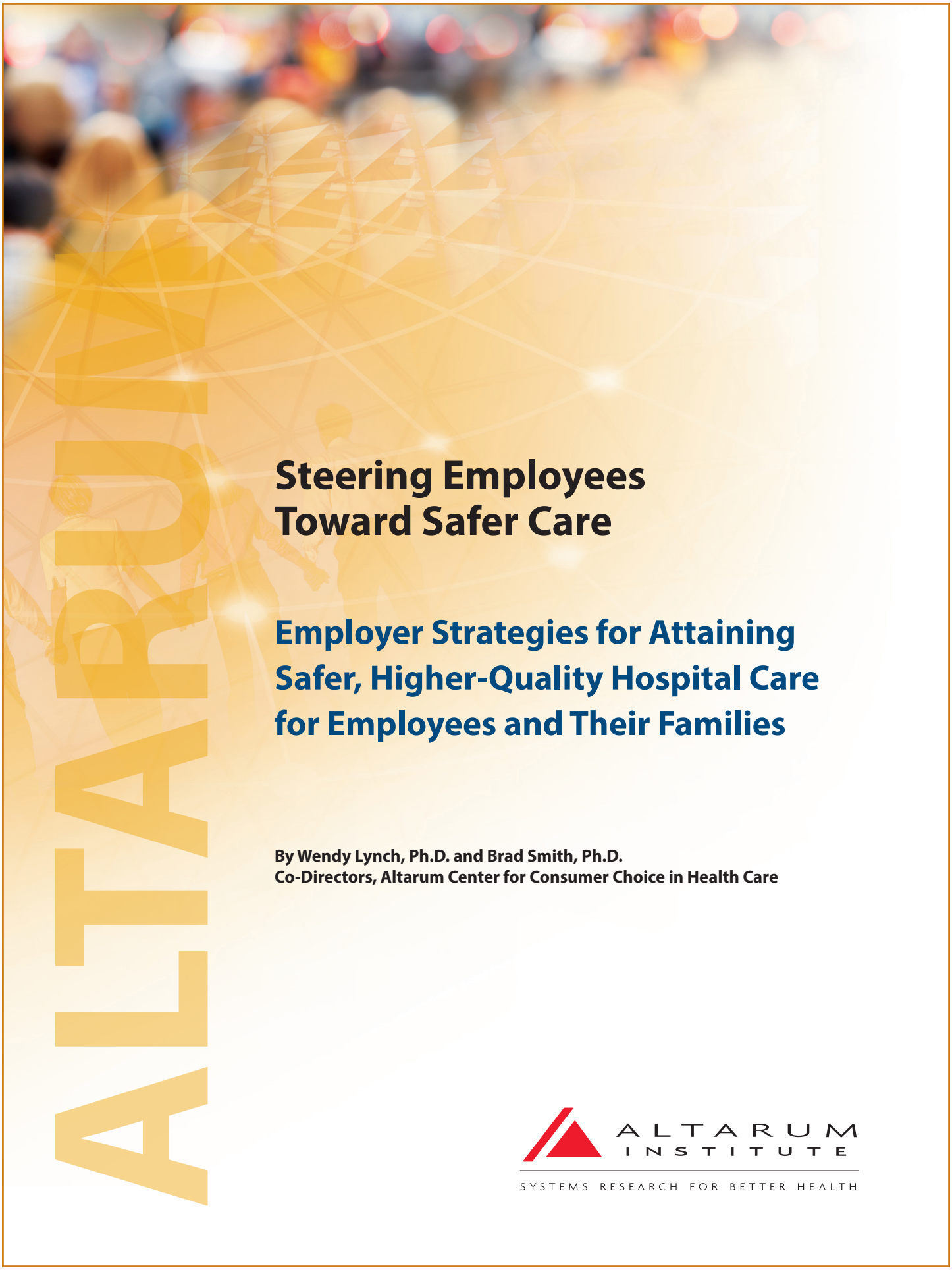

Steering Employees Toward Safer Care

Employer Strategies for Attaining Safer, Higher-Quality Hospital Care for Employees and Their Families

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On a sunny, warm afternoon a few months ago, I had the good fortune to travel to one of the nation's most iconic and beautiful beach communities, joining a group of business leaders touring the prestigious hospital that served the region. In response to the request of these employers, the hospital had voluntarily reported its performance to Leapfrog, so local residents could find out how the hospital compares nationally on infection rates, early elective delivery rates, mortality from certain procedures, and other important factors that truly amount to life and death along this pristine beach.

Although the setting on that day dazzled, the mood turned dismal. The hospital senior management team greeted our delegation with an admonishing lecture. It seems that by asking the hospital to invest 40 hours of staff time a year responding to Leapfrog, we tested the limits of their endurance. "Although we are committed to reporting to Leapfrog as you have asked, in the future we might have to stop," warned the director of quality. "You see, given the shortage in resources, we will eventually have to focus our quality reporting on those who pay our bills."

There was silence. My business colleagues nodded sympathetically.

"With due respect," I said, pointing to our employer delegation, "but these are the guys paying your bills."

"Oh, I didn't mean to offend," said the quality director. "I just meant we have to prioritize responding to the health plans."

"Well, not to get too technical, but these are the guys who pay the health plans," I responded.

The hospital's seeming naïveté about the relevance of these businesses to their operational existence was surprising. But perhaps even more shockingly, my employer colleagues shared that naïveté. They did not react to the notion that they were not paying the bills. Yet together, these executives represented the largest companies in the hospital's service area, spending tens of millions of dollars when their employees used this hospital. Their largesse likely funded that dazzling lobby entrance with its glass rotunda, the new 64-slice CT scanner, and the robotic surgery unit that gave this little beach community access to state-of-the-art medicine. Like many employers, they may have invested more in employee health benefits than they earned in profits during the prior year. Why, then, did these leaders respond so passively to the incredible assertion that they were not a priority for the hospital that they support?

