

MANAGED CARE

OUTLOOK

The Insider's Business Briefing on Managed Healthcare

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At Presstime

AHRQ Releases Toolkits

The Department of Health and Human Services' Agency for Healthcare Research and Quality has released 17 toolkits designed to help doctors, nurses, hospital managers, patients, and others reduce medical errors.

The toolkits, developed by AHRQ-funded experts who specialize in patient safety research, are free, publicly available, and can be adapted to most health care settings. The toolkits range from checklists to help reconcile medications when patients are discharged from the hospital to processes to enhance effective communication among caregivers and with patients to toolkits to help patients taking medications.

The toolkits were developed through AHRQ's Partnerships in Implementing Patient Safety program. Researchers who developed the toolkits examined best practices in a variety of health care settings, including small rural facilities, large urban hospitals, health clinics, and hospital emergency departments. They also studied patient safety interventions among diverse populations, including children and older patients.

For more information and a complete listing of the 17 toolkits, visit www.ahrq.gov/qual/pips. ■

Why Health Literacy Matters

By Michael Villaire and Gloria Mayer

Although the term "health literacy" may seem like a narrow bit of health care nomenclature to some, its impact on our lives — and the health care system — is quite profound. Health literacy, or the ability to obtain, understand, and apply health information in an appropriate fashion, matters in myriad areas: economics, morbidity and mortality, ethics, and liability, to name a few. It also represents an informational divide that can determine whether, in fact, we are actually delivering health care to our patients.

While there are many accepted definitions, health literacy is, at its most basic level, how well we can comprehend and effectively navigate the health care system to achieve the best possible

(See Why Health Literacy ... page 3)

Employees: Get Healthy, or You May Have to Help Pick Up the Tab for Your Health Insurance

As 2007 gives way to 2008, it seems like a good time to step back and reflect on some of the most significant developments over the last 12 months and examine what might lie ahead in the next 12 months.

As far as traditional consumer-directed health plans (CDHPs) are concerned, perhaps the most significant event or story to report is that they not only hung around but also saw modest gains as employers increasingly turned to them as a viable option for providing coverage to their employees.

"There are people on both sides — some predicting that consumer-directed plans are the revolution that will save us all

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National Briefs

CDC Study Finds no Real Increase in Obesity Among Adults: After a quarter century of increases, obesity prevalence has not measurably increased in the past few years, but levels are still high — at 34 percent of U.S. adults aged 20 and over, according to a study released by the Centers for Disease Control and Prevention (CDC). The report, “Obesity Among Adults in the U.S.: No Significant Change in 2005-06,” is the latest analysis based on the National Health and Nutrition Examination Survey, conducted by CDC’s National Center for Health Statistics. Obesity rates have increased over the past 25 years. Among men, there was an increase in obesity prevalence between 1999 and 2006. There was no significant change, however, in obesity prevalence between 2003-2004 and 2005-2006 for either men or women. The full report is available at www.cdc.gov/nchs.

HSA Plans Cover Preventive Care on a First-Dollar Basis: Most health savings account (HSA) plans cover recommended preventive benefits on a first-dollar basis, according to a survey released by America’s Health Insurance Plans (AHIP). Among HSA and high-deductible health plan (HDHP) policies offering first-dollar coverage for preventive care, 100 percent cover adult and child immunizations; well-baby and well-child care; mammography; Pap tests; and annual physical exams and screenings. Nearly 90 percent provide first-dollar coverage for prostate cancer screenings, and 83 percent offer this coverage for colonoscopies. Virtually all HSA/HDHP policies purchased in the large-group market (99 percent) and small-group market (96 percent) provide first-dollar coverage for preventive care.

Aetna to Offer Access to Confidential Telephonic Cancer Genetic Counseling: Aetna will offer members confidential telephone and Web-based cancer genetic counseling services as a component of health benefit plans, which include coverage for genetic testing. The services will be offered through Informed Medical Decisions, a national genetic counseling company staffed with board-certified genetic counselors with expertise in cancer genetic counseling. All discussions between Aetna members and genetic counselors are private and will not be shared with the member’s employer or with Aetna. Neither Aetna nor the member’s employer will receive test results.

