

State of Oregon  
Public Employees Benefit Board

## **Implementation of Vision 2007**

# **Report on Communications and Technical Implementation Strategies**

Part II: Specific Technical Criteria by Care Setting

Foundation for Accountability  
Portland, Oregon

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## Background

FACCT and the Technical Advisory Committee (TAC) have been asked to advise PEBB on a set of criteria it can use to contract for health care services for the state's 110,000 employees and dependents. For the purposes of analysis, we have organized these services into nine categories:

- Wellness
- Screening
- Primary care
- Specialty care
- Hospital care
- Mental health
- Prescription drugs
- Chronic care
- Information services

These are not discrete categories, of course – primary care providers would offer many of these services, for example. During 2004, FACCT and the TAC identified criteria in each category, and then reviewed the complete set to identify themes or requirements that cut across multiple categories. Those cross-cutting themes are captured in the domains reported in Part I of this report.

The additional detail that is provided here can be used in several ways. First, individual elements or criteria might be extracted and used in contract terms or in developing reporting requirements. Second, and more generally, this information may assist bidders in understanding the specific elements that PEBB would like to see occur in each care setting in order to fulfill the expectations that are distilled into the broader themes of Part I. For example, the behavioral health section of Part II lists very specific activities that should be performed to fulfill PEBB's expectations for high quality depression screening and monitoring, but these are not enumerated in Part I.

## Primary Care

### Initial Board criteria for Primary Care Services

In May 2004, the PEBB Board offered its guidance regarding the most important criteria – broadly stated – in each category. With regard to primary care, the Board indicated its interest in providing services that are:

- Accessible (in terms of location, cost, culture)
- Effective at coordinating care across settings and providers and offer a “medical home”
- Efficient and comprehensive
- Accountable for performance (outcomes)
- Consistent with scientific evidence
- Proactive and lead to reduced demands for episodic care
- Integrated with electronic health records and clinical decision support

#### Current primary care arrangements

- Kaiser
  - No. of members: about 15% of PEBB membership (5,800 of 44,000 subscribers)
  - Geographic availability: Portland metro (about 2,800 subscribers) and Salem (about 2,800) only
- Regence Blue Cross
  - No. of members: 85% of membership
  - Plan design: PPO (discounted FFS)
  - Highly dispersed members throughout state (see map)

### Current primary care performance on Board criteria

The Board is not satisfied that its primary care criteria are being met with the current arrangements. From the Board perspective, it is not possible to distinguish between having evidence that the goals are being met vs. whether they are being met because the supply of relevant information is simply not adequate. For example, the Board is interested in knowing if the best possible health outcomes are being achieved, yet it presently has virtually no information on the current health status or intermediate outcomes (lipid levels, asthma symptoms, etc.) of its members.

In order to move towards the 2007 Vision, PEBB will need to encourage movement on several parallel levels:

1. Encourage adoption of an adequate information infrastructure that will permit monitoring of goals (system or “structural” changes)
2. Encourage performance of specific care processes consistent with evidence

3. Encourage measurement and tracking of individual patient outcomes (or population-wide outcomes).

These are interdependent and cannot be achieved overnight in the current provider environment. The primary care strategy needs to be mapped to the realities of the Oregon delivery system infrastructure and encourage innovative and incremental steps towards these criteria.

### **Models to consider**

PEBB may ultimately wish to apply the primary care contracting criteria in a variety of ways, including:

- Individual physician performance criteria (e.g., U.K. GP contract) for selection into panel or pay-for-performance
- Members choose PCPs based on recognition of performance levels and/or use of financial incentives to encourage choice of higher-performing MDs
- Contracting with delivery systems that commit to criteria (e.g., Greenfield, PEBB operated clinic, IPA contracting)
- Bundled payment for populations, outcomes (e.g., fee for solution)

### **Criteria**

#### Provider-facing criteria

- Evidence-based practice
  - Conditions: e.g., asthma, diabetes, back pain
  - Domains: e.g., screening, US CPSTF
  - Services: e.g., prescribing
- Health risk assessments and monitoring of progress on behaviors
- Define and achieve health outcome goals (e.g., Bridges to Excellence)
- Patient satisfaction: access, communication, experience of care
- Transparency, willingness to report data (e.g., chronic care outcomes)
- Use of clinical information systems (e.g., electronic health record, e-prescribing, patient e-mail)
- Chronic care model (e.g., Casalino care management processes)
- Training and education; care team composition

#### Member-facing criteria

- Incentives to members (can be linked to clinician incentives)
  - Pay for HRA to be done

- Pay to accomplish behavior goals (e.g., smoking, weight)
- Pay to select preferred MD
- Pay to achieve chronic care goals

## Issues

Regardless of the contractual criteria we might recommend, a number of difficult implementation issues exist. These should be reviewed in the context of the recommended criteria and might lead to changes in how we view the practicality of the criteria:

- Application to rural areas
- Incentives vs. standards (requirements)
- Incentives for quality performance vs. incentives for system/process adoption
- Incentive design: Withhold vs. bonus
- Perceived value of practice profiling, risk adjusted outcomes?
- Identifying partners (purchasers, payers) willing to use same model, create common incentives
- Which of these strategies can be done without partners, with small penetration of PEBB members into most PCP practices?
- Possible member hostility at being directed to certain practices

## Principles for Primary Care Contracting

At its July 2 meeting, the Technical Advisory raised several critical points:

- Criteria and incentive structures that emphasize choice or recognition of “high-quality” providers are not likely to be effective in much of Oregon where few providers are available – and for most members who currently have strong relationships with their providers.
- The primary care incentives and criteria should support greater “systemness” in practice and delivery system design across all settings.
- Individual physician profiling will not be of high value until data is available that addresses the elements of PEBB’s Vision, so initial contract criteria should encourage adoption of the necessary infrastructure. Member choice or competition among primary care providers as a driver of change will be two to four years away, pending the availability of relevant data.
- The attributes of the “medical home” are important to adults as well as children, and should be supported in the criteria list.

- The criteria should encourage primary care providers to solicit and respect patient values and preferences, recognizing that patient values are not always aligned with the standards of evidence-based practice. The criteria should begin with an expectation of evidence-based care, but accommodate patient preferences. This dimension should be reflected in:
  - Greater use of shared decision-making tools
  - Measurement of and reward for achieving good health outcomes as defined by the patient, including functioning, quality of life, self-care ability.
- Measurement and reporting of a small set of high-value care processes can be reasonably achieved across most primary care settings.
- Use of interoperable clinical information technology is essential to many of the changes PEBB seeks, including evidence-based practice, better patient-provider communication, and quality reporting, and should be encouraged across all settings.
- The proposed criteria are appropriate to use in contracting but the challenge will be in devising a program that encourages their adoption across a variety of settings, cultures, and geography.

