



There are many more organizations working to advance the wise use of health care resources than could be featured at the 2011 ABIM Foundation Forum. A selective list of initiatives undertaken by a wide range of stakeholders from across the country follows. While the list is current as of this writing, these efforts undoubtedly have continued to evolve since this document went to press; in addition, we have little in the way of data or studies to gauge the effectiveness of these pioneering efforts.

The listed initiatives range from small programs in their infancy to broad national initiatives mandated in the health reform law with the full backing of the U.S. government and Treasury. These varying efforts and a growing chorus in Congress signal a recognition that continuing with “business as usual” is not sustainable for the health system or the country’s economy; that it is no longer sufficient to talk about improving quality without focusing on reducing waste and furthering more appropriate resource use. We look forward to discussing these and other initiatives at the Forum and to continuing the discussion on efforts to improve health care decision-making and resource use on the ABIM Foundation’s website and blog.

Key Initiatives to Promote Appropriate Resource Use

Michelle Johnston-Fleece, MPH
Amy Cunningham, MPH

These varying efforts and a growing chorus in Congress signal a recognition that continuing with “business as usual” is not sustainable for the health system or the country’s economy; that it is no longer sufficient to talk about improving quality without focusing on reducing waste and furthering more appropriate resource use.

GOVERNMENT HEALTH REFORM INITIATIVES

Patient Protection and Affordable Care Act (ACA)

Center for Medicare and Medicaid Innovation

Congress created the Center for Medicare and Medicaid Innovation (CMMI or Innovation Center) in the ACA and authorized it to “test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care” for those receiving Medicare, Medicaid or Children’s Health Insurance Program (CHIP) benefits. CMMI officially launched in April 2011.

The Innovation Center “evaluate[s] each model on the quality of care furnished and the changes in spending.” The Center’s mandate gives it great flexibility in selecting and testing innovative payment and service delivery models, enables it to work with Medicare, State Medicaid and CHIP programs, and provides \$10 billion in direct funding in fiscal years 2011 through 2019 to support this mission. The mandate also allows the Secretary of the Department of Health and Human Services (HHS) to expand, through rulemaking, the scope and duration of models proven effective after evaluation, including implementation on a nationwide basis to cover the entire Medicare, Medicaid or CHIP populations. In order to expand a model, the Secretary must determine that the model improves the quality of patient care, and the Centers for Medicare & Medicaid Services (CMS) actuary must certify that expanding the program will stabilize or lower costs.

Examples of care models and initiatives that CMMI will test and advance are: the use of “bundled payments” for episodes of care; the patient-centered medical home, through Federally Qualified Health Center (FQHC) and Multi-Payer Advanced Primary Care Practice Demonstrations; and care and payment models emphasizing public health approaches to preventing and minimizing the burden of chronic diseases.

Medicare Independent Payment Advisory Board

The ACA creates an Independent Payment Advisory Board (IPAB) and establishes specific target growth rates for Medicare. The IPAB is charged with all of the following:

- 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
- 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 twelve being:

- Nationally recognized experts in health finance, payment, economics, actuarial science or health facility and health plan management
- Representatives of providers, consumers and payers

A 10-member consumer advisory council will be established to advise the IPAB.

Since the IPAB is imbued with fairly broad powers to control Medicare costs and its members will be unelected, it has been controversial; a bipartisan group of Members of Congress has called for its elimination in advance of its formation.

Medicare Physician Feedback/ Value Modifier Program

Medicare currently provides private feedback to physicians about their resource utilization, based on claims data, as directed by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), with the idea that having such data could cause outlier physicians to “self correct.” Section 3003 of the ACA continues and expands the Physician Feedback/Value Modifier Program and requires the Secretary—beginning in 2012—to provide meaningful and actionable feedback reports that compare patterns of resource use of individual physicians and medical groups to that of “similar professionals,” i.e., a peer group or physicians of the same specialty. The ACA states that data should be risk-adjusted for differences in socioeconomic and demographic characteristics, ethnicity and health status and to eliminate the effect of geographic adjustments in payment rates. In addition, the ACA requires CMS to use cost and quality data when determining physician payments by implementing a value-based payment modifier in the Medicare Physician Fee Schedule (MPFS) beginning in 2015. (By 2017, the modifier will be applied to nearly all physicians in the MPFS.)

It is unclear how this program relates to Medicare’s Physician Quality Reporting System’s (PQRS) feedback reports, which were intended to eventually include resource use, although the ACA requires CMS to harmonize similar measures across programs and a related report to inform that effort is due from the National Quality Forum (NQF) this fall. According to the Medical Group Management Association, CMS is also still working on a method to define an episode of patient care in order to measure resource use within that episode. CMS also will have to determine how to apportion resource use among physicians in instances where patients are receiving care from multiple providers (e.g., if a referral is made by one physician to another, to whom is resource use attributed) for PQRS.