Breast Cancer Report Outlines Progress Made: Susan G. Komen for the Cure has published the State of Breast Cancer report, a snapshot of where the United States and the global community are in the quest to end breast cancer. The report provides information on advancements in diagnosis, treatment, and research that have made breast cancer a survivable disease for more than two million people in the United States. But the news is not all good. The report also explores cultural, social, educational, and financial barriers — or disparities — that prevent many people from getting screened and receiving life-saving breast cancer care. The report is available at www.komen.org/sobc2007. ■

Why Health Literacy...

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outcome. Optimal health literacy, then, could be seen as our ability to successfully execute a number of steps at critical points along a continuum:

- When we are ill, we understand that we need health care;
- We are able to identify and get to a facility that provides that health care;
- We understand the information requested of us and accurately provide all this information;
- We communicate effectively with all health care providers and ancillary staff to accurately convey information about our condition that cannot be detected through empiric observation and testing;
- We understand our conditions as they are explained to us, we understand everything that is asked of us, and we carry out instructions (medication dosing regimens, test preparations, lifestyle changes, et cetera) to perfection; and
- When we are not ill, we listen to our health care providers on ways to keep ourselves healthy, understand these instructions, and carry out preventive measures explicitly.

If this best-case scenario were the rule rather than the exception, health literacy might be relegated to the specialty niche of interesting case studies. Inadequate health literacy, however, is much more widespread than we might like to think, and its impact on our lives and the health care system is extensive and profound. In this short piece, we will look at the incidence and cost of poor health literacy in the United States and two elements that greatly affect health literacy: communication and culture.

Prevalence and Cost of Poor Health Literacy

Depending on who you ask, about 87 million American adults, or more than one in three, have trouble understanding and carrying out basic health care instructions. Stated another way, about 36 percent of American adults have basic or below basic health literacy skills. These figures from the most recent national data set

available, the 2003 National Assessment of Adult Literacy (NAAL), show that about one in three American adults have trouble with the most basic skills required to navigate the health care system and, therefore, are at risk for diminished and inappropriate care. They also represent individuals most likely to be responsible for higher (and unnecessary) costs to a health care system already sagging under its \$2 trillion annual price tag.

So, what is the cost of poor health literacy in the United States? Using newly released data from the Medical Expenditure Panel Survey (MEPS) and the NAAL, researchers at the University of Connecticut have come up with an alarming update of the cost of low health literacy.

Previous research by Friedland in 2002 (prior to the NAAL survey) had put the cost of low health literacy (due to such factors as readmission to hospitals because of not understanding pre- or post-hospitalization care or medicine dosing instructions, et cetera) around \$58 to \$73 billion a year. These costs are in addition to existing costs and, in theory, are preventable.

The University of Connecticut researchers, using the newer data, estimate the cost at between \$106 billion and \$238 billion annually. When one considers the annual health care bill at somewhere around \$2 trillion, this means roughly between 5 percent and 12 percent of all health care expenditures are attributable to low health literacy. That's a big bill to pay for our inability to effectively communicate with our patients.

Communication

Regardless of whether they can understand health information presented to them, health care consumers prefer receiving easy-to-understand materials. Unfortunately, most Americans read at no higher than an eighth grade level (many at much lower levels), and most health care information is delivered at a high school or collegiate level — or higher. This disconnect in printed materials' reading level is at the heart of much

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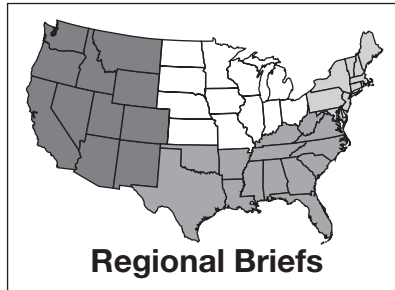
Northeast

Harvard Pilgrim Recognizes 32 Hospitals: Harvard Pilgrim Health Care has identified 32 hospitals in Massachusetts, New Hampshire, Maine, and Rhode Island as the first members of its new Hospital Honor Roll, which highlights adult, acute care hospitals whose performance was among the top 25 percent of those measured nationally on a set of quality measures as reported by the Centers for Medicare and Medicaid Services on Hospital Compare and Leapfrog patient safety measures. For a complete list of the acute, adult care hospitals named to the Honor Roll, go to www.harvardpilgrim.org.

