King County Health Reform Initiative

The Health Reform Initiative (HRI) required evaluation and peer review. The following notes are from the August 2010 Final Health Reform Initiative Measurement and Evaluation Report.

The HRI was launched in 2005. HRI has 3 goals: (1) improve the health of employees and their families; (2) reduce the rate of cost increase for health care; and (3) determine whether employee productivity increased as a result of improvements in health. (Third goal was added in 2007)

King County negotiates with 92 bargaining units. "The county and unions started the HRI with an emphasis on improving health behaviors with the intention to change plan design to encourage the use of higher value care and discourage the use of lower value care as shared tools and information on cost and quality became more available."

Health care costs were rising at 3 times the CPI.

5% of all people covered accounted for 58% of costs. Low back pain, cancer, depression, diabetes, coronary artery disease, and asthma were most costly conditions.

High cholesterol and high blood pressure were the most common risk factors.

14% of people covered had five or more chronic conditions. For each chronic condition a person had, the cost of health care doubled.

The evaluation reports notes a study from Edington (University of Michigan) that one of the most important factors in controlling health care costs over time is to keep people from getting worse. A program should aim to keep 75% or more of the population at low risk and keep moderate and high risk people from getting worse.

Some of the growth in health care costs in 2009 may be from a larger than usual number of very high claims before the end of the year because in 2010 benefit plans had higher out-of-pocket expenses and from employees who may have been anticipating a lay-offs in 2010. (Figure 7 shows changes to plan design – and says the changes are expected to reduce projected costs by $37 million from 2010 -2012.)

Increases in health care costs were higher than for other Seattle employer populations. From 2004 to 2009 increased 58% (9.6% per year) Average cost for other employers in Seattle was 41% (7.1% per year).

One of the main reasons for creation of the Puget Sound Health Alliance was to create a single set of provider quality and efficiency measures that would be used by all providers and made available to the public. The Puget Sound Health Alliance also oversees a community health evaluation "community check-up" of the insured population. "The work the Alliance is doing to promote transparency of quality of services by providers, hospitals and health plans:

- Creates public accountability, including for health disparities,
- Sets targets for improvement,
- Stimulates dialogue among providers to complete, and
- Gives consumers more information about the care they need and how providers vary.

The HRI has a Wellness Assessment and an Individual Action Plan component. There are financial incentives for employees and their spouses/domestic partners to complete the assessment and participate in the Individual Action Plans. The participation rates by Eligible Employees and Spouse/Domestic Partners (Figure 11) are:

Year	Number Eligible	% completing wellness assessment	% of wellness assessment takers completing action plans
2006	17,844	90.6%	88.0%
2007	17,772	91.7%	89.5%
2008	17,410	89.3%	92.4%
2009	18,788	89.1%	80.8%

Incentives are structure through three cost structures for health insurance: Bronze (does not take health assessment or participate in action plan), Silver (take health assessment, do not participate in action plan, and Gold (take assessment and participate in action plan).

Figure 18

	Annual Deductible	Co-Insurance	Office Visit Co-Pay	Hospital Co-Pay
GOLD	$100/individual $300/family	10%	$20	$200
SILVER	$300/individual $900/family	20%	$35	$400
BRONZE	$500/individual $1500/family	20%	$50	$600

There is no employee cost share for premium

- From 2006 to 2009, employees and spouses/domestic partners showed improvement in 12 of 14 health-related behaviors and risk factors as measure in the health risk assessment.

- For 2 measures: physical activity and blood glucose the changes were not significant.

- The percentage of people taking the health risk assessment that were categorized as high risk dropped from 4% in 2006 to 34% in 2009.

- Body Mass Index risk dropped from 67.8% in 2006 to 65.4% in 2009.

- Smoking dropped from 10.4% to 6.2% from 2006 to 2009.

- From 2006 to 2009, there was a decline in employees' perception of their supervisor's support for improving health and maintaining healthy lifestyles. Studies show that leadership is key to maintaining a culture of wellness and productivity.

In 2010, funding for the HRI will cost $16.71 per month per person for contribution to the Puget Sound Health Alliance, workplace health promotion, and benefit plan design (Figure 17).

King County estimates that the HRI has saved $26 million when comparing actual cost increases to cost increases that were projected before the HRI was implemented.

There was no reported change in absenteeism.

The report notes four "lessons learned." (attached ©1-2). With regard to lesson #3, about changing reimbursement, the evaluation notes advocates for changing to a value-driven model of healthcare reimbursement that has the following characteristics:

- Paying for someone (ideally the Primary Care Physician) to coordinate all of the various providers and services to help patients avoid unnecessary/preventable services.
- Paying all providers in ways that encourage them to coordinate their services and be more efficient.
- Creating and paying for the information infrastructure that facilitates coordination and use of efficient services.
- Providing education/incentives to patients to allow coordination, adhere to treatment plans, and choose high-value providers and services.
- Creating organizational mechanisms to enable efficient/effective coordination and accountability without creating larger monopoly providers.

Final Health Reform Initiative Measurement & Evaluation Report

Key Findings and Policy Recommendations

Goals

- Improve the health of employees and their families.
- Reduce the rate of cost increase for health care.
- Increase the average number of "healthy hours worked" per employee.

Results/Program Effects

- The Health Reform Initiative has:
  - Improved 12 out of 14 health risk factors in employees.
  - Reduced use of health care for 3 out of 5 key health conditions directly affected by changes in those risk factors.
  - Reduced growth in health care costs. King County and employees spent an estimated $26 million less than expected based on cost trends in place before the Health Reform Initiative was implemented.
  - Maintained the average number of healthy hours worked per employee.
- The Puget Sound Health Alliance is starting to influence quality in the local health care delivery system.

Lessons Learned

1. The county's supply and demand side approaches to containing health care costs was farsighted and still reflects the nation's best thinking on the most effective strategy for moderating cost growth.
2. Moderating health care costs requires both short- and long-term strategies.
   a. Plan design changes that impact health care utilization patterns cut costs in the short term.
   b. Long term, sustained cost savings are achieved through reduction of risk factors and improvement in health.
3. Changing the way medical services are reimbursed is critical to aligning market forces behind the delivery of quality healthcare rather than the amount of services provided.
4. Annual measurement and evaluation reports produce data useful beyond King County, but require program consistency that limits flexibility to respond to changing conditions.
5. Motivating employees to make healthy lifestyle changes and building a culture of wellness requires sustained support, energy and innovation. Employees respond to well-calibrated incentives, removal of barriers and strong communication and education campaigns.

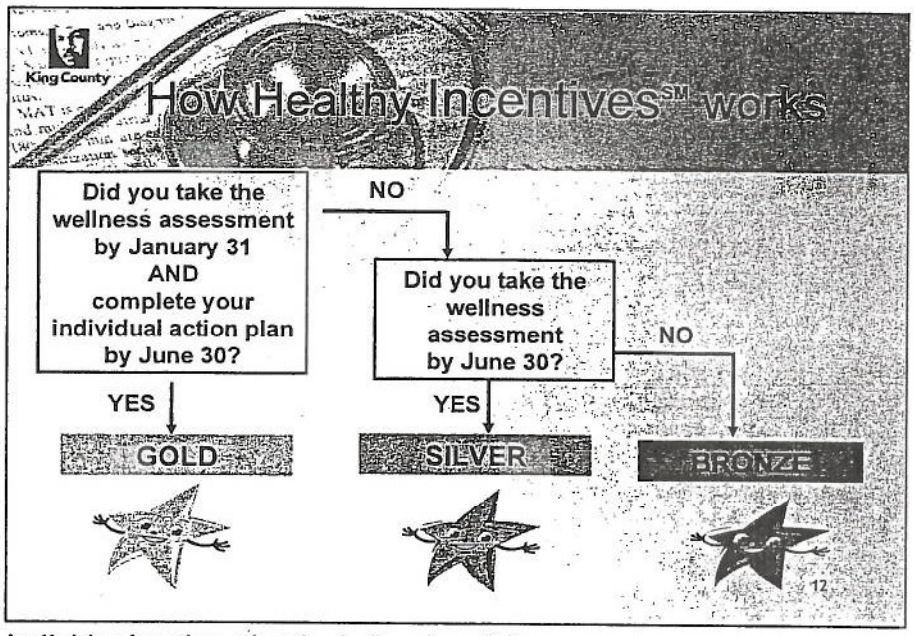
Key Findings and Policy Recommendations continued

Policy Recommendations

1. Transition the HRI to an on-going Employee Health and Well-Being Program responsible for continuing the comprehensive, integrated effort to make a healthier King County workforce comprised of more knowledgeable and conscientious health care consumers, along with a health care system that is more efficient and effective in its delivery of health care.
2. Establish health policy for labor negotiations focused on changing incentives and plan design in ways that reinforce and support employees taking an active role in their health care, and reinforcing improvements in the health care delivery system.
3. Continue active support for and leadership in the Puget Sound Health Alliance whose mission is to create a more efficient, high quality health care delivery system.
4. Integrate the ongoing measurement and evaluation of the Employee Health and Well-Being Program into the Executive's overall performance management process, and shift the Program to become more of a laboratory that uses near-time data to identify emerging opportunities to improve health and manage costs, and quickly design, implement and measure the effect of more situation-specific interventions.
5. Reinvigorate leadership investment in creating a healthy workplace culture. Individual healthy behaviors thrive when change is supported and rewarded.

