



2012

ABIM FOUNDATION FORUM

There are many more efforts to advance the wise use of health care resources than could be featured at the 2012 ABIM Foundation Forum.

This publication contains a select list of initiatives undertaken by a wide range of stakeholders from across the United States. Under each category, efforts are listed alphabetically by their sponsoring organization. While the list is current as of this writing, these programs undoubtedly have continued to evolve since this document went to press.

The listed initiatives range from small programs in their infancy to broad national efforts mandated in the health reform law. As of mid-June 2012, the Supreme Court had not issued a decision on the constitutionality of the Affordable Care Act (ACA), including the individual mandate and proposed expansion of Medicaid eligibility. Nonetheless, work has moved forward to test a number of new models

Key Initiatives to Promote Appropriate Resource Use

Amy Cunningham, MPH

Work has moved forward to test a number of new models for wise stewardship of health care resources, including accountable care organizations (ACOs), advanced primary care models and new payment methods.





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We look forward to discussing these and other programs at the Forum and to continuing the discussion on efforts to improve health care decision-making and resource use post-Forum.



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I. Creating Accountable Care Organizations

A. Center for Medicare & Medicaid Innovation (CMMI)

The [Innovation Center's](#) current initiatives include several ACO programs. Currently, 32 pioneer model ACOs and six physician group practice transition demonstration organizations are participating in Medicare shared savings programs. This group of grantees spans the country and represents a diverse group of organizations, ranging from the Bronx Accountable Healthcare Network to Brown & Toland Physicians, a California-based physician group.

In April 2012, CMMI announced that 27 ACOs have also entered into agreements with the [Centers for Medicare & Medicaid Services](#) (CMS) through its Shared Savings Program. Five of the Shared Saving Program ACOs will participate in the Advance Payment ACO Model, which will provide advance payment of expected shared savings to selected ACOs that would benefit from additional start-up funding. Participating organizations range from [Arizona Connected Care](#), a Tucson-based ACO, to the [Chinese Community Accountable Care Organization](#), a New York City-based ACO that will focus on delivering culturally competent care while improving quality and lowering costs.

B. Private-Sector ACOs

In addition to Medicare-supported ACOs, numerous private sector ACOs have been created in the past year, comprised of various combinations of insurers, physician organizations, hospitals and other stakeholders. The following is a small sampling of the many recently launched private-sector ACOs.

ACO Learning Network

[The Learning Network](#) is a collaboration of the [Brookings Institution's Engelberg Center for Health Care Reform](#) and the [Dartmouth Institute for Health Policy and Clinical Practice](#). The ACO Learning Network offers a number of tools for its members and has also funded several pilot sites, including:

- [Carilion Clinic](#), a multispecialty Virginia group practice with 500 physicians and seven not-for-profit hospitals, partnering with Aetna;
- [Healthcare Partners and Monarch Healthcare Systems](#), both California Independent Physician Associations, in collaboration with Anthem and WellPoint;
- [Norton Healthcare](#), a Louisville, Kentucky-based integrated delivery system in collaboration with Humana; and
- [Tucson Medical Center](#), a nonprofit hospital working with UnitedHealthcare.

Other Private Sector Efforts

Horizon Blue Cross Blue Shield of NJ
[Horizon Blue Cross Blue Shield](#) created a wholly owned subsidiary, [Horizon Healthcare Innovations](#) (HHI), which is overseeing its ACO pilot. The pilot includes 1,000 to 2,000 patients receiving care in a large multispecialty group who have commercial preferred provider organization (PPO) coverage. This is one of the numerous Blue Cross and Blue Shield ACO pilots nationally.

[Cigna and Weill Cornell Physician Organization](#)

This ACO was launched in 2012 and benefits individuals covered by a Cigna health plan who receive care from one of the 71 Weill Cornell primary care doctors. This is one of 17 ACO arrangements in which Cigna is participating.

HealthPartners and

Allina Northwest Metro Alliance

Minneapolis-based [HealthPartners](#), a health system with its own health plan, teamed up with [Allina Health Hospitals and Clinics](#) to form the [Northwest Metro Alliance](#). The Alliance is pursuing the triple aim of better care, better health and lower cost for HealthPartners members in northwest Minneapolis. To date, the program has focused on increasing generic drug use, reducing elective labor induction before 39 weeks, expanding urgent care options to reduce emergency room use and improving chronic care management.

WellPoint and Dartmouth-Hitchcock Medical Center

[WellPoint](#) has several pilot ACOs, including a partnership with [Dartmouth-Hitchcock Medical Center](#) in New Hampshire that began in 2011. This ACO is looking at a number of outcomes, including total emergency room visits, brand prescription drug usage and total per member per month costs.





The ABIM Foundation has sponsored an initiative designed to increase the appeal of primary care practice for both current practitioners and medical students and residents.

II. Developing Patient-Centered Medical Homes (PCMHs) and Enhancing Primary Care

A. ABIM Foundation *Joy in Practice Initiative*

The [ABIM Foundation](#) has sponsored an initiative designed to increase the appeal of primary care practice for both current practitioners and medical students and residents. Led by Christine Sinsky, MD, the project has studied more than 20 innovative primary care practices to see how they have improved patient care while also increasing job fulfillment for physicians and other clinicians. Featured innovations include the employment of physician assistants or other personnel as scribes to enable greater physician concentration on the patient, the use of pre-visit check-ins and labs, and the more efficient use of teams. The project leaders are now attempting to disseminate these promising practices across primary care more broadly.

