



imagination at work

healthymagination

Building Better Healthcare in Cincinnati:

How employers are collaborating with other healthcare stakeholders to improve health and reduce costs in the Queen City



Executive Summary

As one of America's largest employers, GE has a front row view on the shifting landscape in U.S. healthcare. GE's U.S. employee benefit programs support more than 500,000 workers, their spouses and children, and retirees. Like most U.S. employers, GE has been feeling the growing pressure imposed by rising medical costs.

In 2010, GE and other large local employers, hospitals, insurers, government, physicians and patients in Cincinnati came together to improve healthcare quality and access to care, and cut costs. If done well, this approach could transform healthcare from an on-going economic risk to a competitive advantage.

The partners built the program around five pillars: primary care, information technology, quality improvement, consumer engagement, and payment innovation. They have been collecting metrics on healthcare improvement, health outcomes and costs, and tracking goals for the metropolitan area's 2.2 million residents. At the same time, the community has invested in digital records, better care delivery



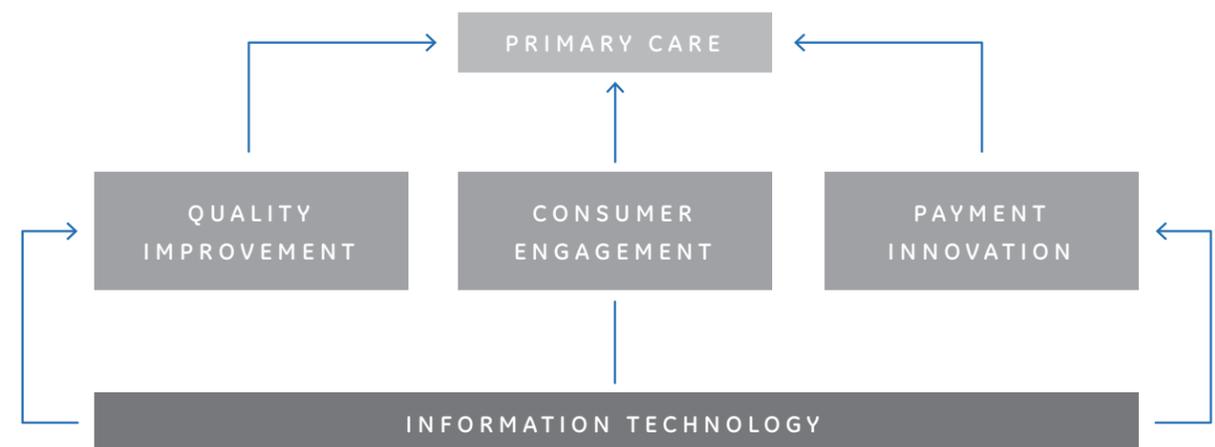
models and consumer engagement through websites like yourhealthmatters.org to improve healthcare efficiency and generate better value.

The results so far have been encouraging. Cincinnati has become one of the nation's most medically wired communities. The U.S. government selected the region to participate in the prestigious Comprehensive Primary

Care (CPC) initiative organized by the Center for Medicare and Medicaid Innovation. This project has the potential to bring \$100 million in incentive payments to primary care doctors who improve the coordination of care for their patients.

An analysis of GE's own medical claims data is already beginning to show gains

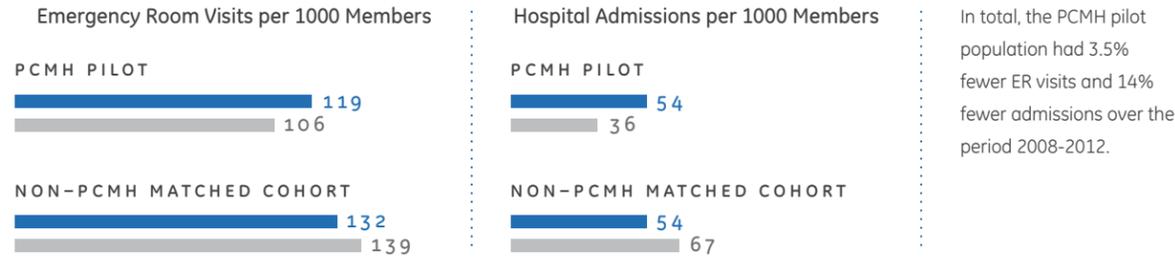
5 PILLARS OF SUCCESS



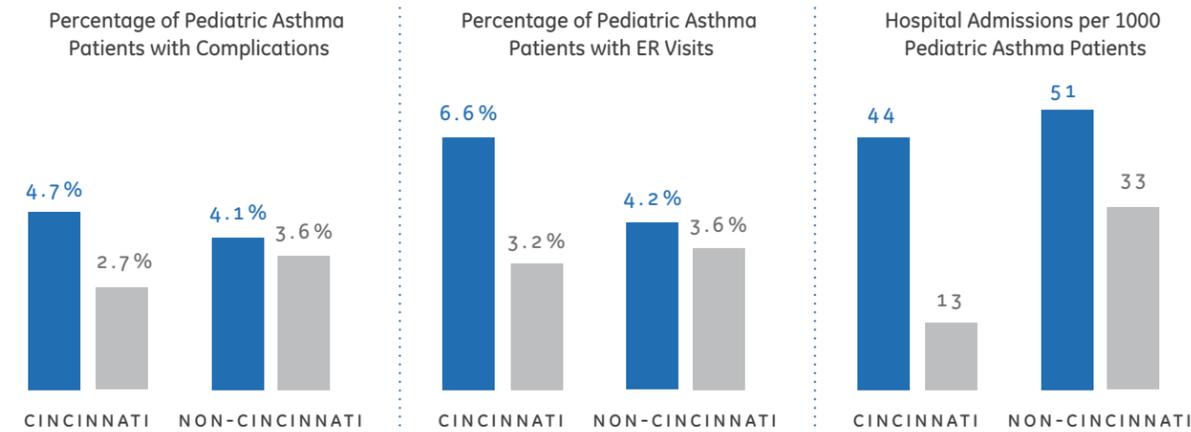
INITIAL SUCCESS FOR 3 POINTS OF FOCUS

IMPROVING PRIMARY CARE THROUGH PCMH

● 2008 ● 2012

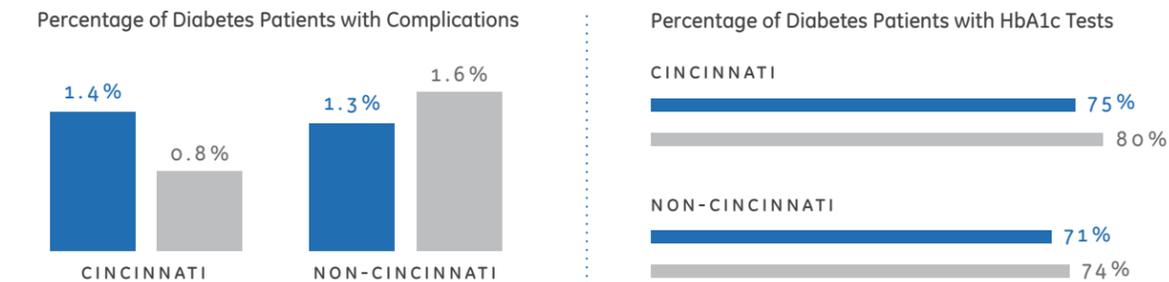


QUALITY IMPROVEMENT IN THE CARE OF PEDIATRIC ASTHMA



QUALITY IMPROVEMENT IN THE CARE OF ADULT DIABETES

● 2008 ● 2012



from such coordinated care. Investment in Patient-Centered Medical Homes (PCMH), an innovative healthcare model where primary care physicians coordinate treatment for their patients, has reduced ER visits and hospital admissions. Similarly, quality improvement efforts focused on pediatric asthma and adult diabetes are beginning to show fewer complications and hospital admissions for patients with these chronic conditions.

GE has now partnered with RAND to quantify the impact in greater depth and at the community-wide level.

The early results were strong enough that GE expanded its community-level efforts to two additional cities in 2012—Erie, Pennsylvania, and Louisville, Kentucky. GE has also just partnered with the Clinton Foundation’s new Health Matters Initiative to help build healthy communities nationally.

Our report illustrates Cincinnati’s approach and achievements in detail.

IMPROVING HEALTHCARE IN CINCINNATI

Employers are Collaborating with Other
Healthcare Stakeholders to Improve Health
and Reduce Costs in the Queen City

Learn how
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Improving Healthcare Value

The Business Case for Collaboration



A message from Sue Siegel,
CEO, *healthymagination*, GE

EMPLOYEE HEALTHCARE HAS BECOME A BUSINESS PRIORITY.

In 2010 the United States spent nearly a fifth of its GDP on healthcare, higher than any other developed nation. With the aging population and prevalence of chronic diseases, cost pressures are not likely to abate. In 2012 the Council on Foreign Relations cited reports from economists saying that “these ballooning dollar figures place a heavy burden on companies doing business in the United States and can put them at a substantial competitive disadvantage in the international marketplace.”

GE is not immune to these pressures. That is why we have worked to put in place health benefit plans and programs that improve health, engage employees as more informed consumers, and control costs. Our U.S. employee benefit program supports more than 500,000 lives, and globally, we spend more than \$50M a year on health and wellness programs. These efforts are driving results, but they can only take us so far. To fully realize the opportunity to improve health,

productivity and healthcare value, we need a healthcare system we can rely on to provide consistently high quality care, better medical outcomes, and greater access to doctors at an affordable price.

Since healthcare is local, the implication is that we need to engage key healthcare stakeholders in the communities where our employees and their families live and work. As healthcare purchasers, businesses need to focus on value and work collaboratively with healthcare providers, local leaders, health plans and other stakeholders to identify and prioritize value improvement opportunities, and put systems in place that measure and reward value creation. This is a complex task. But it is essential to identifying the best ideas and driving innovation.

This report profiles a healthcare initiative in Cincinnati, Ohio, where GE and other large employers have been engaged in a robust collaboration with leading healthcare delivery systems, physicians, insurers, local government, and other stakeholders to address quality, cost and access to care in the city and surrounding area.

The report describes key processes and outcomes for the Cincinnati initiative. We hope that it will not only inform but also inspire similar initiatives in cities across the U.S. Why? Because we think healthy communities give U.S. businesses a better competitive advantage. They also provide a springboard for better jobs for the employees and families who work and live in them.

The early results from Cincinnati have been so impressive that last year we expanded our efforts to two additional cities—Erie, Pennsylvania, and Louisville, Kentucky. We’ve also just partnered with the Clinton Foundation’s new Health Matters Initiative to build healthy communities nationally.

We realize that healthcare improvement is a long-term investment, and we are committed to following the impact in Cincinnati and other communities over time. That’s why we’ve partnered with RAND to study the impact in more depth. We plan to share the results of that research as well when it is completed.