Horizon Expands Bilingual Program: Horizon Blue Cross Blue Shield of New Jersey has expanded its bilingual pharmacy education program into the City of Newark. The program provides pharmacy-related educational materials in Spanish to pharmacists and Hispanic and Latino residents. As part of the program, pharmacists will print prescription labels with usage instructions in Spanish, distribute patient and pharmacy education information in Spanish, and display signage to let Spanish-speaking residents know that these services are available. Participating pharmacists also will receive the “Essential Spanish for Pharmacists” booklet, produced by the American Pharmacists Association; a tabletop poster to alert customers that prescription labels are available in Spanish; “How to read a medicine label” flyers in Spanish; and “Taking Over-the-Counter Medicine with Care” flyers, produced by the National Council on Patient Information and Education.

South

Wellmont to Build Medical Complex: Wellmont Health System will seek state approval to construct Wellmont Emergency Care and Diagnostic Center at Boones Creek, a multi-faceted medical complex aimed at dramatically reducing emergency room wait times,



improving access to primary-care and specialty physicians, and restoring health care choice for the people of Washington County. The health system will file a certificate-of-need application for the groundbreaking project. Pending state approval, construction of the 30,000-

square-foot facility will begin in early 2008 with a projected opening in the summer of 2009.

Covenant Health, BCBSTX Announce Agreement: Covenant Health System and Blue Cross and Blue Shield of Texas (BCBSTX) have reached an agreement to again provide in-network access to health care at all Covenant Hospitals, Covenant Rural Health Clinics in Plainview and Levelland, and Covenant Medical Group (CMG) physicians. The agreement means BCBSTX members will be able to see their CMG physicians as in-network physicians beginning December 1, 2007.

Midwest

Amerinet and Advantage Healthcare Net Form Alliance: Amerinet Inc., a national health care group purchasing organization, and its affiliate partner Advantage Healthcare Net have formed a new alliance designed to reduce costs and create new efficiencies for 28 health care providers in Minnesota. Amerinet will provide the resources through its competitive portfolio of product and service contracts to meet the needs and challenges of the alliance members. The partnership will focus on total spend management solutions including data integrity and price accuracy, savings identification, financial and operational benchmarking, and educational opportunities. Amerinet will also implement cost reduction initiatives.

CMS Announces Key Changes to Badger-Care Program: The Centers for Medicare & Medicaid Services (CMS) has announced that Wisconsin received approval to make important changes to BadgerCare, the State Children’s Health Insurance Program (SCHIP) for that state. These changes reflect the state’s ongoing

efforts to restructure the BadgerCare program and its financing. With the approved changes, Wisconsin will be able to enroll children in families of four making up to \$51,625 or 250 percent of the federal poverty level. Wisconsin's program also addresses "crowd out" in SCHIP by requiring a waiting period prior to a family signing up for BadgerCare. Families that previously had access to employer-provided health insurance would be required to satisfy a longer waiting period before signing up for BadgerCare.

West

BCBSMT and Delta Dental Announce Partnership: Blue Cross and Blue Shield of Montana (BCBSMT) and Delta Dental Insurance Company have announced a partnership between the two companies that will provide dental coverage for BCBSMT groups across the

state. The partnership with BCBSMT will allow the company to continue to grow and add to its dental network of 170 Delta Dental Premier dentists statewide. Delta Dental has 23,000 enrollees statewide.

