Overview

Mission

Bridges to Excellence is a program designed to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

- A multi-stake approach to creating incentives for quality
  - Employers, health plans, consumers, physicians, and group practices

- Guided by three principles, its purpose is to create programs that will realign **everyone's** incentives around higher quality.
  - Reengineering care processes to reduce mistakes will require investments, for which purchasers should create incentives;
  - Significant reductions in defects (misuse, underuse, overuse) will reduce the waste and inefficiencies in the health care system today;
  - Increased accountability and quality improvements will be encourages by the release of comparative provider performance data, delivered to consumers in a compelling way.

- Focus
  - Diabetes care, office practices, cardiac care
  - Roll-out in selected markets
  - Program costs paid by participating employers

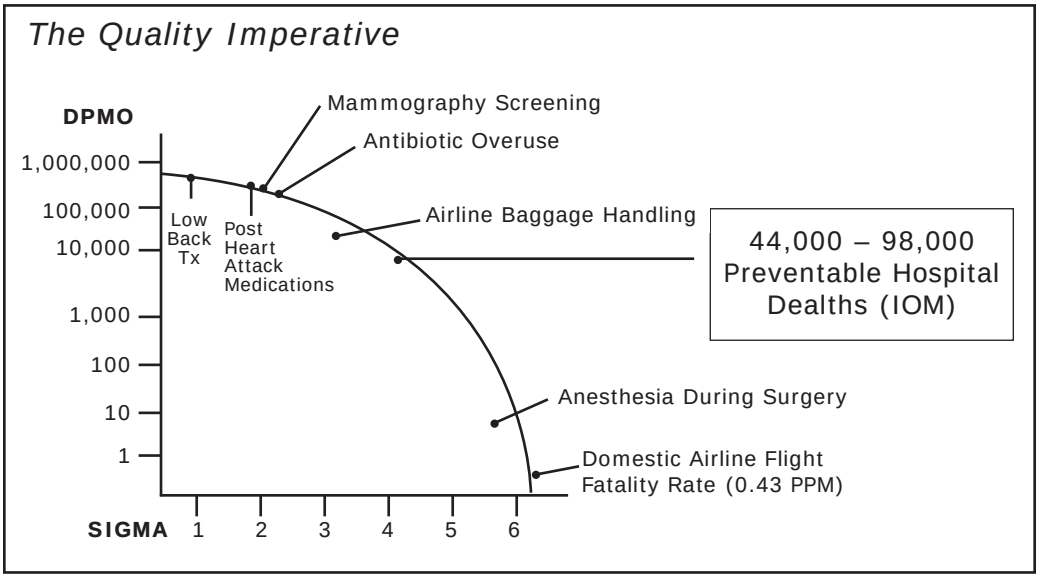
What is Bridges to Excellence and will it work in my region?

Bridges to Excellence (BTE) is an initiative that is designed to re-align incentives in the market between providers, purchasers and patients around better outcomes and processes of care. Participating in BTE means that, as a purchaser, you recognize that:

- The market is not delivering optimal care,
- That patient, provider and purchaser interests can be at odds,
- That purchasers have little way of knowing how effectively and efficiently their health care dollars are being used
- That there is little or no accountability at the individual provider level for the quality of care delivered,
- And that, as a purchaser, you have not yet created a robust business case for better quality of care by recognizing and differentially paying providers that can demonstrate better outcomes.

Changing the delivery system so that it better meets the six aims defined by the Institute of Medicine in its 2001 report: Crossing the Quality Chasm - safe, timely, equitable, efficient, effective, patient-centered - requires a concerted effort by public and private purchasers to remove any barriers to the adoption of better systems of care, and create stronger incentives for quality enhancements.

Today, the lack of appropriate incentives has contributed to create a delivery system that, on average, produces many errors (errors of underuse, misuse, overuse) as depicted in the chart below.



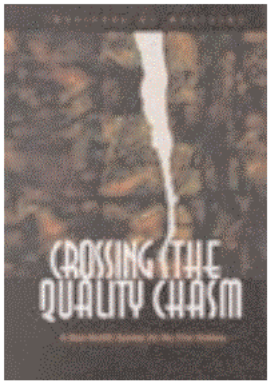
Poor quality costs purchasers millions every year

Condensed Pitch

This presentation is used to communicate to other employers the mission of Bridges to Excellence objectives and program components.

