Labor-Management Groups Drive Delivery System Redesign

Maine

The Maine Health Management Coalition (MHMC), a partner in AF4Q Maine, wanted to encourage its members to seek care from the high-quality, cost-effective providers MHMC identified. But MHMC encountered three problems: (1) getting people to use the publicly reported quality information, (2) helping labor and management to see eye-to-eye on changing benefits to get care at a better value, and (3) offering a business case for providers to improve quality or cost.

The State Employee Health Commission (SEHC), a member of MHMC, had been galvanized into action after the Institute of Medicine's reports on health care quality were released in 1999 and 2001. Its executive director spent several years helping educate SEHC members on the quality and cost problems they faced and built a group eager to address these problems in a positive way.

In 2006, SEHC offered members a $200 deductible waiver if they would go to hospitals that were rated higher in the MHMC's publicly reported quality ratings. The impact was dramatic. Hits to the website increased from an average of 50 per week to more than 3,000 the week the program was announced, and they remained at more than 100 per week for the next few months.

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After members initially complained, they discovered the ratings used were credible and pressured their lower-performing hospitals to step up their game. In response, hospitals made dramatic improvements in patient safety. The SEHC followed by tiering physician practices in 2007, waiving a $10 copay with similar results. Because of the tiering, Maine hospital participation in Leapfrog increased from 18 to 36 (all acute care hospitals in Maine), and medication safety scores improved by 127 percent in the first year and 13 percent in the subsequent two. Physician practices with the highest quality ratings increased by 31 percent as the practices obtained more quality designations to be included in the preferred network.

The University of Maine Hospital System also adopted the state's tiering structure. In addition, it began to focus on wellness as a driver. While it had an active wellness program, only about 25 percent of members were participating in a health risk appraisal. The University's goal, however, was 90 percent member participation. As an incentive to members, the University doubled the cost of health insurance for those employees or dependents not wanting to take the appraisal, keeping the contribution almost flat for those participating.

Also, the University changed a benefit design with a $25 emergency department (ED) copay to one with a $100 ED copay and changed primary care physician copay from $20 to $10. As long as the focus of the program is on improving member health while containing costs, the labor members are enthusiastic participants. Finally, the University joined with SEHC in its work with health care systems to form ACOs.

Thanks to these effective collaborations, Maine experienced the second-largest improvement in health care quality in the United States in 2010, according to Agency for Healthcare Research and Quality state snapshots.

Researchers at the University of Southern Maine, through a study funded by the Robert Wood Johnson Foundation, found that collecting information for these quality reports made a dramatic impact on most participating practices by spurring them to improve their chronic and preventive care, participate in quality improvement initiatives, use quality benchmarks and outcomes to motivate patients to improve self-care, improve their health care procedures, and sharpen their administrative practices.

While the accomplishments have been great, the obstacles have been significant. "The biggest challenges are gaining trust with the labor groups and helping task force members understand that quality matters, it varies dramatically, and there is something they can do about both quality and costs," said Ted Rooney, MHMC project leader and Maine AF4Q project director.

"They needed to believe you can have high-quality and cost-effective health care. It takes a year or two of dedicated time and a trusting relationship to develop an effective group. It is not for the faint of heart."

Lessons Learned

- Any efforts must be about improving health first and containing saving costs second.
- You must have a concrete incentive to get people to pay attention to quality ratings—but that incentive doesn't have to be much.
- Using a multi-stakeholder process to develop metrics is critical. People want their doctors involved, and they don't want their employers or health plans determining the quality ratings.
- Union leaders are consumers with the skills needed to help effect change. They know how to organize people, facilitate consensus, and negotiate—and they aren't afraid to stand up to the medical profession.
- It takes some time for people to see themselves less as members receiving benefits and more as population health managers trying to improve the health and quality of their members' lives.
- This process takes much time and trust.