THE FUTURE IS HERE:
Transforming American Healthcare Through Private Sector Innovation
Those who devote their lives and careers to healthcare tend to have a revolutionary spirit, merged with generous dashes of optimism and stubbornness. They believe that the timeline of healthcare progress – taking us from the discovery of penicillin to organ transplants to the mapping of the human genome – is far from complete and that there will always be a new idea, a new invention, a new discovery that will extend and improve lives.

This determination to innovate is a necessity in order to meet our current healthcare challenges. Achieving a 21st century healthcare system that keeps people healthy, successfully combats the escalation in chronic disease, improves patient outcomes, and maintains affordability requires constant improvement from every health sector. Meeting today’s and tomorrow’s patient and consumer needs hinges upon a fierce and focused desire to break new ground.

The good news is that the American healthcare revolution is a robust, ongoing process, and many of its highlights are documented in this publication. The Healthcare Leadership Council (HLC) is a coalition of chief executives from all disciplines within U.S. healthcare. HLC members – hospitals, integrated delivery systems, pharmaceutical companies, medical device manufacturers, group purchasing organizations, insurers, distributors, and other sectors – have contributed the metric-supported examples on these pages that cumulatively tell an exciting story about delivery system transformation and disease prevention and management.

Optimally, this volume will serve not only as a chronicle of how healthcare is changing before our eyes, but will also act as a blueprint for accelerated, systemwide improvements. Throughout the country, real progress is being made and lives are being changed for the better. HLC members look forward to a continuing collaboration with policymakers to expand upon these successes and achieve our shared healthcare ideals – an enhanced patient care experience, a more cost-effective system, and a population that enjoys greater health and well-being.

Mary R. Grealy
President
Healthcare Leadership Council

Gregory Irace
President & CEO
Sanofi US and
Chairman, Healthcare Leadership Council
## CONTENTS

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Note on Replicability and Expanding the Scope of Innovative Progress</td>
<td>6</td>
</tr>
<tr>
<td>A Note on Workplace Wellness Programs</td>
<td>7</td>
</tr>
<tr>
<td>HLC Workplace Wellness Survey</td>
<td>8</td>
</tr>
<tr>
<td>Healthcare Leadership Council</td>
<td>10</td>
</tr>
<tr>
<td>Aetna Oncology Solutions</td>
<td>12</td>
</tr>
<tr>
<td>Wellness at Aetna</td>
<td>14</td>
</tr>
<tr>
<td>E-Procurement Solution</td>
<td>16</td>
</tr>
<tr>
<td>Amerinet</td>
<td>18</td>
</tr>
<tr>
<td>ASD Healthcare’s myCubixx</td>
<td>20</td>
</tr>
<tr>
<td>AmerisourceBergen</td>
<td>22</td>
</tr>
<tr>
<td>Hospital Engagement Network - Early Elective Deliveries (EED)</td>
<td>24</td>
</tr>
<tr>
<td>Ascension Health</td>
<td>26</td>
</tr>
<tr>
<td>Hospital Engagement Network - Preventing Readmissions</td>
<td>28</td>
</tr>
<tr>
<td>Ascension Health</td>
<td>30</td>
</tr>
<tr>
<td>Reducing Glycemic Control Disparities</td>
<td>32</td>
</tr>
<tr>
<td>Baylor Health Care System</td>
<td>34</td>
</tr>
<tr>
<td>Scientific Collaboration Ushers in New Era in Cancer Diagnostics</td>
<td>36</td>
</tr>
<tr>
<td>Bio-Reference Laboratories</td>
<td>38</td>
</tr>
<tr>
<td>well@work</td>
<td>40</td>
</tr>
<tr>
<td>BlueCross BlueShield of Tennessee</td>
<td>42</td>
</tr>
<tr>
<td>Commit to Health</td>
<td>44</td>
</tr>
<tr>
<td>Boehringer Ingelheim Pharmaceuticals</td>
<td>46</td>
</tr>
<tr>
<td>National Nursing Room Project</td>
<td>48</td>
</tr>
<tr>
<td>Cardinal Health</td>
<td>50</td>
</tr>
<tr>
<td>Networks of Care Accelerate Change and Improve Patient Outcomes</td>
<td>52</td>
</tr>
<tr>
<td>Edwards Lifesciences</td>
<td></td>
</tr>
<tr>
<td>Valvular Heart Disease Innovation</td>
<td></td>
</tr>
<tr>
<td>Healthy Lives™</td>
<td></td>
</tr>
<tr>
<td>Franciscan Missionaries of Our Lady Health System</td>
<td></td>
</tr>
<tr>
<td>Accountable Care Organization (ACO) Shared Savings Agreement</td>
<td></td>
</tr>
<tr>
<td>Health Care Service Corporation</td>
<td></td>
</tr>
<tr>
<td>Shared Decisions, Shared Success</td>
<td></td>
</tr>
<tr>
<td>Health Dialog</td>
<td></td>
</tr>
<tr>
<td>Dr. Dean Ornish’s Program for Reversing Heart Disease</td>
<td></td>
</tr>
<tr>
<td>Healthways</td>
<td></td>
</tr>
<tr>
<td>Healthways SilverSneakers® Fitness Program</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>INOMAX® Therapy Package</td>
<td>54</td>
</tr>
<tr>
<td>Ikaria</td>
<td></td>
</tr>
<tr>
<td>Living Well</td>
<td>56</td>
</tr>
<tr>
<td>Ikaria</td>
<td></td>
</tr>
<tr>
<td>Healthy Results</td>
<td></td>
</tr>
<tr>
<td>Indiana University Health</td>
<td>58</td>
</tr>
<tr>
<td>Comprehensive Kidney Care Management</td>
<td></td>
</tr>
<tr>
<td>inVentiv Health</td>
<td>60</td>
</tr>
<tr>
<td>CEO Cancer Gold Standard</td>
<td></td>
</tr>
<tr>
<td>Johnson &amp; Johnson</td>
<td>62</td>
</tr>
<tr>
<td>Live for Life</td>
<td></td>
</tr>
<tr>
<td>Johnson &amp; Johnson</td>
<td>64</td>
</tr>
<tr>
<td>Marshfield Dental Initiative</td>
<td></td>
</tr>
<tr>
<td>Marshfield Clinic</td>
<td>66</td>
</tr>
<tr>
<td>Physician Group Practice Demonstration</td>
<td></td>
</tr>
<tr>
<td>Marshfield Clinic</td>
<td>68</td>
</tr>
<tr>
<td>Stress Less</td>
<td></td>
</tr>
<tr>
<td>Mayo Clinic</td>
<td>70</td>
</tr>
<tr>
<td>McKesson VITAL Nurse Advice Line</td>
<td></td>
</tr>
<tr>
<td>McKesson Corporation</td>
<td>72</td>
</tr>
<tr>
<td>CareLink® Network</td>
<td></td>
</tr>
<tr>
<td>Medtronic</td>
<td>74</td>
</tr>
<tr>
<td>Bold Goals for Excellence</td>
<td></td>
</tr>
<tr>
<td>MemorialCare Health System</td>
<td>76</td>
</tr>
<tr>
<td>Influenza Protection Program</td>
<td></td>
</tr>
<tr>
<td>MemorialCare Health System</td>
<td>78</td>
</tr>
<tr>
<td>The Adherence Estimator®</td>
<td></td>
</tr>
<tr>
<td>Merck</td>
<td>80</td>
</tr>
<tr>
<td>Energy Management &amp; Sustainability Program</td>
<td></td>
</tr>
<tr>
<td>New York-Presbyterian Hospital</td>
<td>82</td>
</tr>
<tr>
<td>New York-Presbyterian Regional Health Collaborative</td>
<td></td>
</tr>
<tr>
<td>New York-Presbyterian Hospital</td>
<td>84</td>
</tr>
<tr>
<td>Screening for Undiagnosed Hypertension</td>
<td></td>
</tr>
<tr>
<td>NorthShore University HealthSystem</td>
<td>86</td>
</tr>
<tr>
<td>Better Diabetes Screening</td>
<td></td>
</tr>
<tr>
<td>Novo Nordisk</td>
<td>88</td>
</tr>
<tr>
<td>The National Diabetes Prevention Program</td>
<td></td>
</tr>
<tr>
<td>Novo Nordisk</td>
<td>90</td>
</tr>
<tr>
<td>Value Analysis Engineering</td>
<td></td>
</tr>
<tr>
<td>Owens &amp; Minor</td>
<td>92</td>
</tr>
<tr>
<td>Live Well, Be Premier</td>
<td></td>
</tr>
<tr>
<td>Premier healthcare alliance</td>
<td>94</td>
</tr>
<tr>
<td>Cities for Life</td>
<td></td>
</tr>
<tr>
<td>Sanofi US</td>
<td>96</td>
</tr>
<tr>
<td>Keeping Seniors Living Independently</td>
<td></td>
</tr>
<tr>
<td>SCAN Health Plan</td>
<td>98</td>
</tr>
<tr>
<td>The Power to Save: Stryker</td>
<td></td>
</tr>
<tr>
<td>Power-PRO XT Cot and Power-LOAD Cot Fastener System</td>
<td>100</td>
</tr>
<tr>
<td>Incentives for Adoption and Use of E-Prescribing</td>
<td></td>
</tr>
<tr>
<td>Surescripts</td>
<td>102</td>
</tr>
<tr>
<td>Be Well</td>
<td></td>
</tr>
<tr>
<td>Takeda</td>
<td>104</td>
</tr>
<tr>
<td>Improving Patient Safety - Everyone’s Responsibility</td>
<td></td>
</tr>
<tr>
<td>Texas Health Resources</td>
<td>106</td>
</tr>
<tr>
<td>emPower—An Employee Wellness Program</td>
<td></td>
</tr>
<tr>
<td>ValueOptions</td>
<td>108</td>
</tr>
<tr>
<td>VHA IMPERATIV™</td>
<td></td>
</tr>
<tr>
<td>VHA Inc.</td>
<td>110</td>
</tr>
<tr>
<td>WellTransitions®</td>
<td></td>
</tr>
<tr>
<td>Walgreens</td>
<td>112</td>
</tr>
<tr>
<td>Weight Management on Prescription: Coverage of Clinical-Community</td>
<td></td>
</tr>
<tr>
<td>Collaboration to Address Obesity</td>
<td></td>
</tr>
<tr>
<td>Weight Watchers</td>
<td>114</td>
</tr>
<tr>
<td>Contact Information</td>
<td>116</td>
</tr>
<tr>
<td>HLC Membership</td>
<td>120</td>
</tr>
<tr>
<td>About HLC</td>
<td>121</td>
</tr>
</tbody>
</table>
A Note on Replicability and Expanding the Scope of Innovative Progress

Bold new ideas and innovative successes are not meant to be constrained. By profiling programs and initiatives that are making significant advancements in elevating healthcare value and individuals’ well-being, HLC and its members intend to light the way forward for health improvements of a larger scale.

The examples catalogued here are illustrative of a broad array of best practices and new approaches that can be adopted by organizations, workplaces, and communities throughout the country. Many of these concepts are scaleable so they can be implemented in various venues, be they Fortune 500 corporations or small startups. What defines success time and again is the commitment of leadership to better healthcare and to collecting, quantifying, and analyzing data to bring the right programs to the right populations.

There is a universal acceptance that all of those involved in healthcare need to find ways to achieve better outcomes, advance wellness, and contain costs. And budget constraints at all levels of government, as well as the efforts of companies to be economically competitive, are indeed making it necessary to achieve gains in both quality and cost-efficiency. The good news is that this is not an impossible quest. As the following pages demonstrate, new ideas are flourishing throughout private sector healthcare, ideas that can be brought to patients and consumers nationwide.
A Note on Workplace Wellness Programs

In addition to the effect on families and communities, the chronic disease epidemic has a significant and severe impact in the workplace. Health risks such as unhealthy eating, inactivity, smoking, obesity, and stress have a well-documented correlation to disability, absenteeism, and presenteeism, in addition to direct healthcare costs for employers and the healthcare system.

The examples in this volume and the results of the HLC Employer Wellness Survey demonstrate the ways in which HLC members are at the forefront in developing and implementing meaningful, comprehensive wellness programs that engage employees in a variety of ways. HLC members, as innovative healthcare leaders from multiple sectors, are uniquely positioned to create cultures of wellness that motivate and empower employees to reach their health goals.

While many of the wellness programs described here have already demonstrated a strong value and return on investment, others are in early groundbreaking stages and are still reaching their full potential for health improvement and savings. All of the examples featured clearly exemplify best practices that are generating documented, positive results in employee health, productivity, and healthcare cost savings. And all of our HLC members, in their role as health sector leaders, will continue to track results in this shared effort to improve the health of all Americans – starting with our own healthcare workplaces.
Overview

- The Healthcare Leadership Council (HLC) is an alliance of chief executives of the nation’s leading healthcare companies and organizations. HLC members are simultaneously health providers, employers, and good neighbors in their communities, and they have developed solutions to confront the growing crisis of chronic disease.

- This survey documents the wellness initiatives that HLC members are offering their employees and demonstrates the leadership role HLC companies have taken to create a healthier population.

- By completing this survey, HLC companies have provided a roadmap of best practices for which all types of organizations in all sectors can strive.

Background

- The survey was conceived in 2012 as a way to quantify the ways in which HLC members are taking the lead in improving the health and well-being of their employees.

- 99% of HLC members responded—43 members representing all sectors of American healthcare: providers, manufactures, distributors, and retail.

- These interventions affect millions of lives. 38 respondents are large employers (500+), and all have multiple facilities.

- Many respondents indicated that some items on the survey were under development when they filled it out and would be in place in 2013.

Description

- HLC member best practices:
  - CEO-level engagement and support;
  - Making healthy food options the easier option;
  - Encouraging physical activity; and
  - Enabling employees to take greater responsibility for their health behaviors through increased engagement and access to tools, support, and information.

Metrics

- 91% of HLC members have instituted changes to promote wellness in all their locations, not just headquarters.

- 91% of HLC members have a designated person to promote wellness in their organization.

- 77% of HLC members evaluate the financial impact of wellness programs and initiatives.

High Participation: Approximate Percentage of Employees that Utilize Wellness Benefits as Part of the Employee Health Plan

- HLC organizations have seen best practices pay off with increased employee engagement in wellness programs.
- Most HLC members have seen over 50% participation in their wellness offerings.
Low prices on healthy food choices
Making vending machine food healthier
Reformulating recipes or menus to be healthier
Increasing the amount of fresh fruits and vegetables
Increasing the availability of healthy beverages
Offering an adult wellness meal option
Expanding salad bars
Eliminating or reducing the amount of fried food
Reducing or eliminating displayed junk food
Reduced marketing of unhealthy products
Clear nutrition labeling on food and menus

Incentives

Technology Use

Improved Nutrition

Incentives

Increasing Physical Activity

Many HLC members also reported sponsoring fitness competitions to encourage employees to get active.
**AETNA ONCOLOGY SOLUTIONS**

**Overview**

* Aetna is one of the nation’s leading diversified healthcare benefits companies, serving about 44 million people with information and resources to help them make better informed decisions about their healthcare.

* Aetna offers a broad range of health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities, Medicaid healthcare management services, and health information technology services.

* Aetna’s Oncology Solutions delivers progressive, comprehensive cancer care programs for Aetna members and participating oncologists – supporting patients before the first scheduled treatment and continuing throughout the course of therapy.

* Aetna is working with the medical community to expand the use of evidence-based guidelines and expert nurse support to deliver proven quality cancer care that helps patients beat cancer with fewer side effects, less time in treatment, and less financial strain.

**Background**

* The program was developed with Innovent Oncology, a business within McKesson Specialty Health that draws upon the expertise and resources developed by the U.S. Oncology Network, one of the nation’s largest networks of community-based oncology physicians dedicated to advancing cancer care in America.

* The pilot was available to Aetna members treated by physicians with Texas Oncology, an affiliate of the U.S. Oncology Network, between June 2010 and April 2012.

**Description**

* Guidelines based on medical evidence and nurses certified in cancer care were used to reduce ER and in-patient admissions. Such reductions lower the cost of cancer treatment and improve care quality.

* The Innovent Oncology program supports patients before the first scheduled treatment and continues throughout the course of therapy. Three key components ensure consistency in care, control costs, and provide a better experience:

  * **Level I Pathways and Health Information Technology** – Guidelines based on evidence direct treatment to clinically proven options that optimize outcomes and minimize side effects. Health information technology gives doctors electronic access to these guidelines and other decision-support resources at the point of care.

  * **Patient Support Services** – Innovent Oncology’s nurses work with the oncology practices and Aetna’s care management team to provide patients proactive care. The nurses specialize in cancer care and help manage treatment symptoms and side effects, including depression.

  * **Advance Care Planning** – Members have access to end-of-life planning and support, if those hard decisions become necessary. Innovent nurses as well as clinicians from Aetna’s Compassionate Care program, who have expertise in end-of-life support, offer these services.
Metrics

- Members in the program had the same or better health outcomes compared with members who were not part of the program.
- The program effectively decreased emergency room (ER) visits by 39.8%, decreased hospital admissions by 16.5% and reduced the number of hospital days by 35.9% among 184 enrolled members. The program resulted in approximately 12% cost savings among lung, breast, and colorectal cancers alone.

Value

- Aetna’s experience from its 2010 lung cancer study showed that using clinical evidence in cancer care leads to the same or better results, with lower costs. This study showed that Aetna can provide members additional support while improving the quality of care across many types of cancer.
- Aetna will continue to work with the medical community to bring this kind of clinical information – and more – into real-time decision making to improve healthcare and lower costs.
Overview

☆ Aetna is a leading provider of health and wellness solutions, including programs that provide identification and reduction of risks for individuals at all stages of health.

☆ Aetna believes in viewing the whole person as an individual to encourage sustained behavior change and improved outcomes.

☆ Aetna meets members where they are and want to be through online, social networking, telephonic, and face-to-face channels.

Background

☆ Wellness is core to Aetna’s overall care management philosophy to support its members at every stage of health.

☆ Aetna’s strategies and solutions have evolved beyond traditional models of “educate and implore” and “prescribe and treat” to a thoughtful blend of coaching and engagement methodologies.

☆ Aetna’s programs extend past diet and exercise to include needs of the whole person, such as stress management and prevention.

Description

☆ Risk Identification
  • Biometric screenings
  • Health assessment

☆ Risk Mitigation
  • Get Active! fitness competition
  • Lifestyle coaching
  • CareEngine® and personal health record (with trackers)
  • Walk station

☆ Self-directed virtual care
  • Online wellness programs
  • Member Health Engagement Plan

☆ Value Added Services
  • 24-hour nurse line
  • Member discount programs

☆ Aetna’s wellness programs blend virtual care and personal interaction based on the needs and preferences of plan members.

☆ Lifestyle coaching solutions empower plan members to make changes in the areas they care about most, such as losing weight, quitting tobacco, eating healthier, or managing stress.

☆ Motivational interviewing and mindfulness techniques, as core competencies, are incorporated into individualized coaching interactions.

☆ Aetna’s integrated, online tools provide real-time information to help plan members make more informed, meaningful decisions.

☆ Get Active! Fitness Competition helps plan members connect with people they trust to help
them achieve health goals. Participants create their own goals and wellness plans by planning events, forming groups, and creating new challenges.

* Participants track their progress online and motivate and support each other along the way toward achieving valuable health benefits.

**Metrics**

* Coaching programs*
  - 46% more likely to reduce Body Mass Index (BMI);
  - 67% more likely to reduce risk score on health assessment;
  - 48% less likely to have risk of inadequate exercise;
  - 46% less likely to have risk of low consumption of fruits and vegetables in diet;
  - 46% less likely to have risk of high fat consumption in diet; and
  - Average $294 savings per member, per year.

* Get Active! fitness competitions
  - Preliminary results demonstrate 1 point BMI reduction on average.

* 24-hour nurse line**
  - Avoided 2.23 unnecessary physician office visits per year; and
  - Almost 1 in 3 families avoided an unnecessary emergency department visit per year.

**Value**

* Aetna recognizes that wellness is about treating the whole person—improving interpersonal relationships, getting through the day with as much ease as possible, and living a life that has meaning and purpose.

* Aetna’s ability to integrate wellness across their care management solutions allows for seamless connections of data, action oriented goals, and meeting the unique needs of each individual.

* Aetna’s solutions help empower plan members to achieve such meaningful outcomes, as well as help employers reduce medical costs.

---

*Q2 2008 Aetna Informatics observational study
E-PROCUREMENT SOLUTION

Overview

* Amerinet is a leading national healthcare organization that collaborates with more than 60,000 members to create and deliver unique solutions that lower costs, raise revenues, and champion quality.

* To help members purchase important healthcare products and aid in reducing overall health spending, Amerinet partnered with Coupa, the fastest-growing provider of cloud-based spending optimization software, via certified Coupa reseller, CCP Global, as its e-Procurement Solution.

* Through Amerinet’s e-Procurement Solution, members can access Coupa’s intuitive, easy-to-use cloud-based software to streamline and optimize purchasing for their organizations.

Background

* Hospitals face an increasing challenge of maintaining control of spending – both clinical and nonclinical – coupled with the consistent demand to reduce costs and increase efficiency in the delivery of high-quality healthcare.

* Employees have experience shopping online as consumers and expect similar ease of use and efficiency when purchasing supplies for their organization in the workplace.

* Currently, many hospitals still rely on inefficient and cumbersome paper-based or manually tracked purchasing process, which leads to backlogged and overwhelmed purchasing departments.

Description

* The cost of supplies is second only to cost of labor for most hospitals. Bringing supply costs down allows healthcare facilities to free up resources dedicated to their primary purpose of providing quality care to patients.

* Quality of care initiatives and reduced reimbursement are a reality of healthcare reform. Hospitals that want to remain profitable and serve patients in their community will need to adhere to the new low-cost, high-quality paradigm.

* The healthcare supply chain provides the data needed to report on the cost and quality of care for reimbursement and to meet meaningful use requirements for EHRs.

The cost of supplies is second only to cost of labor for most hospitals. Bringing supply costs down allows healthcare facilities to free up resources dedicated to their primary purpose of providing quality care to patients.
Metrics

Through Amerinet’s e-Procurement Solution, Amerinet members:

• Amplify their spending power and reduce costs up to 11%;
• Reduce off-contracting spending by 30 – 50%;
• Centralize all purchasing for the organization under one procurement umbrella;
• Maintain greater control and compliance on employee spending – both clinical and nonclinical;
• Decrease paperwork on purchase order/invoice process;
• Empower users to make better purchasing decisions.

Value

Spotlight on Avalon Healthcare

Avalon Healthcare, a provider of long-term care, skilled nursing, rehabilitation, and memory care services in the Western United States, only had 40% visibility on its spending data. This lack of visibility meant that the organization could not enact change on employee purchasing decisions over which the purchasing department had no control.

To avoid the creation of additional staff burden on purchase orders, Avalon Healthcare realized it needed a technology solution to help manage its procurement process. The organization turned to Coupa because its e-Procurement Solution sets a market standard by offering customers usability, time to value, and the ability to incorporate new features quickly.

Avalon Healthcare recognized that it was critical for its business units to make the right purchase decision at the right time at the right price. Coupa made that easy since its solution is accessible on any mobile phone, tablet, or mobile device for employees to place and approve orders.

Coupa’s easy-to-use, intuitive interface enabled Avalon Healthcare employees to make better decisions at the time of purchase. Employees found the system easy to learn, and they were immediately comfortable using the solution because it provided information they needed in a reliable way.

Coupa saved the organization about 75% of the time it would have taken for implementation and management. The organization did not need to invest in staff, server space, and all of the various aspects of the idiosyncrasies of the technology.
ASD HEALTHCARE’S MYCUBIXX®

Overview

✱ AmerisourceBergen is one of the world’s largest pharmaceutical wholesale and services companies. With a focus on the pharmaceutical supply chain, the company provides both pharmaceutical manufacturers and healthcare providers drug distribution and related services designed to reduce costs and improve patient outcomes.

✱ ASD Healthcare is part of the AmerisourceBergen Specialty Group. It provides the healthcare community with specialty pharmaceuticals and innovative solutions, like myCubixx. This patent-pending technology puts life-saving medications in the patient’s home, while its real-time data capture provides instant visibility to all stakeholders. Each refrigerated unit can store a range of specialty medications with unique handling requirements. The advanced radio frequency capabilities of myCubixx deliver instant tracking and reporting of health events and product usage.

Background

✱ For patients with rare diseases, who largely rely on Medicaid for high-dollar medications, myCubixx ensures that they are receiving and following the most beneficial treatment plan for their healthcare needs.

✱ Preventable events – like high-cost emergency visits – are reduced or eliminated altogether.

✱ Patient medication compliance improves, leading to better healthcare outcomes for a higher quality of life.

Description

✱ Product tracking and accountability improve with the advanced data-capture capabilities of myCubixx from ASD Healthcare. The system captures:
  • Product information,
  • Patient usage information,
  • Time stamps of product access for scheduled infusions and for off-schedule access.

✱ When accessed, myCubixx records real-time data that provide visibility and transparency to partner stakeholders – payers, healthcare providers, caregivers, and others to take the guesswork out of product usage.

✱ The system can automatically notify providers and caregivers when a treatment plan is not followed, as well as when an unexpected patient event occurs.

✱ Using radio frequency monitoring, myCubixx ensures that only patients or caregivers gain access to the life-saving product, helping prevent loss or abuse that adds to payer expense.

✱ Ultimately, the myCubixx data reporting system lowers costs and delivers better healthcare results for healthier lives.

USING MYCUBIXX

• Patient inputs bleed details on myCubixx touch-pad tablet.
• Target joint, pain rating, and treatment are recorded.
• myCubixx records that information and provides controlled access to product.
• myCubixx unlocks to provide product access.
• myCubixx records how much product is taken.

*Example for hemophilia patient given.
Metrics

- According to a 2012 patient pilot of the myCubixx system, hemophilia patients reported the following attributes of myCubixx:
  - Supports my independence – 90%;
  - Adds shelf space through self-contained storage – 90%;
  - Provides dedicated storage for my factor products – 90%;
  - Makes hemophilia a smaller part of my life – 80%;
  - Reduces my concern about having the factor on hand – 50%;
  - Makes it easier to interact with my doctor/care provider – 40%.

Value

- The myCubixx allows both patient and providers to know where their product is, when it is used, and to feel confidence in accurate and efficient reporting of usage data.
- The accurate reporting data ultimately lead to better patient outcomes.
- Lowering healthcare costs while improving results takes innovative solutions with the human touch, and myCubixx delivers, providing:
  - Lower healthcare costs;
  - Enhanced patient experience; and
  - Improved quality of life.
Overview

- Ascension Health is transforming healthcare with the goal of providing the highest quality to all, with special attention to those who are poor and vulnerable.
- Ascension Health is committed to developing care delivery models that promote person-centered care.

Background

- In 2004, Ascension Health launched its “The Journey to Zero” as an initiative to improve patient safety with a focus on improving perinatal safety.
- Three pilot sites collaborated with the Institute for Healthcare Improvement (IHI) and Premier hospitals on an ideal perinatal care system. This led to the development of the Ascension Health Perinatal Safety HANDS® program and included a bundle for the safe use of oxytocin using the American College of Obstetricians and Gynecologists (ACOG) Early Elective Deliveries guidelines.
- Consensus between the delivery hospitals in 2006 established the 39-week rule as a standard of care.

Description

- The program includes EED data collection through the adoption of metrics and the establishment of an EED baseline rate, and monthly data submissions from all participating hospitals. Partnership leaders evaluate monthly data and support hospitals with variation.
- Ascension identified and spread best practices (such as the “Hard-Stop” policy) across the health system. The OB physician leadership is encouraged to review all scheduled early inductions with a focus centered on 100% compliance with reducing variation across the system.
- OB physician leaders and lead RNs attended the High Reliability Forum, with a breakout on EED covering:
  - EED panel discussion
  - EED “Hard-Stop” policy from specific hospital success story
  - The role of hospital CEOs supporting the EED policy
- In May of 2012, full consensus was reached to eliminate all EEDs prior to 39-weeks gestation without medical indication by fall 2012.

