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Illustrating Innovation

Through Bright Spots

Aligning Forces for Quality

Improving Health & Health Care
in Communities Across America
www.forces4quality.org

Illustrating Innovation

Aligning Forces for Quality is, at its heart, about innovation. The communities and people who engage with this unique program are not only open to new ideas, but also **enthusiastic to find them; not only willing collaborators, but also eager to build strong partnerships; not only the most creative scientists, but also determined to experiment** until the answers become clear.

There is no recipe for success in improving health care quality. We would welcome a clear solution to a challenge like ensuring equity in care. How much simpler it would be if one **community could try on solutions until one fit, and then everyone could replicate it. We would like nothing more than to offer up the answers to the hard problems we face.**

But of course, each community is different – in the illnesses that plague it, in the socioeconomic grid that impacts it, in the people that define it. There can be no one recipe for improvement, no one template for reform.

Which is why we need creative laboratories like the 16 that comprise AF4Q.

There is no recipe, but the Aligning Forces communities and others engaged in this work are creating a roadmap, one that points out both areas to avoid and areas worth a harder look.

The bright spots featured here are illustrative of the type of ground level innovation and **experimentation going on every day, in ways big and small, where change can be measured and assessed in real time. Both sparks of success and hard lessons learned offer** important guidance.

They don't begin to cover all that we have learned, but they begin to light the way.

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Engaging Providers Through Practice Coaching

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Innovation Grantees

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Payment Incentives

Mulit-Site: Mapping Payment Reform Strategies | Memphis: Lighting the Way to Payment Reform | North Carolina: A Tough Room: Talking Costs to Employers and Consumers | South Central Pennsylvania: Making Inroads to Payment Reform | Wisconsin: Payment Pilots as an Alternative to Fee For Service

Cultivating the PCMH Model in the Safety Net

Engaging Purchasers, Driving Improvement

Puget Sound

The Aligning Forces for Quality (AF4Q) Puget Sound Health Alliance had long been reporting physician and hospital performance when the local provider community asked, "When are you [also] going to focus on the performance of health plans?"

The Alliance answered the call by exploring existing health plan performance measurement tools and processes, landing finally on **eValue8**™, a standardized request-for-information (RFI) tool developed by the National Business Coalition on Health and used by large purchasers and coalitions around the country.

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Lessons Learned

- **Currently, the publicly reported eValue8 results are not likely to be very** useful to consumers who receive coverage through their employers because they often have little choice about their health plans. However, when state-run **health insurance exchanges come on line for the individual market, eValue8** results may be useful in providing rating information for consumers.

- **Health plans care about how their results stack up in comparison to their** competitors, and the public transparency helps stimulate improvement.

- **eValue8 is a good way to organize purchasers and help educate them about** what health plans can and should be doing to drive improved value in the market.

Puget Sound got the ball rolling by assembling a dozen purchasers interested in sponsoring the **eValue8 effort and subsequently** approached all six major commercial health plans in the area to participate.

eValue8 works by asking health plans detailed questions about how they operate, with a particular focus on their commitment to accelerating quality improvement in the delivery of care and "results-oriented" reimbursement. The National Business Coalition on Health scores the answers nationally and then provides users, including Puget Sound, with detailed results it can use to compare participating health plans to others in its market and against national best practices for HMOs and PPOs. The Alliance then publicly reports summary-level, unblinded results.

"It has been an excellent tool to evaluate and report on the performance of health plans," said Susie Dade, the Alliance's deputy **director. "But more than that, the eValue8 process has been a superb organizing tool for purchasers to come together with health plans to talk about successful programs and issues of common concern in improving value and to review specific areas where** they can improve."

Health plan involvement has been very successful, with five of the six major local health plans participating in the eValue8 effort on an ongoing basis. The Puget Sound Alliance continues to encourage the other plan to re-engage, after it dropped out of **eValue8 after two years of participation.**

So far, the results have been encouraging. Purchasers say they have learned much about what health plans can do to drive value in the market, and what they each are actually doing – and not doing – to push toward value-based purchasing. The process also has brought health plans and purchasers together to brainstorm strategies for reducing variation and waste in health care delivery.

"Purchasers can be very effective in driving change, but they need assistance in tackling these complex, thorny issues, and eValue8 is one effective way to structure the discus-sions," said Dade.

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Cultivating the PCMH Model in the Safety Net

Statewide Initiatives Using PCMH to Transform Care in the Safety Net

Massachusetts

In Massachusetts, increasing provider dissatisfaction was exacerbating an already critical primary care workforce shortage operating in the context of the state's universal coverage mandate. The problem is even more pronounced in community health clinics (CHCs) that are committed to delivering primary care to a low-income, vulnerable population in a fee-for-service system. These CHCs are also under pressure to provide coordinated care with limited resources for populations with complex social, behavioral, and economic issues.

The Massachusetts League of Community Health Centers (MLCHC) is the state's primary care association, a network of both **federally qualified and hospital licensed CHCs located throughout the state. The MLCHC is a co-executive sponsor of the Commonwealth** Foundation-Qualis Safety Net Medical Home national demonstration (SNMHI) in the state. There are 14 practice sites actively working in SNMHI towards medical home practice transformation and NCQA patient-centered medical home (PCMH) **certification.**

In addition, the Massachusetts Executive Office of Health and Human Services (EOHHS) implemented a state-sponsored, multi-payer medical home initiative for 45 primary care practices across the state. These include the 14 SNMHI CHC sites, other CHCs, academic practices and private primary care practices. The MLCHC is a member of this project team and collaborates in the planning, implementation, and evaluation of the state medical home initiative.

Goals of both the SNMHI and EOHHS initiatives are to transform primary care practices, especially those serving the safety-net populations, to medical homes as illustrated by planned, proactive primary care that engages patients' and meets patients' needs for access, continuity of care, and care coordination managing safe transitions within the health care system.

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This was not an easy and straightforward task, particularly in fully engaging the practices to participate in the PCMH transformation.

"We knew we needed to engage practice leadership but we underestimated the **importance," said Joan Pernice, Director of Clinical Health Affairs at MLCHC.** "The practice leaders must be present and visible on the ground throughout the process."

Another goal of the initiative was to spark improvements in patient outcomes. The MLCHC has been engaged in quality improvement for 15 years to improve chronic disease outcomes for patients in the safety-net. However, despite early **gains, the measures began to flat-line.**

Since participation in the SNMHI and EOHHS initiative, patient satisfaction has significantly improved in surveys as well as anecdotally. Patients are feeling and seeing the difference. Most notably, patients comment on the ease of scheduling an appointment when it is requested and feeling more connected to a care team, understanding they can speak with a nurse or medical assistant as well as their provider. Consumer board members have also noted the changes in practice structure that resulted in increased patient satisfaction.

Provider satisfaction, critical in the context of the workforce shortage, also improved. Through the initiatives, provider satisfaction **surveys are administered annually, and from baseline to first year of implementation, there has been an overall score increase of 35% in provider satisfaction. This result reflects a more positive attitude with the work setting, their practice, and with primary care in** general. Respondents indicated a more hopeful opinion on the future of primary care within the larger healthcare environment.

Patient clinical outcome improvements are still a struggle, even after **2 years in the initiatives. The** initiatives have established a core set of both outcome and process measures to monitor the performance improvement and impact of practice transformation. These include clinical measurement in chronic illness such as diabetes, hypertension, and asthma and operational measures such as access to care, continuity of care, and patient engagement. Yet, standard clinical measures are not demonstrating **significant improvement** trends. The interpretation of this is that (1) patient clinical improvements **take more time to reflect the changes in practice and (2) practice** redesign needs to be stabilized and implemented for some period of time before they can impact patient outcomes.

Lessons Learned

- **Engaged practice leadership is a critical factor in the success of practice transformation work.** The organizational "buy-in" and support of the cultural shift to a patient centered medical home and an organization of continuous quality improvement is an ongoing process that must be led by administrative and clinical leadership.

- **Operationalization of team-based care and associated work flows are both critical and** foundational. Practice transformation cannot occur without cohesive, functional multi-disciplinary teams.

- **It is important to change the understanding of what a team is and the decision making** process within the team in a practice. This is especially relevant with integration of care management functions and with integration of behavioral health.

- **Care management and care coordination are interrelated (but separate) functions that might prove the most effective in moving the improvement curve on costs and patient clinical** outcomes.

- **Use of data and reliable reports is essential to monitor performance, gauge impact, and set goals for next phase of redesign work. Data drive performance improvement.**

- **Change inertia happens and can be difficult to overcome but is not insurmountable.**

Thanks to this non-AF4Q community for sharing its bright spot at the AF4Q national meeting in May 2012.

Local QI Collaborative Provides Forum for Culture Shift

The Humboldt-Del Norte Independent Practice Association (IPA), a major partner in the Humboldt County AF4Q alliance, has long acknowledged the essential role of patient engagement in developing and redesigning systems of care. Yet, putting this value into action has been an incremental process.

As the organizational body that represents 98 percent of all medical providers in the county, the IPA has a history of supporting its members in quality improvement initiatives. In 2009, the IPA adopted an ambulatory quality improvement collaborative model pioneered at Care Oregon, called Primary Care Renewal (PCR). Open to ambulatory care practices in the community, the PCR collaborative has provided a forum for medical practices to become familiar with quality improvement methodologies, gain exposure to best practices, and learn about elements of system redesign. Now in its third iteration, the PCR is managed by a leadership team of IPA administrative leaders, community consumer leaders, and a PCR project manager. Practices signed contracts and received stipends based upon completion of core expectations.

In PCR 1.0, practices were introduced to quality improvement methodologies, core curriculum topic areas, and the patient experience of care (via a meeting featuring consumers living with chronic health conditions).

As expected, PCR 2.0 grew in terms of collaborative expectations, practice team support, and patient engagement. To put the patient **truly in the center, the steering committee embedded "patient partners" into the design of PCR 2.0, working off a carefully designed** model of patient engagement in quality improvement developed by Betsy Stapleton and Jessica Osborne-Stafsnes from Aligning Forces Humboldt.

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The patient partners were paired with each of the 18 practices to become members of their respective quality improvement teams and were continuously trained and supported by the Collaborative.

