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Executive Summary

The Purpose of the Task Force

In December 2003, King County Executive Ron Sims convened a broad-based leadership group, *The King County Health Advisory Task Force,* to develop an integrated strategy to address the systemic problems facing the health care system in the Puget Sound region. In particular, the County Executive requested that the Task Force focus on three inter-related issues:

- The increases in health care costs for both patients (employees and their families) and purchasers (employers who buy coverage through benefits plans).
- The quality of care provided by health professionals.
- The importance of improving the health of the community.

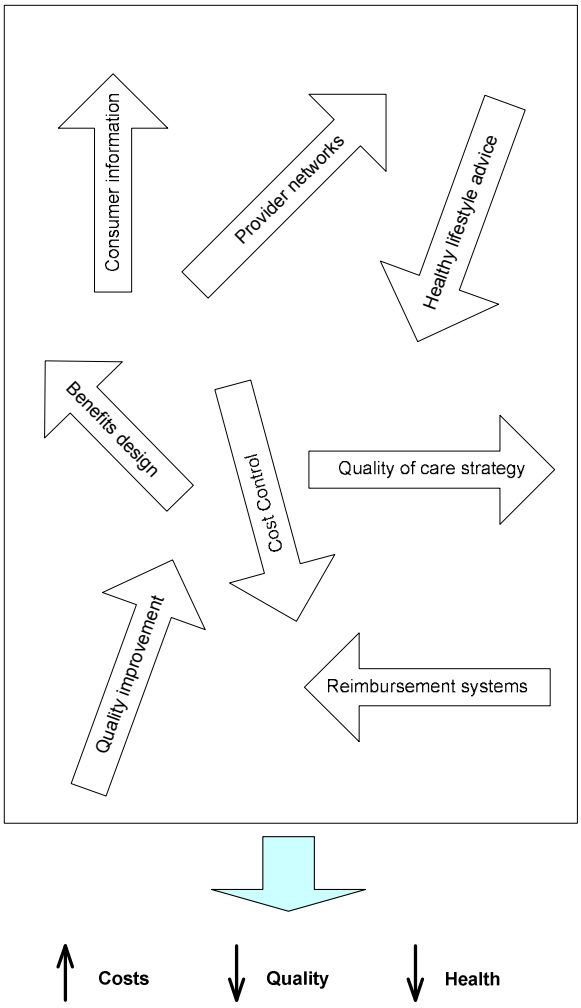
The Task Force Membership

The Task Force included a number of self-insured employers (employers who manage the insurance risks of their employees internally as opposed to through health insurance plans), experts in the health care arena, including physicians, a nurse practitioner, legal, labor and economic experts, and a pharmacist. The Task Force was chaired by two local experts who have numerous years of experience in improving the health care system, Alvin J. Thompson, M. D. and Edward Wagner, M.D.

In addition to relying on its own expertise, the Task Force invited outside experts to assist in its deliberations, including Sally Trude, Ph.D., Senior Health Researcher, Center for Health System, Dr. Arnie Milstein, Medical Director of the Pacific Business Group on Health , and David Lansky, Ph.D., President of the Foundation for Accountability (FACCT).

The Health System Today

The current system of health care financing and delivery can best be depicted by a series of disconnected strategies (Graphic 1) all working concurrently but without a system steward, or neutral leader, to coordinate them and ensure that they are achieving the optimal mix of cost, quality, and health outcomes.



Graphic 1: What Our System Looks Like Now

This lack of systemic leadership and absence of agreement on what the system is intended to accomplish has resulted in an unsustainable approach to health care in the Puget Sound region.

The Key Outcomes

The Task Force began its work by creating a critical foundation – agreement on a set of intended outcomes for the region's health care system:

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 services.

B. Mitigate 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.

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

D. Develop a system in which health plans, providers, purchasers and employees use shared health information and technology to continuously improve health outcomes and decrease medical errors.

The Importance of an Integrated Strategy

During the course of its discussions the Task Force recognized that achieving these four outcomes requires the integration of financial, insurance, and health care delivery strategies on a regional basis. It also concluded that the current health care system is not structured to allow for systemic and sustainable change in cost, quality, and health improvements. For example, although the health care literature has documented that managing diabetes to attain better health and cost outcomes may require electronic registries, group visits, nutrition advice, and telephonic support by provider teams, it is not common for provider reimbursement schemes or benefit designs to include financial incentives and payment contracts that reward or support this approach.

In order to achieve this type of systemic and long lasting improvement, the Task Force realized that a coordinated set of changes must be supported by the four key partner

communities in the health system: practitioner, purchaser, patient, and health plan. Each group plays a critical role in an integrated approach to health care:

- The purchasers require clinical advice from the practitioners about how best to structure benefits to achieve better health at lower costs.
- The health plans need to bridge the needs of purchasers, patients, and providers in supporting the systems for change.
- The providers need to understand from patients how best to deliver convenient and high quality care.
- The patients need to understand how to best seek and receive care that is most likely to improve their health at the most optimal costs.

The Task Force's Recommendations: An Integrated and Collaborative Approach

In carefully examining how to bring about this type of system change, the Task Force concluded that there is currently no organizing mechanism for ensuring that these four groups work together effectively to improve health in the region. To fill this void, the Task Force is recommending the creation of a regional partnership to provide the leadership necessary to implement an integrated set of system improvement strategies. Such a partnership will serve as the central reference point and leadership body for the health care players that are dedicated to improving health and health care in the Puget Sound region.

In order to bring about changes in the health system, the Task Force recommends that this partnership build on what is known to be effective as the basis for making improvements to the delivery and financing mechanisms at play in the Puget Sound region. Key elements of what is effective that will be integrated into the partnership's strategic approach include:

1. Chronic disease management to improve health, quality and cost outcomes. Local examples of success are included in this report.
2. Scientific evidence to guide providers and patients to attain better health.

3. Data driven clinical quality feedback to improve provider performance.
4. Quality and payment strategies to effectively reinforce each other.
5. Alignment of health care benefit design with high quality clinical delivery models.
6. Opportunities for practitioners to learn together with similar avenues for patients.
7. Evidence based formularies and the systems to support them to reduce costs.
8. Decreasing practice variation to improve quality and decrease costs.
9. Preventive care to improve health and save money in the long run.
10. Employer and purchasers involvement to ensure that the dollars spent in health care are used wisely on best practices.
11. Quality measurement and reporting to support practice improvement and allow patients to seek appropriate care.

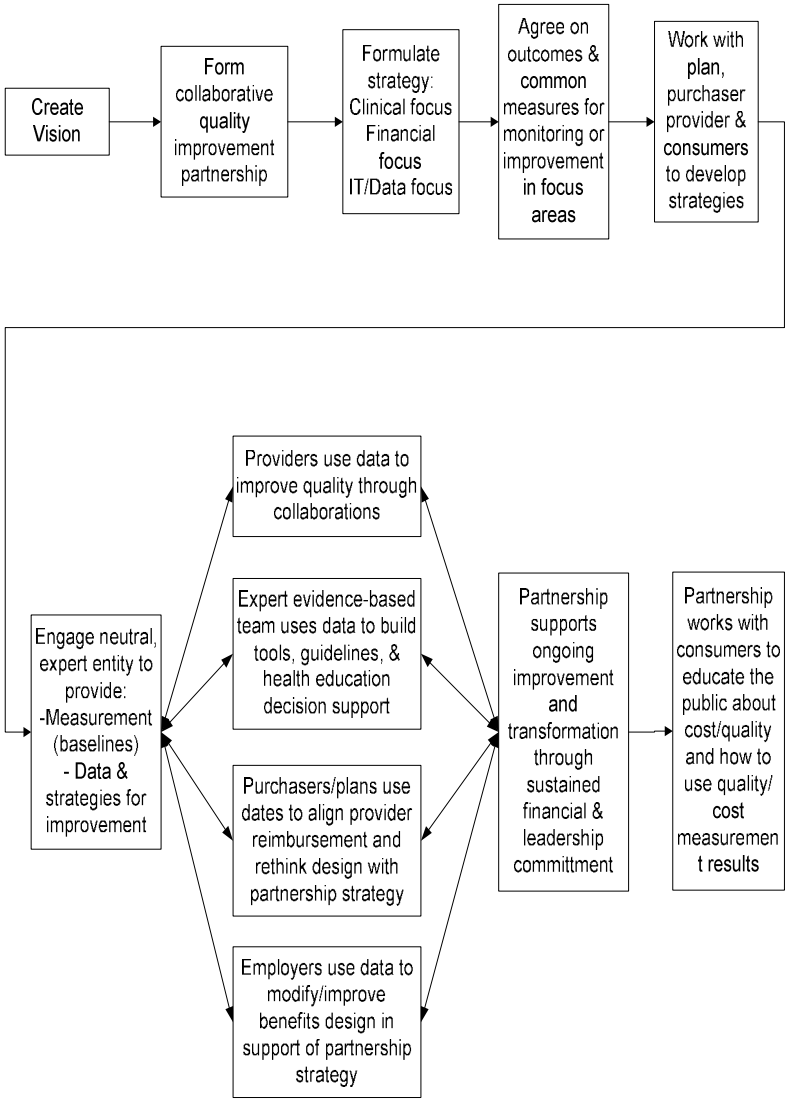
The Starting Point

The Task Force recommends that the Partnership support building the necessary components to achieve optimal outcomes for the health system in the Puget Sound region. It recommends that this work be organized around five areas of health care delivery:

- Chronic disease services;
- Acute and episodic care;
- Prevention services;
- Safety practices; and
- Service quality.

