Prospectus: January 7, 2013

Executive Summary

In Modern Healthcare’s annual survey of large companies, the “typical” (median) respondent purchased health care benefits for approximately 23,500 individuals, at a cost of $94 million, with a yearly cost increase of 4%. Each percentage point of increased cost represents nearly $1 million in additional spending for health care benefits. If an employer were able to hold costs steady with no increase, the result would be a cost reduction of approximately $4 million – added to the employee compensation pool or used for other corporate priorities. In this initiative, we seek to move from reducing the cost trend, to keeping trends flat, to actual lower health care costs for employers and their employees.

Thus far, employers have used a variety of approaches to controlling costs, with mostly incremental results, and usually involving only one sector. For example, some employers have redesigned benefits and initiated wellness programs to engage employees in controlling costs and taking responsibility for their health. Some health care providers have begun shared savings programs with purchasers. Healthy Employees, Lower Premiums & Costs is an initiative organized by the Institute for Healthcare Improvement (IHI) to combine sector-focused approaches into a coherent system with the aim of lowering costs to employers and their employees while improving the employees’ health and their experience with the health care system – IHI’s Triple Aim.

Structure: The structure of Healthy Employees, Lower Premiums & Costs is the engagement of a small number of multi-sector alliances to pursue the goal of reduced cost and improved health. The alliances could take many forms. For example, an alliance might be composed of a large, self-insured employer partnering with the two major health care providers in their region and their third-party administrator. Another alliance might be ten small to medium companies with the same health plan vendor, joining together to increase their influence with local health care providers. A third option could be a health care provider with an affiliated health plan, focusing on its own employees as its population of interest and therefore having many of the necessary elements of an alliance under one organizational roof. Regardless of the form each alliance takes, the commitment of each alliance is to total cost reduction. We suggest that an alliance that joins this initiative starts with at least two sectors (employer, union, health plan, health care provider) committed to the goal of lowering costs through system design. IHI is available to assist with engaging parties in an alliance as needed.

Benefits: Membership in the Healthy Employees, Lower Premiums & Costs network will provide several advantages to leading organizations seeking to increase the value of their health care spend and the health of their employees:
The unambiguous goal of cost reduction with a minimum decrease of at least 1% from baseline cost;

Transparent sharing of data on costs and outcomes with other members of the network;

Expertise in the engagement of the health care system in a manner that is consistent with health care’s focus on the patient;

Motivation from peer organizations;

Efficient and accelerated learning; and

Identification of promising approaches outside the network.

Interactions among the participants will be mostly virtual. However, to enhance learning across sites, there will be some high-value site visits and an annual meeting for additional shared learning. Participating alliances will also receive individual attention from the Healthy Employees, Lower Premiums & Cost team, including a site visit.

For those interested in larger national change, the network offers the opportunity to demonstrate results that could influence policies and expectations of government and commercial purchasers of health care. IHI also believes that health care providers and health plans that can be effective participants in multi-sector alliances will be rewarded in the marketplace with more volume or more flexibility to pursue transformational change.

Faculty: Donald Berwick, MD, MPP, former President and CEO, Institute for Healthcare Improvement, and former Administrator, Centers for Medicare & Medicaid Services, will serve as the faculty chair of this effort. The IHI operations team will be led by Tom Nolan and Lindsay Martin.

Dr. Berwick and the IHI team will be assisted by an Advisory Group consisting of the following:

- Heath care provider expert (to be announced shortly)
- Catherine Baase, MD, Global Director of Health Services, The Dow Chemical Company
- John M. Hogan, MBA, President and CEO, Capital Health Plan
- Employee expert (to be announced shortly)

To date, the Advisory Group has been associated with results that include the following:

- Ten years of health spending growth of less than or equal to 2%, without changes to benefit design;
- Engagement of Boards, clinicians, executives, and union and non-union employees in the effort to reduce costs and improve health;
- Development of leading-edge methods for reducing costs and improving outcomes in health care;
- Coordination of services for better care of complex, high-cost patients; and
- Consistently keeping health plan administrative costs below 5% while achieving high member satisfaction.
The Advisory Group has been chosen not only because of their past accomplishments, but also because of their commitment to a multi-sector solution to the problem of health care value that breaks new ground. The IHI, the Advisory Group, and all entities that join the network must be committed to driving down health care premiums and costs.

