Outcomes-Based Contracting[tm]

The Value-Based Framework for Optimal Accountability

CENTER FOR HEALTH VALUE INNOVATION

INFORMATION EXCHANGE FOR VALUE-BASED DESIGN

EXECUTIVE SUMMARY

The importance of aligning incentives cannot be overstated: for health status to improve all of the stakeholders must be focused on producing a healthier person or persons, which is an investment strategy. But no rational investor just places money down; he or she analyzes the prospects, quantifies the risk, and invests where the best economic opportunities are. The dividend is dependent upon how well the investors' goals and rewards line up with the investee's goals and rewards. The importance of this alignment cannot be overstated when considering what is at risk in improving health. The exquisite tension between health and economics can be alleviated when the focus is on engagement and accountability for outcomes. The engagement is not just on the part of the consumer or patient. It carries into the payer or plan sponsor, and it travels across all of the service providers (health plan, clinicians, communications companies, manufacturers of equipment and pharmaceuticals, hospital systems, information management companies). If one of these stakeholders is "squeezed," while others prosper, the friction is increased. If the dividends of reduced health risks and costs are shared across the stakeholders, then everyone wins–the friction is reduced. The goal, then, is to find that harmony, and it is best found in engagement and accountability that produce healthier people, healthier organizations, and healthier communities. This is accomplished through an Outcomes-Based Contract.

In an Outcomes-Based Contract, the strategy is to cause behavior change that will result in better health outcomes and predictable economic trends. This behavior change happens through a series of "levers" (health insurance, incentives and disincentives, and reimbursement strategies for patients, clinicians, manufacturers, data managers, heath systems, and care coordinators-everyone who is part of the health value supply chain). Using a value-based design, plans and purchasers realign to cause the behavior changes that result in improved outcomes of health status, risk reduction, higher quality of care, and reduced cost trends. The dividends are reinvested as new risk arises, behaviors slip, or new technologies are uncovered that improve efficiencies of care. In every case, the long-term strategy is focused on outcomes, beginning and ending with engagement and shared accountability.

Measures can be identified that will show the improvement in prevention and wellness, in chronic care management, and in care delivery. Evidence of the success of these plan designs to broaden and hasten engagement has been shown, and now sustainability is being demonstrated not only in waste reduction, risk reduction, and improved optimal health for the individual (1). There is now market evidence that the retooling of plan design at the corporate level is causing system change in the community, enabling other companies and individuals to reap the benefits of the early value-based adopters (2). As more companies come together to share in the dividends, the community benefits with realigned resources: less are used on inefficient care and more are available to invest in community health and economic recovery (3).

This is the power of the re-engineering of plan design that is focused on value, driven by engagement and aligned on outcomes. In this manuscript, the case is built and a framework is constructed in which the reader learns how an Outcomes-Based Contract can accelerate engagement and accountability. It details the health value supply chain and the required alignment of resources to produce healthy, engaged and accountable consumers, payers, and providers. It shows the potential of dividends that accrue across the community when the focus is shifted away from dollar-cost and instead to improved health–personal, corporate, and community. An Outcomes-Based Contract, then, is the lubrication that removes the friction and accelerates health improvement.

The subject of this manuscript, *Outcomes-Based Contracting^{tm}, is the first in what will become a focused series that accelerate the alignment of incentives across the health value supply chain. This paper will provide a framework for creating accountability between the purchaser and the supplier, the potential friction points and challenges that must be acknowledged, and a "sector study" of OBC–showcasing early successes in pharmaceutical contracting and the pathway for improvement –will be highlighted.

It is important to note that this is an evolving concept, just as the concept of value-based purchasing and value-based benefit designs have evolved, and continue to evolve, over time. Health is not static, and, therefore, any measurements, interventions, and potential improvements to the system of accessing or paying for health must not be static. Instead, innovation will drive new concepts that will improve the system over time, if, and only if, the incentives–the development of new interventions coupled with the purchasing/payment for the new interventions–are aligned to support the ultimate "product": ***the engaged and accountable individual who uses the information to manage his or her own health and economic improvement through engaged, accountable providers (4).***

This paper is the output of the Innovators' Summit of February 4, 2010, called to order by the Center for Health Value Innovation. Sponsors of the summit included WellPoint, Genentech, Mayo Health, and Johnson and Johnson Health Care Systems, all of whom are also members of the Center. We in the Center acknowledge their generosity as well as the thought leadership of the participants of the Summit. We would like to accent the enormous talent and input of **Laurie Amirpoor, PharmD, Staff Vice President, Clinical Program Policy at (5) WellPoint**, and a member of the Advisory Board of the Center.

As a co-founder and the author of this paper, I wish you, the reader, and your community, the best of health outcomes.