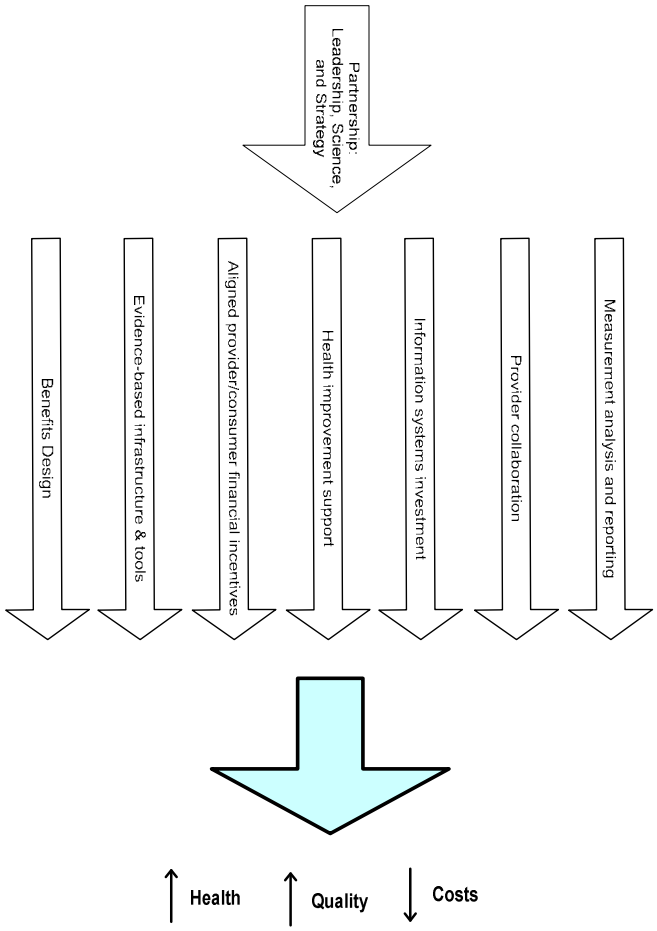
The Partnership will ensure the integration of evidence-based clinical decision support, with evidence-based patient education and self-management tools, and will provide the

infrastructure to support provider-based learning collaboratives for quality improvement. It will also build a system to analyze and report on quality and cost outcomes in the region. This data will be used as a resource for all partners to continually create aligned health and financial strategies for the population of Puget Sound. The following graphic depicts the Partnership's activities:



Graphic 2: The Collaborative Process

By conducting this type of integrated, collaborative approach, the Partnership will move the health system to an aligned approach that is able to achieve affordable costs, better care, and healthier patients. Graphic 3 shows what this aligning of interests looks like:



Graphic 3: Aligning Interests

Aligning Interests to Achieve Change

The Task Force considered the difficulties in moving towards its vision of a high quality, affordable health care system. There are always market dynamics that can serve to obstruct such a vision. However, in numerous dialogues with all parts of the health care system, there is a uniform sentiment that there must be major change.

The current system is unsustainable. Each community of participants must play a significant role. If even one element of the health care system does not participate, it is

impossible to achieve optimal outcomes for the region. Patients are increasingly interested in the care they receive and how to positively affect their health. Providers want to do what is best clinically for their patients and are requesting financial payment to support it. Purchasers are engaged and willing to try something new. Health planners have experience and ideas about how to positively effect change. Public health and other governmental and policy-making entities are actively creating strategies to support healthy lifestyles.

The Task Force believes that enough is known in the fields of science, finance and actuarial risk, public health, technology, quality measurement, health-seeking behavior, health care delivery, and quality improvement to activate a partnership for better care, healthier people and affordable costs. By providing the needed leadership, the Partnership can use this knowledge to bring about a new system.

The Puget Sound region is home to world class innovation and expertise in the fields of technology, health care, and science. There is nothing standing in the way of improving the health and the health care for the residents of Puget Sound. The partners are ready; the Task Force recommends immediate formation of the Partnership to provide the leadership necessary to move the region forward.

Section I. The Business Case for Quality

In December 2003, King County Executive Ron Sims convened a broad-based leadership group, *The King County Health Advisory Task Force*, to develop an integrated strategy to address the systemic problems facing our health care system. In particular, the County Executive expressed his intention that the Task Force address three inter-related issues:

- Increasing health care costs facing employers and employees;
- Questions about the quality of care; and
- Concerns about the community's health.

As the cornerstone of the Task Force's efforts, the County Executive invited a number of other large, self-insured employers to join the county in bringing about significant changes in the region's health system: Microsoft, Washington Mutual, Costco, Starbucks, the City of Seattle, and the State of Washington became critical members of the Task Force. In addition, the membership included experts in the health arena: physicians, industry executives, a nurse practitioner, a pharmacist, an economist and a labor representative.

To ensure that the Task Force had the leadership necessary to accomplish this effort, Executive Sims appointed Alvin J. Thompson, M.D. and Edward Wagner, M.D. as co-chairs. Both of the co-chairs brought many years of experience to the Task Force's charge.

Executive Sims encouraged the group to develop a portfolio of strategies that includes both short-term and long-term approaches. He expressed concern that the current escalating costs and stagnating of quality in health care require that the Task Force develop some strategies that can deliver short-term results i.e., progress within one to two years.

I refuse to sit back and allow the county and its employees to be victims of these seemingly uncontrollable cost increases. Further, I refuse to accept there are only two choices: reducing benefits to our employees and their families, or paying crippling annual increases. Tweaking the edges of the problem will no longer work.

- Ron Sims
"Creating a road map for health-care reform" Seattle Times: Friday, November 14, 2003.

Increasing Costs Brought Us to the Table

The purchasers of care who joined the Task Force - as well as other employers locally and nationally - are facing an urgent need to effectively contain the rise in employee health care costs. For example, if the current rate of cost increases experienced by King County government continues at approximately 15 percent per year, the county will incur an increase in premium spending from $124 million per year in 2003 to $249 million per year in 2008. This staggering rate of increase and the underlying factors contributing to the county's trend are the same issues threatening to overwhelm employers locally, regionally, and nationally.

Nationally, health spending accounts for over 15 percent of the nation's economy.[1] Projections put health spending at 17.7 percent of gross domestic product by 2012.[2] Projecting today's trends forward, hospital care and prescription drugs will account for much of this overall increase both locally and nationally. [3]

Much of the cost increases relates to care for chronic conditions (which patients and providers can work together to manage) and catastrophic events (which are unpredictable and therefore not amenable to management).[4] The experience of health plans which cover King County employees, and which are typical of other large employers, reflect the following distribution of costs:

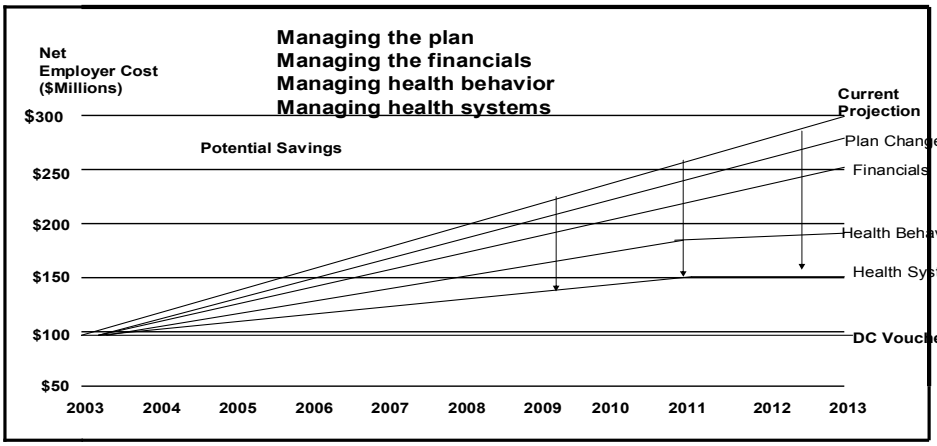
- 10 percent of the total work force have chronic and catastrophic conditions; these individuals accounted for 70 percent of the claims dollars in 2002.
- 64 percent of the members (including employees and their family members) had claims of less than $1,000 and represented only 7 percent of the claims dollars.

Graphic 1 below demonstrates the potential costs savings to employers when they bring about systemic improvements and manage four key components that impact health care costs: the plan; the financials; health behaviors; and health systems.