GE is optimistic about the future—we believe tomorrow can be better than today. We strongly believe that you simply cannot solve a problem as big as healthcare without bigger collaborations at the local level. Collaborations like this one in Ohio are vital to driving sustainable transformation that yields better health and healthcare value for our businesses, our employees, their families and communities. We hope others, especially our fellow employers, will be inspired by this report to get involved in their local communities and help to shape a better healthcare system for us all.

A handwritten signature in black ink that reads "Susan E. Siegel". The signature is written in a cursive style.

Why GE Got Involved in Cincinnati

A Comprehensive Health Strategy

Shortly after the May 2009 launch of healthymagination, GE's \$6 billion strategy to improve the quality, access and affordability of healthcare, the company embarked on a journey that would substantially accelerate the size and scope of its commitment to "better health for more people." Rather than simply focus on commercial innovation, GE leadership also looked internally and positioned the health and wellness of its employees, their families, and the communities in which they live and work as a strategic priority for the company.

At the time, the healthcare landscape in the U.S. was undergoing rapid change, with the cost of healthcare growing much more rapidly than inflation and placing an increasingly unsustainable burden on companies, both large and small. GE, for all of its purchasing power as a large self-insured employer—and despite a long history of diligently managing healthcare costs and developing innovative tools and wellness programs—was no different. In the midst of the Great Recession, the health reform debate, and an extremely challenging business environment, it was clear that something bigger and more imaginative needed to be done.

The company saw a strategic opportunity to address several key points:

- Build a competitive advantage by taking steps to further improve employee health and productivity while placing its own healthcare costs on a more sustainable trajectory;
- Capitalize on its size and scale as a large employer to partner with other key opinion leaders in piloting innovative solutions at the national and local levels;
- Drive future growth for GE's diverse healthcare businesses by bringing to market new products and services that enable better care at lower total cost.

As GE—along with many other organizations at the time—diagnosed the situation, it became apparent the underlying causes of problems in the U.S. healthcare system included four major factors:

- Standard delivery models did not provide enough attention to wellness, disease prevention, chronic conditions or the coordination of care.
- Traditional health benefit designs and a fee-for-service payment system rewarded delivering more services instead of improving health, causing a misalignment of incentives among all stakeholders, including the patients and providers who should bear the greatest accountability for achieving better health.
- Transparency in quality and cost information was not sufficient to effectively evaluate the performance of providers and hospitals, help them improve or empower patients to make informed decisions about their healthcare.
- The information technology infrastructure was not in place to measure progress and gain insights into what works and what doesn't, resulting in an inability to adequately address the other three factors.

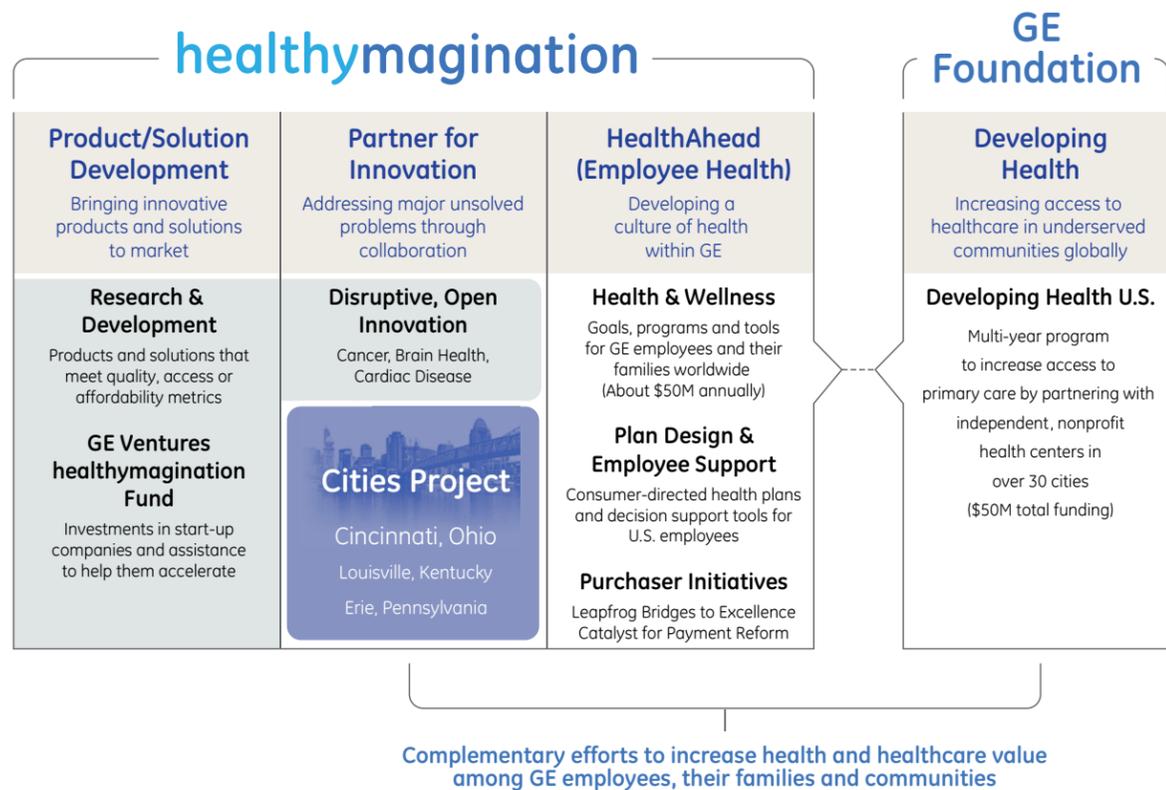


FIGURE 1
GE's Major Strategies to Improve Employee Health and Healthcare Value

Recognizing the complexity of the challenge, GE introduced or accelerated a number of programs to address these issues and increase health, productivity and value among its employees and within the broader U.S. healthcare system. Figure 1 highlights where these strategies fit into healthymagination and also identifies some complementary work the GE Foundation (the company's philanthropic organization) has been doing to help underserved populations access better care.

This paper focuses on a "Cities Project" in Cincinnati, a project which exemplifies GE's goal of seeking to "disrupt" healthcare in positive ways by partnering and investing in new solutions that improve healthcare quality, access and affordability. It is also a model for other critical success factors common among GE's efforts, including collaboration among stakeholders, measurement and operational rigor.

The Cities Project

A few months after the launch of healthymagination, GE began working on the "Cincinnati Project," which would later be renamed the "Cities Project" with the 2012 expansion to two additional GE cities (Erie, Pennsylvania, and Louisville, Kentucky). The intent of the project was to actively support, influence and learn from selected healthcare delivery and payment experiments at the local level. The decision to pursue this type of work was based on the following insights:

- Almost all healthcare is delivered locally, so new solutions for healthcare must be piloted within markets in order to determine what works.
- Since successful pilots require effective collaboration among multiple stakeholders—including providers, purchasers and health plans—local multi-stakeholder initiatives have the practical advantage of enabling live meetings, which help with trust-building needed for collaboration.

SELECTING CINCINNATI

GE evaluated a number of communities to decide where piloting this collaborative approach to improving healthcare might be most effective. They ultimately selected Cincinnati for a number of reasons, chief among them being:

- GE's significant presence there, with the highest concentration of employees, dependents and retirees of any community in the U.S.—thanks primarily to the GE Aviation business, which is headquartered in Cincinnati and manufactures aircraft engines there;
- A strong civic culture with a rich history of business-community partnerships across a broad range of initiatives; and critically,
- Recent progress in a multi-stakeholder initiative to improve healthcare, which established a strong foundation for even more ambitious change.

In addition, a GE Aviation representative, Craig Osterhues, was already playing an active role in community health. He brought vital local knowledge, relationships and credibility to the project.

The Cincinnati metropolitan region is a community of 2.2 million inhabitants



in southwest Ohio, northern Kentucky and southeast Indiana. Five major health systems serve this market—Mercy Health, St. Elizabeth, TriHealth, UC (University of Cincinnati) Health and The Christ Hospital. It is also home to Cincinnati Children’s Hospital Medical Center, one of the nation’s leading pediatric hospitals and an early national leader in quality improvement. UnitedHealthcare, Anthem and Humana have a major presence in this market, and the largest private sector employers include Procter & Gamble, Kroger, GE Aviation, Macy’s and Ethicon Endo-Surgery (a Johnson & Johnson company), along with several large regional employers.

These leading organizations and other healthcare stakeholders have been pursuing an extensive agenda for healthcare improvement since 2007, when Cincinnati was one of 16 communities nationwide selected to participate in the Robert Wood Johnson Foundation’s Aligning Forces for Quality (AF4Q) program. Figure 2 provides an overview of the main elements and key accomplishments of the Cincinnati AF4Q program during 2007–2009.

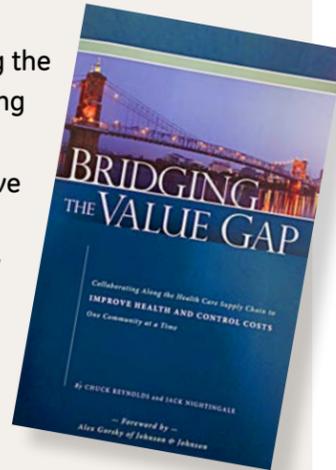
FIGURE 2
Cincinnati’s Healthcare Improvement Initiative, 2007–2009

Program Element	Key Accomplishments
Public reporting of physician practice quality measures	Collected and published evidence-based metrics for adult diabetes from clinical records
Piloting quality improvement initiatives for primary care	Implemented a pilot initiative to assist participating primary care practices with transition to NCQA ¹ -certified Patient-Centered Medical Homes
Consumer education and engagement	Launched <i>yourhealthmatters.org</i> website to present quality measures and other information to consumers

¹National Committee for Quality Assurance

BACKGROUND READING ON CINCINNATI MULTI-STAKEHOLDER INITIATIVES

Readers interested in understanding the formative period for multi-stakeholder initiatives in Cincinnati should consult **Bridging the Value Gap: Collaborating Along the Health Care Supply Chain to Improve Health and Control Costs, One Community at a Time**, by Chuck Reynolds and Jack Nightingale. Chapter Four in the book, “Cincinnati Aligning Forces for Quality,” is a case study of Cincinnati’s progress from 2006 through early 2010. Johnson & Johnson provided financial support for the publication of **Bridging the Value Gap**, and copies are available free of charge to interested readers at www.bridgingthevaluegap.com.



AN OPPORTUNITY FOR GREATER INVOLVEMENT

Relative to the vast majority of communities, Cincinnati had accomplished a great deal by the end of 2009, and important infrastructure elements were already in place for multi-stakeholder collaboration:

- **Implementing organizations with multi-stakeholder boards, including:**
 - The Health Collaborative*, the entity that was awarded the AF4Q grant
 - HealthBridge*, a health information exchange that had operated for several years and was developing new technology infrastructure in support of the initiative
- **An engaged set of stakeholders led by the Greater Cincinnati Health Council and its member health systems, major health plans and the largest private sector employers**
- **A corps of dedicated staff and stakeholder volunteers who had the vision, technical knowledge and relationships to execute on transformative projects**
- **A track record of success in project implementation that demonstrated an aptitude for collaboration in healthcare improvement**

Nevertheless, the pace of continued progress was far from certain. In fact, leaders were concerned that the proliferation of organizations and projects was creating some strain due to overlapping and sometimes conflicting agendas. According to Tom Finn, a senior executive with Procter & Gamble who has long been a leading force in the Cincinnati initiative,

“There were so many initiatives and organizations that they were sometimes working at cross or duplicate purposes.”

