COLLABORATIVE
PARTNERSHIPS
IMPROVING
COMMUNITY HEALTH

FINDING THE BALANCE POINTS:

THE CHANGING STATE OF
HEALTH CARE IN KING COUNTY

JANUARY, 2000

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EXECUTIVE SUMMARY

Background

Prompted by concerns that health system evolution in King County could bring with it negative unintended consequences, the King County Council passed a Motion in December of 1995 calling for a representative group to study the health status and changing state of health care in King County. The group was charged to recommend actions to the King County Council so that the county and Public Health can most appropriately carry out their roles to protect and promote the health of the residents of King County.

The original Advisory Panel of public and private health care and community leaders appointed by the King County Executive and the Mayor of Seattle was chaired by the Director of Public Health - Seattle & King County. In April, 1997 that group issued its report and recommended that Public Health take the lead in designing and implementing a new, comprehensive program to monitor the health of King County residents and the performance of the region's health system.

Since that time, the original advisory panel has become a broader coalition of public and private health care organizations committed to mobilizing resources to improve the health status of King County residents through voluntary collaborative efforts. Members of the King County Health Action Plan include Public Health - Seattle & King County, the Washington State Hospital Association, health plans, hospitals, long-term care providers, community organizations, community clinics, local and state government, university, business, labor, consumer and foundation groups.

Monitoring Program

The Action Plan's monitoring program includes:

- Working with various parties in King County to assure high priorities are addressed
- Using existing data to the maximum extent possible
- Tracking specified measurement areas over time
- Reporting regularly to the public and policy makers to highlight key findings and recommendations

Initial Report

In this report we will provide a backdrop of general information about the health care system as a whole which we believe is venturing off balance. We will highlight key findings and make recommendations for the future that key off successful model pilots of integration and collaboration. We will then focus on specific health conditions and model interventions that illustrate how the public health system can work with the medical system to improve both health and cost outcomes. The King County Health Action Plan has striven to catalyze public and private ventures that demonstrate the value of closer integration between public and private health strategies. **In particular the Action Plan has focused on implementing projects at the intersection of disease management and population health to improve worsening trends affecting vulnerable populations.** These pilot programs linking managed care plans with projects that improve the populations' health are highlighted throughout the report.

For this report we have joined public health data with community intervention programs to illustrate how disease prevention and health promotion can be incorporated more extensively in the current health care system. This public health viewpoint focuses on achieving a synergy of population health and managed care, enhancing partnerships between public health and private delivery systems, sharing information and joining forces to create new programs that improve population health.

Key Findings

Our data trends show an evolving health care system that is spinning without apparent long-term direction. It is segmented into unrelated parts that orbit each other without connection and with little relationship. Consistent percentages of citizens are left totally outside while those in it are chronically unhappy and disappointed with the lack of cohesiveness and integration system components provide. Opportunities for stability and balance are continually thrown off by the daily stressors of competition and the need for organizational survival. Creative communication and collaborative efforts for visions about brighter possible futures are overcome by individual self interests and worsening trends continue to deepen among the most vulnerable of our populations. Consistency, predictability and stability are not now foremost in our health care picture.

Recommendations

- Collaboration among players on specific models can enhance trust and provide leadership to strengthen links between fierce and competing worlds and should be encouraged and rewarded. Population-based preventive approaches when integrated within an individual disease-focused model can yield both improved health status and cost effective replicable strategies and should be funded.
- Support for a model program to test the feasibility of simplifying access to care for kids should be provided.
- Public reporting of successful performance indicators can motivate system change and future monitoring reports will continue to develop this direction.
- Collective purchasing around key required indicators can be an effective tool for system improvement and policy change and should be further explored by the City and the County.
- King County and the City of Seattle should follow the lead of a number of national employers and provide comparable managed behavioral health coverage to county and city employees, and encourage other local employers to do the same.
- Proactively restructuring and reweaving the current "safety net" to address the need for dental care is necessary.

Conclusion

Our complex health care system has spun itself too close to the edge of chaos. Strategic interventions that can provide improvement, integration, collaboration and balance need to be risked and supported.

INTRODUCTION

A young child with asthma on Capitol Hill is rushed to the emergency room barely able to breathe on his own for the third time in as many months. A Vietnamese American woman from White Center is driving to work unaware that cervical cancer is progressing in her body like a silent time bomb. A widower in Shoreline cooks bacon and eggs for breakfast as he's done every morning for decades, despite the consequences for his aging heart and diabetes.

These real King County residents need a responsive and coordinated health system. In addition to medical care, they need guidance in modifying the child's allergen-ridden home and irregular source of medications, interpreter assistance and health education to explain in Vietnamese the need for cancer screening even when no illness can be felt, and nutrition and behavioral suggestions and reinforcement to alter years of entrenched dietary habits. However, too frequently coordination between the clinical and community components of health care does not occur. Needs go unmet with the consequences of poor health outcomes, particularly among vulnerable populations in King County.

The primary policy objectives of the American health system over the past several decades have been to contain costs, improve access to care, and maintain quality of services. In the current system it has become increasingly difficult to meet these objectives with any consistency. In King County and throughout the country we seem to be at a critical point in health system evolution. Balancing the individual and often conflicting needs of consumers, providers, insurers, and institutions, as well as implementing strategies to ensure predictability, stability, and capacity for the system as a whole is a challenge that seems beyond our grasp.

This report will focus on three areas of concern to provide a potential road map for a more coordinated and prevention-focused health care system. In this time of uncertainty about the future of health care, the report will:

- Provide a summary of the major factors causing disconnects and prevention opportunity costs, which exacerbate imbalance in the current health system.
- Spotlight local, newly developed collaborative programs that combine individual health services with population-based strategies to produce sustainable improvements in health outcomes.
- Present recommendations for local action and collaborations to create a better future for both individuals and the health care system as a whole.

CHAPTER I

THE CHANGING STATE OF HEALTH CARE IN KING COUNTY: HOW CLOSE TO THE EDGE?

> *"Complex systems tend to locate themselves at a place we call 'the edge of chaos.' We imagine the edge of chaos as a place where there is enough innovation to keep a living system vibrant, and enough stability to keep it from collapsing into anarchy ... Finding the balance point must be a delicate matter … Too much change is as destructive as too little. Only at the edge of chaos can complex systems flourish."* The Lost World *Michael Crichton*

This literary description of biological evolution applies aptly to the state of the health care system. We seem to be at a delicate point in the evolution of the health care systems at the national, state, and local levels. Just as conflict and upheaval are present, so too are innovation and creativity. The health care system is no longer solely the domain of hospitals, health plans, nurses, and physicians. New trends such as the growth of consumer health information on the Internet, direct marketing of prescription drugs through the general media, greater use of alternative care and natural medicine, identification of genes responsible for once unpredictable diseases, and the potential to tailor therapies to the exact genetic blueprint of the individual will change the health care landscape in profound ways.

Yet despite these most often optimistic developments, at latest count the total number of uninsured in the country exceeds forty-four million. In Washington State, 12.3 percent of working age residents lack health insurance, up from 11.4 percent in 1997. Despite a robust economy in King County, **11 percent of the population age 18 to 64 lacks health insurance, with particular ethnic minority populations having more than one in three people uninsured.**

In the sections that follow we distill the major trends influencing health care and the public's health in our region. Key supporting data will be highlighted in the text. More detailed data are provided in the Appendices.

A Bigger Part for Consumers*

Across the country and in King County surveys show the public is becoming increasingly vocal and frustrated with health care organizations. In King County, a Public Health survey shows greater dissatisfaction with tightly managed HMOs than with other plans. Complex bills that are hard to read and unsatisfactory calls to customer service representatives were sources of frustration for many members of related focus groups. Despite specific areas of concern, however, overall satisfaction with the care they receive still remains high for the surveyed King County residents.

When state employees were asked to rate their 20 health plans in 1998, only QualMed received a high score in all areas, with Virginia Mason Health Plan doing well in almost as many measures. Medicaid enrollees ranked Kitsap Physicians Service and Group Health Cooperative the highest for adult care. Ironically, three of the four highest ranking health plans are no longer doing business in 1999. This begs the question; do purchasers take consumer satisfaction into account when choosing to contract with health plans?

Consumers are assuming more control in their health care treatment decisions. Consumers have shown an increasing desire to seek services outside of their traditional health insurance coverage even though that means incurring larger out of pocket expenses. In growing numbers the very sick and those with chronic conditions have been looking outside the traditional allopathic medical model for relief.

Other consumer related trends include the Internet, which offers computer literate consumers vast amounts (though of uneven quality and scientific grounding) of technical and anecdotal information about their illnesses. Drug companies have relied on empowered consumers to select specific brand name drugs marketed directly to them, bypassing traditional physician promotion methods.

The availability of alternative services coupled with more extensive access to health information and direct marketing of prescriptions and health products has produced a more informed consumer and altered the dynamics of health care relationships.

An Expanded View of Health

The phrase "an expanded view of health" has been coined by the Institute for the Future to encompass medical as well as socio-economic, behavioral, social, and environmental factors contributing to productive functioning and physical, mental, social, and spiritual well-being. The Action Plan has also recognized that the traditional framework must be expanded and last year advised against the arbitrary limits placed on mental health and substance abuse treatment services in most employer offered health plans and for voluntary efforts to achieve parity of treatment coverage.**

Arguably another indicator of consumer dissatisfaction with the current health care system and of a search for relief from unsolved discomfort is the growing use of alternative care providers. The Action Plan sponsored focus groups of users of alternative medicine that showed the biggest reason these providers were used was to deal with chronic

* Refer to Appendix II: Consumer Satisfaction
** Refer to Appendix III: Behavioral Health

pain and because of the personal attention provided by practitioners. The use of alternative care systems, particularly those that relate mind and body in health, are becoming more prevalent in King County.* Their efficacy is being tested and often validated with rigorous randomized control trials and reported in mainstream medical journals.

Public Health - Seattle & King County along with John Bastyr University and the Community Health Centers of King County are partners in the country's first publicly funded clinic offering both allopathic and natural medicine services in Kent. A recent survey funded by the Action Plan of randomly selected King County residents revealed that one in ten adults had recently seen a chiropractor, and that one in thirty had seen naturopaths and acupuncturists. **The continued integration of complementary care therapies into Western medical systems is expected to increase in response to consumer demands and demonstrated effectiveness.**

Access: Who's Left Out?**

Access to adequate and timely health care can often prevent or mitigate illness and improve health status and quality of life. Unfortunately, there are significant barriers to access for many King County residents, including lack of health insurance, no regular doctor or other provider, and difficulty, if not the impossibility, of securing dental care.

Some key indicators: **Despite continuing growth in the regional economy, over the last two years 11 percent of county residents report no health insurance.** This problem is not evenly distributed throughout the population. Twenty-nine percent of those earning less than $20,000 per year are uninsured as compared to three percent of those earning more than $50,000 per year. Over one third of Hispanic, Korean, and Vietnamese residents of King County do not have health insurance. Despite an overall increase in average salary, many young adults in King County are not insured, with almost one in four 18- to 24-year-olds without health insurance.

Despite continuing growth in the regional economy, over the last two years 11 percent of county residents report no health insurance.

The individual health insurance market accounts for an additional 11 percent of the state's population. Since individual coverage is no longer sold by insurance carriers in King County and in most of the state due to unstable market conditions, the numbers without health insurance are likely to rise. In a related move, starting in January 2000, the state's Basic Health Plan is closing off new enrollment and plans are dropping current enrollees for those with incomes above 200 percent of the poverty level, or about $33,000 for a family of four. As availability of insurance products decreases, many now see the access discussion as one that asks, "access to what?"

Dental coverage is much less prevalent than medical insurance. It is common for employee health plans not to include dental insurance, while programs such as Medicaid only offer limited coverage, primarily to children. Even for many of those with dental insurance, cost sharing can be considerable when services are used. As a result access to care is greatly impeded for many King County adult residents.

* Refer to Appendix IV: Alternative Care/Natural Medicine
** Refer to Appendix V: Access to Care

One in three residents in King County lack dental insurance.

One in three residents in King County lack dental insurance. According to the 1998 King County Access to Care Survey, twenty-five percent of King County residents blamed costs for unmet dental needs. Among those with dental coverage, high copayments and deductibles contribute further to cost limiting dental access.

Although low-income children can get dental coverage through Medicaid, only 34% of Medicaid-enrolled children in King County saw a dentist in 1998. Adults who are not pregnant and those without disabilities are not eligible for Medicaid dental coverage, thereby making it more difficult for low-income adults to obtain dental care. Since Medicare does not cover dental care older adults are also at particular risk of being uninsured. More than two thirds of seniors lack dental insurance.

Common misconceptions lead the public to believe that dentists don't provide charity care. The 1997 American Dental Association Survey of Current Issues in Dentistry found that nearly two-thirds of respondent dentists provided charitable dental care to elderly and low-income non-elderly patients.

The traditional "safety net" providers of care to the uninsured for both medical and dental care is fraying. **We cannot assume that today's safety net delivery system will be tomorrow's.** The "system" has been patched together over the years through an accumulation of policy decisions, grant funding, and annual allocation renewal. Extreme competition for Medicaid patients who come with payment "attached" has led private clinics to locate facilities in some cases across the street from existing public clinics. While the new clinics may attract more Medicaid patients, they often cannot accommodate the uninsured and linguistic minority populations who were previously served by safety net providers.

Through the concerted and collaborative efforts of the kids.health.2001 campaign hundreds of individuals in King County who are eligible for public programs such as Medicaid and the Basic Health Plan have been identified and enrolled. Targeted outreach efforts into various ethnic communities have been undertaken and coordinated throughout King County. In most cases the resources required are significant with upwards of ten contacts necessary to achieve a single enrollment. With the debut of the Children's Health Insurance Program (CHIP) in January, 2000 which puts our state on the verge of providing universal health insurance for children, there is renewed interest in constructing in King County a presumptive eligibility model for deeming all kids insured and working behind the curtain to process the claims.

A model program that would track the care received by the uninsured and redirect individuals to more appropriate and prevention-oriented venues is a candidate for grant funding and a trial run in King County. Other ideas for local interventions to chip away at the rising problem of the uninsured are creation of local health purchasing cooperatives (HIPCs) as well as other creative mechanisms for insuring the uninsured as may be provided by expanded sponsorship opportunities.

This access area is one of the most daunting and challenging to find local solutions for what is at root an employer-based health insurance system failure with policy and regulatory jurisdiction at the state and national levels.

Public Health System*

Public health systems across the nation are undergoing major challenges. Community-oriented services focused on preventing health problems from starting, spreading, or progressing have historically framed the responsibilities of public health. Over time, many state and local health departments entered the arena of direct clinical services, particularly maternal and child health care among high risk and low-income populations. These direct services (Family Health, WIC, Immunization, Home Visiting, Infectious Disease Control) are vitally important to the community. Decreasing tax support for local public health and increasing need for both personal and population health services has Public Health - Seattle & King County stretched to the limit.

Public Health - Seattle & King County, like health departments in other large metropolitan counties in the country, remains committed to the provision of direct clinical services as a key element in prevention-based health care. Moreover, as a high quality provider of last resort for many uninsured and racial and linguistic minorities, Public Health clinics are an important component of the health care safety net in the county. With their expertise in caring for low-income individuals, special populations such as the homeless and teenagers, and communities of ethnic, cultural and linguistic diversity Public Health clinics fill a necessary niche in the health care system. Additionally, the home visiting and clinic staff possesses the expertise and experience to address special needs that may arise in these groups and the knowledge of how to tap into other community resources to benefit the client.

While maintaining a commitment to direct care services, Public Health is also sharpening its focus to address the highest priority prevention issues which include tobacco use, injury prevention, domestic violence, emerging infectious disease, chronic disease, and food borne disease to name a few. **Critical questions of how to finance broad population-based strategies in a fiscal climate where only direct clinical services have any revenue base are clearly challenges faced by all local health departments and other health care providers.** These clinical services are important to a comprehensive public health approach and in no way limit or trade-off population services, however they are not a substitute for primary prevention. Another major challenge for Public Health is the rise in provision of direct clinical services to enrollees of health plans (out of network care) for whom Public Health cannot currently collect payment.

Health Plan Viability**

After a series of profitable years in the early '90s, the late '90s have brought red ink to many health plans that has only been offset by outside investments**. Nine of the ten largest Washington health plans reported an operating loss in 1997.** Financial conditions have been deteriorating in the last three years. Excluding outside investments, the industry as a whole logged $29 million in net income in

* Refer to Appendix VII: Public Health System
** Refer to Appendix VIII: Health Plan Viability

1996, in 1997 $116 million was incurred in losses. Such operational losses are not sustainable, and mergers have resulted.

In recent years, the Providence Health System stopped operating health plans in Washington. The Office of the Insurance Commissioner took over Kitsap Physicians Service and closed Unified Physicians of Washington. Virginia Mason Health Plan and NYLCare were sold to Aetna. Group Health Cooperative entered a limited joint venture with Kaiser Permanente. Blue Cross of Washington and Alaska and the Medical Services Corporation (MSC) combined as Premera Blue Cross. Several Blue Shield and medical bureau plans, including King County Medical Blue Shield, merged to become Regence BlueShield. The Community Health Plan of Washington, a statewide plan contracting primarily with public health and community clinics, has expanded its market share by enrolling a growing number of Healthy Options Medicaid and Basic Health Plan enrollees. It would seem that here as elsewhere in the nation, the market is consolidating.

When 80 percent of health care costs are accounted for by 20 percent of the population, a focus on high cost conditions that are amenable to intervention is natural.

In the aftermath of these consolidations, three health plans dominate the region: Kaiser/ Group Health, Premera Health Plans, and the Regence Group. Each of these three plans has market shares of at least 20 percent in King County. Regence BlueShield is the largest in Washington State, accounting for almost half of the net worth in this market. It is noteworthy that the largest of the remaining plans include newcomers from national for-profit firms like United Healthcare, Cigna, and Aetna US Healthcare. Public Health and other community organizations have direct experiences indicating that investments in local data reporting and community services are much more difficult to obtain from national versus local companies.

Over one million Washington health plan enrollees are in public programs, and they account for 30% of total enrollees. The revenue from the four major public programs (Medicare managed care, Medicaid managed care, Basic Health Plan, and Public Employees Benefits Board) represents over one-third of total health plan revenues and expenses. To the extent these public programs cover or do not cover the health care costs of their enrollees they have a direct effect on health plan viability.

With at least three consecutive years of running losses and more consolidation likely, health plans are in a state of flux and belt tightening. How do we strengthen population health partnerships between health plans and public health under these conditions? The emphasis on demonstration projects with a focus on cost effectiveness, and ideally cost savings, is likely key. Projects that can relatively quickly mitigate the costs of high cost health conditions will be the most likely candidates for successful implementation.

In King County, health improvement projects have focused on high cost chronic conditions for these reasons. **When 80 percent of health care costs are accounted for by 20 percent of the population, a focus on high cost conditions that are amenable to intervention is natural.** Diabetes and its

related conditions represent one seventh of all health care dollars, and intensive patient self-care can drastically change health outcomes. With diabetes, in many circumstances, the patient can learn to keep himself or herself relatively healthy and dramatically slow the progression of disease.*

Another point of mutual interest is in the rise of vaccine-preventable diseases. When pertussis broke out in Issaquah last winter, Public Health - Seattle & King County bore most of the vaccination costs of controlling the spread of the disease and health plans paid for related hospitalizations. **Keeping avoidable outbreaks and subsequent hospitalizations to a minimum is good for the population and good for the bottom line.** The outbreak has spurred efforts to diagnose and treat pertussis in older children and adults quickly, since the protection provided by childhood vaccines wears off over time. The development of an adolescent or adult vaccine may eventually be needed.**

Hospital Viability***

Unlike health plans, hospitals in King County have been generally solvent over the last decade. Gross margins have been positive as a group from 1992 to 1998, though they have been declining. Taken as a group, the six downtown hospitals have seen eroding margins from four percent to just under one percent during that time, and seven suburban hospitals have experienced a drop from six percent to just over one percent.

Financial pressures from charity care and bad debt have held steady in recent years. Bad debt, or uncollectable charges from patients who have not been deemed charity cases, has held steady at about two percent of revenues. Charity care represented approximately three percent of revenues through the mid ’90s.

Hospitals are important employers for King County, with total compensation growing steadily from $700 million in 1992 to over $1 billion in 1998. Employee benefits have consistently represented close to 22 percent of salaries.

Local hospitals are scheduled for reductions in Medicare compensation over the next five years, and it is expected that margins will continue their downward trend. Financial difficulties may be on the horizon, since only slim margins were earned in 1998. Like health plans, hospitals are choosing innovations for coordinated population/prevention opportunities that promise to be cost effective over time.

Workforce Impacts ****

What are working conditions for health care professionals? According to the American Medical Association (AMA) there is an oversupply of physicians in the country, particularly of specialists and physicians in urban areas. With over a quarter of the nation’s insured population in health maintenance organizations, **the rise in managed care has seen a decline in physician independence.** Some physicians have responded by unionizing, an unprecedented move for the profession. Locally, the physicians at Medalia have joined a union, and the AMA has endorsed physician unionization at the national level.

Physician surveys on perceived quality of care at different health plans and delivery systems offer a largely untapped source of

* Refer to Appendix IX: Diabetes
** Refer to Appendix X: Immunizations
*** Refer to Appendix XI: Hospital Viability
**** Refer to Appendix XII: Workforce Impacts

comparison information. A recent survey of physicians associated with Minnesota health plans revealed that considerably fewer physicians would recommend one of the three plans surveyed to family members.

As hospitals have shortened stays and new technologies have kept very sick patients alive, nurses have borne greater workloads with less time to carry them out.

In the nursing profession, the workforce is aging as fewer young people choose this career. This trend will be exacerbated by increased demand for nursing services as the baby boomers reach old age. In addition, demand is currently rising for highly trained nurses in areas such as intensive care units and surgical specialties. As with other health care professionals, greater diversity that reflects the population is needed. In focus groups of Seattle area nurses, participants said that patients of color were much more likely to communicate openly and avoid misunderstandings with health professionals of similar ethnic backgrounds.

As hospitals have shortened stays and new technologies have kept very sick patients alive, nurses have borne greater workloads with less time to carry them out. Paperwork has increased and the need to educate family members about how to care for sicker patients returning home has become more critical, making it all the more difficult for time to be spent on disease prevention and health promotion education.

Long-Term Care

Many of the pressures felt by hospitals and other acute care organizations, are also being experienced in long-term care. With the aging population and shorter hospital stays, nursing homes and home health agencies are now caring for residents with more complex and acute care needs. However, **while the level of care required is increasing, the federal and state reimbursements are being curtailed.**

The Balanced Budget Act of 1997 requires that beginning in the year 2000 nursing home rates for post-acute care under Medicare are based on a prospective payment system (PPS). Each facility receives a base payment amount adjusted for local wages and the clinical characteristics of individual patients. Under the previous system of basing payment on nursing home costs, the skilled nursing facility benefit was one of the fastest growing components of Medicare spending. Under PPS, the payments are related to the condition of the patient rather than a set amount per patient. The PPS implementation began in 1998, and the payment rate for nursing homes is gradually shifting from facility specific rates to federal rates over a four-year period.