### **Proposed Approach**

This approach recognizes that primary care is now delivered through many mechanisms, ranging from large integrated group practice (e.g., Kaiser) to small group practice (e.g., Greenfield) and solo practice in much of rural Oregon. We also understand that each practice is at a different starting point and will make its own progress towards the key attributes PEBB seeks to encourage – such as use of EMR, the chronic care model, and evidence-based care. PEBB can recognize practices that are taking steps towards improved care, reward them financially, and provide them with a few tools to support their improvement. Conceptually, this approach classifies each of the primary criteria into one of three categories:

- Core competency – expected of all primary care providers serving PEBB members
- Patient-centeredness
- System-ness

We understand that small practices, for example, will find it harder to achieve “systemness” than large group practices with substantial infrastructure and diverse professional staff. But we would expect them to perform well on patient-centeredness

while they continue to explore partnerships and care designs that help them achieve the attributes of “systemness.”

PEBB can also establish transparency to the members and the public. Transparency to the member should not only include reporting of quality measures and structural characteristics of primary care practices, but also engaging members in the use of assessment and educational tools, particularly those that involve close coordination between patient and primary care provider.

This approach also borrows from the General Medical Contract in the U.K. both the notion of creating a fluid scoring system to capture improvement and the idea of providing financial rewards for “aspiration” as well as achievement, i.e., for moving from a baseline score to an improved score year by year, rather than checking off static requirements.

These criteria and this scoring approach can be used in several ways:

1. For rating and selecting providers (or networks) for contracting
2. For providing member incentives for selecting higher-performing practices within a large network
3. For providing differential payment incentives to providers within a large network
4. As an educational strategy, to establish provider understanding of PEBB’s goals and emerging requirements.

In the short term, PEBB could use this approach to design an RFI to be issued to plans, IPAs, or individual practices that want to rate themselves on these criteria – essentially simulating their current score.

If used as a payment system, PEBB could invite contracted provider networks (or individual practices) to rate themselves at the beginning of the contract (beginning of Year 1) and to propose a target score for Year 2, then make both “aspiration” and “achievement” payments during each of the first three years.

This draft model assumes that PEBB has made several key resources available, such as HealthDialogue and the WebMD Health Quotients. PEBB would also need to specify the various process measures and patient satisfaction survey instruments.

The weights illustrated below could be adjusted over time. Initially, the weights might put greater emphasis on achieving the core but gradually be changed to favor outcomes reporting and outcomes improvements.

**Sample Weighted Criteria Set for Primary Care Selection and Rewards**

	Phase of Primary Care development	Structure, Process, Outcome	Incentive points	Units
Electronic medical record	Core	s		100 per MD
Provides patient access to EMR/PHR	Pt centered	s		50 per MD
Offers secure email with patients	Pt centered	s		50 Per MD
E-prescribing	Core	s		50 per MD
<b>Reports</b> selected process measures for entire panel (e.g., screenings, immunizations, diabetes process measures)	Core	p		100 Per MD
<b>Reports</b> enhanced measures for target populations (e.g., Bridges to Excellence outcomes – BP control, lipid control, HbA1c control)	System	o		100 Per MD
<b>Achieves</b> BTE target values for PEBB members with diabetes, heart disease	System	o		10 Per patient
Can demonstrate <b>positive change</b> in BTE standards per patient, 1 year	System	o		20 Per patient
Can document completed HRA with patient	Core	p		10 Per patient
Can document health risk behavior plan with patient	Pt centered	p		10 Per patient
Refers patients to HealthDialogue portal where appropriate	System	p		10 per patient
Refers patients to WebMD HRA where appropriate	System	p		10 per patient
Refers patients to patient coaching tool (CYC, Subimo, Nexcura) for selected conditions	System	p		10 per patient
Conducts patient satisfaction survey to entire panel & reports results	Pt centered	o		100 Per MD
Has completed ACIC chronic care improvement self-assessment tool (from Ed Wagner’s group)	System	s		100 per MD

## **Stakeholder Feedback – August 4, 2004**

### **Key participant observations - *overall approach***

- Make sure there is sound evidence to support each criterion; e.g., health risk assessment
- Make sure each criterion can be realistically assessed
- Test each criterion for possible unanticipated consequences
- Avoid one-size-fits-all solutions; identify “basic rules,” allow local models, different parallel rural and urban pilots
- Focus on selected conditions likely to stimulate clinical behavior change

### **Key participant observations - *member-oriented***

- Develop and communicate a better understanding of PEBB members: risks, needs, demographics
- Make sure criteria reflect needs and capabilities of PEBB members (e.g., connectivity)
- Member expectations, preferences, and “entitlement” are barriers to providing evidence-based medical care
- Need to align patient incentives with provider incentives

### **Key participant observations - *system-oriented***

- Technology - especially EMR – state-of-the-art still evolving; don't focus on technology, per se, but on desired outcomes
- Add criteria on outpatient credentialing, patient safety (e.g. medication management)
- Understand and leverage the existing experience and infrastructure in the marketplace, including delivery systems, OHP plans and providers
- Make the RFI or RFP simple and minimally burdensome

## Specialty Medical Care and Hospital Care

### Board criteria

In May 2004, the PEBB Board identified its most important purchasing criteria with regard to **specialty medical care**:

- Adhere to evidence where available
- Outcomes reporting
- Follow volume guidelines
- Board certification, recertification

With regard to **Hospital care**, the Board highlighted:

- Electronic medical record and CPOE
- Error reporting
- Patient satisfaction: compassion, caring, communication, customer service
- Voluntary hospital reporting system
- CMS Pay for performance
- Deploy systems to reduce risk of future errors

The Board recognizes several challenging issues in these areas:

- Only a few Oregon communities have multiple hospitals (Portland, Eugene, Medford) so “hospital choice” or market share is not a significant driver in much of the state.
- Community norms, including the value of protecting local hospitals and collegial referral patterns, make it difficult or unwise to export many cases away from community hospitals.
- Hospitals provide critical infrastructure for procedures and acute medical care, but specialists often control the quality and utilization of services provided in hospitals. The relationship between specialty practice and hospital services is close and complex in many specialties.
- Selection of specialists is often determined by physician referrals and local knowledge of subspecialty expertise.
- The criteria for specialist and hospital quality may be more straightforward than the contracting approaches available to PEBB for implementing these criteria.