Cyndy Nayer, Chief Executive Officer
Center for Health Value Innovation

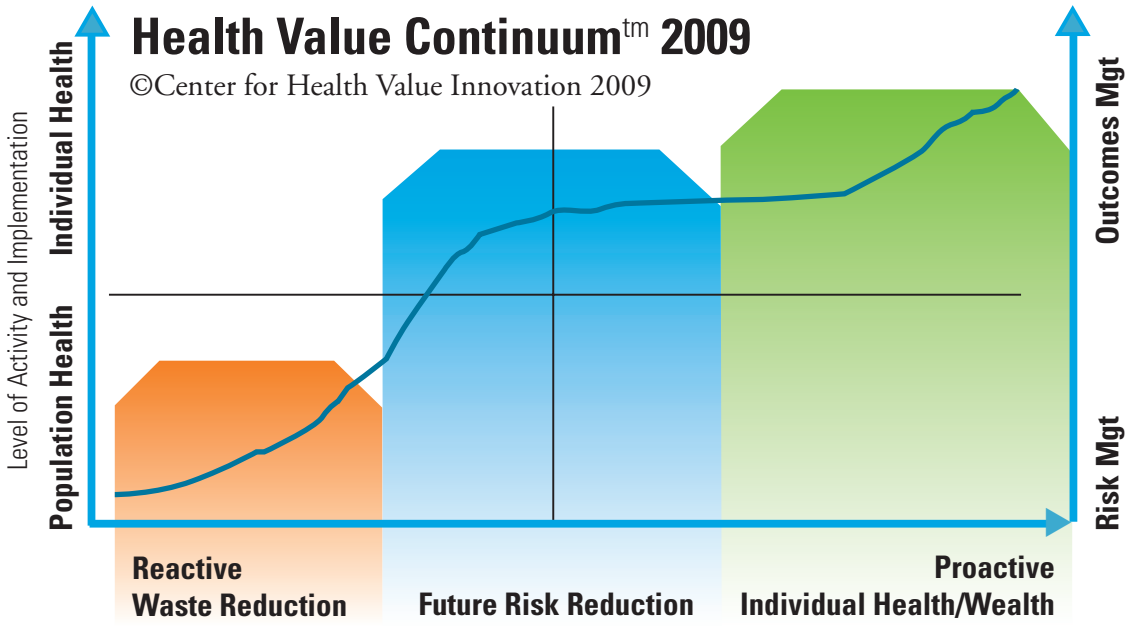
LEVERAGING HEALTH: A FRAMEWORK FOR ALIGNMENT OF INCENTIVES IN OUTCOMES-BASED CONTRACTING[tm].

As the nation considers the concepts and impact of health care reform, it is still quite clear that health care is local and the economics of health care are local. Some of the recent evidence shows that:

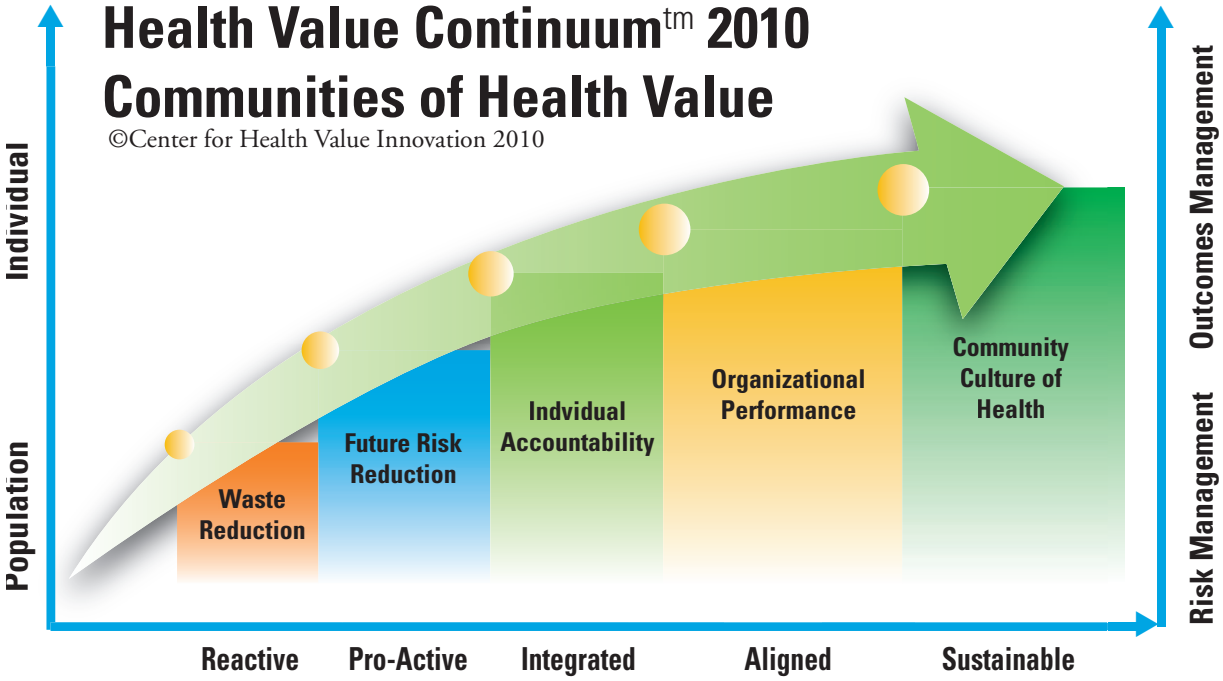
1. One out of five workers with access to insurance benefits is uninsured.
2. Tax bases continue to erode, causing escalation in the unreimbursed medical expenses, in turn resulting in less access and more underinsured.
3. In the economic downturn, more people are undermanaging their chronic care, seeking symptomatic relief at the expense of a growing burden of chronic disease.
4. More physicians are frustrated with the unengaged patient and the declining rates of reimbursement.
5. Services for engaging the patient and improving outcomes continue to be purchased on the commodity (widgets of service, number of treatments or pharmaceuticals) platform instead of the improved health and financial status of the patient, the plan sponsor and the provider (6).