**Commitment:** Alliances joining the *Healthy Employees, Lower Premiums & Costs* network make a commitment to each other to collaborate for three years to reduce cost and improve health. (A group may leave the network at any time without penalty.) Alliances further commit to share their data and learn with each other, using IHI as the aggregator and disseminator of information. The yearly fee for membership in the network is $100,000 per alliance, which includes all organizations that are part of the alliance enabling the fee to be divided among several organizations at their discretion. A reduced fee is available for alliances with an employed population for which the $100,000 exceeds .5% of the health care costs.

Members of the IHI faculty are available for individual calls with interested organizations to discuss this opportunity and answer any questions. If you would like to set up a conversation, please contact Kathryn Brooks at kbrooks@IHI.org.
Description of Network Activities

Design Concepts:
The Healthy Employees, Lower Premiums & Costs network uses a set of design concepts to organize the testing and change process:

- Redefined common purpose across the system (employer, health plan, health care provider) focused on reduced cost, balanced by measures of quality and outcomes;
- Increased transparency between the sectors; and
- Redefined money flow, systems integration, determination of cooperation/competition.

These design concepts and the detail for system design in Appendix A, Health System Design for Decreased Cost and Improved Health in Commercially Insured Populations, were a result of a year-long Research & Development effort by IHI that engaged leading edge organizations and leaders from each of the sectors (health care, industry, government, unions, and health plans). To realize unexpected decreases in premiums, IHI expects that changes will be needed between and within sectors. The concept design of the system in the appendix is not prescriptive but is a starting point to be adapted to local conditions based on testing and scaling up effective elements of the proposed design.

To set up the learning approach IHI suggests the following:

1. **The established clear purpose** of reducing total cost and premiums across the system to guide the overall execution efforts. For an employer, this might mean adopting IHI’s Triple Aim for all employees or members: better health, improved experience of health care, and lower costs. The employer could require reporting on Triple Aim results from health plans and then choose health plans and health care providers based on success achieving the Triple Aim. We believe this specification by the employer will require a health plan to develop an operations plan and build infrastructure (including reporting) to achieve the IHI Triple Aim for the employed population or union membership that is supported by a business model that is sustainable when health care costs and premiums are decreasing. Health care providers likely will need to shift practice to ensure a business model in which better outcomes and lower costs translate into a better financial position.

2. **A cogent set of high-level measures that operationally define cost, individual experience, and health for all members of the system.** Over the last four years IHI’s efforts in running collaborative initiatives focused on the Triple Aim has produced a starter set of such measures (http://www.ihi.org/knowledge/Pages/IHIBlackBooks/AGuideMeasuringTripleAim.aspx). Having a clear measurement system will enable entities to design and execute on the same established purpose. These measures could be a component of a quality control to uncover and communicate adverse trends in quality and cost as a mechanism to maintain regional integrity of care.

3. **A portfolio of projects and investments will be built by each alliance to focus the execution efforts on the common purpose.** The grid in the Appendix will provide a method for engaging the sectors...
in the negotiations that will lead to a portfolio that balances outcomes and effectiveness, an approach to how money will flow through the system, the integration and management of the system, and the tension between when to cooperate and when to compete in a local market.

4. A means of coordinating across the components of the system that aligns initiatives and investments will likely be required. IHI suggests that it is the employers’ responsibility to unambiguously establish the integration role of the system either by a department within the company, a union, a health plan, or a health care provider.

