engaged public

Engaged Benefit Design

Adding Value to Insurance

December 2011

Contents

Executive Summary

It is well documented that the United States spends more for health care than other industrialized countries, covers fewer citizens and that people often suffer adverse health outcomes due to uneven access to adequate care and the underuse and overuse of health care services.

These problems result, in part, because current financial incentives to both insured patients and providers tend to encourage overuse of services that are frequently expensive and often not necessary. This makes care, and therefore insurance, more expensive. When insurance costs more, fewer people can afford it contributing to lack of coverage. In order to reduce the cost of premiums, high deductibles are often imposed to limit the use of resources, but this often leads to decreased use of cost-effective, low-cost services such as prevention and good chronic disease care. Payment reform efforts are underway to create incentive structures for providers to reduce unnecessary services and assure provision of high value care (the provision of health services for individuals and populations, at an affordable cost, that increase the likelihood of desired health outcomes and are consistent with current professional knowledge). Engaged Benefit Design (EBD) is intended to move consumer incentives away from unneeded care and toward effective care and to make coverage more affordable and available. It also aims to educate and engage consumers in their health care decisions.

Current health insurance benefit designs do not typically function to guide consumers to pursue high value services or to undertake informed consideration of services that may or may not benefit them. These latter services are referred to as preference sensitive and supply sensitive care and represent a significant portion of healthcare expenditures. The Dartmouth Atlas of Health Care provides reports on both forms of care.

Preference sensitive services are those that may be appropriate in some circumstances and not in others, often depending on the needs and values of the person receiving the service. Unfortunately, the choice to provide the service often reflects the preference of the provider, who is compensated to provide it, rather than that of the consumer who is most directly impacted and pays for it, either directly or indirectly. This is because current delivery structures, the complexity of such decisions and the absence of clear available information about risks, benefits and alternative options favor deferral of care choices to providers. (Click here for a report on Preference Sensitive Care)

Supply sensitive services are often appropriate but are delivered to a higher proportion of a population when the supply of those providing services in the region is higher. In many cases, this increased delivery of services can be associated with worse rather than better outcomes and usually results in higher costs (Click here for a report on Supply Sensitive Care)

EBD provides a mechanism to build incentives into benefit design that encourage consumers to seek high value care and to undertake informed consideration of preference sensitive and supply sensitive care options according to their own needs and values. It also discourages or excludes some low-value care. In many cases, it provides incentives for use of Patient Decision Aids (PDAs) to inform consumers about the services available for treatment of a specific condition and to facilitate a true shared decision-making process between patients and their providers.

EBD consists of three elements:

- First is a set of high value services which evidence supports as contributing to improved health and which are known to be underused. Included are screening, prevention and evidence-based chronic disease care. These are provided to consumers without cost sharing.

- Second is a set of services that are preference sensitive or supply sensitive and which evidence indicates are overused. These are subject to increased cost sharing. Examples include joint replacement surgery, MRI of the low back and coronary artery stenting.

- Finally, EBD includes incentive strategies to engage consumers and providers in the use of well-studied PDAs produced by the Foundation for Informed Medical Decision Making. These decision aids, developed for a broad audience, contain clear explanations of what the research shows about the pros and cons of treatment and screening choices to help consumers work with their providers to make decisions that are best for them. Current research indicates that informed consumers tend to choose less invasive, sometimes less expensive care when they fully understand their options.

The number of services treated with variable cost sharing should be large enough to impact cost and improve outcomes but small enough to administer and for consumers and providers to understand. The selection of services is based on evidence and with the scrutiny of Colorado medical experts that are financially disinterested. There should be actuarial equipoise or balance between these collections of services such that increased cost sharing and reduction in consumption of unneeded care will serve as a cost offset for first dollar coverage of high value services.

EBD is intended to be applied to existing health insurance plans by reducing or eliminating cost sharing for those services identified as high value and raising cost sharing for selected preference sensitive and supply sensitive services. The increased cost share is in the form of additional co-payments for specific services that do not count toward a patient's deductible. Incentives for use of PDAs may include reductions in this additional cost sharing, compensation to providers whose patients complete appropriate decision aids and/or a reward to patients after completion of a PDA such as a cash award or gift card.