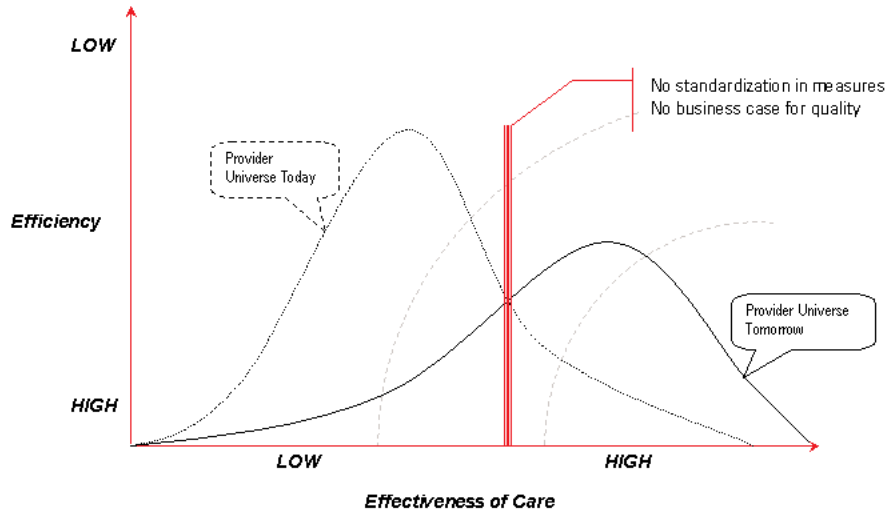
Bridges To Excellence – Rewarding better quality care

Why Isn't Quality Better



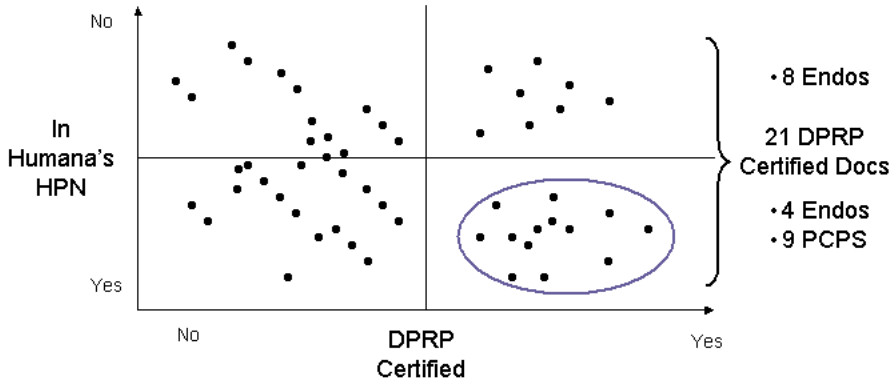
- Growing complexity of science and technology
- Poorly organized delivery system
- Inadequate information infrastructure
- Gaps in leadership and education: Missed opportunities in "systems" thinking and continuous improvement
- Toxic payment system

