospitals in Maine, a state that only has three tertiary facilities.

3. Results from the Centers for Medicare and Medicaid Services (CMS) Hospital Compare Web site measuring clinical performance for acute myocardial infarction, heart failure, pneumonia, and surgical infections.

To be designated as preferred, hospitals must have: completed the 2005 Leapfrog safe practices survey; demonstrated the hospital "has made good early stage effort in

implementing recommended safe practices" according to the Maine Health Management Coalition Medication Safety Survey; and have had an aggregate CMS clinical measure score that meets or exceeds the national average.

In the second and third phases of the pilot, the Commission adopted the [Maine Health Management Coalition's blue ribbon designations](#) to identify preferred hospitals. Preferred institutions have to receive blue ribbons in patient safety (based on the Leapfrog survey results and the Coalition's medication survey) and selected clinical quality measures (as reported to Hospital Compare). Though the blue ribbon benchmarks are calculated somewhat differently than those used in phase one of the pilot and are slightly more challenging, they are based on the same, most recently available, data sources. The Coalition also measures patient experiences, based on the Hospital Consumer Assessment of Healthcare Providers and Systems survey, and this will be added as a third criterion for the preferred hospital designation in 2010.

A tiered benefit for primary care practices was introduced in phase two of the pilot. Again, this was based on the Maine Health Management Coalition's [Pathways to Excellence Physician Steering Committee's blue ribbon designations](#), which assess a practice's use of clinical office systems, adult diabetes care results compared with national guidelines, use of appropriate heart disease tests and treatment, childhood immunization rates, and treatment of pediatric asthma. Those practices that achieve two or three blue ribbons are identified as "preferred practices."

Process of Change

The first phase of the pilot had two objectives: to make state health plan

members aware that health care quality varies by provider, that quality of care matters, and that quality can be improved; and to encourage providers to publicly report their performance.

Maine Employee Health & Benefits held 60 informational sessions throughout the state to educate employees and retirees about the tiering initiative. Hospital leaders were informed early in 2006 that their institutions' performance would be evaluated, and those hospitals that met the criteria established by the Pathways to Excellence committee would be designated as "preferred hospitals."

The initial benchmarks were fairly modest to "downplay hospital objections in the first phase, with the intent of ramping up the measures with successive rating periods," says Johnson. The first set of preferred hospitals, released on July 1, 2006, included 14 of the state's 36 hospitals (Table 1). Hospital performance, which is reassessed every six months to note a provider's progress in meeting established benchmarks, improved at 11 institutions by January 1, 2007, increasing the number of preferred hospitals to 25.

While neither the health plan nor employees were expected to save money during this first phase of the pilot, services billed by preferred hospitals were exempt from a member's annual deductible. (As these services did not contribute toward the annual deductible, members were likely to meet the deductible regardless of whether the hospital at which they received care was "preferred.")

In the second phase of the pilot, Maine Health Management Coalition's blue ribbon designation was used to identify preferred hospitals. Though the same measures were used for this designation, the benchmarks were set incrementally higher. As a result, the number of preferred hospitals dropped to

16 on August 1, 2007; the member incentive to seek care at these institutions remained the same.

Table 1. Maine Hospitals "Preferred" Designations Following the State Employee Health Plan's Launch of a Tiering Pilot

<i>Number of "Preferred Hospitals"</i>	
July 1, 2006	14
Jan. 1, 2007	25
Aug. 1, 2007	16
Jan. 1, 2008	20
Oct. 1, 2008	27
Feb. 1, 2009	28

To be designated as a preferred hospital from July 1, 2006 to Jan. 1, 2007, institutions must have met the performance criteria established by the State Employee Health Commission for phase one of the pilot. The criteria for subsequent preferred designations, from Aug. 1, 2007 to Feb. 1, 2009, were established at the outset of phase two. (See Case text for more details on these performance criteria.) There are 36 hospitals in Maine, three of which are tertiary facilities.