In addition, while new federally funded programs were emerging that created opportunities for Cincinnati to participate in the next wave of innovation, the community risked being overwhelmed by the demands of implementing additional high-profile projects.

As GE saw it, there was an opportunity to help catalyze an acceleration of the momentum that already existed in Cincinnati.

Building on the Foundation to Accelerate Change, 2010–2012

Strengthening Stakeholder Alignment

Given the strengths present in Cincinnati and the challenges the initiative faced, GE's greatest opportunity lay in helping to reinforce the alignment and commitment of key stakeholders. The steps GE took over the course of 2010 are identified in Figure 3 and described below.

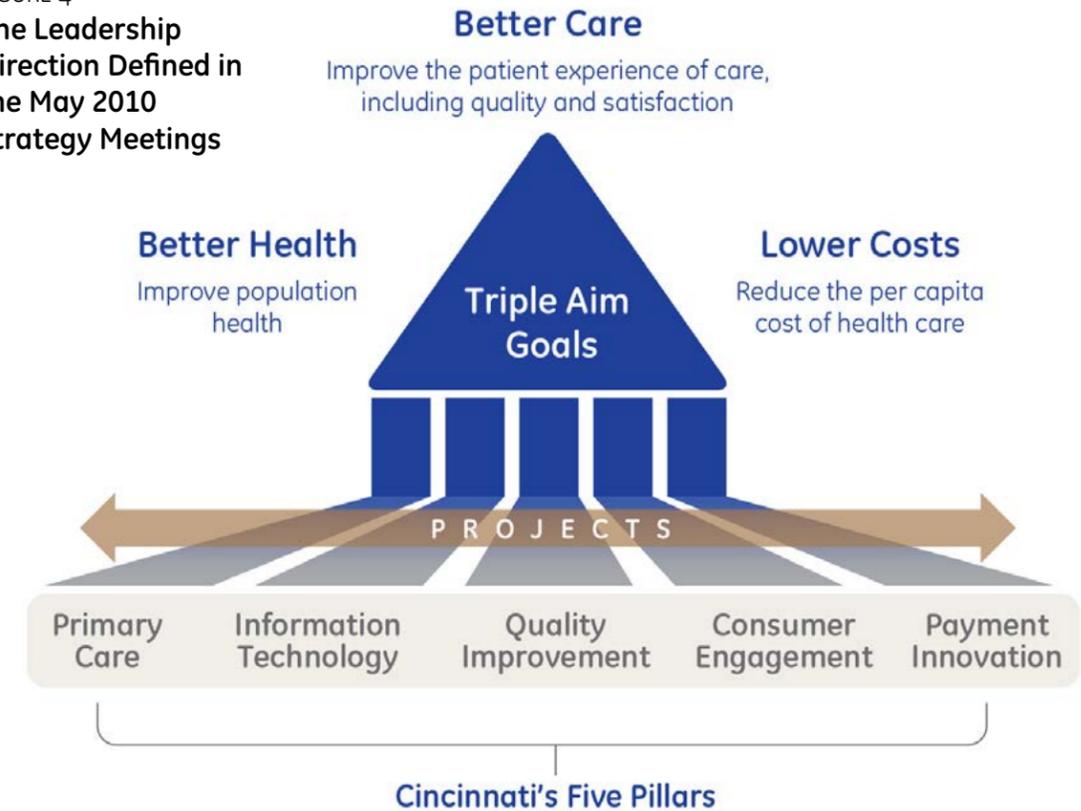
CALL TO ACTION

GE's role as a catalyst began in February 2010 with a speech by GE Chairman and CEO Jeff Immelt to the regional chamber's CEO Roundtable. The speech covered a range of topics, but prominent among them was the role that private sector employers can play in healthcare: "The solution to healthcare has got to come from business. There's no such thing as national healthcare. It must be done city by city by city. Cincinnatians have to decide to work together on this. And business has got to be front and center."²

FIGURE 3
GE Contributions to Reinforce Alignment and Engagement of Stakeholders in 2010



FIGURE 4
The Leadership Direction Defined in the May 2010 Strategy Meetings



STRATEGY MEETINGS

In May, GE issued an invitation to leaders of all key stakeholder organizations in Cincinnati to attend a two-day set of strategy meetings. The first session, which GE hosted at a downtown Cincinnati location, was a luncheon meeting for CEOs that featured former Centers for Medicare and Medicaid Services (CMS) head Dr. Mark McClellan as a speaker. The next day, GE invited the next tier of executive leadership for these organizations to a full-day strategy meeting at GE Aviation's facilities. The day consisted of a series of breakout and full-group sessions facilitated by GE Aviation's health services team leader, Joyce Huber, along with Dr. Bob Graham of the University of Cincinnati and a professional facilitator.

The attendance was impressive for both meetings, with a total of about 150 leaders in attendance. Jim Anderson was CEO of

Cincinnati Children's Hospital Medical Center from 1996 through 2009. As Jim notes, "GE successfully got everyone in the same room for substantive engagement toward a specific goal." He adds, "No one failed to show up, even though GE's approach was not heavy-handed. That says something about the power of a major employer. No other stakeholder had the ability to do that. Employers are the ones that pay the bills."

Even more important, though, was the degree of alignment that emerged from the meetings. Through these discussions, the leaders agreed on a common vision and set of priorities for healthcare transformation initiatives (see Figure 4).

As one of the meeting’s participants recently put it, the overall vision coming out of the meeting was to “make Cincinnati a great place for healthcare and a great place to live.” The objectives they agreed to were the “Triple Aim” goals of Better Care, Better Health and Lower Costs that had been defined by the Institute for Healthcare Improvement and subsequently adopted by CMS and many health systems, payers and multi-stakeholder initiatives nationwide. To operationalize these goals, the leadership group also agreed to a set of strategies—or “pillars”—that would be the focus of the community initiative across all projects. (See “Cincinnati’s Five Pillars for Healthcare Innovation.”)

For the most part, these goals and pillars were not new. Many of them had been woven through Cincinnati’s AF4Q grant application and subsequent implementation efforts. However, by embracing the Triple Aim, with its comprehensive approach to healthcare value (including cost), and prioritizing the Five Pillars, the strategy meeting achieved greater clarity for the direction of all multi-stakeholder projects. The clarity and commitment that resulted from this meeting have proven extremely valuable to subsequent decisions and implementation efforts.

Cincinnati’s “Five Pillars” for Healthcare Innovation

1. PRIMARY CARE

Invest in primary care and experiment with Patient-Centered Medical Homes (PCMH) to change the way high-value healthcare is delivered and paid for.

2. INFORMATION TECHNOLOGY

Build out an interoperable exchange to deliver information at the point of care, as well as inform the measurement, quality improvement and payment innovation work.

3. QUALITY IMPROVEMENT

Strengthen evidence-based care for chronic conditions, while deploying information technology and process improvement to better manage the transition of patients from one care setting to another.

4. CONSUMER ENGAGEMENT

Make quality transparent and provide a web-based information platform to empower patients and caregivers.

5. PAYMENT INNOVATION

Explore ways to pay for healthcare so value is recognized and rewarded.

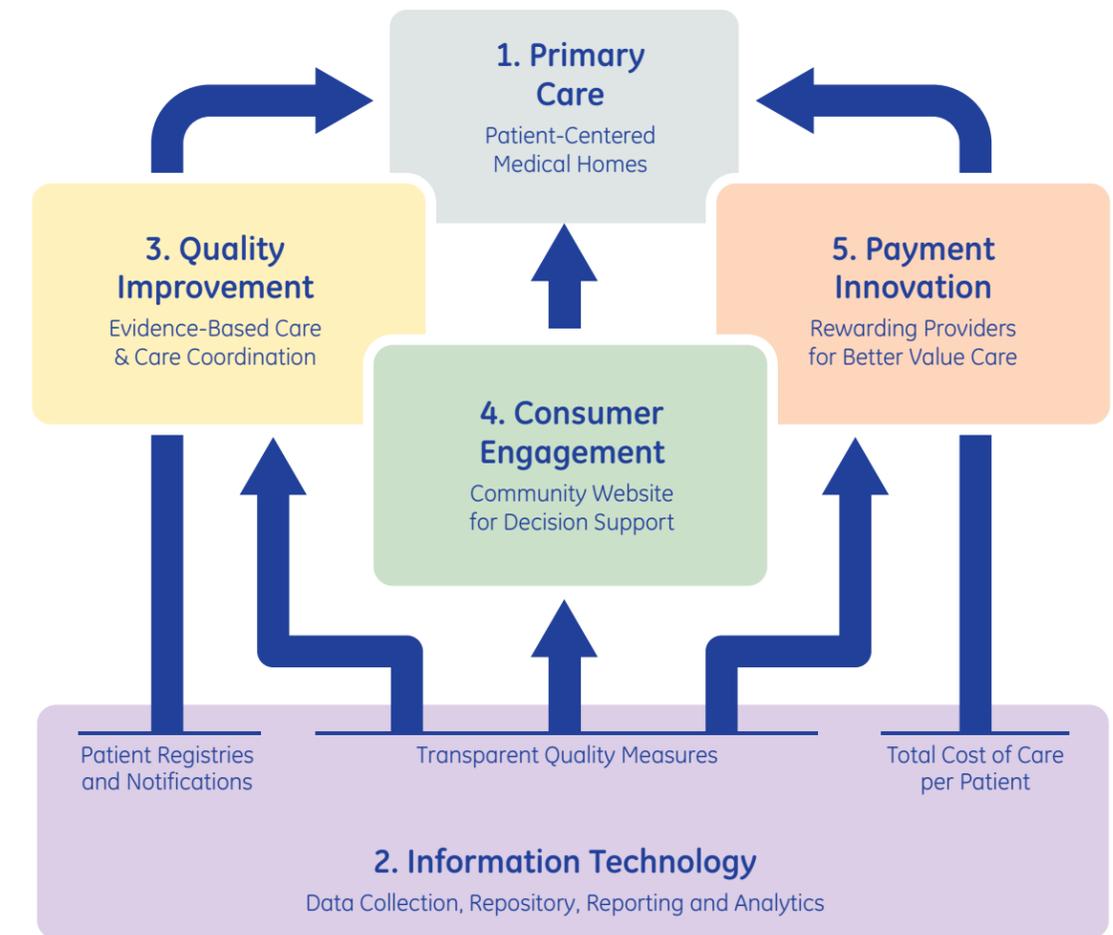


FIGURE 5
**Taking a Comprehensive Approach to Healthcare Improvement:
 An Operational View of the Five Pillars**

These five pillars constitute an exceptionally comprehensive approach to healthcare improvement. Figure 5 shows how the pillars work together operationally to support higher value care. The objective of every element is to improve patient care, with a clear focus on primary care and the management of chronic conditions such as adult diabetes and childhood asthma that are:

- Prevalent in the Cincinnati population;
- Frequent causes of costly emergency room visits and hospital admissions when not managed properly;
- Readily controllable in most cases through standard, evidence-based treatments and effective patient self-management.