Better Quality Can Cost Less

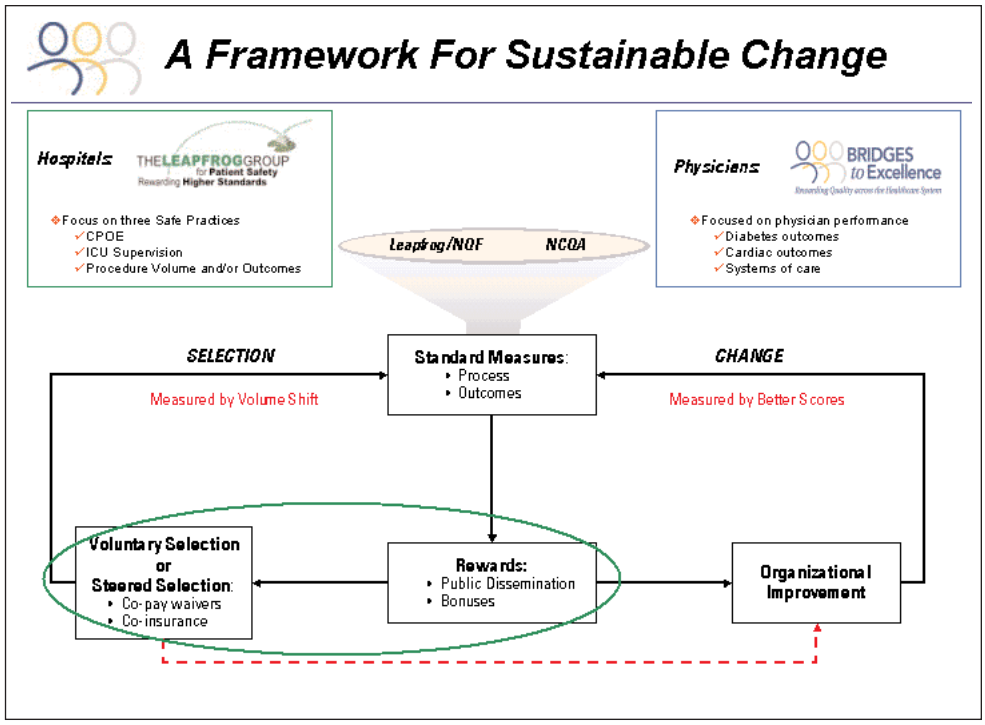


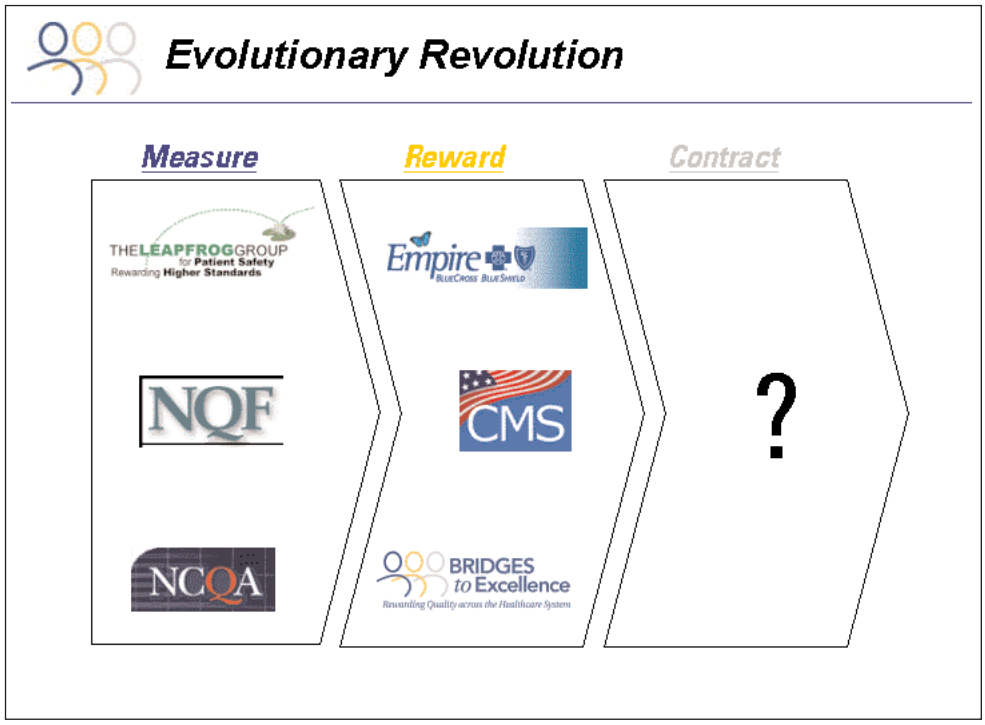
One example of better quality costing less

Distribution of PCPs & Endos in Humana's Networks in L'ville and Cinci



All DPRP Certified PCPs are also in Humana's most efficient tier (80th percentile)…a good start, but we need a few more.


A Framework For Sustainable Change
Hospitals:
THE LEAPFROG GROUP for Patient Safety Rewarding Higher Standards
Focus on three Safe Practices
CPOE
ICU Supervision
Procedure Volume and/or Outcomes
Physicians:
BRIDGES to Excellence
Focused on physician performance
Diabetes outcomes
Cardiac outcomes
Systems of care
Leapfrog/NQF
NCQA
SELECTION
Measured by Volume Shift
Standard Measures:
Process
Outcomes
CHANGE
Measured by Better Scores
Voluntary Selection or Steered Selection:
Co-pay waivers
Co-insurance
Rewards:
Public Dissemination
Bonuses
Organizational Improvement


Evolutionary Revolution
Measure
Reward
Contract
THE LEAPFROG GROUP for Patient Safety Rewarding Higher Standards
Empire BlueCross BlueShield
NQF
CMS
?
NCQA
BRIDGES to Excellence

BTE Performance Dimensions

Structure (PPC):

PHYSICIAN OFFICE LINK

- Patient safety – e-prescribing
- Guideline-driven care – EHRs
- Focus on high-cost patients – Care coordination
- Improved compliance – Patient education & support

NCQA

Process & Outcomes (DPRP & HSRP):

DIABETES CARE LINK

- HbA1Cs tested and controlled
- LDLs tested and controlled
- BP tested and controlled
- Eye, Foot and Urine exams

CARDIAC CARE LINK

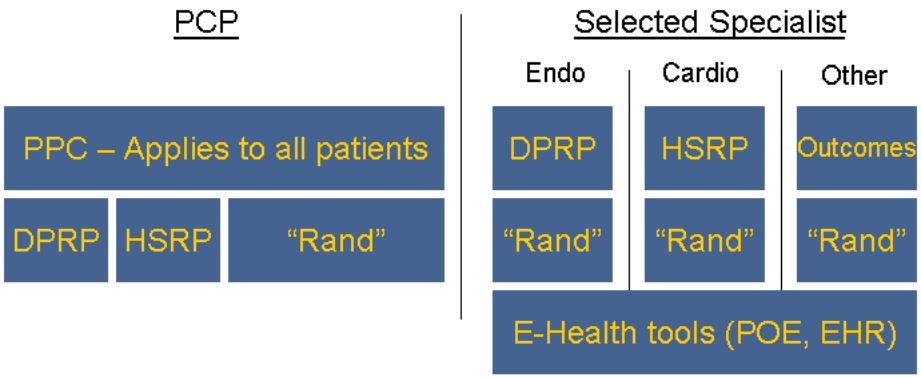
- LDLs tested and controlled
- BP tested and controlled
- Use of aspirin
- Smoking cessation advice