We've said publicly that we are not going to turn our back on our people, but the hard facts are that we are on a collision course with time. And there has to be a significant level of reform. There has to be, I think, some partnership between government, business and the consumer in which we're going to see a change, a significant change so that companies like Starbucks can continue to provide this opportunity.

- Howard Shultz, Chief Executive Officer of Starbucks

Determining the potential savings



Figures from Watson Wyatt Worldwide

Improving Quality of Care is the Path to Containing Costs

Numerous studies have shown that significant "waste" in the American health care system results from inadequate quality of care including excessive services and redundancy, under-treatment of risk factors and predictable conditions, and inappropriate treatment. The Dartmouth Center for Evaluative Clinical Science states that 20 to 30 per cent 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.[5] The Institute of Medicine in Washington, D.C., estimates that health care costs could be reduced by 25 percent if inappropriate care were eliminated.[6]

In support of these findings, data from the National Committee for Quality Assurance's (NCQA) show that regardless of what health condition a person has, or whether care is provided by a public or private plan, the quality performance of our health care system varies widely.[7] This inconsistency takes a significant financial toll, costing the nation more that $1 billion dollars in avoidable hospital bills each year.[8] In addition, the associated nearly 41 million missed worked days result in an estimated loss of $11.5 billion in revenue for American businesses.[9]

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry,[10] the Institute of Medicine (IOM),[11] and/or the U.S. Department of Health and Human Services, have drawn attention to the fact that health care is too often inappropriately delivered, is of poor quality, and is unsafe. The IOM report, *To Err is Human*, published in 2000, stated that approximately 98,000 preventable deaths occur each year because of medical errors.[12] A 2003 New England Journal of Medicine report based on the Community Quality Index Study found that the study patients were receiving only about 55 percent of recommended care across various conditions and treatments.[13] That study concluded that "the gap between what we know works and what is actually done is substantial enough to warrant attention".[14]

We hope this study stimulates a dialog among patients, doctors, employers, hospitals, and insurers in these 12 communities…about the best local solutions to these serious deficits.

- Elizabeth A. McGlynn, PhD, Associate Director of RAND Health and co-author of study

Other studies on using evidence-based guidelines give an indication of the actual costs when providers do not follow these guidelines. A report published by the American Medical Association on April 21, 2004 reports that greater adherence to evidence-based guidelines for the management of hypertension could save $1.2 billion nationally each year.[15]

There is Room for Improvement in Cost and Quality Performance

Even in the face of overwhelming evidence to the contrary, many people do not understand or believe that there is a quality problem. Many think that the care delivered by their doctors, or in their community, is better than the care delivered in the nation as a whole. Most perceive their care to be individualized to their needs or requests. However, a recent Harris interactive survey found that only one-third of Americans age 50 or over agreed that the chronically ill receive adequate care.[16]

Recent research conducted by RAND Health entitled the Community Quality Index (CQI) Study confirms this public perception of chronic diseases.[17] Published in May 2004, the CQI provides a comprehensive examination of how

effectively health care is delivered in Seattle and eleven other metropolitan areas. For example, the study documented the following findings specifically for Seattle:

- People with diabetes received just 54 per cent of the recommended care.
- Individuals requiring cardiac care received 60 per cent the recommended care.

The conditions selected for the CQI study represent 52 percent of all ambulatory care utilization and 46 percent of hospital utilization. There is a strong correlation between the conditions selected for this study and those the Task Force is recommending for emphasis in its strategy. The deficits in care documented for these conditions in the CQI Study present serious concerns relating to health outcomes and translate into thousands of preventable complications and deaths per year as shown in the table below:

Condition	What RAND Found	Potentially Preventable Complications or Deaths (US annual)
Diabetes	Average blood sugar not measured for 24 percent	2,600 blind; 29,000 kidney failure
Hypertension*	Less than 65 percent received indicated care	68,000 deaths
Heart attacks*	39-55 percent did not receive needed medications	37,000 deaths
Pneumonia*	36 percent of elderly received no vaccine	10,000 deaths
Colorectal cancer*	62 percent not screened	9,600 deaths

*Source: Woolf SH, "The Need for Perspective in Evidence-Based Medicine," *Journal of the American Medical Association*, Vol. 282, 1999, pp. 2358-2365.

A Commitment to Action

Following its discussions on the impacts of rising health care costs and the national research indicating opportunities to improve care as an approach to containing these costs, the Task Force members agreed to take a quality improvement approach to the problem. With this framework in mind, the group

turned its attention to gaining a more complete understanding of dynamics driving the health system in the Puget Sound region.

Section II. Findings: Our Health System Today

One of the Task Force's most important actions was to take a critical look at how the health system in our region functions now. By carefully examining the system's current strengths and weaknesses, the group was able to identify the most important areas to focus on for improvement. For example, the following scenario could happen in our system today:

> ***Scenario A (now):***
> A mother seeks help for her child's worsening asthma from her provider (physician, nurse practitioner, etc.). Unfortunately, the provider is not equipped with up to date guidelines to guide the use of medications, assessment instruments to determine severity, or patient education tools to teach the parent and child how to effectively manage the asthma. As a result the child has not received mediation to prevent further attacks, and the family remains ill-prepared. Several days later the child has a serious asthma attack; the mom calls in sick to work in order to take her child to the emergency room for treatment. Following treatment at the emergency room, the mother returns home with her child. The mother still does not know how to effectively manage her child's asthma; she has missed a day of work; she has incurred emergency room costs (paid in part by her self-insured employer and in part by herself); and her child is still at risk.

The Task Force's intent is to change this scenario to the one below:

> ***Scenario B (following system improvements):***
> A mother seeks help for her child's asthma from her provider (physician, nurse practitioner, etc.). Her provider has access to state of the art evidence-based decision support guidelines and assessment instruments and patient education tools for reference and use in treating the asthma

and for teaching the mom and the child how to manage the asthma. Several days later the child is taking appropriate controlled medications, is monitoring his/her condition and is able to avoid a serious asthmatic attack. The mom and the child know what to do – they have the tools the provider gave them and put them to use immediately. The child is able to go to school; the mother goes to work; there is no trip to the emergency room; there are no unnecessary costs incurred.

The Constituencies that Comprise Our System

To better understand the factors underlying Scenario A and B, the Task Force looked closely at the constituencies that make up our system:

Health Professionals (Providers):

A wide range of clinicians deliver the health services in our system today. Physicians, nurse practitioners, nurses, pharmacists, public health staff all play a role in working directly with patients to improve their health. These clinicians provide a full continuum of health care services, including prevention, primary care, specialty care, and hospital care. Pharmacists play a critical role in working with providers and patients to ensure the safe and effective use of medications.

Consumers (Patients):

A diverse array of people comprise the population that receives care in our health system. Some segments of this population receive health care benefits through their employers. Other groups obtain their care through government-sponsored programs such as Medicaid and Medicare, and sadly many have no health insurance. And broadly speaking, all patients are community members for whom public health initiatives are created to control disease, help people with addictions such as tobacco and alcohol, and improve healthy lifestyles through exercise and diet.

Purchasers:

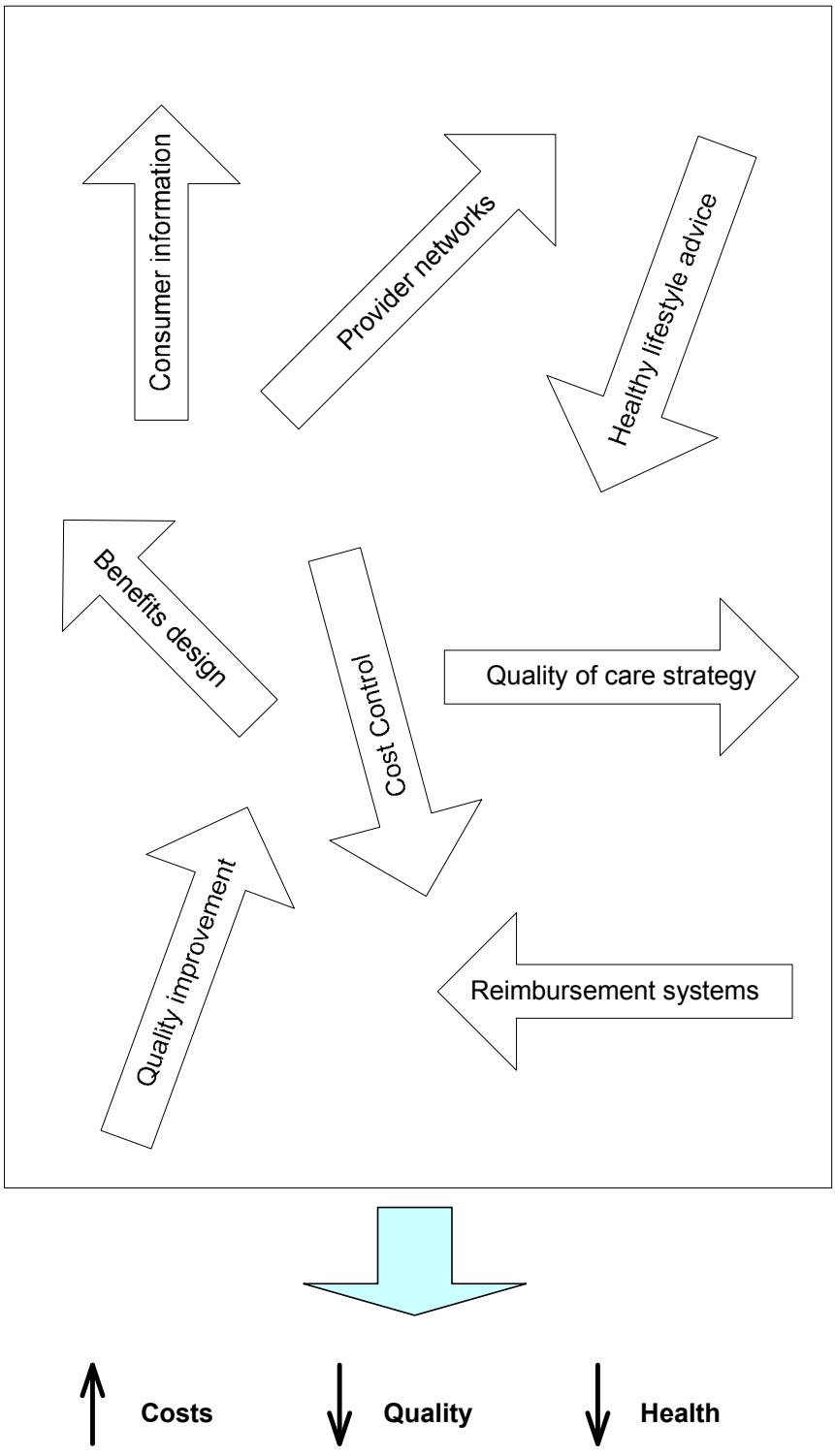
Employers are the source of health coverage for many people through the health benefits they provide. The government is the purchaser for others via programs such as Medicaid and Medicare. Purchasers of care can play a critical role in ensuring that the care they are purchasing is effective in improving their beneficiaries' health and that it is affordable. Many large employers operate on a self-insured basis, i.e. managing the risk for their workforce themselves, and contracting with third party administrators to process the claims for their employees.

Health Plans:

Health insurance plans are the fourth component of our health system. While some large employers (including governments) do not use insurance plans to manage their risk, most medium and smaller employers provide their employees with health coverage through health plans, e.g., Aetna, Community Health Plan of Washington, Group Health Cooperative, Molina, Premera, and Regence.

After looking at the evidence and these constituencies, the Task Force considered the following fact and questions: *We have a healthcare system that does not provide quality care at an affordable cost. Why is there no* ***system steward,*** *a neutral entity that is providing integrated leadership for the system; Who is integrating the cost and quality strategies for each of the key players in the health arena;* and *Who is pulling together the different components to achieve the best value (cost/quality)?* The Task Force realized that without a system steward, it is impossible to create a health system that successfully balances the needs of all of its constituencies and achieves a healthier population at an affordable cost.

The current system of health care financing and delivery can best be depicted by a series of disconnected strategies (Graphic 2) all working concurrently but without a system steward to coordinate them and ensure that they are achieving the optimal mix of cost, quality, and health outcomes.



Graphic 2: What Our System Looks Like Now

The Impact of Market Forces

Given that a considerable body of knowledge is available to support the provision of quality care and improve people's health at an affordable cost, why hasn't the health system in the Puget Sound region made more progress in that direction? To answer this question, the Task Force examined some of the economic and structural dynamics that have discouraged the development of a common regional infrastructure to support the achievement of top quality outcomes, better health, and decreased costs.

In a 2004 article Len Nichols, Paul Ginsberg, et al conducted an analysis of whether market-based reforms by themselves will produce the urgently needed improvements in the efficiency and quality of the nation's health care system.[18] They outline *four* key areas where market forces may work against accomplishing significant improvements in health systems:[19]

1. **Provider Market Power**
   Large groups of providers can refuse to contract with specific health plans unless the providers are able to influence key terms of the agreement. In these situations, for example, providers might use this power to negotiate rates of reimbursement or to ensure their placement in preferred provider networks. In addition, providers may use consumer preference to force purchasers to include them in their network based on consumer demand rather than cost and quality performance.

2. **Large Provider System Inefficiencies**
   Efficient provider systems are difficult to create in the current environment. The consumer demand for large provider networks has made it difficult for provider groups to focus on defined patient populations for whom they are uniquely responsible. There are still some examples of effective provider groups that are willing and able to bear risk, thereby allowing them to invest in the tools and

infrastructure necessary to provide high quality and cost effective care.

3. **Employer Attempts to Control Costs**
   Employers are encountering difficulties in pushing the system towards efficiency and quality. The preference for broad networks by large heterogeneous workforces has led employers to offer similar plans through different carriers. Employers may respond to recent large premium increases by either passing more of the premium costs to employees or "buying down" the actuarial value of their benefit packages. A frequent way of doing this is to increase patients' cost sharing at the point of service. Employers do not have confidence in this approach, and are beginning to seek other solutions.

4. **Competition Among Plans**
   Health plan competition is not working effectively. Distinct provider networks that compete on cost and quality are not a significant market force in the Puget Sound region. Health plan dynamics have devolved to competing on things such as administrative efficiencies, customer service related to claims payment, and increasing market share to better negotiate discounted reimbursement rates.

Other Systemic Problems

Systems as complex as health care are not able to easily organize themselves into highly functioning, cost effective entities. Nichols, Ginsberg et al point out that market forces alone do not provide sufficient control to create a high functioning health care system; in fact they contribute currently to the problems of mediocre quality and runaway cost inflation.[20] They also note that regardless of the market dynamics in effect, there are policy and strategy approaches that high quality systems must incorporate to achieve cost and quality gains.[21] These include:

- state of the art evidence-based medicine;
- data for comparing quality among providers so that consumers,

providers, health plans, and purchasers can make informed choices about how to design insurance programs, purchase or seek care, and whether to seek particular services in specific patients' cases;

- investment in health information infrastructure, at the provider level and at the more aggregate population levels, to track both care being provided *and* to assess it for quality and cost outcomes;

- governmental facilitation of research and collaboration among providers and quality accreditation bodies; and

- community-based conversations with all parties discussing how to the take next steps in addressing quality and cost concerns.[22]

In examining the current health system in our region, it is clear that there are a number of key infrastructure elements that are missing. In order to correct the current imbalances in the market, we must create the following infrastructure elements:

1. A *forum and delivery mechanism* through which it is possible to develop, disseminate, and continuously update a set of uniform evidence-based guidelines and decisions, support tools for professional and patients.

2. A *trusted central repository* of evidence-based patient education and self-management tools that enable patients to effectively manage their health care decisions and health behaviors.

3. A *common measurement system* for routinely collecting, analyzing, and reporting on results of quality and cost improvement. To be effective, this system requires both data exchange technology, data base management, and expertise in clinical measurement, analysis, and reporting of performance.

4. A *region-wide support system* for supporting collaboratives or other

learning initiatives to support practice systems change and provider improvement. There are discrete local examples where this approach has been effective: COAP (Clinical Outcomes Assessment Project) and the Diabetes Collaborative funded by the Institute for Healthcare Improvement are both success stories in this region.

5. An *organized forum* where the impacts of various benefit designs and provider payment methodologies are studied and placed in alignment with cost, quality, and health improvement goals.

6. A *regional leadership forum* where purchasers, plans, patients, and providers can work collaboratively to design and implement the strategies that will improve the health system.

The Importance of not "Reinventing the Wheel"

During the course of its deliberations the Task Force learned a great deal about the *local initiatives* originating among purchasers and providers. In addition, the group invited experts from other parts of the country to share their results and ideas. As a result of these discussions, the group has also learned a great deal about *innovative and successful health system improvement efforts*, both here and in other parts of the country. The Task Force recommends that we learn from these examples and incorporate their insights into our efforts.

Section III. Findings: What Works

Creating a health system that improves health, provides high quality care, and is affordable is not an easy goal to accomplish. A number of communities throughout the United States have tried to bring about major, systemic improvements in the health systems. A few have succeeded; many more have failed.

A wide range of current studies describes state-of-the-art approaches to improving quality as a key driver for achieving gains in health status at an affordable cost:

1. **Chronic Disease Management Offers Successful Models**
   There are proven models for managing chronic disease that both improve health and drive down costs.

   For example, the Task Force received information from *four local groups* of practicing physicians which described their experience and their actual and projected cost for quality gains from implementing planned, proactive systems of care for and managing diabetes.

   - The *Northwest Physician Network* has a team of instructors teaching primary care practitioners how to move from an acute, episodic model of caring for chronic disease to an active management model, and in two years time has reduced HbA1C averages for its diabetic population from 7.4 to 6.9.

   - *The Everett Clinic* reports scoring above the 90th percentile nationally on three diabetes test rates (HbA1C, LDL and Microalbumin) since the inception of its diabetes program. In addition, The Everett Clinic has quality improvement teams

working on asthma, hypertension and congestive heart failure.

