Appendices

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Appendix A
Benefit Design Incentives

Benefit Design Incentives for System-wide Improvement

The Use of Demand Side (Consumer) Tools

As the cost of health care continues to escalate throughout this region and across the country purchasers of insurance are once again looking to increase the use of deductibles, co-pays, co-insurance and other consumer related incentives to control costs. Indeed, up until this time, these tools have been used primarily as cost sharing devices, not as part of an integrated strategy designed to provide economic incentives for consumers who make rational care decisions.

As noted by the leading report on health systems reform, consumer directed tools such as co-pays and co-insurance have been used as a kind of "blunt instrument" to promote cost sharing among all types of care including those types of interventions, such as disease management utilization, that we hope to encourage.[1] This is true, despite the fact that there is strong data to suggest that demand side incentives do play a significant role in affecting consumer utilization patterns.[2]

The time has come to reform the way in which these incentives are used.[3] The Task Force agrees that demand side approaches will play a critical role in the creation of a health system that is both affordable and efficient, but the true utility of demand side tools will be

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[1] Aon Consulting and OHSU Center for Evidence-based Policy, "Report to the PEBB Board - Strategic Planning 2003," 15 Jan 2004, p.17, "The problem is that the use of such incentives has been through broad and blunt benefit designs overlaid on poorly informed patients and providers. Cost sharing in general has not been use to incent quality. As a result such blunt tools result in poor discrimination of services; preventive services for important but asymptomatic diseases are more likely to be avoided while ineffective services for limited symptomatic diseases are preferred."

[2] Id. p. 3, "There is a surprising lack of interest in exploring choice strategies despite strong evidence that patients are willing to make choices based on cost and quality. Instead patients are currently presented with similar benefit plans provided by identical delivery systems. See also Kaisernetwork.org's synopsis of the 10 May 2004 New Yorker article where one recent study involving Connecticut-based Pitney Bowes corporation revealed that ... "by reducing asthma and diabetes co-insurance rates to 10%, Pitney cut annual median medical costs for diabetes patients by 12% and cut median costs for asthma patients by 15%. Within a year, Pitney was paying more for maintenance drugs, but "significantly less" for rescue medications."

[3] Robinson J, "Reinvention of Health Insurance in the Consumer Era," JAMA, (21 April 2004), discussing the health insurance industry's new strategy to … "shift emphasis from reducing health care costs on behalf of corporate purchasers to structuring health care choices by individual consumers."

found in their ability to provide economic incentives for consumers to make informed health care decisions based on the principles underlying the strategies outlined in this report.[4] Examples of such an approach might include lowering or waiving the co-payment requirements for all chronic care management visits, charging a high co-insurance fee for emergency room usage, but waiving such a fee if the consumer is actually admitted to the hospital for treatment, or charging no consumer fee at all for interactions with medical professionals via email.[5]

Perhaps the best example of this type of demand side strategy to influence care utilization can be found in the increasingly successful three tier approach to pharmaceutical drug programs. As recently reported by King County's human resource division establishing a co-payment system that first rewards the use of generic drugs over their more expensive brand name counter-parts; creates a higher co-pay for a class of brand named drugs that have been proven to provide a high level of value; and reserves the highest co-pay for those brand name drugs that are of questionable utility or present excessive costs has saved the county over $6 million dollars in its first year.

There is, of course, a very reasonable explanation as to why such a sophisticated, system-wide use of these tools has not been implemented across our region. As we have discussed throughout this report, it is impossible to have an integrated system-wide strategy when there is not yet a functional, transparent, patient centered system in place.

This point emphasizes the fundamental need to build the type of regional infrastructure necessary to support the use of these powerful economic levers. For example, it is not

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[4] Robinson J, "Renewed Emphasis On Consumer Cost Sharing in Health Insurance Benefit Design," Health Affairs (2002) p. 145 "Cost sharing creates financial disincentives for the use of cost-effective and clinically effective services as well as for their more discretionary fellow travelers. Some health plans are exempting particularly valuable services, such as preventive care, from deductibles and co-payments altogether, while varying the cost-sharing requirements for other services."

[5] Trude S and Grossman J, "Patient Cost-Sharing Innovations: Promises and Pitfalls," Issue Brief No. 75, "[i]n the past, potential cost savings depended on workers' annual choice of a health plan. Innovations in patient cost sharing, in contrast, emphasize choice at the point of service and do not require a year long commitment by the patient. Form many common decisions, such as choice of drugs, providers and some services, a patient could fist choose a lower-cost option but switch to the higher cost option if dissatisfied. For example, a patient might choose between a less costly X-ray and more expensive magnetic resonance imaging MRI for a joint problem."

possible to reward consumers of care for choosing high performing doctors unless we have a system validated by the medical community that is actually capable of evaluating doctors. In addition, consumers themselves must come to understand and accept the metrics that guide such a system, because, as we have seen with the decline of managed care in this country, without a grassroots understanding and approval of why certain care choices are made more expensive than others, consumers are likely to reject such a system entirely.[6]

Taken from another perspective, all the work that will be done to create a uniform system of performance measures, including developing a shared data system for regional claims analysis, will have little effect if those reforms are not acted upon by the consumers of care. By placing the right incentives to promote the delivery of the right care at the right time, those reforms will spring to life as each new patient rewards those members of the provider community who participate in the new standards-based approach. [7]

The Use of Supply Side (Provider) Tools

In addition to the consumer related strategies discussed above, the Task Force recommends that the provider community have access to a series of performance-based payment initiatives to support those types of care that have proven to provide positive health outcomes efficiently and effectively.[8] Unlike the system now in place which essentially rewards higher utilization, the Task Force recommends that plan designers create a system of payments that are structured to reward providers for doing such things as ordering appropriate screenings for high risk conditions, having in place a registry of information to

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[6] Grol R, "Improving the Quality of Medical Care, Building Bridges Among Professional Pride, Payer Profit and Patient Satisfaction," JAMA, 28 Nov 2001, includes a detailed discussion about the dynamics of patient empowerment See also Trude and Grossman noting the lack of transparency of pricing mechanis ms in the current health system as a significant impediment to adequate consumer participation.

[7] Cutler D, "Your Money or Your Life," (New York, Oxford University Press, 2004), p.101 provides a complete discussion of what a performance based system might look like.

[8] See PEBB p. 28 for a similar series of recommendations.

better track patient compliance with treatment protocols and achieving high levels of customer satisfaction on standard customer survey tools.

In addition to direct financial incentives, we recommend that the Partnership investigate a means of providing certain legal liability protections for providers that are in compliance with established evidence-based guidelines, and be given discounts on medical liability insurance if they maintain a certain performance level established by a neutral monitoring agency or organization.

It is critical to note that all of the provider based financial rewards should be directly linked with those financial incentives put in place to provide incentives for consumer behavior.[9] For example, if benefits design programs are to waive insurance deductibles for patients that make all of their scheduled appointments for the maintenance of a given chronic condition, those doctors that are responsible for scheduling and tending to those appointments should be given a similar bonus should the patient adhere to the schedule. Such a program of incentives could be made available to insurers as well. As noted by a leading health economist "[i]nsurers that had more patients who got recommended screening, better risk factor control, and good surgical outcomes would earn bonuses over those that did not." [10]

[9] Id. p. 5 "…patient and practitioner incentives will need to be aligned."

[10] See Cutler D, p. 101.

Appendix B
Employer-Sponsored Programs

Evidence-based Approaches for Employer-Sponsored Chronic Disease Prevention and Management Programs

As health care costs rise, employers are looking outside of the traditional cost management strategies that focus on the *supply* (*i.e.* the providers of care, the system of care. insurance, the resources used in health care, *etc.*) of health care, and are now increasingly focusing on managing the *demand* (*i.e.* the patient's need, their health care use behavior, the attitudes of users, *etc.*)for health care by improving morbidity patterns, health status and health care use behavior among employees and their family members.

The chart below lists examples of demand-side health cost management interventions[11]:

Framework for Demand-Side Health Cost Management Interventions	
Educational Interventions	***Plan Design Modifications***
Benefit Communications	Preventive medical benefits
Medical self-care	Plan structure and choice options
Consumer health education	Point–of-service cost sharing
Injury prevention	Error correction incentives
Advance directives	
	Individual Interventions
Wellness Incentives	Targeted at-risk intervention
Plan utilization incentives	High-risk intervention
Wellness achievement incentives	Condition management
	Disease management
	Selective user intervention

The intervention activities in demand-side health cost management are aimed at moving employees and family members with higher risks to lower risk, and keeping those at lower risk healthy. The expectation that prevention and disease management will result in

[11] Chapman L, "Health Cost Management Strategies for Health Promotion Programs," *The Art of Health Promotion,* Vol 5, Num 5 November/December 2001.

overall cost savings for employers stems directly from evidence that many leading causes of disability and premature death in the U.S. are potentially avoidable or controllable, including most injuries, and many serious acute and chronic conditions.

Chronic diseases – cardiovascular disease (primarily heart disease and stroke), cancer, chronic lung and respiratory diseases, and diabetes – are five of the six leading causes of death and disability in the United States, according to the National Center for Health Statistics in 2001. Over 45 percent of the U.S. population has at least one chronic condition, and 21 percent have two or more chronic conditions.[12] People with chronic conditions are the heaviest users of health care services in all major service categories, accounting for 78 percent of all health care dollars spent in the United States. In fact, the total medical expenditures for a person with a chronic condition are more than five times higher than for a healthy person.[13]

These data point to the need for individuals to play a more active role in their health. Many employers have implemented health promotion/wellness programs to help employees understand the importance of making lifestyle and health behavior changes. Traditionally, questions about hard dollar return on investment (ROI) have impeded the growth of these programs. This is changing for a number of reasons. First, empirical research demonstrating improved health, cost savings and a positive ROI is more readily available. Second, the health care cost epidemic has many experts recommending a shift from treatment-focused to preventive-focused care. Lastly, recent press coverage and government initiatives on issues such as tobacco cessation and obesity have focused public attention on these issues.

The United States Preventive Serves Task Force (USPSTF) has published the *Guides to Clinical Preventive Services,* an evidence-based review of the effectiveness of over 70 prevention options, including immunizations, preventive therapy, reducing behavioral risk factors, and screening for disease.[14] The table below, extracted by the Alliance for Reducing Cancer Northwest from the USPST report, summarizes 17 clinical preventive

[12] Wu S-Y, and Green A, "Projection of Chronic Illness Prevalence and Cost Inflation," RAND Corporation, October 2000.
[13] Data from "Medical Expenditure Panel Survey," 1998.

services aimed at reducing chronic disease. Of these, ten are effective services that doctors or other healthcare workers should provide. This table also shows that healthy diet and physical activity are important but best dealt with outside the healthcare system.[15]

Recommendations for Clinical Preventive Services Aimed at Reducing Chronic Disease		
Preventive Service	***Age***	***Recommended?***
Immunizations:		
Influenza	6-23 mos, >50 yrs	Yes
Pneumoccocal	>65 yrs	Yes
Preventive therapy:		
Aspirin, low-dose	Any, if at heart disease	Yes
Reducing Behavioral Risk Factors:		
Stopping smoking	Any	Yes
Counseling to stop smoking	>21 yrs	Yes
Medications to stop smoking	>21 yrs	Yes
Eat healthy diet (low saturated fat, high fruits and vegetables)	Any	Yes, but patient-driven
Counseling for health diet		Insufficient evidence
Physical activity	Any	Yes, but patient-driven
Counseling for physical activity		Insufficient evidence
Screening for disease:		
Breast cancer (mammogram)	>40 yrs.	Yes
Cervical cancer (Pap smear)	>21 yrs	Yes
Cholesterol	Men >35 yrs Women >yrs	Yes
Colorectal cancer (colonoscopy, flexible sigmoidoscopy, fecal occult blood test)	>50 yrs	Yes
Diabetes		Insufficient evidence
High blood pressure	>50 yrs	Yes
Prostate cancer (prostate-specific antigen)		Insufficient evidence

[14] United States Preventive Task Force, 2003.
[15] Harris J, Kulner J, Pellegrini A, "Chronic Disease Prevention Opportunities at Weyerhaeuser," August, 2003.

Source: United States Preventive Services Task force, 2003 *Note: "insufficient evidence" indicates there is not enough or consistent enough information to recommend for or against a preventive service.*

The Partnership for Prevention, a national non-profit organization serving employers, has ranked over 50 effective clinical preventive services in terms of overall health impact and relative cost effectiveness. Of this list, the top three high impact, high value clinical preventive services aimed at preventing chronic disease that are cost-saving or cost-neutral and offer payback in fewer than five years are: counseling and medications to stop smoking, influenza immunization, and pneumococcal immunization.

The Task Force on Community Preventive Services, 2003 report has also developed a list of recommended preventive services relevant to employers in the areas of diabetes, immunizations, physical activity, sun exposure and tobacco. There are 18 recommended preventive services. Of these, six are cost-saving or cost-neutral; the rest have no data available on cost-effectiveness. Not shown is information on what has not been proven to work. The most remarkable negative finding is that education alone has rarely been shown to reduce risk behaviors or increase the use of clinical preventive services.[16]

[16] Harris J, et al, Conclusion of authors of "Chronic Disease Prevention Opportunities at Weyerhaeuser"

Effective Work - Place Relevant Preventive Services Aimed at Reducing Chronic Disease	
Preventive Service	***Cost-Saving/Neutral?***
Diabetes	
Case management – focused on individuals with diabetes	--
Disease management – focused on populations with diabetes	Yes (prenatal)
Self-management education in communities, for type 2	--
Self-management education at home, for type 1	--
Immunizations	
Co-pays/deductibles reduced or eliminated	--
Measurement/accountability systems fed back to providers	--
Programs that educate and expend access (hours, locations, *etc.*)	--
Reminder systems for patients, providers	--
Standing orders to make automatic	--
Physical activity	
Facilities, easy to access, with information outreach	Yes
Group programs, such as walking groups	Yes
Individualized-goal group programs, such a *Active for Life*	Yes
Stair-use reminders	--
Sun exposure	
Education and policy (hats, sunglasses, sunscreen) in recreational settings	--
Tobacco	
Co-pays/deductibles for cessation treatment reduced or eliminated	--
Reminder systems for providers	--
Restrictions/bans (prevent secondhand smoke exposure)	Yes
Telephone counseling	Yes

Source: Task Force on Community Preventive Services, 2003

Employer-sponsored health promotion and disease management programs

Worksite wellness and chronic disease control programs are most effective when they focus on a limited set of risk-reducing behaviors and clinical preventive services; this helps to avoid employee confusion and leverages the greatest return from the programs. The data from the studies listed above indicate that tobacco cessation, increased physical activity, and eating to maintain or decrease current weight are productive areas for employers to develop health promotion programs. Diabetes, cardiovascular disease, cancer, and asthma are excellent targets for workplace-based disease management programs.

There are many examples of successful health promotion and disease management programs. The following are some specific examples of employer-based programs.

Tobacco Cessation:

Tobacco use is one of the leading causes of death and disability in the U.S., and tobacco cessation programs are common in employer-sponsored wellness efforts. The *U.S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence*, published in June, 2000 summarizes thousands of studies on all aspects of tobacco cessation and recommends the following elements be included for an effective program:

- Physician advice to quit;
- Counseling by qualified cessation specialists in one of the following forms – telephone, face to face, or groups; and
- Pharmacotherapy in one of the following forms—nicotine gum, patch, inhaler, nasal spray, or bupropion (Zyban®).

The guideline's summaries show that the success rate for quitting "cold turkey" is only about 5 percent. Adding the elements listed above increases the long-term quit rate to 15-

30 percent, three to six times the "cold turkey" quit rate. Here are results of four tobacco cessation programs:

1. ***The Carpenters Health and Welfare Trust of Western Washington***[17]*:* This was a carefully designed study on the costs and benefits of tobacco cessation involving 325 participants who had been on the program for at least 12 months. At one year after registration, 27.5 percent were not smoking. The pilot program costs were 6¢ per hour of contributions (about $11 per full-time employee per year). Ninety-four percent of the participants were highly satisfied. The estimated savings due to reduced use of health care to treat tobacco-related illness are estimates to be worth 15 times the program's cost, for an annual return on investment of over 27 percent. During the first two years of the program, 12.6 percent of all smokers enrolled.