Each element of this operational model is critical to success. Of particular note:

- **Transparent quality information supports provider efforts to identify opportunities for improvement, while enabling consumers and purchasers to make more informed choices in selecting providers.**
- **Payment innovation provides an ongoing revenue stream to providers that rewards them for better care and enables them to continue reinvesting in quality improvement.**
- **A shared community-wide IT infrastructure provides the foundation for care coordination, measurement and reporting, and tracking of healthcare costs across all payers and providers.**

When fully implemented, the changes represented in this figure will be transformative—particularly when combined with steps that stakeholders can take internally, such as employers implementing benefit plan designs that encourage greater patient accountability and health systems implementing compensation plans that reinforce physician accountability. But as Cincinnati stakeholder leaders are quick to point out, their approach has also been deliberately evolutionary. Each project builds upon existing capabilities and involves piloting innovative solutions to test and refine them before trying to drive more widespread adoption. And because all key stakeholders endorse the direction, Cincinnati is already seeing broad adoption for solutions like PCMH.

GE'S COMMITMENT OF RESOURCES

Several stakeholder leaders have commended GE for taking concrete steps—for “putting its money where its mouth is”—and not being satisfied to simply deliver speeches and convene meetings. Dr. Richard Shonk was regional medical director for UnitedHealthcare until he joined the Health Collaborative as chief medical officer in the spring of 2013. He observes that:

“GE upped the ante for all other stakeholders. The community was already moving in the direction, but it made a big difference for a major employer to say ‘We’re behind this,’ and back it up with real commitments.”

Beginning with the strategy meeting, GE announced a set of in-kind investments to support Cincinnati’s direction, as GE healthymagination pledged \$1M in donated services and expenditures through the Cities Program. Of particular note, GE made Craig Osterhues, a healthcare manager at GE Aviation, available to the community as a loaned executive for two years. Craig had long been an active and influential volunteer in the multi-stakeholder initiative, serving as board chair for HealthBridge and supporting several AF4Q projects. Now Craig was able to support the initiative as his full-time job. He never assumed a formal role or title beyond “loaned executive to the community.” His approach was generally to operate behind the scenes to help

rally other stakeholders in support of key actions such as the pursuit of new program opportunities. Other stakeholder leaders consistently praise Craig’s contributions. Will Groneman of TriHealth says, “Craig is recognized among providers as very effective—very visible, credible and helpful.” Dr. Bob Graham of the University of Cincinnati adds that “Craig has energy, vision, and a commitment to getting the right things done. He also has his ego well in control, which makes him a pleasure to work with.”

THE EXECUTIVE STAKEHOLDER COUNCIL

In the fall of 2010, Craig Osterhues helped establish an Executive Stakeholder Council,

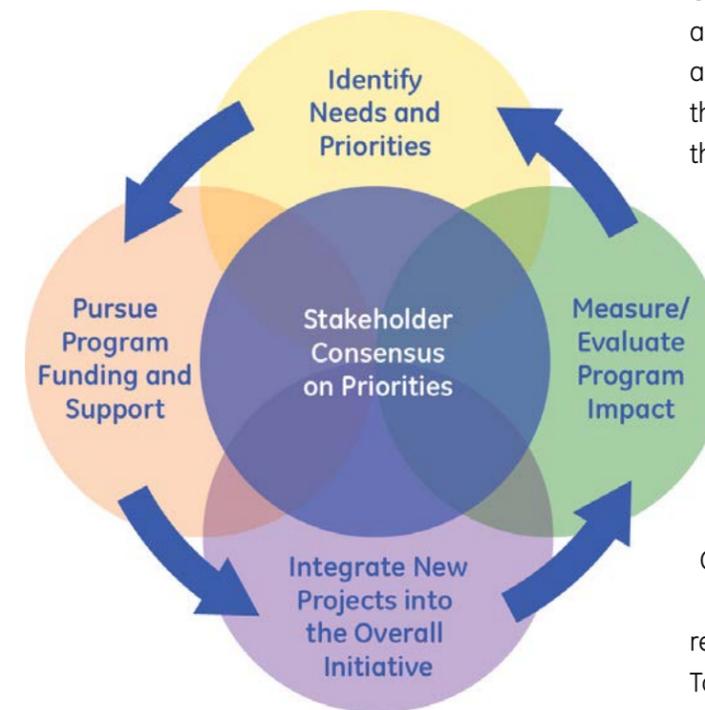


FIGURE 6
Executive Stakeholder Council Drives Ongoing Alignment of Funding and Projects

which would serve as the main vehicle for stakeholder engagement and alignment for the next two years. The purpose of the Stakeholder Council was to bring senior leaders from all the major stakeholder organizations together for regular meetings to reach decisions impacting current and potential multi-stakeholder projects. Although the council had no formal power, its senior-level membership enabled it to provide effective overall leadership to the Cincinnati initiative.

The fundamental role of the Stakeholder Council was to ensure effective execution of the Five Pillars by providing strategic direction to the initiative. Figure 6 shows how the council’s approach created a virtuous cycle, enabling Cincinnati to capture important new program and funding opportunities while ensuring close alignment between individual projects and the overall initiative. At each point in the cycle, the council made an effort to look ahead to

future implications of current decisions. For example, when they adopted a scorecard for the initiative in 2011, they deliberately selected measures that CMS had issued for evaluating Accountable Care Organizations (ACOs)³ so Cincinnati would be well-positioned for future collaboration with CMS on multi-payer programs like the Comprehensive Primary Care initiative, discussed on p. 24.

Members of the council understood they represented the entire stakeholder community. Tom Finn of P&G and Dr. Bob Graham of the University of Cincinnati served as council co-chairs, and membership included senior leaders from all leading stakeholders. The exceptional record of attendance by senior leaders at

³<http://innovation.cms.gov/initiatives/aco/>

the meetings underlines the importance the members placed in the council.

The Executive Stakeholder Council was in place for a little over two years. By late 2012, local stakeholder leaders saw a need for even closer coordination of the three implementing organizations—the Greater Cincinnati Health Council, the Health Collaborative and HealthBridge. They made the decision to realign the boards of the three organizations and hire a single CEO to manage all three organizations. In November 2012, the boards announced the selection of Craig Brammer as CEO. Craig had previously served as director of Cincinnati AF4Q before leading the Beacon Community Program, a U.S. Department of Health and Human Services (HHS) initiative to demonstrate the value of health IT and electronic health records (discussed further on p. 21).

By the end of 2012, the Stakeholder Council decided it had served its purpose as a leadership vehicle and disbanded, having accomplished its main objectives:

- Cincinnati had developed a robust funding base for multiple pilot projects that were closely aligned with the Five Pillars (see Figure 7).
- A strong network of local and national stakeholders was engaged in the projects (see Figure 8, p. 27).
- An effective operating model was in place with a strong leader to manage the initiative in 2013 and beyond.

Seizing New Funding Opportunities

The strategy meetings in May 2010 had defined an ambitious agenda for Cincinnati. The next step was to secure funding for implementation. Fortunately, Cincinnati was well positioned to participate in new federal programs. First, the American Recovery and Reinvestment Act of 2009 provided funding for programs to encourage adoption of electronic health records (EHRs). Then, passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010 led to a new set of Federal healthcare innovation research programs that have funded regional pilot projects. Communities selected by HHS to participate in these programs have tended to be those—like Cincinnati—that have already established key infrastructure elements and engaged a group of stakeholders who could respond quickly and effectively to requests for proposals (RFPs).

Cincinnati was able to capitalize on several major opportunities and is the only community participating in all the programs listed in Figure 7, which shows the major programs underway in Cincinnati by the end of 2012. The list includes Aligning Forces for Quality, which is funded by the Robert Wood Johnson Foundation, additional projects funded by a local philanthropy, Bethesda Inc., and three programs funded by HHS.

While the total dollars associated with these programs are impressive, Cincinnati

Alignment with the Five Pillars

Program	Key Projects Funded	Primary Care	Information Technology	Quality Improvement	Consumer Engagement	Payment Innovation
Aligning Forces for Quality [\$5M from Robert Wood Johnson Foundation]	<ul style="list-style-type: none"> • Patient-Centered Medical Home • Physician and Hospital Quality Improvement • Public Reporting/Consumer Engagement 	•		•	•	
		•		•	•	
Bethesda Inc. [\$4M]		•		•	•	
Regional Extension Center [\$10M from HHS]	<ul style="list-style-type: none"> • Meaningful Use Support • Master Patient Index • Interoperability: Patient-Level Data Access 	•	•			
		•	•	•		
Beacon Community [\$14M from HHS]	<ul style="list-style-type: none"> • Data Registry/Analytics • Discharge Alert System 	•	•	•		
Comprehensive Primary Care [Potential \$100M in Payments to Providers from Government and Commercial Payers]	<ul style="list-style-type: none"> • Accountable Payment • Continuous Improvement Enabled by Data • Optimal Use of Health IT • Comprehensive Primary Care Functions 	•	•	•	•	•

FIGURE 7
Program Funding for Cincinnati Health Improvement Projects

stakeholder leaders emphasize that the objective was not to “chase” grants. Instead, it was to pursue grants that aligned well with the direction they had jointly established. Figure 7 also shows how the programs collectively address all of Cincinnati’s Five Pillars. The figure highlights how the various programs built upon each other with each successful

implementation helping to position Cincinnati to win upcoming opportunities—culminating in the Comprehensive Primary Care (CPC) initiative, which addresses all the pillars through one integrated program.

No summary description can do justice to all the projects underway in Cincinnati under the aegis of these five programs. This paper will describe the main areas of progress under each of the Five Pillars.

Implementing Key Projects

Pillar #1: PRIMARY CARE

Over the past several years, the Patient-Centered Medical Home (PCMH) has been embraced by many organizations as an important part of the pathway to achieving the Triple Aim objectives. According to the Patient-Centered Primary Care Collaborative, “The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system.” The National Committee for Quality Assurance (NCQA) manages the gold-standard certification process for primary care practices seeking recognition as medical homes, with the objective being for providers to achieve PCMH Level III status.