**Estimated EED Neonatal Intensive Care Unit Cost Projection**

<table>
<thead>
<tr>
<th>EED NICU Cost Decline Pre, Roll Out &amp; Post</th>
<th>$2,500,000</th>
<th>$2,000,000</th>
<th>$1,500,000</th>
<th>$1,000,000</th>
<th>$500,000</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-2011 – 2/2012</td>
<td>$2,219,702</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/2012 – 10/2012</td>
<td>$1,364,310</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/2012 – 10/2013</td>
<td>$522,085</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

-3.6% EED Rate
-1.0% EED Rate
<-1% EED Rate
Metrics

✱ Ascension Health, a microcosm of the nation’s healthcare providers, delivers approximately 70,000 infants annually at 47 hospitals in 16 states.

✱ During a 14 month period:
  • Ascension Health Ministries succeeded in reducing EEDs by 68% from baseline (2/1/2012 – 7/31/2012).
  • Approximately 16,400 mothers delivered over this time period (>37 and <39 weeks) for any reason.
  • This equates to about 1,200 births (>37 and <39 weeks) per month and 20 EED cases per month.

Value

✱ Through the success of the Early Elective Deliveries (EED) program, Ascension educates and raises awareness of variance in EEDs. Presentations on EED national evidence, patient education materials and training on common challenges in eliminating unnecessary early deliveries is making a difference across the health system.

ASCENSION HEALTH & NATIONAL EDD RATES 2006 – 2011
NON MEDICALLY INDICATED EARLY ELECTIVE DELIVERIES ≥ 37 – < 39 GESTATION

<table>
<thead>
<tr>
<th>Year</th>
<th>Ascension EDD Rate</th>
<th>National EDD Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>21%</td>
<td>22%</td>
</tr>
<tr>
<td>2007</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>2008</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>2009</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>2010</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>2011</td>
<td>12%</td>
<td>10%</td>
</tr>
</tbody>
</table>

ESTIMATED EDD NICU COST AVOIDANCE 2006 – 2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$2,105,800</td>
</tr>
<tr>
<td>2007</td>
<td>$4,195,800</td>
</tr>
<tr>
<td>2008</td>
<td>$4,762,800</td>
</tr>
<tr>
<td>2009</td>
<td>$4,068,678</td>
</tr>
<tr>
<td>2010</td>
<td>$4,435,093</td>
</tr>
</tbody>
</table>

Total Cost Avoidance: $26,686,136
HOSPITAL ENGAGEMENT NETWORK - PREVENTING READMISSIONS

Overview

* Ascension Health is transforming healthcare with the goal of providing the highest quality to all, with special attention to those who are poor and vulnerable.
* Ascension Health is committed to developing care delivery models that promote person-centered care and effective care transitions to minimize acute care readmissions.

Background

* The key goals for reducing readmissions include promoting the development, alignment, and spread of effective patient-centered interventions, while also targeting resources, strategies, and new models of care to manage patient populations who are most vulnerable for acute care readmissions.

Description

* Ascension Health’s Clinical Integration Committee (CIC) and Clinical Excellence Committee (CEC) evaluated various population healthcare models and their impact on patient quality and safety, which led to the development of the Preventing Readmissions Bundle.

<table>
<thead>
<tr>
<th>Preventing Readmission Strategies</th>
<th>Number of Hospitals Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilize risk for readmission screening tool</td>
<td>32</td>
</tr>
<tr>
<td>Care transition models (Project RED, BOOST, Care Transitions)</td>
<td>53</td>
</tr>
<tr>
<td>Communication hand-off to providers and post acute care facilities</td>
<td>43</td>
</tr>
<tr>
<td>Medication reconciliation at discharge</td>
<td>3</td>
</tr>
<tr>
<td>Schedule PCP appointments (within 3 – 7 day for at-risk)</td>
<td>47</td>
</tr>
<tr>
<td>Provide a “rescue” call number</td>
<td>22</td>
</tr>
<tr>
<td>Contact patients post-discharge for compliance with discharge instructions, medications and PCP appointments</td>
<td>40</td>
</tr>
<tr>
<td>Process to identify and refer patients for palliative care</td>
<td>23</td>
</tr>
<tr>
<td>Trigger tool for palliative care consult</td>
<td>29</td>
</tr>
<tr>
<td>Assist with acquiring and/or provide resources to meet self-care needs in the home (education, media, DME)</td>
<td>46</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>54</td>
</tr>
<tr>
<td>Review of high-risk medications (warfarin, oral anti-platelet agents, oral hypoglycemic)</td>
<td>32</td>
</tr>
<tr>
<td>Use of “teach back” method</td>
<td>43</td>
</tr>
<tr>
<td>Identify preferred partners across the continuum</td>
<td>50</td>
</tr>
</tbody>
</table>
• Implementing transitional care services
• Collaborating with skilled nursing facilities (SNF), home nursing agencies, and family members to optimize care protocols
• Utilizing palliative care services

Knowledge has been shared across Ascension Health through the Preventing Readmissions Huddle Space website, monthly webinars, and events, such as in-person meetings that connect high-performing hospitals with those experiencing challenges.

Many Ascension Health ministries participate with local agencies to promote care transitions and affect the need for acute care readmissions by:
• Engaging with community agencies as part of the CMS Community-based Care Transitions Program
• Collaborating with organizations that have been awarded funds through the CMS Initiative to Reduce Avoidable Hospitalization
• Working with local quality improvement organizations and community consortiums to improve care transitions

Metrics

Ascension Health monitors two readmission metrics for all patients and diagnoses:

• Observed 30-day readmission rates to the same hospital per 100 discharges
• And expected 30-day readmissions (3M risk adjusted)

Sixty six out of 69 participating facilities submit readmissions data to Ascension Health Hospital Engagement Network. The facilities not currently integrated within Ascension’s data management system will begin reporting once the integration process is complete and data are available.

Seventy six percent of reporting facilities showed improvement compared with their CY 2010 baseline.
Although we did not reach the system-wide observed readmission rate goal of 9.00% by November 2012, the rolling 12 month rate trend shows a 3% decrease in observed readmissions from baseline to end of first quarter 2013.

Value

Ascension Health has shared knowledge across its network to create the Preventing Readmissions Bundle and has driven down readmissions for all patients and diagnoses through process improvement, knowledge sharing, and collaboration.
The Diabetes Health and Wellness Institute (DHWI) is a multifaceted health equity improvement and outreach model designed to improve healthcare access and health outcomes among people living in South Dallas.

DHWI is an affiliate of Baylor Health Care System (BHCS) and Baylor University Medical Center (BUMC), a not-for-profit organization providing services to a network of acute care hospitals and related healthcare entities, and a partner with the city of Dallas.

DHWI is comprised of four fundamental components:

- Collaborative financial support and governance;
- Integration of social, cultural, political, and economic initiatives;
- Removal of barriers to clinical care; and
- Community-based, multidisciplinary research.

DHWI opened in June 2010 to tackle the high prevalence of diabetes in South Dallas and reduce the number of diabetes-related emergency department (ED) visits to Baylor University Medical Center (BUMC) at Dallas.

The incidence of diabetes is increasing each year in Texas. In South Dallas, the rates exceed the norm. Diabetes affects 11.4% of the population in Dallas County, which is above both the state average of 10% and the national average of 8%.

Within the city of Dallas, people who live in the southern part of the city suffer more complications from diabetes and have a 17% higher rate of hospitalization for diabetes than people who live in any other area of Dallas County.

There is a lack of knowledge about preventing and managing diabetes among South Dallas residents and numerous barriers that make adopting a healthy lifestyle difficult. A community needs assessment revealed that many people believe their family history of diabetes makes developing the disease “inevitable.”

All incoming DHWI members complete a Health Risk Assessment (HRA) and undergo biometric screening to identify their health status and risk for developing diabetes. New members are paired with a DHWI Health Partner, who uses the HRA to develop a personalized plan of care that addresses beliefs and attitudes that negatively affect health status.

DHWI offers a clinic staffed by a team of physicians, nurses, care coordinators, and diabetes education specialists and provides healthcare delivery, diabetes self-management education, community health worker training, fitness programs, healthy cooking classes, the weekly Farm Stand, and the annual DHWI Healthy Harvest Fun Walk/5K Run.

Personalized care at DHWI includes:

- **Primary Prevention:** Providing lifestyle programming and personalized care to prevent diabetes.
- **Secondary Prevention:** Identifying and treating asymptomatic people who have risk factors for developing diabetes, early stage diabetes-related complications, or prediabetes with the goal of helping people reduce their risk of developing complications, reduce their healthcare costs, minimize hospital visits, and reduce lost work or school time.
- **Tertiary Prevention:** Caring for people who have diabetes by helping them regain their highest functional level, minimize the negative...
side effects of the disease, and prevent the progression of complications.

Education, personalized counseling, goal-setting, and evaluation of outcomes across the seven key behaviors for diabetes health helps patients understand how multiple factors can affect their glycemic control and overall health status. These include:

- Being active
- Reducing risks
- Healthy coping
- Problem solving

DHWI is based on the Chronic Care Model (CCM) for people with chronic disease. The CCM includes five core elements:

- Delivery system design
- Self-management support
- Decision support
- Clinical information systems
- Community resources and policies

### Metrics

As of May 2013, biometric assessments for diabetes patients compared to their baseline measurements show:

- 50.2% improvement in the proportion of members meeting A1c guidelines for optimal health (>7.0%);
- 37.8% improvement in the proportion of members meeting blood pressure guidelines for optimal health (<130/80 mm/Hg); and
- 22.4% improvement in the proportion of members meeting LDL guidelines for optimal health (≤100 mg/dl).

A 2010 study of DHWI members indicated a reduction in emergency department (ED) visits. Participants had 228 BUMC ED visits prior to enrollment in DHWI. Visits decreased to 137 after enrollment. The average difference in BUMC ED visits before and after enrollment is 0.514, or approximately one-half of a visit.

### Value

While elements of the DHWI’s multifaceted approach have been implemented and tested in other communities, DHWI reaches beyond the scope of these initiatives.

By improving the overall health and wellness of entire communities, programs like DHWI can translate into community revitalization and economic growth.
Overview

- BioReference Laboratories is among the largest clinical laboratories in the U.S. and the largest independent lab in the Northeast, focusing on molecular genetics, pathology, women’s health, routine clinical and inherited genetic disorders.
- GenPath, the company’s oncology division, saw an evolution in oncology diagnostics from merely determining the tumor type to now identifying the underlying genetic drivers of the patient’s cancer.
- In January 2011, BioReference entered into a licensing agreement with a leading cancer institution to address the unmet need for patient access to cost-effective, broad-based tumor profiling.
- The collaboration resulted in more personalized treatment options for cancer patients within their own communities and opportunities for patients to join clinical trials for the newest treatments.

Background

- Currently, 80% of cancer patients are treated in a community setting, rather than an academic institution, limiting their access to cutting-edge diagnostics.
- Only 3% of U.S. cancer patients are enrolled in current clinical trials, limiting advancement in cancer research and new therapeutic development.
- Each cancer tumor may harbor a specific set of mutations. Genotyping of these tumors can affect treatment decisions significantly and direct patients to appropriate clinical trials.

Description

- GenPath collaborated with Mass General Hospital (MGH), developer of a proprietary tumor genotyping assay, SNapShot, that identifies over 100 mutations across 14 cancer genes from 1 tissue sample.
- Through this tumor genotyping program, GenPath has been able to move cutting-edge technology from the research lab to the nationwide medical community. Since the launch of OnkoMatch, GenPath successfully matched hundreds of cancer patients to relevant clinical trials and/or FDA-approved targeted therapy.
- Doctors can now utilize therapies that are less toxic than chemotherapy and more targeted to the patient, as researchers have identified mutations that may cause some malignancies and indicate the likely progression of disease.
- OnkoMatch provides specific genetic information about a patient’s tumor that can direct clinical decisions and indicate interventions that may effectively “turn off” the drivers of the cancer.
- The GenPath reporting system uses ClinicalTrials.gov to match patients to suitable clinical trials offering therapeutic intervention. Physicians receive a written report that includes information on the specific mutation (if detected), tumor type, and current clinical trials.
- OnkoMatch finds one or more mutations in > 45% of all cases. More than 90% of patients with at least 1 mutation are matched to 1 or more clinical trials.

Metrics

- To illustrate the benefits of tumor genotyping, look at the adjunctive therapy being effectively employed following the diagnosis of colon cancer related to a PIK3CA mutation. Studies show that the regular use of aspirin is associated with higher survival rates for patients with mutated-PIK3CA.
  - In the referenced study, aspirin therapy appears to stop the progression of this particular cancer and resulted in an 82% reduction in overall mortality.
GenPath has processed more than 800 OnkoMatch tests finding a mutation positivity rate of about 45%. Almost 36% of tumors have multiple mutations, which may be relevant to patient management for dual targeted therapy.

**Value**

Prior to this technology, there was no cost-effective means of profiling tumors across more than 2 or 3 genes. The SNapShot assay was a scientific breakthrough, but was limited in access to academic settings.

- The partnership led to additional technological advances for a comprehensive, clinically valuable assay with a 4-day turnaround and a price of $395.

Use of this methodology provides a more effective, less expensive, and more benevolent approach to care because it:

- Provides a cost-effective test that does not overburden the healthcare system and minimizes patient out-of-pocket costs;
- Potentially reduces the use of ineffective add-on chemotherapy that causes harm without halting the progress of the specific cancer;
- Helps payers direct reimbursement for the most effective interventions;
- Opens the door to greater understanding of the function of genes and how mutations drive the development of cancer;
- Increases the profiling of tumors which will accelerate pharmaceutical research.
WELL@WORK

Overview

✶ BlueCross BlueShield of Tennessee (BCBST) has focused on the health and well-being of Tennesseans for more than 65 years. Today, BCBST serves 3 million members in Tennessee and across the country.

✶ BCBST is an independent, not-for-profit, locally governed health plan company that lives and works alongside local business customers and plan members.

✶ The vision of BCBST’s wellness program is to create a sustainable culture of wellness that serves as a model for customers and communities while producing an encouraging work environment.

✶ The program’s mission is to promote healthy lifestyle choices and enhance all forms of wellness for balanced, healthy living via accessible educational and support resources. The program objectives are in two parts: (1) improve employee lifestyle behaviors and related clinical outcomes relative to benchmarks; and (2) reduce demand for healthcare utilization, thereby controlling cost trends.

Background

✶ Unsustainable increases in the healthcare costs of BCBST’s workforce pushed BCBST to embark in 2009 on a multiyear effort to reengineer how employees are engaged.

✶ Also in 2009, BCBST moved into new corporate headquarters and leveraged the move to lay the foundation for a new culture of health. From that point forward, the program has come to exemplify BCBST’s corporate mission of becoming a true wellness company.

Description

✶ Building on previous efforts related to year-round health coaching, stress management, annual biometric screening, and health risk assessment (HRA), the new, comprehensive well@work program became fully functional in 2009 with the addition of:

• An on-site fitness center with group fitness classes;

• Expanded health coaching offerings; and

• Financial incentives for participation.

✶ In late 2010, a robust steps-based activity program was added.

✶ In 2012, a premium differential was added to medical benefits for program nonparticipants.

Metrics

✶ From 2008 to 2011, BCBST employees have demonstrated a decrease in healthcare costs compared with participants in a control group. Employees with more engagement have shown even greater savings.

✶ BCBST’s 2008—2011 healthcare cost, utilization, and medical care compliance trends have stabilized while population health has improved in the areas of smoking, exercise, cholesterol, and blood pressure, especially for those engaged in more than one wellness program offering.

• This improvement is particularly evident in the percentage increase of employees reporting they are getting the recommended amount of moderate exercise each week, rising from 44.7% in 2008 to 67.1% in 2011.

• BCBST exceeded HP2020 targets and CDC state benchmarks in the areas of exercise, smoking, cholesterol, and blood pressure, but not for BMI or consumption of fruits and vegetables.
Analysis of BCBST claims data indicates the wellness program is engaging costlier and sicker employees. Employees engaged with five or more programs from 2009 to 2011:

- Had higher Charlson Comorbidity Index scores at baseline than those with less engagement and had 24% to 30% higher total healthcare costs in 2008;
- Showed better chronic condition care compliance than those with fewer program engagements; and
- Drove an overall decline in hospital admissions for BCBST employees.

Value

Three-year total healthcare cost savings exceeded program costs by a margin of 2.29:1. Robust but costly participation incentives drove high program engagement, but also precluded total program ROI. Including incentive costs in the cost-benefit equation showed a ratio of 0.39:1. Including indirect cost savings from improved presenteeism and absenteeism rates may have resulted in break-even total ROI.
Overview

* Boehringer Ingelheim (BI) is one of the world’s 20 leading pharmaceutical companies. Since it was founded in 1885, the family-owned company has committed to making “more health” for patients and families, the community, and its employees.

* Commit to Health is BI’s U.S. benefit and employee wellness initiative. BI’s vision is to empower employees and their families to “Commit to Health” today for a healthy future. BI accomplishes its vision through an integrated team of professionals that provides employee benefits and wellness solutions to encourage optimal quality of life, health, and productivity. In addition to the overarching Commit to Health initiative, each BI subsidiary offers additional, location-specific resources and programs to employees and their families.

Background

* The Commit to Health program aligns with BI’s published statements on brand, purpose, and image. It aims to:
  * Create a culture of health for employees and their families;
  * Reduce indirect and direct healthcare costs; and
  * Keep healthy employees healthy.

* Analysis at Boehringer Ingelheim Pharmaceuticals, Inc. (BIPI) determined that the costs of medium-risk program participants are $3,336 more than the cost of low-risk participants. Similarly, high-risk participants had $6,691 more in average costs compared to low-risk participants.

Description

* The wellness initiative at BIPI is well-established with over 20 years of success. Key components of the Commit to Health initiative at BIPI include a health risk assessment, wellness screenings (metabolic syndrome, skin cancer, mammography), flu shots, nutrition, physical activity, weight management, and work/life effectiveness programs.
  * Employees with risk factors are invited to participate in the Improve What Matters program, which includes nutrition counseling and personal training.
  * Employees who participate in wellness activities can earn points redeemable for prizes and cash.

* BI provides onsite occupational health services, a fitness center for employees, their spouse/partner and retirees, healthy dining options, and indoor/outdoor walking paths. An annual fitness center reimbursement up to $150 is available for field sales-based employees.

* Families enrolled in BI’s medical plan through Aetna have access to health coaching, disease management resources, a nurse hotline, online wellness programs, an employee assistance program, and 100% coverage for preventive medical and dental healthcare. Plan-covered employees, spouses, or partners can participate in Aetna’s Healthy Actions and each earn up to $250.

* Keys to success:
  * **Partnerships** – BI marketing brands, BI business groups, leaders, and wellness champions keep goals aligned and maximize resources with collaboration with key departments;
  * **Program Plan** – BI reviews health claims, health risk appraisal results, consulting experts like the University of Michigan Health Management Research Center (UMICH-HMRC), and most importantly, employee interests;
  * **Program Design** – Health improvement programs are created using wellness research and
theories of behavior change. BI creates awareness about targeted health topics or problems by first launching a health education campaign and a way to assess health status, followed by programs to improve or maintain health status.

**Metrics**

* Program Participation
  - In 2012, program participation increased significantly. BI recorded 4,666 wellness encounters in 2011 and 12,657 in 2012. The unique participant number also increased by 172.

* Program Satisfaction
  - BI has a high satisfaction rate. Based on a satisfaction rating scale (5 = “very satisfied” to 1 = “very dissatisfied”), the average satisfaction score is 4.66.

* Health Improvements
  - Of Improve What Matters participants, 55% improved in all risk factors that qualified them for the program and 96% felt the program helped improve their health;
  - Of Eat Right for Life participants, 50% lost weight;
  - Of Watch Your Weight participants, 90% maintained their weight over the holiday season.
  - Of repeat participants, 93% retained their low risk status, and 84% of the overall participant population was identified as low risk.

* UMICH-HMRC uses the low-risk status percentage as a benchmark measurement. It advises companies to strive for maintaining 80% or more of its employees in the low risk category.

**Value**

* The estimated ROI from flu shot clinics for the 2011-2012 flu season was 3.5:1.
* BI’s excess cost level of 7.1% is better than the average cost of 20%-30%.

**Flow of Risk—Improve What Matters**
NATIONAL NURSING ROOM PROJECT

Overview

✳ As the business behind healthcare, Cardinal Health helps pharmacies, hospitals, ambulatory surgery centers, and physician offices focus on patient care while reducing costs, enhancing efficiency, and improving quality.

✳ Cardinal Health made the commitment to go above and beyond lactation room requirements mandated by the Patient Protection and Affordable Care Act.

✳ The primary goals of the National Nursing Room Project are to:
  • Create a supportive and inclusive culture for mothers returning from maternity leave;
  • Ensure consistency of comfortable nursing room accommodations across all Cardinal Health locations with 45 or more employees;
  • Emphasize the company’s commitment to Healthy Lifestyles and Work/Life.

✳ The National Nursing Room project was deployed and completed in 6 months, resulting in the renovation of 82 nursing rooms nationally.

Background

✳ Cardinal Health recognizes the impact that work/life resources have on employees. For 6 years, a comprehensive Healthy Lifestyles program has included both wellness and work/life benefits for employees and their families.

✳ In addition to work/life benefits offered year-around, each year Cardinal Health commits to making innovative progress in the evolving area of work/life effectiveness. A national lactation room project was identified as a top priority for 2012.

Description

✳ Cardinal Health spent $250,000 to renovate 82 facilities across the United States within six months.

✳ This ambitious goal required teamwork across the organization, and involved mass communications to site-specific human resources and facilities contacts, emphasizing quick turnaround for construction requests and order-form submissions.
  • Employee demographics at each location were considered to create sufficient capacity based on the location’s average age and percentage of women.

✳ This project resulted in a uniform standard for each Cardinal Health lactation room, ensuring an equitable and comfortable offering for nursing mothers across the country, whether they work at corporate headquarters or in a distribution center.
  • Rooms include comfortable chairs, refrigerators, cabinets, pictures, and soothing yellow paint. Medical curtains with subtle patterns were hung in lactation rooms with capacity for 2 or more mothers, and plumbing upgrades and sinks were assembled wherever necessary.
Metrics

✿ This project was deployed in 100% of Cardinal Health facilities with 45 or more employees.
✿ Although it is difficult to measure project outcomes since completion in December, 2012, Cardinal Health expects the following results:
   • An increase in employee loyalty and retention of returning mothers, leading to increased productivity and commitment to employer;
   • Increased visibility and utilization of Work/Life programs, leading to enhanced employee satisfaction;
   • Cardinal Health also expects to experience positive results as identified by the Healthy People 2020 Breastfeeding Objectives.

Value

✿ Although it is difficult to show a direct cost savings for the National Nursing Room project within the first year of implementation, Cardinal Health finds value in creating a supportive work environment. In addition, the company leads by supporting national initiatives such as the Healthy People 2020 Breastfeeding Objectives released by the U.S. Department of Health and Human Services and other research that supports the benefits of breastfeeding.
While growth in healthcare knowledge and technology is significant, the National Institutes of Health identifies spread of best practices as a key issue in medicine. Studies show that it takes 17 years on average for research findings to be fully implemented into clinical practice.

Cardinal Health is a healthcare services company with deep supply chain experience and innovative process improvement resources. From data analytics to formulary development to implementation and compliance support, Cardinal Health helps healthcare companies discover new ways of improving quality and satisfaction while lowering costs.

In 2008, 3 networks were established focused on improving patient outcomes: Ohio Children’s Hospital Solutions for Patient Safety (OCHSPS), Healthcare Value Network (HVN), and the Patient Safety and Clinical Pharmacy Services Collaborative supported by the Alliance for Integrated Medication Management (AIMM).

The Cardinal Health Foundation, focused on increasing the efficiency and effectiveness of healthcare, was the founding sponsor of OCHSPS and provides support for HVN and AIMM.

While each of the networks has slightly different frames of reference – high reliability vs. lean methodology vs. team-based medication management – each shares common strategies to improve patient outcomes and accelerate change.

Engage leadership through formal professional development and informal networking at the C-suite and board level.

Focus board meetings on patient outcomes rather than financials.

Start small with pilots and spread best practices.

Assure all voices are heard and respected.

Provide robust training programs with branded messaging to embed new thinking.

Include the patient and their families as a critical component of care.

Be informed by best practices and protocols.

Continuously track both processes and outcomes. Measure and share not only rates but the number of people affected, as well.

Let the data drive and inform the work.

Work transparently, sharing data broadly both internally and across the networks.

Use an all-teach, all-learn method where each institution plays a role in the network’s success.

Learn by experiencing.

Focus on continuous improvement.

Stay focused on the patient and patient outcomes with a goal of providing better patient care in the most efficient manner. Although the bottom line is important, the patient is the center of all decisions.
Ohio Children’s Hospital Solutions for Patient Safety represents a comprehensive effort to eliminate serious harm in children’s hospitals. What started as a collaboration of 8 children’s hospitals in Ohio now spans nearly 80 children’s hospitals across the U.S. – all working together to reduce specific hospital-acquired conditions by 40%, readmissions by 20% and serious safety events (SSEs) by 25%.

- Early Ohio work achieved a 60% reduction in surgical site infections and a 34.5% reduction in adverse drug events, saving more than 7,700 children from harm and avoiding $11.8 million in unnecessary healthcare costs;
- Since 2011, Ohio children’s hospitals have cut the incidence of SSEs in half;
- The national network has developed pediatric-specific measures and established shared national harm reduction goals.

The Healthcare Value Network includes healthcare leaders from 60 health systems in the U.S. and Canada focused on providing high-quality, cost-effective care through the application of lean concepts.

- Network providers have reduced patient falls with injury by more than 60%;
- Total parenteral nutrition (TPN) medication error rate has been reduced by more than 65% over 3 years.

Participating in networks of healthcare institutions that are focused on improved patient outcomes appears to be a very good value for time invested. Such networks have the ability to accelerate change, improve patient outcomes, and significantly reduce healthcare costs.

Metrics

Ohio Children’s Hospital Solutions for Patient Safety are expressed as a rolling 12 month average per 10,000 Adjusted Patient Days (APD).

- # of Serious Safety Events (SSEs)
- Serious Safety Event Rate (SSR)

- Goal (0.45)
- Baseline (0.9)

Serious Safety Events (SSEs) are defined as deviations from standard care resulting in severe harm to patients.
Cleveland Clinic's Center for Lifestyle Medicine

Overview

* Cleveland Clinic, a nonprofit multispecialty academic medical center, has consistently sought to shift the national focus from providing “sick care” to promoting wellness.

* As part of this commitment, Cleveland Clinic launched the Center for Lifestyle Medicine, a department focused on reversing or decreasing the effects of several common chronic diseases that plague the healthcare system.

Background

* The mission of the Center for Lifestyle Medicine is to make preventive medicine and wellness the driving force in medicine and society.

* Lifestyle interventions were developed based on more than 25 years of research, as well as the principle that lifestyle management can reverse a spectrum of common chronic conditions, such as obesity, diabetes, cardiovascular disease, and some early cancers.

Description

* Lifestyle 180®

  - Over the course of a year, participants meet on a regular basis in a stress-free setting to follow a 72 hour, evidence-based curriculum in a group setting, which includes:
    - Practical, attainable nutrition education taught by licensed, registered dietitians;
    - Hands-on cooking classes in a teaching kitchen with Cleveland Clinic chefs;
    - Exercise instruction, including resistance and strength training;
    - Instruction in breathing, meditation, and stress management techniques from behavioral health specialists and certified yoga therapists to encourage mindfulness in all choices and to address behavioral issues that are barriers to achieving optimal health.