## Possible structures

Given the issues mentioned above and the relatively low hospital utilization patterns of the (under 65) PEBB membership, a few implementation options appear to exist:

- Second opinion or prior authorization of selected procedures
- Use of “triage” centers for selected conditions or procedures
- Centers of excellence or tiered network: differential incentives for use of higher quality programs for selected procedures
- Provider recognition: “gold star” recognition for providers or institutions that adopt desired systems or practices (without differential payment)
- More stringent certification criteria for some specialties, tied to network availability or differential payment
- Bundled payment: pay for complete episode of care regardless of service mix
- Outcomes payment: pay differentially for good and bad outcomes for selected procedures
- Transparency: require carriers to collect and disclose specialist and hospital performance and volume data
- Assertive consumer education and use of decision-support tools for selected conditions or procedures

## Potential criteria

### Specialists

- Board certification
- Recertification (“maintenance of certification”)
- For procedures, above appropriate volume threshold
- Participates in appropriate outcomes registry

### Hospitals

- CPOE adoption (Leapfrog reported)
- Intensivist use (Leapfrog reported)
- Meets volume targets (Leapfrog reported)
- Reports (voluntarily) to Leapfrog
- Participates in CMS voluntary hospital reporting
- Scores in top 10% or top 50% on CMS measures
- Collects and reports H-CAHPS survey data
- Scores above targets on selected H-CAHPS items
- Participates in selected registry programs
- Participates in patient safety programs

## Treatments

- Identify “top ten” conditions or procedures for attention
- Require (or reward) use of patient decision-support tools
- Require (or reward) second opinion review
- Require prior authorization
- Require (or reward) review by “triage” center (e.g., back clinic)

## **TAC Recommendations**

### *General*

- Information sharing should be PEBB’s principal tool to encourage quality hospital and specialty care. PEBB and its vendors should increase the availability of information on outcomes, volumes, and practice variations, and offer decision-support tools and second opinion services to assist patients and doctors in making appropriate decisions. ***Use incentives to encourage use of information tools – not to direct care to particular providers.***
- Financial incentives for particular preferred providers are too heavy handed in this setting – will alienate members, will alienate most physicians and hospitals, may not be justified given what we know about quality. As more information about specialty and hospital performance becomes available, financial incentives could be introduced. The committee encourages use of incentives to discourage inappropriate care, but not to direct care among providers when the treatment is clearly indicated.
- Be wary of over-emphasis on volume based decisions, don’t want to encourage people do just do procedures to qualify, regardless of appropriateness.

### *Specialty care*

- Use patient information tools as a vital “bridge” in the referral process – a way to slow down the rush to intervene and allow patient to fully understand implications, choices.
- Identify “top ten” problems – based on variation, cost, risk – and provide information tools that increase likelihood of better care:
  - Shared decision-making
  - Information on outcomes, volumes, provider qualification
  - Second opinion service
  - Waive co-pays or otherwise provide incentive to use information tools, not for particular decision

- Explore more stringent provider credentialing or maintenance of certification in target areas, including financial penalty for obtaining care from non-certified (KP lowers salaries of non-recertified)
- Encourage more active clinical communication between specialists and primary care doctors, such as email transmission of consulting reports.

### *Hospitals*

- Recognize participation in Leapfrog and other reporting initiatives
- Implement CMS pay for performance model (0.4% withhold) in Oregon contracts
- Recognize hospital transparency by use of standardized patient surveys
- In target areas, reward participation in national outcomes registries (heart, neonatal, orthopedics, cancer)
- Recognize participation in Oregon Patient Safety reporting system

### **Conditions to consider for the “top ten” hospital/specialty care topics**

1. Low back pain, including laminectomy
2. Maternity, including c-section
3. Cardiac cath/angioplasty/CABG
4. Prostatectomy
5. Cholecystectomy (gall bladder removal)
6. Tonsillectomy
7. Myringotomy (ear tubes)
8. Knee arthroscopy
9. Hysterectomy

*Note: this list should be refined based on empirical data on PEBB members' utilization experience. The list will reflect actual experience, evidence about supply- and preference-based variation, and practical opportunities to influence decisionmaking.*

### **Sample implementation program**

These elements could be implemented by a health plan or IPA which is entering into contracts with hospitals and specialists. The details of those terms, such as withholds vs. bonuses, the differential distribution of revenue, and the amounts of bonus payments should be determined by the vendor providing services to PEBB as part of the competitive bid process. Administration of these information and

incentive approaches could be outsourced to a third party or performed by the carrier or IPA.

### ***Specialists***

1. Distribute **volume data** for selected procedures (angioplasty, CABG, cancer surgery, orthopedic surgery) to both referring physicians and members.
2. Provide incentive to physician for **maintenance of certification** in identified specialties.
3. Provide incentive to patient for using **shared decision-making** tool for selected conditions
4. Provide incentive to patient for seeking **second opinion** prior to agreeing to selected treatments (e.g., [www.elevelandclinic.org](http://www.elevelandclinic.org)).

### ***Hospitals***

1. Distribute **volume and outcome data** for selected procedures.
2. Provide incentive to hospital for annual reporting on **Leapfrog measures**
3. Provide incentive for participation in **national and regional outcomes registries**
4. Withhold proportion of hospital payment to parallel **CMS pay-for-performance** model
5. Withhold proportion of hospital payment contingent on collection and publication of **H-CAHPS survey data**
6. Withhold proportion of hospital payment contingent on submission of data to **Oregon Patient Safety Commission**

### ***Member***

1. Member education and incentive program to increase use of **decision-support tools**, including second opinion program and shared decision-making program
2. Member education program **regarding performance of hospitals** and specialists, including volume data, outcomes, survey results, participation in preferred hospital programs

## Stakeholder feedback

### Key participant observations - *overall approach*

- Benefit design needs to *precede* requirements and incentives for provider reporting
- These are good ideas but will only lead to very slow changes in system performance and no short-term effect on prices charged to PEBB
- Good for PEBB to support and piggy-back on parallel national efforts, like CMS, in support of creating systems that are ultimately necessary
- Should consider more use of NQF 30 “safe practices”

### Key participant observations - *about reporting*

- Obtain volume and performance data from third-parties (CMS, OAHHS) rather than by adding burden
- Making provider comparisons and quality reports public is risky and wrong, and can harm low volume providers
- Risk adjustment methods are not good enough to justify any outcomes-based payment
- Physicians will be fearful and unwilling to disclose key performance information and plans won't fight them
- Publishing volume data only is unwise, can be misleading (e.g., Redding CABG program)
- Avoid rigid thresholds - like Leapfrog's “meet” vs. “does not meet” criteria

### Key participant observations - *about focusing on “top ten”*

- Consider a *larger* number of conditions, as OHP plans already have worked up protocols for many Consider diagnostic testing and medications among “top ten” targets
- Consider listing conditions among the “top ten,” not just procedures

**Key participant observations - *about incentives and financing***

- Few providers or systems have sufficient capital to build the systems needed to generate these reports; up-front financing options should be part of the design
- Provide incentive for physicians to meet evidence-based standards - such as showing that each cardiac cath is indicated by objective data
- Make quality reporting a contractual requirement - not something triggered by incentives
- Consider paying a fixed capitation amount for total number of patients seen, as a way to create initial capital for system investments

**Key participant observations - *about other criteria***

- Member education programs will not have much traction without substantial financial incentives
- Virtually all physicians are already board certified and maintain certification routinely - usually linked to doing sufficient volume, too
- Consider shared decision-making tools for emergency department visits (70% unnecessary)
- Consider "back school" model for discretionary procedures, including back and prostate surgery, breast cancer
- Allow surgeons to "graduate" from second opinion requirement based on demonstrated practice standards

## Prescription drug benefits

### Board criteria

In May 2004, the PEBB Board indicated its interest in providing services that:

- Increase use of appropriate generics
- Increase member appreciation of evidence-based medicine
- Encourage use of most effective drug at the best price
- Increase member knowledge and understanding about medication effectiveness
- Reduce medication errors
- Ensure that adherence issues are addressed
- Encourage shift towards e-prescribing.