B. American Academy of Family Physicians *TransforMED*

[TransforMED's](#) many programs to support the development of PCMHs include practice assessments, transformation plans and Practice Enhancement Facilitators (PEFs) to assist in practice transformation. TransforMED is also part of numerous PCMH demonstration projects nationwide.

C. American College of Physicians (ACP) *Medical Home Builder®*

ACP released the second version of its [Medical Home Builder](#) in July 2011. This tool offers online modules about the medical home, clinical topics and office management to help medical practices improve the quality of their care.

D. Center for Medicare & Medicaid Innovation *Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration*

This three-year demonstration project is a partnership with the [Health Resources Services Administration](#) (HRSA). Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, and coordinate care for patients. Centers are paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. CMS and HRSA are also providing technical assistance to the FQHCs. Five hundred FQHCs are currently participating in this project, which began in September 2011.

Comprehensive Primary Care Initiative (CPCi)

In this program, Medicare will work with Medicaid and private insurers to provide enhanced payment to practices delivering comprehensive primary care. The program will test two models; the first is a service delivery model characterized by risk-stratified care management, access and

continuity, planned care for chronic conditions and preventative care, patient and caregiver engagement, and coordination of care across the medical neighborhood. The second model is a payment model that includes a monthly care management fee paid to the selected primary care practices on behalf of their fee-for-service Medicare beneficiaries and the potential to share in any savings to Medicare.

In April 2012, CMMI announced that seven multi-payer markets will be participating in its [Comprehensive Primary Care Initiative](#):

- Arkansas: Statewide
- Colorado: Statewide
- New Jersey: Statewide
- New York: Capital District-Hudson Valley Region
- Ohio: Cincinnati-Dayton Region
- Oklahoma: Greater Tulsa Region
- Oregon: Statewide

CMMI plans to select 75 practices to participate in each market; it released a call for applications in June 2012 and will announce its selections in August 2012.

E. National Academy for State Health Policy (NASHP)

Among its PCMH efforts, [NASHP](#) is supporting 14 states' current medical home initiatives through The Commonwealth Fund 3rd State Consortium to [Advance Medical Homes in Medicaid and Children's Health Insurance Program](#).

F. National Center for Medical Home Implementation (NCMHI)

[NCMHI](#) is the result of an agreement between the federal [Maternal and Child Health Bureau](#) and the [American Academy of Pediatrics](#). The Center's mission is to ensure that all children and youth, including children with special needs, have access to a medical home. The Center carries out its mission through policy advocacy, training and providing technical assistance for practices.

G. Patient-Centered Primary Care Collaborative (PCPCC)

Center for Multi-Stakeholder Demonstrations
The [Center for Multi-Stakeholder Demonstrations](#) is one of PCPCC's many activities supporting the implementation and sustainability of medical homes. The Center assists multi-stakeholder patient-centered medical homes through the sharing of best practices, results and lessons learned, and it connects participating organizations with quality improvement and other organizational resources. Some of the larger participating programs are:

- [Blue Cross Blue Shield of Michigan](#): Patient-Centered Medical Home Program, a collaboration between Blue Cross Blue Shield of Michigan and physician organizations;
- [MediQHomeSM Quality Program](#), a Blue Cross Blue Shield of North Dakota initiative designed to improve care coordination through MDinsightTM, a clinical decision support tool; and
- [Pennsylvania Chronic Care Initiative](#), an effort overseen by the Governor's Office of Health Care Reform. The initiative focuses on using patient-centered medical home standards and the Chronic Care Model developed by Dr. Ed Wagner to improve care for patients with chronic illnesses.



III. Identifying Unnecessary Care and Supporting Value-Based Cost-Effective Clinical Decisions

A. ABIM Foundation

Choosing Wisely® Campaign

[Choosing Wisely](#) is part of a multi-year effort of the ABIM Foundation to help physicians be better stewards of finite health care resources. On April 4, 2012, the ABIM Foundation, along with nine medical specialty societies and Consumer Reports, formally launched the *Choosing Wisely* campaign. Participating specialty societies each identified “Five Things Physicians and Patients Should Question” to help spark conversations between physicians and patients about the need—or lack thereof—for many frequently ordered tests or treatments. The partners announced at the initiative launch were:

- American Academy of Allergy, Asthma & Immunology
- American Academy of Family Physicians
- American College of Cardiology
- American College of Physicians
- American College of Radiology
- American Gastroenterological Association
- American Society of Clinical Oncology
- American Society of Nephrology
- American Society of Nuclear Cardiology

Additionally, these consumer partners are working with [Consumer Reports](#) to disseminate and explain the lists to consumers:

- AARP
- Alliance Health Networks
- Leapfrog Group
- Midwest Business Group on Health
- National Business Coalition on Health
- National Business Group on Health

- National Center for Farmworker Health
- National Partnership for Women & Families
- Pacific Business Group on Health
- SEIU
- Wikipedia community (through a dedicated Wikipedian in Residence)

Additional medical societies' lists will be announced in fall 2012. Future participating societies will include the American Academy of Hospice and Palliative Medicine, American Academy of Neurology, the American Academy of Otolaryngology–Head and Neck Surgery, the American College of Obstetricians and Gynecologists, the American College of Rheumatology, the American Geriatrics Society, the American Society for Clinical Pathology, the American Society of Echocardiography, the Society of Cardiovascular Computed Tomography, the Society of Hospital Medicine, the Society of Nuclear Medicine, the Society of Thoracic Surgeons and the Society of Vascular Medicine.