A tiered benefit was also introduced for primary care practices, effective July 1, 2007. As with the hospital tiering initiative, Maine Employee Health & Benefits held 35 information sessions across the state to explain the preferred physician designation, and members were offered a modest incentive to seek care from preferred providers. Office visit copayments are waived for care received at these high-value practices, as is the annual deductible for any services billed by the practice.

The third phase of the pilot, rolled out on October 1, 2008, revised the benefit in response to a \$3.5 million reduction in plan funding for the fiscal year 2009. The benefit changes included a bigger financial incentive for employees to seek care from preferred

hospitals. Copayments of \$100 per day for inpatient admissions and \$50 per event for outpatient surgery were introduced; these fees are waived for admissions and services at preferred hospitals. A \$50 copayment for advanced imaging, including MRIs, CT scans, PET scans, and SPECT and nuclear cardiology, applies regardless of where care is received. As of February 1, 2009, the number of preferred hospitals reached 28.

Results

The State Employee Health Commission has identified several improvements in provider performance since the pilot was rolled out:

First, the number of hospitals completing the Safe Practices Score section of The Leapfrog Group's Hospital Survey increased from 18 in 2005 to 35 in 2006. Within this same time frame, the number of hospitals completing the Maine Health Management Coalition medication safety survey increased from 30 to 36 hospitals. Further, as of January 1, 2007, all hospitals are providing data to both organizations.

Second, the number of preferred hospitals has increased from 14 at the outset of the pilot, on July 1, 2006, most recently to 28, on February 1, 2009. This increase has occurred even as the performance benchmarks have become more challenging.

Third, the CMS core clinical measures for Maine hospitals have improved, both individually and collectively.

And fourth, the number of primary care practices achieving two or three blue ribbons has increased. Among the 447 practices, those achieving two blue ribbons increased by 20 percent (114 to 137) from 2007 to 2008, and those achieving three ribbons increased by 35 percent (103 to 139) in the same period. Overall, more than 50 percent

of the primary care practices have achieved either two or three blue ribbons.

Implications

At the same time that more providers have achieved preferred status, plan members have responded to the incentives to seek care from these hospitals. Claims data demonstrate a 5 percent shift in outpatient services from non-preferred to preferred hospitals. Though similar data are not available on physician services, it is likely that the financial incentive will have a similar effect on enrollees seeking primary care.

A hospital's status as a non-preferred or preferred provider does not appear to follow a pattern relative to its location in a rural or urban area, nor to its location's economic status. While two of the four largest hospitals that the state employee health plan contracts with have failed to make the preferred list at one point, several small rural hospitals, as well as a small community hospital in an economically challenged community, have consistently received this designation. Further, proximity doesn't appear to override a hospital's quality rating. "The preliminary data suggests that members have been willing to travel to a facility other than their local hospital for outpatient services," says Johnson.

Competitive markets have seen the most movement of physicians from non-preferred to preferred status. While there are geographic pockets of the state that lack preferred primary care practices, they occur in both urban and rural areas, and often in the same areas that have a paucity of physicians generally. Johnson also notes that the program was not intended to disrupt existing doctor-patient relationships, but only to encourage employees looking for a new physician to consider practices with a preferred designation.

There also is anecdotal information that employees are pushing local hospitals that have failed to achieve preferred status to make improvements in quality. Motivated plan members, in one instance, were able to make the necessary change—ensuring constant access to a pharmacist to monitor medication dispensing—a condition of their hospital's certificate of need application. The state's Department of Health and Human Services assesses a hospital's need for expanded services or facilities through these applications. This process gave state employees an opportunity to make their case for improvement to the hospital leadership at a certificate of need hearing, which they had requested. "It was clearly more important for the local hospital administrator to hear from them rather than some bureaucrat in Augusta," says Johnson.

As a result of this success, several health systems have expressed an interest in learning about the Commission's incremental approach to benefit tiering. The health plan's leadership also has been asked to present their experience to organizations including The Leapfrog Group, the National Business Coalition on Health, the Robert Wood Johnson Foundation, and the National Leadership Council.

