



Cancer in the Workplace:
PREVENTION, DETECTION AND SUPPORT

**Report of a Consultation
with Business and Health Leaders**

*June 6, 2001
Washington, DC*

SPONSORED BY:

CDC

*Centers for Disease Control and Prevention
Division of Cancer Prevention and Control*

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Table of Contents

Acknowledgements	III
Preface	IV
Meeting Agenda and Speakers	1
Detection and Management of Cancer: General Issues	2
<i>Cancer in the Workplace: Caring for Your Employees is Good Business</i>	2
<i>Cost-effectiveness of Cancer Screening: Determining Priorities Among Clinical Preventive Services</i>	6
<i>Health Excellence: Cancer Prevention and Intervention – An Employer Perspective</i>	7
<i>The Short-Term Cost Impact of Colorectal Cancer Screenings on Health Insurance Plans</i>	8
<i>Cancer Information for the Employee</i>	8
Case Study: Colorectal Cancer	10
<i>Prevention and Early Detection of Colorectal Cancer</i>	10
<i>Testing for Colorectal Cancer Among an Insured Population at General Motors</i> ..	11
<i>Screening for Colon Cancer: The Business Case</i>	13
<i>Advancing Health Plan Accountability and Quality: The NBCH V8 Process</i>	14
Appendix A: Participant List	17
Appendix B: Resources	19

Acknowledgements

Many people devoted their time and expertise to plan, implement, and follow up on the Business Consultation on Cancer. I would like to extend special thanks to the Division of Cancer Prevention and Control, Centers for Disease Control and Prevention (CDC), for their generous support in convening this meeting and developing this report. Particular thanks go to Georgia Moore, who worked with us to plan and bring about the meeting. Throughout the process, the professionals at the CDC have clearly demonstrated their commitment to partnering with the business community, and their leadership has started a dialogue that will continue well beyond this meeting.

We are also indebted to Tom Hiriak at Ortho Biotech, as well as Carol Staubach of Comstock Consulting, who gave so generously of their time and talent in bringing together leaders from the business and public health communities for this important discussion.

Finally, I would like to thank Susan Murray Young for her role in developing background materials and writing this report.

Julianna S. Gonen, Ph.D.
Director, Center for Prevention and Health Services
Washington Business Group on Health

This meeting and report were supported by Cooperative Agreement Number U38/CCU317929-02 from CDC. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Preface

The diagnosis of cancer strikes fear in the hearts and minds of those who receive it. There have been significant advances in our understanding of cancer, and great strides made in prevention, early detection and treatment, all of which means that more people than ever before can survive cancer.

But cancer is still frightening, often painful and debilitating, and always costly—in both human and economic terms. The economic impact of cancer can be devastating for a patient without adequate health care coverage. It can also stress the health care bottom line among employers who provide insurance to employees, retirees and dependents. The costs of treatment and follow-up care are obvious. But these obvious costs of cancer are only about half the total incremental costs attributable to this disease. Disability, absenteeism and reduced productivity increase costs dramatically.

Given these facts, the Washington Business Group on Health (WBGH) and the Centers for Disease Control and Prevention (CDC) recently joined forces to initiate a dialogue on this subject between the business and public health communities.

This dialogue was the fifth in a series of Business Consultations sponsored by the CDC. As with the first four—which addressed diabetes, healthy pregnancy, hepatitis, and musculoskeletal disorders—WBGH first surveyed its membership (made up of 150 large public and private employers) regarding current practices in managing cancer. Then, with the help of a group of experts from both communities, WBGH and the CDC convened *Cancer in the Workplace: Prevention, Detection and Support*, a consultation with business and health leaders, on June 6, 2001, in Washington, D.C.

Participants, whose names and affiliations are listed in Appendix A, included employers, public health professionals, managed care companies, disease management vendors, and other experts on cancer.

Cancer in the Workplace: **PREVENTION, DETECTION AND SUPPORT**

JUNE 6, 2001 ■ 10:00 A.M. – 3:00 P.M.

**WASHINGTON BUSINESS GROUP ON HEALTH
50 F ST., NW ■ 4TH FLOOR CONFERENCE CENTER ■ WASHINGTON, DC**

AGENDA

10:00 – 10:15 **Welcome and Introductions**
Mary Jane England, MD President, *Washington Business Group on Health*
Georgia Moore Cancer Information Specialist, *CDC*

Detection and Management of Cancer: General Issues

10:15 – 10:40 **Cancer in the Workplace: Caring for Your Employees is Good Business**
Marcia L. Comstock, MD, MPH
President, *Comstock Consulting Group*

10:40 – 11:00 **Cost Effectiveness of Cancer Screening: Determining Priorities Among Clinical Preventive Services**
Lisa Koonin, MN, MPH
Director, Office of Health Care Partnerships, *CDC*

11:00 – 11:20 **Health Excellence: Cancer Prevention and Intervention – An Employer Perspective**
Janet L. Solomon, M.A.
Health Benefits and Wellness Director, *Texas Instruments*

11:20 – 11:40 **The Short-Term Cost Impact of Colorectal Cancer Screenings on Health Insurance Plans**
Durado Brooks, MD, MPH
Director, Prostate and Colorectal Cancers, *American Cancer Society*

11:40 – 11:55 **Cancer Information for the Employee**
Elisabeth Handley, MPA
Associate Director of Outreach and Partnerships, *National Cancer Institute*

11:55 – 12:30 **Interactive Discussion with Attendees**

12:30 – 12:45 **Break / Lunch**

Case Study: Colorectal Cancer

12:45 – 1:05 **Overview: Prevention and Early Detection of Colorectal Cancer**
Laura C. Seeff, MD
Medical Epidemiologist and Internist, *CDC*

1:05 – 1:25 **Testing for Colorectal Cancer Among an Insured Population at General Motors**
Reuben K. Varghese, MD, MPH
EIS Officer/Medical Epidemiologist, *CDC*

1:25 – 1:45 **Screening for Colon Cancer: The Business Case**
Patricia R. Salber, MD, MBA
Medical Director, Managed Care Health Care Initiatives
General Motors Corporation/The Permanente Company

1:45 – 2:05 **Advancing Health Plan Accountability and Quality: The NBCH V8 Process**
Suzanne Paranjpe, PhD
Vice President, Strategic Development, *National Business Coalition on Health*

2:05 – 3:00 **Interactive Discussion with Attendees**

DETECTION AND MANAGEMENT OF CANCER: GENERAL ISSUES

CANCER IN THE WORKPLACE: CARING FOR YOUR EMPLOYEES IS GOOD BUSINESS

Marcia Comstock, MD, MPH¹
President, Comstock Consulting Group

Cancer as a diagnosis is particularly frightening for individuals and their families. The good news is that over the last few decades there has been a significant decrease in the morbidity and mortality associated with cancer. Many individuals with cancer are now living better lives. They are able to return to normal activities, and they go back to work. Herein lies the challenge—and the opportunity—for employers.

