VALUE-DRIVEN HEALTH CARE PURCHASING: CASE STUDY OF WASHINGTON STATE'S PUGET SOUND HEALTH ALLIANCE

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August 2007

ABSTRACT: The Puget Sound Health Alliance in Washington seeks to improve the quality of health care by 1) using guidelines for evidence-based medicine to develop performance reports and 2) aligning incentives in purchasing and consumer decision-making to promote quality and reduce costs. The group's current focus is on developing and disseminating the region's first set of public comparison reports on health care providers across the five counties the alliance represents. By providing the necessary information and tools, the alliance and its participating organizations believe they will be able to align incentives between the supply and demand sides of the health care system and support overall quality improvement. Instrumental to the alliance's successes to date include strong leadership, interdisciplinary teamwork, collaboration among stakeholders, and willingness to compromise. Nevertheless, the alliance faces many challenges, including pressure to produce a long-awaited public report; keeping its stakeholder base invested; and balancing stakeholder needs and concerns.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This report and other Fund publications are available online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1055.

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Health Management Associates (http://www.healthmanagement.com) is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985 in Lansing, Michigan, HMA provides leadership, experience, and technical expertise to local, state, and federal governmental agencies; regional and national foundations; multi-state health system organizations; single-site health care providers; and employers and other purchasers in the public and private sectors.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the support of The Commonwealth Fund for funding this research. They also acknowledge the following Puget Sound Alliance staff and participants without whom this report would not have been possible: Margaret Stanley, executive director; Diane Giese, director of communication and development; Lance Heineccius, director of information and incentives, and Susie Dade, director of quality improvement and administration, the Puget Sound Health Alliance; Steve Hill, administrator, Washington State Health Care Authority; Hugh Straley, medical director, Group Health Cooperative; Annette King, director of benefits, Starbucks; Rick Cooper, CEO, the Everett Clinic; Dorothy Teeter, interim director and health officer, King County Public Health; Ron Sims, county executive for King County; Diane Zahn, secretary treasurer, UFCW Local 21; Andrew Oliveira, medical director, Aetna; Drs. Gary Kaplan, chairman and CEO, and Robert Mecklenburg, chief of medicine, Virginia Mason Medical Center; Dr. Lloyd David, executive director/CEO, The Polyclinic; and Rich Maturi, senior vice president, and Scott Forslund, communications director, Premera Blue Cross.

VALUE-DRIVEN HEALTH CARE PURCHASING: CASE STUDY OF WASHINGTON STATE'S PUGET SOUND HEALTH ALLIANCE

BACKGROUND

Motivated by the desire to stem the increased cost of health coverage for public employees, Washington State's King County Executive Ron Sims was the driving force behind the formation of the Puget Sound Health Alliance in December 2004.[1] The alliance's creation stemmed from the recommendations of the Health Advisory Task Force (HATF), which was brought together by Sims to address how to rein in rapidly rising health care costs. The task force's intention was to reduce misuse of care and improve quality, rather than cut benefits or shift costs onto King County employees and their families. Co-chaired by Dr. Ed Wagner from the MacColl Institute and Dr. Alvin Thompson from the University of Washington, HATF included benefits representatives from purchasers, providers, and academic experts from the University of Washington. Task force members believed that an ongoing, multi-stakeholder forum for dialogue and joint initiatives would promote cooperation among interest groups and minimize opposition, thereby improving the likelihood of successful reform of the local health care system.

Beginning in August 2004, Sims, later joined by Margaret Stanley (who later became the alliance's Executive Director), met with potential participants in person to explain the importance of building an alliance and the impact that such a group could have on the health care system. Virtually all stakeholder leaders who were approached signed on. As awareness of the alliance and its mission spreads, participation continues to expand.

The alliance includes more than 140 participating organizations, including public and private employers; health plans, physicians and other health professionals; hospitals; community groups; and individual consumers. This group represents over a million covered lives, or about a third of the population in the five counties: King, Kitsap, Pierce, Snohomish, and Thurston. As of October 2006, every health plan in the state was participating, as were many of the state's largest employers, including Starbucks, Boeing, and Washington Mutual Bank.