Cincinnati was an early adopter of the PCMH model, deciding in 2007 to make it a key strategy under Cincinnati AF4Q. Since then, certification has been a primary focus for the Cincinnati initiative. Cincinnati’s approach to implementation has included:

- **Setting a high bar for achievement by the participating practices, including process and system redesign plus culture change**

to support comprehensive, coordinated, patient-centered care;

- **Providing expert assistance to participating practices to advise them on their redesign and certification efforts;**
- **Rewarding the practices for their investments in PCMH through health plan and employer-funded payments on a per-member, per-month (PMPM) basis in addition to the standard fee-for-service payments.**

The provider community has enthusiastically adopted PCMH from the beginning of the community-wide initiative. Under the auspices of AF4Q, the first nine practices—including independent practices as well as practices owned by the major health systems—achieved PCMH Level III certification in 2009. Slots in the initial pilot were oversubscribed, and subsequent pilots expanded the number of participating practices rapidly. By the end of 2012, over 130 practices had achieved PCMH Level III certification, and all five major health systems are moving to adopt PCMH across all of their primary care practices.

As Will Groneman of TriHealth notes,

“There is no finish line with PCMH.” As the understanding of medical homes has increased, the bar keeps rising: “If NCQA’s 2008 standards were like a high school diploma, the 2011

standards are like a college degree. Of course, neither diplomas nor degrees are worth much by themselves, unless you use what you learn to actually do something productive with them. The key for Cincinnati is the health systems are taking PCMH seriously, and it is changing how they practice medicine.”

Dr. Bob Graham of the University of Cincinnati is a national expert who has been deeply involved with PCMH adoption in Cincinnati.

“Based on the current trajectory,” he predicts, “there is a legitimate scenario that within three to four years, 60% of the population in the Cincinnati region will be receiving care that is ‘accountable’ and delivering on the Triple Aim goals.”

Pillar #2: INFORMATION TECHNOLOGY

Cincinnati is one of a handful of communities that has had a Health Information Exchange in place for several years. HealthBridge was established as a not-for-profit organization

in 1997 by the Greater Cincinnati Health Council to provide secure electronic transfer of patient medical information—lab test and radiology results, as well as hospital admission, transfer and discharge messages—among provider organizations. Since then, the mission of HealthBridge has evolved to encompass providing support for health information technology adoption and the innovative use of information for improved healthcare outcomes among provider organizations in the region.

HealthBridge’s engagement in this broader mission at the nexus of information technology (IT) and healthcare quality improvement began with its participation in Cincinnati AF4Q. However, these efforts did not include a substantial upgrade in the technology infrastructure to support better care. The most significant investments in IT infrastructure and capability began in 2010 when HealthBridge and other Cincinnati stakeholders successfully accessed new funding from HHS.

In February, HHS provided an \$11M grant to the Tri-State Regional Extension Center, established by HealthBridge and partnering organizations. The intent of the Regional Extension Center program was to provide a local resource to help primary care practices adopt electronic health records (EHRs), use the technology in a meaningful way to improve care, and qualify for stimulus funding from CMS.⁴

The next funding opportunity was the Beacon Community program, established by HHS under the Office of the National Coordinator for Health IT to help selected communities build and strengthen their health IT infrastructure and exchange capabilities to improve care coordination, increase the quality

of care, and slow the growth of healthcare spending.⁵ HealthBridge responded to the original RFP but learned in May 2010 that it was not chosen; however, HHS issued a second national solicitation, providing an opportunity for communities to re-apply. There was understandable reluctance on the part of the community to invest effort in another application with a very short deadline. After consulting with key stakeholders and learning that participation in Beacon would be an important consideration for HHS in selecting communities for future programs, GE stepped in and helped lead the reapplication process.

GE brought payer and purchaser expertise to the discussion, enlisted the services of a professional grant-writer and organized a multi-stakeholder effort to strengthen the content, placing a greater emphasis on how Cincinnati would use the technology to enhance the quality of patient care. Jeff Immelt, GE's Chairman and CEO, also authored a letter of support for Cincinnati's application, committing GE resources to aid the community in its efforts.

In addition to HealthBridge, the new consortium included Cincinnati Children's Hospital Medical Center, the Greater Cincinnati Health Council, the Health Collaborative, the University of Cincinnati, Hamilton County Public Health, GE and dozens of area hospitals and physician practices. This consortium proposed to use the funds to develop new quality improvement and care coordination initiatives that focus on patients with pediatric asthma and adult diabetes and encourage smoking cessation, while providing better clinical information and IT "decision support" tools to physicians, health systems, federally qualified

health centers, and critical access hospitals. In September 2010, Cincinnati successfully secured designation as one of seventeen Beacon Communities nationwide. The total amount of the HHS award was \$13.8M.

The implementation challenges of the Beacon program have proven significant. In their quest to be early adopters of health IT, Cincinnati stakeholders have sometimes found themselves on the "bleeding edge" of innovation. For example, in order to provide notification to primary care practices when their patients receive care in a hospital emergency room, HealthBridge took responsibility for collecting information in real time from area hospitals, despite a lack of interoperability standards among the various health systems' EHRs.

While the Beacon implementation effort has been challenging and extremely resource intensive at times, the program has nevertheless achieved significant progress. The experience gained through Beacon is also a critical step toward the vision of an interoperable IT infrastructure that enables effective coordination of care across all providers. Furthermore, as Dr. Richard Shonk notes,

"Participation in the Beacon and Extension Center programs positioned Cincinnati to be successful in pursuing the Comprehensive Primary Care initiative in 2012." (See the "Payment Innovation" section below.)

⁵<http://www.healthit.gov/policy-researchers-implementers/beacon-community-program>

Pillars #3 and #4:

QUALITY IMPROVEMENT AND CONSUMER ENGAGEMENT

Improving healthcare quality and transparent measurement of how well providers and hospitals deliver evidence-based care go hand-in-hand. Since the beginning of Cincinnati AF4Q, public reporting has been the foundation supporting both of these pillars. As Tom Finn of P&G notes,

"There are two ways transparent quality information can be used. The first is to use it in selecting provider organizations as a healthcare consumer or purchaser. The second is to spur the providers themselves to make improvements to the way they deliver care—by appealing to their natural competitive instincts and by giving them actionable information about the opportunities for improvement."

Leaders of the Cincinnati initiative have understood from the beginning that it was important to engage the physician community as true partners. Project elements within the Quality Improvement pillar involved physician leaders in the selection of evidence-based quality metrics and in the execution of projects to improve care. These efforts focused on process redesign and the use of information technology to streamline the delivery and coordination of care.

Leaders also recognized that patients play a critical role in ensuring effective care and positive health outcomes, but many patients are not accustomed to playing an active role as healthcare consumers. So project elements in the Consumer Engagement pillar focused on coming up with consumer-tested approaches to display quality information and related health advice through the website, www.yourhealthmatters.org. A loaned executive from Procter & Gamble, Judy Hirsh, led these efforts on a half-time basis before joining the Health Collaborative full time in 2010. Initial funding was provided by Cincinnati AF4Q, but in 2010 a local philanthropic organization, Bethesda, Inc., provided additional funding to accelerate implementation.

Both the Quality Improvement and Consumer Engagement efforts have been built around selected conditions that can lead to high healthcare costs and quality of life issues for patients if they are not managed effectively. As of the end of 2012, [yourhealthmatters.org](http://www.yourhealthmatters.org) provided quality information on physician practices along with other consumer information concerning adult diabetes, cardiovascular health and colon cancer screening. The site also provides quality data on hospitals and a directory of primary care practices that have qualified as patient-centered medical homes. Quality Improvement projects have focused on conditions like pediatric asthma and adult diabetes. GE is already seeing encouraging early results. (See "The Return for GE in Cincinnati—Early Results," starting on p. 32.)

Pillar #5 Payment Innovation

As noted in the description of Primary Care above, PCMH pilots in Cincinnati have included PMPM payments to participating providers. However, serious efforts at payment innovation really got underway with the Comprehensive Primary Care (CPC) initiative.⁶ One of the Executive Stakeholder Council's major conversations in 2011 concerned whether to apply for CPC and how to mobilize the stakeholders to accomplish CPC's ambitious objectives.

The Center for Medicare and Medicaid Innovation (CMMI) announced CPC on September 28, 2011.⁷ The initiative was to begin as a demonstration project in five to seven healthcare markets across the country, with about 75 primary care medical home practices participating in each market. The agency committed to pay these practices based on a blended payment model that combines fee-for-service with a per-patient, per-month (PMPM) care coordination fee ranging from \$8 to \$40, depending on the health risk of the Medicare patients under the care of a particular practice. Participating practices would also have an opportunity to participate in shared savings from the project. (Commercial payers in CPC follow a similar approach, but each payer negotiates its own PMPM rates individually with each practice. These rates also depend on the health risk of their particular patient population, which tends to be lower for commercial payers than for Medicare.)

In making the announcement, Richard Baron, MD, director of the seamless care models group in CMMI, noted: "What we are

hoping for in launching this initiative is for the private sector to join CMS in designing new [payment] models that are aligned in a way that will accelerate and powerfully drive practice transformation." CMS requested letters of intent from commercial insurers on November 15, 2012 and a formal application by January 17, 2013.

As Cincinnati stakeholder leaders have noted, the very short application deadlines of programs like CPC are a great test of a community's ability to collaborate. In this case, the request for proposals went to national health insurance companies. Internally within these companies, the local market leaders advocated for Cincinnati's selection based on the community's recent success with the PCMH pilot. They also worked through the Executive Stakeholder Council to enlist GE and other major employers to reinforce these internal efforts and to help recruit additional payers and other stakeholders. With this mobilization of activity, Cincinnati met the deadlines, and all the major health plans and provider organizations participated in the application. (Ultimately, Mercy Health was excluded because Mercy Health Select, the managed care component of Mercy Health, participates separately in the Medicare Shared Savings Program as an Accountable Care Organization.) In April 2012, Cincinnati learned it was among the 7 regional markets selected to participate.

Implementation of CPC has proven no less challenging. Participants in the pilot have until 2016 to demonstrate that the savings are greater than the infrastructure costs to implement the program, which one provider leader considers an "aggressive but legitimate"

objective. To get there, the stakeholders need to solve some difficult issues:

STAKEHOLDER ENGAGEMENT

The RFP that CMMI issued for the CPC initiative required all participating practices to have at least 60% of patients covered by payment plans that include a value-based component.

DATA SHARING

Effective implementation of CPC requires health plans to share claims data and provider organizations to share clinical data.

MEASURING COST SAVINGS

Ultimately, the success of CPC depends on the credibility of the calculations for cost savings. All stakeholders will need to view the calculations as a reliable and fair reflection of the true savings produced by better care.

To ensure they could reach the 60% threshold for participation, GE and the major health plans (Humana, UnitedHealthcare and Anthem) recruited additional payers Aetna, Medical Mutual and Ohio State Medicaid. Among self-funded employers, GE Aviation, Macy's, Kroger and a few large regional employers agreed to participate as well. One health plan medical director estimates Cincinnati CPC will achieve 75-80% coverage for participating practices, which is well above the threshold.

Given all the sensitivities associated with data sharing and measurement, it should not be surprising that stakeholder leadership

meetings addressing Cincinnati CPC have been both well-attended and at times contentious, but participants are optimistic they will work through the challenges. Will Groneman of TriHealth has observed,

"The level of stakeholder commitment [to the Cincinnati initiative] has increased substantially over the last two to three years—reflected in the degree of buy-in, the quality of people who are attending the meetings and the level of energy and innovative thinking they bring to the discussions."