The executives in my delegation are not normally passive or naïve. On the contrary, they are highly successful leaders and tough negotiators when dealing with other vendors and suppliers. They are competitors. None of them would have shown such sympathy to any other vendor trying to explain why 40 hours a year is too much effort to earn their business.

Nor were these business leaders unique in their deer-in-the-headlights approach to dealing with hospitals. Employers normally rely on third parties such as health plans to manage their relationship with health care providers, so they have little experience with the language and culture of the hospital environment and feel unqualified to address it. Hospitals can be intimidating, inscrutable, and highly technical. Just as even a highly trained neurosurgeon might be perplexed when plunked on the floor of an automotive plant, so is the automotive executive out of her element in the operating room (OR) suite or the intensive care unit (ICU). Thus, for many employers, the strategy when dealing with hospitals is to stay out of their business, let them run their ICUs and ORs as they know how, and delegate to the health plans the business of wrestling the costs and demanding quality.

Unfortunately, this strategy has proven to be an unmitigated failure. Purchasers' reluctance to get involved has helped give hospitals a record of poor quality and escalating costs that would be unacceptable in any other industry. One in four inpatients is harmed by a hospital stay, while costs have grown more than 100% in the last decade. Would you walk into a retail store or buy a car if you thought that you had a one-in-four chance of being harmed by the experience or that the price would be twice what it was in 2002? Purchasers can no longer afford to delegate the task of demanding better.

Many employers tell me that their main strategy is keeping people out of hospitals, hoping to control benefit costs by promoting wellness and disease management. Prevention is important, but is it wise to use prevention as a substitute for managing other significant parts of your health benefits program? No matter how effective the prevention program, employees will continue to have babies, break arms, and get cancer and heart disease. Many purchasers spend 50% or more of their health benefits budget on hospitals, and every day they will have employees admitted to hospitals suffering medication errors, infections, injuries, and/or wasteful or inappropriate care that harms or even kills them. Purchasers pay the bills for all of them, including the mistakes.

The Leapfrog Group was founded 12 years ago by a group of employers aiming focus on hospitals to improve their performance. By leveraging their collective investment in health benefits, these employers brought together the nation's top health system experts and created the Leapfrog Hospital Survey—and, this year, the Hospital Safety Score—to drive a transparent market for hospital excellence.

What has been the experience of these employers and the hundreds of others participating in the Leapfrog movement? That was the question asked by Altarum Institute in this white paper. They investigated the experience of employers aligned with Leapfrog's vision for hospital quality and value. Known for brilliant work in integrating evidence and best practices, Altarum brought one of the nation's most innovative thought leaders on health benefits, Wendy Lynch, to lead this investigation. She interviewed employers and business groups on health and offered some initial thoughts on the achievements and the promise of purchaser strategies to influence hospital quality. The results are an incisive list of specific strategies that purchasers have used to drive a market for better hospital care and a practical to-do list that any purchaser can use immediately to see results.

I will be sending this white paper to my business colleagues in that beachfront community from last year. I hope that it will inspire them to apply to hospitals the savvy business practices that made them successful in other industries. We need their business savvy as never before to address the significant challenges ahead. Thanks to Altarum for these important insights and to the purchasers represented here whose leadership and innovation are critical for the challenges ahead in health care.

Leah Binder, MA, MGA

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Introduction

More than 1,000,000 American patients are injured each year from preventable errors in hospitals, and about 100,000 (1) die as a result. Beyond the tragic loss of life, these errors cost Americans an estimated $28.4–33.8 billion (2) in excess health care costs, associated absences, and lost productivity each year (3). The most appalling aspect of these errors, which include hospital-acquired infections, medication errors, and procedural mistakes, is that virtually all of them are avoidable through the implementation of known, low-cost best practices and evidence-based clinical guidelines.

One staggering figure is this: one in three hospital admissions includes an adverse event (4). Another frightening statistic: at the best performing hospitals, 4.8% of patients having inpatient surgery will die of avoidable complications (5). At the worst hospitals, almost four times as many (16.7%) will die (5). Yet patients cannot successfully guess which hospitals are safer; having a well-known facility with a strong public reputation does not guarantee better results. Hospital safety varies dramatically within and across hospital systems. For example, rates of patient falls range from 1 to 7 per 1,000 inpatient days (6). Rates of often-fatal central-line infections are as high as 4% in some facilities (7), despite the fact that they have been almost completely eliminated by 142 U.S. hospitals (8). Knowing which hospital is safest requires easily accessible data about specific metrics, collected on a regular basis. Unfortunately, many hospitals still do not release safety information.

By far the most powerful determinants of hospital safety practices are the priority that hospital leaders place on safe outcomes and the systems and policies put in place to achieve them. Revenue, or threats to revenue, is one motivator that influences adoption of safe practices. Using that motivation, in recent years, Medicare officials have begun to encourage safer practices by limiting or denying payments for treatments of hospital-acquired injury or illness. In essence, these payment rules place appropriate financial consequences on hospitals when errors occur. Furthermore, beginning in 2014, the Centers for Medicare & Medicaid Services (CMS) plans to adjust payments based on hospitals' ability to report specific safety outcomes.