  - The program also includes regular one-on-one sessions with a medical team to track biometrics, review changes in lab work throughout the year that may necessitate a decrease or elimination of medication(s), and establish realistic and achievable goals.

* Cardiac Lifestyle Intervention Program

  - Cleveland Clinic’s Wellness Institute is the first in Ohio to offer a three-month comprehensive Cardiac Lifestyle Intervention Program (CLIP) developed by Dr. Dean Ornish for people with heart disease.

  - Patients participate in a three-month course that involves 72 hours of intensive lifestyle intervention aimed at heart health. It includes:
    - Nutrition education to help participants adopt a low-fat vegetarian diet;
    - Monitored fitness to help participants start and gradually increase low-impact exercise;
    - Stress management to help participants better handle stress through relaxation techniques and meditation; and
    - A support group to help participants understand and gain support for emotional issues related to heart disease.

* Dr. Esselstyn's Program

  - This nutrition-based therapy program, developed by Caldwell Esselstyn Jr., M.D., educates patients with heart disease on plant-based, oil-free nutrition that has been documented to reverse heart disease.
• This program addresses the actual causes of heart disease—dietary choices.
• Each participant attends a single day, five-hour counseling seminar that includes review of epidemiology, mechanisms of action, plant food acquisition, preparation, and food label reading.

Metrics

• Lifestyle 180®
  • The Lifestyle 180® program launched in the fall of 2008. To date, it has provided guidance and support for more than 670 people to reverse disease and change their lives.
  • After 12 months of participation in the Lifestyle 180® program, participants with multiple chronic conditions experienced statistically and clinically significant health gains:
    - Decreased body weight, waist circumference, and blood pressure;
    - Improved cholesterol profile and glucose metabolism, and decreased inflammation;
    - Reversal of metabolic syndrome for 50% of affected participants;
    - Improved mood, reduced perception of stress, and better quality of life; and
    - Reduced medication use.
• Cardiac Lifestyle Intervention Program
  • The successful outcomes of the Cardiac Lifestyle Intervention Program have led Medicare and many private insurers to offer coverage of this program.
• Dr. Esselstyn’s Program
  • More than 89% of 198 participants with coronary artery disease who enrolled in Dr. Esselstyn’s Program adhered to his therapeutic diet during an average follow-up of 3.7 years.
  • Among nonadherent patients, more than two thirds experienced major adverse cardiovascular events.
  • In sharp contrast, among adherent patients there was only one major cardiovascular event; 22% of patients had documented disease reversal.

Value

• More than 130 million Americans are diagnosed with chronic disease and have a significantly higher than normal risk of death and disability. Preventable chronic diseases continue to drive healthcare costs substantially upward, in part due to a lack of sustainable treatment options. The Cleveland Clinic’s Center for Lifestyle Medicine is at the forefront of developing treatments that will improve health and lower costs for those with chronic disease.

C. R. Bard, Inc. (BARD) is a leading multinational developer, manufacturer, and marketer of innovative, life-enhancing medical technologies in the fields of vascular, urology, oncology, and surgical specialty products, employing over 12,000 people around the world.

Over the past several years, clinically significant advances in urological infection control have contributed to a reduced incidence of catheter-associated urinary tract infections (CAUTIs).

BARD has been at the forefront of these advances with the BARDEX® I.C. Anti-Infective Foley Catheter with Bacti-Guard® silver alloy coating.

CAUTIs are one of the most common healthcare-associated infections in acute care hospitals, even though up to 69% of these infections are preventable.\(^1\)

The economic impact of CAUTI is substantial, costing the healthcare system over $500M each year.\(^2\)

Despite the surveillance definition change for CAUTI, asymptomatic bacteriuria is often treated, thus increasing the inappropriate use of antibiotics and potentially increasing the risk of antibiotic resistant infections.\(^3\)

It is well known that biofilms containing microorganisms can develop intralumenally or extralumenally in urinary catheters. Technology that may prevent biofilm formation is a logical goal for reducing the risk of CAUTI.

CAUTIs are one of the hospital-acquired complications chosen by the Centers for Medicare and Medicaid Services (CMS) for which hospitals no longer receive additional payment.

Bacti-Guard® Silver Alloy and BARD® Hydrogel coatings are permanently bonded to surface of the BARDEX® I.C. Anti-Infective Foley Catheter.

- The synergy between these coatings provides the catheter its unique anti-infective properties;
- Silver ions penetrate pathogens on or near the surface of the catheter and minimize adherence of the microorganisms, including gram-negative bacteria, gram-positive bacteria and yeasts.

The BARDEX® I.C. Anti-Infective Foley Catheter's unique, permanently bonded coating remains intact while indwelling in the patient absorbing mucosal fluid, forming a “cushioned” barrier between the catheter surface and urethral tissue.

- This lubricious surface resists bacterial adherence and reduces the risk of biofilm formation – a common cause of antibiotic resistant infections – and allows for non-abrasive insertion and removal.
The BARDEX® I.C. Anti-Infective Foley Catheter has been documented in the literature, and has been shown in multiple clinical trials to reduce the risk of catheter associated urinary tract infections.

- In a recent multi-center study assessing the impact of the BARDEX® I.C. Anti-Infective Foley Catheter with Bacti-Guard® Silver Alloy and BARD® Hydrogel Coating on symptomatic catheter-associated urinary tract infections, the authors demonstrated a 58% relative reduction in the NHSN CAUTI rate as compared to standard catheters. (0.60 per 1,000 patient days vs. 0.25 per 1,000 patient days) (odds ratio 0.42; p<0.0001; 95% C.I. 0.34-0.53).4
- The same study noted a dramatic reduction in antimicrobial therapy days for the treatment of CAUTIs (From 1,165 in the standard catheter group to 406 in the BARDEX® I.C. Anti-Infective Foley Catheter group).4

Another study demonstrated the occurrence of UTI is 3.7 times greater in patients catheterized with a standard catheter than in patients catheterized with the BARDEX® I.C. Foley Catheter with BARD® hydrogel and Bacti-Guard® silver alloy coating (95 C.I. 2.0-6.8).

By reducing the number of CAUTIs each year, BARD is working toward improving patient safety and quality, as well as reducing healthcare costs.

Please consult product labels and inserts for any indications, contraindications, hazards, warnings, cautions and directions for use. Bard and Bardex are trademarks and/or registered trademarks of C. R. Bard, Inc.

THE BARD LIVE WELL PROGRAM

Overview

- C. R. Bard, Inc., (Bard) is a leading multinational developer, manufacturer, and marketer of innovative, life-enhancing medical technologies in the fields of vascular, urology, oncology, and surgical specialty products, employing over 12,000 people around the world.
- As a company in the healthcare industry, Bard has always regarded the health of its employees as a priority.
- In order to promote the health and well-being of employees, Bard offers a fully integrated employee health and wellness program that features lifestyle risk management, health coaching, and disease management.

Background

- With the cost of healthcare increasing steadily year after year, Bard thought it prudent to look at ways to help employees manage and improve their health.
- The vision for the Bard Live Well program was to create a culture that promotes the health and well-being of employees by providing a program designed to improve their overall individual health, encourage responsible and healthy behavior, increase health awareness, and reduce health-related costs for the company.
- Launched on April 1, 2012, the Bard Live Well program involves a multiyear strategy based on the identification of lifestyle risk information from employees and their spouses.

Description

- The Bard Live Well program is designed to engage employees and their spouses in health awareness, coaching, and behavior modification in an effort to lower the incidence of lifestyle risks and chronic health conditions.
- Employees are required to complete a Member Health Assessment questionnaire and biometric screening by May 31 of each year.
- Beginning in the second year of the program, spouses who are covered under the Bard medical plan also completed a Member Health Assessment questionnaire.

Metrics

- In the first year of the program, 91% of medical plan members (representing an estimated 79% of employees eligible for benefits) completed a Member Health Assessment and biometric screening during the assessment period in April and May of 2012.
• More than 800 employees engaged in U.S.-wide walking program;
• More than 250 employees engaged in a U.S.-wide weight loss challenge;
• More than 600 employees have engaged with a health coach; and
• More than 175 chronically ill employees have engaged in a care plan.

Value

If employees are able to make wise healthcare and lifestyle decisions, Bard can improve employee absenteeism and increase productivity, while simultaneously decreasing out-of-pocket costs for employees and reducing the company’s overall healthcare expenditure.
Overview

- Edwards Lifesciences is the global leader in the science of heart valves and hemodynamic monitoring.
- Edwards’ tissue replacement heart valves and heart valve repair devices are utilized by surgeons worldwide to help in the treatment of the approximately 300,000 patients who undergo heart valve procedures globally each year.

Background

- Aortic stenosis (AS) is a narrowing of the aortic valve that prevents normal blood flow. Once a patient develops severe symptomatic AS, typical symptoms include angina, syncope, shortness of breath, fatigue, and heart failure.
- After symptom onset, AS progresses rapidly and is life threatening.
- Without a valve replacement, about 50% of severe symptomatic AS patients die within 2 years. Unfortunately, many patients are not treated with the gold standard – aortic valve replacement (AVR) – because of prohibitive surgical risk caused by underlying medical or anatomical conditions.

Description

- Transcatheter Aortic Valve Replacement (TAVR): Edwards has developed a less-invasive treatment option to replace the native aortic valve without the need for open-heart surgery. A catheter is inserted into a small incision in the leg or in the chest, and then delivered to the heart. The procedure is done while the heart beats.
- This therapy has fostered a shift in clinician partnership, resulting in a dedicated heart team approach to treating patients with severe AS. Cardiothoracic surgeons, cardiologists, echocardiographers, and anesthesiologists collaborate in an interdisciplinary approach to provide the best possible patient-centered care.

Metrics

- For patients who are too sick to undergo surgery, TAVR improves survival by 20 percentage points at one year, compared with the current standard of care. The survival benefit for TAVR further improves to 25 and 27 percentage points at two and three years, respectively.
- These TAVR patients also report a profound improvement in their quality of life – tantamount to a 2-level improvement in New York Heart Association (NYHA) functional class and a 10-year reduction in effective age.
- For high-risk surgical patients, TAVR provides a less-invasive, clinically proven alternative that does not
require opening the chest or placing the patient on heart-lung bypass. TAVR results in faster procedure times, shorter post operative hospital stays, and shorter recovery periods compared with surgical AVR.

* Landmark studies have indicated that TAVR is a cost-effective therapy compared with commonly used therapies for other highly comorbid conditions.

**Value**

* TAVR addresses the urgent medical needs of patients suffering from AS who are determined to be inoperable or at high risk for surgery, and who currently have no or few viable treatment options.

* The emergence of this therapy has fostered the establishment of specialized centers that manage patients using a multidisciplinary heart team to ensure the most successful patient outcomes. Appropriate and timely access to this proven therapy is supported by comprehensive clinical, quality-of-life and economic evidence, demonstrating TAVR’s ability to significantly enhance patient well-being in a cost-effective manner.
EVIDENCE-BASED CARE FOR HOSPITALIZED DIABETICS

Overview

* Our Lady of Lourdes is a 186-bed hospital in Lafayette, LA. Lourdes is a subsidiary of the Franciscan Missionaries of Our Lady Health System (FMOLHS), which is the largest locally owned, not-for-profit health system in Louisiana. FMOLHS’s mission is to extend the healing ministry of Jesus Christ to God’s people, especially those most in need.

* Our Lady of Lourdes has provided comprehensive healthcare to the people of Acadiana for more than 60 years and employs more than 1,200 people, in addition to over 400 physicians in a variety of medical and surgical specialties. Additional services include multiple clinics, four imaging locations, and a primary care physician network.

* As diabetes is prevalent in Louisiana and in this region, attention to this population is a part of the Our Lady of Lourdes ministry and its drive to provide “healthcare to the highest power.”

Background

* In hospitalized patients with diabetes, coordination of meal times with administration of short-acting insulin is often poor, increasing the patient’s risk for hypoglycemic episodes. Hypoglycemic events in hospitalized diabetics are associated with:
  - Increased median length of stay (LOS) (4.2 days);
  - Increased median inpatient charges ($15,806); and
  - Increased hospital mortality (87%).

* Data showed that hospitalized patients at Lourdes were receiving capillary blood glucose (CBG) 75 minutes before breakfast, but guidelines jointly released by the American Diabetes Association and American Association of Clinical Endocrinologists in 2009 recommended coordinating short-acting insulin within 15 minutes of food intake.

**Redesigned Workflow to Promote Meal-Insulin Coordination**

- **CA (7am shift)**
  - Day CA completes CBG and documents in Cerner via PDA
  - CA prepare patient for breakfast
  - Tray delivered to patient
  - Patient starts eating
  - Stop

- **Dietary**
  - Diet log reviewed and starts tray assembly
  - Dietary person starts filing trays
  - Tray leaves dietary
  - Tray arrives on 3 East
  - Food cart log sheet signed

- **3 East Nurse**
  - Doc order
  - Get’s change of shift report from patient
  - Review CBG Cerner results
  - Administers sliding scale insulin based on CBG
Description

Time studies were used to analyze the time needed to provide meals to patients. Based on feedback from team members and subject matter experts, the following practices were implemented:

• The day shift measures blood sugars and administered insulin in lieu of the night shift.
• The night staff takes responsibility for wound care.
• One nurse assistant delivers the meal trays, allowing others to prepare the patients for their meals.
• Nurses are notified to administer insulin within 15 minutes of meal tray delivery.
• Food Services adjusted meal times and snacks.
• The pharmacy changed insulin administration times.

Selected front line team members were responsible for educating everyone on the new process and for implementing the team’s recommended changes. This included:

• Discussing revised policy and competencies;
• Providing education on new processes at department meetings;
• Designating the nurse assistant as the “Champion for Change;”
• Ongoing monitoring and communication with staff; and
• Emphasizing patient empowerment via a Bill of Rights.

Metrics

• Due to department collaboration and coordination, the percent of blood glucoses administered between 7 a.m. and 8 a.m. (the preferred time) increased from 4.6% to 85.6%.
• As a result, the “spoon to tongue time” (STT) (the time from when insulin is given to the time the patient ate breakfast) decreased from 81 minutes to 9 minutes.
• LOS decreased from 6.21 to 5.88 from the time period 8/8/10 – 10/11/10 with the new process.

Value

• Over 126 days before meal insulin coordination was implemented, Our Lady of Lourdes diabetes patients had 47 hypoglycemic events, costing approximately $15,806 per patient. Projected over the year for the entire hospital, this created a $2,280,384 per year cost.
• The value to diabetic patients includes decreased LOS, and the elimination of the cost associated with excess LOS and treatment of hypoglycemic episodes.
HEALTHY LIVES™

Overview

* Franciscan Missionaries of Our Lady Health System (FMOLHS), headquartered in Baton Rouge, LA, provides care to 40% of Louisiana’s population and includes four hospitals, more than 10,000 team members, and 2,000 physicians.

* FMOLHS established a strategic imperative to serve as a leader in healthcare reform. A new arm of the organization, Franciscan Health and Wellness Services, was created to explore innovative models of care in the area of population health management.

* Franciscan Health and Wellness Services developed and implemented the Healthy Lives™ program in the 2011 benefit year for its team members and dependents to build a healthier workforce and improve the value of healthcare delivery.

* Since its introduction with the 2011 benefit year, Healthy Lives™ has improved the health of FMOLHS team members and reduced overall health plan costs.

* FMOLHS began sharing Healthy Lives™ with other employers and health systems in January 2012. Since then, 30 employers, including three health systems, are implementing the Healthy Lives™ program, which represents nearly 80,000 lives across eight states. The model is now being expanded to manage the health of other populations, including Medicaid and the uninsured.

Description

* Rising healthcare costs and escalating concerns over healthcare reform are causing employers to seek innovative, value-driven models of care delivery. Local employers looked to FMOLHS and its affiliated hospitals, as the trusted resource and experts in healthcare, for practical solutions.

* Healthy Lives™ is a comprehensive wellness program based on a best-practice, holistic model of care developed by physicians and other clinicians that is rooted in evidence-based medicine.

* Healthy Lives™ has four components that provide a cost-effective program for employers:
  
  - Creation and analysis of a comprehensive workforce population profile, using a robust analytics program that draws from several data sources, including medical and pharmacy claims, in order to understand a company’s health risks;
  
  - Biometric screenings and health risk assessments of employees along with the other data sources model the risk and create a detailed health risk report for each employee. While individual health information is private, the company receives a report outlining the health risk profile of the company’s workforce in aggregate;
  
  - Wellness services are customized for a company and its employees based on the data and culture and include consultation on incentives, health education, and clinical expertise;
  
  - Health coaching by local, registered nurses and dieticians, who provide support and motivation to help employees overcome obstacles to reach their health and wellness goals. When needed, the coaches work collaboratively with physicians.

Background

* After a review of the dramatic growth in health plan expenses, FMOLHS leaders realized that if utilization continued at the same rate and the health of the population did not improve, covering employees and their families under the current benefit structure was unsustainable.
Metrics

Based on data from the 2011 and 2012 program years, Healthy Lives™ has demonstrated value through improved health of FMOLHS team members and has reduced overall health plan costs. Results include:

- Member participation in Healthy Lives™ is at 80%, up from 47% prior to implementing the program;
- Population risk profiles exhibit a positive trend in risk reduction, with overall reduction of high-risk members from 11% in 2009 to 6% in 2012, suggesting improvements in care management consistent with Healthy Lives™ health coaching and care management models;
- Positive trends in utilization and medical management of the population continued in 2012, with a 3% reduction in hospitalizations and a 60% reduction in readmissions. (Decreased hospitalizations drive decreased health plan costs.);

Value

- Evidence-based, quality-of-care performance scores continued overall positive trends since 2009, with a focus on wellness/prevention, diabetes, high cholesterol, and high blood pressure.
- Total health plan expense for 2012 continued a downward trend from expected costs since 2009.
- Total health plan expense per employee per year (PEPY) was $11,419, performing below the national benchmark mean (Towers Watson/NBGH 2012).
- FMOLHS projects a 4:1 return on its investment over five years. This equates to $37.3 million in savings to the health plan and a savings of 1.7 days per year per employee in absenteeism costs.
ACCOUNTABLE CARE ORGANIZATION (ACO) SHARED SAVINGS AGREEMENT

Overview

Health Care Service Corporation is the country’s largest customer-owned health insurer and fourth-largest health insurer overall, with more than 13.7 million members in its Blue Cross and Blue Shield plans in Illinois, Montana, New Mexico, Oklahoma, and Texas.

Blue Cross and Blue Shield of Illinois (BCBSIL), the state’s largest health insurer, and Advocate Health Care, Illinois’ largest healthcare system, launched an accountable care organization (ACO) in late 2010, as a three-year shared risk agreement that rewards improved care quality and value.

Goals include: continuously improving clinical quality, patient safety, and patient satisfaction, while also working to contain healthcare costs—curbing medically unnecessary admissions, ER visits, and 30-day readmissions.

Background

The ACO consists of 450,000 BCBSIL members—250,000 who seek episodic care (e.g., surgery) and 200,000 who have a personal physician at Advocate Health Care.

BCBSIL’s goals:
• Reduce Advocate’s medical cost trends to lower pricing;
• Develop replicable approach to total cost management via an ACO model in a PPO product;
• Facilitate market transition to value-based care.

Advocate’s goals:
• Sufficiently reduce costs on a total per member basis to enable participation in exchange network products;
• Leverage infrastructure investments to better manage risk;
• Align incentives.

Description

The organizations have a three-year (2011 – 2013) shared savings PPO agreement that includes a global risk HMO agreement. They share both the risks and benefits of the endeavor.

When medical cost trends improve and patient quality, safety, and satisfaction metrics are met, then BCBSIL and Advocate will share in the savings.

The program is currently administered at nine Metro Chicago, IL hospitals and one Bloomington, IL hospital.

The collaboration facilitated both companies’ progress from volume-based to value-based service, while it supported ongoing investments in new technologies and services.
Metrics

- Outperformed unadjusted cost trend by about 2% in year one.
- Maintained targeted high-level performance on clinical quality and service metrics.

Value

- Blue Cross and Blue Shield of Illinois added Advocate to its low-cost HMO network, creating a product that better served consumers while also achieving further moderation of medical cost trends, leading to lower prices for consumers.
- Advocate Health Care grew new market share and reduced costs without sacrificing revenue.
- The collaboration facilitated both companies’ progress from volume-based to value-based service, while it supported ongoing investments in new technologies and services.
- The expanded long-term strategic partnership allows both companies to focus on future innovation in improving care for consumers.
SHARED DECISIONS, SHARED SUCCESS

Overview

✳ Health Dialog has been a leading provider of healthcare analytics and decision support that helps health plans, employers, and physician groups improve healthcare quality while reducing overall costs since 1997.

✳ Shared Decision Making is a process that aims to give patients the care they want and nothing less, and the care they need and nothing more. Patients use an evidence-based, unbiased medical decision aid followed with constructive discussion between patient and physician.

✳ When patients have the tools and information they need to make their own healthcare choices, they become more engaged and satisfied with their care. This increased collaboration between patients and their physicians also reduces costs and utilization while improving healthcare quality for health plans and employers.

Background

✳ Although medical decisions are very common, there are important deficits in information sharing between physicians and patients and in the level of involvement that healthcare consumers have in their decisions.

✳ A study published in the February 2013 issue of Health Affairs shows that providing patients Shared Decision Making-based health coaching reduces the overall costs of care, hospitalizations, and surgeries dramatically.¹

✳ Some 60,185 individuals with a preference-sensitive condition (such as angina, joint arthritis, back pain, benign uterine conditions, and early-stage prostate cancer) participated in a year-long study. Patients with these conditions frequently encounter complex treatment decisions in which multiple viable options are available with substantial trade-offs between benefits and risks to the patient.

Description

✳ The study compared the effects on patients engaging in key health and treatment decisions receiving a usual level of support with the effects of receiving enhanced levels of support.

✳ A team of healthcare coaches including registered nurses, dieticians, respiratory therapists, and pharmacists provided healthcare coaching. Health coaches were trained to give study participants knowledge and awareness of their treatment options, engage them in discussions to help them sort out their treatment preferences, and encourage them to communicate those preferences to their healthcare providers.

✳ The health coaching included telephone contact and access to educational material, literature, and videos that could be mailed, emailed, or delivered giving unbiased information about the pros and cons of multiple treatment options.

Metrics

✳ Compared with patients who received the usual level of support, patients who received enhanced support had:
  - 5.3% lower medical costs (including 8.7% lower costs for those with heart conditions);
  - 12.5% fewer hospital admissions; and
  - 9.9% fewer preference-sensitive surgeries (including 20.9% fewer preference-sensitive heart surgeries)
The enhanced support intervention saved more money than it cost to deliver.

- The monthly cost to deliver the intervention was less than $5.00 per member while the average savings was $23.27 per member, producing a net savings of more than $18.00 per member per month.

- A separate study found that the introduction of certain decision aids by healthcare providers was associated with 26% fewer hip replacement surgeries, 38% fewer knee replacements, and 12%–21% lower costs over six months among patients of a large health system.\(^2\)

Recent federal and state policies advocate shared decision making, including the Affordable Care Act (ACA), Medicare's Shared Savings Program and its Pioneer Accountable Care Organization program, and the Center for Medicare and Medicaid Innovation's Health Care Innovation Challenge funding opportunity. In addition, legislation enacted in Washington State has created pilot projects in partnership with its leading health plans and providers to test the outcomes of broad-scale implementation, and Maine has a pilot project assessing shared decision making as a key aspect of patient-centered care. Measures of shared decision making are also being used by a variety of accreditation and measurement standards organizations.

---

HEALTHWAYS

DR. DEAN ORNISH’S PROGRAM FOR REVERSING HEART DISEASE

Overview

* Healthways is the largest independent global provider of well-being improvement solutions that optimize individuals' health and productivity while reducing their health-related costs.
* Healthways is the exclusive provider of Dr. Dean Ornish's Program for Reversing Heart Disease, the first program scientifically proven to reverse heart disease without drugs or surgery.
* The 72-hour outpatient experiential program is a noninvasive, physician-led treatment option that combines four components – fitness, nutrition, stress management, and love and support – to slow, stop, and even reverse the progression of coronary artery disease.
* In January 2011, Medicare began covering Dr. Dean Ornish’s Program for Reversing Heart Disease under a new benefit category, “intensive cardiac rehabilitation.”

Background

* For more than 35 years, Dean Ornish, M.D., and his colleagues at the nonprofit Preventive Medicine Research Institute (PMRI), in collaboration with the University of California, San Francisco and other leading academic institutions, have conducted a series of research studies showing that changes in diet and lifestyle can make a powerful difference in our health and well-being, how quickly these changes may occur, and how dynamic these mechanisms can be.
* Findings from these studies have been published in the world’s leading peer-reviewed journals, and Dr. Ornish is the author of six best-sellers, including in 1990 with Dr. Dean Ornish’s Program for Reversing Heart Disease.
* In addition, these studies have documented that the progression of other chronic diseases such as type 2 diabetes and early stage prostate cancer may also be reversible by making significant lifestyle changes.

Description

* Dr. Dean Ornish’s Program for Reversing Heart Disease helps participants make healthy, sustainable lifestyle changes in what they eat, how they respond to stress, how much activity they have, and how much love and support they have.
* The primary determinant of the degree of improvement is not age, disease severity, or genetics, but the degree of change in diet and lifestyle.
* Certified sites have a dedicated team of caring professionals that support individuals at every step, including a physician, nurse case manager, exercise physiologist, clinical psychologist, registered stress management instructor, and registered dietician.
* Participants meet for 18 four-hour sessions over a 9-, 12-, or 18-week period (depending on the format offered at a particular site).
* After 72 hours of training, participants move into a “self-directed community” in which they...
continue to meet on a regular basis to support the lifestyle changes.

Healthways trains and certifies health systems, health plans, hospitals, and physician groups, allowing them to deliver the program in a consistent fashion.

**Metrics**

- Findings from all of the 3,780 patients who went through Dr. Dean Ornish’s Program for Reversing Heart Disease via Highmark Blue Cross Blue Shield in Pennsylvania, Nebraska, and West Virginia (as of October 2011) include the following:
  
  - Overall attendance after 1 year was 87.9%.
  - Of these patients, 45.2% had heart disease, 34.0% had type 2 diabetes, and the others had only risk factors (high blood pressure, cholesterol, or weight), yet adherence was comparable in all categories of patients (85-90% after 1 year);
  - The average patient lost 13.3 pounds in the first 12 weeks and 15.9 pounds after 1 year;
  - Significant reductions in systolic blood pressure, diastolic blood pressure, total cholesterol, triglycerides, and LDL-cholesterol after 12 weeks were still significant after 1 year.
  - Exercise capacity increased from 8.7 to 10.6 METS after 12 weeks (18% increase) and to 10.8 METS after one year (24% increase);
  - Significant reductions in depression and hostility (the emotions most strongly linked with heart disease) after 12 weeks were still significant after 1 year;
  - Hemoglobin A1c in diabetics decreased from 7.4% at baseline to 6.5% after 12 weeks and 6.8% after one year (complications of diabetes such as blindness, kidney failure, heart disease, and amputations can be prevented when hemoglobin A1c is less than 7.0%);
  - After 1 year, 96.5% of patients reported improvement in severity of angina (chest pain).

**Value**

- Patients have better adherence and clinical outcomes than have ever been reported from a program of comprehensive lifestyle changes.
- The program, the efficacy of which has been rigorously evaluated in numerous peer-reviewed studies, offers a significantly less expensive alternative to surgery.
- Medicare coverage for the program – the first time that Medicare has covered an integrative medicine program – is indicative of its value.
Healthways is the largest independent global provider of well-being improvement solutions that optimize individuals’ health and productivity while reducing their health-related costs.

SilverSneakers, the nation’s leading physical activity program designed exclusively for older adults, provides activity, healthy lifestyle support, and socially oriented programming to help seniors take greater control of their health.