Program Overview

- Engage Physicians
  - Reward DPRP Certification at up to $100/dp/y
  - Reward HSRP Certification at up to $160/cp/y
  - Reward SCCRP Certification at up to $50/p/y
- Engage Patients
  - Reward compliance with diabetic care and HbA1c control
  - Reward compliance with cardiac care and BP/LDL controls
  - Encourage rating physicians on patient experience of care and using performance information to select care providers

Bonuses actuarially calculated to yield positive ROI for purchaser

Outpatient Performance Measures



- PCPs have to adopt new care processes and IT, then demonstrate performance through better outcomes on cardiac and diabetes patients (if applicable) and/or a set of RAND/HEDIS measures
- Specialists have to demonstrate good performance on outcomes and a specialty-specific subset of RAND/HEDIS measures, and adopt e-health tools.

BTE Incentives

Offices meeting Passing Score in:		POL			DCL/CCL
		Clinical Information System	Patient Education & Support	Care Management	
Any Module	*Y1*	*$50*			20% of bonus is withheld until practice meets DCL and/or CCL (depends on whether attribution id's diabetics and/or cardiac patients) Doc gets full POL bonus plus extra $80 for each diabetic and cardiac patient when meeting CCL/DCL
	Y2	*$20*			
	Y3	*$10*			
Two out of three Modules	*Y1*	*$50*			
	Y2	*$50*			
	Y3	*$30*			
All three Modules	*Y1*	*$50*			
	Y2	*$50*			
	Y3	*$50*			

A top scoring practice can earn up to $20K per doc/year

Reward Example

- 3 PCP Practice with 1000 patients covered by the program:
  - 3.5% are diabetic patients
  - 2.5% are cardiac patients
- Practice receives total of $54,800:
  - $40 * 1000 = $40,000 for meeting POL measures
  - $80 * 60 + $10 * 1000 = $14,800 for meeting DCL & CCL measures
- Purchaser saves a total of $55,000 less program costs ($6 pmpy)

Engaging Consumer-patients

Create

⇒ Take action
⇒ You can do it
⇒ "It's your health"
⇒ "Research shows"

Comprehensive Toolkit

Connect

⇒ Own Nurse/Doc
⇒ Volunteers from the American Diabetes Association/CDEs
⇒ On Site Clinics

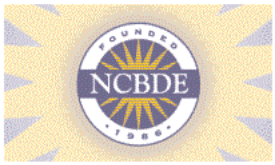
Multiple Touchpoints

Support

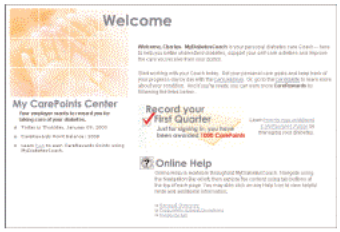
⇒ In person coaching
⇒ Checklists of treatment goals
⇒ Expert care team lists

CTQ-driven Tools

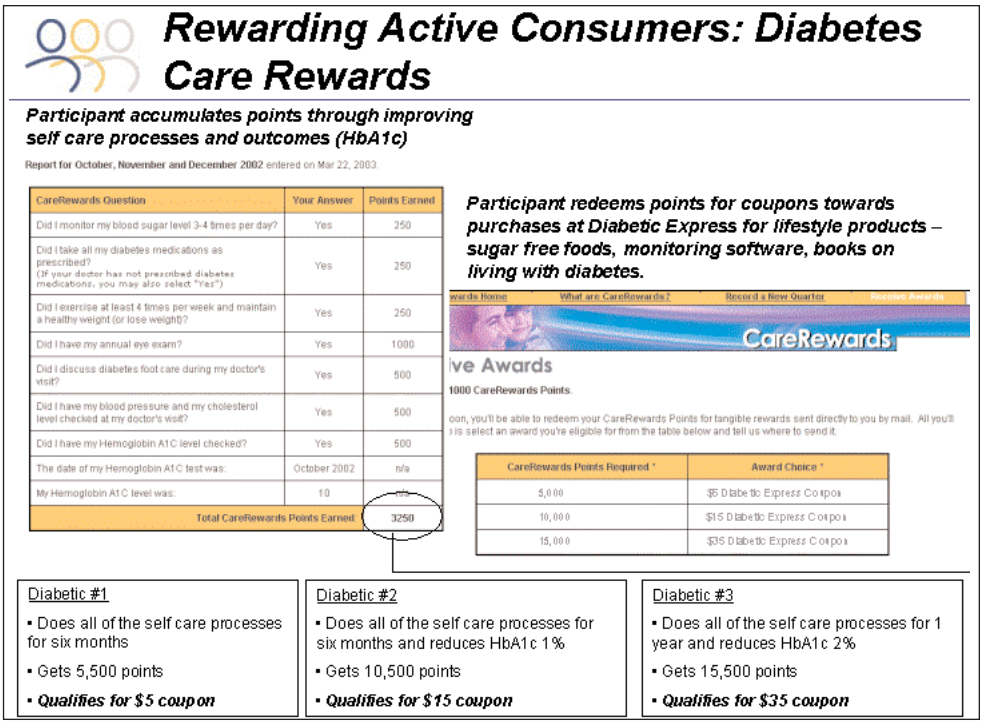
- Four invitational letters based on different patient stories/themes
- A series of 4 newsletter articles
- 12 E-mail alerts…and more



- Use CDEs to connect eligible patients to the support tools and the expert care team lists
- Supplement the CDEs with internal connectors – OSM, HR, etc..