2. ***The Uniform Medical Plan***[18]*:* The UMP is a self-insured preferred provider health insurance plan offered by the Health Care Authority that is available to 90,000 Washington State employees, both active and retired, and their dependents. Beginning in January 2000, UMP implemented a telephone-based tobacco cessation program. A total of 1,334 UMP members enrolled in the program between January 2000 and December 2002. In the second year of the program, UMP and its program provider evaluated the impact of the $17.50 program registration co-payment and standard pharmacotherapy co-insurance on program participation by suspending the co-payment and co-insurance for all plan members enrolling from November 1 – December 31, 2001.

   Suspending the co-payment and pharmacotherapy co-insurance appeared to have a strong, positive influence on program enrollment. Participation in November and December of 2001 soared to 341 and 270 respectively, compared with enrollments of 31 and 20 for November and December of 2000. The co-payment was reinstated starting January 1, 2002 and enrollments dropped from 270 in Decembers 2001 to

[17] McAfee T, Montanari D, Tifft S, and Zbikowski S, "Preventing Premature Death: Tobaccos Treatment Services for Employees," Employee Benefits Journal, March, 2004.
[18] Ibid

only 23 one month later. These results were replicated when similar promotions were offered in 2002 and 2003.

3. ***Group Health Cooperative***[19] has compared four different tobacco cessation program designs ranging from 50 percent cost sharing for both medication and phone counseling to 100 percent health plan coverage (with usual pharmacy co-pays.) The study found that the most effective design for successfully getting the largest numbers of smokers to quit was 100 percent health plan coverage for this benefit. With 100 percent coverage and telephone delivery of counseling, levels of participation as high a 12 percent of employees were reached.

4. ***Weyerhaeuser***[20]***:*** In August, 2003, a team of experts from the University of Washington Health Promotion Research Center and the American Cancer Society reviewed the health promotion and disease management programs for employees and family members at Weyerhaeuser. The team made recommendations for Weyerhaeuser's tobacco cessation program that incorporate the same kinds of findings noted above:

    - Add health insurance coverage for the full range of effective tobacco cessation treatments – clinical counseling and over-the-counter nicotine replacement medications to reduce the number of employees who use tobacco.

    - Remover co-pays and deductibles for effective and cost-effective preventive services to increase their use.

    - Contract with health insurance companies to build measurement/accountability systems with feedback to providers.

    - Contract with health insurance companies to build reminder systems for both patients and providers.

[19] Ibid
[20] Harris J, et al, August 2003.

- Contract with health insurance companies to implement standing orders that make delivery of appropriate services the automatic default wherever care is delivered.

- Contract with a quit-line vendor to provide telephone-based tobacco cessation services to increase cessation options for tobacco users.

- Ban or restrict smoking at all worksites to protect non-smoking employees and reduce fire risk and legal liability.

The report notes that these options differ in their complexity and will require considerable work, dialogue, and time to implement. The report notes, however, that the evidence of effectiveness of each is compelling. Some may be best achieved by purchasing add on services from vendors outside of their insurance carriers.

Based on case studies like these, The Center for Health Promotion[21] recommends that employer-sponsored tobacco cessation programs include the following:

1. Obtain leadership agreement that helping employees quit smoking is good for business. Benefits design should be guided by an objective to encourage a significant fraction of employees who smoke to take advantage of the benefit.

2. No financial barriers – No co-pays higher than for the rest of the plan.

3. Easy access to benefit – If the program can be accessed through a workplace benefit, employees will enroll and will use the program, and many will succeed with quitting smoking.

4. Telephonic counseling that is convenient and does not detract from work time. On-site groups can also conveniently reach some people, however community programs are very unlikely to be used by more than a tiny fraction of employees.

[21] McAfee T, et al, March, 2004.

5. Cover counseling and pharmacotherapy in the benefits – Encourage the use of both.

6. Market and promote the cessation benefit internally – The employer must be committed to marketing the benefit to its employees to ensure understanding of the benefits and its merits.

7. Benefit use tends to also improve with the adoption of a smoke-free workplace policy.

Obesity:

The Centers for Disease Control and Prevention now list overweight and obesity as a health crisis second only to tobacco use. According to the CDC, 64.5 percent of adult Americans are overweight or obese, resulting in annual costs of $117 billion.

Employer-based programs can effectively reduce employee's weight – and employers' costs. The Health and Human Services 2003 report, *Prevention Makes Common "Cents,"* cites unnamed health promotion and disease management prevention programs that "return a median of $3.14 for every dollar spent." The National Business Group on Health toolkit *Best Practices and Strategies for Weight Management: A Toolkit for Large Employers* lists companies and suppliers that seem to have winning formulas.

Other experts warn, however, that trying to make obese people thinner is a losing battle. These experts suggest that supporting efforts to help thinner people stay within acceptable weight ranges and keeping overweight and obese people from gaining even more is a better investment. Glenn Gaesser, professor of exercise physiology at the University of Virginia and author of *Big Fat Lies: The Truth about Your Weight and Your Health* (Gurze, 2000) argues that the health problem is not the obesity *per se*, but lifestyle.

Gaesser contends that people who have BMIs over 30 who cut out junk food and start exercising – 30 minutes a day, five days a week – will "… improve their health in a matter of days, even if they don't lose weight." Gaesser also contends that lean people who fail to

exercise and eat right are getting a false sense of security when they look at their BMI. Lifestyle and fitness, says Gaesser, are more powerful predictors of risk than weight.

Gaesser's contention about the value of increased exercise has been borne out in a study by Feifie Wang and colleagues at the University of Michigan reported in the May, 2004 Journal of Occupational and Environmental Medicine. Wang studied 23,500 workers at General Motors, where he estimated that getting the most sedentary obese workers to exercise would save about $790,000 a year, or about 1.5 percent of health care costs for the whole group. This would translate to $7.1 million per year across the whole GM workforce.

Of the whole group of workers studied, about 30 percent were of normal weight, 45 percent were overweight, and 25 percent were obese. Annual health care costs averaged $2,200 for normal weight, $2,400 for the overweight, and $2,700 for obese employees. Among workers who did no exercise, health care costs went up by at least $100 a year, and were $3,000 a year for obese workers who were sedentary.

Wang found that adding two or more days of light exercise – at least 20 minutes of exercise hard enough to increase heart rate and breathing – lowered costs on average $500 per employee per year. The study authors concluded, "This indicates that physical activity behavior could offset at least some of the adverse effects of excess body fat, and in consequence, help moderate the escalating health-care costs."

Employers choosing to target obesity directly in the health promotion and disease management programs will need to think through their approach carefully.

> ***Weyerhaeuser***[22]*:* The team studying Weyerhaeuser's health promotion programs noted that Weyerhaeuser is an exceptional employer in that they already provide on-site gyms, bicycles and other physical activity facilities, and they sponsor two programs, *Active for Life* to promote physical activity and participation in the

[22] Harris, et al, August 2003.

American Cancer Society's *Relay for Life* programs. However, the team suggested the following additions to Weyerhaeuser's current programs:

1. Build sidewalks and walking trails, or identify walking routs at worksites, to encourage and enable employees to increase their level of physical activity.

2. Install stair-use reminders at worksites, particularly those with elevators, to encourage employees to increase physical activity.

Ten Low-Cost Ways Employers Can Address Obesity

1. Offer voluntary heath risk appraisals through health plans and health professionals to obtain base line data.
2. Requires vendors to include health food choices in cafeterias and vending machines.
3. Provide nutrition information for cafeteria selections.
4. Offer on-site classes related to nutrition and exercise.
5. Offer "Weight Watchers at Work" or other special targeted programs to support employees.
6. Create safe walking paths and encourage the use of stairs in lieu of elevators.
7. Distribute health education materials.
8. Sponsor "lunch and learnt" sessions on fitness, healthy lifestyles, stress management and other weight-related "triggers."
9. Consider an allowance for health clubs.
10. Support community-based weight management programs and fitness resources, such as biking paths, heart-healthy dishes in restaurants and events.

Source: National Business Group on Health

Diabetes and Asthma:

Pitney Bowes[23] has recently released data from its disease management programs for diabetes and asthma that reinforce the point about making sure that all parts of an employer's health care strategy are well integrated. Three years ago Pitney Bowes moved from fixed co-pays in its prescription drug plan to co-insurance rates of 10 percent for generics, 30 percent for preferred brand and 50 percent for non-preferred brand drugs or drugs that have a cheaper generic alternative.

This strategy significantly reduced Pitney Bowes prescription cost trend. For example, in 2002 Pitney Bowes' drug costs rose 12 percent, lower than the national average of 16 percent. In 2003 Pitney Bowes experienced an 11 percent cost trend, compared with a 15 percent national average. Pitney Bowes' experience is in line with a 2002 Rand Corp study in the late 1990s that found that doubling co-pays in a single-tiered plan – from $5 to $10 – caused the annual average drug cost per worker to fall 22 percent to $563.

However, a recent study by Haiden Huskamp and other researchers at Harvard Medical School and Medco Health Solutions Inc found that patients may stop taking necessary medications if faced with a steep co-pay. Pitney Bowes was ahead of that study however; several years ago they conducted a predictive modeling study that determined that their co-pay structure was discouraging appropriate and cost-effective use of prescription drugs by people with chronic asthma and diabetes. Based on the study Pitney Bowes reduced the all asthma and diabetes co-insurance rates to 10 percent. Implementing this change in plan cost $1 million. By late 2002 they were seeing a higher rate of prescription drug refills and a shift to more expensive, but often more convenient, combination drugs.

At the same time the drug costs were going up for people with asthma and diabetes, the company was spending significantly less on rescue medications for these two conditions. This change more than made up the $1 million annual investment the company made in the plan. Cost analysis conducted earlier this year shows that the lower co-pay led not only to better health, but also a 10 percent annual reduction in overall drug spending for diabetes and asthma patients. This reduction in drug costs contrasts with an 11 percent increase for the rest of Pitney Bowes' population.

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[23] *The Wall Street Journal*, May 10, 2004.

Other Workplace-based Health Promotion Opportunities

The team studying Weyerhaeuser's health promotion programs had several other recommendations that other employers may also want to consider[24]:

1. Require use of sun-protection equipment (wide-brimmed hats, sunglasses, sunscreen) by all out-door workers to decrease employee risk of skin cancers and cataracts.

2. Deliver select clinical preventive services (flu shots, pneumococcal immunization, and other) at the worksite to both active and retired employees to reduce risk for contracting diseases.

3. Offer chronic disease management programs to educate affected employees on self-care of their diseases.

4. Implement a system to monitor (at the total group level, not the individual employee level) employees' risk behaviors and use of clinical preventive services to evaluated effectiveness of the prevention investment.

Bridges to Excellence

The Bridges to Excellence[25] is the nation's largest employer-sponsored effort to reward physicians for delivering high-quality care. The coalition is a not-for-profit organization created to encourage significant leaps in quality of care by recognizing and rewarding health care providers who demonstrate that they deliver safe, timely, effective, efficient and patient-centered care. Bridges to Excellence participants include large employers, health plans, the National Committee for Quality Assurance, MEDSTAT, and WebMD, among others. The organizations are united in their shared goal of improving health care quality through measurement, reporting, rewards and education.

Bridges to Excellence has three programs in all:

1. ***Physician Office Link*** enables physician office sites to qualify for bonuses based on their implementation of specific processes to reduce error and increase quality. They can earn up to $50 per year for each patient covered by a participating employer or plan. In addition, a report card for each physician office describes its performance on the program measures and is made available to the public.

2. ***Diabetes Care Link*** enables physicians to achieve one-year or three-year recognition for high performance on diabetes care. Qualifying physicians receive an $80 bonus for each diabetic patient covered by a participating employer or plan. In addition, the program offers a suite of products and tools to help diabetics get in their care, achieve better outcomes, and identify local physicians that meet the high performance measures. The cost to employers is no more than $175 per diabetic patient per year with savings of $350 per patient per year.

3. ***Cardiac Care Link*** enables physicians to achieve three-year recognition for high performance in cardiac care. Qualifying physicians are eligible to receive up to $160 for each cardiac patient covered by a participating employer or plan. In addition, the program offers a suite of products and tools to help cardiac patients get engaged in their care, achieve better outcomes and identify local physicians who meet the high performance measures. The cost to employers is no more than $200 per cardiac patient per year with savings up to $390 per patient per year.

Calculating ROI for Disease Management and Health Promotion Programs[26]

The size, demographics and health claims data for an employee population are important factors in determining the appropriateness of a particular health promotion or disease

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[24] Harris J, et at, August, 2003
[25] www.bridgestoexcellence.org
[26] See discussion of "Return on Investment (ROI) in Disease Management," In Focus, Fourth Quarter 2003.

management program. ROI measurements are dependent on a number of variables. There are two major pitfalls in calculating an accurate ROI – regression to the mean and selection bias. Regression to the mean refers to the tendency of high-cost/high utilization patients (outliers) in one plan year to incur closer to average costs in the following plan year regardless of disease management initiatives.

For example, a patient might have high expenses one year due to a surgery, and the next year participates in a disease management program. The lower expenses in the second year might be credited to the disease management program when in reality costs would have likely fallen (regressed to the mean) without the disease management intervention.

Selection bias refers to measuring costs and outcomes for disease management participants only, excluding those not enrolled in the program who have the same chronic conditions. The cost savings are inflated because the participants are more inclined to improve their health than non-participants. ROI can also be inflated in disease management programs that only enroll the highest risk/sickest individuals.

The most reliable way to determine the effectiveness of a disease management program is to track claims data for all plan participants with a particular condition and compare any changes in claims costs with any change in claims cost for all plan members. The next level analysis involves isolating a group with a particular chronic condition and comparing the costs of those people utilizing the disease management program with those not participating.

There is no reliable way to estimate the outcomes program participants would have had if they had not participated. In the final analysis, determining ROI means looking at total health care costs for years *prior* to implementation of a disease management program, versus total health care costs for plan years *after* implementation of the program.

Most often employers will use ROI to measure the financial impact of a disease management program; however ROI does not tell the whole story. Net or absolute, savings provide a more bottom-line assessment of the value of a disease management

program. As illustrated below, the program with the largest ROI does not necessarily result in the greatest net savings.

Return on investment (ROI) versus absolute savings.

By looking at ROI, one would choose to implement program 2, but the program that offers the greatest savings is actually program 4.

Program #	ROI	Gross Savings	Program Cost	Net Savings
1	1.39	$800,000	$600,000	$200,000
2	2.0	$800,000	$400,000	$400,000
3	1.5	$2,100,000	$1,400,000	$700,000
4	1.2	$6,000,000	$5,000,000	$1,000,000
Source: American Healthways, *Calculating Return on Investment, 1999*				

Using claims data to identify potential disease management candidates has some problems. First, claims data does not identify high-cost users early on. A truly predictive model would detect patients prior to the start of high costs. Second, medical claims data is often miscoded. To get around this problem requires an actual review of patient charts to identify potential disease management participants.

The long term cost effectiveness of disease management programs has not been determined. Most studies capture only one to two years of data. Even so, disease management programs have the potential for significant cost savings, but only plan sponsors with patience and perspective will realize the long-term benefits. Employers with high employee turnover may not be the best candidates for disease management programs. There are up-front costs to establish data management systems and increased health care utilization because prevention includes increased use of prescription drugs, laboratory tests and physician visits. Short term ROI for most disease conditions (except, perhaps, high risk pregnancies, diabetes and asthma) will be minimal.

Finally, enrolling sufficient numbers of employees in disease management programs will be an on-going challenge. Extensive communication and education efforts are essential, and using financial incentives, such a waiving the co-pays for prescription drugs, may

increase participation and encourage compliance. Automatic enrollment based on claims data also substantially increases participation rates over self enrollment.

