

CURRICULUM VITAE

David M. Lawrence, MD
Chairman & Chief Executive Officer
Kaiser Foundation Health Plan, Inc.
and Kaiser Foundation Hospitals
One Kaiser Plaza
Oakland, California 94612

BIOGRAPHIC

Date of Birth:

P6/b(6)

Place of Birth: Portland, Oregon

PROFESSIONAL AND EDUCATION EXPERIENCE

EDUCATION

- 8/58 - 6/62 Amherst College, Amherst, Massachusetts
BA Degree, American History
- 9/62 - 6/66 College of Medicine, University of Kentucky, Lexington, Kentucky
MD Degree
- 1/72 - 5/73 School of Public Health and Community Medicine, University of Washington,
Seattle, Washington, MPH Degree, Health Services
- 1970 - 1973 Residency, General Preventive Medicine; John Hopkins School of Hygiene &
Public Health; University of Washington School of Public Health and
Community Medicine

PROFESSIONAL

- 1997 - Present Board of Directors, Kaiser/Group Health
- 1996 - Present Board of Directors, Kaiser Permanente International
- 3/92 - Present Chairman of the Boards; Chief Executive Officer
Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals
- 7/91 - 3/92 Vice Chairman of the Boards; Chief Executive Officer
Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals
- 7/91 - 12/97 Chairman of the Boards of Kaiser Foundation Health Plan of the Mid-Atlantic
States, Inc., Kaiser Foundation Health Plan of Texas, Kaiser Foundation Health
Plan of Connecticut, Inc., Kaiser Foundation Health Plan of North Carolina,
Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan
of New York, Kaiser Foundation Health Plan of Kansas City, and Foundation
Health Plan of Massachusetts, Inc.

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PROFESSIONAL (Cont'd)

- 7/90 - 7/91 Vice Chairman of the Boards; Chief Operating Officer
Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals
- 9/88 - 6/90 Senior Vice President and Regional Manager, Northern California Region,
Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals
- 3/85 - 8/88 Vice President and Regional Manager, Colorado Region, Kaiser
Foundation Health Plan, Inc., Kaiser Foundation Hospitals
- 1/81 - 3/85 Vice President of Medical Operations, Northwest Permanente, P.C.,
Area Medical Director, Bess Kaiser Hospital, Kaiser Permanente Medical
Care Program
- 1/79 - 12/80 Health Officer and Director, Multnomah County, Oregon, Department
of Human Services, Portland, Oregon
- 8/77 - 12/79 Medical Director, Multnomah County, Oregon, Department of Human
Services, Portland, Oregon
- 1/72 - 8/77 Faculty, Department of Family Medicine, School of Medicine, University of
Washington, Associate Professor (last rank)
- Faculty, Department of Health Services, School of Public Health and
Community Medicine, University of Washington, Associate Professor (last
rank)
- Director, MEDEX Northwest, School of Public Health and Community
Medicine, University of Washington
- 1/70 - 12/71 Public Health Advisor to National Health Services (Ministry of Health,
Government of Chile) and USAID/Chile: Department of International
Health, The John Hopkins University School of Hygiene and Public Health
- 2/69 - 11/69 Office of Medical Programs, Peace Corps, Washington, D.C., Regional
Medical Officer, Deputy Director, Acting Director
- 7/67 - 2/69 Peace Corps Physician and Commissioned Officer, USPHS, Dominican
Republic
- 7/66 - 6/67 Intern, Internal Medicine (eight months) and Pediatrics (four months),
University Hospital and Affiliated Hospitals, University of Kentucky
- 1965 International Clerkship in Community Medicine, University of Kentucky
College of Medicine (Fall), Bolivia

PROFESSIONAL (Cont'd)

1963 - 1964 Summer Fellow, Department of Community Medicine, University of Kentucky College of Medicine; 1963 Tuberculosis Case Finding and Control Study in Eastern State Mental Hospital; 1964 Nutritional Status of Indians of Central and Coastal British Columbia

TEACHING

Spring 1991 SAHS Course #201 - Health Paradigms and Deliberate Social Change, UC Berkeley, Department of Social Administrative Health Sciences, School of Public Health

1985 - 1988 Preventive Medicine Residency Advisory Committee, Department of Public Health and Preventive Medicine, University of Colorado School of Medicine

1977 - 1985 Preventive Medicine Residency Advisory Committee, Department of Preventive Medicine and Public Health, Oregon Health Sciences University
Course Committee: Public Health for First Year Medical Students, University of Oregon School of Medicine

1976 - 1977 Manpower Planning Seminar: School of Public Health and Community Medicine, University of Washington

1972 - 1978 Supervisor and Committee Member: Masters and Ph.D. Students, School of Public Health and Community Medicine, University of Washington

1972 - 1977 Faculty and Course Chairman: Community Medicine, First and Second Year Medical Students, School of Medicine, University of Washington (Course Chairman 1974 - 1977; WAMI Coordinator 1974 - 1977)

PROFESSIONAL APPOINTMENTS

(Partial: 1985 - Present -- Others Available Upon Request)

1997 - Present Hospital Research & Educational Trust (AHA), Board Member

1997 - Present International Federation of Health Funds, Chairman

1997 - Present Raffles Medical Group of Singapore, Board Member

1997 - Present Board of Visitors of the School of Economics and Business Administration for Saint Mary's College of California, Member

1996 - 1997 University of California's Commission on the Future of Medical Education, Member

1996 - 1999 Advisory Committee for the Commonwealth Fund's Healthy Steps for Young Children, Member

PROFESSIONAL APPOINTMENTS (Cont'd)

- 1995 - Present The Conference Board, Board of Trustees
- 1995 - Present Hewlett Packard, Board of Directors
- 1995 - Present Colby College, Board of Overseers
- 1995 - Present PG&E, Board of Directors
- 1994 - 1995 United Way, Board of Directors
- 1994 - 1998 The Healthcare Forum
- 1994 - 1995 Center for Community Responsive Care
- 1993 Present Institute of Medicine of the National Academy of Sciences
- 1992 - 1995 Institute for Healthcare Improvement, Board of Directors
- 1992 - 1995 Medical Education for South African Blacks, Board of Directors
- 1992 - 1995 Urban Strategies Council, Board of Directors
- ~~1992 - 1997~~ ~~Member, California Business Roundtable~~
- 1991 - 1993 National Alliance of Business, Board of Directors
- 1991 - 1997 Board of Directors, California College of Arts and Crafts (inactive)
- 1991 - 1995 Member, Collective Bargaining Forum
- 1991 - Present Member, The 100 Club
- 1990 - 1991 California Association of Hospitals and Health Systems (CAHHS) - Board of Directors - Representative of Hospital Council of Northern California
- 1987 - 1988 Member, Ad Hoc Steering Committee for Development for Center for Research in Health Promotion and Disease Prevention -- Community and School of Medicine (University of Colorado) partnership
- 1987 - 1988 Health Policy Program, School of Public Policy, University of Colorado at Denver
- Governor's Task Force on AIDS, Chairman
- 1985 - 1988 Colorado Alliance for Business
1988 - Chairman
1985 - 1988 Board Member
1985 - 1986 - Drop Out Prevention Project Advisory Committee

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PROFESSIONAL APPOINTMENTS (Cont'd)

- 1985 - 1988 Tri-County Coalition on Care for the Medically Indigent

 JCAHO, Professional Technical Advisory Committee on Managed
 Care, Vice Chairman
- 1980 - 1985 President, Amherst Alumni Association

BIBLIOGRAPHY

- Lawrence, D., "The Peace Corps Medical System," Proceedings of the Second International Congress on Industrial Tropical Medicine, Harvard University Press. 1970
- Lawrence, D., "The Rush to Respectability: Danger Signs in the PA Movement." The PA Journal, Vol. 4, No. 3, pp. 3-5. 1974-Fall
- Lawrence, D., DeMers, J., et al., "Training Physicians to Teach, Utilize and Supervise MEDEX." Proceedings of Second Annual Conference on New Health Practitioners: New Orleans, pp. 51-57. 1974
- DeMers, J., Lawrence, D., et al., "Standardizing, Monitoring, and Evaluating Preceptorships: A Model for Decentralized Medical Education." J. Med. Ed., 50: 471-473. 1975-May
- Lawrence, D., "Primary Care and New Health Practitioners." MEDEX Northwest. 1969-1975
- Lawrence, D., "Primary Care and New Health Practitioners." Bulletin King County Medical Society. 1975-May
- Hall, T. L., Reinke, W. A., and Lawrence, D., "Measurement and Projection of the Demand for Health Care: The Chilean Experience." Medical Care, Vol. 13, No. 6, pp. 551-552. 1975-June
- Lawrence, D., "MEDEX" Education and Deployment," J. Med. Ed. 50:12:2: 85-92. 1975-December
- Lawrence, D., and Callen, W., "The Demand for New Health Practitioners," New Health Practitioners, Fogarty International Center Series on the Teaching of Preventive Medicine, Vol. I, Chapter 2, pp. 13-22. 1975
- Cherkin, D., and Lawrence, D., "An Evaluation of the American Medical Association's Physician Masterfile as a Data Source - One State's Experience." Medical Care, Vol 1, No. 9, pp. 559-767. 1977
- Lawrence, D., "A Perspective on the New Health Practitioner Movement in the United States," prepared for the Central Treaty Organization (CENTRO), Second Seminar Workshop on Low Cost Rural Health Care Systems, Isfahan, Iran. 1977 - June
- Lawrence, D., "The Impact of Physician Assistants and Nurse Practitioners on Health Care Access, Costs and Quality: A Review of the Literature," Health and Medical Care Services Review: 1:2: 1978 - March, April

BIBLIOGRAPHY (Cont'd)

Lawrence, D., Nurse Practitioners as New Health Practitioners - A Space Odyssey," Chapter in Nurse Practitioners." Sultz, H. et al. 1979

Lawrence, D., "Project Health, A Case Study in Government-Sponsored Competition," Hope Conference Report, pp. 385-393. 1981

Record, Jane C., and Lawrence, D., "Further Research on New Health Practitioners: Which Directions?" to be published in Monograph: Provider Requirements, Cost Savings and the New Health Practitioner in Primary Care: Estimates for 1990. Jane C. Record, Principal Author. (Springer)

Lawrence, David MD, "Learning from HMOs," Health Management Quarterly, pp 12-15, Vol, X11, No. 3, Third Quarter 1990

Lawrence, David McK., MD, MPH, "A Provider's View of Prevention Approaches in a Prepaid Group Practice," Cancer, Vol. 67, No. 6, March 15, 1991.

Lawrence, David M. and Early, John F., "Strategic Leadership for Quality in Health Care," Quality Progress, pp. 45-48, 1992-April.

Lawrence, David M., "The Market is Already Doing It," The Wall Street Journal, March 16, 1994

Lawrence, David M., "Exploring Behavioral Healthcare," Independent Voices, pp 21-22, Spring 1994

Lawrence, David M., "Welcoming Presentation to the Henry J. Kaiser Family Foundation Forum on AIDS and Managed Care," Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 8 (Suppl 1): S4-S6, Raven Press, Ltd., New York 1995

Lawrence, David M., MD, and Williams, James B., "The Organizational Characteristics of High-Performing Systems," Healthier Communities Direct, pp 5-13, Summer 1995

MONOGRAPHS

Lawrence, David M., "The High Cost of Health," The GAO Journal, pp.14-15, Summer/Fall 1991.

Lawrence, David M., MD, "Fulfilling the Potential," Healthcare Forum Journal, pp. 31-37, 1992-March/April.

Lawrence, D., and Wilson, W. (Eds.), A Progress Report on MEDEX Programs in the United States, the National Council of MEDEX Programs, Utah Press, 51 pages. 1974

Lawrence, D., and Cherkin, D., The Physician Manpower Experience in Washington, Alaska, Montana and Idaho, 1960-1974, Department of Health Services, University of Washington, Seattle, 235 pages. 1975-August

MONOGRAPHS (Cont'd)

Lawrence, D., and Cherkin, D., Physician Manpower Sourcebook-Washington, Alaska, Montana and Idaho 1974. Department of Health Services, University of Washington, Seattle. 243 pages. 1975-August

DeMers, J.D., Lawrence, D., Callen, W., Educating New Health Practitioners: The MEDEX Northwest Approach, Seattle: University of Washington Publications, 303 pages. 1976-May

Lawrence, David M. and Lane, James A., "Cost and Quality Issues," Critical Issues in U.S. Health Reform, Westview Press, 1994

Lawrence, David M., "Health Care: Public Good or Private Enterprise?" Syracuse University, Center for Policy Research, Policy Brief, No. 6/1996

Lawrence, David, "Why We Want To Remain A Nonprofit Health Care Organization," Health Affairs, March/April 1997, Volume 16, Number 1

Lawrence, David M., Mattingly, Patrick H., and Ludden, John M., "Trusting in the Future: The Distinct Advantage of Nonprofit HMOs," The Milbank Quarterly, A Journal of Public Health and Health Care Policy, Volume 75, Number 1, 1997

OTHER

Lawrence, D., "Health and the Urban Indian," a 27-minute videotape for use in Medicine, Health and Society Courses and as general introduction to health status and problems of the Urban Indian. 1975

Lawrence, D., Physician on PM Magazine (NBC Affiliate) 2 times per week with health tips. August 1979 to June 1980

PROFESSIONAL ASSOCIATIONS

American Hospital Association
American Public Health Association
American College of Preventive Medicine
California Association of Hospitals and Health Systems
Group Health Association of America
Western Consortium for Public Health

SPECIALTY BOARDS

General Preventive Medicine. 1974

Curriculum Vitae
David M. Lawrence, MD
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HONORS

Sphinx (Junior Honor Society), Amherst College. 1960-1961

Outstanding Research Award, University of Kentucky School of Medicine. 1966

President, Senior Class (Medicine)

Annual Distinguished Alumnus Award, School of Public Health and Community Medicine:
University of Washington. September 1980

Honorary Degree, Amherst College (Doctor of Science, 1994)

Outstanding Alumnus, College of Medicine, University of Kentucky (1995)

Hall of Distinguished Alumni, University of Kentucky (1995)

Honorary Degree, Colgate University (Doctor of Letters, 1995)

Society of Scholars, Johns Hopkins University (1997)

Honorary Degree, University of Kentucky (Doctor of Science, 1997)

LANGUAGES

Spanish (fluent)

6/98

PAUL MICHAEL MONTRONE

Paul M. Montrone is Chairman and Chief Executive Officer of Fisher Scientific International Inc. The company is the world leader in supplying a broad range of products and services to research and clinical laboratories. It is headquartered in Hampton, New Hampshire.