Figure 20 illustrates the process for earning eligibility for lower out-of-pocket expenses:

Figure 19



In 2007, 2008 and 2009 the program repeats itself – members who take the wellness assessment and participate in an individual action plan to improve their health habits in 2007 will earn lower out-of-pocket expenses in 2008, and so on.

Under the rules negotiated in 2005, participation in an individual action plan is defined as follows:

- Members who are identified as —lowisk" are already engaging in health-related behaviors that are shown to reduce risk of chronic disease—such as eating right, exercising regularly, avoiding tobacco use and managing stress. These members complete eight weeks of logging of their activities related to nutrition or physical activity.

- Members who are identified as being at —moderate" or "high risk" enroll in a telephone-based coaching program for at least 90 days during which they participate in at least three coaching sessions (with follow-up activities between coaching sessions). Members are encouraged to continue participation for up to six months for moderate risk and 12 months for high-risk members.

It is essential to note that earning the lowest out-of-pocket expense levels is based on participation, not the achievement of a specific health status or outcome. The goal is foster success in making significant, life-long changes in health-related behavior.

Appendix C

Supportive Environment Programs and Resources

Programs

The King County Health Reform Initiative includes evidence-based programs designed to build and maintain a healthy workplace environment:

Eat Smart is designed to educate, encourage and empower employees (and their families) to make smart choices about what they eat. The program uses multiple media (print, web, email, live presentations, etc.) to provide quizzes, recipes tools and tips to decrease fat intake and incorporate more fruits, vegetables and whole grains into the diet.

Move More is designed to educate, encourage and empower employees and their families via multiple media to make physical activity a part of each day.

Stress Less is designed to increase awareness of the causes and effects of stress and encourage employees and their families to use tools and techniques to manage their stress. Special emphasis is placed on encouraging use of the county's Making Live Easier program.

Quit Tobacco program informs employees of the benefits and advantages of smoking cessation including online tools, printed materials and easy access to information about the assistance available through the KingCare℠ and Group Health medical plans.

Choose Well was launched in January of 2007 to empower employees and their families to be smarter health care consumers. The program highlights online decision support tools that help people find quality, affordable health care. A critical component of Choose Well, —Goose Generics," works in partnership with our prescription benefits manager, labor unions and the Puget Sound Health Alliance to inform both consumers and physicians about the benefits of choosing the lower cost but chemically identical drugs.

Healthy Workplace Funding Initiative provides funds at a rate of $25 per employee for workgroups to purchase health-enhancing goods and services such as yoga fitness training, exercise videos, stress reduction classes and nutrition information.

Gym Discounts from more than 30 fitness organizations that offer county employees an average 20 percent discount at 124 locations throughout the Puget Sound region.

Healthy Vending Machine pilot program works in partnership with vendors to stock machines with healthy snack options and drive consumer choice to healthier options by making the healthy snacks less expensive than chips, candy bars and cookies. Machines are in the King County Administration Building, the Exchange Building, the Regional Justice Center, the Wells Fargo Building, and a number of smaller worksites.

Weight Watchers at Work®, a proven weight-loss program, holds regular sessions at several workplaces throughout King County. To date, more than 10,000 pounds have been shed by participants who drop an average of eight pounds per 13-week session.

Take the Stairs annual winter campaign has spurred a movement of hundreds of stair-stepping groups and individuals, expanding lung capacity and sprucing up passageways around King County along the way.

King County Walks Week is an annual week-long event when employees are encouraged to sign up in teams to walk over lunch. Tools to make walking more enjoyable, like walking maps, are highlighted. Since the program began in 2007 more than 2,000 employees have signed up to walk over lunch and often continue the momentum after the week is over.

Worksite Flu Shot program is offered annually in workplace offices throughout King County. Each year more than 3,500 employees are vaccinated at work against the flu. In early 2010, a special joint effort with the county's health department brought onsite H1N1 flu vaccinations to over 1,000 employees and their family members at a time when many could not get vaccinated through their provider. .

Live Well Challenge is a friendly annual event where employees compete in teams for prizes and earn points for healthy activities. Since the program began in 2006, more than 3,000 employees have competed on hundreds of teams spanning every sector of county government. In 2010, it was made a Healthy Incentives℠ individual action plan

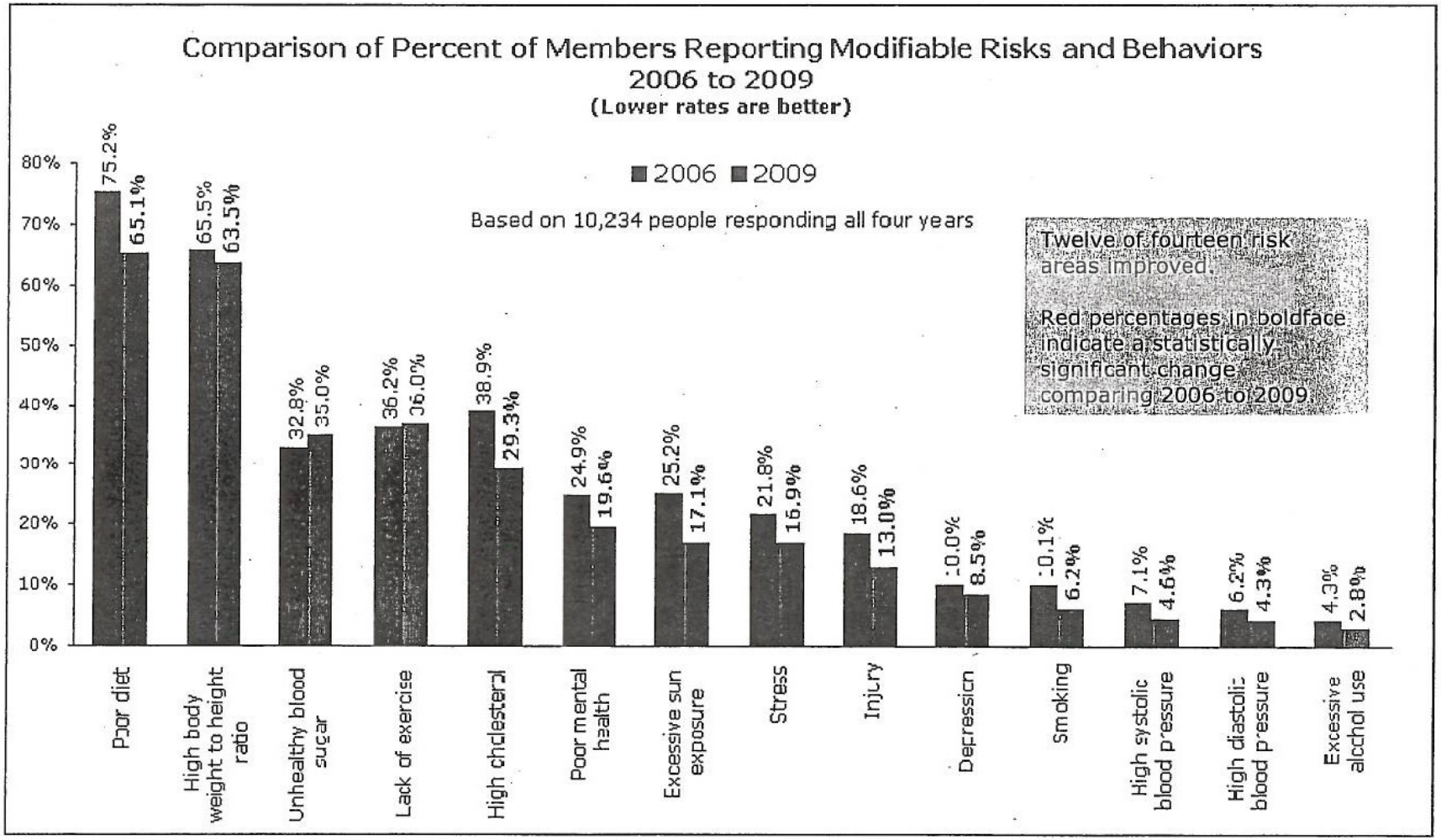
Health & Benefits Fair brings thousands of employees out to learn about personal health and to sample the opportunities available through the workplace and at home.

