

Value-Based Purchasing

A newsletter from The College for Value-Based Purchasing of Health Benefits (CVBP)

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Editor's Updates from the College

CAMHB Gets a New Name

The College for Advanced Management of Health Benefits has been renamed *The College for Value-Based Purchasing of Health Benefits (CVBP)*. When the College was founded in 2004 the term "value-based purchasing" was relatively unknown outside of the limited circle of employers and coalitions that were already engaged in VBP activity. Since that time, the VBP movement has gathered steam, due in no small part to DHHS' stated commitment to becoming a value-based purchaser of health services. The College curriculum has always been focused on value-based purchasing, and will continue to have this focus, so, in a year of major change for the nation, we thought the time right to update the College's name. Hope you approve.

CVBP Schedule for 2009

The College for Value-Based Purchasing of Health Benefits will hold two sessions in 2009:

- June 1 - 4, Columbus, Ohio, hosted by Employers Health Purchasing Corporation of Ohio
- September 14-17, Memphis, Tennessee, hosted by the Memphis Business Group on Health

The programs are open to any interested registrant who is in a health benefits purchasing position or works on behalf of benefits purchasers, i.e. registrants don't have to be members of the host coalition. More information is available at www.cvbp.org.

What's Ahead for College Programs?

In addition to the two offerings of the "basic" four-day College course in 2009, we are exploring the possibility of offering an "advanced" two-day course for College alumni and other benefits purchasers who feel that they already have a good understanding of the VBP basics. An alumni survey is currently underway to assess the level of interest in such a program and gauge interest in specific topics that an advanced course might cover. If you are an alumnus, we hope you will complete the web-based survey; if you are not an alumnus, we welcome your ideas via e-mail (neil.goldfarb@jefferson.edu).

The other major development on the curriculum front is beginning to design a "blended learning" model for delivering the College curriculum, i.e. offering a program that includes both web-based self-study and an in-person one or two day training. This planning process is in response to the request from many of our alumni, including coalition leadership and staff, to find a way to deliver the curriculum to a broader audience, and to scale back the in-person time commitment. We are currently reviewing the College curriculum to determine which components lend themselves to web-based learning, and which are more suited for in-person interaction and discussion. We also are exploring the various technologies available for web-based learning, including both asynchronous (people sign on whenever they want) and synchronous (people all are in the same web place at the same time) approaches. Expect an announcement by the end of 2009 regarding the launching of this new blended approach for programs in 2010.

Neil Goldfarb, Editor
Value-Based Purchasing



Consumer Health Websites Accelerate Consumer-Driven Healthcare

Richard Toner, MS

Consumer health websites (sites) have been around for more than a decade now. WebMD, RevolutionHealth, MyOptumHealth, HealthCentral, EverydayHealth, QualityHealth... the list of sites goes on and on. Employers, employees, health plans, providers, and general healthcare consumers have had varying reactions to these sites and buy-in remains largely a personal preference.

What may come as a surprise to some, however, are innovative features and tools recently developed by these sites that generate an enormous amount of self-knowledge and independence for healthcare consumers. Though not intended to replace a physician's expertise or discretion, these tools give consumers a better understanding of, and more control over, their health.

Newer features include: drug interaction checkers, symptom checkers, various health-related calculators, pill identifiers, patient forums, fitness trackers, and of course, personal health records (PHRs). These interactive features have replaced the one-way information delivery tools that originally characterized these sites.

The brief summaries below provide the bases on which employers, employees, and other healthcare stakeholders might begin to reassess their perceptions of these rapidly evolving, predominantly free consumer health sites and their usefulness in consumer-driven healthcare.

Drug Interaction Checkers & Pill Identifiers: Patients, especially those with multiple chronic conditions, often take more medications than they or their multiple specialists can keep track of. Drug Interaction Checkers, though varying in look and design, enable consumers to personally investigate if one of their drugs adversely interacts with another. More advanced versions of this tool allow patients to enter their symptoms or abnormal lab tests to see if their drugs might be causing them.

If consumers find themselves confused about which capsule is for which medication, Pill Identifiers help them to identify medications by name or visual appearance. Consumers can search by imprint (an indented or printed symbol, text, or number on the pill), then by color, and then by shape.

Symptom Checkers: Usually designed as an interactive picture of the human body, Symptom Checkers allow consumers to click on the part of the body where symptoms are occurring. The user then progresses through a sequence of questions that narrow the symptoms to a series of potential causes - similar to the differential diagnosis technique used by clinicians. In appropriate instances, responses lead to a recommendation that the patient seek immediate medical attention e.g. "Dial 911 for an ambulance immediately. If you are not allergic to aspirin, chew and swallow any size aspirin immediately."

Health Calculators: Health calculators and risk assessments are nothing new to health professionals. However, making these tools widely accessible and configuring them in a way that allows consumers to use them without difficulty is a novel and positive change.