Blue Shield of California Offers New Benefit: Blue Shield of California members enrolled in certain employer group plans may soon be paying less for their generic drugs, thanks to a new pharmacy benefit offered to businesses with more than 50 employees. The new plan eliminates or reduces copayments for generic drugs. Blue Shield's new pharmacy benefits with generic copayments of zero or three dollars at retail network pharmacies are offered to employer groups with 51 or more employees and will cover generic drugs for both retail and mail-order prescriptions. The new benefit design options will be available January 2008. ■

Why Health Literacy...

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of health literacy issues, but it is by no means the only problem. Additional problems include:

- Providers who use jargon and spend what is ultimately wasted time with patients in the examination room explaining diagnoses and care plans in ways that are not understood;
- Prescription labels with unclear, incomplete, or incomprehensible dosing information; and
- Patient education materials that are written at many grade levels above the reading ability of the recipients.

This is not to say that the problems associated with poor health literacy are all the responsibility of the health care system. Patients with learning disabilities, those who speak English as a second language or who have limited English proficiency skills for other reasons, those with lower education, and in particular the elderly are all groups with greater risk factors for lower health literacy.

Health literacy, however, is not about "us versus them." Being health literate means

having a clear understanding of what we need to do in order to achieve health: "the ability to obtain, understand, and apply health information in an appropriate fashion."

Just as someone with little experience in the field of nuclear physics would have trouble understanding an industry white paper, many well-educated people have trouble grasping the particulars of treatment and medication regimens for certain disease conditions. Just because you do not completely understand the many complexities of your health care condition does not make you stupid. It just means you do not understand your health care condition.

Pharmaceuticals are a significant area of concern for those studying health literacy issues. Inappropriate use of medications — both prescribed and over the counter (OTC) — cost the health care system billions of dollars every year. Of course, this is not even taking into account the injuries and deaths attributable to adverse drug events that are primarily the responsibility of the patient. But the scope of the problem of patients misunderstanding instructions on their prescription medications is appalling.

In a study by Wolf et al., 46 percent of patients misunderstood one or more instructions on their prescription medication bottle label, and 54 percent had trouble deciphering information on the auxiliary labels (the additional warning labels placed along the side of the bottle or package). A warning label written at a first grade reading level, “Take with food,” was understood by 84 percent of people in the study. Although this sounds encouraging, it is frightening to note that 16 percent *did not understand* this instruction. A more complex label written at a 12th or 13th grade reading level, “Do not take dairy products, antacids, or iron preparations within one hour of this medication,” was understood by only 8 percent of patients.

Culture and Health Literacy

Even optimal communication strategies on the part of the health care provider can be confounded by factors such as culture. Different belief systems can destroy the patient-provider relationship and render all other efforts moot when one side does not understand and respect what is of value and meaning to the other.

A clear and tragic example of this is presented in Anne Fadiman’s book, “The Spirit Catches You and You Fall Down.” This book tells the story of a young Hmong child whose epilepsy is misdiagnosed due to breakdowns in the health care system and the conflicting belief system of her parents. An inability to communicate with the child’s parents upon presentation, use of an unskilled *ad hoc* translator, and a clash of two cultures in which western medicine providers present a treatment plan for a condition that the Hmong parents believe is spiritual in nature all complicate the equation and ultimately lead to the child’s death.

The demographics of our society are changing, not only nationally but also within our cities and neighborhoods. Other cultures with differing languages, belief systems, value systems, spiritual beliefs, and systems of authority are now the rule rather than the exception. If the health care system wishes to work effectively with these patients, a system

of acknowledgment and understanding must be put in place. Translators and interpreters are only part of the solution. Cultural competence is needed.

Cultural competence includes a number of elements. Among them is *cultural awareness*, which the Institute of Medicine (IOM) defines as a “deliberate, cognitive process of recognizing cultural beliefs, values and practices...” Another component is *cultural knowledge*, which the IOM identifies as a continuum of competency from unconscious incompetence (being unaware that one has a deficit of knowledge in this area) to unconscious competence (being able to spontaneously deliver culturally sensitive and appropriate care without having to stop and think about it). *Cultural skill* refers to the ability to perform clinical duties within the demands of a cultural system, *e.g.*, to be able to collect information from a patient from a different culture.