Farm to Work coordinates delivery of boxes for employees of fresh fruits and vegetables directly to worksites. The program is currently operating in the Chinook Building and King Street Center.

The Goat Hill Giving Garden is a demonstration garden in downtown Seattle where employees teach other employees how to grow and prepare health food. Employees maintain the garden on their own time and attend classes to learn how to build healthy soil, what to grow when and how to harvest and prepare the food. A website makes it possible for employees from all over the county to follow the growth in the garden and learn as the seasons progress. All produce is donated to the Pike Place Senior Center food bank.

Health Screenings are brought directly to employees at the worksite when the Health Reform Initiative has been able to secure partnership or grant funds that make them possible. More than 600 employees at six worksites have received free biometric screenings and health counseling from registered nurses.

Figure 21



Data are for employees and spouse/domestic partners who completed the wellness assessment in both 2006 and 2009.

6

Smoking

From 2006 to 2009 the self-reported rate of smoking decreased 3.9 percentage points from 10.1 percent to 6.2 percent (Figure 23). This change was statistically significant. Overall, costs for smoking-exacerbated conditions (unadjusted) are lower than expected, based on prior years (Figure 24.) Rates of bronchitis, asthma, respiratory infection, pneumonia, and flu are reduced in populations with lower smoking rate (Figure 25.)

Figure 22

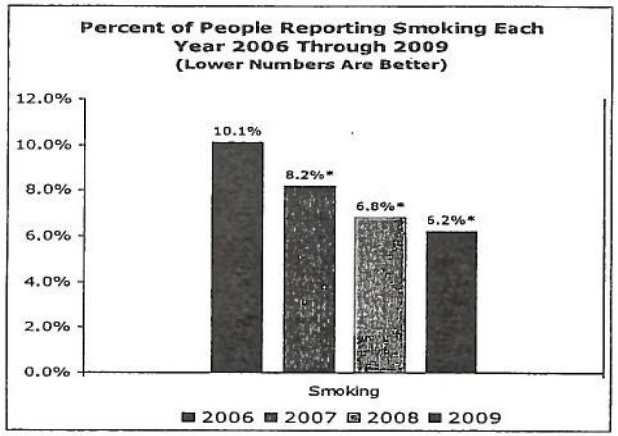


Figure 24

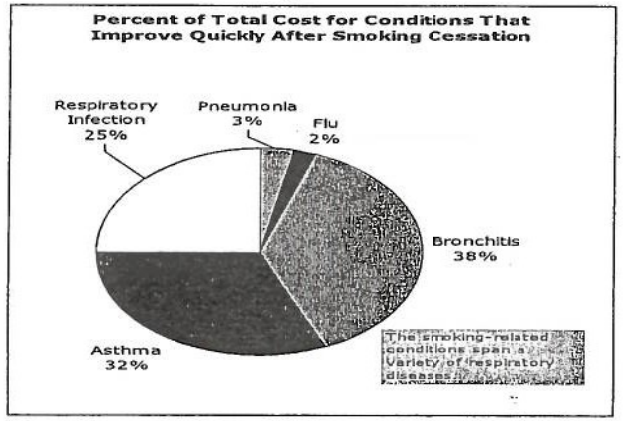
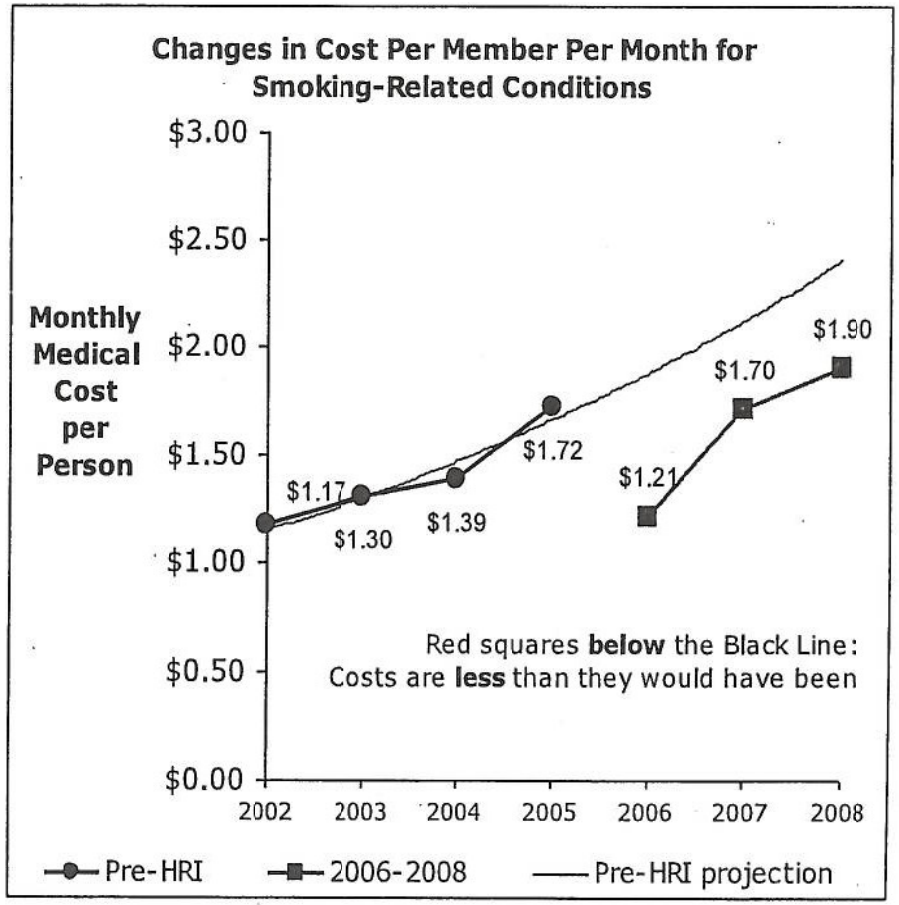


Figure 23



Uncontrolled high blood sugar and cholesterol

High blood sugar, high cholesterol and high blood pressure are closely associated (Figure28.) The self-reported number of participants who had high cholesterol dropped a statistically significant 9.6 percentage points between 2006 and 2009, and the number with high blood sugar rose 2.2 percentage points. The change in the number of people reporting high blood sugar is not statistically significant (Figure 26.) Costs for these conditions (unadjusted) dropped in 2006 before rising faster than the trend in 2007 (Figure 27.)