By contrast, employers, whose health insurance benefits cover more than 60% of nonelderly Americans (9), have not exerted similar pressure on hospitals that admit their employees. In many regions of the country, employees remain unaware of differences in safety among hospitals in their communities and lack information about how to find out. In cases where hospital mistakes are not fatal, hospital errors lead to lengthened stays, extended absences, and lost productivity. Because hospital errors are the third-leading cause of death for all Americans and certainly the most avoidable, employers have a clear imperative to save lives while reducing costs.

Despite a number of real and perceived barriers that companies face in their efforts to improve the safety and quality of their employees' hospital care, there are several examples where employers are successfully doing just that. This white paper provides an overview of a variety of strategies that employers use or could use to influence safety and quality of care. These include efforts to guide employees to safer, higher-quality hospitals and, by extension, place pressure on hospitals to improve outcomes.

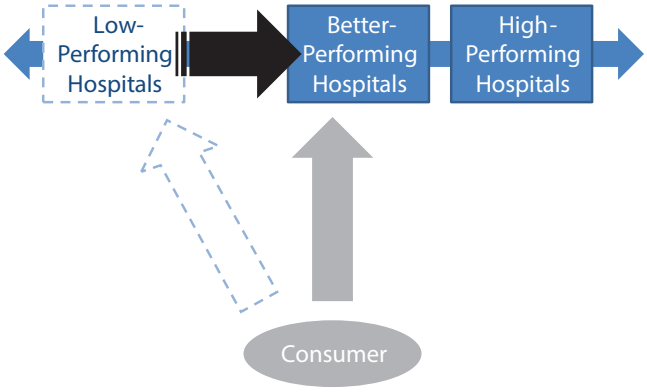
The timing of this report coincides with the release of the fall 2012 results on HospitalSafetyScore.org, a scoring system developed by national quality experts and released by the Leapfrog Group. While Hospital Safety Scores are certainly not the only metric that employers can use to guide employee choices and are not without controversy and objections from hospitals receiving lower scores, the purpose that they serve is crucial. If patients at Hospital X experience far more infections, falls, respiratory failure, blood clots, and injuries than at Hospital Y, consumers should know about it. One can argue about the relative weights applied to various outcomes and practices, but the underlying rates are straightforward. The message is this:

> *The most knowledgeable experts about quality have developed a thoughtful consideration of nationally reported outcomes, comparing all hospitals against one another; it warrants our collective attention.*

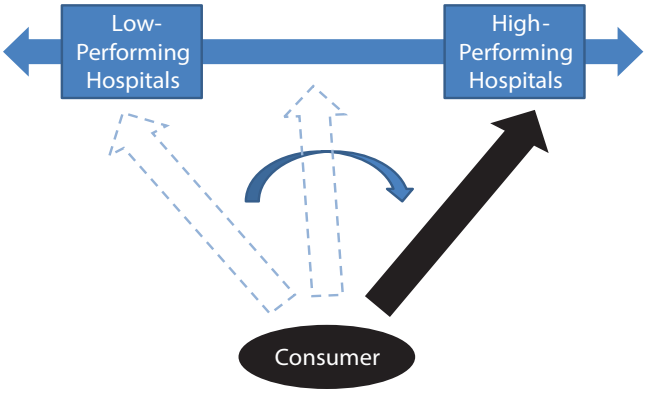
The intention of this overview is to provide a framework describing both simple and comprehensive actions that employers can take to influence the safety and quality of care employees receive and minimize their exposure to avoidable errors. Hopefully, it encourages all employers to take some action, no matter how small it may seem.

Two Strategies

Strategy 1: Shift Hospital Performance



Strategy 2: Shift Consumer Choice



There are two overarching strategies used by payers to influence the safety of inpatient care. One is to change hospital practices by applying pressure to encourage low-performing hospitals to improve safety (see graphic on left). In this case, policies focus directly on providers in ways that either reward high performance or penalize low performance. By improving safety in the lowest-performing facilities in a region, it increases the overall likelihood of any patient receiving better care. On its own, this strategy targets the supply side of health care.

The other strategy is to steer consumers toward safer hospitals (see graphic on right). This involves policies that target consumers (the demand side) directly in ways that encourage safer choices or discourage unsafe choices. Instead of working to improve care delivery in low-performing hospitals, this strategy seeks to have consumers avoid those facilities altogether.

The two strategies are not mutually exclusive and, as examples in this paper will illustrate, can be used effectively in combination. Also, they reinforce each other. If sufficient numbers of consumers begin to choose high-performing facilities over others, hospitals may act to recapture patient volume. Similarly, hospitals that achieve and promote quality and safety outcomes may attract more patients.

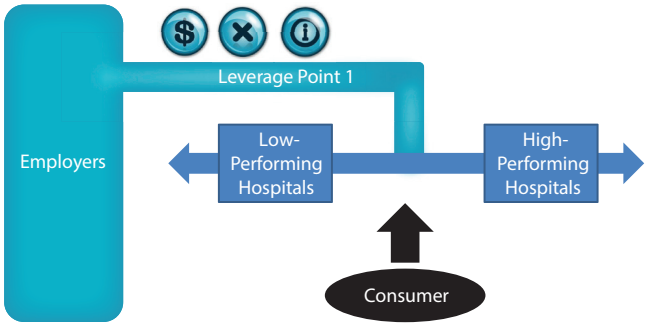
Three Forms of Leverage

In both strategies, payers can apply three types of leverage: exclusions, financial differentials, and information/awareness. Exclusions refer to policies that simply do not allow a particular action (e.g., excluding a hospital from a plan). Financial differentials refer to policies that pay better hospitals a higher rate of reimbursement or require patients to pay more at lower-performing hospitals. Information can be used to publically release hospital performance or to educate consumers.