In addition, on the state level, the Department of Social and Health Services (DSHS) has implemented a case-mix payment system for Medicaid residents in nursing homes. Under case-mix, reimbursement for direct care services is based on the acuity level of the residents.

The above-mentioned changes are placing significant financial pressures on most nursing homes. In addition, there is pressure from DSHS to place residents in the lowest levels of care. This has a “ripple” affect on other long-term care services. For example, many individuals who previously were referred to nursing homes are now being placed in assisted living facilities or at home to be cared for by family members and home health workers. This has an impact on the level of services required, the skills needed and the costs of the assisted living facilities and the home health agencies.

As with acute care organizations, long-term care providers are also facing labor market pressures. It is very difficult for organizations to pay competitive wages with the decreasing reimbursement and the strong economy. In addition, long-term care organizations require a higher level skill in their staff than in the past in order to meet the needs of today’s nursing home residents.

Medicare’s PPS and Medicaid’s case mix for skilled nursing facilities will help to control costs but they will put significant financial pressures on the long-term care system at a time when the population is aging, the needs of the older population are more complex, and the labor market is very tight.

CHAPTER II

INTEGRATION AND INNOVATION IN HEALTH CARE DELIVERY

Pathways for Change

This preceding snapshot of the evolving health care system shows a significant lack of glue among its many parts. In King County alone, despite a thriving economy, thousands are excluded from the central health insurance system while those included face uncertainty as to their ability to remain insured. Public health and community clinics serve growing numbers of ethnic minority and non-English speaking populations and increasing numbers of uninsured persons. Insurers themselves face precarious and unpredictable futures with three main carriers emerging to control the market. Consumers seek care outside the boundaries of their coverage at their own expense, are Internet seekers of health information and no longer passive participants in the health care dialogue. Providers grow restless lacking the satisfaction and independence they once had as time with patients is compressed and the demands of paperwork increase.

Constellations of activities orbit each other but information and strategies for moving upstream to promote health and prevent disease occur often by chance rather than through systematic planning. Competition mutes communication, and short-term survival rather than longer-term system improvement consumes everyone's energy.

We can build another path for change. Collaboration on specific models to improve clearly defined healthcare problems can enhance trust and provide leadership to strengthen links between these competing worlds. **Deliberate public and private strategies can insert preventive approaches developed by a public system into the bottom line cost conscious world of the private sector.** The health system and consumer both win.

King County Health Action Plan

The King County Health Action Plan convenes leaders throughout the health care field to determine how public/private joint ventures can demonstrate the value of integrating population health promotion strategies more closely with the current medical system. The incentive to keep people healthy is shared by public health and managed care. The group believes cross-pollination of successful approaches can be mutually beneficial and can lead to a paradigm shift that will enhance the health of King County residents today and into the future.

The Action Plan has emphasized projects that demonstrate the potential for system integration and improvements to be realized in the areas of community benefits, disease management, data reporting, and mental health comparability of coverage. Within these areas, projects were chosen that demonstrate success and require public/private collaboration. **In particular, the Action Plan has focused on implementing projects at the intersection of disease management and population health to improve worsening trends affecting vulnerable populations.** Our goal is to make a more seamless continuum between community-based and clinical services.

One way to concretely improve the well being of many county residents is to adopt a broader understanding of health and the wide variety of factors that contribute to a sound mind and body. For example the Action Plan supports the principle of providing mental health and substance abuse treatment service on a comparable basis with other health services. As research into the biology and treatment of mental health and addiction problems has revealed, the distinctions between mental and physical health are mainly artificial. The interdependence of the mind and body has been conclusively demonstrated in modern medicine although much more research is necessary to understand and treat these complex disorders.

An important component of the Action Plan has been to report data on the health status and health care system in King County. This data review function directed the group's attention to the health conditions and interventions that will be described in the next section. More broadly, the appendices to this report display tracking data on several dimensions of the health care system. Data trends are assembled from numerous sources, including the Health Plan Employer Data and Information Set (HEDIS), with an emphasis on county-specific reporting and on conditions that disproportionately affect the most disenfranchised and vulnerable residents.* An understanding of the major quantitative trends in health care will inform those vested to make policy decisions on the population's behalf and will create wise watchers and innovative designers for those involved in system improvement.

In our experience the most effective projects have been those where actions are driven by hard data. The group has focused on implementing demonstration projects that target health conditions that can be improved by known interventions. In particular, problem areas have been selected that have worsening trends and that disproportionately affect vulnerable populations, as exemplified in the next section.

* Refer to Appendix VIII: Health Plan Viability

Environments of Need – Collaborative Projects

"...the willingness of managed care to invest in population-based care puts the King County Health Action Plan ahead of the rest of the nation. This is the kind of thing we'd like to see across the country."

Data showing worsening health trends affecting vulnerable populations provide a backdrop of choices for targeted collaborative interventions. A focus on selected chronic diseases where strategies of early and cost effective intervention and improved health outcomes is possible lead to a look at specific community programs which have integrated these approaches. The guiding elements that help these programs stand as models for future collaborative interventions are:

- The potential for expanded impact in a high cost health area
- The integration of community public health strategies employed in a disease management model
- The availability of data collection over time to test effectiveness of interventions
- The collaborative framework presenting opportunities for the public and private sectors to work together

The unrelenting rise in asthma among young low-income children of color makes it a compelling area of interest.* The anomolously high rates of cervical cancer among Vietnamese Americans, and the efficacy of early detection and treatment made it a logical choice.** The general increase in diabetes, and particularly the exceptionally high mortality rate for African Americans, likewise was cause for concern.*** Furthermore, much is known about effective methods of prevention and disease management for all of these health problems, but too often that knowledge is not applied where it is needed, and rarely integrated along a community-clinical continuum.

The Action Plan, through the Community Benefits Program, selected projects addressing these three health conditions to be the recipients of initial funding efforts. To date, eight founding funders participating in the Community Benefits Program have contributed nearly $50,000 with a commitment to maintain and/or increase funding for three years. Outcome measures will be collected for all the projects and shared with all participants. These founding funders represent eight health care providers and managed care organizations working in King County.[1]

In an article published in July 1999 by the American Medical News, Dr. Mohammad Akhter, Executive Director of the American Public Health Association, stated "…the willingness of managed care to invest in population-based care puts the King County Health Action Plan ahead of the rest of the nation. This is the kind of thing we'd like to see across the country. But it's not happening (in most places) because managed care is too involved in managing cost."[2]

Each of the following four projects represents a new way of detecting and managing chronic disease that makes use of both provider skills and the expertise of other important partners, including foremost the patient and the community. These projects are especially promising because the approaches the public and private sector partners are employing can be systematically tailored for use with other health problems.

* Refer to Appendix XIV: Asthma
** Refer to Appendix XV: Breast and Genical Cancer
*** Refer to Appendix IX: Diabetes

The Asthma Outreach Project at the Odessa Brown Children's Clinic identifies children with severe asthma and uses an outreach worker and pediatrician to serve as a tag team delivering social and medical services. For example, the outreach worker secures cleaning equipment to keep the home environment dust free, while alerting the physician that the child's symptoms during the home visit seem severe enough to warrant stronger medications.

The Breast and Cervical Cancer Early Detection Program at the International District Health Services employs Vietnamese and other specific Asian ethnic outreach workers to offer cancer screening information in various community locations, such as churches, community centers, grocery stores and laundromats. Low-income women of color are targeted and provided referrals for no cost women's cancer screening and follow-up.

The Community Diabetes Initiative involving the community and public health clinics in Seattle and King County promotes standardized data collection and improvement strategies for the delivery of diabetes care in public clinics. Each clinic selects staff to receive intensive training in the latest quality improvement techniques. Progress in improving the frequency of eye and foot exams, and measurement of blood sugar levels, among others are closely tracked.

The African American Elders Program housed within the City of Seattle's Senior Services Programs provides individual customized services for elderly African Americans, many of whom suffer from diabetes. Health and home services are provided by caseworkers, outreach workers, and public health nurses. Clients are also connected to additional needed community resources such as utility bill and rent assistance.

These innovative and effective projects are succeeding against the odds in a health care system that has grown competitive with increasing financial pressures forcing mergers and cost cutting strategies. By employing techniques of collaboration and integration, and with a focus on early intervention, these projects link the health care system together while providing a more comprehensive service to the patients they serve.

Pilot Projects: Models for Change

During the coming year, the Action Plan's monitoring workgroup will collect and review evaluation data provided by the interventions in collaborative project areas set forth above which were funded as components of the first year Community Benefits program.*

Additionally, a diabetes disease management pilot program will be launched to integrate the delivery of the best population health practices of public health with the latest disease management techniques of managed care. The shared objective of keeping patients healthy blurs the distinctions between the public and private approaches, and those involved find that clinical quality improvement efforts integrate well with public health promotion practices. African Americans, Latinos and Asian Americans with diabetes in the participating health plan will be identified, requested to participate, and subsequently matched with a coordinated array of outreach, clinical, nutritionist, social work and patient education services. The feasibility of closely

* Refer to Appendix XIII: Community Benefits Program

linking health plan and Public Health services to improve health outcomes in a cost-effective way will be evaluated.

This pilot program will serve as an opportunity to pre-test interventions in coordination with the planning phase of the CDC's REACH grant recently received by Public Health - Seattle & King County to address health disparities among ethnic minority populations.

During this period of uncertainty it seems especially vital for the major parties to find a place to talk and listen to one another for the sake of developing solutions over the long term.

Finding the Balance Points

Our complex health care system has demonstrated more chaotic tendencies in the past than cohesive strategies linked to community needs. The recommendations that follow represent pathways for real and feasible improvement in the short term. During this period of uncertainty it seems especially vital for the major parties to find a place to talk and listen to one another for the sake of developing solutions over the long term. We have the opportunity in King County to all participate at a central table and to create and nurture an environment where promising risks can be taken. In this way, through continued collaboration and innovation we can achieve some balance points in our evolving system and by working together realize that the whole is truly greater than the sum of its parts.

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[1] The eight founding funders are Aetna US Health Care, Community Health Plan of Washington, First Choice Health, Group Health Cooperative of Puget Sound, Group Health/Kaiser Permanente Community Foundation, PacificCare of Washington Inc., Regence Blue Shield, Swedish Health Services,.

[2] Moran, Mark. *Public-private partnership*. American Medical News. July 5, 1999. Vol. 42. No. 25.

CHAPTER III
RECOMMENDED ACTIONS

mall changes if carefully chosen can be building blocks for major improvements and innovations. Strategic interventions that respond to the critical findings and emphasize integration and collaboration within the existing system will create an improved health system in King County. All recommendations must meet the following criteria:

- Must lie within the working capacity of the Action Plan
- Must emphasize prevention at the intersection of disease management and population health
- Must address the specific needs of vulnerable populations
- Must be evaluated and have measurable impacts and outcomes

Focused collaboration among the private and public health sectors on specific models can generate trust, provide leadership, and mitigate competition and dysfunction. Population-based preventive approaches when integrated within individual disease-focused models can yield both improved health status and cost effective replicable strategies. These approaches can be tested and refined through carefully evaluated pilot projects.

What follows are several specific recommendations about how the City of Seattle and King County as well as partners in the county health system can support population-based health improvements that can benefit the individuals involved and the system as a whole.

I. The Community Benefits Program

Under the umbrella of the Action Plan a program of focused contributions to targeted community projects has been initiated. The Community Benefits Program helps channel funds from health plans and health care organizations to intervention programs addressing asthma, diabetes, and cervical cancer in specific populations. After receiving national recognition for the value of connecting managed care organizations with local intervention programs, broadened support from additional participants for the selected programs will be sought during the coming year.

Recommendations

1) Increase funding for the King County Health Action Plan's Community Benefits Program. The following four projects that address worsening health trends in vulnerable populations in King County should be funded: Odessa Brown Asthma Outreach Project, African American Elders Program, Community Diabetes Initiative, and the International Community Health Service's Breast and Cervical Cancer Screening Among Asian Women.

- Project staff will track and report outcome measures for each of the four projects and share information with the eight founding funders of the Community Benefits Program.
- The eight founding funders will increase funding for a second year based on positive outcome data.
- King County Health Action Plan will explore funding expansion through additional community funders and grant writing activities.

II. An Integrated Model for Managing Diabetes

Effective control of blood sugar can often prevent or delay long-term complications, and early management of existing complications can slow the progression of the disease. Research has demonstrated that controlling blood sugar to maintain near-normal levels can reduce complications by 25% to 50% for patients with diabetes. Achieving these health improvements could have substantial cost paybacks. In 1998 diabetes hospitalizations in King County had a total cost of over $13 million. Two primary public health approaches may also reduce diabetes-related complications: diabetes self-management education and better organization of health care services for diabetics that emphasize population-based management.

The diabetes project described below can serve as a bellwether showing how public health and managed care organizations can work to mutual benefit. The disease management techniques implemented in this pilot potentially can be used as a model of integrated best practices for a multitude of health conditions.

Recommendations

1) A collaborative disease management pilot program which utilizes the public health techniques of population-based health prevention and early intervention combined with the cost effective approaches of managed care will be developed and implemented to address diabetes in ethnic minority populations.

- The King County Health Action Plan will convene representatives from interested health plans for planning sessions to develop a pilot project.
- The King County Health Action Plan will consult with diabetes clinical specialists regarding project design elements.
- The King County Health Action Plan will coordinate development of the pilot project with existing community and state programs to help amplify and not duplicate efforts.
- Public Health - Seattle & King County and the King County Health Acton Plan will work in coalition with health plans and hospitals to implement the planning phase of the CDC's REACH grant, which will address health disparities among ethnic minority populations.

2) Opportunities to share information regarding collaborative programs and model approaches via conferences, local and national presentations, media, and community networking will be pursued.

- The King County Health Action Plan will develop and share with health plans and health system participants an inventory of community programs available in the pilot sites of the diabetes disease management pilot program described above.
- The King County Health Action Plan will take part in federal research and field testing of collaborative assessment tools developed by Dr. Roz Lasker of the New York Academy of Medicine.

III. Presumptive Insurance Eligibility for Children

Low-income children in families earning up to 250% of poverty are eligible for publicly funded health care coverage through a variety of state and federal programs, including Medicaid's Healthy Options, Basic Health Plus, and the Children's Health Insurance Program. Yet, an estimated 30,000 children are still uninsured in King County. Recent outreach efforts have shown that as many as ten contacts per family are necessary to achieve a completed enrollment application. Even then it is unknown how many of the newly enrolled Medicaid eligible children actually establish a "medical home" with a provider.

In this current "system" the front-end focus on the insurance process is often an insurmountable obstacle to achieving actual and consistent care. Language and cultural barriers are significant, paperwork overwhelming, and the fears of government knowledge prohibitive. In short, although the insurance is available and kids are eligible, the current process acts as a barrier to care.

Recommendations

1) There are ways available to restructure elements of the current "system" so that it becomes reflective of a focus on access to care rather than on eligibility for insurance. This could be achieved through incremental improvements to current system components leading over time to total system transformation that would operate from a presumptive eligibility threshold.

- The King County Health Action Plan will continue to explore with the Mayor's office, the Washington State Hospital Association, the Economic Opportunity Institute and others the development of a pilot area program, currently named "Kids Get Care," to explore ideas such as:
  - Improved Medicaid registration capabilities to assure that all participating providers (pediatricians) in the designated pilot area are equipped with the software and hardware necessary to facilitate enrolling increased volumes of Medicaid/CHIP eligible children. (This system readiness would be achieved via a grant request for required computer components.)
  - Introduce a *Health Access Card* or *Health Access Coupon* to be used in obtaining certain health services such as, school required immunizations, sports physicals, eyeglasses, dental cleaning and check-ups, for free at specified locations (attached to the card or coupon could be a listing of participating pediatricians' offices, public health and community clinic sites, etc.). These cards or coupons could be distributed in targeted regions of the City/County before the start of school.
  - A *Passport To Care Card* would offer a reward system to card carriers. By offering the same services as above and utilizing similar distribution methods, children would receive a stamp on their card after completing each designated service. Once the carrier obtains the maximum number of stamps by completing all of the designated services, he/she would be entitled to redeem a prize (choice of culturally different and significant prizes such as Nintendo systems, trips, etc. to be part of a grant request).
  - Outcomes demonstrating the overall effectiveness of this new approach (such as comparing before and after measures of emergency room visits) in the pilot areas could be developed. A social accounting of health improvements for this population of participants should be possible over time. By employing "attractive triggers" of free care for limited prevention-oriented services and prizes for completion of a model health screen, the above programs over time will reduce paperwork barriers, improve a population's health, and expedite a child's journey from being uninsured to having a medical home.

IV. Public Reporting

A notable feature of the health care market is the difficulty in assessing the quality of the services being used or purchased. Collecting and disseminating information on the quality of health services delivered by providers and health plans will enable purchasing to be based on better informed decisions and move the market toward high quality providers. Simply collecting and reporting performance indicators can motivate creative ways to move toward improvement. Reporting can inform consumer choice, improve system alignment, and enhance accountability.

Recommendations

1) In health care, "you change what you measure," yet there are significant costs associated with accurate reporting, so judicious selection of key indicators is critical. Selective criteria for reporting over time should be based on the following indicators (1) a disproportionate effect on vulnerable populations (2) the possibility of

effective intervention, such as preventive services and community benefits.

- The King County Health Action Plan will continue to collect the following HEDIS measures from health plans and report results over time: prenatal care in the first trimester, eye exams for diabetes, and fully immunized two-year-olds. Other HEDIS measures that relate to Action Plan priorities will be considered for future reporting. The HEDIS results collected to date are presented along with other sources of data for those measurement areas in the Health Plan Viability Appendix.
- The King County Health Action Plan will research reporting mechanisms adopted by other metropolitan areas and large employers and suggest ways in which Seattle and King County could provide measure and disseminate clear and objective health care cost and quality information.

V. Health Care Purchasing

Purchasing can be viewed as a policy tool. Basing employee benefits purchasing decisions on the quality and types of services, in addition to their costs sends a strong message that high quality health care and preventive services are valued. With health insurance costs rising at three times the overall inflation rate in 1999, purchasers will continue to be pressed to obtain the highest value for their employee benefits. All purchasers can influence change to greater degrees than is currently happening by measuring what gets done and by choosing to report on available data that connects to those desired outcomes.

Recommendations

1) The City of Seattle and King County together purchase health benefits for approximately 59,000 employees and dependents from four health plans. Working in tandem with employee representatives, contracting guidelines can be devised that weigh quality and other desired measures along side premium costs. Contract language can specify that health plans report well-known quality measures and assure that preventive services are delivered in accordance with nationally accepted schedules. Both the City and the County require performance reporting already and have plans to continue doing so.

Health plans that are the most responsive to their members and score the highest on consumer satisfaction measures similarly can be rewarded in the selection process. Participation in existing collaborative quality improvement projects can be a condition of the contracts. Employee benefits contracts offer an effective avenue to implement health care policy objectives agreed upon by labor and management.

- As employers, the City of Seattle and King County should explore the adoption of the joint quality requirements used by the Department of Health, DSHS Medical Assistance Administration, and the Health Care Authority (and currently being reviewed by Microsoft). This would provide an excellent opportunity for expanded consistency and comparison.
- The King County Health Action Plan will convene public and private employers to discuss and disseminate strategies for health care purchasing which model the state quality requirements.

VI. Behavioral Health

Two major advances in the delivery of behavioral health services (mental health and chemical dependency services) have taken place in recent years: (1) *managed* behavioral health care has helped control costs; and (2) clinical advances have significantly improved the treatment success rate for behavioral health disorders. The combined result of these advances has made it more affordable and equitable to cover behavioral health services on a par with insurance for other health services.

A number of national employers have invested in their employees' behavioral health needs. After small, if any, cost increases the first year, many have experienced savings over time. Black & Decker, Boeing, Digital, DuPont, Federal Express, Pacific Bell, Xerox, and other employers report cost *reductions* with comparable, managed behavioral health coverage compared to behavioral health coverage with artificial limits. They report that managed behavioral health services, combined with Employee Assistance Programs, offer early access and effective cost controls. These advances have contributed to 28 states and the federal government enacting a variety of behavioral health parity laws. Following a presentation by members of the Action Plan, the Board of Health passed a resolution supporting the following recommendations in the Spring of 1999.

Recommendations

1) Comparable managed behavioral health services should have the following features in common with other health services:
   - Comparable lifetime dollar or service limits will be used.
   - Comparable cost sharing levels (co-payments, co-insurance, and deductibles), if applicable, will be used.
   - Enrollees will receive credit toward their out-of-pocket limit for behavioral health services cost sharing; after the limit is met, behavioral health cost sharing will be capped (as is cost sharing for other health services).
   - Use of chemical dependency services covered by earlier policies will not be selectively counted toward lifetime limits, if earlier uses of other health services are not.
   - Exclusions will not be written so broadly as to reduce substantially the coverage described under "covered services."
   - Benefits descriptions will use simple, understandable language to describe clearly the benefits to the consumer.
   - Financial incentives to use network providers will be in place.
   - Access to quality, appropriate behavioral health services will be provided through use of the best of managed care practices – such as diagnostic assessments, practice guidelines, formularies, and pre-authorizations combined with proven treatment methods that are carefully evaluated and documented for outcomes.

2) The King County Health Action Plan Steering Committee, King County, and the City of Seattle will explore providing comparable behavioral health coverage for their employees and family members.

◆ As health care leaders and employers, the Steering Committee members commit to work toward providing comparable managed behavioral health services coverage to their employees and families by 2002.

- King County and the City of Seattle, as model employers and within the framework of collective bargaining, should work toward providing comparable managed behavioral health services coverage (as described above) to county and city employees and their families by 2002.
- The elected officials of King County and the City of Seattle should actively encourage other employers in King County to provide comparable managed behavioral health services coverage (as described above) for their employees and families.
- King County and the City of Seattle should support state action to include managed behavioral health services coverage comparable to other health services covered by the state's public programs, such as the Public Employee Benefits Board programs and the Basic Health Plan.[1]

VII. The Dental Safety Net

Dental care has had a weak tangential relationship with medical care. Yet clearly the teeth are part of the body, and devastating debilitation can result from oral health crises. King County has a network of active dental care providers working to provide low cost care, particularly for 64% of residents with incomes below $20,000 per year who lack dental insurance. But the existing dental safety net is fragile and it is failing to meet the needs of many low-income residents. This network must be reinforced to help fill the gaps in dental care and solidify the dental safety net for low-income residents.

Recommendations

1) Key players within King County's dental care system, including policymakers and funders, must work to promote and expand services to low-income residents. Development of a donated dental services program that is under consideration by the Dental Safety Net Task Force is recommended for development with additional access avenues to be explored such as:

- Public Health - Seattle & King County dental clinics, and other public clinics will screen clients, treat them for emergent needs and refer them to participating providers for speciality care or other treatment.
- The Seattle-King County Dental Society and other dental organizations should contribute to the design phase and promote awareness of the donated dental services program. When it is implemented they should encourage active participation among their members.
- The Community Health Access Program (CHAP) should provide dental referrals for children covered by Medicaid and for low-income families unable to locate a primary dental care provider.
- Public Health - Seattle & King County will continue to provide preventive and basic dental care in its own facilities and support communities and agencies in strengthening their system of oral health care. In an effort to meet this goal, Public Health should sustain and preferably increase the number of schools and students participating in its Oral Health Program for grades K-6.