Within the domain of culture providers must be able to sense and respond sensitively and effectively to many factors that shape and affect patients’ ability to carry out health instructions. Among these are family relationships (including power centers and belief systems), sex and gender issues, race and ethnicity, spiritual beliefs and values, and more. When any one or more of these areas is disregarded, the cascade of events from an incongruent exchange and subsequent loss of trust can be expensive, ineffective, or even fatal.

Awareness of health literacy and its potential impact on the health care system and the lives of those with diminished skills is the first step toward addressing this growing problem. Many resources exist to help providers and health care systems develop patient friendly environments in which good, mutual communication takes place, understanding is the norm, and respect and trust are hallmarks of the patient-provider relationship. ■

Michael Villaire, MSLM, and Gloria Mayer, RN, EdD, are authors of the book, “Health Literacy in Primary Care: A Clinician’s Guide,” available from Springer Publishing or from the Institute for Healthcare Advancement Web site located at www.iha4health.org.

Employees: Get Healthy,...

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and change everything and then others who say they aren't growing as fast as they should be and adoption isn't that great," explains Shawn A. Jenkins, president and chief executive officer of Benefitfocus. "What we are seeing, however, is a steady growth of employers offering flexible plan options — including health savings accounts — and employees getting more comfortable with adopting them. We believe that trend will continue in 2008."

Much of this consumer-directed growth, however, is dependent upon improved communication channels and enhanced product offerings, adds Jenkins. "Early HSA offerings were not full function and were hard to understand. We see the technology getting better, and as a result, we see people becoming more and more comfortable with them."

Under the whole communications umbrella, there has been a great deal of activity and investment over the last year in the health care industry. Many of the developments taking place in other industries — such as videos on the Web and social networking — are beginning to move into health care, and as they do, available tools and technologies are getting easier for consumers to use, says Jenkins.

"As people get more comfortable managing their money online and comparing things online, we see that affecting something as traditional as their health insurance," notes Jenkins. "As more employers continue to offer some sort of consumer-directed plan or high deductible plan or flexible plan design, members are in a better position to understand what it means to them."

Employers are also starting to take steps to impress upon employees the need to be more engaged in their health care decisions. "You have employers telling employees that they need to be more engaged and they need to pay more attention to the health care spend," says

Jenkins. "They want their employees to get more engaged in the discussion and start making decisions on their own behalf."

Employers are looking at items such as health screening tools, scoring tools, and health risk assessments to track employee health throughout the year. They are beginning to examine employee behaviors and determine if those behaviors are contributing to increased medical costs and also are beginning to look at ways to hold employees more accountable for those behaviors.

"What I saw in 2007 and particularly in the '08 design is employers getting much bolder and saying, 'I'm going to let these employees know how they stand as far as their health is concerned, and if they are exhibiting behaviors that are detrimental to their health, I'm going to teach them that it is going to drive up our cost as an employer and they are going to have to start picking up part of the tab for that,'" notes Jenkins.

For instance, if an employee smokes, an employer might look for ways to illustrate to the employee how much that behavior costs the company, give the employee a period to kick the habit, and explain to the employee that he will not receive credits or discounts that other employees receive at the next open enrollment if he is still smoking at that time.

Smoking is only one example. Employers are also beginning to take measures involving weight management. For example, if an employee's body mass index (BMI) is above a certain level and the employee is not enrolled in a walking program or diet program, that employee may have to pay a little more for health insurance during the next open enrollment.

"That's a bold step," says Jenkins. "Five or six years ago — when employers were kind of held hostage — even the notion of introducing a high deductible health plan and asking someone to *maybe* contribute a little bit was kind of scary. That, however, has become kind of commonplace, and I see employers getting

much more aggressive and saying, 'Hey, we are going to give you a whole bunch of tools to improve your health, and if you aren't willing to participate, then you are going to bear more of the cost of your health coverage.'