Putting the Charter into Practice Grant Program

The [Putting the Charter into Practice](#) grants provide financial support to professional medical organizations, health systems/hospitals, academic medical centers and medical practices as they work to advance medical professionalism. In 2011, five grants were awarded to facilitate the development of innovative, emerging strategies to advance appropriate health care decision making and stewardship of health care resources. Current grantees and their projects include:

- The [American College of Physicians](#) is developing case studies focusing on the professional considerations relevant to physician decisions about resource allocation and stewardship.

- [Costs of Care](#) is creating an interactive, case-based video module to facilitate reflective learning among students, house staff and faculty physicians. The video module will spotlight the costs of medication, laboratory testing, imaging and procedures, as well as the financial consequences of unnecessary inpatient and outpatient services.
- [Johns Hopkins Bayview Medical Center](#) is focusing on reducing the overutilization of cardiac enzyme panels, a commonly ordered diagnostic test, by aligning physician ordering behavior with established guidelines for appropriate testing and changes in billing systems. Low performers will receive coaching; high performers will be interviewed to identify best practices.
- [The National Physicians Alliance](#) (NPA) is building on its 2009 Putting the Charter into Practice grant project, which convened workgroups to develop lists of how primary care physicians can be good stewards of resources. NPA is developing resources and training physicians to communicate with patients on tests and procedures where potential harm exceeds benefits based on recommended lists.
- [The University of Minnesota's Division of Pediatric Emergency Medicine](#) is developing and implementing evidence-based practice guidelines and electronic clinical decision support tools for common causes of pediatric emergency room visits such as acute gastroenteritis and suspected appendicitis, which can result in overuse of laboratory testing and, in the case of suspected appendicitis, overuse of computed tomography (CT) scans.

B. Alliance for Radiation Safety in Pediatric Imaging

Image Gently™ Campaign

The Alliance for Radiation Safety in Pediatric Imaging was founded by the Society for Pediatric Radiology, the American College of Radiology, the American Society of Radiologic Technologists, and the American Association of Physicists in Medicine, and includes the American Board of Radiology (ABR), the ABR Foundation and numerous other organizations. [The campaign](#) has developed teaching materials and checklists to encourage interventional radiology professionals to use the lowest dose necessary when performing procedures on children, including CT scans, dental procedures and interventional radiology procedures. To date, 14,653 professionals have taken the *Image Gently* pledge to make the campaign a priority in staff communications and review protocols, and to communicate respectfully with other members of the imaging team and openly with patients.

C. Joint Task Force on Adult Radiation Protection

Image Wisely™ Campaign

The Joint Task Force on Adult Radiation Protection was founded by the American College of Radiology and the Radiological Society of North America. The Task Force worked with the American Association of Physicists in Medicine and the American Society of Radiologic Technologists to create the *Image Wisely* campaign. The campaign's objective is to lower the amount of radiation used in medically necessary imaging procedures and eliminate unnecessary procedures. Similar to *Image Gently*, *Image Wisely* offers teaching materials, checklists, and a pledge.





April 2012, ACP and Consumer Reports announced a High-Value Care partnership, which will include the development of resources to help consumers weigh the risks and benefits of common clinical procedures.

D. American College of Physicians (ACP)

High-Value, Cost-Conscious Care Initiative
Announced in April 2010, ACP's [High-Value, Cost-Conscious Care Initiative](#) is an effort to assess the benefits, harms and costs of diagnostic tests and treatments for various diseases to determine whether they provide value. As part of this initiative, in January 2011, ACP released a position paper, "How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?" In addition, ACP has published clinical practice guidelines and patient summaries on the use of diagnostic imaging for low back pain, oral medications for Type 2 diabetes and screening for colorectal cancer in the *Annals of Internal Medicine*. Additionally, in April 2012, ACP and Consumer Reports announced a *High-Value Care* partnership, which will include the development of resources to help consumers weigh the risks and benefits of common clinical procedures. ACP is also a participant in the *Choosing Wisely*[®] initiative.

E. Institute of Medicine

Roundtable on Value and Science-Driven Healthcare
[This Roundtable](#) has been convened to transform the way that evidence on clinical effectiveness is generated and used to improve both health and health care. The vision of the Roundtable is for a health care system that draws on the best

evidence to provide the care most appropriate to each patient, emphasizes prevention and health promotion, delivers the greatest value, adds to learning throughout the delivery of care and leads to improvements in the nation's health. The Roundtable's goal is that, by the year 2020, 90 percent of clinical decisions will be supported by accurate and timely clinical information that reflects the best available evidence. Members include clinicians, patients, health care organizations, employers, manufacturers, insurers, health information technology experts, researchers and policymakers. The Roundtable consists of five Innovation Collaboratives, ad hoc convening initiatives to catalyze action on issues central to advancing the science and value of care. The five Collaboratives are: Best Practices, Clinical Effectiveness Research, Digital Learning, Evidence Communication, and Value Incentives. The Value Incentives Learning Collaborative is a learning network to convene individuals and organizations working to design, develop, test and evaluate innovative approaches to reforming payment to produce value. Examples of this collaborative's activities include the identification and assessment of incentive misalignment in health care and scoring returns on prevention. In 2011, the Roundtable held workshops on the infrastructure needed for comparative effectiveness research and patient engagement in a learning health system. It also published a comprehensive assessment of contributors to health care costs.