Generally, exclusions are more influential than financial leverage, and financial differentials are more influential than information alone. However, despite information being less effective, employers have been more willing to use it and least willing to use exclusion due to negative reactions from hospitals and consumers. More about this tendency will be discussed in a subsequent section titled "Barriers Encountered."

All three forms of leverage, alone and in combination, have been applied by employers to influence hospital and consumer behavior.

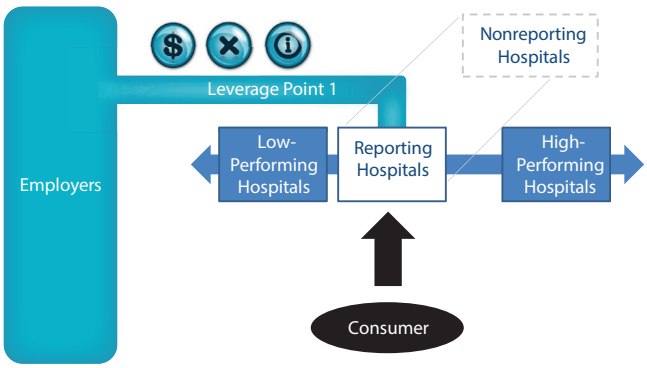
Strategy 1: Improve Hospital Safety



Strategy 1 focuses on reducing the variation in hospital performance by improving low-performing hospitals. It takes aim at performance metrics and applies leverage based on how well a hospital scores. Employers' influence on making measureable improvement in hospital safety often depends on the portion of patient volume at stake. In a smaller community, a single midsized employer may have enough leverage to have an impact. To get attention from hospitals in larger communities may require a collective group of employers or a multistakeholder coalition. Regardless of the actual entity imposing safety policies, the basic types of leverage are the same.

A First Step: Require Transparency

Neither strategy—efforts to improve safety or shift demand—can occur without having sufficient information to distinguish between low- and high-performing hospitals. Payers need to know to which hospitals their patients should go. Historically, there have been few requirements for hospitals to report critical safety outcomes such as mortality rates, falls, infection rates, or surgical mistakes. As a result, many hospitals still report limited information about their practices or outcomes; patients and employers remain mostly unaware. Thus, the minimum essential requirement for improving the safety and quality of care is transparency. Does the hospital follow specific care processes? How often do problems occur?



Evidence confirms that hospitals reporting their own actions and outcomes perform better on objective metrics than those choosing not to report. Consequently, every successful effort by employers to influence safety and quality begins with a basic requirement that hospitals provide information. The essential first step is to pressure hospitals to become more transparent.

The strategy implemented by the state of Maine provides a blueprint of how employers can transform regional hospital practices (see the textbox on page 10). It started by emphasizing a hospital's willingness to report (10). Similarly, the Health Services Coalition, a nonprofit collaborative in Las Vegas that negotiates hospital contracts on behalf of large and small self-insured employers, requires that hospitals report specific quality metrics before the hospital can qualify for financial incentives (11). Many employers and health plans require reporting in order to be eligible for other incentives.

When Horizon Blue Cross Blue Shield of New Jersey implemented their Recognition Program in 2006, only six hospitals completed the Leapfrog Survey. By making safety and quality awards dependent on completing the survey, that number increased to 37 hospitals.[1]

Companies of any size can adopt language and make direct requests for quality assessment and reporting transparency. Examples are available from Catalyst for Payment Reform (CPR) (12), a multistakeholder organization dedicated to payment reform advocacy, research, and tools. Any employer can adopt recommended CPR sample contract language for an agreement with health plans to require transparency. By including these specifications in contracts, health plans can advocate on behalf of their customers (employers), requesting that sufficient data be provided to allow for meaningful comparison of providers. Employers should require the following:

> *For hospitals…the program should promote and advocate…the benefit of measures including, but not limited to National Quality Foundation (NQF)-endorsed measures, Leapfrog Group's safety and quality practices, and measures Medicare uses for reporting and payment purposes.*

1 Unless otherwise noted, specific data or anecdotes are from personal communications with Wendy Lynch in 2012

Leverage through information and awareness

Safety and quality scores are progressively becoming more available to the public. The release of safety letter grades by the Leapfrog Group (listed on HospitalSafetyScore.org) in the spring of 2012 attracted significant national attention (5). A detailed review of the methodology reveals a detailed, thoughtful, evidence-based approach constructed by leading national experts. While some receiving lower grades objected to the scoring methods, one finds it difficult to argue with the approach to comparing performance.

Whether a local hospital agrees or disagrees with its specific rating, a letter grade provides an opportunity for business leaders to discuss safety with hospital leaders. Awareness increases through dialog about how a hospital is performing on specific aspects of safety. Explaining that safety scores could be used in the future to determine network inclusion or reimbursement levels can start the conversation about employers' interest in safety. Furthermore, a meeting among local employers, publicized to the press, can be a catalyst to increase public awareness and encourage hospital actions. Thus, regardless of whether dollars or access are at stake, information alone can be used as leverage.

Leverage through financial incentives

Differences in safety or quality can form the basis for powerful financial incentives through reimbursement or awards. For example, Horizon Blue Cross Blue Shield of New Jersey uses the Leapfrog Hospital Survey to recognize hospitals with an annual bonus, on top of regular reimbursement fees, based on achievement scores. The average payment was close to $150,000, with a maximum of $250,000. Hospitals must complete the survey to be eligible for the recognition program. As an alternative, the Health Services Coalition in Las Vegas ties some of its annual increases in fee reimbursement to quality and safety scores.

Some coalitions report an intention to increase their payment differentials (either awards or reimbursement) progressively over time while also elevating the criteria required to earn greater payments.