Most companies today have focused disease management, whether internally or in conjunction with health plans, for disorders such as diabetes, asthma, or cardiovascular disease. But there are very good business reasons, both humanistic and pragmatic, for employers to consider getting engaged in integrated cancer care.

Dr. Comstock first explained why employers should become proactively involved in cancer-related programs. Second, she described the drivers of excess costs in cancer care and the opportunity this presents for employers to influence both the diagnosis and the treatment of cancer. She then outlined briefly a model for an employer-based integrated cancer care program.

In 1999, over eight million Americans (3 percent of the population) required some form of treatment for cancer. 1.2 million individuals are diagnosed with cancer every year. And although cancer is perceived as a diagnosis of older people, the reality is that 40 percent are between the ages of 18 and 64. These people have a major impact on health care costs in the workplace. Interestingly, older patients with

cancer can also impact on productivity in the workplace, because many of them are being cared for by members of the active workforce.

THE COSTS OF CANCER

The direct cost of cancer is estimated at about \$50 billion, which is much higher than many other chronic diseases. One HMO study showed that the annual costs exceeded those of cardiovascular disease, depression, and diabetes; in fact there was a nine-fold increase in annual costs for a patient with cancer versus another individual in that work force who didn't have cancer. In 1995, costs associated with the treatment of cancer accounted for about five percent of U.S. health care expenditures.

There are many factors that contribute to the costs associated with cancer. Cancer is a complex disease with great variability in terms of patient response to treatment. There is a need for specialized personnel services and technology to treat cancer; and there are many costs associated with the side effects of treatment, and with co-morbid conditions.

Two important studies shed light on the costs of cancer. The first is focused on the direct costs. Practice Pattern Sciences (PPS) developed a financial model based upon 2.1 million lives enrolled in a variety of health plans. By using a proprietary relational database, PPS could link the claims for medical care and pharmaceutical costs to look at cancer prevalence and associated costs by age and gender and type of cancer. The data was also evaluated by service categories (for example, inpatient costs, ambulatory, diagnostic testing).

To estimate the cancer cost associated with a working population, PPS took a subset of 1.48 million of these individuals between the ages of 18 and 64. Not surprisingly, they found that cancer prevalence ranged from about 3 percent (3 per 1000) in individuals between the ages of 43 and 52 to almost 7 percent in the age group 53 to 64. Cancer-related *direct costs* were approximately 8.1 percent

¹ As President of Comstock Consulting Group, Dr. Comstock consults with a broad cross-section of health care stakeholders, including employers, healthcare service providers, pharmaceutical manufacturers, and trade associations. She was formerly the Medical Director for Consolidated Rail Corporation and for AT&T Bell Laboratories.

of total health care expenditures. And cancer charges as a percent of total increased with the age of the patient.²

Further analysis addressed two points. First, PPS looked at individuals with cancer compared to age and gender matched individuals without a diagnosis of cancer and found that their total average medical costs were higher and expenses for every service category and utilization of all services was higher. Then PPS took a subset and looked at common side effects of cancer treatment. When they examined costs associated with anemia, for example, they found that 6.4 percent of the cancer patients had anemia, and these individuals had higher annual charges and utilization of services.

The second study was another case-controlled study of a major employer with over 100,000 employees. This study tried to quantify the full cost of cancer in the workplace, including lost productivity from disability. Specifically, they wanted to distinguish between *costs associated with the diagnosis of cancer*—including cancer and its associated disability costs—and what they called *excess costs*—costs incurred by people with cancer but unrelated to the cancer diagnosis itself.

They found that medical costs for employees with cancer were five times higher than those without; they also found that the excess costs (those costs not directly associated with that diagnosis but associated with co-morbid conditions) were substantially greater than direct costs. When they looked at the full, expected excess costs over the entire period of treatment for an individual newly diagnosed with cancer, they estimated it at \$83,000. The clear message is that the economic impact of cancer is much larger than it first appears.

This study found that these excess costs arose from a number of different causes. First, there was an excess of medical treatment for other kinds of problems, like infections and dental procedures. There was a five-fold greater prevalence of asthma claims in these cancer patients, and the duration of disability

was twice as great. There were also significant claims related to the adverse effects of cancer and its treatment—things like anemia, fatigue, and nausea. Unfortunately, there is much data that suggests that physicians who treat cancer are not paying as much attention to other issues like side effects and the psycho-social needs of patients.

Another very important group of employees is those who care for family members with cancer. One study found that forty percent of caregivers indicated that their ability to work was impacted, and 77 percent report increased stress. Of these, 28 percent require some kind of medication to help them cope. Another study, published in JAMA, indicated that individual caregivers who perceived they were experiencing a great deal of stress had higher morbidity and mortality risks; one can intuitively assume that these are also high consumers of health care resources. Surveys have suggested that employers are concerned about these individuals, and they want to do the right thing, but only six percent provide any kind of benefit beyond the basic health care package.

DRIVERS OF CANCER COSTS

What are the drivers of excess costs in the treatment of cancer? Cancer is a very diverse set of conditions, and the cost varies by the type of cancer, the stage at diagnosis, the age of the patient, and co-morbid conditions.

Barriers to access to screening impact early detection. Cultural issues are also important. In addition, health care delivery issues impact the use of screening. If a person doesn't have access to regular care, they are not going to get regular screenings. Interestingly, managed care frequently improves the coverage of screenings, but if there are barriers intrinsic to the plan that make it laborious or difficult, or if an individual has to spend time in their primary care office and then get referred again, this can be a barrier to getting adequate screening.

Physician factors are important. Some physicians are either not aware of current recommendations,

2 Dr. Comstock noted that her company has used this database with several employers who didn't have access to their specific claims information, to be able to estimate what the prevalence and what the cost was based upon the demographics.

don't believe in them, or, given the way our health care delivery system works today, may not have time to focus on prevention. Patients also may only seek them out when they have an acute illness.

Clearly, there are many opportunities for employers to influence early detection through their benefit design, and through partnering with plans to communicate to individuals the value of screening, and what is recommended for certain ages and genders. They can also directly intervene through their provider networks to schedule employees for screening. In some cases, employers in large companies are increasing the convenience by providing screening services onsite.

The second driver of excess cost is extremely important: gaps in notification. Screening does not make a diagnosis. So definitive testing is absolutely essential if screening is to be of benefit. But many individuals don't get timely screening, or they don't get timely notification of the results of screening, or they don't follow through. One study showed that providers in plans were responsible in about 45 percent of cases where there were gaps. Twenty-five percent were attributed to the individual patient who didn't follow through after being notified. And 17 percent of the time it was a combination.