Lessons Learned

At the outset of the project, the Commission chose to update the preferred hospital list every six months to reflect, in a timely manner, efforts that hospitals were making to improve their performance. However, this has led to some frustration among hospitals, particularly those that have moved on and off the preferred list, and to confusion among employees about whether they stand to benefit from the financial incentives. "It's been a tricky analysis to determine what kind of movement we are seeing and why," admits Johnson.

As a result, the Commission plans to update the preferred hospital designation on an annual basis, following CMS's release of the most recent 12 months of clinical data. It also might establish an absolute threshold for performance on the CMS measures, as comparing hospitals to the average performance of hospitals nationwide creates a moving target. "We're really hoping the list will stabilize," Johnson says.

While the education sessions for plan members were "costly and resource intensive," they appear to have paid off, says Johnson. Explaining the importance of health care quality to employees and retirees and sharing the data sources used to establish a provider's preferred designation ultimately has helped to ensure the pilot's success. "They understood what we were trying to accomplish and they became instrumental in getting hospitals to move from noncompliance to compliance and becoming preferred hospitals," he says.

Limitations

Despite the ability to demonstrate some effect on quality, at least for those dimensions of care measured and publicly reported as part of the pilot, the program's impact on cost has not been evaluated. Further, in order to fully implement value-based purchasing, cost and efficiency measures must be introduced to the program.

The Commission is exploring partnerships with academia to assess the return on investment and potential savings of the hospital tiering pilot. It also plans to push for increased cost transparency at the provider level, and consensus on protocols for evidence-based medicine.

Next Steps

The Commission would like to identify preferred specialty physicians—a step in which plan members have also expressed an interest. Currently, representatives from six specialties—cardiology, cardiothoracic surgery, OB/GYN, orthopedics, gastroenterology, and general surgery—have been working to establish a series of process and clinical outcomes measures to use to establish this designation. However, most of the specialties have yet to make much progress in developing these measures, leading the Commission to consider combining the primary care and specialty designations and instead asking the primary care physicians who led the Pathways to Excellence physician steering committee "to push the agenda," says Johnson. This approach also makes sense given that primary care physicians participating in a multi-payer, patient-centered medical home pilot will start assuming some risk for specialty care referrals this year. "They'll have an interest in identifying the more efficient specialists and hospitals," says Johnson.

The Maine Health Management Coalition plans to continue publicly reporting providers' quality of care. However, it has a

small grant to help facilitate a transition from using Coalition performance measures for physician practices to nationwide standards such as those established by Bridges to Excellence and for National Committee for Quality Assurance accreditation. Practices that meet these new standards for the blue ribbon designation will retain their preferred status for three years.

Only one other Maine employer, Hannaford Bros, a northeast supermarket chain, has implemented a performance incentive similar to the state's tiering pilot, says Johnson. But he believes that the basic principles are transferrable, both within Maine and in other markets.

"In our experience, if you have a fairly strong statewide presence like we do, or a fairly strong local presence, then you can change the dynamics in the marketplace," says Johnson. "The biggest obstacle for many of our colleagues has been to make the case internally, within the organization. In the end, paying for value and quality makes a lot more sense than the perverse system we have right now, where you're just paying for volume. Once you have that acceptance and acknowledgement, then it just makes life a whole lot easier."

This study was based on publicly available information and self-reported data provided by the case study institution(s). The Commonwealth Fund is not an accreditor of health care organizations or systems, and the inclusion of an institution in the Fund's case studies series is not an endorsement by the Fund for receipt of health care from the institution.

The aim of Commonwealth Fund-sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.

For Further Information

Contact Frank A. Johnson, executive director of Maine's Employee Health & Benefits, at Frank.A.Johnson@maine.gov.