Attracting and Retaining Participants in Health Promotion and Disease Management Programs

In order to gain maximum ROI for health and disease management programs it is essential to get employees and their family members to participate. William Atkinson[27] has developed the following check list of ways to attract and retain participants in disease management and health promotion programs based on a series of interviews with executives at health plans and organizations involved in disease management programs:

1. Identify the population accurately. Augment claims data with information from case managers and providers.

2. Make sure employees know about the program and what it can do for them. Publicize the program before it is launched.

3. Present the larger picture, too. Talk about both improving the employee's health and well-being and saving everyone money on health care costs.

4. Reassure employees about how their information will be used. It is essential that employees trust that their data will be kept confidential and will not be used to discriminate against them.

5. Explain that the disease management program is not redundant. Make sure employees understand that the program is not a duplication on what their personal physician is doing but rather a complement to it.

6. Enlist providers and other consumers to spread the message.

7. Be sensitive to people's readiness for change. All stages of readiness (from denial to eager to be involved) and all points on the disease continuum (from recent

diagnosis to long time adaptation) must be taken into account when approaching candidates for a disease management program.

8. Remember the importance of timing. One good time to reach patients is when they have just been released from the hospital.

9. Don't tell people what to do. Encourage members to stop smoking, start exercising, and take medication more consistently, rather than telling them.

10. Make it convenient. Onsite programs and classes, Internet resources and other easy to access program elements encourage participation.

11. Create a variety of ways to interact with the program. No one size fits all – make available telephone intervention, personal visits, Internet messaging, voice automated technology, and information in the mail.

12. Offer incentives. Reduce employee portions of costs for health services, add more money to the employee's health reimbursement account or provide other incentives.

13. Train nurses for the first contact. Programs that include nurse help lines should train nurses to convey the right information, provide encouragement and follow up.

14. Encourage participants to set personal goals. People are not motivated by what may happen 20 years from now. They need something that will make them feel better in the near term.

15. Establish on-going communication. Keep the communications coming even after the early adopters are on board.

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[27] Atkison W, "Attracting and Retaining Participants: A Checklist," Healthplan Magazine, Nov/Dec 2003 pp 44-45.

Appendix C

Prescription Drug Costs, Issues, Strategies

Prescription Drug Trends, Issues and Possible Strategies
Follow-Up Discussion

By Andy Stergachis, Ph.D., R.Ph., Professor of Epidemiology and Affiliate Professor of Pharmacy, University of Washington. stergach@u.washington.edu

A. Key Findings

1. The use of and spending for prescription drugs is rising with over 3 billion prescriptions dispensed and $140 billion spent on drugs in the U.S. in 2001. Prescription drug spending is now about 11% of personal health care spending - one of the fastest growing components. Growth in prescription drug spending has been in the double-digits in each of the past 7 years.

2. The payment sources for prescription drugs have shifted from consumer out-of-pocket to employer-based private health insurance. The latter now accounts for about half of all prescriptions dispensed in the U.S.

3. Three main factors are driving the increases in drug spending:[28]

    a. Increases in the number of prescriptions used accounts for 47% of the overall increase. At present, overall drug use in the U.S. is approximately 11.6 prescriptions per person per year.

    b. Changes in types of drugs used with newer, higher priced drugs added or replacing older, less-expensive drugs. This accounts for 27% of the overall increase. This is influenced by research and development, the FDA approval process and direct-to-consumer (DTC) advertising.

    c. Drug manufacturers' price increases for existing drugs accounts for 26% of the increase. According to IMS Health, retail prescription prices increased an average of 7.3% a year from 1992-2002, or double the average inflation rate.

4. A preliminary analysis of drug utilization for King County (KC) employees was performed using summary, aggregated data obtained from AdvancePCS (the pharmacy benefits manager for 77% of KC employees) and Group Health Cooperative (GHC). Results showed markedly different utilization patterns in the top 50 drugs between plans, with a greater use of generic drugs and a lower cost per prescription for KC employees who are members of GHC.

[28] Prescription Drug Trends. Kaiser Family Foundation: Melno Park, CA, May 2003. www.kff.org.

B. Proposed Strategies

1. Expanded use of Drug Formularies

At the center of most pharmacy benefits programs is the drug formulary system, although plans vary in their degree of restrictiveness or control of the drug formulary. A drug formulary is a continually updated list of prescription drugs which represent the current clinical judgment of providers and experts in the diagnosis and treatment of disease. Recall, an important cause of rising expenditures on drugs is the shift in mix of drugs prescribed – where more expensive drugs are being prescribed in place of less expensive older medications. Preferred drug lists, such as the Washington State Evidence-based preferred drug list, www.rx.wa.gov, are related programs intended to promoting the prescribing of preferred drugs. A regional approach to the use of formularies and/or preferred drug lists should be explored.

2. Maximize the Use of Generic Drugs.

Generic drugs play an important role in slowing the rate of cost increases for prescription drugs. Looking ahead, no fewer than 40 key drugs (worth more than $40 billion per year) are projected to lose patent protection by 2007. One PBM (Express Scripts) estimates a savings of 1.2% in plan drug costs for every 1% increase in generic dispensing rate. Key findings from the preliminary analysis of KC data indicate that the use of generics varies between plans for KC employees and their dependents, with GHC demonstrating a greater use of generic drugs. Coalitions have formed in other parts of the country to promote generic drugs (e.g., California, Michigan). Our region should consider a coalition approach to promoting the use of generic drugs.

3. Tiered Patient Cost-Sharing Programs where consumers pay less out-of-pocket for less expensive drugs.

Tiered prescription plans incentivize consumers to choose lower-cost products by offering different cost-sharing formulas based on formulary status and whether the product is a generic or a brand-name drug. Cost sharing increases patient awareness and accountability for the cost of pharmaceuticals. There is evidence that cost-sharing reduces total plan expenditures on pharmaceuticals through shifting some of that cost onto the consumer and reduces the amount of "unnecessary" use of prescription medications (e.g., Harris et al, 1990). As part of the drug formulary provision, plans often implement incentives (or restrictions) for members to utilize mail-service pharmacies and specialty pharmacies, where appropriate. Tiered co-payments are presently used by KC employees.

4. Promote the Use of Evidence-Based Medication Therapy and Drug Utilization Management Services

Medication therapy management (MTM) is considered to be a patient-specific and individualized service or set of services provided usually by a pharmacist directly to the patient or caregiver. The patient specific nature of MTM is complementary to, but different from, population-focused quality assurance measures for medication use, such as drug utilization management and generalized patient education and information activities. These services are designed to help ensure that the goals of drug therapy are met and may include monitoring and promoting adherence/persistency with medication regimens, reductions in unnecessary polypharmacy, and monitoring for adverse effects of medications. There is evidence on the effectiveness (e.g., http://www.ahrq.gov/clinic/pharmimp, http://www.guild.org.au/public/researchdocs/reportvalueservices.pdf) and models exist for providing pharmaceutical services to persons with chronic diseases involving the employer and provider community (e.g., The Asheville Project).

5. Patient/Employee and Provider Education and Incentive Programs

Patient/employee education can take many forms, including access to tools to view out-of-pocket costs for drugs, Web sites, newsletters, etc. Physician and other provider education programs could, for example, promote the use of generic drugs, present appropriate evidence-based practice guidelines, and provide provider-specific prescribing profiles. Such efforts should utilize best practices, in terms of interventions (e.g., academic detailing) and technology (e.g., electronic prescribing and real-time notifications).

C. Postscript

While the above strategies have been shown to manage drug costs, some carry risks of creating unintended potential consequences, such as prescribing of less desirable substitutes and/or cost-shifting into other health care services, or onto the consumer. Thus, it is important that prescription drug management efforts are consistent with good clinical practice. Prescription drug importation from Canada or other foreign countries is not a recommended strategy as it is unlawful and carries potential health safety risks, in the absence of safety certifications. However, several of the above strategies are based on policies in use in Canada.

Appendix D
Government Role in Improving Regional Health

Improving Health in our Region

The Task Force carried out its work against a backdrop of significant health status issues that face the population throughout the Puget Sound region. While improving the quality of health care that people seek and receive is critical, it is also imperative that broader preventive approaches expand to address some of the underlying causes of the health problems the population is experiencing.

Public health plays a lead role in designing, implementing and evaluating preventive methods for improving people's health. The governmental mandate for public health entities offers a platform from which to address health issues from a community or population basis. This role complements the role the health care system plays as it provides care to individual patients. Public Health has the ability and the role of bringing together a broad range of public and private partner organizations and agencies to work to prevent chronic diseases, craft injury prevention programs, and provide surveillance for disease outbreaks and prevention or mitigation strategies.

In order to improve the region's health, Public Health and local health care professionals must work together to address a number of critical issues. For example, the current obesity epidemic offers and excellent opportunity for the local health care delivery systems to interface with Public health to achieve sustainable improvements in health. Public Health can develop health education materials and community resources for the residents of the region to access with regard to health eating and active lifestyle. Health care delivery systems and worksite health programs can use these materials and refer people to community resources for physical activity or nutrition classes. The proposed regional partnership must have a strong linkage to the Public Health system in order to ensure effective interactions for the population with both individual providers and the resources available within local communities. Public Health strategies may also be applicable to the worksite, and the Task Force recommends that coordination of worksite, public health, and health care delivery strategies be coordinates whenever it makes sense. A publicly funded smoking cessation program, for example, might be something to which a worksite health program would refer employees.

Government has a critical role to play in promoting and improving the health of communities.

Public Health, and other governmental agencies work together to ensure that interventions for health are coordinated. In King County, for example, a study to understand and identify how travel patterns, health and overall quality of life are impacted by specific land use and transportation decisions is being sponsored by the Departments of Transportation, Development and Environmental Services, and Public Health – Seattle and King County. King County's Land Use, Transportation, Air Quality and Health Advisory Committee serves to integrate this varied expertise into land use, transportation and health policy to improve health.

The role of government is key in leveraging resources to improve the overall health of the region's residents. This contribution, if effectively leveraged, has the potential to decrease the actuarial risk for those who are funding health care benefits, and to help hold down costs for individuals seeking care. Public messages and advice about maintaining healthy eating habits and active lifestyles, and preventing disease and injuries can echo throughout worksites, health care facilities and community meeting places, thereby complementing the advice offered by individual health care professionals. The partnership model recommendations include the interaction of Public Health and other governmental strategies for chronic disease prevention and health improvement with the overall strategies for cost and quality performance improvement.

Appendix E
Matrix

	Evidenced Based Clinical Decision Support Available?	Improved Quality Leads to Decreased Costs? (ST/LT)	Improved Quality Leads to Increased Health?	Evidence of Unnecessary Resource Variation?	Evidence of Unnecessary of Quality Variation?	Consumer Involvement in Care Leads to Decreased Costs?	Consumer Involvement in Care Leads to Improved Health?	Proven Preventive Strategies Lead to Decreased Costs (LT)?	Improved Quality Leads to Increased Workplace Productivity?	Healthy Lifestyle Impacts Cost?	Healthy Lifestyle Reduces Disease Impacts?
Area 1: Chronic Disease Management											
Coronary Artery Disease	Yes	Yes (ST/LT)	Yes	Yes	Yes	Yes (LT)	Yes	Yes	Yes	Yes (ST/LT)	Yes (LT)
Pediatric Asthma	Yes	Yes (ST/LT)	Yes	Yes	Yes	Yes (ST/LT)	Yes	Yes (LT)	Yes	Yes (ST/LT)	Yes
Diabetes	Yes	Yes (ST/LT)	Yes	Yes	Yes	Yes (ST/LT)	Yes	Yes	Yes	Yes (ST/LT)	Yes
Depression and Anxiety	Yes	Yes (LT)	Yes	Yes	Yes	TBD	Yes	TBD	Yes	TBD	TBD
Hypertension	Yes	Yes (LT)	Yes	Yes	Yes	Yes	Yes	Yes	TBD	Yes	Yes
Congestive Heart Failure	Yes	Yes (ST/LT)	Yes	Yes	Yes	Yes	Yes	Yes	TBD	TBD	Yes
Area 2: Acute and Episodic Care											
Low Back Pain	Yes	Yes (ST/LT)	Yes	Yes	Yes	Yes	Yes	TBD	Yes	Yes	Yes
Maternity Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	TBD	TBD	Yes	Yes
Digestive Disorders (TBD)											
Musculoskeletal Disorders (TBD)											
Breast Cancer / Colorectal Cancer (TBD)											
Procedure Rates:											
Myringotomy	Yes	Yes (ST)		Yes	TBD						
Tonsillectomy	Yes	Yes		Yes	TBD						

	Evidenced Based Clinical Decision Support Available?	Improved Quality Leads to Decreased Costs? (ST/LT)	Improved Quality Leads to Increased Health?	Evidence of Unnecessary Resource Variation?	Evidence of Unnecessary of Quality Variation?	Consumer Involvement in Care Leads to Decreased Costs?	Consumer Involvement in Care Leads to Improved Health?	Proven Preventive Strategies Lead to Decreased Costs (LT)?	Improved Quality Leads to Increased Workplace Productivity?	Healthy Lifestyle Impacts Cost?	Healthy Lifestyle Reduces Disease Impacts?
		(ST)									
Cholecystectomy	Yes	Yes (ST)		Yes	TBD						
Laminectomy	Yes	Yes (ST)		Yes	TBD			Yes		Yes	
Cardiac Catheterizations	Yes	Yes (ST)		Yes	Yes			Yes		Yes	
Coronary Artery Bypass Grafts (CABG)	Yes	Yes (ST)		Yes	Yes			Yes		Yes	
Angioplasty	Yes	Yes (ST)		Yes	Yes						
Prostatectomy		Yes (ST)		Yes	TBD						
C-Section	Yes	Yes (ST/LT)		Yes	Yes						
Pharmaceutical Prescribing Profiles	Yes	Yes (ST/LT)	Yes	Yes	Yes	Yes	Yes			Yes	
Area 3: Preventive Services											
Childhood Immunizations	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Smoking Cessation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Mammograms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Cervical Cancer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Pneumococcal Vaccine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Chlamydia Screen	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Healthy Weight	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			

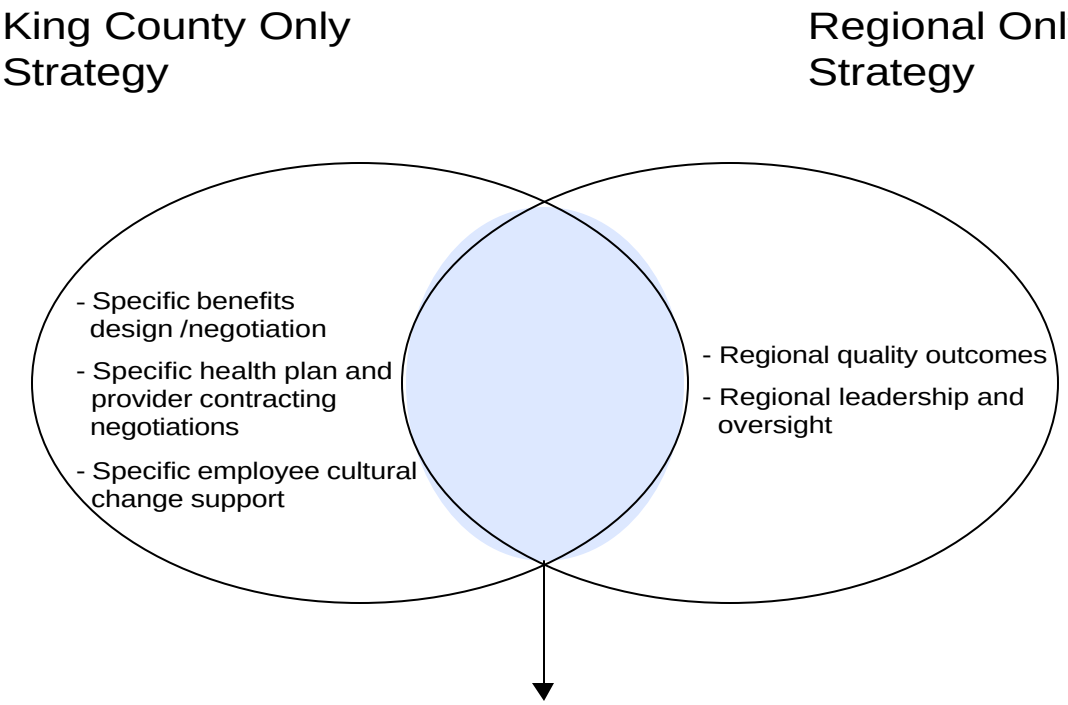
	Evidenced Based Clinical Decision Support Available?	Improved Quality Leads to Decreased Costs? (ST/LT)	Improved Quality Leads to Increased Health?	Evidence of Unnecessary Resource Variation?	Evidence of Unnecessary of Quality Variation?	Consumer Involvement in Care Leads to Decreased Costs?	Consumer Involvement in Care Leads to Improved Health?	Proven Preventive Strategies Lead to Decreased Costs (LT)?	Improved Quality Leads to Increased Workplace Productivity?	Healthy Lifestyle Impacts Cost?	Healthy Lifestyle Reduces Disease Impacts?
Area 4: Safety Practices											
Medication Errors	Yes	Yes (ST)	Yes	Yes	Yes	Yes	Yes				
Surgical Wound Infections	Yes	Yes (ST)	Yes	Yes	Yes	Yes	Yes	Yes			
Area 5: Service Quality	?										
Provider/Patient Communication	Yes	Yes	Yes		Yes	Yes	Yes				
Appointment Wait Time	Yes	Yes			Yes	Yes	Yes		Yes		
Use of Electronic Communication		Yes		Yes	Yes	Yes			Yes		

Appendix F
Meeting Summary

King County Health Advisory Task Force
Summary of Meetings

Preliminary Session on December 16, 2003: We found that we were familiar with the preliminary notebook information and ready to pursue a regional effort. HATF membership represents a good spectrum of interests. Pre-session survey findings are included in as Attachment 1 to this Appendix (pages 14-19).