In addition to large employers, the State of Washington participates in the alliance through public employees and Medicaid. The Washington State Health Care Authority (HCA), which administers benefits for about 350,000 state employees and higher education staff, has been involved in the alliance's development from its inception and has a seat on the board of directors. The HCA participates as a large public employer which,

according to an HCA representative, is dealing with "out of control costs and a desire to purchase on quality, efficiency, and affordability." The Washington Department of Social and Health Services (DSHS) and Medicaid, which represent 900,000 lives receiving public assistance, are also involved with the alliance and will be providing data to include in the public performance reports on health care quality. Inclusion of Medicaid data in the performance report makes it more robust and useful, according to Diane Giese, director of communication and development of the alliance, because Medicaid reflects a significant portion of care provided at some medical practices.

The alliance has an executive director and nine staff members, who together guide the Quality Improvement Committee (QIC), Clinical Improvement Teams (CIT), and other committees. They convene and facilitate meetings with participating organizations; develop and implement the initiatives chosen; and essentially steer the shift toward value-based purchasing (VBP) in Washington State. Key to the alliance's success is the nearly 200 business, health care, and community leaders—many of whom are physicians—who volunteer time and expertise on the various committees. To finance the organization, participating health plans pay a tiered fee based on their market share; providers pay according to their number of full-time employees; and purchasers and community groups pay a fee for each "covered life"—the number of employees and their families receiving employer-based health benefits. Individual consumers can join the alliance for $25 per year.

ALLIANCE MISSION AND AGENDA

The alliance participants were drawn together by a common objective of developing value-driven solutions that could be supported by all stakeholders so that real change could occur. They hope to build connections among patients, doctors, hospitals, employers, and health plans to promote health and improve quality and affordability.

The alliance hopes to accomplish this mission by reducing overuse, underuse, and misuse of health care services. Actions to support the mission fall into two categories: 1) encourage providers and insurers to provide better value to the consumer, and 2) give consumers tools to help them manage their care more effectively. The alliance has outlined several initiatives:

- adopt evidence-based clinical guidelines for diabetes, heart disease, back pain, depression, asthma, prevention, and the appropriate use of pharmaceuticals;
- produce publicly available reports measuring quality performance of providers in the Puget Sound area and potentially across the state;[2]

- encourage greater adoption of health information technology, including electronic medical records (EMRs) and chronic disease registries;
- make recommendations designed to align incentives in health care that will result in improved health and treatment outcomes, while simultaneously rewarding quality care, affordability, and patient satisfaction; and
- provide tools for employees, employers, and unions on how to manage their health, health care, and to support better health, respectively.

The overall work of the alliance, including implementation of the recommendations from the clinical improvement teams, is guided by four primary committees, each of which consists of representatives from participating organizations and other experts in the regions. The committees are focused on health information technology; quality improvement, communication, and incentives. Coordination across all groups is important to carrying forward the key initiatives, described further below. Also, the alliance is structured to ensure that consumers' voices and perspectives are heard: it has a consumer advisory group, two consumers sit on the board, and consumer representatives are on the CITs (described below). The alliance and its participants, including consumers, often reach out to patients, employees, and other consumers in the community to provide education about quality and encourage greater consumer engagement in health care. Following are the main initiatives the alliance is pursuing.

Public Reporting

For 2007, the alliance's highest priority is producing the region's first public report on aspects of quality. The report is expected to be updated quarterly and over time will include measures of quality, cost, and patient experiences in clinics and hospitals across the region. The alliance is using some of the performance measures outlined in the Institute of Medicine's 2005 report on performance measurement.[3] It is in the process of collecting claims data from health plans, self-funded employers, government programs, and union trusts to use as the basis for report results. The first report is expected to be available in mid-2007.