VIII. CATALYZING COMMUNICATION

Education of other health care providers, health plans, the public, and other health departments about their potential roles in instigating and supporting population-based health improvements in the context of collaborative models can go a long way toward accomplishing system improvements. Information sharing across system lines regarding new models of collaboration and outcomes from pilot projects will help continued improvement and innovation.

Recommendations

1) Public Health - Seattle & King County has a significant role in convening major participants of the health care system to take an overall look at the region's health status data and the health care system's performance. In King County, this convening activity takes place through the Action Plan. It allows public and private sector participants to understand major health trends in the county and to develop collaborative responses.

- The Action Plan will continue to convene private and public health leaders, and those participants will contribute time, leadership, data, and funding for agreed upon projects.

CONCLUSION

The City of Seattle and King County have shown leadership in the area of public health many times in the past. These recommendations offer the opportunity to demonstrate the value of partnering with the private delivery system to make real improvements in the health of vulnerable populations. Adopting a system wide view will make the most of the work carried out today by dedicated health professionals, and community organizations throughout the region.

In short, collaboration and public/private partnerships on specific models can produce improved health for the system as a whole, and for the citizens and communities of Seattle and King County.

[1] Differences of opinion were expressed by Steering Committee members about whether or not the timing is right to change the Basic Health Plan's benefits, given the current financial pressures on the plan, particularly on the non-subsidized component of the plan.

APPENDIX I

STEERING COMMITTEE

Chair: *Alonzo L. Plough*, Director, Public Health - Seattle & King County

Albert J. Alvarez, Executive Director, Swedish Medical Center Foundations

Nancy Anderson, Epidemiologist, MAA, Washington State Department of Social and Health Services, Division of Health Services, Quality Support

Dennis Braddock, Chief Executive Officer, Community Health Plan of Washington

Margaret Ceis, Past Member, Harborview Board Of Trustees

Shelley Cooper-Ashford, Executive Director, Center for Multi-Cultural Health

Sue Crystal, Director of Executive Policy, Governor's Executive Policy Office

Ben Danielson, Medical Director, Odessa Brown Children's Clinic

William Dowling, Professor and Chair, Department of Health Services School of Public Health & Community Medicine, University of Washington

Karin Dufault, S.P., Chair of the Board, Providence Health System

Barbara Flye, Executive Director, Washington Citizen Action

Ralph Forquera, Executive Director, Seattle Indian Health Board

Kenneth Graham, President & Chief Executive Officer, Overlake Hospital

Leo Greenawalt, President & Chief Executive Officer, Washington State Hospital Association

Walter T. Hubbard, Special Assistant to the Mayor, City of Seattle

David Hutchinson, Mayor, City of Lake Forest Park

Catherine Kanda, Chief Executive Officer, Nikkei Concerns

Dianna L. Kielian, Vice President, Mission, Franciscan Health System

Joseph Leinonen, Chief Medical Officer, First Choice Health Network, Inc.

James LoGerfo, Professor of Medicine and Health Services Director, Northwest Prevention Effectiveness Center

Pam MacEwan, Vice President, Public Policy and Governance, Group Health Cooperative of Puget Sound

Mary O. McWilliams, Senior Vice President, Healthcare Services and Boeing, Regence BlueShield

Margaret Pageler, Member, Seattle City Council & State Board of Health

Derick Pasternak, Chief Executive of Puget Sound Service Area, Providence Health System

Randy Revelle, Vice President, TRIAD Special Projects, Washington State Hospital Association

William Riley, President and Chief Executive Officer, Pacific Medical Center

Rick Rubin, Vice President, Strategic Develoment, Pointshare Corporation

Cheryl Smith Payseno, Chief Operating Officer, St. Frances Hospital

Diane Sosne, President, District 1199 NW, Hospital and Health Care Employees Union, SEIU, AFL-CIO

Tom Trumpeter, Executive Director, Community Health Centers of King County

Greg Vigdor, President, Washington Health Foundation

Bob Watt, President and Chief Executive Officer, Greater Seattle Chamber of Commerce

Nancy Woods, Dean, University of Washington School of Nursing *King County Health Action Plan Staff*

Susan Johnson, Director

Kirsten Wysen, Policy Analyst

Susan Thompson, Health Program Analyst

Meg Strawbridge, Health Program Assistant

Roger Jansson, Graduate Intern

APPENDIX II

CONSUMER SATISFACTION

Consumer Satisfaction

There is widespread consumer frustration with health care plans across the nation, with many Americans feeling that health organizations are confusing, expensive, unreliable, and impersonal. There have been a plethora of national surveys that measure consumer satisfaction and public perceptions of health care and hospitals in the last few years. Many surveys attempt to compare consumer satisfaction and quality of care with managed care to fee-for-service insurance coverage, with mixed results. For instance, one national survey found that enrollees in traditional private health plans gave higher grades to their insurance plans than enrollees in managed care.[1] Other national surveys indicate that HMO and fee-for service patients report similar satisfaction levels with their health plans.[2,3] Although it is not suggested by these mixed results that a return to a fee-for-service environment is a panacea, it is suggestive of consumers' need for having both choice and affordability as part of their health insurance package

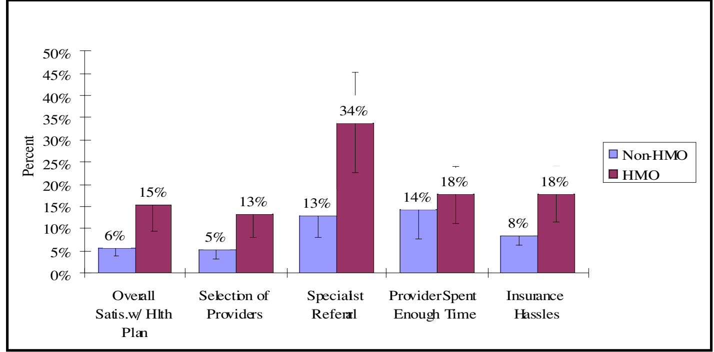
There is less publicly available data on consumer satisfaction at the local level. In Washing-ton state, both the Medicaid managed care program (Healthy Options) and the Health Care Authority's state employee program (PEBB) have administered the Consumer Assessment of Health Plans Survey (CAHPS) to measure consumer satisfaction of their members.[4] Several of the questions in the CAHPS survey measure overall satisfaction and other questions measure satisfaction with specific health care topics. The scores for each survey question are rated at three levels (better than average, average, and below average).

The PEBB CAHPS survey results are based on responses by 15,885 members of 20 PEBB health plans in 1997. When adult consumers were asked to rate their health plan overall, one-quarter of plans were rated "below average," almost half of plans were rated "average," and almost one-third of plans were rated "above average." However, only two plans were rated "above average" for overall quality of care. In this survey, Qual-Med was the only health plan that received "better than average" scores on all survey areas, and Virginia Mason received "better than average" scores in many areas. For instance, Qual-Med and Virginia Mason were the only health plans that scored above average for "getting care without long waits," "doctors who communicate well with patients," and "doctors who spend enough time with patients and know their medical history."

The Healthy Options CAHPS survey results are based on responses by 10,591 Medicaid members enrolled in 12 health plans in 1998 (about 420 adults and 480 children from each plan). When adult consumers were asked to rate their health plan overall on a scale from 1-10, 44% rated it from "1-7," 34% chose "8-9," and 23% chose a "10." One quarter of respondents stated that they sometimes/never "get care without long waits," 17% stated that they sometimes/never see "doctors who communicate well with patients," and 22% stated that they sometimes/never see "doctors who spend enough time with you." In this survey, Northwest Medical Bureau and Regence BlueShield receive the best scores overall for questions about

childrens' care, and Kitsap Physicians Service and Group Health Cooperative receive the best scores overall for questions about adults' care.

Figure 1.
Percent Not Satisfied* with Selected Measures of Performance of Health Plan by Type of Health Plan, King County, 1998



*of those who have seen health care provider in last year

In addition to the CAHPS surveys, Public Health - Seattle & King County conducted a survey that measured consumer satisfaction in King County in 1998.[5] According to the survey, 15% of respondents in HMOs reported overall dissatisfaction with their health plans, compared to 6% of respondents in non-HMO health plans. HMO respondents also reported lower levels of satisfaction than non-HMO respondents for: selection of providers, specialist referrals, time spent with providers, and insurance hassles (see table).

The King County Health Action Plan hired the Gilmore Research Group to conduct two focus groups designed to obtain information from middle class consumers of health care in King County about consumer satisfaction and quality of care.[6] The two consumer groups were comprised of a total of 20 respondents (ten per group), aged from 21 to 70 years old. There was an even split of men and women in each group, and there were several representatives of minority populations (one Asian and three African American participants). The geographical distribution of these residents was well mixed, with respondents from Seattle as well as towns in North, West, and South King County.

Some of the findings of the King County Health Action Plan's (KCHAP) focus groups on consumer satisfaction were related to key systematic issues of relationships, referrals, reliability, time and trust:

- Referrals to specialists were considered a problem by a number of respondents, most often among those who did not have an established relationship with a primary care physician (PCP). In addition, they described the referral process as a waste of time and money because they would have to see two doctors for the same ailment or condition. For instance, many reported needing to see a PCP first to get a referral to a specialist, thus missing more work and having to pay co-payments twice. One respondent stated:

  "I had to explain the problem to a medic, my PCP, and finally an eye doctor; meanwhile, I'm in severe pain."

- Respondents with good rapport with a PCP over a number of years were more likely to be happy with the referral process. Most of these respondents reported that they can call the PCP's office and ask for referrals by phone.

- Other referral problems related to the health plans that were mentioned included: difficulty in obtaining referrals outside the plan, and the problem of not getting to see the same specialist for recurrent episodes of the same

type of the problem. Because some HMOs reportedly refer the patient to different specialists regardless of whom they have seen previously, a number of respondents complained that they had to explain the history of the same health problem to each new doctor. These consumers thought they should be able to call the same specialist they had seen before, even if several months had elapsed.

- The amount of waiting time reported for a routine check-up with a general practice physician varied from one-and-a-half weeks to one-and-a-half months. The amount of waiting time reported to see a specialist was from two months (which seemed too long) to quick referrals (sometimes even the same day within an HMO).
- Once inside the doctor's office, respondents reported a two-stage waiting process. The first wait in the outer office was ten to fifteen minutes, which was considered acceptable. The second wait is in the examination room, which was reported to last longer.
- Many health care consumers would like to have more time with the physician, but they generally placed the blame for brief visits on the health plan and, in some instances, on capitation.
- When asked whether the doctor should talk to them about topics such as diet, exercise, and injury prevention, two respondents mentioned overweight women who might delay going to a doctor because they do not like to be lectured about eating habits. Several respondents did not want to hear about exercise, because they are not open to incorporating physical activity into their lives. Others felt that doctors should discuss exercise, because "every little reminder helps." Many respondents were more receptive to the idea that these topics should be covered in conjunction with the treatment of a particular disease, such as diabetes or heart disease.[7]
- Women were more likely to want doctors to improve listening, while men were more likely to want the diagnosis and the cure. Many would like the PCP to take a holistic approach and cover the gamut of input that contributes to a person's health.
- There were mixed opinions about the concept of involving patients in decisions about their own care. One respondent, whose wife suffers from a chronic disease, emphasized the importance of patient input:

  "My wife has been in her body longer than the doctor."

- The idea that consumers have to educate themselves was voiced repeatedly, with comments such as:

  "People ought to shop for their doctors who take care of them as well as they shop for their cars."

- Stability of the doctor-patient relationship contributes strongly to positive interaction and perceptions of health care. Long-term relationships were important to consumer satisfaction, exemplified by this quote:

  "As long as I can go to my doctor, I don't care who my insurance company is."

- The majority of respondents of one group felt that the health care system has improved over the past five years, and respondents in the

other group felt that health care is better in some aspects and worse in others. The parts of the health system that are reportedly improved are: the doctors, the facilities, and the drugs. The parts of the health system that are reportedly deteriorating are: billing and information as well as customer service.

- Billing was considered a problematic and frustrating issue, and many referred to a large number of bills from numerous entities that arrive over a period of months for the same medical visit. They described these bills as having "inherent indiscernability" and as being "staggering." Some respondents allow bills to stack up from a single medical event over several months, and then try to compare bills to be sure that there is not overlap and determine what the insurance has paid. Several respondents stated that they purposefully wait for the second bill, so that they know the amount is one that they definitely need to pay. Overall, consumers would like health care bills to be simplified and easier to understand.
- The majority of respondents (16 of 20) indicated that they have called customer service for their health plan or insurance companies at some time. The customer service department was not seen as a positive aspect of the managed care system by most respondents. They complained about confusing telephone answering systems that have a menu of options, and that some customer service staff seem inexperienced. One suggestion was to have a live operator answer and direct calls to the appropriate set of menus; another suggestion was to offer initial instruction about how to get an operator if needed or how to go back to previous menus in the system.

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[1] Kaiser Family Foundation/Harvard University. *Public Opinion Update: Managed Care*. 1998

[2] American Association of Health Plans. *Summary of Consumer Satisfaction Surveys and Health Plans*. 1997

[3] Office of Personnel Management/The Gallup Organization. *Survey of Federal Employee Health Benefits Program (FEHBP)*.1996

[4] This national standardized survey was funded by the federal government and developed by the CAHPS Consortium, a group of survey experts associated with Harvard Medical School, RAND, and the Research Triangle Institute.

[5] 1998 King County Access to Care Survey. Public Health-Seattle & King County. This survey used standard BRFS methodology, and surveyed 1202 King County residents stratified by region (400 each in South, East, Central and North).

[6] The two focus groups were conducted on Monday, December 7, 1998 at the Gilmore Research Group. Staff of the King County Health Action Plan observed the sessions, which were audio-taped.

[7] The Access to Care survey found that less than 30% of respondents were counseled on diet, exercise, and smoking.

APPENDIX III

BEHAVIORAL HEALTH

Behavioral Health Benefits Survey Summary

- **Primary Finding:** All 22 employers represented on the King County Health Action Plan Steering Committee in March 1998 provided substantially less coverage for behavioral health (mental health and chemical dependency) services in 1997 than for other health services. Typical benefits were:
  - Chemical dependency: Up to $5,000 in services every two years
  - Mental heath: 12 inpatient days and 20 outpatient visits
  - Other health services: A $1,000,000 lifetime limit, or no limit
- **Other Findings**:
  - Higher cost sharing was usually applied to behavioral health services compared to other health services; for example, $5 per medical visit versus $20 per mental health visit.
  - Out-of-pocket limit or "stoploss" protection did not apply to mental health.
    - Mental health cost sharing often did not count toward the limit.
    - Once the limit was met, mental health cost sharing continues.
  - Previous chemical dependency services counted against the lifetime maximum, whereas earlier uses of other health services did not.
  - Exclusions often narrowed the behavioral health coverage; for example, only three of the 22 employers offered a health plan that covered treatment for eating disorders; only five employers covered treatment for Alzheimer's disease; and only 12 employers offered coverage for self-inflicted wounds.
  - Language used in benefits books
    - Language was complex, and difficult to understand.
    - Simple language was available; for example, the State of Ohio management and union representatives devised health benefit language at the eighth grade reading level.
- **Survey Methods:** Employee benefits booklets for 1997 were collected from the 22 employers on the Steering Committee. Chemical dependency, mental health, and other health services coverage were abstracted into charts. Each employer's human resources manager and Steering Committee member reviewed their chart for accuracy.

Participating Employers: Cascade Vista Convalescent Center; City of Lake Forest Park; City of Seattle; Community Health Centers of King County; Community Health Plan of Washington; District 1199NW, SEIU; Evergreen Hospital Medical Center; FirstChoice Health Network, Inc.; Foundation for Health Care Quality; Greater Seattle Chamber of Commerce; Group Health Cooperative of Puget Sound; Highline Community Hospital; Odessa Brown Children's Clinic; Overlake Hospital Medical Center; Regence BlueShield; Seattle Indian Health Board; Public Health - Seattle & King County; Sisters of Providence Health System; State of Washington (Department of Social and Health Services, Governor's Office, Harborview Medical Center, and the University of Washington); Swedish Health Services; Washington Citizen Action; and the Washington State Hospital Association.

Cost Of Comparable Behavioral Health Services Summary

Actuarial Studies' Key Findings: The costs of comparable behavioral health coverage under managed care are relatively small.

Year	*Actuarial Study*	*Cost Increases*
1994	Washington Health Services Commission	◆ $1 per member per month
1996	Congressional Budget Office	◆ 4% first year; 1.6% long-term
1996	Milliman & Robertson	◆ 2.5% for severe mental illness
1996	Watson Wyatt Worldwide	◆ 8 to 11% annual increase
1997	RAND Corporation	◆ $7 per year
1998	SAMHSA	◆ 3.6% annual increase
1998	PriceWaterhouseCoopers in WA	◆ 2.1% annual increase

Employers:

- ◆ Black & Decker, Boeing, Digital, DuPont, Federal Express, Pacific Bell, Xerox, and other companies report cost *reductions* with comparable, managed behavioral health coverage.
- ◆ Managed behavioral health services, combined with Employee Assistance Programs, offer early access and effective cost controls.

28 States have passed Behavioral Health Parity Laws

Cost Increases: The cost increases for managed behavioral health services in states with parity laws are relatively small.

- ◆ Maryland 0.6% increase per year
- ◆ Minnesota $0.26 per member/month increase for Allina; *reductions* for Blue Cross
- ◆ Texas $3.47 increase per year
- ◆ Vermont Estimated 3.4% increase

Affordable Costs: Managed care and clinical advances make comparable behavioral health services affordable.

- ◆ ***Managed Care***:
  - ➢ Fewer inpatient stays and less long-term psychotherapy
  - ➢ Increased early outpatient visits, medication management, and inpatient substitutes
- ◆ ***Clinical Advances***:
  - ➢ Higher treatment success rates: schizophrenia - 60%; bipolar disorder- 85%; and major depression – 60%.
  - ➢ Improved lives and lower costs; e.g., schizophrenia drugs cost $4,500 per year versus $73,000 for annual hospitalizations.

APPENDIX IV

ALTERNATIVE CARE/NATURAL MEDICINE

Alternative Care/ Natural Medicine

Population-based approaches to health management reveal the consequences of poor disease prevention and health promotion. The use of alternative care systems, particularly those that relate mind and body in health, are becoming more prevalent and their efficacy is being studied. The continued integration of innovative therapies into allopathic (traditional) health care systems is expected to increase in response to consumer demands.

In the Institute for the Future's recent report *A Forecast of Health and Health Care in America,* the authors argue that there is no single term that captures the attempts to view health and disease through a wider lens outside of the biomedical model. Medical efforts to address the upstream determinants of disease beyond genetics and access to care, such as socioeconomic, behavioral, social, and environmental factors, have been labelled as "alternative," "complementary," "holistic," "expanded," "natural," and "mind-body." The report settles on the phrase "**expanded view of health**" to integrate the concepts of curative medicine (absence of disease) with public health (absence of excess mortality, morbidity, and risk factors for disease), and to include productive functioning and physical, mental, social, and spiritual well-being. [1] The National Institute of Health (NIH) has recently established an Office of Alternative Medicine and the American Public Health Association (APHA) has convened a special interest group on Alternative and Complimentary Health Practices.

The growing acceptance and increasing use of natural medicine led to the King County Council's 1995 call for the establishment of a natural medicine clinic. In November 1996, the nation's first publicly-funded clinic offering both allopathic and natural medical services opened in Kent, Washington. A grant from Public Health-Seattle & King County funded the clinic's operations and also called for the Statistics and Epidemiology Research Corporation (SERC) to report on the clinic's early experiences. This report described the clinic's early experiences with treating hypertension, otitis media, and migraine but was limited in scope and duration. Further larger prospective studies are needed to evaluate treatment effectiveness.

In the Spring and Summer of 1998, John Bastyr University and the Division of Alcohol and Drug Abuse Services of Public Health - Seattle & King County collaborated on an acupuncture detoxification and nutritional pilot project. This new pilot project is designed to provide a low barrier approach to community-based drug treatment. The evaluation of the efficacy of this pilot project is expected when data become available.

Public Health - Seattle & King County conducted King County Access to Care surveys in 1996 and 1998.[2] The following summary findings relate to alternative care:

- 13% of respondents in the surveys reported they had seen a chiropractor in the last 12 months. Of this group, 8% had full or partial insurance coverage for the service, 4% were insured but their insurance did not cover chiropractic care, and 1% had no insurance.

- 3% of respondents in the surveys reported they had received naturopathic care in the last 12 months. Of this group, 0.9% had full or partial insurance coverage for the service, 2% were insured but their insurance did not cover naturopathic care, and 0.4% had no insurance coverage.
- 3% of respondents in the surveys reported they had received acupuncture care in the last 12 months. Of this group, 0.4% had full or partial insurance coverage for the service, 2% were insured but their insurance did not cover acupuncture care, and 0.3% had no insurance coverage.

The King County Health Action Plan also conducted three focus group discussions with King County residents.[3] The following are summary findings from three focus groups where alternative care was one of the topics discussed:

- The majority of respondents had health care insurance, however, these insurance plans typically did not cover their costs for alternative care, or cover some services to a limited extent.
- Half of the middle class consumer group and all of the alternative care consumer group have used alternative care services.
- Most frequently used alternative care service among the middle class consumer group was massage therapy and chiropractic therapy; the alternative care group reported using massage therapy, acupuncturists, chiropractic services, naturopathic doctors, a midwife, herbal therapists, an acupressurist, a Rolfing practitioner and a Native American Shaman.
- Reasons stated by respondents for seeking alternative care services included: a perception that allopathic medicine is good for certain purposes but is limited in its ability to treat long-term pain and chronic illnesses; a perception that all "regular" doctors can do is offer drugs; a perception that allopathic-trained doctors seem disinterested or do not have the time to explore all the underlying conditions that may contribute to a medical problem that is not a specific disease state; a perception that alternative care practitioners offer more time to their patients, and empower the patient in health care decision making; alternative care services are perceived as a "long-term fix and lifestyle change."
- Among the alternative care users group, the number one reason identified for consumers seeking alternative care providers was the relief from chronic pain.
- Several respondents in the group noted that the positive results after seeing an alternative provider was worth the out-of-pocket expense.

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[1] *A Forecast of Health and Health Care in America*. Prepared by Institute for the Future for the Robert Wood Johnson Foundation. November 1998.

[2] 1998 King County Access to Care Survey, Seattle-King County Department of Public Health. Survey of 1202 adult King County residents, stratefied by region (South, East, Central and North, 400 in each region). Standard BRFS methodology was used. Similar survey conducted in 1996.

[3] The KCHAP collaborated with the Gilmore Research Group to conduct three focus group with King County residents in November and December, 1998. Two of the focus groups included general middle class consumers (10 in each group), and a third included 11 alternative care consumers.