"Having a patient presence during the collaborative changed the cultural **environment significantly from PCR 1.0 to PCR 2.0," said Osborne-Stafsnes,** program manager for patient engagement at Aligning Forces Humboldt. **"During the first meeting of PCR 2.0, patients were welcomed with thunderous** applause as valued participants in the project."

However, practices fell along a continuum of engagement in both the patient partners and quality improvement components of the collaborative. Stapleton and Osborne-Stafsnes are developing support structures for patient partners to feel more meaningfully engaged.

"Enriching the working relationship of patients and providers is challenging and is a current focus area in PCR 3.0.," said Osborne-Stafsnes. Some practices also encountered the challenge of diffusing quality improvement efforts to all practice providers, especially in the presence of unsupportive leadership.

Despite the challenges, PCR 2.0 was a success both in terms of demonstrated improvements in quality and integration of patients into highly clinical settings. Of the 17 teams participating in PCR 2.0, all demonstrated improvement in at least one preventive care **measure. Out of the 122 measures tracked collaborative-wide, 73 percent of teams showed improvement or maintained 90 percent of HEDIS Commercial PPO. Anecdotally, teams reported they valued having an opportunity to convene, connect, and** share best practices with other providers and practices. PCR provided a forum to break down the feeling of isolation sometimes **present in small ambulatory care practices. Additionally, teams reflected that participation in PCR 2.0 enhanced practice teamwork and began to establish in-office** QI processes.

The presence of patients on QI teams also broadened the team's perspective. Overall, 17 of the 18 practices that completed PCR 2.0 met the patient partner requirement of having their patient partner repre**sented at 50 percent of the collaborative meetings. Many practices** exceeded this requirement by **engaging patients in in-office team** meetings.

"The PCR collaborative has been a platform for a cultural shift in the way that local medical practices view QI and the value of engaging patients in this realm of work," Osborne-Stafsnes concluded.

Lessons Learned

- **Highly engaged consumers or consumer champions participating at the "steering"** level of collaborative planning help generate meaningful opportunities for patient engagement at the practice level.
- **Having a highly structured and focused framework for patient engagement in** quality improvement work is essential.
- **Practice teams were generally eager to work with their patient partners, but there** was an evident learning curve regarding engaging the patients in a meaningful way.
- **Tracking quality measures is important, but developing in-practice systems to** support quality improvement is essential.
- **The engagement of the group makes the collaborative meetings go well. Providing** opportunities for teams to participate in collaborative meetings is important, as it provides them with a feedback loop (meeting evaluations) to ensure the curriculum and format of the collaborative is meeting their needs.

A Patient's Story: Integrating Equity in PCMH

Kansas City

In practice, patient-centered health care should fit the unique needs and preferences of individual patients, instead of a "one size fits all" approach. As many communities are striving to achieve this model of care, some like Kansas City, serving a diverse population, are further challenged by racial and ethnic disparities that occur in both processes and outcomes of care. According to the Dartmouth Atlas, leg amputation rates for Medicare enrollees in Kansas City are 4.5 times higher for black patients than non-black patients.

To improve and sustain high-quality, patient centered and equitable care, the Kansas City Quality Improvement Consortium (KCQIC) partnered with Swope Health Services, a federally qualified health center and one of the city's major safety net clinics, in the AF4Q Equity Quality Improvement Initiative. The initiative aims to integrate equity into all facets of Swope's health care organization to make a profound impact on patient care.

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Lessons Learned

- Equity (racial, ethnic, or other socioeconomic markers) should be a focus in the planning and implementation of patient-centered medical home initiatives, particularly in diverse communities.

- Health care and social providers should partner closely to provide wraparound services to patients and provide patients with information for self-management.

- The individual approach to PCMH is challenging, especially for diverse populations, but can result in real impact not only on the patient's well-being but also the well being of a community.

A male patient recently presented himself to Swope Health Services with multiple medical conditions including diabetes, high blood pressure and painfully swollen feet.

This patient was a teacher in both India and Pakistan before moving to the U.S. with his wife. Although he has been at Swope for many years, he also has a growing number of specialists for his multiple health issues, resulting in an incompatible and unmanageable array of medications. At its peak, the patient had 32 prescriptions on his medication list.

During one of the recent visits at Swope Health Services, the patient met with a nurse case manager and discussed his health conditions and complaints. The case manager, along with a physician, conducted an extensive health assessment and found no record of a current foot exam, despite his diabetes status.

The primary care physician at Swope worked with the patient's specialists to determine which medications could be eliminated from his regimen. The case manager engaged the Certified Diabetes Educator to share crucial dietary information with the patient that would lead to better nutrition and help ease painful symptoms such as his swollen feet. The staff even reviewed the list of ingredients on canned goods to help him avoid products high in sodium, which leads to fluid retention.

Further services through Swope's Healthcare Home Department included the provision of comfortable footwear by a diabetic shoe specialist and nursing support specifically for keeping track of his medications. Concurrently, the Diabetes Educator remained in close contact with Swope staff who organized the patient's appointments, advocated on his behalf, and assessed community resources he could access.

The patient reports that he is now in significantly less pain on a daily basis. In fact, staff reported that he comes to his healthcare visits with a smile on his face.

"This experience is just one of many that reflect the impact of patient-centered health data on improving patient-provider relations," said Ron Ellison, director of community outreach for KCQIC. "What we are trying to do is continue this work with the aim to improve the health care quality and reduce disparities for the broader Kansas City community."

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Simple Strategies Can Lead to Big Wins

Of the four Community Health Partners (CHP) clinics in rural Southwestern Montana, three have Level III PCMH certification and one has Level I certification. In total, CHP serves about 12,400 patients in an area larger than the entire state of Connecticut.

In the early stages of PCMH transformation, the CHP site in Livingston, MT, used a patient-centered interaction self-assessment tool developed by the Safety Net Medical Home Initiative (http://nchealthliteracy.org/toolkit/) and identified a significant issue with phone call access for patients.

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Lessons Learned

- By stating the goal—to answer every phone call—clearly, staff were able to work together with available data to devise a plan that addressed the issue without the need for additional staffing and minimal resources.

- Engage staff in the solution. Since CHP-Livingston was not able to add staff, it had to work with existing staff to change their job expectations, provide appropriate training, and adjust schedules to accommodate each staff person rotating through the call center.

- Small, early wins matter in the long run. The clinics have much bigger challenges ahead of them—transforming team structure, elevating the role of the medical assistant, improving care management, etc. By engaging staff in finding solutions, communicating within functional teams, and using the PDSA cycle, the practice has the tools and sense of pride from early improvements to feel empowered to take on the next challenges.

"For years we had been hearing (and experiencing) that it was hard to get through on the phones at CHP-Livingston, and not until we were ready to hear the resounding feedback from staff—they thought it was a significant issue for patients and the community, related to patient-centered care, access, and health literacy—were we prepared to address it," said CHP CEO Lander Cooney.

The staff identified that too many phone calls were going to voicemail, frustrating patients and creating more time for unnecessary call backs.

To find a solution, the front desk coordinators at CHP-Livingston and CHP-Bozeman (a neighboring site with slightly better call access) formed a team with other administrative staff, as well as the information technology and clinic managers from both sites.

The team analyzed existing call volume data and numbers of phone calls going to voicemail and mapped the phone call process, including identifying reasons calls could not be answered or bottlenecks in the system. This led to redesigned staffing models at both sites to initiate a "call center" (consisting of a new workstation and headsets) during high-volume call times. After one month with the new staffing model, calls going to voice mail reduced to nearly zero.

The total call numbers have decreased because patients no longer need to call back. The time saved with this more efficient system enables staff to focus more on patient needs than listening to voicemails and calling patients back.

And the community is noticing. Patients are reporting on patient satisfaction surveys that access has improved at the CHP-L site. Cooney said other medical providers, pharmacies, and labs have also commented on their improved service. The recognition further motivates the staff to continue quality improvement endeavors.

Cooney said the clinics hope to align the teams as a next step so patients get the information they need every time they call.

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Thanks to this non-AF4Q community for sharing its bright spot at the AF4Q national meeting in May 2012.

Consumers and Purchasers Driving Change

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.

Combating Inertia of the Status Quo

With a firm belief that only cooperative relationships among employers, health plans, hospitals, and providers can produce positive and progressive changes in healthcare at the local level, the Healthcare 21 Business Coalition (HC21) has taken a multi-pronged approach to making an impact on healthcare quality in its region.

One method HC21 has used to spur improvement is introducing hospitals to the Leapfrog Group's national standards, which have been shown to increase patient safety. As one of seven original rollout leaders for Leapfrog, HC21 is one of the most successful regions in the nation to encourage local hospitals to complete a self-evaluation tool on how they've implemented national patient safety standards.

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Lessons Learned

- Recognize the link between health and productivity, and recognize it as a national crisis.

- Tenacity with constant focus on your vision and a bit of risk will develop perseverance and solutions.

"Every two years HC21 works with regional and national health plans to endorse plans that offer the best value—in other words, a combination of quality and cost."

Another approach involved working with the Memphis Business Group on Health to use the nationally recognized eValue8 tool to encourage health plans to improve their quality processes.

eValue8 provides detailed results on every health plan and can compare each to others in their market. Additionally, the reports compare the health plans' performance to national best practices for HMOs and PPOs.

But value is also an important part of the equation, so every two years HC21 works with regional and national health plans to endorse plans that offer the best value—in other words, a combination of quality and cost.

HC21 staff and member purchaser committees select the plans to endorse after thorough review of request for information responses and health plan interviews.

One of the greatest challenges HC21 has faced, according to HC21 President and CEO Jerry Burgess, is the "inertia of those that want to protect the status quo."

To combat this inertia, HC21 developed a health risk management model, a training program for benefit managers. The model, known as the College of Value-Based Purchasing, or CVBP, has trained more than 400 buyers and suppliers in the principles of value-based purchasing of health benefits.

"Developing the model was a real 'ah-ha' moment for us," said Burgess. "As a result of these combined efforts, we've seen measureable improvement in hospitals and in the quality health plans provide our members."

