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*18<sup>th</sup> Better Government Competition*

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**PIONEER INSTITUTE**  
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# 2009 Better Government Competition

## WINNER

**SeniorLink™** ..... 7  
*Caregiver Homes, Inc. of Massachusetts, Boston, MA*

## RUNNERS-UP

**"YourChoice" Health Plan** ..... 13  
*Center for Health and Lifestyle Management, Manatee County, FL*

**Occupational Health Services Project** ..... 20  
*Department of Labor and Industries, Olympia, WA*

**Statewide Surgical Collaborative to Reduce Surgical Complications** ..... 25  
*QCMetrix, Inc., Waltham, MA*

**Retail Clinics: Expanding Access to Health Care** ..... 31  
*Heinz College for Health Care Policy and Management, Carnegie Mellon University, Pittsburgh, PA*

## SPECIAL RECOGNITION

**Wellness Health Incentive Payment Program** ..... 39  
*Maricopa County, AZ*

**A National Market for Individual Health Insurance** ..... 41  
*Division of Health Policy and Management, Minneapolis, MN*

**Health Insurance Cost Control** ..... 44  
*Fallon Community Health Plan, Worcester, MA*

**CPOE Initiative** ..... 47  
*New England Health Care Institute and Massachusetts Technology Collaborative, Cambridge, MA*

## Foreword & Acknowledgements

Dear Friend,

The timing of this year's Better Government Competition could not be better. At a time when the federal government is focused on the state of the nation's healthcare, this volume provides a rich list of empirically proven and exciting reforms.

The spirit of the Better Government Competition is to enlist the brains and energy of people across the country to bring solutions to Massachusetts, and our peer states. We set a modest prize and each year are amazed at the quality and number of entries that outline what has been done and the results of efforts undertaken elsewhere; or, simply, the potential of some terrific ideas. We are gathered tonight at the 18th Competition Dinner to celebrate the success of these individuals and programs.

Unlike the mud-slinging going on at the federal level, we are focused on what works and what is important. This year, the question we posed was a simple one: What can Massachusetts (and the country) do to contain costs and ensure better quality care? The 250-plus entries from across the country came from doctors, practitioners, hospital officials, trade associations, academicians, students, government officials, patient groups, and concerned citizens. This is a heartening response and it tells you of the vivid interest in this issue of citizens across the country, a sense that individuals can make a difference, and that the quality of ideas really does matter in the public realm.

Our winner this year is SeniorLink, a service of Caregiver Homes of Massachusetts, which offers a unique care giving model that couples a stable family home environment with the specialized medical, mental health, nutritional and social interventions needed by adults who are unable to care for themselves. SeniorLink, and its proprietary web-based "extranet" called SeniorTouchtm, employs immediate family members or relatives as the primary caregivers. This allows for the elder or disabled adult to remain in a comfortable, familiar environment while receiving the care they both need and deserve.

Our Runners-Up and the Special Recognition Award winners all bring better outcomes and seek to put the right incentives in place to promote individual health and prevention, as well as healthy competition.

I would like to thank our sponsors for their belief in the Competition, and for their deep interest in giving our citizenry more and better health options.

Finally, I would like to express Pioneer's gratitude for the yeoman's work that our talented panel of judges did this year in selecting the prize winners. The judges demonstrated their expertise and passion in identifying the winners. No mud. Just a good intellectual debate.

Thanks for your attendance this evening, and thank you for your interest in Pioneer's work.

Cordially,

Jim Stergios, Executive Director





**Better Government Competition**

**2009 WINNER**

## **SeniorLink™**

Caregiver Homes, Inc. of Massachusetts  
Boston, MA

### **BACKGROUND**

Edmund Dern and Florence Whelan live on the South Shore. Although they need 24-hour care, they are still able to live at home with the support of their full-time caregivers and Caregiver Homes™ of Massachusetts.

Caregiver Homes' Adult Foster Care Program pays caregivers up to \$18,000 each year and trains and educates them to provide care at home for a senior or disabled adult. Professional support is provided by Registered Nurse and Care Manager teams that develop individual Plans of Care and monitor client health with regular visits and by checking daily caregiver online notes. Care Managers also coordinate with other services such as Adult Day or Home Health, Hospice and Private-Duty Nursing. Caregivers appreciate the reimbursement (it's not taxed and non-reportable to the IRS) and support that allow them to care for a family member, and clients are comfortable at home and in their communities.

A Hull resident, Dern is an accomplished musician and singer who performed with his band on the South Shore almost nightly for many years. He casually mentions that he was once the opening act for Sammy Davis, Jr. and Liza Minnelli at the old Diplomat Hotel in South Florida. He just as casually talks about the stroke and two amputations he had to undergo, and that he now requires the use of a wheelchair and full-time caregiver. "It could be worse," says the ever-optimistic Dern.

After his stroke, Edmund was told by hospital doctors and staff that he would need to arrange around-the-clock care before he could go home. Seeking information about Adult Foster Care, the Dern family spoke to Denise Baxter-Powell, the Regional Director of Caregiver Homes. Denise "stepped us right through the process and got us into their program within six weeks," says Donna Dern, Edmund's daughter. "Caregiver Homes just took such a weight off my shoulders."

Under Adult Foster Care and MassHealth regulations, spouses and legal guardians are not allowed to become paid caregivers. The person who stepped in to become Edmund's full-time caregiver was Janet White, long-time friend of both Edmund's and Donna's. Donna says, "Before Janet came, we had a lot of difficulty arranging care. We had to have daily meetings about who could be here to cover." Now, with Janet's full-time care, and the ongoing support and payment she receives from Caregiver Homes, life is much calmer. "I'm just glad he's alive. I couldn't have done it without this program," says Donna.

Marshfield resident Florence Whelan had been living with her daughter, Carol, and son-in-law, Richard, for twenty years when her son-in-law passed away. Carol was concerned that she would lose her house and

the ability to care for her 97-year-old mother, until she saw an ad and contacted Caregiver Homes.

Again, it was Denise Baxter-Powell who responded to her call. Florence was able to qualify for Medicaid and Caregiver Homes under the Frail Elder Waiver, and Denise walked them through the application process. “Who would ever know a program like this existed? It sounded too good to be true,” Carol comments.

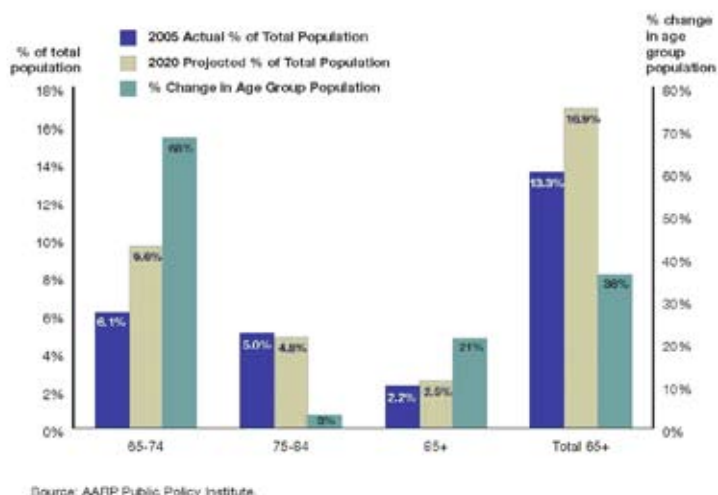
In addition to the twice-monthly payments that have allowed Carol to keep her home, she appreciates the support of her mother’s Care Manager, Miriam MacKenzie, and Registered Nurse, Karin Sullivan. She comments, “That’s why it’s so nice to be in this program, there are people you can talk to. It’s always nice seeing these two!”

When asked how her days are spent as her mom’s caregiver, Carol smiles and says, “I’m so lucky, my mother is always so pleasant, and she’s such a good mother. It’s wonderful that I’m able to do this.”

Medicaid is a joint federal-state program (known as “MassHealth” in Massachusetts) that provides health insurance coverage to certain categories of low-income individuals. It was created on July 30, 1965, through Title XIX of the Social Security Act and is responsible, among many things, for providing eldercare services to the indigent disabled adult population. Each state administers its own Medicaid program. The Federal Center for Medicare & Medicaid Services (CMS) monitors the state-run programs and establishes requirements for service delivery, quality, funding, and eligibility standards. Federal contributions to each state program’s costs are made on a specific ratio. The ratio for Massachusetts is 50/50. Medicaid programs are the primary payer for 64% of nursing facility residents in the USA. Nationally there are over 15 thousand nursing homes that generate a total inventory of approximately 1.7 million beds with costs growing at a rate of 3% annually. In 2007, Medicaid spent nearly \$48 billion providing nursing home care.<sup>1</sup>

Massachusetts spent \$2.59 billion on nursing home care in 2007 through MassHealth.<sup>2</sup> The Commonwealth’s population of elders 65+ years of age was near 860,000.<sup>3</sup> Of that group, over 26% had disabilities<sup>4</sup> and 20% of the adults with a disability were poor<sup>5</sup> – living at or below the official definition of poverty by the federal government – a subtotal of approximately 45,000. Accordingly, because the over 65 population is increasing rapidly (Figure 1), the number of older persons with disabilities is escalating. The Commonwealth’s population of those

Figure 1:  
Comparisons of the 2005 Actual and 2020 Projected Number of 65-85+ Year Old Persons in Massachusetts



aged 65 and older is projected to grow by 35+% from a level of 850,000 in the year 2000 to a total of 1.16 million by the year 2020; a potential for an additional 62,000 poverty-stricken disabled elders.<sup>6</sup>

## PROBLEM

The growing demographic of elderly and disabled individuals compounds the State's problem of an expensive long-term care delivery system that is skewed toward nursing facilities. According to national figures compiled in 2005 by CMS combined with the 2000 US census data, Massachusetts has the 17th highest number of nursing home beds in the nation and more than twice as many beds per capita as Florida, which has the highest percentage population of elders in the nation. Consequently, elders represent 12% of MassHealth recipients, yet account for 37% of its expenditures.<sup>7</sup> Given the projected increase in Massachusetts' elderly population in the coming years, both the Office of Health and Human Services and the Office of Elder Affairs have been lobbying for solutions to the eldercare problem:

“Supporting an increased number of people with disabilities in the community is key to creating a fiscally sustainable long-term system while better meeting the needs and preferences of the Commonwealth's citizens.”<sup>7</sup>

The Commonwealth's current administration of the has further reinforced the need to find more effective approaches to providing long-term supports for aging adults, particularly those with disabilities. Officials are continuing the initiatives of the Romney administration to find solutions that allow older adults to remain in the community and that carry lower costs than nursing home care:

“The Patrick Administration's long-term care policy is community first, an approach that emphasizes maximizing independence in home and community settings while assuring access to needed institutional care.”<sup>3</sup>

There are other governmental initiatives supporting community based solutions. CMS approves waivers that allow states the flexibility to manage their long term care programs. MassHealth implemented a waiver that allows community based eldercare programs to operate through the State's Adult Foster Care program (AFC). Additionally, the Caring Homes Pilot was introduced in the 2006 budget that allows family members to be paid in return for providing housing and care for frail elderly family members. Finally, the State's 2005 Legislative Session voted on “Acts concerning nursing home relocation, pre-admission and choice of long term settings”.

## SOLUTION

SeniorLink™ (SRL) is a Boston-based elder care company that has created a unique, cost effective, community-based program for elders with disabilities. The program is administered by Caregiver Homes of Massachusetts, Inc. (CGH), a wholly owned subsidiary of SRL. The CGH program was developed primarily for elders who meet MassHealth/Medicaid criteria for nursing home care. It began with the tenet that many elders with disabilities can prosper and live life to their maximum functional capability with independence and dignity in a community setting.

CGH couples a stable family home environment with the specialized medical, mental health, nutritional and social interventions needed by each disabled adult. This is accomplished by enlisting a caregiver, often a family member or local acquaintance, to provide food, board and care for the disabled



adult. CGH pays the primary caregiver a stipend that represents the majority of the daily AFC rate of \$83.09 and provides them with the support and oversight to manage their duties. MassHealth is billed for days the client is in service. The program combines the benefits of safe, residential care, in a community setting at less than 50% of the \$170 daily rate of nursing homes. In essence, CGH saves the Commonwealth an amount equal to its revenue. Further, as the payment made to the caregiver is a stipend, it is consequently considered tax free income.

The CGH program brings together all of the medical and social services needed by adults with levels of disability that qualify them for nursing home care. The concept wraps intensive assessments of the total health and social strengths and weaknesses of each elder, the suitability of the intended home setting and appropriate consideration of the potential caregiver. From these assessments, a Geriatric Care Manager (GCM) and Nurse form a multidisciplinary team to develop an individualized treatment plan. The team continuously assesses the implementation of the plan and measures its success. It is important to note that CGH is responsible for the oversight of care and not for the direct administration of medicine or therapy.

A vital tool of the program is SeniorTouch™, a proprietary web based application used to oversee and manage the care of the elders. SeniorTouch™ is used daily by the caregiver and clinical team. It is a HIPAA compliant, electronic medical record of care and a database of all program histories available to the GCM, physicians, administrators and others who may view relevant information on a “permissions” basis. Each day, a caregiver must log in and complete a daily note that answers questions relative to the physical and mental condition of the elder and include comments on life at home. SRL compiles this information into a database that has grown in less than three years to over 200,000 daily notes that contain over 10 million answers and comments concerning geriatric care. This is a first of its kind gerontological database and veritable gold mine of expert knowledge for medical research.

SeniorTouch™ is also a valuable tool for the caregiver as it includes a messaging system, document downloads, links to research on particular topics, training tutorials, policies and procedures and answers to frequently asked questions. CGH staff train the caregiver on the use of this system and offer caregivers computers when needed.