#### Current prescription drug arrangements

Both Kaiser Permanente and Regence Blue Cross provide prescription drug coverage as part of their overall medical benefits contract with PEBB. PEBB uses a three-tier formulary structure, with copayments at \$10, \$15, and \$25 for generic, preferred, and non-preferred drugs, respectively.

### Models to consider

In keeping with PEBB's Vision 2007, the Board has expressed strong interest in benefit designs which favor use of medications based on scientific evidence, and which use reference pricing to encourage selection of the lowest price comparable drug. Patients are required to pay the differential between the reference drug and any equivalent prescribed product. This approach has been the subject of a detailed analysis by Aon Consulting. Immediate issues for PEBB include whether to self-insure and implement such a program directly or to seek a PBM interested in administering the program and bearing financial risk.

The proposed reference pricing strategy is expected to lead to more frequent use of medications supported by the scientific evidence, and higher levels of consumer sensitivity to prescribing decisions and cost.

Several other important dimensions of high quality medication management are not likely to be addressed with the reference pricing strategy alone, however. Other techniques or programs may be needed to achieve improved health outcomes and long-term delivery system improvements.

The common quality problems with contemporary medication management include:

- High rates of inappropriate dosing, such as finding fewer than ½ of CHF patients were receiving adequate daily dose (Roe 1999)
- An estimated 25% error rate in routine dispensing – most commonly errors in product labeling (Allan 1995)
- Approximately 25% of outpatients experiencing adverse drug events, often unreported and uncorrected, but leading to increased non-adherence and some serious, negative outcomes (Gandhi 2003)
- An estimated 25-40% non-adherence rate, associated with high proportions of ineffective treatment (e.g., cholesterol or hypertension management) (Avorn 1998)
- High rates of failure to achieve desired clinical outcome, such as an estimated 15% success rate at sustained cholesterol lowering (Majumdar 1999)

As with the purchase of medical benefits, PEBB may fail to achieve its goals if it simply adjusts how it purchases individual services or product units. Achieving the “Vision” in this area also requires a re-examination of the entire system of care. PEBB can review its medication program along a complete continuum, from the initial prescription to the achievement of a desired outcome. For example, PEBB should assure that its suppliers can assure quality at each step of the medication management continuum:

- The initial prescription
- Any adjustments to the prescription (based on formulary, cost, drug interactions, etc.)
- Dispensing
- Self-administration
- Dosing and product adjustments
- Adherence
- Outcomes

The physicians and pharmacy vendors who influence these decisions should be subject to purchasing criteria, requirements, or incentives to increase the chance of success at each decision point. Some of the relevant concerns and quality strategies are noted below.

## Criteria

### Initial prescription:

- Is the prescriber aware of all other medications being taken by the patient?
- Is the appropriate prescription written, at the therapeutic dosage?
- Is the prescriber aware of any relevant allergies or previous problems?
- Are other prescribers informed of new prescriptions being issued?
- Is the initial prescription checked by an automated system for possible drug-drug interactions, drug-age interactions, or dosing errors?

#### *Common strategies:*

- Encourage use of e-prescribing
- Encourage use of electronic medical record, with interface to prescribing system
- Develop and provide access to complete medication list
- Implement clinical alerts and corrections system

### Adjustments to initial prescription:

- Are possible interactions or allergies reported to the pharmacist and prescriber?
- Does patient understand and have opportunity to participate in drug selection (especially regarding costs and benefits of alternative medicines)?

#### *Common strategies:*

- Two-way e-prescribing
- Formulary decision-support tools at point of dispensing
- PBM alerts systems and summary reporting

### Dispensing:

- Is the prescription filled as intended by the prescriber?
- Is the dispensed product labelled accurately?
- Does the patient understand proper use of the medication?
- Is the medication made available to the patient quickly and conveniently?
- Are refills handled promptly, conveniently and accurately?

#### *Common strategies:*

- Robotic dispensing systems
- Routine quality audits for dispensing error rates
- Pharmacist counseling and follow-up
- Web support for prescribed medications
- Flexible retail pharmacy hours, good service, mail order, on-line ordering

### Dose and product adjustments

- Is the prescriber aware of any adverse events, side effects, or non-adherence?
- Is the PCP aware of all medications and disease management programs?

#### *Common strategies:*

- Nurse follow-up with patients
- Personal health records
- Secure e-mail exchange
- Consolidated electronic medical record
- Disease management programs

### Adherence

- Is the patient using the medication consistently at a therapeutic level?
- Is the prescriber aware of any reasons for non-adherence (i.e., costs, side-effects, drug interactions, inconvenience)?
- Is the prescriber taking action to encourage adherence?

#### *Common strategies:*

- PBM or DM adherence programs
- Claims monitoring programs

### Outcomes

- Is the prescriber (or payer) aware of patient outcomes?
- Are positive outcomes recognized and rewarded?
- Are unsuccessful outcomes addressed and corrected?

#### *Common strategies:*

- Outcomes research studies and audits
- Personal health records
- Disease registries

## **Issues**

Adoption of an evidence-based and reference-priced model may help address some of these challenges but may compound some.

- Based on national data, PEBB is probably spending a high proportion of its drug outlay without achieving the therapeutic objectives. A benefit design that provides patients a less-expensive, comparable product is not likely to address errors, non-adherence, and therapeutic ineffectiveness. It may lead to modest increases in non-adherence and complications. (Tamblyn 2003; Goldman 2004)
- Prescribers may now be operating without adequate clinical information at the time of prescribing. They often do not know what drugs the patient is actually

taking or whether relevant allergies exist. They may not have current information about recommended dosing for this patient type or situation.

- Prescribers have no means of monitoring the outcomes, adherence, or problems associated with prescribed drugs and patients are often unwilling to report on their own initiative.
- The prescribing and dispensing infrastructure is poorly coordinated and generally not well integrated with the larger system of care. Ideally, the medication management process would be tied to the primary care and medical home environment and be supported by sufficient information to optimize outcomes.