Quality Matters Podcast: Increasing the Value of Health Care

An Interview with Dr. A. Mark Fendrick, Co-Director of the Center for Value-Based Insurance Design of the University of Michigan

Interviewed by Sarah Klein

To listen to the interview, please visit the Fund's Web site www.commonwealthfund.org/Publications/Newsletters/Quality-Matters.aspx

News Briefs

CMWF Report Outlines Path to Health Reform

A Commonwealth Fund Commission on a High Performance Health System [report](#) published last month recommends a comprehensive set of insurance, payment, and system reforms that, if in place by 2010, could lead to affordable coverage for all by 2012, improve health outcomes, and slow health spending growth by \$3 trillion by 2020. Central to the Commission's strategy is establishing a national insurance exchange that offers a choice of private plans and a new public plan, along with reforms to make coverage affordable, ensure patient access, and lower administrative costs.

Building on that foundation, the report recommends policies to change the way the nation pays for care, increase investments in information systems to improve quality and safety, and promote health. By stimulating competition among providers and promoting delivery system changes aimed at providing more effective and efficient care, the policies could yield higher value and substantial

savings for families, businesses, and the public sector.

"To improve health and enhance our family and national security, we need to invest in substantial reforms," said Commonwealth Fund President Karen Davis. "With our economy in crisis, health costs squeezing family budgets, and coverage deteriorating, we can't afford to continue on our current path. The Commission has laid out a pragmatic strategy that could rapidly move us in more positive directions—if we start now."

Wal-Mart to Market Electronic Health Record System

Wal-Mart, the world's largest retail chain, [announced](#) this month that it will offer an electronic health record system to individual doctors and small physician practices. Most U.S. doctors work alone or in small groups, and many of them have been slow to adopt information technology because of its cost.

This move comes at a time of renewed interest in bringing physician practices into

the digital era. The Obama administration's economic stimulus package includes \$19 billion in incentives to encourage physician practices to invest in electronic health record systems.

Wal-Mart plans to offer a "package deal" for its electronic health record system, which would include hardware, software, installation, maintenance, and training. It will partner with Sam's Club, a division of Wal-Mart, to market the system; Dell will provide the computers and eClinicalWorks will provide the software.

The company maintains that its position as a high-volume marketer enables it to provide the technology at lower cost than its competitors. Wal-Mart's electronic health record system will cost less than \$25,000 for one physician and about \$10,000 for each additional physician in a practice. After installation and training, continuing annual costs for maintenance and support will be about \$4,000 to \$6,500 annually.

Pay-for-Performance Programs Make a Difference, Survey Finds

A recent [survey](#) of health plans found evidence that pay-for-performance programs (P4P) are improving the quality and efficiency of care. The survey—fielded by Med-Vantage, a health care software company, The Leapfrog Group, and the Integrated Healthcare Association, a health care improvement alliance based in California—includes responses from 75 sponsors of P4P programs (including individual health plans and coalitions) representing 150 million health plan members. This is the fourth time the survey has been conducted since 2004.

According to the findings, P4P programs have matured over the years. Most programs are more than five years old and have become integral parts of their sponsors'

budgets (rather than one-time experiments). On average, P4P payments represent 7 percent of physicians' overall compensation and 4 percent of hospitals' overall compensation; in some programs, performance-based payments make up as much as 30 percent of physician compensation. P4P programs are also expanding in scope. Many current programs, for example, include greater numbers of physician specialties than in 2006, the survey's first year.

The most notable finding, however, is that P4P programs appear to be having a substantial impact on the quality of care. In the two years since the last survey, the percentage of programs that reported quality improvements related to performance payments nearly doubled. More than half of the programs reported measureable increases in clinical quality. P4P programs also reported advances in cost control measures, particularly the adoption of health information technology.

Patients Report Greater Satisfaction with Medical Practices

A Press-Ganey [report](#) found that patients' satisfaction with their medical practices rose in 2008, compared with 2007. The report synthesizes survey responses from nearly 2.4 million patients treated at 10,000 locations across the nation.

The authors attribute this increase to practices' efforts to solicit patients and meet their expectations. Practices are taking these steps because of the competition posed by walk-in clinics and the fact that payers are increasingly including patient satisfaction as a factor in their reimbursement. Patients, too, are able to use public reports and other resources to learn about and compare physicians and practices, choosing those that best meet their needs.