Figure 25

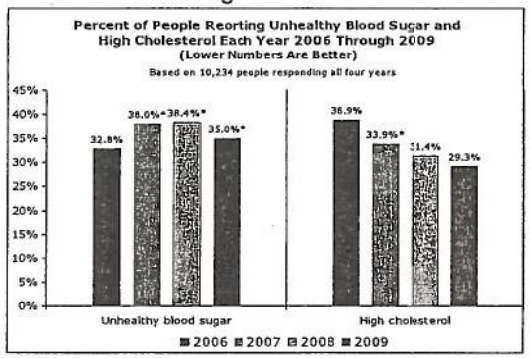


Figure 27

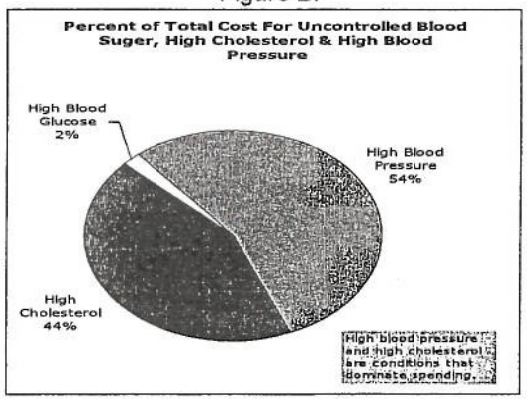
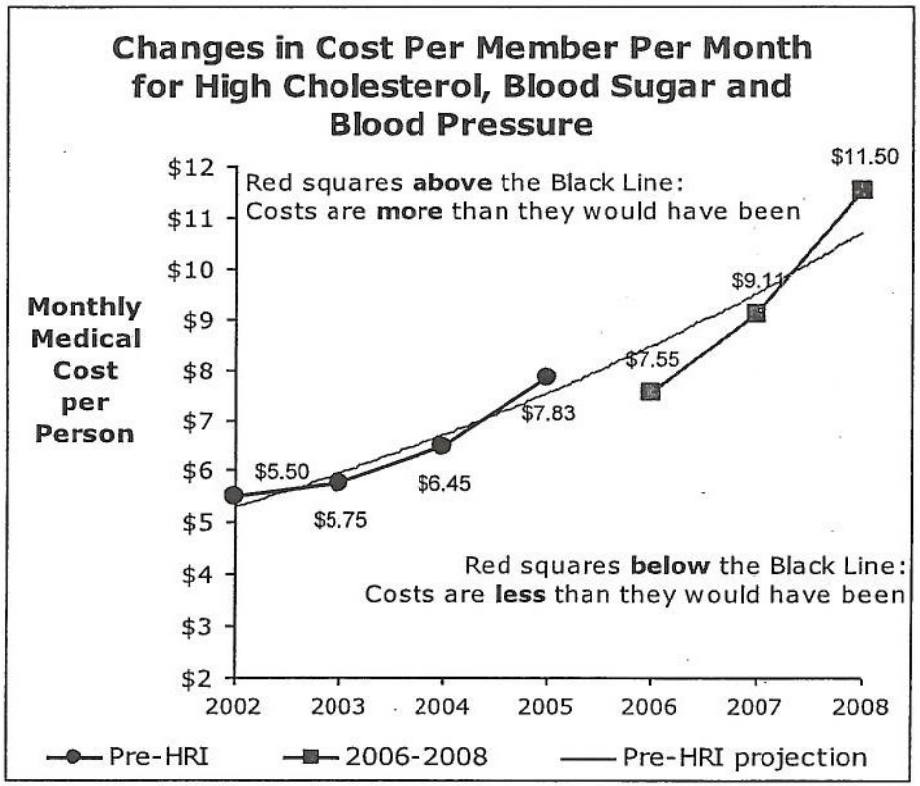


Figure 26



Obesity

Spending is tracked for patients whose primary diagnosis is obesity. Many obese patients are diagnosed for conditions related to obesity without the diagnosis code for obesity being used; only people who have an actual diagnosis of obesity are included in this analysis, and thus only —obesity" is shown in Figure31. People diagnosed as —obese" are a subset of the total number of people reporting high body weight to height. The percentage of participants self-reporting a high weight to height ratio dropped a statistically significant 2.0 percentage points from 2006 to 2009 (Figure29.) Costs for treating obesity (unadjusted) dropped in 2006 and 2007, and rose sharply in 2008 (Figure30.) This rise may be related to expanded communication regarding a medically-supervised weight management program available to KingCare[SM] members who are obese and requesting bariatric surgery.

Figure 28

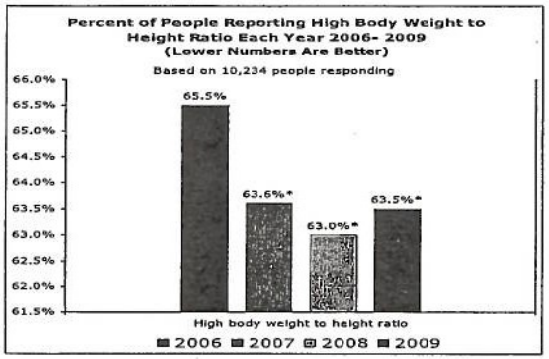


Figure 30

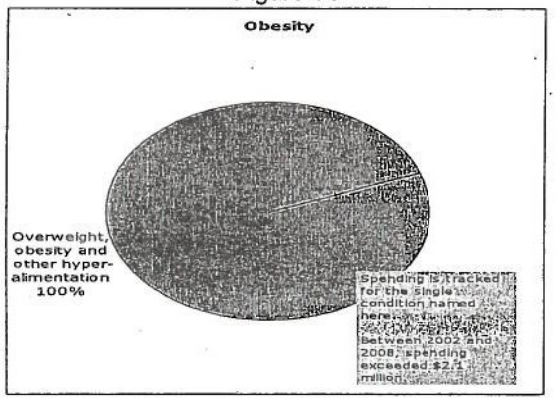
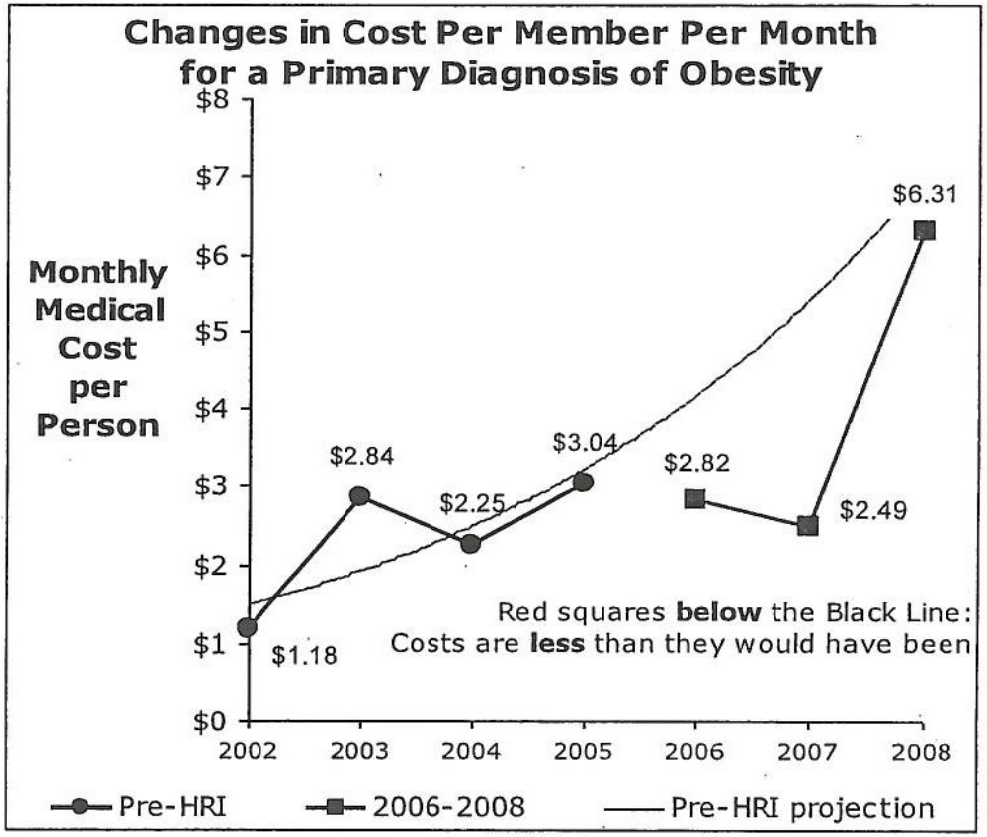


Figure 29



Alcohol Abuse

Rates of gastro-intestinal hemorrhage, gastritis and other conditions are higher in populations who abuse alcohol (Figure34.) There was a statistically significant drop of 1.5 percentage points in the number of people self-reporting alcohol abuse on the wellness assessment from 2006 to 2009 (Figure32.) Costs for conditions related to excessive alcohol (unadjusted) are lower than they would have been based on pre-HRI projections (Figure33.)