APPENDIX V
ACCESS TO CARE

Access to Care

Access at the National Level

Access to adequate and timely health care can often prevent or mitigate ill ness and improve health status and quality of life. Unfortunately, there are significant barriers to access to care at the national and local levels, including lack of health insurance, lack of a usual source of health care, and lack of access to dental care. These barriers to adequate and timely health care result in unmet medical needs and increased hospitalizations for potentially avoidable diseases. There also has been a substantial national decrease in the percentage of employers offering health coverage over the last ten years.[1] Quality data on trends in employment-based coverage are not yet available for Washington State, but employees in large firms in Washington State are more than twice as likely to be insured through their employer as those in small firms.[2] According to some experts, it is likely that access to care will become increasingly "tiered," with the top third of consumers having more discretionary income, education, and use of technology to get information and share health decisions. The second tier will consist of the middle-third of worried consumers, with some access to health insurance but little choice of health plans. The third tier will be comprised of the bottom third of excluded customers, including the uninsured, those on Medicaid, and those without access to market-based insurance.[3]

Our existing system of providing health insurance does not meet the needs of millions of working Americans. It is estimated that one out of every six Americans lacks health insurance. Of the over 44 million uninsured Americans, 58% are full-time workers, 18% are part-time workers, and only 24% do not work.[4] Low-income workers have the highest rates of uninsurance, with almost 20% of working Americans earning under $35,000 lacking insurance and 41% of those earning under $20,000 lacking insurance.[5] Low-income workers have low rates of health insurance in large part because their employers do not provide it: over 42% of employees earning under $20,000 are not offered employer-based insurance or are not eligible to participate. Low-income workers report difficulty paying their medical bills, with over half of those earning under $20,000 and almost one-third of those earning under $35,000 unable to pay all of their medical bills in the last year. There are also racial differences in the percentage of workers not offered employer-based insurance: 18% of Caucasians, 17% of African Americans, and 34% of Hispanics are not offered employer-based insurance.[6]

Not only are a person's ethnicity and employment situation related to differing levels of access to health insurance and therefore health services, so too a plethora of recent research demonstrates that "social class - as measured not just by income but also by education and other markers of relative status - is one of the most powerful predictors of health, more powerful than genetics, exposure to carcinogens, even smoking."[7] Thus the fragmentation of the health system mirrors the fragmentation of the social system. Furthermore, the system is often disconnected and hard to navigate. For instance, different types of care (acute, chronic, and long-term) are often fragmented and available in different

settings. Likewise, the health system is fragmented by types of insurers and providers: public, employer-based, individual, and safety net. Access to these types of insurance and care is unstable and unpredictable for many individuals, and changes from one year to the next.

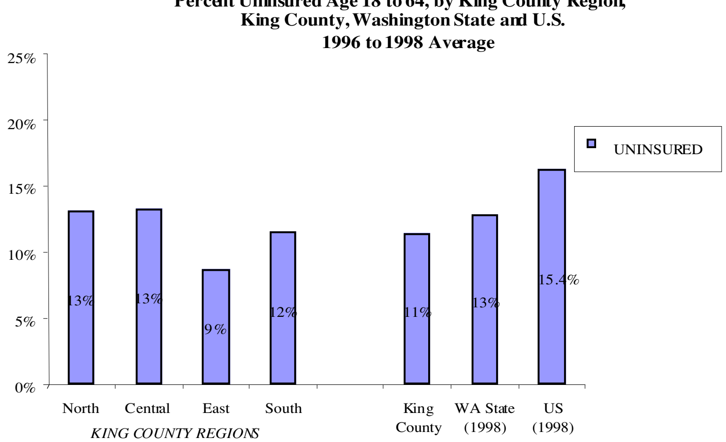
Access in King County as a Whole

Public Health - Seattle & King County conducted surveys on access to care in King County in 1996 and 1998.[8] These and other local surveys, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), found that there has been no improvement in the percent of insured adults in King County even though there has been recent economic growth and relatively low unemployment rates. Among King County adults under 65 years of age, 11% (almost 120,000 people) lacked health insurance altogether. Most of the uninsured residents had lacked coverage for an extended period of time: 62% of the uninsured had lacked coverage for at least one year, and 45% had lacked coverage for at least two years. The percent uninsured in Washington State (13%) was slightly higher than that in King County (11%), and the national rate was substantially higher (15%) than that in King County (see Figure1).

Nationally, the proportion of employees enrolled in coverage through their employer among firms with 100 or more employees dropped from 97% in 1984 to 76% in 1997. Despite this trend, the percentage of the total population enrolled through an employer actually has increased slightly since the early 1990's because more people have become employed.[9]

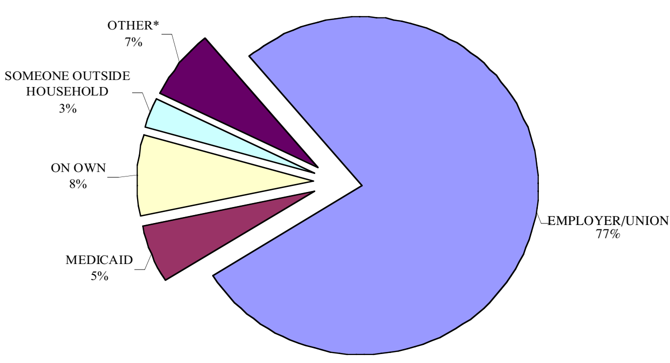
Among adults under 65 insured in King County, 77% obtain insurance through their employers, 8% purchase insurance privately, and 5% are covered by Medicaid (see Figure 2).

Figure 1.



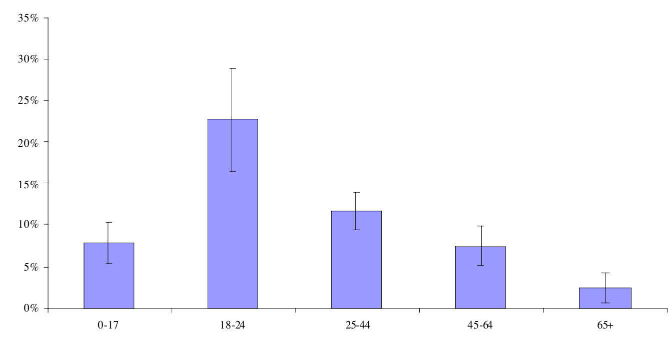
Source: Behavioral Risk Factor Surveillance System (BRFSS), Washington State Department of Health
Small area BRFSS, Public Health - Seattle & King County, 1998

Figure 2.
Primary Source of Insurance Coverage, King County 1998



* Medicare, Military, Basic Health Plan and Other response categories each made up less than *2% of the total and are included in Other above.
Source: Washington State Population Survey, Office of Financial Management, 1998.

Figure 3.
Percent Not Currently Insured by Age, King County, 1998

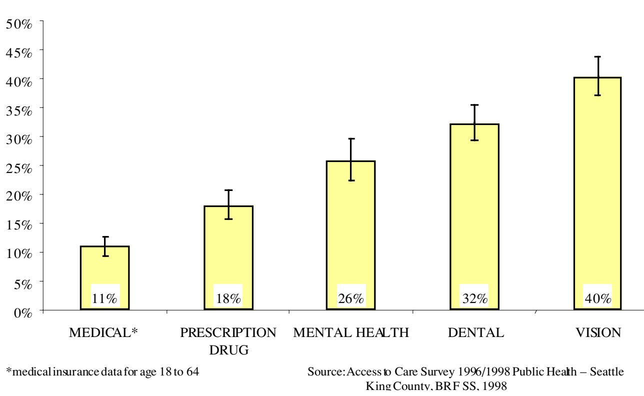


Source: State Population Survey, Office of Financial Management

King County residents also often experience gaps in health insurance. Eighteen percent of King County adults under 65 lacked coverage at some time in the previous year (this percentage includes 11% currently uninsured). There are large differences in the uninsurance rate by age. Almost one in four young adults (23%) aged 18 to 24 lack insurance, more than twice the overall rate (see Figure 3). Among children under 17, 8% (over 30,000 children in King County) currently lack insurance. Children who are eligible for Medicaid are much more likely to lack health insurance than children living in families with higher incomes. For instance, 18% of children living in poverty lack insurance, 16% of children living between 100% and 200% of poverty lack insurance, and only 5% of children living above 200% of poverty lack insurance. With Medicare, older residents aged 65 and older have the lowest rate of uninsurance, at only 2%.

Lack of specific insurance categories was more common than lack of medical insurance in general. For instance, the combined 1996 and 1998 average of King County adults lacking prescription drugs was 18%, lacking mental health coverage was 28%, lacking dental coverage was 34%, and lacking coverage for eyeglasses was 41% (see Figure 4). More information on King County residents' access to health care coverage is available in Public Health - Seattle & King County's January 2000 *Data Watch* on that topic.

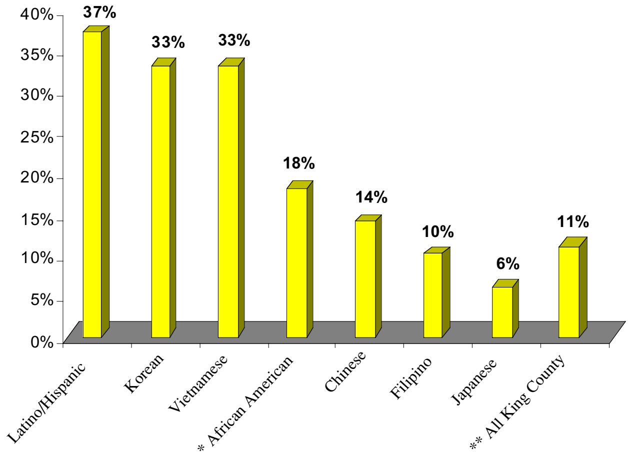
Figure 4.
Percent Without Medical, Prescription Drug, Mental Health, Dental and Vision Coverage, Age 18 and Over*



Access In King County Among Minorities

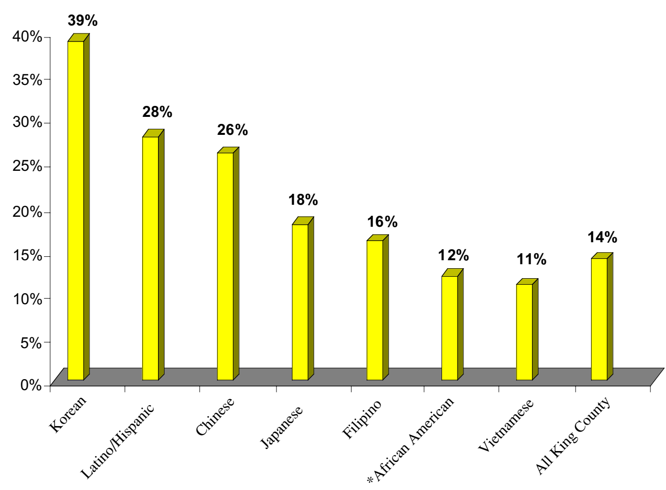
In 1995 and early 1996 Public Health - Seattle & King County conducted the Ethnicity and Health Survey among adults of seven of the largest ethnic minorities living in King County.[10] Survey results showed that there are significant racial and ethnic differences in access to care. For instance, the survey found that over one third of the Latino/Hispanic, Korean, and Vietnamese respondents reported not having health insurance, compared to 11 percent in King County as a whole. Eighteen percent of African American respondents reported having no health insurance (see Figure 5). Many of the minority ethnic groups also reported having no usual source of medical care and delaying to seek medical treatment at higher rates in comparison with overall rates in King County (see Figures 6 and 7).

Figure 5.
No Health Insurance by Ethnic Group in King County, Adults Age 18-64



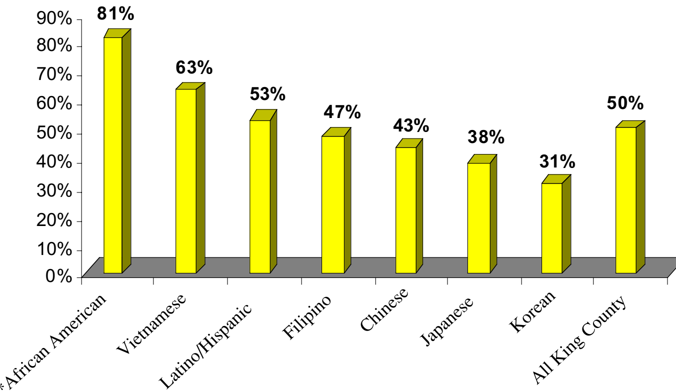
Source: The King County Ethnicity and Health Survey 1998, Public Health - Seattle & King County
* Source: Washington State Department of Health, Center for Health Statistics, BRFSS 1993-1997
** Source: Access to Care Survey 1996/1998, Public Health - Seattle & King County

Figure 6.
No Usual Source of Care by Ethnic Group in King County



Source: The King County Ethnicity and Health Survey 1998, Public Health - Seattle & King County
Source: Washington State Department of Health, Center for Health Statistics, BRFSS 1993-1997

Figure 7.
Delaying to Seek Medical Treatment in 12 Months Prior to Survey by Ethnic Group

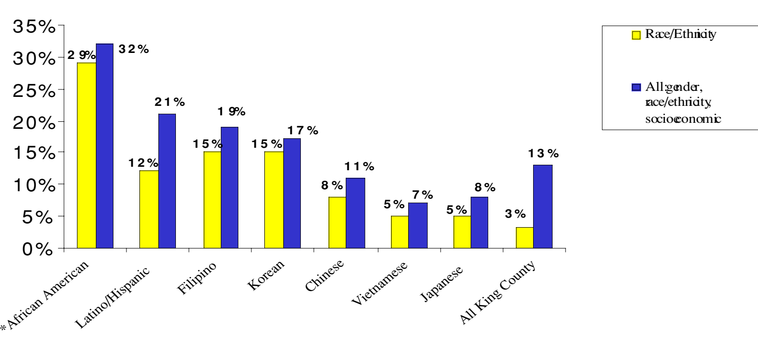


Source: The King County Ethnicity and Health Survey 1998, Public Health - Seattle & King County
*African Americans living in Central and Southeast Seattle only

Responses to these three measures of access varied even within the same ethnic group indicating complex realities of access barriers and calling for intervention approaches that are specific to each ethnic community.

The Ethnicity and Health Survey also explored the subject of perceived discrimination among ethnic minority groups when seeking health services. Nearly one third of African American respondents reported having experienced discrimination based on their race/ethnicity when seeking health care. Among respondents from Latino/Hispanic, Filipino and Korean heritage, 10 percent or more reported having experienced discrimination when seeking health services based on race/ethnicity. Difficulties in accessing health services were evident for all seven survey groups among those reporting discrimination based on their race/ethnicity or more broadly based on any reported discrimination (race/ethnicity, gender, socioeconomic status)(see Figure 8). All respondents of all groups who reported being discriminated against reported delaying to seek health care in the past 12 months at a higher rate than respondents who did not report being discriminated against. These findings are being followed up in a qualitative study to hone in on more information on types and consequences of the perceived discrimination.

Figure 8.
Perceived Discrimination When Seeking Health Services



Source: The King County Ethnicity and Health Survey 1998, Public Health - Seattle & King County
*African Americans living in Central and Southeast Seattle only

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[1] Source: *The Pulse Indicators: Taking the Pulse of Washington's Health System.* A publication of Vital Signs of Washington's Health.
[2] Ibid.
[3] *A Forecast of Health and Health Care in America*. Prepared by Institute for the Future for the Robert Wood Johnson Foundation. November 1998: 3.
[4] Source: March 1998 Current Population Survey.
[5] Source: "Can't Afford to Get Sick: A Reality for Millions of Working Americans." A Report analyzing the Commonwealth Fund 1999 National Survey of Worker's Health Insurance.
[6] Ibid.
[7] Goode, E. "For Good Health. It Helps to Be Rich and Important." New York Times: 6/1/99.
[8] Access to Care Survey 1996 and 1998. Public Health - Seattle & King County. (Both surveys used standard BRFS methodology. The 1998 survey was completed by 1202 King County Residents, stratified by region with 400 surveys in South, East, Central/North regions).
[9] *1999 Pulse Indicators*, University of Washington Health Policy Analysis Program, VITAL SIGNS of Washington's Health.
[10] The minority groups surveyed were African American, Latino/Hispanic, Chinese, Filipino, Japanese, Korean, and Vietnamese.

APPENDIX VI

THE HEALTH CARE SAFETY NET

The Health Care Safety Net

Definition of the Safety Net

The health care safety net typically refers to those health care providers who are legally obligated to provide care for free or at reduced rates to people who lack their own resources to afford health care. In King County these providers include: the community health centers, Public Health - Seattle & King County, Harborview Medical Center, Planned Parenthood, programs funded through Health Care for the Homeless and Ryan White funding. Safety net providers also include non-profit hospitals that provide uncompensated care as part of their community benefit obligation and private physicians, clinics, and other organizations that offer care at no charge or at a discounted rate.

Why Is the Safety Net Essential?

- ***The safety net is the largest provider of care to the uninsured.***

  Nationally approximately 44.3million are uninsured.[1] The number of uninsured in King County is less than the national statistics but still approximately one of 10 King County adults age 18-64 (about 108,000 people) lack health insurance coverage of any kind.[2] Nationally, 46 percent of community health clinics' patients have no health insurance.

- ***The safety net provides a continuum of care regardless of insurance status.***

  One in five Americans is uninsured for some portion of the year.[3] Additionally, Medicaid recipients are covered on average only eight months of the year. In contrast to mainstream providers, community health centers are organized to provide health services to persons before their insurance coverage begins and after it ends, thereby, offering these patients important continuity of care.

- ***Safety net providers in King County are specialists at what they do.***

  Community and public health clinics specialize in caring for low-income individuals, special populations such as the homeless and teenagers, and communities of ethnic, cultural and linguistic diversity. These are precisely the groups that have difficulty accessing and using mainstream health care. Moreover, the staff possesses the expertise and experience to address special needs that may arise in these groups and the knowledge of how to tap into other community resources that may be of benefit to the client.

- ***The overwhelming majority of safety net patients in King County are poor.***

  Approximately 76 percent of community clinic patients and 67 percent of Public Health patients are very low-income, with incomes below 100 percent of the federal poverty level. Moreover, approximately 94 percent of community clinic patients and 89 percent of Public Health patients are low-income, with incomes below 200 percent of

the federal poverty level. For many of these individuals the safety net providers in King County are their only point of entry to access health care services.

- ***Safety net providers serve a diverse clientele.***

  Over half of the clients served by community health centers and Public Health are non-White; by comparison, 15 percent of the general population of King County in non-White. Other safety net providers serve similar diverse populations. All health centers strive to provide culturally sensitive services and several specialize in serving specific ethnic communities. Many employ bilingual staff to serve the large number of limited English-speaking who use the health centers as their primary source of health care.

- ***Safety net providers respond to issues of poverty that affect health care utilization.***

  Many of the following socio-economic factors affect health care utilization: unemployment, homelessness, single parenthood, multiple children, limited English proficiency, refugee or recent immigrant status, legal problems, physical or other disabilities, low educational status, illiteracy, hunger, domestic violence, a history of child abuse and/or sexual assault, chemical dependency, mental illness, lack of transportation. Safety net providers understand the importance of helping families to cope with difficult life issues while addressing health problems

- ***Safety net providers focus on prevention.***

  Many poor and uninsured people will not seek health care when prevention or early intervention is possible, but rather when the need becomes acute. The risk of death for uninsured people is 25 percent higher than for those who have health coverage. Safety net providers craft programs to reach high risk populations and emphasize health and nutrition education, preventive care and primary care. As a result, patients who use community and public health centers have lower hospital and emergency room use rates than patients who use private physicians.[4]

Threats to the Health Care Safety Net

It cannot be assumed that today's safety net delivery system will necessarily be tomorrow's. The way the health care safety net has been developed with a policy decision here, grant funding there, a funding allocation requiring annual renewal, etc., the safety net is vulnerable to losing funding sources and creating gaps in services. In addition, a political climate which favors downsizing government, limiting government spending, and balancing government budgets raises questions regarding the funding streams traditionally relied upon by safety net providers. Some issues that could potentially put pressure on the health care safety net are discussed below.

- ***The Dental Safety Net***

  There is no existing safety net to provide dental care for uninsured adults without disabilities. The Dental Safety Net Task Force was recently convened by Public Health - Seattle & King County to seek public-private partnerships that improve access to dental care. The task force hopes to set up a collaboration between the public

and private sector involving clients, specifically low-income adults, screened by Public Health - Seattle & King County dental clinics and other public clinics, treated for emergent needs, and then referred for speciality or other treatment that cannot be provided in the public-non-profit sector. This model will be based on the Donated Dental Services (DDS) model in other states. The King County Health Action Plan supports innovative pilot projects that focus on improving access, prevention, continuum of care, and public-private partnerships.

The availability of low-cost dental care has been curtailed in the area and creative new ways to increase capacity are sorely needed. Focus must be paid to increasing adult access to care, as well as building patient-doctor relationships and educating consumers on the benefits of routine exams.

- ***Market competition and Medicaid managed care***

While there is virtually no competition among providers to serve uninsured patients, the transition of Medicaid recipients into managed care plans (in the state of Washington all AFDC recipients are required to choose a managed care option) has produced a dramatic surge in competition for Medicaid enrollees among health care providers including community health clinics. Safety net providers rely on Medicaid reimbursements for a substantial portion of their total revenues. If significant loss in Medicaid revenue occurs it will almost certainly reduce their ability to subsidize care for the uninsured.

- ***Potential increases in uncompensated care by safety net providers and subsequent decreases in revenue could potentially impact the viability of safety net providers***

Welfare reform legislation has taken away Medicaid eligibility from many former welfare recipients. The full impact of this massive change in public policy are not yet clear. However, it is feared that all too often these individuals, the majority of whom are women with children, lack sufficient job skills and/or training to secure a job either offering employer-based health insurance, or the salary compensation that would allow self-purchase of health insurance. One potential impact of welfare reform could be an increase in the number of uninsured former welfare recipients resulting in an increased demand on safety net providers for uncompensated services as opposed to revenue-producing services.

The state of Washington recently announced that the Basic Health Plan (BHP) for the non-poor would take no new applicants after January 2000, and that four of the nine carriers covering BHP clients would drop their existing enrollees. This, coupled with the recent collapse of the individual health insurance market in the state (there are now 25 counties in Washington with no major private insurer willing to take on individuals), could increase the number of uninsured in the region placing additional demands on safety net providers to provide uncompensated care.

Public Health clinics have experienced a recent increase in uncompensated direct medical services with a subsequent decline in revenue generated from providing these services. Additionally, the following areas have potential effects on safety net funding streams: disproportionate share payments to hospitals, Medicaid cost-based reimbursement to Public Health and community clinics, and impacts from welfare reform.

[1] Pear, Robert. "Total Number of Uninsured Tops 44 Million." *Seattle Post-Interlligencer.* October 4, 1999. A1.
[2] 1998 King County Access to Care Survey. Public Health - Seattle & King County.
[3] "Uninsured in America." Kaiser Health Reform Project. January 1994.
[4] The Evolution of a Community Controlled Health Plan, supra.

APPENDIX VII

PUBLIC HEALTH SYSTEM

Public Health - Seattle & King County

Mission Statement: To achieve and sustain healthy people and healthy communities throughout King County by providing public health services which promote health and prevent disease.

In 1889, the Washington State Constitution established the State Board of Health, which legally identified public health as a government responsibility. Since then, state law has further defined the role, responsibility, and structure of public health.