According to the report, patients' top priority in selecting a medical practice was the level of sensitivity shown by caregivers to patients' needs, followed by the overall

cheerfulness of practices. The time spent waiting to be seen was also an important factor: the longer a patient has to wait, the lower their overall satisfaction.

Recent Publications of Note

Selected articles on quality improvement from a number of journals, including the *American Journal of Medicine*, *Annals of Internal Medicine*, *Archives of Pediatric and Adolescent Medicine*, *BMJ*, *Health Affairs*, *Health Services Research*, *International Journal for Quality in Health Care*, *Joint Commission Journal on Quality and Safety*, *Journal of the American Medical Association*, *Journal of General Internal Medicine*, *Journal of Patient Safety*, *Journal of Safety and Quality in Health Care*, *Medical Care*, *The Milbank Quarterly*, *The New England Journal of Medicine*, and *Pediatrics*. The articles are nominated by Editorial Advisory Board members from a preselected list.

Health Care System Performance

Greater Care Intensity Associated with Lower Patient Satisfaction, Quality

In order to examine associations among hospital care intensity, the technical quality of hospital care, and patients' ratings of their hospital experiences, the researchers linked the results of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and measures of technical process quality, both available on the Centers for Medicare and Medicaid Services Hospital Compare Web site, with data from the Dartmouth Atlas of Health Care. They found that greater inpatient care intensity was associated with lower quality scores and lower patient ratings, and lower quality scores were associated with lower patient ratings. In their conclusion, they

wrote: "Our study suggests that efforts to encourage better coordination of care, rather than simply training more physicians or spending more money, holds the key to future health care reform." J. E. Wennberg, K. Bronner, J. S. Skinner et al., [Inpatient Care Intensity and Patients' Ratings of Their](#)

[Hospital Experiences](#), *Health Affairs*, Jan./Feb. 2009 28 (1): 103–112.

Publicly Reporting Hospital Scores Doesn't Affect Patients

A retrospective analysis, using the National Hospital Ambulatory Medical Care Survey, 2001–2005, assessed emergency department visits by adult patients with respiratory symptoms to determine whether public reporting has led to any unintended adverse consequences. It compared rates of pneumonia diagnosis, antibiotic use, and waiting times to see a physician before and after public reporting of hospital scores on antibiotic timing in pneumonia. The study found that such reporting has not led to increased pneumonia diagnosis, antibiotic use, or a change in patient prioritization. M. W. Friedberg, A. Mehrotra, and J. A. Linder, [Reporting Hospitals' Antibiotic Timing in Pneumonia: Adverse Consequences for Patients?](#), *American Journal of Managed Care*, Feb. 15, 2009 15 (2): 137–144.

Quality Tools in Practice

Multidisciplinary Teams Needed to Manage Chronic Disease

The number of Americans with chronic illnesses is rising, and there is a striking gap between the high prevalence of chronic conditions among people living below the federal poverty level compared with the average prevalence in the general population. Evidence strongly suggests that multidisciplinary teams in primary care and public health are best suited to deliver higher-quality and lower-cost chronic and preventive care to this growing population. Yet, workforce projections indicate a growing number of specialist physicians per capita coupled with shortages of primary care clinicians and other multidisciplinary team members—leading the authors to suggest several "serious policy reforms" to prevent and manage chronic illness. T. Bodenheimer, E. Chen, and H. D. Bennett, [Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job?](#), *Health Affairs*, Jan./Feb. 2009 28 (1): 64–74.

Evidence Supports Chronic Care Model

Despite advances in treating chronic diseases, which are responsible for 59 percent of deaths and 46 percent of the global disease burden, many patients do not get the care they need. The Chronic Care Model aims to transform care for these patients from "acute and reactive to proactive, planned, and population-based." This paper reviews articles published since 2000 to examine the model's effectiveness. These studies show that, though more needs to be learned about the practicality, effectiveness, and cost implications of the Chronic Care Model, its use to guide practice redesign leads to improved patient care and better health

outcomes. K. Coleman, B. T. Austin, C. Brach et al., [Evidence on the Chronic Care Model in the New Millennium](#), *Health Affairs*, Jan./Feb. 2009 28 (1): 75–85.