### **Approaches to consider**

1. Contract with pharmacy benefits manager with requirements or incentives to address critical outcomes, such as alerts, dispensing errors, adherence, and outcomes.
2. Establish information infrastructure to permit close monitoring of medication pathway by primary care physician and establish incentives for successful medication management by PCP.
3. Examine “pharmaceutical care” model, common in Europe, to charge community pharmacists with larger responsibility for care coordination, medication management, and chronic disease management.
4. Identify disease management program for selected conditions and require close collaboration between PBM and DM programs with operational and outcomes reporting.

### **TAC comments on prescription drug proposal**

On September 7, the Technical Advisory Committee reviewed both the Aon report on implementing an evidence-based, reference-priced drug program and the FACCT memo on quality issues in medication management. There was general agreement with PEBB’s direction. The TAC also offered several strategic and cautionary comments regarding implementation of this direction. For the purposes of Board discussion, we have left the original prescription drug memo intact and summarize the TAC comments here.

#### **1. Reference-priced, evidence-based drug benefit**

- **Overall recommendation:** TAC supports this model and advises PEBB to make sure it is implemented with a system for legitimate alternatives, strong provider feedback systems, and strong member education.

- Strict adherence to reference pricing is too restrictive in practice. There are many drug classes where the prescriber should legitimately recommend a specific, higher-priced drug and not penalize the patient.
- Some Medicaid plans address these appropriate variances with a second prescription pad, which provides space for documenting the indications justifying the non-conforming prescription at the reference price.
- A strength of this model is that all drugs are “covered” but cost-share varies depending on evidence-base. No member is deprived of access to desired or recommended medications.
- Member education will be crucial, even for members to understand that there are multiple, appropriate medications and that they should participate in the choice among them.

#### Feedback systems

- To alter prescribers’ behavior, regular feedback about their drug prescribing practices is essential – more important than cost-sharing, prior authorization, or education alone.
- It is vital to give the prescriber tools that direct clinicians to “do the right thing.”

#### Tactical focus

- TAC members agreed that PEBB should focus on a limited number of drug classes and build the system out from these. Even one or two drugs subject to a coordinated program in year one would be a strong start. Kaiser has a “target drug program” that has been successful; it will share the list with PEBB.

#### Implementation

- PEBB should engage one statewide prescription drug plan vendor (possible exception for Kaiser) to implement this new and complex approach. PEBB should begin discussions with PBMs soon to explore capabilities and interest.
- Make sure that system is not overly restrictive and that it does permit continuous learning. One advantage of starting with just a few drug classes will be allowing PEBB to learn about various effects of this approach without encumbering the entire drug benefit. It may be that the provider feedback system will be equally effective; try to design implementation to allow comparison of different approaches to drug management.

## 2. Quality requirements in a prescription drug plan

- **Overall recommendation:** PEBB should conduct dedicated pilots to improve quality of prescribing, adherence, and outcomes. Relying only on plan design is not likely to achieve quality objectives. Pilots could include:
  - e-prescribing and on-line medication lists
  - pharmaceutical care (community pharmacy)
  - adherence incentives
- Primary care doctors often do not have all of the information they need to make sound prescribing decisions. PEBB should help stimulate improvements in the information systems. The eMPOWERx program in Florida Medicaid (3,000 MDs) is a good model for pushing all necessary drug information to the point of care.
- The consolidated medication list needs to be available in real time to prescribers, members, and family caregivers.
- Effective use of medications should be integrated into primary care and the chronic care model. The Asheville, NC public employee model, relying on pharmaceutical care in the community, should be considered or conducted as pilot.
- Mail order provides safer dispensing practice than community pharmacy. Plan design should include incentives for members to use mail order pharmacies.
- Adherence is an enormous problem but requires coordination across continuum of time and providers. PEBB should create a specific, shared-incentive program to experiment with improved adherence (similar to Bridges to excellence model).

## Stakeholder Feedback

### Key participant observations - overall approach

- Evidence-based formulary is sound
- Reference-pricing is logical and attractive but unfamiliar, unpredictable
- Information tools at point of care are essential
- Quality pilots are important:
  - e-prescribing in small community
  - clinical pharmacists more involved in care management
  - shared incentives to increase adherence

### Key participant observations - about formulary design

- Current formularies very similar to proposed OHSU evidence-based list
- Need movement towards one community-wide formulary; there is wide agreement on evidence base; PEBB should assemble partners
- General agreement on evidence, but pricing dictates ultimate formulary design in reality

### Key participant observations - about reference pricing

- Current tiered cost differentials are not wide enough to materially change patient behavior
- Member cost-sharing based on co-insurance model, with caps, would be effective way to make members more cost-sensitive
- Adjust member cost-sharing so co-insurance (or copay) is highest on me-too drugs where there are not significant clinical differences
- Be cautious with reference pricing: we don't know how it will affect behavior compared to three-tier and it could reduce productive competition

### Key participant observations - about implementation

- General agreement that reference-pricing model can be implemented very quickly
- Select drug classes for implementation based on high cost, high utilization; anti-depressants and anti-psychotics, for example, could be included
- Single PBM carve-out may have advantage of efficient, consistent administration but disadvantage of sub-optimization, shifting burden to providers and others, and lack of local input and buy-in
- If PEBB permits multiple PBMs to operate, they must agree to a collaborative formulary development process and transparency

**Key participant observations - about information technology**

- Critical to help provider at point of prescribing
- EMR with evidence-based formulary makes it easy for prescriber to do the right thing
- Kaiser model generally admired: 70% generics, EMR displays if proposed drug is on formulary, alternatives ranked by safety, evidence, and cost; series of intelligent prompts to guide selection of non-preferred drugs; if criteria are satisfied, system waives co-pay – all automatic

**Key participant observations - about e-prescribing**

- Very important strategy, but much of the benefit comes from simply touching the formulary, sharing cost information, and eliminating handwriting; e.g., even use of a handheld device to transmit rx via fax without electronic transmission or return feedback from pharmacy is valuable
- Worthwhile to do modest pilot in a community with widespread EMR and cooperative community pharmacies

**Key participant observations - about quality pilots**

- Pharmaceutical care: general support for expanded role for clinical pharmacist, such as Asheville model; some plans have had disappointing pilot projects due to low pharmacist participation
- Shared incentives: promising area but focus on high-risk population, like post-AMI, depression; waive co-pays or provide other incentives for achieving outcomes; financial incentive must be substantial to affect behavior; allow long enough time frame to measure results

**Key participant observations - other comments**

- Don't pursue strategy that puts doctor in adversarial position to patient; e.g., rejecting patient requests for particular medications
- Consider international purchasing to reduce PEBB costs
- Provider feedback is valuable to help providers think about populations, rather than one patient at a time