January 12, 2004: We agreed that the same set of strategies and elements of infrastructure needed for King County's benefit plans also are needed for a regional approach. The diagram below illustrates the intersection between the King County strategy and a regional strategy. It should be noted that there is very little that pertains to King County that does not pertain to a regional strategy. It is more a matter of scale, breadth of leadership and consumer engagement, and complexity of clinical support and information systems infrastructure that differentiate them. The specifics of the benefits design for King County employees will most likely differ by employers, but the understanding of the relationship between benefits structure and incentives for cost and quality will be universal.



- Conceptual framework for plan/provider contracting
- Conceptual framework for benefits design
- Quality and cost measurement
- Evidence based resources
- Self management resources
- Information Technology Infrastructure and Community Health Information Network

January 26, 2004: We asked in an earlier session for a response to the question: What is the number of covered lives required to impact the Puget Sound provider market? We agreed that between 250,000 to 500,000 lives are required for adequate leverage. The self-insured plans on the HATF represent approximately 350,000 cover lives in the four county region of King, Pierce, Snohomish and Kitsap. See Attachment 2 to this appendix for this analysis (page 20).

We agreed that our effort would focus on strategies relating to four outcomes and that Outcome A would drive our process.

Barriers to reform must be acknowledged and anticipated in advance of strategy implementation. Understanding this need as well as the history of past health care reform efforts, we identified key obstacles relating to the four outcome areas:

Outcome A: Increase the likelihood and predictability that King County employees and other health care beneficiaries in the Puget Sound region will receive high quality, patient-centered health care service.

1. Sally Trude, Ph.D., Senior Health Researcher, Center for Health System Change told us there is little evidence demonstrating comprehensive achievement of this outcome.

2. Because of competition, there is a common mentality of secrecy and a general lack of data sharing.

3. In the Puget Sound region, health care is predominately delivered by small practices. This reality makes the need for infrastructure to support data sharing more difficult and costly to implement.

4. It will be critical to sustain involvement and participation in the coalition in order to implement lasting reform.

Outcome B: Mitigate the increases in personal costs/financial responsibility for health care benefits for King County employees by implementing strategies to effectively reduce the increase in total health care expenditures.

1. Consumers of health care are not aware of total cost of care.

2. There is a good deal of suspicion by employees.

3. Strategy requires strong reliance on good data.

4. There is a need for transparency in costs.

5. Employees must align all cost sharing so that unintended consequences don't create barriers to good health outcomes.

6. Strategy will likely require complicated plan design and contracting to insure alignment in incentives for providers and patients.

Outcome C: Increase the involvement of King County employees and other health care beneficiaries in the Puget Sound region in managing their own health and competence to act as partners with providers in making evidence-based health care decisions.

1. Must assess the readiness of employees to engage as partners in their care.

2. Behaviors are hard to change, but account for 50 percent of health determination.

3. Need credible sources of information so that employees and providers can make good health decisions.

4. Need to focus on correct incentives to apply to the message.

5. Some people are unresponsive to the message.

Outcome D: Develop a system in which health plans, providers and employees use shared health information and technology to continuously improve health outcomes and decrease medical errors. In this system, employers, employees and providers will use appropriate health information to ensure the most effective use of each dollar spent on health care services by monitoring costs, changes in health risk factors, changes in patient behavior, and changes in provider practice patterns.

1. Large electronic medical record isn't necessarily a panacea.

2. Implementation issues are significant.

3. Privacy/HPAA issues must be addressed in every stage of systems design.

4. Shared data standards must be agreed to.

5. Cost to implement and run the system could be significant.

6. Claims data does not include risk information

Mikel Gray, Mercer Consulting briefed us on the basics of financial dynamics in the current health care market. He noted that King County utilization mirrors national trends wherein large claims drive most of the costs. The national obesity crisis was noted and discussed. See Attachment 3 to this appendix, pages 21-29.

February 9, 2004: **Initial Findings Report and Integrated Strategy:** We endorsed the Initial Findings Report including the draft integrated strategy. The Initial Findings Report is provided as Appendix G. We noted that the regional strategy covers the Puget Sound region, not just King County. Many of the partners who should be involved are not currently on the Task Force, e.g., Medical Society, Nurses Association; we determined the need for separate meetings with medical leaders before issuing our final report in June (two meetings were held with thirty representatives on April 26 and June 1). The initial measures we recommend should link to national measures and should be first employed as feedback to providers – to demonstrate room for improvement.

Our agenda included a presentation by **Sally Trude, Ph.D., Senior Health Researcher, Center for Health System Change** (HSC) on Opportunities and Challenges implementing the draft integrated strategy in the Puget Sound region. Dr. Trude is an author of the 2002-2003 Community Report conducted by HSC in Seattle. Community Reports provide information and insights about developments in the 12 communities that HSC is studying intensively over time to better understand the changing health system and variations across markets. The reports describe what has changed every two years in these communities, including how care is organized and delivered; the strategies of local employers and public purchasers; and how the actions of lawmakers and regulators are shaping health care. These reports represent long-term assessments of the nation's health care system at the community level. A summary of her observations follow:

- Employer coalitions have met with a great deal of resistance from providers who don't want to provide data on quality. Hospitals have also resisted sharing quality data. The big resistance comes when MD/hospital data gets to the actual reporting stage (vs. the planning and discussion).

- We've created a culture where healthcare data is used to harm providers – we need to recognize this and make the sharing of data "safe" for them.

- It is critical that providers be involved very early in any type of system change process -extensive provider education on data reporting is essential to making progress in this area.

- The level of misinformation and misunderstanding among healthcare consumers is enormous, e.g., in a CHS survey the people most dissatisfied with being in an HMO were not actually in one!

- Creating alignment between provider and consumer incentives is critical.

- Some companies are doing a good job of using healthcare data to inform their decision-making; they have an improved understanding of costs and are able to build in additional tools like second opinions to exert greater control.

- Some national companies are using innovative approaches to educating consumers.

- There's not much innovation out there in healthcare right now.

- There are some cities we can learn from – primarily because they tried and failed to do what we're trying to do now.

This session also featured a presentation by **Dr. Arnie Milstein**, **Medical Director of the Pacific Business Group on Health** (PBGH), the largest health care purchasers' coalition in the U.S. Dr. Milstein's work focuses on improving health care programs for large purchasers, providers and government. Dr. Milstein was a member of the National Committee on Quality Assurance to assist in developing HEDIS, and is a Leapfrog Group co-founder. A summary of his observations follow:

- Puget Sound providers are more collaborative than those in other places.

- Now is the time to make big changes in healthcare – there are major opportunities to increase affordability and improve quality since the current healthcare system provides such a bad starting place as a baseline.

- Minneapolis has an integrated delivery system similar to Seattle's but its business partnership (the Business Healthcare Action Group) has not made much progress.

- New England Journal of Medicine report that while physicians are only track with current best practices only 55 percent of the time, they believe that they are achieving best practice 95 percent of the time.

- There are no clear benchmark levels among providers – give providers information about where they're starting and show them improvements they're making – change the incentives away from punishment toward education and recognition.

- Each plan has a different set of benchmarks; purchasers use insurance company standards; providers use multiple benchmarks.

    - An important first step for the Partnership would be to reach agreement about how quality and efficiency will be measured – it probably needs to be statewide to work – it also needs to include Medicare due to its role in the healthcare market.

- Currently negative incentives are more common as a health promotion approach – charge consumers more if they don't comply.

Strategy Discussion with Drs. Trude and Milstein:

- What type of timeframe is appropriate for implementation of the types of changes the Partnership is considering? Starting place for implementation (over two year timeframe):

    - Have all plans come up with a defensible plan for including people in their networks; move from cost to longitudinal efficiencies.

    - Give providers information on the quality of care they're providing.

    - Implement patient education approaches.

- Create a high level project plan that describes what the Partnership intends to accomplish in year one, year two, and year three.

    - Develop tactical strategies that will give providers, plans, consumers some early successes.

- Select three high level measures to monitor – we don't need to have agreement across plans on which measures to track – use measures that have already been validated – focus on conditions where the most gains will be made for the cost.

- Use risk stratification software to identify the high cost consumers, select the subgroup that needs the most help managing their conditions, and match this subgroup to high quality/efficient providers, e.g., centers of excellence programs for chronic disease management, and/or work with consumers' providers to improve cost and quality of care.

    - Use health risk assessment as part of prevention program – include it as a benefit - consumer participation in health improvement activities must be optional.

- Opportunities are great to improve self care and improve provider care at the same time.

March 8, 2004: A key agenda item was discussion of a core measurement set around clinical quality.

Mike Stuart, M.D. presented "Why do performance measures?" He advised that clinicians will need to understand the evidence behind the measures that are proposed. For example, if a measure directs an annual eye exam for diabetic patients, the clinician may want to see evidence that an annual eye exam improves patient health outcomes.

It was noted that experience has shown that measures need to cover a group of at least 50 patients in a clinical unit to minimize patient variability.

Mike Stuart recommended that measures be focused by gap – where the biggest yield is for savings and quality improvement.

It was suggested that there are two types of data, with different collection implications – outcome data and process data. Chronic disease measures have multiple internal outcomes that add up to a broad outcome measure of disease control (i.e. good blood pressure, sugar, cholesterol).

The need to balance chart review costs with value of measure was stressed.

Measures on obesity, healthy lifestyle, tobacco use and BMI, rate of generic substitution and need to deal with over-prescribing of antibiotics – rates of prescription are needed.

Andy Stergachis, Ph.D., R.Ph. made his presentation on prescription drug use in King County. He identified some strategies that could be pursued to help control drug costs. His recommendation is included in the final report.

We discussed the makeup of the regional partnership to implement our integrated strategy and made the following observations:

- Literature says that structural leaders and opinion leaders are both needed for success, i.e. medical director and highest level administrative counterpart.

- Representative from organization's Quality Committee- leaders should draw in these folks.

- Advocates and consumers/employees

- Look at other partnership structures for ideas.

- Select representatives who can make things happen - we need people who can see the bigger picture and maintain public interest over self interest or corporate interest.

- The mix of the partnership is critical. Need to bring together key players – purchasers, providers, political will. All three have not been present TOGETHER in any prior effort.

- We are leading with information and quality improvement and plan design changes will naturally follow.

- Must be clear about providers' ability to collect information on measures

April 12, 2004

The HAFT purchaser members discussed their view of the future in relation to the draft strategy and discussed what it would take to gain their organizations involvement in the Partnership. In summary they believe that evidence of return on investment and improved health outcomes will drive future participation. Their vision for how the current situation would change if the strategy was implemented is summarized on the chart provided as Attachment 4 to this Appendix on pages 30-34. In summary their envisioned future state purchasers would:

- Purchase health care based on a common set of measurable, evidence-based quality outcomes that are understood and shared by purchasers, plans, providers and patients.

- Use combined purchasing power, technical expertise and market performance data to design over arching cost management strategies and programs. Plan details (*e.g.* incentive levels, specific high performers who are included in the networks, levels of cost sharing with employees) may vary by purchaser but all would rely on the same underlying data and reward both providers and patients based on the same interpretation of desired behavior.

- Provide health promotion and disease management programs through the Partnership that are based on the overall data set and actively engage patients and providers in a collaborative effort to avoid (when possible) and manage (when necessary) chronic and catastrophic disease states. All plans and purchasers give employees that same message, support the same strategies, and explain the same evidence in the same way.

- Develop a system in which health plans, providers and patients use shared health information and technology to continuously improve health outcomes and decrease medical errors. In this system purchasers, providers and patients use appropriate health information to ensure the most effective use of each dollar spent by monitoring costs,

changes in health risk factors, changes in patient behavior, changes in provider practice, and changes in overall health status of the population.

Larry Chapman, MPH, provided a summary briefing on return on investment for health promotion. Key point in his presentation included:

- Health-related costs will continue to increase at a high rate.
- A large part of underlying morbidity driving health care demand is avoidable or modifiable.
- There are a variety of newer demand-side health cost management strategies for working populations.
- There is a broad base of very credible evidence for these interventions.
- Health & Productivity Management style worksite health promotion programs can be a major solution for the national problem of health costs

David Lansky, Ph.D., President of Foundation for Accountability (FACCT) advised us that there are three common barriers to health care reform: payment, culture and infrastructure. To overcome those barriers, Dr. Lansky suggested a four pronged strategy: visibility to innovators so that the public is aware that there is a better way and a way to replicate sound innovation; mobilize public demand for change; identify policy initiatives in diverse areas; and organize support for selected policy initiatives.

He further identified high-leverage initiatives for the redesign of the health care system that address each barrier as follows:

Payment:

- Universal coverage for "essential" health care services, defined by a public process;
- Private and public purchasers adopt outcomes-based payment; and
- Intermediary organization (plans, employers, unions) implement financial incentives for patient-centered care, including self-care, health maintenance, non-visit care.

Culture:

- Create a high-visibility grassroots organization devoted to safer and higher-quality care; and
- Policymaking bodies and health care organization include diverse, representative consumers and patients at every level of governance and redesign.

Infrastructure:

- National commitment to health information infrastructure; all health care organization receiving federal funds are required to adopt standards and implement necessary systems; and

- Mandatory publication of performance data by all federally funded health care organizations.

May 10, 2004

We approved in concept the following integrated strategy:

After several initial meetings, the HATF has formulated the following key outcomes for its health actions strategy:

The HATF proposes that no one sector of the health care field can achieve cost and quality outcomes alone. It also proposes that if even one sector is not aligned in the methods and approaches for achieving better quality, more sustainable costs and improved health, then it will not be possible to achieve excellence. For example, if a proven mechanism for encouraging individuals to manage their chronic disease is to take part in group visits, then both the health benefit design and the provider payment mechanisms must reflect and support this. If they do not, cost, quality and health improvement outcomes are all at risk of being suboptimized.