Mr. Montrone is also Chairman of the Board and principal shareholder of The General Chemical Group Inc., a diversified producer of inorganic chemicals and industrial products. He is also a Managing Director of Latona Associates Inc. Previously, he was Chairman of the Board and Chief Executive Officer of Wheelabrator Technologies Inc., a leading environmental services company, which is now a majority-owned subsidiary of Waste Management, Inc.

Earlier in his career, Mr. Montrone was President of the Henley Group, Inc. and Executive Vice President of AlliedSignal Inc. Prior to the merger in 1985 of Allied Corporation and The Signal Companies Inc., he was President of Signal's Engineered Products Group.

He began his career in Washington, D.C., in the Systems Analysis Group in the Office of the Secretary of Defense. He served as Chairman of the Government Fiscal Policy Committee (New Hampshire) in 1982-1983. Mr. Montrone is a member of the Industry Policy Advisory Committee (IPAC), headed by Commerce Secretary William Daley; The Business Roundtable; and President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Mr. Montrone is a director of Fisher Scientific and Waste Management, Inc., as well as an advisory director of Zeneca Inc., and Sintokogio Ltd. He was formerly a director of Abex Inc., Mack Trucks Inc., The Pullman Company, Tyco International Ltd., and Beacon Properties Corporation.

His board memberships also include various nonprofit institutions, including the Metropolitan Opera (New York), the Wang Center for the Performing Arts (Boston), the National Foundation for Biomedical Research (Washington, D.C.), the Jackson Laboratory (Bar Harbor, Maine) and the Columbia University Graduate School of Business (New York).

Born in Scranton, Pennsylvania in 1941, Mr. Montrone was graduated magna cum laude from the University of Scranton in 1962 and holds a Ph.D. from Columbia University.

Mr. Montrone and his wife, Sandra, have three adult children and reside in Hampton Falls, New Hampshire.

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Post-It™ brand fax transmittal memo 7671		# of pages > 1	
To	KIRA	From	Tom Robbins
Co.	White House	Co.	Fisher Sci.
Dept.		Phone #	603/926-5911
Fax #	202/456-5557	Fax #	603/926-1152

NANCY-ANN MIN DePARLE
Administrator
Health Care Financing Administration
Department of Health and Human Services

Nancy-Ann DeParle, 41, was sworn in as Administrator of the Health Care Financing Administration November 10, 1997. She was nominated by President Clinton June 27, 1997 and confirmed by the Senate November 8, 1997.

The HCFA Administrator, a key health policy advisor to the HHS Secretary and other top Administration officials, directs the Medicare and Medicaid programs, which help provide health insurance coverage for more than 67 million Americans at a cost of more than \$320 billion annually.

Before joining HHS, DeParle was associate director for health and personnel at the White House Office of Management and Budget, where she oversaw budget and policy matters relating to all Federal health programs, including veterans' programs and federal employee compensation and personnel practices.

From 1987 to 1989, DeParle served as Commissioner of Human Services in Tennessee Governor Ned McWherter's Administration. DeParle administered a 6000-employee agency that provided food stamps, welfare, rehabilitation and child protective services. She has also worked as a lawyer in private practice. In 1994, *Time* magazine selected DeParle as one of "America's 50 Most Promising Leaders Age 40 and Under".

DeParle received a Bachelor of Arts degree from the University of Tennessee in 1978 and a J.D. degree from Harvard Law School in 1983. She also received an M.A. in Politics and Economics from Oxford University, which she attend as a Rhodes Scholar.

A native of Rockwood, Tennessee, she is married to Jason DeParle. They reside in Washington, D.C.

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WASHINGTON BUSINESS GROUP ON HEALTH

777 North Capitol Street, N.E. Suite 800 • Washington, D.C. 20002

202.408.9320 • Fax: 202.408.9332



Fact Sheet

MARY JANE ENGLAND, M.D.

Mary Jane England, M.D., is president of the Washington Business Group on Health (WBGH). WBGH is a nonprofit national health policy and research organization whose membership includes the nation's major employers. ~~The Washington Business Group on Health~~ represents employers in promoting performance-driven health care systems and competitive markets that improve the health and productivity of companies and communities.

Dr. England serves as the national program director of the Robert Wood Johnson Foundation's Mental Health Services Program for Youth, which works with states to fund comprehensive home- and community-based services for young people with serious mental, emotional, and behavioral disorders. Dr. England serves on the executive committee of The Health Project and is the chair of the advisory committee for the Robert Wood Johnson Foundation's program, Making the Grade: School-Based Clinics. Dr. England also sits on the Board of Directors of Allina Health System in Minnesota.

Dr. England has been a featured guest on the MacNeil/Lehrer NewsHour on national legislative health care reform strategies. She is a prominent spokesperson for large employers on health care policy issues and is quoted regularly in the *Wall Street Journal*, *Washington Post*, *The New York Times*, and other national and local media outlets.

Dr. England was vice president, Group Medical Services at The Prudential Insurance Company of America from 1987-1990. She was responsible for the development of mental health policy and programs for the Prudential health care system.

Before joining Prudential, Dr. England was associate dean and director of the Lucius N. Littauer Master in Public Administration (MPA) Program at the John F. Kennedy School of Government, Harvard University. Dr. England was at the Kennedy School from 1983-1987.

As the first commissioner of the Massachusetts Department of Social Services (DSS) from 1979 to 1983, she helped establish and administer a new state agency for children and their families. Before her appointment at DSS, Dr. England served as the associate commissioner of the Massachusetts Department of Mental Health and Mental Retardation.

A psychiatrist with an M.D. from the Boston University School of Medicine, Dr. England received her psychiatric training at University Hospital in Boston and Mt. Zion Hospital in San Francisco, and completed a child and adolescent psychiatry fellowship at Boston University-Boston City Hospital Child Guidance Clinic.

In 1995, Dr. England served as president of the American Psychiatric Association. She is a past president of the American Medical Women's Association. She has been elected to the National Academy of Public Administration, the American College of Psychiatry, the American College of Mental Health Administration, and the Group for the Advancement of Psychiatry. Dr. England also served the Board of Overseers for the U.S. Department of Commerce, Malcolm Baldrige National Quality Award and currently serves on the DHHS Substance Abuse and Mental Health Services Administration National Advisory Council and the National Institute of Mental Health Advisory Council.

Dr. England is the chair of the Board of Visitors of Boston University School of Public Health and a member of the Board of Visitors of Boston University School of Medicine.

Dr. England holds honorary degrees from Regis College, the Massachusetts School of Professional Psychology and the University of Texas. She is also a recipient of the 1995 Boston University Distinguished Service to the Community Award.

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David M. Lawrence, MD

**Chairman and Chief Executive Officer
Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals**

David M. Lawrence, MD, was named Chief Executive Officer of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals in 1991 and Chairman of the Board in 1992. The Oakland-based Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals is co-partner with 12 Permanente Medical Groups in the enterprise known as Kaiser Permanente.

Prior to assuming his current role, Dr. Lawrence served KFHP/KFH as vice chairman and chief operating officer (1990-91); senior vice president and regional manager for Northern California (1988-89); vice president and regional manager in Colorado (1985-88). He also was vice president and area medical director for Northwest Permanente in Portland (1981-85). Dr. Lawrence also served as health officer and director of Human Services in Multnomah County, Oregon; on the faculty of Department of Health Services and Director of MEDEX in the School of Public Health and Community Medicine, University of Washington; as advisor to the Ministry of Health of Chile; and as Peace Corps Physician in the Dominican Republic and Washington, D.C.

Dr. Lawrence is a graduate of Amherst College (BA), the University of Kentucky (MD), and the University of Washington (MPH). He is Board Certified in General Preventive Medicine (Johns Hopkins and University of Washington). He is a member of Alpha Omega Alpha (Medical Honorary Society) and the Institute of Medicine (National Academy of Sciences). He currently serves on the Boards of Pacific Gas and Electric Company, Hewlett Packard, the Bay Area Council, Raffles Medical Group of Singapore and the Hospital Research and Educational Trust (AHA).

Dr. Lawrence has been recognized as the Outstanding Alumnus of the School of Public Health and Community Medicine, University of Washington (1980); and The Outstanding Alumnus of the College of Medicine, University of Kentucky (1995). He was inducted into the Hall of Distinguished Alumni of the University of Kentucky (1995); and has received honorary degrees from Amherst College (Doctor of Science, 1994), and Colgate University (Doctor of Letters, 1995).

Now 50 years old, Kaiser Permanente is the largest, fully integrated private health care system in the United States, providing care to 6.6 million members in 16 states and Washington, D.C., and representing the leading national model for integrated health care financing and care delivery. Kaiser Foundation Health Plan, Inc. and Hospitals is the largest not-for-profit health care organization in the United States.

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David M. Lawrence, MD

Chairman & Chief Executive Officer
Kaiser Foundation Health Plan, Inc. and
Kaiser Foundation Hospitals

David M. Lawrence, MD was named Chief Executive Officer in 1990 and Chairman of the Boards of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals in 1991. He began his career with Kaiser Permanente with the Northwest Permanente Medical Group in 1981.

Dr. Lawrence currently serves on the Boards of Hewlett-Packard, Pacific Gas and Electric Company, Raffles Medical Group of Singapore, the Conference Board, the Bay Area Council, and the Hospital Research and Educational Trust (AHA) among others. Prior to joining Kaiser Permanente, Dr. Lawrence worked in academic medicine, public health, and international health.

Dr. Lawrence earned his BA degree from Amherst College, his MD from the University of Kentucky, and his MPH from the University of Washington. He is Board Certified in General Preventive Medicine. He attended the Advanced Management Program at Harvard. He is a member of the Alpha Omega Alpha Society and the Institute of Medicine.

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News Release

John Layman



U.S. Department of Labor

Office of Public Affairs
Washington, D.C.

*U
200 Const Ave, NW
Room 2524
20210*

PENSION AND WELFARE BENEFITS ADMINISTRATION

CONTACT: GLORIA DELLA
OFFICE: (202) 219-8921

FOR RELEASE: Immediate
June/1997

MEREDITH MILLER/BIO

*soon to be
Acting Assistant
Sec.*

Meredith Miller, who has been involved for more than 14 years with on-the-job benefit programs for American workers, is serving in her fifth year as Deputy Assistant Secretary for Policy in the U.S. Department of Labor's Pension and Welfare Benefits Administration.

Miller, originally from Spring Valley, N.Y., works closely with the agency's assistant secretary, Olena Berg, in guiding administration policy.

PWBA is the federal agency that oversees more than 700,000 pension plans with assets of approximately \$3.5 trillion and another six million plans involving other job benefits such as health and dental policies. The agency is responsible for the administration and enforcement of the Employee Retirement Income Security Act, otherwise known as ERISA, which is the federal law regulating pension operations, health benefits and other job benefit plans for private companies and unions.

ERISA does not apply to government workers at the federal, state or local levels or certain other categories.

Miller came to her federal assignment from the AFL-CIO where her last position was assistant director of the employee benefits department. She was with the AFL-CIO since 1988 and served in other roles involving employee benefits.

From 1983 until 1988 Miller was assistant research director for employee benefits with the Service Employees International Union and taught at the college level for one year before that.

Miller graduated from Hampshire College in Massachusetts in 1977 and earned her master's degree a year later in industrial and labor relations from the London School of Economics in England where she finished first in her class.

- more -

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Professional activities include serving on the Labor Department's ERISA Advisory Council, on the editorial board of Business and Health Magazine and on the advisory boards of the Bureau of National Affairs Pension and Benefits Reporter and the National Resource Center on worksite health promotion of the Washington Business Group on Health. She holds memberships in several organizations including the National Academy of Social Insurance and American Friends of the London School of Economics.

She is a published author of magazine articles, brochures and pamphlets on pension and other job benefits and also has appeared in several videos on the same subjects.