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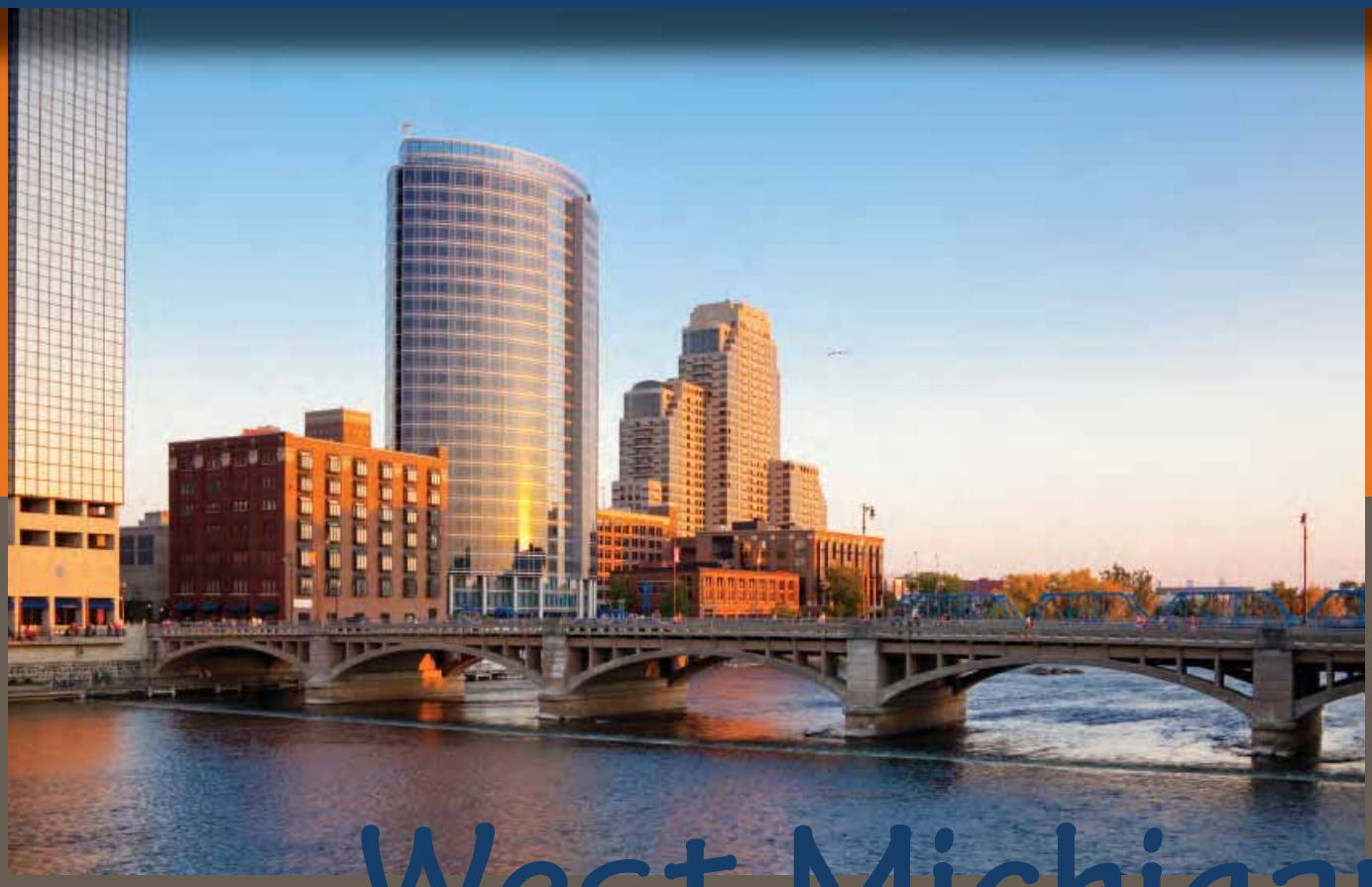
Thanks to this non-AF4Q community for sharing its bright spot at the AF4Q national meeting in May 2012.

Persistence Lures Employers to the Table



West Michigan

Employers have critical knowledge and experience in benefit plan design, wellness programming, process improvement, and waste reduction, but getting them involved in AF4Q can be problematic.

"We have longed believed that strong and visible health care purchaser/employer engagement in Aligning Forces is a critical ingredient for success," said Bob Parrish, project director for the West Michigan AF4Q Alliance for Health. "These are the people paying the bills and absorbing increase upon increase in health care costs. They must be the primary catalyst for the transformative work the Alliance for Health is facilitating through AF4Q."

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To reach out to this critical group, Alliance for Health started by hosting—in partnership with Amway, one of West Michigan's largest employers—an invitation-only event billed as a CEO summit on health care. The event was highly successful, and Parrish attributes that success to efforts to encourage turnout and a program with well-prepared and passionate speakers.

The Alliance for Health knew this summit would be only the beginning, so it made immediate plans to follow up with a meeting to do a deeper dive into what AF4Q is doing.

An employer engagement planning group composed of human resources and employee benefit directors has helped guide the group. As a result, at least four influential HR executives have committed to promoting AF4Q engagement to their respective CEOs.

But the request isn't merely for time and talent—it's also for treasure. The Alliance for Health, as part of a strategy to start building sustainability, also is asking for financial investment in AF4Q. And they're getting results. This core group of committed purchaser leaders has become an advocate for AF4Q, not only within their respective organizations but also to other employers.

"This type of support is invaluable and far exceeds the influence AF4Q [alliance] staff could have in engaging other purchasers," said Parrish.

To reach these purchasers, Parrish said, the Alliance for Health "spent countless hours honing the AF4Q message to make it concise, clear, and compelling to employers. With pared-down staff and budget woes, no one has time to read a 20-page document. We have to convey AF4Q's many moving parts and interconnected strategies in a way that doesn't hopelessly confuse our audience."

Lessons Learned

- It's challenging to secure financial investment from the purchasers over and above what they are already paying out in claims and related health care expenditures. Be persistent.
- It is absolutely necessary to cultivate and develop influential civic and community leaders who are already well known and respected by business leadership. These champions are the foundation of success.
- No matter how compelling your case for supporting AF4Q, you must be prepared for a skeptical audience.
- Clarity and conciseness are absolutely necessary. You need to make succinct explanations of AF4Q focused on "what's in it for employers."
- Don't give up. Persistence is important.

Innovations in Reducing Emergency Department Visits

Community Outreach Campaign Exceeds Expectations

When the Albuquerque Coalition for Healthcare Quality in Albuquerque, NM, spent $80,000 for radio and print advertising to launch a public information campaign about how to get the right care at the right time at the right place, it hardly expected to triple its projected reach.

But that's exactly what happened when the AF4Q Alliance's "Is it an emergency or an urgency?" campaign caught on in the Albuquerque media market. The program, which aimed to help consumers determine whether their medical situations warranted a visit to an emergency department (ED) or an urgent care facility, clearly struck a chord with the public and local media alike. Although the Coalition spent more than $57,000 on radio advertising (about 715 spots), it received more than 1,700 free public service announcements—more than $150,000 in free radio advertising.

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Lessons Learned

- **Work with a data analyst or workgroup to identify the best sources of data** and how to ask hospitals and plans to release the information. After receiving the original set of data, it was clear we could have worked more closely with our analyst to possibly identify other data sources that were appropriate and useful to evaluate the potential results.

- **Include primary care in the campaign. Kemp thought if they had done this, it** might have created a more well-rounded campaign message.

- **Don't reinvent the wheel. This campaign was created by a local public relations and marketing firm in New Mexico for another health system, so the** Coalition obtained permission from the original system to use the campaign in the Albuquerque/Bernalillo County area and paid a fee to use already-developed campaign materials, which included posters as well as discs of materials that could be printed or placed in newsletters, or websites.

"There was tremendous uptake in the community with these free spots," said Jennifer Kemp, senior communications specialist for the Coalition. "It's clear the media thought this message was worthwhile."

Additionally, the Coalition received unsolicited feedback from community members about the campaign, further proving that the media push was generating quite a buzz. In fact, the Coalition continues to receive calls and inquiries from the community about the campaign.

For example, after hearing one of the radio spots, the local Air Force Base Commander asked his medical group executive **officer to contact the Coalition** to get more information about the campaign and how it might be used with Air Force Base personnel.

The problem at the center of the campaign: Even if they have insurance and a primary care physician, many patients choose to **go to the ED for non-emergency purposes—often because they perceive EDs as being more convenient or offering better care.** But in Albuquerque, a competitive health care market combined with a shortage of primary care physicians created a concern that treating non-emergency conditions in EDs could tie up resources for patients requiring emergency care. While no one wanted to keep emergency care from anyone who truly needed it, the Coalition believed it was important to help consumers make the distinctions that would enable them to get the "right care at the right time in the right place."

"We identified a few 'a-ha!' moments," said Kemp. "We discovered the community is very interested in this type of campaign, as evidenced by the media coverage and number of earned radio PSAs. We also learned health plans are not aware their nurse advice lines were not listed on the back of their membership cards. They realized listing those numbers was a small step they could take to help patients get the right care. Employers have seen the project as a way to reduce health care expenditures, **and hospitals have supported it because they believe it is a way they can rally around something that will benefit all EDs and** the community at large."

The Coalition received funding for this project through a Robert Wood Johnson Foundation mini-grant for communications. Three local hospital systems-Lovelace, Presbyterian, and University of New Mexico—provided support by allowing the Coalition to employ their brands.

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Simple Tools Reduce Emergency Department Use

Detroit

A team convened by the Greater Detroit Area Health Council (GDAHC), an AF4Q Alliance, was able to devise a plan and conduct a pilot demonstrating substantially decreased emergency department (ED) use for primary care treatable conditions—all by using inexpensive, "low-tech" methods.

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GDAHC's purchaser members had identified ED use as a top priority in reducing costs and improving access to care. In response, the team established a goal of reducing ED use for primary care physician (PCP) treatable conditions. To accomplish this, the group worked with PCPs to demonstrate actions they could take to achieve this goal.

Working hand in hand with Blue Care Network of Michigan (BCN), a nonprofit, statewide health maintenance organization, and Oakland Southfield Physicians (OSP), an independent practice association of approximately 300 family and general practitioners, pediatricians, and internal medicine physicians, the team developed and implemented a pilot program to test interventions and tools for use in PCP practices.

They collected metrics on ED use both before and after the launch of the pilot to assess whether these interventions made an impact on ED use for conditions that could be treated by PCPs instead. The interventions used in the pilot were straightforward and already in use in many practices.