There are several elements to the health care improvement strategy that the HATF is recommending. These include:

1. Evidence based clinical decision support tools for providers that would hold state of the art evidence about key clinical conditions, and guidelines for use in daily practice. Included would be easy to use interrelated clinical guidelines and protocols for managing chronic diseases such as diabetes, asthma, hypertension, coronary artery disease. Also included would be evidence-based indicators and criteria for performing certain procedures.

2. Evidence based patient education and self-management tools and approaches that reflect the clinical guidelines described above. Also included would be an up to date listing of community based services which support health improvement and provide self management support groups for those who wish to sign up.

3. The design, and development of clinical, resource utilization and cost measurement analysis and reporting systems that would support the ongoing improvement in delivering high quality, cost effective care. Such measurement support would be shared with both the providers and the purchasers, so that together they could work with clinical and cost measurement experts to build meaningful cost and quality improvement measures for consumers, as well as providers.

4. Consumer information for use in making health-related decisions such as evidence based formulary recommendations, health care treatment choices, participation in cancer clinical trials; accessing centers of excellence would be easily accessible and continuously updated. Information about the cost and quality connection for consumer health care choices would

be available in easy to understand formats. Assistance in finding high quality providers and hospitals that have a track record in ensuring evidence based high quality and cost effective services may also be necessary.

5. Easily accessible information about healthy eating and active living, and behavior change strategies for improving one's own health or the health of one's families.

6. Health plan benefits design that best supports the delivery of high quality and cost effective care.

7. Information technology to support clinical data exchange, storage, and retrieval. Shared infrastructure to house the measurement data and use it for improvement.

8. Clinical expertise and epidemiological expertise in ensuring that as new evidence surfaces, or as new issues arise from the public, the providers, the plans or the purchasers, that the key leverage areas of this partnership remain current.

9. Reimbursement strategies that are supported and informed by expertise in quality improvement methods, systems design and measurement.

10. Pay for performance incentives for providers, and consumer incentives to choose evidence based care and service.

These elements of a successful strategy must be organized and integrated to provide tools and support for patients and providers through out the region. The HATF recommends the formation of a leadership partnership whose key function would be lead a regional effort to achieve better health at more sustainable costs and with better quality of care delivered. This partnership would build and support the infrastructure needed to ensure the provision and alignment of the elements outlined above. This partnership would be characterized by a dedication to quality improvement principles, state of the art evidence based clinical decision tools and care delivery mechanisms, and a constancy of purpose that building sustainable systems requires. Section IV describes the structure and function of this partnership more fully.

When choosing strategic areas upon which to focus resources for quality, cost and health improvement, the following questions should be considered:

1. For which clinical conditions are there evidence based recommendations that will lead to improved quality, improved health and decreased costs?

2. Which clinical areas drive the costs for the purchasers?

3. What is the relative size of the populations being affected?

4. Where do resource utilization profiles indicate the greatest degree of unexplained utilization variation?

5. Where do quality measures indicate the highest degree of variation in the quality of services being delivered?

6. What pharmaceuticals are driving costs? Are there generic substitutes that can be safely used?

7. What are the clinical conditions for which providers and consumers seek the most assistance or demonstrate the most interest?

8. Which areas of preventive health are proven to be most efficacious?

9. Which areas have the most potential to improve workforce productivity?

10. What is the predicted short term and long term financial ROI for improving the quality of care delivered within these conditions?

After considering the current state of the evidence, and considering information about each of the above questions, the HATF is recommending that the following areas be considered first. It is important to remember that while the infrastructure described above will be necessary for even one or two of these areas, these areas of focus would be phased in as design, implementation and sustained improvement steps. Focus will be on the areas that we believe have the greatest probability of improving care, decreasing costs and improving health.

Area 1: Chronic Disease Management

Chronic diseases account for over 70 percent of deaths and a majority of health care expenditures as well. Managing chronic diseases using evidence based planned systems of care has been shown to save money, reduce unnecessary complications or exacerbations, and ultimately to improve the health status of those with chronic disease.

A systemic approach to managing diabetes, preventable and harmful impacts such as amputations, blindness, and renal failure occur with greater frequency than when a systemic approach is used to manage this disease.

- Coronary Artery Disease
- Pediatric Asthma
- Diabetes
- Depression and Anxiety
- Hypertension
- Congestive Heart Failure

Area 2: Acute and Episodic Care:

Acute or episodic care includes diagnosis and treatment of unpredictable clinical problems such as ear infections, back pain, sore throats and fractures. While investments in planned systems of care do not make sense for this category, there is high value in examining the

variation in diagnosis and treatment decisions for specific areas. For example, low back pain is a top diagnosis on people visiting their primary care provider. Treatment plans for low back pain are extremely variable. Ensuring that the use of the expensive laminectomy procedure as a treatment option for low back pain as a last resort option will save money and unnecessary surgical procedures.

- Low Back Pain
- Maternity Services
- Procedures: Myringotomy
  Tonsillectomy
  Cholecystectomy
  Laminectomy
  Cardiac Catheterizations
  Coronary Artery Bypass Grafts (CABG)
  Angioplasty
  Prostatectomy
  C-section rates
- Pharmaceutical Prescribing Profiles

Area 3: Preventive Services:
Clinical preventive services are services for which there is evidence that their use prevents illness, disability or death. Childhood immunizations prevent severe illnesses such as pertussis and measles. Screening for breast cancer ensures early detection rates, thereby increasing chances of health, and possibly preventing some very costly extensive cancer treatments. Ensuring consistent, high rates of preventive services such as mammography or cancer screening is key for cost savings and health improvement.

- Childhood Immunizations
- Smoking Cessation
- Mammograms
- Cervical CA
- Pneumococcal Vaccine

Area 4: Safety
Monitoring the safety of certain medical procedures with prescribing practices is an area which provides information about the technical gravity of care delivered. Medical errors, for example, can cause harm; decreasing the rates of errors will prevent avoidable harms and decrease costs.

- Medication Error

- Surgical Wound Infection Rates

Area 5: Service Quality
The quality of service related to health care provision is an important area to monitor. For example, provider teams with organizations whose appointment waiting times are short are saving time for their patients and ensuring rapid attention to health problems. Electronic means of communication between patients and their providers indicates an investment in systems to make health care easy to access, and offers a substitute for time consuming and costly face to face visits when the patient would prefer email.

- Provider/Patient Communication
- Appointment Waiting Time
- Use of Electronic Communication

The HATF recommends the use of HEDIS measures for the measurement system. HEDIS measures have been validated for clinical measurement and are used nationwide to compare and improve performance. Overtime, consumer understanding of clinical quality measurement and cost implications would be added to this measurement set.

Using diabetes as an example, the partnership would be supporting the following regional approach to managing diabetes care in the Puget Sound region:

1. Identify the diabetics receiving care from providers in the partnership.
2. Document the evidence about the state of art for managing diabetes.
3. Create the provider and consumer tools and services for effectively managing diabetes, including guidelines, self management services, group visits, registries, reminder systems, pharmaceutical support.
4. Work with plans and purchasers to ensure that diabetic supplies, group visits, access to support services are all included in health care coverage. Providers initially unable to provide this set of services would demonstrate the improvement strategies undertaken to meet the diabetes system of care requirements.
5. Measure and monitor the success of the clinical improvement intervention for the population with diabetes.
6. Support ongoing measurement and quality improvement for providers and their patients.
7. Overtime, ensure that those providers/provider groups for whom diabetes management is not a strength must demonstrate improvement to remain in the provider network.
8. Sustain optimal performance over time.

June 14, 2004
We endorsed the final report and discussed next steps.

King County Health Care Advisory Task Force
Survey Findings
January 2004

Strategies For Success

Scope

- Task Force members who hold a big picture view.
- Good understanding and definition of the problems to be resolved.
- Clear mission/vision statement agreed upon by all.
- Common understanding of specific expectations and deliverables.
- Realistic timeframe for development and implementation.
- Willingness to accept incremental change on the way to a longer-range goal.
- Focus on no more than three initiatives. The Leapfrog has gotten so much traction because they have chosen not to boil the ocean but rather focus on a few initiatives where meaningful change can be achieved. For success the Task Force needs a similar strategy.

Data and Information

- Actionable data is the one critical success factor. No one plan has enough data on individual providers or groups of providers to be able to understand practice variation/outcomes/costs. If the data is shared across plans useful information can be generated.
- Decisions based on good reliable, credible data.
- Good enough data on which to base decisions.
- Good environmental assessment.
- Brief and clear understanding of the current system as a starting point.
- Good understanding of the views of stakeholders.
- Find the WIFM for motivation and incentive for participation.
- Information on "cost-drivers" of health care expenditures for King County employees, etc.
- Information on the nature of health issues/conditions/medical care utilization for King County including prescription drug information, utilization, detail on benefits program, PBM, etc.
- A complete internal and external landscape as well as benefits guiding principles should be completed for King County. Internal landscape would be member focus groups, surveys, conjoint analysis to see what members/employees truly value most and least in their overall benefits package, full demographic analysis. External landscape would be a review of King County's competitor healthcare plans and cost analysis. The benefits guiding principles would outline King County's principles around benefits' competitiveness, compliance cost and culture.

- Evaluate the current healthcare situation for King County employees, current and historical. This includes the types and location of current care as well as cost. What is the retiree situation? Do they have coverage?
- Define future needs of King County: Will the work force grow in size, location, needs (Is the average age of enrollees changing?).
- Evaluate the current providers for King County and how they are chosen.
- Study how other municipalities have tackled this problem – not just the successes, but there is much to learn from others' failures.

Quality Improvement and Prevention (Disease Management and Wellness)

- Definition of what it means for an organization to be quality-improvement driven.
- Develop common quality measures between health plans and providers.
- Challenge physicians to adopt nationally recognized standards for treatment and regular screenings (vis-à-vis HEDIS) and reimburse/reward accordingly.
- Have plans agree to a common set of clinical guidelines for conditions that are costly and/or where high degree of practice variation/uncertainty exists.
- Complete a detailed claim review analysis and data mining focus on claim specific disease management and wellness program implementation for King County to identify and address chronic conditions such as diabetes, asthma, heart disease, etc., depending on the analysis.

Collaboration

- Structures, processes, and performance measures to bond the quality-improvement driven organizations together to achieve value and agreements, processes and tools to do the work.
- Form a working partnership between a sufficient number of large self-insured employers to drive change.
- Leverage the collective action of local payors (i.e., business and government) to essentially force plans to the table to begin to address agreement of guidelines, practice variation, and outcomes data.
- Bring health plans to the table to begin collaborative process that will involve aggregating data so that it is possible to gain insight into practice of individual providers and provider groups (e.g., identify practice variation; where possible assess outcomes).
- Work with department of public health and other government and non-government (especially non-profit) entities to increase community capacity around "healthy living," e.g., bus routes that make it easier to access parks, etc. Public health on-going initiatives that could be reinforced/better executed with support for business and payers

Consumer Participation

- Focus on providing health care quality information so Americans can become better consumers. Today there is more information on buying a TV than there is on choosing a health care provider– even though the data exists.
- Educate employees (and their family members) about the health care (non) system and enlist their participation when they have been totally divorced form the cost of health care for so long. It's a big leap.

- Focus on chronic disease prevention and improved capacity of the community to provide resources that enhance ability of patients with chronic disease to self manage their illness
- Emphasis on healthcare consumerism. Americans are good consumers on a variety of levels; health care is not one of them. We need to get Americans more comfortable with asking their physician's questions like: what is this going to cost, what alternatives are there, where would you have this done, etc.
- A robust health care consumerism campaign designed and implemented (and potentially a CDHP if it makes sense for the culture and goals of the organization). This campaign would educate employees/members on how to be smarter/better/more empowered consumers and would focus on areas, which need improvement (Those could be found through claims analysis.)
- Emphasis on health promotion as a means for reducing health care expenditures.

Benefit Design

- Plan redesign that would generate high cost savings while meeting employee needs. This could be by limiting coverage or adding/modifying cost sharing. Focus on areas of high costs and trends such as prescription drugs, chronic care, etc. Also consider a vendor re-selection if the current vendor is charging high administration fees or does not provide adequate provider discounts.
- Implement plan design changes, which require cost sharing from employees to promote understanding that health care, is insurance, not a free ride. Then, integrate the strategy into a total compensation approach.
- Research and implement an online health portal, 24-hour nurse line, discounted rates to a fitness club, and potentially more health promotion type programs.

Task Force Processes

- Good project management.
- Make it easy to communicate with workgroup members on specific tasks, provide clear time requirements for task completion, have clear criteria and compatibility with work group members' perspective, ensure staff support to assist in draft document preparation.
- Inventory Task Force resources to ensure effective use of expertise of participants
- Ensure cross-fertilization of ideas among Task Force members and workgroups throughout the process.
- Mix, match and add the attributes that we feel are the best of the strategies that we have read about and those we come up with during the course of the Task Force process.
- Ensure open dialogue and communication between members and staff.
- Where possible, divide participants into working groups with specific mandates.
- Define clear criteria for incorporating work group issues, i.e., consensus model
- Ensure that momentum and high interest continue in workgroups.
- Establish effective communication channels among participants, work groups, and Task Force staff to ensure prompt access to information and resources.
- Establish realistic time frames for performance with hard deadlines.
- Commitment from the Task Force members to complete actions items on time.
- Documentation of action items.

- Good follow through.

Threats to Success

Scope

- National scope of the problem.
- Scope and complexity of the issue.
- The goals are lofty. Coming up with a plan that can be implemented is a great challenge in today's healthcare milieu.
- A group this size charged with a mission and tasks this far reaching may have difficulty maintaining focus, effectively utilizing resident expertise, and managing limited time effectively.
- All committees are at risk of being ineffective secondary to poor leadership, misstated or misdirected goals and loss of enthusiasm to work toward the goals
- Loss of the big picture vs. constituent views.
- Task Force members holding an advocacy role.
- Coordinating the "non-system" of care and initiatives that will successfully influence all players in the entire health care market.

Task Force Processes

- Lack of a clear mission and purpose.
- Unrealistic expectations.
- Time.
- Task Force members spending enough time on this activity, i.e., conflict of commitments.
- Lack of time to complete responsibilities.

Resources

- Possible need to bring in others for specific expertise.
- Inability to fund possible initial financial investment that might be required to create long term system change and substantial system efficiencies resulting in lower total cost.
- Lack of resources to accomplish mission and tasks.
- Lack of budget to assist in accomplishing missions and tasks, i.e., budget for benchmarking and data analysis.

Outside Forces

- Federal legislation.
- Political resistance to change within the system.
- Inability to negotiate with the 90 bargaining units.

Consumer Issues

- Ability to educate consumer regarding the true costs of care.
- Realistic expectations of consumers.
- Getting consumer buy-in.
- Employee resistance and lack of understanding.
- Lack of buy-in from employees (that is why it will be important to get their input early on and involve them in the process).

Collaboration

- Design and development of quality improvement initiatives such as disease management programs.
- Ability to rally in providers, plans and payers around a common/shared goal in the short term, payers have the most to gain; providers and plans have the most to lose.
- Logistics and costs of getting all providers to agree to one set of quality measures.
- Recognition that health care is a cottage industry and many of the providers operate in a 2-5-physician practice. Therefore, the solutions must be applicable to this group.
- It is very difficult for separate organization to work together and requires careful construction of the structures, e.g., a leadership group, clinical group, etc.

Contributions to Success

Expertise

- Potentially bringing in the state (PEBB and BH) into initiatives the Task Force develops and potentially increasing the leverage to influence true change in the marketplace.
- Experience in implementing cost sharing with employees and labor management agreements.
- Leverage work doing on healthcare consumerism and health care quality.
- Extensive knowledge of health service research field, especially related to utilization management and chronic disease management.
- Perspective and credibility of a practicing primary care internist and hospital administrator for credibility in the provider community.
- Assistance and ideas about devising an appropriate healthcare strategy through creating guiding principles and gauging the internal and external landscape. We recently went through this exercise and I can share best practices.
- Since most of money in healthcare is being spent or directed through specialists I believe I can offer a perspective from the field that others may not have. As a public hospital physician I can also help from the perspective of the uninsured/Medicaid provider, as I believe that the results of this Task Force may some day be applied to these patient populations.