Structure:
The structure of Healthy Employees, Lower Premiums & Costs is the engagement of a small number of multi-sector alliances to pursue the goal of reduced cost and improved health. Regardless of the form each alliance takes, the commitment of each alliance is towards total cost reduction. We suggest that an alliance that joins this initiative start with at least two sectors (employer, union, health plan, and health care provider) committed to the goal of lowering costs through system design. We believe there is benefit to the overall network to having alliances that are shaped differently as they allow for diverse learning experiments that will be synthesized by IHI thereby multiplying the learning for each individual alliance. Furthermore, by selecting alliances from across the country, the group will be able to acknowledge and test within the geographic variations in care, thus enabling us to apply lessons learned appropriately from one region to another.

For an alliance that has two of the sectors engaged and is pursuing another, IHI will work with the alliance to structure a plan to engage the additional sector. We will use the support of the faculty, Advisory Group, and the breadth of influence from other alliances to establish an opportunity for engagement.

IHI is looking for an innovative group of five to ten alliances from across the country to begin experimentation and commit not only to their individual alliance goal, but also to a larger national cost reduction figure for the group as a whole. By adding the decrease in total cost from each alliance that joins Healthy Employees, Lower Premiums & Costs, we will have additional weight to demonstrate the impact on cost that is possible when a system solution is implemented.

Benefits

Membership in the Healthy Employees, Lower Premiums & Costs network will provide several advantages to progressive organizations seeking to increase the value of their health care purchasing and the health of their employees:

- **The unambiguous goal of cost reduction with a minimum decrease of at least 1% from baseline cost:** We expect that each alliance will have a goal of at least 1% decrease in cost from
baseline cost. This represents a decrease in actual dollars spent on health care. Given that the Institute of Medicine has recognized that waste in health care is approximately $765 billion, we are certain that some alliances will be more ambitious than a 1% decrease. Cost reduction has been an elusive goal for nearly all health care organizations; past efforts have been focused on reduction as a byproduct of quality improvement rather than a direct goal of system redesign. Most often, increasing health care costs are passed on directly to employers and while most employers have aggressive and successful cost reduction procurement strategies for their supplier relationships (such as transparency between the purchaser and supplier with a keen focus on reducing costs), these strategies have not been applied to the purchase of health care. A system approach, strengthened by the commitment and parallel learning by multiple alliances, will help to tackle this challenge and achieve the goal of each alliance.

- **Transparent sharing of data on costs and outcomes with other members of the network:** All alliances will be asked to share their progress on outcome measures for cost, patient experience and health. At first IHI expects that this sharing of data will be facilitated by IHI being the data base administer and blinding the attribution of a data set to any particular alliance unless given specific permission. This data will be made available to all network members and will be used for learning. While specific data elements may vary from alliance to alliance, all members of the network will report the same outcome data on cost. The graph below is a helpful illustration of the type of data that will be used to compare costs; it shows both the average family premium and the medium household income for the region. The horizontal dashed line shows the mean for both family premium and median household income. IHI will produce graphs like this using the data from each alliance. This will allow each alliance to compare and learn from the variation in their costs from the average costs in their region and nationally. An employer that had sites in the cities below could add their own data, they may opt to run an experiment in New Mexico, where the family premium exceeds 30% of the median household income if their data follows this pattern. This example uses publicly available data; transparent data sharing across members in the network will enable us to deepen and accelerate the learning that is possible.
A shared measure set within each alliance and across the entire network will also be necessary to enhance learning. There must be clear data on cost per capita, patient experience, and the health of the population. The IHI White Paper, *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost* (http://www.ihi.org/knowledge/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx) is the basis for the measure set.

- **Expertise in the engagement of the health care system in a manner that is consistent with health care’s focus on the patient:** In the past, some organizations have struggled with an approach to engage health care systems in change. This is due in part to the unique nature of the services health care systems provide, and in part to a difference in language and approach, which has served as a barrier to cooperation. IHI has over 20 years of experience working with health care systems across the United States and abroad. By leveraging this experience, we will be able to bring health care systems into a design that still focuses on the individual needs of patients, but does not exclude the need to address the health of the population or the overall cost of care.