He notes with enthusiasm that a recent meeting included 5 employers, 5 payers, 3 health systems and an independent primary care practice. Similarly, Dr. Richard Shonk, who represented UnitedHealthcare in the meetings, is encouraged that "the serious issues have been debated openly and frankly, and the participants are focused on coming up with reasonable solutions to them." For example, the Health Collaborative is playing an important role in data sharing as a neutral facilitator that is trusted by all the stakeholders.

⁶ <http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>

⁷ <http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20110928compinitiative.html>

A Collaboration of Healthcare Stakeholders

Collaboration across all stakeholder groups is critical to achieving sustainable success. Figure 8 presents a picture of the many organizations that have been key to the progress Cincinnati has achieved to date, including: major employers, health systems and health plans; national, state and local government agencies and philanthropic organizations; local nonprofits dedicated to improving healthcare. But even this picture is incomplete, since smaller organizations such as independent medical groups and regional employers have also been active participants.

While this paper highlights GE's contributions to the Cincinnati initiative, the reality is that success would not have been possible without all stakeholders working together—including the broader employer community. The Cincinnati experience shows that when employers join forces to take an active role in these initiatives, their participation is welcomed by the other stakeholders and their contributions can play a pivotal role in the initiative's success.

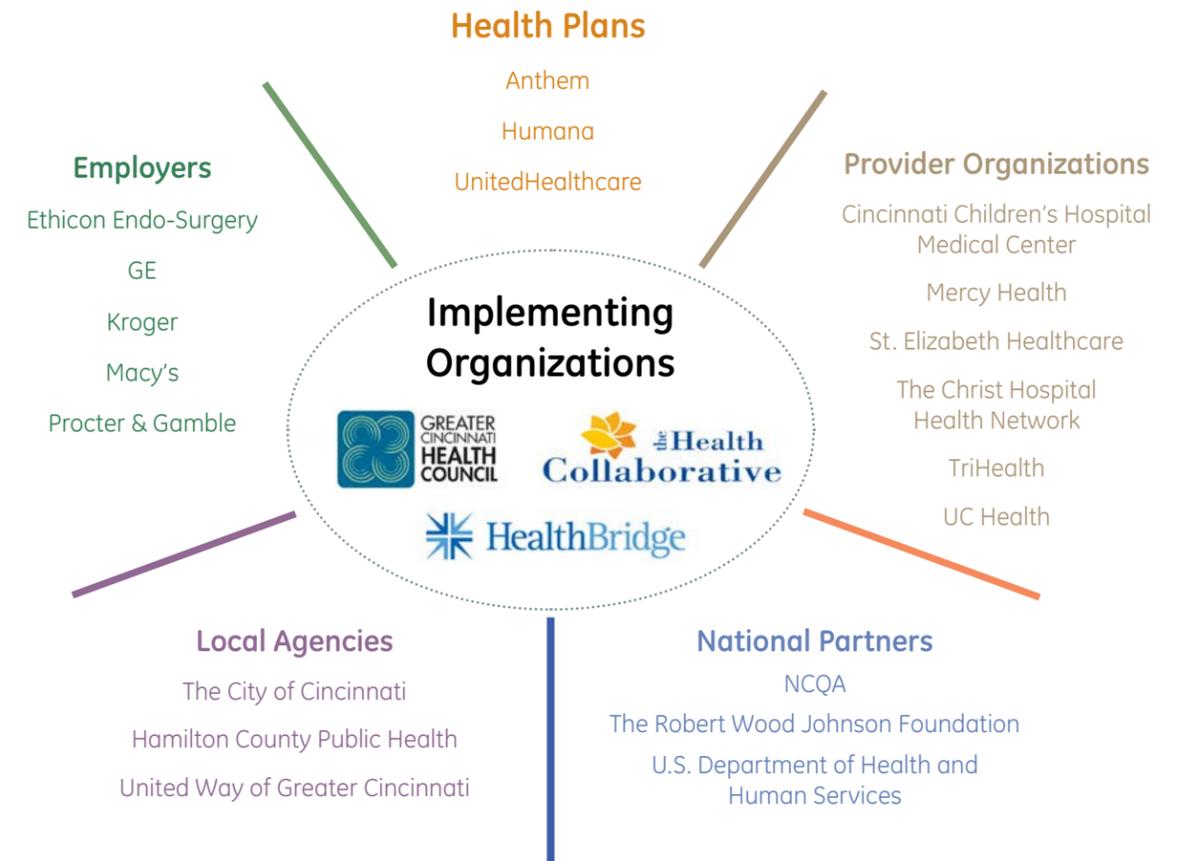


FIGURE 8
Key Collaborating Stakeholders in Cincinnati's Healthcare Transformation

The Real Heroes

The real heroes are the many individuals who have devoted considerable time and effort to the Cincinnati initiative. A few of these individuals have played especially important leadership roles (see "Key Stakeholder Leaders"), but they constitute a fraction of the many people that have taken part in the various pilot projects. Beyond the professional staff of the dedicated nonprofits, most of these people have donated their time as volunteers. In many cases, they have also taken professional risk as champions for the initiative within their own organizations. Collectively, they have operated as the glue that holds the initiative together and the energy source that fuels its progress.

KEY STAKEHOLDER LEADERS

Among the many people who have made major contributions to the success of Cincinnati's healthcare improvement initiative since 2010, a few individuals stand out for their leadership.



Tom Finn
Procter & Gamble

Tom has been president of P&G's global healthcare business since 2007. During this period, Tom has served as one of the most influential business leaders throughout the history of the Cincinnati initiative. He helped champion Cincinnati's pursuit of the initial AF4Q grant and subsequent program opportunities. In addition to his vision, he helped put the management disciplines in place that have been key to the initiative's success. Tom continued his active leadership through 2012, serving as one of the two co-chairs of the Executive Stakeholder Council. Today, he serves as a board member of the Health Collaborative of Greater Cincinnati.



Craig Osterhues
GE Aviation

Craig was healthcare manager for GE Aviation before he was assigned to the Cincinnati initiative as a loaned executive in 2010. Prior to this assignment, Craig was an active member of the Cincinnati initiative as board chair for HealthBridge and a member of the core team of stakeholders supporting AF4Q. In his role as loaned executive, Craig was an influential champion of the initiative, providing local leadership within GE's Cities Project and helping to support the effectiveness of the Executive Stakeholder Council.



Dr. Robert Graham
The University of Cincinnati

Bob joined the faculty of the University of Cincinnati School of Medicine in 2005, following several years of national policy leadership positions, including CEO of the American Academy of Family Physicians. Bob has been a powerful champion of the Patient-Centered Medical Home (PCMH) projects since 2007. He has devoted much of his professional time during this period to AF4Q, becoming the Cincinnati program director in 2010 and national program director in 2011. Bob provided overall leadership to the Cincinnati initiative as the other co-chair of the Executive Stakeholder Council from 2010 through 2012.



Will Groneman
TriHealth

Will has been the executive vice president of System Development for TriHealth since 1995. He is another long-standing champion for the Cincinnati initiative. As chairman of the Greater Cincinnati Health Council in 2011 and 2012, Will helped to shape the direction of the Cincinnati initiative. He also led TriHealth's active engagement in alignment with TriHealth's internal quality improvement program.

Jim Anderson

Cincinnati Children's Hospital Medical Center



Jim is an attorney and former manufacturing company CEO who in 1996 made the transition from non-executive chairman of the board to CEO for Cincinnati Children's Hospital Medical Center (CCHMC). As a relative outsider to healthcare, he challenged traditional approaches to healthcare management and championed a strategic focus on quality and value within CCHMC, helping it attain a national reputation for leadership in this area. In 2007, Jim joined the board of the Institute for Healthcare Improvement. He stepped down as CEO of Cincinnati Children's at the end of 2009 but continued as advisor to the president. He was instrumental in getting Cincinnati to adopt the Triple Aim goals during the May 2010 strategy meetings, and he brought CCHMC into projects such as Beacon with a focus on improving the care of childhood asthma.

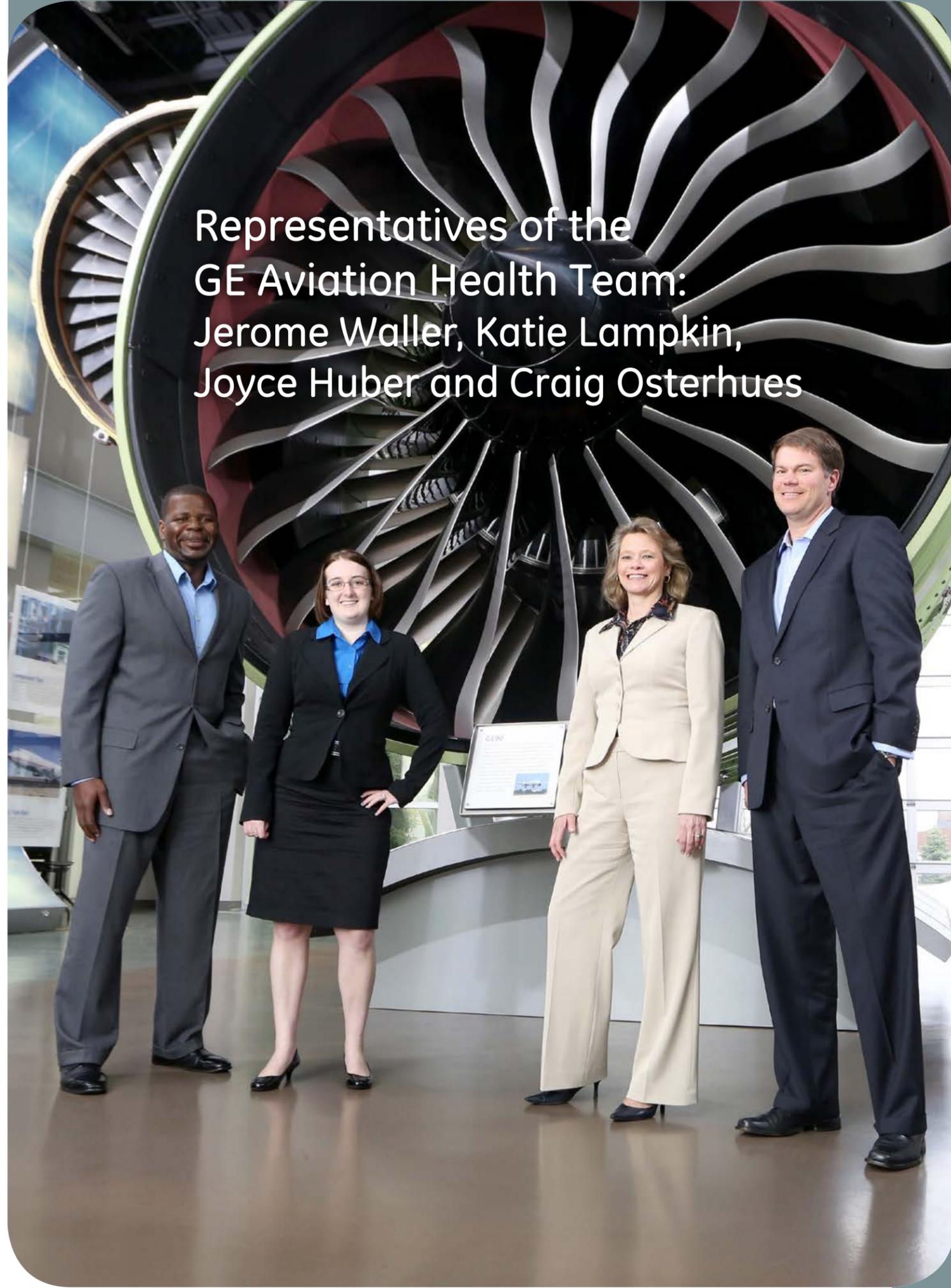
Dr. Richard Shonk

UnitedHealthcare/Health Collaborative



Dick was regional medical director for UnitedHealthcare in Southwestern Ohio beginning in 2007 when he moved from the Cleveland Clinic. Dick has been one of the leading forces behind the Cincinnati initiative since his arrival in Cincinnati. He first suggested the PCMH pilot as a component of AF4Q, and he helped build payer support for the project. Since then, he has been instrumental as a health plan leader for both quality improvement and payment innovation projects, especially CPC. In April 2013, Dick became chief medical officer for the recently combined Greater Cincinnati Health Council, Health Collaborative and HealthBridge so he could devote himself 100% to the Cincinnati initiative.