In all cases where payment differentials were used as leverage to improve hospital performance, groups report engaging in a collaborative, transparent process with local hospitals. The process defines a clear set of criteria, well in advance of the measurement year. Usually, these criteria evolve over time as hospitals become more familiar with measurement and comfortable with the overall process.

Without consistent effort, safety efforts can move backwards

In one Midwest coalition, despite achieving early success in convincing hospitals to participate, employer members were reluctant to apply meaningful levels of rewards or penalties based on participation or performance in Leapfrog Surveys. As a result, participation in Leapfrog dropped from approximately 90% of regional hospitals to less than 20%. Conversely, in states where coalitions actively applied safety scores in either contracts or promotion, participation in Leapfrog has remained strong and consistent.

Leverage through exclusion

Complete exclusion of a hospital from a health plan network is unusual. However, a few self-insured employers have used safety or quality scores to remove a hospital completely from a network.[2] In these examples, the hospitals are already familiar with a quality- or safety-scoring system used by a coalition in their region and understand that participation in reporting or achieving certain levels of safety is required for higher reimbursement. However, in some instances, specific employers have decided to apply it in a more severe way by completely eliminating the hospital from an allowed network.

Reverse exclusion, or special inclusion, can also be applied by making a chosen facility a preferred source or center of excellence. If a specific hospital is identified as having superb safety practices or outcomes for a given procedure (e.g., expensive services such as back surgery, transplants, or cardiac procedures), then the employer can designate it as "in network" or offer a higher reimbursement to that facility. Interestingly, designation as a preferred hospital can also change. In one example, an employer was preparing to designate a hospital as a center of excellence when it was discovered that the Hospital Safety Score was low; the decision was postponed.

As an alternative, employers can use restricted quality networks offered by health plans, such as Blue Distinction®, UnitedHealth Premium®, and Aetna Aexcel®(13).

Lastly, some employers are beginning to contract directly for services rather than use networks defined by health plans. These direct contracts may require a "bundled," all-inclusive payment that essentially carries a financial penalty if the patient requires additional care because of an adverse event. In some cases (e.g., Purdue Farms), the direct contracts extend beyond hospitals to include primary care providers (PCP) (14). These strategies may be out of reach for small employers.

2 Technically, exclusion could be categorized as the most extreme form of financial differential because consumers are often allowed to use the facility for a non-network rate. However, the perception of many consumers will be that the hospital is "not covered."

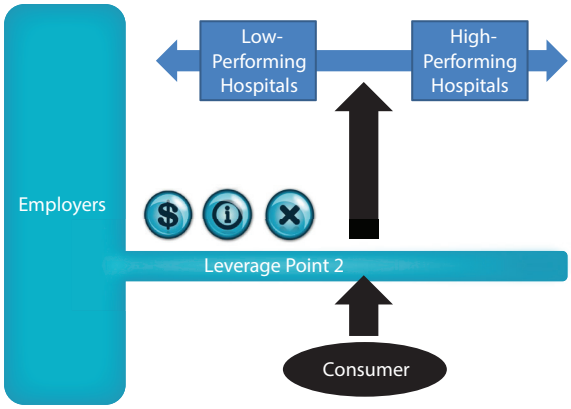
Barriers Encountered in Strategy 1

In Strategy 1, employers attempt to influence the actual level of safety of care delivered by the hospitals their employees use. The most basic step is informing hospitals that safety is important. Stronger pressure can be exerted through policies that reward safer hospitals with higher pay or more patient volume.

Employers and employer coalitions often report reluctance to apply pressure or negotiate with hospital leaders. The hospitals themselves may be employers in the community and fellow members of an employer coalition. Furthermore, employers often experience rebuttals from hospital representatives about the validity of specific metrics or the burden of collecting information. Without expertise to counter such arguments, employers may back away from important safety criteria.

Employers reluctant to negotiate directly can begin by choosing health plans (e.g., Horizon Blue Cross Blue Shield of New Jersey) or Third Party Administrators (TPA) that monitor and reward safety and quality or by including language in their health plan contract from the template provided by Catalyst for Payment Reform. Also, to make criteria simple for hospitals to complete, employers can choose one metric, such as the Hospital Safety Score or the Leapfrog Group hospital survey.

Strategy 2: Shift Consumer Choice



Rather than trying to change hospital performance directly, Strategy 2 focuses on shifting consumer utilization to safer, higher-quality hospitals. It acknowledges that some hospitals perform better than others and applies leverage to push consumers toward those that perform best. Employers' influence on patient choice depends on several factors. First, hospital performance must be known; patients need some mechanism of comparison. Consumers then need to be aware of what constitutes a "better" or "worse" performer. Finally, there needs to be a clear, meaningful reason for consumers to select the better facility, even when their providers suggest a different hospital. Given the need for both awareness and incentives, successful efforts to shift consumer admissions to safer hospitals often include a multifaceted approach.

Leverage through information and awareness

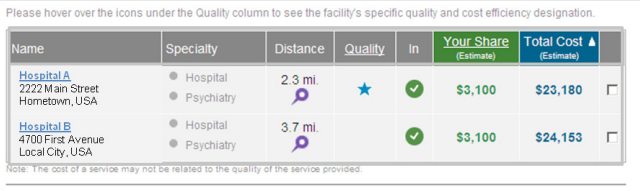
Employers provide information about hospital safety and quality through a variety of media. Some post links on company websites, such as LeapfrogGroup.org and HospitalCompare.gov. Others conduct group meetings to educate employees about the differences between low- and high-performing hospitals. Education comes in a variety of formats, either online or through mailed materials to the home. In one instance, an employer created a "The Price is Right" game that quizzed employees about both price and quality and gave awards. In another example, a high-tech firm rewarded employees with credits toward prizes when they performed information-seeking behaviors, such as using safety and quality scores in their decisions. Additionally, some employers require that their health plans, TPAs, and vendors (disease management or health coaching) reinforce a message about hospital quality and safety.