Employers don't want to be mean, adds Jenkins. They simply want tools to help manage their health spend.

From the medical side, hospitals and physicians are also looking for ways to engage consumers and help them better understand their medication costs and the costs of their health care spend.

"What I call direct-to-consumer is really what we see as one of the hottest things from our carrier partners — the health plans themselves — right now," notes Jenkins. "Consumers are beginning to shop for health coverage outside of their employer, and they are getting much more engaged in how they spend their money."

Individuals are no longer calling brokers and asking them to sit down and explain the available options. Instead, consumers are going online directly to health carriers and shopping

for insurance, much like they do with car insurance and stereos and cars.

One of Benefitfocus' long-term clients has seen a 300 percent increase in its direct selling to consumers and has also seen incredible traffic count. Beyond just looking for health coverage, people are actually comparing what they could get through their employer versus what they could buy online. Some are opting their children out of the employer's coverage and buying standalone policies for their children while staying on employer coverage for themselves or for employee plus spouse.

"A lot of what I would call sophisticated shoppers are beginning to not just accept their employer's plan and are getting engaged in what we call direct to consumer," says Jenkins. "We see that consumers are hungry for that — a lot of searching, a lot of shopping for coverage, and we see the health plans investing heavily in technology and rebranding their products to be able to reach out directly to that consumer market. That is a trend we believe will continue into 2008 as well."

For additional information about Benefitfocus, go to www.benefitfocus.com. ■

Continua Health Alliance Reveals Key Components of New Technical Guidelines

The Continua Health Alliance, a group of technology, medical device, and health and fitness industry leaders, recently unveiled key components of its first set of technical guidelines. The primary purpose of these guidelines is to establish a market of connected personal health and fitness products and services, thereby enabling patients, caregivers, and health care providers to more proactively address ongoing health care needs.

In its first year, Continua focused on continuum of life and care methods, particularly in the area of chronic disease management. The organization's goal is to create a network of readily connected health and medical devices

that will allow people with diabetes or other chronic diseases to share vital information with their doctors. These interoperable devices include blood glucose tests, blood pressure monitors, pulse oximeters, and other basic vital sign monitors.

Continua's first set of guidelines, due out early 2008, are designed specifically to help increase assurance of interoperability between devices, allowing consumers to share information with caregivers and service providers more easily. Manufacturers of products that meet these guidelines will be permitted to use the Continua Health Alliance certification logo to promote their products.

The Continua Version One standards are a blend of health care informatics data standards with proven consumer electronic technologies. This combination enables connectivity across a wide variety of personal telehealth devices and services.

“Continua is about standards-based approaches to consumer telehealth devices,” explains Joseph C. Kvedar, MD, founder and director of the Center for Connected Health, a division of Partners Healthcare and a participating company of the Continua Health Alliance. The Center for Connected Health works with Harvard Medical School-affiliated teaching hospitals, including Massachusetts General and Brigham and Women’s Hospitals.

“As we continue to move care *to* the patient — in the patient’s home and in the patient’s workplace — it will be very helpful to be able to point patients to Continua-labeled devices,” notes Kvedar. “The same way that people can get a toaster or an iron with a stamp on it saying it has passed a safety test, people will have access to Continua-labeled devices with a similar assurance. We will know these devices have a certain level of standards, and we can recommend them to our patients.”

There is the issue of cost, however. Despite advances in technology and increased accessibility of tools and devices, cost can sometimes stand in the way of fully realizing the benefits of these advancements, stresses Kvedar. As a result, there needs to be a relentless focus on lowering the cost of these tools.

Integrating various tools and technologies can also pose a challenge. If a patient has several different chronic conditions, he or she is going to have a different need than someone who just has hypertension or just has diabetes.

“It is critical that we integrate technology and make it simple so that patients will be able to plug in devices, connect them easily, and then make sure on our end that the integration to the electronic health record is essentially seamless,” notes Kvedar. “This can be done

through the standard messaging capabilities that Continua is offering.”