Representatives of the GE Aviation Health Team: Jerome Waller, Katie Lampkin, Joyce Huber and Craig Osterhues



The Return for GE in Cincinnati—Early Results

Despite the maturity of the collaboration efforts in Cincinnati, the reality is that much of the real, measureable change that has occurred by way of the Five Pillars was still at an early stage by the end of 2012. Many projects were in a development or pilot phase, and even more advanced project elements such as PCMH certification have only recently achieved fairly widespread adoption. It is not too early to begin evaluating evidence of a return on investment (ROI) for the participating stakeholders, but any results at this stage are extremely preliminary.

Measuring ROI for any stakeholder should begin with an assessment of progress against the three Triple Aim goals. Better Health and Lower Costs—the goals that are ultimately most relevant to employers—are likely to lag somewhat because it can take time for differences in care to translate into measurable differences in health outcomes and ultimately in cost. Measures of Better Care (e.g., increased HbA1c testing) and early indications of Better Health (e.g., fewer complications and fewer ER visits) are the leading indicators and the focus of the findings summarized in this section.

Finally, it is important to note that GE has been working at the national level on a number of strategies (see Figure 1) to improve healthcare quality and affordability for its employees and their families. Therefore, the analysis for Cincinnati should assess results beyond what the company has been able to accomplish nationally (see “GE’s National Results”).

Bearing all these caveats in mind, GE analyzed the results for its population of employees and dependents in Cincinnati to evaluate Triple Aim progress, with particular attention to Primary Care and Quality Improvement, the two pillars with the most readily measureable impact.

Cincinnati Results

Over and above GE’s progress at the national level, preliminary results through 2012 indicate GE will gain measurable benefits from its investments in the Cincinnati initiative discussed in this paper. GE found that among its members:

- **Patients of Cincinnati primary care practices that were early adopters of PCMH experienced lower (better) trend for emergency room (ER) visits as well as hospital inpatient admissions, bed days and readmissions than patients of other Cincinnati primary care practices.**
- **Cincinnati pediatric asthma patients experienced a lower (better) trend for complications, ER visits and hospital admissions than those in the rest of the country.**
- **Cincinnati adult diabetes patients experienced better trend than those in the rest of the country for increased testing of HbA1c and reduced complications.**

GE believes that the improvements in patient outcomes and more appropriate utilization of high cost services are in part a consequence of the care its members are receiving in Cincinnati. GE expects that continued improvements will translate over time into a lower total cost of

medical benefits for Cincinnati employees. The company is committed to following results for several years, modeling what works and assisting other communities in achieving similar results. To that end, GE has engaged RAND to conduct an independent, in-depth study of healthcare utilization and cost trends at the community level in the Greater Cincinnati region, with results expected late in 2013.

GE’S NATIONAL RESULTS

Since 2008, GE has managed overall U.S. healthcare costs to less than 3% average growth per year. The company has also experienced significant productivity gains by reducing U.S. health-related absence rates every year for the last decade. In fact, these lower trends have been so impressive that GE is now operationalizing similar proactive, integrated approaches to managing health-related absence in a dozen countries.

The following pages provide a brief description of the methodology GE used to assess progress in Cincinnati and the preliminary results of the assessment.

Improving Primary Care through PCMH

METHODOLOGY

To evaluate the impact of PCMH on health outcomes, GE studied claims data in two populations of approximately one thousand members each who were continuously enrolled from 2009 through 2012. The first population was patients of the original pilot group of 14 practices that achieved PCMH certification in 2009. The second group was a matched cohort with similar age, gender and risk score makeup from the Cincinnati market. GE's analysis compared data from the pre-intervention period of 2008 to 2012, the most recent data available at the time of evaluation.⁸

RESULTS

The PCMH pilot population had 3.5% fewer ER visits and 14% fewer admissions over the period 2008–2012. As Figure 9 shows, the PCMH group showed decreases over the evaluation period in both ER visits and hospital admissions, compared with slight increases for the non-PCMH group. GE also found better results for the PCMH population in hospital inpatient bed days and in hospital readmissions (not pictured).

⁸The reported results for 2012 in Figures 9 through 11 are annualized estimates based on results for the first three quarters of 2012.

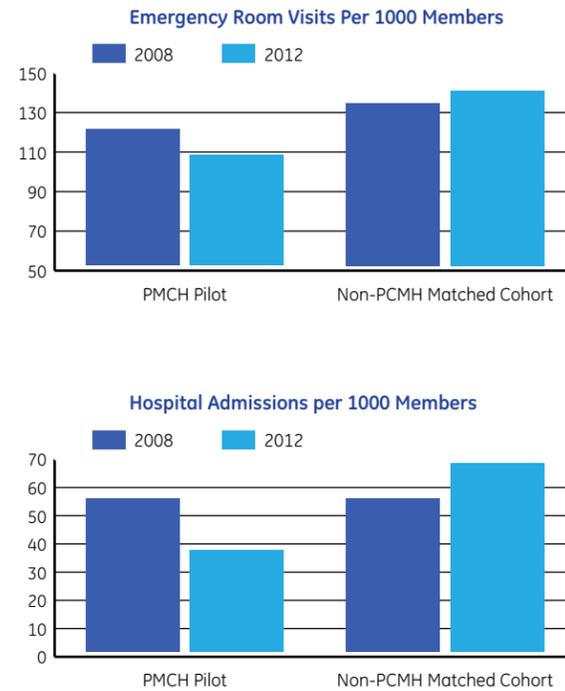


FIGURE 9
Emergency Room Visits and Hospital Admissions: PCMH Pilot Practices vs. Matched Cohort

Quality Improvement in the Care of Pediatric Asthma

METHODOLOGY

To evaluate the impact of Cincinnati's community-wide projects to improve the care of pediatric asthma, GE compared claims data for pediatric asthma patients in Cincinnati with patients in the rest of the U.S. ("non-Cincinnati").⁹

RESULTS

Figure 10 shows that complications, ER visits and hospital admissions have declined nationally for pediatric asthma patients, but the improvement has been better for Cincinnati, including 14 points of lower annual trend for ER visits over the period 2008–2012.

⁹For pediatric asthma from 2008–2012, there were an average of approximately 200 Cincinnati patients and 4,000 non-Cincinnati patients annually. The two groups (i.e., Cincinnati and non-Cincinnati) are not matched cohorts so age, gender and risk scores may vary; however, they are targeted groups for the condition and age requirements of pediatric asthma.

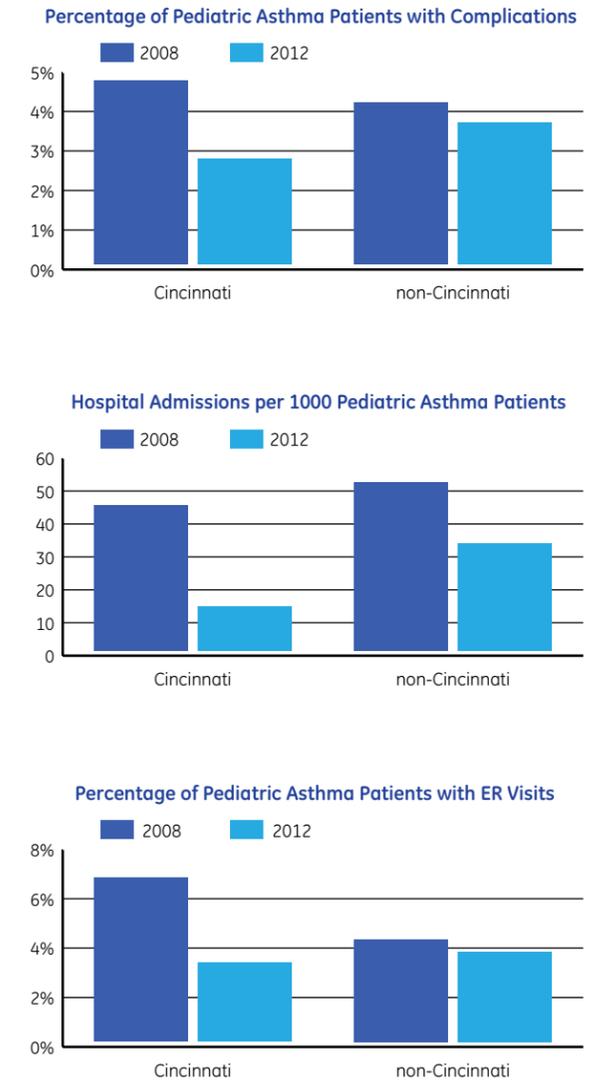


FIGURE 10
Pediatric Asthma Complications, ER Visits and Hospital Admissions: Cincinnati vs. Rest of U.S.

Quality Improvement in the Care of Adult Diabetes

METHODOLOGY

To evaluate the impact of Cincinnati's community-wide projects to improve the care of adult diabetes, GE applied the same methodology as for pediatric asthma. They compared claims data for adult diabetes patients in Cincinnati with patients in the rest of the country.¹⁰

RESULTS

Figure 11 shows that while HbA1c testing has improved nationally, at 80% there is more prevalent testing in Cincinnati. Additionally, with 23 points of lower annual trend over the period 2008-2012, diabetes patients in Cincinnati are experiencing fewer complications.