> "You know what works? Postcards to the home, quarterly. Promoting it often. It's about trying to keep it top of mind and then putting a structure around it—an easy number to call. Also, lots of publicity. When a story appears in the local paper about your company, your neighbor may say something that makes you think about it."
>
> —TPA administrator

> "We require that all plans have a link to Leapfrog. And we talk about it whenever we can… why quality matters, and reinforce the importance of being a well-informed consumer."
>
> —corporate manager of health quality, Fortune 100 firm

At General Electric (GE), which is one of the founding members of Leapfrog, employees see information about safety and quality on their internal website. Plus, when employees contact a health coach for information, part of the coach's job is to educate them about hospital quality. In addition, GE provides employees a Total Cost Calculator tool that includes not only comparative price information but also an indicator of hospital quality based on health plan ratings of high quality. Users can investigate further to identify specific procedures for which the facility was designated high quality. Several different metrics are

listed about each facility in the summary table below. Users can drill deeper into specific information on what criteria went into the ratings.


Please hover over the icons under the Quality column to see the facility's specific quality and cost efficiency designation.

Name	Specialty	Distance	Quality	In	Your Share (Estimate)	Total Cost (Estimate)	
Hospital A 2222 Main Street Hometown, USA	Hospital Psychiatry	2.3 mi.	★	✓	$3,100	$23,180	☐
Hospital B 4700 First Avenue Local City, USA	Hospital Psychiatry	3.7 mi.		✓	$3,100	$24,153	☐

Note: The cost of a service may not be related to the quality of the service provided.

While much work remains to determine the most effective format for presenting safety, quality, and cost information for consumers, these tools help to highlight an important concept that has been invisible to consumers: Care varies dramatically. Leading employers can play the critical role of alerting employees to key metrics that indicate the efficiency and effectiveness of care. As a first step, employers are building awareness that employees' choice of hospital can have a significant impact on health outcomes.

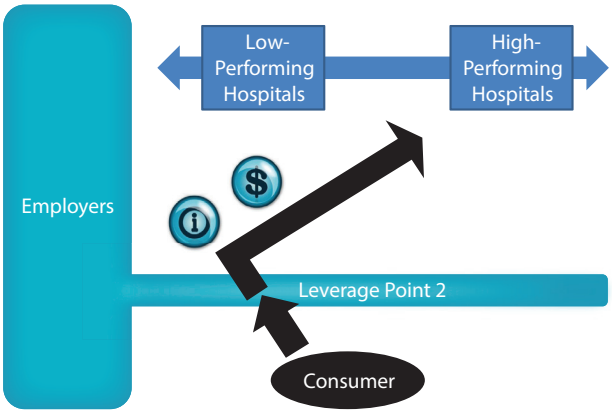
Of note, PCPs also have a clear opportunity to guide employees to safer hospitals. In their role of coordinating care and facilitating health decisions, PCPs, especially those in employer-sponsored clinics, can discuss safety and quality with their patients. While few PCPs report choosing hospitals based on safety and quality information (15), their participation in promoting safety and quality scores could provide significant leverage for increasing awareness. At present, it is a missed opportunity.

Leverage through financial incentives

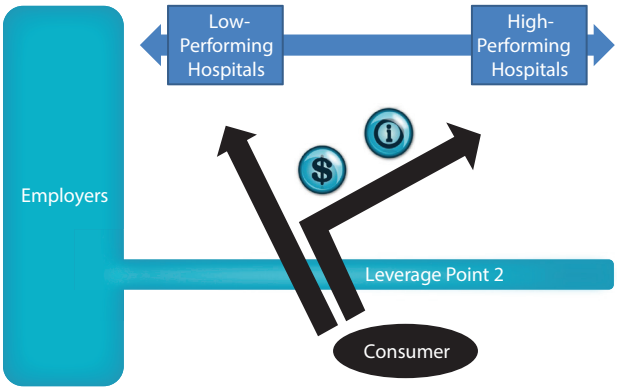
Requiring a different level of employee payment based on hospital safety or quality sends a powerful message; the larger the differential, the more impact it has. Though not widely used, a few innovative employers assign a financial incentive based specifically on safety and quality scores. For example, employees working for the state of Maine may face a differential of thousands of dollars depending on the scores of the hospital that they choose (10) (see the textbox on page 10).

Employers sometimes narrow their targets and apply financial incentives to encourage consumers to seek a particular safe or high-quality facility for designated procedures or conditions. Most commonly, these are expensive procedures sometimes done unnecessarily, such as back surgery or heart bypass. For example, at Walmart (16) and Kroger Co. (17), employees who receive treatment at a Center of Excellence, which the company has already confirmed as a safe facility with superior outcomes, pay no coinsurance for treatment. If employees seek care elsewhere, then they will pay the full deductible and 20% of the remaining cost of an expensive procedure. In addition

Shifting Choice Based on Overall Safety and Quality



Shifting Choice Based on Procedure-Specific Safety or Quality



to diverting care to safer facilities, seriously ill employees are referred to a high-performing hospital such as Mayo Clinic to obtain a company-paid second opinion. Notably, more than 20% of the employees who seek an opinion from the Mayo Clinic are advised that the treatment, the procedure, or their diagnosis is not appropriate based on evidenced-based guidelines.

