

SATURDAY PM – SESSION #2
CREATING A SONOMA COUNTY COALITION

Our topic is what are the components to build a Sonoma County coalition, is that what it says? Control costs and improve care. Let's start with ideas.

The fundamental question is, is this going to be grassroots building up? Are we going to have a single payer system that comes from the federal government or are we going to build something locally?

Before we start, since you are the lucky person to be there, we need somebody to write down –

The person that was over there had such good handwriting.

So is the premise that we're doing something grassroots? I've been sort of waiting and hoping that somebody would bring a single payer system, that deus ex machina we would have it.

Are we going to talk about highlights of what was in the previous groups, or is this just - ?

No, not the previous groups. The previous groups' information, Skip says he's going to gather that and send that out.

Remind me of some things that were in the previous group that would have –

Reduce costs, improve quality.

Can I make a suggestion that we just start with the same format, we start with what are the problems? Because now we're an integrated group here. Let's start with what are the problems we're facing here in Sonoma County and then we can look at solutions.

The problem for classified school employees in this county in particular is that the cost of care becomes so expensive that the employer can't pay for it and so they're asserting caps on our contribution, and as the cost goes up each year, we have fewer and fewer people that can qualify for benefits.

So you want to say affordability of health care for working people, which is fundamentally different than affordability of health care for not working people. So I think that's important. Affordability for working.

I think affordability for non-working people is also important.

But it's another issue.

Would it be useful to divide this into functional or structural issues? Because since that problem has its roots in a fragmented purchasing system, the fact that there's no employment income and employer financing and benefits, benefits have no stability. There's no guarantee. If you're going to set out four or five things you wanted to fix, what would they be? And I'm offering the first one would be the fragmentation that can actively affect either cost or quality.

Okay. But at the end of that, Tom, if the goal here is to talk about the things we have to do to structure a coalition building, can we frame some of those issues as vehicles to use to build those coalitions. I think that's what he was asking us to do.

Let me ask a question. If we just put this down as affordability of care for the working people of Sonoma County. How are we going to achieve that through either a lower cost, we're going to maintain costs or we're going to control costs – they're going to go up at a lower rate than they have been going up. Are we in a position to lower costs in any way?

Yes.

How are we able to lower costs?

Maybe the emperor has no clothes and it just seems so obvious and simple, but we spend twice as much as the next closest competitor, three times as much as the Europeans, obviously we're wasting money.

All right, but how do we lower costs?

Maybe getting somebody from France to come over and tell us how they do it. I mean I have my own ideas –

You're reducing access. You can reduce cost by providing less care.

Well, you can lower costs by doing things that are medically important to do and not doing things that are not important to do, by using rational pharmaceuticals rather than – ibuprofen is 1/10 the cost of Celebrex, etc., etc. etc. I mean anybody that's experienced this, I can map out a plan and we could save – I could cut the costs of health care in half with no change.

I think you're talking about pharmaceuticals and I think you can also talk about unnecessary surgeries, efficiencies in the use of technology.

Surgeries provide required care.

Back in the '70s we used to say that 25% of the surgeries were unnecessary. Has anyone heard that number recently?

Yes. They're still saying the same thing.

There's another set of issues that have not shown up yet, and this is the waste that's involved in processing claims. And it seems to me that one of the issues – and I think a lot of that processing actually an artificial employment creation process. And one of the interesting questions is what are going to do with the people who would be laid off if we had a rational health care system?

That's a legitimate question.

In other words, what he's saying I think is if we went to a single payer system, we would have massive unemployment of all the people working for insurance companies, the brokers, the claims adjusters.

That's a problem. It may be true.

They should think it's a problem.

There would have to be some sort of return or regression –

Some alternative. In some ways ___ getting a little bit macro but I don't think you can really solve that problem unless you address the issues that have to do with the full employment economy. That is, people need to believe that there is going to be alternative employment if they're going to be willing to be laid off. Otherwise they're going to fight it tooth and nail.

I think the issue that we're being asked to look at is what we can do as _____ to lower cost and improve quality. So I think somebody spoke earlier about the fact that you can start with a model in one community and get it to work and see where you can export it. But what can we do here?