Figure 31

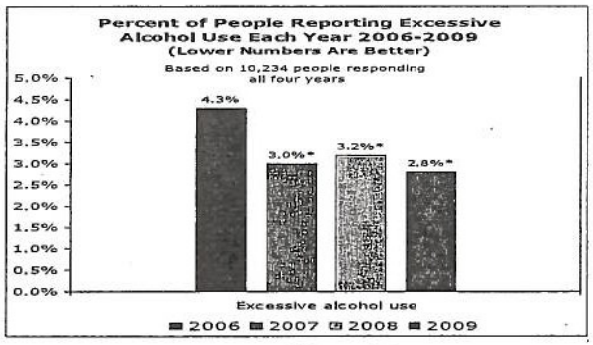


Figure 33

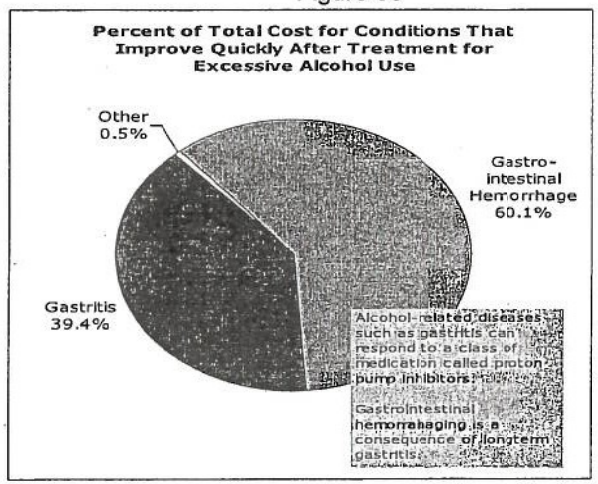
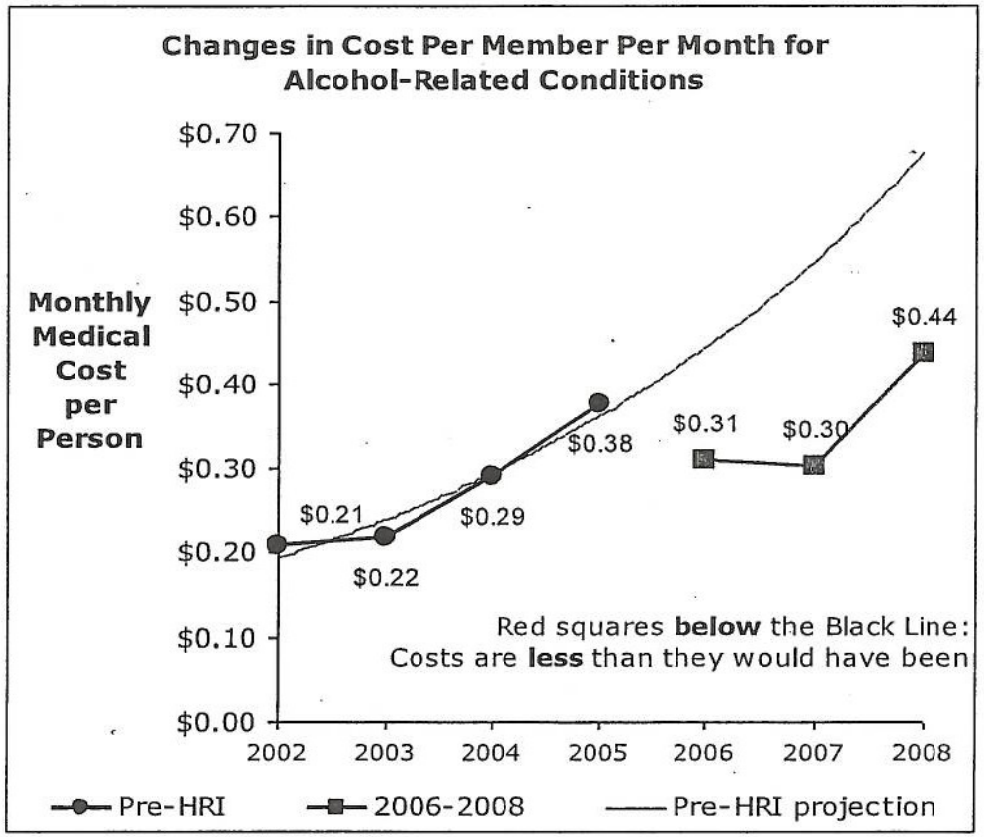


Figure 32



Common Mental Health Conditions

There are three sections of questions on the wellness assessment related to mental health. Between 2006 and 2009 the number of people reporting problems in these three areas showed statistically significant drops as follows: depression—1.5 percentage points, stress—4.9 percentage points and mental health—5.3 percentage points (Figure35.) After remaining on the on the 2003-2004 trend in 2005, costs (unadjusted) rose rapidly in 2006 and 2007 (Figure36.) It is important to note that the Washington State Mental Health Parity Act went into effect in 2006. This law requires plans that offer mental health benefits to provide them with the same level of coverage (*e.g.* co-pays) and restrictions (*e.g.* annual or lifetime maximum benefits) as the non-mental health benefits in the plan. As members became aware of this change in benefits the county saw a significant increase in both the number of claims and the cost per claim for mental health-related conditions. In many respects this increase in costs for common mental health conditions is actually a good sign that members are now seeking assistance for problems that can have a very high impact on both their ability to work productively and their quality of life overall. Figure 37 shows the proportion of common mental health costs for depression, anxiety and insomnia.

Figure 34

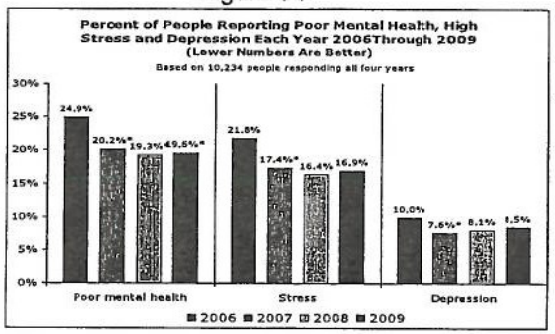


Figure 36

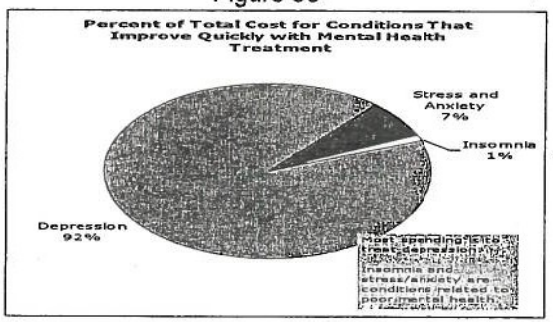
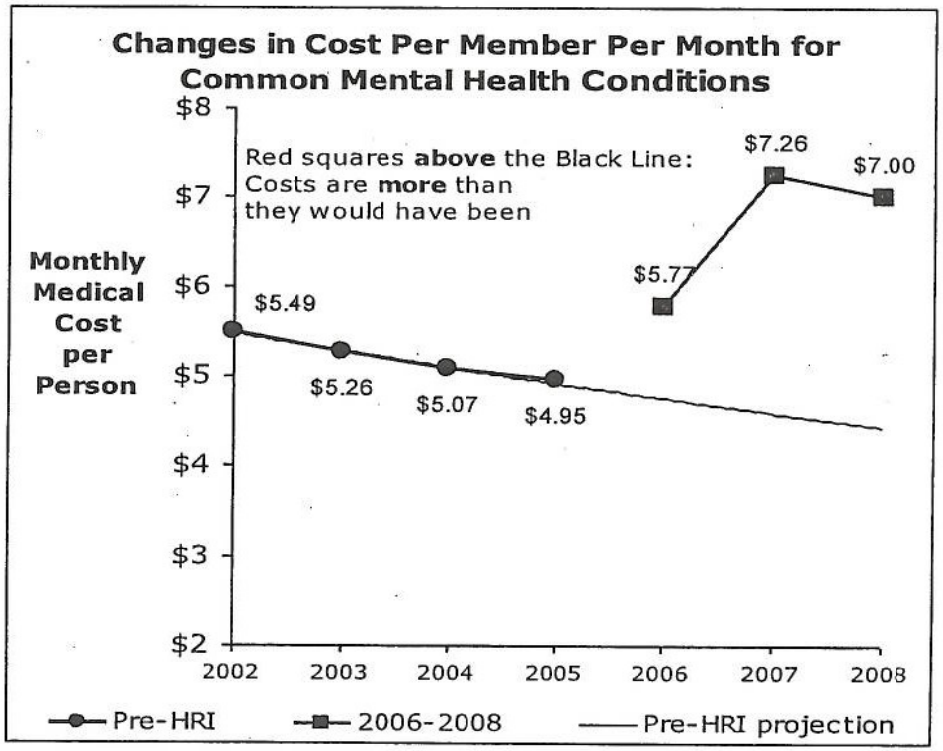


Figure 35



Notes on Johnson and Johnson Health and Wellness Program

From Linda McMillan - Taken from May 2002 article in the Journal of Occupational and Environmental Medicine, "The Long-Term Impact of Johnson and Johnson's Health and Wellness Program on Employee Health Risks."