### **GENESIS**

SRL was established in 1999. SRL is a for-profit business that derives revenues through two subsidiary businesses, Seniorlink Care and CGH. Initially the business was based on Seniorlink Care, a national network of GCM's working as private contractors for seniors in need of eldercare supervision. It is a private pay business model that serves families where the elders typically live a great distance away from the children or guardians. In 2004, the CGH concept began. CGH is based on the nationally recognized care model of “Mentor Homes”. In 2006 the “Caring Homes” pilot began, but it was not until 2008 that CGH would have its first full year of business.

The largest cost associated with the start up of CGH has been the continued development of SeniorTouch™. By the end of 2009, development costs for that software system will have exceeded \$2.5 million. The cost of funding CGH to breakeven, beyond the Seniortouch expense, has been approximately \$2 million of equity and \$1 million of debt. As the business grows, the cash flow requirements have increased, owing to the lag between payments to caregivers and receipts from MassHealth.

Expanding the CGH program into other states will require additional use of a line of credit to cover related start up costs. The estimated start up costs for establishing an individual state subsidiary range between \$300,000 and \$1 million depending on the regulations and the velocity of the business growth. These costs assume a cash flow breakeven in 12 to 24 months. Alternatively, larger amounts of investment can be made to rapidly expand a subsidiary with a correlated change of time to break even.

Recently the Commonwealth of Pennsylvania accepted a proposal from SRL for “development and training support for domiciliary care enhanced models.” Essentially, that consulting assignment leverages the procedures of the current CGH business in Massachusetts and combines them with best practices of other community-based elder programs around the country. SRL engaged in this assignment to help establish a CGH program in Pennsylvania. The proposal’s work will be completed by September of this year and the operation could begin in PA later this fall. Currently, there are also discussions with three other states interested in starting CGH programs.

## **PROCEDURE**

Today, CGH is a proven alternative to nursing home placement. The ability to be paid a tax free stipend for their services has allowed many individuals the opportunity to provide care for an elder. Most often the caregiver is not financially able to stay at home and provide care without the CGH compensation. That monetary situation often leads to the difficult family decision of placing an elder in a nursing home, likely the most undesired setting the elder would choose. CGH is an important option for poor, disabled elders to remain in the community.

SRL was able to demonstrate to MassHealth that allowing family members to be caregivers is a positive step toward creating and scaling a community-based eldercare program. Historically, the notion of a relative’s being paid for care was prohibited in the public health arena. In reality, this ban had no logical basis and primarily existed due to a misconstrued view that there was an underlying conflict of interest in paying family caregivers. However, as Adult Foster Care has taken hold in several states with diverse populations, it has become apparent that relatives actually provide the best care to the elder, are the most immediate caregiver candidates and that few conflicts of interest exist. Nevertheless, it took a considerable effort to change the Commonwealth’s policies regarding family caregivers, with the exception of spouses and guardians. Now that Caregiver Homes has progressed within the State, the same forces that first resisted family caregivers have come forward to propose that spouses and guardians should also be eligible caregivers. Unfortunately that proposal has not yet succeeded. (As a matter of note, Seniorlink is experiencing the same initial questioning of family caregiving as it prepares to do business in Pennsylvania.) Over 90 percent of the CGH caregivers in MA are related to their clients. Through SeniorTouch™ data, CGH is demonstrating that the quality of care provided by a family member is typically superior to that provided by a stranger.

Comparing the cost of an AFC placement (\$83 per day) to the cost of a nursing home placement (\$170 per day), the resulting savings to the Commonwealth are approximately \$32,000 per year per CGH placement. In 2008, on an annualized basis, CGH saved MassHealth/Medicaid over \$11 million by placing 357 disabled adults in a community setting. The Company is on track to more than double its number of placements in 2009.

### CONCLUSION

CGH intends to expand nationally. The problems MassHealth faces are prevalent in most states. Overall, Medicaid spends over \$60 billion for institutional Long Term Care.<sup>10</sup> The level of savings that the Commonwealth enjoys through CGH can also be achieved by other states. Potentially, the CGH program could save Medicaid billions of dollars per year.

The first CGH expansion is in Pennsylvania. The Company recently signed a contract with that state and fully expects to have an operating business there by the end of Q4, 2009. Further, CGH intends to expand its services beyond the elderly disabled to all adult disabled (16 years old and above), contracting business with other healthcare departments.

Massachusetts is steadily adopting AFC as an alternative as an option to nursing homes. While the State understands the financial and other benefits of community based care, it has not pressed the option within the MassHealth system. Most of the Commonwealth's Medicaid elderly dollars go to institutions, despite the fact that elders prefer care in a community setting. The State has one of the highest levels of 65+ nursing home utilization in the country. Over the past two decades, states such as Oregon, Vermont and Washington have grown their community based care for the elderly to a level where the minority of Medicaid clients are being served in nursing homes. Over that same period of time, the home care population in Massachusetts had fallen--the exact opposite trend. Clearly, in order for home care numbers to grow to the point of being on par with those of nursing homes, the State needs to emphasize community-based options. The current process for choosing a long term care setting needs to be reevaluated to allow for a longer decision making period in the pre-admission process and a relocation option for elders already placed in nursing homes needs to be encouraged.

### ENDNOTES

1. The Henry J. Kaiser Foundation. State Health Facts.org Retrieved from <http://www.statehealthfacts.org/profileind.jsp>
2. MassHealth Office of Long-Term Care. Boston
3. U.S. Census Bureau (2008). Table 16. Resident Population by Age and State: 2007. Washington, DC: Author. Retrieved from <http://www.census.gov/popest/states/asrh/SC-EST2007-02.html>
4. Commonwealth Corp, The Links between Poverty and Disability, Vol. 4 - Is. 6, 2006
5. U.S. Census Bureau, Population Division, Interim State Population Projections, 2005
6. Center for Disease Control, State-Specific Prevalence of Disability Among Adults -- 11 States and DC, 1998
7. ARP, A Balancing Act: State Long-Term Care Reform (#2008-10)
8. Executive Office of Health and Human Services, Executive Office of Elder Affairs, "Transforming Long-Term Supports in Massachusetts" (December 1, 2003)
9. Executive Office of Health & Human Services and Exec. Office of Elder Affairs. (2008) Long-Term Care in Massachusetts: Facts at a Glance
10. The Henry J. Kaiser Foundation. State Health Facts.org Retrieved from <http://www.statehealthfacts.org/profileind.jsp>

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## ***Better Government Competition*** **2009 RUNNER-UP**

### ***“YourChoice” Health Plan***

Manatee County Center for Health and Lifestyle Management  
Manatee County, FL

#### **BACKGROUND**

“Brenda”, a County employee for 20 years, is living with diabetes. After the inception of the “YourChoice” program, she recognized an improved level of focus and productivity, noting, “For the first time in 20 years, I know what I am doing at my job. . . Before the Diabetes Management Program, I did not have the knowledge of how to regulate my blood sugar or how I could feel so much better with exercise and diet.”

“YourChoice” addresses the issue at hand for many employers how to convert the present “Sickcare” System into a “Healthcare” System. The current “Sickcare” system addresses acute and chronic diseases which result in 20% of the people generating 80% of the costs. More than 95% of our nation’s health expenditures, including most of the billions of dollars employers spend on health coverage, are committed to diagnosing and treating disease only after it becomes manifest. Researchers have estimated that preventable illnesses make up approximately 70% of the burden of illness and the associated costs. Research also shows that poor health and preventable illnesses significantly contribute to elevated employee absenteeism, poor work performance, worker compensation claims and short and long term disability claims.

Previously, the practice at Manatee County Health Plan was to provide “Sickcare” benefits in the typical manner provided by employers. We offered a PPO/HMO look-a-like plan, paid 100% employer contribution for employees, administered it in-house and contracted directly with providers. There was dissatisfaction with the system, and costs and chronic conditions continued to rise. Mr. Goodman approached senior management with a plan for broad change; specifically, he sought permission to design a new medical benefit plan that paid benefits according to evidence-based qualifying events that would make employees and their families accountable for their lifestyle choices.

#### **PROBLEM**

The problems that Manatee County Government addressed are similar to those facing all employers. For example, how do we make employees more accountable for their lifestyle choices and reduce medical benefit costs? How does an employer address the root of the problem as opposed to simply shifting costs? How do we educate employer and employee that improving the health of employees is important in controlling medical costs, not only for the employee, but also for the employer through

increased productivity and reduced absenteeism, both of which impact an employer's "bottom line"? How, as a public employer, do county officials and employees demonstrate to the community the need to build a better workforce and provide excellent customer service?

### SOLUTION

To answer these questions, in 2004 Manatee County created an alternative "Accountable Health Care Model" with their employees, holding them accountable for their lifestyle choices. Critical to this effort was altering plan design so as to prioritize accountability over paternalism.

By developing a "YourChoice" plan design, the county provided medical benefits based upon the completion of evidence-based qualifying events. Manatee "YourChoice" offers three plan levels ("Best," "Better" and "Basic") to members. All plans have identical coverage, including identical prescription and behaviors health benefits and only differ in the levels of reimbursement which are determined by members completing the plan's evidence-based qualifying events:

- The "Best" Plan has a \$25.00 co-pay per office visit with no deductible or coinsurance. Hospital, surgery and out-patient services are covered at 100% up to \$1,400 annually.
- The "Better" Plan has a \$500 deductible and a 75/25% coinsurance up to \$3,600 annually.
- The "Basic" Plan has a \$1000 Deductible and a 50/50% coinsurance up to \$5,000 annually.

All new enrollees must qualify to be enrolled in a plan and from that point forward their qualifying years are age-based: 20, 25, 30, 35, 40, 43, 46, 49 and 50 and older. The qualifying events consist of the following evidenced-based practices:

1. Comprehensive Biometric Lab work, including A1C (diabetes testing) and Cotinine (nicotine testing)
2. Completion of an on-line Health Risk Assessment (HRA)
3. A wellness exam that is a comprehensive physical exam with a review of systems as well as lifestyle choices and behaviors and includes recommendations for programming to assist with health improvement.
4. Age based screenings, including, at appropriate ages, prostate exams and testicular exams for men; colonoscopies and skin screenings for men and women; and mammograms, pelvic exams, pap smears and clinical breast exams for women.
5. Tobacco cessation programs for all tobacco-using members.
6. A diabetes management program, including A1C value and lipid profile, annual foot and eye exam and physician visit. If a member has an A1C of 7.0 or above, there are additional qualifying events required: (i) a two-day diabetes workshop, (ii) online learning and a face to face visit with the diabetic educator, (iii) a six hour workshop addressing preparation for lifestyle change, and (iv) structured exercise program at our fitness center.

To be eligible for the "Best" plan adult members must do all the qualifying events listed above, including tobacco cessation and diabetes management if applicable. For the "Better" plan the adult members must complete specified health risk assessment, biometric lab work and the wellness exam, and for the "Basic" plan adult members have no qualifying events to complete.

Each adult member - employee, spouse or dependent age 19 and older - is enrolled in an individual plan based upon their own qualifying event choice. Regardless of age, the tobacco and diabetes qualifying events are required annually if applicable. All children in a family must complete a wellness exam, dental exam and have their immunization up to date to be in the "Best" plan. Over 93% of our members participate in all of the qualifying events and are therefore enrolled in the "Best" plan.

Some of the qualifying events are provided on-site. For example all of the events for tobacco cessation and diabetes management are provided on-site. In addition, throughout the year, we have Quest Laboratories do worksite lab draws for the qualifying events so members can get their qualifying lab draw done at a worksite as opposed to going to a local Quest Patient Service Center. The health risk assessment is an on-line tool and we provide help sessions throughout the year to assist them in completing their assessment. The other qualifying events such as the wellness exam, the age-based screenings (mammogram, colonoscopy, pelvic, etc) are all conducted at in-network providers in the community as a medical service. However, members are not charged for any of these qualifying events despite being conducted at their physician's office.

#### *Incentives*

"YourChoice" provides financial rewards or "Health Bucks" to members who are willing to make healthy, on-going lifestyle choices. Examples of programs and health/lifestyle conditions that earn "Health Bucks" include being a non-tobacco user, participating in our exercise and diabetes management programs, achieving and maintaining a healthy weight, and participating in our healthy baby program, and Cardiac Health for Life. The participation in these programs and the "Health Bucks" awarded are provided by the staff under the Center for Health and Lifestyle Management (described below). These "Health Buck" rewards can be applied to reduce medical and dental premiums or can be placed in the employee's Healthcare Spending Account. In 2008, the County's plan paid in excess of \$900,000 in "Health Bucks" to covered members.

#### *Health & Lifestyle Management – Moving from "Sickcare" to "Healthcare" Management*

The Center for Health and Lifestyle Management is the division of the "YourChoice" Health Plan that creates and operates the various programs. The Center's staff is provided by independent contractors and are full time local employees. The staff works as an integrated team reporting directly to the County Benefits Manager.

The team has grown significantly over the past few years. What started in 2002 with a health advocate (RN) and diabetic coach has now become a team of 12 multi-disciplinary professionals dedicated to the health and well-being of our members. The Center's team is designed to create integrated, outcome-producing and evidenced-based programming. Originally the plan provided just voluntary HRA and biometric testing. Now, eight years later the plan has a comprehensive and integrated approach to health management. Programs are in place and being continuously re-evaluated to give members the opportunity to be more educated about and improve their health status. Both the HRA Aggregate Report and the plan's data warehouse (D2 Hawkeye) are demonstrating improved outcomes and substantially lower cost trends than the national average.

In 2007, based on the success of a pilot program provided specialized mental health counseling sessions to members who were undergoing cancer treatment, the County developed a new model for an employee assistance program (EAP), focused on, among other issues, stress, parenting, financial

needs, motivation to change, tobacco cessation and behavioral health (mental health and substance abuse). The reasons for the new behavioral health program were that depression is four times greater in people with chronic pain; depressed people are 60% more likely to develop Type II Diabetes; and employees experiencing depression and stress utilize health care at a rate 250% higher than other employees.

This new integrated EAP and behavioral health program, known as LAMP (the Lifestyle Assistance and Modification Program), has become the cornerstone of the County's programs, allowing the County to incorporate behavioral health and change process concepts into all of its medical management and weight loss/nutrition programs.