The alliance is undergoing the difficult process of acquiring the necessary information and creating a solid database from which to proceed. According to Sims, getting the health plans to agree to a uniform data "dump" was "a wrenching process," with none of the plans wanting to divulge claims data or any proprietary information on pricing and reimbursement. At this time, all major health plans, in addition to other data suppliers mentioned above, have agreed to provide Milliman, Inc. (the alliance's contractor

to handle data aggregation and analysis) with the same data sets they are providing to Mercer Human Resources Consulting under the Care-Focused Purchasing program.[4]

Data suppliers are not being asked to provide financial data. While some feel that this defeats the purpose of developing a tool for VBP, others argue that price data have no relationship to what consumers actually pay in the marketplace, thus making it an incomplete tool for measuring value or efficiency. When it comes to value, many agree that understanding what services were provided over the course of an episode of care is more relevant than the price of specific services. During 2007, the alliance is defining a recommended approach to measuring efficiency, including identifying additional data elements needed, if any. This year, it is also working on the best way to measure and report on patient satisfaction.

At the time of this report, the alliance board, staff, and participants are still discussing and making decisions about a number of challenges and elements that will shape the first report, including:

- What is the approach for the public report that will identify physicians and other health professionals at the group, practice, and individual level?
- How will the reports be made relevant to each of the target audiences (purchasers, consumers, and providers) given their different needs and ways of using the information?
- What will be the initial set of performance measures?
- Will formal benchmarks for each measure be established?
- How will the alliance balance the differences in opinion about when the initial reports should be produced? It must satisfy physician interest in stretching out the timeframe against the interest of purchasers, consumers, and health plans in producing the reports as soon as possible to begin to see real change in the region.

The alliance hopes to have all data for the public reporting collected and aggregated by the second quarter of 2007. In collaboration with the Washington State Medical Association (WSMA) and others, physicians have given feedback on the proposed approach and will have the opportunity to review the draft report before it is finalized and distributed. Purchasers (the "owners" of the data) will have the same opportunity. Critics worry that trying to please the doctors will delay the public reports and that participating employers, health plans, and consumers will become impatient. However, the alliance is firm in its desire to build trust and confidence in the reports from providers, so it will use

the reports for quality improvement. Building trust and confidence will also help to avoid the type of backlash that one health plan experienced recently when it sent letters to enrollees on the quality of care provided by certain individual providers.[5]

Purchasers, however, are excited about the public reporting and hope it will motivate their employees to really examine how providers compare. According to one purchaser, "Transparency is the key to improving quality, and public reports are the key to transparency." Sims does not think employees will change providers based solely on the reports, but he does hope that consumers "realize they will end up paying more in the long run if they go to a low-quality provider."

The HCA is very supportive of the report, and it has requested that the legislature appropriate funds so that it can gain access to the data. It will then be able to apply the same performance measures to providers across the state and distribute the reports statewide. Thus far, King County has provided a grant to the alliance of $439,000 per year for three years to cover the cost of the contract with Milliman to aggregate and analyze the data. Many are interested in having the state provide financial support for broadening the report's reach in future years.

Evidence-Based Clinical Guidelines

The alliance's QIC oversees several CITs that review, adopt, and endorse evidence-based treatment guidelines and related measures. The committee is also recommending a change in strategies for implementing these guidelines into common practice. CITs have completed work on heart disease, diabetes, low back pain, depression, and pharmaceutical prescribing, and in 2007 will address asthma and prevention. CIT reports and recommendations are disseminated to the relevant professionals and medical organizations. The board voted on asthma and prevention care at its last board meeting and these committees to address these factors are in the process of being created.

The teams that work on these guidelines are multidisciplinary and focus primarily on the selection of best-of-breed clinical guidelines that have already been developed. Depending on the condition, however, some challenges have arisen in adopting one consistent set of protocols. For instance, the depression team identified two different guidelines: the "Colorado," which is a two-page algorithm, and the Institute for Clinical Systems' Improvement's 35-page guidelines. In this case, the two complement each other. In the case of low back pain, however, alliance staff found no clear national agreement on evidence-based practice. The National Center for Quality Assurance (NCQA) released a set of measures based on debated guidelines, but the alliance does not plan to adopt them

without some additional consideration. In the meantime, developing protocols for spine care has been put on hold while further evidence and research are collected.