Another approach to influencing consumer choice is to apply incentives to specific methods of treatment. The Colorado Springs School District chose to target five common surgical procedures that could be performed laparoscopically, called minimally invasive surgery (MIS), rather than through older techniques that require an open incision (18). The logic was that MIS were safer, cost less, and had significantly faster recoveries. Plus, the most common reason for not using MIS on an eligible patient is a lack of training by the physician. Consequently, the health benefit was designed to include a preauthorization for a non-MIS surgery. If the employee was a candidate for MIS but chose an invasive procedure instead of finding a physician who could perform MIS, he or she was charged an additional $500. The result was a significant shift to MIS and notable cost avoidance. Not surprisingly, the incentive produced a marked increase in rates of lower-cost, safer MIS.

Overall, policies that apply significant financial consequences to medical choices do influence consumer behavior. Whether narrowly focused on the type of procedure or condition or broadly focused on choosing safer facilities, employers can effectively steer employees to safer care. The state of Maine example on the following page represents one of the most advanced approaches to influencing both the consumer and the hospitals to report quality metrics and improve quality and cost outcomes.

Leverage through exclusion

A few employers have taken the extra step to exclude a low-performing hospital from their approved network of providers based on failure to achieve safety or quality criteria. Financially, this simply means that a consumer will pay significantly more if he or she chooses this hospital. While potentially disruptive when employees live in small communities, it does send an especially strong signal that certain hospitals should be avoided. Anecdotally, employers report instances where consumers complain not only to their employer but directly to the hospital about the inconvenience of not having their local facility in the approved network.

Barriers Encountered in Strategy 2

One of the more common concerns expressed by employers regarding steerage is delivering quality and safety information in an understandable way. Can consumers assess quality scores, especially during a stressful health episode? Some employers mitigate this concern via patient advocates who can support employees in the selection process. Others conduct detailed seminars or provide detailed education modules online.

Employers also worry about the accuracy of guiding an employee to one hospital over another. If quality varies within hospital departments, is the individual being steered appropriately? Company representatives worry about directing all patients to one hospital versus another when a hospital might excel at maternity care but fall short in cardiac care. This increases the tendency to choose specific areas for which Centers of Excellence can be designated as the single, best provider.

As in Strategy 1, there remains some overall discomfort in choosing exactly which quality score to promote as the key indicator for employees to follow.

State of Maine: Information and Incentives Influence Employee Selection of "Preferred" Hospitals

Today, employees working for the state of Maine face a significant difference in cost depending on what hospital they choose. A $20,000 procedure might result in a $5,200 ($1,500 deductible plus 20%) out-of-pocket cost at one hospital but only $1,225 ($300 deductible plus 5%) at another. The difference applies because of the hospital's achievement of "preferred" status, which is the result of combined criteria for reporting, quality metrics, patient safety, and cost-efficiency. The difference between the two tiers, preferred and nonpreferred, determines the price the employees pay.

The evolution of a "preferred" designation illustrates a progressive set of actions taken by the state, requiring higher levels of achievement by hospitals and imposing larger cost differentials for employees each subsequent year. The effect has been significant: Only 14 hospitals qualified as preferred in 2006; now 29 of 36 hospitals qualify.

The ability to make comparisons among hospitals was made possible by a multistakeholder coalition in Maine (Maine Health Management Coalition), which includes employers, providers, health plans, and public agencies. This coalition collects medical data from a variety of sources and sets collective goals for improving the quality and lowering the cost of health care across the state. The coalition also aggregates and disseminates quality and safety information from CMS and Leapfrog. Those data are shared with the public on a website (19) maintained by the associated Maine Health Management Foundation.

In 2005, the State Employee Health Commission adopted a value-based purchasing strategy to realign benefit design to reward hospitals based on value rather than volume of care. The Commission is a labor/management organization that serves as health plan trustees. Labor and management each have one vote on matters related to vendor selection, benefit design, and member out-of-pocket obligations.

The following year, the commission initiated its first step toward guiding patients to better-performing hospitals. Criteria for achieving preferred status evolved as follows:

Evolution of the "preferred" designation

2006

Hospitals

1. At or above national average on CMS Core Measures
2. Complete Safe Practices Section in Leapfrog survey
3. At least early-stage adoption of medication safe practices

Employees

Waiver of $200 deductible

2007

Creation of a multistakeholder panel that would designate 'blue-ribbon' cut-off levels of all metrics, rather than simple completion

Hospitals

Must meet blue-ribbon levels of ALL metrics to be preferred

Employees

Same, waiver of $200 deductible

2008

Same as 2007, with some modest increases in blue-ribbon requirements

2009

Created four levels of achievement on metrics: low, good, better, best

Hospitals

Must meet "good" blue-ribbon levels of ALL metrics to be preferred

Employees

Same, added a $100/day copayment for nonpreferred hospitals and per-admission deductible

2010

Added (after 1-year notification) the Hospital Consumer Assessment of Health Providers and Systems Survey, which asks patients directly about their experiences in the hospital, to the list of criteria; 12 hospitals that were formerly preferred failed to qualify

Hospitals

Must meet "good" or better in ALL levels of metrics to be preferred

Employees

Same

2011

Added cost (after 1-year notification) to list of criteria (low = cost 15% or more above state average; good = 4–14.9% above; better = 0–3% above; best = below state average) and began weighting (quality = 40%; safety = 30%; satisfaction = 10%; comparative cost =20%)

Hospitals

Weighted score across 4 of 70 categories

Employees

Same

2012

Shifted weighting (quality = 30%; safety = 30%; satisfaction = 10%; comparative cost = 30%)

Hospitals

Same

Employees

1. Changed nonpreferred deductible to $1,500 and coinsurance of 20%
2. Preferred deductible of $300, coinsurance of 5%

Representatives from the state have conducted hundreds of presentations over the years to explain and promote the importance of the preferred ratings.