This strategy allows for broad application across a variety of benefit designs and maintains consumer choice while still improving value and managing cost. It is also a tool for "managing the medical commons". Pooled resources, like insurance premiums, are subject to overuse when services are available at low cost. By providing timely information about decisions and including incentives to consider care choices more thoughtfully, consumers are empowered to make better decisions for themselves and, at the same time, to reduce unnecessary care that may expose them to unnecessary risk and cause insurance premiums to rise.

Introduction

Health insurance benefit packages define what health care services we consume and how they are paid for. Benefits should reflect the values of those who seek care and of those who contribute the resources needed to pay for that care. Benefits should also promote quality as defined by the Institute of Medicine - "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".

Because healthcare is complex and because few people know what services they will need in the future, it is difficult to make wise choices when purchasing healthcare insurance. Both over-insurance (rich benefit packages that cover and encourage use of marginally effective but expensive services) and under-insurance (poor coverage for high value services that are then underutilized) are common in the United States.

There is a need to be more thoughtful about shared resources, such as health care paid for by insurance, and how they are used in the care of a population while also respecting the needs and values of individuals. Coherent economic incentives are needed to accomplish these goals. This can be undertaken on the delivery, or supply, side of healthcare by changing the way providers are paid to encourage better health outcomes rather than a greater volume of service delivery. This strategy has resulted in the development of bundled payment systems like Prometheus and the Medicare ACE pilots, Patient Centered Medical Home pilots and the movement to organize the broader delivery system toward Accountable Care Organizations with global budgets.

It is also reasonable to have aligned incentives on the consumer, or demand side, of the healthcare cost equation as envisioned by EBD. The structure of healthcare benefit packages is an under-recognized way to promote the goals of better resource stewardship, affordability, improvement in overall health, encouragement of personal responsibility and the creation of new incentives for positive redesign of the health care system.
Such incentives, on both the supply and the demand side of the healthcare equation, should be evidence-based and structured to make the best use of resources in promoting individual and community health.

EBD is an approach to health care that consists of a list of evidence-based, high value services that are included in a benefit package without cost at the point of care and a list of preference sensitive and supply sensitive services for which cost sharing is increased. A third component of EBD is the inclusion of incentives to learn about risks, benefits and alternatives to selected care decisions that are best made with the full and informed participation of the person seeking care.

The approach is intended to respect individual choice in selection of health insurance by its adaptability to a variety of existing benefit structures. It also respects individual choice in the selection of services while giving incentive to pursue high value services and to give careful consideration of some preference sensitive and supply sensitive care. It is designed to keep overall health care costs controlled so that it is affordable and available to more people while enhancing quality of care. Services treated with variable cost sharing are those suggested by current best evidence. Information provided to patients in the decision-making process is also evidence based and presented in a format that is accessible by a lay population.

Value-Based Benefit Design is increasingly viewed as one element among strategies to improve the value of healthcare through a smarter approach to constructing insurance products. Its goal is to encourage wiser healthcare decisions by consumers through recognition of the variability in the value of different healthcare services. This project aims to improve on that model by incentivizing and empowering patients to participate in decision-making regarding their care as a way to add another dimension of value.

EBD was developed by Engaged Public through an iterative process with a financially disinterested group of Colorado physician leaders, public and private insurance experts, brokers, and business and consumer representatives (See appendix E). The project also engaged an advisory group composed of prominent community leaders representing hospitals, government, consumers, health policy experts, and others that meet quarterly to review and advise the project (See appendix F).

Basic Principles

The foundation for the structure of EBD is based on a group of fundamental principles. These are not new concepts but understanding them is critical to understanding the rationale for EBD and its goals.

1) Not all health services are created equal:

It is clear that healthcare services are highly variable in terms of effectiveness, impact on health outcomes, cost and applicability to specific individuals. Current health insurance values these with little discrimination so that coverage for high cost services with marginal benefit is often the same as coverage for low cost services that have great benefit. To the degree possible, benefit design should be based on evidence for safety, effectiveness, efficiency and value.

2) We do too many unnecessary things and don't provide all the services known to produce better health:

The Institute of Medicine, the Dartmouth Atlas and other resources clearly indicate a high prevalence of underuse, overuse and misuse of healthcare resources, which has led to suboptimal health outcomes for Americans and the waste of valuable resources. Underuse of high-value services contributes to poor outcomes. Overuse and misuse contribute to the high cost of healthcare that consumes potential funding for other public needs like education and economic growth. The opportunity cost of our current system is high and chips away at factors that are major contributors to the health of a community.