According to alliance staff, the clinical guidelines embody their collaborative mission and that "employers who use health plans will ultimately benefit if the plans and providers take the recommendations stemming from the guidelines to heart." Thus, "taking the guidelines to the street" is a priority. Providers are informed of the CITs' recommendations either online, through education groups, or through professional associations.

Views on the impact of the CIT's efforts so far are mixed. One provider said he thought there was a "reasonable following of the CITs among group practices but not among solo providers." Other providers and health plans expressed concerns that acceptance and implementation of the guidelines and recommendations have not been robust, and thus their impact on patient care is not yet significant. In some cases, providers such as Group Health Cooperative, the Everett Clinic, and Virginia Mason Medical Center are already providing care in the way the CITs have recommended. In some cases these providers are leading teams focusing on certain conditions.

One area that met with success and significant recognition is pharmacy value. The alliance board adopted recommendations urging medical clinics, hospitals, and other facilities where patient care is provided to adopt policies that reduce or eliminate the influence of pharmaceutical sales and marketing on provider-prescribing decisions. Specifically, the board adopted statements against allowing unfettered access by drug representatives to physicians and the distribution of free drug samples. The positions are supported by both WSMA and the Washington Chapter of the American Academy of Family Physicians. In a recent WSMA newsletter to physicians statewide, the front page headline reads: "To ensure independence in prescribing: just say no to drug samples, drug reps." The Everett Clinic, which has participated in the alliance since its inception, boasts prescription costs of 15 to 20 percent lower than the market baseline, which they attribute to their 75 percent generics prescribing rate.

Other alliance activities include identifying or creating, when necessary, one-page "toolkits" written for the consumer audience, with steps on how to work more effectively with their providers to prevent sickness and manage illness. Future toolkits will be geared toward employers and unions/consumer representatives on how to support healthy living for employees.

Incentives and Pay-for-Performance

Recognizing the growing number of pay-for-performance (P4P) programs taking hold nationally, the alliance is trying to decide what its role in these programs will be. The incentives workgroup is considering two potential roles: a disseminator of information on the subject, or an active participant in bringing stakeholders together (similar to the Integrated Health Care Association in California). Many alliance participants have already implemented some form of P4P: Premera has a P4P program with certain medical groups, Regence has a one-time bonus it sends to physicians who scored highly on a number of quality measures, and Aetna is involved in the national Bridges to Excellence P4P program. Boeing tried to encourage its employees into hospitals that scored well on Leapfrog's measures by offering co-insurance discounts, a strategy that so far has not yielded significant results. And the Washington HCA is considering an incentive strategy of providing a 4 percent bonus to providers who participate in efforts by Leapfrog and Surgical Outcomes.[6]

With the state now considering developing a tiered network structure for its employees, the alliance held a conference on quality-based purchasing in December 2006, co-sponsored by the U.S. Agency for Health Care Research and Quality, to explore the short- and long-term cost benefit of such programs. For the alliance, the ultimate goal in this area is to educate stakeholders on how to align incentives through benefit design, P4P, establishing protocols that become recognized by NCQA, and using public reports on quality. An alliance board member took this goal even further by noting that the alliance could ultimately "play a key role in trying to get community consensus on how to create payment systems based on quality and efficiency."

Despite the push for P4P programs within the alliance's territory and across the country, not all alliance participants are in favor of it. One interviewee said incentive programs are more art than science, and they "get people's attention, but accomplish little else." From his perspective as a provider within an integrated system that also serves as a health plan, he noted that rewarding individual doctors can lead to gaming the system. Several other providers and purchasers remarked that incentive programs may not be as useful in the long run as the public reporting, noting that the amount of the incentive is typically too small to really make a difference to providers.