- CareGuide
- CareJournal
- CareRewards
- Physician Finder



Rewarding Active Consumers: Diabetes Care Rewards

Participant accumulates points through improving self care processes and outcomes (HbA1c)

Report for October, November and December 2002 entered on Mar 22, 2003.

CareRewards Question	Your Answer	Points Earned
Did I monitor my blood sugar level 3-4 times per day?	Yes	250
Did I take all my diabetes medications as prescribed? (If your doctor has not prescribed diabetes medications, you may also select "Yes")	Yes	250
Did I exercise at least 4 times per week and maintain a healthy weight (or lose weight)?	Yes	250
Did I have my annual eye exam?	Yes	1000
Did I discuss diabetes foot care during my doctor's visit?	Yes	500
Did I have my blood pressure and my cholesterol level checked at my doctor's visit?	Yes	500
Did I have my Hemoglobin A1C level checked?	Yes	500
The date of my Hemoglobin A1C test was:	October 2002	n/a
My Hemoglobin A1C level was:	10	
Total CareRewards Points Earned:		3250

Participant redeems points for coupons towards purchases at Diabetic Express for lifestyle products – sugar free foods, monitoring software, books on living with diabetes.

wards Home | What are CareRewards? | Record a New Quarter | Receive Awards

CareRewards

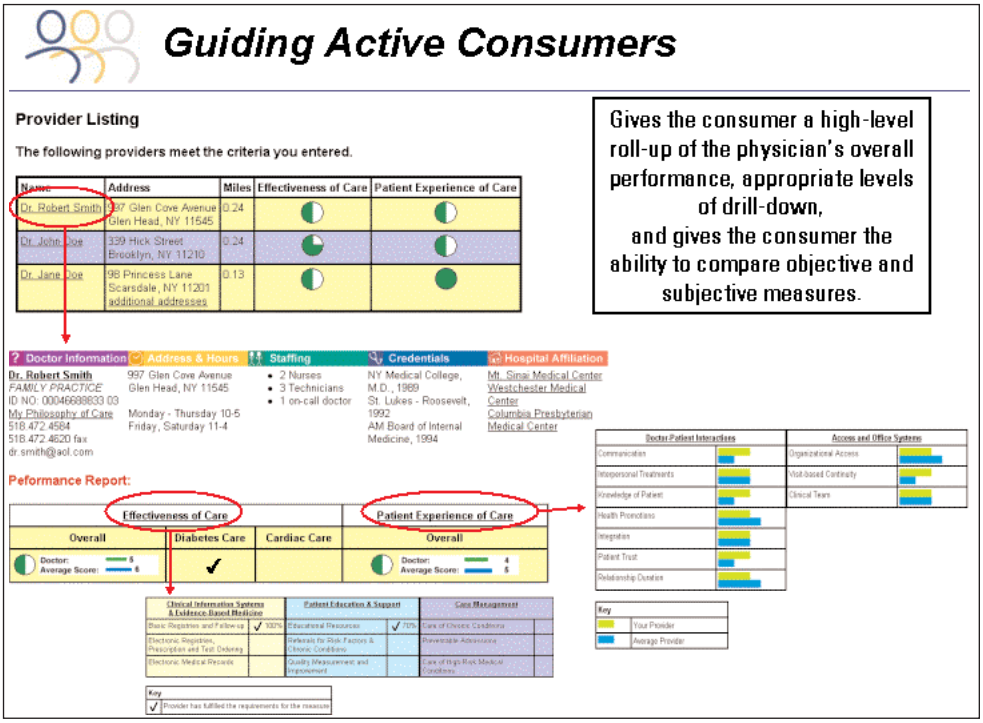
ve Awards

1000 CareRewards Points.

oon, you'll be able to redeem your CareRewards Points for tangible rewards sent directly to you by mail. All you'll) is select an award you're eligible for from the table below and tell us where to send it.

CareRewards Points Required *	Award Choice *
5,000	$5 Diabetic Express Coupon
10,000	$15 Diabetic Express Coupon
15,000	$35 Diabetic Express Coupon

Diabetic #1	Diabetic #2	Diabetic #3
▪ Does all of the self care processes for six months	▪ Does all of the self care processes for six months and reduces HbA1c 1%	▪ Does all of the self care processes for 1 year and reduces HbA1c 2%
▪ Gets 5,500 points	▪ Gets 10,500 points	▪ Gets 15,500 points
▪ ***Qualifies for $5 coupon***	▪ ***Qualifies for $15 coupon***	▪ ***Qualifies for $35 coupon***



Guiding Active Consumers

Provider Listing

The following providers meet the criteria you entered.

