



Benfield  
ARTHUR J. GALLAGHER & CO.

# NC Chamber Healthcare Strategy Roadmap: Preliminary Report

MAY 27, 2016

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# Project Purpose and Objectives

- As part of its *Vision 2030* strategic plan to make North Carolina a Top 10 state for business, the North Carolina Chamber has identified population health and healthcare value as key elements of a supportive business environment for the state. The Chamber's priority on healthcare reflects its members' concerns: in response to the Chamber's 2015 member survey, businesses identified healthcare costs as their top issue—and the one over which they believe they have the least control.
- The NC Chamber retained Benfield to help develop a Healthcare Strategy Roadmap for the state—with the goal of making North Carolina a Top 10 state for health and healthcare value. The intent of the Roadmap is to provide the framework for a state-wide, multi-stakeholder initiative under the leadership of the NC Chamber to achieve the *Vision 2030* goal.

## Project Objectives

- Clearly define what it means for North Carolina to be a “Top Ten” state for health and healthcare value
- Define a high-level strategic pathway for NC to achieve “Top Ten” status
- Begin building engagement and alignment of key stakeholders whose commitment will be needed

# Project Approach

(See slides 17-21 for detail)

- Benfield implemented this project in six steps (see below).
- We held a kick-off meeting with Gary Salamido and his team to clearly understand the context for the project, refine the approach, and identify the stakeholders to target for initial engagement.
- For the Situation Assessment, we conducted interviews with 14 stakeholder executives, including CEOs and HR leaders for large and medium employers, as well as CEOs of leading healthcare delivery networks, the leading health insurer and the leading pharmaceutical company based in NC. We also conducted secondary research, including comparative statistics on state-level health and healthcare value.

## Project Steps

Step 1:  
**Project  
Kick-Off**

Step 2:  
**Situation  
Assessment**

Step 3:  
**Initial Findings  
& Framing  
Concepts**

Step 4:  
**Stakeholder  
Roundtable  
Meeting**

Step 5:  
**Summary  
Report**

# Project Approach (cont.)

- On April 21, 2016, Benfield helped NC Chamber convene a Key Stakeholder Roundtable Meeting to begin outlining the Roadmap.

## Participating Stakeholders

### Providers

- Novant Health – COO
- UNC Health – VP Strategy
- WakeMed – Exec. VP & CFO

### Manufacturers

- GSK – President, N. Am.

### Health Plans

- Blue Cross Blue Shield of NC – CMO

### Other

- NC Health Information Exchange – Executive Director

### Employers

- Duke Energy – Dir. Of Benefits
- Hanes – VP Govt. & Trade Rel.
- State of NC Employee Health Plan – Dir. of Policy, Planning and Analysis

- 
- Biltmore – VP HR
  - Medical Mutual – HR Dir.

- This report summarizes Benfield’s research findings, the results of the Roundtable Meeting and our high-level recommendations for the Roadmap.

# The Current State of Health and Healthcare

(See slides 22-33 for detail)

- There was broad agreement among stakeholders around:
  - The population health challenges facing NC
  - Strengths and gaps in NC healthcare—including challenges of cost, value and access
- Health outcomes of North Carolina's population are below average—in some cases, well below average—among the 50 states.
- Key drivers are health-related behaviors (e.g., poor habits for nutrition and exercise) and disparities in access to healthcare.
- NC has a number of well-respected healthcare delivery networks and other provider organizations, particularly those serving the population centers in the Piedmont region.
- However, NC's per capita healthcare costs are only slightly below average (and in any case, the national trends are unsustainable), competition is not primarily focused on delivering greater value, and access to providers is grossly inadequate in many areas, particularly in the western and eastern regions of the state.

## North Carolina Health Ranking 2015

Rank	State
1	Hawaii
2	Vermont
3	Massachusetts
4	Minnesota
5	New Hampshire
6	Connecticut
7	Utah
8	Colorado
9	Washington
10	Nebraska
31	<b>North Carolina</b>
Avg.	United States

Source: America's Health Rankings 2015 – United Health Foundation

# Health & Healthcare Value Improvement Initiatives

- Healthcare stakeholders in North Carolina have pursued a range of internal, local and statewide efforts to improve health and healthcare value; however, these efforts have tended to be too fragmented to meaningfully and sustainably change the trajectory for NC on their own.
- Most employers are trying to address cost challenges through internal strategies (benefit design, wellness programs, etc.), but only a very small number of employers are engaging with partners along their health benefit supply chain to drive greater value.
- In contrast, there are well-established multi-stakeholder initiatives in many other states that have been successfully pursuing better health outcomes, better care and lower costs for several years. These initiatives are raising the bar for membership in the top-tier states—and they also provide models that NC can learn from. The most successful initiatives have built strong multi-stakeholder leadership and professional staffs, and they are aligned with national programs that provide funding and other support.

## **Selected Past and Current Initiatives in NC**

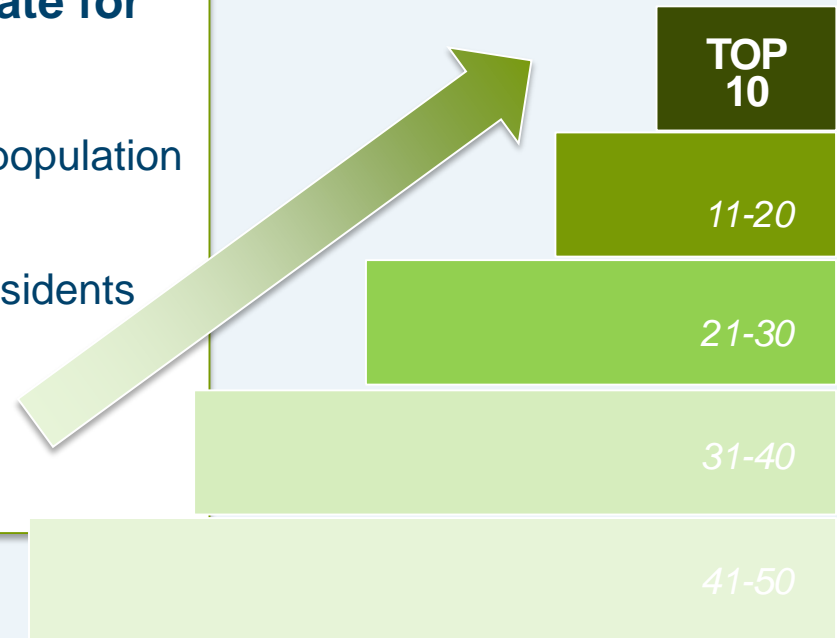
- The Ashville Project
- Carolina Community Care Collaborative
- Healthy Charlotte Council
- North Carolina Business Group on Health
- North Carolina Healthcare Quality Alliance
- Population Health Improvement Partners

# Defining the Vision for NC in 2030

- The participating stakeholders at the Key Stakeholder Roundtable Meeting, supported the vision of North Carolina as a top-10 state for health and healthcare value.

## Benefits of Becoming a “Top 10” State for Health and Healthcare Value

- Healthier, more productive workforce and population
- Lower, more predictable healthcare costs
- Easier access to high-quality care for all residents
- Better quality of life
- More attractive destination for employers and for families





# Developing the High-Level Roadmap

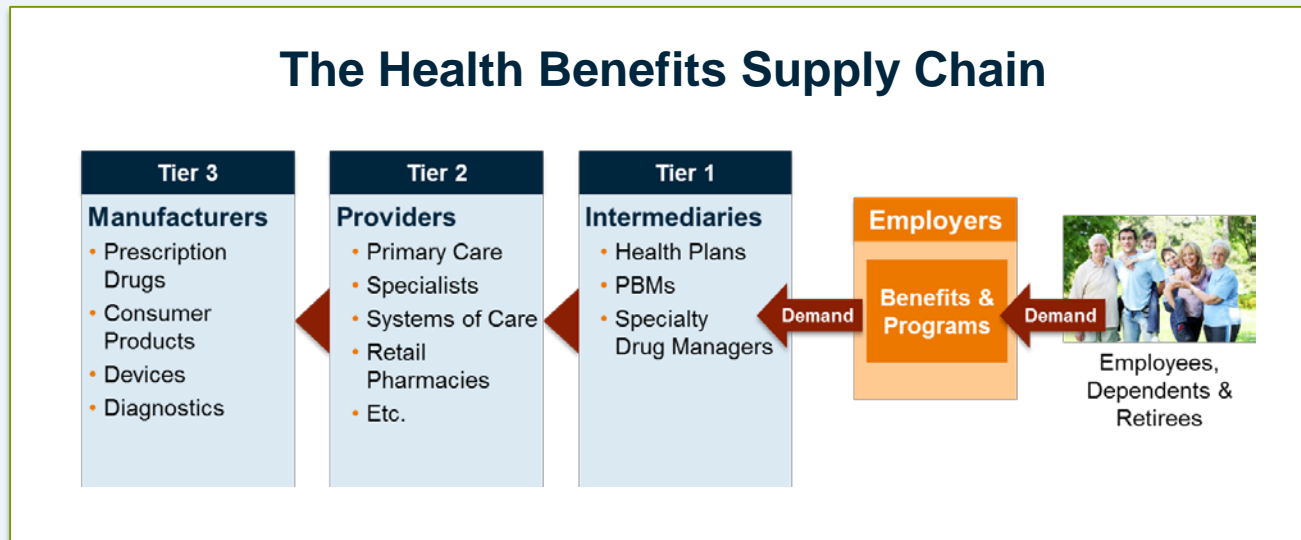
- At the Roundtable Meeting, after presentations and discussions about the current status and vision, Benfield presented information and case studies regarding other transformational efforts to help frame discussion about key elements of a strategic path to better health and healthcare value.
- Following the presentations and related discussion, Benfield led a structured discussion of key elements and asked stakeholders if they were in agreement about each element's inclusion as part of a high-level strategic roadmap.
- Stakeholders agreed that each of the following 6 key points should be part of a preliminary, high-level roadmap for this initiative:
  - 1. The roadmap should reflect an employer-driven but collaborative approach.**
    - The primary focus of the initiative will be joint action by the healthcare stakeholders to shift the healthcare market toward a greater focus on quality and value.
    - And all participants stated that they definitely want to stay engaged in the initiative.
  - 2. It makes sense for the NC Chamber to be the convener – the Chamber is a “natural owner” of this process.**
    - The sense of the Roundtable Meeting was that there should be a single statewide initiative—with the proviso that a few participants suggested that the approach will also need to address the unique challenges facing different regions of the state.
    - The Chamber's membership includes representatives of all key stakeholder groups, along with the most extensive set of employers.

# Developing the High-Level Roadmap (cont.)

(See slides 36-45 for detail)

## 3. Strategic Supply Chain Management should be used as the framework for collaboration.

- To apply SSCM concepts to healthcare, employers must:
  - Act collectively to set clear and consistent expectations for value as major healthcare purchasers, in alignment with the value-based purchasing strategies of the other major purchaser, CMS.
  - Work collaboratively with other stakeholders to translate those expectations into practical, sustainable solutions.