***F. Kaiser Permanente
Center for Effectiveness
and Safety Research (CESR)***

Kaiser Permanente established the CESR in 2009. The Center is a network of Kaiser Permanente investigators, data managers and analysts who evaluate the effectiveness and safety of drugs, devices and biologics and disseminate findings to inform comparative effectiveness and patient safety initiatives.

***G. Patient-Centered Outcomes
Research Institute***

The ACA established the [Patient-Centered Outcomes Research Institute](#) (PCORI or the Institute) as a non-profit organization to assist patients, clinicians, purchasers and policymakers in making informed health decisions by carrying out research projects that provide high-quality, relevant evidence on how diseases, disorders and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored and managed. PCORI is supported by a newly established Patient-Centered Outcomes Research Trust Fund, funded through September 30, 2019 by a combination of appropriations, transfers from the Medicare Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, and fees assessed on health insurance and self-insured health plans.

The 21 members of PCORI's Board of Governors were named in September 2010, including 19 representatives from the following interests: patients/health care consumers; physicians and providers; private payers; pharmaceutical, device and diagnostic manufacturers or developers; quality

improvement or health services researchers; and federal or state government health agencies. In addition, the Director of the Agency for Healthcare Research and Quality and the director of the National Institutes of Health serve on the Board.

Accomplishments to date include:

- Establishment of a standing Methodology Committee to develop and periodically update scientifically based methodological standards for research conducted through PCORI;
- Recruitment and training of 48 study section members to review over 800 solicited project proposals for engaging patients and other stakeholders in research; and
- Development of national priorities for research and a research agenda (proposed priorities include assessment of options for prevention, diagnosis and treatment), improving health care systems, dissemination and communications research; addressing disparities and accelerating patient-centered outcomes research and methodology; and solicitation of public comment on the priorities and research agenda.

In May 2012, PCORI issued announcements for \$96 million in funding for comparative clinical effectiveness research in the areas of assessment of prevention, diagnosis and treatment options; improving health care systems; communication and dissemination; and addressing disparities. PCORI plans to issue a funding announcement for \$24 million to accelerate patient-centered and methodological research in summer 2012.





Best Buy Drugs are selected based on effectiveness and safety, side effects, convenience and cost.

IV. Providing Information to Consumers

A. CAREOperative

Healthcare Blue Book

[Healthcare Blue Book](#) is an online search tool that allows consumers to find “blue book prices” for common procedures. The site is geared primarily toward consumers who are uninsured or may be going out-of-network to receive care. The prices are based on industry data gathered from employers, payers and providers across the United States.

B. Centers for Medicare & Medicaid Services

Physician Compare

The ACA mandated the creation of the [Physician Compare](#) website, which launched on December 30, 2010. Updated monthly, the site allows individuals to search for a physician or other health care professional by specialty, location, gender and the status of a health care professional’s acceptance of the Medicare-approved amount as payment in full on all claims. Other information available includes language(s) spoken, group practice locations, education and hospital affiliation.

Physician Compare does not yet contain information about physician performance, although it currently lists physicians and group practices that have submitted quality information to Medicare through the Physician Quality Reporting System (PQRS). The ACA mandates that by January 1, 2013, the site include “comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program” and stipulates that this information should include the following, to the degree scientifically sound measures are available:

- Measures collected under PQRS
- Assessment of patient health outcomes and the functional status of patients
- Assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use
- Assessment of efficiency
- Assessment of patient experience and patient, caregiver and family engagement
- Assessment of the safety, effectiveness and timeliness of care
- Other information as determined appropriate by the Secretary of Health and Human Services

C. Consumer Reports

Consumer Reports Health Best Buy Drugs™
[Best Buy Drugs](#) is a public education project of Consumer Reports. The project provides information on drug effectiveness, safety and pricing for commonly used medications for 12 conditions, including chronic pain, depression, diabetes and high blood pressure. The project's comparative effectiveness data come from the [Drug Effectiveness Review Project \(DERP\) of Oregon Health & Science University's Evidence-Based Practice Center](#). Consumer Reports obtains information on the average retail prices paid by consumers for given drugs, as well as safety information. Best Buy Drugs are selected based on effectiveness and safety, side effects, convenience and cost. Consumer Reports encourages consumers to share this information with their physicians to find the most effective and safe drugs that also provide the best value. Consumer Reports has conducted outreach campaigns with a variety of partners to disseminate Best Buy Drugs information.

D. FAIR Health

Consumer Cost Lookup
[FAIR Health](#) was created from a settlement between insurers and New York State Attorney General Andrew Cuomo's office. FAIR Health is an independent, not-for-profit corporation that uses millions of de-identified health care claims to create a database aimed at helping insurers determine their reimbursement rates for out-of-network charges and to providing patients with estimates of out-of-network health care costs.

E. WellPoint

Care Comparison
The [Care Comparison](#) tool is designed to provide consumers with an easy-to-use cost and quality comparison to promote informed decision-making.

Care Comparison discloses real price ranges for 59 specific health care procedures and services. All costs are given as a "bundle of care," meaning all facility-specific charges that are typically a standard part of a procedure or treatment are included in the cost ranges. Care Comparison also includes facility-specific measures of quality.