More than 10 million Medicare beneficiaries are eligible for the program, including 7.4 million Medicare Advantage and 2.7 million Medicare Supplement members.

SilverSneakers has been helping improve the lives of older adults and reduce healthcare costs for nearly 20 years.

Emphasizing wellness and prevention, SilverSneakers improves the lives of Medicare Advantage members, Medicare Supplement subscribers, and group retiree plan members across the nation.

No other program currently available offers the scope and depth of SilverSneakers, the most comprehensive fitness program available to Medicare-eligible adults.

SilverSneakers is convenient and accessible, available at more than 11,000 fitness and wellness centers across the country, including sites at community centers and churches.

SilverSneakers includes a variety of robust offerings to engage members in improving their health.

- **Fitness membership:** Use of amenities and signature SilverSneakers group fitness classes at more than 11,000 locations nationwide; certified instructors trained specifically in older-adult fitness; Program AdvisorSM for guidance and assistance; social and educational events;

- **FLEX:** Classes and activities outside the traditional fitness location include tai chi, yoga, and walking groups; led by certified instructors at parks, recreation and senior centers, churches, and other local venues;

- **SilverSneakers® Steps:** Alternative for members who cannot get to a fitness location; choice of four kits – general fitness, strength, walking or yoga – for fitness at home or on the go;

- **Online resources and support:** At silversneakers.com, members can look up fitness locations, find FLEX classes and enroll, and request a replacement ID card.

Healthways joins with an array of community fitness providers – private and public – to deliver these assets.

- Variety of quality offerings, including a fitness membership with national reciprocity;

- High-touch member engagement tactics, including a Program Advisor, a dedicated fitness staff person serving as members’ program liaison;
• Options outside the traditional fitness location;
• Opportunities for enhancing social well-being;
• More than 6,500 certified instructors specifically trained in older-adult fitness, and certified by nationally accredited organizations;
• Dedicated local field staff comprising more than 300 instructor coordinators and fitness account managers.

**Metrics**

* SilverSneakers members are healthier in mind, body, and spirit.
  * Some 60% of SilverSneakers participants responding to the 2012 Annual Member Survey reported their health as “excellent” or “very good,” compared with only 32% of older adults nationally.

* According to a study funded by the Centers for Disease Control and Prevention (CDC) and published in Preventing Chronic Disease, SilverSneakers participants utilize preventive care more often, are admitted to the hospital less often, and have lower overall healthcare costs.

* Older adults with diabetes who participate in SilverSneakers are admitted to the hospital less often, have lower inpatient care costs, and have significant reductions in their overall healthcare after only a year of participation, according to a study published in Diabetes Care, the journal of the American Diabetes Association.

* A study published in the American Journal of Preventive Medicine also found that SilverSneakers is associated with significantly lower risk of depression in older adults.

* A 2013 Population Health Management study, “Impact of a Senior Fitness Program on Measures of Physical and Emotional Health and Functioning,” found that participation in SilverSneakers is associated with better physical and emotional health, higher functioning and lower disability among seniors across many measures. This allows members to remain independent and postpone the need for long-term care.

**Value**

* **SilverSneakers attracts more health plan members:** 78% of all Medicare Advantage respondents to the 2012 Annual Member Survey indicated SilverSneakers was an important factor in their decision to join their health plan.

* **SilverSneakers increases loyalty and retention:** 60% of 2012 Annual Member Survey respondents said their health plan’s offering of the program makes them more likely to stay with their plan.

* **SilverSneakers reduces claims costs:** One national client realized up to 37% in reduced claims costs and hospital admissions for SilverSneakers members compared with nonparticipants in the third year of a member/nonmember study.

* **SilverSneakers supports health plans’ star ratings:** The program indirectly and directly supports multiple star ratings on up to 16 performance and quality measures.
Overview

Ikaria, Inc. is a critical care company focused on developing and commercializing innovative therapies designed to address the significant needs of critically ill patients. Ikaria has executed and supported clinical trials in more than 4,000 critically ill patients across multiple ICU settings.

Ikaria’s lead product is INOMAX® (nitric oxide) for inhalation, a pharmaceutical drug in gas form that is FDA approved to treat hypoxic respiratory failure (HRF) in term and near-term infants.

INOMAX® is provided as part of an all-inclusive offering of the drug itself, use of proprietary delivery systems, onsite training, and 24/7 technical assistance and support, which is known as the INOMAX Therapy Package.

The INOMAX Therapy Package is marketed in the United States, Puerto Rico, Canada, Australia, Mexico and in Japan, where INOMAX is marketed as INOflo®.

Background

Newborns with HRF do not get enough oxygen into their blood. Newborns with this form of respiratory failure are unable to breathe on their own and have high blood pressure in the blood vessels of their lungs, which is known as pulmonary hypertension.

Since 1999, INOMAX is the only FDA-approved therapy for the treatment of HRF. Treatment with INOMAX reduces the need for extracorporeal membrane oxygenation, a highly invasive and expensive procedure that requires the use of a heart-lung machine.

INOMAX® is mixed with oxygen in a ventilator. The drug relaxes the blood vessels so blood flow improves. This allows more oxygen to be picked up by the bloodstream and improves oxygen levels in the infant’s blood.

Description

INOMAX is delivered through Ikaria’s proprietary drug-delivery systems, which feature intelligent software to ensure safe, consistent, and reliable delivery and monitoring of drug therapy, as well as compact size and weight that allow use at bedside and during transport.

- INOMAX® DS - The second-generation drug-delivery system
- INOMAX® DSIR - This third-generation drug-delivery system utilizes infrared technology to expand the informatics connecting the system with the cylinder containing INOMAX, ensuring ‘whole-of-system’ integrity.
- INOpulse® DS - This portable, investigational, future-generation device, engineered to deliver inhaled nitric oxide to spontaneously breathing patients, is being utilized in trials for pulmonary arterial hypertension (PAH) and pulmonary hypertension secondary to chronic obstructive pulmonary disease (COPD).

Metrics

- Rapid and sustained oxygenation: Adding INOMAX significantly improves PaO2 in as little as 30 minutes, demonstrated in trial after trial.
- Effective across disease severity: Adding INOMAX improves oxygenation, independent of baseline OI.¹
- Decrease the probability of developing severe HRF: Fewer infants progressed to an OI>40 with INOMAX.
- Improve OI over time: In patients with moderate HRF (10<30), adding INOMAX significantly improved OI over 48 hours.²
Less median time on ventilation: Adding INOMAX shortens time on mechanical ventilation, as shown in a retrospective pooled analysis of 3 controlled studies. The median time on mechanical ventilation was 11 days in the ventilation + INOMAX group versus 14 days in the ventilation-alone group.\(^1\)

Less median time on oxygen: Adding INOMAX shortens time on oxygen therapy, as shown in a retrospective analysis of data from the CINRGI study. The median time on oxygen therapy was 17 days in the ventilation + INOMAX group versus 34 days in the ventilation-alone group.

In a separate randomized, controlled, open-label study of early versus late INOMAX treatment in 56 term and near-term infants with moderate HRF, the median time on oxygen therapy in the early INOMAX group was 11.5 days versus 18 days in the control group (P<0.03).\(^2\)

Value

Critical care medicine is primary care for the critically ill patient, whose illnesses or injuries present a significant danger to life, limb or organ function.

- Five million Americans will be admitted into the ICU each year, with some 56,000 patients treated in ICUs each day.
- While the critical care market is large, it is easy to reach and impact due to the concentration of ICUs. According to data from the Hospital Cost Report Information System, or HCRIS, in 2005, there were more than 3,000 hospitals in the U.S. with more than 90,000 ICU beds, 80% of which are located in only 1,300 of these hospitals.
- In the United States, approximately 80 percent of individuals will experience a critical care injury or illness as a patient, a family member or a friend.

The use of INOMAX in newborns with HRF may also reduce the need for a procedure called extracorporeal membrane oxygenation (ECMO). ECMO requires surgery to remove blood from the baby’s body and flow it through a machine that adds oxygen back into the blood and then returns it to the body.


Overview

★ Ikaria, Inc. is a critical care company focused on developing and communicating therapies designed to address the significant needs of critically ill patients.
★ Living Well aims to improve the health and well-being of Ikaria employees and their families. Healthy families, in turn, encourage employee productivity and improved attendance.
★ Dedicating wellness resources allows Ikaria to support individual employee goals for health and fitness, and makes it easier for employees to invest in themselves.

Background

★ It is not always easy to balance work life and personal life, so Ikaria has brought resources directly to the employee.
★ Ikaria’s leadership understands the importance of making an investment in employees and their health.

Description

★ Living Well consists of numerous components, including:
  • Weight Watchers on-site;
  • Fitness facilities and opportunities, on-site;
  • Annual health screenings, on-site;
  • Annual flu shot clinics, on-site;
  • Fitness training, on-site;
  • Coaching program for medical plan participants, online;
  • Health education programs, online and web-based;
  • Monthly newsletters focused on health, nutrition and safety;
  • Chair massage, on-site; and
  • A program survey to gather feedback.
★ Ikaria plans to expand Living Well with programs such as on-site fitness classes and incentives to reward employees for the steps they take toward healthier lifestyles.

Metrics

★ Healthcare premiums have remained flat over the last two years.
★ During a 17-week Weight Watchers pilot program, 30 employees lost over 350 pounds. The program is now ongoing.
★ Fitness centers are available at all major Ikaria locations. Over 65 employees take advantage of a reimbursement program for membership to private fitness clubs.
Value

The Living Well programs have created a motivational environment amongst Ikaria employees. Participation in the program has increased every year since inception and employees appreciate the company’s investment in them, not only as employees, but as individuals.

“I love that Ikaria has a state-of-the-art gym on-site for employees to use. It allows me to get a quick workout in during the day and come back to the office refreshed and rejuvenated.”
- Jim McLaughlin

“Weight Watchers provided a road map for a life change that I was desperate to make. At the end of my journey, I realized I didn’t have to be deprived and I could always rely on my Weight Watchers team members for support.”
- Polly Owens
HEALTHY RESULTS

Overview

- Indiana University Health (IU Health) is a statewide healthcare organization in Indiana employing approximately 26,000 people.
- IU Health’s mission, vision, and values include commitment to and leadership in wellness for its employees and community. IU Health created the Healthy Results Employee Wellness program to establish a culture of health.
- IU Health programs and efforts are proven to improve employee health, wellness, and productivity over time.
- All employees can adopt best-in-class programs such as health assessments, Quit for Life smoking cessation, Weight Watchers at Work, health coaching, and disease education at low or no cost.

Background

- Indiana University Health is committed to providing employees with the tools and programs they need to improve and enhance their personal well-being – mind, body, and spirit.
- Healthy Results was formed in 2001 with health coaching alone to help employees live their best and healthiest lives.
- Over the past 12 years, IU Health has added health risk assessments, incentives, health screenings, health surveys, disease management, disease education, tobacco cessation, weight management tools and programs, a 24-hour nurse line, a wellness portal, and more.
- Through senior leader commitment and marketing and communications efforts, IU Health continues to increase participation and affect the culture of well-being and employee health.

Description

- A sampling of what is available to IU Health employees:
  - Healthy meal and snack options in cafeterias, gift shops, and vending machines;
  - Free personal health coaching and disease education to help them understand any health conditions and to refer to appropriate services and programs;
  - Employee assistance counselors help with stress management, personal crisis situations, conflict resolution, financial issues, and more;
  - On-site, low-cost fitness centers and exercise classes;
  - One-mile walking maps for many IU Health facilities;
  - Discounts to many off-campus fitness centers and exercise classes;
  - Bike racks at multiple locations;
  - Six-week summer bicycling challenge;
  - Annual employee weight-loss challenge;
  - A weekly “Sanctuary Moment” published each Monday to encourage staff to pause and feed or soothe their spirits;
• An online Emotional and Spiritual Well-being Toolkit to help them “check in” with themselves;
• Periodic employee newsletter inserts, featuring employee success stories and health/well-being program information;
• Weight Watchers at Work discounts and attendance reimbursements;
• No-charge, voluntary health assessments to identify possible health risks (such as diabetes, high blood pressure, high cholesterol) and referral to programs that can help those at risk;
• Wellness Track incentives in the form of health insurance premium reductions of $240-$720 per year;
• 24/7 nurse line;
• No-charge access to the Quit for Life tobacco cessation program;
• Tobacco-free workplaces;
• Intranet access to information about physical activity, nutrition, emotional/spiritual well-being, and links to behavior modification programs for stress management, tobacco cessation, weight loss, and more.

Value

• Healthy Results at IU Health has resulted in:
  • Recruitment and retention of highly valued employees;
  • Increased productivity;
  • Increased engagement and participation in programs; and
  • Health improvements in a variety of health factors, including BMI, A1c, cholesterol, and blood pressure.

Metrics

• IU Health was a recipient of the 2012 and 2013 Healthiest Employers of Indiana Award for organizations with more than 5,000 employees.
• A number of studies and projects comparing the health of IU Health employees have shown improved health year over year (both individual-level results as well as aggregate population). Employee health was improved in every factor examined except for tobacco cessation.
• IU Health is finalizing a project with Indiana University to publish comparisons from 2011 to 2012.

*2012 measurement values are statistically significantly from 2011 at the p<0.05 level except change in tobacco use.
COMPREHENSIVE KIDNEY CARE MANAGEMENT

Overview

※ inVentiv Medical Management, a unit of inVentiv Health, helps employers improve the lives of employees and their families by promoting accountable care and wellness. The URAC-accredited Comprehensive Kidney Care (CKC) program addresses health risks, manages health issues, and holds down the cost of treatment.

※ CKC’s population health management approach pairs surveillance software such as predictive risk modeling with human experts who negotiate with providers for the best price, detect billing errors, and recognize patterns of fraud or abuse. The pairing improves care while lowering claims costs.

※ Grounded in evidence-based methods, in-house physicians, nurses, claims analysts, and other specialists respond to risks before they escalate into catastrophic claims for 500,000 lives in the CKC program as well as in oncology, cardiovascular disease, and other disease areas.

Background

※ Chronic kidney disease affects 26 million Americans. Guidelines for “normal-risk” individuals call for screening at age 60, but overweight, sedentary younger adults also are at risk.

※ In early stages, there may be no symptoms. Data suggest that 90% of undiagnosed workers with markers for kidney disease do not suspect that they are likely to become sick. Early detection is critical—once the disease progresses to Stage 3 (moderate impairment), it cannot be stopped.

※ The financial burden of kidney disease on companies and taxpayers is growing exponentially due to the rise of obesity, a risk cofactor. Medicare spending on end-stage renal disease exceeds $33 billion annually.

Description

※ The CKC program focuses on early detection and lifestyle intervention, then transplantation, and dialysis as the last resort. Many care management programs underemphasize transplants and focus solely on negotiating lower prices for dialysis, which has 44% mortality by the third year of treatment.

※ Managing 916 patients with chronic kidney disease over a 10-year period, the CKC program helped many receive kidney transplants, sparing them the misery, high costs, and poor prognosis of dialysis. When the transplant option was unavailable, the program focused on significantly delaying dialysis. CKC promoted “peritoneal” home dialysis in lieu of hemodialysis when aggressive intervention became unavoidable.

※ A focused staff that includes a board-certified nephrologist is central to the CKC program.
  • The staff works with employers and third-party administrators.
  • The team monitors adherence to evidence-based medicine and patterns of billing fraud and abuse by examining insurance claims data, prescription drug data, precertification and other patient records, health risk assessment and biometrics data from wellness programs, and cases flagged by board-certified physicians.
  • Medical staff is in frequent touch with providers. For example, a CKC staff nephrologist may call a dialysis center to say that a patient’s blood work indicates he is receiving too much erythropoietin, a blood-boosting drug often overprescribed in clinics.

※ A “data surveillance engine” uses “physician logic” and algorithms to scrutinize claims and other unstructured clinical data.
Metrics

• Some 13% of late-stage CKC patients received kidney transplants, versus a national average of 5%. In addition to higher quality of life, the transplant option yielded dramatic cost savings:
  • Dialysis and medications: $560,000/year, on average;
  • Kidney transplant: $260,000, plus $30,000/year for antirejection drugs.

• Among patients with Stage 3-5 (moderate-to-severe) kidney disease, many achieved a four-month delay in progression to dialysis compared with the national average.

• Some 21% of patients in the program who required dialysis were treated at home with an advanced “peritoneal” approach, versus 6% nationally. Compared with conventional hemodialysis in a clinic or hospital, the home-based approach is:
  • 25% less expensive;
  • Gentler on the patient;
  • Less likely to cause infections and other complications;
  • Less likely to result in a visit to the ER; and
  • Associated with lower mortality rates.

Value

• The CKC program realized $3.3 million in cost savings on dialysis and medications over three years.

• A return on investment (ROI) of 6:1 was achieved for CKC patients with Stage 3-5 kidney disease:
  • 60% saved through slower progression to dialysis;
  • 18% through cost containment (avoiding double-billing, misapplied fees, etc.);
  • 15% through indirect employee costs such as absenteeism; and
  • 5% through avoiding cardiovascular events.

• An ROI of 4.7:1 was achieved for CKC patients with end-stage renal disease on dialysis:
  • 52% through alignment with evidence-based medicine (curtailing overtreatment with “blood-boosting” drugs and other steps);
  • 31% through cost-containment and claim surveillance;
  • 10% through preference for peritoneal dialysis;
  • 6% from steering patients quickly to kidney transplant; and
  • 1% through reduced cardiovascular event.
CEO CANCER GOLD STANDARD

Overview

* The CEO Cancer Gold Standard™ is an initiative of the CEO Roundtable on Cancer. Created by Roundtable member CEOs, the CEO Cancer Gold Standard™ defines what private sector CEOs and their organizations can do to prevent cancer, detect it early, and ensure access to the best available treatment for those who are diagnosed with cancer.

* Former Johnson & Johnson Chairman William C. Weldon chaired the CEO Roundtable on Cancer (2007 – 2011), a nonprofit group comprised of corporate executives from major American companies representing diverse industries, whose mission is to work toward the elimination of cancer as a disease and as a public health problem. Johnson & Johnson’s CEO and Chairman Alex Gorsky continues to lead the way in the fight against cancer.

Background

* 70% of deaths for the most prevalent types of cancer are preventable;

* U.S. employers spend $206.3 billion on cancer-related costs annually:
  - $17.9 billion in productivity;
  - $110.2 billion in premature death; and
  - $78.2 billion in direct medical care.

* Employers spend $16,000 in direct annual medical costs for cancer patients compared to $3,000 for those without cancer.

Description

* Organizations that adopt the CEO Cancer Gold Standard™ measure their annual improvement against established baselines in five areas: tobacco use, diet and nutrition, physical activity, screening and early detection, and access to quality treatment and clinical trials.

* Risk Reduction through Lifestyle Change

  * Tobacco Use
    - Establish and enforce tobacco-free worksite policies;
    - Ensure that health benefit plans include coverage at no cost for evidence-based tobacco treatments (counseling and medications);
    - Establish workplace-based tobacco cessation initiatives.
  
  * Nutrition
    - Sustain a culture that values, supports, and promotes healthy food choices;
    - Provide access to healthy weight and/or nutrition programming.
  
  * Physical Activity
    - Sustain a culture that values, supports and promotes physical activity;
    - Provide access to opportunities for physical activity.

* Early Detection

  * Prevention, Screening and Early Detection
    - Sustain a culture that values, supports, and promotes the prevention, screening, and early detection of cancer;
    - Ensure that health benefit plans cover, at either no cost or at a reasonable cost-sharing level, screening services for breast, colorectal, and cervical cancer, and all FDA-approved vaccines for the prevention of cancer.
Quality Care

- Access to Quality Treatment and Clinical Trials
  - Ensure that health benefit plans provide access to cancer treatment at Commission on Cancer-accredited programs and/or National Cancer Institute-designed cancer centers;
  - Provide education about cancer clinical trials;
  - Ensure that health benefit plans continue to provide coverage for the current standard of care when covered individuals are participating in cancer clinical trials.

Metrics

In 2010, the Harvard Business Review highlighted the CEO Cancer Gold Standard™ as an example of a high-quality, signature program that can boost the overall effectiveness of a broad spectrum of workplace wellness initiatives. The article showed that the return on investment (ROI) can be as high as 6 to 1.

In recognition of the organization’s efforts in building a culture of health and wellness, particularly in the area of cancer prevention and risk reduction, Johnson & Johnson earned the CEO Cancer Gold Standard™ accreditation in 2006, and has sustained its accreditation for the past seven years. By reducing tobacco use and focusing on diet and nutrition, physical activity, and early detection and screening for cancer, Johnson & Johnson has been able to demonstrate the value of these efforts on employee health, wellness, and business success.

Value

In addition to preventing cancer, sustaining a culture that reduces the health risks that contribute to cancer can reap its own benefits. For example, providing coverage for tobacco cessation treatments such as over-the-counter quitting aids, prescription medications, and counseling raises cessation rates and is highly cost-effective relative to other clinical interventions. Each employee who quits smoking saves his or her employer an estimated $1,300 per year.

The impact of the CEO Gold Standard™ has increased exponentially since 2006. There are now over 140 participating organizations and over 3,400,000 covered lives reaping the benefits of a workplace culture that encourages healthy lifestyles and promotes wellness benefits. In 2013, the accreditation process was extended to include global application requirements for organizations accredited in the U.S. with a presence overseas.
Overview

• The Live for Life™ program provides 38,000 eligible U.S.-based Johnson & Johnson (J&J) employees with a holistic approach to wellness, including mental health and well being, occupational health, energy management, and health promotion, education, and awareness.

• Johnson & Johnson’s health promotion efforts have expanded internationally with the goal of creating a “Global Culture of Health” for employees.

Background

• J&J has a long history of creating effective workplace health and wellness programs that improve employee health and productivity and achieve documented savings.

• The focus and direction of the employee health program is based on aggregate population health data compiled from a health risk assessment (HRA), data from Global Health Services, utilization, and claims.

Description

• The Health Profile is a key component of J&J’s employee health program.
  • Online HRA and resources help employees learn about their health and how lifestyle factors may affect it;
  • All U.S. employees and their spouses and partners are eligible to take part;
  • Employees with certain results are eligible for health advising—one phone conversation with a professional, degreed health educator;
  • Choices-eligible employees can earn a $500 medical contribution discount each year by completing the profile and participating in health advising;
  • Employees who are not choices-eligible can still participate without getting the discount;
  • A physician summary provides an at-a-glance review of Health Profile results that employees are encouraged to share with their healthcare provider.

• The My Live for Life website contains tools to help employees get healthy and stay healthy. On the site, employees can:
  • Access the Health Profile;
  • Learn more about exercise reimbursement;
  • View wellness and exercise schedules by company location;
  • Use personal health trackers, daily health reminders, healthy recipes, health program discounts, workout logs, and fitness and nutrition calculators;
  • Read vital health news;
  • Access a full suite of HealthMedia™ digital health coaching modules for web-based coaching aimed at healthy lifestyle behaviors and chronic conditions; and
  • Search for J&J-provided health resources to address health risks or prevention concerns.

• Addressing lifestyle-related behaviors, such as healthy eating and physical activity, are critical to support maintenance and prevention of obesity, diabetes, hypertension, and other health conditions.

• J&J supports employee weight loss goals by investing in resources such as wellness professionals, subsidized Weight Watchers® programs, employee assistance program counselors, Health Services, and HealthMedia® digital health coaching at all U.S. locations.

• To promote physical activity, fitness centers, exercise classes, and personal trainers are provided to employees at many U.S. locations. Field
employees and others are eligible for an exercise reimbursement program. The Million Step Challenge is a campaign designed to encourage all employees to take 10,000 steps daily — a recognized standard for improving health.

• The J&J employee healthy eating initiative, “eatcomplete,” is a collaboration between Global Health Services and the company food service provider that avails healthy food choices at every cafeteria, food station, vending machine, and catered event. Healthy eating is also encouraged through awareness events, healthy preparation of food, and placement, taste, and promotion of nutritionally dense whole food throughout the food service experience.

✳ Energy for Performance in Life increases engagement and physical and emotional capacity by incorporating the energy management concepts of the Human Performance Institute’s Corporate Athlete® training. J&J provides Energy for Performance in Life courses to employees through a variety of scalable opportunities.

Metrics

✳ In 2012, compared to a multiemployer database, J&J employees show lower risk prevalence in all 11 health risk areas (unhealthy eating, obesity, inactivity, hypertension, total cholesterol, glucose, tobacco use, stress, alcohol use, safety belt usage, depression).

• The areas with the largest gap between J&J employees and others are inactivity (49.4% at risk compared to 21.1% at J&J) and obesity (34.4% compared to 20.8% at J&J).

✳ Of U.S. participants who completed the Health Profile in 2012, 42.2% stated the Health Profile helped them to uncover an unknown health issue while 72.7% said it helped them to maintain or improve a healthy lifestyle.

In 2012, J&J employees participated in the Million Step Challenge.

• 60% of participants reported having more energy;

• 40% experienced weight loss;

• 15% lowered their blood pressure;

• 14% lowered their cholesterol; and

• 27% noted an overall improvement in stress levels.

In 2012, approximately 9,000 employees were touched by energy management principles and training globally. More than 20,000 employees have had access to Energy for Performance in Life courses and keynotes.

Top Three Risks

<table>
<thead>
<tr>
<th>Problem</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>20.8</td>
</tr>
<tr>
<td>Inactivity</td>
<td>21.1</td>
</tr>
<tr>
<td>Unhealthy Eating</td>
<td>56.6</td>
</tr>
</tbody>
</table>

Health Profile Summary, Choices Eligible Employees 1/1/2011-12/11/2012

Value

✳ At the end of 2012, Johnson & Johnson U.S. employees avoided an estimated $27 million in healthcare costs.

✳ Average annual per employee savings were $565 in 2009 dollars, producing a return on investment equal to a range of $1.88-$3.92 saved for every dollar spent on the program.

✳ Benchmarking against similar industry firms shows an average rate of growth in medical and pharmaceutical costs that is 3.7% lower.
Marshfield Clinic

MARSHFIELD DENTAL INITIATIVE

Overview
※ Marshfield Clinic is a not-for-profit healthcare system with more than 50 locations providing care in Northern Wisconsin
※ In 2002, Marshfield Clinic partnered with Family Health Center to begin to address oral health access disparities, reduce preventable pain and suffering, integrate medicine and dentistry, and start planning an educational program designed to reform dental education and workforce issues.
※ The Marshfield Dental Initiative (DI) better enables its partners to address comorbid conditions and improve the productivity of low-income populations, thereby resulting in improved community health.

Background
※ Studies have shown that dental care is closely linked to broader physical health:
  • Treatment of periodontal disease in pregnant women leads to better birth outcomes, reduction in preterm births, and low birth-weight babies.
  • Diabetic patients with periodontal disease have more difficulty managing their disease.
  • Poor oral health has been linked to many other systemic diseases such as heart disease.
  • In 2000, the Surgeon General released an Oral Health in America Report, detailing huge disparities in access to oral health service among the poor. The report noted that oral health is essential to general health and called for an integration of oral health into overall health.
  • When the Dental Initiative was founded, less than one in four adults and children on Medicaid had access to dental care.

Description
※ Expanded Capacity
  • Since the inception of Dental Initiative, Marshfield established 8 dental centers with 41 dentists and 39 hygienists to serve those who do not have regular access to dentists.
  • DI regionalized dental care services in rural counties and based dental operations in the primary city within each county.
  • DI hosted dental students from other schools to train and improve recruitment and retention for Marshfield’s growing dental network, especially in rural areas.
  • DI established an advanced education general dentist (AEGD) program to train dental residents in an integrated EHR and interprofessional healthcare system aimed at bidirectional (medical & dental) management.
※ Integration of Care
  • Marshfield has developed an electronic dental record accessible to both dental and medical practitioners to provide a comprehensive record when developing treatment plans.
  • Marshfield developed decision support tools to allow physicians to interpret dental health information and integrate that information in treatment plans.
  • Marshfield trained local nursing home staff on proper oral health procedures for residents to reduce hospitalizations.
※ Increased Access
  • Marshfield conducted outreach to Head Start using teledental technology that allows dentists to remain in the clinic while hygienists remotely examine children using interoral cameras.
  • Marshfield built large treatment rooms with
wheelchair access to allow services to the cognitively and developmentally disabled who have the greatest difficulty accessing dental care.