- **Motivation of the alliance from peer organizations:** Within an alliance it is likely that members will vary in their will to take on the goal. The leaders of the alliance will be aided in building will and trust by having members of their alliance engage with progressive peers in other alliances, for example hospital to hospital or health plan to health plan. Through the diffusion of innovation, we expect that somewhere within the members of this network early adopters of change will be found in each sector and will lead the way for their peers. Through individual
sector peer relationships, the power of each alliance and the network will be to bring along the early majority in each sector to gain increased support and momentum for change.

- **Efficient and accelerated learning:** Through IHI’s synthesis of the activities of the network alliances, we will be able to share learning faster. Given that different approaches towards cost reduction will be tested in different alliances, the network overall will benefit from learning that is occurring in parallel. Alliances across the network will be able to benefit from the successes and challenges of their peers much faster than would be possible working alone. IHI seeks to be an “honest broker” among the different alliances promoting learning and transparency. IHI faculty and the Advisory Group will synthesize the learning across all members of the network and then use that synthesis to improve the progress of the network; it will be IHI’s responsibility to reduce the transaction cost of learning from others and minimize the “voltage drop” that commonly occurs when learning is transferred from one experiment to another. Furthermore, by having a faculty and an Advisory Group that spans all sectors, we will work to bridge the different cultures and interests among the sectors working to optimize both cooperation and competition. By engaging leaders from all sectors during the design phase of this work, the IHI team was able to determine where each sector was planning to focus their efforts, which enabled the group to build a system portfolio.

- **Identification of promising approaches outside the network:** Through IHI’s global scanning capability (engaging with health care leaders worldwide, running international Forums, working with hundreds of world class faculty in all aspects of care and care delivery, and serving as the repository for unsolicited ideas in innovation and improvement), IHI will continue to look for and learn from approaches outside of the network that we can apply within the network. This scanning will focus on all sectors, both within the United States and abroad. Through ongoing calls and visits, network members will learn about new approaches from IHI’s experience running collaborative innovation projects and large learning opportunities, such as the IHI Forum on nearly every continent. Through IHI’s Board of Directors and appointments for members of the IHI team and the Advisory Group, IHI is connected to all sectors, continuously learning from challenges and successes.

Interactions among the participants will be mostly virtual. However, to enhance learning across sites, there will be some high-value site visits and an annual meeting for additional shared learning. Participating alliances will also receive individual attention from the Healthy Employees, Lower Premiums & Cost team, including a site visit. The following is an overview of how the network will operate:

- **Monthly submission of data and online reports:** IHI will use an online, easy-to-use electronic forum that will allow all alliances to submit updates on their experiments and accompanying data. All members of the network will have access to the website and will be able to follow not
only their progress but the successes of other alliances. An alliance will submit data for a set of core metrics; these will be few in number and will focus on outcomes with measures of cost, patient experience, and population health. Recognizing that different experiments will require additional metrics, IHI will create individual metrics for sites wishing to add to the core measure set. Data submission will not be onerous; it will be simple but vital to our shared success.

- **Monthly All-Site Calls**: One-hour, monthly WebEx sessions will take place with IHI faculty to explore Healthy Employees, Lower Premiums & Costs design concepts, topics in effective measurement, and examples of execution of system change. The calls will provide an opportunity for learning, networking, and refinement of action plans. Teams will be asked to come to the Monthly All-Site Calls with a summary of their work to date.

- **Topic-Specific Learning Sessions**: Teams will convene for up to six virtual learning sessions. These meetings will be topic-driven sessions and are likely to address such topics as developing a business model in which better outcomes and lower costs translate into better financial position; motivating and assisting employees or members and their families to improve their health, engage in preventive measures, and be wise consumers of health care; and removing payment method as an obstacle to improved outcomes and lower costs. We will finalize the topics based on the needs of the sites and invite experts to attend and facilitate the discussion. In each session at least one site will have the opportunity to present its work and receive active coaching and recommendations from faculty and the other sites.

- **In-person Meeting at a Site**: Once or twice during the year, all the sites will be invited to attend a one-day learning session at one of our participating sites. This will be an opportunity for the site to highlight one or two aspects of their progress and share their learnings with other sites.