Care Comparison has been implemented in all 14 of WellPoint's affiliated health plans, and the Blue Cross and Blue Shield Association (BCBSA) adopted the tool, making it available to BCBSA's 100 million members residing throughout all 50 states.

V. Improving Care Transitions

A. Center for Medicare & Medicaid Innovation Community-based Care Transitions Program (CCTP)

In [CCTP](#), community-based organizations will use care transition services to improve care transitions and reduce readmissions for Medicare beneficiaries. CMMI is accepting applicants on a rolling basis and as of May 2012 had awarded grants to 30 organizations.

B. Kaiser Permanente Heart Failure Transitional Care Program

In 2007, Kaiser Permanente implemented a [program to improve care](#) transitions from hospital to home for heart failure patients to improve quality and prevent readmissions. The program includes hospital care management, home health evaluation by a nurse or pharmacist and ongoing care management. The program has resulted in a 30 percent drop in hospital readmission rates, a statistically significant reduction in mortality rates, and cost savings of about \$12 million for heart failure patients.





VI. Developing Measures

A. National Committee for Quality Assurance

*Relative Resource Use (RRU) Measures
Healthcare Effectiveness Data and
Information Set (HEDIS)*

[RRU](#) measures indicate how intensively health plans use resources (including physician visits, hospital stays and other resources) to care for members with one of five chronic diseases: cardiovascular disease, COPD, diabetes, hypertension and asthma. When coupled with HEDIS quality data, RRU measures help members, plans, employers, benefit managers and other interested groups assess the value of health care provided. As a result, health plan members get a more detailed look at the value of services they pay for, while plans can see how effectively they use resources, as compared to other plans.

B. National Quality Forum (NQF)

National Priorities Partnership

The [National Priorities Partnership](#) (NPP) is an ongoing effort, coordinated by NQF, of 51 partner organizations representing various stakeholder groups, including physicians, policymakers, researchers, quality experts, labor, consumers and payers, who have joined to develop and advance a core set of National Priorities and Goals to improve health care. The National Priorities and Goals are: access; patient and family engagement; population health; safety; care coordination; palliative and end of life care; overuse; and infrastructure supports. For overuse, the NPP calls for all health care organizations to continually strive to improve the delivery of appropriate patient care and to substantially and measurably reduce extraneous service(s) and/or treatment(s) such as: inappropriate medication use, unnecessary tests and procedures, and preventable emergency department visits and hospitalizations.

As a result of the ACA, the NPP was contracted by the Department of Health and Human Services (HHS) to provide annual input into the National Quality Strategy. The full NPP served as an overarching committee, while the National Priorities Partners divided into three subcommittees specific to three domains of the National Quality Strategy: healthy people/healthy communities, better care and affordable care. On September 1, 2011, NPP provided its initial input to the Secretary of Health and Human Services. For the goal of providing affordable care, NPP proposed a number of potential measures, including a consumer affordability index, average annual growth in health care expenditures and multiple measures of unwarranted variation and overuse.

Resource Use Measurement Project

This [effort](#) focuses on identifying measures of costs as a building block toward measuring efficiency, a multidimensional concept that encompasses both quality and costs. The first phase of the project includes research and identification of episode-specific and cost-measurement issues through the development of a white paper entitled “Criteria For Determining the Appropriateness of Episode-based Resource Use Measures.”

[During Phase II](#), which began in January 2011, NQF conducted a Consensus Development Process project to evaluate potential resource use and cost measures. In April 2012, NQF released a report endorsing eight measures as voluntary consensus standards:

- Relative resource use for people with diabetes
- Relative resource use for people with cardiovascular conditions
- Relative resource use for people with asthma

- Relative resource use for people with COPD
- Episode treatment group (ETG)-based pneumonia cost of care
- Total resource use population-based per member per month (PMPM) index
- Total cost of care population-based PMPM index
- ETG-based hip/knee replacement cost of care

C. Quality Alliance Steering Committee (QASC)

High-Value Health Care Project

[This initiative](#), funded by the Robert Wood Johnson Foundation, aimed to advance the development of a national set of episode-based cost of care measures for a set of common acute and chronic health care conditions in order to understand how providers use resources and compare to national benchmarks. A QASC Steering Committee, in partnership with the America's Health Insurance Plans Foundation and the American Board of Medical Specialties Research and Education Foundation, developed 22 separate measures covering 12 conditions, including asthma, acute myocardial infarction, diabetes and low back pain. The measure development process addressed episode definition, duration, identification of clinically relevant services, risk adjustment and attribution. A standard pricing approach was used for the cost assignment. Program staff tested the measures using a commercial health care claims data set containing data on 15 million individuals. Currently, the Robert Wood Johnson Foundation is helping five of the 16 Aligning Forces for Quality communities implement selected episode-of-care cost measures, and program staff is exploring other dissemination channels.

VII. Recognizing Organizations

A. National Committee for Quality Assurance (NCQA)

Accountable Care Organization Accreditation
NCQA released its [Accountable Care Organization Accreditation](#) standards in November 2011. NCQA will evaluate applicants based on the following criteria:

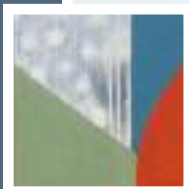
- ACO structure and operations
- Access to needed providers
- Patient-centered primary care
- Care management
- Care coordination and transitions
- Patient rights and responsibilities
- Performance reporting and quality improvement

Based on the above criteria, ACOs can receive one of three recognition levels.