Miller and her husband, Barton Bracken, have two children: a son Myles, 8 and a daughter, Madison, 6.

#

This information will be made available to sensory impaired individuals upon request. Voice phone call (202) 219-8921, TDD phone 1-800-326-2577.

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BIOGRAPHICAL SKETCH

JOHN C. ROTHER

John Rother is the Director of Legislation and Public Policy for the American Association of Retired Persons(AARP.) He is responsible for the federal and state legislative advocacy activities of the Association, and for the policy research and public education programs that support that effort. He is an authority on health care, long-term care, Social Security, pensions and employment policies.

Prior to coming to AARP, Mr. Rother served eight years in the U.S. Senate as Special Counsel for Labor and Health to former Senator Jacob Javits(R-NY), and as Staff Director and Chief Counsel for the Special Committee on Aging under its Chairman, Senator John Heinz(R-PA.)

He serves on several Boards and Commissions, including the Corporation for National Service, the National Committee for Quality Assurance, the Foundation for Accountability in Health Care, the Institute of Medicine's National Roundtable on Health Care Quality, the National Academy on Aging, Generations United and the National Academy of Social Insurance's study panel on Medicare.

He has served as a member of the ERISA Advisory Council for the Secretary of Labor; as a member of the Secretary's Blue-Ribbon Advisory Commission on the FDA (Edwards Commission); and as a member of the Commonwealth Fund's Commission on Elderly People Living Alone. In 1996, Mr. Rother was on special assignment to study the future implications of the transition to managed care in the health care system, and the retirement challenges facing the boomer generation.

John Rother is an Honors Graduate of Oberlin College and the University of Pennsylvania Law School, where he was Editor of the Law Review.

POWERS, PYLES, SUTTER & VERVILLE PC**PETER W. THOMAS**

Peter Thomas, a principal in the firm, has a federal law and legislative practice in the areas of health care, rehabilitation, disability, and employment. Mr. Thomas graduated *cum laude* from Boston College in 1986 and from Georgetown University Law Center in 1989 where he served as Associate Editor of the *Journal of Law and Technology*. Mr. Thomas was previously associated with a New York City civil defense litigation firm before becoming general counsel for the National Association for the Advancement of Orthotics and Prosthetics (NAAOP), in Washington, D.C. He currently focuses his practice on health care reform, rehabilitation research appropriations, and Medicare coverage and reimbursement policy, specializing in assistive technology such as artificial limbs and orthopedic braces.

Mr. Thomas served as Chairman of the Subcommittee on Consumer Rights, Protections, and Responsibilities of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, where he was responsible for shepherding the Consumer Bill of Rights through the Commission for presentation to President Clinton. He also served on the National Advisory Board for the Center on Medical Rehabilitation Research at the National Institutes of Health from 1991 to 1996. He currently serves on the board of directors of the Center on Disability and Health and Physicians Against Land Mines (PALM). He serves as cochair of the Health Task Force of the Consortium for Citizens with Disabilities, a Washington-based working coalition of 120 national disability-related organizations.

Mr. Thomas has personal experience with disability and is coauthor of *The Americans with Disabilities Act: A Guidebook for Management and People with Disabilities*, Quorum Books, Greenwood Publishing Group, Westport, Connecticut, 1993. He is admitted to practice in New York State and the District of Columbia.

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JAMES R. TALLON, JR.

James R. Tallon, Jr. is president of the United Hospital Fund of New York. The Fund, the nation's oldest federated charity, addresses critical issues affecting hospitals and health care in New York City through health services research and policy analysis, education and information activities, and grantmaking and voluntarism.

Mr. Tallon serves as chair of the Kaiser Commission on the Future of Medicaid and is a member of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). He serves as secretary for the Alpha Center and for the Association for Health Services Research, and is also on the boards of the Alliance for Health Reform, The Commonwealth Fund, and the New York Academy of Medicine. He recently concluded a three-year term as a member of the Prospective Payment Assessment Commission (ProPAC), and has held visiting lecturer appointments at the Columbia University and Harvard University schools of public health.

Prior to joining the Fund in 1993, Mr. Tallon served in the New York State Assembly for nineteen years, beginning in 1975. As majority leader from 1987 to 1993 and as chair of the health committee from 1979 to 1987, he spearheaded efforts to reform the Medicaid program while expanding eligibility for pregnant women, and children. His 1991 legislation required the implementation of Medicaid managed care programs statewide. Under his leadership, the Assembly also enacted measures to assure transitional health coverage for laid-off workers, reimburse hospitals in a fair and cost-effective manner, foster high-quality and cost-efficient home health care services, encourage organ donations, promote AIDS research and education, and foster regional health planning agencies.

Mr. Tallon received a B.A., cum laude, in political science from Syracuse University and an M.A. in international relations from Boston University. He has also completed graduate work at the Maxwell School of Citizenship and Public Affairs at Syracuse University. In 1995, he was awarded honorary doctorates of humane letters from the College of Medicine and School of Graduate Studies of the State University of New York Health Science Center at Brooklyn, and from New York Medical College.

December, 1997

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Christopher Queram

Biographical Summary

Christopher Queram assumed his position as Chief Executive Officer of the Employer Health Care Alliance Cooperative (The Alliance), in Madison, Wisconsin, in June 1993. The Alliance, a non-profit cooperative formed by Dane County employers in 1990, partners employers and providers in an effort to improve the cost and quality of our health care system. The Alliance currently serves more than 700 corporations of all sizes in Dane County and southern Wisconsin, representing over 75,000 individual subscribers.

Prior to joining The Alliance, Mr. Queram was employed as a hospital administrator in Madison and Milwaukee, Wisconsin.

Mr. Queram graduated from the University of Wisconsin with a Bachelor's degree in Political Science and History and a Master of Arts in Health Management (hospital administration). In addition to his role at The Alliance, Mr. Queram is a member of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and serves as vice chair of the National Business Coalition on Health.

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**Consumer Coalition
for Quality Health Care**

*here's
me
b/w
packet*

BRIAN W. LINDBERG

Brian W. Lindberg is the Executive Director of the Consumer Coalition for Quality Health Care (Consumer Coalition), which is a national, non-profit membership organization comprised of a diverse group of health care and consumer organizations representing over 30 million Americans. The Consumer Coalition advocates for programs and policies that address the critical need for a health care system that provides meaningful consumer choices and information, consumer participation, grievance and appeals rights, consumer advocacy, and independent quality oversight and improvement.

Prior to his current position, Mr. Lindberg worked in Congress for 10 years - most recently as the staff director of the House Select Committee on Aging's Subcommittee on Housing and Consumer Interests, and prior to that on the Senate Special Committee on Aging. Mr. Lindberg holds a Master's in the Management of Human Services from the Florence Heller Graduate School at Brandeis University, a Bachelor of Social Work from Temple University, and studied health and human services at the University of Stockholm's International Graduate School.

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American Federation of Labor and Congress of Industrial Organizations



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GERALD M. SHEA

Gerry Shea is currently Assistant to the President for Government Affairs at the AFL-CIO. Mr. Shea was appointed to this position by John J. Sweeney when Mr. Sweeney was elected President of the AFL-CIO in October 1995.

Mr. Shea had held various positions at the AFL-CIO from August 1993 through October 1995, serving first as the director of the policy office with responsibility for health care and pensions, and then in several executive staff positions.

Before coming to the AFL-CIO, Mr. Shea had been with the Service Employees International Union since 1972 as an organizer and local union official in Massachusetts and, later, on the staff at the national union's headquarters.

Mr. Shea was a member of the 1994-1996 Advisory Council on Social Security and is a member of the current Social Security Advisory Board. He is also a member of the Prospective Payment Advisory Committee (PROPAC), the congressionally appointed advisory body on Medicare. Mr. Shea holds a seat on the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) representing union and consumer interests. He is also a founding member of the Foundation for Accountability, a national coalition of organizations whose mission is to help consumers make health care choices based on quality.

Mr. Shea is a native of Massachusetts and a graduate of Boston College.

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American Medical Association

Physicians dedicated to the health of America



Thomas R. Reardon, MD
Chair
American Medical Association

Thomas R. Reardon, MD, a general practitioner from Portland, Oregon was elected Chair of the American Medical Association (AMA) Board of Trustees in June 1997. A member of the Board of Trustees since 1990, he served on its Executive Committee since 1994, as Secretary-Treasurer to the AMA from 1994 to 1995 and as Vice Chair of the Board of Trustees from December 1995 to June 1997. Prior to Dr. Reardon's election, he represented the Hospital Medical Staff Section in the AMA House of Delegates from 1983 to 1990. Dr. Reardon served on the AMA steering committee which established the Hospital Medical Staff Section.

A graduate from the University of Colorado School of Medicine in 1959, Dr. Reardon interned at Baltimore City Hospital and served in the US Air Force from 1960 to 1963. He has been active in the general practice of medicine for over 30 years.

Dr. Reardon began his activities in medical politics with Multnomah County Medical Society (MCMS) and Oregon Medical Association (OMA), serving as President of MCMS from 1980 to 1981 and President of OMA from 1983 to 1984. He was the recipient of the MCMS Distinguished Service Award in 1982.

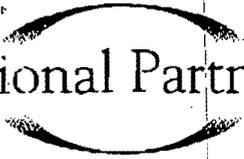
In 1986 Dr. Reardon was nominated by the AMA to serve on the Congressional Physician Payment Review Commission (PPRC) to which he was appointed. He served on PPRC for 8 years (1986-94). Dr. Reardon served as an AMA Commissioner to the JCAHO prior to being nominated and elected to serve on the National Committee for Quality Assurance (NCQA) Board of Directors in October 1994. Dr. Reardon currently serves on the President's Commission on Patient Rights and Quality of Care.

Outside the medical/political arena, Dr. Reardon's interest in horticulture has led him to found and develop a thriving wholesale nursery business on land adjoining his home outside Portland. He has been active in the American Rose Society and is a past president of the Portland Rose Society. He served for six years as chair of the judges for the Portland Rose Festival Parade.

Dr. Reardon and his wife, Elizabeth, reside in Boring, Oregon.

1997-1998

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National Partnership for Women & Families

JUDITH L. LICHTMAN

President, National Partnership for Women & Families

Judith L. Lichtman has been a guiding and influential force in the women's movement for more than 20 years. As president of the National Partnership for Women & Families, her commitment, vision, and talent as an attorney and advocate have made a profound difference for women and families across the United States.

After receiving her law degree from the University of Wisconsin in 1965, Lichtman worked at the Urban Coalition, at the U.S. Commission on Civil Rights, and as the legal advisor to the Commonwealth of Puerto Rico. In 1974, Lichtman became the executive director and first paid staff person for the Women's Legal Defense Fund. The Women's Legal Defense Fund became the National Partnership for Women & Families in February 1998.

Lichtman has built the National Partnership from a small volunteer group to a national organization with thousands of members. Under her leadership, the organization has become one of the country's most influential political forces, shaping national policy through its advocacy, lobbying, litigation, and public education. Lichtman's vision and the National Partnership's strength have resulted in the passage of some of the most important legal protections for American women and families, including the Pregnancy Discrimination Act of 1978 and the Family and Medical Leave Act (FMLA) of 1993. More recently, the National Partnership helped shape key provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that make it easier for women and their families to get and keep health coverage.

Lichtman has been recognized by civic and legal organizations, business and labor leaders, and others for her strategic abilities, political savvy, effectiveness in building powerful and diverse coalitions, and tireless commitment to building a truly just society. At the National Partnership's 25th anniversary luncheon in 1996, President Clinton called Lichtman "a remarkable national treasure." *Washingtonian* magazine has identified her as one of Washington, D.C.'s most powerful women. The Women's Bar Association and Foundation of the District of Columbia named her Woman Lawyer of the Year in 1989, a year in which she also received the Sara Lee Frontrunner Award. She received the Martin Luther King, Jr. Civil Rights Leadership Award in 1993, and the Washington, D.C. Bar Association's Thurgood Marshall Award in 1996.

Lichtman has become a leader for families while raising her own. She lives in Washington, D.C. with her husband, Elliott Lichtman. They have two grown daughters. Says Lichtman, "For more than 20 years, I've tried to make this world a better place for women and families. We've come a long way, but our work is far from done. My daughters, and all our children, deserve a future where every school and workplace is truly free of discrimination, and where all families have the support they need to succeed at home and on the job. I know from experience -- if we can imagine it, we can make it happen.

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2/98

Bruce E. Bradley

Bruce E. Bradley has been Director of Managed Care Plans for General Motors Health Care Initiatives since June 1, 1996.

Bradley joined GM after five years as Corporate Manager of Managed Care for GTE Corporation. ~~In addition to his health care management experience at GTE, he spent nearly 20 years in health plan and health maintenance organizations (HMOs) management.~~ From 1972 to 1980, he was Executive Director of the Matthew Thornton Health Plan, Nashua, N.H. From 1980 to 1990, he was President and Chief Executive Officer for the Rhode Island Group Health Association, Providence, a staff-model HMO.

Bradley was a co-founder of the HMO Group, a national corporation of 15 non-profit, independent group practice HMOs, and the HMO Group Insurance Co., Ltd.