The third driver of excess cost relates to treatment. Proper staging clearly influences the kind of treatment that the provider will recommend, but the reality is there are significant variations in terms of what happens after that. For example, the medical specialty, the level of knowledge of the particular cancer, individual preferences, local patterns of care and geographic proximity to certain kinds of treatment are all important. We know that proper staging leads to better survival, but there is great variation in terms of the performance of a standard diagnostic workup for different kinds of cancer. For example, there is a greater frequency of proper staging in young women with breast cancer than older women; there is better staging in men versus women; in Medicare patients in HMOs versus fee-for-service; in whites versus blacks; and in urban versus rural populations.

The care an individual receives is also influenced by their insurance coverage and concerns about

financial issues. Of course, communication between patients and providers has a major impact, but that communication varies depending upon patient characteristics. Doctors communicate differently with men and women. They communicate differently depending upon the socio-economics and ethnicity of the patient, and they communicate differently depending upon the perceived prognosis. We know that an individual patient's beliefs and attitudes are going to influence whether they seek care, and also whether they are compliant with treatment recommendations. Treatment will also depend upon the patient's perception of potential side effects and, very definitely, on the kind of support structure they have.

END OF LIFE CARE

End of life care also presents both a key issue and a tremendous opportunity. At the end of life, care may focus on heroic efforts to cure the patient, but that may not be in their best interest. Pain management and psycho-social support are crucial, but the management of pain will depend on factors such as:

- Patient attitudes—stoic patients will tend not to report pain.
- Belief that pain is normal with cancer.
- Fear that if they focus on their side effects (depression, nausea, fatigue, pain) that the doctor's attention will be diverted from focusing on treating the cancer.
- Ethnicity.

Studies point to an improvement in the response of providers to treating issues at the end of life. However, there are still many physicians who are not aware of the appropriate treatment for these problems. When it comes to pain medications, there are concerns with regard to regulatory issues. Financial issues are important because patients may be afraid they will deplete their family's financial resources. Finally, there are many issues related to the use of hospice.

There are often delays in referrals to hospice. Most employer plans have coverage for hospice, but it may be hard to find in the plan description so many employees don't know it exists. There are also barriers because, under Medicare, it is necessary that

a patient's prognosis be limited to six months or less before she can get coverage. So the actual referral is frequently delayed, and these patients suffer needlessly.

THE ROLE OF EMPLOYERS

Clearly, there are many opportunities for employers to influence the development of a continuum of care that focuses on prevention, early detection, quality care, rehabilitation and return to work, if possible, as well as palliative care at the end of life.

First, if cancer can be prevented, or detected early, costs will be less and the suffering will be minimized. If side effects could be anticipated and prospectively managed, this could impact lost work time and reduce hospitalization. And, if the link between cancer treatment and flare-up of other conditions is recognized, and the whole person is addressed, costs will be limited and absenteeism will decrease.

What might an employer model look like? Obviously, the exact specifications, components, and strategies depend upon the employer. Crucial factors include:

- Demographics and geographic distribution of the workforce.
- Culture.
- Internal resources.
- Relationships with external health care service vendors, health plans, EAPs, etc.

Organizational support is essential, and an employer can assess this by asking some key questions:

- Do all of your health plans support prevention? Early detection through screening?
- Does the referral process encourage or inhibit follow-through?
- Is there plan outreach to individual employees with regard to the kind of screenings that are critical at their age and for their gender?

- Are there protocols for cancer care? Coverage of clinical trials? Integrated disease and disability management: are these things being done?
- Do your HR policies and programs support work continuity when it makes sense?
- Are there well-designed EAP strategies that are linked with medical treatment?
- Are there creative accommodations available to employees?

The *population-based* program components of an integrated cancer care model are relevant to all employees, because they enhance knowledge of cancer, minimize fear and distress, and motivate individuals to modify and decrease their risk of cancer, as well as to get proper screening. A great tool is a cancer risk appraisal, preferably delivered today through the Internet. It is not expensive, it is not intrusive, and employers can consider optimizing success by partnering with health plans, putting some pressure on them to do the kinds of things that might add value to employees and improve productivity. Employers might also consider working with providers to get people involved in screening, and to ensure follow-up on those screenings.

The *targeted* programs are for the at-risk population—those people who, because of family history or other factors, require a specific set of screening tests at certain ages. They are also for the diagnosed population—those who already have cancer and need information on staging, current recommendations for treatment, and access to both psychosocial and peer support. There are many wonderful not-for-profit agencies and associations that have these services and will provide them for employees.

So, sometimes it is only about providing information, providing access, and coordinating care. That is all that it really takes. And although all employers face constraints in terms of financial resources, and personnel resources, there are many ways to be extremely proactive and creative in developing these programs.

COST-EFFECTIVENESS OF CANCER SCREENING: DETERMINING PRIORITIES AMONG CLINICAL PREVENTIVE SERVICES

Lisa Koonin, MN, MPH³
Director, Office of Health Care Partnerships, CDC

Ms. Koonin discussed a recent study that addressed priorities for clinical preventive services. This study was conducted primarily by the Partnership for Prevention, with sponsorship from CDC and the Health Care Financing Administration (HCFA). The study took a number of years to conduct, and has yielded some very useful information.

The U.S. Preventive Services Task Force (USPSTF), which is the gold standard for recommendations for preventive services, recommends approximately 50 clinical preventive services. There are also other authorities and organizations that recommend preventive guidelines, but all stakeholders know that the delivery of effective preventive services is incomplete. Resources are quite limited, and preventive services differ in their potential for health impact and cost.

Many clinical preventive services work, but given those many recommendations and guidelines that advocate for preventive services, particularly in cancer, where do we begin?

The goal of this study was to look beyond the evaluation of effectiveness and assess each clinical preventive service (CPS) based on its relative value, looking at the whole composite of services recommended, and then to rank them against each other in terms of relative value. This was purposefully designed to assist decision makers in choosing where to increase delivery rates first.

The committee that conducted the work chose to assess 30 clinical preventive services recommended by the USPSTF for the general population. Some of the recommendations were clustered and treated as a

group; for example, instead of individual childhood vaccines as separate services, they were put together as a single group. Tertiary preventive services were not evaluated in this study.

This study is the first to measure the magnitude of health benefit and cost effectiveness consistently across the whole complement of services. The committee ranked two dimensions—*clinically preventable burden*⁴ (that is, the death or disability prevented) and *cost effectiveness* (the net cost relative to a health benefit). The purpose of comparing clinically preventable burden and cost-effectiveness was to identify services that provide the greatest health benefit with limited resources. This provided a way to rank comparable preventive services and determine which hold the best value.

The study committee chose to use a simple scoring system. Clinically preventable burden and cost effectiveness estimates were assigned scores of one to five; that is, each preventive service got a score from one to five for clinically preventable burden and a score from one to five for cost effectiveness. Those total scores were then sorted, divided into quintiles, and then both were added together for a total score. The scores for each dimension were then added together and, finally, the services were put in priority order with the highest ranking services identified.