- In a letter to the Task Force, *The Polyclinic* also indicated two-year returns on improved quality performance of its diabetic patients, with a 30 percent increase in patients with HbA1C < 7 percent, and a 25 percent increase in patients with LDL cholesterol < 100.

- *Group Health Cooperative* provided information that documented several dimensions of improved performance in diabetes care over a six year timeframe. The percent of diabetics with documented foot exams increased by 70 percent over a six year period. The percent of patients obtaining a retinal eye exam has increased 35 percent. As of February 2004, the percent of patients with HbA1C less than 8.0 is 67 percent.

The cost savings from such approaches are reported to exceed the investments made in building these planned systems of care. Northwest Physicians report that they use the cost savings to invest in new quality improvement efforts. The Polyclinic estimates that with a fully implemented diabetes care system, their 2000 diabetic patients (or their payers) could save as much as $600,000 annually. Group Health's experience indicates an 11 percent cost savings over a two year period, resulting from 26 percent fewer inpatient days, 30 percent fewer unnecessary visits to physicians, and an 11 percent increase in needed pharmaceuticals.

These provider organizations uniformly state that aligning health benefit design and physician payment methods with proven methods of delivering chronic disease care are *key* to the ongoing success of managing chronic diseases.

These models of planned care require the use of current evidence about

what constitutes effective treatment; measurement systems for providers and patients to use to monitor and improve both the care provided and the self-management plans; and information systems (patient registries) for providers to keep track of the care provided for various clinical subpopulations.

2. **Scientific Evidence to Guide Care is in the Hands of Providers and Patients**

   There is wide variation in the availability of sound scientific data for treatment of various clinical conditions. Depending on the clinical area, such scientific evidence exists for 20 percent to 82 percent of medical interventions.[23] The challenge now is to make sure that physicians have up-to-date evidence-based information at hand when they are treating or advising their patients. The May 2004 RAND study demonstrated that fewer that 65 percent of those with hypertension received the indicated care, resulting in 68,000 potentially unnecessary deaths and a great deal of unnecessary care.[24] If both patients and physicians had access to the needed information and it was integrated into practice, this cost and quality gap could be more easily closed.

3. **Feedback Improves Provider Performance**

   Providers are more likely to improve the quality of their care if they have credible information available that describes how they are managing key conditions. For example, quality improvement reports that indicate that only a fraction of his/her hypertensive patients are being treated according to indicated guidelines can help the practice focus on improving that percentage and sustaining a higher level of performance.

4. **Quality and Payment Should Go Together**

   The implementation of payment and reimbursement systems that reward high quality reinforces the notion that misuse, under-use or overuse of health care resources leads to poor quality. David Cutler, a health economist at Harvard, points out that medicine is the only industry in the

United States where high quality is reimbursed at no higher rate than low quality.[25] The current method of payment pays for what is done, not for what is accomplished.

5. **Providers Learn Best Together**

   Providers prefer to learn and improve in collaborative environments where they can share knowledge and expertise. There is a growing national push to improve the care of chronic diseases, for example, through the use of organized regional learning and improvement collaboratives. Providers embrace the idea of improving care for their patients, and will support systems of financing and delivery that keep this as the aim. In a recent meeting with key medical leaders in the Puget Sound region, physicians noted that collaboratives are a good training ground for care improvement and encouraged the development of a more robust infrastructure and financing mechanism to support them.

6. **Aligning Benefits and Needs is Essential**

   Improved quality and lower costs can result when we align health benefits design with health care needs. The Wall Street Journal (May 10, 2004) featured Pitney-Bowes's use of a counter-intuitive approach to pharmacy co-pays as a means of improving quality and lowering costs. Instead of raising the co-pay costs for drugs to treat asthma and diabetes, the company lowered them. Previously, the patient's share of these drugs was as high as 50 percent. Under Pitney-Bowes new approach, the patient was responsible for only 10 percent. Because these patients could then afford to purchase these needed drugs, they were able to manage their chronic disease more effectively and avoid the need for higher expense care. As a result, the overall annual cost of care for the median asthma patient fell 15 percent and the cost for the median diabetes patient fell 12 percent.[26] (See Appendix A for a more in-depth discussion of these issues.)

7. **Evidence-based Formularies Reduce Costs**

The implementation of pharmacy systems that support the use of less costly yet equally effective drugs bring costs down. The transition to these evidence-based formularies requires a strong education and support system for both providers and patients as they learn to use them in ways that support high quality care.

8. **Decreasing Practice Variation Improves Quality and Decreases Costs**
   There is currently unnecessary and unexplained variation in treatment regimens for conditions such as low back pain. It is possible to decrease this practice variation by analyzing the clinical decision-making practices of physicians. John Wennberg at the Center for Evaluative Clinical Sciences, Dartmouth points out that rates of underlying illness do not account for differences in spending among regions.[27] The Center found about 41 percent of practice variation is driven by the supply of physicians and hospitals rather than by the demand for the care they provide.[28] Wennberg has found that improved health does not result from more money being spent, and that, in fact, excessive care can cause harm.[29]

9. **Investments in Quality Improvement Pay Off**
   The National Committee for Quality Assurance 2003 Report notes that there *are* health plans performing at high quality levels.[30] This provides evidence that investments in clinical guidelines, measurement reporting and analysis, quality improvement infrastructure, and ongoing monitoring assist providers in achieving and maintaining high levels of performance.

10. **The Web is an Information Source for Patients**
    Consumers are increasingly relying on web-based information for help in making informed health care decisions. They are looking for accessible, easy to understand information and decision support about their health, their health care decisions, and about the quality of the providers they can

access.[31] The web offers the opportunity to make up-to-date, accurate information available at a reasonable cost.

11. Preventive Care Improves Health and Saves Money

Preventive care has a critical role to play in improving the community's health and keeping health care costs under control. The May 2004 RAND study noted that 36 percent of seniors did not receive their flu vaccine. This resulted in 10,000 deaths (and numerous more unnecessary visits to the doctor for flu symptoms and treatment.). A 2002 study on the impact of the flu in the workplace, published in the Annals of Internal Medicine, estimated that the annual spate of influenza cost employers nearly $400 per employee in lost work and medical expenses, costs that could be easily avoided by inoculation.

12. Employers Have a Critical Role to Play

There are currently evidence-based approaches to implementing employer-based prevention and chronic disease management programs. These efforts offer employers the opportunity to focus on what they can do to prevent misuse, under-use, or overuse of care by providing employees and family members with proven approaches to play a greater role in their own health and reduce their utilization of health care services (See Appendix B for a thorough presentation of employer-sponsored prevention and chronic disease management examples.).

13. Patients Have a Critical Role to Play

All of the systems we create must ultimately influence patients to play an active role in managing their own health, selecting quality, cost-effective health care and complying with best-practice treatments regimens. In the final analysis it is the patient who is making the choice to seek and receive care. The following is a checklist from the Foundation for Accountability (FACCT) on achieving patient-centered systems:

FACCT Strategies for Achieving a Person-centered Health Care System

1. We require our plans to have consumer representation on their Board of Directors and all advisory, strategic and quality management committees.
2. We require our plans and providers to disclose quality performance information, and we provide our employees with comparative quality information.
3. We encourage our plans and provider systems to collaborate with other health plans and provider systems within our community to adopt common data standards and create interoperable clinical information systems so they can exchanges appropriate data with each other.
4. We encourage our plans and provider systems to reward providers that adopt Computer Physician Order Entry and Electronic Medical Record systems.
5. We encourage our plans and provider systems to provide patients with access to online medical information.
6. We encourage plans and provider systems to use incentives in their provider contracts for superior quality and safety performance.
7. We participate in pay-for-performance programs to reward our health plans for superior quality and safety performance.
8. We work with our employees to help them understand the costs of their care options and make responsible decisions.
9. We sponsor in-house dialogues for employees on universal coverage, options for benefit designs and the trade-offs facing society.

10. We encourage our employees to seek care from providers that offer new patient-centered services, including same-day appointments, e-mail consultations, electronic medical records and chronic care management.
11. We educate our employees about evidence-based medicine and emerging standards for safety and quality, and encourage them to seek care from providers who follow these standards. We offer health risk assessment and chronic disease monitoring tools to our employees on our health Web pages.
12. We are working with public schools in communities where we're located to train youth to become smarter health care users and citizens.
13. We provide visibility and recognition to higher quality and safer hospitals and doctors.
14. Our government relations staff monitors state and federal legislation affecting health care safety and quality, and advocates for public policy that ensures better information is available to the public and greater consumer involvement in policy formation.

Section IV. Recommendations

Recommendation 1: Align Quality and Cost

The Task Force has found that essentially all the local players in the health care system (patients, providers, purchasers, and plans) are unhappy and searching for solutions. Today's sense of frustration is in sharp contrast to the 1980's when providers were defending the system in the face of escalating costs. Currently, major concerns relating to safety, quality, clinical variation, and cost are broadly shared and there is a strong interest in working collaboratively to make systemic improvements.