In recent surveys by several companies, a common theme has emerged: financial investment in health must deliver measurable dividends that support the purchasers' goals (7, 8, 9). In the work published by the Center for Health Value Innovation, surveys have defined changes in value-based benefit designs, their impact on the consumer and the plan sponsor, and their resulting definition of the Health Value Continuum[tm].

The Continuum was first identified in 2007, when, through interviews conducted on behalf of the Center, a qualitative scoring was used to measure the level of innovation of the interviewed company on the scales of data, design, delivery of services, and dividends. Accountability was measured in each of the early interviews and subsequent surveys (2). The Continuum has changed over time, becoming more defined in its segments (Entrants are focused on waste reduction; Fast Followers are focused on future risk reduction; and Experts expand their vision to include performance and productivity metrics) (1). Fundamental to the expansion, reach and success of value-based benefit designs is the early installation of levers that promote prevention and wellness in the population (1). The graphic below (Figure 1) demonstrates what was known and confirmed about the path of the Health Value Continuum[tm] in late 2009.



In early 2010, the reach and definition of the Health Value Continuum™ was recast as emerging evidence showed two levels of impact: risk management at the population level and outcomes management at the individual level. Value-based benefit designs were more widely adopted as a solution to the health care burden, positively influencing the improved health status and economic performance of the organization and the community. In part, this was accelerated by the economic crisis of 2008, in which budgets and personnel were frozen (or cut) at the organizational level and revenues decreased in the public sector (1). Both of these changes meant that efficiency and predictable economic trends were more important than ever. The result was that the experiences of early adopters in contracting, measuring, and guiding change spilled into the communities in which they were located and drove improvement in provider systems, health plan analysis, and information management. (Figure 2)



In moving from the population-based design to the individual/condition-based design, the early adopters experienced accelerated and measurable reduction in cost trend as well as health improvement, often through expanded engagement of the beneficiaries and adherence to evidence-based performance measures. But what is now certain, from the surveys and the rapid expansion into the cities/counties/states, is that the impact of value-based benefit design into the organizational and community health is measurable.

1. Companies that had value-based benefit designs in place, supported by appropriate communications and prevention strategies, have kept the designs in place despite the decrease in annual budgets or tax revenues (1).
2. Their leadership, whether emanating from a single employer or a collaboration of employers (the demand side of the health value chain), has begun to influence the very fabric of health, both from the support of quality improvement and, concurrently, from the engagement of the provider community (the supply side of the chain) (10).
3. These collaborations are resulting in increased competence in data as well as metrics for success (1).

Outcomes-Based Contracting™ Accelerates Health Value

The imperative now is to align the incentives across the stakeholders in the community in order to accelerate the value of every health dollar invested. The goal may be best illustrated in the metaphor of an over-the-road truck: all wheels must be aligned and pointed toward the goal, the route for best efficiency should be smooth and safe, and the truck should be fueled and in peak operational condition. If all of these metrics are met, the cargo has the best chance of arriving in good condition. Further, highway cones should be guiding the truck driver away from danger and toward the safe segments of the road, just as behavior levers (incentives/disincentives) that increase engagement of all beneficiaries–all of the organizations that influence quality of care–should be deployed in health and performance improvement. This is the basis of value-based benefit design.

The same is true of the health value chain, which combines both the demand (consumer/patient use) with the supply (manufacturers, health system, clinicians, payers): all incentives should align to remove the friction in the health value chain (the wheels); the system (the truck) should be functionally equipped to carry the cargo; the measures should supply the data that support periodic adjustments (efficiency), and the communication to all stakeholders should be consistent and sufficient for support. This alignment of the stakeholders will then produce the healthy, productive, engaged individual, and groups of healthy individuals will produce a healthier community.

The levers of value-based benefit design–the suite of incentives that drive engagement across the stakeholders–must therefore:

1. Be based upon measurable indicators or outcomes.
2. Move the individual, the provider, the plan sponsor, and the suppliers toward the same goal.
3. Produce the expected outcome: improved health, performance, quality, and financial trend for all of the stakeholders.

Friction Must Be Decreased

As the system resets to deliver value, there are identifiable friction points that need to be addressed. These occur across all of the stakeholders, and when solving for only one segment, the friction may actually be increased for one or more of the others. The value-based benefit design must envelope all of the stakeholders in order to produce better quality, better performance, and better outcomes [table below] (11).