• Marshfield provided a sliding-fee program to allow individuals in poverty and those with limited income to obtain dental services at a greatly reduced rate.

Metrics

• In 2012, the Dental Initiative provided 130,770 dental visits to 47,848 patients. More than 90% of services were provided to individuals whose incomes were at or below 200% of the federal poverty level.

• Marshfield has served more than 88,251 people from all 72 counties in the state. When complete, the initiative will provide care for more than 100,000 residents.

Value

• Patients’ experiences illustrate the importance of medical-dental integration to co-morbidities and service coordination:

• A patient’s cancer treatments were contributing to poor oral health, difficulty eating, and weight loss. After being referred to dental treatment, the patient had improved oral health, nutrition and healthy weight gain.

• A diabetic patient had severe oral disease, jaundice, and a large lesion on his leg that would not heal. Following dental treatment, the patient had good skin color, blood glucose levels under control, and a healed skin lesion.

• The Marshfield Dental Initiative has provided significant clinical and economic value to patients and communities, which has improved the overall healthcare system. A 2-year study of 144,000 insured patients by Aetna found that earlier periodontal treatment reduced overall medical care costs by 9% for diabetics, 16% in coronary artery disease patients, and 11% in cerebral vascular disease patients.

• Additionally, treatment of periodontal disease in low-income, publicly insured populations provides great potential to improve lives and reduce costs.
Marshfield Clinic

PHYSICIAN GROUP PRACTICE DEMONSTRATION

Overview

- Marshfield Clinic is a large independent not-for-profit group medical practice in Wisconsin. The clinic is engaged in providing high-quality healthcare services, healthcare education, and medical research.
- Marshfield employs more than 750 physicians and 6,500 other staff members. The clinic has more than 50 regional centers in addition to the main Marshfield location. The clinic also operates in 37 Wisconsin communities throughout central, western, and northern Wisconsin, which are predominantly rural areas.
- The system uses one common EHR. With this infrastructure, the clinic now publicly reports clinical outcomes, provides physicians and staff quality improvement tools to analyze their clinical and business processes, eliminates waste and unnecessary redundancies, and improves consistency while simultaneously reducing unnecessary costs.

Background

- Medicare’s first physician pay-for-performance initiative;
- Encourages physician groups to coordinate their care for chronically ill beneficiaries;
- Promotes active use of clinical data to improve efficiency and patient outcomes;
- Awards performance payments to Physician Group Practices (PGPs) for increased efficiency and quality;
- Quality is measured and rewarded using 32 quality metrics covering five conditions modules:
  - Diabetes mellitus
  - Heart failure
  - Coronary artery disease
  - Hypertension
  - Preventative care
- Participated in CMS PGP Transition Demonstration 2011 and 2012 – results pending
- Selected as an Accountable Care Organization (ACO) in January 2013

Description

- Patient-Oriented Quality Improvement
  - Developed best practice models for core conditions;
  - Provided continuing medical education opportunities;
  - Instituted care management programs, such as 24/7/365 Nurse line and heart failure programs;
  - Provided population-based feedback for providers;
• Created physician/clinical nurse specialist regional teams;
• Developed partnerships with other PGP demonstration sites to discuss effective care processes and review standards and approaches:
  - Marshfield Clinic has 34 primary care sites recognized by NCQA as Level 3 patient-centered medical home-physician practice connections (PCMH-PPC);
  - Some 45 registered nurse care coordinators embedded into practice sites;
  - Care coordination for chronic care and transitions of care implemented.

**Enhanced Electronic Health Records**
• Systematically expanded to work to achieve the Triple Aim.
  - The goals of the Triple Aim are defined by the Centers for Medicare and Medicaid (CMS) as:
    > Improving the patient experience of care (including quality and satisfaction)
    > Improving the health of populations
    > Reducing the per capita cost of health care
• Completely paperless charts;
• Helps avoid communication breakdowns and duplication of services;
• Enables physicians to easily access treatment information, analyze data, and make evidence-based treatment recommendations for patients;
• Provides electronic provider reminders that flags patients who need monitoring;
• Retrievable data fields allow analytics to focus efforts with limited resources and promote decision support tools.

**Metrics**
• Marshfield Clinic saved the Medicare program more than $118 million in the five years of the PGP demonstration.
• Marshfield Clinic exceeded 130 of 133 metrics CMS set during PGP demonstration.
• Marshfield earned performance payments for improving the quality and cost efficiency of care in all five years of PGP demonstration.

**Value**
• Marshfield Clinic’s ongoing demonstration of quality improvement while working to decrease expenditures in the PGP demonstration illustrates ongoing work in progress to achieve the Triple Aim, by showing the promise of redesigning payment methodologies to tie incentives to results and value.
• The experience of Marshfield Clinic demonstrates that proactive and coordinated care can serve to improve the health of populations of patients while achieving large savings. The required quality measures focused on common, high-cost conditions and the wide variety of care management interventions developed and implemented to address these conditions shows that there is no one solution to the challenge of reaching the Triple Aim.
Overview

▪ Mayo Clinic is a nonprofit worldwide leader in medical care, research, and education.
▪ The Stress Less study examined the effectiveness of a 12-session, multidisciplinary stress reduction program on reducing perceived stress and improving health behaviors (e.g., sleep, nutrition, and physical activity), and quality of life for women. Results indicated a significant improvement in all of those areas.
▪ Mayo believes that, in addition to offering a wellness center, employers should also offer specific stress reduction programs such as Stress Less in order to see significant improvement in employee quality of life.

Background

▪ High stress is associated with increased healthcare costs due to medical problems and mental health issues, disability, and workplace absenteeism.
▪ Detailed written descriptions of implementation and delivery methods of stress management programs are often unavailable and make it challenging to develop advanced evidence-based outcomes.

Description

▪ Program Design
  ▪ Stress Less was designed by a multidisciplinary team, including licensed psychologists, employee wellness program counselors, and wellness coordinators, and delivered by wellness coordinators trained in behavior change and health promotion.
  ▪ The discussion-based program took an educational approach geared toward a female audience (because of the possibility for gender differences in level, sources, and responsiveness to stress and because 74% of Mayo Clinic employees are women). It included behavior strategies, self-reflection, relaxation training, problem solving, and group support. Gender-specific components of the program incorporated discussion of women’s roles and impacts on stress level in workplace and at home.
  ▪ The curriculum described workplace scenarios and relaxation exercises that could be used in the workplace. Additional educational material discussed approaches that could be applied in any setting.

▪ Program Implementation
  ▪ Some 138 female employees and eligible spouses who were also members of the Mayo Clinic wellness center, the Dan Abraham Healthy Living Center (DAHLC), met in groups of 12 or fewer, one hour per week for 12 weeks, and returned one month after conclusion of the 12-week program for a single session follow-up.
  ▪ Each weekly session included:
    ▪ Group discussion of current stressor (10 minutes);
    ▪ Review of implementation of the previous week’s topic (10 minutes);
    ▪ Skill-building methods implemented through presentations, situational skill building, and related education materials (30 minutes);
    ▪ A relaxation experience taught by wellness coordinator, choreographed to relaxation music (10 minutes); and
    ▪ Weekly assignments and reminder emails to encourage participants to practice skill-building methods and relaxation techniques.
  ▪ Participants were measured on:
    ▪ Life Experience Survey (LES), a 47-item questionnaire that asks respondents to indicate events experienced in the past year;
Perceived Stress Scale (PSS), a 10-item scale designed to measure the degree to which situations are appraised as stressful; and Current Health Behaviors (CHB) and current health status.

Metrics

Some 75% of women enrolled completed at least 8 of 12 sessions, 90% of those completed post-program surveys, and 77% of these completed 1-month follow-up surveys.

Results indicate significant improvement in PSS scores and CHB. In addition, individual CHB found significant improvement in the level of quality of sleep, stress, overall health, quality of life, physical activity and confidence to lead an active lifestyle, nutritious eating habits, spiritual well-being, and social support.

Value

Given the high prevalence of stress in society and workplaces and the impact of stress on an individual's health and quality of life, effective workplace stress programs are critical.

The results of Stress Less demonstrate that incorporating a range of techniques can effectively help female employees reduce their perceived stress levels and improve their overall quality of life and health behaviors.

A 2011 study of Mayo Clinic employees joining a wellness center that was published in the American Journal of Health Promotion, found that employees with high stress levels reported lower levels of perceived health and positive health behaviors than average. The same study also noted:

- “High levels of perceived stress are associated with poor work performance, higher health costs, and poor quality of life;” and
- “If high-stress employees can be identified, tailored wellness programs would improve their health behaviors and work productivity and thereby reduce healthcare costs.”

Reduction of stress in employees should translate into increased productivity, decreased absenteeism, and decreased healthcare costs in the long term while increasing staff satisfaction in wellness programs in the short term.
Overview

- As America’s oldest and largest healthcare services company, McKesson helps health plans and payers navigate a demanding, constantly changing industry by offering a comprehensive suite of flexible, interoperable care management solutions.
- The McKesson VITAL Nurse Advice Line gives health plan members 24/7 access to highly trained registered nurses by phone, chat, or e-mail.
- The advice line nurses use patented, algorithm-based clinical assessment tools in order to accurately identify members’ needs and direct them to the proper care.
- The advice line has delivered a return on investment greater than 2:1 across our customers, resulting in a net savings of over $46 million. The line has also achieved a positive redirection rate of 82%, guiding patients to the proper care needed.

Background

- McKesson has been offering nurse advice line services for over 21 years. This program has achieved full accreditation from Utilization Review Accreditation Commission (URAC) and certification from the National Committee for Quality Assurance (NCQA).
- The McKesson VITAL Nurse Advice Line was created to help health plans and payers reduce inappropriate care, increase member satisfaction, improve member access to care, and facilitate better clinical outcomes.
- The line is designed to assist all members – whether they face only periodic acute healthcare needs or have chronic healthcare needs.

Description

- The program provides 24/7 access to registered nurses and allows consumers to reach a nurse licensed in their state immediately through either phone or Internet.
- Each nurse is backed by a physician who is always on call to answer questions or assist the nurse with questions.
- Unique patented clinical decision support algorithms and protocols accurately direct callers to the right level of care, assisting the patient and helping to alleviate the payer’s workload.
- Health coaches are used to support member education for sustained behavior change.

Metrics

- Of the approximately 1 million callers to the McKesson VITAL Nurse Advice Line each year:
  - Some 82% of callers who plan to visit an emergency room are redirected to a less urgent level of care facility; and
  - Some 58% of callers are redirected to a less emergent level of care than they initially intended, and 33% are appropriately advised for self-care.
In a 2012 survey of McKesson’s VITAL Nurse Advice Line callers:

- Some 97% of callers were pleased with McKesson staff responsiveness, knowledge, and friendliness;
- Some 95% reported that staff experience and knowledge exceeded expectations;
- Some 94% respondents were “satisfied” or “very satisfied” with the service;
- Some 94% reported that they would use the service again;
- Some 97% of callers agreed with the nurse’s advice and recommendations; and
- Some 75% of callers who followed the nurse’s recommendations agreed that their medical reason for calling was resolved.

Value

- Staffed entirely by registered nurses, they are licensed in the state in which they receive member calls, 24 hours per day, 7 days per week.
- Since 1995, the McKesson VITAL Nurse Advice Line service has delivered a return on investment greater than 2:1, reflecting a net savings of more than $46 million.
- The McKesson VITAL Nurse Advice Line is algorithm-based, rather than guideline-based. This brings clinical integrity and reproducible outcomes to a nurse advice program. It is more effective for ruling out serious conditions and providing callers with the appropriate level of care for their symptoms.

McKesson VITAL Nurse Advice Line

82%

of callers who had planned to visit the emergency department are redirected to a less emergent level of care

58%

of all callers are redirected to a less urgent level of care than they planned prior to calling
Overview

- Medtronic Inc., headquartered in Minneapolis, MN, is the global leader in medical technology – alleviating pain, restoring health, and extending life for millions of people around the world.
- For people with chronic diseases like diabetes and heart conditions, managing their condition is a lifelong collaboration with healthcare teams. Medtronic makes this process easier with CareLink® systems.
- These systems allow patients with certain heart devices and insulin pumps to download information captured by their device and transfer that data via a secure server to the CareLink® website. For some devices, patients can capture information at home, which is of particular value to those in rural areas.
- This seamless communication allows patients and providers access to information needed to make smart, timely healthcare decisions.

Background

- More than 2 million Americans have a pacemaker or implantable cardioverter defibrillator (ICD), and 70% of patients are age 65 or older. Some 52% of people who are 65 and older have at least one ER visit annually. Often, when patients visit the ER a device check is needed, even for a potentially unrelated condition. Patients with implanted cardiac devices who arrive at a healthcare facility usually wait for qualified personnel to arrive to check their device. This process can take upwards of 2 hours, and these unscheduled checks typically occur in expensive care settings (operating and emergency rooms), and extended delays increase the cost of care for hospitals, payers, and patients.
- Heart failure is the single most costly medical condition in the United States, according to the American Heart Association. It results in more than 1.1 million hospital admissions every year, is one of the most costly inpatient episodes of care, and is the leading cause of death in the U.S.

Description

- CareLink
  - CareLink® Express Service is the world’s first remote monitoring service designed for use in the acute care setting. It allows clinicians to communicate quickly with 97% of Medtronic implanted cardiac devices using a CareLink® monitor and receive a remote status report on the status of the device in minutes. This can be done by a technician or administrative assistant. The information is delivered to a remote monitoring center for experts to review in real time.
  - Within 15 minutes, the remote monitoring center places a call to the location to speak with the attending physician about the cardiac device function. The device report can then be transferred to the patient’s electronic health record (EHR) and to the CareLink® Network.

- OptiVol
  - Many Medtronic heart devices help failing hearts pump better, but a patient’s condition can still worsen. One sign of worsening heart failure is fluid build-up in the thoracic cavity.
  - Medtronic developed OptiVol Fluid status monitoring and built it into many devices to detect potentially serious conditions such as congestive heart failure. Through this technology, inpatient admissions may be avoided with medication or diet adjustments.
Diabetes Management

- Medtronic’s CareLink® system for diabetes allows patients with a Medtronic insulin pump and continuous glucose monitoring (CGM) system to see glucose trend reports and share them with their care teams.
- Medtronic is in early-stage development of having information sent in real time from a patient’s CGM-equipped insulin pump to caregivers and medical professionals, which could help avoid potentially life-threatening high or low glucose conditions, and help better manage the patient’s diabetes. For example, this information can be used to alert parents and caregivers to make critical decisions when children are at school or away at camp.
- Patients using CareLink® to monitor their diabetes report better glucose control.

Metrics

- Through the use of OptiVol fluid status monitoring, expensive inpatient admissions can be avoided and more serious conditions such as congestive heart failure can be mitigated.

Value

- In a study of heart patients who used the CareLink® network, the time from a clinically actionable event to when they were treated was 17.4 days less than heart device patients who did not use remote monitoring, via the CareLink® network with automatic CareAlert® notifications.
- Multiple clinical studies have demonstrated the clinical value of CGM in managing blood glucose. Another study has shown CareLink® systems use among patients with diabetes led to significant blood glucose (A1c) reductions.

CareLink® systems deliver greater efficiency of care with fewer office visits for patients. The network allows physicians to coordinate care for their patients quickly, effectively, and efficiently. The result is a higher quality standard of care for patients and reduced costs and waiting times in expensive acute care settings.

With chronic disease rates on the rise, CareLink® systems give patients more ownership over managing their conditions to help relieve the burden on healthcare systems.

A heart device with OptiVol® monitoring has constant sensing technology that detects fluid build-up and helps doctors identify patients at risk of worsening heart failure via the CareLink® network.
BOLD GOALS FOR EXCELLENCE

Overview

- MemorialCare Health System is a not-for-profit delivery system in Southern California and one of the top integrated systems in the U.S.
- Introduced Bold Goals for Clinical Quality in 2006 to focus performance improvement on achieving improved outcomes and reduced potential for harm.
- Launched its newest “Bold Goal” in 2009 to achieve a cost of providing care at or below Medicare reimbursement rates by 2014.
- The impact of Bold Goal efforts is calculated by estimating the number of “Lives Touched.”

Background

- Bold Goal aims to reduce expenses on each discharge, achieved by focusing on 4 key platforms coined by the acronym “PLUC”:
  - **Productivity** – Productivity Collaborative for all high-volume departments initiated in 2009. Teams compared opportunities and developed best practices to reset staffing standards and initiated an online daily productivity monitoring tool.
  - **Lean** – Lean-thinking 21st century management system implemented to drive out nonvalue-added steps, unneeded processes or supplies, and other waste.
  - **Utilization Management** – Focus on utilization management launched to reduce nonvalue-added consumption of resources, such as duplicative lab tests, during the inpatient stay and across the continuum.
  - **Care Model** – MemorialCare Leadership Academy identifies ways to reduce total bed-site labor costs by redesigning “bedside care” using Lean.

Description

- MemorialCare’s strategic planning pyramid incorporates 6 key areas of focus, including physicians as partners.
- The Physician Society is a unique partnership of hospital leadership and physicians formed to develop and utilize evidence-based, best-practice medicine.
- Responsibilities include creating expectations for clinical performance, leading development and implementation of best-practice guidelines, and spearheading physician informatics and outcome-related initiatives.
- The Physician Society oversees the design, building, and validation of workflow and evidence-based clinical order sets for MemorialCare’s electronic medical record. For example, best practice teams have developed order sets to prescribe care for sepsis patients in the first 6 hours and hard-wiring of antibiotic selection and timing within 60 minutes of surgery, and a standardized assessment and prophylaxis for risk of blood clots (DVT).
Metrics

* System achieved $86 million in reduced costs thanks to the systemwide Productivity Collaborative.
* Lean-thinking focus has saved $18.4 million for fiscal years 2010-12; 10-year return on investment projected to save $57 million.
* Lean thinking also resulted in enhancements in quality and safety – reduced “door to doctor” time from more than an hour to 2-5 minutes.

Value

* Reduce chance of serious infection via optimal hand hygiene and other methods.
  * Result: Campaign slogan resulted in 98% compliance and helped to reduce chance of serious infection by 80%.
* Reduce preventable mortality.
  * Result: Reduced and sustained medical emergency call rate through use of rapid response teams by more than 50%.
* Aim to achieve “Perfect Care” through 95% compliance with core measure indicators.
* Performance improvement tracked via the Performance Improvement Radar with more than 15,000 “lives touched” since the inception of the Bold Goals.

MemorialCare’s “Bold Goals for Excellence” have catalyzed system transformation to improve patient care and enhance value at every point along the care delivery process. The result is better, safer care for patients, a great place to work and practice, and the ability to foster MemorialCare’s vision: Exceptional People, Extraordinary Care, Every Time.
Overview

* MemorialCare Health System, a not-for-profit integrated delivery system based in California, recognizes the risk to patients, its own staff, and physicians from inadvertent spread of H1N1 or seasonal flu by unvaccinated healthcare workers. MemorialCare believes it is an ethical imperative to protect all those for whom they care from the flu.

* The flu protection plan calls for a mandatory “vaccinate or mask” approach to influenza protection. It is now an ongoing part of MemorialCare’s infection prevention and wellness approach and is in effect every influenza season.

Background

* Even though a substantial number of infected individuals may not have influenza symptoms, they can still transmit the flu to others, endangering colleagues as well as patients who are even more susceptible to infection.

* The Centers for Disease Control and Prevention (CDC) estimates that from the 1976-1977 season to the 2006-2007 flu season, flu-associated deaths ranged from a low of about 3,000 to a high of about 49,000 people annually. The CDC suggests that healthcare facilities vaccinate staff, but efforts to encourage voluntary vaccination have traditionally resulted in low staff vaccination rates.

* The atypical H1N1 pandemic in 2009 provided an urgent need to achieve universal vaccination both globally and at MemorialCare. In the spring of 2009, MemorialCare established the multidisciplinary Influenza Task Force, with representation from each of its hospitals including patient safety, nursing, infection control, human resources, employee health, pharmacy, and laboratory personnel, as well as physician and senior leadership from the health system level. The team convened weekly to develop a new approach and continues to meet in response to seasonal needs.

Description

* All staff, volunteers, and physicians are required either to receive a flu vaccine or wear a mask while at work during the influenza season. Additionally, on-site contractors and students are required to comply.
  * Employees or caregivers who refuse to comply with the policy are excused from work.
  * Employees, volunteers, students, and physicians receive stickers on their name badges when they are vaccinated for the season. This sign makes it easy to see who has and who has not received vaccination.
  * Guidelines are in place for passive to active visitor screening and real-time visitor education, depending on the season and levels of influenza activity in the community.
  * The “vaccination or mask” policy recognizes the employee’s right to refuse or legitimately be unable to receive a vaccination (e.g., allergy to components of the vaccine) while allowing MemorialCare to protect patients and caregivers from inadvertent infection.

* The “vaccinate or mask” policy is endorsed by systemwide leadership teams, up to the Governing Board. The Medical Executive Committee at each hospital collaborates (which enables the policy to apply equally to physicians because California hospitals cannot employ physicians directly).

* MemorialCare provides easy access to current and updated influenza information through an Influenza Resource Center on the MemorialCare intranet. The center disseminates the policy, public health
and vaccination information, and helpful tips. Staff is trained in flu prevention, and a public relations campaign provides information for patients and staff.

A sharing program for vaccine supplies is in place, as well as tiered administration priorities for potential vaccine shortages. Disaster preparedness plans and drills are reviewed for epidemic and near-epidemic patient influenza levels.

**Metrics**

- After the 2009-10 flu season, when the policy began, MemorialCare noted a demonstrable increase in the number of staff receiving vaccinations.
- Higher rates of vaccination resulted in fewer patient care providers/staff getting sick themselves, which then minimized treatment costs, including pharmaceutical claims related to the treatment of viral infections, secondary infections, or complications.
- Even during seasons of increased levels of influenza in the Long Beach community, MemorialCare was able to sustain its mission and provide care to all those who needed it without long waits or overcrowding.

**Value**

- MemorialCare’s flu policies protect patients from being infected with the flu while they are in the hospital. In addition, by preventing employee illness, MemorialCare has avoided costs related to influenza and its complications, such as absenteeism, health treatment costs, and employee replacement costs.

---

**Employee Vaccination Rates**

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Hospital of Long Beach</td>
<td>Prior to affiliation</td>
<td>58%</td>
<td>83%</td>
<td>93%</td>
<td>98%</td>
</tr>
<tr>
<td>Long Beach/Memorial and Miller Children’s Hospital, Long Beach</td>
<td>68%</td>
<td>88%</td>
<td>73%</td>
<td>92%</td>
<td>93%</td>
</tr>
<tr>
<td>Orange Coast Memorial Medical Center</td>
<td>52%</td>
<td>61%</td>
<td>66%</td>
<td>83%</td>
<td>86%</td>
</tr>
<tr>
<td>Saddleback Memorial Medical Center</td>
<td>49%</td>
<td>65%</td>
<td>64%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>MemorialCare Medical Foundation</td>
<td>Prior to affiliation</td>
<td>77%</td>
<td>55%</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>Shared Services (corporate office)</td>
<td>Pre-program deployment</td>
<td>Pre-program deployment</td>
<td>Pre-program deployment</td>
<td>75%</td>
<td>84%</td>
</tr>
</tbody>
</table>

*Does not include medical staff, volunteers, and contractors*
THE ADHERENCE ESTIMATOR®

Overview

* Merck is a global healthcare leader working to help the world be well.

* Through its prescription medicines, vaccines, biologic therapies, and consumer care and animal health products, Merck works with customers and operates in more than 140 countries to deliver innovative health solutions. We also demonstrate our commitment to increasing access to health care through far-reaching policies, programs, and partnerships.

* Medication adherence has been cited as the single most modifiable risk factor that compromises treatment outcomes. Merck is committed to playing a leadership role in supporting the development and use of science-based interventions to improve medication adherence.

Background

* Nonadherence has been a significant, long-term problem with substantial financial and public health implications, representing an opportunity for Merck to support the development of solutions to help healthcare professionals improve patient health outcomes.

* Adherence requires patient agreement and is a collaborative association between the healthcare professional (HCP) and patient.

* Adherence is the extent to which a person’s behavior (taking medication, following a diet, implementing lifestyle changes) corresponds with agreed-upon recommendations from a HCP.

* Research conducted by Merck scientists focused on the identification of patient beliefs that represent barriers to adherence. This research informed the development of a patient-centered resource that can be used to help identify patients with a likelihood for nonadherence.

Description

* The Adherence Estimator is a validated, patient-based resource that gauges the likelihood of adhering to a newly prescribed oral medication for certain chronic conditions.

* The development process included a comprehensive literature review, focus groups, and 2 rounds of quantitative testing.

* Conclusions of the study revealed 10 key adherence tenets and 3 domains that were most accurate in predicting adherence. The following 3 domains or barriers emerged as the best predictors of adherence to prescription medications:
  * Commitment: Perceived commitment to (or need for) prescription medication;
• Concern: Perceived concerns about prescription medication;
• Cost: Perceived prescription affordability.

• Three response cards – 1 for each predictor (Commitment, Concern, Cost) – are available to HCPs to help identify patients with a likelihood for nonadherence and intervene accordingly.

• An education brochure – “Medication Matters” – is made available to HCPs to help guide their discussions with patients with a likelihood for medication nonadherence.

• The implementation process is at the HCP level:
  - A new prescription is identified for certain chronic conditions;
  - The Adherence Estimator is administered; and
  - The HCP scores the survey and addresses the results with patient support resources.

Metrics

• Merck’s work on the Adherence Estimator demonstrated that it was 88% accurate in classifying self-reported nonadherent patients as medium or high likelihood for nonadherence.

Value

• Improving adherence to prescription medications and lifestyle modification recommendations may offer several important benefits for health. Nonadherence may lead to suboptimal clinical outcomes.

• Resources, such as the Adherence Estimator and MerckEngage, are available to assist HCPs and patients to improve their communication about adherence.

• Improving adherence could contribute to lowering the almost $300 billion spent each year attributable to medication nonadherence.

MerckEngage

MerckEngage is a free, health support program that offers resources to help consumers achieve their health goals in partnership with their HCP, including improved adherence to their HCP’s treatment plan. MerckEngage.com is a web site for consumers designed to help them make – and stay with – healthy choices. Web site resources include:

• Health condition and general wellness information;
• Recipes and fitness ideas based on national nutrition and fitness guidelines;
• Tools for tracking nutrition, activity, and health conditions;
• Personal health tracking and condition information;
• Weekly e-mails with tips and Program updates;
• Rx for Health section, including The Adherence Estimator® and other adherence tools and resources;
• Support and encouragement for caregivers as well as for the people in their care;
• Updates to HCPs on their patients’ activity in the Program.
ENERGY MANAGEMENT & SUSTAINABILITY PROGRAM

Overview

✳ NewYork-Presbyterian Hospital (NYP) is a 2,278-bed academic medical center that provides patient care, teaching, research, and community service to a large and diverse population in New York City.
✳ For several years, NYP has identified excellence in energy management as an institutional priority in order to reduce costs and improve air quality for patients and employees.
✳ The energy program is fully embedded in the way that business is done across the enterprise. The organizational commitment includes:
  • Strong involvement from senior leadership;
  • A multidisciplinary, management-level Sustainability Council; and
  • A designated sustainability officer and an energy programs manager.
✳ By better conserving energy resources, NYP has saved approximately $27.7 million. The hospital can focus scarce resources on its vision of “Putting Patients First” and improving healthcare services for the community.