Health calculators likely to be found on these sites include: Body Mass Index (BMI), Metabolic Rate, Ovulation Estimator, Cigarette Cost Calculator, Real-Age Calculator (based on biometrics), 10-year Heart Attack Risk, 10-year Stroke Risk, Healthy Weight Estimator, Stress Test, Children's Growth Calculator, Baby Due Date... the list is infinitely long.

Patient Forums: Also known as support groups, discussion boards, and message boards, this feature allows patients to share knowledge and experience with, and receive support and guidance from, patients suffering from the same or similar conditions. Patient forums are often moderated or hosted by clinical experts within the field who aide and facilitate discussion.

Fitness Trackers: A focus on disease prevention is a key value-based purchasing strategy. However, long-term tracking of dietary intake and physical activity using traditional logs or journals can be tedious and challenging for healthcare consumers. The latest versions of online Fitness Trackers make the task of managing health easier and more rewarding.

With minimal input on a few demographic and biological metrics, patients are provided with dietary and physical activity decision support, projections on what can be expected given certain lifestyle changes, and the computing power to generate charts and reports across specified time intervals; for example, tracking clinical metrics like glucose level, blood pressure, or basal body temperature over time. Consumers can access their web-based trackers from any location with Internet access, e.g. the gym or workplace. If a consumer misses a day, a week, or a month, he/she can resume at any time because health historical data remains secured in personal profiles.

Personal Health Records: Most stakeholder groups support the increased infusion of information technology into healthcare. Allowing consumers to control their own health information is central to continuity of care. PHRs allow consumers to store their own clinical information - e.g. medications, medical history, radiology results, lab results, appointments - in a secure, online profile. While some proprietary companies offer PHRs to consumers for a fee, consumer health sites have expanded their scope of services and now offer PHRs free-of-charge to consumers. PHRs hosted through these sites allow consumers a one-stop-shopping experience for managing their health.

Conclusion: The innovative, widely-accessible, and free services provided by consumer health sites are gaining recognition as powerful tools for achieving the ultimate goal - a more informed healthcare consumer. The websites discussed in this article are at the cutting edge of a much broader change occurring in healthcare. If history tells us anything, it is that social changes often follow major technological innovations. True consumerism in healthcare will not be achieved through consumer-driven health plans or innovative benefit designs alone, but rather in combination with readily accessible health information made possible by the Internet. Purchasers of healthcare services would be wise to examine the latest generation of consumer health websites and assess their usefulness in wellness and prevention initiatives.

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The Patient Centered Medical Home: What Employers Need to Know

Richard Jacoby, MD

In their capacity as payers for their employees' medical services, employers need to be aware of trends that impact the provision and payment of healthcare services. One such trend in primary care healthcare services – specifically, the Patient Centered Medical Home (PCMH) - meets both of these criteria by providing financial incentives to physicians for meeting certain quality criteria. In the following paragraphs, I'll elaborate on the concepts underlying the PCMH, its potential to impact quality and cost of patient care, and some of the barriers to its implementation.

A familiar concept in the medical literature, PCMH now has taken on a "physical form" and, as such, has become the subject of much attention in both medical and lay publications. Patients may look at this term and ask, "Is this just a fancy name for my current doctor's office?" In short, the answer is no. The physical location may be the same as a primary care physician's office, but the designation of PCMH requires a practice to meet specific criteria concerning care processes that are beyond the scope of processes in the average primary care office.

First introduced by the American Academy of Pediatrics in the 1960s as a means to improve care for children, the PCMH has recently been resurrected for primary care. In February, 2007, the PCMH model was endorsed by a number of organizations including the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, all of whom have worked with various aspects of the model for decades. They have jointly defined the medical home as "a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians."*

Conceptually, the PCMH is an idealized vision of primary care (those practices that include family and general practice, internal medicine, pediatrics, and obstetrics and gynecology). A PCMH is a familiar place, with familiar people, that delivers high quality, well-organized, accessible care. It was conceived to address the current issues of fragmentation of care by providing the infrastructure to support care along the full spectrum from wellness and prevention, to chronic care management, to hospitalization and end of life issues.

Research has definitively demonstrated that higher ratios of primary care physicians (compared to specialists) provide higher quality care at a lower cost. However, it is also well recognized that there are inequities in valuing compensation to primary care physicians compared to specialists. As a result, far fewer physicians are choosing careers in primary care. In addition, surveys indicate that many physicians in primary care are disillusioned and considering early retirement or career change. The PCMH approach to care is, in truth, an innovative and promising response to the crisis in primary care. Throughout the United States, Medicare, Blue Shield plans, and other payers are providing financial incentives for PCMHs while researchers further test the concept in various demonstration programs.

PCMH serves as a means for appropriately compensating primary care providers in a timely manner without major legislative intervention. In theory, the increased costs incurred from direct payments to primary care providers will be offset by savings to the system through higher quality. The peer-reviewed literature documents improved quality, reduced errors, and increased satisfaction when patients identify with a PCMH. Some studies estimate that a primary care-based health care system would cost 30% less than the one in which we currently operate.