This motivation to work together stems from a variety of dynamics at play throughout the Puget Sound region. For example, we have a good model to align health improvement, quality improvement, cost sharing, and cost containment strategies. To support this alignment, database, data exchange, and data sharing technologies have matured and can be scaled to address regional solutions. Clinical quality and cost measures are available to create meaningful performance profiles and to direct and support improvement efforts.

Furthermore, the clinical community is supportive of the ideal of evidence-based practice, seeks common guidelines and tools, and is interested in working on implementation. On the patient side, increasing public awareness of gaps in quality and interest in ensuring high quality and sustainable costs is evident. Employers and plans appear are ready to invest in innovative health care benefit contracting provisions and health improvement programs.

The Task Force members recognize that no one sector of the health care system can achieve cost and quality outcomes alone. We also realize that if one sector is not aligned in the methods and approaches for achieving better quality, more sustainable costs and improved health, it will not be possible to achieve our

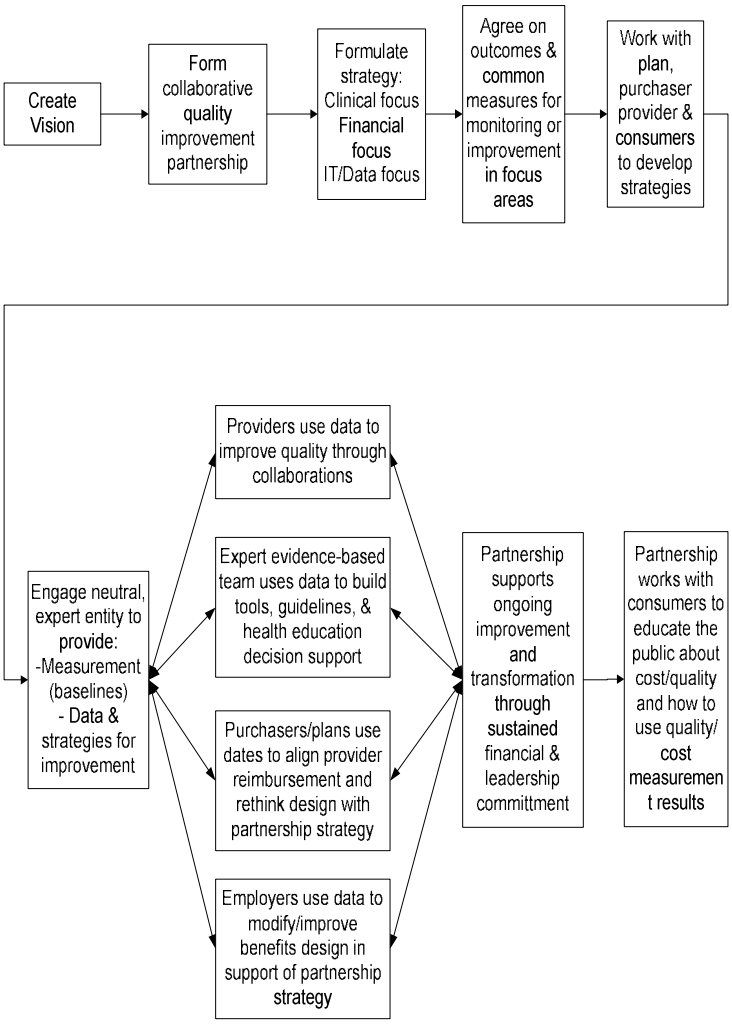
"Imagine a solo violinist, a solo cellist, a pianist, a clarinetist—all playing beautifully, but taking no notice of each other. Dissonant; noisy; unpleasant. This is the sound presented to patients and health plan members by health plans, physicians, and hospitals in most regions in our country. We would all benefit from a regional collaboration and alignment, from regional health care orchestras."

Gorden Mosser, M.D., Executive Director of the Institute for Clinical Systems Improvement

intended outcomes.

(ICSI) in Minneapolis Minn.

The successful achievement of these impacts calls for the active participation of and collaboration among all health care sectors. Clinicians, hospitals, purchasers, employers, health plans, and patients who live and work in the Puget Sound region have a critical role to play in aligning the health care benefits, health plan products, clinical interventions, care delivery systems, consumer education services, and financial reimbursement systems necessary to make improvements in quality and contain costs. Graphic 3 depicts the Task Force's concept of the process by which the health system's constituencies will work together to achieve better care at an affordable cost.



Graphic 3: The Collaborative Process

The Vision

The Task Force recommends implementation of an integrated strategy that incorporates a compelling vision, a clear set of principles, measurable outcomes, and an array of evidence-based quality improvement activities targeting *five* high leverage areas. Our *new vision statement* reflects the type of system we believe the Puget Sound region deserves:

A state of the art system that achieves better care,
healthier people, and more affordable costs.

The Outcomes

The Task Force believes that the achievement of the following outcomes will result in significant improvements to health in our region:

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 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 ability 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.

The System's Components

The Task Force recommends the formation of a region-wide partnership that

designs, implements and sustains an integrated strategy with the following components. These components will align the many forces that are currently at play and move us toward the vision and outcomes described above.

1. **Develop and Disseminate Evidence-based Clinical Decision Support Tools**

   These tools will contain state-of-the-art evidence about key clinical conditions and reflect consensus about guidelines for use in daily practice. They will be supported by easy to use protocols and aides for managing chronic diseases such as diabetes, asthma, hypertension, and coronary artery disease. The tools also will provide evidence-based indicators and criteria for performing certain procedures.

2. **Increase Patient Use of Evidence-based Patient Education and Self-management Tools**

   The system-wide availability of information and tools to support healthy eating and active living will provide patients and their families with evidence-based behavior change strategies to improve their health and use the system's resources more efficiently. Thoughtful linkage of these tools to benefits design will help reinforce the need to be active in making lifestyle changes, seeking appropriate care, selecting high quality providers, and following through with their part of treatment and disease management programs.

3. **Design and Implement Region-wide Performance Measures and Reporting Systems**

   The design and implementation of region-wide performance measures, quality costs and utilization will support ongoing improvement in delivering high quality, cost-effective care. The measurement results will be shared with both providers and purchasers; this will enable them to work jointly with clinical and cost measurement experts to build a meaningful cost and quality improvement measurement system for our region. The implementation of information technology to support

clinical data exchange, storage, and retrieval should assist providers in improving the quality of their care as well as its efficiency.

4. **Provide Patients with More Information for Decision-making**

   Patients will have access to high quality information for use in making health-related decisions; this information will include evidence-based formulary recommendations and health care treatment choices. In addition, patients will be able to obtain a variety of information that will help them use the health system more effectively, including guidance in accessing centers of excellence and assistance in finding high-quality providers and hospitals that have strong track records in ensuring evidence-based high quality and cost effective services. In addition, patients will be able to learn about the connection between cost and quality in easy-to-understand formats.

5. **Provide Infrastructure for Provider-based Collaboratives**

   The provision of an underlying structure and resources to support provider learning will advance the rate at which clinicians adopt evidence-based practice and improve their quality of care. These collaboratives have proven to be successful in engaging providers and giving them the opportunity to learn and improve in a peer environment.

6. **Financial Incentives for Consumers and Health Professionals**

   By seeking advice on how to align health benefits design and pay for performance expertise with insurance benefit strategy and financial systems, the health system will be able to design and implement approaches that will achieve the four intended outcomes described above. For example, designing incentives for providers to demonstrate good clinical outcomes, for hospitals to demonstrate safe practices, and for patients to actively participate in their care. (See Appendix B for a description of the role of financial incentives in health care.)

7. Support Health Promotion in the Workplace

The implementation of evidence-based workplace programs that support increased employee involvement in the high leverage areas, e.g., smoking cessation as an element of the prevention area, will complement the other components of the integrated strategy. (Appendix A provides an in-depth description of evidence-based workplace programs that align with the Task Force's strategy.)

8. Increase the Use of the Most Effective and Affordable Drugs

Changes in how we purchase prescription drugs offer the opportunity to save significant costs, provided prescription drug management efforts are consistent with good clinical practice. The elements of an improved approach include:

- pursuit of a regional approach to formularies and/or preferred drug lists;
- utilization of coalitions to maximize the use of generic drugs;
- offering of tiered patient cost-sharing programs where consumers pay less out-of-pocket for less expensive drugs;
- promotion of the use of evidence-based medication therapy and drug utilization management services such as medication therapy management[32]; and
- implementation of patient/employee and provider education and incentive programs.

In all cases, these prescription drug management efforts must be consistent with good clinical practice and should be carefully designed to ensure that patient co-pays do not become a barrier to patients obtaining the most appropriate medications and complying with treatment

regimens.

The Task Force discussed the issue of importing drugs from Canada (or other foreign countries) as a drug management strategy. The group recommends against this approach, however, a number of the strategies outlined above are based on policies in use in Canada. (See Appendix C for additional information regarding the issues related to prescription drugs.)