Background

✳ NYP launched its energy management and sustainability program in 2003, which included use of ENERGY STAR’s best practices in energy management guidelines (NYP would go on to become an eight-time winner of ENERGY STAR’s Partner of the Year award for Sustained Excellence in Energy Management.)
✳ In 2008, NYP enhanced its commitment to the program by forming:
  • A Senior Executive Sustainability Committee; and

Description

✳ The Energy Management and Sustainability Program unites energy management and waste management goals into a range of projects, including infrastructure upgrades, facilities retrocommissioning, energy audits, new building construction, and operations and maintenance process improvements.
✳ Specific high-impact projects include:
  • NYP’s Regulated Medical Waste Reduction Program handles regulated medical waste within the standards set by local and state regulations. The program increases staff awareness, with a special focus on high waste-generating areas such as operating rooms.
  • Through the Clinical Device Reprocessing Program, NYP started to purchase re-processed clinical devices rather than new devices in select areas, including some catheters, scalpels, and sleeves.
  • The Combined Heating and Cooling Plant (CHP) system generates electricity (using 27% less fuel than from the grid) and uses steam by-product for space heating and hot water. The system is designed to operate and remain fully functioning during a power outage, ensuring
that critical patient care operations at the hospital can continue without interruption.

- The Retro-Commissioning Program optimizes the operation and energy use of NYP’s facilities, including indoor environmental quality, hot water, heating and cooling, plumbing, electrical, and lighting efficiencies.
- The Facilities Aesthetic Condition Enhancement Program (FACE) provides continuous renewal and improvement to NYP’s infrastructure through regularly scheduled refurbishment work.
- Chiller Plant Web-Based Energy Monitoring has been implemented to continually analyze NYP’s chiller plant operations and district cooling systems.
- NYP diverts items, including boxboard, cardboard, magazines, and plastics, from the municipal solid waste stream (and eventually, the landfill) to recycle them. NYP also launched a recycling initiative for desktop printer cartridges.

**Metrics**

- **Regulated Medical Waste Reduction Program:** In 2012, NYP saved nearly $100,000 through improved medical waste disposal.
- **Clinical Device Reprocessing Program:** In 2011, NYP saved $1.1 million and in 2012 it saved $1.2 million through this initiative. It also eliminated more than 15,000 pounds of waste in 2011 and 28,000 pounds of waste in 2012.
- **Combined Heating and Cooling Plant:** In 2012, NYP realized cost savings of over $4 million through use of the combined heating and cooling plant.
- **Retro-Commissioning Program:** In 2012, this program realized savings of more than $1 million. NYP has made a commitment to realizing $4.3 million in utilities cost savings over four years.
- **FACE Program:** In 2012, the FACE team replaced 1,500 lamps with more energy efficient versions, the energy savings equivalent to the annual emissions of 25 passenger vehicles.
- **Chiller Plant Energy Monitoring:** In 2012, as a result of optimization and web-based monitoring, NYP attained $2.2 million in energy cost savings, equivalent to the annual emissions of 397 passenger vehicles.
- **Mixed Recycling Program:** This program diverts approximately $100,000 annually from the regular waste stream.

**Value**

- Since 2008, NYP has saved approximately $27.7 million through its energy management initiatives.
- In 2012, the net effect of NYP’s energy reduction measures was equivalent to the following:
  - Annual gas emissions of 1,765 passenger vehicles;
  - Annual CO2 emissions from 20,939 barrels of oil;
  - Annual CO2 emissions from the electricity use in 1,123 homes; or
  - Annual emissions avoided by recycling 3,137 tons of waste.
NEW YORK-PRESBYTERIAN REGIONAL HEALTH COLLABORATIVE

Overview

• New York-Presbyterian Hospital (NYP) is a 2,278-bed academic medical center that provides patient care, teaching, research, and community service to a large and diverse population in New York City.

• NYP developed a project to address the unmet needs of people living in the Washington Heights-Inwood neighborhood (upper Manhattan), who suffer from several socioeconomic and health disparities, including high levels of poverty, and high prevalence of chronic conditions such as asthma, diabetes, heart failure, and depression.

• To address these needs, NYP collaborated with Columbia University Medical Center, community providers, and community and faith-based groups, to develop a collaborative model of regional health planning and care coordination. The goal of the Regional Health Collaborative is to improve measurably the health of the local population, reduce disparities, and control costs.

• The Regional Health Collaborative is focused on reorganizing the fragmented local healthcare system into a virtually integrated “medical village” where everyone collaborates on a common approach to managing the care of patients with chronic conditions, directing patients to the necessary clinical and community services to best manage their conditions.

Background

• The residents in upper Manhattan were experiencing gaps in care and unmet needs while health costs escalated.

• In 2008, NYP initiated a major review of the local healthcare delivery model and found high rates of asthma, diabetes, heart failure, and depression during a formal health needs assessment of the community.

• NYP developed a multifaceted program to target those conditions. The goal was to create a population-based system of care that met the identified needs of the community, improved access to care, and coordinated care for each patient, wherever he or she received care.

• The transformed system launched in October 2010.

Description

• NYP and community practices were reorganized into NCQA-certified “patient-centered medical homes” focused on managing chronic conditions.

• Providers were reorganized into multidisciplinary care teams to collaborate more effectively on patient care.

• The use of preventive care and disease management was promoted to help patients manage their chronic conditions and prevent hospitalizations and emergency department (ED) visits.
  • This included a special focus on screening patients for depression because depression can hamper patients’ ability to take care of themselves.

• The Regional Health Collaborative model developed and implemented new information technology tools, including:
  • Registries to track patients with chronic conditions and identify adverse utilization trends and unmet needs; and
  • Dashboards to give providers a longitudinal picture of patients’ care and identify pending or overdue examinations, tests, or screenings.
• Specialized nurse care managers identified patients with complex conditions, such as multiple chronic conditions, and provided them extra attention and support – especially aiding their transition across different settings.

• Information systems were integrated across care sites to ensure providers can collaborate on patient health and coordinate care.

• Providers received cultural competency training to aid cross-cultural communication with patients. Bilingual-bicultural community health workers formed an integral part of the care teams.

**Metrics**

• The first six months of the program demonstrated a 9.2% decline in ED visits for so-called “ambulatory-sensitive conditions.”

• More recent unpublished data from the second performance year show much larger decreases in ED visits and hospitalizations for these conditions.

**Value**

• NYP invested $1.7 million in direct costs, and expects to receive $3.3 million in incentives from New York State’s Medicaid program for implementing the patient-centered medical home care model.

---

**Emergency Department: Use By Patients With Diabetes, Asthma, or Congestive Heart Failure, New York-Presbyterian Hospital, 2010 – 2011**

---

The Regional Health Collaborative is focused on reorganizing the fragmented local healthcare system into a virtually integrated “medical village” where everyone collaborates on a common approach.
SCREENING FOR UNDIAGNOSED HYPERTENSION

Overview

★ NorthShore University HealthSystem (NorthShore) is a comprehensive, fully integrated, healthcare delivery system that serves the Chicago region.
★ NorthShore has utilized an electronic health record that spans the ambulatory and inpatient continuum of care for more than 10 years.
★ Development of innovative approaches to diagnosis and therapeutic interventions in chronic disease management has arisen directly from NorthShore’s commitment to research informatics and quality and clinical analytics.
★ Deployment of more effective and efficient approaches to the diagnosis and treatment of chronic diseases will reduce the clinical and economic burden from these diseases.

Background

★ Some 29 percent of adults in the U.S. have hypertension. Approximately one third of patients with hypertension are undiagnosed.
★ Undiagnosed and untreated hypertensive patients are at a higher risk of developing heart disease, stroke, and chronic kidney disease.
★ One of the major reasons patients have unrecognized and undiagnosed hypertension is the unavailability of accurate and relevant blood pressure readings that promote clinical decision making and early intervention to treat hypertension and prevent longer-term consequences.
★ Since primary care physicians are often unaware of blood pressure readings collected outside of the office (readings taken in other office settings, including trends over time), it is important to provide information gleaned from the entire health system to support more effective care decisions.

Description

★ NorthShore’s enterprise-wide data warehouse allows for the collection of critical data points, while the Research Informatics and Quality and Clinical Analytics teams created algorithms to help weave raw data points into a probability index for basing the diagnosis of hypertension on these systemwide readings from multiple locations.
★ Patients with a high index of suspicion for the diagnosis of true hypertension were contacted using telephonic, patient portal (NorthShore Connect), and mail channels.
★ Use of an automated office blood pressure machine (AOBP) gave patients who were contacted a more accurate blood pressure reading performed in the office setting.
★ Using a set of informatics tools ranging from a fully deployed electronic health record, enterprise-wide data warehousing, research informatics, quality and clinical analytics resources, predictive modeling, patient portal-based communication, and office-based workflow changes, many new patients with historically unrecognized hypertension were found, producing greater opportunities to reduce cardiovascular risk in this population.

Metrics

★ In the first 18 months of the program, the rate of undiagnosed hypertension fell from 14% to 8% of the primary care adult population.
  • Some 1,586 patients were identified who satisfied at least one of the predictive algorithms created to help recognize patients with putative hypertension.
  • Of the initial population of patients identified by informatics algorithms to have possible
hypertension, 33% of them came to a NorthShore Medical Group office to validate their blood pressure.

- Of the patients who had blood pressures recorded by AOBP, 38.5% were found to have a verified diagnosis of previously unrecognized hypertension, and 41.5% had clinically relevant prehypertension, which is also a risk factor for future cardiovascular disease.

- Based on this initial success, approximately 50 new patients per month are found with a de novo diagnosis of hypertension where interventions ranging from lifestyle modification to medication starts have been implemented. Patients are also being recognized during office visits, where clinical decision support alerts identify patients who meet the criteria for being at high risk of having hypertension.

- Surveys of physicians were conducted to assess the value of the program:
  - 88% said the program led to a measurable improvement in patient care;
  - 79% said the intervention produced a change in their personal practices of patient care.

**Value**

- Most screening programs for hypertension rely on labor-intensive interventions across untargeted groups of patients. By instituting a program that focuses on patients identified as having probable hypertension, NorthShore can more effectively and efficiently intervene with patients having the highest risk for cardiac complications.

- Providing information about hypertension to patients and treatment teams at NorthShore has enhanced recognition of hypertension and allowed more effective treatment planning and higher degrees of patient engagement.

- This innovation has produced better diagnostic efforts leading to better quality of life and prevention of cardiovascular complications of patients with a very prevalent chronic disease state.
Overview

- Novo Nordisk Inc., a healthcare company with a 90-year history of innovation and leadership in diabetes care, is focused on changing the way America prevents and treats diabetes.
- Nearly 26 million adults in the U.S. have diabetes, and 7 million of them do not know it; they are the undiagnosed.
- Some 79 million Americans have prediabetes and are at high risk of developing type 2 diabetes within 7 to 10 years if no action is taken. About 90% of people with prediabetes are unaware of their condition.
- Targeted screening of people at high risk for type 2 diabetes is an essential first step to identify:
  - Those with prediabetes who can be referred to evidence-based, community-based diabetes prevention programs that focus on diet, exercise, and weight loss measures to prevent or delay the disease;
  - Those with undiagnosed diabetes who can begin treatment as early as possible in the course of their disease to prevent or delay the onset of complications.
- Targeted screening for diabetes and prediabetes is the entry point to stopping or curtailing the disease.

Background

- The Centers for Disease Control and Prevention (CDC) estimates that as many as 1 in 5 adult Americans could have diabetes by 2025 if current trends continue, and 1 in 3 adults by 2050.
- Diabetes typically has few or no recognizable symptoms in its early stages. As a result, when people are first diagnosed with the disease, they often already have complications.

Federal guidelines from the U.S. Preventive Services Task Force (USPSTF) recommend screening for type 2 diabetes only in asymptomatic adults with high blood pressure.
- Under the Affordable Care Act, coverage of preventive services such as screening for diabetes is tied to these guidelines. Thus, many individuals with risk factors for type 2 diabetes may not be eligible for free screening for type 2 diabetes with no insurance co-pay.
- Novo Nordisk commissioned research that resulted in an article published in Health Affairs in January 2012, “The U.S. Preventive Services Task Force Should Consider a Broader Evidence Based in Updating its Diabetes Screening Guideline.” The authors recommend that prevention of type 2 diabetes itself should be an important health outcome that the task force consider when assessing the value of screening for type 2 diabetes.

Description

- The current guidelines of the American Diabetes Association (ADA) are based on multiple risk factors and recommend screening individuals who are overweight or obese and have one or more risk factors:
  - Physical inactivity, family history of diabetes, high-risk race or ethnicity, hypertension, high cholesterol, cardiovascular disease, history of gestational diabetes, delivery of baby weight more than nine pounds, or polycystic ovary syndrome.
  - For individuals without risk factors, ADA recommends that screening begin at age 45 and, if no diabetes is found, be repeated at least every three years.
- Other entities that recommend risk factor-based screening include: Centers for Medicare and
Medicaid Services (CMS), Department of Defense, Department of Veterans Affairs, the American Association of Clinical Endocrinologists, National Diabetes Education Program, National Institute of Diabetes and Digestive and Kidney Diseases, and the American College of Physicians.

In May 2013, the USPSTF announced that it will begin an evidence review on screening for type 2 diabetes to update its current screening recommendation.

In May 2013, the USPSTF announced that it will begin an evidence review on screening for type 2 diabetes to update its current screening recommendation.

Metrics

Research shows that compared to the current federal guidelines, the screening guidelines of the ADA are better at identifying people with undiagnosed diabetes and prediabetes and more cost-effective.

• A retrospective study of nearly 47,000 adult patients comparing the ADA and USPSTF guidelines found that USPSTF guidelines identified one-third fewer people with diabetes.

• A study that applied USPSTF guidelines to National Health and Nutrition Examination Survey (NHANES) data for more than 7,100 adults found that the USPSTF screening recommendations identified fewer than half of those with undiagnosed diabetes.

• A modeling study found that screening for type 2 diabetes reduces complications and deaths when started between the ages of 30 and 45, with screening repeated every three to five years.

• This study also found that the current USPSTF guideline detects fewer cases of type 2 diabetes and has a smaller effect on preventing eye, kidney, and nerve damage than screening based on age.

Value

• Screening is the entry point for preventing both the disease and its complications. Research recently published by the ADA shows that in 2012, diabetes cost the nation $245 billion – a 41% increase from 2007.

• People with diabetes have medical costs that are more than twice as high as people without the disease. With targeted screening of people at high risk for diabetes, we can identify more people with prediabetes and undiagnosed diabetes and begin to alter the human and economic toll of diabetes.

**79 MILLION WITH PREDIABETES—BUT THEY DON’T KNOW IT**

- **SCREENING**
  - Diagnosed Diabetes
  - Diagnosed Prediabetes
  - Steps to prevent complications
  - Steps to prevent diabetes
  - People who are undiagnosed get screened and therefore get treatment

**MORE HEALTH CONSEQUENCES PREVENTED BY SCREENING ADULTS STARTING AT AGE 45**

- Heart Attack Prevented
- Complications Prevented
- Deaths Prevented
Overview

* Novo Nordisk Inc., a healthcare company with a 90-year history of innovation and leadership in diabetes care, is focused on changing the way America prevents and treats diabetes.

* The National Diabetes Prevention Program (National DPP) is an evidence-based lifestyle intervention designed to help prevent or delay the onset of type 2 diabetes in people with prediabetes who are overweight. The community-based program can also have positive impact on other conditions, disease states, and outcomes by:
  - Helping achieve weight loss;
  - Encouraging an increase in physical activity levels;
  - Facilitating healthier eating habits;
  - Improving the risk factors for cardiovascular disease; and
  - Improving health-related quality of life

* Novo Nordisk’s goal is to defeat diabetes by working toward better prevention, detection, and treatment. In the fight against type 2 diabetes, National DPP is a game changer.

Background

* Nearly 26 million people in the United States have diabetes, and 7 million are undiagnosed.
  - More than 90% of people with diabetes have type 2 diabetes.
  - Diabetes is the leading cause of kidney failure, nontraumatic limb amputations, and new cases of blindness in American adults. People with diabetes are 2 to 4 times more likely than people without diabetes to develop heart disease or suffer a stroke.
  - Diabetes costs the nation $245 billion in 2012, a 41% increase from 2007.
  - The Centers for Disease Control and Prevention (CDC) estimates that as many as 1 in 5 adults could have diabetes by 2050.

* Prediabetes is a condition in which blood glucose (blood sugar) levels are higher than normal, but not high enough for a diagnosis of diabetes.
  - Individuals with prediabetes are at high risk of developing type 2 diabetes within 7 to 10 years, unless they take steps to prevent or delay the disease.
  - In 2005-2008, 35% of U.S. adults aged 20 years or older had prediabetes (50% of adults aged 65 years or older). Of the entire U.S. population in 2010, an estimated 79 million American adults aged 20 years or older has prediabetes.

Description

* The Diabetes Prevention Program (DPP), a $200 million clinical trial conducted by the National Institute of Diabetes and Digestive and Kidney Diseases, found that overweight and obese individuals diagnosed with prediabetes who lost a moderate amount of weight (5% to 7% of their original body weight) and engaged in regular physical activity reduced their chances of developing type 2 diabetes by 58%. Adults aged 60 years and older reduced their risk by 71%.

* The Diabetes Prevention Program Outcomes Study (DPPOS), a 10-year follow-up of DPP participants, found that prevention or delay of diabetes and its complications persisted for a decade or more.

* Research scientists at Indiana University successfully replicated the DPP lifestyle change...
protocol in groups in community settings, demonstrating that they could achieve similar outcomes to the DPP study for about $300 per participant.

**Metrics**

* Community-based programs recognized by the National DPP can potentially reduce the risk of developing type 2 diabetes by 58% in people at high risk of developing the disease and by 71% in adults aged 60 and older.

* From 2010 through early 2012, YMCA of the USA (Y-USA) rolled out DPP in 51 cities in 26 states and enrolled more than 4,000 participants. Average weight loss among participants who completed the program was approximately 5%.

* The National DPP now operates in 32 states delivering life-changing interventions at more than 500 sites.

**Value**

* In 2010, Novo Nordisk gave a grant to Y-USA to provide 400 scholarships for Medicare-age adults with prediabetes who are overweight to participate in the YMCA’s Diabetes Prevention Program in Louisville and Lexington, KY; Phoenix, AZ; and Atlanta, GA.

* In 2012, Y-USA received a nearly $12 million Innovation Grant from the Center for Medicare and Medicaid Innovation to provide the YMCA’s Diabetes Prevention Program to 10,000 Medicare beneficiaries in 17 communities with an estimated cost savings to Medicare of $4.2 million over 3 years and $53 million over 6 years.

* One study has estimated that rolling out evidence-based diabetes prevention programs across the U.S. through the National DPP could save the nation $191 billion over the next decade, with 75% of savings going to Medicare and Medicaid.

* In 2010, Congress authorized the Centers for Disease Control and Prevention (CDC) to establish and lead the National DPP to bring to scale the evidence-based DPP lifestyle intervention in communities across America.

  * CDC partnered with the YMCA of the USA (Y-USA) and UnitedHealth Group (UHG) to begin to roll out the program nationwide. Now, the CDC has multiple partners across the country.
  * In July 2013, the Senate Appropriations Committee approved $10 million for the National DPP. This commitment for 2014 funding brings the total federal commitments to the National DPP to $42 million and means that more National DPP sites will be available to thousands of Americans at risk for type 2 diabetes.
VALUE ANALYSIS ENGINEERING

Overview

* Hospitals face increasing pressure to create sustainable cost savings while improving the quality of care delivered to patients. Owens & Minor supports hospitals so they can contain and reduce costs efficiently, comprehensively, and with finely tuned precision.

* Owens & Minor has developed a strategy for systematic and sustainable savings within supply chains at hospitals and health systems through value analysis engineering (VAE), which uniquely combines unparalleled nonlabor cost knowledge with deep hospital operations expertise to engineer processes that achieve significant, sustainable savings.

Background

* Value analysis engineering differs from traditional value analysis. VAE is a value-based partnership that brings strategy and discipline to optimize the cost-to-value of nonlabor supplies and services across the healthcare network in order to create and sustain broad savings.

* It is a collaborative, organizational effort that uses multi-disciplinary teams and processes to achieve the greatest value at the lowest total cost for all non-labor expenses, for repeatable and predictable savings.

Description

* Case Study: PinnacleHealth
  * The leading hospital and healthcare provider in central Pennsylvania, PinnacleHealth, faced declining financial performance across its healthcare system due to lower patient volumes, higher demands for uncompensated care, escalating supplier costs, and mounting reimbursement pressures.

RAISE: OWENS & MINOR’S APPROACH TO VALUE ANALYSIS ENGINEERING

* RESPONSIBILITY
  Building a “winning” culture where multi-disciplinary.

* ANALYSIS
  Impart critical knowledge and insight that identify predictable, repeatable savings.

* INTEGRATION
  Design and implement the processes and tools to optimize non-labor cost savings.

* SYNCHRONIZATION
  Bridge processes, systems, and departmental relationships across organizations to increase effectiveness.

* EMPOWERMENT
  Transfer knowledge and build-in infrastructure for sustainable savings.

- In January 2010, Owens & Minor and PinnacleHealth teamed up together to realign the supply chain and achieve cost savings goals to remove at least $10 million from the operating budget.
- With PinnacleHealth, Owens & Minor helped form 7 committees of hospital employees within the following hospital departments: perioperative, laboratory, support services, patient care, administrative, cardiology/imaging, and pharmacy.
- Owens & Minor provided value analysis counsel as well as tools for committee members to develop skills that challenged the status quo of purchasing practices, encouraging individuals to think differently about how to identify, compare, and purchase products and services.
Metrics

* As a result, PinnacleHealth employees embraced their role in savings. Owens & Minor helped Pinnacle staff analyze more than $115 million in total expenses through more than 370 initiatives. PinnacleHealth showed improvement in negotiation tactics and strategies, creating lasting value for individual hospital departments and lasting savings for the organization.

* Using a VAE approach, PinnacleHealth saved more than $11 million in its first year – roughly 10% of its total supply-related expenses.

Value

* Owens & Minor understands that culture change means creating engagement and accountability across the organization. Each of the 7 committees of hospital employees achieved its departmental goal. Five teams exceeded expectations.

* Owens & Minor introduced a new approach to supply management that will have lasting effects. Not only did the team help to drive major savings in the first year, but the Pinnacle team is also on track to continue generating value. Only halfway into its second year of value analysis engineering, the health system has already saved an additional $5 million, with an annual goal of $6 to $7 million.

* PinnacleHealth expects to maintain 3 percent annual savings in supplies and purchased services over time. Value analysis engineering is not simply a peer review or a cost-cutting exercise, but a collaborative, organization-wide effort that creates a sustainable foundation for continued supply chain savings.

<table>
<thead>
<tr>
<th>SAVINGS AREA</th>
<th>IMPLEMENTED SAVINGS</th>
<th>PERCENT CHANGE</th>
<th>FOCUSED ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH INFORMATION MANAGEMENT</td>
<td>$140,267</td>
<td>74%</td>
<td>Contract renegotiation, waste elimination, and enhanced capture for PPI practices</td>
</tr>
<tr>
<td>TELECOMMUNICATIONS</td>
<td>$125,787</td>
<td>74%</td>
<td>Service and technology consolidation and program improvements</td>
</tr>
<tr>
<td>LINEN MANAGEMENT</td>
<td>$856,873</td>
<td>33%</td>
<td>Inventory buyback, conservation, labor reductions, and other process improvements</td>
</tr>
<tr>
<td>PLANNING, MARKETING, &amp; COMMUNICATIONS</td>
<td>$597,167</td>
<td>32%</td>
<td>Modification and elimination of programs, advertising, and services</td>
</tr>
</tbody>
</table>

**Owens & Minor/PinnacleHealth Partnership at-a-Glance**

- Analysis of more than **$117 million** in expenses;
- Total savings of more than **$11 million** through 372 initiatives;
- Supply savings of **$8.8 million** from a total spend of $89.5 million;
- Purchased services savings of **$2.9 million** from a total spend of $28.3 million.

**Department “AHA” Savings Moments – A Sampling**
Overview

- The Premier healthcare alliance is a performance improvement alliance of more than 2,500 U.S. hospitals and 72,000+ other healthcare sites using the power of collaboration to lead the transformation to high-quality, cost-effective care.
- If the purpose of Premier is to improve the health of communities, then the purpose of Live Well, Be Premier is to improve the health of Premier.
- Premier evaluates Live Well, Be Premier by analyzing results from biometric screenings and employee participation levels. Premier employees have consistently gotten healthier in the past few years and healthcare costs have stayed relatively flat.

Background

- “Our people make us Premier,” and we know that our employees are the foundation of Premier’s success. Premier first took strides to create a culture of wellness about eight years ago. Today, wellness is a deeply ingrained culture.
- Premier has always supported grassroots efforts and ideas from our employees, and the need and desire for a wellness program was no different.
- The Premier Wellness Committee works to create an abundance of wellness opportunities reflecting the unique needs of Premier employees.
- In 2013, over 800 people, nearly 70% of employees, completed health biometric screenings and online health risk assessments.

Description

- Live Well, Be Premier focuses on providing employees with a wide variety of wellness offerings to help employees remain healthy and engaged at home and at work.
- Premier employees can earn up to $25 per month in “Healthy Credits” for taking action and falling within healthy ranges on annual biometric screenings.
- Premier’s “Move 365” program was created in partnership with Healthyroads and designed to encourage employees to exercise on a daily basis. Every quarter, employees participate in fun competitions and challenges.
  - Employees are rewarded for their participation in competitions in various ways, including receiving points for a recognition and rewards program. The points have a monetary value that employees can redeem to purchase items of their choosing.
- Premier has collaborated with many “neighbors.” For example, Premier has a partnership with a local Y as well as Carolina’s Healthcare System to offer everything from on-site exercise classes and sports leagues to Physician Walk and Talks.

Metrics

- Over the past two years, Premier has seen a significant decrease in its identified population with high health risks through biometric testing. The number of employees with:
  - High risk for metabolic syndrome has dropped 18%;
  - High blood pressure is down 21%;
  - High total cholesterol is down 16%; and
  - A high waist circumference is down 12%.
- Based on projected savings from improved health risks, Premier has saved more than $700,000 in annual claims costs to its health plan (an approximate 6% savings of total claims cost).
Premier has also seen a significant decrease in health risks over the past 2 years for employees who have participated in the biometric tests year-over-year. In this "cohort" population:

- Employees at high risk for metabolic syndrome has dropped 15%;
- Employees with high blood pressure are down 20%;
- Employees with high total cholesterol are down 10%; and
- Employees with a high waist circumference are down 7%.

Premier employees are healthier than the average employee, and because of this, Premier sees lower healthcare costs than most employers.

Premier saw only a 5.4% increase in total claim costs in CY 2012 after a 28% increase in CY 2011.

Premier employees have about 20% fewer inpatient admissions, bed days, and ER visits than Cigna’s book of business. Premier employees also have lower medical spending on both inpatient and outpatient care.

In CY 2012, Premier saw a decrease in year-over-year per-member-per-month costs overall.

The only metric in which Premier’s cost was higher than the benchmark was for preventive care.
CITIES FOR LIFE

Overview

* Sanofi is an integrated global healthcare leader that discovers, develops and distributes therapeutic solutions focused on patients’ needs. The company’s innovations focus on diabetes solutions, human vaccines, innovative drugs, consumer healthcare, emerging markets, animal health, and the new Genzyme.

* Sanofi US has taken a leadership role in Cities for Life, a diabetes management program in Birmingham, Alabama, with the American Academy of Family Physicians Foundation because it is committed to helping people living with type 2 diabetes.

* Cities for Life works with community groups to create an environment that facilitates healthy lifestyles and diabetes management.