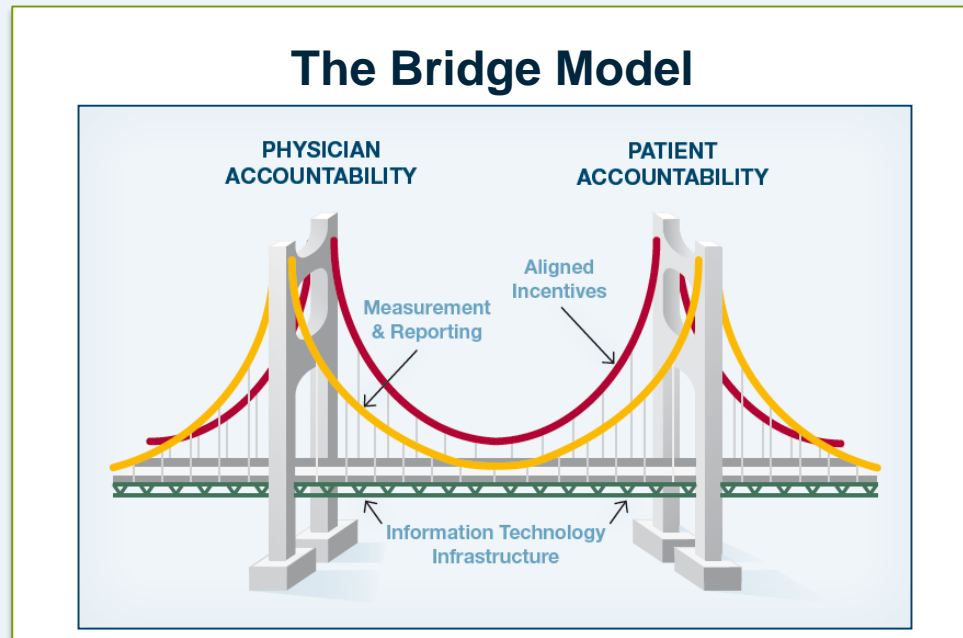


# Developing the High-Level Roadmap (cont.)

(See slides 46-52 for detail)

## 4. The roadmap should focus on building a complete “Bridge”.

- The “Bridge” model for improving health and healthcare value focuses on developing:
  - Patient/Consumer Accountability
  - Physician/Provider Accountability
  - Measurement and Reporting of Quality and Cost Data
  - Aligned Incentives Among All Stakeholders
  - Information Technology Infrastructure

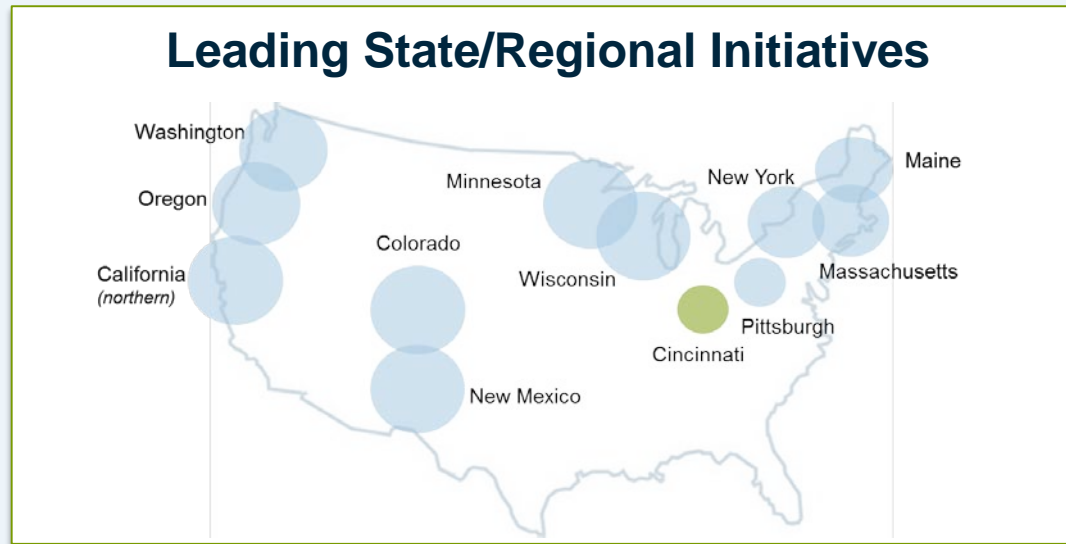


# Developing the High-Level Roadmap (cont.)

(See slides 53-66 for detail)

**5. The roadmap should include intentional processes to learn from others and to leverage their solutions and experiences.**

- “Others” include:
  - Efforts and entities outside of NC (e.g., similar initiatives in other states)
  - Efforts and entities inside of NC (e.g., transparency initiatives at BCBS)
  - Other initiatives within NC that can at least provide reference points if not be enlisted in the collaboration

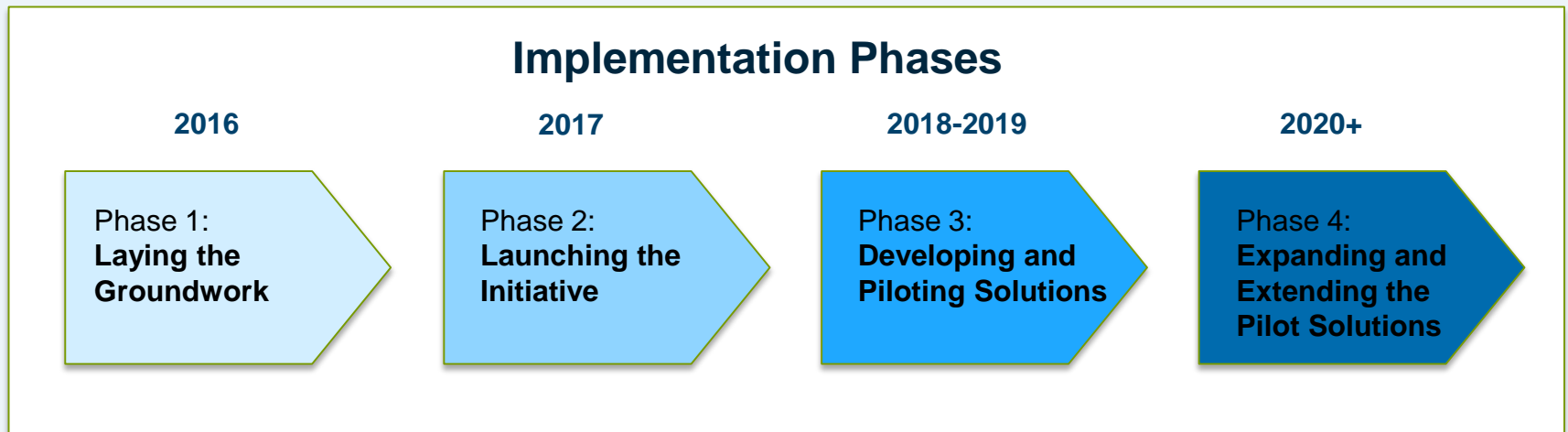


# Developing the High-Level Roadmap (cont.)

- 6. The roadmap should include early research and a collaborative focus on employee/consumer/patient engagement and activation.**
  - Individual stakeholders such as BCBSNC have pursued patient/consumer education initiatives. The results—measurable changes in patient/consumer behavior—so far have been disappointing.
  - Nevertheless, Roundtable Meeting participants recognized that shifting behavior of patients/consumers will be critical to success for the initiative. And a collective approach to engagement involving employers, providers and health plans will greatly increase the odds of success—particularly if they are supported by greater insight into employee/consumer/patient perspectives and the most effective levers for engaging and activating them.

# Implementing the Roadmap

- The following recommendations are high-level and meant to characterize the deliberate and staged approach that will be needed to implement the roadmap successfully. It is based on insights from studying other statewide/regional health and healthcare value improvement initiatives.
- A critical early step will be to establish a project plan and timeline that will, by its nature, be significantly detailed for early phases, but will account for key milestones through 2030. For now, we can identify four implementation phases and the key tasks in each one.



# Implementing the Roadmap (cont.)

**2016**

## **Phase 1: Laying the Groundwork**

- Gain guidance from the NC Chamber Board and finalize the high-level Roadmap
- Identify and engage an expanded set of stakeholder leaders
- Get a critical mass of employers on board and committed to the initiative
- Conduct research to:
  - Benchmark state/regional initiatives
  - Identify and prioritize opportunities using data analytics
  - Evaluate in-state entities and initiatives that can be leveraged/engaged
  - Identify funding programs/sources that align with the Roadmap

**2017**

## **Phase 2: Launching the Initiative**

- Secure seed funding and in-kind donations
- Establish leadership and organization/governance structure; hire the core professional staff
- Identify pilot projects that address all elements of the Bridge model in a focused approach and deliver tangible “wins”
- Build in explicit stakeholder engagement strategies—especially for patients/consumers and physicians/providers
- Develop grant applications, along with the overall project plan and budget
- Develop the public policy advocacy agenda

# Implementing the Roadmap (cont.)

## 2018-2019

### Phase 3: Developing and Piloting Solutions

- Secure full funding and in-kind donations
- Recruit stakeholder leaders and participants
- Develop detailed project plans including metrics and milestones for each project
- Establish mechanisms to ensure accountability for achieving milestones and effective coordination among pilots
- Evaluate progress and address issues/opportunities
- Develop plans to achieve accelerated “scale up”, including statewide adoption of successful pilots

## 2020+

### Phase 4: Expanding and Extending the Pilot Solutions

- Drive accelerated statewide adoption of pilot solutions to close the gap with leading states
- Update/recalibrate milestones for 2020-2030 based on the experience to date
- Continue to build and reinforce stakeholder leadership and professional staff
- Plan/initiate the next phase of pilots and extensions to lay the foundation for national leadership



# PROJECT APPROACH

# Project Steps and Timeline

Week beginning:

February 22 29 March 7 14 21 28 April 4 11 18 25 May 2 9 16 23

Step 1:  
Project Kick-Off



Feb. 25

Step 2:  
Situation Assessment

Step 3:  
Initial Findings  
& Framing  
Concepts

Step 4: Key  
Stakeholder  
Roundtable Mtg.

Note: The NC  
legislative session  
begins April 25th



Step 5:  
Summary  
Report

April 20-21

May 27



# Situation Assessment

## Stakeholder Interviews



## Secondary Research

Centers for Disease Control  
America's Health Rankings  
Kaiser Family Foundation  
Agency for Healthcare Research & Quality  
U.S. Census  
Coalitions & Trade Groups  
North Carolina Institute of Medicine  
North Carolina State & City Data  
North Carolina Community Health Orgs  
Regional Healthcare Providers  
Regional Employers



## Key Findings

- ✓ Population health rankings and underlying factors
- ✓ Healthcare market dynamics
- ✓ Quality, cost and value trends
- ✓ Challenges and strategies of employers & other stakeholders
- ✓ Improvement initiatives

# Stakeholder Interviews

## Providers

- Novant Health – CEO
- UNC Health – CEO
- WakeMed – CEO

## Health Plans

- Blue Cross Blue Shield of NC – CEO

## Employers

- Duke Energy – CHRO
- Hanes – VP Govt. & Trade Rel.
- Lowe's – VP Benefits
- PNC – Regional President
- State of NC – State Treasurer

## Manufacturers

- GSK – President, N. Am.