9. **Improve the Linkages Between Public Health and the Health Care System**

   It is essential to establish a strong connection with public health systems and local governments throughout the region to support community-based health and wellness programs and policies to assist people's participation in health improvement activities. These programs provide people with easy to access activities and facilities that support an active lifestyle. **(**See Appendix D for a more complete discussion of the role of government in supporting health and wellness.)

The Starting Point: Five Clinical Focus Areas

The Task Force carefully examined the available research and employer data to determine where cost and quality strategies would produce the most significant gains in quality, cost, health outcomes, and workplace productivity. This research, validated by the purchasers on the Task Force, served as the group's foundation for identifying a set of five high leverage clinical focus areas around which to initiate its integrated strategy for quality improvement and cost containment.

In looking at where to focus, the Task Force identified 11 questions to serve as the screening mechanism. (See Appendix E which includes the complete matrix summarizing this analysis.)

The first question, "*Is evidence-based clinical decision support available?"* served as one of two initial screens. If the answer was no, the clinical area dropped off the list; if the evidence was unavailable, it would not be predictive of quality of care or health improvement.

Another primary screen inquired if implementing quality-improvement efforts would produce the cost containment necessary to the purchasers via the second question, "D*oes improved quality lead to decreased costs (short-term and/or long-term)?"*

The third question looked at quality improvement from the perspective of improved health, "D*oes improved quality lead to increased health?*," to ensure that the intention of the overall system was positively impacted.

In total, the group examined the 11 questions to determine which clinical areas were most likely to produce positive impacts based on current knowledge. The additional questions included:

> *Is there evidence of unnecessary resource variation? Is there evidence of quality variation? Does consumer involvement in care lead to decreased costs? Does consumer involvement in care lead to improved health? Do proven strategies lead to decreased costs (long-term)? Does improved quality lead to increased workplace productivity? Does healthy lifestyle impact costs? Does healthy lifestyle reduce disease impacts?*

As a result of its analysis, the group identified the following five clinical high leverage areas, along with the specific conditions or issues to focus on for each, as the starting point where quality improvement efforts are most likely to produce positive impacts in quality, cost, health outcomes, and workplace productivity.

Area 1: Chronic Disease Management

Chronic diseases account for over 70 percent of deaths and a majority of health care expenditures as well.[33] These diseases include coronary artery disease, pediatric asthma, diabetes, depression and anxiety, hypertension, and congestive heart failure. Purchasers and providers can all play critical roles in managing these types of diseases.

- Coronary artery disease
- Depression and anxiety
- Pediatric asthma
- Hypertension
- Diabetes
- Congestive heart failure

Area 2: Acute and Episodic Care (Reducing Unnecessary Variation)

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:

- Low back pain
- Maternity services
- Digestive disorders
- Musculoskeletal disorders
- Breast cancer/ colorectal cancer
- Pharmaceutical prescribing profiles
- Prostatectomy

Procedure rates:

C-section
Laminectomy
Myringotomy
Tonsillectomy
Cardiac catheterizations
Coronary artery bypass grafts

Area 3: Preventive Services

Prevention offers the opportunity to avoid significant health care costs and employee and family member illness and disability. There are currently evidence-based methods to implement provider and purchaser-based disease prevention activities.

- Childhood immunizations
- Smoking cessation
- Mammograms
- Cervical cancer
- Pneumococcal vaccine
- Chlamydia screen
- Healthy weight

Area 4: Safety Practices

Monitoring the safety of certain medical procedures and prescribing practices is an area which provides information about the technical gravity of care delivered. Leap Frog, a quality improvement initiative focusing on hospital care, has identified a number of safety practices that are critical to track.[34] Decreasing the rates of errors will prevent avoidable harm and decrease costs.

- Medication errors
- Surgical wound infections

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 wait time
- Use of electronic communication

How to Measure Progress

The Task Force recommends the use of Health Plan Employer Data and Information Set (HEDIS) measures as the means for establishing a baseline and tracking the system's progress related to these five clinical focus areas. These measures have been validated for clinical measurement and are used nationwide to compare and improve performance. In addition, other initiatives such as the National Quality Forum are working to establish cost and quality measures. The Task Force recommends that the system remain open to adding and/or substituting newly-validated measures as they become available.

A Structure to Support Implementation of the Integrated Strategy

As a result of this analysis, the Task Force was able to focus its attention on the subset of the issues most likely to produce the impacts of concern to the membership: Improving quality, containing cost, improving health, and increasing workplace productivity. In looking at the question of how to create a mechanism to carry this work forward, the Task Force addressed this key question: *If the regional health care system needs to focus on high leverage clinical areas, and it needs to build the infrastructure described here, what is the best structure through which to execute this regional strategy?* What are some best practices from which the Puget Sound region can learn? Recommendation 2 describes the Task Force's conclusion regarding these questions.

Recommendation 2: Forge a Collaborative Health Partnership

In deciding on a model which would best support the achievement of cost and quality outcomes, the Task Force looked to an October 2003 study of similar efforts completed by The Rand Corporation's Health Sciences Program. This study conducted an in-depth examination of four regional health quality organizations to gain insight into which of the initiative's elements were critical

to their success.

The study's findings offer many useful insights into the characteristics of successful and sustainable quality improvement initiatives. One of the study's findings, not surprisingly, is that strong, visionary leadership is essential: "[o]ne or two strong leaders with vision and charisma…to bring stakeholders to the table and then keep them engaged and willing to risk participation during a coalition's uncertain formative years."[35]

In addition, the study found that successful initiatives were able to show real benefits to the stakeholder groups that supported them and provided two specific recommendations in this regard: first, "[a]lignment of coalition vision, mission, and activities with its stakeholders' clinical practices, financial incentives, or organizational values is necessary for coalition sustainability,"[36] and second, "[a] coalition will be sustainable if it continues to yield benefits for the most actively involved stakeholder groups."[37]

An example involving the Cleveland Health Quality Choice (CHQC) is instructive. After obtaining both the commitment and financial investment of hospitals to provide quality data and improve performance, it became apparent that the business community was not sending additional business to the participating hospitals that were offering the best performance. Accordingly, the hospitals stopped participating and the CHQC ultimately ceased operations.[38] The lesson was clear: failure to financially reward those stakeholders that are devoting resources toward quality improvements will likely result in those stakeholders leaving the coalition.

In terms of legal structure, the Task Force found that the major quality coalitions function as not for profit organizations operating under section 501 (c) 3 of the federal tax code. This tax status enables these groups to compete for grants from both public and private funding sources, a key to their long-term sustainability. Among the funding sources for quality coalitions around the country were local businesses, health plans, income generated from health insurance premiums,

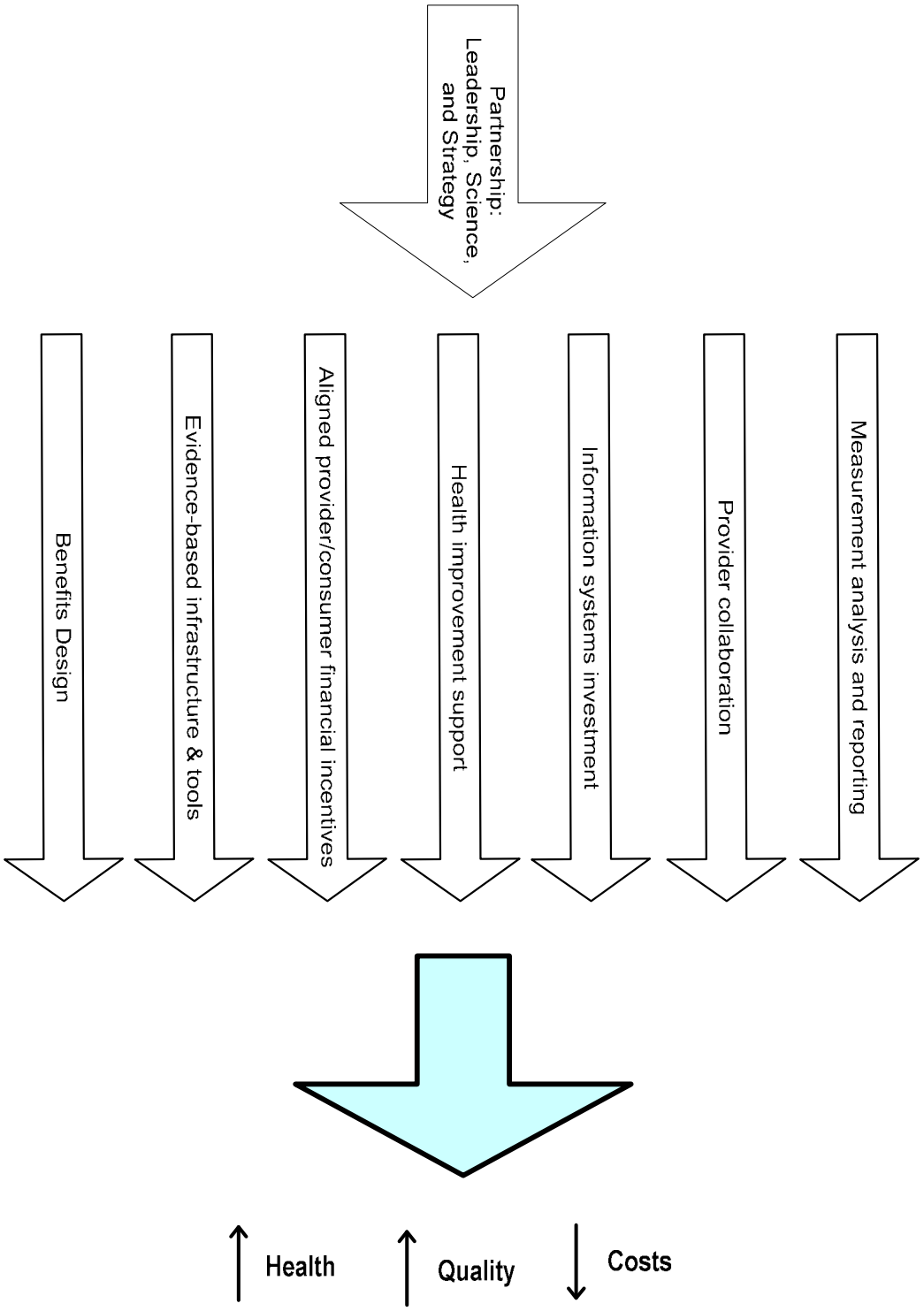
foundations, major corporate sponsorship, and federal government research initiatives. In addition, there have been instances of "in kind" funding by members of the provider community.