There also needs to be a focus on raising awareness of available tools and technology, says Kvedar. “We are confident that we can improve quality and lower costs in the long run, but a lot of people aren’t even aware that these tools are available. We need to raise awareness that they exist and that they can make life easier for the end customer.”

It is also important to focus on changing individual behaviors, which can be quite difficult, admits Kvedar. Just because it is difficult, however, doesn’t mean you quit trying.

“We cannot be resigned to accepting that some people just don’t want to participate,” stresses Kvedar. “Right now, the health care system basically says you’re naughty if you don’t take care of yourself, which is a very limited approach at motivating people. We’ve got to change our approach and not just wait until people get sick and then take care of them. We have to change their behavior from the start.”

In addition to outlining the new elements of the guidelines, the Continua Health Alliance also announced it is working with Abt Associates Inc. on a research project targeting reimbursement policy. Abt Associates will assist in cataloging, synthesizing, and assessing all telehealth studies and the peer-reviewed cost-effectiveness literature. This work will help Continua determine strategies for initiating increasing telehealth cost effectiveness, initiating quality improvement studies, and securing reimbursement for telehealth products and services.

Continua Health Alliance was launched in June 2006 to address the lifestyle, health, and demographic trends contributing to the rising health care costs. Since its launch, Continua has added 105 new corporate strategic partners, reaching a total of 133 member companies.

To learn more about the Continua Health Alliance and its participating companies, go to www.continuaalliance.org. ■

Value-Driven Health Care Initiative Continues to Evolve

By Harry M. Feder

“Every American should have access to a full range of information about the quality and cost of their health care options.” — *Health and Human Services Secretary Michael Leavitt*

The Value-Driven Health Care Initiative was launched early in 2007, as a means of implementing the President’s executive order to empower Americans to find better value and better quality health care by increasing the transparency of our health care system.

Led by Health and Human Services (HHS) Secretary Michael Leavitt, the initiative is aimed at enhancing personal- and population-centered care by improving the quality of health care services and reducing health care costs. Central to the goals of the initiative is the premise that consumers deserve to know the quality and cost of their health care; that transparency provides consumers with the information necessary, and the incentive, to choose health care providers based on value; that providing reliable cost and quality information empowers consumer choice; and that consumer choice motivates the entire system to provide better care for less money.

The plan calls for development of nationally chartered, locally directed coalitions of community stakeholders to become part of a system that will apply nationally recognized standards to measure and improve quality of care at the community level. While the federal government is helping to organize this network, HHS is looking to coalitions of providers, purchasers, and consumers to direct and implement the system.

BQI Pilot Sites

The Value-Driven Health Care initiative was launched in February 2007 via a pilot project known as “Better Quality Information to Improve Care for Medicare Beneficiaries (BQI).” The pilot was designed to test approaches for a national model for data aggregation, quality measurement, and public

reporting and to promote the use of physician performance information to drive improvements in quality of care.

The Centers for Medicare & Medicaid Services (CMS) designated six regional multi-stakeholder collaboratives as pilot sites to pioneer the pooling of private data with Medicare claims data. Each regional group includes employers, health insurance plans, providers, and, in some cases, QIOs and Medicaid programs. The BQI pilot sites are collecting and aggregating claims data from multiple private and public sources to produce comprehensive measures of quality of services at the physician level, test approaches to data collection strategies, and promote the use of information by Medicare beneficiaries and providers to support quality improvement.

Delmarva, the QIO for Maryland and the District of Columbia, was contracted by CMS to manage the BQI pilot sites, partnering with the National Committee for Quality Assurance (NCQA) to provide technical assistance, conduct data analysis, and coordinate communication between sites. Results of the BQI pilot sites’ work are expected to be made available in October 2008.

CMS plans to use this data to provide performance information to physicians to assist them in improving the quality of care they deliver. Beneficiaries will have access to this information to help them make more informed physician and treatment decisions. The information also will provide a foundation for a physician compare Web site, similar to the other Medicare provider sites available on www.medicare.gov.