Some providers also noted that once quality standards are implemented and institutionalized, incentives will not make much sense because a new baseline will have been created. Some discussion involves the fact that the public reports may lead to health plans and self-insured employers developing tiered networks whereby consumers pay

higher cost-sharing for lower-rated providers as an incentive, and some noted that providers are fearful of this. Others argued that tiered networks, if developed, must be based on value and quality, not just price. The alliance has not taken a specific position on tiered networks, but it is an issue to watch.

Using Benefit Design to Promote Quality

One of the goals of the alliance is to motivate self-insured employers, union trusts, and health plans to design their benefit packages in such a way that promotes wellness and prevention and reflects accepted quality care protocols. This could be accomplished by waiving copayments for maintenance of chronic conditions, for example, and paying for wellness programs such as tobacco cessation or preventive measures such as flu shots. However, the term "preventive care" is fraught with challenges. With each chronic condition, the evidence suggests a variety of different screenings, e.g., nutritional checks and retinal scans for diabetes patients. Therefore, developing a consistent benefit package that addresses the preventive care needs of multiple chronic illnesses can become complex as well as costly. Some health plans have responded that as benefit packages become richer, keeping premiums affordable will become more and more difficult.

Some quality reform movement, however, is taking hold, particularly among self-insured employers.[7] For example, the HCA has changed its benefit package by removing the deductible for preventive care in its self-insured plan, as well as in two of its HMOs. Perhaps the biggest example of using benefit design to encourage healthier lifestyles is King County's own "Healthy Incentives" program, in which all the unions agreed to participate (see text box below).

King County's "Healthy Incentives"

Healthy Incentives was launched in 2006 (after being piloted in 2005) to improve the health status of the county's 35,000 employees and dependents. Features include the following:

- a lower deductible for employees who voluntarily take a fitness test and complete a follow-up plan;
- assignment of "high risk" employees (70 percent of those taking the fitness test) to a coach who helps guide them toward healthier behaviors; and
- age- and gender-appropriate preventive screenings at 100 percent of in-network providers. Examples include:
    - annual mammograms for women over age 40;
    - colonoscopies every 10 years for men and women age 50 and older; and
    - annual flu shots for all members.

With costs for diabetes and heart disease skyrocketing, county officials expect the Healthy Incentives program to show significant cost benefits over time.

Promoting Interoperable Health Information Technology

The alliance's Health Information Technology (HIT) committee is working on promoting the adoption of interoperable technology across the state and a publishing and dissemination plan for the public reports. The state is taking the lead in setting standards through its State Health Information Infrastructure Advisory Board. The alliance is partnering with the Washington HIC to encourage the adoption or expansion of HIT, such as electronic medical records or chronic care registries. The collaborative distributed $1 million in 2006 to small physician practices and rural hospitals.[8]

STAKEHOLDER PERSPECTIVES

Transparency, information, and incentives: these are the three ingredients that a number of alliance participants believe are necessary to bring about substantive change in the state's health care market. As one interviewee put it, "First you need to create transparent measures of quality that are consistent across the board. Then you need to build the public performance reports to inform all stakeholders. Finally, you have to provide incentives for providers to implement the recommendations of the clinical improvement teams." The alliance views its broad stakeholder support and enthusiasm as key to forming strategies that involve interaction among the three ingredients. Despite this common view, each set of stakeholders—providers, purchasers, plans, and consumers—has its own perspective on the alliance's mission, strategies, and overall chances at success.

Purchasers

For this case study, interviews were conducted with representatives from three purchasers, one private (Starbucks) and two public (Washington State and King County). They agreed that most purchasers were very anxious about rapidly rising costs and the effects on productivity, and were therefore eager to join the alliance to be at the table with all stakeholders.

A representative from Starbucks expressed that the company was motivated by the opportunity to shape what could become a model for its global approach to health care coverage for its workers. Starbucks hopes that public reporting will motivate health plans to change benefit packages and encourage employees to really consider the quality of providers' care in their decision-making. It is particularly concerned with trying to control health care costs, given that it offers a generous health coverage package available to all employees who work at least 20 hours per week.[9] The company recognizes that this level of benefits may soon be unsustainable, as health care spending as a percentage of the company's overall spending grows every year. It also fears that as health care costs rise for employers in general, fewer employers will make the effort to provide health coverage,

placing more of a burden (in the form of higher premiums) on those employers who continue to do so. Large corporations and public employers cannot absorb this cost shifting in the long term.