Cost-Based or Financial Design	Value-Based Design
• Focused on line-item costs	• Focused on outcomes
• Short-term timeline	• Long-term commitment
• Applies to the entire population	• Focused on at-risk population
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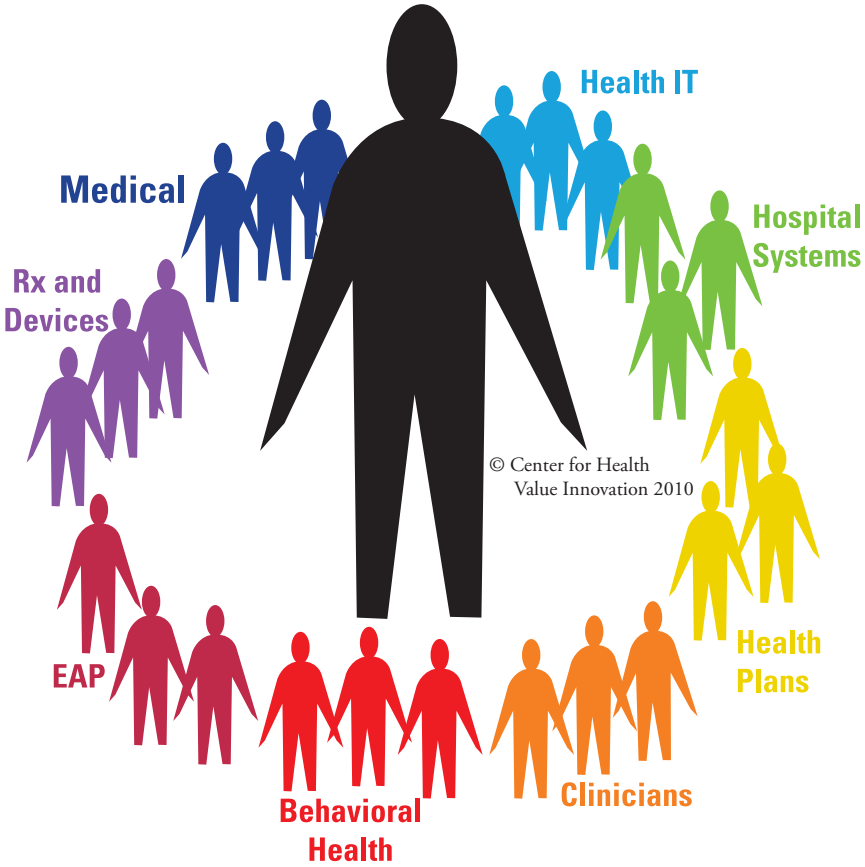
For instance, when engaging the consumer-patient, a suite of levers may be used to engage and support the behavior change desired for reduction of risk or improvement in wellness, such as reduced out of pocket (OOP) costs for annual screenings. If there is not a coordinated suite of levers for the provider organization to better manage those patients who are not in compliance with guidelines, then the provider organization suffers friction through loss of revenue. If there is a cap on total out of pocket expense to the individual that occurs before all of the appropriate screenings occur, there is friction at the patient level. If adherence to treatment plan is the focus of the suite of levers, then time for counseling about the importance/challenges/costs must be considered, and the levers, including the reimbursement strategies for the physician/clinician/pharmacist/health promotion practitioner must be aligned as well.

Therefore, driving value in one segment of the health value chain, through the value-based levers, may actually increase the friction in other segments if the designer is siloed in his or her vision.

With a focus on cost, there is no "system" that manages outcomes. All of the stakeholders are in disarray, competing for the budgeted dollars through widgets of care instead of improved health. Without a clear focus on individuals and complicated by competing interests, there is little engagement of the individual in his/her health, and little accountability across the system as a whole.

Using the value-based design process of Data, Design, Delivery and Dividends (the 4Ds), the risk is identified, the waste is removed, the service providers are aligned in the output, engagement is increased, health resources are used appropriately. When goals are aligned, the "Health Value Supply Chain" begins to form into a system that supports engagement at the individual level. But there are still friction points in the system, as rewards do not accrue across all of the suppliers producing a healthier, engaged individual.



With an Outcomes-Based Contract, the goals are aligned, and the shared risks and rewards build a Health Value Supply Chain that is effective and efficient. Engagement accelerates and accountability for health, wealth, and performance becomes a shared, achievable outcome.

Dividends accrue to all of the participants in a measurable, incremental process that produces healthier people, organizations and communities.

Engagement Drives Behavior Change

A value-based benefit design is a suite of insurance plan plus incentives and disincentives that cause behavior change in health management. This change may occur at any segment of the health value chain:

- At the consumer level, such as participating in an annual biometric screen or managing the personal health record
- At the clinician level, through improvement in adherence to evidence-based guidelines (as an example, changing prescribing practices for diabetes based upon new national quality guidelines)
- At the manufacturer level, with comparative effectiveness guidelines that show earlier use of certain prescription drugs keep chronic care management in check
- At the hospital/health delivery level, with appropriate infection-management efforts or minimally invasive surgical procedures
- At the supply chain level, where care-extenders (nurse practitioners, pharmacy consultants, chiropractors or convenient care clinics) may enhance sustainable behavior improvement
- At the system level, where centers of excellence may improve overall outcomes and return to work