A Case for Chronic Disease Programs in Hospitals

While the Chronic Care Model and the patient-centered medical home have "worked around" the hospital and acute care system, the current funding environment largely provides acute care tools to deal with chronic disease. The authors conclude that there is a business case for hospitals to offer chronic disease programs customized to their local circumstances. Innovative chronic disease programs could be combined into a service line that would include prehospital, hospital, and posthospital programs. "Beyond benefits to hospitals, patients and payers could benefit from improved patient outcomes and costs; society could benefit from more appropriate deployment of resources," they write. A. L. Siu, L. H. Spragens, S. K. Inouye et al., [The Ironic Business Case for Chronic Care in the Acute Care Setting](#), *Health Affairs*, Jan./Feb. 2009, 28 (1): 113–125.

Discharge Intervention Reduces Rehospitalization

A randomized trial was used to test whether additional discharge services could minimize emergency department visits and rehospitalization after patients are discharged. These services included a nurse discharge advocate who worked with patients during their stay to arrange follow-up appointments, confirm medication reconciliation, and conduct patient education, as well as a clinical pharmacist who followed up with patients to review medications. The study found that patients who received this intervention had lower hospitalization utilization. B. W. Jack, V. K. Chetty, D.

Anthony et al., [A Reengineered Hospital Discharge Program to Decrease Rehospitalization](#), *Annals of Internal Medicine*, Feb. 3, 2009 150 (3): 178–187.

Care Coordination Can Improve Chronic Care

Chronically ill Medicare beneficiaries were randomly assigned to intervention or control (usual care) groups to assess whether a care coordination program reduced hospitalizations and costs, and improved selected quality of care outcomes. Nurses contacted patients in the intervention group about two times a month, mostly via telephone, to improve treatment adherence and their ability to communicate with physicians. Thirteen of the 15 programs showed no significant differences in hospitalizations; none of the 15 programs generated net savings; three programs had lower monthly Medicare expenditures than the control group. The authors concluded that these programs are unlikely to yield net Medicare savings unless they have a strong transitional care component, and that substantial in-person contact can be cost-neutral and improve some aspects of care. D. Peikes, A. Chen, J. Schore et al., [Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials](#), *Journal of the American Medical Association*, Feb. 11, 2009 301 (6): 603–618.

Complaint Data: A New Analytical Tool for QI

This study assessed whether complaint data, which are available at a fraction of the cost of conducting patient satisfaction surveys, yield insights into an organization's performance. The authors found that analyzing the last 100 complaints (collected in a 50-day period) was sufficient to detect significant change in the

processes of care. Because complaint data represent only very dissatisfied patients, as opposed to the reports of satisfied and dissatisfied patients to satisfaction surveys, more can be revealed about a unit's operations when both types of information are used. F. Alemi and P. Hurd, [Rethinking Satisfaction Surveys: Time to Next Complaint](#), *Joint Commission Journal on Quality and Patient Safety*, Mar. 2009 35 (3): 156–161.

Health Care Costs

Rising Medical Costs Threaten Patient Trust in Physicians

A cross-sectional household survey, conducted largely by telephone, was used to examine the association between high medical cost burdens and self-reported measures of patients' trust in their providers and their perceptions of the quality of care. Adjusted analyses showed that patients with high medical cost burdens had greater odds of lacking trust that their physician will put their needs above all else and refer them to specialists when needed. They were also more likely to believe that physicians would perform unnecessary tests and had more negative assessments of the thoroughness of the care received. These associations were greatest for privately insured persons and, the authors conclude, have the potential to make health care delivery less effective. P. J. Cunningham, [High Medical Cost Burdens, Patient Trust, and Perceived Quality of Care](#), *Journal of General Internal Medicine*, Mar. 2009 24 (3): 415–420.