Providers

Several providers interviewed expressed enthusiasm over the opportunity that the alliance gave them to interact with purchasers, thereby addressing cost issues from a quality and value standpoint. Providers seemed very supportive and engaged with the alliance strategies concerning clinical improvement protocols, public reporting, and to some extent, incentives. All the providers interviewed were ahead of the curve on treating some of the same conditions on which the alliance is focusing, and thus have been able to lead the way on some of the CITs. Virginia Mason hospital, for example, was already working with some employers, health plans, and purchasers to re-engineer care for cardiac care, migraines, gastroesophageal reflux disease, and back pain. Working with Starbucks and Aetna, Virginia Mason changed reimbursement levels for back pain in order to be reimbursed accurately for appropriate care (physical therapy), rather than for unnecessary care (MRIs and other imaging screenings).

One provider contended that 50 percent of the money spent on health care in this country adds absolutely no value to the customer, meaning more than enough money would be in the system if it were being applied appropriately. He argued that much of the time spent caring for patients does not actually add value to the health outcome. Another provider remarked that physicians run multiple, often unnecessary, and usually redundant diagnostics, because they do not trust the work of other physicians and feel the need to do their own testing. As one provider put it, "Inappropriate care is where all the money is. Doctors say they have to practice defensive medicine."

Health Plans

Most interviewees agreed that of all the stakeholder groups, health plans were the most reluctant to join the alliance. They felt compelled to do so, however, in order to have a voice in any changes made to a highly competitive market. From the health plans' perspective, they joined the alliance, as one representative put it, "to explore what is needed and can be best done commonly, and to best support innovation."

One health plan representative expressed concern about the public reports, questioning whether they would really have an impact, particularly if the data were reported at the group practice level rather than at the individual physician level. This representative agreed that a reimbursement mechanism that allows providers to be paid

according to condition, rather than to individual episode of care, would go a long way toward reining in costs. He argued that "doctors who order more and unnecessary tests and send patients to hospitals rather than ambulatory care sites end up costing plans more money." He also noted that since 35 percent of health care costs are tied up in hospital spending, that is where the alliance should focus its energies, rather than targeting primary care providers. The alliance does plan to use hospital data in its public reports, most likely using existing sources such as the Centers for Medicare and Medicaid Services, the Joint Committee on Accreditation of Healthcare Organizations, and Leapfrog.

Other health plan representatives described previous efforts they had made to work on quality and efficiency issues to set up high performance networks and develop quality metrics. They noted that these efforts had failed, however, due to providers complaining about the variation in measures being used by different health plans, which resulted in some providers being rated poorly by one plan but highly by another for providing the same set of services. For example, one plan collected data on how many times a service was performed in the prior six months, while another asked if two of these services were performed throughout the year. Without a common mediator to oversee the development of common measures, such efforts to address quality of care by health plans fell apart.

Consumers

The idea that consumers ultimately are paying the price of rising health care costs due to cost shifting influenced union negotiators during the most recent set of contracts with the county and state (King County employees alone are represented by 30 different unions and 94 different bargaining units). Rather than accepting cuts in benefits or higher cost-sharing, the unions wanted to figure out how to actually reduce the cost of care overall without sacrificing value. They realized that investing scarce resources in the alliance is risky but were committed to improving information transparency and consumer education.

One of the challenges facing the alliance (as well as other value-based health care collaboratives) is how to get consumers engaged. The alliance has a Consumer Advisory Group, which consists of individual consumers and representatives of labor unions and other consumer groups. The group meets monthly to provide input to alliance work and evaluate approaches for improving engagement and educating consumers on how to obtain appropriate care. Initial steps have included: linking consumer resources from trusted sources (e.g., American Diabetes Association, Federal Drug Administration) to the alliance's site, creating a clearinghouse for health promotion information, providing benefit plan design advice to employers, and making available a health risk assessment tool as well as technical assistance on how to use it. One representative noted that public

reporting is the main tool by which consumers will be able to get the information they need to make informed choices of health care plans. Nevertheless, one interviewee stated plainly that in terms of consumer engagement, "We are not there yet."