Johnson and Johnson introduced the "Live for Life" program in 1979. The purpose of the program was to make Johnson and Johnson employees the healthiest in the world. The initial program included money for evaluation.

Evaluations in 1980s and 1990s showed improved employee health, reduced inpatient health care expenditures, decrease in absenteeism, better employee attitudes

The program underwent revisions and in 1993 and was recast as "Johnson and Johnson Health and Wellness Program (HWP)." Integrated health, wellness, disability management, employee assistance, and occupational medical were included. The goal is to reduce individual behavioral and psychosocial risk factors before they are transformed into disease and disability.

There is a financial incentive for employees completing a health risk assessment and enrolling in appropriate high-risk intervention programs. Financial incentive and corporate culture result in 90% of the domestic US employees participating (about 43,000 employees.)

A $500 medical benefit plan credit was given to those who completed the health risk assessment and participated in recommended high-risk intervention programs (named *Pathways to Change or PTC*). People with borderline risks received targeted mailings and low-risk employees received general health education materials. It is participation in the risk assessment and intervention program that made the employee eligible for the credit, not the outcome from participation.

The evaluation that is the topic of this 2002 JOEM article compared health risk assessments of people who completed at least two health risk assessments with appropriate time intervals and participated in the PTC (for those in the high risk categories) compared to non-participants. Health risk assessments were completed between 1995 and 1999.

Risk areas are: nutrition, aerobic exercise, tobacco use, motor vehicle safety, blood pressure, cholesterol, body composition, diabetes.

The evaluation was based on 4,568 employees; ½ of who were in the PTC and ½ who were not. PTC participants were 40% female compared to 51% in the non-PTC group. PTC participants were slightly older than non-participants (42.5 years vs. 41.2 years). The average number of risk factors recorded in the first HRA was the same for participants and non-participants.

There were statistically significant changes for 8 of 13 risk factors for ALL (4,586) Health and Wellness Program participants:

% of ALL employees at high-risk

	Time 1	Time 2	Change
Poor aerobic habits	45.8	35.1	(10.7)
Any tobacco use	39.2	27.6	(11.6)
High body weight	75.7	77.8	2.1
High blood pressure	9.7	1.3	(8.4)
High total cholesterol	66.2	43.2	(23.0)
Seat belt use	4.5	2.7	(1.8)
Drinking and driving	3.5	2.9	(0.6)
Poor nutrition: high fat	22.4	25.4	3.0
Poor nutrition: low fiber	49.6	41.0	(8.6)
Diabetes risk	49.4	51.7	2.3

Change in % at-risk for PTC and Non-PTC Participants

	PTC Participants	Non-PTC Participants	PTC Perfomance
Poor aerobic habits	(11.9)	(10.9)	Better
Cigarette smoking	(2.5)	(16.8)	Worse
High body weight	0.4	3.4	Better
High blood pressure	(2.8)	(0.2)	Better
High total cholesterol	(35.8)	(14.2)	Better
Seat belt use	(1.4)	(2.3)	Worse
Drinking and driving	(0.3)	(1.2)	Worse
Poor nutrition: high fat	2.8	3.6	Better
Poor nutrition: low fiber	(8.9)	(9.6)	Worse
Diabetes risk	(0.9)	2.9	Better

PTC participants performed better than non-participants in six of the categories listed above.

The decline in high blood pressure for non-participants over time was not statistically significant.

The decline for drinking and driving was statistically significant for non-participants but NOT for participants.

The program was not successful in reducing risk factors associated with increased age: high body weight, risk for diabetes, and high fat diet.

The PTC programs were particularly targeted to employees with high cholesterol, high blood pressure, and those who smoke.

Important lessons from this effort include the positive impact on all employees that participated in the Health and Wellness Program whether they participated in the PTC programs or not and that it demonstrates that a complex, large scale health management program can be implemented in a large corporation and have a very high participation rate.

Identified limitations of this evaluation: (1) no comparison group could be established because there is such high participation in the HWP; (2) the HRA is based on self reporting and people may not identify all risks in order to get the health plan credit but avoid having to participate in intervention programs; (3) not part of a randomized study so there is not adjustment for demographics.

Maryland P3 Program

(Notes by Linda McMillan from Evaluation of P3 Program January 2008 through December 2008 commissioned by the Department of Health and Mental Hygiene)

The Maryland Patients Pharmacists Partnership (P3) Program was designed in 2006 to reduce employee and employer costs by eliminating obstacles to diabetes care and improving overall health outcomes.

Pharmacists-coaches from Maryland Pharmacist Association and University of Maryland use best practice guidelines to provide patient-centered care that medication adherence, lifestyle changes, and improve disease self-management knowledge.

In 2008, the P3 Program served 225 employees at four employer sites in Alleghany County, Frederick County, Howard County, and Baltimore City. There were 138 trained pharmacists in 2008 but 30 provided direct care to patients during the evaluation period. Employers were responsible for enrollment of participants, sharing data from third party administrators and pharmacy benefits managers, and make payments to pharmacist providing services.

92% of U.S. adults diagnosed with diabetes are prescribed at least 1 medication. Medication adherence can dip to as low as 36% for patients with multiple drug therapies. A study at University of Maryland found that for patients with diabetes, obesity, and metabolic syndrome, and average of 5.4 medications were prescribed.

P3 Trained Pharmacist met with participants at least quarterly but an average of 6 times per year.

At the beginning, each patient received a baseline health assessment, and completed a Knowledge Assessment. During regular visits coached the patient on blood glucose self-monitoring, oral medication and insulin self-administration, nutritional choices, appropriate foot, skin, eye, and oral health care, and stress management. After each visit the P3 Pharmacist communicated in writing to the primary health care provider and health care team.

Three primary measures of effectiveness:

1. HbA1c control rate
2. Cholesterol (LDL) level
3. Blood pressure

Five secondary measures of effectiveness:

1. Number of participants receiving recommended vaccinations
2. Number of participants performing foot exams
3. Number of patients with annual dilated eye exam
4. Patient satisfaction with pharmacist care
5. Overall cost savings per patient

Evaluation included 176 participants

Age of Patient	% of Total
25-34	1.1%
35-44	9.3%
45-54	21.8%
55-64	55.6%
65 and older	12.1%

Evaluation compared P3 Participants at the end of the program with comparison groups from the Health Plan Employer Data and Information Set (HEDIS).

9.1% of P3 patients had poor control of HbA1c levels at the end of the year compared to 30% of diabetes patients in Maryland commercial insurance plans and 45.9% of those in Maryland Medicaid. Slightly more than ½ of P3 patients met their therapeutic goals.

39.4% of P3 patients had LDL levels of less than 100 mg/dl compared to 46% of diabetes patients in Maryland commercial insurance plans and 35.4% in Maryland Medicaid. One employer site demonstrated average LDL reduction from 128 to 99 mg/dl; a second from 104 to 95 mg/dl.

71% of P3 patients had blood pressure below 140/90 mmHg compared to 56% of diabetes patients in Maryland commercial insurance plans and 51% in Maryland Medicaid.

67% of P3 patients had flu vaccine
25% had pneumonia vaccine
58% had dental exam
67% complied with foot exams
73% had annual dilated eye exam

Two participating employers document savings of $109,112 and 56,120 respectively.

The evaluation concludes that key outcome measure moved in a positive direction and that this is preliminary evidence that this could be an emerging approach to control health care costs for chronic disease management. The evaluation recommends that Maryland providers have an opportunity to improve patient care while decreasing overall health care costs by expanding collaborative opportunities to expand the P3 program to other patient populations.

Summary of NCQA Accreditation

Source: NCAQ Website, Accessed October 2011

The National Committee for Quality Assurance (NCQA) is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. NCQA offers six accreditation programs (Disease Management, Health Plan, Managed Behavioral Healthcare Organization, New Health Plan, and Wellness & Health Promotion), along with five certification programs and five physician recognition programs. Accreditation requires plans and programs to report clinical quality measures, utilize patient experience measures, meet system and process standards, and publish performance reports.

The following briefly summarizes the Wellness & Health Promotion and Disease Management Accreditation Programs. For more information about NCQA, please see the website at http://www.ncqa.org/tabid/834/Default.aspx.

Wellness & Health Promotion Accreditation

NCQA's Wellness & Health Promotion (WHP) Accreditation program evaluates fundamental areas of health promotion such as (1) how wellness programs are implemented in the workplace, how provided services help participants develop skills to make healthy choices and how individual health information is properly safeguarded.