3) If something costs more, you are less likely to buy it:

This is not a surprise to anyone and application of the principle is most apparent in high deductible insurance plans. While the cost of insurance and overall short-term costs are reduced, valuable care is often forgone resulting in higher downstream costs, complications and poor health.

4) If something costs less, you are more likely to buy it:

Application of this strategy is most visible in current Value-Based Insurance Design, which lowers cost sharing for a few high value services or pharmaceuticals. By reducing barriers to specific types of effective care, beneficiaries receive more care that has been

shown to improve health. Some emerging data suggests this does not necessarily lead to higher overall long-term costs (Health Aff March 2010 29:530-536).

5) If you have already paid for it, you feel entitled to it:

The 'Tragedy of the Commons', referring to the management of common pooled resources, predicts that when the marginal cost of consuming resources is independent of the number of resources consumed, a rational consumer will take as much as possible. This underlies such recognized problems as overfishing in a shared fishing ground. In healthcare, this is often referred to as moral hazard and, as an example, underlies the incentive to consume more services once a deductible is met. Many feel this is a primary contributor to high healthcare costs.

6) Patients are interested in what happens to them:

The people with the greatest interest in healthcare outcomes are patients. At stake are their lives and health. In spite of this, treatment decisions are usually made without complete understanding on the part of patients and their families about risks, benefits or alternatives. The major player in such decisions is frequently a provider who will be compensated to provide the service. It is appropriate for patients to be fully informed and to fully participate in their healthcare decisions. Not only does this benefit patients, it also supports providers the practice of high quality, safe medicine.

7) The best treatment for a given individual may depend on his or her own goals and values:

The same treatment may not afford the best outcome for different individuals. For example, the benefit from treatment for prostate cancer, which can result in loss of sexual function and urinary incontinence, might be a fair tradeoff for one person and not for another. This is especially true since it is not clear who will live longer and healthier after treatment. There is evidence that care decisions are often based on faulty information about risks, benefits and alternatives. It is important for patients to understand their choices and match them to their own goals and values so that decisions reflect what is best for them as individuals.

9) Employers need support, both from patients and providers, to afford meaningful health insurance for their employees. A benefit design that varies co-payments based on evidence and supports decisions with consumer education are essential.

8) Factors that should be considered when making coverage decisions include:

a) Use comparative effectiveness research, evidence-based medicine, and other health information to seek to maximize the health generated through use of shared resources.
b) Promote the use of safe, effective, high value care and discourage the use of unsafe, ineffective, low value care.
c) Respect the unique healthcare needs of individuals and offer flexibility and responsiveness to the most vulnerable individuals and those with critical needs.
d) Seek to include ways to effectively engage consumers in healthcare decision-making through the use of information about effectiveness of screenings and treatments.

High-Value Services

Some services are of high value but are underutilized (principle 1 above). Evidence supports use of these services to improve the health of individuals and populations. Examples include effective screening, effective preventive measures and evidence-based management of chronic diseases like diabetes, asthma and heart failure as well as basic maternity care and basic dental services. EBD favors these services by elimination of cost sharing. Services covered include a limited number of office visits, medications, laboratory testing and other services as listed in Appendix A. It is hoped that some behavioral health and end-of-life services will be added at a later date. Many, but not all, of these services also reduce the long-term cost of care. Most experts agree that provision of these services produces high value and more health per dollar spent.

The elimination or sharp reduction of cost sharing for this specific set of high-value services promotes their use by individuals that may otherwise perceive cost as a barrier. In this way, they are incentivized to take more responsibility for their care.

Selection of these services is based on evidence from multiple trusted sources as well as their positive impacts on health (see appendix C). These services are, in most cases, shown to prevent illness progression and complications, improve health and avoid preventable hospitalizations and emergency department visits.

The list of services should be large enough to have meaningful impacts on health. It will be updated on the basis of new evidence and experience.

Selected Preference Sensitive and Supply Sensitive Services

Preference sensitive care report (pdf)

Supply sensitive care report (pdf)

Because the addition of new services with reduced or no cost sharing is intended to increase utilization, short-term costs are likely to increase. A mechanism is required to offset new costs if premium cost neutrality is to be accomplished. If a benefit package is more expensive, it is less likely to succeed in the market.