- **Use telephone triage and recorded messages to direct patients to the appropriate care provider.**
- **Establish a strategy for what patients should do when confronted with an acute, but minor, illness or injury and their** PCP is not available, and communicate that strategy to patients.
- **Ensure office scheduling allows same-day appointments, including evenings and weekends.**

The pilot ran during a four-month period in 2010 and included six practice sites with 17 PCPs and hundreds of continuously enrolled health plan members with the same copay. It produced clear results. Chosen pilot sites had three years of increasing ED visits for PCP-treatable conditions (a worsening trend) before the interventions were implemented and demonstrated substantial improvement, with pilot sites performing better than control sites, which had a three-year trend of decreasing use **(improving trend) before 2010.**

"This outcome shows that just having the right tools is necessary, **but not sufficient," said Lisa Mason, director of cost quality for GDAHC.** "There must be motivation to use **them effectively."**

GDAHC asserts that the pilot's success was attributable to both the practice interventions and tools, **but also to OSP's direct supportive efforts with each practice site. All** sites involved in the pilot believed these tools made ED visits for PCP-treatable conditions less likely. Additionally, most believed a follow-up letter or call after an ED visit would help reduce future use.

Lessons Learned

- **Develop relationship-based interactions with PCP offices.**
- **Help PCP offices figure out how to answer the question, "How** accessible are we to our patients?"
- **Provide templates for office protocols and insight on how to use them.**
- **Commit to measuring and interacting with offices with high rates of** ED visits for PCP treatable conditions.
- **Establish frequent and repetitive contact with each spotlighted** practice site.

Providing Health Care for the Acute Mentally Ill: A Community Response

San Antonio

Managing mental illness at the community level can keep the mentally ill out of jail and out of the emergency department (ED), illustrated by the success of a collaborative program between healthcare providers and law enforcement in Bexar County, Texas. Jail diversion programs have been in place in the United States for decades, but they have increased in the past few years, according to a recent policy report on the Bexar County program.

The Bexar County Jail Diversion Program and Crisis Mental Health System offers an example of how a joint effort involving the medical, legal, and mental health communities can help more people get the care they need with less drain on both law enforcement resources and ED resources.

Jail diversion steers mentally ill individuals into the mental health system and can ease the burden of crowded jails. The Center for Health Care Services created the diversion program in 2002 with a three-pronged intervention plan in mind: Identifying persons with mental illness who might be vulnerable to arrest, recommending alternatives to jail for persons already in the criminal justice system, and providing mental health and support services to prevent recidivism.

To help identify vulnerable individuals, a law enforcement officer and licensed counselor go into the community in an outreach effort to assess those at risk and determine what help they might need before a crisis occurs.

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The second phase of the program provides alternatives to jail for persons who have been arrested. Individuals are screened for mental health problems, and they may be able to go directly to treatment programs instead of to jail. Traditionally, EDs have been used to facilitate this process.

Critical to the early success of the jail diversion effort was giving officers fast, convenient access to "drop off" crisis care resources for detainees other than an Emergency Department.

In 2005, the Center for Healthcare Services (Bexar County Mental Health Authority) established the CCC, a 24-hour crisis stabilization unit that's staffed by medical, psychiatric, and social work professionals, so police officers have a place to take individuals other than to jail or the ED for a psychiatric evaluation. **Open to the public and to law enforcement, the CCC receives 500 to 700 individuals monthly. Since opening, the center has added a** well-equipped medical procedures room to provide treatment for minor injuries and provide medical clearances, a 20-bed sobering **area for public intoxicants, a 15-bed inpatient detox/counseling area, and an on-site mental health/drug court.**

The CCC is managed collaboratively by the Center for Health Care Services, University Health System, and the University of Texas Health Science Center at San Antonio. Currently, the Crisis Care Center along with the Public Safety Unit manages approximately **1,500 cases a month that would have been seen in an emergency department. Of these 1,500 cases per month, about 50 cases per** month end up being transferred to an ED.

Crisis intervention training, community crisis care, and jail diversion efforts are cutting recidivism and saving millions. Within a 12 month period during 2010-2011, 5,100 persons were screened, referred to, or provided service at the Crisis Care Center, while 8,000 people utilized sobering, medical detox, medical clearance, and intensive outpatient drug abuse services. During two budget years, 2009 and **2010, these programs have documented direct savings of $15.5 million** dollars for local governments through jail diversion, consumer engagement and treatment. Recidivism among **non-violent offenders referred to treatment is below 10 percent.**

The Bexar County Jail Diversion program and Crisis Mental Health System received the Gold Award from the American Psychiatric Association in 2006, and it has been adopted by the state of Texas as a model for the entire state.

Dr. Hnatow emphasized, "this is a community problem, and it requires a community solution."

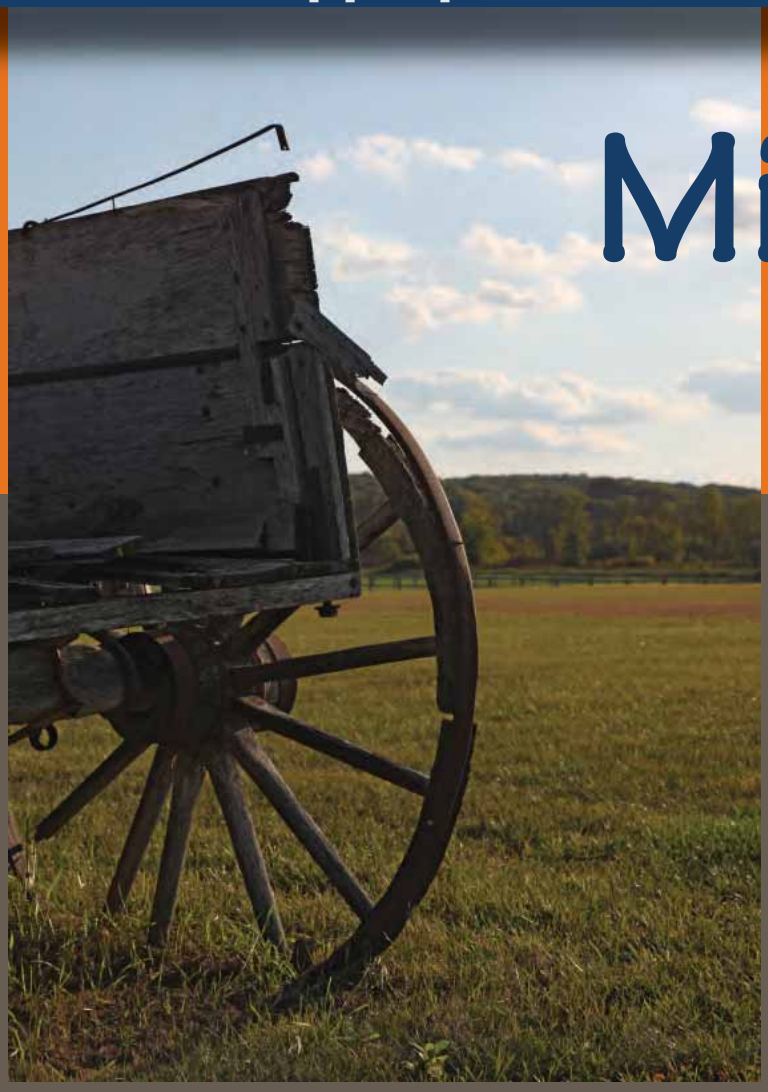
Lessons Learned

- **Single idea can bring vast returns**
- **Effective communication is essential**
- **Team focused culture of change developed**
- **Leadership support for change initiatives**

Thanks to this non-AF4Q community for sharing its bright spot at the AF4Q national meeting in May 2012.

Reducing Waste and Controlling Cost

Red, Yellow, Green: Appropriate Use of Diagnostic Imaging



Minnesota

Millions of Americans undergo costly and often invasive diagnostic procedures each year. Sometimes these tests help them avoid even more invasive tests, but are they really what the doctor ordered? Some new work in Minnesota points to signs that too many unnecessary high-tech diagnostic imaging (HTDI) scans are being made, which is a large contributing factor in the meteoric rise in health care costs.

HTDI use has been increasing at 15 percent to 20 percent annually—twice the rate of prescription drugs and far greater than the 10 percent annual increase in overall health care spending.

From 2000 to 2006, Medicare spending on HTDI skyrocketed from $3.6 billion to $7.5 billion, a more rapid ascent than that of any other physician-billed Medicare service during the same period.

In response, many health plans in Minnesota enacted prior notification (PN) rules requiring providers to contact a health plan service before ordering an MRI, CT, PET, or nuclear cardiology test to see if it would be covered by insurance order.

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"While this practice reduced the number of HTDI test in Minnesota, whether it resulted in more appropriate use of HTDI remained unclear," said Cally Vinz, vice president, health care improvement and member relations, Institute for Clinical Systems Improvement (ICSI). "Further, the resulting delays in testing and possibly treatment burdened patients, who **often had to return at a later date for a different test if the health plan** service denied the initial order.

The Institute for Clinical Systems Improvement (ICSI) brought providers, radiologists, and health plans together to develop and conduct a pilot program to study an alternative so providers could order HTDI test while with their patients. Five medical groups, four insurance companies, and the Minnesota Department of Human Services took part in the program.

ICSI devised a model that would be available in providers' offices to offer clinical decision support, based on American College of Radiology appropriateness criteria, while the provider is discussing the test options with the patient and before the tests **are ordered. The criteria also are embedded into an electronic medical record (EMR) or made available on a website and are continually enriched and expanded.**

The decision-support software makes it simple to order the right scan. After the provider runs a patient's clinical indications **through EMR or web-based appropriateness criteria, he or she receives immediate feedback on the usefulness of the tests** being ordered. A "Green" rating indicates the test would be highly useful for that circumstance, "Yellow" indicates it would be moderately useful, and "Red" indicates the test would be of little value. Results are evidence based.

Data from the pilot show that providers can reduce inappropriate HTDI use by using this model. In fact, one study of the data found a 10 percent improvement in the utility of scans ordered when using the model.