What was the end result? There were a number of very high priority services identified, some of which have low delivery rates. *This is the place to start.* These services have shown effectiveness, but are delivered currently to less than 50 percent of the population. Number one was assessing tobacco use and providing tobacco cessation counseling for adults. Number two was screening for vision impairment in older people. And number three was colorectal cancer screening.

The point of this study? In trying to determine which service to deliver first, it is important to look at the under-utilized services. Colon cancer is the second

3 Ms. Koonin is the Director, Office of Healthcare Partnerships, at the Centers for Disease Control and Prevention in Atlanta, GA. She directs and coordinates CDC's policy, program and planning activities that impact health systems delivery and relate to managed care and other health care delivery systems.

4 Clinically preventable burden is the portion of disease, injury, and premature death prevented if the service were delivered to all persons in the target population on a regular basis (i.e., under optimal conditions).

leading cause of cancer death for men and women, and the USPSTF recommends screenings for all persons 50 years and older with an annual fecal occult blood test and/or sigmoidoscopy. If these services are delivered, they can reduce about a third of the deaths related to colorectal cancer.

But screening is not happening. In 1997, fecal occult blood testing was only delivered to 18 percent of the target population. Sigmoidoscopy fared better for this population—approximately 30 percent—but nowhere near where it should be, or could be, in preventing death.

The study was published June 22, 2001 in the *American Journal of Preventive Medicine*. The information should prove very useful to health departments, health plans, and particularly to purchasers, helping to clarify which services are highly ranked but under-utilized. Employers and purchasers can improve the delivery of these high priority health services by covering them as a health benefit, by holding health plans accountable for their delivery, and by encouraging the use of these services through financial incentives, flexible work schedules, delivery at the worksite, education, and other means.

HEALTH EXCELLENCE: CANCER PREVENTION AND INTERVENTION — AN EMPLOYER PERSPECTIVE

*Janet Solomon, MA⁵
Health Benefits and Wellness Director,
Texas Instruments*

Texas Instruments (TI) prides itself on having an integrated approach to health promotion and disease prevention. The health promotion, health benefits, occupational health and environmental safety programs all reside within the same department, so their goals are aligned with one another and with the business as a whole.

The vision at TI is to optimize performance through an environment that values the health of TI employees and their dependents. The mission is to effectively deliver an integrated set of resources that:

- Supports personal accountability for health and well-being;
- Supports worker productivity as a product of employee health;
- Aligns with business goals;
- Aligns with attraction and retention goals; and
- Aligns with cost-containment strategies

“We always want to make sure that our employees are aware of the resources that they have at Texas Instruments,” Solomon stressed, “and that they understand that these are important for their quality of life.”

The Health Excellence program hypothesis is that prevention, early detection and wellness efforts will:

- Increase employee and dependent preventive benefit utilization;
- Decrease health plan costs by preventing disease or treating disease in early stages of development; and
- Increase employee productivity by keeping employees on the job, healthy and happy.

Recently, Janet Solomon and her staff had the chance to test this general hypothesis in a very specific way: by benchmarking their cancer and prevention cost data against one of their health plan’s books of business and against projections produced using demographic data in a cancer cost model.

TI has approximately 45,000 covered lives; 60 percent are male and 40 percent are female. When these and other pertinent demographic data were “plugged in” to a model developed by Practice Pattern Sciences (PPS),⁶ the model suggested that TI should be spending about 8 percent of their health care dollars

5 Ms. Solomon joined the Texas Instruments (TI) Total Compensation and Benefits Department in January, 2000 as the Director of Health and Wellness Programs. Her responsibilities include strategy and program development for the Health Promotion Programs, the Texins Activity Centers, Rewards and Recognition Services and the Concierge Service. She recently added to her overall responsibility the administration of the US Health Benefit Plans.

6 This model is discussed in greater detail in the presentation by Marcia Comstock, MD.

on cancer-related causes. In reality, that figure was only 6.8 percent. Also encouraging: the PPS model suggested that TI was likely spending about 3.3 percent of health care dollars on preventive care. The actual number for prevention at TI was 5.8 percent.

To further explore this scenario, Ms. Solomon asked TI's data provider to look at a book of business for TI and compare it not only against what the PPS model said, but also against their book of business. The most comparable book of business was their point service (POS) plan, which covered 2.8 million lives. The POS plan had about 7.5 percent of its dollars related to cancer-related care (compared to TI's 6.8 percent). Also, the POS plan showed .56 claims per member for those 2.8 million lives, and at TI the number was .32 claims per member. What about prevention? Again, the POS plan was spending about 5 percent of overall health care dollars on preventive efforts. The PPS model suggested that TI was probably spending about 3.3 percent on prevention, but the actual TI number was 5.8 percent.

Ms. Solomon and her staff are proud of these numbers, and feel that they demonstrate not only Texas Instruments' commitment to prevention—they invest more than would be expected to keep their employees healthy—but also that this commitment is paying off in the bottom line for cancer—lower total costs *and* fewer claims per member.

The backbone of TI's cancer prevention efforts include:

- Benefit plans that enable and encourage well checks, following national health standards and guidelines;
- Benefit plan review and revisions yearly;
- Convenient on-site mammography and male health screenings;
- Resource awareness campaigns;

- Specialized campaigns (i.e., Race for the Cure, skin cancer screenings)
- Self-referral nutrition therapy; and
- On-site nurse case management/accommodations.

THE SHORT-TERM COST IMPACT OF COLORECTAL CANCER SCREENINGS ON HEALTH INSURANCE PLANS

Durado Brooks, MD, MPH⁷
Director, Prostate and Colorectal Cancers,
American Cancer Society

[The research presented by the American Cancer Society at this consultation was preliminary and not yet available for public dissemination. Please contact ACS directly for further information on this study.]

CANCER INFORMATION FOR THE EMPLOYEE

Elisabeth Handley, MPA⁸
Associate Director of Outreach and
Partnerships, National Cancer Institute

The National Cancer Institute (NCI) is one of the 27 centers and institutes that are part of the National Institutes of Health in Bethesda, Maryland. NCI's mission is to lead the nation's fight against cancer by supporting and conducting groundbreaking research in cancer biology, causation, prevention, detection, treatment, and survivorship. NCI has a diverse network for communication with patients, families, clinicians, providers, advocacy groups, medical societies, the research community, cancer centers, hospitals, and government agencies. The Institute's annual budget of 3.3 billion dollars has been on the rise in recent years, and because NCI is a scientific-based organization, most of that 3.3 billion dollars goes to fund actual scientific research.

7 Dr. Brooks is a specialist in Internal Medicine and practiced primary care internal medicine for 15 years. In 1999, Dr. Brooks received a Masters degree in Public Health from the Harvard School of Public Health. Following a one-year Senior Health Policy Internship with the U.S. Department of Health and Human Services, he joined the American Cancer Society as the Director of Prostate and Colorectal Cancer programs at the National Office in Atlanta, GA.