## Behavioral health benefits

### Board criteria

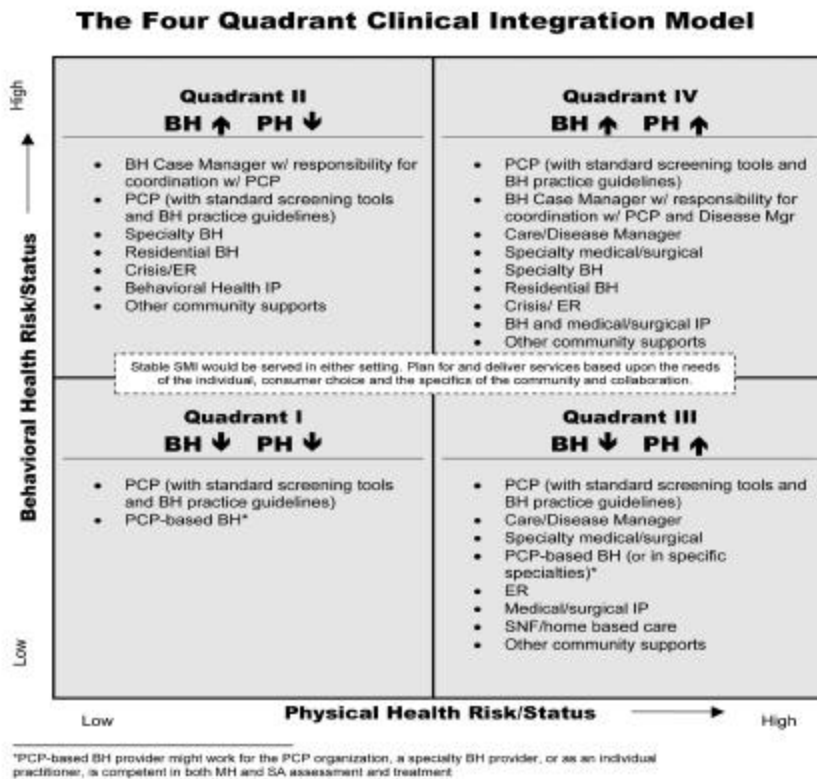
In May 2004, the PEBB Board offered its guidance regarding the most important criteria – broadly stated – in each category. With regard to behavioral health, the Board indicated its interest in providing services that:

- Increase use of evidence-based practices
- Demonstrate effectiveness at improving outcomes and reducing lost work time
- Provide PEBB with information about outcomes and value
- Justify high use of anti-depressant medication, particularly by primary care providers
- Allows PEBB to interpret shifts in cost and utilization (e.g., does 20% increase in pediatric drugs produce better children's mental health?)

#### **Current behavioral health arrangements**

Both Kaiser Permanente and Regence Blue Cross provide mental health coverage within their medical benefit program and provide benefits at a parity level with medical coverage. Regence provides behavioral health services through a contract with Reliant Behavioral Health. PEBB employees have a full parity benefit for outpatient and inpatient mental health and chemical dependency services. Residential care for **mental health diagnoses** is limited to a 45-day maximum per year. PEBB employee residential care benefit for chemical dependency is not subject to a limitation. Reliant provides Regence with utilization management services, including treatment plan review and preauthorization for residential or inpatient care.

**Model to consider: primary care integration**



The four-quadrant model depicted above provides a useful framework for considering the degree of integration needed between primary care and behavioral health specialty care. The horizontal axis indicates people at increasing risk or impairment on the physical health spectrum; the vertical axis indicates increasing risk on the behavioral health spectrum. The lower two quadrants (I and III) signify people with low or moderate behavioral health severity, who are likely to receive most of their mental health care under the auspices of their primary care physician. In both cases, primary care can be enhanced by the availability of behavioral health specialty care and consultation, either on-site or through a convenient service provider.

The upper two quadrants (II and IV) generally indicate a degree of mental health severity that can not be adequately addressed in the primary care setting. For such patients, an effective assessment and referral linkage is critical.

In all cases, an opportunity exists to provide continuity between primary care and behavioral health services – from assessment to referral to follow-up. Most PEBB clients are likely to need services in the lower two – primary care – quadrants, and the design challenge is twofold – to improve the training and tools available to the

PCP and to ensure that adequate specialty consultation is conveniently and appropriately available.

## Criteria

The contractual criteria necessary to achieve integration between primary care and behavioral health must operate in both settings. Some criteria should be included in primary care contracts, to improve capacity and performance in that setting; others should be included in any behavioral health carve-outs or subcontracts, to ensure that adequate support is available to the primary care network.

### Primary care

**Goal:** universal screening of new adult patients (or periodic screening of established patients) for depression and anxiety disorders, using the PHQ-9 (based on the Prime-MD).

Criterion: proportion of new patients screened

**Goal:** targeted screening of high-risk populations, including post-partum mothers and young adults and teens

Criterion: proportion of target populations screened

**Goal:** demonstrate appropriate follow-up for patients screened positive

Criterion: percentage of positively screened patients seen for follow-up visit between 4 and 8 weeks

**Goal:** demonstrate improved depression outcomes in primary care setting

Criterion: Documented PHQ-9 score at six months following positive screen. Number of patients initially screened positive with 50% reduction in PHQ-9 score at six months.

**Goal:** early detection of substance use disorders

Criterion: Proportion of new patients screened with CAGE instrument:

C - Have you ever thought you should **CUT DOWN** on your drinking?

A - Have you ever felt **ANNOYED** by others' criticism of your drinking?

G - Have you ever felt **GUILTY** about your drinking?

E - Do you have a morning **EYE OPENER**?

Two or more positive answers indicate a positive risk for alcohol misuse.

### Behavioral health specialty care

**Goal:** Demonstrate adoption of evidence-based practices

Criterion: Document use of the six SAMHSA recommended practices (medication management, illness management and recovery, supported employment, family psychoeducation, assertive community treatment, integrated dual disorders treatment ([www.mentalhealthpractices.org](http://www.mentalhealthpractices.org))).

**Goal:** Provide appropriate specialty consultation to primary care network.

Criterion: Availability of appropriately trained clinical specialist by phone or co-location with primary care providers.

### **Approaches to consider**

Ideally, the behavioral health provider will recognize its responsibility to train and support the primary care network, which is frequently the front-line service provider for behavioral health issues. The behavioral health and primary care networks should work together to screen, assess, treat, and refer appropriate patients, and be capable of reporting health outcomes.