KEY INGREDIENTS

While the alliance is still in its infancy and has yet to publish the initial public reports that constitute its major product, the mere fact that it exists and has pulled together representatives from each stakeholder group to address rising costs and the need for improved quality is an achievement in itself. A few key ingredients appear to be instrumental in the alliance's creation and its successes to date. They involve leadership, interdisciplinary teamwork, collaboration among stakeholders, and compromise.

A universal theme among all interviewees was that strong leadership was key to the alliance's success in bringing together multiple stakeholders and getting them to cooperate and compromise to achieve a universal goal. Sims and Stanley were heralded as "local leaders with national reputations" who were able to bring everyone to the table. One interviewee pointed out the symbolic value of Sims traveling to the offices of Fortune 500 company CEOs to make his pitch for the alliance, rather than asking that they come to him or talk by phone. Others remarked on the strength of the alliance's staff, and the fact that the organization put time and effort into creating a strong infrastructure to support all the committees and clinical improvement teams.

Another key ingredient behind the alliance's accomplishments to date includes the QIC, the CITs, and their interdisciplinary make-up. The fact that all stakeholders are represented, and, as one person put it, "are all brave and willing to make compromises," is essential to developing the clinical improvement recommendations that form one of the pillars of the alliance's mission. Stakeholders are being asked to take a risk in order to reconfigure a system that has many severely entrenched problems. While short-term strategies will keep most people confident and upbeat, all involved have an understanding that significant long-term accomplishments are needed to sustain the alliance and keep its participants from fleeing.

A third ingredient is the collaborative nature of the Washington State health care market. The already-existing relationships among many of the stakeholders that are now participating in the alliance helped pave the way for this collaborative effort. Several interviewees described the history of health care reform in the state and how those efforts established relationships that eventually made it possible to form the alliance. This history of collaboration may raise particular challenges if other regions without such histories choose to replicate the alliance model.

An issue that was raised by several interviewees was the fact that the alliance is not in the business of pursuing policy change. While its staff may assist the state or participants when it comes to legislative action that affects alliance work, alliance members do not see themselves as lobbyists. Sims's vision for the alliance was an organization that would create change through the market, not through the government.

Although the alliance is still young, interviewees noted a number of lessons that have been learned through its development and early operation. First, without strong and enthusiastic leadership by individuals who are well known and have "built in" credibility, an effort like this will not succeed. Second, despite all the enthusiasm, it is crucial to begin with incremental change when attempting to overhaul something as unwieldy as the health care system. Third, it is important to remain a neutral broker by staying focused on the key pillars of transparency, information, and incentives.

CHALLENGES

Despite the expressed goodwill among stakeholders and the fact that they are all at the same table, the alliance faces many challenges. The largest is how to counter a health care system characterized by enormous over-utilization. Payers and purchasers know they are paying for services that may or may not be effective, but how can they stop a ship that has been sailing for decades using the same reimbursement system? Aligning reimbursement methods using quality standards and reducing overuse in episode-of-care treatments are critical but difficult to achieve.

As noted above, consumer education and engagement are also significant challenges. Stakeholders universally agree that unless consumers recognize the waste and overuse in the system (i.e., that they do not need all the care they are receiving) and the role they and their doctor play in the quality and cost problems, the system will not change. All interviewees also agreed that the alliance does not have strong enough consumer representation, and that until that changes, efforts to create strategies for engaging them will not take shape.

Purchasers are also in need of education. Encouraging employers to be real health care managers, promoting health and wellness with employees and using quality information when purchasing benefits, will require education, outreach, and support—and may be an uphill battle. The alliance will need to develop a strategy, using input from its purchaser participants, for guiding employers to this new level of responsibility.