~~He has gained recognition for his work in achieving health plan quality improvement and for his efforts in developing the Health Employer Data and Information Set (HEDIS) measurements and processes.~~ He is a member of the NCQA Committee on Performance Measurement, a Trustee of The Managed Health Care Association and a member of the board of FACCT.

A native of New Rochelle, N.Y., Bradley holds a bachelor's degree in psychology from Yale University and a master's degree in business and health care administration from the Wharton School at the University of Pennsylvania.

More than a third of the 1.6 million enrollees covered by GM health plans are members of managed care options. GM contracts with 114 health maintenance organizations and 32 Preferred Provider Organizations in the United States.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Administrator



Agency for Health Care Policy
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John M. Eisenberg, M.D., M.B.A.
Administrator
Agency for Health Care Policy and Research

John M. Eisenberg, M.D., M.B.A. was appointed Administrator of the Agency for Health Care Policy and Research (AHCPR) in April 1997. As Administrator, Dr. Eisenberg oversees the lead federal agency charged with conducting and sponsoring research to enhance the quality, appropriateness, and effectiveness of health care services, and access to care.

Dr. Eisenberg also serves as the Senior Advisor to the Secretary on Quality, with AHCPR designated as the Department of Health and Human Service's (HHS) lead agency for health care quality improvement issues. He coordinates HHS's work on behalf of the Secretary regarding the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and chairs an interagency committee on quality. He also co-chairs the Department's Data Council. Since May, 1997 Dr. Eisenberg has also been Principal Deputy Assistant Secretary for Health and has served as Acting Assistant Secretary for Health.

A clinician and researcher, Dr. Eisenberg has held key positions in academic and clinical medicine. Prior to his appointment at AHCPR, Dr. Eisenberg was Chairman of the Department of Medicine, Physician-in-Chief, and Anton and Margaret Fuisz Professor of Medicine at Georgetown University. Previously, he was Chief of the Division of General Internal Medicine and Sol Katz Professor of General Internal Medicine at the University of Pennsylvania.

From 1986 through 1995, Dr. Eisenberg was a founding Commissioner of the Congressional Physician Payment Review Commission, serving as its Chairman from 1993-1995. He was the first physician to be elected President of the Association for Health Services Research in 1991-1992, and also served as President of the Foundation for Health Services Research. He has been President of the Society for General Internal Medicine, and Vice President of the Society for Medical Decision Making. Dr. Eisenberg is a member of the Institute of Medicine of the National Academy of Sciences. He served on the Board of Regents of the American College of Physicians and is a Master of the College, and was on the American Board of Internal Medicine.

Dr. Eisenberg has published over 200 articles and book chapters on topics such as physicians' practices, test use and efficacy, medical education, and clinical economics. His book, *Doctors' Decisions and the Cost of Medical Care*, was published in 1986. He was co-author of *Paying Physicians*, published in 1992, and co-editor of *The Physician's Practice*, published in 1980.

He is a magna cum laude graduate of Princeton University (1968) and the Washington University School of Medicine in St. Louis (1972). After his residency in Internal Medicine at the University of Pennsylvania, he was a Robert Wood Johnson Foundation Clinical Scholar and earned a Master of Business Administration degree at the Wharton School with distinction.

2/09/98

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Gail L. Warden

Gail L. Warden is President and Chief Executive Officer of Henry Ford Health System in Detroit, one of the nation's leading vertically integrated regional health care systems.

Henry Ford provides a comprehensive array of health care services for 800,000 Southeast Michigan residents. It provides insurance to 550,000 people through its Health Alliance Plan, Medical Value Plan and Alliance Health and Life Insurance units. The Henry Ford Health Sciences Center integrates teaching, research and advanced patient care to make the System a premier academic medical center. Health care services include: a tertiary care hospital, nine owned or managed community hospitals, more than 30 ambulatory care centers, a 1,000-physician medical group, a full-service psychiatric facility, a chemical dependency center, home health care services and two nursing homes.

Since joining Henry Ford, Warden has streamlined operations and governance. He introduced a regional planning process to respond to changes in the environment and guide resource allocation, redeveloped the Health Sciences Center mission and launched a major philanthropic effort. He introduced total quality management throughout the System and directed development of a major affiliation with Case Western Reserve University School of Medicine. To optimize health care services in the Macomb County area, he spearheaded a joint venture between Henry Ford and Mercy Health Services. To coordinate pediatric services in Southeast Michigan, he oversaw an affiliation with Children's Hospital of Michigan. In 1995, he oversaw a merger with Horizon Health System, which became Henry Ford's osteopathic subsidiary.

In 1996, the System received the Executive Leadership Council's Corporate Award for commitment to creating a business environment that values the talents and contributions of African-Americans. In 1994, the National Committee for Quality Health Care awarded Henry Ford the first National Quality Health Care Award for Health Care Integration. The System received the Healthcare Forum and 3M Health Care 21st Century Innovators Award in 1993.

Warden is an elected member of the Institute of Medicine of the National Academy of Sciences, as well as a member of the Institute's Governing Council, its Board on Health Care Services and its Coordinating Committee on Health Care Quality. He is a member of the Board of Trustees of the Robert Wood Johnson Foundation and Director Emeritus and past Chairman of the Board of the National Committee on Quality Assurance. He is Chairman of The Hospital Research and Educational Trust and a member of the National Commission on Civic Renewal. He also serves on the board of the National Resource Center on Chronic Care Integration. In addition, Warden is a member of the board of Comerica Bank.

In March 1997, President Clinton appointed him to the Federal Advisory Commission on Consumer Protection and Quality in the Health Care Industry. In 1995, Warden served as Chairman of the American Hospital Association Board of Trustees. He also is a former member of the Pew Health Professions Commission.

In 1997, Warden received the Columbia University School of Nursing Second Century Award for Excellence in Health Care. In 1993, he received the CEO Award from the American Hospital Association's Society for Healthcare Planning and Marketing. In 1992, he received B'nai B'rith International's National Health Care Award.

Before joining Henry Ford Health System in April 1988, Warden was President and Chief Executive Officer of Group Health Cooperative of Puget Sound in Seattle (1981-88). Previously, he was Executive Vice President of the American Hospital Association (1976-81) and Executive Vice President and Chief Operations Officer of Rush-Presbyterian-St. Luke's Medical Center (1965-76).

He is a graduate of Dartmouth College with a master's degree in health care management from the University of Michigan. He holds an honorary doctorate in public administration from Central Michigan University. Warden, his wife, Lois, and family reside in Grosse Pointe, Michigan.

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Quality Notes

A Programwide publication for sharing successful practices and information about quality assessment and improvement.

May 1997

This issue of *Quality Notes* is devoted to profiles of the 1997 winners of the James A. Vohs Award for Quality.

Overview of the Vohs Award

The Vohs Award — established in honor of former President, CEO, and Chairman of the Board, James A. Vohs and his tireless emphasis on the moral and strategic importance of continuous quality improvement — is conferred annually to quality improvement projects that directly and measurably advance the quality of patient care, are transferable to other Divisions, and utilize the synergy of multidisciplinary teams.

Award Criteria

The Vohs Award, plus those given to the runner-up and honorable mentions, must meet the following selection criteria:

1. The project represents a well-established, sustained effort.
2. The project addresses quality issues of significant scope and magnitude.
3. The project makes substantial, institutionalized changes to improve direct patient care.
4. The project's impact is measurable and sustained, and objectively documented improvement has been shown in measures of quality and/or cost-effectiveness of care.
5. The project results in performance levels at or near the top of Programwide performance levels.
6. The project results are equivalent to or exceed the comparable industry benchmarks or other relevant scales outside the Program.
7. The project is multidisciplinary, involving team members from both Health Plan/Hospitals and the Medical Group.
8. The project is transferable; its success is not dependent upon a unique feature of the Division.

Nomination Format

Nominations should follow the guidelines available through the Program Offices Department of Quality and should include a cover letter signed by the Division President and Medical Director. Letters should be addressed to: Vohs Award Selection Committee, c/o Department of Quality, One Kaiser Plaza, Oakland, CA 94612, FAX (510) 271-6836.

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Nominations for the 1998 Vohs Award are due no later than September 2, 1997. We actively encourage all Divisions to apply and welcome nominations.

Contacts: Rami Shahrivini, (510) 271-6894 or Terri Kielhorn, (510) 271-6827.

First Place: The Cooperative Health Care Clinic

Colorado's Cooperative Health Care Clinic (CHCC) is the first place award winner in the 1997 James A. Vohs Award for Quality. The CHCC's innovative approach to health care occurs in a group setting, rather than in the traditional 15-20 minute doctor-patient, one-on-one encounter.

John Scott, MD, an internist and geriatrician practicing in the Rocky Mountain Division, and one of the originators of the CHCC, was searching for a way to improve the health status of his ambulatory elderly patients while reducing resource utilization. Specifically, said Dr. Scott, "our aim was to improve our patients' health by actively encouraging preventive medicine, such as flu vaccines and increased knowledge of self-care; helping patients to continue to live independently; and improving their access to the full spectrum of care that can be offered by a multidisciplinary team of health care professionals."

A Major Shift in Care Delivery

To meet the dual objectives of improved health status and reduced cost, care had to be provided that addressed the complex medical issues of the elderly, as well as their social and emotional needs. A group setting, Dr. Scott and his task force reasoned, might enable this to happen. In the group setting, physicians can spend more time explaining the functional limitations or psychological changes that elderly patients are likely to encounter. Care giving is also less fragmented and repetitious. And because social, emotional, functional, and medical needs are all thoroughly addressed in the group setting, practitioners do not have to rely on X-rays, lab tests, or prescriptions in situations where other care may be more appropriate.

The Pilot Study

To prove the value of the idea, Dr. Scott and a small task force of physicians and nurses designed a one-year, randomized trial to compare patient outcomes in two groups of elderly, chronically ill patients: those treated with the traditional one-on-one approach versus those treated in the CHCC. Using the senior health questionnaire (SHQ) baseline data on functional status, activities of daily living, stress, and depression was collected at initiation of the pilot.

The pilot involved 321 high-resource-utilizing patients, aged 65 or older, who had chronic conditions such as diabetes, arthritis, hypertension, and/or heart disease. "A major challenge was identifying utilization measures — hospitalization, SNF admits, and home health data — in the database. To further complicate matters, encounter data such as office visits, urgent care, and emergency room visits were kept in a separate data repository.

In addition to patient identification and recruitment for the pilot, staff and administrators had to be convinced of the merit of the group approach to care delivery. One of the obstacles to buy-in was communicating the group process to potential members of the interdisciplinary team. To overcome this, a video was made to explain and promote the concept. Later, a second video was produced to document the results of the pilot and to serve as a means of communicating best practices to other KP Regions.

Resources also had to be obtained. With the help of an \$86,770 grant from the Garfield Memorial Fund, the pilot was on its way.

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Program Results and Benefits

A second SHQ, administered one year after program inception, indicated that patients were very satisfied with the quality of the care they received through the CHCC. While phone calls to nurses were more frequent in the CHCC group than in the control, all other measures of health care utilization, such as ER visits, hospital admissions, x-rays, and visits to physicians, were reduced.

Reduced utilization translated into reduced costs. Aggregate cost savings were estimated at \$31,928 or \$14.19 per participant per month during the course of the pilot study.

The cost savings, the greater patient and provider satisfaction, and the pilot's obvious transferability to other patient groups who deal with chronic diseases has led to expansion of the pilot to 32 groups within the Rocky Mountain Division; funding for the expansion has come from a two-year Robert Wood Johnson Foundation Grant. Benefits from the expansion are expected to be comparable to the original pilot.

Contacts: John Scott, MD, (303) 657-6808; Arne Beck, PhD, (303) 344-7347; or Deborah Jackson, RN, (303) 338-3829.



Runner-Up: Northern California's Self-Care Program

The runner-up for the 1997 James A. Vohs Award for Quality is Northern California's Self-Care Program, which is now also being implemented in Southern California, Hawaii, Ohio, the Northeast, the Northwest, Colorado, and the Mid-Atlantic States. Started as a pilot at the Fairfield Medical Offices in 1992 and implemented throughout Northern California in 1994, the Self-Care Program has been shown to enhance quality, satisfaction, accessibility, and cost-effectiveness.

The Self-Care Program is a unique system intervention that encourages a partnership between members and providers to develop members' self-care skills. A key aspect of the program involved mailing more than a million copies of a customized *Healthwise Handbook* to all Northern California Kaiser Permanente members, giving them advice on more than 170 common health problems — including prevention and self-care tips as well as advice on when to call Kaiser Permanente. A translation of the book, entitled *La Salud en Casa*, is available to Spanish-speaking members.

The program also involved widespread educational and promotional activities directed at physicians, staff, and members. For example, every facility had an implementation team that participated in an initial all-day training, held regular meetings, and rolled out the Self-Care Program to physicians and staff at their facility with the aid of slide shows, videos, e-mail, special events, and printed materials. Meanwhile, members received newsletter inserts and postcards reminding them to use the *Healthwise Handbook*.

The decision to implement the Self-Care Program throughout Northern California was based on the results of an evaluation of the Fairfield pilot. During an eight-month period following the mailing of the *Healthwise Handbook* in Fairfield, the number of phone calls to advice nurses at that facility dropped significantly—an 11.9% decrease in the Department of Obstetrics/Gynecology and a 7.7% decrease in the Department of Medicine. Over a two-year period, there were also marked decreases in primary care, urgent care, and Emergency Department visits; total visits at Fairfield decreased 6.3% during this time.