Based on the pilot program, ICSI made this model available to all medical groups and hospital-based clinics in Minnesota. The use of decision support has contributed greatly to reduce inappropriate HTDI scans. While Minnesota saw an 8% annual increase in scans from 2003-2006, it has seen only a 1% increase since 2007, saving an estimated $124 million.

And another benefit having nothing to do with dollars and cents but everything to do with **delivering excellent and safe** care: Using the model decreases **exposing patients to** unnecessary radiation.

Lessons Learned

- **Appropriateness criteria are not as robust as providers would like.** When the American College of Radiology creates a national standard of criteria, that will help the situation.

- **Integrating into EMRs require the EMR vendors to be interested in this** integration, and meaningful use criteria help support this.

- **Implementing the model within an organization is much easier than across a region or state, which requires a great deal of consensus** building.

- **Integrating into an EMR better supports clinical workflow, while a** web-based approach is more likely used away from the point of order **(e.g., at a call center or by non-physician staff).**

Working with Consumers to Tackle Low Back Pain

The Oregon Health Care Quality Corporation (Quality Corp) had already worked with the Oregon Health Authority, Oregon Health Leadership Council, and the Center for Evidence-Based Policy at Oregon Health and **Science University to develop an Oregon-specific, evidence-based guideline to help practitioners evaluate and manage low back pain. But this Aligning Forces for Quality (AF4Q) Alliance realized that consumers also needed some tools to help them understand low back pain and reset their expectations about safe and effective care.**

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Lessons Learned

- **It's important to get consumer feedback on any materials developed for consumers—the results can be surprising.**

- **It's critical to a program such as this to have a multi-**stakeholder steering committee overseeing the development **of materials. Not only can the steering committee provide content expertise, but it also can help you anticipate potential concerns from community members and provide distribution channels.**

So Quality Corp worked with a multiple-stakeholder steering committee to develop consumer-friendly tools for **Oregonians. The** committee translated the practitioners' guideline and its key messages into a con**sumer booklet and an online, interactive quiz** to help people learn how to take simple steps to relieve their **low back pain and** avoid unnecessary **treatment.**

"The booklet and quiz help consumers better understand their treatment options, when to see a doctor, and the potential harms of unnecessary care," said Katrina Kahl, director of communications for Quality Corp. "We tested the materials with consumers, and early feedback has been positive."

In fact, within a week of mailing the booklets to providers, Quality Corp received numerous requests for more copies. And its public reporting website, www.PartnerforQualityCare.org, received a nearly 15-fold increase in unique visitors to the site compared to the same period the previous year.

Kahl attributes the project's success to the fact that it was a collaborative, community process. "We worked carefully with our low back pain steering committee to create an evidence-based resource, while also anticipating potential concerns of consumers in our community. The main messages behind the campaign, simple steps to take on your own before seeking care and receiving unnecessary tests and procedures, speaks to all of our work through the lens of a common condition that will affect nearly everyone at some point in their lives."

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Using Transparency to Encourage Accountability

Puget Sound

The Aligning Forces for Quality (AF4Q) Puget Sound Health Alliance knew that increasing generic prescribing **could translate into significant savings without compromising quality.**

Armed with this knowledge, the Alliance used a multi-stakeholder process to create a report on variations in generic drug prescribing among and within medical groups in the four classes of drugs measured in the 2011 Community Checkup.

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For example, generic statins were prescribed by primary care physicians 91 percent of the time by Group Health Physicians, but only 41 percent by Bellevue Family Medicine. Moreover, individual group health providers' results clustered in a very narrow range, from 65 percent to 98 percent, while Bellevue providers spanned 26 percent to 52 percent.

"Generic prescribing is the area of performance measurement and public reporting with the greatest variation across medical groups," said Puget Sound Executive Director Mary McWilliams. "Also, the measures and data are reasonably straightforward, making them more credible."

A task force assigned to the project believed the transparency of the results alone would appeal to the inherent competition between medical groups, while also putting them on notice that the information is being shared with purchasers and consumers. After gathering the results, the Alliance issued a report that makes it easy to see prescribing variations across and within medical groups.

While seemingly a slam dunk, the project was not without its challenges.

The task force initially was concerned about the currency of the data and the generic drug list, although it concluded the information was sufficiently reliable to be useful. The Alliance acknowledged the data limitations in its report and listed some factors that could enable some medical groups to perform better than others.

In another nod to better transparency, the Alliance shared a draft of the report with the medical groups and revised it based on comments it received before releasing the final report publicly.

Lessons Learned

- Nothing is ever as simple as it seems.
- Be broadly inclusive in vetting the proposal; use feedback from stakeholders to shape the report.
- Make sure you have an expert sign off on a list of generics.
- Keep purchasers involved in the process so you can later make the case if needed with providers to accept this further transparency

Engaging Providers Through Practice Coaching

Coaching for Clinical Change

Cleveland

Better Health Greater Cleveland (Better Health) began offering primary care practices free on-site technical assistance to improve the quality of care and care delivery in 2009.

The coaches are focusing their efforts on improving clinical outcomes, care coordination, patient experience, and optimizing electronic health record (EHR) use. In addition, the coaches work with the practices to achieve certification and National Committee for Quality Assurance (NCQA) patient-centered medical home status.

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Lessons Learned

- It is best to assess the needs of practices before beginning a coaching program to ensure the abilities of coaches match the needs of practices.

- Every coaching project should have a specific goal and metrics to assess the outcome.

- Coaching programs help better understand practices' needs and accomplishments, and can better share those accomplishments, to accelerate quality

For NCQA applications, all Better Health partners use the same conditions (diabetes, hypertension, heart failure) and EHR-related methods. This makes it easier for them both to improve their systems and make the application.

In 2011, 10 Cleveland Clinic sites got Level 3 (highest) recognition; MetroHealth recently received Level 3 recognition for 13 sites.

All of these partner sites collectively represent almost all of the recognized sites in Northeast Ohio, and more are in the pipeline.

To date, Better Health has coached 36 projects on the following topics: implementing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; depression screening; culture change; MOC IV certification; patient experience; implementing patient self-management programs; patient-centered medical home transitions; team-based care; workflow redesign and EHR assistance.

Each coaching project is tailored to the individual medical practice and executed with measureable goals and outcomes. The practice coaching program has been a great incentive to increase regional collaboration and a benefit to Better Health members, from Cleveland Clinic to the Federally Qualified Health Centers. Another benefit of the coaching program is that coaches better understand practices' needs and accomplishments, and can better share those accomplishments, to accelerate quality.

The program also supports the alliance's goals for quality improvement and payment reform in support of the patient-centered medical home model. Requests to participate have been growing. Better Health is continuing to expand this program and create additional capacity through partnerships and collaboration.

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Leveraging Existing Infrastructure for Statewide Practice Improvement

Maine

In 2006, Medical Care Development (MCD) successfully obtained grant funding over two years to establish the Maine Practice Improvement Network (MPIN). At that time, MCD **partnered with five large regional Physician Hospital Organizations, the Maine Medical Association, the Maine Primary Care** Association, and multiple physician practices throughout the state, to form the Maine Practice Improvement Network. The goal **was to create a structure and a process for the members of the MPIN to share effort, cost, resources, and learning related to office practice redesign, improvement knowledge, and implementation of the Planned Care Model, leading ultimately to** improved patient outcomes.

When the funding ended, MPIN did not. Satisfaction with the benefits of the network led most of the participating entities to continue the network by using their own resources to maintain the activities. The benefits of MPIN were also recognized and supported by statewide partners such as Quality Counts, Maine's leading organization in health care improvement, and the Maine CDC's Cardiovascular Health Program.

The early work of MPIN focused on education, training and embedding quality improvement (QI) coaches in health systems to **improve access, efficiency, and the delivery of patient-centered planned care for patients with multiple and/or complex chronic conditions (such as heart failure, COPD, depression, and diabetes). The MPIN quality coaches also began to provide technical assistance to health care practices participating in NCQA Patient-Centered Medical Home (PCMH).**

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Lessons Learned

- **Scan the environment and make an assessment first to see what organizations are already doing, then identify those with solid experience and expertise** you can tap into.

- **Bring leaders together from various partner organizations and get them on** board early in the process. This increases the geographic and population reach.

- **Enlist statewide health care system and QI representation to set collective** priorities and agreed upon milestones.

- **Draw on evidence-based coaching methods that exist on local, state and** national level. Model the methods you teach in your own work and relationships.

- **Evaluate the work and hold all partners to quality standards.**

In past five years, Maine has continued to make significant progress in the commitment to transform primary care to a more patient centered model of care, with the ultimate goal of helping all practices transform to a PCMH model. **Maine** was chosen as one of the 16 Alliances in Aligning Forces for Quality (AF4Q) and has successfully launched the **Maine PCMH Pilot. Both of** these statewide initiatives are led by Quality Counts in close partnership with the Maine **Health Management Coalition** and the Maine Quality Forum. **The PCMH pilot engages quality organizations, payers,** providers, employers, consumers, and other stakeholders in a statewide initiative aimed at practice transformation through collaboration.

With the increasing QI initiatives, one of the major goals of Maine's AF4Q Alliance was to support and expand the statewide network of QI coaches to provide opportunities for mentoring, education, training, and networking. This coordination **supports a more efficient and cost effective system than each organization undertaking QI efforts individually. This model also** ensures standard levels of competency and service for QI coaching across the state.

Representing three organizations and Maine's QI coaching professionals, Elizabeth Foley from MCD, Valerie Jackson from Maine Medical Center Physician-Hospital Organization, and Sue Butts-Dion from Quality Counts were charged with examining the existing resources and building on these for the development of standardized statewide practice coaching resources. "Together we wanted to provide a balanced and all encompassing perspective to help develop standardized training and coaching competencies in the state," said Foley. This meant developing job descriptions, practice service agreements, and other tools all covered in a training curriculum that could be agreed upon and implemented statewide.

In 2011, MPIN launched the Quality Improvement Coach Training with experienced faculty and 16 coaches-in-training. The curriculum includes quality improvement theory, instructional materials on how to build QI infrastructure, engage practice leaders, and change culture within a practice, it also covers team dynamics, facilitation and relational skills. It is designed as a very interactive training with didactic instruc**tion, case studies/scenarios, open inquiry, role playing and group exercises.**

The MPIN Quality Improvement Coach Training is a significant step in supporting the growth and sustainability of practicing coaching as tool in helping all practices trans**form to a PCMH model. Maine has more than 25 coaches either embedded in health systems or as external consultants. The Patient-Centered Medical Home Pilot** currently has 13 coaches actively supporting 26 adult and 4 pediatric practices.