## Other

- NC Health Information Exchange – Executive Director

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- Biltmore – CEO
  - Medical Mutual – CEO
  - Sepi Engineering – CEO



= Representative attending the Roundtable Meeting

## Interview Topics

- The current state of health and healthcare value in NC and their impact on employers
- The direction for improving health and healthcare value in NC
- Key success factors for the Healthcare Strategy Roadmap initiative

# Key Stakeholder Roundtable Meeting

## Providers

- Novant Health – COO
- UNC Health – VP Strategy
- WakeMed – CFO

## Health Plans

- Blue Cross Blue Shield of NC – CMO

## Employers

- Duke Energy – Dir. Of Benefits
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- State of NC Employee Health Plan – Dir. of Policy, Planning and Analysis

## Manufacturers

- GSK – President, N. Am.

## Other

- NC Health Information Exchange – Executive Director

- 
- Biltmore – VP HR
  - Medical Mutual – HR Dir.

## Meeting Discussion Topics

- Vision: Where are we going?
- Gaps: From where are we starting?
- Roadmap: How will we get from here to there?

# CURRENT STATE OF HEALTH AND HEALTHCARE IN NC

# North Carolina Health Ranking 2015

Rank	State
1	Hawaii
2	Vermont
3	Massachusetts
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*America's Health Ranking 2015*

## **Most Improved – North Carolina**

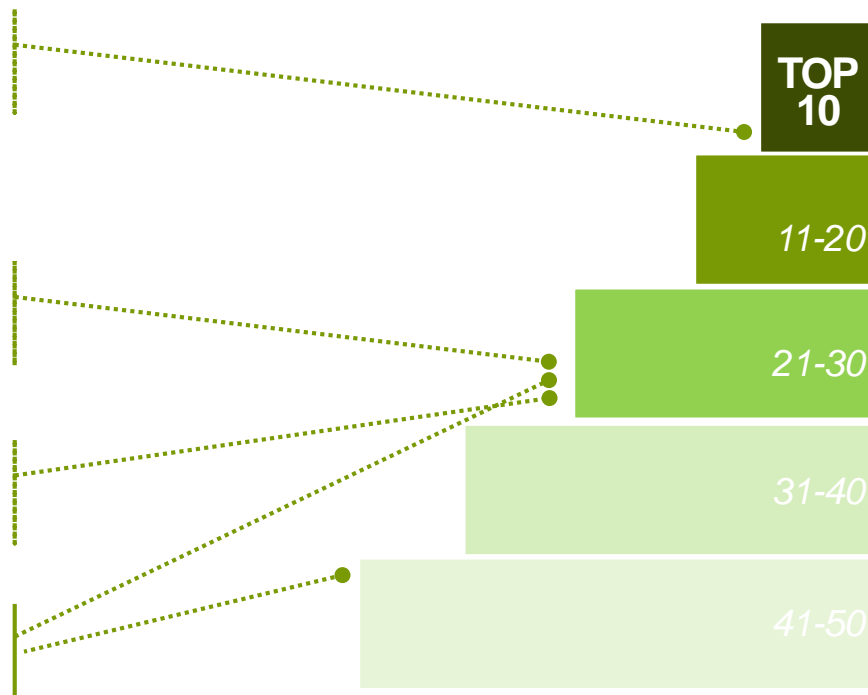
North Carolina shows the biggest improvement in rank over the past year, moving up 6 places.

The state's rise is due to an improvement in the percentage of immunizations among children and HPV immunizations among adolescent females. Also, there was a decline in physical inactivity and in the incidence of Salmonella infections.

Source: America's Health Rankings 2015 – United Health Foundation

# Lifestyle & Risk Factors

- ▶ **Excessive Drinking:** NC Ranks 9<sup>th</sup> in nation in adults excessive drinking, with just 15% of adults indicating excessive drinking compared to 17.6% across the nation.
- ▶ **Physical Inactivity:** NC Ranks 26<sup>th</sup> – nearly ¼ (23.2%) of population reports a lack of regular physical activity
- ▶ **Smoking:** NC 28<sup>th</sup> in nation with nearly 1 out of 5 adults smoking
- ▶ **Diet & Nutrition:** Fruit and vegetable consumption is inadequate - NC ranks 41<sup>st</sup> and 27<sup>th</sup> respectively on these measures



Source: America's Health Rankings 2015



# North Carolina – Smoking Snapshot

## Tobacco Smoking

Rank	State	Score (%)
1	Utah	9.7
2	California	12.8
3	Hawaii	14.1
4	New York	14.4
5	Texas	14.5
6	Maryland	14.6
7	Massachusetts	14.7
8	New Jersey	15.1
9	Washington	15.3
10	Connecticut	15.4
28	<b>North Carolina</b>	<b>19.1</b>
Avg.	United States	18.1

North Carolina currently has about 1% more smokers than total U.S. average, and is off Top 10 by 3.7%. Assuming an adult population of 7.73 million in NC, that equates to about 1.48 million adult smokers.

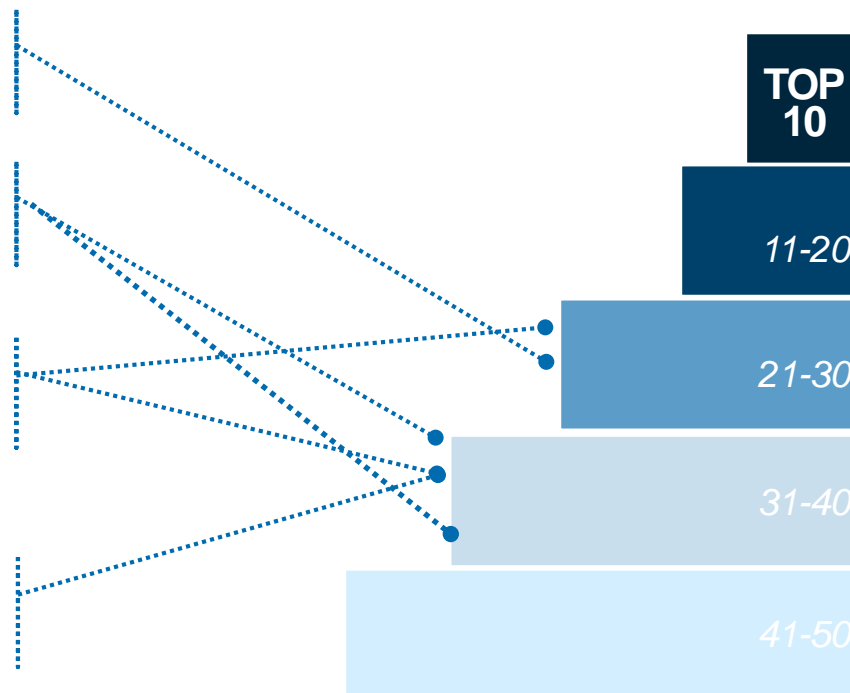
To reach Top 10, NC would need to reduce by ~290,000 smokers.

Percentage of adults who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke)

Source: America's Health Rankings 2015

# Lifestyle Health Outcomes

- ▶ **Obesity:** With nearly 30% of population having BMI >30, **NC ranks 26<sup>th</sup> in U.S.**
- ▶ **Cardiovascular Death & Disease:** **31<sup>st</sup>** in U.S. in cardiovascular deaths and **40<sup>th</sup>** in cardiovascular disease prevalence.
- ▶ **Cancer:** **22<sup>nd</sup> in incidence rate** (diagnosed cancers) and **33<sup>rd</sup> in cancer deaths**. Lung cancer is responsible for 30% of cancer deaths.
- ▶ **Diabetes\*:** **33<sup>rd</sup> in U.S.** with 10.8% of adults having Type II diabetes, nearly 20% higher rate than the 2015 Top 10 threshold.



Source: America's Health Rankings 2015;  
Kaiser Health

\*Excludes pre-diabetes and gestational diabetes

# North Carolina – Obesity Snapshot

## Obesity: BMI >30

Rank	State	Score (%)
1	Colorado	21.3
2	Hawaii	22.1
3	Massachusetts	23.3
4	California	24.7
5	Vermont	24.8
6	Utah	25.7
7	Florida	26.2
8	Connecticut	26.3
9	Montana	26.4
10	New Jersey	26.9
26	<b>North Carolina</b>	<b>29.7</b>
Avg.	United States	29.6

Source: America's Health Rankings 2015;  
Kaiser Health

Like all states, North Carolina's population has a high prevalence of obesity. NC is currently about 3% points off the Top 10 and is just about on par with average obesity rate across all of the U.S.

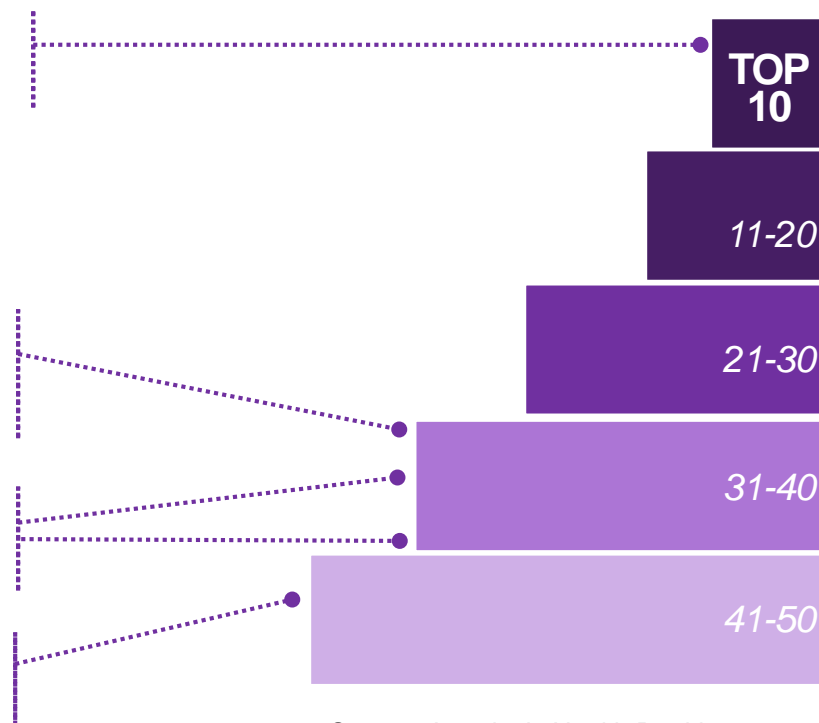
Obese employees – morbid obesity\* in particular – drives up health care costs and these employees are also more likely to be absent from work.

**Child Overweight & Obese:** Looking at children age 10–17, North Carolina has a high prevalence of childhood overweight and obesity, which can be a health issue that can persist in to adulthood and lead to additional disease states.