In terms of sustainability, alliance staff and representatives of participating organizations unanimously agreed that without measurable successes within the next three to four years, interest in the alliance will begin to drop and the organization will probably suffer. One key to sustainability will be disseminating the first round of public reports and keeping up the momentum to publish subsequent reports. Other short-term "wins" could include getting other organizations to support increased transparency, achieving real changes in reimbursement policy, and showing measurable savings and improved outcomes following implementation of the CIT recommendations. Some stated that getting a reasonable number of health plans to adopt P4P programs would be a sign of success, but as described earlier, not all stakeholders would be in favor of that. Overall, providers, plans, purchasers, and consumer groups will soon want to see a return on their investment into the alliance, which weighs heavily on the minds of the organization's staff.

Finally, an issue that underlies every step the alliance takes is getting common agreement on the group's general direction and individual initiatives. With stakeholders representing different interests and priorities, obtaining and maintaining broad buy-in is an ongoing struggle.

CONCLUSION

The inclusion of all stakeholders in the alliance is a testament to its dedication to creating solutions that all parties can agree upon. While this is a laudable goal, a number of associated pros and cons have developed. The alliance has created an environment in which every player's perspective on issues related to quality improvement and performance measurement are heard, facilitating buy-in on strategies. The value of this is enormous. The alliance, however, may find itself needing to act more slowly in some areas in order to reach consensus among disparate stakeholders. Yet it is under pressure to show results to maintain interest and financial support. Thus far, the organization has been able to make some headway and has achieved several impressive short-term goals. Whether it can continue along this path—keeping all participants energized and excited—remains to be seen.

FOR MORE INFORMATION

For more information on the Puget Sound Health Alliance, contact Diane Giese, director of communication and development, by e-mail at Diane@pugetsoundhealthalliance.org.

NOTES

[1] The alliance is cited as the first organization of its kind to be started by an elected official. H. Eitan Hersh and D. Kendall, *The Puget Sound Health Alliance,* Progressive Policy Institute Case Studies in Innovation, Jan. 2006.

[2] While the alliance is not expanding beyond its current five counties at this time, the public quality report may include data from additional counties. In addition, the Washington State governor has proposed providing funding to the alliance to take the performance reporting statewide.

[3] Institute of Medicine, *Performance Measurement: Accelerating Improvement* (Washington, D.C.: National Academies Press, Dec. 2005), http://www.iom.edu/CMS/3809/19805/31310.aspx.

[4] Care-Focused Purchasing is a database created by Mercer Human Resources Consulting in 2002. Mercer collects claims data from health plans and self-insured businesses to create Episode Treatment Group measures.

[5] Regence BlueShield sent the information to Boeing and state employees. Many physicians were reportedly angry and demanded the approach be stopped. A lawsuit over the issue is pending.

[6] Surgical Outcomes is an organization that collects, analyzes, and benchmarks clinical outcomes data for the purposes of accreditation, risk management, and quality improvement. http://www.soix.com/index.shtml.

[7] A survey recently conducted by the National Business Group on Health and Watson Wyatt Worldwide indicates that employers who offer programs to help employees maintain healthy lifestyles have a lower rate of growth in health care costs than employers who shift the cost to workers. http://www.businessgrouphealth.org/pressrelease.cfm?ID=77.

[8] Funding for these awards came from the State Health Care Authority and First Choice Health Networks, and Quality Health provides consulting assistance to award recipients. First Choice Health is a Seattle-based physician- and hospital-owned company in operation since 1985. See www.fchn.com.

[9] Several years ago (before the alliance was formed), Starbucks worked closely with Virginia Mason Medical Center (VMMC) (another current alliance member) on a protocol for approaching chronic back pain care. After discovering that an extremely high number of its employees were going to VMMC for back care, the company worked with physicians there to shift the emphasis from diagnosing the problem using expensive imaging technology to treating the problem using less expensive but more effective physical therapy. Health plans responded by offering reimbursement that would motivate providers to shift patients into lower-cost physical therapy.

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