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Aligning Lean Techniques and Patient Partners

South Central Pennsylvania

From airline checklists to agricultural cooperative extension centers, those working to improve the health care system are taking and adapting enterprising improvement approaches developed in other industries. In South Central Pennsylvania (SCPA), the Aligning Forces for Quality alliance is taking advantage of its location in the "fast food capitol" to enlist manufacturing experts as quality improvement coaches in ambulatory practices. Rush Gross, an ex-Airman trained in lean process methodologies with previous stints at Frito-Lay and General Mills, serves as the coordinator for AF4Q–SCPA's Planned Care Collaborative (Collaborative) where he and his team of practice coaches deploy into 16 local primary care practices to help improve the quality of care they provide.

Lean methodologies (or "lean" for short), best known as the processes responsible for the Toyota production system's success, emphasize the quest to eliminate waste, improve quality, and drive down production costs. These principles of value have been adopted by top health care systems in the country, such as Denver Health and Virginia Mason in Seattle, WA.

In SCPA, practice coaches in the Collaborative are using lean to help practices achieve patient-centered care. Coaches help practices collect and interpret quality data, identify and improvement goals, and test strategies and spread successful innovations.

At Aspers Health Center, seven of eight diabetes process measures improved while the practice was in the Collaborative. Between May 2011 and March 2012, 24 more diabetes patients had their hA1c levels updated – increasing from 89 percent to 94 percent of all patients – and 44 more had current microalbumin tests – increasing from 76 percent to 89 percent. There was a 24 percent improvement in eye exams, but providing them to 45 percent of patients was still far from the goal of providing them to 90 percent of patients.

Practice coaches also work with practice leadership to remove waste from work flow. A review of one practice resulted in moving a refrigerator to a more central location to reduce the time it takes for nurses to retrieve vaccines. Saving this time allowed nurses more time with patients, particularly to review self-management techniques.

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What makes the Collaborative approach in South Central PA unique from Toyota's lean process is the inclusion of patient voices. "We realized that the practice leadership teams were missing a key stakeholder to truly become patient centered—the patient," said AF4Q–South Central PA Project Director Chris Amy. "[The practices] could only get so far with their quality improvement efforts and needed to work with patients in a team setting."

The Collaborative paired practices with patient-partners who became part of their improvement team. The patients, volunteers who seek care at the practice they are paired with, provide practices with invaluable insight and feedback, from décor in the waiting room to initiatives impacting patient health. In one clinic, a patient-partner brought attention to outdated diabetes testing meters, which resulted in the practice purchasing new meters for each exam room. "Each patient partner has expressed surprise at the volume of work and complexity of a primary care practice," said Amy. "The providers are grateful patients are willing to give their input."

An extraordinary example is the FRED initiative at Apple Hill Internal Medicine (AHIM). When data showed a problem with high blood pressure (BP) in their patient population, the practice leadership team sent residents out to collect strategies from other practices in the Collaborative that were doing well. The discovery period resulted in FRED, which emphasizes frequent visits for patients with high BP, regularly rechecking BP levels, educating patients about their levels and lifestyle changes, and use of drugs that lower BP.

The result? The percentage of patients who avoided poor BP control increased from a low of 63 percent to 74 percent in just one year. The practice leadership team plans to further spread FRED to patients directly as they continue to track improvements. "We have achieved some very dynamic results," said Gross. "The motivated and outspoken patient partners in the Collaborative have demonstrated not only teamwork with the practices but among themselves."

As the Collaborative approaches the end of the second cohort, Gross is thinking ahead about how to sustain improvement in the practices with limited coaches.

"Now that the economy is picking back up, recruitment of coaches from the manufacturing plants is more difficult," he said. To build sustainable and internal capacity, practices are training select staff to be "QI Apprentices" with basic knowledge about basic lean processes.

Lessons Learned

- **When developing and launching a collaborative, think about sustainability.** The first cohort of the Planned Care Collaborative with seven practices struggled to sustain improvements. To boost engagement, the Collaborative continues to hold periodic meetings and dinners for practice leaders to report on progress. The Collaborative also connects practices from current and past cohorts to encourage mentorship and spread.

- **Patients provide invaluable knowledge and perspectives that help practices achieve** patient-centered care. Partners should be trained in health care and quality improvement so they are confident in providing input.

- **Hold dinners, meetings, and conferences for patient partners to gather and learn** among themselves. These events give patients an opportunity to share their strategies and work through challenges together.

The Power of a PEA

Western New York

When Universal Primary Care (UPC) needed to transition to a new electronic medical record (EMR) system at **the same time they were starting to work on NCQA Patient Center Medical Home (PCMH) certification and** "meaningful use" attestation, they contracted with the Upstate New York Practice Based Research Network and P2 Collaborative of Western New York to bring in a Practice Enhancement Associate (PEA).

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The PEA, essentially a practice coach trained in quality improvement resources, was sent in to help UPC—a rural clinic that predominately serves low-income Medicaid patients—navigate the complicated transition from a paper-based system to an electronic one. The short-staffed and cash-strapped clinic was at first skeptical and reluctant to welcome the PEA into its practice.

"As a safety net practice, with very little extra capacity to take on new projects, I was a bit hesitant about the PEA process," said practice CEO Gail Speedy. "It seemed to me that I was going to have to reallocate resources already deployed on **other projects within our organization to help out the PEA, train the PEA on our** EMR, etc."

The PEA initially helped UPC with the transition to the new EMR system, while also laying the groundwork within the practice **for the changes that needed to be made for PCMH certification. She established good relationships within the practice with all** of the functional areas, including practice administration, IT, and clinical personnel. Then, step by step, the PEA helped the practice develop a PCMH plan and a methodical, detailed process for collecting data and tracking progress.

The hard work paid off as UPC received level III PCMH certification, which Speedy accredits to the "phenomenal" partnership between the practice and the PEA. "Had we not had a PEA, I very much doubt we would be a PCMH right now," she said.

Kate Ebersole, director of regional QI for P2, said the greatest challenge was the practice's fear that the PEA would create unnecessary work and skepticism that the process could actually help it achieve PCMH and transition to EMR at the same time. **Today, UPC is reimbursed at a higher rate, including a $3 PPM higher reimbursement from the largest health plan in Western New York. Through the PEA program, P2 has provided this kind of QI support, resulting in financial advantages through meaningful use incentives to 150 practices (approximately 695 providers) and with five hospital systems (consisting of another 130** providers) throughout Western New York.

Having a good fit between the PEA and the practice, and a well-**trained and effective person in the PEA role, indeed benefited the** practice.

"As a one-time doubter, I've become a champion of the PEA program…the PEA that I work with has been an ideal for our organization and has not, as I feared, created work for us," said **Speedy. "Instead, she has done the** opposite and saved us an incredible amount of time and energy. I would highly recommend the PEA program to anyone. We are certainly grateful for the opportunity."

Lessons Learned

- **A good practice coaching and facilitation program needs to be** built on a combination of factors, including good relationship-**building with the practice before initiating the process, well-trained** coaches, and a feedback loop from the practice to ensure the coach **is a good fit and doing the work expected at the practice level.**

- **Successful programs like this one require local resources and** funding. The PEA program is working on a sustainability and **expansion model by diversifying grant opportunities.**

Primary Care Alchemy:
Practice Coaching Turns QI into Dollars

Western New York

The last time Linda Franke visited practices in the three rural Western New York counties she supports as a practice enhancement associate (PEA) before taking time off on maternity leave, she received not only a fond farewell but also a collective sigh of relief.

The practice leaders said, "We really like you, Linda, and we are happy about your baby, especially because it means that you won't be visiting us for a while and we can get a bit of a break from all this quality improvement work," according to Franke.

Before her leave, Franke had been working with practices for over a year, slowly introducing patient-centered medical home (PCMH) certification requirements, improving workflows, and connecting practices with health information technology Regional Extension Centers to help qualify for meaningful use of electronic health records (EHR) incentive payments.

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Lessons Learned

- **Building relationships with practices takes time. Some practices will welcome help without going through real culture change. Once practice coaches build trust and respect, they can help the practice recognize and tackle the areas that need improvement.**

- **Practice coaches should be sensitive to the fact that practices are often overwhelmed with limited resources and staff. However, working together to achieve improvement goals and incentive payments can motivate further involvement.**

Working with the practices as a PEA posed significant challenges from the beginning. Many of the practices serving rural areas with a primary care provider shortage were already overwhelmed with their patient population, working extremely long hours, and struggling to keep up with requirements set forth by Medicare, Medicaid, and other health plan payers. These practices rely heavily on nurses, billing and front desk staff, and quality improvement staff to take the reins of any procedural or technology-related projects for high reimbursements and incentive programs.

One practice, Letchworth Family Medicine, a five-physician practice in Perry, NY, went so far as to send Franke a letter requesting a delay of additional grant opportunities and QI work in their practice.

What added to the challenge was a suspicion among practices that the incentive payments promised for meaningful use and PCMH would never be paid.

But the incentive checks started flowing in. Less than a month before she was due back, Franke received calls from both Letchworth and Dr. Alan Barcomb, the founding physician of a solo practice in rural Orleans County. "Linda, I hate to bother you on maternity leave, but we started receiving our meaningful use checks, and we want to know how soon you can come back and work with us on the other initiatives that are available right now," said the Letchworth practice manager in a voicemail.

Dr. Barcomb's office manager also asked Franke to return to their practice to review recent payments from Medicare and the Health Now health plan.

"These payments aren't right – they are too high," said the office manager. The additional reimbursements turned out to be correct. In fact, extra payments were a direct result of the practice achieving level III PCMH, something the practice accredits to Franke.

Patients also benefited from Franke's work with the practices. At Letchworth, Franke helped the practice use its electronic health records to pull a diabetic patient registry, including LDL cholesterol levels. After resistance from a physician who was convinced this was a waste of time, the data uncovered that the practice's diabetic population had out-of-control LDL levels.