Community Leaders Named

The Value-Driven Health Care initiative was expanded in March 2007 when Secretary Leavitt visited communities across the country to encourage local business and health care leaders to work together to create

local collaboratives. Since then, more than 79 coalitions have been recognized by the Agency for Healthcare Research and Quality (AHRQ) as “community leaders.” This group includes QIOs in over 20 states.

The QIO in New York, IPRO, has partnered with key stakeholders representing health plans, employers, physicians, hospitals, consumers, and the State Department of Health to establish the New York Value Exchange. One of IPRO’s key partners in this endeavor is the New York Business Group on Health (NYBGH), a coalition of over 150 businesses exclusively devoted to employer health benefit issues.

As a designated community leader, the New York Value Exchange is one of the many groups across the country working to advance the Four Cornerstones of Value Driven Health Care: *health information technology, quality reporting, cost reporting, and incentives for quality and value*. The community leader designation is a prerequisite for eligibility as a “chartered value exchange” (CVE), the next generation of local collaboratives envisioned to carry out quality improvement and public reporting activities.

To support community leaders in their efforts to apply for chartered value exchange status, AHRQ plans to sponsor a learning network for community leader coalitions in 2008, with the goal of preparing all community leader coalitions to become chartered value exchanges or join an existing CVE within three years of designation.

Chartered Value Exchanges — the Next Generation

To further HHS’ goal of creating a value-driven health care system, AHRQ

has established consensus-based core functions and selection criteria to designate mature community collaboratives as value exchanges. Chartered value exchanges, as defined by HHS, are organizations that have taken clear action in their communities (local and/or state) to convene industry stakeholders and advance the Four Cornerstones of Value Driven Health Care. These organizations will be eligible to receive Medicare-inclusive multi-payer physician-performance data and will participate in the national learning network, to be administered by AHRQ, to support quick expansion and sharing of quality improvement techniques.

Chartered value exchanges will have full representation from key stakeholders — purchasers, health plans, providers, and consumers. By working at the local level, these multi-stakeholder organizations, on a local, state, and national basis, will be able to implement meaningful changes where health care is actually delivered.

AHRQ opened the enrollment process for value exchanges in October 2007 with the release of an application, “Chartering Value Exchanges for Value-driven Healthcare.” AHRQ plans to announce the first round of chartered value exchanges in late December 2007, with additional organizations added every six months thereafter. ■

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Report Shows Diabetes Incidence and Costs on the Rise

Employer-paid diagnosed (non-pharmaceutical) medical costs for diabetes continue to rise significantly — as much as a 64 percent increase in just five years,

according to a recent study released by Gordian Health Solutions, a national health and productivity improvement company.

Gordian researchers looked at claims data from 2000 to 2004 and found that in 2004 inflation-adjusted dollars, per member per month (PMPM) diabetes costs increased from \$1.98 in 2000 to \$3.25 in 2004.

“Diabetes rates continue to rise dramatically. It is no wonder that large employers are engaging the services of population health and disease management providers to reach out to diabetics and those at risk for developing the disease, to encourage them to follow physician recommendations and better self-manage their condition,” says Adam Long, PhD, vice president of research and informatics at Gordian.

“The goal of conducting this research is to assist physicians in better understanding diabetes incidence rates compared to employer-paid medical costs for diabetes, in hopes that the observed differences will spark innovative treatment ideas,” he adds.

Additional findings from the study include the following:

- Females’ diabetes incidence rates increased 267 percent (from 4 percent to 10.7 percent) with age (19 to 44 versus 45 to 64 years). Their diabetes costs also increased with age, from \$2.13 to \$5.45 per member per month, a 256 percent increase.
- In comparison, males’ diabetes incidence rates increased 714 percent (from 2.1 percent to 15 percent) with age. Their diabetes costs also increased with age, from \$1.90 to \$5.88 per member per month, a 309 percent increase.

The research is based on Gordian’s work over the past 11 years with large national employers and includes claims data accumulated from 61 organizations totaling nearly \$5 billion.

For additional information, go to www.gordian-health.com. ■



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