General

- Attend meetings and participate.

- Be an active team player and fulfill the expectations that are expected regarding preparation, participation and teamwork.
- Do necessary work outside of committee.
- Convey ideas, experience to the group.
- Focus on areas of expertise, but also consider more general areas as well.
- Be sufficiently informed.
- Have sufficient time to engage with the group.

Willingness to Participate in Small Group Work

- Everyone is willing to participate with the understanding that other commitments can have limiting influence on the time availability.

How many "lives" are necessary to influence the Puget Sound Market?
Assumptions: The focus of influence should be placed on physicians rather than Health Plans or Hospitals. Implementation efforts will focus on practice processes, like evidence based medicine or measuring quality and/or efficiency rather than on rate negotiation. Therefore, a significant number of physician practices is required to gain attention. The table below tells us that 22 percent of the patients are coming from Medicaid and Medicare (which may represent a greater percent of the business considering the health status of the Medicare population.)

Population Distribution by Insurance Status, state data 2000-2001, U.S. GO TO

	WA #	WA %	US #	US %
Employer	3,433,720	58	162,950,380	58
Individual	344,050	6	13,246,180	5
Medicaid	647,400	11	31,048,960	11
Medicare	670,000	11	32,841,390	12
Uninsured	785,810	13	41,206,410	15
Total	5,880,980	100	281,293,330	100

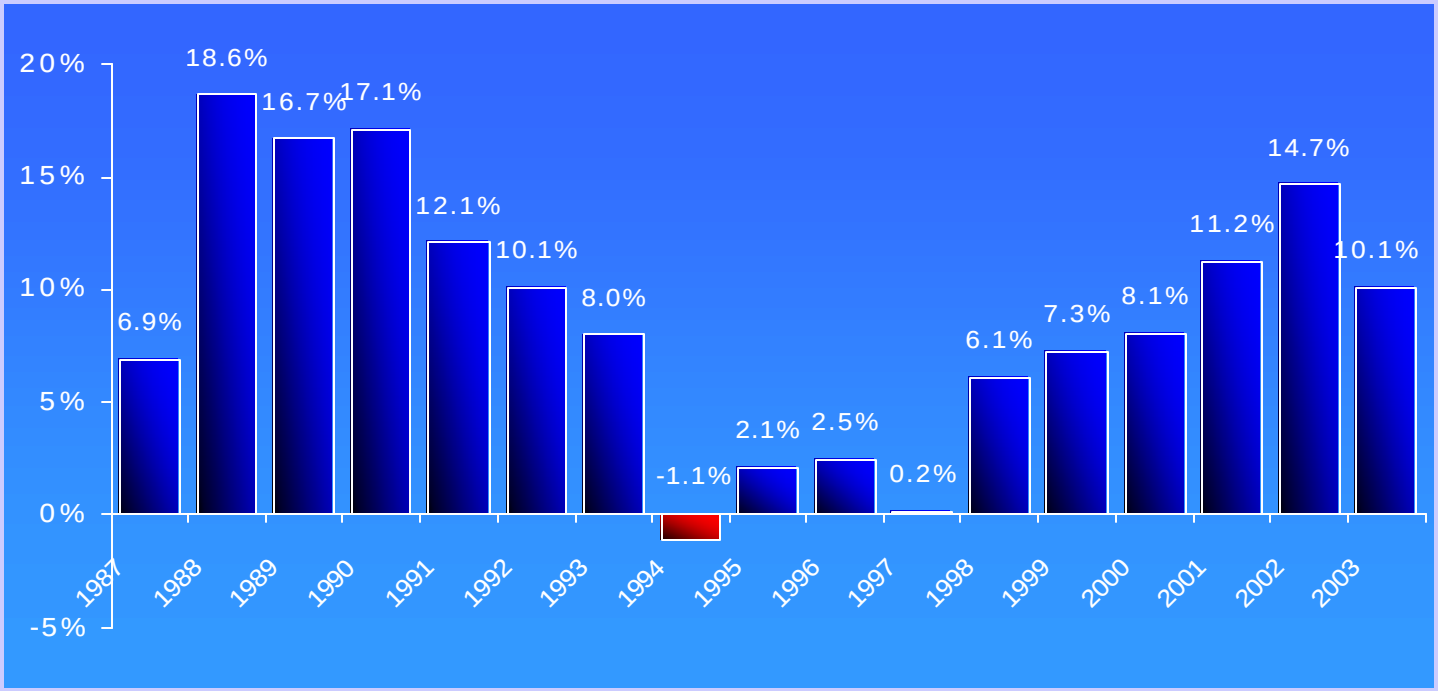
2003 Estimates **Washington 6,098,300** **US 292,500,000**

County	2000 Population	2003 Population
King	1,737,034	1,779,300
Pierce	700,820	733,700
Snohomish	606,024	637,500
Kitsap	231,969	237,000
Total	**3,275,847**	**3,387,500**

Assuming that Puget Sound is distributed like the State of Washington, 64 percent of patients to physicians come from private insurance that would be almost 2.1 million citizens. 250,000 to 500,000 members would represent 12-24 percent of their practices. Mercer Consulting advises that this is significant enough to engage this audience. They also believe that the largest clinics in Puget Sound may influence the smaller clinics and solo practices. This could lead to an even smaller number being acceptable if it is located where the largest clinics do business. There are slightly less than 350,000 lives represented by self-insured employers on this Task Force as shown on the table below.

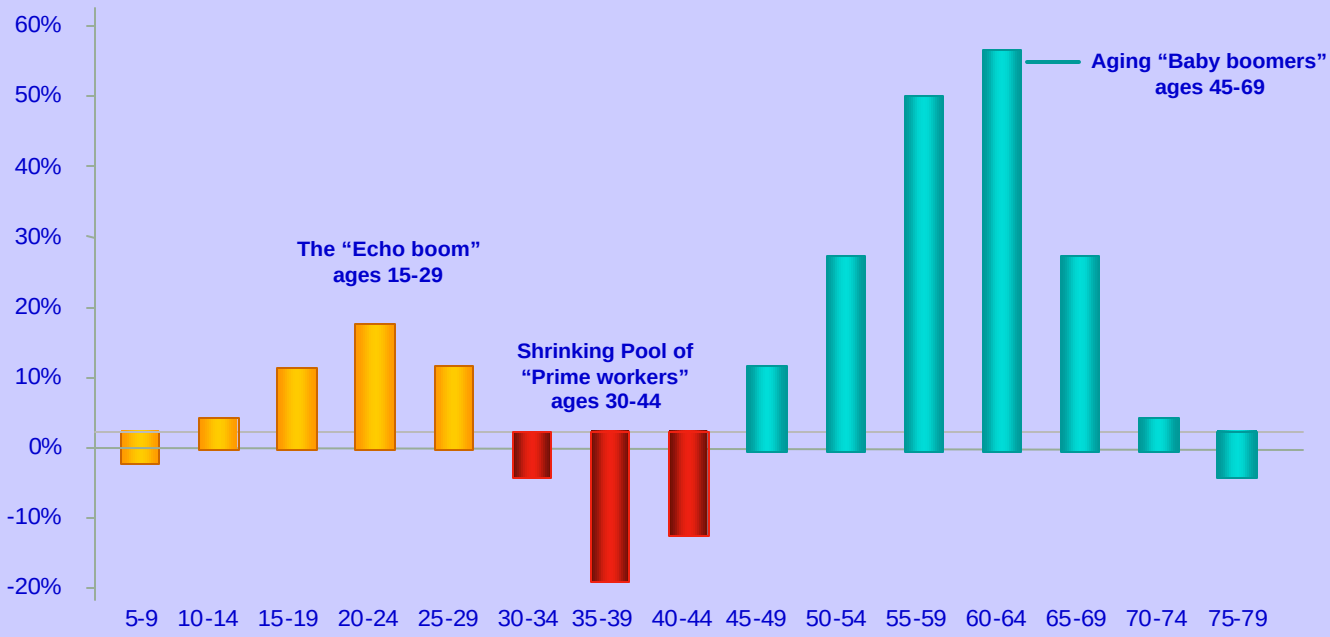
Employer	#Covered Puget Sound Lives	Primary Carriers/Third Party Administrator
King County	29,000	Aetna, Group Health, and Regence and PacifiCare (King County Police Officer's Guild)
Costco	25,000	Aetna, Group Health
Washington Mutual	20,000	Aetna, Group Health
Microsoft	66,000	Premera, Group Health
City of Seattle	24,819	Aetna, Group Health
Washington State	177,691	All except Aetna
Starbucks	7,390	Aetna
Total	**349,900**	

Sustained Double-Digit Cost Inflation



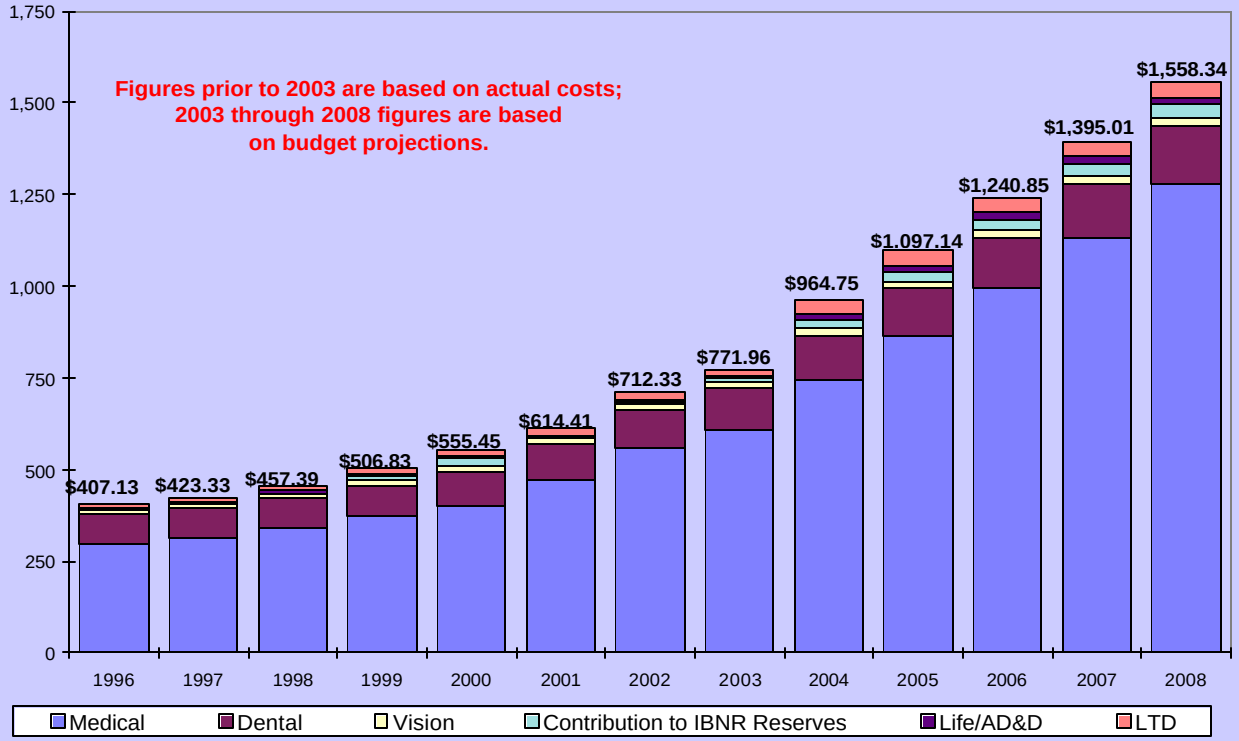
Negative Tidal Wave of Available Talent

Percent change in population by age group, 2000-10



Source: DRI, *World at Work Journal* , fourth quarter 2001

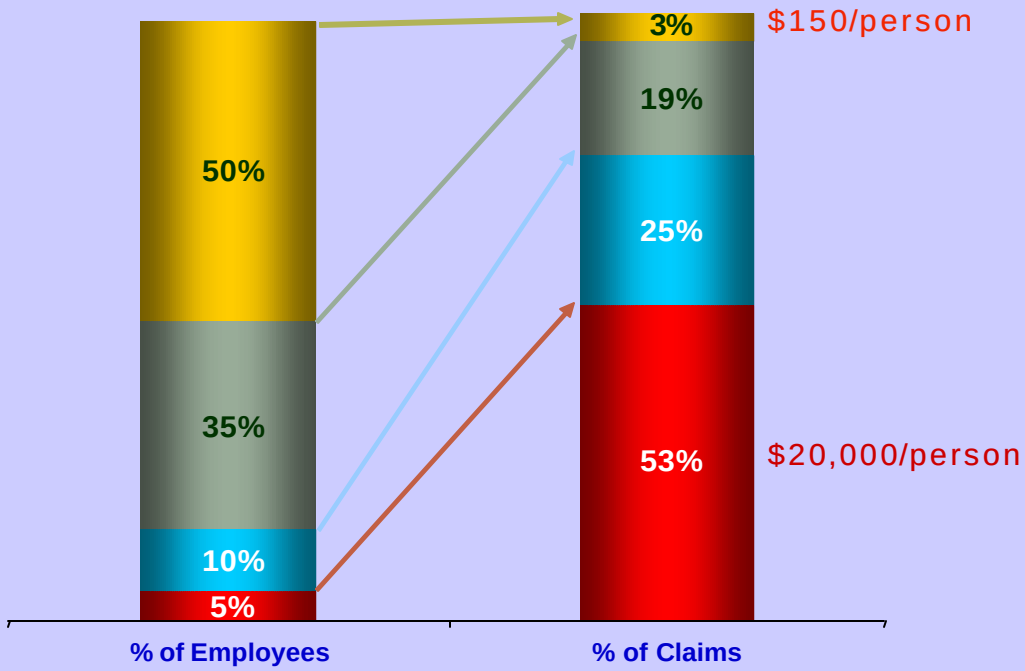
Actual Years 1996-2002
Estimated Years 2003-2008



*Prior to 1998, contribution to IBNR reserves was included in Medical/Dental/Vision.
Note: Above information is for Full Time Employees only, it does not include Police or Part Time Transit.
The composite rates do not include internal King County administrative expenses.