\* BMI  $\geq$  35 with obesity-related comorbidity or BMI  $\geq$  40

# Infant and Child Health

- ▶ **Child Vaccinations:** NC ranks 2<sup>nd</sup> in nation in in young child vaccination rates. With 81% of young children receiving recommended vaccines, NC scores nearly 10% in this area than the national rate.
- ▶ **Child Access to Medical & Dental Health:** 31<sup>st</sup> in children having received both medical *and* dental preventive care in past 12 months
- ▶ **Pre-term Birth & Low Birth Weight:** NC ranks at 34<sup>th</sup> and 40<sup>th</sup> respectively on these early indicators of infant health
- ▶ **Infant Mortality:** 42<sup>nd</sup> in infant mortality at 7.2 deaths per 1,000 live births, well off the Top 10 mark of 5.0/1000

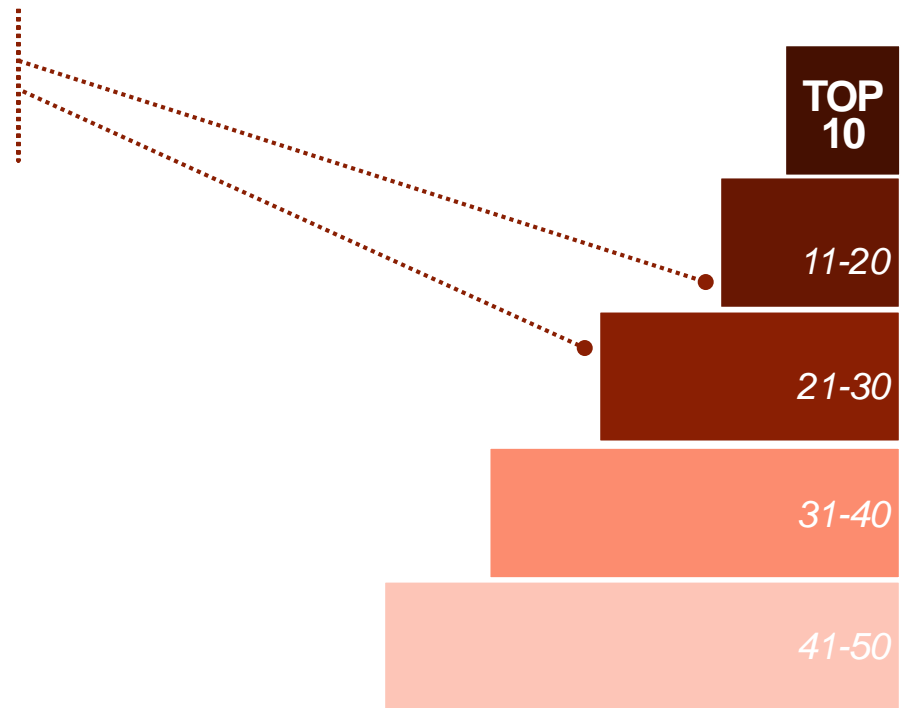


Source: America's Health Rankings 2015;  
Kaiser Health

- ▶ **Child Poverty & Uninsured:** With 24.4% of children living in poverty and 8% aged 0-18 not having health insurance, ensuring timely, quality care when needed is a challenge

# Healthcare Costs

- ▶ **Total Premium** (combined employer & employee contribution): NC ranks 17<sup>th</sup> in cost for single coverage and 24<sup>th</sup> for family coverage
- ▶ In NC, total premium costs are equivalent to 20% or more of the income for an estimated 1/5 of under 65 population

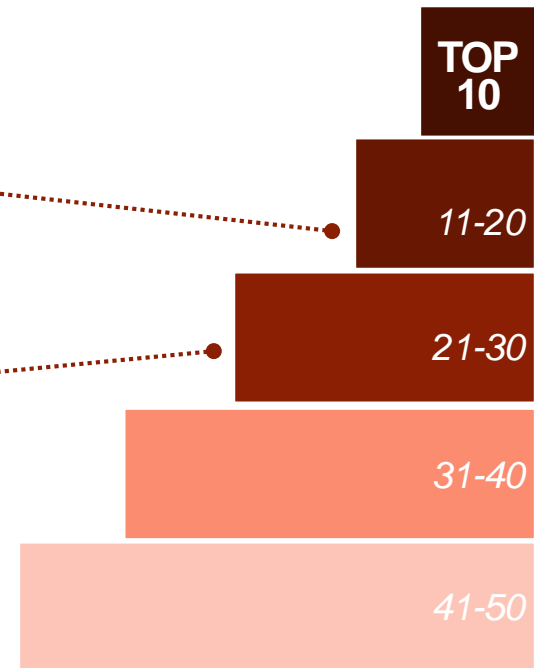


Source: Agency for Healthcare Research and Quality (AHRQ) 2014; Kaiser Health

# Healthcare Costs

- ▶ **Hospital Expenses 2014<sup>1</sup>** (not-for-profit) **17<sup>th</sup> in estimated hospital expenses** per inpatient day. Note: These are not reflective of actual charges or reimbursement for care provide.

- ▶ **Medicare Reimbursement 2012<sup>2</sup>** (adjusted for age, sex and race) **NC ranks 25<sup>th</sup>** in total Medicare reimbursement per enrollee. Top states have lower reimbursement rate.



Source: <sup>1</sup>Kasier Family Foundation;  
<sup>2</sup>Dartmouth Atlas of Health Care

# Access & Equity

## Service Areas & Resources Allocation

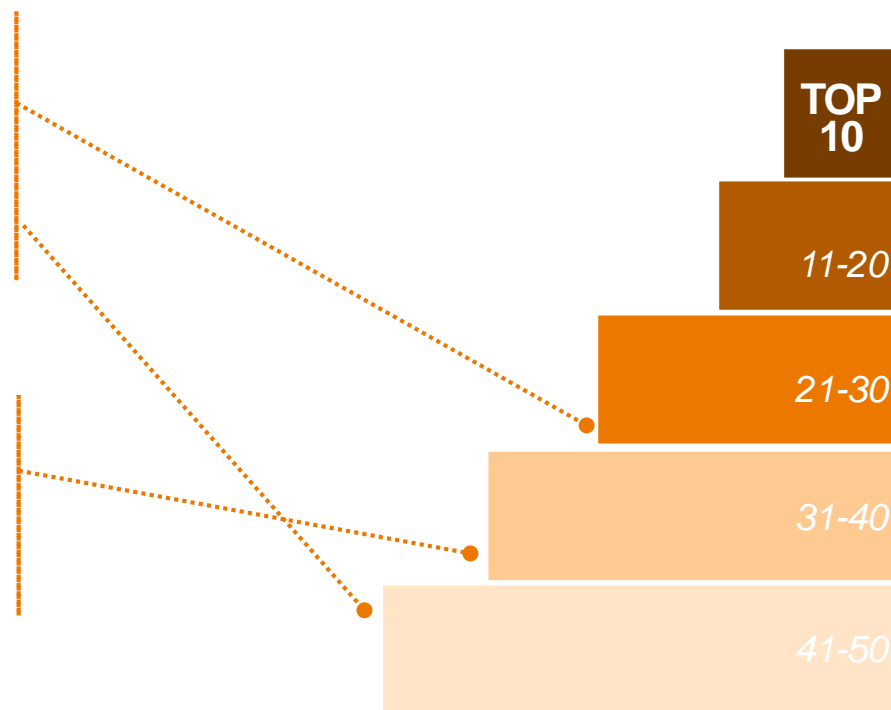
- ▶ NC Ranks **27<sup>th</sup> in mental health shortage** areas, with 52% of coverage across the state
- ▶ NC ranks **42<sup>nd</sup> in primary care shortage** areas, with less than ½ of coverage need being met across the state

## Cost Barriers

- ▶ 16.2% of adults report not having seen a doctor because of costs, compared to just 7 – 10.6% for top 10 performing states. **NC Ranks 39<sup>th</sup>** in the nation on this measure.

## Disparities

- ▶ Disparities in in both health access and disease burden based on race as well as urban vs rural population continue to be an issue in North Carolina

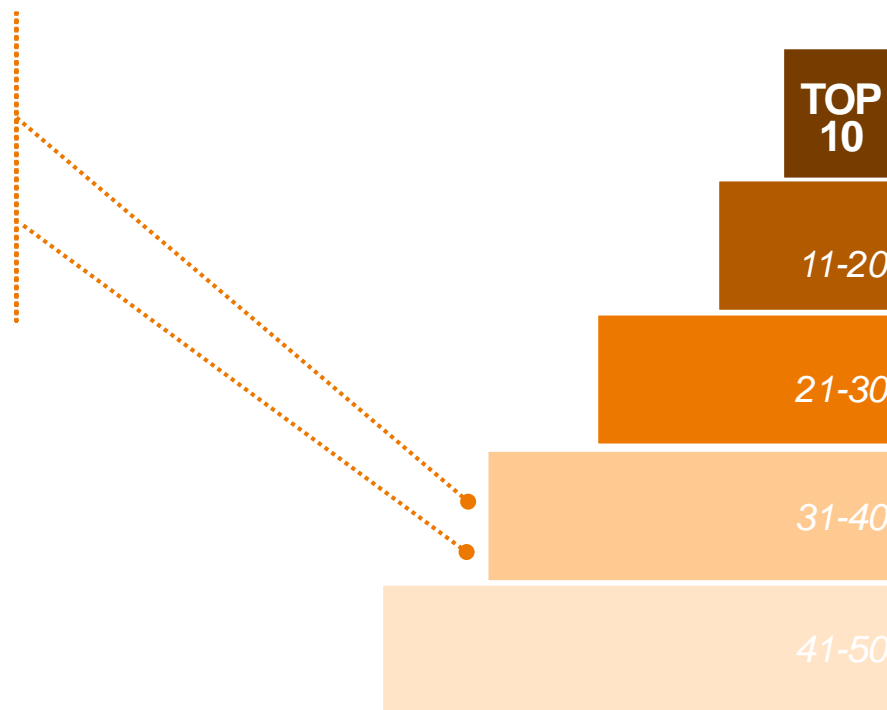


Source: America's Health Rankings 2015;  
Kaiser Health

# Access & Equity *(cont.)*

## Uninsured Population

- ▶ 8% of children under age 18 do not have insurance, ranking **NC 34<sup>th</sup>** in the nation on that measure – more than double the rate of a Top 10 State
- ▶ Total non-elderly uninsured rate of NC is 14%, **ranking 38<sup>th</sup>** in the nation
- ▶ Nationally, uninsured dropped from 17 percent in 2013 to 12 percent in 2014



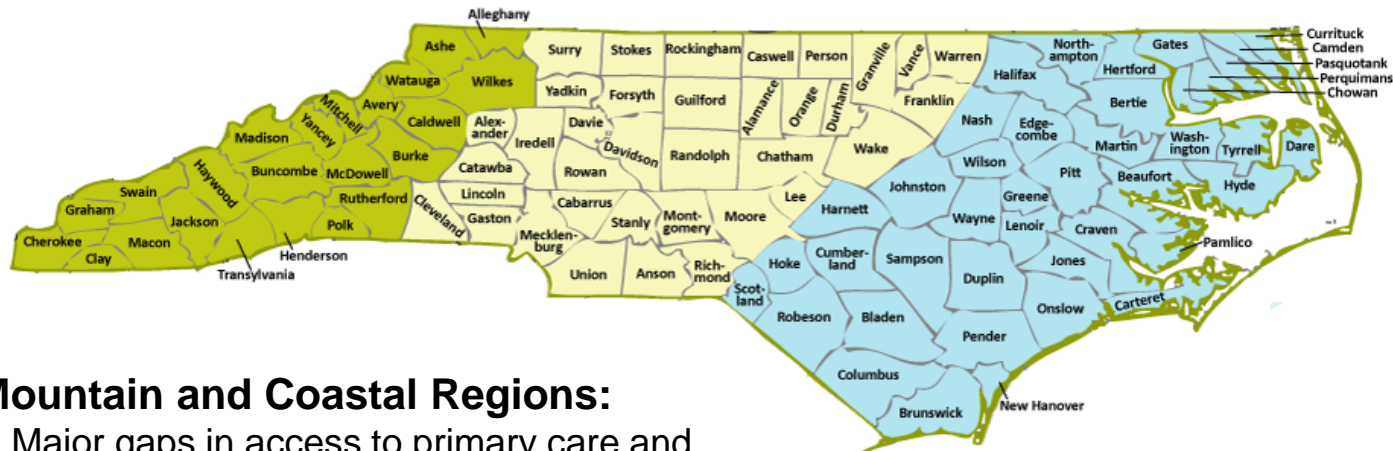
Source: Kaiser Health



# Diverse Challenges: A State with Three Regions

## Piedmont Region:

- Highly-respected healthcare delivery organizations
- Ready access to providers and facilities
- Competition among large, integrated systems