Background

* Nearly 26 million people in the U.S. live with diabetes. It is currently projected that 1 in 3 Alabamians born after 2000 will develop diabetes during their lifetime.1,2

* Birmingham was selected for Cities for Life out of more than 50 cities.

* Cities for Life launched in April 2012. The clinical component of the program is currently wrapping up, while the community component of the program will continued to be sustained in Birmingham.

* Local founding partners and Steering Committee members include:
  - University of Alabama Birmingham (UAB) Department of Family and Community Medicine;
  - UAB’s Diabetes Research and Training Center’s Community Engagement Core;
  - UAB HealthSmart; and
  - YMCA of Greater Birmingham.

Description

* **Clinical Components**
  - Local family medicine practices referred patients living with or at risk for type 2 diabetes to patient navigators. The patient navigators worked with patients to identify the best programs in their local areas to help patients manage their condition, encourage program participation, and serve as a resource for patients in addition to their physician.

* **Community Components**
  - A Community Action Team (CAT) of more than 80 organizations with programs and activities that can help diabetic participants united.
  - The CAT informs www.mydiabetesconnect.com, a free searchable database that alerts people to the availability of local programs and services.
  - The CAT identifies or created educational programs, relevant local events, etc. for community members.
  - A Steering Committee leads the CAT and coordinates day-to-day program work.

Metrics

* The program has reached a wide audience.
  - More than 80 organizations recruited to the CAT
  - Some 36 local events and speaking engagements reached more than 7,444 people;
  - Two citywide events, featuring participation by the mayor of Birmingham, several members of the Birmingham City Council, and Tony award-winning actor Ben Vereen;
  - Some 35.5 million media impressions;
• Monthly e-mail updates to CAT;
• Distribution of 8 collaboration awards to expand resources for people living with diabetes in Birmingham;
• Two patient navigators provided services to 167 patients referred by PCPs from six physician practices
• Launch of mydiabetesconnect.com;
• Abstracts for publication or poster presentation accepted at:
  ✴ The American Diabetes Association 73rd Scientific Sessions;
  ✴ The North American Primary Care Research Group – Practice-Based Research Network Conference; and
  ✴ The American Association of Diabetes Educators Annual Meeting and Exhibition.
• Changes in attitudes and perceptions about diabetes and community resources were measured at baseline via surveys of physicians, people at risk for or diagnosed with type 2 diabetes, and members of the community at large. (Surveys will be repeated at program conclusion.)
  ✴ Baseline survey findings revealed gaps in perception between primary care providers (PCPs) and patients regarding diabetes management. These perceptions include:
  ✴ 70% of PCPs believe their diabetes patients participate in recommended programs, but only 31% of patients reported participation;
  ✴ Zero PCPs believed that their diabetes patients receive major support from family and friends, but 54% of patients reported that they receive major support; and
  ✴ PCPs view weight loss programs and the use of Certified Diabetes Educators as significantly more helpful resources than patients.
• Clinical measurement will include:
  • Physician and staff interviews at baseline and endpoint;
  • Site visits to collect process and workflow data;
  • Evaluation of the referral and tracking system;
  • Historical review of patient charts from pre-Cities for Life to endpoint;
  • Review of typical clinical markers; and
  • Surveys and one-on-one interviews with patients.

Value
• By connecting people living with diabetes to community-based resources that can help them manage their disease, Sanofi and the American Academy of Family Physicians Foundation are helping to improve diabetes management in Birmingham and demonstrating how a new model for diabetes management can be used by other communities across the country.

Overview

* SCAN Health Plan is a not-for-profit Medicare Advantage plan serving more than 145,000 beneficiaries in California and Arizona. It was founded by a group of senior citizen activists to help the chronically ill continue to live independently while managing a variety of health challenges.

* SCAN’s Model of Care provides the right care at the right time, catering to each individual’s unique needs across the care continuum.

* SCAN’s Dual Eligible Special Needs Plan (D-SNP) fully integrates Medicare and Medicaid benefits for the nearly 8,000 members enrolled. These beneficiaries qualify for coverage under both programs, and they are among the most complex and costly individuals in the healthcare system.

* SCAN’s D-SNP members are eligible to receive comprehensive, coordinated services, which help keep them out of institutions allow them to receive care in a home or community-based setting.

* A 2012 study conducted by Avalere Health found that dual eligibles enrolled in SCAN’s D-SNP were 14% less likely to be admitted to a hospital and 25% less likely to be readmitted within 30 days of discharge, compared with a similar group of dual eligibles receiving care in Medicare fee-for-service (FFS).

Background

* Dual eligibles, including seniors and disabled adults with acute care needs, are the most vulnerable beneficiaries served by Medicare and Medicaid, but federal and state governments face unsustainable growth in the cost of caring for these individuals.

* Medicare costs associated with this population totaled $127 billion in 2010 and were approximately twice the average spent on non-dual Medicare beneficiaries.

* In Medicaid, dual eligibles accounted for 40% of total spending but only 15% of the program’s enrollment in 2008. In addition to high healthcare costs, dual eligibles have complex needs: nearly 50% of dual eligibles have some form of mental impairment or dementia, and roughly 35% have four or more chronic conditions.

Description

* For more than 30 years, SCAN’s Model of Care has met the medical, mental health, and long-term care needs of dual eligibles by focusing on the entire person.

* The personalized services offered by SCAN include motivational interviewing, personal care, medical transportation, adult day care, caregiver support services, home-delivered medicines, a 24-hour nurse line, and advance care planning.

* To assess the value of SCAN’s model, Avalere looked at the Healthcare Effectiveness Data and Information Set (HEDIS) 30-day all-cause hospital readmissions rates for more than 5,500 dual-eligible SCAN enrollees and an equivalent number of FFS dual eligibles in California with similar medical conditions.

* This methodology was designed to help ensure that similar risk profiles were being compared across SCAN dual eligibles and FFS dual eligibles.

Metrics

* SCAN’s D-SNP members had a hospital readmission rate that was 25% lower than those in FFS. In addition, SCAN performed 14% better than Medicare fee-for-service on the “prevention quality indicator (PQI) overall composite” — keeping people out of the hospital to begin with.
Comparing “apples to apples” on hospitalization rates, SCAN outperformed Medicare FFS in 9 of the 12 individual PQI measures that make up the overall composite.

The study also showed the potential for additional cost savings in caring for this population. If California Medicare FFS dual eligibles had the same hospitalization and readmission rates as SCAN’s dual eligibles, there could be 1,320 fewer hospitalizations and 1,773 fewer readmissions. This would result in approximately $50 million in annual cost savings to Medicare FFS in California.

**Value**

SCAN’s Model of Care provides policymakers with a ready-made template to improve the health of vulnerable populations and control healthcare costs. These results are particularly valuable as federal and state budgets continue to be stressed as the nation grapples with how to care for an aging society.

Because dual eligibles are more likely than other Medicare beneficiaries to go into and stay longer in the hospital, the ability to avoid hospitalization has meaningful budgetary implications. If the FFS program were able to achieve those lower rates of hospital care, the Medicare program would realize considerable savings.

Integrated care can mean better care if individuals are carefully tracked, if care is coordinated, and if members are directed into the types of programs that fit their needs and allow them to age well.
THE POWER TO SAVE: STRYKER POWER-PRO XT COT AND POWER-LOAD COT FASTENER SYSTEM

Overview

※ Stryker is one of the world’s leading medical technology companies and is dedicated to helping healthcare professionals perform their jobs more efficiently while enhancing patient care. The company offers a diverse array of innovative medical technologies, including reconstructive, medical and surgical, and neurotechnology and spine products to help people lead more active and more satisfying lives.

※ Stryker’s emergency medical service (EMS) equipment provides innovative solutions to address a broad array of emergency transport needs, while reducing the risk of injury to medics and enhancing patient care.

Background

※ EMS response personnel face significant risk of back strain and injury due to growing patient weights, the subsequent transporting of patients up and down stairs, the lifting and lowering of cots, and the loading and unloading of cots into and out of ambulances.

※ A survey of 1,356 National Association of Emergency Medical Technicians (NAEMT) members reported that 4 in 5 EMS workers have experienced some kind of injury or medical condition as a result of their work.

※ The risk for EMS workers of injuries and lost workdays is six times more likely than the national average. Some 1 out of 4 EMS providers will suffer a career-ending injury in their first 4 years.

※ The lifting process accounts for 62% of medic injuries, and back strain is the cause of 78% of compensation paid for lost productivity.

※ Stryker EMS is dedicated to understanding the cause of injury to the EMS industry and developing products that reduce spinal load and increase a medic’s margin of safety.

Description

※ Stryker Power-PRO XT cot reduces the risk of injuries when raising and lowering a patient. An innovative battery-powered hydraulic system raises and lowers the patient at the touch of a button. Backsmart® ergonomic design minimizes the risk of injury to the EMS professional, as well.
Stryker Power-LOAD Cot Fastener System reduces the risk of injuries when loading and unloading a patient from an ambulance. Power-LOAD lifts and lowers the cot into and out of the ambulance, reducing spinal loads and the risk of cumulative trauma injuries. The Power-LOAD cot fastener system improves operator and patient safety by supporting the cot throughout the loading and unloading process.

The Stryker Power to Save Guaranteed program guarantees that using the Stryker Power-PRO cot will result in at least a 50% reduction in cot-related injuries pertaining to raising and lowering cots, or Stryker will replace all Power-PRO™ cots with equivalently configured manual cots plus the difference in price after the first year.

**Metrics**

In a recent study, the biomechanical impacts on paramedics and emergency medical technicians (EMTs) were evaluated when lifting and loading 3 cot designs into an ambulance using 3 different cot fastener systems.

The study compared the lifting, loading, and unloading of Stryker Power-PRO using a manual loading system, Stryker Power-PRO using Stryker Power-LOAD, and two manual lift cots using manual loading systems.

Study results showed that:

- The Stryker Power-PRO cot alone provides a 50% decrease in compression forces compared with a manual cot during lifting, loading, and unloading;
- Adding Power-LOAD to the Power-PRO cot may decrease exposure to compression forces by 30% during loading and unloading;
- The Stryker Power-PRO cot alone provides a 44% reduction in low back disorders (LBD); LBD are disabling low back troubles possibly related to work intolerance;
- Adding Power-LOAD to the Power-PRO cot provides a 62% reduction in LBD risk.

**Value**

Keeping employees injury-free is a top priority for employers. Users of Stryker EMS equipment have saved money, costs, careers, and risk of injury to employees and patients alike.

Injuries to patients and workers have been significantly reduced, significant savings in Workers Compensation Insurance premiums have been achieved, and productivity has increased by reducing “lost” and modified workdays due to a work injury. Stryker products empower EMS caregivers so that they can provide better patient care.

INCENTIVES FOR ADOPTION AND USE OF E-PRESCRIBING

Overview

✿ Surescripts operates the nation’s largest clinical health information network, guided by the principles of neutrality, transparency, physician and patient choice, open standards, collaboration, and privacy.

✿ Surescripts will enable the healthcare system of the future through enhanced care collaboration and connectivity. The company is committed to saving lives, improving efficiency and reducing the cost of healthcare for all.

✿ Surescripts has found that financial incentives can drive providers’ adoption and use of health information technology such as e-prescribing, and that health information networks can be a powerful tool in tracking incentives’ progress.

Background

✿ E-prescribing, or the electronic generation of a prescription and its routing to a pharmacy, is generally believed to improve healthcare quality and reduce costs. However, physicians were slow to embrace this technology.

✿ In 2008, Congress authorized e-prescribing incentives as part of the Medicare Improvements for Patients and Providers Act (MIPPA). The federal government made $148 million in MIPPA e-prescribing bonus payments to physicians in 2010.

✿ To date, no one has been able to track the return on investment for federal intervention; Surescripts is in a unique position with access to timely, comprehensive and accurate data.

✿ In July 2013, Health Affairs published an original research paper entitled, “E-Prescribing Adoption and Use Increased Substantially Following the Start of a Federal Incentive Program.” The study showed robust evidence of the effects of federal intervention on health IT adoption, utilization, and eventually health outcomes.

Description

✿ Surescripts was created in 2001 to enable electronic prescription routing between providers and pharmacies. The Surescripts e-prescribing network is used by pharmacies, payers, pharmacy benefit managers, physicians, hospitals, health information exchanges, and health technology firms.

✿ Surescripts sought to answer the following questions:

• Did incentives accelerate rate of e-prescribing adoption?

• Did incentives affect providers who had adopted e-prescribing systems prior to the incentive program?

• Was the impact of incentives limited by certain factors, such as geography, or could it be observed across practice settings?

✿ Incentives were very effective for several reasons:

• The program included a sliding scale of financial incentives and penalties, which provided higher returns on investment to those who adopted earlier than to those who waited to adopt.

• The incentives were tied to providers’ reimbursement for Medicare services, making the program relevant to a high proportion of providers.

• The incentives were provided not just for adoption but also for the continued use of e-prescribing during each measurement period, so providers were motivated to invest in long-term workflow adjustments.

• Eligibility for the incentives was based on clear and measurable results—numbers of e-prescriptions—instead of a demonstration of
compliance with a process. This gave providers the flexibility to choose e-prescribing technology that was appropriate for their specific needs and to decide how they would adapt their workflow.

**Metrics**

- Some 40% of prescribers adopted between July 2008 and December 2010, (89,000 to 94,000 more than expected absent MIPPA) in response to the incentive program.
- During the same period, use among legacy e-prescribers increased 9-11% in response to incentives, equivalent to 6.8-8.2 prescriptions per month, per prescriber.
- Increase in adoption occurred across practice size with no statistical difference among socioeconomic status.

**Value**

- Insights from Surescripts’ experience with incentives can inform assessments of the impact of other electronic health record incentives in effect and plans to structure or adjust future incentive programs to maximize return on investment.

---

BE WELL

Overview

* Takeda is one of the top 15 pharmaceutical companies in the world, with market presence in around 70 countries worldwide. Globally, Takeda employs more than 30,000 employees, with 3,400 employees based in its largest U.S. facility in Deerfield, IL.

* Takeda strives towards better health for people worldwide through leading innovation in medicine. Takeda’s rich 230-year history is rooted in a dedication to improving health and wellness, and that commitment begins with its own employees.

* Be Well is Takeda’s Deerfield wellness initiative that strives to foster a culture of wellness and provide the resources, programs, and tools that encourage good healthcare choices and healthy lifestyles.

Background

* Be Well is founded on the belief that the choices people make every day lead to a lifetime of better health. To aid in this pursuit, Takeda provides access to preventive health care opportunities, often to employees and their families, as well as a variety of programs to better physical, emotional, and financial wellness.

* Be Well formally launched in early 2013; however, Takeda has offered numerous wellness programs to employees and their dependents, including free annual onsite flu shots and health screenings.

* Based on the evaluation of clinical test results gathered during free annual health screenings, Takeda has earned recognition in three of the past five years as a “Healthiest Company in America” from Interactive Health, an outcomes-based wellness and health management solutions company. The award identifies companies that demonstrate improved employee health across an index of key health indicators.

Description

* Takeda’s Be Well program focuses on providing employees with relevant information to inform good choices for better health and well-being.

* Be Well is anchored by free annual health screenings.

  * All employees covered under Takeda’s medical benefits and their covered spouse/domestic partner may receive free health screenings. Non-employees or contractors may participate for a fee.

  * The screening results generate a personalized health assessment that may be sent directly to the employee’s physician for further discussion. It contains details on blood pressure, total cholesterol (good/bad cholesterol), blood glucose level, and triglycerides—along with resources to help address any problem areas.

  * Within 24-48 hours after health screening, Interactive Health contacts anyone who has been identified as having lab values in the critical to life-threatening range.

* A Personal Health Score is also derived from the health screening and is designed to help participants understand where they stand for future risk of coronary artery disease and diabetes.
• The score is comprised of five lifestyle-related, modifiable risk factors: tobacco use, blood glucose, cholesterol, triglycerides, and blood pressure.

• Takeda provides the following benefits on-site to employees:
  • Free fitness center;
  • Weight Watchers meetings;
  • Flu shots;
  • Walking path;
  • Onsite nutritionist (for a fee); and
  • Healthy, sustainable food service.

• In addition to onsite opportunities, Takeda offers employees:
  • 100% coverage for preventive care services at in-network physicians;
  • Annual “Takeda Cares Day” 5k run/walk benefiting charity;
  • Personal counseling through an employee assistance program;
  • Access to expert financial planning assistance;
  • Tobacco cessation;
  • Disease management and fitness challenges;
  • “Ask Our RD” program, providing virtual contact with a live registered dietician
  • 24-Hour NurseLine, an informed health line with 24/7 access to registered nurses; and
  • Numerous online resources.

**Metrics**

• Takeda’s health screening results have shown an increase in participation year over year.
  • In 2013, 1,108 participants completed a health screening (906 employee/202 spouse).
  • More than 80% of participating employees fall in the low-risk category for current health conditions. Less than 10% overall fall in to the high-risk category.

• Compared with Interactive Health’s book of business (BOB) and national averages, Takeda employees are healthier:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Takeda (2012)</th>
<th>Interactive Health’s BOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metabolic syndrome (pre-diabetes)</td>
<td>8%</td>
<td>28%</td>
</tr>
<tr>
<td>Referred to a physician</td>
<td>41%</td>
<td>58%</td>
</tr>
<tr>
<td>Require a critical outreach call (lab values are in the critical to life-threatening range)</td>
<td>1%</td>
<td>2-3%</td>
</tr>
<tr>
<td>Tobacco use (self-reported)</td>
<td>&lt;4%</td>
<td>National average for working population is approx. 14%</td>
</tr>
</tbody>
</table>

**Value**

• Takeda’s year over year aggregate Health Score in 2012 was 9, a one-point improvement over 2011. The first year Takeda offered Interactive Health’s program (2007) the score was 6. By investing in employee health, Takeda has seen real returns in employee health, which will drive sustained changes in health cost.
Overview

- Texas Health Resources is a large north Texas, faith-based nonprofit system of 25 acute-care, transitional, rehabilitation, and short-stay hospitals and 18 outpatient facilities with 21,100 employees and more than 5,500 physicians.
- Texas Health adopted a systemwide approach to three important patient safety activities: hand hygiene, two-patient ID, and time out. These results linked to Success Sharing for all employees.
- An innovative measurement approach that began in 2008, it uses a 2-tiered observation process independently to measure adherence to the 3 patient safety measures and provides feedback for targeted improvement from these observations.

Background

- Three important patient safety processes have been identified as key factors in reducing hospital acquired infections and catastrophic events: hand hygiene, wrong-site surgeries, and patient misidentification.
  - The Institute of Medicine reports that 90,000 patients die each year from hospital-acquired infections linked closely to poor hand hygiene. Yet, only about 40% of all healthcare workers comply with hand hygiene rules.
  - The Cost of treating hospital-acquired infections in the U.S. approaches $4.5 billion annually.
  - Wrong-site surgery is a rare catastrophic event that is caused by failures in communication, procedural noncompliance, and ineffective leadership.
  - Errors related to misidentifying patients are not well-reported but can result in medication, blood, and other laboratory-related errors.

Description

- In 2006, Texas Health studied the Nuclear Regulatory Commission’s observation techniques in order to observe the medical process better without being seen as observers.
- These observation processes allowed Texas Health to provide feedback on three patient safety measures that are traditionally very difficult to measure and for which self-reporting was unreliable.
- Texas Health created and trained two teams of observers: hospital teams and systemwide teams. This 2-tier strategy allowed hospitals to use the methodology as an improvement technique, and system observers collected patterns of systemwide opportunity in performance.
- They also implemented Success Sharing, a bonus structure, for all full-time employees based on performance measured by the independent observers.

Metrics

- Performance improved on all 3 patient safety indicators from the baseline of 88% compliance to 94% during the 3 years of Success Sharing.
- Hand Hygiene compliance improved, even when the observation and compliance rate expanded from staff to include volunteers and the independent medical staff. Central Line Associated Blood Stream Infections (CLABSI) declined significantly in all areas after observation of hand hygiene began.
- Two methods of patient identification are a key safety check prior to administering medications, conducting tests, or drawing specimens. Failures in patient identification are closely linked to errors in these processes. Texas Health measured significant improvement along with a marked decrease in adverse drug events – particularly related to “wrong patient” issues.
Time out in the procedural areas is both a teamwork and communication safety step. This process is measured in the preoperative holding area, the procedure room and finally as the patient is exiting the procedure area. Texas Health used a process of involving physicians (anesthesiologists and surgeons) along with procedural staff in the design of the information shared and when and how it was shared. Time out compliance has increased significantly, and wrong site surgery decreased.

**Value**

- Improvement from baseline measurement of 88% compliance with hand hygiene, two-patient ID, and time out to 94%.

- Central Line Associated Blood Stream Infections (CLABSI) rates declined from 3.5/1000 line days to 0.6/1000 line days. Return on investment from this improvement was roughly $16,500 for each of about 290 patients.

- Two-patient ID improved from 90% to 95%, reducing medication errors from 1.1/1,000 doses to 0.8/1,000 doses administered. This reduced registered medication errors by 724 per year, which results in potential savings of $2,000 per medication error.

- Time out compliance increased from 86% to 94% for avoiding wrong-site surgeries. The actual reduction in wrong-site surgeries was 3 each year.
**Overview**

- ValueOptions® is a health improvement company that specializes in mental and emotional well-being and recovery.
- ValueOptions delivers innovative, flexible solutions that enable people to improve their health and wellness, no matter how complicated their conditions.
- In addition to promoting health and well-being among their clients, ValueOptions encourages its employees to adopt healthy behaviors through emPower, a wellness and health education campaign.

**Background**

- For more than 30 years, ValueOptions has maintained an unwavering focus on providing timely, quality behavioral healthcare for Medicaid recipients and dual eligibles; military personnel, retirees and their families; and employees and their dependents.
- In 2012, ValueOptions began focusing on a wellness initiative for its more than 3,000 employees, with an emphasis on personal and professional well-being.
- ValueOptions developed the umbrella brand emPower to unify its employee offerings.

**Description**

- emPower helps employees achieve their personal and professional aspirations while supporting ValueOptions’ goal to become a world-class, healthy organization. Combined, these initiatives help the company fulfill its corporate mission to help people live their lives to the fullest potential. This is accomplished through several well-being and high-performance programs that include:
  - **Welcome Wellbeing:** Activities and resources to help employees reach their well-being goals.
    - ValueOptions introduced biometric screenings and well-being surveys to employee populations to provide them with the knowledge they need to make changes in their lifestyles and to commit to healthier habits that help reduce future medical costs.
    - All of ValueOptions’ campuses became tobacco-free in 2012, and employees were encouraged to discontinue tobacco use. “Kick It,” a smoking cessation benefit, was offered to employees and their dependents to help them become tobacco-free. To date, there has been strong employee and dependent participation in the program.
  - **Grow and Succeed:** A job learning center, best practices forum, and training program help employees reach their professional potential.
  - **Reduce Risk:** A program to promote service excellence and operational integrity and compliance.
Stamp Out Stigma (S.O.S.): A campaign (which is also being rolled out externally to clients and healthcare providers) to help raise awareness about mental illness, encourage people to ask for help, and remind everyone of the potential for hope through recovery. To support the S.O.S. initiative, the company created:

- www.stampoutstigma.com to further engage employees, as well as the general public. Social media users can also follow the S.O.S. Twitter page;
- A video series featuring employees who have experienced stigma and their personal journeys to overcome it; and
- Collateral such as wristbands and wall clings that allow employees to share why it is important to talk about mental illness.

All emPower tools and information are housed on the company’s intranet or available on an employee web portal, providing easy, 24/7 access to valuable resources.

In the fall of 2013, ValueOptions will assess its progress to date through focus groups, key informant interviews, and an all-employee survey. This information will also help plan for the next phase of the program.

Metrics

- emPower is less than a year old, but already making a sizeable impact.
  - More than 1,200 employees (42% of the employee population) participated in a biometric screening;
  - More than 1,900 employees (62% of the employee population) took the first annual well-being survey.
- A revitalized communications strategy supporting emPower resulted in an online utilization increase of its employee assistance program (EAP) resource.
- ValueOptions’ EAP use is currently 14% higher than the national average.

Value

- While still in its early stages, the emPower brand has already had a strong impact on the ValueOptions employee population. For example, EAP utilization has increased 11% thus far in 2013, and employee feedback on emPower articles and tools has been 100% positive.
- ValueOptions will use the aggregated data from emPower to make more informed decisions about employee benefits. In the fall of 2013, ValueOptions will assess progress and plan for the next phase of the program.
Overview

- VHA is a national network of not-for-profit healthcare organizations serving more than 1,350 hospitals and more than 72,000 non-acute care providers nationwide.
- VHA leverages its expertise in analytics, contracting, clinical performance, consulting, and networks to help members achieve their operational, clinical, and financial objectives.
- VHA developed VHA IMPERATIV™ to help healthcare providers achieve exceptional performance in a highly complex, outcome-based environment.

Background

- Hospitals are focused now more than ever on providing high-quality, cost-effective, patient-centric care.
- The healthcare system is becoming increasingly complex, due to a variety of factors ranging from healthcare reform to new payment models.
- Healthcare leaders understand the need, but are challenged to take on broader accountability to manage the health and total cost of care in their communities.
- Declining reimbursements are putting pressure on hospitals to reduce costs while improving quality and patient/family experience.

Description

- VHA IMPERATIV™ is a customizable solution designed to:
  - Help any hospital accelerate and sustain clinical, operational, and financial improvements;

Blueprints showcase not only the process, but also the cultural factors that influence performance providing a faster and more efficient path to the adoption of leading health care practices within their own hospital environments.

- Provide members different levels of support based on where they are in their performance improvement journey;
- Offer hospitals the data and analytics, along with guidance from clinical and operational advisors and proven leading practices, to support targeted performance improvement.
- VHA IMPERATIV™ experienced advisors leverage analytics, knowledge resources, and collaboration to accelerate improvements.
  - Advisory services: Partners with hospitals to interpret data, prioritize opportunities based on their goals, and develops and facilitates a performance improvement plan to achieve results;
  - Analytics: VHA IMPERATIV™ online portal provides an integrated view of business and clinical performance analytics and comparative data in easy-to-use dashboards;
• **Knowledge resources:** Leading Practice Blueprint® library with more than 180 blueprints focused in areas such as clinical outcomes and cost reduction, patient safety, and patient experience; accredited education programs available;

• **Collaboration:** Unique peer-to-peer networking and collaboration opportunities to share and learn from each other and helps to facilitate members’ adoption of leading practices.

**Metrics**

- Nurses from almost 30 hospitals across the VHA Central Atlantic region united to share information, clinical experiences and ideas as part of VHA’s Return to Care™ initiative resulting in fewer falls and skin infections, higher patient and nurse satisfaction scores and better HCAHPS scores.

- Upper Chesapeake Health System in Maryland improved patient satisfaction, exceeding the state average.

- Vidant Medical Center (formerly Pitt County Memorial Hospital), Greenville, NC, reduced its falls with harm by more than 70%.

- The Indiana Heart Hospital, Indianapolis, IN, significantly reduced urinary tract infections in less than six months and became a leader in the reduction of catheter-associated urinary tract infections.

**Value**

- To know where to go and move confidently, today’s busy healthcare professionals need access to internal and external data, with frequent monitoring and course correction. VHA IMPERATIV™ helps hospitals to map and manage a path that reduces costs while improving clinical outcomes and patient experiences. VHA IMPERATIV™’s tools and resources help members identify areas for improvement, which can easily be adapted within their organization.