Select services that are expensive and not always appropriate for a given individual are assigned higher cost sharing in the form of a higher co-payment that does not count toward the deductible. This brings more money in to pay for services, but more importantly, reduces consumption of these services. It also provides incentives to consumers to become informed about risks, benefits and alternatives regarding care choices to help them make decisions that are right for them.

A good example of this kind of service is angioplasty and stenting done for a narrowed coronary artery that is causing chest pain (stable angina). If the narrowing is not immediately threatening to cause a heart attack, this expensive intervention usually provides no reduction in the risk for a future heart attack or death. It is sometimes more effective than medication alone in managing chest discomfort but does not eliminate the need for medication and can also lead infrequently to significant complications including stroke, heart attack and death. In spite of this, a recent study documented that 88% of patients who had the procedure thought it would prevent a heart attack and 76% thought it would help them to live longer (*Rothberg MB. Annals Intern Med 2010; 153:307)*. The physician who performs and is paid highly for the procedure most frequently makes the decision as to whether it should be done.

By increasing the cost sharing for these procedures and providing clear evidence in a patient friendly format with incentives to use it, the decision-making process can be democratized so that patients are fully informed and participatory in the decision-making process.

Services in this category include coronary angioplasty, coronary artery bypass surgery, MRI scans for back pain, hip and knee replacement surgery, back surgery, bariatric surgery and hysterectomy for benign bleeding or fibroids.

Some services for which there is not good evidence for benefit would be excluded including arthroscopy for arthritis of the knee and coronary calcium scoring.
See Appendix B for a full list of these services.

Shared Decision-Making

Shared decision-making recognizes the appropriate role of patients and their families in making decisions about their own care. It also addresses the inherent problems associated with knowledge disparities between patients and their providers and the lack of time in most clinical practices for patient education.

Available evidence demonstrates that fully informed patients tend to choose less invasive, less expensive care when they understand the risks, benefits and alternatives for the treatment of their medical problems. Well-informed decisions tend to result in lower costs, fewer unanticipated complications and more appropriate care choices that reflect patient goals and values.

The model for shared decision-making integrated with this tool was developed by the Foundation for Informed Medical Decision Making. It makes use of Patient Decision Aids (PDAs) that are developed from best current medical evidence and updated regularly to reflect any changes in the evidence base. They are available as DVDs, booklets and via the Internet. Information is formatted for easy understanding by a lay audience and includes statistical information and interviews with patients and medical experts. They are unbiased and intended not to favor a particular choice but to present information that informs and allows patients to bring their own interests to the decision making process. PDAs may be viewed repeatedly and shared with friends and family as a patient feels is appropriate.

When a patient faces a specific decision, his or her provider can prescribe a decision aid. The PDA is to be provided with a brief assessment survey to be completed by the patient. After the aid is viewed, the brief assessment tool is used to determine whether information needed to make a decision has been acquired and if the patient feels confident to engage in a shared decision with their provider. In some cases, a financial incentive is provided upon successful completion of a decision aid. Where necessary, a health care professional will be available to facilitate full understanding of all factors that affect a care decision. Once successful completion of this process is demonstrated, the patient and/or their provider may become eligible for the incentive.

The intent of this process is to improve the quality of care as well as care decisions and to promote more effective and appropriate use of valuable health care resources. The full library of PDAs will be available to promote their use in decisions, including those not affected by variable cost sharing, as a way to advance their use as a normal part of the care process.

For a list of available PDAs, see Appendix D.

Organizational and Implementation Considerations

Implementation of this strategy will require several organizational structures and processes. It is intended for use with an existing benefit plan and would change cost sharing for specific services as outlined above and enumerated below. Claims processing would need to include management of differential co-payments. Payers will also have to consider systems to identify affected claims through coding audits and, if incentives are to have immediate impact, accomplish this in a timely way.

Balancing the cost effects of the high-value list and the list of selected preference sensitive and supply sensitive services will be required to reach actuarial equipoise, the point at which cost offsets lead to a stable insurance premium.

The integration of Patient Decision Aids (PDAs) into a benefit package will require a structured arrangement for distribution of PDAs, assessment of decision adequacy/quality and decision support by a health care professional when necessary. These functions are needed to assure completion of a PDA, to foster a clear understanding of care alternatives and to measure confidence before decisions are finalized with a provider. Adequate completion as determined by a survey tool developed by FIMDM will be required for application of incentives. The size of a 'Decision Support Center' that can accomplish these functions will depend on the number of lives covered. For small groups, a single, well-trained person available by appointment or by telephone may be adequate. The 'Decision Support Center' for larger groups may be a centralized, staffed resource (see attached example for possible associated work flows).