- **Site Visits by IHI Faculty**: Each site will have one visit by an IHI faculty member each year. Prior to the visit, the agenda will be mutually developed to ensure that learning time is optimized. When appropriate, other sites may be invited to join the visit to accelerate learning across similar systems.

**Faculty**

Donald Berwick, MD, MPP, former President and CEO, Institute for Healthcare Improvement, and former Administrator, Centers for Medicare & Medicaid Services, will serve as the faculty chair of this effort. The IHI operations team will be led by Tom Nolan and Lindsay Martin.

Dr. Berwick and the IHI team will be assisted by an Advisory Group consisting of the following:

- Heath care provider expert (to be announced shortly)
- Catherine Baase, MD, Global Director of Health Services, The Dow Chemical Company
- John M. Hogan, MBA, President and CEO, Capital Health Plan
Employee expert (to be announced shortly)

As appropriate, IHI will engage experts from within and outside of health care to advance the learning of the group.

Commitment

Alliances joining the Healthy Employees, Lower Premiums & Costs network make a commitment to each other to collaborate for three years to reduce cost and improve health. (Participation will be renewed annually and a group may leave the network at any time without penalty.) Alliances further commit to share their data and learn with each other, using IHI as the aggregator and disseminator of information. The yearly fee for membership in the network is $100,000 per alliance regardless of the number of organizations that are part of an alliance. It is at the discretion of each individual alliance to determine how to divide the fee. A reduced fee is available for alliances with an employed population for which the $100,000 exceeds .5% of the health care costs.

Given the level of commitment needed and the significance of the goal each alliance is making, we believe the following will be helpful guiding principles for the structure of each alliance to achieve the rapid pace of change proposed:

- **Senior Leadership Support**: Because of the strategic and system-level focus of Healthy Employees, Lower Premiums & Costs, participating alliances need to have senior leader support to be able to remove barriers and gather support to execute on a quick timeframe. By recognizing this work as a strategic priority, leaders will be able to provide the resources necessary to align the work and drive towards success.

- **Dedicated Project Resources**: Alliances should determine a senior level, day-to-day leader who is able to orchestrate overall participation and to drive progress on the site’s Healthy Employees, Lower Premiums & Costs project portfolio. For each project within the portfolio, a project leader with the time, resources, and accountability to succeed should be designated to oversee the day-to-day activities. Because of the challenges in securing population-level data, we strongly recommend designating a data expert to the team who is able to keep the data updated with the progress made.

- **Improvement Skills and a Record of Successful Improvement**: To succeed in Healthy Employees, Lower Premiums & Costs organizations must have strong improvement capabilities at the individual project level and at the organizational, system, or population level. Suitable organizations are skilled and agile in using the Model for Improvement, Lean, Six Sigma or other similar models, running small tests of change in rapid succession, and implementing change on a large scale.
• **Dedicated Support for Measurement and Data Infrastructure:** Since few organizations or alliances currently track all three elements of IHI’s Triple Aim (cost, experience, and health metrics), most participants will need to develop new ways to collect and use data, including looking beyond their own data systems to external sources. Each participating alliance should identify a measurement lead to support the tracking of results over time.

• **Partnering and Inclusion:** Participating alliances will need to reach beyond their usual boundaries to develop cross-sector partnerships to include employers, health plans, and health care provider systems. As needed, IHI faculty will be available to support the alliances in initiating these partnerships.
Appendix A

**Health System Design for Decreased Cost and Improved Health in Commercially Insured Populations**

**Goal:** Unexpected decrease in premiums through a system design that is focused on better health outcomes and lower cost