Patient-Centered Outcomes Research Institute

The ACA established the Patient-Centered Outcomes Research Institute (PCORI or the Institute) as a nonprofit 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. The members of PCORI’s Board of Governors were named in September 2010 and have since had a number of meetings; no papers or reports were forthcoming on the date of publication.

PCORI’s duties include identifying research priorities and establishing and carrying out a research project agenda that must achieve the following required objectives:

- Establish a standing Methodology Committee to develop and periodically update scientifically-based methodological standards for research conducted through PCORI
- Ensure peer review—designed to avoid bias and conflicts of interest on the part of reviewers—to assess scientific integrity and adherence to the methodological standards adopted

Section 3003 of the ACA continues and expands the Physician Feedback/Value Modifier Program and requires the Secretary—beginning in 2012—to provide meaningful and actionable feedback reports that compare patterns of resource use of individual physicians and medical groups to that of “similar professionals,” i.e., a peer group or physicians of the same specialty.

- Provide public comment periods prior to adoption of national priorities, the research project agenda, the methodological standards and the peer review process, as well as following the release of draft findings with respect to systematic reviews of existing research and evidence
- Publicize research findings within 90 days

This means that PCORI must conduct research that compares the effects of treatments on various populations that vary by age, gender, race, ethnicity and disease status, for example, and share findings in a way that is usable by patients and physicians in making care decisions. A fair amount of controversy surrounds PCORI's ability to "ration" health care, though the Institute is prevented by the legislation from making payment or coverage recommendations.

PCORI will be 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.

There are 21 members of the Board of Governors of PCORI. The Board of Governors is made up of 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 AHRQ and the Director of NIH serve on the Board.

A fair amount of controversy surrounds PCORI's ability to "ration" health care, though the Institute is prevented by the legislation from making payment or coverage recommendations.

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. 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 the Physician Quality Reporting [System]
- 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

The inclusion of efficiency measures, as well as a number of quality measures, could make robust and scientifically sound information about a large portion of physicians readily available to consumers, researchers and policymakers, enabling them to judge the value of health care provided at the individual physician level.



PHYSICIAN ORGANIZATION INITIATIVES

American Board of Medical Specialties (ABMS)

High-Value Health Care Project

As part of a larger initiative funded by the Robert Wood Johnson Foundation aimed at improving care effectiveness and quality, ABMS's High-Value Health Care Project aims to advance the development of a national set of episode-based cost of care measures for a group of common acute and chronic health care conditions in order to understand how providers use resources and compare to national benchmarks. The measure development process addresses episode definition, duration, identification of clinically relevant services, risk adjustment and attribution. A standard pricing approach will be used for the cost assignment. The measures will be pilot tested on both commercial and public datasets prior to submission to the NQF for endorsement. Thus far, 22 separate measures have been outlined covering 12 conditions, including asthma, acute myocardial infarction, diabetes and low back pain.

American College of Physicians (ACP)

High-Value, Cost-Conscious Care Initiative

Announced in April 2010, ACP's High-Value, Cost-Conscious Care Program 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, the Clinical Efficacy Assessment Technical Advisory Committee will develop "ACP's High-Value, Cost-Conscious Care Recommendations," which will be submitted for review and consideration for publication in *Annals of Internal Medicine*. Also, the next edition of ACP's Medical Knowledge Self-Assessment Program (MKSAP) will focus on optimal diagnostic and treatment strategies, based upon considerations of value, effectiveness and avoidance of overuse and misuse. Additional phases of the initiative may include patient education materials and curricula for medical students and residents.



As part of a larger initiative funded by the Robert Wood Johnson Foundation aimed at improving care effectiveness and quality, ABMS's High-Value Health Care Project aims 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.

QUALITY ORGANIZATION INITIATIVES

Institute for Healthcare Improvement (IHI)

Impacting Cost + Quality

Impacting Cost + Quality is a forthcoming training program for hospital leaders to reduce waste while simultaneously improving quality. The program, which will begin in fall 2011, includes use of IHI's Hospital Inpatient Waste Identification Tool, which provides 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. In early 2011, IHI published a white paper outlining how to use the tool in both inpatient and non-acute settings.