Summary

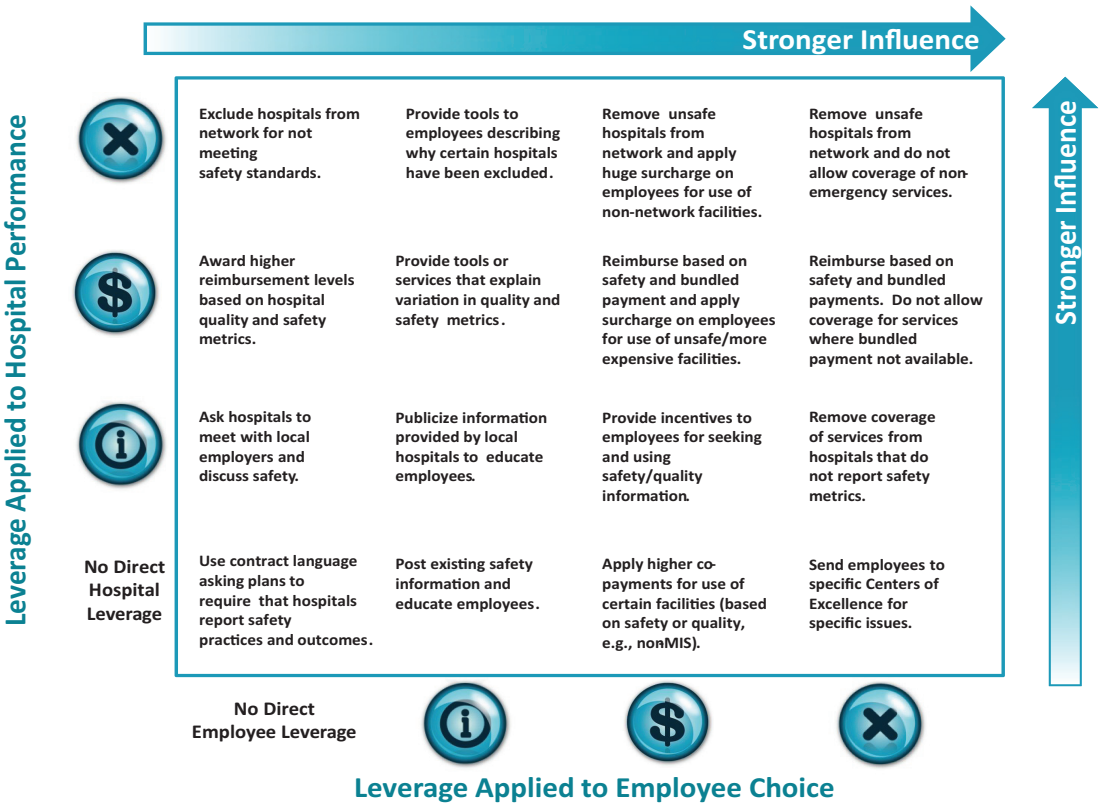
Unsafe hospital practices may be one of the least publicized, most modifiable aspects of health care quality. The magnitude of avoidable suffering, loss of life, and added cost is alarming, yet the problem attracts far less attention than it deserves.

Acknowledging that health care quality can be notoriously difficult to define and that most media stories include strong objections from hospital officials who insist that the metrics are biased or unfair, the underlying threat cannot be minimized. Where it is possible to achieve an infection rate near 0%, patients at many hospitals still have a significant likelihood of dying from infections. Where it is possible to have avoidable death rates of less than 5% for inpatient surgery, rates at some hospitals are close to 17%. Simply put, every patient can and should seek a facility where the fewest accidents happen.

As long as employers continue to facilitate access to health care, they can and should play a role in educating their employees about hospital safety. They can highlight and celebrate hospitals that adopt the safest practices and steer employees in their direction. They can guide employees with information, advice, cost differentials, or excusive arrangements. They can reward facilities directly for achieving better outcomes. As described here, there are many ways to exert pressure on underperforming hospitals, either directly via payment design or indirectly by directing patients elsewhere.

The table below provides a diagram of the many ways in which employers and employer coalitions can steer employees and their families to safer, higher-quality hospitals. As shown, whether using leverage to influence hospital performance or influence employee choices, there are many ways employers can directly or indirectly improve safety. The strongest influence will come from applying stiff financial penalties on both hospitals (for not achieving safety levels) and patients (for using those hospitals). However, there are many other points of leverage that begin with rewarding hospitals for willingness to report and rewarding employees for learning about safety and quality.

Every employer community can request that local hospitals report safety and quality practices. Every employer community can meet with local hospital officials to discuss their safety scores, good or bad. Every employer community can express a desire to attach payment to hospital performance. Evidence from active coalitions suggests that employers can and do influence reporting practices and, in the best cases, influence both the safety and cost of care.



Resources for Employers and Employees

Leapfrog Hospital Survey Results: www.leapfroggroup.org/cp
Hospital Safety Scores: www.hospitalsafetyscore.org
CMS Hospital Compare: www.hospitalcompare.hhs.gov
The Commonwealth Fund's quality information website: www.whynotthebest.org/
Consumer Reports Health Ratings: www.consumerreports.org/health/home.htm
HealthGrades: www.healthgrades.com/
WebMD: www.webmd.com
ShareCare: www.sharecare.com
Blue Distinction Center Finder: www.bcbs.com/innovations/bluedistinction/center-list/selector-map.html

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