In reality, this desired integration will take some time to achieve. We recommend a staged approach, with initial emphasis on increasing screening and treatment. In broad terms:

- Year One: Increase screening for depression, anxiety disorders, alcohol use
- Year Two: Document use of evidence-based treatment practices for selected conditions (probably depression)
- Year Three: Document outcomes achieved for screened population

For Year One, the desired infrastructure would include:

- Increased adoption of electronic medical records and related patient registries
- Training of PCPs in behavioral health screening and referral
- Provision of paper or digital tools to help PCPs conduct screening
- Co-location of behavioral health specialists in larger PCP practices
- Provision of telephone consultation by clinical specialists to assist PCPs
- Training of PCPs in evidence-based practices, including Texas Medication Algorithms (see example below)

## Stakeholder Feedback

### **Key participant observations - *behavioral health***

- Co-located behavioral health specialist raises challenges:
  - Only covered by some plans
  - Some key tasks not reimbursable
  - Builds private practice rather than “on the team”
- Could make better use of on-line HRA to identify people at risk
- Could use telemedicine programs to reach members in rural areas

### **Key participant observations - *behavioral health***

- Access to mental health providers may be a problem, esp. child psychiatry, some communities
- Navigating mental health system very hard for most members; EAP program can be key entry point
- Need to reallocate payment system: less for individual psychotherapy, more for assessment, monitoring, other provider types
- Initial screening (e.g., PHQ-9) can be burdensome for busy PCPs; need appropriate technology (Kaiser device) or staff redeployment

### **Key participant observations - *behavioral health in primary care***

- Screening with PHQ-9 too expensive to apply to every patient
- Focus on some populations: coronary disease, other chronic illness

### **Key participant observations - *behavioral health specialty care***

- Not all SAMHSA “best practices” apply in the commercial population
- Requiring best practices could be expensive for providers to implement
- Skills for co-located (or telephone access) behavioral health specialist are not common; needs to fit in to primary care team
- Reference-priced formulary potentially dangerous in mental health care, where fitting the drug to the patient is complicated

## Wellness services

### Board criteria

In May 2004, the PEBB Board offered its guidance regarding the most important criteria – broadly stated – in each category. With regard to wellness, the Board indicated its interest in providing services that:

- Reached a substantial number of members
- Affects how members understand and reduce their health risks
- Inform PEBB leadership about the prevalence of various risks across the membership and identifies opportunities for intervention
- Address specific behaviors, including exercise, nutrition, smoking, stress, obesity, and informed consumerism
- Goes beyond primary care, where episodic model reduces effectiveness of lifestyle change efforts
- Uses non-traditional approaches to encourage wellness, including yoga, massage, eastern medicine

#### **Current wellness services**

PEBB has made a significant commitment to health risk assessment tools, now offered through WebMD and directly by Kaiser. Utilization has been modest but continues to increase. PEBB does not have evidence regarding the influence of the HRA in altering its users' behavior. It has also continued to shift the focus of the PEBB health center from being primarily a convenient source of primary care to serving as the hub of a statewide wellness program, including significant outreach across the state. A quarterly "Living Well" newsletter appears to be well received. The PEBB Board has maintained strong interest in the wellness and prevention approach, and has begun to fold chronic disease management and self-care education into this overall program strategy.

### **Model to consider: assigning wellness responsibilities across the system**

The committee encouraged the PEBB Board to revisit and restate its objectives for the wellness program, noting that there are many appropriate objectives but that each might require a different strategy and different partners:

- a. To promote a healthy work force,
- b. To support primary care,
- c. To retain employees,

- d. To reduce costs,
- e. other?

The TAC also noted that any part of the current program could stand alone—health center, health screenings, health education, web-based tool, health risk assessment, chronic disease management, library and community resources, pilots for walking and tobacco cessation. The committee recommended that the Board separately evaluate each of three objectives:

- Lifestyle change and greater awareness
- Screenings and preventive medical care
- Programs to affect individual health-related behavior

And that the approach for each of these three objectives be shaped differently for members who appear to have an active working relationship with a primary care doctor than for those who don't. In general, the TAC encourages PEBB to support the primary care physician in coordinating and focusing the patient's attention on these activities while also supplementing the PCPs work and avoiding redundancy. This approach was summarized in the following table:

Member Status	Population & Lifestyle	Screenings & Preventive Care	Individual Behavioral Intervention
have medical home	employee wellness programs	done or managed by PCP	use planned care model, by PCP or through referral to health center
no medical home	employee wellness programs	workplace screenings	use planned care model, through DM program or at health center



Population based, appropriate for worksite wellness programs



Individually targeted, linked to source of routine care

**Role of the Health Center:** The TAC supports the recent shift in the focus of the health center—its earlier use for episodic or acute care undermines the idea of a “medical home” and is not consistent with the challenge of redefining the delivery system. With health center visits and health screenings, the potential exists for duplication or taking the PCP out of the loop – services should augment those provided directly by the PCP. Generally, the TAC encourages PEBB to find a niche for the health center that complements primary care:

- provide community based lifestyle changes to entire PEBB population

- identify members who don't have a medical home and help them establish one – consider using inverse predictive modeling to identify them from utilization data
- concentrate on services not being addressed by medical community: lifestyle changes, moving people to a medical home through screenings, self management, etc.
- provide a resource to primary care providers – particularly for rural and small providers who lack supplementary services from a group practice or IPA – to allow them to write a prescription for customized services to be provided by the health center such as education, pre-disease state interventions, nutritional and exercise counseling, tobacco cessation, diabetic and other chronic disease education, self-management classes, etc.
- link findings and members back to the PCP (through an authorization to share findings with PCP, in much the same way specialists report back to PCP)

The TAC also believes that PEBB could have more impact by selecting a focused campaign each year, rather than attempting to support the broad range of wellness education and programming. It suggests that PEBB select one or two messages for the year, such as a focus on nutrition and physical activity (for everyone), as opposed to obesity (for targeted group).

Finally, the committee made several general suggestions:

- That PEBB seek or develop more evidence in support of community based wellness programs, noting that the most effective of these have been carefully and narrowly designed;
- That PEBB work closely with DAS and individual agencies to gain their support for workplace policy changes that support the wellness objectives;
- That PEBB use incentives to encourage behavior change at all levels: member, provider, vendor
- That PEBB concentrate its own wellness programs on state employees, with dependents welcome but not targeted, in order to take advantage of PEBB's unique opportunity to reach workers on the job
- That PEBB carefully evaluate the effectiveness of the program.

### **Recommended approach**

The TAC recommends adjusting the wellness program to mirror the rows and columns of the matrix outlined above.

The first column (Population and Lifestyle) continues to present opportunities for statewide programs. The TAC recommends a focused campaign approach, such as nutrition and activity, close cooperation with employers and DAS, and an

emphasis on worksite-based programs. Program management could be done by PEBB staff, Health Center staff, or an outside vendor.

The second column (Screenings and Preventive Care) should be handled differently depending on whether the patient has a routine source of care (medical home). If there is evidence that the member is seeing a primary care provider, PEBB should expect (contractually) that risk assessments, screenings, immunizations, and other preventive education should occur in that setting. PEBB should be monitoring performance, rather than supporting a separate infrastructure to deliver services. If the member is not getting routine care, the PEBB wellness program should invite the member to participate in the appropriate wellness activities through the Health Center, web-based tools, or worksite offerings and those resources should attempt to engage the member in a primary care relationship.