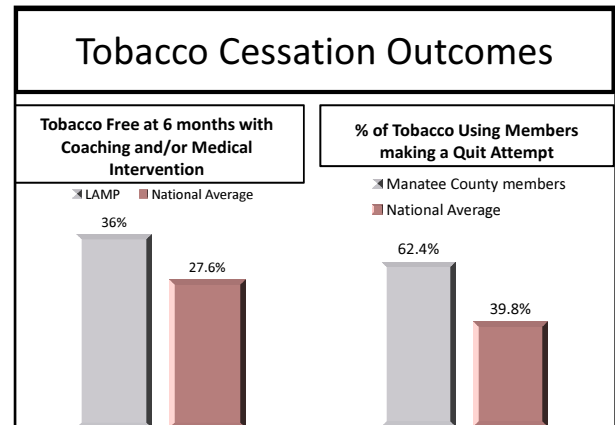
Four LAMP in-house, contracted practitioners specialize in behavioral health and provide individual, family and group mental health counseling and psychiatric services in addition to tobacco cessation counseling and motivation to change workshops. LAMP does more than encourage members to make healthy choices: the program offers specialized and individualized programming related to stress, anxiety, depression, parenting, etc. Because the services are all provided in-house and integrated with medical management and fitness/nutrition, we can effectively incorporate concepts of behavior change and preparation to change into all aspects of health and well-being.

Manatee's model is to provide all plan members disease, medical, health, preventive and wellness management plus education and advocacy resources using a "people to people" approach rather than a telephonic one. Manatee's program design is based on the knowledge that change is a process and that in order to create lasting change and a "culture of health; people need ongoing advocacy, support and resources in a face to face environment where opportunities to engage members in a relationship of support and respect can occur.

As Kim Stroud, Director of Health and Lifestyle Management, notes, "Change is difficult. We have found that incorporating the individualized behavioral aspect into all of our health management programming is most important in creating a 'culture of health' which results in lasting change. Specifically, we... [recognize] that people need a diverse menu of opportunities to change based upon their stage of change. By assisting members to prepare for change after understanding their own barriers and potential relapse triggers, advocates and coaches are seeing significantly improved outcomes within all of our programs."

The County provides employees with a variety of integrated work-site based health and lifestyle management programs, in great part developed with information from HRA, biometric testing, claims, lab and pharmacy data. The County has found that integrating benefit plan design and health management programming yields significant outcomes and that these outcomes have stabilized employee health costs and given more credence to "return on investment."

The following are some statistical outcomes for various programs, many of which have been written up in national and international professional journals. Weight loss and fitness and exercise programs



yielded the following results:

- Bariatric Surgery Program: Patients averaged a loss of 157 pounds 24 months after surgery and a reduction in Body Mass Index (BMI) greater than 10 points; most participants discontinued or reduced medications for hypertension, Type II diabetes and cholesterol; this population's PMPM drug costs dropped 40%; and PMPM claims dropped 20% post surgery.
- Lighten Up Weight Management: 134 people participating, 998.0 total pounds lost
- Medical Weight Loss Program (6 months intensive). 2007: 128 members participated. BMI decreased by an average of 5 points, body fat by 77.2%, weight by 29.4 lbs per person. 2008: 150 members participated. BMI decreased by an average of 6 points, body fat by 81.5%, and weight by 33.7 lbs per person.
- Medical Weight Loss Maintenance Program (6 months in duration): Once completing the initial 6 months of medical weight loss, participants work with a fitness coach to assist with their continued goals. Outcomes show that after one year of enrollment in the program, participants continued with their weight loss goals and achieved an average of 40.3 lbs lost per participant.

<b>LAMP Outcomes</b> <b>1<sup>st</sup> Year Results</b>	
•	<b>8% Decrease</b> in Pharmacy Claims for Antidepressants*.
•	<b>16% Decrease</b> in ER Visits related to Depression*.
•	<b>17% Decrease</b> in Hospital Admissions related to Depression*.
•	<b>32% Decrease</b> in PMPY total costs related to Depression*.
•	<b>50% Increase</b> in total weight loss by each member participating in a weight management program after incorporating Emotional Eating into the program components. <small>Source: Lighten Up Outcome Tracking</small>

Pharmacy Outcomes were as follows:

- Generic utilization went from 59% in 2007 to over 67% in 2008
- PMPM amount paid for pharmacy has been reduced by over 7% since 2006
- 2008 pharmacy costs were less than 3% with no reduction in compliance due to the economic conditions.

Medical Spending and Outcomes:

- Only a 2.9% change in total (medical and pharmacy) costs from FY 06-07 to FY 07-08.
- Improvement in modifiable spending from 2007 to 2008 was \$406,342.
- Average length of a hospital stay is down 37% from 2007.
- High Risk for chronic disease is 6% below the national average.

*Heading into the Future*

The Manatee staff is implementing the following changes to quantify outcomes and to hold members more accountable for their lifestyle choices. To start, the staff is adding a fourth ("Ultimate") tier to the benefit plan effective January 2011. To be eligible for the new tier a member will have to be a non-tobacco user (verified by lab testing). The "Ultimate" level of reimbursement will be identical to the present "Best" plan.

In addition, that same year the "Health Buck" Incentive Program will be tied more closely to approved, evidence-based biometric tests for minimum participation in the "Ultimate" plan. Participants will have to show measured improvement to be paid Health Buck incentives. As a result of this change, the programs offered by the Center for Health and Lifestyle Management will become more intensive and



integrated, all incorporating the concept of “change is a process”. We will have the opportunity to teach more of our members about the process of change and the preparation to make it lasting, ultimately achieving a more productive employee and employer population who understand the need for and have a desire for a culture of health.

Finally, personal health records (PHR) and wellness electronic medical records (WEMR) will become effective by Fall 2009 to ensure that the best quality of care is provided to members. The plan’s PHR and WEMR systems are state of the art pre-populating information systems for members and physicians and are automatically updated with HRA, lab, medical and prescription claim data. Providers and members will be paid incentives to use the system.

**COSTS**

Since inception, the program has reduced cost trends by more than 63% of the national average. Currently the plan’s cost is trending below the prior year and in the current economic times there has been no reduction in prescription utilization, indicating that members are remaining compliant with their plans of care. See the Trend Comparison Chart for outcome detail.

In rolling out the program, Manatee County underestimated the willingness of employees’ and families’ desire to change. 93% of the members completing qualifying events for the “Best” plan. We also lacked automation for qualifying event enrollment and calculating incentives. Finally, we needed to restructure the health and lifestyle programs to meet the needs of our members and their changing health statuses. In particular, the incorporation of a behavioral health component (LAMP) in our programming was vital to supporting positive outcomes among our members.

	April 07-May 08	April 08-May 09	% Difference	2008 National Trend
Medical Plan Paid	\$30,761,668	\$28,482,479	-7.4	9.3%
Pharmacy Plan Paid	\$4,827,392	\$4,740,744	-1.8	9.3%
<b>Total Plan Paid</b>	<b>\$35,589,060</b>	<b>\$33,223,223</b>	<b>-6.6</b>	<b>6.1%</b>
<b>PMPM</b>				
Inpatient Hospital Plan Paid	\$93.56	\$89.89	-3.9	
Outpatient Hospital Plan Paid	\$69.42	\$44.23	-36.3	
Office Plan Paid	\$92.17	\$82.21	-10.8	
ER Visits Per 1000	187.6	140.8	-24.9	

Source: D2Hawkeye

The HRA and biometrics reporting is demonstrating incremental progress and the plan trend is consistently reporting below national trends. In fact, 2009 prescription utilization is not reporting a decline due to the economy (as has been evidenced with other health plans and insurance companies), and costs are still down 3.8% from the previous year. Also, the plan is trending monthly between 5.3% and 8.3% below the previous 12 months. Our total administrative cost is approximately 18% below other plans.

**CONCLUSION**

Massachusetts faces the same problem that all Governments face: increased health care costs, reduction in staffing and funding and increased stress among employees. Our value-based, integrated approach holds employee and all state residents accountable for their lifestyle choices. By applying lessons from Manatee County, Massachusetts could reduce costs and improve employee retention, recruitment, absenteeism, and overall work performance.

“YourChoice” plan and its approach to health and lifestyle management are becoming a proven model to address the issue of controlling healthcare cost and to build a new, healthier workforce. The Manatee

"YourChoice" plan design and the Center for Health and Lifestyle Management could play a relevant role in Massachusetts by reducing the cost of medical insurance for state and local governments, employers and individuals by providing incentives based upon accountable plan designs.

By adopting the "YourChoice" plan design, Massachusetts could develop incentive-based multi-tier plans for plan sponsors and individuals to provide medical insurance that would hold their employees and families accountable for completing evidence-based testing, screening and health and lifestyle programs. By tying the preventative/wellness benefit to the level of reimbursement, it creates an incentive in itself to make positive choices.

Equally as important is the Center for Health and Lifestyle Management. Its integrated "people to people" approach for educating lifestyle change, is important for providing an ongoing support system rather than the impersonal telephonic approach used by traditional disease management organizations and insurance companies. Community-based centers for employers, local institutions such as community colleges or local or county governments are logical choices for centers. Pairing a value-based plan design with a Center for Health and Lifestyle Management, with professionals who desire to work in an "out of the box" environment where creativity and change is not only encouraged, but expected, can benefit Massachusetts on a multitude of levels.

The Manatee model will help communities build healthier, vibrant individuals who are invested in improving their own quality of life. Equally as important, employers will become more competitive through decreased absenteeism and improved productivity.

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[manateeyourchoice.com](http://manateeyourchoice.com)



## *Better Government Competition* **2009 RUNNER-UP**

### **Occupational Health Services Project**

Department of Labor and Industries  
Olympia, WA

#### **BACKGROUND**

Workers' compensation systems throughout the U.S. are faced with the challenge of trying to improve health care in order to reduce workplace disability and control rising costs. Washington's State Fund workers' compensation system provides workers' compensation insurance for two thirds of Washington's workforce, about 2,570,000 employees working for 171,000 employers. Self-insured employers provide workers' compensation for the other one third of Washington's workforce.

The State Fund spends approximately \$600 million a year on health care. Premiums paid by employers and workers, plus investment earnings, finance the program. Making sure that money is spent on high quality health care that reduces disability is a top priority for the Department of Labor & Industries (L&I) and our business and labor stakeholders.

#### **PROBLEM**

Occupational health is not covered in any depth in medical schools or during residencies. In practice, care for injured workers is typically a small part of the primary care provider's panel. Because care for injured workers is such a small part of their regular practice, providers struggle to understand and work within the complexities of workers' compensation.

One aspect of workers' compensation that is not familiar to most providers is the relationship between recovery and return to work. Approximately 20% of injured workers will miss more than four days of work due to their injury. For those workers, L&I will pay partial wage replacement (also known as time-loss). Data shows that 50% of these workers will return to work within 4 weeks, but once a worker misses three months of work their likelihood of ever returning is greatly reduced.

Providers aren't taught about the importance of setting return-to-work goals in their initial treatment plan and helping the worker set an expectation of returning to work. They need to know, and share with the worker, that part of recovery is to maintain a connection with the workplace and to make returning to work a goal of the treatment plan. The window of opportunity for focusing on return to work is early in treatment. Efforts that are focused after this "early intervention" period are less likely to succeed.

## SOLUTION

L&I worked with Washington's Workers' Compensation Advisory Committee (WCAC) to design and implement the Occupational Health Services Project. OHS is aimed at improving injured worker outcomes and reducing disability through a community-based change in health care delivery. The project uses a combination of strategies that include incentive payments to health care providers linked to quality improvement, clinical leadership and organizational support, and training for providers in occupational health best practices.

The project works entirely within Washington's existing workers' compensation framework of free choice of physician and fee-for-service payment. The project goal is to expand occupational health care expertise and improve care delivery to achieve better outcomes for injured workers.

The project established community-based Centers of Occupational Health and Education (COHEs) through partnerships with two leading health care organizations. The two original COHEs provide support to over 1,000 health-care providers. One COHE is located in Western Washington and the other in Eastern Washington. The project design was created through careful research with feedback from a business-labor advisory board.

The project uses a variety of tools to achieve results:

- Institutional and clinical leadership in occupational health.
- Financial incentives and provider education for occupational health best practices, which include:
  - a. Submitting reports of accident within two business days.
  - b. Documenting work status and physical capabilities at each visit.
  - c. Contacting the employer to help develop return-to-work options.
  - d. Assessing barriers to return to work when the worker is likely to miss at least four weeks of work.
  - e. Developing a plan to remove the barriers to return to work.
- Health Services Coordinators to monitor the care of injured workers, provide return-to-work assistance and ensure better decision-making among health care providers, employers, and workers.
- Business and labor support for the overall project, including local advisory boards.
- Continuous quality improvement through performance feedback to providers.
- Project evaluation by the University of Washington.

### *Outcome Measures*

Based on ongoing evaluation by the University of Washington, the COHEs have substantially prevented long-term disability, reducing costs by an average of \$480 per claim and lost work time by an average of four days. These savings continue to accrue three to four years after the claim is filed, even though the COHE intervention occurs during the first 12 weeks of the claim. In the first year alone, the Renton and Eastern Washington COHEs together saved approximately \$8 million compared to control groups.

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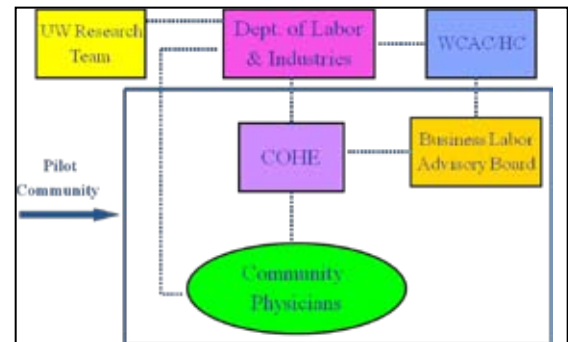
In Eastern Washington, workers in the COHE were 33% less likely to have time away from work. In Western Washington, workers were 17% less likely to have time away from work and were 23% less likely to still be off work 360 days after their injury.