Easy access to telephone support for both patients and providers should be available and early outreach and education prior to implementation should be pursued as these alterations to benefit design 'change the rules' for selected services and require participation of involved parties. An appeals process will be needed and should be prompt, patient friendly and fair.

Provider outreach and education is important to gain buy in and to assure new arrangements are understood. Some training in shared decision making for providers is encouraged as well as strategy to improve recognition of patients eligible for incentives at the point of care. Consideration of incentives for providers is encouraged.

Education of employees and others covered by this design is important as well. It will be important to understand that co-payments may vary with service type as well as type of provider as defined by the benefits.

The IBD tool will be updated on an ongoing basis to recognize changes in the evidence base and to reflect experience with it.

Appendix A
Enhanced Benefits: No Co-Pay, High Value

Condition	Services Visits are per year, maximum 6 without co-payment per year	Rx	Imaging	Lab	Other
Prevention	USPSTF A&B recommendations				PDA for colon screening
Depression	2 office visits without co-pay	Generic SSRI, SNRI, tricyclics			PDA available
Congestive Heart Failure	2 office visits without co-pay	Generic beta-blocker, ACEI, diuretic, aldosterone antagonist	Echo for LVEF, repeat for change in clinical status	LDL-C Q year, electrolytes, creatinine	Education PDA available
Coronary Artery Disease	2 office visits without co-pay	Generic beta-blocker, ACEI, diuretic, statin		FLP, lytes, creat yearly	PDA available
Diabetes	2 office visits without co-pay	Generic sulfonylureas, metformin, NPH & regular insulin, supplies		A1c Q 6 mo, FLP, microalb, Cr Q yr	Education PDA available
Asthma	2 office visits without co-pay	At least one inhaled corticosteroid controller, Short acting and long acting bronchodilator			Spirometry twice yearly
Hypertension	2 office visits without co-pay	Generic diuretic, ACEI, ARB, CCB and/or beta-blocker		Lytes, Creat, UA, EKG	Home blood pressure cuff
Long acting reversible contraception	Visits as required	IUD, Implants and injectable			
Dental	1 preventive visit, 2 cleanings per year, fluoride treatments per guidelines				
End of life	Inpatient Palliative care consultation				PDA available for advance directive planning in the setting of serious illness
Pregnancy	USPSTF A & B screenings in pregnancy Exclude elective early induction of labor or elective C-section B4 39 wks USPSTF A & B neonatal screening	Prenatal Vitamins	1 Ultrasound before 13 weeks and at 16-22 weeks of pregnancy	Routine, no genetic testing w/o risk factors Screen for gestational DM at 26-28 weeks	
Immunizations	Per guideline				

Appendix B
Selected Preference Sensitive and Supply Sensitive Services: Costs More, Learn More

Service	Additional Co-Payment Amounts are recommended, may vary with characteristics of insured population	PDA Consider cash award, check or gift card for completion.
Upper endoscopy for GERD	$250	No
Outpatient MRI, CT, and PET screening	Excluded	For heart testing
MRI for low back pain w/o radicular symptoms	$250	Acute Back Pain (< 3 months) Chronic Back Pain (> 3 months)
Lumbar fusion for back pain	$500	Acute Back Pain (< 3 months) Chronic Back Pain (> 3 months)
Lumbar discectomy	$500	Herniated Disc
Surgery for lumbar spinal stenosis	$500	Spinal Stenosis
Vertebroplasty, Kyphoplasty, Sacroplasty	Excluded	No
PTCA with or without stents	$500	Treatment Choices for Coronary Artery Disease
CABG Surgery	$500	Treatment Choices for Coronary Artery Disease
Coronary CTA outside ED	Exclude	No
Coronary Calcium Scoring	Exclude	No
Hip Replacement	$500	Treatment Choices for Hip Osteoarthritis
Knee Replacement	$500	Treatment Choices for Knee Osteoarthritis
Arthroscopy for Osteoarthritis	Excluded	Treatment Choices for Knee Osteoarthritis
Carotid Endarterectomy	$500	Treatment Choices for Carotid Artery Disease
Bariatric Surgery	$500	Weight Loss Surgery
Surgery for Benign Prostatic Hyperplasia	$500	Treatment Choices for Benign Prostatic Hyperplasia
Hysterectomy for Uterine Bleeding	$500	Treatment Choices for Abnormal Bleeding
Hysterectomy for Fibroids	$500	Treatment Choices for Uterine Fibroids