The Self-Care Program has also increased member satisfaction. After implementation throughout Northern California, surveys revealed that 75% of members who had the *Healthwise Handbook* had used it to get health information. In addition, 59% reported having a more positive opinion of Kaiser Permanente after receiving the book. These results have been mirrored with Kaiser Permanente members across the country.

"The lasting impact of this program is a culture change within Kaiser Permanente, where we are inviting our members to become more active in their own care and encouraging staff to promote self-care in their interactions with members," said David Sobel, MD, MPH, Director of Patient Education and Health Promotion in Northern California. "While other health care organizations have provided self-care books to their members, none have integrated their use into medical practice and culture. Only the Kaiser Permanente Self-Care Program has prepared providers at all levels to support and reinforce the use of appropriate self-care."

Contacts: David Sobel, MD, (510) 987-3579; Pamela Larson, MPH, (510) 987-3578; Ann Banchoff, MSW, MPH, (510) 987-4908



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Honorable Mention: The Northwest's Improved Processes of Care for Members in Psychiatric Crises

Honorable mention for the 1997 James A. Vohs Award for Quality goes to the Northwest Division's Improved Processes of Care for Members in Psychiatric Crises. Started in 1994, the new processes have improved the continuity of care, provided timely follow-up for mental health patients in an outpatient setting, and reduced inpatient utilization.

The new processes allow for better patient monitoring and utilization tracking. Specifically, improvements include:

- establishing mental health urgent care services at all clinics;
- implementing a psychiatric nurse case manager liaison between contracted inpatient facilities and Kaiser Permanente;
- establishing a triage phone line for hospital social workers; and
- adopting various communication and outcome measurement tools.

In 1995, these improvements saved the Northwest Division more than \$1.1 million. Inpatient days decreased from 2,293 in 1994 to 1,267 in 1995; readmissions within 30 days of discharge dropped from 9.2% to 4.25%; and the average length of stay in inpatient psychiatric facilities was almost halved — from 25 days to 13 days per thousand members. Furthermore, the HEDIS (Health Plan Employer Data and Information Set) measure for ambulatory follow-up after hospitalization increased from 72% in 1994 to 88% in 1995.

"Before, members either had to access mental health services through our emergency department or through outpatient mental health, which often had a wait of several weeks," commented Stuart Oken, MD, of the Mental Health Department in the Northwest Division. "Now we have a team of psychiatrists and allied health professionals who are dedicated to urgent psychiatric care and have the flexibility to see patients immediately and as often as needed on an outpatient basis."

Added Mark Leveaux, MD, chief of the Northwest Division's Mental Health Department, "In order to reduce inpatient utilization, you need to have continuity of care and readily accessible services throughout the continuum of care. We used the quality management process to make these changes, and it worked — without being too lengthy or cumbersome."

Contacts: **Stuart Oken, MD**, (503) 249-5263, **Mark Leveaux, MD**, (503) 331-5254

Honorable Mention: Hawaii's Diabetic Limb Treatment Program

Another honorable mention for the 1997 James A. Vohs Award for Quality goes to the Hawaii Local Market's Diabetic Limb Treatment Program (DLTP). This aggressive, multidisciplinary approach to diabetic lower extremity infection or gangrene has improved the quality of care in Hawaii and decreased amputation rates as well as emergency and hospital admissions and lengths of stay for patients with diabetes.

Even before the development of the DLTP in Hawaii, the lower leg amputation rate for patients with diabetes — at 50.6 per 10,000 — was better than the national average of 59.9 per 10,000 but still had room for improvement. Fragmentation of care for diabetic patients was common, with primary care physicians often unclear about which of several specialists might be best able to treat these patients. The new process directs primary care physicians to refer existing and potential limb problems among patients with diabetes to a weekly Diabetic Limb Treatment Clinic. There a team of physicians and nurses specializing in vascular surgery, internal medicine, orthopedics, and podiatry

apply a variety of treatment algorithms designed to save limbs. Among the possible treatments are leg revascularization, aggressive foot debridement, standardized wound care, and correction of structural foot deformities.

In 1995, after initiation of the DLTP, the rate of leg amputations in our Hawaii Local Market decreased from 50.0 to 26.1 per 10,000 patients with diabetes annually — more than meeting the Department of Health and Human Services' goal of a 40% reduction in lower limb amputation rates by the year 2000. In addition, the number of hospital days for patients with diabetes decreased by 60% and the average length of stay by 51%.

"Sixty percent of the more than 100,000 patients who undergo limb amputation in the United States every year are patients with diabetes," said Peter Schneider, MD, the vascular surgery member of the Diabetic Limb Treatment Clinic in Hawaii. "This is a complicated problem that really requires a multidisciplinary approach. Unlike heart patients, diabetic patients cannot be easily assigned to one type of specialist. By sharing the work and having access to immediate consultation with each other, our team can give patients with diabetes the best possible treatment."

Contact: Peter Schneider, MD, (808) 834-9119

Nominations for the 1997 Vohs Award were also received from Southern California and Ohio. The Southern California submission, "Group Assessment and Education: A Model for Delivering Physical Therapy Services," consisted of an interdisciplinary approach to assessment of patients with musculoskeletal disease that improved member access to evaluation and treatment. The outcomes of the program were greatly enhanced productivity for physical therapists and improved patient satisfaction with shorter wait times to treatment. Additionally, the total cost savings for 1994-1995 was estimated at \$661,704.

Contact: Linda Frankenberger, (909) 353-4681

The Ohio submission, "The Clinical Decision Unit (CDU)," can be described as a dedicated outpatient medical care observation unit where chronically ill patients receiving continuous therapy are monitored and treated. Early and timely CDU intervention frequently prevents costly and unnecessary one-day hospital admissions. In fact, the use of the CDU has resulted in a 22% decrease in hospitalizations in the Region. Patients evaluated are usually those with chest pain, abdominal pain, and asthma.

Contact: Neal Kaforey, MD, (330) 928-1681

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David M. Lawrence, MD

Chairman & Chief Executive Officer
Kaiser Foundation Health Plan, Inc. and
Kaiser Foundation Hospitals

David M. Lawrence, MD was named Chief Executive Officer in 1990 and Chairman of the Boards of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals in 1991. He began his career with Kaiser Permanente with the Northwest Permanente Medical Group in 1981.

Dr. Lawrence currently serves on the Boards of Hewlett-Packard, Pacific Gas and Electric Company, Raffles Medical Group of Singapore, the Conference Board, the Bay Area Council, and the Hospital Research and Educational Trust (AHA) among others. Prior to joining Kaiser Permanente, Dr. Lawrence worked in academic medicine, public health, and international health.

Dr. Lawrence earned his BA degree from Amherst College, his MD from the University of Kentucky, and his MPH from the University of Washington. He is Board Certified in General Preventive Medicine. He attended the Advanced Management Program at Harvard. He is a member of the Alpha Omega Alpha Society and the Institute of Medicine.

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File Quality
Form.

Christine A. Van Noy
Assistant to the Chairman
and Chief Executive Officer

June 2, 1998

Mr. Christopher Jennings
Deputy Assistant to the President for Health Policy
The Old Executive Office Building, Room 216
Washington, DC 20502

Dear Mr. Jennings:

As we discussed today, I am forwarding information on three quality improvement areas:

1. Colorectal Cancer Prevention Program
2. The Cooperative Health Care Clinic
3. End Stage Renal Disease

Also enclosed is Dave Lawrence's biography. Please let me know if you need any additional information.

Sincerely,

CVN:pf

Enclosure

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XEROX

Office of External Affairs

1401 H Street, N. W.

Suite 200

Washington, DC 20005-1110

202-414-1200

File

*Quality
Forum*

Fax Cover Sheet

DATE: JUNE 17, 1998

TIME:

Recipient Name	Fax Number	
Sara Bianchi	456-5557	
Peter O'Keefe	456-6218	

FROM: MICHELE CAHN

PHONE: 202-414-1288

FAX: 202-414-1217

Number of pages: COVER +1

MESSAGE:

As we discussed . . .
Michele-

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THE DOCUMENT COMPANY
XEROX

Patricia M. Nazemetz
Director, Total Pay

Xerox Corporation
800 Long Ridge Road
Stamford, CT 06904
203-968-3158
203-968-3761 - Fax

The Honorable Albert Gore, Jr.
Vice President of the United States
Old Executive Office Building
Washington, DC 20501

Dear Vice President Gore:

On behalf of Xerox Corporation, it is my honor to accept your invitation to participate on the health care Quality Forum Planning Committee. Xerox has long been a leader in championing continuous quality improvement in the design and operation of health benefit plans for all our employees, and we believe the Planning Committee is an important step in establishing national health care quality benchmarks.

For well over a decade Xerox has sought to develop performance measures to help both employers and employees better understand quality health care outcomes and ensure all our employees and their dependents are able to maintain happy and healthy lives. Xerox believes the establishment of the Quality Forum Planning Committee, funded with private support, and comprised of nationally recognized private purchasers, health care providers, health professionals, labor, health plans, as well as public purchasers will provide an unprecedented opportunity to create a national framework and model to ensure quality health care outcomes for all Americans.

Once again thank you for this opportunity to participate on the Quality Forum Planning Committee. Xerox looks forward to sharing its experience and expertise with the Committee throughout its tenure.

Sincerely,

Pat Nazemetz

Pat Nazemetz

PN:dmf

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**Patricia M. Nazemetz
Director, Total Pay
Xerox Corporation**

Patricia M. Nazemetz is Director, Total Pay for Xerox Corporation, Stamford, Connecticut. Her responsibilities include the direction and development of Total Pay strategies and programs including U.S. and International compensation, executive pay, benefits, policies, workplace flexibility and HR communications.

Ms. Nazemetz joined Xerox Corporation in 1979 as a benefits operations manager and held a variety of assignments in corporate human resources before being named to her current position in 1997. Before joining Xerox Corporation, she worked as a benefits analyst at W.R. Grace & Company.

Ms. Nazemetz serves as a director on the boards of the Kaiser Health Plan of New York, Washington Business Group on Health, Care Select and the northeast region of the National Alliance of Business. She is past Chairman of the board of the National Committee for Quality Assurance. Ms. Nazemetz is also a member of the Academy of Women Achievers of the YWCA of New York City and a Trustee of Fordham University.

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File

Health

June 15, 1998

The Honorable Albert Gore, Jr.
Vice President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Care
Quality
Forum

Dear Vice President Gore:

We are pleased to convey our support for the efforts of the White House to begin the planning work for the Forum for Health Care Quality Measurement and Reporting, as recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. We understand that the Forum is intended to focus on ensuring a system-wide capacity to evaluate and report on the quality of care. In addition, the Forum will be expected to develop and implement effective, efficient, and coordinated strategies for ensuring the availability of valid and reliable information on quality for use by consumers, purchasers, oversight organizations, providers, and other interested parties.

We believe it essential that attention be focused on both the adequacy of our nation's infrastructure for undertaking quality measurement activities, and on ways to ensure that performance measurement efforts will result in information that will be useful to key audiences and cost-effective to collect. In May, our three organizations announced the formation of the Performance Measurement Coordinating Council (PMCC), a collaborative effort designed to coordinate performance measurement activities across the entire health care system. We view the efforts of the PMCC as particularly synergistic to the goals of the Forum, and we look forward to working closely with the members of the Planning Committee.

There is today a confluence of events and circumstances in health care that make it more important than ever that the public and private sectors act in unison. The American public is concerned about the quality of its health care and its access to needed services, while purchasers want to ensure that they obtain value in return for their significant health care expenditures. Further, physicians, provider organizations, and health plans need information that is useful to their efforts to deliver high quality services. The nation is now beginning to build the infrastructure that will give it the data needed to assess quality, access, and answer pressing questions about health care issues. However, the demands for data are many, while the costs for its collection and reporting are substantial. Thus, it is imperative that as we enter this new era of performance measurement, we coordinate efforts to the fullest extent possible to reduce the burden of measurement and optimize the utility of the resulting information.

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The Honorable Albert Gore, Jr.
June 15, 1998
Page Two

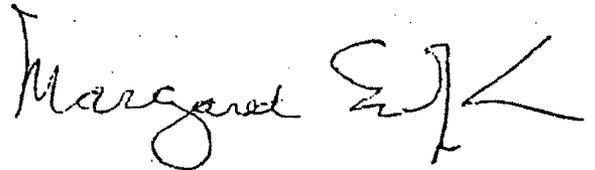
We also believe that the Forum holds significant promise to move the science of performance measurement forward. There is much work to be done on the underlying scientific issues associated with performance measurement, such as risk adjustment and techniques for standardizing data elements. There could not be a better time for the public and private sectors to join forces.

Our organizations stand ready to act as a resource and share our expertise and experience in the performance measurement area with both the Planning Committee and the Forum as it takes shape.