Name	Address	Miles	Effectiveness of Care	Patient Experience of Care
Dr. Robert Smith	997 Glen Cove Avenue Glen Head, NY 11545	0.24		
Dr. John Doe	339 Hick Street Brooklyn, NY 11210	0.24		
Dr. Jane Doe	98 Princess Lane Scarsdale, NY 11201 additional addresses	0.13		

Gives the consumer a high-level roll-up of the physician's overall performance, appropriate levels of drill-down, and gives the consumer the ability to compare objective and subjective measures.

Doctor Information | Address & Hours | Staffing | Credentials | Hospital Affiliation

Dr. Robert Smith
FAMILY PRACTICE
ID NO: 00046688833 03
My Philosophy of Care
518.472.4584
518.472.4620 fax
dr.smith@aol.com

997 Glen Cove Avenue
Glen Head, NY 11545

Monday - Thursday 10-5
Friday, Saturday 11-4

- 2 Nurses
- 3 Technicians
- 1 on-call doctor

NY Medical College, M.D., 1989
St. Lukes - Roosevelt, 1992
AM Board of Internal Medicine, 1994

Mt. Sinai Medical Center
Westchester Medical Center
Columbia Presbyterian Medical Center

Peformance Report:

Effectiveness of Care			Patient Experience of Care
Overall	Diabetes Care	Cardiac Care	Overall
Doctor: Average Score: 5 6	✓		Doctor: Average Score: 4 5

Doctor-Patient Interactions	Access and Office Systems
Communication	Organizational Access
Interpersonal Treatments	Visit-based Continuity
Knowledge of Patient	Clinical Team
Health Promotions	
Integration	
Patient Trust	
Relationship Duration	

Key: Your Provider; Average Provider

Clinical Information Systems & Evidence-Based Medicine	Patient Education & Support	Care Management
Basic Registries and Follow-up ✓ 100%	Educational Resources ✓ 70%	Care of Chronic Conditions
Electronic Registries, Prescription and Test Ordering	Referrals for Risk Factors & Chronic Conditions	Preventable Admissions
Electronic Medical Records	Quality Measurement and Improvement	Care of High Risk Medical Conditions

Key: ✓ Provider has fulfilled the requirements for the measure

Primary Source of Savings

PHYSICIAN OFFICE LINK

Measure Focus	Primary Impact	Estimated Impact
Disease Management	• Reduced variation in overall costs of care • Increased compliance with guidelines, better control of patients with chronic conditions	5% of Total Gross Spend
ACPOE	• Reduced outpatient medication errors • Reduced lab and radiology overuse	3% of Total Gross Spend
EHR	• Reduced adverse drug events • Increased compliance with care guidelines	5% of Total Gross Spend
Amb. Care Sensitive Hosp	• Reduced hospitalizations for patients at higher risk of being hospitalized	2% of Total Gross Spend
Care Coordination	• Reduction in duplicative testing • Reduction in hospitalizations	5% of Total Gross Spend

DIABETES CARE LINK
CARDIAC CARE LINK

	• Increased compliance with care guidelines • Reduced variation in practice patterns and resource use • Reduced hospitalization and ER visits • Reduced severity of disease complications	6.4% of Gross Spend on Diabetes
		10% of Gross Spend on Ischemic Vasc. Diseases

Program Rational & ROI

These programs were developed using a few key guiding principles:

- The performance measures used had to meet important criteria defined by providers - measurable, actionable, standardized, fair, difficult but achievable, assessed by an independent third party
- Meeting the performance measures would indicate clear demonstrable better performance in effectiveness and efficiency
- There was an actuarial analysis that would support that better performance would reduce costs of care by increasing the quality of care.

As a result, each BTE program has an expected per patient savings estimate associated to every patient that goes to a physician that meets the performance measure. That sets up the mechanism to share that savings with the provider in a fair and equitable way, creating a business case for more and more providers to compete for quality. But for that business case to be compelling, the patient are the key ingredient: lots of patients, which means many participating employers-purchasers in the program. Both as participants in the consumer – focused programs, and as covered lives to increase the rewards when measures.

In focus groups and other independent research, bonuses of at least $1000 are needed before a physician will pay attention to a program. And if significant change or allocation of internal resources is needed to achieve the quality goals, then the bar is raised to between 5% and 10% of a physician's income - or some
where between $5,000 and $10,000.