### *Satisfaction*

Health care provider and injured worker satisfaction are high. In surveys conducted in 2003 and 2004, more than 75% of providers reported their ability to treat injured workers has improved through the project, and more than 50% reported they are willing to see more injured workers. These results were confirmed during provider focus groups in late 2007 and early 2008. Injured workers reported high satisfaction with the care they received for their work-related injury or illness.

### *Process Measures*

Workers treated by participating providers received benefits faster and had fewer disputes. Providers are sending in the initial report of accident much faster (an increase from 8% to more than 80% within two business days). That has led to a 13-day reduction in the time it takes to determine validity of a workers' compensation claim as compared to injured workers who are not treated by COHE providers. The faster processing contributes to reduced risk of long-term disability for injured workers.



In sum, the system was able to improve health care delivery to achieve better outcomes for workers while demonstrating significant efficiencies. Additionally, free worker choice of provider was maintained to ensure worker satisfaction with care. Participating health care providers felt their ability to treat workers' compensation patients had improved. This community-based quality improvement model has proven to be very effective and has met the needs of workers, employers, and providers in Washington.

### *Growth*

Since the Western and Eastern Washington COHEs began in 2002, there has been a constant increase in the number of providers who choose to participate. In December 2003, there were just over 300 participating providers. These same two COHEs currently provide services to over 1,000 providers. Approximately 25% of injured workers covered by Washington's State Fund seek their initial care from COHE providers.

The Eastern Washington COHE has also grown geographically. At the beginning of the project, it recruited providers in three counties of the state. In 2005, it expanded its coverage to a total of 16 counties in Eastern Washington.

In 2007, L&I decided to add two smaller COHEs to see if the positive outcomes could be transferred to new areas. The smaller COHEs allow L&I to test whether similar outcomes can be achieved in a multi-disciplinary clinic and a regional trauma center. An evaluation of the trauma center COHE shows large improvements in processes and communication between L&I and the trauma center

emergency department. An outcome evaluation of the clinic-based COHE is due in July 2009.

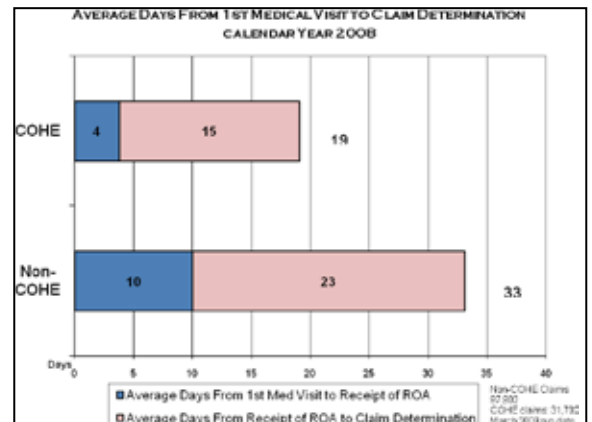
Based on the demonstrated success of the COHEs, L&I recently engaged the Workers' Compensation Advisory Committee Health Care Subcommittee (WCAC-HC) in a formal collaborative process to determine a roadmap to the future. While COHE results have been positive, all parties want to make sure that any expansion is done in a deliberate way that enhances success and effectively manages costs.

The transition goals include:

- End the pilot phase of the COHEs and report results to the Workers' Compensation Advisory Committee (WCAC).
- Work with the WCAC to determine the future role of a business-labor advisory function.
- Expand the use of occupational health best practices in a methodical, systematic and disciplined fashion:
  - a. Develop an ongoing funding mechanism for current and future COHEs.
  - b. Develop criteria for implementing proven best practices statewide with a plan for monitoring utilization, quality and cost/benefit.
  - c. Establish and implement standards for COHE certification.
  - d. Recruit at least two new COHEs.
- Work with self-insured employers and their Third Party Administrators (TPAs) to make occupational health best practices available for self-insured programs and workers. Self-insured employers provide workers' compensation for one third of Washington's workforce.
- Make occupational health best practices available to all providers and workers in the workers' compensation system by 2015.

## COSTS

The COHE is funded through the Medical Aid Fund, which covers medical expenses for injured workers. Initially, each COHE received \$192,500 per year to pay for the administrative expenses associated with implementing and managing a COHE. Incentives paid to health care providers for using occupational health best practices added approximately \$60 per claim. These costs were distributed over 18,000 workers who received care from COHE participating providers in the first evaluation year.



## CONCLUSION

The challenges that we face in Washington are not unique. All workers' compensation insurers rely on health-care providers who have limited exposure to occupational health in their training and experience. Providers struggle to understand workers' compensation systems and the issues that are unique to injured workers. For example, providers are not trained to focus on return to work, which

is a necessary focus of workers' compensation. The additional paperwork required by workers' compensation insurers can be confusing and frustrating to providers.

In Washington, we decided to develop a resource for providers within the community of health care. That allows the provider to get assistance from a knowledgeable peer or colleague rather than the insurer. This model works in Washington's workers' compensation system, but could work equally well in other models of health care delivery, both workers' compensation and general health.

Once insurers agree to participate in the project, they could use the same process that we used in Washington; working with providers and/or researchers to identify best practices and provider incentives that are most applicable to their state. In Washington, we issued a Request for Proposals and negotiated contracts with the successful bidders. Contract management could be handled by a team appointed by the participating insurers. The administrative costs of setting up and running a Center of Occupational Health and Education (COHE) could be shared jointly by the participating insurers.

By working together to fund the community-based COHE, the insurers could help communities focus on improving outcomes for injured workers rather than trying to meet the requirements of different insurance products. Each insurer would see a return on its investment through decreased medical and disability costs, as well as increased access to providers who understand workers' compensation and want to help injured workers recover.

We designed the Occupational Health Services Project as a change in the healthcare delivery system. The staffs of the Centers of Occupational Health and Education (COHEs) are recognized as resources to help the provider rather than someone who is interested in managing claim costs. Providers see COHE staff as a part of their team, not the insurer's. Giving training and resources to providers helps them to deal with any injured worker who seeks treatment, regardless of who pays the bills.

Our approach worked particularly well in Washington because we are in a state-run workers' compensation system that insures over two-thirds of injured workers (there are several hundred self-insured employers who manage their own claims). Our system gets the direct benefit of the lower disability rates and medical and disability costs.

This model can also be applied in workers' compensation systems with multiple insurers and in general healthcare. The concept is to provide modest incentives for using best practices and place resources within the healthcare community to help providers follow those practices. By investing resources up front, the entire system can benefit from improved outcomes in the long run.

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*Better Government Competition*  
**2009 RUNNER-UP**

## **Statewide Massachusetts Surgical Collaborative to Reduce Surgical Complications**

QCMetrix, Inc.  
Waltham, MA

### **BACKGROUND**

Surgical complications are expensive for all constituencies in the U.S. health care system: the surgical patients who pay the price with their own health and safety; private and government (federal and state) payers; and hospitals.

Systematic data-driven surgical quality improvement, within one hospital and across multiple hospitals, took a leap forward in the 1990's with the advent of the Veterans Administration's National Surgical Quality Improvement Program (VA NSQIP) and, building on that foundation, with the advent of the American College of Surgeons program for private sector hospitals, the ACS NSQIP, in 2004. Both programs have demonstrated significant success in reducing risk-adjusted 30-day mortality and morbidity outcomes in the participating hospitals.

These efforts have been taken to a yet higher level by the Michigan Surgical Quality Collaborative (MSQC), which has demonstrated significant additional quality improvement – and resulting cost reductions – by adding the element of continuous regional collaboration. Following Michigan's model, a similar effort has been launched in Tennessee.

This paper recommends a similar approach for Massachusetts.

### **PROBLEM**

Based on federal government data for 2005, as well as papers published by the University of Michigan regarding the costs of surgical complications, QCMetrix, Inc. has estimated that the total annual cost to the U.S. healthcare system of only four common surgical inpatient complications is \$12 billion. Of this, \$5 billion is estimated to be avoidable. Of this \$5 billion in recurring annual avoidable cost, approximately \$2.8 billion is incurred by the Centers for Medicare and Medicaid Services (CMS) and state governments.

The four surgical complications, identified by CMS as those it has targeted for improvement in the coming years, are: Surgical Site Infections, Myocardial Infarctions, Venous Thromboembolism, and Pneumonia. An in-depth paper published by the University of Michigan in the Journal of the American



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	Infectious	Cardiovascular	Respiratory	Thromboembolic
Unadjusted Hospital Costs (95% C1)	\$8,209 (\$5,566-\$10,853)	\$13,256 (\$6,720-\$19,799)	\$54,430 (\$51,770-\$57,091)	\$28,355 (\$22,580-\$34,130)
Adjusted for Procedure Complexity (95% C1)	\$4,798 (\$4,110-\$5,486)	\$13,330 (\$11,579-\$15,082)	\$44,554 (\$43,753-\$45,356)	\$15,727 (\$14,004-\$17,450)
Adjusted for Complexity and Patient Characteristics (95% C1)	\$2,207 (\$1,301-\$3,113)	\$7,519 (\$5,607-\$9,437)	\$51,409 (\$49,868-\$52,950)	\$18,341 (\$16,422-\$20,259)

College of Surgeons quantifies these costs as follows:

Massachusetts represents 2.3% of the total surgical inpatient volume in the country. QCMetrix therefore estimates the annual cost of avoidable surgical complications to the Massachusetts health care system is \$115 million. Of these, approximately \$66 million are incurred by the federal government (CMS) and the state of Massachusetts.

### SOLUTION

QCMetrix is a privately held corporation based in Waltham, Massachusetts. Its mission is to improve clinical and financial outcomes for surgeons and hospitals by developing and applying: information systems for the collection of reliable clinical data; data-driven disciplines and research for quality improvement; health care data analytics; and knowledge of emerging mandates.

The company was established in 2001 to help bring the Veterans Administration's National Surgical Quality Improvement Program (NSQIP) to private-sector hospitals.

QCMetrix proposes to apply in Massachusetts a statewide model for surgical collaboration that has already demonstrated success in Michigan and is now being implemented in Tennessee. The Michigan Surgical Quality Collaborative (MSQC) is a payer-funded collaboration among 34 surgical centers in Michigan, including the state's preeminent hospitals, that has demonstrated marked financial benefits by reducing surgical complications.

There are two fundamental elements to the MSQC:

- Participation in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP)
- The statewide collaboration for sharing best practices and conducting focused surgical quality improvement initiatives.

The track record of the NSQIP in reducing surgical complications is significant:

- For the ten-year period between the launch of the NSQIP within the VA in 1994 and 2004, the VA experienced a 45% reduction in complications. While most of the improvements were achieved in the first three years, continued improvements were sustained over the subsequent seven years.

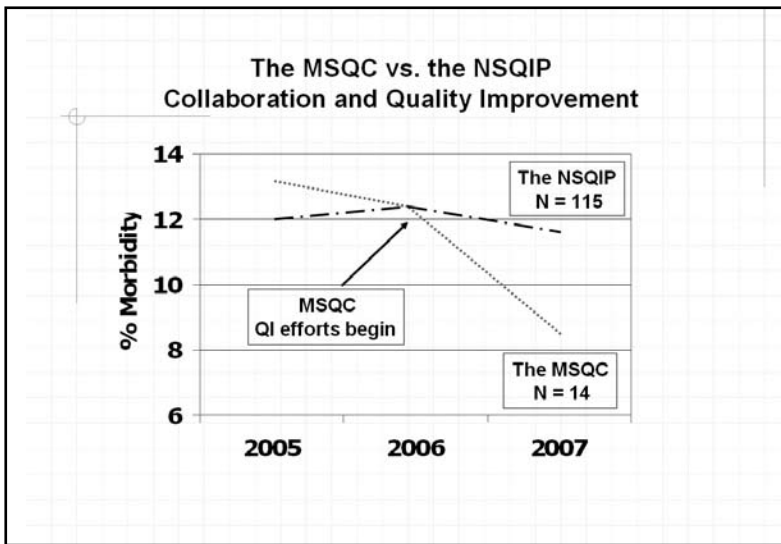
- When the NSQIP was first implemented outside the VA at 14 large academic medical centers during 2001-2004, complications were reduced by 9% over three years, or approximately 3% per year.
- The ACS NSQIP, launched in 2005 by the American College of Surgeons, is now in approximately 250 hospitals nationwide.

Percent reduction in rates of post-surgical events (*p<0.05)		
	NSQIP	MSQC
Morbidity	1.3	9.4*
Mortality	0	16.7
SSI	0	13.1
Sepsis	11.0*	34.1*
Pneumonia	8.2*	28.9*
Vent > 48 hours	0	21.9*
Cardiac Arrest	0	32.8*

The results of the MSQC to date make a compelling case in favor of ongoing statewide collaboration. The graph and the chart below both demonstrate significant reductions in complications by MSQC, over and above those reductions achieved by ACS NSQIP hospitals that are not involved in a state-wide collaborative. (Please note that for the periods of these comparisons, there were still only 14-16 hospitals in the MSQC.)

QCMetrix has played a central role in providing the information systems and the day-to-day program management and clinical training for the ACS NSQIP and for MSQC and now also for the Tennessee

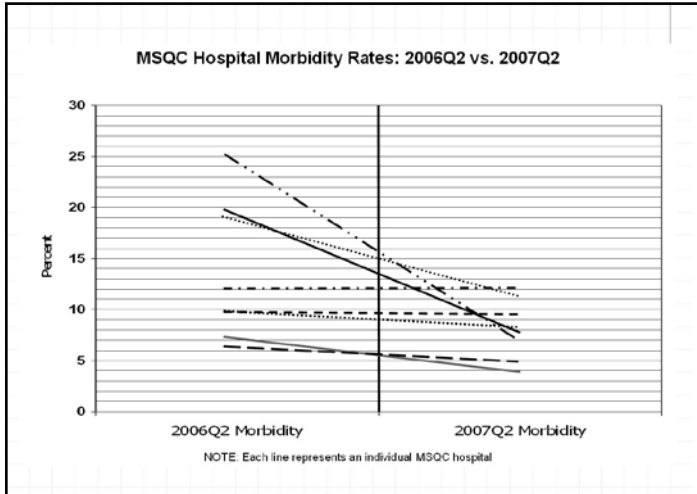
Surgical Quality Consortium. In addition, QCMetrix has strong relationships with the leadership of MSQC. As a Massachusetts-based company, QCMetrix would propose to facilitate the establishment of the Massachusetts Surgical Quality Collaborative (MA-SQC).