NCQA assesses wellness programs using an evidence-based set of requirements to distinguish quality services and standardized program measures that allow employers to make informed comparisons when choosing among health plans and wellness program providers. The following are NCQA's Wellness Standards:

- Employer and Plan Sponsor Engagement
- Privacy and Confidentiality
- Engaging the Population
- Health Appraisal
- Identification and Tailoring
- Self-Management Tools
- Health Coaching
- Rights and Responsibilities
- Measuring Effectiveness
- Delegation
- Incentives Management (when applicable)
- Reporting WHP Performance (when applicable)

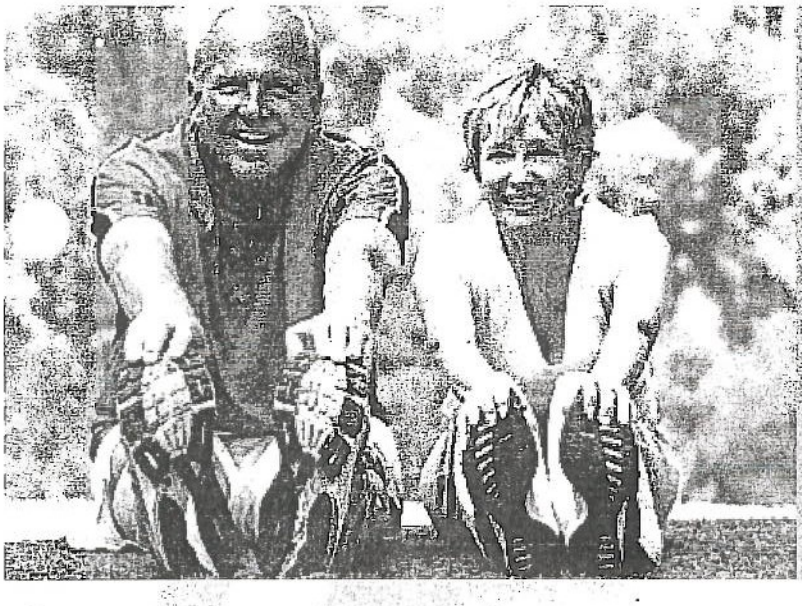
In addition, NCQA requires the following performance measures for WHP Accreditation:

- Health Appraisal Completion
- Health Promotion for the Population
- Staying Healthy
- Prevalence of Core Risks Identified on Health Appraisals
- Number of Core Risks Identified on Health Appraisals
- Participation
- Risk Reduction-Overall
- Risk Reduction-BMI Reduction and Maintenance
- Risk Reduction-Smoking or Tobacco Use Quit Rate
- Risk Reduction-Physical Activity Level

Disease Management Accreditation

NCQA offers accreditation for organizations that offer comprehensive DM programs with services to patients, practitioners or both; and Certification for organizations that provide specific DM functions. NCQA utilizes standardized performance measures that address care for people with an array of chronic conditions including asthma, diabetes, chronic obstructive pulmonary disease (COPD), among others. The standards are organized into the following seven categories:

- Evidence-Based Programs (EB): The organization uses the best clinical evidence to develop program content.
- Patient Services (PT): The organization works with the patient to encourage self-management behavior that enables good outcomes.
- Practitioner Services (PR): The organization supports the practitioner's plan of care by providing actionable and timely information on their patients' conditions.
- Care Coordination (CC): The organization makes information about patients' care plans accessible to patients and practitioners.
- Measurement and Quality Improvement (MQ): Standards are designed to impose principles of good measurement.
- Program Operations (OP): Supporting and maintaining the operational aspects of the DM program are important to its success.
- Performance Measurement: The organization regularly assesses its performance against a standardized, evidence-based set of measures. Sample performance measures include:
    - Management of People With Heart Failure
        - Influenza vaccination
        - Pneumococcal vaccination
        - Assessment of tobacco use
    - Management of People With Asthma
        - Appropriate medication use
        - Influenza vaccination
        - Pneumococcal vaccination
        - Assessment of tobacco use



NCQA Disease Management Accreditation and Certification

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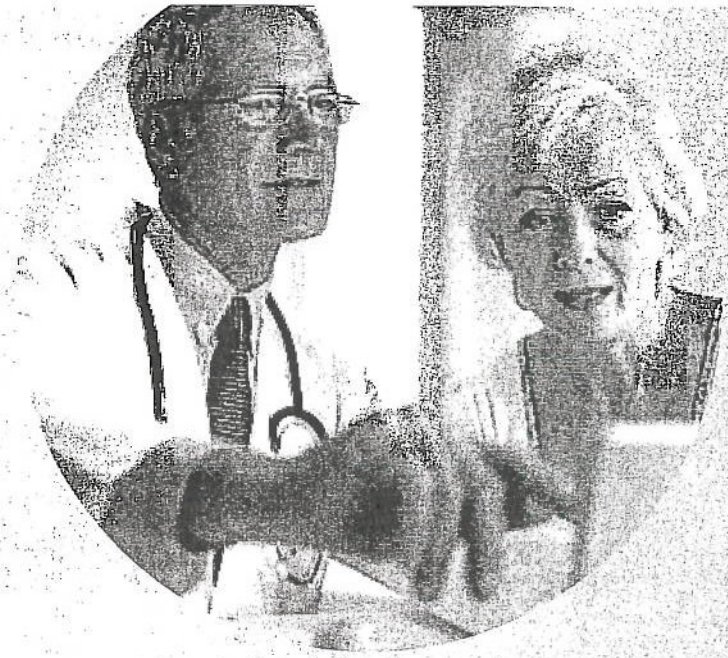

NCQA Disease Management Accreditation and Certification

NCQA's flexible disease management (DM) evaluation programs include accreditation for organizations that offer comprehensive DM programs with services to patients, practitioners or both, and certification for organizations that provide specific DM functions. The program standards are built on NCQA's years of experience, detailed market research and input from health care industry experts and other stakeholders. Moreover, NCQA is the first DM accreditation organization to utilize performance measures to assess the impact of programs on care for people with asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart failure and ischemic vascular disease (IVD).[1] NCQA has incorporated standardized performance measures that address dimensions of care for people with these diseases into our latest DM standards. The DM performance measures also include preventive health measures for tobacco use, influenza vaccination and pneumococcal vaccination, which apply to people in each area.

There are two NCQA Accreditation options:

- **Patient and Practitioner-Oriented Accreditation:** For organizations that deliver comprehensive DM programs that include criteria for patient identification, evidence-based content, interventions directed at patients and practitioners and systems to support program operations.
- **Patient-Oriented Accreditation:** For organizations that deliver comprehensive DM services to patients and do not have regular contact with practitioners.

There are two NCQA Certification options:

- **Program Design Certification:** Contains requirements for development of DM content based on clinical guidelines. DM content distribution may incorporate printed, electronic, telephone or face-to-face methods.
- **Systems Certification:** Contains requirements for the design of clinical information systems used to support DM services.

[1] Organizations seeking NCQA DM Accreditation can earn the status "Accredited With Performance Reporting" for the above conditions. Organizations must submit measures annually to retain this status.

Why NCQA Disease Management Programs?

Organizations that have earned NCQA DM Accreditation and Certification meet or exceed NCQA standards. NCQA Accreditation and Certification allows organizations that offer quality DM programs and services to receive the market advantage and recognition from key industry players. Accreditation, certification and public reporting of measurement results tell employers and consumers that the DM programs they choose are transparent, accountable and committed to continuous quality improvement.

NCQA-Accredited DM organizations show that they:

- Provide comprehensive programs delivering evidence-based care
- Make efficient use of resources
- Have high levels of customer satisfaction
- Deliver improved health outcomes

NCQA-Certified DM organizations demonstrate that they:

- Provide evidence-based content and systems to support DM comprehensive programs
- Drive quality care and services by addressing patient safety and delivering improved services

Who can apply for NCQA Disease Management Accreditation and Certification?

- Disease management organizations
- Population health management organizations
- Health plans, including HMOs, PPOs and POS plans
- Managed behavioral healthcare organizations (MBHO)
- Provider organizations, including medical groups, hospitals and integrated delivery systems
- Pharmaceutical companies and pharmacy benefit managers (PBM)
- Software and biometric device companies
- Case management organizations

How to Apply[2]

Interested organization can download a free application for a DM Accreditation or Certification Survey at www.ncqa.org/publications, or contact NCQA Customer Support at 888-275-7585.