## Mountain and Coastal Regions:

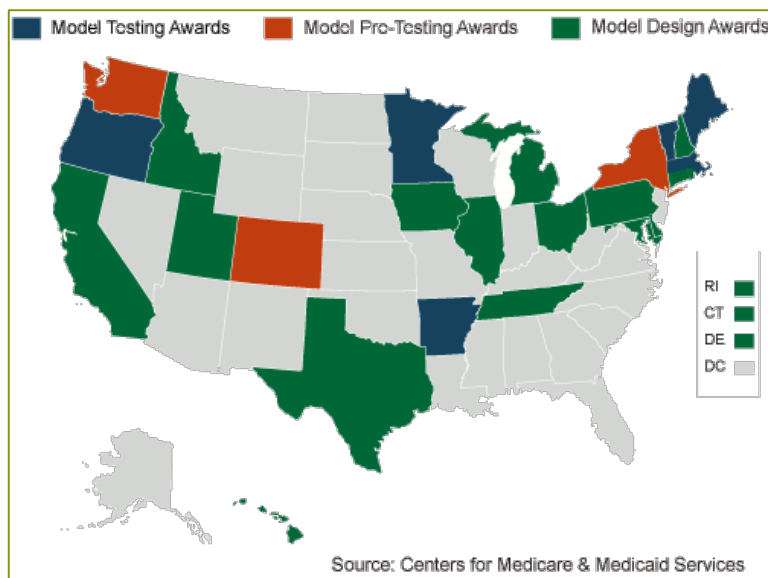
- Major gaps in access to primary care and behavioral health providers
- Very limited competition among delivery systems

Source: NCPedia

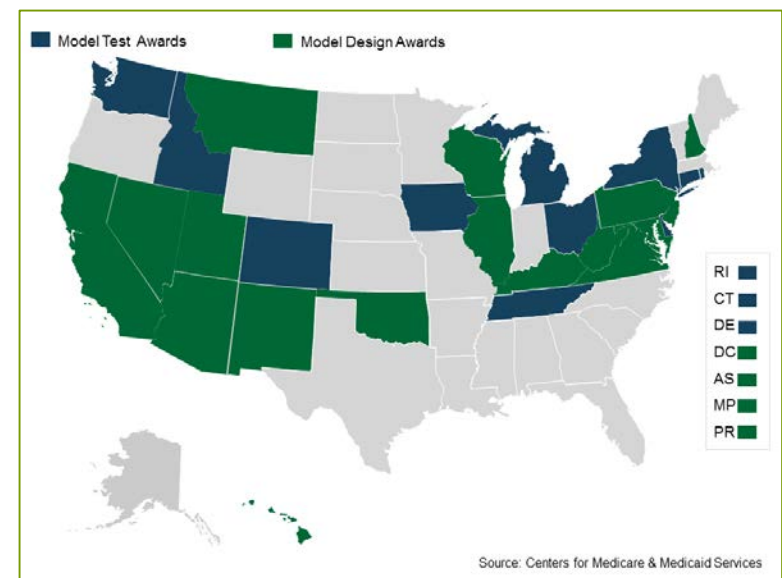
# The Competition: An Expanding Number of States with Federally-Funded Initiatives

## One Measure: Participation in the CMS State Innovation Model Initiative

### Round 1 Awards (\$300M)



### Round 2 Awards (\$660M)



“The State Innovation Models (SIM) Initiative is providing financial and technical support to states for the development and testing of **state-led, multi-payer health care payment and service delivery models** that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.”

-CMS

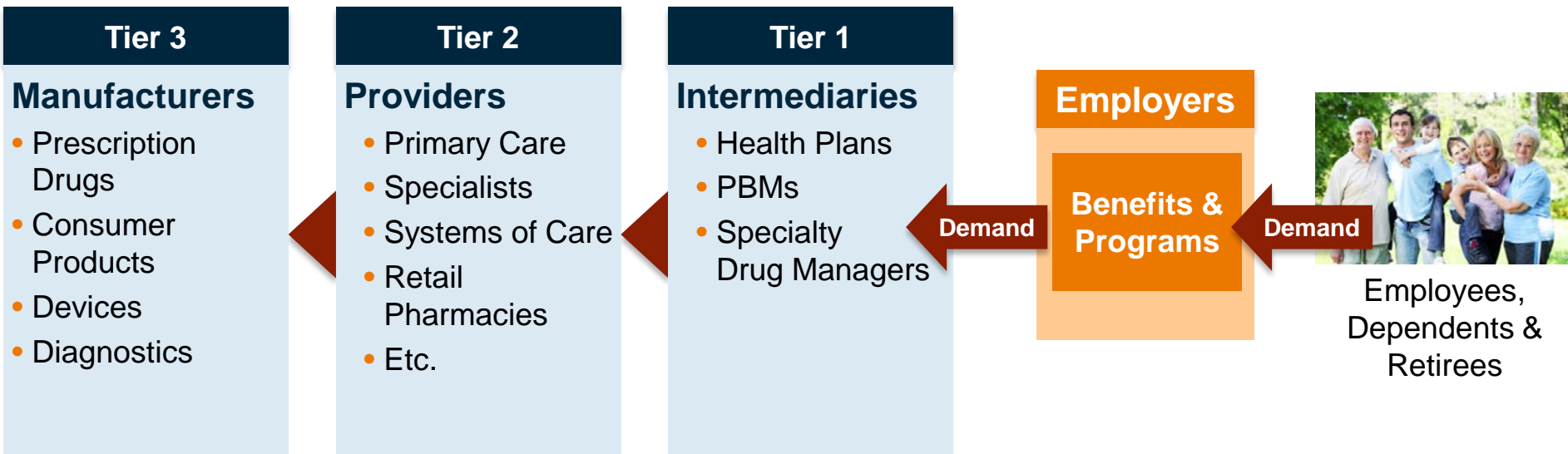
# Implications for North Carolina

- NC is joining a national trend that is already validated
- Competition for “Top 10” status is getting tougher
- There are resources available to leverage—and multiple models to learn from and build on
- NC will need to excel at designing and executing its own initiative

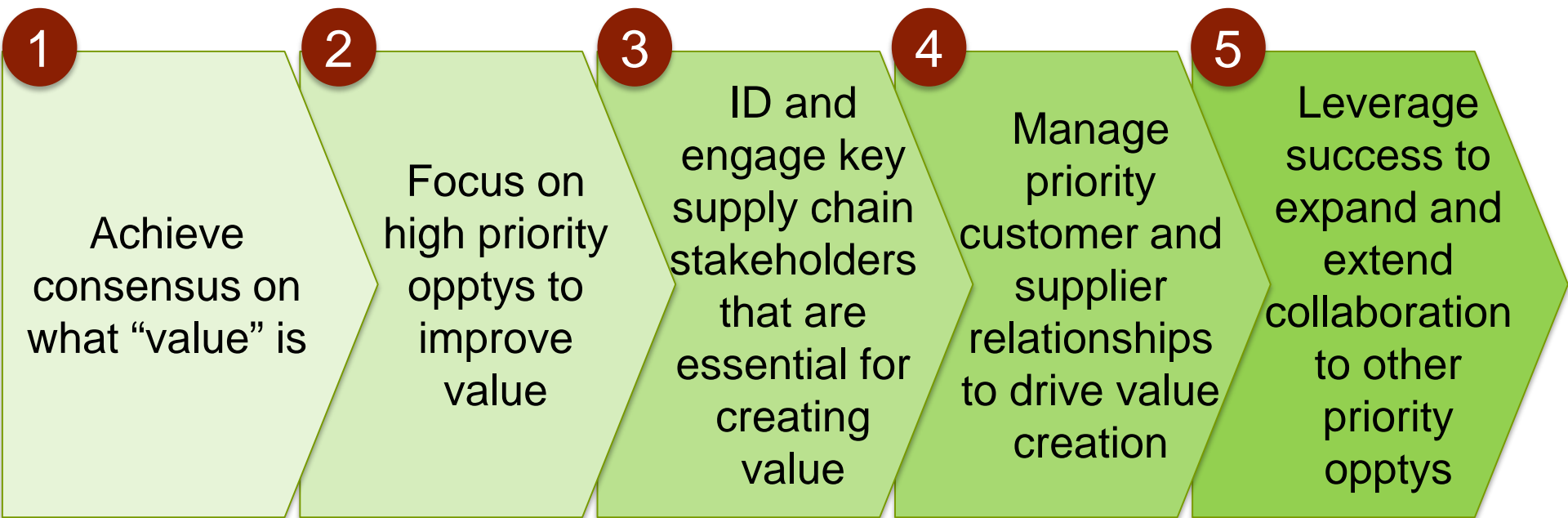
# APPLYING STRATEGIC SUPPLY CHAIN MANAGEMENT TO HEALTHCARE

# The Framework: Strategic Supply Chain Management

## The Health Benefits Supply Chain



# Strategic Management of the Health Benefits Supply Chain - Principles



# 1: Defining Value – Employer Perspective



# Defining Value – Employer Perspective

**Value of Investments in Health** =

**Health outcomes + reduction in risk/future cost + lower absence + lower disability + higher work output + improved work safety + talent attraction and retention**

---

**Employer Cost + Opportunity Cost + Employee Cost**



## 2: Focus on High-Priority Opportunities to Improve Value

- Data-Driven
- Identify/Start with Winnable Collaboration Opportunities
- Keep Next Priority In Sight

*“We’re thinking about this like building a highway. We’re only paving one lane, but we’re grading eight.”*

Craig Osterhues – GE Aviation

### 3: Identify and Engage Key Stakeholders Who Are Essential for Creating Value

- “Key” stakeholders will vary, based on the collaboration opportunity being pursued
- Stakeholders include the end-user (employee/consumer/patient)
- In practice – as the effort focuses on initial opportunities but plans for the future – most/all major stakeholders will be invited to participate
- Not all stakeholders will want to enter into collaborative models

## 4: Manage Key Stakeholder and Customer Relationships to Engage Them in Value Creation

- Focus on the stakeholders and employees/consumers/patients that matter
- Treat those relationships differently to align incentives and disincentives toward value-creating behaviors
- Implication = Things get done differently, meaning:
  - New investments
  - Program, policy and procedure changes
  - Different risk and reward arrangements

## 5: Leverage Success to Expand and Extend Collaboration to Other Priority Opportunities

- Start small/think big
- Leverage ROI from initial success to deepen and expand commitment from employers and key suppliers
- Effort moves to pave the next lane...