Appendix C
Resources used for Evidence and Structure

AHRQ Effective Health Care Program
http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/

Center for Evaluation of Value and Risk in Healthcare
https://research.tufts-nemc.org/cear4/default.aspx

Cochrane Reviews
http://www2.cochrane.org/reviews/en/topics/

Health TeamWorks Guidelines
http://www.healthteamworks.org/guidelines/guidelines.html

National Institute for Health and Clinical Excellence
http://www.nice.org.uk/Guidance/Topic

Oregon Health Leadership Council
http://www.orhealthleadershipcouncil.org/value-based-benefits

United States Preventive Services Task Force
http://epss.ahrq.gov/ePSS/GetResults.do?method=search&new=true

Washington State Health Care Authority Health Technology Assessments
http://www.hta.hca.wa.gov/assessments.html

Appendix D
Available Shared Decision-Making Programs

The Foundation for Informed Medical Decision Making develops decision aids by combining systematic reviews of the science and evidence about a condition and its treatment with information gleaned from focus groups and interviews about patient perspectives and preferences. These professional, state-of-the-art Shared Decision-Making® programs (DVDs or VHS with booklet) include unbiased, up-to-date scientific information along with the voice of real patients explaining their decisions based on individual preferences and values.

For more information about how the Foundation creates patient decision aids, click here

By providing this distinctive framing of information, patients are placed at the center of the health care decisions they face, fostering a more effective and efficient dialogue with their health care providers.

Back Care Programs
Acute Lower Back Pain: Managing Your Pain Through Self-Care
Spinal Stenosis: Treating Low Back and Leg Symptoms
Herniated Disc: Choosing the Right Treatment for You
Chronic Low Back Pain: Managing Your Pain and Your Life

Breast Cancer Programs
Early Stage Breast Cancer: Choosing Your Surgery
Early Breast Cancer: Hormone Therapy and Chemotherapy - Are They Right for You?
Breast Reconstruction: Is It Right for You?
Ductal Carcinoma *in situ*: Choosing Your Treatment
Living with Metastatic Breast Cancer: Making the Journey Your Own

Chronic Conditions
Living Better with Chronic Pain
Living with Diabetes: Making Lifestyle Changes to Last a Lifetime
Living with Diabetes: Making Lifestyle Changes to Last a Lifetime (Spanish Translation)

End of Life Decisions
Looking Ahead: Choices for Medical Care When You're Seriously Ill Clinical

Heart Disease Programs
Treatment Choices for Coronary Artery Disease
Living with Coronary Heart Disease
Living with Heart Failure: Helping Your Heart Day-to-Day
Heart Tests: Learning About Your Choices (Booklet only)

Mental Health Programs
Coping with Symptoms of Depression

Orthopedic Programs
Treatment Choices for Hip Osteoarthritis
Treatment Choices for Knee Osteoarthritis

Protecting Your Bones: Preventing Another Fracture (Booklet only)

Prostate Programs

Treatment Choices for Benign Prostatic Hyperplasia
Treatment Choices for Prostate Cancer
Is a PSA Test Right for You?
Is a PSA Test Right for You? (Spanish Translation)
Hormone Therapy: When the PSA Rises After Prostate Cancer Treatment

Screening Programs

Is a PSA Test Right for You?
Is a PSA Test Right for You? (Spanish Translation)
Colon Cancer Screening: Deciding What's Right for You

Women's Health Programs

Treatment Choices for Uterine Fibroids
Treatment Choices for Abnormal Bleeding
Managing Menopause: Choosing Treatments for Menopause Symptoms

Other

Getting the Healthcare That's Right for You
Growing Older, Staying Well
Sleeping Better: Help for Long-Term Insomnia
Treatment Choices for Carotid Artery Disease
Weight Loss Surgery: Is it right for you?

Appendix E
Members of the EBD Medical Advisory Council

Beth Chester, PharmD	Kaiser Permanente
Bruce Cooper, MD	Health District of Northern Larimer County
Chris Stanley, MD	United Healthcare
Cindy Palmer	CEO, San Luis Valley HMO
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Appendix F
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