Day-to-day program management and clinical training would include: design, deployment, maintenance and update of the program's information systems; continuous operation of the information systems; technical support to hospital IT staffs for installation of key software components; documentation and daily support to clinical

data collectors (usually, but not necessarily nurses) for software, application of clinical data definitions, and other issues; initial training and on-going testing of clinical data collectors; validation of data collection.

In the case of Michigan, Blue Cross Blue Shield is the dominant payer, with 47% of the patient population, and has been willing to take this leadership role in the state.



However, in the long run, given the collaborative nature of this work, QCMetrix believes that state governments may be best positioned to act as neutral, independent enablers of this scale of collaboration.

*Return on Investment*

From the graph included in the “Solution” section, above, the complication rates at the participating MSQC hospitals went from 13% to 8% in the first two years alone. This 5 percentage point drop in complication rates translates to a 38% reduction in the number of surgical complications.

The total recurring annual costs to the Massachusetts health care system, as derived in “The Problem” section, above, is \$115 million. Since we propose to establish the collaborative at the 35 hospitals that account for 80% of the state’s surgical volume, the total annual costs of surgical complications at these hospitals is \$92 million.

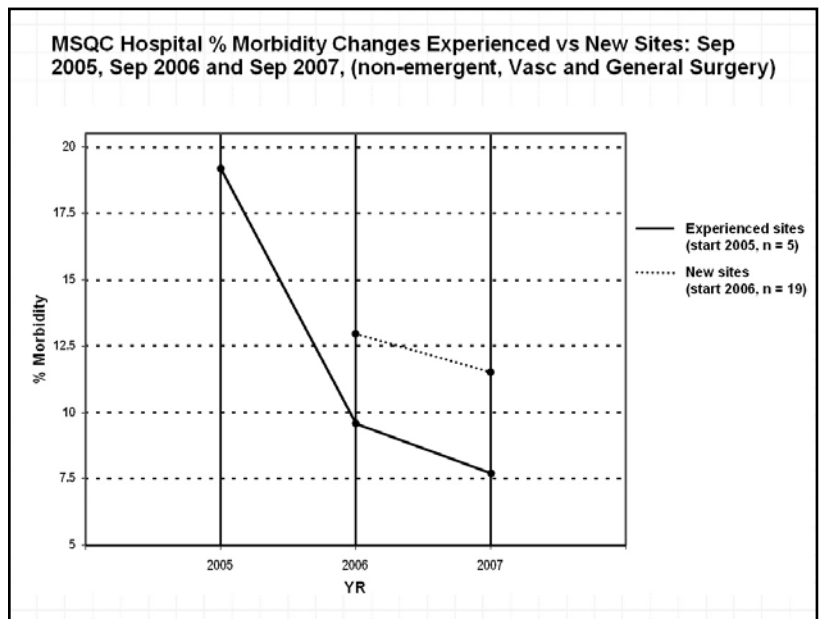
A sustained 38% reduction in these costs amounts to annual savings to the Massachusetts state health care system of \$35 million. Of these savings, we estimate the savings to the state of Massachusetts and the federal government to be \$20 million per year. This would constitute a dramatic return on the investment, assuming no contribution by the federal government or by the participating hospitals themselves.

*Positive Outcomes/Benefits*

The charts on this page are from an article from the Annals of Surgery titled *The Michigan Surgical Quality Collaborative - Will a Statewide Quality Improvement Initiative Pay for Itself?* This lays out both the background of the MSQC initiative and the positive outcomes from establishing a statewide surgical collaborative. They show dramatic reductions in surgical complications over time.

*Program Regulations*

There is no requirement for the passage of legislation, executive order, or mandatory regulations. The NSQIP program is sponsored and overseen by the American College of Surgeons. There has not been any attempt to date to regulate or develop policy for the ACS NSQIP or for the Michigan



Surgical Quality Collaborative (MSQC). However, the leader of the MSQC, Dr. Skip Campbell of the University of Michigan, has spoken with U.S. Congressional panels about the potential of applying this collaborative model nationwide.

## **COSTS**

In order to set up and organize the surgical collaborative, we estimate that the costs of personnel, travel, telecommunications and other associated office expenses will be approximately \$100,000. This would cover six months of an experienced administrator's salary and benefits, with the balance used to cover travel, communications and other office expenses. An additional sum of up to \$20,000 may be needed for designing and developing an identity and a web site for the collaborative, and to support the remote installation of the web-based software on one or several of the hospitals' personal computers, which will be used by the nurse who collects the data. The costs of hardware and software will be covered in the monthly service fee paid by the collaborative for hosting, supporting, and maintaining the data collection software, data analysis, and reports for the hospitals.

In order to participate in the ACS NSQIP program, hospitals are required to hire a trained surgical clinical reviewer whose only task is data collection and submission to the ACS NSQIP. When fringe benefits are included, a surgical clinical reviewer's compensation as well as travel and administrative costs will be, on average, approximately \$115,000/year. The annual hospital fee for participation in the ACS NSQIP, which includes licensing fees for the use of NSQIP methodology, the web site, data automation, data reporting and analysis, and nurse education is \$35,000. Therefore, the per-hospital cost will be \$150,000 per year.

Approximately 35 Massachusetts hospitals account for 80% of the state's surgical volume. The annual cost of funding their participation will be \$5.25 million. We estimate the annual cost of coordinating the collaborative, including statistical analysis, quarterly meetings and staff will be approximately \$1.25 million.

There is no fundamental reason to limit the program to 35 hospitals. This proposal has been based on publicly-available research indicating that 80% of Massachusetts' annual volume of surgical procedures is performed at 35 hospitals and that, therefore, the highest ROI would be derived from working on the hospitals with 80% of cases, but it is certainly true that the program can encompass the participation of all hospitals performing surgery in Massachusetts, and can potentially be extended regionally to other New England states.

The total cost of this proposal, focused on the 35 hospitals, would be \$6.5 million per year. Based on the experience of the MSQC in reducing surgical complications, the state of Massachusetts can realize a significant return on its investment.

## **CONCLUSION**

The initial goals for establishing a statewide collaborative would be to address the lack of good reliable data and the lack of well-organized systems for translating data into meaningful quality improvement. The ultimate goals are to improve surgical outcomes and to reduce costs in Massachusetts. To meet

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these goals, we need to identify 35 Massachusetts hospitals interested in collaborating, establish a sustainable, cost-efficient system for tracking processes and outcomes at each participating hospital, and collaborate with clinical champions at each hospital in identifying and implementing “best practices”. Also, tracking quality improvement initiatives targeted at specific procedures, linking quality improvement efforts to rigorous health services research, and demonstrating to both consumers and purchasers that systems of care are effectively working to optimize surgical quality and outcomes will help achieve these goals.

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*Better Government Competition*  
**2009 RUNNER-UP**

## **Retail Clinics: Expanding Access to Health Care**

Heinz College of Health Care Policy and Management  
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### **BACKGROUND**

Health care costs today are rising at an annual rate of six to seven percent. This is a staggering figure considering that the United States spends almost a fifth of its Gross Domestic Product (GDP) on health care. In spite of these statistics, however, more than 47 million Americans lack health insurance. Given the current economic climate, this situation is likely to worsen, placing an even greater strain on both federally- and state-funded health programs such as COBRA and Medicare. According to the American Recovery & Reinvestment Act (2009), the United States will need to spend \$150 billion in new funds on health care within the next two years just to maintain current obligations.<sup>1</sup>

Because health care services are mostly a fringe benefit of employment, people who lose their jobs face major challenges in obtaining necessary care. When faced with a crisis, their only option is the hospital emergency room. This is because an unfunded government mandate called EMTALA requires that hospitals provide emergency services to all—whether insured or not.<sup>2</sup> This requirement to act as a “health care safety net” leads to an extensive amount of uncompensated care and sets up a domino effect. In the attempt to cover their costs, hospitals raise the rates for those who do have insurance, which raises the cost for all. In spite of this, however, many hospital emergency rooms are closing around the country due to a shortfall in revenues.

In response to these system-wide stresses, new health care delivery models have been developing across the country. One of the most promising is that of the retail clinic. Often located within suburban pharmacies, grocery stores and shopping malls, these private, for-profit entities are characterized by their accessibility and affordability. Because they are open in the evenings and on weekends, patients can receive prompt care without appointments. Because they are mainly staffed by nurse practitioners, they provide services at much lower cost than other health care providers such as emergency rooms, urgent care centers, and physician offices.

Despite their benefits, however, retail clinics pose some challenges for state policymakers and regulatory agencies who are working to improve access, cost, and quality within their health delivery systems. This paper describes the impact that retail clinics have had on the current health care system, as well as some of the challenges they currently face. It also examines how U.S. policymakers are using regulation and

licensure to promote, structure, and/or limit retail clinic operations. It concludes by suggesting several ways in which the United States in general and Massachusetts in particular could incorporate retail clinics into the current health care system.

### PROBLEM

Reforming the U.S. health care system requires that policymakers address an array of issues, including how to control costs, increase efficiency, improve quality of care, and increase access. An important part of the solution could be the retail clinic, which uses evidence-based guidelines and physician oversight to provide walk-in services to people who need health care services. Since consumers are expected to pay for care at the time of service, it does not matter whether they are insured or not. In addition, since most of these clinics also use electronic medical records, it is easy to transfer patient information to family physicians and hospitals, which improves the integration and overall quality of care.

Since their inception into the health care environment in early 2000, retail clinics have expanded rapidly. Today approximately 1,200 clinics exist in 37 states, and approximately 3.4 million Americans have visited at least one. Mehrotra estimates that the number of clinics will grow to almost 6,000 in the next five years.<sup>3</sup>

Numerous studies have proven the efficacy of this model. Thygeson et al. find that retail clinics provide affordable care to the uninsured and to those who have coverage but can't afford the co-payments. They also find that such clinics provide timely care that can prevent acute exacerbations of difficult, costly to treat existing conditions.<sup>4</sup> Mehrotra argues that improving people's access to retail clinics lowers the burden on emergency rooms.<sup>5</sup> Smith suggests that the quality of care in retail clinics is good because they follow evidence-based guidelines for treatment protocols.<sup>6</sup> Partin shows that people with limited financial resources find retail clinics a convenient, affordable resource.<sup>7</sup> Thygeson et al. document that use of retail clinics increases over time.<sup>8</sup>

When compared to health care delivered through hospitals and doctors' clinics, retail clinics offer four major advantages: 1) easier access, 2) better quality of patient care, 2) higher patient satisfaction, and 4) lower costs. Many studies conducted over the past 20 years show that advanced practice nurses and physician assistants provide quality similar to or better than physicians when delivering health services within their accepted scope. Hutchison and colleagues studied patient satisfaction and quality of care in three primary care settings (retail clinics, family physicians' offices and emergency departments) and found that patients perceived retail clinics more positively than the other two. Furthermore, quality-of-care scores were higher in retail clinics than in family practices.<sup>9</sup> The Minnesota HealthScore (a Web site that provides information on the quality of health care) showed that quality of care for pharyngitis (sore throat) and colds is excellent in retail clinics compared to other provider groups.<sup>10</sup>

Retail clinics represent a market-driven approach to cost containment through innovation in primary care. According to Sage, their main commitment is to deliver low-priced services at point of service.<sup>11</sup> Most retail clinic services are priced from \$30 to \$70, which is about half what patients would pay in a traditional physician's office and a small fraction of standard emergency room charges. Thygeson et al.

found that retail clinics cost, on average, \$51 less than urgent care, \$55 less than physician offices and \$279 less than emergency rooms (Table 1). In addition, he found that pharmacy costs are between \$4 and \$5 less than in urgent care and office settings.<sup>12</sup>

**Table 1: Adjusted Mean Pharmacy, Medical, and Total Costs Per Episode, By Site of Care**

Site of care	Pharmacy	Medical	Total
Retail clinic	\$28	\$75	\$104
ED	\$27	\$356	\$383
Physician's office	\$32	\$127	\$159
Urgent care facility	\$30	\$124	\$154

Despite their many benefits, however, retail clinics are currently facing some serious challenges. In fact, current trends show that expansion of retail clinics has begun to decelerate. Some companies are facing financial pressures to offer their services on a seasonal basis rather than year-round, and some have even been forced to close. Private investors, due to profitability issues, are no longer as willing to invest in new clinics. Earlier estimates that retail clinics would turn a profit in three to five years are no longer guaranteed.

In their effort to grow and thrive, retail clinics face four major challenges. The first lies in the limited number of nurse practitioners who are both qualified and willing to work in a retail clinic setting. The second lies in the low volume of patients that such clinics see. The third lies in the need to align with doctors and hospitals. The fourth lies in the need to align with primary care physicians (PCPs). If retail clinics are to continue expanding, especially in underserved areas, these challenges must be addressed from a policy standpoint.

## SOLUTION

To resolve the four challenges identified above, we propose the following solutions.

### *Increase the number of nurse practitioners*

To increase the number of nurse practitioners who specialize in family medicine and are willing to work in a retail clinic setting, we suggest that current nursing school loan forgiveness programs be expanded to include individuals who want to pursue a career in a retail clinic. Currently, the Nursing Education Loan Repayment program provides repayment of 60% of nursing school loans in exchange for two years of service at a critical shortage facility.<sup>13</sup> It would be easy to expand this program to offer incentives for RNs who pursue a nurse practitioner degree and subsequently agree to work for a given period of time at a retail clinic.