The third column (Individual Behavioral Intervention – including smoking cessation, exercise programs, and chronic care self-management support) should be specific to members who qualify and also be implemented differently for members with a medical home than for others. The TAC does not see the current performance of the carrier-based disease management programs as adding significant value and would prefer these responsibilities to be integrated into delivery system contracting. For those with a regular primary care doctor, self-care education, continuous monitoring of health, and adherence to chronic care programs should be managed by the PCP. For those lacking a primary care provider, some of these programs could be offered (or coordinated through existing community programs) by the Health Center.

**Key participant observations - *wellness services***

- ***Incentives*** to members are vital to encourage participation in programs (FSA contributions, tax breaks, benefit design, t-shirts)
- There is no evidence-base supporting use of member incentives; key is risk-sharing with wellness vendors... they need the incentive
- Allow each member to use reserved funds to pay for wellness programs from a menu
- Need state managers to allow release time for wellness activity; leadership from front-line managers is vital; need incentives to the employers

**Key participant observations - *wellness services***

- The more integrated the information, the more likely it will be used; avoid separate EAP program, separate HRA data, separate health plan-sponsored tools
- PEBB health center doing a good job linking to PCPs now
- Existing services (e.g., on-line HRA) could be better linked to PCPs
- PEBB should apply same evidence-based standard to wellness as to medical or drug programs (e.g., support for worksite programs, yoga, massage therapy)
- Self-management skills training just won't happen successfully in PCP office

## Chronic care services

### Board criteria

In May 2004, the PEBB Board offered its guidance regarding the most important criteria – broadly stated – in each category. With regard to chronic care, the Board indicated its interest in providing services that:

- Identified risks early
- Provided effective member education in self-management
- Build upon the current primary care and carrier disease management programs

#### Current chronic care services

PEBB has emphasized chronic care through its publications, risk assessment programs, and asking its two carriers to offer chronic care programs for diabetes, asthma, and heart disease.

### TAC Recommendations

The committee reviewed the preliminary (2001-2002) data from Kaiser and Regence and noted low screening rates, low participation rates, and limited evidence of program effectiveness. It acknowledged that the 2002 results may have been influenced by the high number of newly covered lives at Regence in 2002 and would like to review the 2003 data when it becomes available.

TAC members noted that many chronic disease sufferers experience multiple problems, and DM programs that are organized around individual diseases and not well coordinated with primary care are less likely to be effective. These programs are also impaired by current reimbursement approaches which reward different components – primary care, pharmacy, disease management, specialized clinics – for pushing clinical responsibility and financial risk to the other “silos”.

The TAC notes a natural role differentiation between what PEBB (or a carrier) can uniquely do and what a delivery system can do. PEBB can acquire and integrate data from diverse sources of care: physicians, pharmacies, labs, hospitals, counselors – and identify patients with complex or uncoordinated needs. It can also establish incentives that reward the delivery system for achieving desired outcomes. Contemporary predictive modeling software and related tools can provide a comprehensive perspective that individual providers can not otherwise achieve. The

delivery system can deploy nurses and others to reach out to both patients and health professionals and coordinate care across the network. The TAC would focus PEBB's initial chronic care efforts at prompt and accurate case identification, which guides the work of case managers who coordinate the work of providers and the members themselves.

The committee recognized that individual providers and some delivery systems have trouble absorbing and applying the feedback that can be provided from an external analysis. For that reason, it suggests relatively controlled, staged pilots to determine the most effective mix of roles and strategies.

### **Key participant observations - *chronic care services***

- Appropriate data integration and analysis is very complex; carriers are in good position and have experience to do this well
- American Healthways (with Regence) has techniques to increase participation rates: use sophisticated software to merge lab, rx data to find candidates, recruit them, engage them, outreach through call center
- WebMD able to integrate patient-supplied HRA data, PHR data with claims, rx, lab data and produce customized reminders and alerts to members

## Information services

**Background:** PEBB currently contracts with WebMD to offer a consumer information portal, which includes a variety of health information resources as well as the online health risk assessment. PEBB also receives periodic analytic reports from Aon Consulting, other utilization summaries from Regence Blue Cross, and chronic care profiles from both Regence and Kaiser. In general, the PEBB Board has felt that it does not have ready access to analytic information that could be used to support overall program design, and it questions whether members have access to adequate information to help with their health care decisions.

We note that there are two classes of products that PEBB might use to address both its need for management information and its desire to support member self-care and health system navigation:

1. Management tools
  - 1.1. Predictive modelling
  - 1.2. Custom reports
  - 1.3. Utilization profiles
  - 1.4. Quality profiles
  
2. Member tools
  - 2.1. HRA (e.g., WebMD)
  - 2.2. Health content (WebMD, Mayo, Intellihealth)
  - 2.3. Benefits management
  - 2.4. Provider quality assessment (Healthgrades)
  - 2.5. Provider selection (Geoaccess, Healthgrades)
  - 2.6. Clinical decision support (Subimo, Nexcura)
  - 2.7. Second opinion services (eClevelandClinic)
  - 2.8. Clinical alerts (ActiveHealthManagement)
  - 2.9. Medication management (PBM-sponsored, AHM)
  - 2.10. Provider email communication (RelayHealth)

**General issue:** Should PEBB directly contract with information services companies to help members get health information, navigate the system, or manage their own health? Or should such services be provided by care delivery organizations as they deem appropriate or as PEBB might require in contracts?

**General approach:** The Technical Advisory Committee recommends that:

- PEBB should use its unique position as a data integrator to acquire, integrate and interpret information across the entire span of contracted services.

- PEBB should not offer separate health management tools to members that are unconnected to the delivery system.
- PEBB might provide education to members so that they are better able to search the internet for high quality content.
- PEBB should request more detailed information from WebMD regarding members' use of both the portal as a whole and specific services (e.g., HRA) offered there. The Member Advisory Committee expressed its belief that most people use the WebMD portal as a "starting point" for personal research but did not regard it as comprehensive – and that use of any search engine or consumer portal (e.g., Yahoo, MSN) would be equally effective.

**Recommendation:**

- PEBB should require its 2006 vendors to provide appropriate member education and support tools, both online and in other formats.
- PEBB should require all vendors to provide periodic exports of standardized utilization and, where appropriate, outcomes data.
- Separately, PEBB should contract with a data analytic company or consulting firm to aggregate all program data and provide PEBB with periodic reports. PEBB should evaluate vendors in this category for additional high value services, such as case management reporting, provider outlier analysis, and patient alerts and reminders.

**Public Employees' Benefit Board  
 Technical Advisory Committee Roster  
 MAY TO NOVEMBER 2004**

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