Looking at the governance structures, most quality improvement groups studied by the Task Force operated with a board of directors and some type of participatory technical advisory structure. This enabled the organizations to incorporate high profile leadership and at the same time directly involve the clinical and technical experts needed to develop the specific quality improvement systems necessary to achieve their intended outcomes.

In addition to its findings on governance, the Rand study observed that adequate staffing was essential for success, noting "[t]he presence of an adequately resourced and stable coalition management staff will help ensure that initiatives are carried out and the coalition remains on its defined course."[39]

The Partnership Mission

The Task Force recommends that the key constituencies that comprise the health system (patients, providers, plans, and purchasers) forge a partnership to direct the implementation of the integrated strategy described in Recommendation 1. This collaborative partnership will bring together all of the interests engaged in improving health, provide the leadership necessary to achieve improved quality, better health outcomes and affordable costs. Graphic 4 depicts the alignment the Partnership will strive to achieve.



Graphic 4: Aligning Interests

In order to achieve this type of alignment across the system, the Task Force has identified a *mission* for the Partnership that articulates its role as a highly collaborative system steward:

> *To forge a leadership alliance among patients, providers, purchasers, and plans to design and implement an innovative, high quality, and affordable health care system in the Puget Sound region.*

The Partnership Principles

As in all system change initiatives, it is critical to articulate a set of principles to guide decision-making and action. In developing a set of principles to guide the Partnership, the Task Force addressed the many factors that hold the key to the success of achieving improvements in our region's health care system. The resulting set of principles captures the spirit of our efforts:

1. Support for a collaborative approach that produces benefits for all participants – patients, purchasers, providers, and plans.

2. Commitment to knowledgeable and empowered patients who can make informed health care choices and evaluate the quality and cost of the care they are receiving.

3. Support for the use of incentives for all participants that are real and support the achievement of improved health outcomes, improved quality of care, and sustainable costs.

4. Recognition that evidence-based practice is essential to improving quality and achieving health outcomes at an affordable cost.

5. Commitment to implementation of quality improvement methods in all parts of the health care system.

6. Recognition that all participants require a steady flow of understandable

information to assess how the system is performing.

7. Understanding that bringing about improvements in patient health and in the health care system require a long term commitment.

Organizational Structure

The Task Force recommends that the Partnership adopt a private non-profit structure as its form of governance. The group believes that the governance for this organization should reflect the collaborative nature of the Task Force and include patients, purchasers, providers, and plans as board members. While the Task Force must be collaborative in nature, the Task Force recognizes that the purchasers are the driving force for change in the region's health care system. A strong purchaser community, aligned with the integrated strategy the Task Force is recommending, is essential to influence the market forces that might otherwise stall this type of initiative.

In addition to the critical role played by the board, it is essential that the organization create a highly participatory Technical Advisory Group structure that involves subject matter experts to develop specific approaches to improving care. In particular, the Task Force firmly believes that no sustainable change is possible without the direct participation and validation of the provider community.

Financing the Partnership

The Task Force recommends, based on the size and scope of similar initiatives, that the Partnership have an annual operating budget of between $1.5 and $3 million. This scale of operations will be necessary to enable the Partnership to make significant progress in the implementation of the integrated strategy.

In terms of funding, the group recommends that the majority of the Partnership's revenues come from corporations, governments, provider groups, and plans.

While grants are a possible source of support, the Task Force recommends that the partnership not rely on grant funds for its basic operating expenses, but rather use grant funding for special time-limited initiatives. Similarly, the group views "in-kind" support as a supplement to the partnership's ongoing revenues.

Timeline for Implementation

The Task Force recommends that Executive Sims immediately begin a process that will lead to the creation of the Partnership we have laid out in this report. It is the Task Force's hope that those organizations interested in funding this endeavor will offer financial support within the next sixty days and that an organizational structure will be in place and in operation within 180 days following the completion of our work.

By beginning immediately to tackle the serious problems confronting the health system, the Partnership will ensure the existence of a high quality, affordable health system in the Puget Sound region. This system is within our reach: now is the time to make it happen.

Endnotes

[1] Pear, R. "Health Spending Rises to Record 15% of Economy,", The New York Times, 9 Jan., 2004.

[2] Id.

[3] Id.

[4] Halverson G, Isham G, "Epidemic of Care," (San Francisco, Jossey-Bass, 2003) ch.14.

[5] http://www.dartmouth.edu/~cecs/.

[6] Id.

[7] National Committee for Quality Assurance, "The State of Health Care Quality 2003" (Washington, DC, NCQA, 2003), Executive Summary.

[8] Id.

[9] Id.

[10] President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. "Improving Quality in a Changing Health Care Industry, Chapter One: The State of Health Care Quality: How Good Is Care?" 18 July 1998, http://www.hcqualitycommission.gov/final/chap01.html.

[11] Institute of Medicine, "Insuring America's Health: Principles and Recommendations," Jan 2004, http://www.iom.edu/file.asp?id=17732.

[12] Committee on Quality of Health Care in America, Institute of Medicine, "To Err is Human," (Washington DC, National Academy Press, 2000), p.1.

[13] McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, 26 June 2003, pp. 2635-2645.

[14] Id.

[15] Fischer M, Avorn J, "Economic Implications of Evidence-Based Prescribing for Hypertension," The Journal of American Medical Association, 21 April 2004, p. 1850-1856.

[16] http://www.harrisinteractive.com.

[17] Rand Health Research Highlights, "The First National Report Card on Quality of Health Care in America," May 2004, http://www.rand.org/publications/RB/RB9053/RB9053.pdf.

[18] Nichols L, Ginsburg P, Berenson R, Christianson J, Hurley R, "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning," Health Affairs, Mar/Apr 2004, pp. 8-21.

[19] Id.

[20] Id.

[21] Id.

[22] Id.

[23] See Rand Health Research Highlights.

[24] Id.

[25] Brownlee, S "The Overtreated American," The Atlantic Monthly, 1 Feb, 2003.

[26] Kaisernetwork.org, Daily Reports, Daily Health Policy Report, "Health Care Marketplace | Wall Street Journal Examines Efforts by Companies to Lowewr Health Care Costs by Using Tiered Health Plans," 10 May 2004, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=23625.

[27] John E. Wennberg J, Fisher E, Skinner J, "Geography And The Debate Over Medicare Reform," Health Affairs, 2003.

[28] Id.

[29] Id.

[30] See National Committee for Quality Assurance (2003), Executive Summary.

[31] Taylor H, Leitman R, "eHealth's Influence Continues to Grow as Usage of the Internet by Physicians and Patients Increases," Health Care News, 17 April 2003.

[32] 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. MTM 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 and models exist for providing pharmaceutical services with chronic diseases involving the employer and provider community (e.g. the Asheville Project). (See also http://www.ahrq.gov/clinic/pharmimp, http://www.guild.org.au/public/researchdocs/reportvalueservices.pdf).

[33] National Center for Chronic Disease Prevention and Health Promotion (CDC), "Chronic Disease Overview," http://www.cdc.gov/nccdphp/overview.htm.

[34] http://www.leapfroggroup.org/.

[35] Farley D, Haims M, Keyser D, Olmstead S, Curry S, Sorbero M, "Regional Health Quality Improvement Coalitions: Lessons Across the Life Cycle," (Santa Monica, Rand Corporation, October 2003) p. 54.

[36] Id. p. 56.

[37] Id.

[38] Id. p.13.

[39] Id. p.53.