Appropriate Use of Specialty Care Services

IHI has developed a model for the appropriate use of specialty services. In 2010, the Institute published a white paper, "Reducing Costs through the Appropriate Use of Specialty Services," which outlined the model's key components:

- Engagement of physicians as partners in interpreting the meaning of variation and planning interventions
- Engagement of patients in shared decision-making through use of decision aids
- Local adoption, adaptation or development of appropriateness criteria for selected procedures
- Development of service agreements between primary and specialty care to ensure coordination and consistency of care throughout the patient "journey"
- Design and improvement of care processes for efficiency and reliability

As of May 2011, IHI is developing prototypes to test these models in practice for a number of diagnostic tests and surgical procedures.

SPECIALTY SOCIETIES: Laying the Foundation for Wise Decision Making

In addition to initiatives that explicitly address management of resources, such as ACP's High-Value, Cost-Conscious Care Initiative, specialty societies have a number of projects that may facilitate wise decision-making about resource use. For instance, initiatives such as the American College of Cardiology's Imaging in FOCUS and the American College of Radiology's Image Gently Campaign are designed to ensure appropriate use of services. Other efforts focus on improving quality and reducing costs in the hospital setting, such as the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). The ACS NSQIP provides a database of pre-operative to 30-day post-operative surgical outcomes based on clinical data. According to the ACS, hospitals that have adopted the ACS NSQIP have prevented an average of 251-500 complications annually and have realized significant cost savings. The Society of Hospital Medicine is working, through Project BOOST, to improve transitions for patients between hospital and home; the project's goals include reducing lengths of stay and 30-day readmission rates for general medicine patients.

In addition, the American Society of Clinical Oncology is developing guidelines for conducting end-of-life discussions with patients suffering from advanced cancer in order to enable wise decision making about end-of-life care.

Along with society-specific initiatives, numerous societies have worked collaboratively to lay the foundation for future work in wise decision making. For example, the primary care specialty societies have adopted the "Joint Principles of the Patient-Centered Medical Home." The patient-centered medical home model includes commitments to coordinating care across settings and improving quality of care, particularly for patients with chronic conditions. Other efforts championed by multiple specialty societies have included the development of clinical guidelines to encourage evidence-based decision making. Many societies also have developed registries; while not explicitly addressing costs, these registries could be used to examine and improve resource use, along with enhancing quality and patient safety.

National Committee for Quality Assurance (NCQA)

HEDIS Relative Resource Use Measures

Relative Resource Use (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.

National Quality Forum (NQF)

National Priorities Partnership

The National Priorities Partnership (NPP) is an ongoing effort, coordinated by NQF, of 48 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. The participating organizations have pledged to take action to achieve specific, measurable progress—including action in the key drivers of payment, public reporting, quality improvement and consumer engagement. The NPP work has been informed by and has influenced the HHS’s overarching National Quality Strategy (NQS), which the ACA mandated be developed and updated each year. In fact, the “access” and “infrastructure supports” priorities were added to the NPP’s original six priorities to align with the first draft of the NQS, and NPP has contracted with HHS to provide ongoing guidance and input on the NQS moving forward.

As stated, the NPP identified “overuse” as a priority area, laying out a vision for a health care system that promotes better health and more affordable care by “continually and safely reducing the burden of unscientific, inappropriate and excessive care, including tests, drugs, procedures, visits and hospital stays.” 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 laboratory tests
- Unwarranted maternity care interventions
- Unwarranted diagnostic procedures
- Inappropriate non-palliative services at end of life
- Unwarranted procedures
- Unnecessary consultations
- Preventable emergency department visits and hospitalizations
- Potentially harmful preventive services with no benefit

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).

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 Resource Use Measurement Project includes research and identification of episode-specific and cost-measurement issues through the commissioning of a white paper entitled “Criteria for determining the appropriateness of episode-based resource use measures.” As of April 2011 the final paper was pending NQF Board approval.

During Phase II, which began in January 2011, NQF will evaluate and endorse resource use measures for reporting at multiple levels, including the individual and group physician level. This consensus development process will specifically include evaluation of resource use measures, including per capita and episode-based measures for 18 specific diseases and conditions across two review cycles.

The Resource Use Measurement Project focuses on identifying measures of costs as a building block toward measuring efficiency, a multidimensional concept that encompasses both quality and costs.

EMPLOYER INITIATIVES

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



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.