What does it mean to qualify as a PCMH? On January 2, 2008, the National Committee for Quality Assurance (NCQA) announced a large, voluntary program to certify physician practices as PCMHs using standardized measurement criteria. Practices seeking recognition complete a Web-based survey and provide documentation to validate their responses. Practices are scored along 9 standards on a 100-point scale and are eligible for three levels of recognition (financial incentives). The nine standards are: (1) Access and Communication, (2) Patient Tracking and Registry Functions, (3) Care Management, (4) Patient Self-Management Support, (5) Electronic Prescribing, (6) Test Tracking, (7) Referral Tracking, (8) Performance Reporting and Improvement, and (9) Advanced Electronic Communications. Optimal scoring on the PCMH scale does not explicitly require the physician to possess an electronic medical record (EMR) system, though having one facilitates many of the requirements.

Essentially, the NCQA certification as a PCMH documents that providers have the infrastructure and capabilities to provide and/or coordinate care for patients along the spectrum of care identified above. In the parlance of the health policy quality world, it involves having the "structure" and "processes" in place to enable optimal "outcomes."

How will this play out in the "real world?" Will the PCMH be a "disruptive innovation" in primary care? As of now, the jury is still out. Admittedly, the initiative is very new. However, despite its advocates' enthusiasm, supportive literature, compelling anecdotes, and the NCQA certification program, the PCMH's adoption outside of large-group, academic, and pilot-program settings remains limited. The reasons for this include the usual suspects of cost and time. Whether or not the rate of adoption increases with further publicity and greater financial incentives, PCMH will remain a trend worth following.

* <http://www.ncqa.org/tabid/631/Default.aspx> PPC-PCMH Fact Sheet Accessed 2/3/2009

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Governance and Value-Based Purchasing: What Employers Need to Know

Valerie P. Pracilio

In the current economy, employers are increasingly aware of the need to employ value-based purchasing strategies. Similar strategies can also be used by health care organization governing boards.

Today, more health care providers are accepting positions at the boardroom table than in the past. These providers are well trained in the clinical aspects of health care but not the business of health care delivery. It is not surprising that providers often find themselves unprepared for a board member's role as a decision-maker and steward. It has become clear that education is essential to prepare providers for board positions.

The six core responsibilities of board members primarily rely on business models: financial oversight, quality oversight, setting strategic direction, board self-assessment and development, management oversight, and advocacy.¹ Value-based purchasing (VBP) strategies closely align with these responsibilities. VBP is gaining a stronghold in the marketplace and increasing the quality, safety and cost-effectiveness of care delivery. Governance structures that employ VBP strategies will positively contribute to the value of health care delivery.²

Health Care Boards of Directors: Health care boards of directors are composed of businessmen and providers. A team-based approach to board leadership is necessary to build exceptional board relationships. There are 5,747 registered hospitals in the United States, a majority of which are non-profit (>50%), a small percentage of which are for-profit (<16%) and the remainder of which are governmental organizations.³ The common link among these organizations is the presence of providers on the board.

A health care board typically is composed of stakeholders with a common interest in the organization - payers, clinicians and other employees of the health care organization, accreditors and regulators, members of communities, and the public - all of which have something to gain from VBP strategies.⁴

Governance structures have traditionally been hierarchical, with the board at the top and the chief executive officer and the board committees below. Increasing board accountability has caused a structural shift to a more horizontal arrangement. Boards now rely on the medical expertise of health care providers and the analytic and financial savvy of administration to present a dashboard of the organization's performance.¹ Board structures often include committees which focus on finance, quality, and compensation among other important components of the organization which could benefit from employment of VBP strategies. The individuals serving on these committees inform the board of operations related to their respective component of the organization. Education to prepare leaders for board membership should include VBP to ensure sound decision-making on matters of value and quality.

Quality of Care: The board's role in quality care delivery has been receiving a lot of attention. The greatest advances in quality have come from physicians who recognized the importance of recording and analyzing data which formed the foundation of the quality movement. Dr. Ernest Codman tracked the

results of his surgeries and reported them publicly, a process which later became known as the "End Result Idea."⁵ Dr. Avedis Donabedian introduced the "quality triad" as a mechanism to measure quality. He believed that quality could be measured by looking at the structure of the organization, the process of delivering care, and the outcomes that resulted.⁶ Physicians who, like Drs. Codman and Donabedian, recognize the importance of quality measurement and transparency are ideal candidates for board membership. As pay-for-performance becomes more prevalent in the health care market, provider participation on boards also will contribute to the organization's economic growth.

Providers have the clinical background to understand and interpret the quality reports that are reviewed by the board on a regular basis. Because boards of directors are increasingly held accountable for quality, provider board members have become a critical component of board composition.

Conclusion: Boards of directors of health care organizations are similar in structure to those of businesses. However, the increased scrutiny for board oversight of quality has led to increased participation of providers on boards. Education of incoming board members has not been the traditional model; however, the providers at the board table have become critical to the board's success. The thinking of businessmen and health care providers are very different; therefore, education is necessary to level the playing field. The synthesis of the provider's clinical knowledge and the businessman's financial savvy combined with VBP strategies will lead to the success of the health care organization.

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