Local boards of health, created by statute, are the governing boards of local health departments. They are responsible for establishing the policy framework for the agency and have supervision over all matters pertaining to the preservation of the life and health of the people within its jurisdiction.

Local public health departments develop and implement programs in response to: 1) laws passed by the legislature; 2) rules promulgated by the State Board of Health; 3) needs identified and funded by the U.S. Congress and federal agencies; 4) needs identified locally; and 5) other programs funded from a variety of sources for specific health problems in local communities.

In addition, the County's Health Officer has statutory powers to provide necessary health services needed in the event of an emergency.

The public health system is not only mandated by statute, but is also wanted by constituents. While many people do not know about the functions of a public health agency, when informed, they are highly supportive of public health programs and activities and view them as essential. Basically, people want to know that their water and food are safe, that disease outbreaks will be contained quickly, that emergency medical services (Medic One) will be available when needed (Harris Poll, 1997).

In contrast to medical care that helps one individual at a time, the public health system helps entire communities. This "population-based" approach reaches large groups of people by proactively preventing health problems and by promoting health and wellness. This public health approach is a major contributor to most of the 30-year gain in average life expectancy the United States achieved during this century (Centers for Disease Control, 1993).

This system's role is to protect communities from harmful conditions and to promote health behaviors and actions. Public Health uses a collaborative approach with communities in the region, consulting constituents to establish priorities, design programs, implement interventions, and evaluate effectiveness. Clearly, a strong public health system is essential in order to assure the health of the public, and the local public health department is a key part of the overall public health system which includes local, state, and federal agencies as well as their private partners.

To carry out this responsibility, Public Health - Seattle & King County's scope of work is necessarily broad; and during the next five years, Public Health will need to move beyond the status quo of service provision to improve the health status of all King County residents. Funding will need to be obtained to address several priority issues including the increasing rates of chronic disease as the population ages, controlling infectious disease, assuring health care for low-income people, and promoting health behaviors and actions that establish and sustain a lifetime of excellent health and wellness for the residents of King County.

"Prevention" is a central theme in most public health interventions and is a cost-effective strategy, not only for the public health system, but the entire health system. Public Health utilizes the Determinants of Health Model to develop and implement policies and program aimed at assuring the public's health. This model identifies behaviors, and health actions. Public Health seeks to address these factors in order to prevent illness, injury, and premature death as well as to promote excellent health and wellness.

Prevention strategies can be viewed as primary secondary, or tertiary. Primary prevention promotes health by eliminating the causes of illness or injury. Examples of primary prevention activities include programs that prevent young persons from starting to smoke, that promote exercise and healthy eating, and that provide immunization against infectious diseases.

Secondary prevention activities resolve health problems early, before serious consequences result. Examples of these activities include detecting and treating persons with early tuberculosis before it causes lung disease, getting smokers to quit before they get emphysema, and treating people with high blood pressure to prevent strokes and heart disease.

Tertiary prevention involves amelioration of serious consequences of disease, such as treating persons who have had heart attacks, cancer, or advanced tuberculosis to prevent further progression of disease. Tertiary prevention is largely the responsibility of the larger health care system, but, even with tertiary prevention, public health has an important role, particularly in assuring that everyone has access to advanced health care.

Primary prevention activities are the ideal and are the most cost-effective for public health and the larger health system, because they address the problem before it starts and before expensive treatment is needed. Secondary prevention also can be a cost-effective strategy for some health problems and is often very closely linked to primary prevention. For example, treating persons with early tuberculosis (secondary prevention) protects other persons in the community from getting infected (primary prevention).

Another key public health activity involves assessment and surveillance of the community's health status. The purpose of assessment is to understand the unique health status of the community through monitoring risk factors, and health outcomes of the community and other determinants of health in order to identify goals and set priorities. Surveillance is somewhat like detective work in which public health staff monitor the community's health status in order

to identify issues that require public health action.

In addition, Public Health is charged with protecting the public from health threats and assuring that low-income, under-insured, uninsured, and/or high-risk people receive needed health care services. Protecting the public from health threats involves a variety of activities including respondother agencies providing safety net services. At some sites, Public Health provides direct medical and dental services for people needing them. At other sites, Public Health provides only the "wrap-around" services, for example, interpretation, public health nursing, or family planning.

In 1993, the Washington State Legislature created the Public health Improvement Plan (PHIP), which set direction and provided resources to improve the state's public health system. The PHIP focuses on the core functions of public health (assessment, policy development, and assurance) with the goal of assuring that public health's basic mission "health people and health communities" is met across Washington State.

Public Health - Seattle & King County is guided by its own Guiding Principles (next page). These principles, developed in early 1999) outline strategies for improved public health practice over the next five years, and inherently complement the PHIP's focus on core public health functions.

Guiding Principles for Public Health - Seattle & King County

Mission: To achieve and sustain healthy people and healthy communities throughout King County by providing public health services which promote health and prevent disease.

Improved Public Health Practice

1. Elimination of inequalities in health associated with socio-economic status, race/ethnicity, gender and sexual orientation.	Public Health's priority is to promote health and prevent disease among populations who experience economic marginalization and/or discrimination.
2. Science and data-informed practice.	Strive to use data to make program, policy, and budget decisions and prioritize activities; strengthen our research-based capacity.
3. Accountability in public health practice.	Practice evidence-based public health driven by outcomes. Maintain and monitor an active and changing list of public health practice outcomes. Track issues via a newly established public health practitioner's group.
4. Strengthen community partnerships. .	Power and decision-making shared with the community for both defining priorities for public health policies and for planning, implementing, and evaluating health improvements

Improved Business Practice

1. Integrate departmental and cross-departmental programs and services to leverage resources and achieve efficiencies.	Continuously examine cross-departmental, divisional, and regional opportunities to share information, resources and people.
2. Increase organizational clarity. Clearly define roles and responsibilities at all levels of the department.	Ensure every employee understands their contribution to the accomplishment of the Public Health mission.
3. Streamline business approaches and processes using technology.	With impetus from the implementation of a new management information system and a focus on business planning, improve and standardize business policy and practices.
4. Diminish bureaucracy: challenge traditional ways of doing business.	Consistently examine process and product with the intent to increase efficiency, effectiveness and innovation.
5. Accountability in business operations.	Formally identify annual departmental outcomes and measures necessary to accomplish the department's mission. Monitor monthly and amend as needed. Pay rigorous attention to revenue forecasting and budget management.
6. Diversity: departmental support for an environment that promotes employee development and values the diversity of their skills, expertise, experience, opinions and beliefs.	Consistently follow the Department's standards of conduct statement: continual and active implementation of policies and programs to support diversity and employee training and development.
7. Increase and improve communications to employees as well as external customers regarding Public Health's role/ responsibilities and public health programs, activities, issues, and challenges.	Identify opportunities and strategies for effective communication, update a plan for public health communications, and implement it.

APPENDIX VIII
HEALTH PLAN VIABILITY

Health Plan Viability

One of the goals of the King County Health Action Plan is to demonstrate the positive outcomes from public health and managed care integration, so it is important to highlight the situation of regional health plans. Financial data are presented first for the twenty largest health plans in Washington. Information on public health care programs and their enrollment in health plans follows. A discussion of the deterioration, and in many places disappearance, of the individual health insurance market comes next. At the end of the appendix, data are reported on King County health plans' performance in delivering specific preventive services.

Financial Data

Washington health plans do not report enrollment by county, so it is difficult to determine the twenty health plans with the largest King County enrollment. Therefore, this section will provide financial information at the Washington State level. In 1997, health maintenance organizations (HMOs) covered 17% of the total Washington population. This is lower than the national rate of HMO coverage (27%), because much of our state's managed care enrollment is in Health Care Service Contractors (HCSCs).[1] Dramatic growth in HMO enrollment was expected by many in the mid-1990s, after the 1993 health reform bill mandated health care coverage. However, much of the act was repealed between 1994 and 1996, and there was not a large scale HMO conversion from PPOs and indemnity coverage. Although Boeing used incentives to increase HMO enrollment of its employees from 10% to 50% in 1996, few other employers have implemented this approach.

The largest twenty Washington health plans in 1998 (by enrollment[2]), from largest to smallest, were:

1. Regence BlueShield
2. Premera Blue Cross
3. Group Health Cooperative
4. United Healthcare
5. Cigna Health Care
6. Qualmed Washington Health Plan Inc.
7. Aetna U.S. Healthcare of Washington
8. Northwest Washington Medical Bureau
9. Aetna Life & Casualty
10. PacifiCare of Washington
11. Premera Health Plus
12. Kaiser Permanente
13. Kitsap Physicians Service
14. Virginia Mason-Group Health Alliance
15. Mutual of Omaha Insurance Co.
16. Options Health Care Inc.
17. First Choice Health Plan
18. Aetna U.S. Healthcare Inc.
19. Regence Blue Cross Blue Shield of OR
20. Providence Health Plan

Most Washington State health plans are facing financial difficulties, including recent operating losses, negative net incomes, and reductions in net worth. For instance, nine of the ten largest Washington health plans reported an operating loss in 1997, based on premium income without including investment income.[3] Six of these plans experienced 1997 net losses even after considering investment income. Likewise, ten of the top 20 plans reported net

losses after investment incomes are included. The 1997 growth in premiums for all plans was 8.9% in 1997, or 3.7% increase in premium income per enrollee. This increase in premium income per enrollee exceeded the 2.6% increase in claims incurred by enrollee, and therefore the loss ratio dropped slightly from 92.4% to 92.2%.[4] This trend is a slight improvement in financial performance, but is too small to have a significant impact. Overall net income declined dramatically in 1997, from over $29 million positive net income in 1996 to almost $116 million negative net income in 1997. Much of this decline in net income can be explained by the sizeable losses incurred by PacifiCare and Group Health Northwest.[5]

The amount of net losses that can be sustained over time is determined in large part by the net worth of the health plan. Overall net worth of Washington plans dropped in 1997, and five of the top 20 plans lacked sufficient net worth to sustain the same net losses in 1998 without additional capital. Impaired net worth, defined as less than three times the last year's net loss, can lead to financial insolvency (such as the collapse of Unified Physicians of Washington in 1997 and Kitsap Physician Service in 1999). The following health plans reported impaired net worth in 1997: PacifiCare, Group Health Northwest, Health Plus, Good Health Plan of Washington, Kitsap Physicians Service, Providence Health Plans, and Aetna U.S. Healthcare. In fact, four of these seven plans (Good Health Plan, Kitsap Physicians Service, Group Health Northwest, and Providence Health Plans) have gone out of business since 1997.

In the aftermath of mergers, three health plans dominate the Pacific Northwest: Premera Health Plans, Regence Group, and Kaiser/Group Health. Regence BlueShield alone accounts for almost half of the total net worth for all plans, while two other plans (Group Health Cooperative and Blue Cross of Washington and their affiliated plans) account for another 25% each of the total net worth. The significant market share of these three health plans allows them to drive the market, strengthen bargaining positions with providers, and lower operational overhead expenses. The remaining 25% of the Washington health plan market is shared by 15 smaller plans. It is noteworthy that Community Health Plan of Washington has solidified its position as a major source of coverage for Healthy Options Medicaid and Basic Health Plan enrollees, and has experienced several years of growth and financial stability.

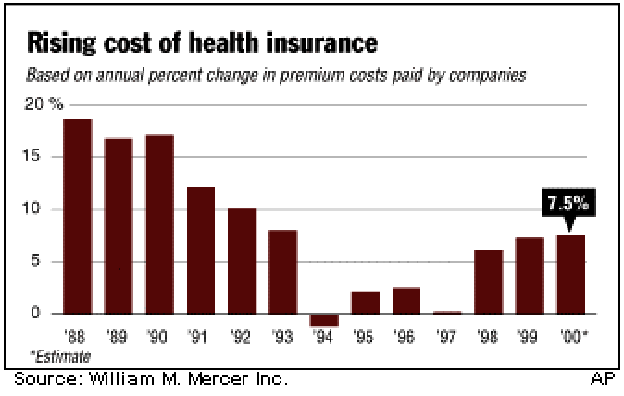
In order to address the imbalance between income and expenses, health plans must improve the bottom line to survive. Rate increases may result. Purchasers may reduce benefits to offset rate increases and health plans may reduce administrative expenses. These corrective actions by the private sector may result in public anger and renewed calls for government solutions to health care. At the national and local levels, most health care consumers can be divided into one of two basic categories: heavy utilizers and light utilizers. The heavy utilizers only account for less than 25% of the enrollees, but are responsible for as much as 80% of the costs. Heavy utilizers are therefore more concerned with and affected by reductions in choice of providers or comprehensiveness of coverage. Alternatively,

light utilizers account for over 75% of the enrollees, and they are often most concerned with increased costs for insurance plans that they only occasionally use. [6]

National Cost Trends

Nationally, health insurance costs have started to rise fairly rapidly in the last two years after a period of little growth. A recent William M. Mercer document reported in the Seattle Post-Intelligencer shows that employers paid 7.3% more for health insurance in 1999 compared to 1998.[7] This rate is three times the rise in general inflation.

Chart 1.



Public Programs

Over one million Washington health plan enrollees are in public programs, and they account for 30% of total enrollees. The revenue from the four major public programs (Medicare managed care, Medicaid managed care, Basic Health Plan, and Public Employees Benefit Board) is over one-third of total health plan revenues and expenses. By Spring 1998, 25% of Washington Medicare enrollees were covered by Medicare managed care, compared to only 16% of Medicare enrollees at the national level. In fact, Medicare premiums account for almost 25% of health care revenues for Washington health plans. Similarly, the percent of Washington's Medicaid population covered by managed care (61% in 1998) is higher than the national rate (48%). The future of some public programs is uncertain, but they account for a large percentage of the total healthcare revenue. The Basic Health Plan (BHP) and the Public Employees Benefits Board (PEBB) face revenue shortfalls, and some Washington health plans have dropped their participation in the Basic Health Plan, Medicaid Healthy Options, and Medicare risk program.

For public programs, data is available on enrollment by county. In King County, there were 203,075 Medicare participants in March 1998, and 64,231 of them were enrolled in Medicare managed care plans (32%).[8] There were 148,225 Medicaid participants in King County in March 1998, and 81,132 of them were enrolled in Medicaid managed care plans (55%).[9] There were over 55,000 Basic Health Plan enrollees in King County in May 1998, and over 77,000 PEBB enrollees in King County in April 1998. [10]

Individual Market in Jeopardy

Washington health plans have faced particular financial difficulties in the individual market, and only three counties offer more than one individual market plan.[11] The costs of plans in the individual market increased after the 1993 insurance reforms, including portability, guaranteed issue, limits on pre-existing condition prohibitions to three months, and mandated

benefits. The state has also limited the ability of health plans to raise premiums. The largest three insurers in the state (Regence BlueShield, Premera Blue Cross, and Group Health) have all stopped accepting new applications for individual policies in the past year, and there are no new individual policies available in King County. In response, the Insurance Commissioner recently opened the state's high-risk pool to individuals who cannot buy individual insurance elsewhere.[12] This high-risk pool is 50% more expensive than the average rate for small group plans, and this strategy is considered by many as a short-term solution to a growing crisis in the local insurance market.

Delivery of Preventive Services

The King County Health Action Plan requested that health plans operating in King County submit Health Plan Employer Data Information Set (HEDIS) data for their King County enrollees for three preventive services. HEDIS data requests with detailed specifications were sent to eight health plans operating in King County in 1998 and 1999 for data from the prior year. Three HEDIS effectiveness measures related to preventive services were requested:

- Childhood immunizations,
- Prenatal care during the first trimester, and
- Eye exams for people with diabetes.

In the future more extensive HEDIS measures will be available in the areas of asthma and diabetes, and may be collected by the Action Plan.

Six health plans submitted data each year. 1997 data were submitted by:

- Community Health Plan of Washington
- Group Health Cooperative
- NYLCare/Aetna
- PacifiCare
- Premera Blue Cross
- Virginia Mason Health Plan/Aetna

1998 data were submitted by:

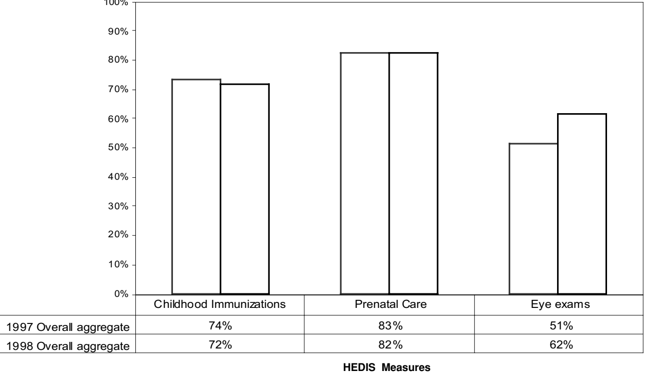
- Alliant Health Plan
- Community Health Plan of Washington
- Group Health Cooperative
- PacifiCare
- QualMed
- Regence BlueShield

Results are reported in aggregate for all the health plans. Aggregate figures are weighted averages of individual health plan data. Data were weighted by overall health plan enrollment in 1997 and by specific population enrollment in 1998. Results representing fewer than 30 enrollees were dropped.

The first figure shows the health plans' rates of completely immunized two-year-olds, pregnant women receiving prenatal care beginning in the first trimester, and diabetes patients receiving annual eye exams.

Approximately three out of four children were reported as fully immunized. Over four

Figure 1.
King County HEDIS Data, 1997 and 1998

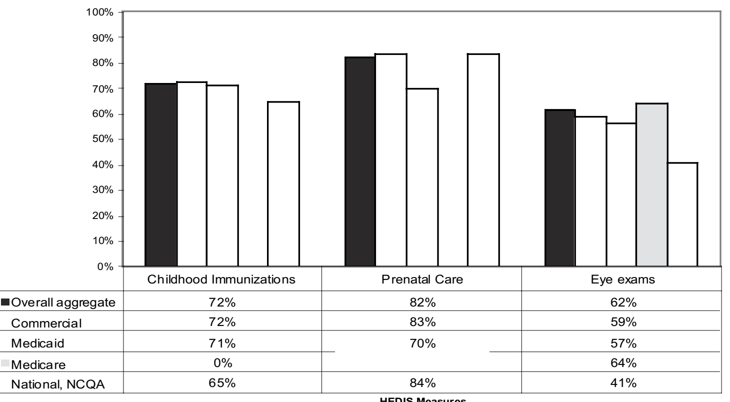


	Childhood Immunizations	Prenatal Care	Eye exams
1997 Overall aggregate	74%	83%	51%
1998 Overall aggregate	72%	82%	62%

out of five pregnant women received early prenatal care. Over half of diabetes patients received eye exams in 1997, rising to three out of five in 1998.

The second figure shows the rates for different payers: commercial, Medicaid and Medicare. These results are also compared with the National Committee on Quality Assurance's national HEDIS figures reported in Quality Compass for 1998. King County health plans show better than national results for childhood immunizations and eye exams for diabetes, and very close to national results for prenatal care. Commercially insured enrollees had higher rates of preventive services than Medicaid enrollees. For eye exams for diabetes, Medicare enrollees had the highest rates at 64%, considerably higher than the national average of 41%.

Figure 2.
King County HEDIS Data by Payer and Compared to National Data, 1998

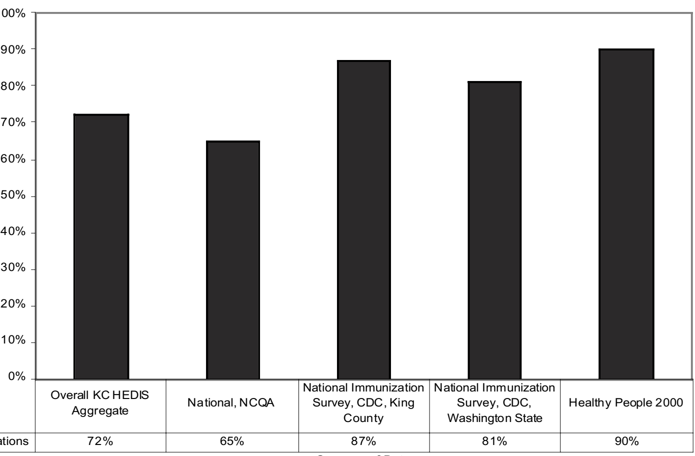


	Childhood Immunizations	Prenatal Care	Eye exams
Overall aggregate	72%	82%	62%
Commercial	72%	83%	59%
Medicaid	71%	70%	57%
Medicare	0%		64%
National, NCQA	65%	84%	41%

Note: The 0%'s above in the Medicare cells indicate that the cell is not applicable to Medicare. No data were submitted for those categories.

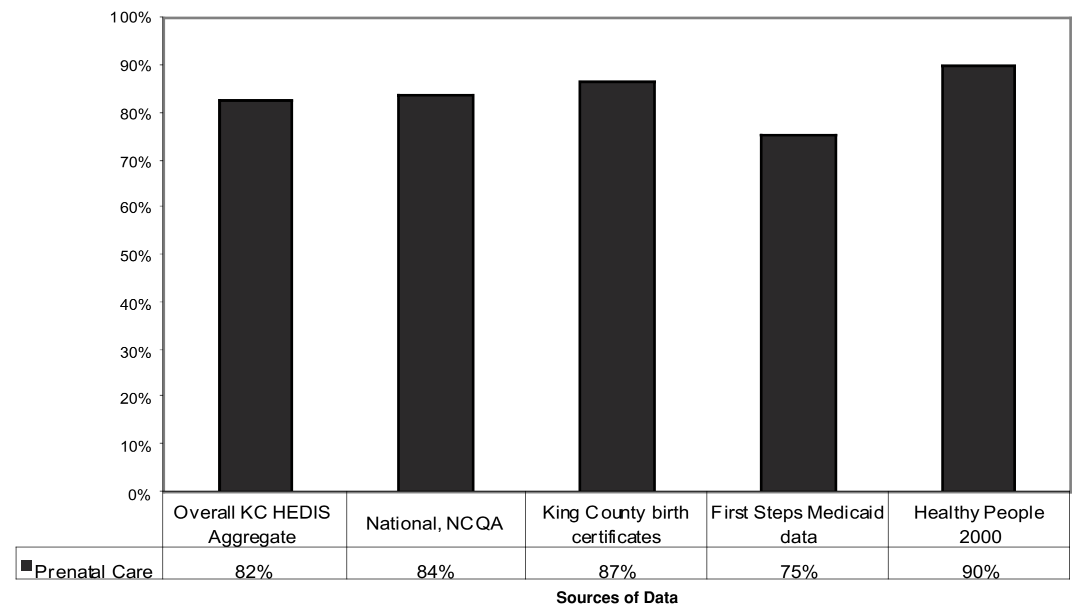
The next three figures show the HEDIS results for each service compared to other data sources and compared to Healthy People 2000 goals. In Figure 3, the local and national HEDIS immunization rates are lower than other sources of data. This finding is probably due to various data issues rather than lower actual rates of immunization. For example, HEDIS has more stringent documentation requirements than the other surveys, and may therefore undercount fully immunized children. Also HEDIS considers "fully immunized" to be four DTP, three polio, one measles, mumps and rubella; two hepatitis B; and 2 Hib; while the reported National Immunizations Survey numbers do not include the hepatitis and Hib vaccines. Finally, the HEDIS rates are based on a sample of chart reviews and the NIS rates are based on household surveys augmented by some provider information.