### *Expand the services retail clinics can provide*

We suggest that retail clinics be allowed to practice basic chronic disease management. According to Harlow, about 44% of the U.S. population has a chronic condition, and up to 75% of U.S. health care spending is on chronic care.<sup>14</sup> In 2007 total spending for chronic disease was \$2.2 trillion. Capturing just 2% of the chronic care market—such as monitoring visits for diabetics—would translate to over 8,500 fully-utilized retail clinics.



### *Encourage collaboration between doctors, hospitals, and primary care physicians*

To increase the number of people who choose retail clinics for their basic health care needs, we suggest that hospitals, community care clinics, and retail clinics be encouraged to collaborate with each other. All of the parties have much to gain from working together. Hospitals and larger care organizations could use retail clinics as a point of entry into their health care network. With a predicted national shortage of primary care doctors, retail clinics could complement the primary care needs for many patients. By working together, they could create a brand or image (co-branding) that would give patients more confidence in the retail clinic as a viable alternative for their health needs.

Collaboration could be incentivized by giving tax cuts to hospitals that are willing to work with retail clinics in their area. Retail clinics could be incentivized by allowing them to receive Medicaid cost-based reimbursement if they collaborate with a local hospital or community care clinic.

In this effort, primary care physicians and retail clinics should not view each other as threats, but as complementary, mutually beneficial partners. Although many PCPs have voiced the concern that retail clinics will take away their easy-to-treat patients, we do not believe this would happen to any great extent. A recent study found that the patient population served by retail clinics and PCPs has limited overlap. It also found that ten clinical problems, such as sinusitis and immunizations, encompass more than 90 percent of retail clinic visits and that these same ten clinical problems make up only 13 percent of adult PCP visits.

An example of how retail clinics could support PCPs occurs in Massachusetts, where current policies encourage retail clinics to play an active role in emphasizing the importance of patient and PCP relationships. The policies require retail clinics to 1) make referrals to primary care practitioners for certain conditions, 2) maintain rosters of PCPs who are accepting new patients and encourage them to obtain a PCP, and 3) provide a toll-free number that will enable a caller to speak with a live practitioner during off-hours. All of these policies could result in a larger patient volume for PCPs.

Collaboration would also help hospitals, PCPs, and retail clinics alike.

### *Increase revenue for all*

One of the major benefits of collaboration lies in the potential for increased revenue for all parties concerned. On the one hand, nurse practitioners in a retail clinic would refer patients with complicated health issues to their partner hospital for treatment. On the other hand, hospitals would refer non-urgent patients who come to their emergency departments to the retail clinic. In this way, the retail clinic could tap into a potentially rich source of referrals from the hospital emergency department, while the hospital could tap into a rich source of referrals for more complex health problems. This process would translate into more patients for both parties.

### *Lower costs throughout the health care system*

Due to the lack of health insurance, many people use emergency rooms for routine health care. Since many of these services are never compensated, it forces hospitals to raise their rates across the board. In contrast, retail clinics are designed specifically to serve this population. If people with inadequate or

no insurance were to use retail clinics as their first choice for basic health care, it would save enormous sums of money throughout the system. Some hospital networks have already recognized these potential benefits and started their own retail clinic chains. Examples include Aurora Health Care in Wisconsin and Alanticare in New Jersey.

#### *Improve quality of care due to record sharing*

Another benefit lies in the potential for improved quality of health care due to the sharing of electronic medical records (EMRs) between retail clinics and hospitals. With patient consent, both the retail clinic and the hospital would have mutual access to information on their patients' medical history, prescriptions, and treatments. This two-way sharing of clinical information could not only improve quality of treatment, but also greatly speed up the referral process between the hospital and the retail clinic. One example of where this is already taking place is the Cleveland Clinic, whose MinuteClinic has become the largest provider of retail clinics in the country.

#### *Lighten the workload for PCPs*

Retail clinics could lighten the load for PCPs by routinely handling minor patient health issues. The benefits of such an arrangement would be many, including better care, improved care coordination, and better health outcomes for patients. It would also give PCPs more time to work with patients who have complicated health issues (which generally have higher reimbursement rates than minor issues do).

#### *Help to reform the reimbursement system for PCPs*

One positive aspect of analyzing the pros and cons of PCP and retail clinic cooperation is that it provides the opportunity to examine the current reimbursement system for PCPs more closely. A major factor in the growing shortage of primary physicians is that they are compensated at much lower rates than specialists are. This puts pressure on PCPs to see as many patients as possible each day and limits the time they can spend with individual patients. A major strength of this model lies in the ability of PCPs to coordinate care for their patients. Unfortunately, they do not currently receive financial reimbursement for such tasks; this leads to fragmentation of care and increases the possibility of making mistakes, especially in patients with multiple conditions. It also increases expenses overall.

Clearly, the PCP reimbursement system is due for an overhaul. One of the benefits of the growing numbers of retail clinics is that they could encourage PCPs to move away from a model that rewards episodic treatment to one that rewards chronic disease management and care coordination.

## **COSTS**

According to a 2006 report prepared by the California HealthCare Foundation, the average start-up cost for a retail clinic is \$50,000.<sup>15</sup> Actual costs range from \$25,000 for a barebones operation to \$145,000 for a well-equipped clinic. For example, Saint Alphonsus in Idaho spends \$110,000 to build each clinic. It spends an additional \$30,000 per location to purchase high-tech equipment such as self-registration computer kiosks and an electronic medical record system.

Compared to the potential benefits, the federal cost of retail clinics would be minimal. The loan forgiveness program would cost between \$12,000 and \$25,000 per nurse, depending on the length of time a nurse agrees to dedicate to the retail clinic. Each additional year would result in a greater percentage

of the government reimbursement for their loan. This money could be allocated from the additional funding given to the Nursing Education Loan Repayment Program by the American Recovery and Reinvestment Act. Any costs for incentivizing collaboration between hospitals and retail clinics and for reimbursing them for basic care and chronic disease management would be offset by the savings inherent in such programs.

**CONCLUSION**

The intent of the 2006 Massachusetts healthcare reform law was to increase health insurance coverage by expanding the state's Medicaid program, to provide government subsidies to make insurance affordable for low-income residents, and to create individual and employer contribution mandates.

These initiatives have had strong public support and shown signs of early success in decreasing the numbers of uninsured. The uninsured rate has reportedly dropped to 2.6%, and public support has increased from 64% to nearly 75%.

Nardin found that despite such success there are many criticisms to this approach to reform. Some claim that the expanded coverage has not done enough and believe that comprehensive reform is necessary in order to make this a sustainable plan. These arguments point to the fact that the plan has failed to control healthcare costs, which has consequently prevented any improvements in access to care. The arguments

**Table 2: Proposed and Enacted Legislation Targeting Retail Clinics in the United States (2007 – 2008)**

State	Legislation Details
FL Title XXXII, Chap. 456.041 (2007).	Prohibits primary care physicians from supervising more than one office facility. Also limits the number of health care professionals (nurse practitioners and physician assistants) a primary care physician is able to supervise to four. Status: HB 699 (2006) Passed and signed into law by governor on 6/20/06.
IL HB 1885 (2007) Rep. McAuliffe.	Would require a permit for the operation of a retail health clinic, issued by the Department of Public Health. Sets requirements for obtaining a permit. Requires clinics to pay \$2,500 per location for permits from a state health department. Clinics must notify patients' physicians about visit details, have 1 physician supervisor per 2 nurse practitioners NPs, and allow patients to fill prescriptions at the pharmacy of their choice. Status: Held in committee; did not pass House as of 10/30/08.
MA Executive Branch Regulation	The Massachusetts Public Health Council, which sets policy for the Department of Public Health, created regulations for the operation of retail health clinics in Massachusetts. These regulations stipulate what medical conditions can be treated, what age groups can be treated, medical record keeping procedures, medical referral procedures, and treatment of repeat patients. They also regulate the sale of tobacco products if the retail clinic is located in a retail location that sells such products. Status: Passed in 1/08
NH HB 1484 (2008) Rep. Emerton Chapter 227	Establishes a commission to study and develop legislation to regulate the operation of retail health clinics and limited service clinics, also known as "mini clinics". Status: Signed into law by governor on 6/16/08.
NC SB 1256 (2007) Sen. Rand	Would provide for a study by the Legislative Research Commission on Store-Based Retail Health Clinics. Status: Carried over to 2008 Session; did not pass by the end of session, 7/25/2008
OK SB 1523 (2008) Sen. Leftwich	Would specify certain scope of practice requirements; would require certain supervision of retail health clinics; would direct the State Board of Health to promulgate rules. Status: Did not pass by the end of session.
OK SB 1638 (2008) Sen. Paddock	Would provide for supervision of non-physician practitioner in certain circumstances. Status: Did not pass by the end of session.
TX HB 1096 (2007) Sen. Patrick.	Would relate to the delegation of certain medical acts by a physician to an advanced practice nurse or physician assistant. Status: Did not pass by the end of session.

Darkened rows indicate signed law

Source: <https://www.ncsl.org/programs/health/retailclinics.htm>

are substantiated by the cost of the reform, which is projected to reach \$1.3 billion for the 2009 fiscal year, an increase from \$1.1 billion in 2008. Insurance premiums are projected to increase by 9.4% in 2009, far more than increases in wages and inflation.<sup>16</sup>

Increasing costs have also forced the state to divert money that would have originally gone to safety-net providers, such as public hospitals and community clinics, to sustain the costs of the reform. This not only hurts the ability of public hospitals and clinics to continue providing the same services, but it may force some to close.

Proponents of the reform argue that since the previously uninsured now have insurance they will no longer need access to safety net providers. However, evidence shows that funding for these services has fallen much faster than demand. One reason for this is that in the state's old health care system, low-income residents were eligible for completely free care. Under the new plan, they are forced to pay co-payments and deductibles they cannot afford. Hence, increased levels of coverage have failed to increase access to care.

This leaves Massachusetts still struggling to find a way to ensure that all of its citizens have access to affordable health care. In the effort to devise a solution, retail clinics clearly have the potential to play a major role. Massachusetts took the first step—developing regulations that fit retail clinics into the health service delivery system—in early 2008 when it created regulations for the operation of retail clinics by establishing limited service clinics (LSCs). Table 3 lists the clinic regulations, and Table 4 shows a list of services that these clinics can provide.

We recommend that Massachusetts treat LSCs like federal quality health centers, similar to the after-hours clinics in New Jersey. The LSCs could work alongside community health centers as part of their cost structure and therefore receive Medicaid cost-based reimbursement encounter rates for federally qualified health centers. Retail clinics could be staffed with community health workers who, together with nurse practitioners and physician assistants, would enroll people in Medicaid, connect them to a primary care doctor, and make sure that they receive appropriate care. Medicaid could pay the LSCs a rate that reflects their overall lower cost structure.

On a national scale, we recommend that retail clinics become a common provider of basic healthcare services. People who lack adequate health insurance, or insurance at all, will find such clinics a convenient, affordable, and high-quality resource. To accomplish this, we need to do the following: 1) educate patients about retail clinics, 2) encourage state officials to enact laws that allow nurse practitioners and physician assistants to work in retail clinic settings, 3) increase nursing school numbers, 4) offer loan forgiveness programs for nurses and physician assistants who want to work in these clinics, 5) integrate retail clinics into the larger health care system, 6) expand the kinds of services that retail clinics can provide, including chronic care, and 7) form a bridge between retail clinics and Medicaid.

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**Table 3: Limited Service Clinics (LSCs)**

LSCs must make referrals to primary care practitioners, including physicians, nurses, and community health centers.
Clinics must maintain rosters of primary care providers who are accepting new patients.
Clinics must develop a process to identify and limit, if necessary, the number of their repeat encounters with individual patients.
With patient consent, LSCs are to provide a record of each clinic visit to the patient's primary care practitioner.
Clinics must provide a toll-free number that will enable a caller to speak with a live physician during off-hours

Source: California HealthCare Foundation

**Table 4: Limited Service Clinic (LSC) Services**

Allergies (ages 6+) Bronchitis (ages 10 -65) Ear Infections Sinus Infection Strep Throat Swimmer's Ear Upper Respiratory Infections	Ear Wax Removal Flu Diagnosis (Ages 10-65) Mononucleosis Suture Removal TB Testing Vaccines and Immunizations NO childhood immunizations other than Flu vaccine. NO limited services clinic may provide treatment to children younger than 24 months.	Athlete's Foot Cold Sores Deer Tick Bites (ages 12+) Impetigo Minor Burns Minor Skin Infections and Rashes Minor Sunburn Poison Ivy (ages 3+) Ringworm Shingles Treatment Wart Removal
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Source: National Conference of State Legislation

**ENDNOTES**

1. American recovery & reinvestment act (2009). Retrieved April 12, 2009, from the World Wide Web: [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=fh1enr.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=fh1enr.pdf)

2. The National Report Card on the State of Emergency Medicine by American college of emergency physicians (2009). Retrieved April 12, 2009, from the World Wide Web: <http://www.emreportcard.org/uploadedFiles/ACEP-ReportCard-10-22-08.pdf.pdf>

3. Mehrotra, A., et al., (2008). Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients' Visits. *Health Affairs* 27: 1276.

4. Thygeson, M., Van Vorst, K., Maciosek, M., & Solberg, L. (2008, September). Use And Costs Of Care In Retail Clinics Versus Traditional Care Sites. *Health Affairs*, 27(5), 1283-1292. Retrieved April 5, 2009, from Academic Search Premier Database

5. Mehrotra, A., et al., (2008). Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients' Visits. *Health Affairs* 27: 1276.

6. Smith, K. (2007). Quality of Care in the Retail Health Care Setting Using National Clinical Guidelines for Acute Pharyngitis.

7. Partin, B. (2007, March). Give Your Input Into the Retail Clinic Debate. *Nurse Practitioner*, 32(3), 11-11. Retrieved April 5, 2009, from Academic Search Premier Database.