8 Miss Handley, Associate Director of Outreach and Partnerships, is in charge of the National Cancer Institute's education campaigns to consumers and health care professionals on cancer prevention and screening, including mammography and cervical cancer screening, the 5-A-Day program, and I-131 communications.

Why such a large budget? There are 8.4 million Americans today that have a history of cancer, and each year another 1.2 million people are diagnosed with new cases of cancer. Nearly 80 percent of those diagnosed with cancers are ages 55 and older. Over the course of a lifetime, men in the U.S. have a one in two lifetime risk of developing cancer. For women the risk is one in three.

NCI can be an invaluable resource for anyone working with cancer patients, but may be especially useful for employers who want to support employees as they move from diagnosis to, hopefully, remission. Some of the available resources include:

- Cancer Information Service (1-800-4-CANCER). Both English and Spanish speaking cancer specialists available; piloting an online chat with people from 12 to 4pm for interactive help;
- Cancer.gov;
- Cancer fax service—can get information via fax by dialing 301-402-5874 and choosing from a list of helpful documents available by fax;
- CancerNet—a service to obtain cancer information by computer;
- Print materials geared from diagnosis to survivorship;
- Low literacy materials;
- Publications in Spanish and Spanish-speaking Cancer Specialists at 1-800-4-CANCER;
- Publications for special populations;
- Posters, PSAs, drop-in articles.

NCI also has a number of prevention campaigns. A current one addresses cervical cancer detection and prevention. Working in partnership with the Health Care Financing Administration (HCFA), NCI is trying to reach the target audience—women 65 and older—with the message that screening at that age is lower than it should be. In the month of July when the cervical screening benefit changed for Medicare to make it a more frequent benefit (one screening every

two years) a packet of materials was disseminated to health professionals, informing them of the change and soliciting their help in increasing screening rates.

The NCI Five-A-Day program has also been quite well received. Since 1991, NCI has been urging Americans to eat at least five servings of fruits and vegetables each day. Television and radio public service announcements (PSAs) have reached Americans with the message that fruits and vegetables are an essential part of a cancer-preventing diet. Some of the 90-second PSAs feature Graham Kerr preparing tasty recipes that are low in fat and high in vegetables and fruits. NCI also partners with Produce for Better Health, a group of nearly 1,000 members of the grocery industry (representing more than 30,000 grocery stores) licensed to carry the Five-A-Day message.

A recent evaluation of the Five A Day program confirmed it is indeed increasing awareness and even changing behavior; since the program began, the percentage of Americans who report eating at least five fruits and vegetables each day has risen from 8 to 20 percent. Of course, the goal is to increase that number even more, with special emphasis on increasing African American and Latino consumption of fruits and vegetables.

As the Associate Director for Outreach and Partnerships at NCI, Ms. Handley is involved in a number of ongoing partnerships. One of those is with a very important employer, the General Motors Corporation. GM is making information available to 140,000 of its female employees and retirees about an opportunity to be screened to determine the risk for developing breast cancer. After the screening, participants are given information about NCI's "STAR" trial, which is a breast cancer prevention study. NCI is also working with a grassroots advocacy group called Us Too to provide more information, at the local level, to men diagnosed with cancer.

9 Study of Tamoxifen and Raloxifene.

CASE STUDY: COLORECTAL CANCER

PREVENTION AND EARLY DETECTION OF COLORECTAL CANCER

Laura Seeff, MD¹⁰

Medical Epidemiologist and Internist, CDC

The leading cause of death among U.S. men and women is cardiovascular disease, while the second leading cause is cancer. Among cancers, the second leading cause of cancer related deaths is colorectal cancer. The American Cancer Society estimates that in 2001 there will be over 135,000 new cases and almost 57,000 deaths from colorectal cancer.

It is a common misconception that this is a disease of just men. This is a disease of men and women, and it is a disease of all races. Rates are higher for men but high in both men and women. Rates have been on a plateau, perhaps trending down just a bit, between 1973 and 1997. The slight downward trend is likely due to a combination of increased screening and some changes in primary prevention. Colorectal cancer is primarily a disease of people in their 50s and older, with rates starting to increase in the 40s and then rapidly rising after age 50.

The vast majority - 65 to 85 percent - of cases occur in people who have either no risk or no known risks for colorectal cancer. About one-third of cases occur in people with a family history of colorectal cancer; that is, a parent or sibling who has had or a polyp at age 50 or younger. The remaining cases involve patients with somewhat rare syndromes that lead to colorectal cancer.

There are several things one can do to reduce the risk of colorectal cancer. The evidence is strong that exercise reduces the risk of rectal cancer, but less strong that it reduces the risk of colon cancer. There are significant data on diet and colorectal cancer, but much of it is conflicting. Researchers certainly know

that a diet low in fat and high in fiber reduces the risk of various chronic diseases like heart disease and diabetes, and it probably reduces the risk of colorectal cancer, as well. Until research confirms the role of diet in preventing colorectal cancer, the CDC still recommends that sort of diet.

There are also numerous pharmaceutical agents being evaluated for their preventive effect in colorectal cancer. Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen or Celebrex are being licensed to prevent polyps and will likely soon be licensed to prevent colorectal cancer in average risk persons. Many others drugs and supplements are under review to determine their possible benefit in reducing colorectal cancer.

The best way to prevent colorectal cancer is by screening—testing people who have no evidence of disease to detect pre-malignant or early disease when outcomes can be most affected. If a pre-cancerous polyp can be detected and removed, it will not have the chance to become cancerous. But once a polyp starts to grow, the patient will develop metastatic disease, and the prevention opportunity is lost. Screening for colorectal cancer works both through prevention and early detection. When a polyp can be removed, a case of cancer is prevented; when cancer is detected earlier, the patient has a better chance at survival.

There are three national guidelines for colorectal cancer screening, and all recommend several or a combination of the following four tests¹¹.

- Fecal occult blood test (FOBT) annual (estimated cost \$10-\$25 per test)
- Flexible sigmoidoscopy every 5 years (estimated cost \$150-\$300 per test)
- Double-contrast barium enema (DCBE) every 5-10 year (estimated cost \$250-\$500 per test)
- Colonoscopy every 10 years (estimated cost \$800-\$1600 per test)

¹⁰ Dr. Seeff is a medical officer and epidemiologist in the Division of Cancer Prevention and Control (DCPC) at the Centers for Disease Control and Prevention. The majority of her work at CDC involves colorectal cancer and efforts to increase colorectal cancer screening rates. Prior to joining CDC in 1998, Dr. Seeff was an assistant professor in the Department of Medicine at Emory University School of Medicine.

¹¹ Digital rectal examinations are not recommended as an effective screening tool for colorectal cancer.

There is excellent evidence to support the use of these screening tests. The strongest data from randomized controlled trials show a reduction in both cases and deaths from colorectal cancer using FOBT. Very good data (from case-control trials) support the use of sigmoidoscopy in reducing mortality. Indirect evidence supports the other two tests. Of course, these are the focus of very active research, and these will probably also be changing.