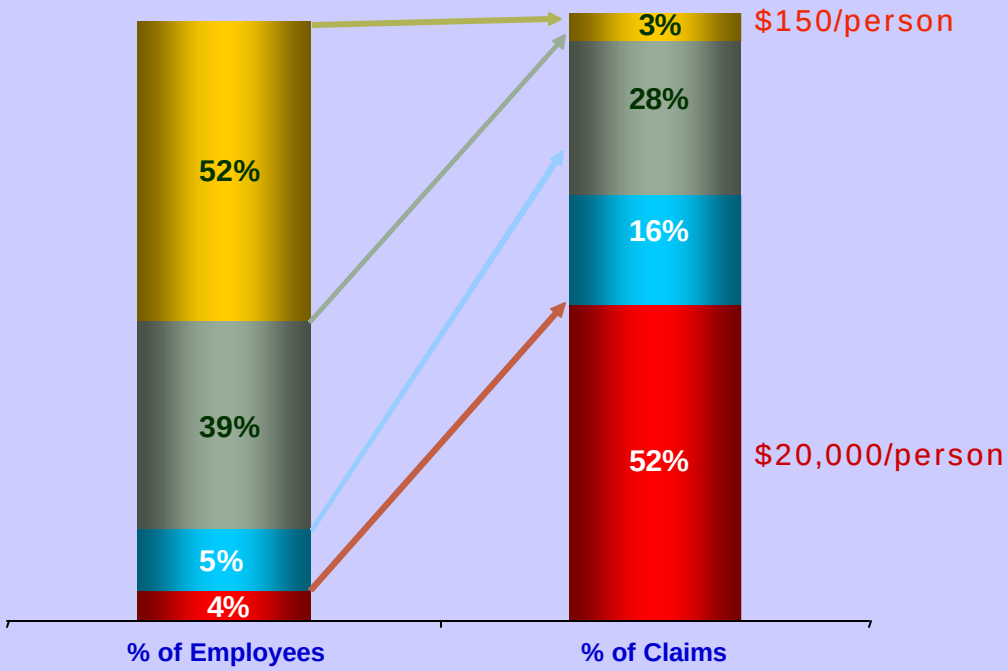
Large Claims Drive Most of the Cost

National Average



Large Claims Drive Most of the Cost

King County Specific Data



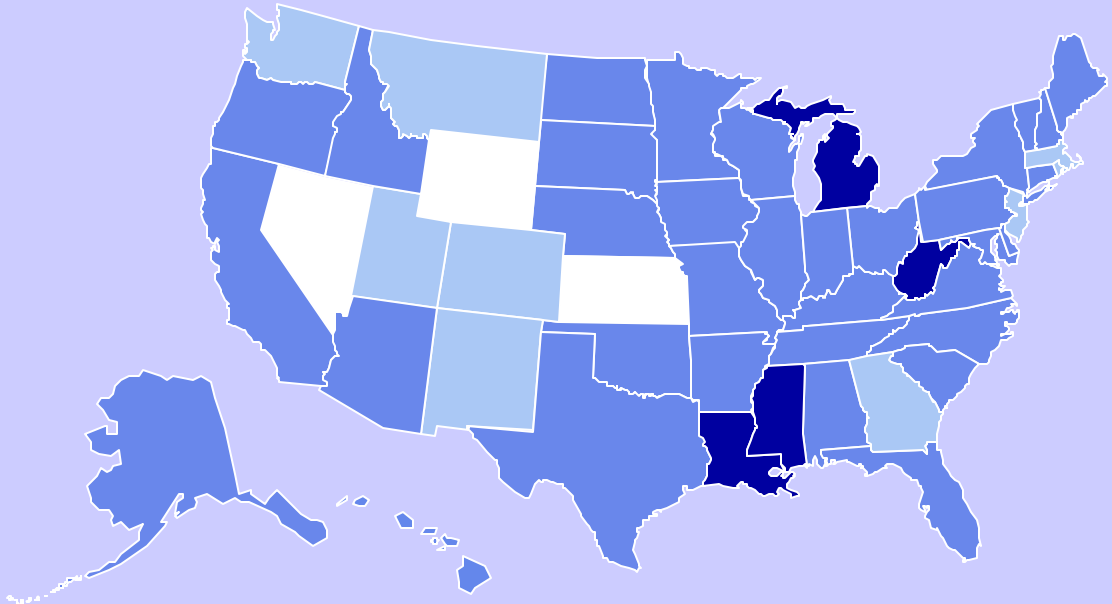
Utilization with Chronic Disease

	Average Number of Prescriptions Used Annually Per Adult	Average Annual Expenditures
All Adults	9	$ 366
Those with Diabetes	34	$1,379
Those with Heart Disease	30	$1,182
Those with Hypertension	25	$1,021
Those with Arthritis	21	$836
Those with Cancer	19	$838
Source: “September 2002 Data Profile,” Centers for an Aging Society analysis from 1998 Medical Expenditure Panel Survey.”		

The Need for Change
Prevalence of Obesity - 1991

Obesity Trends* Among U.S. Adults - BRFSS

(*BMI ≥30, or ~ 30 lbs overweight for 5'4" woman)



Source: Mokdad A H, et al. *J Am Med Assoc* 1999;282:16, 2001;286:10.

The Need for Change
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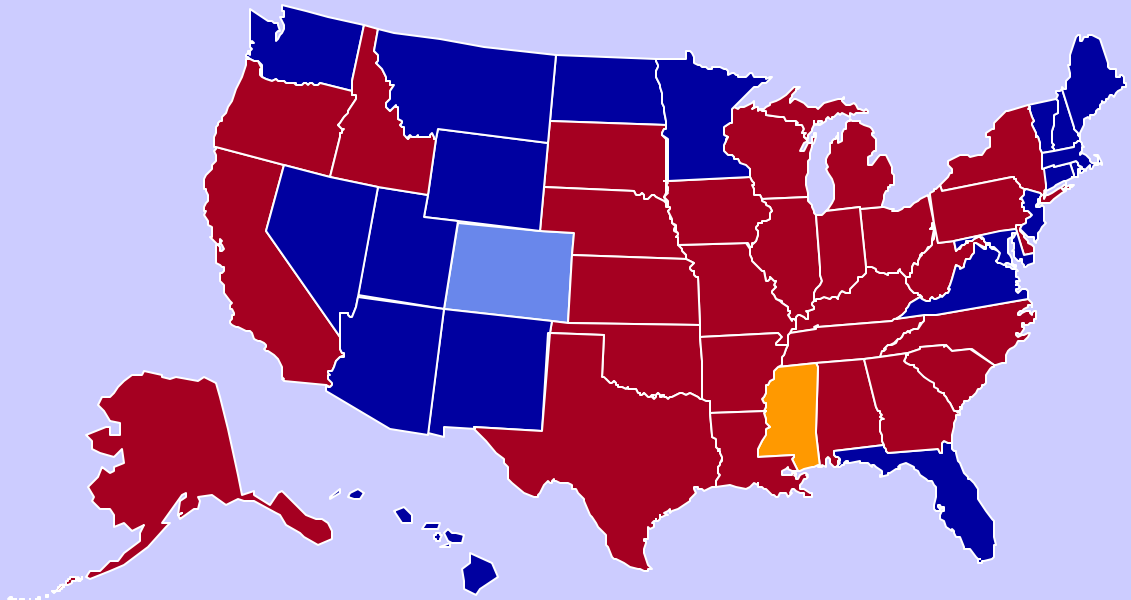
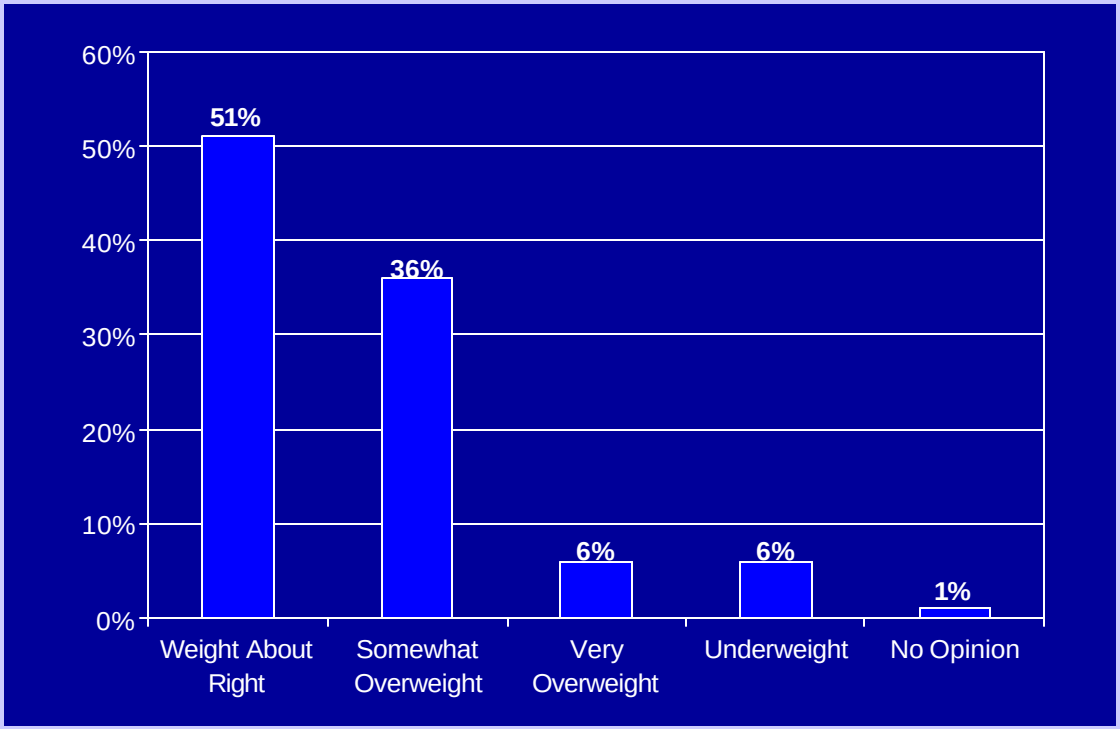


Source: Mokdad A H, et al. *J Am Med Assoc* 1999;282:16, 2001;286:10.

How We Are Thinking



Source: Gallup Poll, November 2002

King County Health Care Advisory Task Force
The Vision for Quality Improvement: The Purchaser's Perspective

What Purchasers are Moving From (2004)	What Purchasers Are Moving to (2008)	Outcome see last page
Purchase health plans and provider networks based primarily on discounted fees and network size; rely on health plans to define and comply with performance and quality measures.	**Purchase health care based on a common set of measurable, evidence-based quality outcomes that are understood and shared by purchasers, plans, providers and patients.** Implementation Steps (How): • Start with a few existing evidence based quality measures (*e.g. Leapfrog*, NCQA, HEDIS) where they exist and use technical experts to develop additional measures; focus on measures that do not require external chart review to be conducted in individual provider offices; periodically review and add measures that "push the bar." • Develop a single repository for all claims data (including actives, Medicare and Medicaid) and use a trusted, neutral third party to apply the measures to health care services on an on-going basis. Additional option: have standard set of measures that plan must report, e.g., as in NCQA/HEDIS reporting. Currently, HCA/State requires plans to report HEDIS measures). • Publish the measures and ratings of service providers in formats that are understandable to, and useable by, each of the four main audiences – patients, providers, purchasers and plans. Use a wide variety of media (even messages on buses) for disseminating this information. • Take action on the basis of performance scores. o Require health plans to use the performance measures in the same way to determine the "quality providers and to develop "quality networks", however all plans latitude in contracting with those providers; *i.e.* all networks don't have to contract with every quality provider. o Use incentives to reward good performers and disincentives to encourage improvement from underperforming services. Pay high performers to participate in the "quality network."	**A**

What Purchasers are Moving From (2004)	What Purchasers Are Moving to (2008)	Outcome
Benefits programs are not strategically designed to target the most expensive care drivers; purchasers settle for pharmaceutical company and health plan initiatives and products. Purchasers miss opportunities for influencing the market by designing benefits packages and purchasing health care in isolation from other purchasers; fail to obtain outcome data and credible measures of return on investment.	**Use combined purchasing power, technical expertise and market performance data to design over arching cost management strategies and programs. Plan details (*e.g.* incentive levels, specific high performers who are included in the networks, levels of cost sharing with employees) may vary by purchaser but all would rely on the same underlying data and reward both providers and patients based on the same interpretation of desired behavior.** Implementation Steps (How): • Develop a universal set of expectations purchasers have for health plans; leverage the plans but make sure the plans then extend the message to providers. • Change purchaser focus from unit cost to quality outcomes **and** a ceiling on the total cost for an episode of care. • Focus quality efforts on key disease states, not primary care doctors. • Look for opportunities that may yield immediate cost savings for purchasers and patients. o Develop a common evidence based prescription drug formulary and supporting structures needed to help patients and providers what is in the formulary and why, and how tailoring can be done for individual circumstances when truly appropriate. o Develop programs around the highest cost/highest impact chronic disease states that engage both patients and providers in partnership. o Support and publish existing quality initiatives such as *Leapfrog (or COAP or S-COAP)* hospital patent safety data. o Provide incentives for plans, patients to contract with or choose highest performing providers or plans.	**B**

What Purchasers are Moving From (2004)	What Purchasers Are Moving to (2008)	Outcome
Employees and their families are not educated or engaged about health, health care costs, health care options and their needs to live healthily and be wise consumers; purchasers rely on external vendors for utilization reviews and disease management programs to "police" access to health care.	**Provide health promotion and disease management programs through the Partnership that are based on the overall data set and actively engage patients and providers in a collaborative effort to avoid (when possible) and manage (when necessary) chronic and catastrophic disease states. All plans and purchasers give employees that same message, support the same strategies, and explain the same evidence in the same way.** Implementation Steps (How): • Jump start consumer support efforts by researching and using existing consumer tools that support employee understanding and action regarding their health and health care options (*e.g. Bridges to Excellence*, the providers rating materials from FACCT). Continue to add relevant resources that are evidence based. • Develop plan for dissemination of common health care cost connection messages for consumers. • Research and select a common health risk assessment tool. • Use the power of the huge data pool to build integrated health promotion and disease management programs that address not just the specific disease but also other health conditions that often accompany that disease. • Continue to test and refine tools. • Conduct formal studies to determine both employer-specific and large scale return on investment in integrated health promotion and disease management.	**C**

What Purchasers are Moving From (2004)	What Purchasers Are Moving to (2008)	Outcome
There is no "system" to the way information is selected, health care is delivered, and paid for. There is no effective communication between multiple providers who may be treating the same patient resulting in waste and medical errors. There is no system that supports providers who want to practice evidence based medicine by sorting out the research and making it available to the provider and the patient at the point of health care delivery.	**Develop a system in which health plans, providers and patients use shared health information and technology to continuously improve health outcomes and decrease medical errors. In this system purchasers, providers and patients use appropriate health information to ensure the most effective use of each dollar spent by monitoring costs, changes in health risk factors, changes in patient behavior, changes in provider practice, and changes in overall health status of the population.** Implementation Steps (How): • Create a general Partnership that becomes the repository for all claims data in the region, researches and recommends evidence based performance standards, applies these performance standards and reports the results to providers, plans, purchasers and patients. o Purchasers are board level decision makers; providers are advisory level. o Purchasers are driving force but are also collaborative and inclusive. o Purchasers provide direction, funding, vision for the Partnership. o Purchasers look for grant monies. • Use the combined buying power of purchasers to encourage health plans to: o Invest in common data set, common performance standards, universal performance rating of providers, and publishing of performance scores. o Build networks based on provider performance and to develop incentives to high performing providers. o Invest in technology that both consolidates a patient's medical record from all sources and puts evidence based information at the provider's finger tips at the point of patient care. o Design benefits that integrate patient risk assessment, information, and patient-provider collaboration to improve health & disease management.	**D**

Task Force's Intended Results

Outcome A
Increase provision of high quality, patient-centered care.

Outcome B
Reduce total health care expenditures and mitigate increases in employee costs.

Outcome C
Increase employee competence as partner in evidence-based decision-making.

Outcome D
Use shared information and technology to improve care and reduce medical errors.

Appendix G
Initial Findings Report

King County Health Advisory Task Force
Initial Findings Report
February 18, 2004

Current Situation

King County is facing an urgent need to effectively contain the rise in employee health care costs. National health care costs (and the cost to the county for employee benefits) are expected to increase at a rate of 15 percent or more per year for at least five more years. For the county, that will represent an increase in spending from $124 million per year on employee health benefits in 2003 to $249 million in 2008. This staggering rate of increase and the underlying factors contributing to this trend are the same issues threatening to overwhelm employers locally, regionally and nationwide. As the Budget Advisory Task Force, formed by Executive Ron Sims in 2002 noted in its final report in July 2003, it is imperative that the county look well outside traditional approaches to funding employee benefits to identify and implement innovative ways to align the employees' interest in quality, affordable health care with the county's need to control costs.

Initial Internal Work

Early in 2003, Executive Sims pulled together a group of benefits experts from inside county government to determine how King County could achieve real, significant and lasting cost containment through both short-term savings and long-term reform in its system. This internal study group had several key findings, including:

- **The issue is larger than just King County's system; it is a regional, state and national crisis.** In buying health care, the employee is essentially using the employer's "credit card." Employees choose whatever care they need or want, providers deliver whatever care they deem most appropriate, and the bill gets paid by the employer. In this model, the normal market checks and balances of purchasing a product do not exist – the employee is not well informed of costs, quality or options; the provider is rewarded for providing more treatment and is not rewarded financially for disease prevention or disease management. And, an employer has no control over the quality, appropriateness or efficiency of the services for which it pays.