Patient-Centered Medical Home Recognition Program

NCQA offers a [patient-centered medical home recognition program](#) for practices providing patient-centered, appropriate care. Participating organizations must possess six “must-pass elements”: access during office hours, use of data for population management, care management, support of self-care, referral tracking and follow-up and implementation of quality improvement. Organizations must also earn a certain number of additional points to receive one of three levels of recognition.





The goal of the Impacting Cost + Quality training program is to improve quality while reducing operating expenses by one percent for participating hospitals.

VIII. Supporting Organizational Improvement

A. Institute for Healthcare Improvement (IHI)

Impacting Cost + Quality

[Impacting Cost + Quality](#) is a training program for hospital leaders to reduce waste while simultaneously improving quality. The program began in fall 2011 and includes use of IHI’s Hospital Inpatient Waste Identification Tool to provide a systematic way for hospital leaders to identify and remove clinical and operational waste and implement initiatives for future cost savings. The tool consists of five modules—Ward Module, Patient Care Module, Diagnosis Module, Treatment Module and Patient Module—to identify opportunities for waste reduction. Each module includes examples of waste types, worksheets and instructions.

The goal of the Impacting Cost + Quality training program is to improve quality while reducing operating expenses by one percent for participating hospitals. Hospitals also develop plans to continue improving quality and reducing operating expenses after completion of the program.

IX. Engaging Communities

A. Agency for Healthcare Research and Quality (AHRQ)

AHRQ Learning Network for Chartered Value Exchanges (CVEs)

Formed in 2007, the [Learning Network](#) consists of 24 CVEs from around the country. Thirteen of these CVEs are statewide, while 11 have a sub-state or regional focus. These collaboratives are multi-stakeholder, consisting of consumers, purchasers, health plans, providers and others, with a goal of improving health care quality and transparency. The Learning Network has three major principles:

- All health care is “local”;
- Transparency in measuring and reporting on quality and cost is the key to helping providers improve and engaging consumers; and
- Collaboratives involving key stakeholder groups hold the promise to foster needed reforms.

Learning Network members share experiences and best practices and receive technical assistance from AHRQ.

B. Greater Boston Interfaith Organization (GBIO)

Health Care Cost Control Campaign

[GBIO](#) was founded in 1996 by a group of 45 clergy and community leaders interested in community organizing to unify different constituencies to act together on common interests. GBIO, along with other advocacy groups, including Health Care for All, was instrumental in securing passage of health reform in Massachusetts.

As a result of that health reform legislation and the increasing urgency around controlling costs in an era of near-universal access to insurance coverage, GBIO began a campaign on health care cost control. The goal of this campaign is to educate a critical mass of consumers among their members to develop a grassroots consumer movement that understands cost issues and can be mobilized to support legislation and/or advocate for policies or organizational efforts to make the health care system more sustainable.

Beginning in December 2010, GBIO gathered 25 of its member congregations interested in this issue. In 2011, leaders and experts from various health care stakeholder groups met with GBIO's group and discussed the challenges of addressing health care costs. The group has also released position statements on Massachusetts health care cost control approaches. In March 2012, GBIO urged state lawmakers to cap state health care cost increases at two percentage points less than the state gross product, rather than the 3.7 percent proposed by state House Speaker Robert DeLeo.

C. Network for Regional Healthcare Improvement (NRHI)

[NRHI](#) is the national membership association for Regional Health Improvement Collaboratives (RHICs). There are currently over 40 RHICs in the United States; these are non-profit organizations based in a specific geographic region, each run by a multi-stakeholder board of providers, payers, purchasers and consumers. The purpose of RHICs is to help community stakeholders identify opportunities for improving quality and value. NRHI provides networking and technical assistance and advocates on behalf of its members. NRHI has also authored a number of reports, including its "From Volume to Value" reports focused on health care payment reform.

D. The Fannie E. Rippel Foundation *Managing the Health Commons*

[Managing the Health Commons](#) was an action-research project with the late Nobel Prize-winning economist Elinor Ostrom to study collaborative management of health care resources in four American communities. The goal was to map systems of health care resource governance in Junction, Colorado; and Bloomington and Bedford, Indiana. Products to date include a paper summarizing the concept of the "health commons" and a webinar on preliminary project findings. The research team found 12 major characteristics of a successful health commons, which include "a formal or informal leadership team involving all (or most) stakeholder groups... with rules and procedures that fit local circumstances."





The Communication Toolkit is designed to help organizations communicate with employees or members about high-quality health care, making better health care decisions and being informed and engaged in their health and health care.

Organizing for Health

[This project](#) is testing a framework, based on the work of Marshall Ganz, for community organizing to improve health and create a sustainable health care system. The Rippel Foundation is piloting an organizing campaign in Columbia, South Carolina. To date, they have recruited more than 140 community leaders and held a series of town halls and house meetings, which culminated in a Community Issues Assembly at which the community decided on a campaign strategy. Community leaders are now implementing the strategy, which focused on improving health literacy and communication, reducing unnecessary emergency department use and reducing costs.