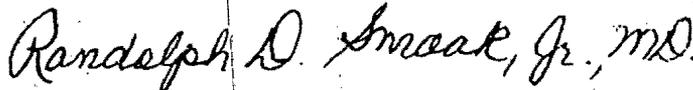
Sincerely,



Dennis S. O'Leary, M.D., President
Joint Commission on Accreditation of
Healthcare Organizations (JCAHO)



Margaret E. O'Kane, President
National Committee for Quality
Assurance (NCQA)



Randolph D. Smoak, Jr., MD, Chair
American Medical Accreditation Program
(AMAP) Governing Body

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American Association of
HEALTH PLANS

June 16, 1998

The Honorable Albert Gore, Jr.
Vice President of the United States
Office of the Vice President
Old Executive Office Building
Washington, DC 20501

Dear Vice President Gore:

On behalf of the members of the American Association of Health Plans (AAHP), we are honored to have the opportunity to assist your efforts as you initiate the planning and design phase of the Forum for Health Care Quality Measurement and Reporting. This Forum has the potential to build a foundation for increasing information on quality and quality measurement and to assist consumers and providers in health care decision-making.

For too long, too many Americans have been subjected to fragmented and costly care of questionable value -- care that has resulted in significant human and financial costs for both our health care system and our nation at large. AAHP member plans believe strongly that resolving this impediment to quality health care should be the focal point of the Forum's work.

Through a partnership with consumers, health care professionals, and employers, America's health plans have pioneered efforts to be accountable to patients and purchasers and to improve quality throughout the entire health care system. This collaboration resulted in the widely accepted HEDIS measurements -- which are continuing to evolve -- and standardized satisfaction survey instruments. Indeed, health plans have long relied on performance measurement, health services and outcomes research, and a wide array of other data to further the provision of evidence-based health care.

As this process moves forward, AAHP member plans strongly believe that health plans' expertise in this fundamental area will be beneficial to your discussions -- particularly for those segments of the health care system that have not moved as quickly to evidence-based care as health plans have. During the coming months and beyond, we look forward to working with you on this initiative and in other areas to improve health care quality throughout the entire system.

Sincerely,

Carmella Bocchino, R.N.
Vice President of Medical Affairs

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JOHN F. SMITH, JR.
Chairman of the Board
Chief Executive Officer and President

General Motors

June 17, 1998

The Vice President
The White House
Washington, DC 20500

Dear Mr. Vice President:

I am writing to offer the support of General Motors in the development and implementation of The National Forum for Quality Measurement and Reporting. This is an extremely important recommendation from the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, and I would like to commend you and the President for your leadership. Accordingly, General Motors is offering GM staff resources as well as information on experience we have gained in our work to measure quality. We have used the results to change the behavior of consumers, health care providers and purchasers.

The core of virtually all the strategies needed to address our nation's health care problems is improving access to appropriate quality health care. Scientifically-based quality measurements are essential to identify and provide the means for addressing the root causes of under-use, over-use, and misuse of health services. In recent years, much progress has been made in developing measures to evaluate health care quality. However, there is now a need to coordinate such efforts, establish priorities and, most importantly, provide the tools and leadership needed to actually implement improved care. Both public sector and private purchasers share the need to assure quality care for our respective beneficiaries. This public-private partnership has the capability to enable the Forum to be a critical implementation vehicle for much of the work that has come out of the President's Advisory Commission.

Experience at General Motors has shown that the use of quality measures actually drives change. Some examples include:

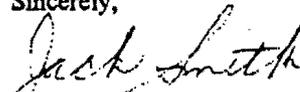
- Quality performance measurement in the auto industry has resulted in significant improvements in quality and value to the consumer.
- GM is using scientifically-based standardized quality performance data to drive health plan accountability through communication to employees and retirees as well as through providing financial incentives to enroll in high quality plans. The results over the past two years are as follows:
 - The better HMOs gained market share
 - Employees and retirees in the aggregate had lower out-of-pocket cost
 - GM realized significant savings
 - HMOs are responding with quality improvement initiatives

The Vice President
Page Two
June 17, 1998

- In the traditional indemnity plan, we have seen improvement in some of the areas measured. An example of the improvement is the increased use of "beta blocker" medication after a heart attack, which significantly reduces the likelihood of a subsequent heart attack. We also have similar data showing improvement in breast cancer screening which in turn results in better patient outcomes.
- We have used the results of performance data to work with our HMO suppliers to drive quality improvement. There are many examples of HMOs with poor performance in providing appropriate care for certain procedures making substantial improvements in a short time frame. Data was used to get the attention of, and provide support for, the medical leadership which enabled this to happen.
- We are seeing many HMO initiatives to improve care in areas being measured such as breast cancer, asthma care, various screening programs, cardiac care, and diabetes management.

There are many other examples of how GM and other companies have used this information to improve health care quality. By bringing together consumers, public and private purchasers, organized labor, and providers around a common mission, the Forum has the potential to bring this movement to the forefront in health care policy and make a real difference to the American people. General Motors will be proud to support these important efforts.

Sincerely,



John F. Smith, Jr.

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600 MARYLAND AVENUE, SW
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WASHINGTON, DC 20024-2571
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[HTTP://WWW.NURSINGWORLD.ORG](http://www.nursingworld.org)

BEVERLY L. MALONE, PhD, RN, FAAN
PRESIDENT

ARGENE CARSWELL, JD, RN
EXECUTIVE DIRECTOR (INTERIM)

June 17, 1998

The Vice President
The White House
Washington, DC

Dear Mr. Vice President:

The American Nurses Association is very appreciative of the work you and President Clinton have done in recent months to encourage and promote the formation of the Forum for Health Care Quality Measurement and Reporting.

This new entity will have a key role in implementing the recommendations of the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry. ANA strongly supports the Advisory Commission's recommendations, including the Consumer Bill of Rights and Responsibilities and the quality issues addressed in the final report last March. The Forum will provide a crucial private sector structure for improving the effectiveness and efficiency of health care quality measurement and reporting. The nursing profession is particularly concerned about the availability of consistent, reliable information for educating individual consumers, purchasers of health plans, health providers, and other stakeholders in the health care system so that they will be able to make informed health care decisions. ANA agrees with the Commission's recommendation that the Forum develop a comprehensive plan for implementing quality measurement, data collection and reporting standards in the industry, and it is ANA's intention to participate fully in offering the nursing profession's expertise in that effort.

The American Nurses Association, representing a profession committed to patient advocacy and the delivery of high quality health care, commends you and the President for your outstanding leadership in advancing the cause of health care quality improvement. We look forward to working with your administration and with other health care organizations in this effort.

Sincerely,

Beverly L. Malone, PhD, RN, FAAN
President

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American Federation of Labor and Congress of Industrial Organizations



815 Sixteenth Street, N.W.
Washington, D.C 20006
(202) 637-5000

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June 16, 1998

The Vice President
Old Executive Office Building
Washington, DC 20501

Dear Mr. Vice President:

I write to congratulate you and the President on the formation of a planning committee to implement the Forum for Health Care Quality Measurement and Reporting recommended by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. It is gratifying to see the Commission's report being acted upon so quickly.

Extensive work in quality assurance and consumer protection in health care among consumer groups, private purchasers, health care providers and accrediting organizations has laid the foundation for major advances in the coming years. Now is the time to take the steps to shape and coordinate those efforts. In quality measurement, data collection, and consumer education and protection, care must be taken to insure reliability, uniformity and effectiveness. Above all, quality improvement efforts must be consumer-centered and designed for maximum accountability among health plans, providers and purchasers.

On behalf of the some 40 million Americans whose employer-based health coverage is negotiated through the unions of the AFL-CIO, we look forward to working with the Administration and others in the health care field on this important project.

Sincerely,

John J. Sweeney
President

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PRESERVATION



33 New Montgomery Street, Suite 1450, San Francisco, CA 94105
Tel: 415-774-2811 Fax: 415-774-0960

June 15, 1998

The Honorable Albert Gore
Vice President of the United States
1600 Pennsylvania Avenue
Washington, DC 20503

Dear Mr. Vice President:

On behalf of the thirty-five public and private sector purchasers of the Pacific Business Group on Health (PBGH), I want to applaud you and President Clinton for assuming leadership on the issue of health care quality. PBGH is honored to serve on the planning committee to design the Forum for Health Care Quality Measurement and Reporting.

PBGH members spend more than \$3 billion annually on health care. Since our inception in 1989, we have actively sought to measure health care quality at all levels of the system - plans, physicians, and hospitals. Several years ago PBGH members established a Quality Improvement Fund, totaling \$1 million to advance quality measurement in California, the Northwest and Arizona. We publicize scientific quality information so that employers and consumers can make more informed decisions about their health care.

We are excited that the Quality Forum will bring together public and private sector representatives to heighten national awareness on this important issue. A more visible and coordinated strategy to accelerate progress on this front will benefit all Americans. Again, we appreciate inclusion in this effort.

Sincerely,

Executive Director

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- | | | | | |
|--------------------------------------|-------------------------------------|--|------------------------------|-------------------------------|
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| GTE | Health Insurance Plan of California | Hewlett Packard | Hughes Electronics Corp. | Pacific Enterprises Companies |
| Lockheed Martin Missiles & Space Co. | Long's Drug Stores | ISI Logic | McKesson Corp. | Mervyn's California |
| PG&E Co. | Public Employees' Retirement System | Ross Stores | Safeway Inc. | SBC Communications Inc. |
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| University of California | VLSI Technology | Varian Associates, Inc. | Wells Fargo Bank | |

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EXECUTIVE DIRECTOR: Peter E. Rowan

MEDICAL DIRECTOR: [Name obscured]



June 16, 1998

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The Honorable Albert Gore, Jr.
Office of the Vice President
Old Executive Office Building
Washington, DC 20501

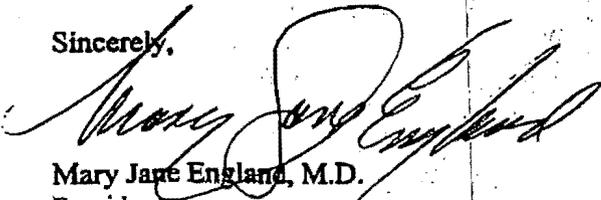
Dear Mr. Vice President:

On behalf of the Board of Directors of the Washington Business Group on Health, I congratulate President Clinton and you for your leadership in promoting a health quality agenda in health care. In particular, the work of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has served as an important focal point for bringing quality issues to the forefront of the public debate over the future of health care delivery in this country.

As purchasers of health care for more than 39 million U.S. workers, retirees, and their families, WBGH members have a strong commitment to ensure that the highest quality health care is delivered at the best price. Employers know that investing in the health of their employees and dependents improves corporate competitiveness and productivity. They also know that there is considerable room for improvement in the health care system and have actively supported the quality movement by participating in the development of HEDIS, by developing their own purchasing and performance standards, and by partnering with health plans around specific quality improvement initiatives. Purchasers are also keenly aware of the burden that uncoordinated quality improvement and monitoring efforts can place on health plans and providers and have supported the development of uniform standards and measurement systems that will allow us to collect information in a cost efficient way.

I appreciate the opportunity to serve on the planning committee charged with designing and establishing the Forum for Health Care Quality Measurement and Reporting. Employer purchasers have an important stake in ensuring that the next steps we take are well reasoned and will produce an approach to quality measurement and reporting that truly meets the needs of purchasers, consumers, and health plans. I look forward to working with you on this important initiative.

Sincerely,


Mary Jane England, M.D.
President

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June 15, 1998

Vice President Albert Gore
The White House
1600 Pennsylvania Avenue
Washington, DC, 20500

Dear Vice President Gore:

I wish to commend you and President Clinton for your leadership in addressing the issue of improving the delivery of health care services to the citizens of the United States. The recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry represent a significant contribution to the public discourse on the best means of accomplishing this important goal.

While much attention has recently been focused on the issue of patient protection, I believe the health care delivery system can be transformed and strengthened through a concerted effort to measure and improve the quality of services provided to consumers. This is an issue of enormous significance to every American and one that is best addressed through a process involving all major stakeholders—including purchasers, consumers, providers, and health plan representatives. By bringing these and other groups together to plan the implementation of the proposed Forum for Health Care Quality Measurement and Reporting, you are laying the foundation that will ultimately enable consumers and purchasers to make informed decisions in response to their health care needs.

It has been my privilege to serve you and the President as a member of the Commission. I look forward to assisting in the process of launching the Forum.

Sincerely,

Christopher Queram
Chief Executive Officer

wsc

Phone
608-276-6620

Fax
608-276-6626

37 Kessel Court
Suite 201

P.O. Box 44365

Madison, WI
53744-4365

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June 16, 1998

The Honorable William Jefferson Clinton
President of the United States
1600 Pennsylvania Avenue, NW
Washington, DC 20502

Dear Mr. President:

AARP has historically championed the interests of Americans of all ages with respect to access to affordable, quality healthcare. In recent years, we have intensified our interest in health quality, in terms of both consumer protections and system-wide quality improvement measures and incentives.

Accordingly, we are pleased to support the establishment of the Forum for Health Quality Measurement and Reporting as a mechanism to help strengthen system-wide quality performance. By coordinating the work of private sector organizations involved in health care quality, the Forum will harness the expertise of the private sector, establish the private sector arm of a public-private partnership to improve quality, and strengthen public support for quality improvement through credible and complete reporting.

We look forward to working with the Forum, the Administration and members of Congress on a bipartisan basis to address the need for higher and more consistent quality in all aspects of American health care.