What this Means Practically

- Employer with 10,000 covered lives:
  - All members counted under POL
  - Only members with diabetes (about 3%) counted in DCL - 300
  - Only members with CVD (about 5%) counted in CCL - 500

- Maximum bonus exposure:
  - POL: 10,000 * $55 = $550,000
  - DCL: 300 * $100 = $30,000
  - CCL: 500 * $100 = $50,000 (still to be finalized)
  - Total bonus exposure if ALL physicians met ALL performance measures:
  $630,000

- Administrative expenses and consumer rewards:
  - Medstat admin expenses: $5 pmpy = $50,000
  - DCL rewards expenses: $75 pppy = $22,500
  - CCL rewards expenses: $75 pppy = $37,500
  - Total if ALL patients got rewards:
  $110,000

• *A review of the business case*

Several strategies have been employed to reduce health care costs and improve quality of care. Various studies have documented the promise of care coordination, disease management, and use of information technology (electronic medical records (EMRs), electronic analysis of claims and clinical data) in achieving both objectives of reducing health care costs and improving quality of care. The question is, at this stage of the health care evolution, how does an employer calculate a return on investment and make the choice between new approaches, like incentive-based quality initiatives, and the strategies tried in the past? In answering that question and assessing the potential of all strategies to have a system wide effect, three important issues emerge: ability to generalize outcomes, simultaneous implementation of two or more strategies and the long-term consequences of interventions.

- **Generalizing Outcomes** - While disease management has shown significant benefits in some instances, it is unclear if disease management programs such as those run by health plans have any clear return on the up-front investment. Given the complexity of healthcare itself and the wide variability in the capabilities of institutions and providers, it is unlikely that one "optimal" approach to implementing a strategy exists.
- **Simultaneous Implementation** - Most studies do not break down savings into individual components (with the notable exception of CITL's report ACPOE10), so it is not possible to clearly identify areas of overlapping cost savings or the effect one strategy may have on another. Since most initiatives attempt to alleviate such basic problems as lack of
coordination of care and the reliance on patient initiated care delivery, it is likely that there is a significant degree of overlap. It can also be expected that there would be significant synergies between the various initiatives. For example, the use of EMRs is likely to make care coordination and disease management programs more effective and efficient.
- **Long Term Effects** - Short-term analyses may underestimate the total benefits both in terms of cost and quality. However, the long-term consequences of implementing new care models, especially when coupled with incentive systems for quality and cost control are also difficult. Such incentives are likely to alter the long-term dynamics of health and stimulate innovations that lead to more efficient and effective care. It is therefore important to consider the "stimulus-effect" when weighing the cost to benefit ratio of certain interventions.

It becomes clear that within the current infrastructure that among the three strategies - *Care Coordination, Disease Management and IT*, no one solution has emerged as the optimal efficient and effective model. Add to that the fact that Care Coordination and Disease Management have limitations because there are no incentives without capitation, the lack of financial and non-financial implementation capacity, and that there are no current IT standards to which incentives can be attached. Creating an incentive system based on linking outcomes and process improvements to lower costs and improve quality is the best approach that payers can take in this stage of the continuing evolution of the health care system. Moreover, since 80% of healthcare costs and a similarly overwhelming majority of quality of care depends on the decision of individual providers[1], it is important that the incentive system be centered on the provider. Given the challenge of measuring quality and the current limitations of capitation, an intermediate approach such as Bridges To Excellence (BTE) can be a powerful tool for payers. By linking financial incentives to measurable outcomes and processes that have been proven to improve quality and/or reduce costs, it becomes an impetus for providers to take advantage of new care delivery models that reduce costs and improve quality and leaves the decision on how to go about doing this to them. Currently, BTE has a limited number of outcome and process measures, but with rapid progress in quality research, the increased use of EMRs and the development of electronic algorithms to evaluate quality through data mining (e.g. ActiveHealth), it will be possible to expand BTE to incorporate more measures.

[1] *Eisenberg, J. Doctors' Decisions and Cost of Medical Care. Health Administration Press. Ann Arbor, MI. 1986*

Most care delivered is outside accepted guidelines

- Smoking cessation counseling given at most 50% of the time for patients with heart condition
- 25% of diabetics receive a glycosylated hemoglobin test every 12 months
- Cox II inhibitors prescribed to 70% of patients needing prescription-strength NSAIDs

Errors of omission and commission abound

- Close to 4% of all hospitalizations are the result of adverse drug events
- Adverse drug events occur in close to 5% of all outpatient visits
- Medication errors have increased overall from 2/1000 medication order in 1987 to 4/1000 medication orders in 1995

Economic analysis estimate that between 20% – 30% of all costs of care are due to waste and inefficiencies... and costs are growing at 10% to 15% with little or no accountability for effectiveness or efficiency

The IOM suggests that redesigning systems of care within practiced and adopting better systems to support the physician will improve quality.