E. The Robert Wood Johnson Foundation (RWJF)

Aligning Forces for Quality

[Aligning Forces for Quality](#) (AF4Q) is a \$300 million campaign to improve health care in 17 communities in the United States by aligning all health care stakeholders in each community to strive toward common goals, including improving health care quality, implementing measurement and public reporting of clinician performance, and engaging patients in medical decision making. Phase one of AF4Q began in 2006 to form and fund leadership teams in the communities to build health care systems and partner with physicians to improve quality, measure and report ambulatory care quality, and engage consumers. As part of phase two, in

2008, AF4Q was expanded to include inpatient care, disparities reduction and promotion of the role of the nursing profession in quality health care. Phase three of AF4Q was launched in May 2011. In this phase, the participating communities create and test models of health care payment that reward value, rather than volume, of services provided while continuing to expand quality improvement efforts. Most of the regional alliances are also beginning to report cost and efficiency measures, with a focus on readmission rates and emergency room visits for non-urgent care.

X. Supporting Employers

A. Anthem

Anthem Employer Health Care Cost Toolkit

The [Anthem Employer Health Care Cost Toolkit](#) provides employers with resources for discussing health care costs with employees. The toolkit consists of three components:

- A customizable employee letter that explains the impact of rising costs on the workforce and lists actions that employees can take to reduce health care costs;
- An e-mail employee educational campaign that includes discussion of costs of services, prevention, diet and activity; and
- A two-page health care cost brochure that explains why health care costs are rising and ways that employees can help keep health care affordable.

B. National Business Group on Health (NBGH)

Evidence-Based Health Care Communication Toolkit

The [Communication Toolkit](#) is designed to help organizations—including employers, health care purchasers, insurers, health plans and others—communicate with employees or members about high-quality health care, making better health care decisions and being informed and engaged in their health and health care. The toolkit was originally published in 2008 by NBGH and updated in 2010 with funding from the California HealthCare Foundation. Materials designed for employees address the following topics:

- Basics of health care quality and the importance of evidence-based information
- Tips for getting high-quality care before, during and after a health care visit
- Cost and quality issues, including how to find high-quality care and make wise decisions about health care spending
- Effective use of the Internet to access reliable health information

The toolkit was developed through a rigorous, evidence-based process consisting of extensive literature reviews, interviews, focus groups, meetings and surveys of employers and consumers. Based on the findings from these efforts, the toolkit includes the following elements:

- Clear, concise explanations of concepts that are unfamiliar to consumers
- Use of vignettes to reinforce key concepts
- Accessible design
- Tips for employees on what they can do and how to learn more
- Opportunity to customize with organization-specific information

XI. Designing Benefits

A. Institute of Medicine (IOM)

Determination of Essential Health Benefits

Under the ACA, certain insurance plans, including those participating in state insurance exchanges, must offer a certain minimum level of health benefits, termed “essential health benefits” (EHB), as determined by the Department of Health and Human Services (HHS). HHS asked the IOM to recommend criteria and methods for determining and updating the EHB package; the IOM was not asked to define which benefits should be included in the package. In October 2011, the IOM issued the report “[Essential Health Benefits: Balancing Coverage and Cost](#),” which recommended criteria to develop the aggregate EHB package, the specific EHB package components, and methods for defining and updating the EHB.

B. Pacific Business Group on Health (PBGH)

Right Priced Care

The [Pacific Business Group on Health’s Right Priced Care Project](#) is gathering data on the price variations in common and often-standardized services. PBGH will then work with employers and purchasers to design benefits that encourage consumers to use the facilities that offer the best value services.





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XII. Convening Experts and Advancing Research

A. Health Care Cost Institute

Health Care Cost Tracker Report and Data Provision

The [Health Care Cost Institute](#), a non-profit research institute, was launched in September 2011 in response to increasing interest from academic researchers and others about timely health care spending data. One of its primary activities will be releasing a biannual health care cost tracker report showing the major drivers of health care spending. To create its reports, the Institute currently has access to data from Aetna, Humana, Kaiser Permanente and UnitedHealthcare and expects to add other health plans. The Institute will also provide data to researchers from universities, think tanks and other institutions for health care cost research studies, and it expects to release its first tracker report and research studies in 2012.

B. Lown Cardiovascular Research Foundation and New America Foundation

Avoiding Avoidable Care Conference

[This conference](#), co-hosted by the Institute of Medicine, took place on April 25-26, 2012 and brought together clinicians, policymakers,

researchers and others to discuss avoidable care and the creation of a network to address how to avoid avoidable care. Conference products included a toolkit of papers and talking points for organizing follow-up meetings at participants' organizations. The conference organizers have also created an online resource center and blog to continue the discussion about avoidable care.

C. West Health Policy Center

Serving as the policy arm of West Wireless Health Institute, [the Center](#) was founded in 2012 and is a non-profit, nonpartisan organization with the goal of saving more than \$100 billion in cumulative health care costs within 10 years through three core functions:

- Funding research (through its fellowship program) to identify savings “that can be acted on immediately and reflect common sense changes in reimbursement and regulation, with no legislative action required”
- Serving as a neutral convener among health care providers, insurers, governmental agencies, drug and device manufacturers, and other health care system participants
- Conducting educational activities with government, industry, academia and non-profit stakeholders

XIII. Implementing Payment Reform

A. Blue Cross Blue Shield of Massachusetts (BCBSMA)

Alternative Quality Contract (AQC)

In 2009, [BCBSMA](#) introduced a new payment model, the alternative quality contract. In this model, physicians and organizations receive global payments for their patients and incentives for meeting quality measures. In turn, participating physicians and organizations agree to assume responsibility for the cost and quality of care given to their patients, regardless of where the care is received. First-year results showed improvement in quality measures, and the AQC appeared to be on track to achieve its goal of cutting spending growth rates in half over five years.