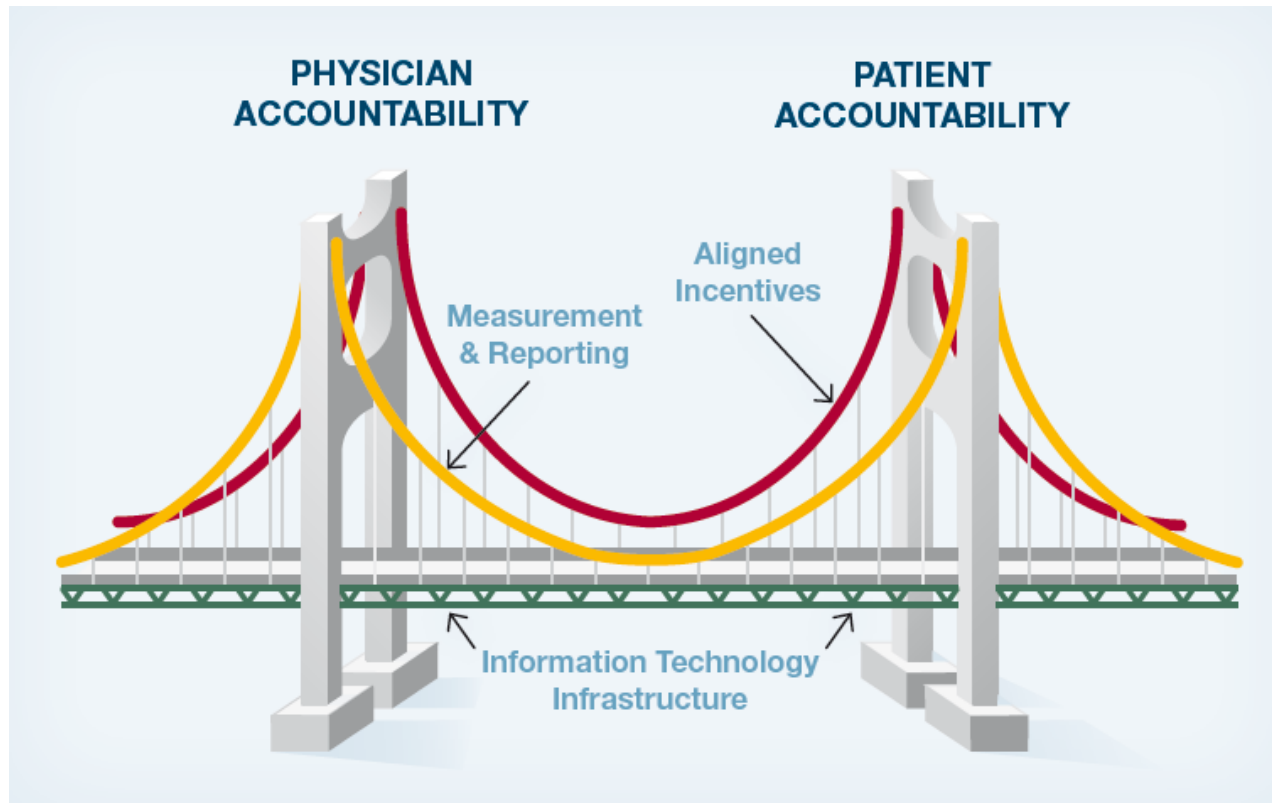
# Implications

- Employers are the focal company: SSCM = Employer-Driven
- Need a critical mass of employers who will not be fickle – who will commit to a process and investment of:
  - Time
  - Energy
  - Data?
  - Resources (cash and in-kind)
- Employee/Consumer/Patient engagement is critical to success, and accomplished in a collaborative context
- Approach needs to enable key stakeholders to win...to thrive...by creating value
- Approach needs to tolerate reality that those who choose not to collaborate to create value will lose

# THE BRIDGE MODEL

# Design Principles: The Bridge Model

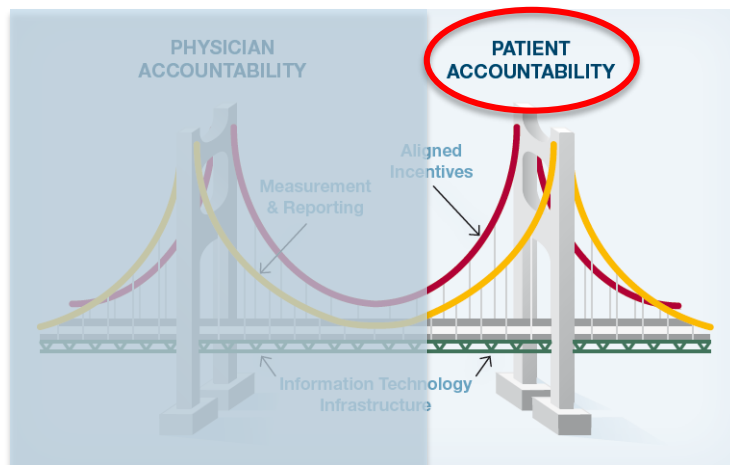
Pursuing Comprehensive, Integrated Solutions for  
Health and Healthcare Value



<http://www.bridgingthevaluegap.com/>

# Patient/Consumer Accountability: Build a Culture of Health and Healthcare Literacy

## Expectations



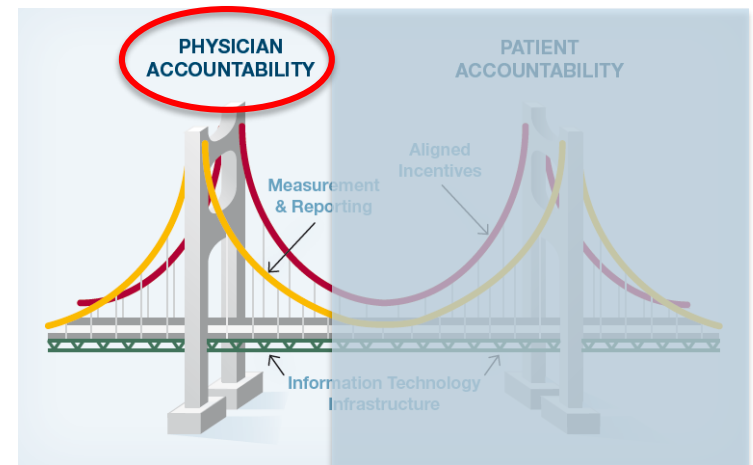
- Adopt/maintain healthy lifestyle
- Access preventive care
- Manage health conditions responsibly
- Utilize best-value providers and therapies
- Comply with evidence-based guidelines for care



# Physician/Provider Accountability: Hold Healthcare Professionals Accountable for Outcomes and Costs

## Expectations

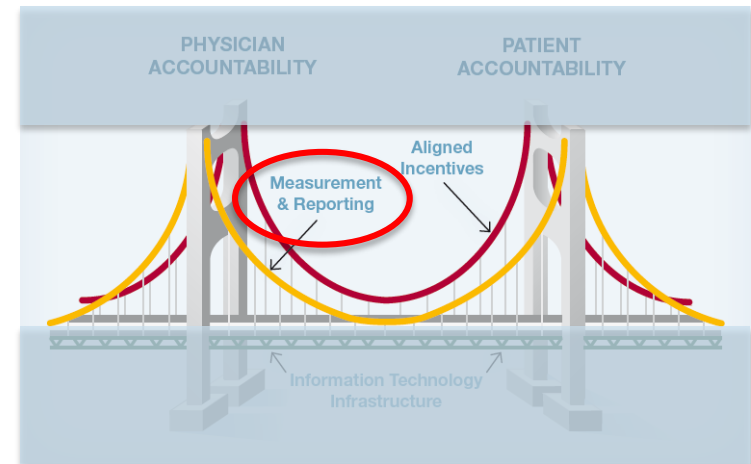
- Maintain patient health
- Provide evidence-based care
- Partner with patients and other stakeholders to influence behavior
- Pursue innovative, value-based therapies and healthcare delivery solutions
- Drive “waste” out of the system



# Measurement and Reporting: Provide Transparent Access to Consistent, Evidence-Based Measures

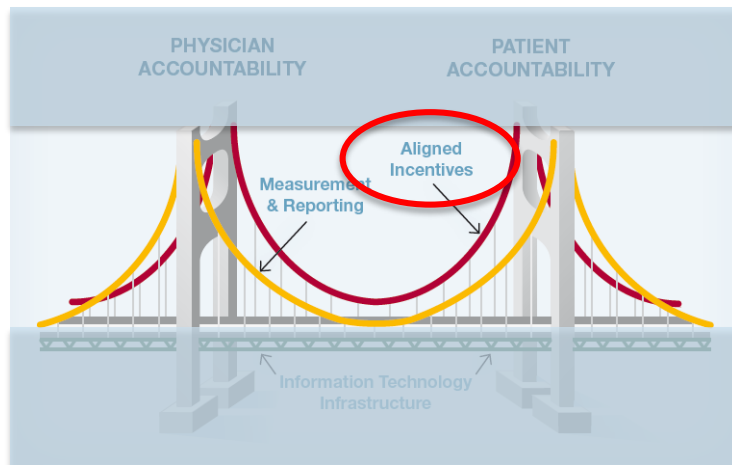
## Expectations

- Develop/implement valid health, quality and cost measures that:
  - Reflect value to purchasers and consumers
  - Are consistent across purchasers and providers
  - Minimize unintended consequences
- Publish the results in a way that is useful to all stakeholders



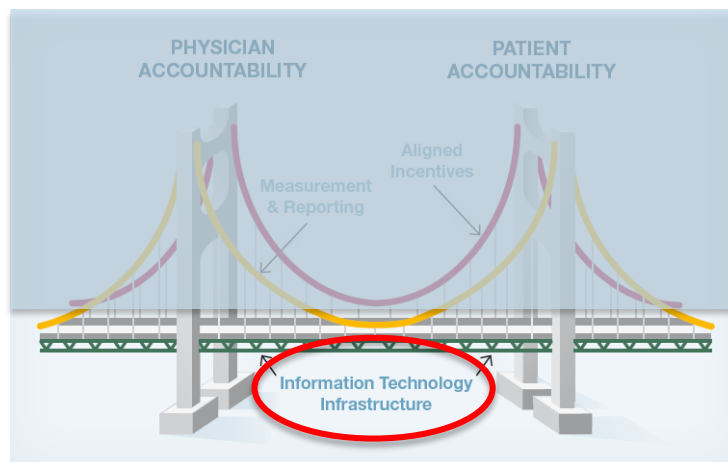
# Aligned Incentives: Reward All Stakeholders for Improving Health and Healthcare Value

## Expectations



- Provide value-based benefit designs for employees and dependents
- Establish value-based purchasing contracts for health plans, providers and manufacturers
- Implement value-based compensation systems for HCPs and stakeholder executives

# Information Technology: Enable High-Performance, Value-Based Care Statewide



## Expectations

- Adopt shared IT infrastructure as appropriate to address common needs
- Support consistent measurement, reporting and payment needs
- Ensure interoperability to facilitate effective care coordination
- Provide analytics to support evidence-based program decisions



# **LEARNING FROM OTHERS: GREATER CINCINNATI AS A MODEL**

# States/Regional Markets with Leading Healthcare Value Initiatives

States and cities across the country are engaging in initiatives; and a number of states/cities have very strong initiatives