Colorectal cancer screening has been compared to various other preventive services in terms of cost-effectiveness; that is, cost per year of life saved:

- Mandatory motorcycle helmets—\$2,000
- Colorectal cancer screening—\$25,000
- Breast cancer screening—\$35,000
- Dual airbags in cars—\$120,000
- Smoke detectors in homes—\$210,000
- School bus seat belts—\$1,800,000

Colorectal screening is clearly cost effective. Unfortunately, many people do not receive these tests. The CDC is very committed to increasing screening rates and controlling colorectal cancer. The Division of Cancer Prevention and Control is in year 4 of “Screen for Life,” a national colorectal cancer action campaign that includes public service announcements that can be put in print, on the radio and on television. All materials are available on the CDC website and can be downloaded and locally tagged with a company’s name. The CDC also has a slide set available on its website called “A Call to Action: Prevention and Early Detection of Colorectal Cancer.” It is designed for health care providers to use in their own settings and can be downloaded as Powerpoint slides.

Finally, Dr. Seeff discussed two of the many research activities being conducted at CDC’s Division of Cancer Prevention and Control. The first is a study called SECAP—the study of endoscopic capacity—which will determine whether there are enough trained providers to perform endoscopic screening if

everyone 50 and over were to be screened. The second is a study to test a proposed Health Plan Employer Data and Information Set (HEDIS) measure. HEDIS was designed by the National Committee for Quality Assurance (NCQA) as a method for measuring the performance of health plans in providing certain services. Since there is not currently a HEDIS measure for colorectal cancer screening, the CDC and NCQA are piloting one.

TESTING FOR COLORECTAL CANCER AMONG AN INSURED POPULATION AT GENERAL MOTORS

Reuben Varghese, MD, MPH¹²
EIS Officer/Medical Epidemiologist, CDC

The CDC and the General Motors Corporation conducted a study examining testing for colorectal cancer among an insured population at General Motors between 1995 and 1999. As the CDC lead for this important study, Dr. Varghese discussed its methods and findings.

In the early 1990’s, a unique partnership developed between CDC and General Motors. This partnership is still in place, and is currently focused on improving the delivery of clinical preventive services among GM’s insured population. While many studies focus on the needs of uninsured populations, the vast majority of Americans are insured, and the data indicate that they often don’t receive the necessary screening benefits.

General Motors Corporation is the number one corporation in the world based on revenues. The workforce comprises mostly hourly workers (80 percent); the remaining 20 percent are salaried employees. The average age of GM employees is 50 years old, which makes this a somewhat older-than-average population.

General Motors is the largest U.S. private health care purchaser, covering more than 1 million lives. In 2000, General Motors spent \$4 billion on health care,

¹² Dr. Varghese is an Epidemic Intelligence Service Officer with the CDC. He has been with the CDC since 2000, working in the Division of Prevention Research and Analytic Methods. His primary research project is analyzing predictors of colorectal test receipt among 50-64 year old employees at the General Motors Corporation.

which translates to about \$1200 per vehicle—more than the price of the steel per car. GM offers three insurance products: fee-for-service (FFS) or traditional indemnity; preferred provider organization (PPO) plans; and health maintenance organization (HMO) plans. The CDC/GM study focused on the first two products (FFS and PPO plans), as General Motors pays for these products directly, and maintains the claims data.

The benefit structure of GM health plans varies by pay type. General Motors pays most of the office visit fee for employees and dependents enrolled in PPOs – whether salaried or hourly. In the fee-for-service population, however, GM pays the office visit fee for salaried employees (and dependents) only; hourly employees and their dependents must pay for office visits themselves.

The CDC/GM study had two objectives: to determine rates of colorectal cancer testing for an insured population and to determine factors associated with colorectal cancer testing rates among insured enrollees, especially the plan type.

This was a retrospective cohort study from 1995 through 1999. It involved insurance claims linked to personnel data and the study population was 50 to 64-year-old employees and their dependents. There were three exclusion criteria. First, those who were Medicare eligible were excluded, as Medicare claims would not be part of GM's claims database, so procedures done in that group could not be captured. Also, those submitting claims for rigid sigmoidoscopy were excluded because this test is not considered adequate for screening. Finally, those with “basic”¹³ GM fee-for-service coverage were excluded because researchers could not be certain they were capturing all of the claims data for this group.

The outcome of interest was any colorectal cancer test. Therefore, anyone who had a fecal occult blood test in the previous year, or a flexible sigmoidoscopy, colonoscopy or double-contrast barium enema in the previous five years, was included. The exposure of

interest was plan type, and the co-variants examined were age, sex, marital status, pay type, and work status (i.e., active versus retired employee).

There were 284,000 people in the study; the majority were aged 50 to 59, with 30 percent being 60 to 64. There was an equal distribution between men and women, and the majority of the individuals were married, at 81 percent. The majority of this age group was retired at 58 percent. Also, 80 percent of this population were hourly employees or their dependents, and the majority were enrolled in fee-for-service plans.

The overall colorectal cancer screening rate (using any of the four accepted tests) for this well-insured, well-paid population was 32 percent during the five-year period. This is similar to data from the Behavioral Risk Factor Surveillance System, which is national self-report data. It also compares poorly with age-appropriate screening test utilization among General Motors women for mammography (65 percent) and Pap smear (57 percent).

It is important to note that colorectal cancer screening was not covered by General Motors during this time period. But that was not the only barrier to screening. Several other factors seemed to determine the likelihood of a given person receiving screening:

- Older people were more likely to be screened: those 55 to 59 years old were 17 percent more likely to undergo testing than the reference group of 50 to 54 year old enrollees, and 60 to 64-year-olds were 28 percent more likely.
- Married people were 9 percent more likely to undergo testing than single people.
- Salaried enrollees and their dependents were 37 percent more likely than hourly enrollees to undergo testing.
- Those enrolled in PPO plans were 33 percent more likely to undergo testing than those enrolled in traditional indemnity or fee-for-service plans.

13 This is a benefit plan for salaried GM employees whose non-General Motors employed spouses provide the benefit coverage for both parties.

Based on previous research on mammography, Pap smear, and actual screening rates at General Motors, there seemed to be an interaction between plan type and pay type. Those enrolled in PPO plans were 9 percent more likely to undergo testing than those enrolled in FFS plans. Hourly employees in PPO plans were 41 percent more likely to undergo testing than the FFS service group. The explanation that seems to be consistent, based on previous and current research at GM, is that paying the office visit fee for testing seems to be the primary barrier. In other words, those who must pay for their own office visit (i.e., hourly employees and dependents enrolled in FFS plans) are the least likely to be screened for colorectal cancer. This effect also held true for mammography, Pap smear, and chlamydia screening among GM employees.

The bottom line messages from this study?