B. Center for Medicare & Medicaid Innovation

Bundled Payments for Care Improvement Initiative

As of May 2012, the [Bundled Payments initiative](#) was seeking proposals for developing models for four types of bundled payment, including three retrospective bundled payment models. In the retrospective models, the episode of care would be defined as either 1) inpatient stay in a general acute care hospital, 2) inpatient stay and post-acute care up to 30 or 90 days post-discharge, or 3) post-acute care within 30 days of discharge from an inpatient stay, with the episode ending no sooner than 30 days after discharge. CMMI will also support a prospective model in which CMS would provide a single bundled payment to the hospital that would encompass all services provided during a patient's stay.

C. Commonwealth Fund

The Commonwealth Fund Commission on a High Performance Health System

In April 2012, the Commonwealth Fund Commission released [recommendations for improving health care quality and slowing](#) the growth of health care spending. The Commission recommended that the Department of Health and Human Services and CMS create 50 to 100 voluntary "Health Improvement Communities" (HICs) comprised of providers, payers, patients and other stakeholders. These HICs would utilize payment reform, primary care and health information technology to care for complex, high-cost patients with chronic illnesses. The Fund estimates that HICs could contribute to \$184 billion in health care savings over a 10-year period.

D. Institute of Medicine

Committee on Geographic Variation in Health Care Spending

IOM is conducting a [consensus study](#), mandated in the ACA and commissioned by HHS in 2010, on the regional variations in health care utilization and costs for individuals with Medicare, Medicaid and private insurance, as well as the uninsured.

The resulting consensus report will explore the way(s) in which this regional variation may or may not relate to issues such as:

- Cost, supply and quality of care, as well as health outcomes
- Patient factors such as diversity, health status, access to care, insurance coverage and treatment preferences
- Physician factors such as treatment decision-making and the availability of reliable medical evidence to guide decisions
- Way(s) a geographic area is defined





IOM also will consider recommending adjustments to Medicare payment systems in order to incentivize high-value, high-quality, evidence-based, patient-centered care through implementation of a value index.

IOM also will consider recommending adjustments to Medicare payment systems in order to incentivize high-value, high-quality, evidence-based, patient-centered care through implementation of a value index (based on cost and quality measures). In response to a request from the Committee, CMS created several new datasets using the new Geographic Variation in Medicare Spending and Utilization (GV) database, which include quality, cost, utilization and demographic indicators for all Hospital Referral Regions (HRRs) and states.

The final consensus study is expected to be released in 2013.

***E. Society of General Internal Medicine
National Commission on
Physician Payment Reform***

In March 2012, SGIM announced its creation of an [independent commission](#) to assess how physician payment impacts patient care, including the impact of new models such as the patient-centered medical home and accountable care organizations. The commission is expected to issue recommendations for physician payment reform in early 2013.

***F. UnitedHealthcare (UHC)
Cancer Care Payment Program***

[UHC](#) piloted a bundled payment program at five oncology practices for colon, breast and lung cancers (all types and stages). Medical oncologists participating in the pilot received an up-front payment for an entire treatment regimen (determined by the oncologist), based on the expected cost for the specific condition. UHC determined this fee by calculating the difference between the physician's current fee schedule and the manufacturer's cost of chemotherapy drugs, then adding a case management fee. Office visits, chemotherapy administration, lab fees and other services continued to be paid on a fee-for-service basis. The oncologist was paid the same fee regardless of the chemotherapy drugs administered to the patient (and the cost of drugs will be reimbursed at manufacturer's cost). As a result, the oncologist's income was decoupled from drug sales, removing an incentive in the current payment system to overuse chemotherapy. Final results from the pilot will be released in the summer of 2012.

XIV. Developing Cost Ceilings

A. Medicare Independent Payment Advisory Board

The ACA created an [Independent Payment Advisory Board](#) (IPAB) and established specific target growth rates for Medicare. The IPAB is charged with

- Developing specific detailed proposals to reduce per capita Medicare spending in years when spending is expected to exceed target levels;
- Submitting annual detailed reports to Congress on health care costs, access, quality and utilization; and
- Submitting to Congress recommendations regarding methods of slowing the growth of private national health care expenditures.

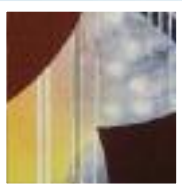
Beginning in 2015, HHS must implement the IPAB's proposals unless Congress adopts equally effective alternatives.

The IPAB's 15 members will be appointed by the President and approved by the Senate for six-year terms. Three of the members will be HHS officials, with the remaining 12 including nationally recognized experts in health finance, payment, economics, actuarial science or health facility and health plan management, and representatives of providers, consumers and payers. A 10-member consumer advisory council will be established to advise the IPAB. It is unclear when the IPAB members and advisory board will be appointed.

Since the IPAB is imbued with fairly broad powers to control Medicare costs and its members will be unelected, it has been controversial. In March 2012, the House Republican majority passed a bill to repeal the IPAB. However, the bill is unlikely to advance in the Senate, and President Obama has indicated that he would veto such a bill.

Author

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Beginning in 2015, HHS must implement the IPAB's proposals unless Congress adopts equally effective alternatives.





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