Sincerely,

A handwritten signature in cursive script that reads "John C. Rother".

John C. Rother
Director, Legislation & Public Policy

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American Association of Retired Persons 601 E Street, NW Washington, DC 20049 (202) 434-2277

Margaret A. Dixon, Ed.D. *President*

Horace B. Deets *Executive Director*

American Medical Association

Physicians dedicated to the health of America



515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

June 11, 1998

The Honorable Albert Gore, Jr.
Vice President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Vice President Gore:

On behalf of the 300,000 physician and student members of the American Medical Association (AMA), I would like to lend our enthusiastic support to your efforts to announce on June 17, the Planning Committee to establish the Forum for Health Care Quality Measurement and Reporting, as recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. We are especially pleased that you have invited Thomas R. Reardon, MD, Chair of the AMA Board of Trustees, to serve on the Planning Committee and to bring his expertise on quality measurement issues to these discussions. His continuity as a member of the President's Quality Commission, along with others on the Planning Committee, will enhance the Committee's discussions and focus.

As you know, the AMA endorsed the Final Report of the Quality Commission and we understand full well the implications for moving the nation's quality of care agenda forward through the establishment of the Forum. We are particularly pleased by your leadership on this critical issue. We believe that the private sector should lead in the development of quality measurement standards, as it is doing currently. The Forum, as envisioned by the President's Quality Commission, would, among other things, "develop a comprehensive plan for implementing quality measurement, data collection, and reporting standards to ensure the widespread public availability of comparative information on the quality of care furnished by all sectors of the health care industry." The Forum is intended to be a public/private sector partnership involving all the key stakeholders to focus on harnessing the best of what the private sector is advancing and to foster improvement in the science of quality measurement.

The AMA is committed to improving the quality of individual physicians through our American Medical Accreditation Program (AMAP). We are pleased to pledge our support for this worthwhile planning effort for the Forum, and we look forward to working with you to make the Forum a reality and then to work towards its ultimate success. All of our best wishes!

Sincerely,

E. Ratcliffe Anderson, Jr., MD
Executive Vice President

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PRESERVATION

150 *Years of Caring for the Country*
1847 • 1997

Consortium for Citizens with Disabilities

June 16, 1998

The Honorable Al Gore
Vice President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C.

Dear Mr. Vice President:

The Consortium for Citizens with Disabilities Health Task Force commends you and President Clinton for your continuing leadership on health care issues. Your efforts to enact patient protection legislation, which developed from the work of the President's Commission on Consumer Protection and Quality in the Health Care Industry, is strongly supported by the disability community.

Your actions today in creating the Quality Forum also derive from the Commission's recommendations and highlight the importance of improving the quality of health care in this country. The CCD Health Task Force strongly supports this effort and welcomes the opportunity to bring improvements in the quality of care provided to people with disabilities and chronic illnesses to the forefront of the health care quality debate.

While the improvement of health care quality has received much attention of late, CCD believes that not nearly enough attention has been paid to measurement, assessment, and improvement in quality as it relates to people with disabilities and chronic illnesses. One reason for this lack of attention lies in the low prevalence of many disabilities and chronic illnesses.

In fact, even the Medicaid program, as it implements changes from the Balanced Budget Act of 1997 related to the quality of care provided to children and adults with disabilities in managed care, has raised serious concerns within the disability community. In addition, recent court decisions threaten access among people with disabilities to very important Medicaid durable medical equipment benefits, which has a dramatic impact on the quality of care of this population.

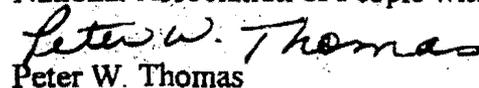
The Quality Forum will be a very effective avenue to address some of the most serious quality concerns of the disability community with all of the stakeholders in the health care marketplace. The CCD Health Task Force joins you today with high hopes that the quality concerns of people with disabilities and chronic illnesses will be at the top of the Quality Forum's agenda.

Sincerely,


Kathy McGinley
The Arc


Bob Griss
Center on Disability and Health


Jeff Crowley
National Association of People with AIDS


Peter W. Thomas
Brain Injury Association

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*File
Quality
Forum*

**Foundation for
Accountability**

Fax

To: Chris Jennings

From: David Lansky

Fax: 202-458-5557

Pages: 10

Phone:

Date: June 14, 1998

Re: Follow-up to 5/27 meeting

CC: Sarah Bianchi (by email)

Urgent For Review Please Comment Please Reply Please Recycle

• Comments:

Email copy of documents being sent to Sarah.

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Memorandum

To: Chris Jennings
From: David Lansky
cc: Sarah Bianchi
Date: June 14, 1998
Subject: Situation analysis for accountability measures

I am enclosing three documents as follow-up to our May 27 meeting and in anticipation of the Forum kick-off this week and the Family Reunion event:

1. Memo to the Vice President - summarizing a few examples of how performance measurement is driving behavior changes with a focus on family health
2. Updated version of "principles" and "action steps" provided to you on 5/27
3. Outline of case statement on performance measurement, along the lines you suggested during our 5/27 meeting

As you said, it is difficult to assemble a "selling" case in the absence of compelling examples. I am assembling a longer list of examples that we can all use in communicating with policymakers, a few of which are mentioned in the memo to Mr. Gore.

The outline is, frankly, a raw "brain-dump" of elements that would address the concerns you raised during our meeting. We have three years' experience wrestling with these issues and most of the same key players. If a full exposition on any of these points would be useful, we would be happy to prepare a document or set of presentation materials. I would prefer to do so based on some guidance from you as to likely audiences and purposes and, therefore, format. As a first step, I think some more explicit treatment of the "barriers" section might be worthwhile.

I wish you luck with the Forum meeting and your many other challenges. Please let me know if we can be of any assistance along the way.

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Memorandum

To: Vice President Gore
From: David Lansky, Ph.D.
CC: Nancy Holt, Pam Johnson
Date: June 9, 1998
Subject: Performance measurement, consumer reporting and family health

Thank you for including me in the Family Reunion planning dinner and for sharing your thoughts about the U.S. health care system. I appreciate your invitation to provide ideas and case studies about how measuring performance and informing consumers can strengthen health care services and improve family health.

This memorandum outlines how improving health care performance measurement and reporting will help America's families—and the steps we should take to implement such a system.

Case Study: Improving heart health at Group Health Cooperative - Seattle

In 1994, Group Health Cooperative of Puget Sound implemented a program to prevent second cardiac events from occurring among its members with heart disease. A specific performance goal was set—52% of patients hospitalized for a cardiac event (e.g., heart attack) should have low density lipoprotein cholesterol (LDL) levels *below 130* within 18 months of their event. We know that people who achieve this target level are substantially less likely to have any subsequent cardiac event.

To reach the goal, Group Health worked with its *physicians and hospitals* to:

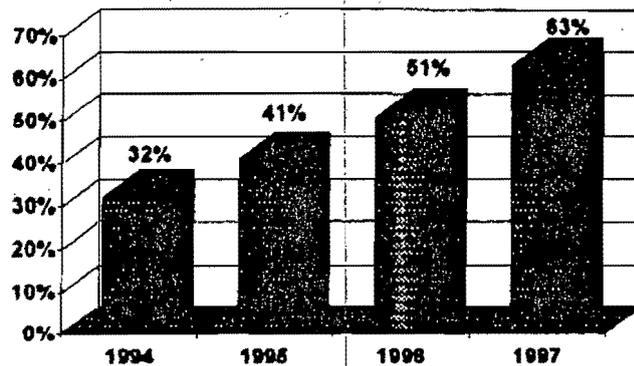
- establish cardiac risk reduction teams at area medical centers
- implement use of secondary prevention treatment guidelines
- switch to more powerful cholesterol-lowering medications
- assess current performance on reducing cholesterol levels and identify areas for improvement

Group Health also targets interventions to heart disease *patients and their families*. Following discharge for a cardiac event, patients are contacted by a nurse who describes

the kind of follow-up care they should expect to receive from their doctor—help reducing cholesterol levels, quitting smoking and increasing their use of aspirin and education about diet and exercise. These elements of care are identical to those in the provider treatment guidelines, and patients are instructed to ask their doctor for this care if they are not receiving it.

A specific outcome goal, systematic outreach to families, and comprehensive programs for providers have succeeded. In 1994, 32% of the heart disease patients had LDL levels below 130 at 18 months after their event. By the end of 1997, the percentage had nearly doubled—63% of patients had LDL levels below 130.

Patients with LDL < 130 Within 18 months Post Cardiac Event
July 1994 - December 1997



And patients are happy. Member satisfaction data show that heart disease patients are more satisfied than the other Group Health members with the coordination and thoroughness of the care they are receiving.

Creating accountability in health care

The drive to establish health system accountability based on performance measurement and consumer reporting builds on two core assumptions:

1. Health plans and providers will seek to excel on publicly reported performance indicators to attract business and retain status.
2. Consumers and patients will seek out the plans and providers that excel.

Although consumer-focused performance measurement and reporting are still in their early stages, these assumptions have been borne out by behavioral changes among consumers, purchasers and providers when provided with performance information. Case studies later in this memorandum provide examples.

In health care, as in business, we know that "what gets measured, gets managed." To encourage changes in consumer, purchaser and provider behavior, we need to measure and report the most relevant aspects of quality. We need to listen to families about what's most important to them—and design measures that reward improvement in those areas.

To date, most of the quality indicators measured and reported to the public are process measures. This measurement focus has often led to better processes—but not always to better results for patients. For example, the *Journal of the American Medical Association* recently reported that the frequency and intensity of *prenatal care visits* has increased substantially for white, insured women—driving the overall rate up—while remaining constant for poor, young and minority women, who continue to account for most neonatal complications. The health system can achieve the process goal of a higher "rate"—without necessarily addressing and improving results for the populations most at risk.

Asking the health system to demonstrate better outcomes instead of better processes prompts more innovative, integrated and comprehensive action—without dictating the specific steps providers and plans should take. Families receive the benefit of better health care results, and providers have the flexibility to deliver positive outcomes in the way they deem most effective and appropriate.

Benefits to America's families

There are three broad ways improved performance measurement and reporting will serve families:

- By **focusing the health care system** on the issues that matter most to families
- By **rewarding plans and providers that do a better job** meeting families' needs
- By **empowering families with information** they can use to care for each other and improve their own health.

Here are examples of current progress in each of these three areas:

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Focusing the health care system on family concerns

In dozens of focus groups and interviews, we have heard that the health care system can do a better job of listening to families and shaping programs to meet their needs.

In focus groups with **parents of children with serious illness**, the most often mentioned quality attributes were an attitude of caring and respect, a knowledgeable provider, and access to the care they needed when they needed it.

"I didn't even know how my child was, like, what his milestones were supposed to be—like he's supposed to be sitting up at this age. Thank God, my next door neighbor had children and he's like 'Lisa, he's not holding his head up, you know.' And I would go to the doctor, his pediatrician, and he would tell me, 'Oh Lisa, he's just being a little poky, you know. He's just a little poky.' Thank God, my mom works at La Rabida [children's hospital] and that's how I got to La Rabida."

— Chicago focus group participant —

Asthma patients often talk about needing education about self-care, controlling their symptoms, and maintaining daily activities.

"One of the problems I see with asthma is that it seems to me there could be a lot of preventive things taking place long before you even get the first attack."

"I think it's very important that a person knows their own health. It's like there's all these little symptoms that precede a hospitalization or attack and if people are not aware of those then they're going to get in trouble real fast. I think there should be more education in that...When an attack occurs, then it's too late, you're in trouble."

"When they give me asthma medicine, high blood pressure medicine they counteract sometimes. And then I have that ol' arthritis... [But] I'll go in, the doctor takes care of my asthma, he completely forgets about the other things."

"The ability to maintain daily activities... that one is important to me... When I climb stairs I have to stop every so often to get up those stairs. Well, if I can't do that at all I need to know."

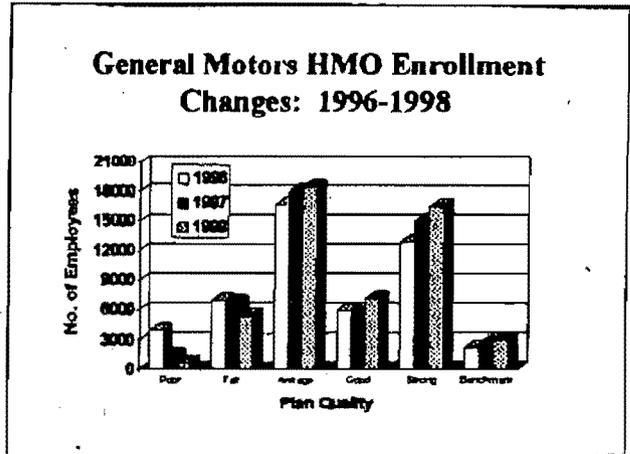
—Seattle focus group participants

While patients commonly cite these concerns, the existing performance measurement strategies used in managed care and hospital oversight have not addressed them. Current systems are dominated by process measures, easily computed from financial transaction databases, and defined only by biomedical research criteria.