- Colorectal cancer tests are under-utilized among the insured.
- Major factors associated with higher colorectal cancer testing rates include enrolling in PPO plans or being a salaried employee/dependent.
- Colorectal cancer test receipt was associated with office visit coverage.

Based on these conclusions, the researchers have recommended the following actions to leaders at General Motors:

- Provide office visit fee coverage for hourly FFS employees and their dependents.
- Expand FFS and PPO coverage to include colorectal cancer screening for average-risk people.
- Educate enrollees and providers about the preventability of colorectal cancer and the effectiveness of available screening tests.

SCREENING FOR COLON CANCER: THE BUSINESS CASE

Patricia Salber, MD, MBA¹⁴
Medical Director, Managed Care
Health Care Initiatives
General Motors Corporation/
The Permanente Company

Colorectal cancer (CRC) is common and deadly. However, screening is known to be effective, and guidelines for screening have been promulgated by leading health organizations. Unfortunately, only one in three Americans is screened for CRC, perhaps because current tests are inconvenient and distasteful, or because people are reluctant to talk about their bowels. Or maybe the reason is systemic: the strong evidence to support screening's effectiveness is fairly recent and not yet entrenched in the practice of medicine.

For employers and health plans implementing colon cancer screening programs, passive availability of screening tests (i.e., benefit design) is not enough. Health care decision makers must be convinced to invest in comprehensive CRC screening. Dr. Salber and her colleagues at Kaiser Permanente have set out to do just that, by developing and promoting the business case for CRC screening.

For a CRC screening program to be effective, several conditions must exist. First, patients and clinicians need to share the belief that CRC screening is important and effective. This means that physicians and plans need to recommend screening to all patients for whom it is appropriate, and patients must act on that recommendation. Second, health care organizations must track whether their members have been screened, which can be especially challenging in a fragmented health care system. Third, the plan must have a strategy for proactive outreach and education targeted at both physicians and members. Patient-specific screening reminders are one proven example. Fourth, providers must have the workforce, facilities

¹⁴ Dr. Salber is a Permanente Medical Group emergency physician and is currently serving as the Medical Director, Managed Care, Health Care Initiatives, for General Motors Corporation. She is board certified in Internal Medicine and Emergency Medicine and has completed a Pew Fellowship in Health Policy.

and technical expertise to perform screening tests well. Finally, health insurance must pay for screening and follow-up exams.

Why should health plans provide comprehensive CRC programs? First, screening is the right thing to do—it saves lives. Screening is also cost-effective—at about \$20,000 per year of life saved, it is far more cost-effective than many other well-accepted preventive measures, including mammography. Increasingly, members and potential members will expect screening program as awareness campaigns begin to take hold and drive increased demand.

Purchasers are also beginning to demand CRC screening programs. For example, the National Business Coalition on Health HMO Performance Expectations and Common RFI, used by the V8 purchasing coalition, GM, Marriott and others to inform purchasing decisions, added a CRC screening question in 2001. Similarly, the NCQA is considering adding a CRC screening measure to the Health Plan Employer Data Information Set (HEDIS) as early as 2004.

There are also legal reasons to consider implementing a comprehensive CRC screening program. Some states have already enacted laws prohibiting the denial of reimbursement for CRC screening. In addition, failure to screen for CRC can result in malpractice claims. While this is not common now, the risk will increase as public awareness increases and screening guidelines become entrenched.

There are, of course, several potential disadvantages of CRC screening. First, setting up and/or beefing up screening programs can be costly:

- \$38 for FOBT
- \$279 for flexible sigmoidoscopy
- \$296 for double contrast barium enema
- \$1012 for colonoscopy

In addition, false positives can lead to additional testing, which brings both additional cost and inconvenience for the patient. Third, the benefits of colorectal cancer screening occur many years after the cost; given that the reduction in mortality is one-third after 13 years, the financial benefits of a CRC screening program may accrue to other payors if the member leaves the plan. Fourth, the measurement of adherence to colon cancer screening is complex. Fifth, screening can cause medical complications with significant human and economic consequences.

Partial implementation of screening programs may be risky, as members forced to wait for testing, results or follow-up care will become frustrated. Full implementation, however, may require the creation of new workforce and care settings. “Focused factories”—where technicians specialize in CRC screening protocols—may be more efficient and proficient in providing screening, but they may also lead to a backlash from providers who offer these services on a more limited scale.

ADVANCING HEALTH PLAN ACCOUNTABILITY AND QUALITY: THE NBCH V8 PROCESS

*Suzanne Paranjpe, PhD¹⁵
Vice President, Strategic Development
National Business Coalition on Health*

As a leader in the V8/Common RFI¹⁶ project for the National Business Coalition on Health, Dr. Paranjpe discussed the RFI process and how it benefits all health care stakeholders—health plans, employers, and members—by improving the quality of health care.

The V8 group started as a group of six coalitions of the National Business Coalition on Health. When the group convened to discuss common goals and opportunities across their various marketplaces, the evaluation of health plans arose as a significant

¹⁵ Dr. Paranjpe is Vice President of Strategic Development for the National Business Coalition on Health in Washington, DC. She is responsible for NBCH's V8 project—a coalition-driven approach to evaluating health plans using standardized measures. She also oversees the Clinical Performance Enhancement Center (CPEC), which provides an informational infrastructure for providers, business, labor and consumers to enhance the quality of care.

¹⁶ Request for Information.

opportunity. At the time, the Pacific Business Group on Health was beginning an effort to set performance expectations, as was the Greater Detroit Area Health Council, among others. Given this common interest, they formed a group and called themselves the Six Pack Group, later to be known as the V8 Group. The “V” stands for verification, a crucial part of the RFI process¹⁷.

The V8 Group continues to move forward, and has since been joined by Marriott International, Lucent Technologies - even the Health Care Financing Administration (HCFA). HCFA’s interest is in what the private sector is doing to evaluate health plan performance, as they are examining the possibility of releasing performance data to Medicare beneficiaries. Of course, behind each of these coalitions are large purchasers, both employers and labor organizations, and in some cases the public sector.

What is the RFI Project? It is a standardized health plan performance evaluation and quality improvement process. Although primarily used to evaluate HMOs, the process is applicable to PPOs, Medicare+ Choice and point-of-service (POS) plans as well, and is implemented in local markets by coalitions on behalf of their members. The RFI process provides a repository of benchmarking data for more than 100 health plans nationally.

What is the benefit of the RFI Project? Standardization is a key benefit. Standardization is core to other industries, such as the automotive manufacturers, who want to give their suppliers a common set of specifications for the product to be delivered. Similarly, the RFI Project is developing a common set of specifications for the delivery of health care. These performance expectations, once standardized, give the health plans in a local community - as well as their “suppliers”(providers) - a common direction and goal for process improvement. The coalitions and the members then have access to the standardized performance data, so they can compare performance of plans in Detroit versus Indiana versus Colorado, and can use that information for value-based purchasing. The key to this process is that coalitions give the health plans

specifications, measure against them, work with them to improve, and make purchasing decisions based on improvement over time.