Figure 3.
HEDIS and Other Data Sources for Childhood Immunization, 1998



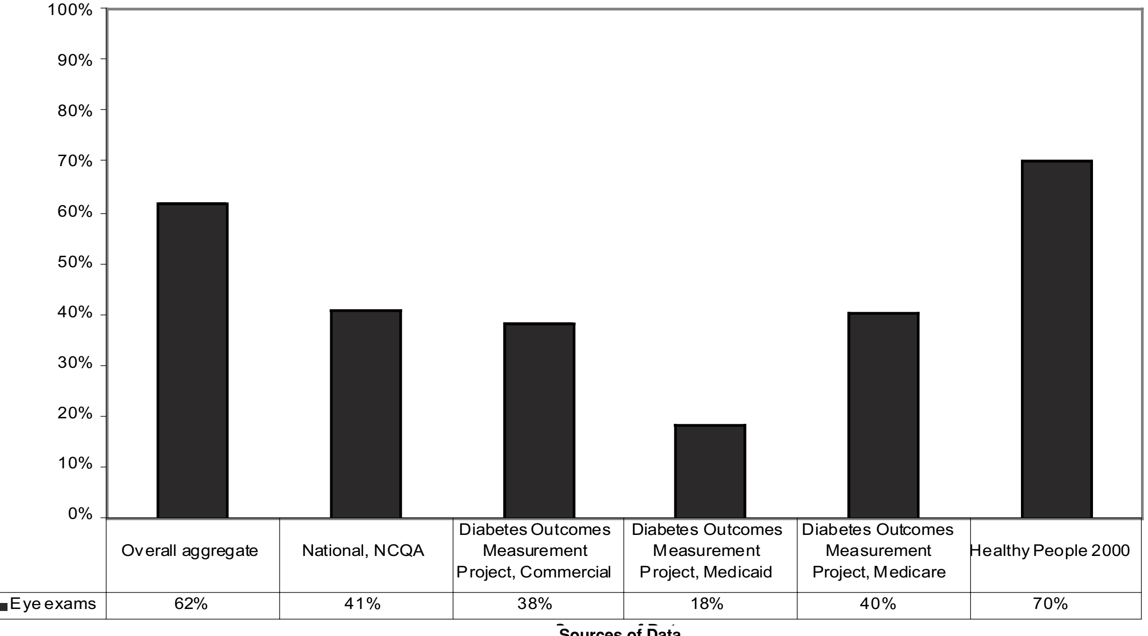
	Overall KC HEDIS Aggregate	National, NCQA	National Immunization Survey, CDC, King County	National Immunization Survey, CDC, Washington State	Healthy People 2000
Childhood Immunizations	72%	65%	87%	81%	90%

Figure 4.



	Overall KC HEDIS Aggregate	National, NCQA	King County birth certificates	First Steps Medicaid data	Healthy People 2000
Prenatal Care	82%	84%	87%	75%	90%

Figure 5.



	Overall aggregate	National, NCQA	Diabetes Outcomes Measurement Project, Commercial	Diabetes Outcomes Measurement Project, Medicaid	Diabetes Outcomes Measurement Project, Medicare	Healthy People 2000
Eye exams	62%	41%	38%	18%	40%	70%

[1] Washington State Hospital Association. *Profile of Washington State Health Plans*. Fall, 1998: 16.
[2] From Puget Sound Business Journal's 1998-1999 Book of Lists. Release date: January 26, 1999.
[3] 1997 is the most recent year that complete data was available at the time of this report, but more recent data continues this trend.
[4] Washington State Hospital Association. page 5.
[5] Ibid, page 5.
[6] Ibid, page 3.
[7] Seattle Post-Intelligencer, "Employers absorb health cost crunch," Phil Galewitz, December 14, 1999.
[8] Source: *Health Care Financing Administration, Medicare Division*
[9] Source: *DSHS, Office of Information Services and Medical Assistance Administration*
[10] Source: *State of Washington Health Care Authority*
[11] Ramsey, B. "State's Health Insurance Crisis Deepens." *Seattle Post-Intelligencer.* September 1, 1999: A1.
[12] Gavin, R. and Galloway, A. "State Moves to Assist Uninsured Individuals." *Seattle Post-Intelligencer* September 2: A1, A13.

APPENDIX IX

DIABETES

Diabetes

Non-infectious diseases are emerging as the major causes of morbidity and mortality in the United States and throughout the developed world.[1] The traditional 'acute disease model' was developed to combat infectious diseases[2], and new population-based public health approaches need to be developed and implemented to effectively prevent and manage chronic diseases. Chronic diseases are emerging as the major cause of morbidity and mortality in the context of new economic considerations in healthcare decisions and the emergence of managed care organizations. Two chronic illnesses, asthma and diabetes mellitus, are often chosen as 'model diseases' to illustrate the problems of dealing with chronic illnesses in the new economic and structural health systems.[3] This section explores the prevalence and nature of these chronic diseases in King County, considers the costs (to health outcomes and financial cost), and identifies promising paths for improvement. Additional information on diabetes in King County is available in the Public Health - Seattle & King County November 1999 *Data Watch.*

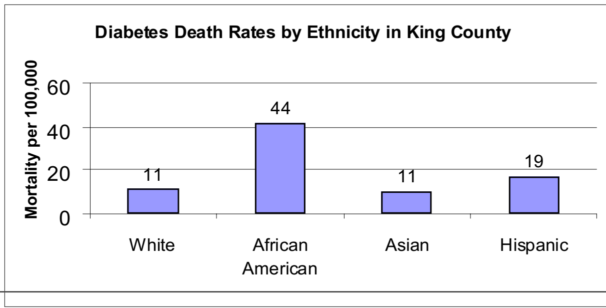
Problem Indicators

Diabetes mellitus is a chronic condition characterized by an inability to produce and/or utilize the hormone insulin, which plays a central role in the metabolism of sugar in the blood stream.[4] Diabetes affects over 14 million Americans, although as many as half of the cases remain undiagnosed. Ten percent of diabetics have insulin dependent diabetes mellitus (IDDM), and ninety percent have non-insulin dependent diabetes mellitus (NIDDM), characterized by ineffective utilization of insulin. Thus NIDDM is the more prevalent type, and affects approximately 10% of the elderly population.[5] In Washington, about 160,000 people are diagnosed with diabetes, and an equal number probably have diabetes but are undiagnosed.[6] In 1996, diabetes ranked as the seventh most common cause of death in King County (behind heart disease, cancer, and stroke).[7]

At both the national and King County levels, the prevalence of diabetes differs among racial subpopulations. Approximately 6.1% of all Americans have diabetes, with higher rates among African Americans (8.3%), Hispanics (5.1%) and Native Americans (15%).[8] In King County, the overall diabetes mortality rate has risen 25% during the past decade, and diabetes deaths among African Americans have risen over 50% in this period.[9] The King County diabetes mortality rate for African Americans is four times the white rate, and the Native American rate is twice that of the total county population.[10] Thus the worsening trend in King County for diabetes incidence and mortality disproportionately affects vulnerable residents.

Known risk factors for diabetes include: family history of diabetes, obesity, high-fat diet, smoking, and inadequate exercise. Most of these risk factors are preventable. Although incurable, diabetes is a potentially preventable or at least manageable chronic condition.

Figure 1.
Diabetes Death Rates by Ethnicity in King County



Source: The Health of King County, Public Health-Seattle of King County, 1998

Impact of Problem Indicators

Diabetes has a significant negative impact on quality of life, including acute and long-term health complications and a difficult regimen to manage the disease. The health impacts include effects on kidney function, eyesight, cardiovascular function, and extremity disease. In addition to being the fourth leading cause of death by disease, diabetes is the leading cause of new cases of blindness in the adult population (in 0.15% to 0.30% of diagnosed cases annually) and is the leading cause of non-traumatic amputations (in 0.675% of diagnosed cases annually).[11] Diabetic kidney disease is also the leading cause of new dialytic cases. Diabetes damages large blood vessels, and results in 3 to 4 times the normal rate of coronary heart disease and stroke among diabetics. The regimen required to manage the disease also impacts quality of life, and includes strict diet, exercise, weight control, and medications or injections of insulin.

Diabetes is one of the most costly diseases in the country.[12] It is estimated that the national medical cost of diabetes is $92 billion annually, with an additional $46 billion in indirect costs from lost productivity. Combining these figures, the average total cost per diagnosed person is over $17,000 per year.[13]

Effective control of blood sugar can often prevent or delay long-term complications[14], and early management of existing complications can slow the progression of the disease.[15] Empirical research has demonstrated that controlling blood sugar to maintain near-normal levels can reduce complications by 25% to 50% for patients with Types I or II diabetes.[16] Two primary public health approaches may reduce diabetes-related complications: diabetes self-management education and better organization of health care services for diabetics that emphasize population-based management. The patient self-management required to maintain near-normal blood sugar levels can be best achieved with the support of outreach workers, health education professionals or nurse managers collaborating with primary care physicians and specialists.[17] However, only 35% of diabetics nationally have participated in an educational class or program.[18] Most diabetics receive treatment for and information about diabetes from their primary provider.[19] A public health, population-based approach to diabetes management is needed to guarantee delivery of a consistent set of services, including monitoring and control of blood sugar and pressure, cardiovascular risk factor screening, annual eye exams and kidney evaluations, foot exams, and ongoing patient education.[20]

We have identified several efforts to improve the access to and adequacy of interventions for diabetics in King County.

Promising Paths for Improvement

Although diabetes is a debilitating condition for many people, the Action Plan members focused on the poor outcomes among African Americans with the condition. Projects targeting African Americans with diabetes were funded in the first year of the Community Benefits program, including the Community Diabetes Initiative and the African American Elders Project.

Three programs to improve diabetes among African Americans in King County:

1. Community Diabetes Initiative: This comprehensive clinical improvement approach is a collaborative project implemented by community and Public Health clinics in King County. The goal of the initiative is to achieve measurable health outcomes among low-income King County residents by implementing a model of care for people with diabetes in collaboration with the Institute for Health Care Improvement[21] and the Robert Wood Johnson Foundation.[22] The project adopts and implements an organizational approach that is population-based, and "…creates practical, supportive, evidence-based interactions between an informed, activated patient and a prepared, proactive practice team."[23] The objectives of the program are to:

- Identify the diabetic population and proactively manage diabetics using a patient database,
- Reduce cardiovascular risks,
- Modify adverse consequences of microvascular risks,
- Achieve glycemic control, and
- Teach and support patient self-management techniques.

These objectives are implemented by a collaborative team of community and Public Health clinics, a steering committee representing the clinics, the informational support provided by the Institute of Healthcare Improvement's learning sessions and final conference, and the state Department of Health's audit and computer programming assistance to create the core patient registry.

2. African American Elders Project: This program provides interdepartmental social and health services to isolated African American elders in the area. The African American Elders Project was initiated in July 1997 under the leadership of former Mayor Norm Rice, and enrolled 140 isolated King County African American elders in the first 18 months. The target population is African Americans over age 60 who need help with basic services in eight target zip codes primarily in the Central region of Seattle. This area has the highest diabetes-related mortality and hospitalization rates in King County.

The project involves customized services provided by donated staff from three City agencies: Aging and Disability Services, Senior Services, and Public Health - Seattle & King County. A case manager, an outreach worker, and a half-time public health nurse are working at full capacity with the current caseload, and it is felt that there is a need for additional resources to serve more African American seniors. A broad array of services are provided, from health assessment, health education, health care services, meals on wheels, nutrition information, chore services, and counseling to transportation, food stamps, home repairs, financial assistance, and financial management.

3. Diabetes Outcomes Measurement Project: This project gathers standardized information on the quality of health care for people with diabetes in Washington State across multiple health systems. Health systems can use this information to improve quality of care for people with diabetes, and in the future consumers and health care purchasers will be able to request information to evaluate and compare health systems. The project has been led collaboratively by public and private groups, including the Washington State Department of Health (DOH), PRO-West, and the Foundation for Health Care Quality. It is directed by the Diabetes Outcomes Measurement Task Force[24] , established in 1996 by the DOH's Diabetes Control Program.

PRO-West and the Diabetes Control Program collaborated on study design, and PRO-West was responsible for data collection and analysis. Health plans provided a list of enrollees with diabetes, and at least 250 randomly selected enrollees from each plan were surveyed. In addition, health plan data and medical records of the selected enrollees were examined. The project selected the following 13 quality of care indicators for measurement: provider visits, dilated eye exam, foot exam, blood pressure, kidney function testing, glycosylated hemoglobin, blood lipid levels, diabetes education, smoking and cessation counseling, daily aspirin use, coping with disease, and maintaining daily activities. The participating health plans receive their own data, but must agree not to release the data to the public or to use the data for marketing purposes. A health plan may release its data to certain health purchasers with which it contracts. The data will be used to design and test different formats for consumer and purchaser reports on quality of care by conducting cognitive interviews and focus groups that compare report formats.

As of April 1999, the Diabetes Outcomes Measurement Task Force is developing a systems approach to improving care for people with diabetes. The intervention focuses on increasing population-based care to ensure the delivery of routine preventive care, and to improve quality of care in a cost-effective manner through partnerships and collaborations using evidence-based practices.

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[1] McGinnis J., Foege, W. "Actual Causes of Death in the United States." *JAMA* 270 (1993): 2207-2212.

[2] Larson, E. "A Retrospective on Infection Control. Part 2: Twentieth Century- The Flame Still Burns." *American Journal of Infectious Control* 25 (1997) 340-349.

[3] Vinicor, F. "Diabetes Mellitus and Asthma: 'Twin' Challenges for Public Health and Managed Care Systems." *American Journal of Preventive Medicine* 14(35) 1998: 87-91.

[4] ICD-9 code 250.

[5] Greenfield, Sheldon et. al. "Measuring Health Care Quality: Diabetes." The Primary Outcomes Research Institute at New England Medical Center. In *Diabetes Discussion Papers*. Foundation for Accountability (FACCT): 1996.

[6] The Health of Washington State: A statewide assessment of health status, health risks, and health systems. Washington State Department of Health. September, 1996: 5.47-5.51.

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[19] Ibid

[20] Diabetes Care, January 1995. 18(1): 177-186.

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[22] Robert Wood Johnson Foundation national program *Improving Chronic Illness Care*.

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APPENDIX X
CHILDHOOD IMMUNIZATIONS

Childhood Immunizations

A century ago, infectious diseases were a major cause of morbidity and mortality for children in the United States. Since 1900, strategic vaccination campaigns have greatly reduced or eliminated many diseases that were once common, including smallpox, diphtheria, tetanus, poliomyelitis, measles, mumps, rubella, and *Haemophilus influenzae* type b meningitis.[1] The national effort to promote childhood immunizations began with the appropriation of federal funds for polio vaccinations after introduction of the vaccine in 1955. Since that time, the vaccine-delivery system has been a collaborative effort of federal, state, and local governments and public and private health care providers.

Although vaccines are one of the greatest achievements in the control of infectious disease in the twentieth century, the U.S. vaccine-delivery system faces significant challenges. The recommended immunization schedule has become increasingly complex, with the 11,000 children born each day in the United States each needing up to 16 doses of vaccine by age 18 months to be protected against 10 childhood diseases.[2] These immunizations are for the following diseases using various combinations of vaccine: diptheria, tetanus, and pertussis (DTaP vaccine), poliomyelitis (polio vaccine); measles, mumps, and rubella (MMR); *Haemophilus influenzae* type b (Hib), hepatitus B, and varicella (chickenpox).

Overall, the U.S. immunization completion coverage rate is at record high levels. In 1997, completion rates among children 19-35 months of age exceeded 90% for three or more doses of diptheria and tetanus toxoids and pertussis vaccine (DTP), three or more doses of poliovirus vaccine, one or more doses of measles-containing vaccine, and three or more doses of Hib vaccine.[3]

In Washington State, the immunization law requires that all children be fully immunized at school entry. A two-year-old child is considered current for the recommended basic immunizations if the child has had four DTP or DTaP doses, three polio, one MMR, one age appropriate series of Hib vaccine, and three hepatitus B immunizations.

The National Immunization Survey conducted by CDC estimated the vaccination coverage rates with the 4:3:1 series[4] and the 4:3:1:3 series[5] among children aged 19 to 35 months for 1998.[6] In King County, these 1998 rates were 87% and 86% respectively, the second highest urban area in the United States. This is higher than the 1996 rates for Washington State (81% and 81% respectively) and for the United States (81% and 79% respectively).

Promising Paths for Improvement

CHILD Profile: Immunization Registry and Tracking System

CHILD Profile is Washington State's health promotion and immunization tracking registry designed to help ensure that children receive needed preventive health services. CHILD Profile, which began in January 1993, is a jointly managed and operated by Public Health - Seattle & King County and Snohomish Health District, in collaboration with the WA Department of Health. Funding for CHILD Profile is provided by the WA Department of Health, DSHS Medicaid, and the Robert Wood Johnson Foundation. There is also a partnership with Health Information Institute (HII), a private corporation that has the primary responsibility for marketing to private providers and developing an Internet interface to the system (CHILD web). Fifty private provider organizations and Public Health clinics enter immunization information into this registry, and private providers pay a small subscription fee to use the service. CHILD Profile is a public-private partnership, and private health care providers, health plans, and public health agencies all share in the cost.

CHILD Profile has two main features:

1. A computerized, population-based registry enables providers to enter the record of each immunization a child receives, and allows current and subsequent providers to determine whether or not a child has received all of their immunizations. This will increase the probability that all children born in King and Snohomish Counties will receive their recommended immunizations on schedule, and will decrease the probability that immunizations will be unnecessarily duplicated due to a lack of current immunization history. Currently, approximately 30% of children in King County have their immunization records in this registry, and the goal is that the immunization information for all children residing in King County will be stored in this common database.
2. Health promotion is achieved by using birth certificates to send all parents of newborns in King County with a colorful growth chart and a schedule of the recommended ages for well-child checkups and immunizations. Reminder letters are also mailed at appropriate times to alert parents to the need for checkups and immunizations. The materials include information on child safety and development information, as well as child health and immunizations.

Vaccine Distribution Program

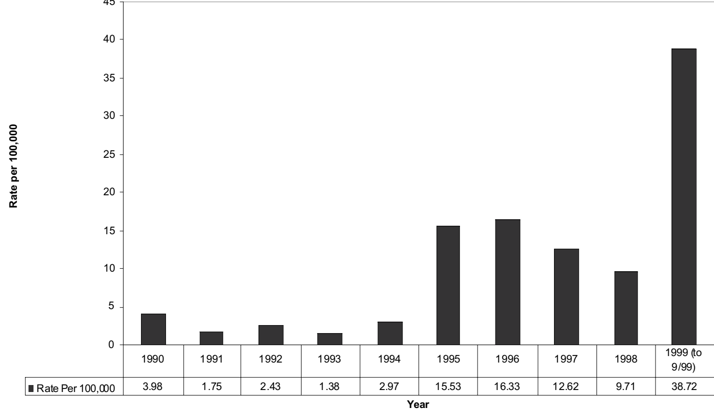
Vaccines for Children (VFC) is a federal program that provides childhood vaccines to states for residents that meet the eligibility criteria: Medicaid, uninsured, underinsured, and Native Americans. The Washington legislature has added funds to enhance this program, providing childhood immunizations for all residents. The WA Department of Health provides the childhood vaccines to county departments of public health, and the county provides them to local private providers. Private providers cannot charge families for the vaccines, but are allowed to charge a small administrative fee. This program provides

vaccines to all Washington residents at reasonable costs. In King County, 260 medical organizations (95%) participate in the VFC program.

Pertussis (Whooping Cough)

One troubling trend is the recent increase of pertussis (whooping cough) in Washington State. Pertussis is an acute bacterial upper respiratory infection caused by *Bordetella pertussis*. A pertussis vaccine was developed in the 1940's. Following the introduction of the vaccine, the incidence of pertussis decreased dramatically over several decades to a low of just over 1,000 cases nationally in 1976. However, the number of reported cases of pertussis began to rise during the 1990s. In 1995, Public Health - Seattle & King County observed that the rate of pertussis jumped from 2-4 cases per 100,000 to over 15 cases per 100,000, and this increased rate continued through 1998.[7] An outbreak in school-aged children has resulted in an even higher rate of over 38 per 100,000 through September, 1999.

Figure 1.
Pertussis in King County,
Cases per 100,000 Residents



Source: Public Health – Seattle & King County. Communicable Disease Epidemiology, 9/30/1999.

Through more intensive investigation of reported cases begun in 1995, Public Health - Seattle & King County has often found many other people with cough illnesses in the homes and social groups of each confirmed case. In fact, 75% of the identified linked cases were school-age children and adults. Likewise, identified sources of infant pertussis were linked to school-age children and adults approximately 80% of the time.[8] Pertussis has traditionally been perceived by health care providers and the community as a disease of children under five, but previously immunized older children and adults are at risk due to waning immunity over time after both immunization and natural disease. Pertussis immunizations are given to infants and young children because they are most likely to become seriously ill and require hospitalization if they contract the disease. Very young infants are at the highest risk for developing related complications. The most common cause of pertussis-related death is secondary bacterial pneumonia.[9] Neurological complications, including seizures and encephalopathy, are also more common among infants. A new type of "acellular" vaccine (DTaP) which has fewer side-effects than the old DTP vaccine is now available for all five of the pertussis immunizations that children receive before age seven.

It is probable that many undetected cases of pertussis occur among older children and adults. Many physicians are unaware that adults can develop pertussis, so it may be misdiagnosed and remain untreated, allowing further spread in the community. Studies of adults with prolonged cough find serologic evidence of recent pertussis infection in 12 to 20% of cases.[10, 11]

Since there is no vaccine licensed for use after the seventh birthday, provider education is important in reducing pertussis in adults and older children. Confirmed cases as well as all members of their households should receive prompt antibiotic therapy, because the attack rate (the percentage of people who contract the disease) in the household of a person with pertussis is over 80%. Even suspected cases can be treated based on clinical symptoms. Persons who are treated with antibiotics remain contagious until after the first five days of treatment are completed. In a 1997 joint endeavour, the Centers for Disease Control, University of Washington School of Medicine and the Washington State Department of Health published an educational pamphlet, titled "Pertussis—What Washington State Health Care Providers Need to Know."[12]

In addition to the Washington State Department of Health Laboratory, only four laboratories in King County can currently test for pertussis: Public Health - Seattle & King County, Childrens' Hospital and Medical Center, Group Health Cooperative, and Valley General Hospital. Specimens collected from King County residents may be sent to Public Health - Seattle & King County laboratory at no charge. The Public Health laboratory plays an important role in efforts to control outbreaks of pertussis. Specimens for non-King County residents are tested at the Washington State Department of Health laboratory.