Behavior change occurs when resistance to change is overcome by a combination of vision (new thinking) and first steps (new solution and commitment). Mahoney and Nayer have characterized this as the deployment of the "Five Cs":

1. **Commitment.** The first step in improving the health of populations is to secure the commitment of the parties involved. Understanding the risk (to the person or the organization) and agreeing to the plan of intervention results in both commitment and accountability.
2. **Concern.** Any hesitation that can undermine the behavior change needs to be addressed, from side effects for the patient, to benefits messaging and cost incurred for the plan sponsor, to the payment change for the clinician or the supplier.
3. **Cost.** Affordability is an issue for all of the members of supply chain and it must be addressed. Predictable cost is a significantly better alternative than unpredictable cost, and the link to the operational and financial changes for all stakeholders (member to plan sponsor to supplier to service provider) must be detailed and confirmed.
4. **Communication.** Few things are more important than frequent messaging to convey the changes needed, reinforce the desired behaviors, and report the early and subsequent successes.
5. **Community.** Peer-to-peer change is one of the keys to sustainable behavior change. Learning and sharing with others accelerates change and creates sustainability. But the transformational change of aligned incentives across the supply chain also results in a change at the community level-moving from a *health care* focus to a *health improvement* focus (12, 13).

It is important to note that behavior change often happens in increments, but these early wins are the building blocks of accountability. Learning to run a marathon is built on learning to run one mailbox at a time; learning health management is also a marathon and demands incremental, measurable success in order to keep improving. So it is with Outcomes-Based Contracting™.

This complete value chain is represented in the iconic logo of the Center for Health Value Innovation.

1. **DATA.** The dark blue panel is the data that shows the trend over time, the high-risk populations, and the opportunity for investments (levers) to improve health behaviors.
2. **DESIGN.** The light blue panel shows the use of levers to influence change across a broader set of behaviors that identify future risk and manage the risk to a lower level. It requires broader engagement and adherence among the stakeholders. The arrow shows the progression of the Health Value Continuum[tm], as the population moves into optimal health and the organizations move into economic efficiency.
3. **DELIVERY.** The orange panel shows the suite of services that are focused on the needs of each consumer to obtain optimal health through behavior change, designed in the person-centric format (focused on each person) but applied across similar populations of the plan sponsor, driving optimal health. Some of these services may be onsite or telephonic, for instance; some are rapidly reported data that show new opportunities for guiding the population to better health. Communication is key in the delivery, as is the Culture of Health that is visibly demonstrated by the senior leadership.
4. **DIVIDENDS.** The green arrows show the dividends that accrue over time to all of the participants in the health value supply chain, a seamless system of health promotion and protection that aligns incentives to secure the optimal health, wealth and performance of all of the contributors (consumer to patient to clinician to payer to supplier to technology to communications and more).

POTENTIAL FRAMEWORK FOR OUTCOMES-BASED CONTRACTING[tm]

The next two pages showcase the framework for deploying Outcomes-Based Contracts[tm], including potential metrics. Outcomes that demonstrate engagement and growing accountability are the ultimate measure, and the dividends accrued can be measured in improved health (clinical), wealth (financial) and performance metrics (functional performance at the individual level, organizational productivity at the population level) (14).

By restating the intent in terms of dividends, the short-term quick fix of line-item cost reduction is removed and sustainable, predictable change is achieved. Building upon previously published works from the leaders of the Center, and using the framework now known as the Decision Matrix for Value-Based Benefit Designs (15), a coordinated framework for Outcomes-Based Contracting[tm] can begin to take shape.

In no way is this intended to be a finite set of questions and suggestions, but, instead, it is intended to re-focus the discussion and align incentives across all the stakeholders, leading to improvement in health status, health care quality, work performance and economic trends from the individual to the community level. In this way, as personnel change and priorities shift within a community, the new personnel and the new priorities will be, by definition, part of the health value of the community.

Potential Framework for Outcomes-Based Contracting™

©Center for Health Value Innovation 2010	Waste Reduction	Future Risk Reduction
	Solve for under-managed, over-managed, un-managed	Solve for disengagement, non-adherence
OUTCOMES-BASED CONTRACT MEASURE **[note, this is NOT a complete list, but serves as a model for consideration]**	**Health**: % Quality improvement **Wealth**: % Decrease in inappropriate service consumption **Performance**: % Improved engagement % Reduction in safety risks, etc.	**Health**: % Quality improvement **Wealth**: % Improvement in PMPY [Per Member Per Year] **Performance**: % Reduction in unscheduled absences % Improved engagement
PREVENTION AND WELLNESS	Reduce Out of Pocket (OOP) for prevention/wellness services	Reduce OOP expense for biometric screens, risk mgt education, lifestyle change
POTENTIAL METRICS	% Increase in annual exams % Increase in immunizations	% Increase in smoking cessation % Increase in hypertension management
CHRONIC CARE MANAGEMENT	Reduce OOP expense for pharmacy or medical management	Reduce OOP expense for labs, counseling
POTENTIAL METRICS	% Improvement in treatment adherence	% Increase in number of biometric screens and enrollment in lifestyle coaching % Improvement in clinical measures
CARE DELIVERY/GUIDANCE	Reduced OOP costs for primary care	Incentives for coaching, care coordination, and medication management
POTENTIAL METRICS	% Increase in use of care coordination	% Decrease in overuse and rescue treatments, such as inpatient days due to medical or Rx errors % Increase in appropriate minimally invasive procedures