"I wouldn't have believed it if you hadn't shown me the data, but now I know where we need to focus our efforts so I would like you to help me start looking at interventions we can implement to improve our outcomes," said Dr. Daniel Zerbe.

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Innovation Grantees

Program Spurs Improvements in Care Transitions

Margie Namie, RN, MPH, CPHQ, divisional vice president of quality at Mercy Health in **southwest Ohio, was honored to be named one of 73 Innovation Advisors (IAs) in the first** cohort of the Centers for Medicare & Medicaid Services Innovation Center (CCMI). Her participation in the program brought an added bonus: reductions in readmissions and costs.

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Lessons Learned

- **Change is local, but the work we're doing provides a vehicle to understand better our local challenges so we can more readily identify and disseminate best practices.**

- **Most of the projects are not focused within the four walls of the hospital, but instead look at how we can better create an integrated network of services that is patient-centered and cost effective.**

- **"It takes a village" to reduce preventable readmissions. The Care Transitions Team is only as effective as the partnerships it builds with home care, physicians, and community agencies.**

The IA program divides participants into groups composed of members with similar or aligned projects, thus offering considerable exposure to shared mentoring and learning. Namie works with a group focusing on safe transitions across settings of care and aiming to reduce preventable readmissions. Mercy Health has implemented two such programs, and the results have been impressive so far.

Because the CMMI program requires all programs to measure the three elements of Medicare's three-part aim of better health, better care, and lower cost, Mercy could demonstrate that its care transition program reduced 30-day readmissions for heart failure, heart attack, and pneumonia by 12 percent across four of the six Mercy hospitals during the first two months of 2012. Further, the hospitals experienced a net cost reduction of more than $25,000.

Similarly, the care coordinator pilot project noted a 29 percent decrease in emergency department visits, a 49 percent decrease in admissions, and a 16 percent decrease in readmissions.

Such gains don't come easily, of course. "CMMI warned us that they—and we—are building a plane in mid-air, and that frequently has been the case," said Namie. "We are constantly learning from one another, although networking in such a large cohort can be challenging."

Namie has found the experience of being an Innovation Advisor exciting, despite its challenges. "The leaders of CMMI have made it very clear that they look upon the IAs as their 'boots on the ground' to describe what is really happening in health care and how some of the changes coming out of the Affordable Care Act might affect it," she said.

"I encourage everyone to consider becoming an IA. The experience is just tremendous, and the connections that are made are invaluable."

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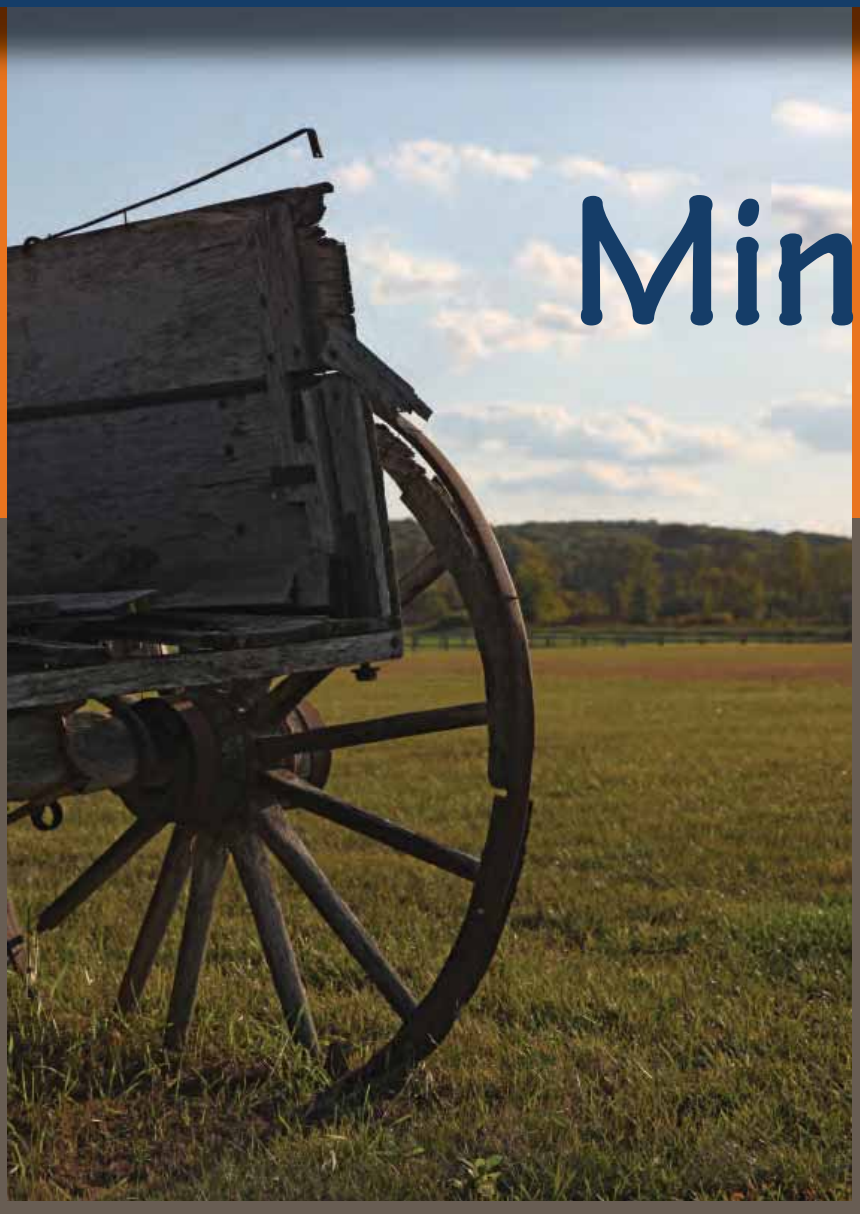
Transforming Care at the Bedside



Minnesota

When the Minnesota Hospital Association (MHA) applied to join the Partnership for Patients (P4P) Hospital Engagement Network, it realized it would need to change the culture both at the leadership **and front line staff levels to bring about the** network's required results.

Hospital Engagement Networks (HEN) work to **develop learning collaboratives for hospitals and provide a wide array of initiatives and activities to improve patient safety. They will be required to conduct intensive training programs to teach and** support hospitals in making patient care safer, **provide technical assistance to hospitals so that hospitals can achieve quality measurement goals, and establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.**

So, although the HEN contract application already outlines 10 focus areas, MHA decided to include both culture and TCAB (Transforming Care at the Bedside) in its contract. As it turns out, TCAB is the perfect methodology for meeting P4P's goals, as all P4P's measures fit into one or more of the four TCAB domains (safe and reliable care, patient-centered care, value-added processes, and vitality and teamwork).

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The culture shift comes into play because TCAB engages front line staff in identifying the changes that need to be made. This signifies a tremendous change as leaders are now managing in a different way. The work dovetails nicely with HEN's objectives.

"Initially TCAB was isolated work, and not until we began the rest of the Partnership for Patients Hospital Engagement Network did we realize that all the initiatives overlap and need to be worked together, integrating TCAB with the other programs," said Mickey Reid, patient safety/quality manager for MHA.

MHA had already been involved in the TCAB project, with 23 hospitals in Cohort 1 and 24 in Cohort 2. It also was active in the rollout of regional TCAB training as an alternative to the expensive national training, as many Minnesota hospitals interested in TCAB didn't have the resources to send staff to the national training. This regional approach has helped spread TCAB considerably throughout Minnesota, building local capacity and enabling teams to learn from each other and collaborate.

Now approximately 40 hospitals are interested in Cohorts 3 and 4, which will be supported by the Partnership for Patients Hospital Engagement Network contract. (TCAB was one of the 12 influencing factors that helped position Minnesota to receive this contract.)

In fact, hospitals in Minnesota have been clamoring for TCAB. And because the P4P measures fit the TCAB model, that one model can serve as a way to get the work done. Having the vast majority of hospitals doing the work using the same methods helps them achieve results faster.

Adding TCAB and culture to its contract brought hospitals some anxiety, however, said Reid, "Working with the hospitals to understand that although this seems overwhelming, it's really just enhancing the work they have already been doing to improve patient safety and quality." MHA found that continued communication about the work they already have done and incorporating information about the added initiatives helped ease the pain.

MHA also found out that involving the front line staff early on with the TCAB principles keeps them engaged as they tackle new initiatives. Staff is beginning to incorporate TCAB principles in some of the readmission work to improve transitions of care and improve care between departments.

"The work is challenging," said Reid, "but the rapid changes to improve patient safety and quality that are occurring are worth the efforts."

Lessons Learned

- It's a good idea to incorporate the last learning day of one cohort with the initial learning for the new cohort—it's a great way to kick off a new group.
- Make sure you understand your customer's needs, create an organized work plan, monitor the data, and be available to support the work.
- Hospitals are anxious for someone to create roadmaps to guide patient safety and quality work.

Community Partnership Smashes Silos

Western New York

In the current health care delivery system, care often seems fragmented, as though various providers and patients are all working in separate silos, with limited communication. The care any one provider delivers may be excellent, but without coordination among everyone involved in the process—and putting the patient and caregiver front and center—important details might be missed.

The results? More than 17 percent of Medicare beneficiaries are re-hospitalized within 30 days of discharge, and the Medicare Payment Advisory Commission estimates that up to 76 percent of these readmissions might be **preventable. Not surprisingly, 64 percent receive no post-acute care between discharge and readmission.**

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Lessons Learned

- **Be willing to reach out to other providers who share patients with your organization to partner in creating an equal playing field for the work of** improving transitional care.

- **Take the time to conduct a root cause analysis of readmissions within your organization and include patients, care givers, community service** providers, and physicians in the process.

- **Involve direct care staff in the root cause analysis for readmissions, as** they are directly involved in the system and know the challenges involved.

- **Place the patient at the center of focus and stress the importance of** redesigning the system, rather than laying blame on a particular setting.

To address this issue, the Centers for Medicare & Medicaid Services (CMS) approved a **two-year community-based** care transitions program that **has been awarded to only 30** communities throughout the United States. One of the chosen was in Western New York, where the P2 Collaborative of Western New York partnered with seven of the region's eight counties, as well as IPRO, the state's Medicare Quality Improvement Organization; **hospitals; skilled** nursing facilities, community service providers, and other stakeholders.