8. Thygeson, M., Van Vorst, K., Maciosek, M., & Solberg, L. (2008, September). Use And Costs Of Care In Retail Clinics Versus Traditional Care Sites. *Health Affairs*, 27(5), 1283-1292. Retrieved April 5, 2009, from Academic Search Premier Database

9. Hutchison, B., Ostbye, T., Barnsley, J., Stewart, M., Mathews, M., Campbell, M., et al. (2003, April 15). Patient satisfaction and quality of care in walk-in clinics, family practices and emergency departments: the Ontario Walk-In Clinic Study. *CMAJ: Canadian Medical Association Journal*, 168(8), 977. Retrieved April 6, 2009, from Academic Search Premier Database

10. Minnesota Community Measurement (2009). Retrieved April 6, 2009, from the World Wide Web: [http://www.mnhealthscores.org/?p=our\\_reports&sf=group&search\\_phrase=&category=15&name\\_id=&compare=](http://www.mnhealthscores.org/?p=our_reports&sf=group&search_phrase=&category=15&name_id=&compare=)

11. Sage, W. (2007, October). The Wal-Martization of Health Care. *Journal of Legal Medicine*, 28(4), 503-519. Retrieved April 5, 2009, from Academic Search Premier Database

12. Thygeson, M., Van Vorst, K., Maciosek, M., & Solberg, L. (2008, September). Use And Costs Of Care In Retail Clinics Versus Traditional Care Sites. *Health Affairs*, 27(5), 1283-1292. Retrieved April 5, 2009, from Academic Search Premier Database

13. US Department of Health and Human Resources, Nursing Education Loan Repayment Program (2009). <http://bhpr.hrsa.gov/nursing/loanrepay.htm> Retrieved April 12, 2009.

14. Harlow, D. (2009). Operating retail based clinics in a heavily-regulated environment. The Harlow Group. Retrieved April 12, 2009, from the World Wide Web: <http://healthblawg.typepad.com/healthblawg/2009/01/david-harlow-speaks-at-retail-clinic-conference.html>

15. California HealthCare Foundation. Retail Clinics: Six State Approaches to Regulation and Licensing. Retrieved April 10, 2009, from the World Wide Web: <http://www.chcf.org/documents/policy/RetailClinicsSixStateApproaches.pdf>

16. Nardin, R. (2009). Massachusetts' Plan: A Failed Model for Health Care Reform. Boston: Harvard Medical School.

*Better Government Competition*

**2009 SPECIAL  
RECOGNITION**

## **Wellness Health Incentive Payment Program**

Maricopa County, AZ

Sustainable healthcare should always involve a responsible partnership between the payor and the healthcare administrative vendor or third party administrator whose paid administrative fees can increase or decrease dependent upon performance measured against nationally recognized health and wellness performance standards. The Wellness Health Incentive Payment (WHIP) Program can hold healthcare administrative vendors accountable for wellness activity and ultimately for facilitating positive health/wellness outcomes, as well as penalize or reward healthcare administrative vendors according to the vendor's performance as measured against nationally recognized standards.

Maricopa County, Arizona, by population, is the fourth largest county in the United States and provides healthcare to approximately 30,000 people through Maricopa County's self-insured \$144 million Employee Health Initiatives Department and Trust Fund. In this innovation, the primary healthcare vendor reimbursement emphasis has been for the payor to reimburse the third party administrator or healthcare administrative vendor solely for medical claims and administrative services with a modest emphasis placed upon reimbursement for annual health and wellness performance and progress towards achieving specific disease prevention milestones in the following areas:

- Mammography Screenings
- Well Adult Screenings
- Well Child Screenings
- Colorectal Cancer Screenings
- Well Child Immunizations

The Maricopa County Employee Health Initiatives, Employee Health Care Request for Proposal (RFP) and subsequent healthcare administrative vendor contract with CIGNA Health Care, Inc, specifies that the healthcare vendor must actively "partner" with Maricopa County and propose fee specific health wellness and other performance guarantees and incentives. Prior to subsequent contract renewal and each year thereafter, these guarantees are negotiated with the contract overseer, Maricopa County's Employee Health Initiatives Department, until the contract is otherwise concluded.

The minimum health and wellness performance standards are based on the national Health Employer Data Information Standards (HEDIS) for specific health and wellness disease preventive activity or an agreed upon higher metric standard.

Immediately following the implementation of the WHIP and measurement of the first year results, the payor and the vendors should shift their focus immediately to negotiating “stretch goals” for the next contractual evaluation period. Payors will need to determine and prioritize how much of their budget will be invested and allocated to the payment of vendor incentives in the event that the vendor exceeds the performance standards. The payor and the vendor must be patient and commit to a vision of continuous long-term improvements in both increased screenings and increased disease prevention activities as well as improving health outcomes and avoiding short term and long term medical costs.

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As a result of the WHIP Program and other factors, Maricopa County has been consistently developing a culture of health awareness and high employee health benefit satisfaction. Costs have increased at a significantly lower rate than the national average.

Massachusetts state and local governments and other private and public payors fund and provide healthcare to populations where the health status outcomes and the cost of care would benefit significantly if the healthcare administrative vendor and their agents are financially encouraged to periodically and systematically evaluate individuals for indicators of the early stages of disease and also take timely preventive measures to prevent disease so that all children and adults live well into the future.

Payors and vendors will need to diligently evaluate the economic values of each of their discrete performance guarantees and performance incentives based on past vendor performance, the demographic needs and the health risks of the payor’s respective population, and/or in what specific health and wellness activity areas the vendor needs more positive or negative reinforcement in contrast to a “straight line” performance guarantee/performance incentive strategy or “scheme” wherein each performance guarantee or performance incentive is always “valued” or “weighted” equally. At any given point in time in any population, one should not assume that all wellness activity performance guarantees should be weighted equally.

The WHIP Program alone will not guarantee that all populations served by the payor and the healthcare vendor will live well into the future. WHIP should be viewed as one instrument in a comprehensive Health Care Reform “tool box” that creates a socially responsible yet financially focused wellness payor/vendor partnership to improve health outcomes, prevent disease, and reduce medical costs.

Payors must be willing to identify, procure and monitor progressive-minded vendor organizations that are willing to be a “true” wellness partner and not select vendors that are conspicuously risk averse in regards to the receipt of the vendor’s reimbursement fees for both health screenings and administrative activities regardless of how the vendor performs in comparison to the minimum performance guarantees or the incentive earning level of performance. Payor and vendors must be patient and mutually commit to a path of continuous long term improvement in both health/wellness and administrative performance activity areas.

## **A National Market for Individual Health Insurance**

University of Minnesota

Division of Health Policy and Management

Minneapolis, MN

### **BACKGROUND**

Health insurance markets are regulated by the states under the McCarran-Ferguson Act (15 U.S.C. 1011) of 1945. The ‘purpose clause’ of the Act states that regulation and taxation of the business of insurance by the states is in the public interest. As a result of McCarran-Ferguson, every health insurer must be licensed in the policyholder’s state of residence. The states have responded with a complex patchwork of mandates and laws that vary widely across the country. As a result, people who buy health insurance in the individual insurance market (i.e. they pay the premium themselves, without an employer or union contribution) pay wildly different premiums depending on where they happen to live. A 49-year old man in Trenton, NJ can enroll in a popular Health Maintenance Organization (HMO) for \$409 per month. If he lived across the Delaware River in Morrisville, PA, the premium for an HMO with the same coverage would cost just \$250 per month. He would also find many more choices in Pennsylvania – 97, compared with 19 in New Jersey. These differences in premiums and choices are not caused by differences in prices or the doctors and hospitals in each community. Our Garden Stater might get his medical care at excellent hospitals in Philadelphia, and the Pennsylvanian could drive over the river to excellent hospitals in New Jersey.

What distinguishes our two customers is that New Jersey is one of the most heavily regulated states in the U.S. It requires that all individual insurance policies be community rated, meaning that insurers are not allowed to recognize differences in risk that cause healthcare costs to be higher for some people than for others. Because community rating requires low-risk policyholders (often young and less wealthy) to subsidize high-risk policyholders, many people have dropped coverage and those who remain insured pay higher premiums. New Jersey also requires insurers to sell insurance to all potential customers regardless of health or pre-existing conditions, and it has 30 insurance mandates that require insurers to cover particular services or providers.

The economic law of demand says that high prices will drive customers away, and that is exactly what has happened in New Jersey’s individual health insurance market. In 2008, we estimate there were only 20,328 individual policyholders in the entire state; in contrast, Pennsylvania, a state with about 40% more people, had 644,614 individual policyholders. The problem of excessive regulation plays out across the country, where we observe that heavily-regulated states have higher premiums and stunted individual insurance markets, while less-regulated states have lower premiums and more vibrant markets. Until we solve this problem, the individual insurance market will never develop adequately to meet the needs of the self-employed and workers whose employers do not offer health insurance.



### SOLUTION

Today, most large employers that offer health insurance are exempt from McCarran-Ferguson through another federal law, the Employee Retirement Income Security Act (ERISA) (Pub.L. 93-406, 88 Stat. 829), which states that firms that provide insurance as an employee benefit without the assistance of a risk-bearing insurer are not subject to state regulation. Self-insured firms can buy insurance anywhere, from any carrier that meets their needs. Only individuals and small employer groups are regulated by the states and must buy insurance from an in-state carrier, if at all.

Federal lawmakers are interested in changing the law that prohibits individual health insurance from being sold across state lines.<sup>1</sup> Advocates of this reform argue that state-level regulations distort prices and that permitting national competition for such insurance has the potential to increase demand for individual health insurance policies.

To fix the problem identified above, we propose to allow people to shop across state lines for individual health insurance. Under our proposal, individuals could buy insurance licensed in another state. We conducted a simulation analysis of three specific alternatives for the state of purchase: the least-regulated large state; the least-regulated state in each of four geographic regions; and the least-regulated of all states. The simulations showed that our proposal has the potential to increase significantly the take-up of individual health insurance in the U.S.

#### *Positive Outcomes*

Literature was reviewed to characterize the state-specific individual insurance markets with respect to state regulations and to identify the effect of those regulations on health insurance premiums. We used empirical data to develop premium estimates that reflect state-specific differences in health care markets and we used a revised version of the 2005 Medical Expenditure Panel Survey (MEPS) to complete a set of simulations to identify the impact of three scenarios for development of a national market. The three scenarios are:

- Scenario 1: Only the five largest states, by population, are eligible for the national market. The idea is that insurance departments in large states have the critical skills to take on additional regulatory responsibilities for new out-of-state customers. The five largest states in the United States are California, Texas, New York, Florida, and Illinois. Of these, Texas has the least-regulated health insurance environment and is the national shopping state in the simulation.
- Scenario 2: The national market is divided into Northeast, South, Midwest, and West. Residents in each region can buy insurance from the state in their region with the most favorable premium due to decreased regulation. This scenario was based on the regional Medicare Part D (drug coverage) and TriCare (armed services) contracts with insurance carriers. The Northeast state with the least regulated environment was New Hampshire; the Midwest, Nebraska; the West, Arizona; and the South, Alabama.
- Scenario 3: For this scenario, the state with the least regulation is identified as Alabama. All interstate consumers are assumed to switch policies to Alabama unless they already are residents of Alabama. This could be the most extreme outcome of legislation similar to that proposed by Rep. Shadegg.

Each scenario was run on a set of minimum, moderate and maximum impacts of state-specific regulations derived from the literature. The impact of each scenario was calculated by multiplying

a given person's original premium by a state-specific adjustment factor to predict the premium for that person in the national market. If the consumer faces a lower premium as a result of the proposed policy change, the consumer will choose the better price. If the new premium is not a better deal than in the home state, they will choose the home state in the simulation.

Under the moderate impact assumption, competition among the five largest states would increase insurance coverage by 4.7 million individuals from a base of 47 million uninsured. Under the scenario of competition within four regions, we find greater insurance take-up with a moderate impact estimate of 7.8 million newly insured. Allowing for a national market where anyone can shop for health insurance in the least-regulated state yields the largest gain of 8.5 million previously uninsured who now have coverage.

We also analyzed the impact of our proposal across different income groups. Selecting household income of \$45,000 as the cutoff because this is roughly the mean U.S. household income, we found a greater percentage increase in insurance occurring among the population with less than \$45,000 income (44%), compared with those with more than \$45,000 income (37%).

### **COSTS**

Development of a national market requires no additional federal resources other than support for legislation to permit the development of such a change. However, under any scenario for interstate shopping, there will be significant implementation issues. Rep. Shadegg's 'Health Care Choice Act of 2005' exempted the policy from coverage laws in the policyholder's state of residence, but left the insurer with some obligations to that state, such as premium taxes and compliance with state fraud and abuse laws. These proposals might form the basis for legislated or contractual agreements to divide regulatory powers between the states of issue and residence. Adequate disclosure to consumers of the states' obligations will be paramount for this plan to work.

### **CONCLUSION**

The Massachusetts plan received a great deal of interest and renewed interest in health insurance reform at the national level. The Commonwealth Health Insurance Connector, where over 350,000 people have signed up for coverage, could play an important role in a national market by allowing people from other states to shop for insurance plans that have the Connector's 'seal of approval.' However, the subsidized insurance program that is at the heart of the state's initiative has suffered from high costs, and employers are finding that the minimum coverage standards for 2009 are making insurance more expensive than they can afford.

A national market could be combined with tax credits for purchasing health insurance, as proposed by then-presidential candidate Senator John McCain (R-AZ), or with a health insurance exchange model, as proposed by President Obama. Others, including Senator Ron Wyden (D-OR), have argued for an individual mandate to buy insurance that is not tied to the workplace. A national market for individual insurance would make the cost of that mandate more affordable.

### **ENDNOTES**

1. Representative John Shadegg's (R-AZ) and Senator Jim DeMint's (R-SC) 'Health Care Choice Act of 2005' (H.R. 2355 and S.1015) would amend the Public Health Service Act (Title 42 U.S.C.) to allow for interstate commerce in health insurance while preserving the states' primary responsibility for regulation of health insurance.