NOTE: the suggestions for improvement and metrics are meant to guide the reader, as they will change with experience and innovation

Individual Accountability	Organizational Performance	Community Health
Solve for improvement in individual health decisions as he/she achieves optimal health [the individual becomes more responsible for personal health, wealth and performance management]	Solve for performance and productivity impact at population and enterprise levels	Solve for the economic stability of the community, including access to food/education/safety, distribution of resources, and improvement in health indicators
Health: % Quality improvement **Wealth**: % Decrease in inappropriate service consumption **Performance**: % Improved engagement % Improved responsibility and accountability	**Health**: % Improved functional performance **Wealth**: % Reduced PMPY **Performance**: % Decrease in absenteeism, short and long-term disability, safety risk % Improved work engagement	**Health**: % Improvement in health indicators **Wealth**: % Decrease in inappropriate service consumption **Performance**: % Improvement in tax revenue/liability % Improved environmental scores, including educational scores, renewable food supplies, etc.
Use incentives for financial counseling, retirement planning, personal health records, choice of care	Purchase services/products that support the population health improvement	Use community groups to amplify success, deploy risk management strategies
% Increase in use of PHR % Increase in use of EAP services	% Decrease in absenteeism % Decrease in safety incidence	% Increase in organizations creating similar levers and metrics % Decrease in county-wide use of emergency services
Reward use of goal-tracking systems	Purchase services that improve adherence	Reward community services that support health status improvement
% Improvement in achievement of health, wealth or performance goals	% Reduction in disability days	% Improvement in access to primary care
Increase OOP expenses for use of inappropriate or ineffective services, such as overuse of imaging, use of emergency room for non-emergent services	Provide access (lowered OOP) to networks and services based upon outcomes of efficiency and quality. Increase communication and alignment of incentives for business channel improvement.	Increase access to affordable care through expansion of care coordination, community health services, school and worksite education
% Decrease in multi-use imaging % Increase in primary care or urgent care % Increase in adherence to treatment guidelines	% Increase in use of primary care % Decrease in total cost of care/per member	% Shift in public health dollars to provide primary care for more people % Decrease in inpatient days % Increase in worksite health services, community clinics

CHALLENGES TO AN OUTCOMES-BASED CONTRACT

Each plan sponsor will have unique metrics, based upon size, sector, demographics and plan design (fully-insured v self-insured, high deductible health plans/health savings accounts v defined contributions and so forth). Additionally, the culture of the organization must be considered, as high-level and high-intensity support from senior leadership will lead to acceleration of the levers, which in turn will accelerate the use of the Outcomes-Based Contract across the various members of the health value chain.

Creating a lasting construct for OBC will be a process. Some of the most ideal "channels" for aligning incentives, such as high-cost chronic care (for multiple sclerosis, rheumatoid arthritis or some cancers, for example) are amenable to the early OBC efforts. But in every case, the alignment of incentives must be built on the alignment of the shared goals of the total stakeholder community.

For this reason, keeping both the clinical and business focus equally balanced within the plan sponsor and across the health value supply chain will be imperative to assure success.

Other key challenges could include:

Impact within the defined population. As an example, considering multiple sclerosis, there are many fewer workers diagnosed with this condition compared with heart disease, back trauma, or hypertension. This could result in a lower priority for the plan sponsor, and, further, more cost-shifting to the patient diagnosed with MS as opposed to those diagnosed with diabetes. Yet, the specialty drug and biologics marketplace may, in fact, be an early and willing participant in outcomes-based management, as the intervention often is much more targeted to specific population segments and therefore can be measured more efficiently.

> **Consider:** How can balance be achieved? In other words, if the benefit plan design will create an incentive for specialty pharmaceutical use or for minimally invasive procedures, for example, will some other segment "lose" in the shared dividend?

Impact across stakeholders. Collaborative incentives have, by definition, the opportunity to equalize the stakes and accelerate system improvement. But the other side of that coin is that one group or another may have to contribute more effort over any period of time in order to achieve the agreed-upon outcomes. Reimbursement models for incentives will need to be developed that will equalize the exposure as well as the input of each stakeholder–and competing organizations will need to learn to collaborate while keeping their proprietary business models separate. This may be accomplished using county, state, or national placeholder benchmarks against which measures can be achieved.

> **Consider:** How can friction be reduced? Identify methods to expand the rewards and incentives to be shared across beneficiaries, even if they have to be sequenced. Where are acceleration points? Identify potential accelerators, such as improved communication or incremental increases in services that would shorten timelines to improve outcomes.

Impact of unintended consequences and/or unintended side effects. Because the human being is complex and unique, population health management is often considered an oxymoron–manage one segment or intervention (such as adherence to chronic care guidelines) and there can be a focus shifted away from another segment (such as side effects or well-person exams). Incentives that reward certain behaviors that are not easily attained by the entire population will need to be weighted. Variations in human behavior, including provider treatment patterns, cultures of communities, and access to care will need to be modeled, tested, and, over time, revised.