INSURANCE INITIATIVES

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:

- Customizable employee letter that explains the impact of rising costs on the workforce and lists actions that employees can take to impact health care costs
- E-mail-based employee educational campaign that includes discussion of costs of services, prevention, diet and activity
- Two-page health care cost brochure that explains why health care costs are rising and ways that employees can help keep health care affordable

UnitedHealthcare (UHC)

Cancer Care Payment Program

In recognition of the development of accountable care organizations and episode-based payment, UHC is currently piloting a bundled payment program at five oncology practices for colon, breast and lung cancers (all types and stages). The goal of the pilot program is to test the model, which is designed to advance best practices in treatment, improve quality of care and potentially reduce costs without reducing payment to physicians. Medical oncologists participating in the pilot receive an up-front payment for an entire treatment regimen (determined by the oncologist), based on the expected cost for the specific condition. UHC determines 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 continue to be paid on a fee-for-service basis. The oncologist is 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 is decoupled from drug sales, removing an incentive in the current payment system to overuse chemotherapy.



UHC is currently piloting a bundled payment program at five oncology practices. The goal of the pilot program is to test the model, which is designed to advance best practices in treatment, improve quality of care and potentially reduce costs without reducing payment to physicians.

Kaiser Permanente

Care Management Institute

The Care Management Institute's programs include "Complete Care for Complex Conditions" (4C). The goal for the 4C initiative is to improve health care delivery and reduce costs for the sickest members who use the most health care resources—the one percent of Kaiser members who incur 27 percent of total costs. The goals for enrolled members are a more integrated care experience, care in the most appropriate venue, effective symptom management and health maintenance. The program emphasizes integrated delivery of care to improve the member experience, health outcomes and affordability.

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.

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) is adopting the tool for all Blue Plans nationwide. Once implemented by the BCBSA, Care Comparison will be available to the Plans' 100 million members residing throughout all 50 states.

POLICY, RESEARCH AND FOUNDATION INITIATIVES

Institute of Medicine (IOM)

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, Evidence Communication, Electronic Health Records 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.

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



Committee on Geographic Variation and 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 (based on cost and quality measures). The final consensus study is expected to be released in 2013.

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 community to build health care systems and partner with physicians to improve quality, measure and report ambulatory care quality, and engage consumers. In 2008, AF4Q was expanded to include inpatient care, disparities reduction and promotion of the role of the nursing profession in quality health care. AF4Q is tackling the quality issues of the U.S. health care system by developing local models for care transformation that serve as examples for other communities.

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.



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.

Payment Reform for High-Value Care

In fall 2010, RWJF issued a call for proposals “for payment reform efforts designed to promote high-value health care outcomes that leverage existing market knowledge, partnerships and resources.”

Although funds will not be used to support existing pay-for-performance (P4P) projects or generic medical home demonstrations, they will be made available for P4P efforts or medical home demonstrations that incorporate outcome-based performance payments, such as, a payment incentive program based on reducing hospital readmission rates for patients with chronic disease. RWJF seeks proposals for multi-stakeholder payment strategies or more limited payment reform approaches, such as, those that include a health plan, employer and health care provider only. In their proposals, applicants are required to identify the participating payers and the nature of their participation.

The Fannie E. Rippel Foundation

Managing the Health Commons

Managing the Health Commons is an 18-month action-research project with Nobel Prize-winning economist Elinor Ostrom to study collaborative management of health care resources in four American communities. The goal is to map systems of health care resource governance in local communities in Cedar Rapids, Iowa; Grand Junction, Colorado; and Bloomington and Bedford, Indiana. Other anticipated products from the project include self-evaluation tools that health care leaders can administer in their own communities to identify both the status of and areas of potential improvement in management of resources, a paper summarizing lessons learned, and ongoing partnerships between the researchers and the local communities.

Hospice vs. Intensive Care: The Drivers of End-of-Life Care

This project is a partnership between the Rippel Foundation and HealthCare Chaplaincy to explore hospital-related factors contributing to different end-of-life experiences among patients with chronic illness. The project objective is to test the implications of policy choices, including access to palliative care in hospital settings that might reduce costs and improve patient satisfaction.

CONSUMER INITIATIVE

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. Beginning in December 2010, GBIO gathered 25 representatives of its member congregations that were interested in this issue. Over the past several months, leaders and experts from various health care stakeholder groups have met with GBIO’s team and discussed the intricacies and challenges of addressing health care costs. 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.

GBIO is currently seeking to expand its work in this area.

Authors

Michelle Johnston-Fleece is the Senior Policy & Research Analyst at the American Board of Internal Medicine and the ABIM Foundation.

Amy Cunningham is the Program Manager at the ABIM Foundation.

GBIO, along with other advocacy groups, including Health Care for All, was instrumental in securing passage of health reform in Massachusetts.



510 Walnut Street | Suite 1700
Philadelphia, PA 19106-3699
215.446.3530 | 1.800.441.2246 x 3530
www.abimfoundation.org

Copyright © 2011 ABIM Foundation.
All rights reserved.