[2] Health plans and other organizations seeking NCQA Accreditation or Certification may receive delegation oversight relief when delegating to an NCQA-Accredited or Certified organization.

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For more information about NCQA Disease Management Accreditation and Certification, visit www.ncqa.org

NCQA Disease Management Standards

NCQA's DM standards are organized into seven categories.

1. **Evidence-Based Programs (EB).** Organizations should use the best clinical evidence to develop program content. Evidence-based programs principles include:

- Using evidence-based guidelines or standards of care in developing program content for patients and practitioners
- Ensuring that all content is consistent with adopted guidelines
- Ensuring appropriate practitioner oversight of programs

2. **Patient Services (PT).** Organizations should work with patients to encourage self-management behavior that enables good outcomes. Patient service principles include:

- Using available clinical data from the client organization or from eligible participants to identify potential participants and stratify them for assignment to different levels of service intensity
- Integrating relevant patient data to produce actionable patient-level information
- Enlisting and measuring active participation of eligible patients
- Supporting patient self-management with consumer-tested information, coaching, reminders and referrals
- Stating a commitment to patient rights, including the patient's right to opt out of the program, and expectations of patient responsibilities
- Encouraging patient and practitioner communication

3. **Practitioner Services (PR).** Organizations should support practitioners' care plans by providing actionable and timely information on their patients' conditions. Practitioner services principles include:

- Supporting practitioner decisions with evidence-based recommendations on care of chronic conditions
- Providing practitioners with feedback on care opportunities that must be addressed
- Stating a commitment to practitioner rights and encouraging practitioners to work with the program to coordinate patient care

4. **Care Coordination (CC).** Organizations should make care plan information accessible to patients and practitioners. Care coordination principles include:

- Giving patients information about their progress toward treatment goals
- Giving practitioners information about the condition and progress of their patients
- Coordinating referrals and providing relevant information to case management programs and other health resources

5. **Measurement and Quality Improvement (MQ).** Organizations should measure patient and practitioner data to assess their experience and act to improve quality where necessary. Standards are designed to impose principles of good measurement that include:

- Measuring quality across the organization and for each condition managed
- Ensuring that all eligible participants are included in the measured population
- Using evaluative patient and practitioner data to assess experience with the DM program for quality improvement
- Measuring cost or efficiency of each program
- Analyzing performance data, acting to improve quality and demonstrating improvement in performance

6. **Program Operations (OP).** Organizations should support and maintain their DM programs by:

- Ensuring convenient access to the organization for patients and practitioners
- Considering patients with special needs
- Employing qualified personnel, giving them the necessary training
- Disclosing marketing activities
- Responding appropriately to patient and practitioner complaints
- Using available information to address patient safety issues
- Protecting the privacy of patient information

7. **Performance Measurement (PM).** Organizations should regularly assess their performance. (Organizations that meet this standard earn "Accredited With Performance Reporting" status.)

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Wellness & Health Promotion Accreditation

Demonstrating Value to Employers and Workers



NCQA's Wellness & Health Promotion Accreditation

Is a broad-based accreditation program for organizations that offer comprehensive wellness and health promotion services.

Assesses health plans and vendors that provide wellness and health promotion services using an evidence-based set of requirements to distinguish quality services.

Evaluates key areas of health promotion, including how wellness and health promotion programs are implemented in the workplace, how services such as coaching are provided to help participants develop skills to make healthy choices and how individual health information is properly safeguarded.

Uses standardized program measures that allow employers to make informed comparisons when choosing among several wellness and health promotion vendors (for the Accredited with Performance Reporting status).

A growing number of employers are offering wellness and health promotion programs to their workers to help improve their health and lower health care costs. By helping workers and their families change their behavior, wellness programs can make a real difference in people's lives and companies' competitiveness.

A recent survey conducted by the ERISA Industry Committee and the National Association of Manufacturers, found 77% of America's leading employers offer formal health and wellness programs. And with good reason. Many employers find that offering such programs can help reduce their firm's health care costs. The 2008 Kaiser Family Foundation/HRET Employer Health Benefits Survey found that 68% of benefits managers at large firms thought that offering wellness programs was effective in reducing health care costs.

To ensure the effectiveness of this rapidly growing field, it is critically important to be able to determine which wellness programs perform best. NCQA's Wellness & Health Promotion (WHP) program will help employers choose wisely and allow wellness companies to demonstrate the value of their products.

Program Benefits

For Employers and Other Purchasers: Affirms the decision to work with a wellness and health promotion program vendor that is NCQA Accredited to create a healthy workplace.

For Organizations Providing Wellness and Health Promotion Services: Demonstrates the value of their services to employers and their workforce.

www.ncqa.org

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NCQA's WHP Standards

1. Employer and Plan Sponsor Engagement	The organization provides information and direction to help employers or plan sponsors implement wellness and health promotion programs that will enable participants to improve their health.
2. Privacy and Confidentiality	The organization has systems in place to protect the confidentiality of sensitive information on eligible individuals.
3. Engaging the Population	The organization actively works to provide wellness and health promotion services to entire populations.
4. Health Appraisal (HA)	The organization helps adult participants manage their health through the provision of an HA, discloses how the information will be used and protects it in accordance with privacy policies.
5. Identification and Tailoring	The organization identifies the unique wellness and health promotion needs of eligible individuals and acts to meet them.
6. Self-Management Tools	The organization provides self-management tools to help individuals stay healthy and reduce risk.
7. Health Coaching	The organization provides coaching services to help participants develop skills to make healthy choices and improve their health.
8. Rights and Responsibilities	The organization communicates to eligible individuals what their rights are, which materials are for marketing purposes versus health advice and how to file a complaint.
9. Measuring Effectiveness	The organization uses quality measures and participant satisfaction results to understand its performance and continually works to improve its program and services.
10. Delegation	The organization remains accountable for and has appropriate structures and mechanisms to oversee delegated wellness and health promotion functions.
11. Incentives Management *(when applicable)*	The organization can administer incentives upon request, as well as evaluate the effects of employer or plan sponsor incentive programs.
12. Reporting WHP Performance *(when applicable)*	The organization strives to improve the quality of its wellness and health promotion services by measuring its performance using standardized measures.

NCQA's WHP Performance Measures

1. Health Appraisal (HA) completion	The percentage of adults who have completed a health appraisal (HA). HA completion rates will be stratified by incentive offered: • No incentive • Small incentive (≤$100) • Large Incentive (>$100)
2. Health Promotion for the Population	The percentage of adults who had at least one interactive contact in an intervention. (Interactive contact must include bidirectional health education or health coaching, and includes in-person, phone, on-line or mail-based, if mail-based involves person to person follow-up).
3. Staying Healthy	The percentage of adults who do not have any of the core risks (obesity, cigarette smoking, or physical inactivity) identified on the baseline health appraisal (HA), as well as on the follow-up HA.
4. Prevalence of Core Risks Identified on Health Appraisals	The percentage of adults who have completed a health appraisal (HA) and who have had any of the following core risks identified: • Obesity (body mass index [BMI] ≥30.0) • Cigarette smoking • Physical inactivity
5. Number of Core Risks Identified on Health Appraisals	The percentage of adults who have completed a health appraisal (HA) and who have had the following number of risks identified: • 0 risks • 1 risk • 2 risks • 3 risks
6. Participation	The percentage of adults who have at least one of the three core risk factors (obesity - BMI≥30.0, cigarette smoking, or physical inactivity) who have at least one interactive contact for a health promotion intervention.
7. Risk Reduction — Overall	The percentage of adults who had at least one of the three core risk factors (obesity - BMI≥30.0, cigarette smoking, or physical inactivity) as identified by a baseline health appraisal (HA) and who reduced their risk as identified by a follow-up HA.
8. Risk Reduction — BMI Reduction and Maintenance	The percentage of adults who were obese (had a BMI≥30.0) with at least one interactive contact specific to weight loss and who have maintained their BMI or reduced their BMI by at least one point.
9. Risk Reduction — Cigarette Smoking Quit Rate	The percentage of adults who were current smokers with at least one interactive contact specific to smoking cessation who have quit smoking cigarettes: • For 180 days • For 12 months
10. Risk Reduction — Physical Activity Level	The percentage of adults who were not getting the recommended amount of physical activity with at least one interactive contact specific to physical activity who now have the recommended level of physical activity.

For more information about NCQA's Wellness & Health Promotion (WHP) Accreditation, visit www.ncqa.org or contact NCQA Customer Support at 888.275.7585.