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[1] CDC. Status Report on the Childhood Immunization Initiative: reported cases of selected vaccine-preventable diseases—United States. 1996. MMWR 1997; 46: 665-671.
[2] CDC. Recommended Childhood Immunization Schedule—United States, 1999. MMWR 1999; 48: 12-16.
[3] CDC. Impact of Vaccines Universally Recommended for Children—United States, 1900-1998. MMWR 1999; 48: 243-248.
[4] Four doses of diptheria and tetanus toxoids and pertussis vaccine/Diptheria and tetanus toxoids (DTP/DT), three doses of poliovirus vaccine, and one dose of measles/mumps/rubella vaccine (MMR).
[5] Four doses of DTP/DT, three doses of poliovirus vaccine, one dose of MMR, and three doses of Haemophilus influenzae type b vaccine.
[6] CDC. Status Report on the Childhood Immunization Initiative: National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19-35 Months—United States, 1996. MMWR 1997. 46(29): 657-664.
[7] Seattle-King County Department of Public Health. *The Health of King County.* August 1998: 100-101.
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[9] Centers for Disease Control. *Epidemiology & Prevention of Vaccine-Preventable Diseases. 4th Edition.* September 1997: 67.
[10] Herwaldt, Loreen. "Pertussis in Adults: What Physicians Need to Know." *Archives of Internal Medicine* 151 August 1991: 1510-1512.
[11] Wright, Seth et al. "Pertussis Infection in Adults with Persistent Cough." *JAMA* 273 (13) April 5, 1995: 1044-1045.
[12] The educational pamphlet can be found at http://www.doh.wa.gov/Publicat/pertussis.pdf.

APPENDIX XI
HOSPITAL VIABILITY

Hospital Viability

Unlike health plans, hospitals in King County have been generally solvent over the past decade, with total operating revenues exceeding total operating expenses in almost all cases. This report provides financial data from the Washington Department of Health on King County hospital cost and profitability trends from 1992 to 1998. For the purposes of this report, we have divided King County hospitals into two categories: downtown and suburban hospitals.

The **downtown hospitals** include:

- Children's Hospital and Medical Center
- Harborview Medical Center
- Providence Medical Center
- Swedish Medical Center
- University of Washington Medical Center
- Virginia Mason Hospital

The **surburban hospitals** include:

- Auburn General Hospital
- Evergreen Hospital Medical Center
- Highline Community Hospital
- Northwest Hospital
- Overlake Hospital Medical Center
- Saint Francis Community Hospital
- Valley Medical Center

Note: Group Health hospitals were not included in the analysis because data were not reported for all years.

Revenues and Expenses

Total revenues have exceeded total expenses from 1992 to 1998 for downtown and suburban hospitals in King County (See figures1 and 2).

However, the gross margin (the difference between revenues and expenses) has eroded over this period. For downtown hospitals, the gross margin has decreased from 3.9% in 1992 to 0.7% in 1998. For suburban hospitals, the gross margin has decreased from 6.0% in 1992 to 1.4% in 1998. The 1997 Balanced Budget Act is expected to further reduce revenues for hospitals over the coming decade at the national and local levels.

Figure 1.
Downtown Hospitals Revenues & Expenses

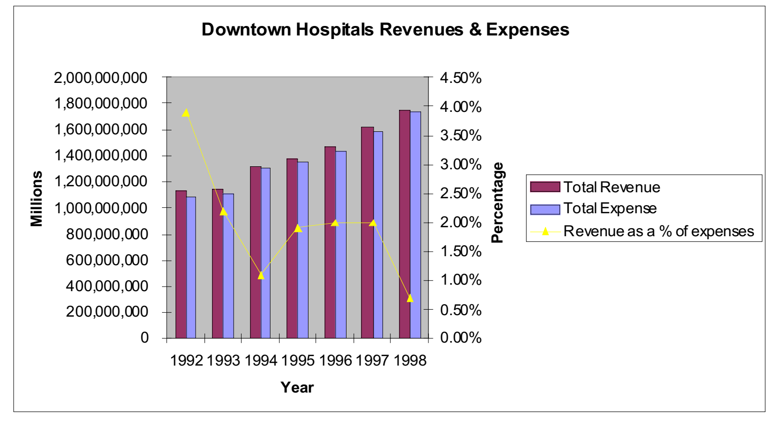
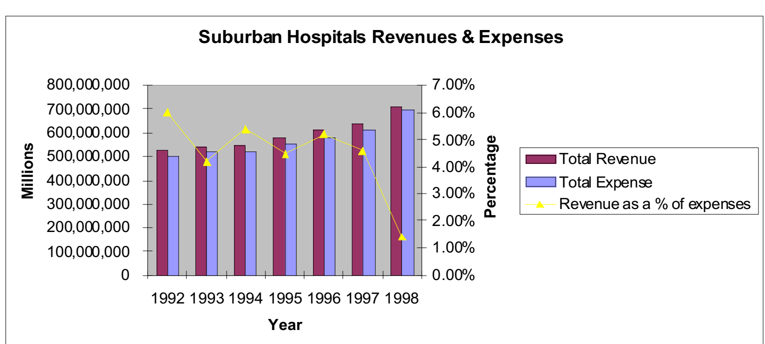


Figure 2.
Suburban Hospitals Revenues & Expenses



Bad Debt

Bad debt is defined by the Washington Administrative Code as the uncollectable charges, excluding contractual adjustments, arising from the failure to pay by patients whose health care has not been classified as charity care.[1] The total amount of bad debt for all King County hospitals has grown steadily in this decade, from under $37 million in 1992 to over $54 million in 1998. However, when measured as a percent of total revenue, total bad debt has remained remarkably steady at 2.2% of revenue for this period.

Charity Care

Charity care is defined by the Revised Code of Washington as necessary hospital health care rendered to indigent persons, to the extent the persons are unable to pay for the care or to pay deductibles or co-insurance required by a third-party payer.[2] The total amount of charity care provided by all King County hospitals has fluctuated more than that for bad debt. The amount of total charity rose from $49 million in 1992 to over $58 million in 1993, then dropped back to near $50 million through 1997.

A broad definition of community benefits includes both charity care (which is collected and reported by the Washington State Department of Health) and community services that hospitals/ systems provide without expectation of reimbursement. Although these non-billed community services have not been collected and reported by the Department of Health, the Washington State Health Association (WSHA) has initiated a program to encourage hospitals and systems to voluntarily quantify and report the value of community services that are rendered without charge. The WHSA Community Benefits Inventory Project includes five categories of community services[3] :

- Community health programs and activities (non-billed services)
- Education
- Subsidized health services
- Health research
- Cash and in-kind donations

This broader picture of community benefits (including charity care and community services) will provide a better picture of the value that hospitals and health care systems provide to Washington state and King County in the future.

Salaries/Wages & Employee Benefits

Total salaries and wages provided by King County hospitals has grown steadily, from slightly under $700 million in 1992 to slightly over $1 billion in 1998. This growth in salaries and wages has been matched by a steady growth in total employee benefits, from over $150 million in 1992 to over $238 million in 1998. When measured as a percent of total salaries and wages, the total employee benefits have remained relatively stable, increasing from 21.8% in 1992 to 22.8% in 1998.

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[1] Washington Administrative Code 246-453-010

[2] Revised Code of Washington 70-170-020

[3] Washington State Hospital Association. *Community Benefits Inventory Project: Preliminary Report*. June 1998.

APPENDIX XII
WORKFORCE IMPACTS

Workforce Impacts

The complex evolution of the structure and practice of health care services will lead to increased changes for the health care professional workforce. An increasing variety of contractual arrangements and managerial oversight of physicians has dramatically changed the medical environment. The local unionization of physicians at Medalia and the recent American Medical Association's endorsement of physician unionization at the national level indicate growing physician concerns about health care management. Nurse practitioners, physician assistants, and other mid-level practitioners are positioned to assume a more central role in the delivery of health services in the coming decades, due to a focus on cost containment. The Pew Health Professions Commission recently released its final report on the health care landscape for health professionals, *Recreating Health Professional Practice for the New Century.*[1] Anticipating the effects of emerging trends in health care, this report makes recommendations for all health care professional groups in the following areas:

- Changing professional training to meet the demands of the new health care system
- Improving the diversity of the health profession workforce to reflect the diversity of the nation's population
- Requiring interdisciplinary competence in all health professionals
- Continuing to more education into ambulatory practice
- Encouraging public service of all health professional students and graduates.

This section briefly explores the workforce impacts of health care system changes on physicians and nurses with a particular look at issues of supply and job satisfaction with the evolving health system.

Physicians

In the face of predictions of a large physician shortage in 1970, the federal government provided financial incentives to medical schools to expand capacity and increase immigration of foreign-trained physicians. From 1970 to 1994, the number of US-trained medical students increased by 65% and the number of residents increased by 100%. The Pew Health Professions Commission has recommended the closure of 20% to 25% of the nation's medical schools. However, medical training takes many years, and changes in medical education will not affect the numbers of medical graduates in the pipeline for a decade.

Now however, the US faces an oversupply of physicians, especially specialists and physicians in urban areas. Approximately 170,000 physicians are currently in medical training in America, and 16,000 new students graduate from medical school annually. Almost 23,000 physicians are produced by residency and fellowship programs annually when international medical graduates are included. After adjusting for the 25% of international medical graduates that practice outside the U.S. and the 7% of physicians that choose administrative and research careers, approximately 19,500 new physicians begin patient care annually. Meanwhile, the number of physicians expected to retire annually is

expected to increase from 8,000 to 13,000 over the next ten years, resulting in a net annual increase from 6,000 to 11,000 practicing physicians. This will increase the supply of non-federal patient care physicians from 450,000 to 600,000 by 2010.[2] Over the past quarter century, the patient care physician to population ratio has increased from 115 to 190 physicians per 100,000 population.

Beyond the excess supply of physicians in general, there is an uneven distribution of U.S. physicians by specialty and by geographic region. For instance, the ratio of specialists to primary care physicians (PCPs) has not changed since 1970: PCPs still only represent 44% of all physicians. However, HMOs require more PCPs as gatekeepers and to shift to outpatient care. The oversupply of specialists is related to their significantly higher median incomes. There are also more physicians per capita in more densely populated regions such as Seattle, leading to barriers to access in rural areas. The problem of physician shortages in areas with less densely population regions has worsened over the past 30 years, and the deterrents for physicians to relocate to rural areas remain significant (such as physician and cultural isolation, long hours, and on-call duties).

The changes in contractual arrangements and management of health plans have reduced physicians' control in their practice of medicine. In one recent national survey of over 1,700 physicians' experiences with managed care plans, physician frustration was high regarding their loss of autonomy in medical decision-making, decreased time with patients, increased administrative burdens, and loss of continuity of care when patients' insurance plans changed.[3] Likewise, a survey of physicians' views on health practices in three health plans (100 physicians in each plan) found that barriers to delivering high-quality care related to lack of time spent with patients, covered benefits and copayment structures, and utilization management practices.[4] This study found a wide disparity of physician's views among the three health plans surveyed, with the percentage of physicians indicating that they would recommend the plan they rated to their own family differing from 64% for plan 1 to 92% for plan 2 and 24% for plan 3.

Nurses

Nurses are well-qualified to meet the behavioral and preventive aspects of care that are central to the emerging health system. As the health environment moves toward outpatient care, it will require health providers to work in teams and assume managerial responsibilities. There will be an increasing demand for the skills of nurses. There are over 2.5 million registered nurses (RNs), the largest single group of health care providers in the nation.[5] RNs enjoy a high employment rate, with over 82% of trained RNs employed. This high employment rate suggests that nursing shortages in the near future cannot be easily remedied by increasing salaries to draw non-practicing nurses back into the profession. In addition, many practicing nurses report increases in workload and decreases in work satisfaction, morale, and quality of patient care over the past decade.[6] The national average salary of RNs ($42,071 in 1996) has been flat or declining in annual real wages since 1990.[7] Although there is a trend from acute care in hospitals to outpatient care, two-thirds of RNs

continue to work in hospitals. From 1984 to 1994, the RN-to-patient ratio increased in hospitals by 29.4%. Yet when adjusted for the case-mix severity, this ratio only increased by 0.3%. Therefore, RNs are providing care to a sicker population of patients. Meanwhile, other hospital staff such as licensed practical nurses (LPNs) and nursing aides have been reduced in absolute numbers, and these staff-to-patient ratios have not kept up with the increased case-mix severity.

The average age of the nursing workforce (44.3 years) is increasing, and only 9% of nurses are younger than 30 years (down from 25% in 1980).[8] Currently, 95,000 new RNs are graduating annually in the U.S., and BSN enrollment is down 5.5% in 1998.[9] The Bureau of Health Professions' Division of Nursing predicts that the national staffing needs for FTE RNs will increase by 18% by 2010 in both hospitals and outpatient settings.[10] In addition, the requirements for FTE RNs are predicted to increase substantially in nursing homes (by 30%) and community health settings (by 44%) by 2010. The Institute for the Future predicts that there will be sufficient future supplies of RNs to meet the increasing demands, with a shift from hospital settings to primary care, nursing homes, and skilled nursing facilities.[11] Alternatively, others predict that the number of RNs who will retire and withdraw from the labor market could exceed the number of younger RNs needed to replace them.[12] The aging of the US population may greatly increase the demand for nurses, with the population over 85 years old projected to double by 2020. Elderly people consume the most health care resources, and the oldest Baby Boomers will turn 65 by 2006. Prolonged life, increased chronic illness, and technology advances (gene therapy, organ transplants, telemedicine) will increase the demand for highly skilled nurses with bachelor and graduate education.

Nurse practitioners (NPs) are registered nurses who work as primary health care providers, focused on health promotion, disease prevention, and diagnosis/management of acute and chronic diseases. Over 90% of NPs work in outpatient settings, although only nine states allow NPs to practice independently from physicians. There are approximately 50,000 NPs nationally, half of whom are practicing as NPs. The increasing demand for their services will lead to an increased supply of NPs, with over 2,000 currently graduating every year.

The King County Health Action Plan conducted two focus groups with nurses in King County to obtain information about changes in nursing practice patterns over the past five years.[13] The nurses reported the following key system issues relating to responsibilities, relationships, time and trust for patients, nurses and the environment:

Patients:
- Shorter patient stays and discharge with insufficient planning.
- More reliance on caregivers including family members outside the hospital.
- Sicker (high acuity) patients at every level of the healthcare system.
- Quicker returns to the emergency room or re-admissions to the hospital.
- Patients do not understand their options of health coverage and care plans.

Nurses:

- Nurses have more responsibilities and less time to carry them out.
- Ratios are changed: more patients to fewer Registered Nurses.
- Skill mix is lower with more use of medical technicians.
- Greater liability risks with licensure for nurses; not enough time for assessment.
- More focus on administrative work than on the care for which they were trained.
- Nurses are being moved into positions as case workers or into utilization review work and away from hands-on patient contact.

Managed Care (Competitive Environment):

- Reimbursement is down, diminishing the resources for patients and the livelihood of health care professionals.
- Insurance companies and HMOs are dictating policy and making decisions that were traditionally made by health care professionals.
- Nurses and other health care professionals are faced with a sea of paperwork and very complex documentation due to the multiplicity of plans.
- The health care systems/organizations are fluid, always changing, and very hard to navigate.
- More uninsured due to high cost of health plans.
- There is more technology available, which along with new medications makes treatment more costly and is not always covered by insurance or health plans.
- With patients being kept alive longer, there are "quality of life" versus "length of life" issues regarding how healthcare dollars are directed.

The nurses participating in the focus groups were asked to enumerate and discuss the most pressing problems and to suggest possible solutions. The following solutions were offered:

- More notice before discharge was suggested to allow for authorization and planning of home treatment or procurement of medications needed.

- In addition to this future solution, nurses described a practical and currently possible solution for transferring information from hospital to outpatient or home care health professionals to provide better continuity of care. One respondent suggested:

  "The problem of transferring information between facilities is a big one, because there isn't a cover sheet [for the chart] that would list medications, treatments, teaching needs, lines, where you can look at it with a quick glance instead of having to look through a chart this thick with every hospital having different forms to figure out what's the status of the patient." (Home Care Nurse)

- Nurses noted that when certain tasks such as taking vital signs of patients are assigned to lower level staff, the nurse must often redo that work in order to make an accurate assessment of the patients' status. Even when the nurse is performing such routine tasks as bathing the patient, the nurse's clinical mind is taking note of any skin or other bodily conditions that may deserve attention. Most nurses seem to prefer the holistic approach rather than having care broken into individual "tasks" that may not be meaningful by themselves.

- Some nurses stated that management should not delegate RN tasks out to CNAs and LPNs, who would need more professional training to perform assessments, as described in the following quote:

  "Quit delegating the professionalism of nursing out to create new professions."

In summary, what nurses perceived as the crux of most of the problems is the fact that the insurance companies or reimbursements drive the medical decisions. Nurses viewed the managed care groups as placing too many restrictions on the care they can provide. They find the payer's focus is "bottom-line based" rather than "patient-oriented." Overall, nurses would like more input for themselves and for physicians (as opposed to managed care) in deciding what is appropriate treatment for the patient, and what length of stay is necessary for the patient.

The Pew Health Professions Commission (1998) proposed specific recommendations for nursing[14], including:

- Adjusting education programs to produce the numbers and types of nurses appropriate to local or regional demand. The nursing workforce lacks diversity: only 5% of nurses are men, and only 10% are minorities (compared to 27.7% of the U.S. population).[15]
- Delineating the knowledge and outcome competencies appropriate for each level of nursing education.
- Radically revamping the content and learning experiences within nursing curricula to produce graduates with the competencies needed for differentiated practice, including learning experiences in ambulatory, long term care, and community-based settings.

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[1] Pew Health Professions Commission. *Recreating Health Professional Practice for a New Century: The Fourth Report of the Pew Health Professions Commission.* San Francisco, Center for Health Professions, University of California, San Francisco. 1998.

[2] *A Forecast of Health and Health Care in America.* Prepared by Institute for the Future for the Robert Wood Johnson Foundation. November, 1998: 69.

[3] The Commonwealth Fund. *Physicians' Experiences with Managed Care: Warning Signs for Patient Care*. March, 1997.

[4] Borowshky, S. "Are All Health Plans Created Equal?—The Physician's View." *JAMA* 278 (11). September 17, 1997: 917-921.

[5] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing. (1996). The registered nurse population; Findings from the national sample survey of registered nurses, March 1996. US GPO.

[6] Buerhaus, P. and Staiger, D. "Trouble in the Nurse Labor Market? Recent Trends and Future Outlook." *Health Affairs* 18 (1) 1999: 214-222.

[7] Buerhaus, P.I. "Is Another RN Shortage Looming?" *Nursing Outlook* 46(3) 1998: 103-108.

[8] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing. (1996). The registered nurse population; Findings from the national sample survey of registered nurses, March 1996. US GPO.

[9] American Association of Colleges of Nursing. "1998-1999 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington: AACN. 1999.

[10] Source: Projections by Division of Nursing, BHP, MRSA, USDMMS: March 1996.

[11] *A Forecast of Health and Health Care in America*. Prepared by Institute for the Future for the Robert Wood Johnson Foundation. November, 1998: 77.

[12] Buerhaus, P.I. "Is Another RN Shortage Looming?" *Nursing Outlook* 46(3) 1998: 103-108.

[13] The King County Health Action Plan collaborated with the Gilmore Research Group to conduct two focus groups with nurses in King County. They were conducted and audio-taped on November 16, 1998. The focus groups were comprised of a total of 20 registered nurses, and represented a variety of work environments and age groups.

[14] Pew Health Professions Commission. *Recreating Health Professional Practice for a New Century: The Fourth Report of the Pew Health Professions Commission*. San Francisco, Center for Health Professions, University of California, San Francisco. 1998.

[15] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing. (1996). The registered nurse population; Findings from the national sample survey of registered nurses, March 1996. US GPO.

APPENDIX XIII

COMMUNITY BENEFITS PROGRAM

Community Benefits Program

The organizations that make up the health care system in King County have a long history of providing important services to the community beyond simply delivering health care. However, in the context of the current health care system landscape, which is acutely competitive and price-sensitive, there is concern that over time a decrease in the level of these community benefits will occur. This concern is magnified when placed in the context of a heightened need for community benefits programs due to continued inequities in coverage and need, particularly for low income households, no improvement in the percent of adults insured despite a robust economy in the region and a fraying of the health care safety net.

When the Steering Committee of the King County Health Action Plan began to establish the points on the compass to which to direct their activities a community benefits program was a primary area of focus. The Steering Committee members, a coalition of public health agencies, private health care providers, managed care organizations, labor and citizen action groups, felt strongly that hard data can drive voluntary action towards community giving focusing on a few prioritized areas of need.

The term "community benefits" was defined by the group to mean a service that responds to community needs or priorities and that is designed to affect the community as a whole, beyond the benefit to the individuals who may be served or to the individuals providing the service.

The Community Benefits Program prioritized its attention on worsening trends impacting vulnerable populations (as identified by the System Monitoring Workgroup). A three-year commitment was made by the group to work in the following areas: childhood asthma, Type 2 diabetes among African Americans, and breast and cervical cancer screenings among Vietnamese women. Following this, the Community Benefits Program sought multi-faceted interventions that had been developed using tailored, evidenced-based solutions to these specific health problems and which incorporated strategies that brought together culturally appropriate clinical, outreach, interpretation, and community services.

The Community Benefits Program selected four projects effectively working in the community in the above mentioned areas to be the recipient of their funding efforts. To date, eight founding funders participating in the Community Benefits Program have contributed nearly $50,000 with a commitment to maintain and/or increase funding for three years. Outcome measures will be collected for all the projects and shared with all participants. These founding funders represent eight health care providers and managed care organizations working in King County.[1]

In an article published in July 1999 by the American Medical News, Dr. Mohammad Akhter, Executive Director of the American Public Health Association, stated ". . . the willingness of managed care to invest in population-based care puts the King County Health Action Plan ahead of the rest of the

nation. This is the kind of thing we'd like to see across the country. But it's not happening (in most places) because managed care is too involved in managing cost."[2]

A profile of the four projects selected by the Community Benefits Program to receive funding are listed below:

- **Odessa Brown Asthma Outreach Project**
  This project is designed to provide culturally sensitive outreach and clinical support to targeted children and their caretakers. Patients are recruited for the program based on their history as a high utilizer of emergency room visits and hospitalizations for asthma. The coordinated care intervention is based on the premise that complex lives of the families of the children with asthma would benefit from services beyond the scope of the traditional medical model and the knowledge that improved health outcomes for the asthmatic child are best achieved by repetition and reinforcement of patient education messages and treatment care plans across social environments. Services include comprehensive evaluation (skin testing, pulmonary function testing, quantitative nasal cytology), treatment (on-site durable medical equipment and medication appropriate to severity level) and home and school visitations and community support by an asthma outreach worker.

- **African American Elders Program**
  This project is a highly targeted program for elderly African Americans suffering from diabetes. Individual customized services are provided by three city agencies: Aging and Disability Services, Senior Services and Public Health - Seattle and King County. A case worker, an outreach worker and a public health nurse deliver services which range from home repairs, financial management, health assessment, health education and health care services. Clients are also connected as needed to community resources for legal services, meals on wheel, nutrition information, chore services, counseling, transportation, food stamps, utility bill assistance and rent assistance.

- **Community Diabetes Initiative**
  This project is a comprehensive and collaborative project among area community and Public Health clinics emphasizing the achievement of measurable health outcomes among low-income Seattle and King County residents. The project seeks to improve patient access to necessary diabetic supplies and provide patient education to improve patient's ability to self-manage their diabetes.