The goals of the P2 Collaborative were to improve care for patients and enhance **self-management skills, reduce** hospital readmissions, and improve access to existing programs.IPRO's experience in transitional care comes from the past four years of facilitating the CMS **initiative, which covered a community serving more than 68,000 Medicare beneficiaries.**

During the course of the program, IPRO worked with 50 cross-setting providers in a five-county region who were able to demonstrate a 10.8 percent relative improvement in the 30-day all-cause readmission rate, an increase in the seven-day follow-up physician appointment rate, and improved patient experience as reflected in HCAHPS survey questions about discharge information.

The biggest challenge in reaching these goals centered around communication, according to Sara Butterfield, senior director of health care quality improvement at IPRO.

"Health care has become a very fragmented delivery system that has many handoffs and opportunities for gaps in communication in care management," Butterfield said. "The willingness for health care providers to partner on equal, cross-cutting levels has been essential to the success and sustainability of care transition efforts."

Another success of the program, apart from impressive readmission statistics, is that it has created an opportunity for all levels of care providers to gather around one table for **the first time to discuss what is working well within their communities, identify areas to improve, provide training opportunities across settings, and implement evidence-based** interventions and gold standards of care.

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Payment Incentives

Mapping Payment Reform Strategies

Multi-Site

There is no one-size-fits-all solution for payment reform, and employers and plans have made mistakes by overlooking a market's distinctive characteristics when selecting reform strategies. Stakeholders need a systematic method for assessing a health care market's dynamics before trying to draw up a road map for change.

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Lessons Learned

- Customizing payment reform solutions for specific markets may be difficult if the major players aren't local. Large employers headquartered elsewhere, national health plans, and large, multiregional health system may not be interested in market-specific approaches.

- When working in an evidence-free zone, consulting with leading experts, including those with on-the-ground experience is essential.

This is where the Market Assessment Tool (MAT) comes in. Developed by the Catalyst for Payment Reform (CPR), an independent organization led by health care purchasers, MAT uses structural data, stakeholder surveys and interviews, and an original market typology to provide recommendations for which types of payment reform might make the most sense to pursue or avoid in particular types of markets.

CPR is refining the tool, taking it from one that describes a market to one that provides payment reform recommendations to a market. This transition has had its challenges.

Market characteristics and payment reform models are complex, so creating a generalizable tool for purchasers has been difficult. To work through this process, CPR has engaged in expert discussions to help classify the primary factors determining a market's success with a payment reform model as well as which models align with particular market attributes.

Although it is not yet finalized, CPR expects MAT will accelerate the adoption of payment reform models that are well suited to the markets in which they are implemented.

"The tool opens a dialogue among market stakeholders, gives them a common understanding of their markets, and helps users filter out options for payment reform," said Suzanne Delbanco, PhD, executive director of CPR.

"As it is used over time, MAT also may provide the basis for building a knowledge base about how to map payment reform options to specific market types."

CPR expects to release MAT this summer.

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Thanks to this non-AF4Q community for sharing its bright spot at the AF4Q national meeting in May 2012.

Lighting the Way to Payment Reform

Memphis

In the rapidly changing landscape of health care delivery in the United States, one thing is becoming clear: Stakeholders, from purchasers to payers, are looking to alternatives to the fee-for-service payment scheme that will move the market toward safer, higher-**quality, affordable health care services.**

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Lessons Learned

- **Taking a structured approach with an agreed-upon framework, process, participation, and results sharing is essential to creating a shared understanding at a community level.**

- **Reliance on one-on-one interviews offers a "safe" environment for stakeholders to be candid in their remarks—but it can limit the number of stakeholders because of time and budget constraints.**

The Memphis Business Group on Health (MBGH), a coalition of employers that is a founding Board member of the Healthy Memphis Common Table and a leader in the Common Table's AF4Q initiative, has already **been working to find a different approach to payment.**

So it made perfect sense that MBGH was asked to represent one of three markets being asked to pilot test a new tool, Catalyst for Payment Reform's Market Assessment Tool (MAT), designed to assess the current situation and readiness of hospitals, physicians, health plans, and purchasers to move away from fee-for-service and toward alternative payment **methods.**

Over the course of three months, MBGH assisted with recruiting stakeholders, reviewing preliminary results, convening regional stakeholders to hear and **discuss the results, and providing feedback about the tool.**

Once MBGH tackled the challenge of scheduling the one-on-one interviews with major stakeholders and providing timely summaries **of the interview results, the pilot yielded a number of benefits.**

"This provided a common understanding and documentation of payment innovation in Memphis," said Cristie Upshaw Travis, **MBGH's CEO. "We have benefited from following a structured approach to identifying and understanding the current payment pilots in the market and strategic goals of participating organizations. We also believe we can better gauge future interest."**

Additionally, said Travis, the project highlighted market dynamics MGBH had not previously acknowledged, such as physicians **equating payment reform with lower reimbursement and health plans viewing payment innovation as a competitive advantage.**

Another benefit the project provided was guidance on such matters as considering early payment changes with only an "up side" for physicians, steps they could take to revise the current fee-for-service model, and assisting physician practices in building **the infrastructure they need to accept new payment models.**

"Our strategies moving forward can incorporate this new information and help us be **more effective," said Travis.**

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Making Inroads to Payment Reform

South Central Pennsylvania

AF4Q's Alliance in South Central Pennsylvania (SCPA) faced a daunting challenge: getting the largest payers and providers to work together to reform payment in a splintered market.

But SCPA was determined to develop a pathway to move the local payment system from fee for service to value-based care. The Alliance also wanted a system providers and payers could agree on—one they designed **through collaboration, all the way down to defining what would be paid for and how the system should** function.

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Lessons Learned

- **Use data to motivate the group.**
- **Start small if you need to—but start.**
- **Find a committed campaign convening organization.**
- **Be willing to hold other events to prime the community to be receptive** to the payment reform pilot you are starting.
- **Consider using a third-party facilitator who has worked in this field; it's** easier for this person to ask hard questions or keep people accountable.
- **This work isn't cheap, and it's not easy.**

The result of this collaboration is the PRICE Work Group, the two Blue plans in the SCPA **Area, the state benefits trust** body, and seven large provider systems, including the Alliance's two largest provider systems, WellSpan and Hanover Hospital. In a short timeframe, PRICE formed two subcommittees to draw up the plan, which will include bundled payment for three inpatient procedures and payment support for patient-centered medical homes (PCMHs).

The group designing PRICE faced substantial challenges. For example, the group found that one of its goals, applying bundled payment to coronary bypass surgeries, was problematic because these procedures are composed of many elements, potentially including valve replacements or treatment for other disease.

To tackle this problem, the group explored several possible payment models. When the PRICE committee reviewed the PROMETHEUS data revealing the potentially avoidable costs for certain procedures and conditions, the group was stunned.

Chris Amy, program director of SCPA, said, "Even with our small data sets—only 483 patients with diabetes—we **realized we could save significant dollars with better care."**

Knowing this, Wellspan, the largest provider and employer in the area, with more than 8,500 employees and more than **15,000 beneficiaries, has committed to continuing to spearhead the work the** group has begun.

Amy is optimistic: "This initiative has brought the two large local Blues plans, which make up the majority of the commercial market, to the table on PCMHs **and bundled payment. The momentum has been significant. We have every indication that by early 2013, throughout our region, some benefit plans and payment will involve PCMH incentives and bundling."**

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Payment Pilots as an Alternative to Fee for Service

Like every other state, Wisconsin faces a problem that cuts two ways—healthcare costs are rising at several times the rate of inflation or wages, while growth in costs considerably outpaces growth in healthcare quality. Although Wisconsin has an advantage over some states in that it has earned a reputation for relatively high-quality, low-cost healthcare, those knowledgeable about healthcare and costs have come to agree that because the current rate of cost growth is unsustainable, something must be done to rein it in.

A logical place to start: fee-for-service reimbursement. This payment model is widely considered a major contributor to the problem at hand. To come up with an alternative, the Wisconsin Health Information Organization (a voluntary, all-payer health claims data organization) and the Wisconsin Collaborative for Healthcare Quality (WCHQ, the grantee organization for AF4Q in Wisconsin and a founding member of WHIO), along with leading healthcare providers, payers, and purchasers, formed a group to explore a new model design and then test that model.

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The project, known as the Partnership for Healthcare Payment Reform (PHPR), began by committing to multi-payer reform on the premise that providers can respond more easily to aligned reimbursement signals from multiple payers.

The PHPR created and launched two pilots: a bundled payment for total knee replacement (TKR) and a shared savings project, transitioning to an episode-based payment, for adults with diabetes.

Both pilots began with patients between the ages of 18 and 64 who are commercially insured. Two hospitals and one ambulatory surgery center have embarked on the TKR pilot, with two more facilities expected to launch by the end of 2012. A large, clinically integrated collaboration of two major hospital and health systems is participating in the diabetes pilot.

Bumps in the road have included competition for resources within the participant—and nonparticipant—organizations, arriving at a common and trusted cost baseline for the episode or bundle definition in question, and identifying and developing appropriate incentives for participation.

To address these challenges, PHPR adopted a tried-but-true method: communication. "We are continuing to build an open dialogue among our participants and a strong commitment to shared learning," said PHPR Director Karen Timberlake.

The fastest progress, Timberlake said, has been achieved by groups that made their participation in the pilot a priority, devoting necessary staff and resources and adopting an attitude of answering the question "how?" with "yes."

So far, feedback from participants has been positive. They have stated that the pilots have catalyzed new conversations with all points in the healthcare stream including providers, payers, patients, employers, and suppliers.

Several sites are using the pilot to redesign care processes and expect to improve patient safety while reducing costs. Some report the existence of the pilots has increased openness to payment reform, even among organizations not participating.

"We have been pleasantly surprised at the potential to realize faster progress when participants come to the conversation with a history of trust and an expectation of moving forward together," Timberlake said.

Lessons Learned

- Participants must decide at the outset if they are prepared to commit the resources necessary to drive a pilot.
- Designing a bundle and episode definition can be very time consuming. Try looking for publicly available definitions and a local validation process.
- The more a payment reform pilot can be incorporated into ongoing processes such as care redesign, payment negotiations, and benefit design, the faster it will proceed and the more impact it is likely to have.

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