The value to the health plans is that this process: significantly reduces the number of disparate RFIs; provides them with a collective voice to tell them what customers want in terms of performance improvement; empowers them to share consistent direction with their “suppliers” (providers); and creates an opportunity for recognition as “Best in Class.”

There are some important principles governing the Common RFI structure and process. For example:

- The RFI should be standardized and reflect state-of-the-art performance expectations.
- The V8 process should not duplicate other processes nor ask for information that will not be used.
- Health plan responses to the V8 RFI must be *verified* and the scoring of information must be consistent across those doing the scoring.
- The focus should be on “moving the needle” and not on the score itself.
- The sharing of comparative data can improve health plan performance over time.

In addition, the whole RFI focuses on integration—trying to ensure that the health plan: is an entity that can *organize and guide*; that it is *accountable*; and that it demonstrates superior *administrative capabilities*.

The health plan organizes and guides:

- Organizes the delivery system
- Promotes member health and participation in care
- Provides a focus on physicians as care managers
- Ensures safe, high quality care (e.g., Leapfrog Group standards)
- Provides timely and pertinent clinical information to providers and members
- Demonstrates an understanding of all aspects of member health, including sensitivity to work-place productivity issues

¹⁷ The RFI can be found on the National Business Coalition on Health website: www.nbch.org.

The health plan is accountable:

- Fosters high level of member trust and involvement
- Provides high-quality member services that are member-centered and member-friendly
- Proactively supports health care providers in efforts to improve quality, service, safety and the cost of care
- Ensures appropriate resource management consistent with high quality care
- Demonstrates involvement in the community, including cooperative efforts with other plans

The health plan demonstrates superior administrative capabilities:

- State-of-the-art information management systems
- Strong organizational structure and financial stability
- Use of continuous quality improvement processes to improve performance
- Financial arrangements with providers that are designed to ensure that members receive appropriate and cost-effective care
- Timely and accurate payment of network providers
- Meets employers' administrative needs

One of the sections of the RFI focuses on clinical preventive guidelines. The guidelines used by health plans should be implemented plan-wide, should be current (i.e., have been reviewed within the past two years), and must be based on a national standard. The

plans are also asked for an in-depth review of two guidelines for which there has been documented improvement. Specifically, what are the key indicators for monitoring this guideline? How does the plan provide feedback to providers on their compliance compared with their peers? What are the mechanisms to improve compliance?

Why does all this matter? It matters because the feedback goes back to the purchasers who ultimately make the decision about plan offerings; and it goes back to the health plans so that they can work to improve. The feedback reports include plan-specific strengths and opportunities and comparative health plan performance at the local, regional and national levels.

The RFI Project is working, and plans are improving based on the RFI feedback process. So what is the future for the V8 Process? First, the V8 Group wants more purchasers to be involved. Group members are hoping that other private sector purchasers join the initiative for 2002, and they are seeing great interest on the part of public sector purchasers in some local markets wanting to become involved. In the long term, the Group would like to see greater collaboration and synergy between the efforts of Medicare and Medicaid in any performance evaluation that takes place.

The V8Group is also planning to: evaluate other areas of the "supply chain," such as integrated delivery systems; provide education about and promote greater use of data; and employ greater use of information technology to improve efficiency and functionality.

APPENDIX A:

PARTICIPANT LIST

Clyde B. Schechter
Assoc. Prof., Family Medicine & Comm. Health
Albert Einstein College of Medicine

Gregg Walker
Director, Health Care Initiatives
American Cancer Society

Carol Friedman, D.O.
Medical Epidemiologist
CDC

Kymber N. Williams, M.A.
Health Communication Specialist
CDC

Donald Shriber
Associate Director, Washington Office
CDC

William Yang, MD
Medical Director
The Coca – Cola Company

Marcia Comstock, MD, MPH
President
Comstock Consulting Group

Carol Staubach
Vice President
Comstock Consulting Group

George C. Carpenter, IV
Chairman & CEO
CORE, Inc.

Vauna Lawrence
Public Health Advisor
D.C. Department of Health

Michael Richardson
Chief, Bureau of Chronic Disease
D.C. Department of Health

Carol W. Garvey, MD
Health Officer
U.S. Dept. of Health and Human Services

Raymond R. Strocko, MD, MPH
Medical Director, U.S. Region
Dupont Co.

Patricia Kryzalka
Occupational Health Manager
Eastman Kodak Company

Carla Dancy
Principal
EDS

Gregory N. Larkin, MD
Director, Corporate Health Services
Eli Lilly and Company

Lillian Koenig
Associate Director, Clinical Services
Federal Occupational Health

Donna Tomlinson, MD
Health Promotions Manager
General Electric Power Systems

Timothy J. Crimmins, MD
Vice President & Director, Health and Safety
General Mills

Jane F. Barlow, MD, MPH, MBA
Physician Program Manager
IBM

Pamella Thomas
Medical Director
Lockheed Martin

Debi Grossman
Director of Training/Medical Affairs
MAMSI

Andie Rowe
Wellness Manager
MAMSI

Al Bacchus, PhD
Program Coordinator, Corporate Health Wellness
Montgomery College

Catherine Kunkle
Vice President
National Business Coalition on Health

Elisabeth A. Handley
Associate Director, Outreach and Partnerships
National Cancer Institute

Ginger Penick Parra
Senior Research Associate
National Health Policy Forum

Cindy Campbell
Strategic Account Director
Ortho Biotech

Tom Hiriak
Director, Strategic Accounts
Ortho Biotech

Laura M. Simonds, M.S., M.Ed.
Strategic Account Manager
Ortho Biotech

Garry M. Lindsay
Director of Business Partnerships
Partnership for Prevention

Barbara Wasserman
Medical Director
Pepco

Bernellyn Carey
Manager, Office of Health
Board of Pensions, Presbyterian Church

Ralph Staggers
Rx Critique

Elaine J. Herrmann
Manager, Benefits Development
Sara Lee Corporation

Mary Anne Restuccia
Nurse Consultant
U.S. Office of Personnel Management

Robert Shaw, MD
Chief Medical Officer
Texaco

Edward C. Alvino, MD
Senior Medical Director
UNUM Provident

Connie S. Lawson
Director, Occupational Health
Health Promotion
Verizon Communications

Tricia Wellenbach
Vice President, Corporate and Community Relations
The Wellness Community

APPENDIX B:

RESOURCES

American Cancer Society

www.cancer.org

Avon Breast Cancer Crusade

www.avonbreastcare.org

Cancer Care

www.cancercare.org

National Breast Cancer Coalition

www.natlbcc.org

National Cancer Institute

www.nci.nih.gov

National Coalition for Cancer Survivorship

www.cansearch.org

National Comprehensive Cancer Network

www.nccn.org

Washington Business Group on Health – CDC Portal Site for Business

www.wbgh.org/cdc