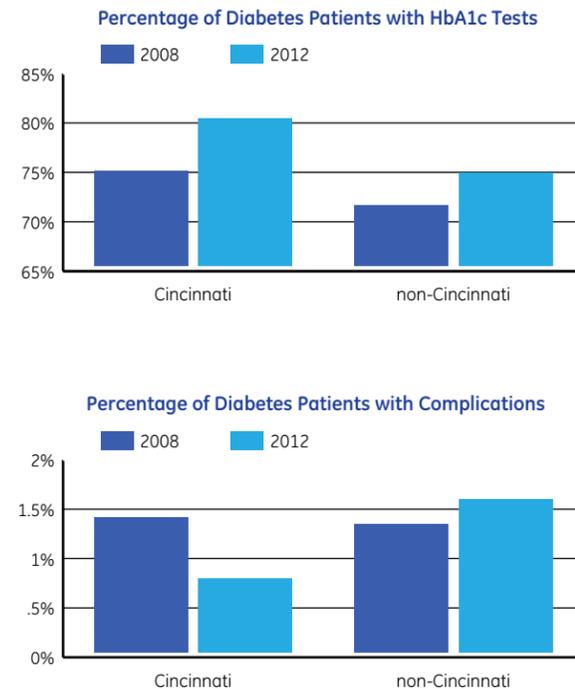


FIGURE 11
Adult Diabetes HbA1c Tests and Complications: Cincinnati vs. Rest of U.S.

¹⁰ For adult diabetes, from 2008-2012, there were an average of approximately 1,000 Cincinnati patients and 14,000 non-Cincinnati patients annually. The two groups (i.e., Cincinnati and non-Cincinnati) are not matched cohorts so age, gender and risk scores may vary; however, they are targeted groups for the condition and age requirements of adult diabetes.

All of these results are very preliminary. However, it is important to note that in each case, the comparisons were for GE employees and dependents. All of them participated in the same benefit design changes (in 2010 for salaried employees and 2012 for production employees), and all were exposed to the same HealthAhead wellness programs and decision support tools. Therefore, we are encouraged that these preliminary results indicate a positive impact over and above the improvements GE has experienced nationally due to corporate health policies and programs.

Lessons Learned

The Cincinnati experience has several important lessons for all healthcare stakeholders. It is particularly important for employers to understand them:

1. HEALTHCARE IS LOCAL, SO HEALTHCARE INNOVATION HAS TO BE LOCAL, TOO.

Cities are laboratories for learning what innovations are effective and how best to accelerate their implementation. As Tom Finn, the P&G executive, put it,

“Employers need to be involved in local piloting and testing or there will never be a national solution.”

Collaborative initiatives enable all stakeholders to have a more effective conversation around quality and value than one-on-one conversations typically afford. Initiatives that lead to greater transparency and broad-based improvement of healthcare delivery in the region are likely to give employers

and their employees a greater choice of high-value providers from which to choose.

2. BROAD STAKEHOLDER PARTICIPATION IS ESSENTIAL.

Every healthcare stakeholder faces the same fundamental challenge when it comes to participation: Will enough of my employees/members/patients be impacted to justify the investment I will need to put into the initiative? This is the “many-to-many” problem, and it is the single greatest barrier to change. It can only overcome if a critical mass of employers, health plans and providers participate. As Dr. Bob Graham of the University of Cincinnati noted,

“You need all three groups engaged, with a shared vision and the common civility to work collaboratively together.”

3. EMPLOYERS HAVE A KEY ROLE TO PLAY.

Large employers have a special ability to convene an audience of other stakeholder leaders. As Will Groneman of TriHealth has observed, if you want to encourage providers and health plans to collaborate,

“It helps to have customers in the room.”

By participating in new payment model pilots and putting supportive employee benefit designs in place, a set of large employers can send a powerful market signal that reinforces the alignment of stakeholder incentives. Employers can also contribute resources such as executive talent that strengthen the leadership of the initiatives.

4. OPPORTUNITY FAVORS THE WELL-PREPARED.

One could read this case study as a series of happy coincidences, in which Cincinnati has all the luck—winning grants, enjoying great participation among stakeholders, etc. Cincinnati may be fortunate that great leaders emerged from each of the key stakeholder groups and that individuals and institutions operated in good faith and trust, even when the payoff was far from clear. But it would be a mistake to ascribe Cincinnati’s success to luck. Cincinnati is emerging as a national leader in healthcare improvement because the stakeholder community has steadily prepared

itself for one opportunity after the next and managed to maintain a collective focus on its shared vision.

5. THE INVESTMENTS ARE SMALL, AND THE POTENTIAL RETURNS ARE BIG.

Even after GE increased its investments in Cincinnati, the amount the corporation spent on payment pilots and in-kind contributions was a very small fraction of its annual spending on healthcare in Cincinnati. As Tom Finn noted,

“You don’t need to do pure innovation. You can apply solutions developed in other markets.”

The early results for GE in Cincinnati show that initiatives like PCMH can lead to better care, which translates into lower utilization of emergency rooms and hospital stays for employees, dependents and retirees. These benefits, it is reasonable to assume, will translate into better population health and cost savings for purchasers. The critical ingredient for employers is to ensure they are represented by talented individuals who are committed to developing the knowledge and relationships necessary for effective leadership in a multi-stakeholder environment.

Employer Roadmap to Greater Healthcare Value

Employers interested in taking a more proactive and collaborative approach to driving better healthcare quality and value through the health benefits supply chain should consider action on two levels, as summarized in Figure 12. Enlisting the commitment and support of executive leadership is key to achieving a sustainable impact across all these tactics.

Align Overall Health Management Strategy

- Health and Wellness
- Consumer/Patient Accountability
- Provider Engagement
- Paying for Performance
- Transparency



Engage in Market-Level (City) Initiatives

1. Choose a Market/City
2. Develop a Straw-Man Strategy
3. Convene Potential Collaborators to Shape and Refine the Strategy
4. Execute the Strategy

FIGURE 12
Employer Action on Two Levels to Drive Greater Healthcare Value

Align Overall Health Management Strategy

Employers (particularly those who are self-insured) have the ability to design their health-related programs, policies and benefits in a way that promotes and rewards contributions to healthcare value along the supply chain—from employees and dependents, to health plans and pharmacy benefit managers, to providers of care. Additionally, employers can and should manage their healthcare strategy as they would anything else, applying process and performance measures to evaluate impact and apply interventions as needed. Core tactics that may be integrated into a value-focused strategy include:

HEALTH AND WELLNESS

Implement awareness, education and behavior-change programs that encourage prevention and support healthy lifestyles, reducing over time the demand for healthcare services. Create healthy work sites that reinforce these principles (tobacco-free, healthy foods, fitness options, etc.), making it easier for employees to live healthy while they are at work and creating a “culture of health” that extends from top leadership to local site operations to all employees.

CONSUMER/PATIENT SHARED ACCOUNTABILITY

Leverage benefit design to engage employees and dependents in healthcare decision-making through incentive alignment (e.g., consumer-directed health plan), access to cost and quality information, and decision support services.

PROVIDER ENGAGEMENT

Work with health plans or third party administrators (TPAs) to encourage utilization of providers who—based on evidence—provide higher-quality and better-value care. Examples include Centers of Excellence, Patient-Centered Medical Homes, and Value-focused Provider Networks.

PAYING FOR PERFORMANCE

Express demand to health plans and TPAs to participate in pay-for-performance programs that reward higher value providers. Differentiation and payments must be evidence-based and focused on value (quality and cost), not just price.

TRANSPARENCY

Relentlessly demand that partners participate in efforts (national and regional) that improve transparency of quality and cost information, which is needed both to engage consumers and to identify and reward value-differentiated providers.

In addition to these tactics, employers are encouraged to engage in regional and national groups and initiatives centered around value-focused endeavors, such as pay-for-performance (e.g., Catalyst for Payment Reform and Health Care Incentives Improvement Institute). Such engagement will help accelerate progress across the market by amplifying the signal employers are sending in favor of better healthcare value.

Engage in Market-Level (City) Initiatives

As has been demonstrated in this paper, employers—working together and in collaboration with other stakeholders along the supply chain—can have a profound impact on healthcare value in markets, where healthcare delivery is organized and executed. Every healthcare market will present unique opportunities, challenges and collaboration dynamics, so there is no one-size-fits-all solution. However, based on GE's experience in Cincinnati and other cities, the following high-level steps can guide action.

1. CHOOSE A MARKET/CITY

Employers with multiple locations need to determine where to invest in change. Those substantially located in one market can use the factors below to determine whether the time for action is right in their city.

CONSIDERATIONS TO WEIGH AND COMPARE INCLUDE:

PRESENCE

In which markets does your organization have a significant presence and, therefore, a lot at stake?

MOMENTUM

Are there signs of change or a readiness to change in the market? Look for employer

or coalition-led quality and value initiatives, information infrastructure projects, well-organized and high-quality/value-provider organizations seeking collaborations or the presence of active pay-for-performance initiatives. This assessment will result in an inventory of key initiatives and people that will be an essential reference point going forward.

READY COLLABORATORS

Likely found at the heart of positive momentum, including other employers, these may be value-focused provider organizations or health plans looking to innovate toward value.

LOCAL LEADERSHIP

This includes both strong leadership within your own organization that will represent your organization's interests, work collaboratively with other stakeholders and ably help facilitate action, as well as a strong community-based organization such as an employer coalition or a group similar to the Health Collaborative in Cincinnati.

2. DEVELOP A STRAW-MAN STRATEGY

This is a balancing act. While it is a big mistake to assume that any one employer's vision and strategy is right for the market, it is also a mistake to enter discussions with potential collaborators without clearly articulating needs, expectations and ideas about what your organization is willing to bring to the table. A straw-man strategy should be developed over time through multiple meetings with potential collaborators (identified above) in which there is a candid exchange of information, aspirations and ideas.

3. CONVENE POTENTIAL COLLABORATORS TO SHAPE AND REFINE THE STRATEGY

Facilitate a focused dialogue and exchange of ideas. Develop and then refine through a disciplined process a vision, goals and key objectives, all backed by metrics. Develop a business model for executing the strategy, making sure all collaborators understand their commitments and are held accountable per established metrics.

4. EXECUTE THE STRATEGY

Key to consider here are the vital roles your organization—as an employer—will likely need to play. The employer does not necessarily bring healthcare expertise to the table (although some do), but what the employer does bring is:

- A comprehensive appreciation for healthcare value, which is driven not only by clinical findings and price, but also by functional outcomes such as return to productive work, lost work time, etc.;
- The purchasing power that comes from paying a considerable share of healthcare costs—which can be used to reward those who create value and not reward those who don't. It will also be needed at times to hold collaborators together;

- Strategy and process management skills combined with a sense of urgency, which promotes progress and reduces wasted time, effort and money;
- A focus on data and analytical rigor, which promote accountability, evidence-based decisions and continuous improvement.

The immutable laws of supply and demand predict that employers can improve healthcare value. What is needed is strong demand—the collective impact of activated employers sending clear, strong and consistent signals to the market, both nationally and at the community level.

Acknowledgements

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Building Better Healthcare in Cincinnati: how employers are collaborating with other healthcare stakeholders to improve health and reduce costs in the queen city

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