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**2009** SPECIAL  
RECOGNITION

## **Health Insurance Cost Control**

Fallon Community Health Plan  
Worcester, MA

### **BACKGROUND**

The combined use of limited, or selective, provider networks and a defined contribution strategy presents an immediate opportunity for government entities and employer groups to achieve significant and sustainable health insurance savings and reduce medical cost trends, while maintaining coverage levels and quality of care. This solution illustrates the impact of changes in consumer behavior that occur as a result of economic conditions and opportunities. Offered together, limited networks and a defined contribution strategy will produce the following benefits:

- Immediate and material savings in employer contribution dollars
- Consistent health insurance benefit and customer satisfaction levels
- Reduction in year-over-year medical cost trends
- Increased predictability in year-over-year employer contributions
- Increased number of consumers making value-based decisions
- Reinforced value of community hospitals

Limited networks include providers carefully chosen using objective clinical and service quality measures. Fallon Community Health Plan's (FCHP) experience proves that the delivery of care by these providers is more efficient and effective. Annual medical costs in FCHP's limited networks are 15% lower than costs in our more expansive network. Consumers receive the same level of benefits and have the same level of satisfaction in the limited network option as they do within a broad network. A defined, "equal dollar" contribution strategy, typically between 80% and 100% of the lowest cost option, is successful in driving consumers toward efficient and effective providers. Increased consumer choice in turn motivates other providers to improve quality, efficiency and infrastructure, ultimately driving down healthcare costs.

Leveraging limited network options in combination with an equal dollar contribution strategy can produce immediate and significant savings for all stakeholders in the health care system and pave the way for sustainable change in the marketplace.

### **PROBLEM**

Health care spending in Massachusetts is 33% higher than the U.S. average.\* Ever-rising health care costs and the recession have combined to create unpalatable decisions for business and government. For

employers, health care spending is the second highest expense behind salaries. Employers, government entities and municipalities in Massachusetts looking for ways to reduce their health care expenses have typically been forced to cut back on benefits or switch to high-deductible health plans for budget relief. These solutions are unfavorable for consumers because it reduces and/or complicates how they are covered. The combined use of a limited provider network and a defined contribution strategy is an immediate opportunity for these entities to achieve significant savings without reducing the level of coverage and quality of care offered to employees.<sup>1</sup>

## SOLUTION

The solution calls for providing a group health insurance plan that is supported by two components: a limited network of providers and a defined contribution strategy.

Providers in the limited network are selected using objective clinical and service quality measures. Most providers in FCHP's limited network have a proven track record of innovation, including the implementation of an electronic medical record system. The level of benefits in the plan design supported by the limited network is identical to the level of benefits of the plan design supported by the more expansive network. The premium is favorably impacted by the combined efficiency and effectiveness of network providers.

Employer contribution strategy is a critical component of health insurance costs. With an equal percentage strategy, the employer contributes an equal percentage across all health plan options offered to employees and employees pay the remaining percentage. With an equal dollar strategy, the employer contributes a fixed dollar amount based on the lowest cost option and employees contribute any premium beyond the fixed dollar amount.

Illustrative example:

Employer group with 70 employees that offers employees a choice of two plans:

- Plan A (expansive network; total cost of \$500 per month per employee)
- Plan B (limited network; total cost of \$425 per month per employee)

*Scenario I. Equal percentage contribution strategy* - employer contributes 80% regardless of plan design

- Plan A - 50 employees enrolled; employer contributes \$400 per employee/\$20,000 total per month; employees each contribute \$100/month
- Plan B - 20 employees enrolled; employer contributes \$340 per employee/\$6,800 total per month; employees each contribute \$85/month
- Total employer contribution = \$26,800/month

*Scenario II. Equal dollar contribution strategy* - employer contributes an equal dollar amount set at 80% of the lowest cost plan (\$340 per employee per month)

Without a change in plan choice by employees:

- Plan A - 50 employees enrolled; employer contributes \$340 per employee/\$17,000 total per month; employees each contribute \$160/month
- Plan B - 20 employees enrolled; employer contributes \$340 per employee/\$6,800 total per month; employees each contribute \$85/month

- Total employer contribution = \$23,800/month for a total savings of \$3,000/month.

*Scenario III. Equal dollar contribution strategy* - same as above but 50% of employees shift from Plan A to Plan B

In this scenario, if 50% of the consumers with Plan A make value-based decisions and shift to Plan B (savings to them of \$75/month), the employer contribution (as in Scenario II) is reduced by \$3,000/month, but in addition, the total employee contribution is reduced by \$1,875/month.

### *Benefits*

- Annual medical costs in FCHP's limited network plan are 15% lower than costs in the expansive network plan.
- FCHP's limited network performed, on average, 1.5% better on four key HEDIS metrics related to preventive care (breast cancer screening, cervical cancer screening, HbA1c screening for diabetics, cholesterol screening for diabetics). Improvements in quality of care can be extended into improved productivity (via attendance) in the workplace.
- Customer satisfaction results are consistent between FCHP members in the limited network plan and the expansive network plan. Consumers are not subject to cost shifting or reduction in benefits which negatively impact their satisfaction.
- Consumer behavior is driven by contribution strategy and influenced by economic conditions that have lowered the threshold for consumers to make value-based decisions.
- FCHP has continued to seek out providers in Massachusetts who have demonstrated their ability to deliver high quality, cost-efficient and cost-effective care. The network now includes 15 provider groups in central and eastern Massachusetts and the North and South Shores. Because of this expansion, approximately two-thirds of this state's population lives within the limited network's service area.
- Membership in the FCHP limited network product has grown by 40% since 2006 and now includes more than 50,000 members.

## CONCLUSION

Through the Group Insurance Commission, state employees are offered a robust portfolio of plan designs, including FCHP's limited network product. However, the contribution strategy is legislated. Commercial insurance costs are estimated at \$983M of which the GIC incurs \$830M and employees contribute \$153M. Under certain assumptions including an equal dollar contribution strategy based on 100% of the lowest cost plan option that engages employees to "buy down" to the next plan design, the GIC contribution could be reduced significantly (an estimated \$82M per year) without a change in the aggregate cost to employees.

The program should be implemented for municipalities, state entities (i.e. transportation authority) and the Group Insurance Commission. As the economic woes aggregate, more consumers may welcome the choice of a lower cost plan offering high quality care and benefits. It is incumbent upon the leaders of organizations in Massachusetts to become educated about the opportunities that limited networks present for them and their constituencies.

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**2009 SPECIAL  
RECOGNITION**

## **CPOE Initiative**

New England Healthcare Institute and Massachusetts Technology Collaborative  
Cambridge, MA

### **BACKGROUND**

In 2004, the Massachusetts Technology Collaborative (MTC), in partnership with the New England Healthcare Institute (NEHI), created the Massachusetts Hospital CPOE Initiative, a six-year-long campaign to speed adoption of a computer technology that can drastically reduce the scourge of harmful medication errors. The Initiative's groundbreaking research revealed that one in every ten patients in a Massachusetts community hospital suffers a serious but preventable medication error. The findings spurred the Massachusetts Legislature, the state's private payers and later the US Congress to enact policy changes encouraging or requiring the use of Computerized Physician Order Entry, or CPOE. NEHI and MTC estimate that statewide hospital adoption of CPOE will prevent 55,000 medication errors and save \$170 million annually in Massachusetts alone. Improving patient safety by preventing harmful medication errors will continue to be an issue of paramount importance as Massachusetts and the nation engage in health reform.

### **PROBLEM**

The quality of healthcare in the United States suffers from a high rate of medical errors, making patient safety a critical concern. Every year, an estimated one million medication errors occur and as many as 100,000 people die from medical mistakes. It is estimated that the costs associated with these medication errors reach \$2 billion a year. Many of those injuries, deaths and costs are actually preventable – and yet they still occur at alarming rates.

Injuries that are caused by medications – such as severe allergic reactions or harmful interactions among medications – are known, in medical parlance, as adverse drug events. Preventable adverse drug events are caused by human error, such as prescribing or administering the wrong dose of a drug. These avoidable yet widespread calamities occur for a variety of reasons, ranging from confusion by a doctor, nurse or pharmacist in deciphering illegible handwritten prescriptions to a physician's failure to check a patient's record for drug allergies or medications already being taken by the patient.

In 2001, a report by the Agency for Healthcare Research and Quality concluded that up to 95 percent of adverse drug events “can be prevented by reducing medication errors through computerized monitoring systems.”

The agency was referring to a technology known as Computerized Physician Order Entry, or CPOE. CPOE is a computer application used by physicians and other caregivers to enter diagnostic and therapeutic orders for tests and drugs for hospital patients. The system assures accuracy through

clinical decision support which provides physicians with knowledge of potential medication errors and recent test results, as well as prompts for standard screening tests, so that the most common errors are avoided.

Despite the potential of these systems to improve clinical outcomes, save lives and save money, only a small percentage of hospitals have acquired and implemented CPOE. Of the 73 hospitals in Massachusetts, for instance, only 13 had CPOE systems in 2005, leaving 60 hospitals, their doctors and their patients without the benefits of this valuable technology.

### **SOLUTION**

The Massachusetts Hospital CPOE Initiative was launched in 2004 by MTC and NEHI, with the ambitious goal of improving patient safety and lowering hospital costs through implementation of CPOE in every Massachusetts hospital within four years. Early on, NEHI and MTC realized that collaboration was critical to the success of the project and brought in key stakeholders including the Massachusetts Hospital Association and the Massachusetts Council of Community Hospitals, as well as senior hospital executives and the leadership of health plans, public payers, health care quality organizations and the business community.

The goal was to research and assess the potential of CPOE to save lives and save money, and then to speed the adoption of CPOE, first throughout the state's hospital system and then nationwide. The initiative began by conducting an assessment of the readiness of all hospitals in Massachusetts to adopt CPOE, developing CPOE standards to ensure that the computer systems contain the necessary capabilities, and estimating what it would cost individual hospitals to adopt CPOE. Then, two key efforts were commissioned to demonstrate CPOE's potential clinical and financial benefits: a clinical baseline study of the existing level of medication errors in Massachusetts community hospitals, and a financial analysis on the potential impact of CPOE on the hospitals and their payers.

The clinical research, conducted by Dr. David Bates of Brigham & Women's Hospital, revealed a shocking reality: one in every ten patients in a Massachusetts community hospital suffered a serious but preventable medication error. Furthermore, the clinical and financial research found that if CPOE were implemented statewide, 55,000 dangerous medication errors would be prevented and \$170 million saved annually in Massachusetts alone.

As a result of the research, NEHI and MTC recommended that all Massachusetts hospitals implement CPOE within the four-year period ending in 2011, and that policymakers adopt incentives for hospitals to meet that goal. Additionally, the Initiative pledged to continue to provide ongoing implementation support to Massachusetts hospitals at all stages of CPOE planning, adoption and operation.

### **COSTS AND BENEFITS**

It was critical for the CPOE Initiative to fully assess the financial costs and savings associated with CPOE implementation because hospitals had long cited financial barriers as reasons for not acquiring CPOE. PricewaterhouseCoopers undertook this assessment, including the capital, one-time operating costs and on-going operating costs of CPOE implementation, as well as an estimate of the payback period as a way of determining the hospitals' recoupment of their investment.

In general, the majority of the savings from implementing CPOE derive from avoiding adverse drug events; the consequence of each adverse drug event is based on an additional and costly 4.6 days of

hospitalization. With patients whose care is paid for on a prospective (fixed) payment basis, those daily variable costs that are avoided accrue directly to the hospital. With patients whose care is paid for on a fee-for-service basis, the public and private payers experience a reduction in cost, but the hospital revenues are then decreased by an equal amount. These savings were calculated according to each of the six study hospital's payer mix.

The key financials for a Massachusetts community hospital are:

- Capital and one-time costs of CPOE acquisition and implementation: \$2.1 million
- Annual ongoing operating costs: \$435,000
- Annual reduction in operating costs: \$2.7 million
- Payback period: 26 months
- Annual benefit to payers: \$900,000

Given the 26-month payback demonstrated by the financial analyses, implementation of CPOE by all Massachusetts hospitals should be affordable. Hospitals can use their own funds, apply for a loan either through conventional means such as banks or through tax exempt financing through the Massachusetts Health and Educational Facilities Authority (HEFA), or go to an investment bank to get a bond issuance. Additionally, smaller critical access hospitals (less than 25 beds) have their own reimbursement methodology and may qualify for other types of federal funds. Neither NEHI nor MTC provided any specific CPOE grants to hospitals.

CPOE also received a boost in the federal Stimulus Bill, which provides financial incentives to hospitals to adopt electronic health records that have the capability of providing clinical decision support and physician order entry – the key elements of the MTC/NEHI patient safety initiative. The legislation reduces Medicare payments for non-adopting hospitals beginning in 2016.

## CONCLUSION

When analysis of the clinical and financial studies began in 2007, there were 18 Massachusetts hospitals with CPOE in various stages of development. In 2009, there are 27 – a 50 percent increase in two years. There are another 27 hospitals with signed contracts for a total of 51 out of 73 in two years – a 70 percent increase.

The 2008 publication of the research findings spurred two major policy changes in the Commonwealth. The first occurred when the private payers, led by Blue Cross Blue Shield of Massachusetts, made hospital adoption of CPOE a condition of their quality reimbursement programs. The second occurred when the Legislature passed, and the governor signed into law, legislation making hospital adoption of CPOE by 2012 a condition of licensure. This provision was included in the 2008 amendments to Chapter 58, the Massachusetts Health Reform Bill.

NEHI and MTC are now also involved in an effort to bolster support for CPOE by demonstrating significant benefit within hospitals that have implemented the technology, in terms of clinical and financial outcomes. This evidence, in turn, would support the enactment of the kinds of policies described above and represent a significant advance in the safety of hospital patients nationwide.

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