Bridges to Excellence Pro Forma savings per patient

	Factors		Flat	Per Patient Per Year
	Number of self/fully-insured employees/dependents	10,000		
	Multiplied by diabetes prevalence rate	3%		
	Multiplied by cardiac prevalence rate	3%		
	Estimated number of covered diabetic employees/dependents	300		
	Estimated number of covered cardiac employees/dependents	250		
	Assumptions			
	% of patients that go to certified docs	50%		
	% of patients that qualify for rewards	50%		
DCL	**Variable Program costs:**			
	physician reward		($80)	($40)
	reimbursement of certification		($25)	($13)
	Patient incentive		($35)	($18)
	Program "fixed admin" costs			
	Consumer Engagement Tool			($48.00)
	Subtotal			**($35,400)**
	Variable Program costs:			
POL	physician reward			($25.00)
	reimbursement of certification		($50)	($5.00)
			($9)	
	Program "fixed admin" costs			
	Consumer Engagement Tool			($1.00)
	Subtotal			**($305,000)**
	Variable Program costs:			
	physician reward			($40)
CCL	reimbursement of certification			($13)
	Patient incentive		($80)	($18)
			($25)	
	Program "fixed admin" costs		($35)	
	Consumer Engagement Tool			($60.00)
	Subtotal			**($32,500)**
				($5.00)
	General Program Administration Fees			**($45,000)**
	Total Cost			**($417,900)**
	Total Savings			**$675,625**
	Diabetes Savings (*Hewitt = $350 PP)*			$78,750
	Cardiac Savings (*Hewitt, Towers = $250 PP)*			$46,875
	POL Savings (*Hewitt, Bates = $110 PP)*			$550,000
	Net Return On Investment			**$257,725**

BTE Program Structure & Organization

Operating Structure

Executive Committee

- Project Strategy
- Critical To Quality

Purpose:
- Set policy, strategy, projects for BTE
- Review overall performances measures
- Discuss/resolve overarching program issues

Responsibility:
- Approves projects initiatives
- Evaluates project results /measures

Composition:
- One rep. from each participant group

Meeting Frequency:
- Monthly: 3rd Tuesday of the month

- Overall Results
- Project Issues

Working Group

Purpose:
- Monitor Critical to Process for overall projects/program

Responsibility:
- Agree on project design/metrics for each project, communicate to regional committees

Composition:
- One rep. from each participant group

Meeting Frequency:
- Monthly (minimum): 2nd Tuesday of the month

- Design
- Metrics

Regional Implementation Team

Purpose:
- Monitor CTP's, regional project metrics

Responsibility:
- Manage/improve region project performance which drives overall project results

Composition:
- GE business & ops reps, plans, purchasers, provider reps for regional project

Meeting Frequency:
- Monthly (minimum): 2nd Tuesday of the month

- Results
- Issues

Organization Structure

Program Management
- Jon Conklin - Medstat

Program Partners
- NCQA
- Michael Pine & Associates

Program Evaluation
- Jon Conklin
- Judy Hibbard
- Tom Lee
- Greg Pawlson

BTE Executive Committee
- Mercer — Arnie Milstein
- UPS — Dale Whitney
- GE — Francois de Brantes
- Verizon — Jeff Hanson
- UHC — Reed Tuckson
- Humana — Tom Granatir
- PCHI — Tom Lee

BTE Evaluation Team
- Montefiore — David Bernard
- GE — Francois de Brantes
- NCQA — Greg Pawlson
- GE — Jessica DiLorenzo
- Lahey — Joe Healy
- Medstat — Jon Conklin (Coord.)
- Consultant — Judy Hibbard
- Univ. of Penn — Rob Burns
- PCHI — Tom Lee

BTE Working Group
- Medstat — Audrey Weiss
- GE — Jacquie Timpanaro
- GE — Jessica DiLorenzo (Coord.)
- WebMD — Jessica Gard
- Medstat — Jon Conklin
- GE — Kelly Conroy
- NCQA — Linda Shelton
- MPA — Michael Pine
- NCQA — Tina Bridgeport

Implementation Committees

PHYSICIAN OFFICE LINK

POL Working Group
- GE — Jessica DiLorenzo
- Lahey — Karen Moyer
- Medstat — Jon Conklin
- Medstat — Audrey Weiss
- NCQA — Linda Shelton

DIABETES CARE REWARDS

DCL Working Group
- GE — Jessica DiLorenzo
- Medstat — Jon Conklin
- NCQA — Lisa Joyner

CARDIAC CARE LINK

CCL Working Group
- GE — Jessica DiLorenzo
- Medstat — John Conklin
- Medstat — Audrey Weiss
- MPA — Michael Pine
- NCQA — Lisa Joyner

Current BTE Regions and Partners

Cincinnati and Louisville

Employers
Cincinnati Children's Hospital Medical Center
City of Cincinnati
Ford Motor Company
General Electric Company
Humana
Procter and Gambel
UPS

Health Plans
Aetna
Anthem Blue Cross and Blue Shield of Kentucky
Anthem Blue Cross and Blue Shield of Ohio
Blue Cross and Blue Shield of Illinois
Blue Cross and Blue Shield of Alabama
Humana
Tufts Health Plan
UnitedHealthcare

Boston

Employers
General Electric Company
Raytheon Company
Verizon Communicatinos

Health Plans
Blue Cross and Blue Shield of Alabama
Blue Cross and Blue Shield of Massachusetts
Harard Pilgrim Health Care
Tufts Health Plan
UnitedHealthcare

Capital Region

Employers
General Electric Company
Golub
Hannaford Bros. Co.
Verizon Communicatinos

Health Plans
Anthem
Blue Cross and Blue Shield of Alabama
Capital District Physicians Health Network
MVP
UnitedHealthcare