Implementing QI for Depression Care Has High Upfront Costs

This study documented the organizational costs of a quality improvement project to develop an evidence-based depression care

model for Veterans Health Administration primary care practices. This included time, salary costs, and costs for conference calls, meetings, e-mails, and other activities for a four-year period. It found that clinical participants spent 1,086 hours at a cost of \$84,438, and technical experts spent 2,147 hours costing \$197,787. The authors concluded that these costs—85 percent of which derived from initial regional engagement activities and care model design—were significant and should be accounted for when planning to implement evidence-based depression care. C.-F. Liu, L. V. Rubenstein, J. E. Kirchner et al., [Organizational Cost of Quality Improvement for Depression Care](#), *Health Services Research*, Feb. 2009 44 (1): 225–244.

Prevention Adds More to Medical Costs than It Saves

This perspective reviews the evidence from 599 cost-effectiveness analysis studies, published between 2000 and 2005, that examined the costs and health outcomes of preventive care interventions. It found that less than 20 percent of the preventive options (and a similar percentage for treatment) fall in the cost-saving category; 80 percent add more to medical costs than they

save. The author concludes that: "Careful choices about frequency, groups to target, and component costs can increase the likelihood that interventions will be highly cost-effective or even cost saving." L. B. Russell, [Preventing Chronic Disease: An Important Investment, But Don't Count on Cost Savings](#), *Health Affairs*, Jan./Feb. 2009 28 (1): 42–45.

Traditional Medicare Presents Challenges to Disease Management

This study summarizes the results to date of seven disease demonstration and pilot programs conducted by Centers for Medicare and Medicaid Services (CMS) in fee-for-service Medicare, including the Medicare Health Support (MHS) pilot. It outlines CMS' interest in disease management, overviews the seven demonstrations, discusses demonstration-level results, and reviews CMS' future plans in this area. Among the findings is that it is challenging to reduce costs sufficient to cover program fees, including those that are provider-based, third-party, and hybrid models. D. M. Bott, M. C. Kapp, L. B. Johnson et al., [Disease Management for Chronically Ill Beneficiaries in Traditional Medicare](#), *Health Affairs*, Jan./Feb. 2009 28 (1): 86–98.

Citation

Quality Matters. Employee Health, The Commonwealth Fund, March/April 2009, Vol. 34.

Special thanks to Editorial Advisory Board members Janet Corrigan and Tom Hartman, and to Stu Guterman, director of the Fund's Program on Medicare's Future, for their guidance with this issue.

Editorial Advisory Board 2008

David Blumenthal, M.D., M.P.P, director of the Institute for Health Policy at Massachusetts General Hospital/Partners Health Care System

Eric Coleman, M.D., M.P.H., associate professor of medicine, University of Colorado

Janet Corrigan, Ph.D., president and CEO, National Quality Forum

Don Goldmann, M.D., senior vice president, Institute for Healthcare Improvement

Thomas Hartman, vice president, quality improvement, IPRO

Rosalie Kane, Ph.D., professor of public health, University of Minnesota

Gordon Mosser, M.D., associate professor, School of Public Health, University of Minnesota

Mary Naylor, Ph.D., R.N., Marian S. Ware Professor in gerontology, University of Pennsylvania School of Nursing

Michael Rothman, director, Quality Improvement, Johns Hopkins Hospital

Paul Schyve, M.D., senior vice president, Joint Commission

Bruce Siegel, M.D., research professor, Department of Health Policy, George Washington University

Robert Wachter, M.D., professor and associate chairman, Dept. of Medicine, University of California, San Francisco

Editorial Team

Anne-Marie Audet, M.D., vice president, Program on Quality Improvement and Efficiency

Vida Foubister, M.A., M.Sc., and Douglas McCarthy, M.B.A., contributing editors

Sarah Klein, B.A., contributing writer

Martha Hostetter, M.F.A., managing editor, mh@cmwf.org