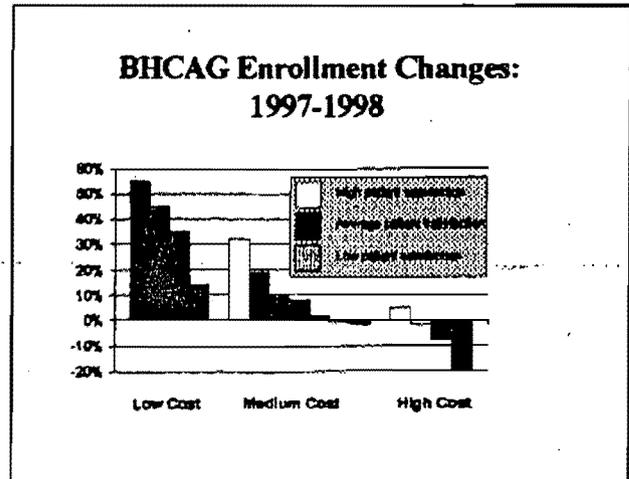
Rewarding plans and providers that do a better job

People will change their health care arrangements if they think they will get better care somewhere else. And providers will change their behavior to respond to performance reports that are given to purchasers and consumers.

General Motors has created a quality index for all of the 126 HMOs it offers its national workforce. For salaried workers, GM makes it less expensive for employees to **select higher quality health plans**. In both the 1997 and 1998 enrollment years, the best plans gained 30% enrollment while the lowest ranked plan lost 82% of its members.



A similar pattern is emerging as workers select among alternative providers of care. The Buyers' Health Care Action Group serving 130,000 employees in Minnesota found that workers **select providers with superior quality ratings** when choosing among alternatives with similar costs.



We also have growing evidence that provider organizations that establish performance objectives and report their results publicly achieve improvements. The Providence Health System in Oregon, for example, set a target of **reducing smoking** among plan members from the 21% level observed in 1994 to under 15% by 2000. The plan introduced more than a dozen provider interventions, another dozen member interventions and joined a series of broad public health campaigns. As of 1997 the smoking rate had come down to 18% across all members, including a drop from 12% to 9.7% among Medicare enrollees.

Performance improvements like those at Group Health and Providence depend upon the coordinated involvement of providers, patients and families. Group Health lowered cholesterol levels by changing selected medications, educating doctors,

providing materials and case management to families, and encouraging patients to ask their doctors tough questions. Providence has created a Quality Bonus Program to pay doctors more when they successfully help their patients achieve quality targets in such areas as elderly immunizations and diabetic blood screening.

Empowering families with information

The same information that can drive health care choices in the market can support better health practices in the general population. The national Diabetes Quality Improvement Program has just announced a consensus set of *accountability measures*, including managing blood sugar and cholesterol, frequent exams of feet and eyes for early signs of disease, and quality of patient education about exercise and diet.

In its widely distributed *patient education* materials, the American Diabetes Association provides patients and families with a set of questions to "ask your doctor." Patients are encouraged to talk with their doctor about blood sugar testing and levels, examinations of eyes and feet, and issues of diet and exercise.

A key factor in the success of the Group Health Coop cholesterol reduction program described above, for example, is encouragement to patients to ask their doctor what they can do to help reduce LDL to the desired level.

When FACCT showed sample performance data about the knowledge and use of peak flow meters and inhalers to asthma patients, they often said "my doctor never talked to me about these things."

Performance measures, if properly selected, can reinforce and direct the exchange of information between providers and families - and tell people which providers are actually doing a good job at the things patients care about the most.

Taking the next steps

These modest signs of progress have emerged out of the fragmented performance measurement and reporting efforts that are under way today. They hint at the far greater benefits that are possible for America's families if we move now to create a focused, comprehensive approach and infrastructure for health care accountability.

Guided by consumers and in partnership with private health care purchasers, public purchasers can use their buying power to set standards for quality measurement and reporting that will lead to better quality and more informed consumer decision making.

Some demonstrations are already underway:

- In **Washington State**, the state Medicaid program, HCFA, the CDC, FEHB, private employers and health plans are working together to gather the nationally standardized *diabetes* performance measures.
- **Six national health plans** are working with FEHB to gather *asthma* performance data, possibly leading to national collection and reporting in the FEHB Guide.
- In **Iowa**, a coalition of private purchasers and state officials are collaborating on uniform measures of *chronic disease care* across major care systems.

Yet these worthy projects are isolated, idiosyncratic, and depend upon the voluntary participation of a few providers who often insist that performance data not be shared with the public - thereby undermining the ultimate power of this approach to induce change.

Specific policy proposal for 1999 action

The Federal government can provide strong and visible leadership to this strategy in 1999. The Administration, under the auspices of the Forum and key executive agencies, should identify one *high-impact health condition* and require all health care organizations serving Federally-covered populations to compile and report selected outcomes based performance information.

HCFA, the Federal Employee Benefits Program, the Veterans Health Administration, federally funded state Medicaid programs, the Centers for Disease Control, and the Indian Health Service can act in concert to send a powerful signal to every organization engaged in health care in America.

Dissemination of selected performance information to America's workers and families will help them decide where to seek care and provide them with concrete information to use when talking with doctors, nurses and others. The content of the reported measures will also drive a rich stream of information to families to enable them to support each other when seeking care and managing their own health.

In 1997, the President endorsed creation of a national Diabetes Quality Improvement Panel, which has just completed its work. The panel has announced a simple set of consensus measures of quality care for Americans with diabetes. The single most important measure is the proportion of people with diabetes who report a Hemoglobin A1c level below 9.5%. To achieve this desirable level of blood sugar control, doctors, health plans, patients and families must work together to change diet and exercise habits, get regular tests and take recommended medications. The panel also endorsed measures regarding maintenance of low cholesterol, smoking cessation and key care processes for people with diabetes.

A single, simple outcome measure of this kind will send a signal to the public and the health care industry. A successful initiative will demonstrate the federal commitment to

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high quality care, provide evidence that performance data can drive change, reassure the public that its interests are being represented, and provide a basis for expanded accountability over time.

Thank you for the opportunity to share these ideas. FACCT would be pleased to provide both technical support and an organizing platform for any initiatives which help consumers make meaningful choices and reshape the health system in the ways that matter most to patients and families.

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WHAT HEALTH CARE CONSUMERS HAVE A RIGHT TO KNOW

Principles of Quality Measurement and Consumer Information

1. Consumers have a right to know about the quality of care they can expect to receive from the health system.
2. The aspects of quality that are measured, how they're measured and how results are reported should be determined by independent, consumer-led organizations that are not financially dependent on the health industry they oversee.
3. Information about quality must be available to consumers for all of the organizations that provide and finance health care.
4. Quality information must be relevant and understandable to consumers.
5. Quality information must include an emphasis on health outcomes—on whether patients achieve good results from the care they receive.
6. Quality information should provide a balanced and complete profile of health care performance—addressing the quality of service and communications; health promotion and disease prevention; care for acute illness; care for chronic illness; and care in times of death and disability.
7. Consumers should receive unbiased education and support about the quality of care when they are making important health care decisions.

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WHAT HEALTH CARE CONSUMERS HAVE A RIGHT TO KNOW
Action Steps for Quality Measurement and Consumer Information

1. The federal government must insist that all health care organizations serving federally sponsored populations provide consumer-relevant quality information.
2. All federal health care suppliers should participate in and share the costs of reporting member/patient satisfaction and health risk behavior data for calendar year 1998.
3. All federal health care vendors organized as HMOs should be required to report HEDIS effectiveness of care measures in 1998.
4. All federal health care vendors not organized as HMOs should be required to field a member/patient survey in 1999 designed to estimate selected HEDIS data.
5. All federal health care vendors should participate in and share the costs of collecting patient outcomes data for selected conditions in 1999.
6. Federal agencies that provide quality information to their beneficiaries should agree on a common template, terminology and context language for communications materials.

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Case Statement on Performance Measurement in U.S. Health Care
Foundation for Accountability

OUTLINE

I. **Problem statement**

- A. The quality of health care in the U.S. is inadequate. Problems of overuse, under use and misuse may be compounded by current trends in cost containment and financing reform.
- B. In particular, we can not determine whether the large public and private investment in health care is producing "value" and we are unable to evaluate proposed changes to health care financing and delivery (e.g., BBA, CHIP, MSA) in terms of social benefits.
- C. A private sector market in health services is emerging, but purchasers are unable to discriminate among providers based on any dimension except price and nominal policies. Such a market is dysfunctional and dangerous, inducing low-priced services to healthy patients and punishing organizations committed to excellence.
- D. U.S. consumers feel angry and powerless to influence their own care. This sentiment is being translated into political pressure and unsystematic policy solutions.
- E. In most areas of American life, consumers expect to exercise autonomy and self-reliance. Most key social systems depend upon the exercise of choice and responsibility. The long-term well-being of the health system requires informed consumers who make important decisions and accept responsibility for the consequences of those decisions.
- F. Information about quality that is relevant and useful to purchasers and consumers does not exist. Affected parties resist public disclosure of meaningful information about results or key care processes. Infrastructure investments that would facilitate such disclosure are not being made.
- G. The lack of available quality information and infrastructure continues to reward those who provide poor care.
- H. The only constituency for consumer empowerment and the provision of relevant information is the American public. The principal channels to reach the public are elected officials, mass media, and consumer organizations - but each must respond to multiple obligations and constituencies as it shapes its approach to health policy. There is no pure advocate for consumer influence in health care.

II. Strategy

- A. Establish meaningful results-oriented measures of the performance of health care organizations.
- B. Establish a relevant and understandable way to communicate performance information to purchasers and consumers.
- C. Compel the systematic collection of quality measures.
- D. Distribute relevant performance information to purchasers and consumers to support specific, marketplace decisions.

III. The Demand for Performance Information

- A. Private sector purchasers have committed substantial resources to HEDIS and to consulting relationships. (statistics) % of Fortune 100 companies use HEDIS and survey and RFI data as part of their purchasing decisions.
- B. Congress, through BBA and CHIP, has established statutory requirements for collecting and publishing reporting information.
- C. GAO and the US Senate have encouraged HCFA and FEHB to increase their commitment to performance information.
- D. Many states have institutionalized selected performance reporting requirements, including NY and PA CABG, NJ and MD HEDIS reports, CA OSHPUD studies, FL distribution of patient/member survey results.
- E. Mass media have identified health care ratings (hospitals, HMOs, doctors) as important editorial and marketing subjects. Newsweek, for example, reports that its HMO rankings issue is its #1 newsstand sales issue.
- F. Consumer survey data confirm that 85-91% of adults want to select high quality plans, hospitals and doctors, that they want information about quality from an independent source, that they want to judge health care choices based on access, ability to help people stay healthy, recover from acute illness and cope with chronic illness.

IV. Barriers to Implementation

- A. Market dysfunction
 - 1. Rarity of organized systems of care
 - 2. Disconnect between purchaser and actual consumer; lack of economic incentives for higher quality
 - 3. Risk-bearing entities unable to influence quality
 - 4. Geographic diversity
 - a) National purchasers vs. regional markets
 - b) Local purchasing models (BHCAG, Iowa)
- B. Employer hesitation
 - 1. Large employers/ERISA
 - 2. Small employers

- C. Resistance by health industry and professions
 - D. Culture of self-regulation
 - 1. History of peer review
 - 2. Role of JCAHO, NCQA, AMA
 - E. Failure of government purchasing
 - F. Poorly organized consumer advocacy
 - G. Consumer psychology
 - 1. Passivity
 - 2. Cost insulation/incentives
 - H. Technical infrastructure
 - 1. Data
 - 2. Expertise
 - 3. Regional information focal points
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- V. **Steps to Overcome Barriers**
- A. Consistent public messaging within stable framework
 - B. Simplicity in language and content
 - C. Explicit incremental, multi-year measurement roll-out
 - D. Broad partnerships with private purchasers, consumer organizations
 - E. Federal purchasers in lead; setting *de facto* standards
 - F. Economic rewards/incentives for performance
- VI. **Incremental steps (recommendations to Forum; see 'action steps' list)**
- A. 1999
 - 1. Action steps
 - 2. Products
 - 3. Expected consequences
 - B. 2000
 - C. 2001
 - D. 2002
 - E. 2003
- VII. **Demonstrations**
- A. General Motors: 16% plan switching towards quality; use of 1997 guide
 - B. BHCAG: consumers choosing better rated medical groups within cost bands
 - C. FEHB: focus group results; use of 1997 Guide; 5-year plan
 - D. VA - end of life care changes
 - E. Air Force - suicide prevention outcomes
 - F. NY CABG: provider behavior changes
 - G. MHCA Asthma: Performance differences leading to improvement
 - H. N. New England CABG/PTCA: differences leading to improvement
 - I. PBGH: Healthscope publications

- J. Auto companies' commitment to path
- K. State commitments: FL, MA, MI, OR, WA, WI

VIII. Principles and pitfalls (see 'principles' list)

- A. Progress will be slow; important to demonstrate serious commitment
- B. Consumer psychology hardest to change, especially with industry resistance
- C. Market requires meaningful choices among entities that can control quality
- D. Self-care information must be mirrored in performance information
- E.

IX. Expected results; evaluation criteria

- A. Consumer psychology
- B. Consumer behavior
- C. Health plan selection
- D. Provider selection
- E. Provider behavior

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