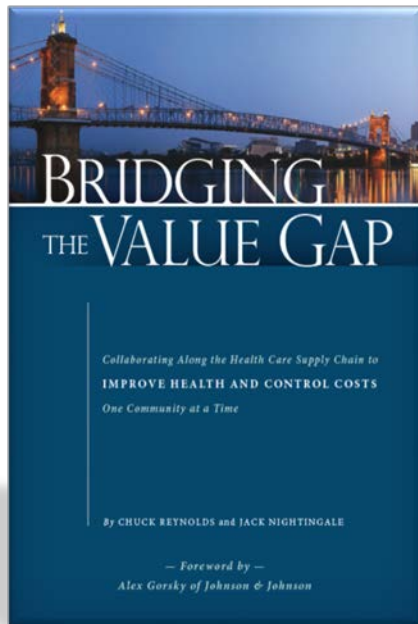
## Characteristics of these leading markets:

- Participate in both national and regionally-led initiatives
- Extensive multi-stakeholder collaboration, with strong local “backbone” organizations—and vision for market leadership
- Beneficiaries of multiple major funding programs
- Pursue initiatives that collectively address all components of a comprehensive solution

Source: Benfield research and analysis

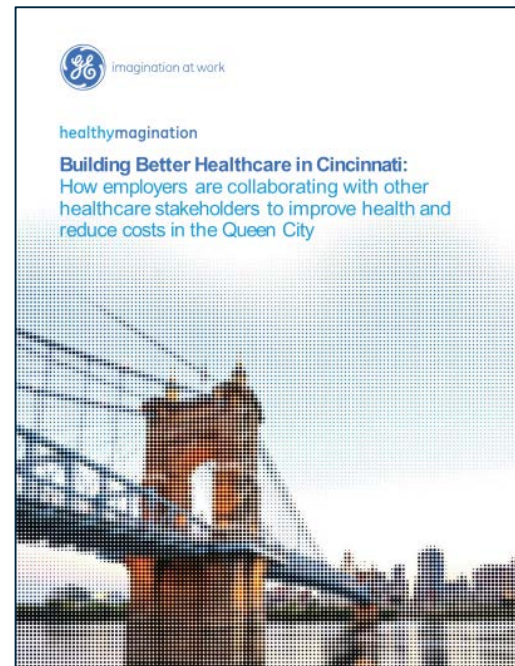
# Greater Cincinnati: Two Case Studies

2010



<http://www.bridgingthevaluegap.com/>

2013



[http://files.gereports.com/wp-content/uploads/2013/09/Building\\_Better\\_Healthcare\\_in\\_Cincinnati.pdf](http://files.gereports.com/wp-content/uploads/2013/09/Building_Better_Healthcare_in_Cincinnati.pdf)

# Healthcare and Healthcare Challenges Facing Cincinnati c. 2006

- Average healthcare quality and value
- Health and healthcare disparities
- History of distrust among stakeholder groups





# A Collaboration of Multiple Stakeholders....



[http://files.gereports.com/wp-content/uploads/2013/09/Building\\_Better\\_Healthcare\\_in\\_Cincinnati.pdf](http://files.gereports.com/wp-content/uploads/2013/09/Building_Better_Healthcare_in_Cincinnati.pdf)

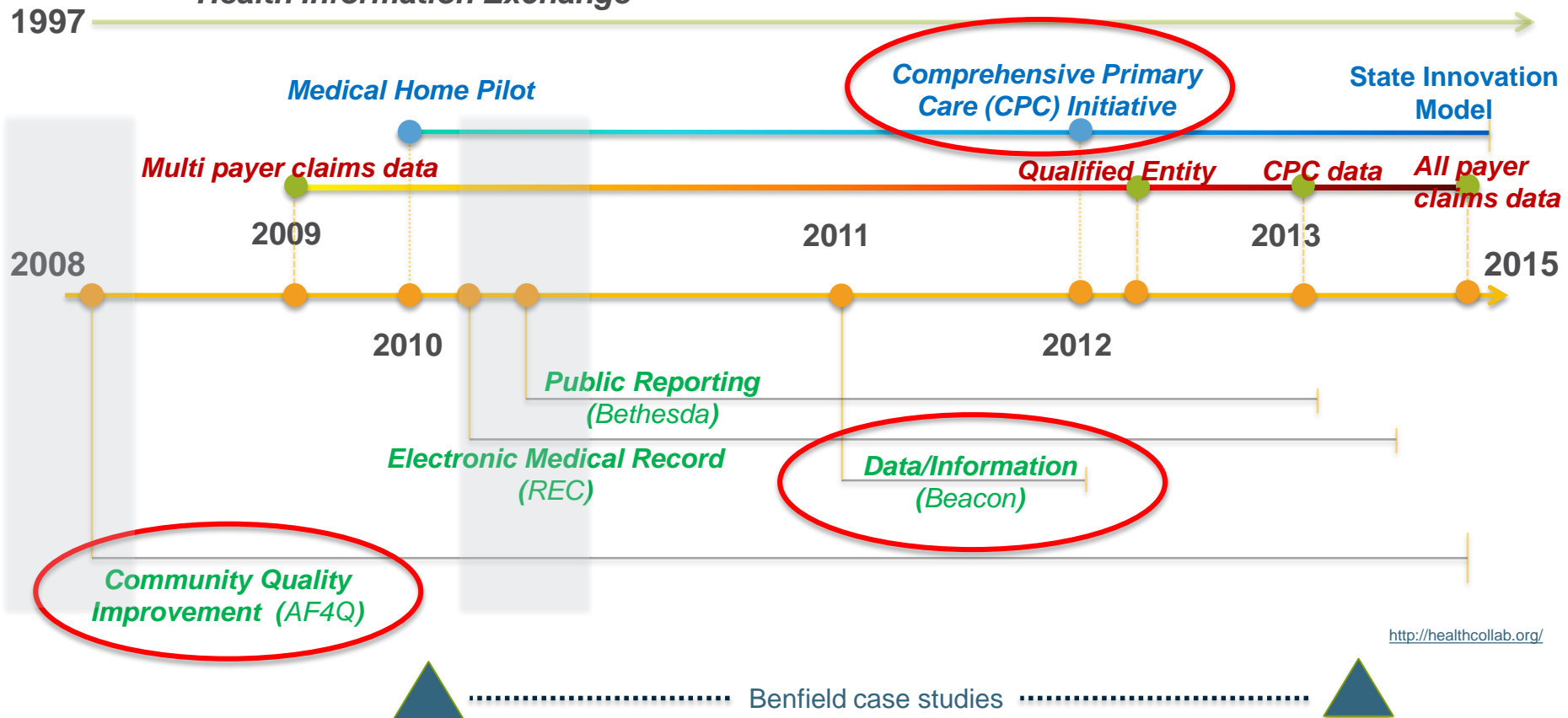
# ....with Strong, Passionate Leaders



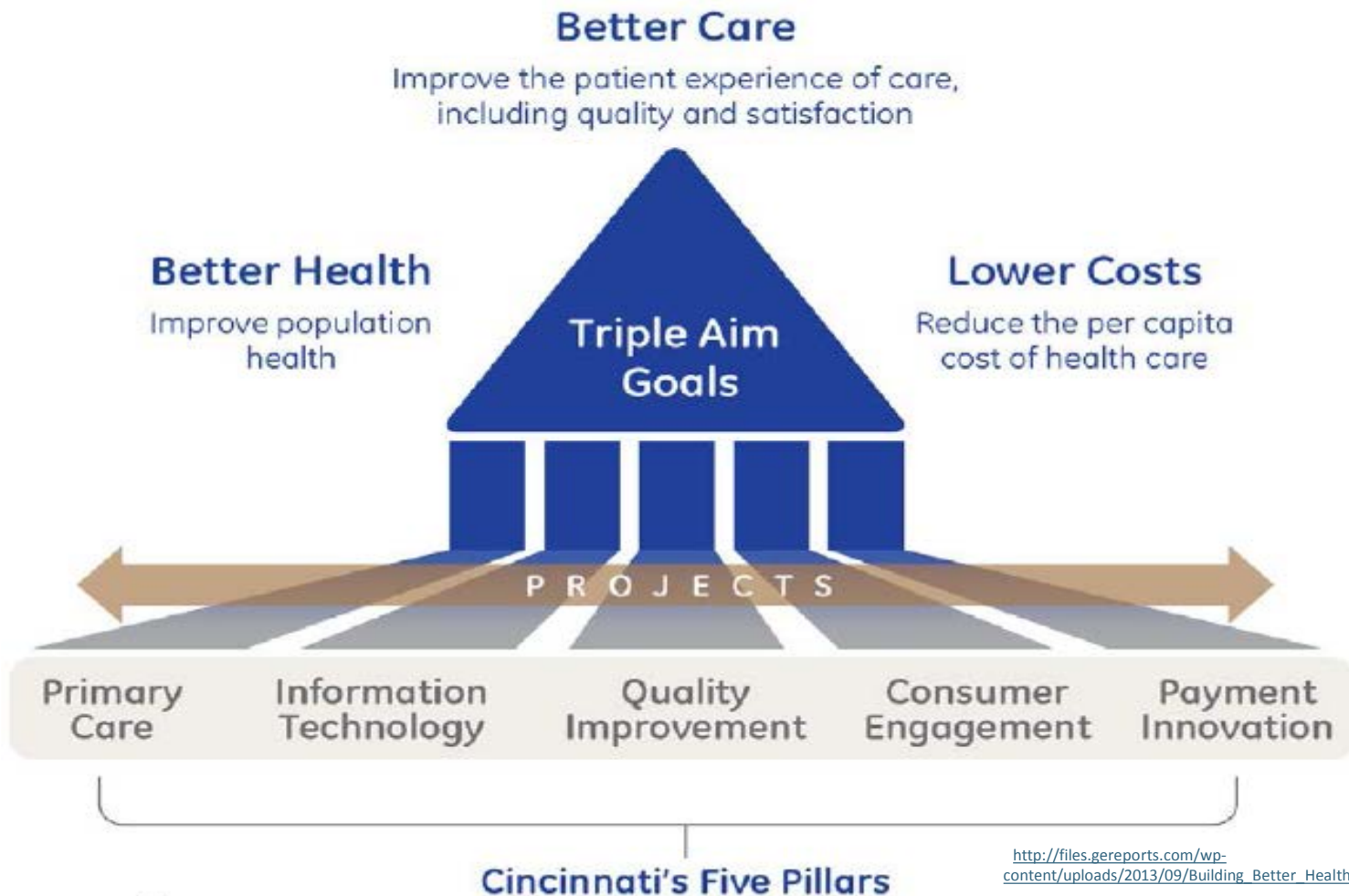
# Building Layers of Success.....and Aligning with National/Regional Initiatives