- **Some employers have demonstrated significant success in managing their health care costs** in the new environment of 15 percent growth trends for the foreseeable future. These more successful employers:
    - Carefully evaluate the competing interests of employees' health care and the need to control costs. This attention to employee concerns effectively reduces the negative effect of plan changes on employee satisfaction.

    - Are forward thinking and explore options that have not been done in the past.

- Emphasize cost sharing through co-pays and point-of-care mechanisms rather than increased premium share.

- Lower costs by successfully negotiating with vendors to maintain quality of service and preserve plan essentials at reduced rates.

- Place significant emphasis on targeted interventions by using demographic and claims data to identify and care for potential health problems before they become too costly.

- Motivate employees and their families to participate in disease management and wellness programs by using incentives such a reduced premiums or lower co-pays and deductibles for members who actively manage their health status.

- Use data to integrate numerous benefits such as disability and sick leave and reduce or eliminate redundancies and inefficiencies among benefit plans.

- **Claims experience in the county's health plans is typical of all health plans. A very few people with chronic or catastrophic conditions account for the vast majority of claims cost.** One solution is a successful cost containment strategy, which must include:
  - Using predictive modeling to determine when chronic conditions are likely to develop and providing interventions and incentives for employees and family members to prevent the full-blown condition from developing.

  - Determining evidence-based methods to identify the best treatments and the most effective providers of specialty care.

  - Developing successful programs for managing chronic conditions that have already developed.

  - Providing support and incentives to employees and family members to become informed, active partners in controlling their conditions and minimizing the impacts of the condition.

- **Several recent studies have shown significant "waste" in the American health care system results from over treatment, under treatment, and inappropriate treatment.** Examples:
  - Dartmouth Center for Evaluative Clinical Science finds that 20 to 30 percent of health care spending in the United States is spent on procedures, visits, drugs, hospitalizations and treatments that do not improve quality or extend life.

  - Institute of Medicine in Washington, D.C., estimates that costs could be reduced by 25 percent if inappropriate care were eliminated.

A number of employers and unions (*e.g.* AFL-CIO) have joined forces in groups such as the *Leapfrog Patient Safety Initiative, Pacific Business Group on Health, The Business Roundtable, Washington Business Group on Health, National Quality Forum* and others. Their goal is to develop standards for measuring and purchasing quality in health care to reduce "waste" and overall costs while improving the effectiveness of care. The approaches common to all of these groups include:

- Developing an independent source of evidence-based information for physicians and consumers regarding the effectiveness of specific health care procedures.

- Exploring ways to measure variations in clinical decision making.

- Improving consumer understanding of the quality and cost implications of the care they receive and the choices they are making.

The county's internal study group found that no single strategy would effectively change the health care cost trend. Instead, a successful program will address four separate elements to achieve maximum impact:

- Maximizing health plan efficiency and effectiveness by finding best in class vendors and providers to deliver services (managing the plan).

- Building the right plan with the right financial incentives (managing the costs).

- Improving and sustaining consumer health and work/life performance (managing health behavior).

- Improving the quality, access and value of health care (managing the health system).

Based on these key findings, the internal study group concluded that to continue to provide the kinds of benefits employees want and that attract and retain qualified staff, King County, in collaboration with its labor unions and non-represented employees, must rethink the existing approach to employee health and health care benefits.

The internal study group developed nine specific actions that the labor-management collaboration effort should include in developing the 2006-2008 benefits package:

Engage employees:

1. Educate our employees and their families about regional and national health care cost trends. By helping employees understand that by exploring new ways of evaluating and purchasing health care and staying healthier we will require less health care services, King County can work with employees to look at other options. In order to maintain the status quo benefits, the only options available to the county will be:
    - significant cost share (premium and out-of-pocket) with employees;

- significant reductions in benefits coverage; and

- significant reductions in force in all departments and all funds.

2. Authorize resources to implement a comprehensive education plan on the health care crisis, its potential effect on employees, and opportunities for improved health and higher quality health care through active health care consumerism. This program is essential to successful labor-management collaboration on benefits.

3. Engage our employees as informed health care consumers by providing education and tools they can use to shop for high quality health care services and improve their and their families' personal health status.

Develop disease management and wellness programs:

4. Use actual claims data to identify most prevalent and costly health conditions.

5. Develop wellness and disease management programs for those conditions to improve employee health and well-being, improve outcomes of care, and restrain increases in plan expenses.

Explore plan-design elements:

6. Research cost sharing arrangements used by other comparable public employers. Use that information to develop plan designs that appropriately share expenses and provide tools to employees for managing those expenses.

7. Consider options for tailoring wages and benefits to meet employee needs for predictability of income and expenses through integrated bargaining of benefit and wage packages.

Influence the health care market:

8. Improve employee health and the quality of health care available in the local market by purchasing effective, evidence-based care.

9. Partner with other employers (public and private) to develop health care consumer education programs and decision-making tools, agree on a uniform set of health care quality measurements, and encourage providers to participate in plans that reward high quality care.

Executive Sims' Health Advisory Task (HAT) Force Creation

In December of 2003, Executive Sims created the Health Advisory Task Force, whose mission is to:

> *Recommend an innovative and achievable set of strategies to improve the quality of health care while moderating costs in the Puget Sound market.*

Members of this Task Force include physicians from the University of Washington School of Medicine and Harborview Medical Center, a pharmaceutical expert from the University of Washington, a labor representative, an attorney with a health care focus, a disease management expert, a health care communications expert, a health care economist, a health care technology expert and other major self-insured employers in the region. Members are listed in Attachment 1.

The Task Force held an initial meeting in December 2003 and has since established a work plan that will conclude in June 2004. The Task Force's initial mission was to analyze and verify that King County has accurately defined the health care problem and identified the most realistic, attainable elements to achieve quality of care and cost containment in its own plan. This task was addressed at the group's January 12, January 26 and February 9 meetings and is detailed in this report.

HAT Force Findings: Analysis and Verification of King County's Proposed Strategies

The Task Force analyzed King County's direction by reviewing the internal employee benefit strategies summarized above. The HAT Force concurs that the action is timely and extremely important.

At its February 9 meeting, the HAT Force endorsed the county's direction and made the following specific recommendations for King County's labor-management collaboration process in building its health care programs:

- Examine the local healthcare market to gain a better understanding of its dynamics, (e.g., increases in capacity, levels of competition, and the impact of these factors on employers, plans, and providers).
- Ensure that benefits design clearly takes into account the cost and quality impacts of various shared cost scenarios. The impact on quality resulting from cost sharing measures such as shared premiums, co-pays, and tiered benefits for pharmacy must be analyzed in light of identified financial and health care quality goals. Issues such as equity, quality, cost control, and risk management must also be considered.

- Estimate potential savings and care improvements (prevention, morbidity, mortality, quality of life) that may result from following evidence-based standards; conduct an

analysis (first of county data, then include other Task Force participant data) to define areas of highest cost and volume.

- Approach communication with employees the same way one would plan a major public information campaign: identify all stakeholders; use focus groups to develop the most relevant and effective communications approach for this employee audience; test messages before delivering; and invest meaningfully in the development of a strategic communication plan for trust-building with employees and unions. Make use of "lessons learned" from other large employers (particularly public employers) who have conducted similar education/cultural change initiatives. This initiative needs to become an ongoing program in order to support success of this approach to health care.

- Provide consistent, meaningful, accurate and simple information on benefits administration and the effect that employee decisions can have on costs.

- Provide employees with information and tools to assist with understanding health conditions, making decisions and successfully carrying out self-care actions and obtaining health.

- Seek feedback from employees on their views about appropriate trade-offs between benefits and cost sharing and their perceptions of the impact of cost sharing on access to and quality of care.

- Research innovative plan designs that create incentives to improve care and reduce costs.

- Create benefit designs that motivate beneficiaries to choose identified quality providers, actively participate with their providers in their own health care, participate in wellness and prevention activities, and manage chronic health conditions.

- Ensure that provider contracting includes both cost control and quality monitoring. Contracted providers and health plans must ensure that they are decreasing practice variation in alignment with evidenced-based guidelines.

- Implement a measurement system to continuously monitor the actual costs, cost variation, and necessity of the care provided. Public knowledge of some parameters of cost and quality is needed.

- Participate in regional initiatives that develop health care performance measures; provide meaningful and usable information to providers, beneficiaries, health plans and purchasers; and create consumer health and health care decision-making tools, and provide state of the art health care education materials.

Next Steps

The Executive is committed to this process and will follow the recommendations of the internal working group as validated by the HAT Force as well as the recommendations issued February 9 and shown above.

The HAT Force will now focus its attention on how to develop a regional infrastructure that supports and maximizes both King County's internal strategies and long-term reform for the region. In looking ahead, the Task Force developed four key outcomes it sees as essential to managing costs, assuring improved health and quality health care, and successfully attaining Executive Sims' stated goal – to achieve real, significant and lasting cost containment through both short-term savings and long-term reforms in health care consumption, delivery and costs. Their final report work plan focuses on strategies relating to the following outcomes.

Outcome A: Increase the likelihood and predictability that King County employees and other health care beneficiaries in the Puget Sound region will receive high quality, patient-centered health care service.

Outcome B: Mitigate the increases in personal costs/financial responsibility for health care benefits for King County employees by implementing strategies to effectively reduce the increase in total health care expenditures.

Outcome C: Increase the involvement of King County employees and other health care beneficiaries in the Puget Sound region in managing their own health and competence to act as partners with providers in making evidence-based health care decisions.

Outcome D: Develop a system in which health plans, providers and employees use shared health information and technology to continuously improve health outcomes and decrease medical errors. In this system, employers, employees and providers will use appropriate health information to ensure the most effective use of each dollar spent on health care services by monitoring costs, changes in health risk factors, changes in patient behavior, and changes in provider practice patterns.

In the next phase, the Task Force will make recommendations to King County and the region on how best to improve the quality, access and value of health care in the Puget Sound regional market. Components of these recommendations may include, but are not limited to:

a. Creating a process to be used in the Puget Sound region for implementing consensus-based standards of health care cost and quality measurements that provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and efficient.
b. Identifying a mechanism that will generate and make publicly available quality and economic efficiency performance information for all levels of care: health plans, hospitals, medical groups and individual physicians.
c. Obtaining health coverage from plans that measure and reward providers of high quality, cost effective care.

d. Promoting consumer understanding and use of health care performance measures and other quality standards.
e. Reinforcing and rewarding provider and patient focus on wellness, disease management, and active participation in health care decisions.
f. Encouraging providers to participate in plans that reward high quality, cost effective care.
g. Identifying opportunities to achieve administrative cost savings as a component of the design and implementation of improved approaches to health care.

The HAT Force is scheduled to meet monthly through May, and will issue a report from this second phase of their study in June 2004.

King County Health Advisory Task Force

Co-Chairs:

Alvin J. Thompson, MD, MACP is a clinical professor of medicine at the University of Washington (UW). His experience includes over 50 years of clinical practice, medical teaching, and community leadership, including serving as governor of the American College of Physicians for Washington and Alaska. For over twenty years, Dr. Thompson has also served as president of the Washington Association of Black Professionals in Health Care.

Edward H. Wagner MD, MPH is a physician/epidemiologist and director of the MacColl Institute for Health Care Innovation. His work includes studies of interventions to reduce disability in seniors and to enhance the care of persons with chronic illness. Dr. Wagner is widely published on topics ranging from the impact of primary care delivery on the survival rate of persons with AIDS to pharmacist screening of octogenarians starting new medications.

Task Force Members:

Larry Chapman, MPH is the chairman of the board for Summex Corp. He is a national expert, frequent lecturer, and author of numerous books, articles, and columns on innovations in health care management. Mr. Chapman is currently working with state and local policy leaders on a wellness- and consumer-driven health plan model.

Michael Cochran, MS is first vice president for Washington Mutual, Inc. In that position, he manages all health, welfare and wellness benefits for a workforce of 60,000 employees, plus retirees. Prior to joining Washington Mutual, Mr. Cochran managed health and welfare benefits at Microsoft. He has significant experience implementing e-health programs for employee populations.

Sally Fox is the director of employee health services with the personnel department of the City of Seattle. Ms. Fox has extensive experience administering all aspects of health benefit plans for large organizations.

Tom Fritz is the CEO for Inland Northwest Health Services. A recognized leader in electronic medical records, Mr. Fritz serves with the Inland Northwest Technology Education Center. Among his many organizational appointments, Mr. Fritz chairs the Workforce Shortage Task Force of the Spokane Area Workforce Development Council.

Richard A. Feldman is the executive director of the Worker Center since 1995. The Worker Center is the economic development and workforce division of the King County Labor Council, AFL-CIO in Seattle, Washington.

David Fleming, MD is the director of Global Health Strategies at the Bill & Melinda Gates Foundation. Dr. Fleming has a distinguished career in health policy, including serving as director at the Centers for Disease Control and Prevention and as the state epidemiologist for Oregon.

Annette King is the director of Benefits & Savings for Starbucks Coffee Company. Ms. King has nearly 20 years of experience with employee benefits. Today she is responsible for benefit planning on a global scale for the Starbucks organization.

Dan Lessler, MD is an internal medicine physician and associate medical director at Harborview Medical Center. Among his many accomplishments, Dr. Lessler has taught and advised extensively on methods for improving the management of chronic illnesses.

Jodi Palmer Long, JD is the associate general counsel for Children's Hospital and Regional Medical Center where she advises health care practitioners and administrators on the financing and delivery of health care. Ms. Long previously served as associate general counsel to Group Health Cooperative.

Richard K. Onizuka, PhD is the director of health care policy for the Washington State Health Care Authority. In this position, he has a key leadership role evaluating new ideas in the field of health care purchasing.

Charles Royer, former Mayor of Seattle, is national program director for the Urban Health Initiative. As mayor, Mr. Royer became a national spokesman for American cities in health care, housing, the arts, energy, civil liberties, and the needs of children and youth. He has served as director of Harvard University's Institute of Politics and is currently a senior lecturer at UW.

David Saperstein, MD is an assistant professor of Ophthalmology at UW, specializing in the medical and surgical treatment of retinal diseases. He was awarded a Physician-Scientist Research Award from the National Eye Institute to develop a research program concentrating on gene therapy for the treatment of retinal disease. While teaching at Emory University, Dr. Saperstein practiced evidence-based medicine.

Andy Stergachis, PhD, RPh is professor of epidemiology and affiliate professor of pharmacy at the North West Center for Public Health Practice. Dr. Stergachis is a national expert who works closely with the Institute of Medicine, the National Committee on Quality Assurance, and the American Public Health Association, among other organizations.

Mike Stuart, MD is a clinical assistant professor at UW and president of the Delfini Group, LLC. He is a nationally recognized expert on evidence-based medicine. Dr. Stuart

is the author of several influential publications on improving the effectiveness of health care delivery.

Jay Tihinen is the assistant vice president of benefits at Costco. He has focused on helping Costco employees become better consumers of care services as the best long-term solution to rising costs.

Debbie Ward RN, PhD is an associate professor of nursing at UW. She is involved locally and nationally in changing the format and content of health service delivery. In addition to teaching health policy, politics, and systems, Dr. Ward is director of the de Tornyay Center on Healthy Aging. She also recently served as chair of the consumer-elected board of trustees of Group Health Cooperative.

Cindy Watts, PhD is a professor in the department of health services at UW, teaching in the areas of health economics, health policy, and effective writing. She also serves as the Director of the Northwest Center for Public Health Practice. Dr. Watts' research includes work on access to health insurance, reimbursement, and health care market structure.

Ana White is the senior benefits manager for Microsoft. Ms. White developed Microsoft's guiding principles for benefits. She has designed and managed U.S. and international health plans for the company.