> **Consider:** Who benefits from each change or lever that can be deployed? Do some suppliers benefit more than others? Are there segments of the population who are more at-risk, harder to engage, or beyond the reach of the current plan design? Because of this increased risk of failure (defined as failure to engage or adhere), is timing (longer time to achieve the engagement), staffing (investment of resources), and/or infrastructure causing friction that can be smoothed?

THERE IS NO ONE RIGHT ANSWER: UNDERSTANDING THE METRICS AND MATURATION OF OUTCOMES-BASED CONTRACTING[tm]

In the mid-1990's, one of the iconic companies in value-based benefit design, Pitney Bowes, deployed its best resources to reduce cost trends–but this first value-based benefit design was not focused on diabetes, asthma, nor hypertension. It was a focus on behavioral health, and the application was the removal of access barriers for Employee Assistance Program (EAP) and behavioral health for those who needed the care (lowering the out of pocket costs for the patient). The results: overall clinical costs for these people were reduced, showing the link between access to appropriate care and total cost trend reduction (16).

Pitney had instituted environmental (changes in food, changes in education) and provider policy changes that fueled prevention, wellness, and early risk detection in the years before the behavioral health interventions. And, after the implementation of levers that promoted behavioral health for total health improvement, more innovation developed, leading to the value-based benefit design for diabetes, asthma and hypertension. Communication supported the desired changes, C-Suite members were visibly supportive and engaged, and culture changed. Yet, the levers continued to evolve, new designs and laser-focused application for value and change ensued, and, today, Pitney continues to evolve.

Every company and plan sponsor chooses early implementation based upon the culture, propensity for risk/investment, and resulting dividends, yet the pathways are similar: prevention and wellness is the early platform driving engagement of the total population; waste reduction (through quality or process or both) is the bridge between years; and data coupled with communication slowly but surely changes the expectation and culture from entitlement to shared accountability (2). Levers are carefully applied at the beginning, but as time goes by they are used in larger numbers and their use accelerates as more case studies, peer-to-peer sharing, and business-based evidence comes forward.

The early innovations in Outcomes-Based Contracting[tm] will travel the same path. The first steps will focus on both breadth of engagement across populations and on health process improvement for high-cost/low-adherence conditions. The gaps will close faster, however, as the experienced innovators will identify the opportunities to accelerate the process to achieve total health management improvement across the stakeholders.

Some early Outcomes-Based Contracts have been built on the pharmaceutical interventions in which evidence exists for health and quality of life improvement at the consumer patient level, such as osteoporosis and cancer. In these cases, the OBC was centered only on the use of the particular drug/treatment. As it evolved, the practice of Outcomes-Based Contracting[tm] began to include the total improvement of the population: a focus on the total adherence and reduction of HbA1c in diabetes became the focus of the population-based OBC (17).

In this newer level of contracting, both the pharmaceutical company and the plan sponsor had responsibility and outcomes to achieve. The plan sponsor (insurance company) had a responsibility to engage more patients in diabetes education and adherence to exams/labs/medication; the pharmaceutical company had a responsibility to improve the reward regardless of which drug was used [the drug did not have to be their drug; if the patient achieved HbA1c control, more incentive dollars were available].

So it will be as the OBC competency matures. OBC will accelerate comparative effectiveness research, as segmentation and adherence data is collected in clinical trials (see text box below). Movement from unit-cost pricing to outcomes-based incentives is a reality. Already we have seen provider-based incentives created by

benchmarking improvement in process and in adherence, use of care teams, and reduction in inappropriate service use. Several more companies are constructing contracts of OBC for engagement and behavior change that reduce current risk (i.e., missing immunizations or non-adherence to nutritional counseling) and future risk (use of minimally invasive procedures; reduction in smoking or inactivity). The OBC contracts will gain momentum faster than the early value-based benefit designs because the innovation pathway has been defined: align the products and services to produce a healthier, engaged and productive workforce, and the effects are felt throughout the community.

FOCUS ON OUTCOMES DRIVES VALUE AND LINKS TO COMPARATIVE EFFECTIVENESS RESEARCH (CER)

Often the words that we choose when we define the outcomes we desire limit the range of possibilities and solutions. As the CER movement has progressed, it has appeared to focus on the head-to-head research of one treatment or drug therapy over another—a completely valid outcome if that were the only condition of success. However, if the patient never engages in the compliance—never takes the drug—then the head-to-head superiority of the drug is a moot point. While we have written extensively on the engagement challenges for health improvement, the purchasing decisions for drugs have been most-often based on rebates that influence formulary positioning.

Yet rebate-based contracting ignores comparative effectiveness of the drug and is built on unit-cost pricing, the very essence of commoditization. Further, the complications involved in class of trade contracts—in which the purchaser is bound by a formula based upon contracting prices in the retail or distributor market—further confuses the Outcomes-Based Contract and misalignment that should be focused on the patient rather than the unit cost.