<table>
<thead>
<tr>
<th>Employer/Union</th>
<th>Health Plan</th>
<th>Providers: Treating medical conditions</th>
<th>Providers: High cost population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopt the IHI’s Triple Aim for all employees or members: better health, improved experience of health care, and lower costs. Require reporting on Triple Aim results from health plans. Choose health plans and providers based on the aim.</td>
<td>Develop an operations plan and build infrastructure for achieving the IHI Triple Aim for the employer population or union membership. Develop capability to report Triple Aim results on employers’ population.</td>
<td>Develop a business model in which better outcomes and lower costs translate into better financial position.</td>
<td>Develop a business model in which better outcomes and lower costs translate into better financial position.</td>
</tr>
<tr>
<td>Motivate and assist employees or members and their families to improve their health, engage in preventive measures, and be wise consumers of health care. Focus on keeping healthy employees, members and families healthy and prevent migration of employers to high risk/high cost.</td>
<td>Develop a business model that is successful when health care costs and premiums are decreasing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes and Effectiveness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Require data on outcomes and cost for high priority conditions and high cost populations. Institute a system for patient reported outcomes.</td>
<td>Identify high-performing providers or those on a positive trajectory by condition specific outcomes. Highlight them as models to be emulated.</td>
<td>Drive practice improvement by following patient outcomes for conditions overtime – episode approach.</td>
<td>Measure success for the individual based not just on health care but overall level of function.</td>
</tr>
<tr>
<td>Assist providers with coordination of care for individuals</td>
<td>Build capability to efficiently customize care to the situational factors of individual patients</td>
<td>Build new skills to better address needs of populations: • Integration of care • Inclusion of behavioral/mental health • Inclusion of social services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Money Flow</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Guide employees to use information and select high value providers for specific conditions. (Attract high cost, socially complex employees to a comprehensive and coordinated system of care.</td>
<td>Make provider information on price and outcomes usable/ actionable for employees, members, families and employers.</td>
</tr>
<tr>
<td>Translate lower health care premiums into higher wages.</td>
<td>Translate lower costs of medical care into reduction in premiums.</td>
</tr>
<tr>
<td>Remove payment method as an obstacle to improved outcomes and lower costs.</td>
<td></td>
</tr>
</tbody>
</table>
**System Integration and Management**

<table>
<thead>
<tr>
<th>Unambiguously establish the responsibility for integration of the system either by a department within the company, a union, a health plan, or a provider.</th>
<th>Trusted source of infrastructure for integration of services, e.g., data analysis, IT, scheduling of services.</th>
<th>Develop processes for coordination of care by multiple providers over time for individuals.</th>
<th>Develop processes for coordination of care across medical services and community resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality control: Uncover and communicate adverse trends in quality and cost as a mechanism to maintain regional integrity of care.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cooperation and Competition**

<table>
<thead>
<tr>
<th>Encourage health plans and providers to agree on measures of outcomes, including patient reported outcomes, and adopt the measures as expectations of all sectors (employees, employers, health plans and providers).</th>
<th>Collaborate with other health plans toward administrative simplification.</th>
<th>Help employers communicate to employees about aspects of health care including, quality, price, and that more is not necessarily better.</th>
<th>Develop a method with public health agencies and community resources to integrate medical care with work on other determinants of health.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invest in improvement in the provider community (e.g., help providers to understand the cost of care).</td>
<td>Collaborate with health plans on administrative simplification by addressing concerns about loosening cost controls.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Basic principles and assumptions:

- In a region, at least some of the health plans, health care providers, and employers will be able to transcend narrow, organizational self-interest and cooperate to develop new business models focused on health outcomes for individuals at lowest cost.
- Competition mostly will be focused within a sector based on outcomes and cost.
- Lack of transparency contributes to keeping the system status quo.
- A primary care infrastructure that extends beyond primary medical care will be an important component of successful system design and will benefit all in the community.
- Business models which are viable as costs are dropping will include revenue enhancing components such as: attracting more patients or members from competitors; contributing to the growth of non-health care jobs and hence expanding the pool of customers; shared savings arrangements; and productivity increases resulting from the Affordable Care Act that allow for new patients to be accommodated with the same resources.
- The grid contains an outline of the proposed system and the interactions among the components. The “how” of system development will rely on learning and experimentation to define processes and build trust among the constituents.