## Close Alignment with the Direction of HHS/CMS in Particular

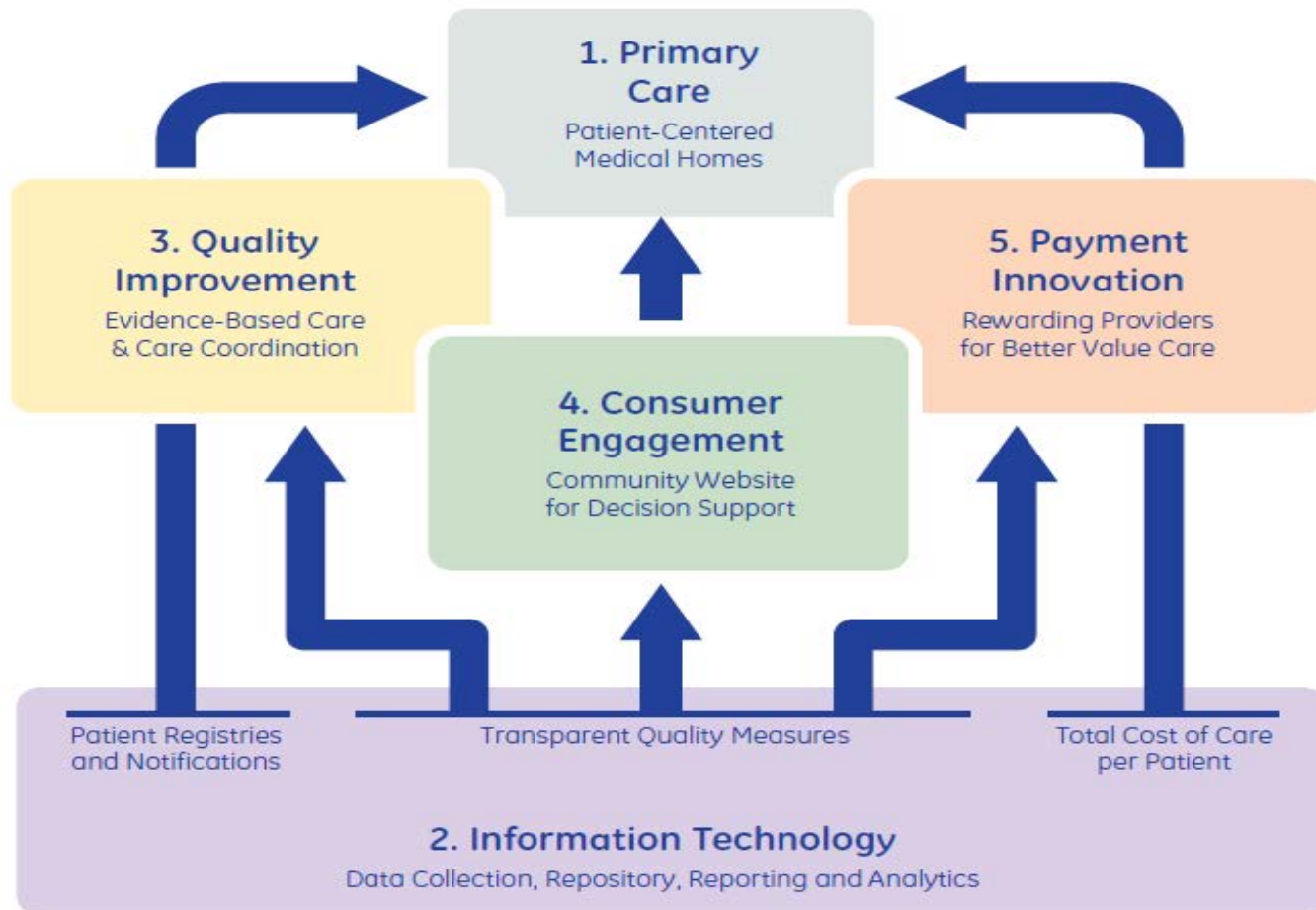
### Health Information Exchange



# Following an Overarching Strategic Framework....



# ...an Integrated Operating Model...

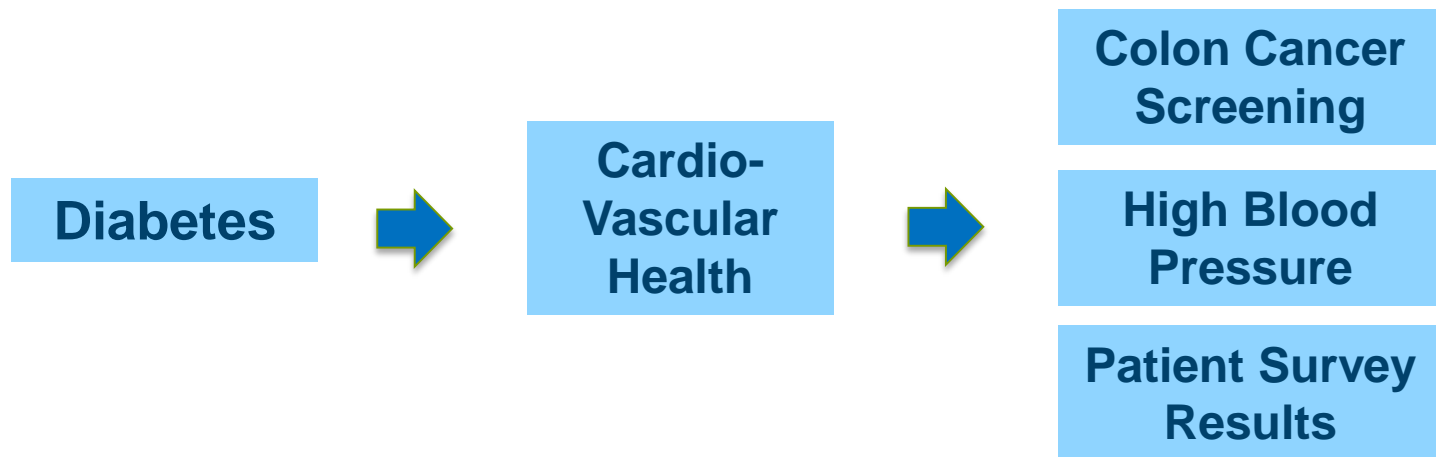


**Move from pilot projects to production**

[http://files.gereports.com/wp-content/uploads/2013/09/Building\\_Better\\_Healthcare\\_in\\_Cincinnati.pdf](http://files.gereports.com/wp-content/uploads/2013/09/Building_Better_Healthcare_in_Cincinnati.pdf)

# ...and a Deliberate, Focused Approach to Implementation

## Progression of Publicly-Reported Quality Measures



<http://yourhealthmatters.org/>



# Early Results: Delivering Measurable Improvements in Quality and Value

## IMPROVING PRIMARY CARE THROUGH PCMH

● 2008 ● 2012

### Emergency Room Visits per 1000 Members

#### PCMH PILOT



#### NON-PCMH MATCHED COHORT



### Hospital Admissions per 1000 Members

#### PCMH PILOT



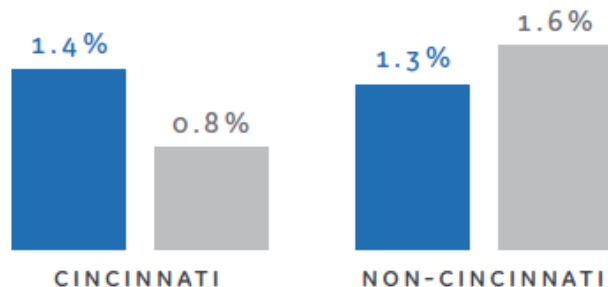
#### NON-PCMH MATCHED COHORT



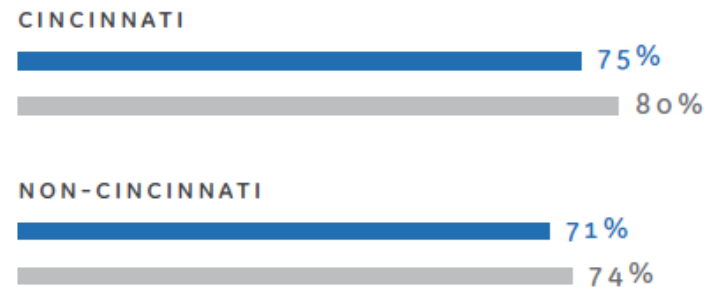
## QUALITY IMPROVEMENT IN THE CARE OF ADULT DIABETES

● 2008 ● 2012

### Percentage of Diabetes Patients with Complications



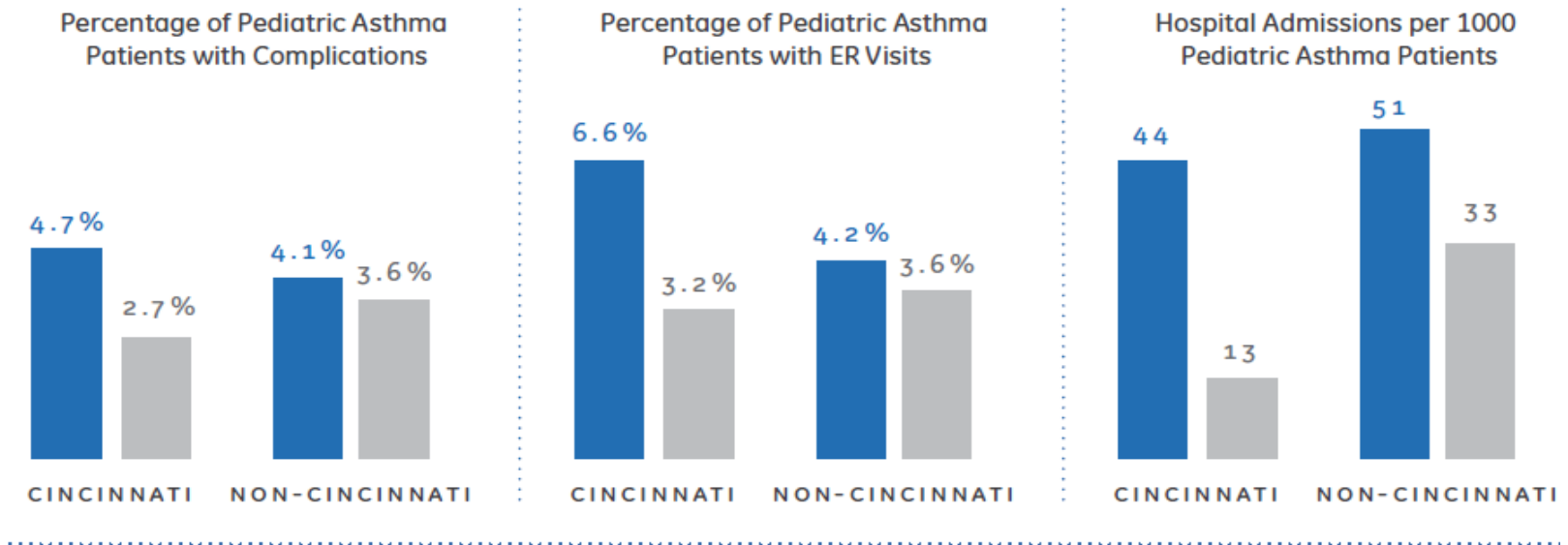
### Percentage of Diabetes Patients with HbA1c Tests



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# Early Results: Delivering Measurable Improvements in Quality and Value (cont.)

## QUALITY IMPROVEMENT IN THE CARE OF PEDIATRIC ASTHMA



[http://files.gereports.com/wp-content/uploads/2013/09/Building\\_Better\\_Healthcare\\_in\\_Cincinnati.pdf](http://files.gereports.com/wp-content/uploads/2013/09/Building_Better_Healthcare_in_Cincinnati.pdf)



# Key Lessons from Cincinnati and Other Successful Multi-Stakeholder Initiatives

1. Place the central focus on improving quality and value
2. Build a complete 'bridge' to healthcare value
3. Think big, but start small
4. Pursue real 'win/win' partnerships with other stakeholders
5. Engage strong leaders to drive the initiative

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# Further Implications: Critical Attributes of a Successful Initiative

- **Data-driven:** Focus on what matters
- **Evidence-driven:** Do what works
- **Innovative:** Pioneer new approaches
- **Disciplined:** Follow a sustained, methodical approach