VHA IMPERATIV™ gives hospital leaders accurate, enterprise wide visibility into key clinical, financial, and operational performance metrics, including patient throughput, patient safety, core measures, and readmission rates to accelerate improving performance.
Overview

- Walgreens is the nation’s largest drugstore chain, daily providing more than 6 million customers convenient, omnichannel access to consumer goods and services and trusted, cost-effective pharmacy, health, and wellness services and advice.
- WellTransitions® is a pharmacist-driven program focused on reducing preventable hospital readmissions by ensuring necessary next steps in the care continuum.
- The program brings hospitals and health systems together in a coordinated care model designed to help reduce hospital readmission rates and overall healthcare costs, while improving patient health outcomes and medication adherence.
- WellTransitions addresses the growing need for coordinated healthcare programs that can help improve patient adherence to medications and help hospitals reduce preventable readmissions and other episodes that can increase healthcare costs.

Background

- Hospitals report medication nonadherence as one of the biggest challenges they face in reducing preventable readmissions, and research shows that more than one in four new prescriptions goes unfilled.
- Preventable hospital readmissions cost the U.S. healthcare system approximately $25 billion per year. Approximately 40%, or nearly 1 million, hospital readmissions are avoidable.
- According to a 2009 study published in the New England Journal of Medicine, nearly one in five Medicare patients is rehospitalized within 30 days of discharge. The Medicare program continues to explore ways to improve patient outcomes and reduce healthcare costs related to preventable readmissions, including imposing penalties on hospitals nationwide for readmission rates that are deemed too high.
- Recognizing that the discharge process can be an overwhelming experience for patients, the WellTransitions program is designed to ease a patient’s transition from hospital to home.

Description

- WellTransitions helps reduce hospital readmissions and overall healthcare costs, while improving patient health outcomes and medication adherence by helping patients understand and adhere to medication therapies after they leave the hospital.
  - Services include bedside delivery of medication before discharge, regularly scheduled intervention-based clinical follow-up calls, and 24/7 pharmacist support.
  - Pharmacists also work with patients to ensure they have scheduled a follow-up appointment with their primary care physician and to reinforce important self-care principles, such as checking their weight daily and reporting any significant fluctuations to their doctor.
Pharmacists counsel patients on their medications and connect them with additional resources, as well as work collaboratively with hospital staff.

Because pharmacists already have the clinical training and experience to fulfill the needs of this program, WellTransitions allows them to work at the top of their license.

**Metrics**

- At DeKalb Medical in Atlanta, patients in a similar pharmacist-led intervention program experienced a lower 30-day readmission rate than patients at the hospital who were not enrolled in the program (5.6% compared to 10.6%).
- Ninety days after the program was implemented, that same study also showed a 26% increase in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores relative to “communication about medicines,” which increased from a score of 50 to 63.
- WellTransitions has already proven instrumental in helping to reduce patient readmissions. According to Washington Adventist Hospital in Maryland, of its first 48 high-risk patients enrolled in the program, only three were readmitted within 30 days of discharge.
- At Sarasota Memorial Hospital in Florida, more than 180 heart failure patients have participated in the program. The program provides patient services at key points during the critical first days following discharge, and while outcomes data are not yet available, hospital officials have reported noticeable positive trends.

**Value**

- WellTransitions is primarily paid for through the savings achieved by participating hospitals. Several reimbursement models are available based on the hospital partner’s needs. The specific cost to an individual hospital is determined by a number of factors, including current readmission data, discharges by disease state, and the amount of avoidable readmissions that Walgreens’ WellTransitions and the hospital jointly think they can prevent.
- WellTransitions has been implemented at a growing number of hospitals throughout the country, including Sarasota Memorial Healthcare System in FL, Washington Adventist Hospital in Takoma Park, MD, Marion General Hospital in IN, and more than a dozen others.
- As many hospitals and medical centers place a greater emphasis on reducing patient readmissions, Walgreens aims to roll out the program broadly to other facilities throughout the United States, including many of the more than 150 hospitals and health systems where Walgreens operates an outpatient pharmacy. The program can also be administered through Walgreens retail locations.
WEIGHT MANAGEMENT ON PRESCRIPTION: COVERAGE OF CLINICAL-COMMUNITY COLLABORATION TO ADDRESS OBESITY

Overview

- Weight Watchers International Inc. is the world’s leading provider of weight management services, helping millions of people achieve healthy, sustained weight loss through its four-pillar approach.
- To address the growing obesity crisis and associated chronic health conditions in the United Kingdom, the National Health Service (NHS) began allowing for coverage of a 12-week course of Weight Watchers multicomponent intensive behavioral counseling upon referral by the primary care provider. This coverage began in 2005.

Background

- Obesity and its associated chronic health conditions is a global health problem. In the United States, almost two-thirds of the population is overweight or obese.
- Fortunately, this health problem can be addressed. Even small advances in healthy living, such as sustained weight loss of just 10%, reduce the likelihood of type II diabetes by 50% and reduce lifetime medical costs by $2,200.²
- Both the U.K.’s National Institute of Clinical Effectiveness (NICE) and the United States Preventive Services Task Force (USPSTF) recommend that primary care providers refer or provide behavioral counseling for healthy weight for those with a body mass index (BMI) of 30 or more.

Description

- The United Kingdom’s clinical commissioning groups can cover a 12-week course of weekly community-based group counseling sessions upon primary care referral and receiving reports on patient progress.
- Primary care providers refer patients with a BMI of 30 or more to community behavioral counseling weight loss programs that meet evidence-based standards for care (multicomponent behavioral counseling).
- Patients are given vouchers to attend 12 meetings with their primary care provider and present the vouchers as they attend the counseling sessions.
- Body weight was measured at the Weight Watchers meetings and relayed to a central database.

Metrics

- Several evaluations of the NHS covered community-clinical collaboration have been conducted and published in peer-reviewed journals. These have consistently found the Weight Watchers program achieved significant weight loss associated with improved health outcomes.
- An audit of 29,316 patients referred to Weight Watchers under this program found that one-third of all patients achieved a 5% or greater weight loss over the 12 week course; 5% weight loss is usually associated with clinical benefits.³
- A randomized clinical trial comparing outcomes across several NHS weight loss providers found community-based programs outperformed primary care-provided weight loss counseling at both 12 weeks and at one year and produced sustained, significant weight loss.⁴
A cost effectiveness analysis found commercial community program cost per kilogram lost and cost per quality-adjusted year of life to be superior to weight loss counseling provided in the primary care setting.

A similar approach can be adopted in the United States. Employee benefits programs and a few Medicaid managed care programs provide coverage for Weight Watchers programs. An evaluation of covering Weight Watchers in TennCare, the Tennessee Medicaid program, concluded that partnerships between clinicians and community resources that allow low-income populations access to weight-loss programs may provide a valuable weight management tool.

CONCLUSION: The CP [commercial provider, i.e., Weight Watchers] was a cost-effective approach from a health funder and societal perspective. Despite participants in the CP group attending two to three times more meetings than the SC [standard care] group, the CP was still cost effective even including these added patient travel costs. This study indicates that it is cost effective for general practitioners (GPs) to refer overweight and obese patients to a CP, which may be better value than expending public funds on GP visits to manage this problem.

1. Richard F. Hamman, et al., Effect of Weight Loss with Lifestyle Intervention on Risk of Diabetes, Diabetes Care, 29:9 DIABETES CARE, 2102, 2105 (Sept. 2006);  
For more information on the innovative value and wellness approaches highlighted in this compendium, and other initiatives of HLC member organizations, please contact:

<table>
<thead>
<tr>
<th>HLC MEMBER</th>
<th>EXAMPLE</th>
<th>POINT OF CONTACT</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Aetna Oncology Solutions</td>
<td>Molly Schild, Associate Director, Federal Government Relations</td>
<td>202.419.7043 <a href="mailto:schildm@aetna.com">schildm@aetna.com</a></td>
</tr>
<tr>
<td>Aetna</td>
<td>Wellness at Aetna</td>
<td>Molly Schild, Associate Director, Federal Government Relations</td>
<td>202.419.7043 <a href="mailto:schildm@aetna.com">schildm@aetna.com</a></td>
</tr>
<tr>
<td>Amerinet</td>
<td>E-Procurement Solution</td>
<td>Evan Danis, Senior Director, Corporate Communications</td>
<td>724.778.3423 <a href="mailto:Evan.Danis@amerinet-gpo.com">Evan.Danis@amerinet-gpo.com</a></td>
</tr>
<tr>
<td>AmeriSourceBergen</td>
<td>ASD Healthcare’s myCubixx</td>
<td>Christopher G. Flori, VP Business Innovation</td>
<td>469.365.7814 <a href="mailto:chris.flori@asdhealthcare.com">chris.flori@asdhealthcare.com</a></td>
</tr>
<tr>
<td>Ascension Health</td>
<td>Hospital Engagement Network – Early Elective Deliveries (EED)</td>
<td>Mary Ella Payne, Senior Vice President, Policy &amp; System Legislative Leadership</td>
<td>202.898.4680 <a href="mailto:mepayne@ascensionhealth.org">mepayne@ascensionhealth.org</a></td>
</tr>
<tr>
<td>Ascension Health</td>
<td>Hospital Engagement Network – Preventing Readmissions</td>
<td>Mary Ella Payne, Senior Vice President, Policy &amp; System Legislative Leadership</td>
<td>202.898.4680 <a href="mailto:mepayne@ascensionhealth.org">mepayne@ascensionhealth.org</a></td>
</tr>
<tr>
<td>Baylor Health Care System</td>
<td>Reducing Glycemic Control Disparities</td>
<td>Venita Owens, Vice President of Administrative Services and Business Development, Diabetes Health and Wellness Institute</td>
<td>214.915.3200 <a href="mailto:venita.owens@baylorhealth.edu">venita.owens@baylorhealth.edu</a></td>
</tr>
<tr>
<td>Bio-Reference Laboratories</td>
<td>Scientific Collaboration Ushers in New Era in Cancer Diagnostics</td>
<td>J. David Liss, Vice President External Relations</td>
<td>201.791.2600 <a href="mailto:dliss@bioreference.com">dliss@bioreference.com</a></td>
</tr>
<tr>
<td>BlueCross BlueShield of Tennessee</td>
<td>well@work</td>
<td>Brad Traverse, Director, Federal Government Relations</td>
<td>202.266.2665 <a href="mailto:brad_traverse@bcbst.com">brad_traverse@bcbst.com</a></td>
</tr>
<tr>
<td>Boehringer Ingelheim Pharmaceuticals</td>
<td>Commit to Health</td>
<td>Jo Chan, Associate Director, Occupational Health/Wellness</td>
<td>203.798.4877 <a href="mailto:jo.chan@boehringer-ingelheim.com">jo.chan@boehringer-ingelheim.com</a></td>
</tr>
<tr>
<td>Cardinal Health</td>
<td>Networks of Care Accelerate Change and Improve Patient Outcomes</td>
<td>Dianne Radigan, Vice President Community Relations</td>
<td>614.757.7481 <a href="mailto:Dianne.Radigan@CardinalHealth.com">Dianne.Radigan@CardinalHealth.com</a></td>
</tr>
<tr>
<td>Cardinal Health</td>
<td>National Nursing Room Project</td>
<td>Jessica Parkinson, Consultant, Healthy Lifestyles</td>
<td>614.757.5271 <a href="mailto:jessica.parkinson@cardinalhealth.com">jessica.parkinson@cardinalhealth.com</a></td>
</tr>
<tr>
<td>Cleveland Clinic</td>
<td>Cleveland Clinic’s Center for Lifestyle Medicine</td>
<td>Emily Fox, Administrator, Center for Lifestyle Medicine</td>
<td>216.448.8282 <a href="mailto:foxe@ccf.org">foxe@ccf.org</a></td>
</tr>
<tr>
<td>C. R. Bard, Inc.</td>
<td>Reducing Catheter-Associated Urinary Tract Infections (CAUTIs)</td>
<td>John Gohde, Director of Marketing</td>
<td>770.784.6225 <a href="mailto:john.gohde@crbard.com">john.gohde@crbard.com</a></td>
</tr>
<tr>
<td>Company</td>
<td>Program</td>
<td>Contact Person</td>
<td>Phone/E-mail</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>C. R. Bard, Inc.</td>
<td>The Bard Live Well</td>
<td>Mark Klemow, Director, Corporate Benefits</td>
<td>908.277.8093 <a href="mailto:mark.klemow@crbard.com">mark.klemow@crbard.com</a></td>
</tr>
<tr>
<td>Edwards Lifesciences</td>
<td>Valvular Heart Disease</td>
<td>Sarah Huoh, Senior Director, Global Communications</td>
<td>949.250.6864 <a href="mailto:sarah_huoh@edwards.com">sarah_huoh@edwards.com</a></td>
</tr>
<tr>
<td>Franciscan Missionaries of Our Lady Health System</td>
<td>Evidence-Based Care for Hospitalized Diabetics</td>
<td>Stephanie Mills, M.D., M.H.C., President &amp; CEO, Franciscan Health &amp; Wellness Services</td>
<td>225.526.4114 <a href="mailto:stephanie.mills@fmolhs.org">stephanie.mills@fmolhs.org</a></td>
</tr>
<tr>
<td>Franciscan Missionaries of Our Lady Health System</td>
<td>Healthy Lives™</td>
<td>Stephanie Mills, M.D., M.H.C., President &amp; CEO, Franciscan Health &amp; Wellness Services</td>
<td>225.526.4114 <a href="mailto:stephanie.mills@fmolhs.org">stephanie.mills@fmolhs.org</a></td>
</tr>
<tr>
<td>Health Care Service Corporation</td>
<td>Accountable Care Organization (ACO) Shared Savings Agreement</td>
<td>Theresa Doyle, Divisional Senior Vice President and Chief Government Relations Officer</td>
<td>202.249.7203 <a href="mailto:theresa.doyla@hcsc.net">theresa.doyla@hcsc.net</a></td>
</tr>
<tr>
<td>Health Dialog</td>
<td>Shared Decisions, Shared Success</td>
<td>David Veroff, SVP, Innovation</td>
<td>617.406.5219 <a href="mailto:dveroff@healthdialog.com">dveroff@healthdialog.com</a></td>
</tr>
<tr>
<td>Healthcare Leadership Council</td>
<td>HLC Workplace Wellness Survey</td>
<td>Teresa de Vries, Director of Federal Affairs</td>
<td>202.449.3436 <a href="mailto:tdevries@hlc.org">tdevries@hlc.org</a></td>
</tr>
<tr>
<td>Healthways</td>
<td>Dr. Dean Ornish's Program for Reversing Heart Disease</td>
<td>J. Michael Eaton, Senior Vice President</td>
<td>757.784.1277 <a href="mailto:michael.eaton@navvishealthways.com">michael.eaton@navvishealthways.com</a></td>
</tr>
<tr>
<td>Healthways</td>
<td>Healthways SilverSneakers® Fitness Program</td>
<td>Suzanne Duda, Industry and Government Relations</td>
<td>202.525.9588 <a href="mailto:susannc.duda@healthways.com">susannc.duda@healthways.com</a></td>
</tr>
<tr>
<td>Ikaria</td>
<td>INOMAX® Therapy Package</td>
<td>Anne Esposito, Vice President, Government Affairs and Public Policy</td>
<td>202.393.7427 <a href="mailto:anne.esposito@ikaria.com">anne.esposito@ikaria.com</a></td>
</tr>
<tr>
<td>Indiana University Health</td>
<td>Healthy Results</td>
<td>Marcella Cooper, M.P.H., RD Manager, Employee Wellness</td>
<td>317.963.5959 <a href="mailto:mcooper4@iuhealth.org">mcooper4@iuhealth.org</a></td>
</tr>
<tr>
<td>inVentiv Health</td>
<td>Comprehensive Kidney Care Management</td>
<td>Roxane Padgett, VP, inVentiv Medical Management</td>
<td>706.855.0830 x2304 <a href="mailto:roxane.padgett@inventivehealth.com">roxane.padgett@inventivehealth.com</a></td>
</tr>
<tr>
<td>Johnson &amp; Johnson</td>
<td>CEO Cancer Gold Standard™</td>
<td>Dr. Fikry Isaac, Vice President, Global Health Services</td>
<td>732.524.3404 <a href="mailto:fisaac1@its.jnj.com">fisaac1@its.jnj.com</a></td>
</tr>
<tr>
<td>Johnson &amp; Johnson</td>
<td>Live for Life</td>
<td>Dr. Fikry Isaac, Vice President, Global Health Services</td>
<td>732.524.3404 <a href="mailto:fisaac1@its.jnj.com">fisaac1@its.jnj.com</a></td>
</tr>
</tbody>
</table>

THE HEALTHCARE INNOVATION COMPENDIUM IS A PRODUCT OF HLC
<table>
<thead>
<tr>
<th>Marshfield Clinic</th>
<th>Marshfield Dental Initiative</th>
<th>Joseph Kilsdonk, AUD Division Administrator Division of Education</th>
<th>715.387.5580 <a href="mailto:kilsdonk.joseph@marshfieldclinic.org">kilsdonk.joseph@marshfieldclinic.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Marshfield Clinic</td>
<td>Physician Group Practice Demonstration</td>
<td>Marilyn A. Follen, RN, MSN Administrator, Institute for Quality, Innovation &amp; Patient Safety</td>
<td>715.389.3020 <a href="mailto:follen.marilyn@marshfieldclinic.org">follen.marilyn@marshfieldclinic.org</a></td>
</tr>
<tr>
<td>Mayo Clinic</td>
<td>Stress Less</td>
<td>Brooke L. Werneburg Health and Wellness Coach Lead</td>
<td>507.538.7016 <a href="mailto:werneburg.brooke@mayo.edu">werneburg.brooke@mayo.edu</a></td>
</tr>
<tr>
<td>McKesson Corporation</td>
<td>McKesson VITAL Nurse Advice Line</td>
<td>Ann Richardson Berkey Senior Vice President, Public Affairs</td>
<td>415.983.8494 <a href="mailto:ann.berkey@mckesson.com">ann.berkey@mckesson.com</a></td>
</tr>
<tr>
<td>Medtronic</td>
<td>CareLink® Network</td>
<td>Melissa D. Schooley, Esq. Senior Director, Government Affairs</td>
<td>202.442.3621 <a href="mailto:melissa.d.schooley@medtronic.com">melissa.d.schooley@medtronic.com</a></td>
</tr>
<tr>
<td>MemorialCare Health System</td>
<td>Influenza Protection Program</td>
<td>Peter J. Mackler Executive Director, Government Relations and Policy</td>
<td>714.377.2946 <a href="mailto:PMackler@memorialcare.org">PMackler@memorialcare.org</a></td>
</tr>
<tr>
<td>MemorialCare Health System</td>
<td>Bold Goals for Excellence</td>
<td>Peter J. Mackler Executive Director, Government Relations and Policy</td>
<td>714.377.2946 <a href="mailto:PMackler@memorialcare.org">PMackler@memorialcare.org</a></td>
</tr>
<tr>
<td>Merck</td>
<td>The Adherence Estimator®</td>
<td>Jane Horvath Executive Director of Health Policy and Reimbursement</td>
<td>202.508.4540 <a href="mailto:jane.horvath@merck.com">jane.horvath@merck.com</a></td>
</tr>
<tr>
<td>NewYork-Presbyterian Hospital</td>
<td>New York-Presbyterian Regional Health Collaborative</td>
<td>Willa Brody, MSW, JD Director, Government and Community Relations</td>
<td>212.821.0573 <a href="mailto:wib9003@nyp.org">wib9003@nyp.org</a></td>
</tr>
<tr>
<td>NewYork-Presbyterian Hospital</td>
<td>Energy Management &amp; Sustainability Program</td>
<td>Willa Brody, MSW, JD Director, Government and Community Relations</td>
<td>212.821.0573 <a href="mailto:wib9003@nyp.org">wib9003@nyp.org</a></td>
</tr>
<tr>
<td>NorthShore University HealthSystem</td>
<td>Screening for Undiagnosed Hypertension</td>
<td>Kenneth P. Anderson, D.O., M.S., CPE Chief Medical Quality Officer</td>
<td>847.570.2008 <a href="mailto:kanderson1@northshore.org">kanderson1@northshore.org</a></td>
</tr>
<tr>
<td>Novo Nordisk</td>
<td>The National Diabetes Prevention Program</td>
<td>Tricia Brooks Director, Public Affairs Strategy</td>
<td>202.626.4528 <a href="mailto:tiib@novonordisk.com">tiib@novonordisk.com</a></td>
</tr>
<tr>
<td>Novo Nordisk</td>
<td>Better Diabetes Screening</td>
<td>Karin Gillespie Senior Manager, Changing Diabetes Policy</td>
<td>609.987.5872 <a href="mailto:kgil@novonordisk.com">kgil@novonordisk.com</a></td>
</tr>
<tr>
<td>Owens &amp; Minor</td>
<td>Value Analysis Engineering</td>
<td>Will Benton Director, Marketing</td>
<td>804.723.7933 <a href="mailto:will.benton@owens-minor.com">will.benton@owens-minor.com</a></td>
</tr>
<tr>
<td>Premier healthcare alliance</td>
<td>Live Well, Be Premier</td>
<td>Allison Golding Sr. Director Total Rewards</td>
<td>704.816.6583 <a href="mailto:allison_golding@premierinc.com">allison_golding@premierinc.com</a></td>
</tr>
<tr>
<td>Sanofi US</td>
<td>Cities for Life</td>
<td>Lori Foley American Academy of Family Physicians Foundation</td>
<td>913.906.6000 x4454 <a href="mailto:lfoley@aaafp.org">lfoley@aaafp.org</a></td>
</tr>
<tr>
<td>SCAN Health Plan</td>
<td>Keeping Seniors Living Independently</td>
<td>Peter Begans Senior Vice President, Public &amp; Government Affairs</td>
<td>202.349.9008 <a href="mailto:pbegans@scanhealthplan.com">pbegans@scanhealthplan.com</a></td>
</tr>
<tr>
<td>Company</td>
<td>Title</td>
<td>Contact Person</td>
<td>Phone Number</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Stryker</td>
<td>The Power to Save: Stryker Power-PRO XT Cot and Power-LOAD Cot Fastener System</td>
<td>Page Kranbuhl Vice President, U.S. Government Affairs</td>
<td>202.974.6333</td>
</tr>
<tr>
<td>Surescripts</td>
<td>Incentives for Adoption and Use of E-Prescribing</td>
<td>Seth Joseph Vice President, Pharmacy Business</td>
<td>703.879.4301</td>
</tr>
<tr>
<td>Takeda</td>
<td>Be Well</td>
<td>Rhea Dever Vice President, Talent and Total Rewards</td>
<td>224.554.6500</td>
</tr>
<tr>
<td>Texas Health Resources</td>
<td>Improving Patient Safety – Everyone's Responsibility</td>
<td>Linda Gerbig, SVP of Performance Improvement and Quality Outcomes</td>
<td>682.236.6275</td>
</tr>
<tr>
<td>ValueOptions</td>
<td>emPower—An Employee Wellness Program</td>
<td>Amy Sheyer Senior Director, Corporate Communications</td>
<td>757.459.5305</td>
</tr>
<tr>
<td>VHA Inc.</td>
<td>VHA IMPERATIV™</td>
<td>Cidette Perrin Senior Director of Government Relations</td>
<td>202.354.2608</td>
</tr>
<tr>
<td>Walgreens</td>
<td>WellTransitions®</td>
<td>Jim Cohn Corporate Communications</td>
<td>847.315.2950</td>
</tr>
<tr>
<td>Weight Watchers</td>
<td>Weight Management on Prescription: Coverage of Clinical-Community Collaboration to Address Obesity</td>
<td>Jody Hoffman Sr. VP &amp; Managing Director, Wexler Walker</td>
<td>202.662.3751</td>
</tr>
</tbody>
</table>
HLC MEMBERS

HLC Chairman
Greg Irace
President & CEO
Sanofi US

Mark Bertolini
Chair, President & CEO
Aetna

Todd Ebert
CEO
Amerinet

Steven Collis
President & CEO
AmerisourceBergen

Anthony Tersigni, EdD,
FACHE
President & CEO
Ascension

Paul Hudson
Executive Vice President,
North America
AstraZeneca

Joel Allison
President & CEO
Baylor Health Care System

Marc Grodman, M.D.
Chairman, President &
CEO
Bio-Reference Laboratories, Inc.

William Gracey
President & CEO
BlueCross BlueShield of Tennessee

Greg Behar
President & CEO
Boehringer Ingelheim Pharmaceuticals

George Barrett
Chairman & CEO
Cardinal Health

Toby Cosgrove, M.D.
CEO & President
Cleveland Clinic Foundation

Tim Ring
Chairman & CEO
C. R. Bard

Michael A. Mussallem
Chairman & CEO
Edwards Lifesciences

Alex Azar
President, Lilly USA
Eli Lilly and Company

John Finan, Jr.
President & CEO
Franciscan Missionaries of Our Lady Health System, Inc.

Patricia Hemingway Hall
President & CEO
Health Care Service Corporation

Robert Mandel, M.D.
CEO
Health Dialog

Ben Leedle, Jr.
CEO
Healthways

Daniel Tassé
President & CEO
Ikaria

Daniel Evans, Jr.
President & CEO
Indiana University Health

Paul Meister
Chairman & CEO
inVentic Health

Gary Pruden
Worldwide Chairman,
Global Surgery Group
Johnson & Johnson

Brian Ewert, M.D.
President
Marshfield Clinic

John Noseworthy, M.D.
President & CEO
Mayo Clinic

John Hammergren
Chairman & CEO
McKesson Corporation

Chris O’Connell
EVP & President,
Restorative Therapies Group
Medtronic

Barry Arbuckle, Ph.D.
President & CEO
MemorialCare Health System

Robert A. McMahon
President, U.S. Market
Merck & Company, Inc.

Steven Corwin, M.D.
CEO
NewYork-Presbyterian Hospital

Mark Neaman
President & CEO
NorthShore University HealthSystem

Jesper Hoiland
President
Novo Nordisk, Inc.

Craig Smith
President & CEO
Owens & Minor

Susan DeVore
President & CEO
Premier healthcare alliance

Chris Wing
President & CEO
SCAN Health Plan

Tim Scannell
Group President, MedSurg & Neurotechnology
Stryker

Harry Totonis
President & CEO
Surescripts

Doug Cole
President
Takeda Pharmaceuticals U.S.A.

Douglas Hawthorne,
FACHE
CEO
Texas Health Resources

Christine Jacobs
Chairman, President &
CEO
Theragenics

Heyward Donigan
President & CEO
ValueOptions, Inc.

Colleen Conway-Welch, R.N.
Dean Emeriti
Vanderbilt University School of Nursing

Curt Nonomaque
President & CEO
VHA Inc.

Gregory Wasson
President & CEO
Walgreens

James Chambers
President & CEO
Weight Watchers International, Inc.
The Healthcare Leadership Council (HLC) is the exclusive national forum for chief executives from all disciplines across the healthcare continuum to jointly develop policies, plans, and programs to achieve their vision of a healthcare system that makes innovative, affordable, high-quality care accessible to all Americans.

Members of HLC – hospitals, integrated delivery systems, pharmaceutical companies, medical device manufacturers, group purchasing organizations, insurers, distributors and other sectors – envision a quality-driven system striving toward constant improvement. The Healthcare Leadership Council advocates measures to increase the cost-effectiveness of American healthcare by emphasizing wellness and prevention, care coordination, and the use of evidence-based medicine.

Providing access to health coverage for the uninsured, accelerating the growth of health information technology and the use of data, and reforming healthcare payment systems to incentivize quality and positive patient outcomes are important HLC priorities, along with developing delivery system reforms and wellness practices that help individuals make sustainable changes that can reduce their risk for chronic disease. HLC also focuses on improving patient safety, addressing the healthcare workforce shortage, enacting medical liability reforms, and developing patient privacy rules that protect confidentiality while enabling the necessary flow of information to healthcare professionals and medical researchers.

For HLC, health reform and health system transformation is not theoretical, it’s already happening. As seen by the innovations in this compendium, HLC members are actively developing and carrying out initiatives that are improving health and increasing the safety, quality, affordability, and value of healthcare in their organizations and communities. These evidence-based practices demonstrate the types of policies and practices that will usher in the future of healthcare.