- **Breast and Cervical Cancer Screening among Vietnamese Women**
  The International Community Health Service Clinic has been working with partial funding from the Center for Disease Control and Prevention's Breast and Cervical Health Program to connect Asian women with important health services that would provide early detection of breast and cervical cancer through regular mammogram and pap test screening. Outreach workers, who speak the same language and dialect as the target population, recruit volunteers from the community, such as religious leaders, community elders, health care workers, and

cancer survivors to assist in connecting Vietnamese women to health services at the International Community Health Service Clinic. The outreach workers and volunteers use visual, as well as written education materials to educate these women regarding the importance of cancer screening. In addition to the presentation of breast and cervical health materials, other women's health issues are addressed and referrals are made if indicated.

[1] The eight founding funders are Aetna US Health Care, First Choice Health, Group Health Cooperative of Puget Sound, Group Health/Kaiser Permanente Community Foundation, Swedish Health Services, Regence Blue Shield, Community Health Plan of Washington, PacificCare of Washington Inc.
[2] Moran, Mark. *Public-private partnership*. American Medical News. July 5, 1999. Vol. 42. No. 25.

APPENDIX XIV

ASTHMA

Asthma

Non-infectious diseases are emerging as the major causes of morbidity and mortality in the United States and throughout the developed world.[1] The traditional 'acute disease model' was developed to combat infectious diseases[2], and new population-based public health approaches need to be developed and implemented to effectively prevent and manage chronic diseases. Chronic diseases are emerging as the major cause of morbidity and mortality in the context of new economic considerations in healthcare decisions and the emergence of managed care organizations. Two chronic illnesses, asthma and diabetes mellitus, are often chosen as 'model diseases' to illustrate the problems of dealing with chronic illnesses in the new economic and structural health systems.[3] This section explores the prevalence and nature of asthma in King County, considers the costs (to health outcomes and financial cost), and identifies promising paths for improvement.

Problem Indicators

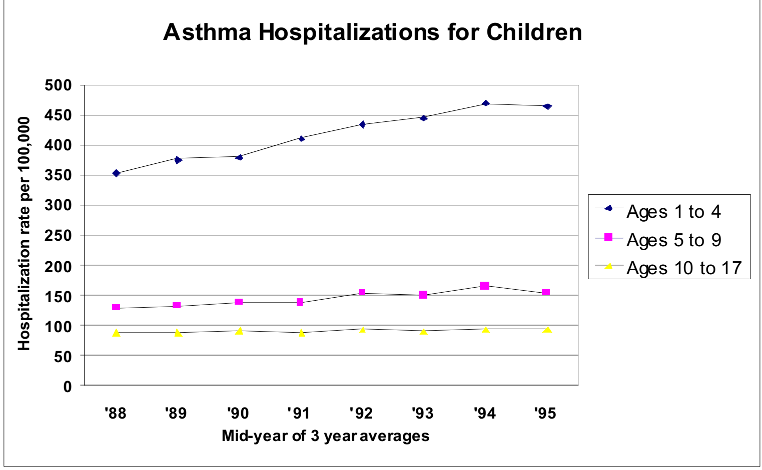
Asthma is a chronic lung disease that is characterized by intermittent, recurring episodes of wheezing, breathlessness, tightness of chest, and coughing. Asthma is the most common chronic illness of childhood, affecting nearly 5 million children nationwide. In the past 15 years, the number of Americans afflicted with asthma has doubled to over 15 million people, and the highest rate increase has occurred in children under five years of age.[4] According to national data, 6% of children under 18 and 4% of adults suffer from asthma.[5]

Although all ages and racial groups are affected by asthma, low-income and minority groups have disproportionately high rates and worse outcomes across the nation. For instance, from 1993 to 1995 there were 38.5 deaths per million from asthma in African Americans, compared to 15.1 deaths per million in whites.[6] Asthma is increasing particularly rapidly among inner-city, African American children.[7] The asthma rates for mortality and emergency room visits are four times higher for African American children than the national average.

In spite of advances in the understanding and treatment of asthma, hospitalizations for asthma among young children have increased by over 25% over the last ten years in King County.[8] Asthma was the second leading cause of pediatric hospitalizations in King County in 1995, and the asthma hospitalization rates are higher in King County than anywhere else in Washington.[9] The rates are highest among young children (one to four years old), and their rates are increasing faster than any other age group.

Although this worsening trend is not fully understood, significant contributing factors to address in reducing morbidity include delayed diagnosis, poor indoor and outdoor air quality, underassessment of the severity of the disease, undertreatment with anti-inflammatory agents, and over-reliance on inhaled bronchodilators or beta-agonists.[10]

Figure 1.
Asthma Hospitalizations for Children in King County



Source: *Public Health Data Watch; Childhood Asthma Hospitalizations*, Public Health-Seattle & King County 1998

Impact of Problem Indicators

It is estimated that national Medicaid and Medicare expenditures for asthma treatment exceed $1 billion annually. In addition, asthma is a leading cause of school absenteeism responsible for over 10 million missed school days.[11] The costs of asthma include medical care, financial burdens to families, and absenteeism from school and work. The estimated total cost of asthma to the US economy has risen from $6.2 billion in 1990[12] to $14 billion in 1996.[13]

Delays in receiving care for asthma, or failure to receive care at all, can lead to hospitalizations that might have been avoided. In 1996, approximately 10% - or 52,000 - of all hospitalizations in Washington state were potentially avoidable. The highest rates were in rural areas. Access to care, including where people live, income level, insurance status, age, and race influence the risk of experiencing a potentially avoidable hospitalization. In Washington state, the people most at risk include children under 18; Native Americans; and migrant and seasonal farm workers.[14]

There are many barriers to effective management of asthma, from cultural and educational factors to environmental and economic conditions. Several studies have found that a comprehensive model of asthma care is effective, including the use of community outreach workers who visit homes of patients in inner-city communities, obtain information, and provide asthma education.[15] The most recent National Heart, Lung, and Blood Institute (NHLBI) guidelines for asthma management focus on building partnerships with patients and approaching asthma as a chronic disease.[16]

According to a recent focus group of pediatric asthma nurses in King County[17], many parents and children are not well trained to manage asthma as a chronic disease or to prevent moderate to severe episodes. For instance, many parents medicate their child during an acute episode, but fail to continue medication or make long-term environmental changes to reduce the asthma triggers in the child's home. The nurses also identified the need for consistent and repeated education in order to achieve attitudinal and behavioral change. They also observed that there is insufficient time for asthma education by school nurses and during short office visits with healthcare professionals.

Promising Paths for Improvement

1. **The Asthma Outreach Project**

   The Asthma Outreach Project is designed to provide comprehensive and culturally sensitive outreach and primary asthma care in an inner-city Seattle pediatric clinic. It is located in Odessa Brown Children's Clinic, an urban satellite clinic of Children's Hospital and Medical Center (CHMC) that serves approximately 3,000 patients who generate over 7,000 visits per year.[18] Odessa Brown serves an urban population of primarily African American children insured by Medicaid. The Asthma Outreach Project targets patients who have had at least one hospitalization or three emergency room visits for asthma in the last two years. To date, 83% of the selected patients have been boys, 87% have been African American, and two-thirds have been under 5 years old.[19]

   The project has adopted a coordinated care model, with a full-time asthma outreach worker, and a pediatrician and medical assistant each working 25% of their time on the project. This coordinated care intervention extends services beyond the traditional medical model to address the complexity of the lives of families of children with asthma. Before each clinic visit, the outreach worker, the physician, and other staff discuss the circumstances of the families to be seen. After each clinic visit, the physician and the pharmacist develop or revise the asthma treatment plan. The outreach worker delivers extended services, and is a liaison to the health care system by interpreting and reinforcing the treatment plan in the context of the families' social environments. The services include comprehensive evaluation (skin testing, pulmonary function, quantitative nasal cytology), treatment (on-site durable medical equipment and medication appropriate to severity level), and home and school visits and community support. The outreach worker conducts home visits monthly in the first six months, and then quarterly thereafter. More frequent home visits are arranged for children in especially chaotic circumstances.

   The Action Plan funded increased physician and outreach worker services for the Asthma Outreach Project. Health plans are eager to receive continuing results from this intervention project.

2. **Seattle-King County Healthy Homes**

   Seattle-King County Healthy Homes is a demonstration project designed to reduce environmental exposures to indoor asthma triggers such as dust, mold, and pet dander among 400 low-income households of children with asthma. The principal investigator of this project is James Krieger, MD, MPH, Chief, Epidemiology, Planning and Evaluation Unit, Public Health - Seattle & King County. The project is funded from October 1997 to September 2001 by the National Institute of Environmental Health Sciences, the Centers for Disease Control and Prevention (CDC), and Public Health - Seattle & King County. It has developed partnerships of low-income tenants, community agencies, environmental justice

organizations, Public Health, the CDC-sponsored Seattle Urban Research Center and the University of Washington.

The project employs outreach workers to conduct an initial assessment visit followed by nine visits over the next year. The outreach workers provide a comprehensive package of education and social support, encourage behavioral changes, provide materials to reduce exposures (bedding covers, vacuums, door mats, cleaning kits), help to locate assistance for structural improvements to reduce moisture, and help to advocate for improved housing conditions. Community volunteers from the Master Home Environment Program work with additional households.

Performance Measurement of Programs

1. **The Asthma Outreach Project**
   The project assesses the effect of its intervention on health services utilization by collecting clinical data, and each study subject serves as his or her own historical control. Health service utilization for asthma is assessed by continuous monitoring of automatic encounter data at CHMC and at the clinic, chart review, and consultation with families during clinic visits. The preliminary findings include reduced Emergency Department use, fewer hospitalizations, and fewer unscheduled clinic visits for asthma among participants. High levels of satisfaction were reported during a structured focus group. This promising model of care has the potential to improve outcomes and reduce costs, but the results must be interpreted cautiously until randomized, clinical trials are performed.

2. **Seattle-King County Healthy Homes**

   The program measures many home environmental indicators at the beginning and end of the study, including water temperature, relative humidity, air temperature, dust and dirt samples, and performs spirometry and skin tests for allergies.

   The effectiveness of this program will be assessed by examining its impact on:

- Asthma symptoms
- Asthma medication use
- Asthma-related quality of life measures
- Asthma-related health services utilization (clinic, ER, and hospital)
- Asthma-related behaviors (e.g., household cleaning, use of allergy control bedding covers)
- Pulmonary function
- Participant satisfaction

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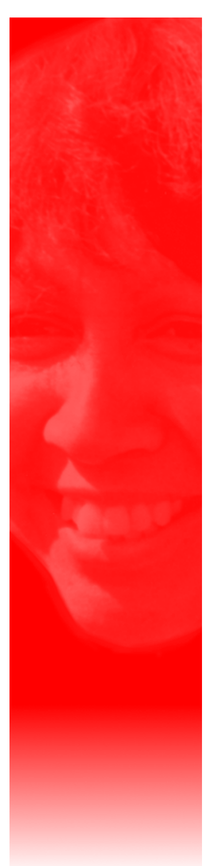
[1] McGinnis J., Foege, W. "Actual Causes of Death in the United States." *JAMA* 270 (1993): 2207-2212.
[2] Larson, E. "A Retrospective on Infection Control. Part 2: Twentieth Century- The Flame Still Burns." *American Journal of Infectious Control* 25 (1997) 340-349.
[3] Vinicor, F. "Diabetes Mellitus and Asthma: 'Twin' Challenges for Public Health and Managed Care Systems." *American Journal of Preventive Medicine* 14(35) 1998: 87-91.
[4] Health and Human Services Fact Sheet. January 28, 1999.
[5] Seattle-King County Department of Public Health. *The Health of King County.* 1998.
[6] Health and Human Services Fact Sheet. January 28, 1999.

[7] Stout, JW et. al. "The Asthma Outreach Project: A Promising Approach to Comprehensive Asthma Management." *Journal of Asthma* 35(1) 1998: 119-127.
[8] Seattle-King County Department of Public Health. *Public Health Data Watch: Childhood Asthma Hospitalizations, King County 1987-1996*. Published in 1998.
[9] Ibid.
[10] Kavuru, MS, Weidemann, HP. *Diagnosis and Treatment of Asthma,* 2nd Edition. Professional Communications, Inc. 1998.
[11] Health and Human Services Fact Sheet. January 28, 1999. Data from the National Center on Health Statistics.
[12] Weiss, K. et. al. "An Economic Evaluation of Asthma in the United States." *New England Journal of Medicine*. 326 (1992): 862-866.
[13] Health and Human Services Fact Sheet. January 28, 1999. Data from the National Center on Health Statistics.
[14] *1999 Pulse Indicators*, University of Washington Health Policy Analysis Program, VITAL SIGNS of Washington's Health.
[15] Stout, JW, et. al. "The Asthma Outreach Project: A Promising Approach to Comprehensive Asthma Management." *Journal of Asthma* 35(1) 1998: 119-127.
[16] Mansmann, HC, editor. Pediatric Asthma, Allergy and Immunology. National Heart, Lung, and Blood Institute, National Asthma Education Program, Expert Panel Report: *Guidelines for the Diagnosis and Management of Asthma*. 5(2): 1997.
[17] Pediatric Asthma Nurse Session Focus Group. The Gilmore Research Group was commissioned to conduct a focus group with eleven registered nurses on November 18, 1998.
[18] Stout, JW, et. al. "The Asthma Outreach Project: A Promising Approach to Comprehensive Asthma Management." *Journal of Asthma* 35(1) 1998: 119-127.
[19] Ibid.



APPENDIX XV

BREAST AND CERVICAL CANCER

Breast and Cervical Cancer

Problem Indicators

It is estimated that 2 million American women will be diagnosed with breast or cervical cancer in the 1990s, and that half a million of these women will die from these diseases. Better access to screening services to women at risk could prevent approximately 15% to 30% of deaths from breast cancer among women over 40 years old, and could prevent virtually all deaths from cervical cancer.[1]

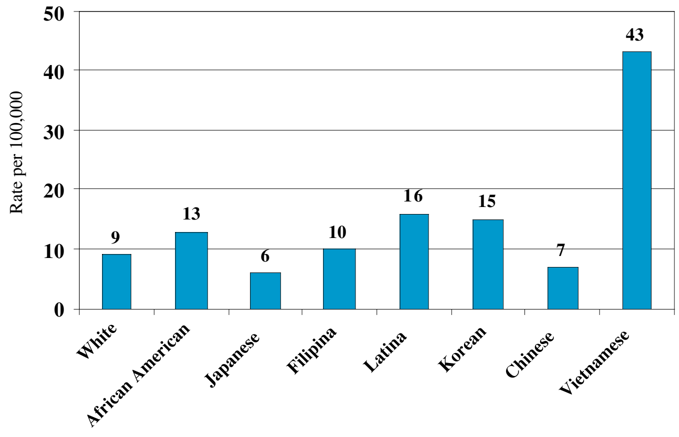
Breast cancer is the most common cancer among American women (excluding skin cancer), and is the second leading cause of cancer-related deaths among women (behind lung cancer). Mammography detects breast cancer an average of 1.7 years before the woman can find a lump herself[2], and locates cancers that cannot be felt during a clinical breast exam (mammograms are also used to distinguish benign and malignant tumors). Earlier detection often improves the survival rate, with 5-year survival rates of 97% for breast cancers diagnosed at the local stage and 5-year survival rates of 21% for breast cancers diagnosed after the cancer has spread.

Since 1990, Washington has exceeded the national objective that 60% of all women age 50 and older report having had a mammogram and clinical breast exam in the last two years.[3] Between 1995 and 1997, the proportion of Washington women age 40-49 that reported having had a mammogram at some point in their lives varied between about 78% and 82%. Differences in rates of mammography are found among racial and ethnic groups and income levels.[4]

Invasive cervical cancer rates have decreased significantly over the past four decades, largely due to early detection efforts. Cervical cancer screenings allow detection and treatment of precancerous lesions identified by papanicolaou (Pap) screening, and can actually prevent cervical cancer. Even if cervical cancer is detected, appropriate treatment in its earliest stage can increase the likelihood of survival to almost 100%.

There are a disproportionate number of the deaths from breast and cervical cancer among women in minority and low-income groups across the nation. Most strikingly, data indicate that cervical cancer rates for Vietnamese women living on the West Coast are five times higher than rates in the general population (see Figure 1).[5]

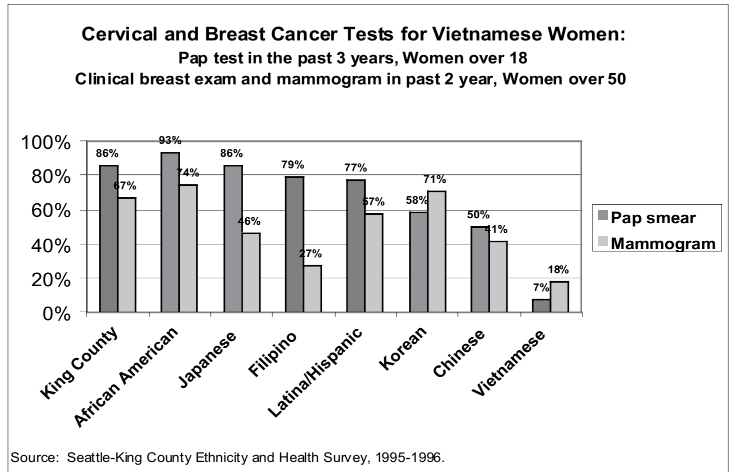
Figure 1.
National Cervical Cancer Rates



Source: *Surveillance, Epidemiology and End Results Program 1988-1992,* National Institutes of Health, National Cancer Institute

In King County, women's cancer screening levels are much lower for some groups of Asian American women than the general population in King County. For instance, only 7% of the Vietnamese respondents reported having a Pap test in the last three years compared to 86% overall in King County (see Figure 2). Likewise, only 18% of the Vietnamese women reported having breast cancer screening in the last two years, compared to 67% of the general population.[6] The rates for breast and cervical screenings are also lower than average among Korean and Chinese women.

Figure 2.



Impact of Problem Indicators

Although cervical cancer is often preventable with regular Pap test screening (it is estimated that between 37% and 60% of cervical cancer deaths could be prevented by full use of Pap tests), there are limited outreach and screening programs for Asian women in King County. Vietnamese women in King County are often recent immigrants with incomes below the poverty level. Two-thirds of Vietnamese respondents to a recent Public Health survey had lived in the United States for less than 10 years, and none had been born here. Similarly, two-thirds of Vietnamese respondents had incomes below 200% of the poverty level, compared to less than one-fifth of the general population.[7] The challenge of increasing cervical and breast cancer screenings to this vulnerable population will require culturally sensitive outreach and education programs.

There are substantial financial costs to delayed treatment of breast and cervical cancer. Treatment for early diagnosed breast cancer may be as little as $10,000 while late-stage treatment may cost up to $345,000.[8] Cervical cancer screening among low-income elderly women saves an average of $1,850 per person screened.[9]

Promising Paths for Improvement

The Breast and Cervical Health Program (BCHP), funded by the Centers for Disease Control (CDC) and Washington State, has provided free breast and cervical cancer screening for low-income women since 1994. The program goals are to:

- Increase early detection of breast and cervical cancer through regular mammogram and Pap test screening,
- Increase preventive health knowledge and behaviors, and
- Facilitate access to health care and insurance.

In Washington State, women who meet the following criteria are eligible:

- Age 40 years or older,
- Household income at or below 200% of the federal poverty level, and
- Uninsured or have insurance that does not cover the full cost of health check-ups or services like mammogram or Pap test.

In King County, the federal funds of the BCHP have been augmented by additional state and local resources to increase the effectiveness of the program, with over 150 community partnerships collaborating through joint projects, funding, technical expertise, and in-kind donations.[10] The program in King County provides community outreach and education to women of color, utilizing seven community-based organizations in the African American, Asian, American Indian, and Hispanic communities.[11] The screening services are provided by 24 community, public, and private-sector clinics and 14 private-sector mammography facilities. Overall, BCHP screened 7,516 women and provided an additional 4,635 repeat screenings from July 1994 to December 1998. This early detection has identified 59 women with breast cancer and 17 with cervical cancer.

The International Community Health Services (ICHS) agency has collaborated with the BCHP for five years, and targets Asian women in King County. Outreach workers targeted Chinese, Korean, and Filipina women from 1995 to 1997, and a half-time Vietnamese outreach worker has been employed since the fall of 1998. The ICHS provided approximately 2,000 screenings between 1994 and 1998, 85% of which were for Asian women. These screenings included 1,329 women, with 644 repeat screenings. To date, this early detection has identified 15 women with breast cancer and 6 with cervical cancer.

Of the 1,745 Asian women screened to date, 19% of them were Vietnamese. Assuming that approximately 19% of all of the targeted Asian women are Vietnamese, there are an estimated 2,000 low-income Vietnamese women over 40 in the county, 332 of which have been screened to date. Prevention and early detection of cancer, while generally well publicized and known among the general population, have not been widely disseminated among refugee and early immigrant groups.

Outreach workers are women who speak the same language and dialect as the target population and recruit community volunteers, such as religious leaders, community elders, health care workers, and cancer survivors. The educational materials are both visual and written. Outreach workers have successfully reached Asian women in multiple community settings, including churches, senior centers, grocery stores, and the womens' homes. The outreach workers acknowledge existing health care practices of the target group and ask participants to consider augmenting them with aspects of the Western medical system. They also address the common misconception that without symptoms there is no need to be screened. In addition to presenting breast and cervical health materials, other womens' health issues are addressed and referrals are made if necessary.

Performance Measurement of Programs

The King County BCHP has documented success in recruiting underserved low income and minority women and providing vital health screening and access to health care. A significantly greater percent of women of color have enrolled than exist in the eligible population as a result of targeted outreach efforts. Additionally, the targeted outreach recruited women most in need, with the lowest screening rates. For instance, only 27% of the BCHP enrollees had a mammogram in the prior two years, compared to 70% of other King County women. Similarly only 76% of the BCHP enrollees had a Pap test in the prior 3 years, compared to over 88% of other King County women. Short-term benefits have been realized for 15% of eligible women in the target population. All enrollees received assistance in applying for health insurance.

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[1] Centers for Disease Control. "The National Breast and Cervical Cancer Early Detection Program: At A Glance." 1998.
[2] Ibid, 3.
[3] *1999 Pulse Indicators*, University of Washington Health Policy Analysis Program, VITAL SIGNS of Washington's Health
[4] Ibid
[5] National Institutes of Health, National Cancer Institute. Surveillance, Epidemiology, and End Results (SEER) Program, 1988-1992.
[6] Seattle-King County Ethnicity and Health Survey, 1995-1996.
[7] Ibid.
[8] Fact Sheet: Breast & Cervical Cancer FY 98 Appropriations. American Public Health Association. 1997.
[9] Ibid.
[10] Seattle-King County Department of Public Health. "The Breast and Cervical Cancer Health Program in King County." April, 1998.
[11] The seven contracted agencies are: Center for Multi-Cultural Health, Yesler Terrace Clinic, Senior Services, Seattle Indian Health Board, Sea Mar Community Health Center, International Community Health Services, and Community Health Centers of King County. Other agencies involved include: Community Health Access Program, Seattle Lesbian Cancer Project, and YWCA Encore Plus.

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