Through measurement within the outcomes-based approach, data will show which populations are more likely to engage sooner and stay adherent longer on any treatment or with any protocol. This will speed the comparative effectiveness compendium, and will shorten the time to improving targeted interventions that support earlier adoption and longer adherence–the hallmarks of improved health status, improved quality of care, and predictability of health economic trends.

FINAL THOUGHTS

Outcomes-Based Contracting[tm] can be measured with many data points that may not have been considered in most contracts to-date. In pharmaceutical trials, data exists that point to adherence barriers and incidence by age, gender, and more. In hospital systems, infection reduction has been achieved when stakeholders aligned around the incidence of disability and mortality, collaborating on new metrics for success. In plan design and engagement, consumer focus and diligence in maintaining screenings and recording lifestyle changes have resulted in lower out of pocket costs for care.

As the value-based benefit designs have grown in sophistication, so, too, they have grown in deployment. After years of development of the levers, early mistakes and challenges have been overcome. There are foundational attributes among the various suites of levers that can be identified:

1. The levers of value-based benefit design [VBBD] influence the adoption of the Patient-Centered Care or Patient-Centered Medical Home to produce improved outcomes The link of the plan design/ incentives to the consumer-focused changes (physician, delivery system, suppliers all focused on improved health and performance) is mandatory. A value-based benefit design that does not consider the delivery side of the equation, including information technology, clinician/care delivery services, and communication, is not sustainable.
2. Risk management strategies are the first step. Identifying the risk of low engagement and unknowable conditions is foremost; reducing extraneous costs through evidence-based guidelines is fundamental.
3. Integration of the total health plan with productivity, safety, and workplace performance must occur. The first step in this process is to integrate the Medical Health Plan and the Pharmacy Plan at the patient level, as, often, in appropriate use, the pharmacy costs may increase while the total cost of care decreases (such is the experience of hypertension and diabetes, for instance). Insurance design is only one piece of the solution. The interventions must include incentives/disincentives so that behavior in any segment can be improved for better outcomes. Integrated Health Management is one platform on which to build better coordination across conditions, service providers, and outcomes.
4. Unintended consequences–also known as challenges–drive innovation and innovation drives new solutions. Testing, measuring, and sharing information is part of the process of improving health and performance.
5. Alignment of incentives is a continual quality improvement process. As risk is shared, rewards must be shared. New risk will develop, innovation will cause new solutions, and new solutions will produce new dividends.
6. Communication is visible, public, transparent and promotional. Engagement is a continual process, too, and communication, in various forms (print, phone, text, web, and more) will accelerate diffusion of ideas and improvement (2).

The value of value-based benefit designs has been documented to increase engagement, health improvement, and predictable economic outcomes. The concept of Outcomes-Based Contracting[tm] will also expand to support organizational performance and communities of health value. The early OBC will most probably focus on those areas where accepted measures are in place: total pharmaceutical costs, pharmaceutical costs by disease/condition, risk reduction, and adherence improvement for high-cost and high-incidence chronic disease. But the OBC contracts will be adopted more rapidly than the early value-based benefit designs because they are the natural extension of shared risk and shared reward.

Businesses require healthy, functionally fit workforces that support global competitiveness. Providers–clinicians, health promotion practitioners, pharmacists, and more–require appropriate time and resources to engage and promote behavior change for healthy lifestyles. Plan sponsors and suppliers require models that identify appropriateness of intervention and incentives driven by effect and effort to achieve them. Communities require an appropriate mix of business, revenue, and services that promote economic growth and health within their borders.

As America emerges from the economic downturns of recent history, community leaders will emerge with vision and experience in driving value. Value-based benefit designs have shown that they can be scaled up and down and replicated across segments of the market. Still, they need collaboration coupled with effective, efficient application in order to deliver in shorter timeframes.

Value is the product of quality and cost improvement, supported by investment, engagement, and reach. The accelerator is activated when the stakeholders are engaged and united on the shared outcome-this is the promise of value-based benefit designs. That acceleration can be achieved with Outcomes-Based Contracting^{tm} between willing innovators and shared across their communities.

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The Innovators' Summit on Outcomes-Based Contracting[tm] was held in Washington, DC in early 2010. Invited attendees included leaders of the Center and guests. Our thanks go to all of these participants.

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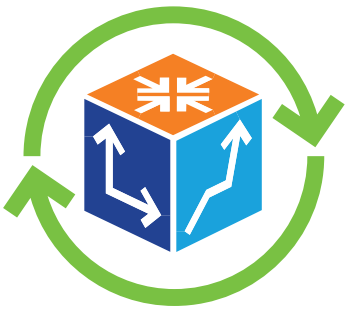
The Center for Health Value Innovation is extremely grateful to the organizations below for their support of the Innovators' Summit on Outcomes-Based Contracting[tm]. Our commitment to improving the value of health cannot be accomplished without the tireless efforts of our members, advisors, and allies.

THE CENTER FOR HEALTH VALUE INNOVATION
was founded as the information exchange for value-based designs. As the repository for the business-based evidence and the clearinghouse for future innovation, we invite you join our work and fuel the knowledge of levers, impact, outcomes, and success.

For more information visit **www.vbhealth.org**



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