Two years ago in November, CTA, CSEA, Service Employees and the County Office sponsored a day of education and brought in Tom to talk about what was driving the cost of care. And one of the goals that we have had has been to partner with other purchasers to look at ways that we could see what is driving the cost here and begin a coalition to try to look at what's driving the cost and try to figure that out.

So partnering with others –

Purchasers.

That's a solution, that's one thing.

So what we're saying is we can lower costs, there are certain things we can do to lower costs, but what are those certain things?

Partnering with other purchasers of care in the community to look at data that would lead us to take action.

Give me an example.

Well, we had one here in Sonoma County about six years ago. It was – I helped create the North Coast Business Group on Health. They were the County employees, the school districts, the city health plans, the city workers, JDSU, First American Mortgage, Corvell, all the major employers, the Chamber of Commerce, essentially we had the labor unions represented, SEIU was represented. At one point we had representatives for 70,000 workers sitting around the table talking about creating the purchasers coalition.

What happened to them?

The first thing that happened is that the large employers, the JDSU's, and the Solar Optical guys were very uncomfortable that labor was sitting at the same table. They felt that labor was getting a second bite at the apple. The other thing is that the large employers started to realize that they get favorable discounts because they're very large. And they weren't ready to share those discounts with small employers who are rated very differently by health plans, and so they started to –

But we had jealousy.

And the other thing is that the executive director for who was hired by the leaders, was a cardiologist's wife and the cardiologist was so upset with the HPR and managed health care that he went off to Texas where he could make millions, and she went with him. So what ultimately happened, though, the larger members of this coalition ended up agreeing that they were more comfortable with Pacific Business Group on Health and joined Pacific Business Group on Health and essentially vacated the field. The biggest single problem was that each of those employers sent employee benefits people who were comfortable working with agents and brokers and don't know the health care system and don't know how to purchase health care, so they never got around to asking – do we have too many hospital beds, do we have too much prescription utilization. So they never got into that. They didn't know that. What we need is CEOs of those enterprises to come together saying, we've got a serious problem and let's bump heads till we get it fixed. That didn't occur. So it collapsed.

Now it's six years later and the question is, how do you build a coalition, either follow along the lines you're talking about or along other lines so that it's learned from what didn't work before but what do we do so that we can have success in 2004?

Well, you need executive leadership involved. That's what you're saying.

You need high level – at least among the employers, to represent employers you need these very high level people who are not so wedded to the agents and brokers and consultants who give them advice on health plans.

But you have executive leadership in the county, executive leadership in the schools, you have executive leadership in the unions. Basically everyone has executive leadership. If they get together and avoid the jealousies, the petty things that you're bringing up that the other coalition had, maybe they'd be more successful.

Also, too, then you're saying exclude the brokers?

No, I'm not saying that. I'm just saying that to get an understanding – in the present, you have a natural problem with the large employers and the small, and representing some very small employers. And there is no – except for the Chamber of Commerce, there is no organizing entity that can speak to small employers and small employers are overwhelmed by all of this – totally. Even RESIG, which tries to represent the schools with expert consulting support, has very limited ability to leverage health plans and medical providers like hospitals and doctors.

So maybe one of the things we could look at is joining – I think you just made a really valid point – and a group like CalPERS. And for us the barrier has been the post-retirement medical

contribution that's been required. Prospectively, that's going to go away or it is gone away in fact and you can bargain – if I'm saying something wrong please correct me, but through the bargaining process bargain a buck. So if I look here at what the PERS rates are and what the RESIG rates are, in fact, our members could save money. Have rates through December 31 of '05 and start a new cycle, and then we would be in a pool with lots of other public employees purchasing and really be able to have some bargaining leverage in Sonoma County.

This is a question about that and that is, how regionalized is what goes on in PERS? In other words, if we're talking about creating a coalition in Sonoma County, is there a chunk of PERS that specifically is interested in Sonoma County that could be part of that, or is PERS mainly statewide and we're kind of mixing apples and oranges?

PERS has 11,000 employees in Napa and Sonoma Counties, and if we could get PERS, if PERS would be willing to treat us as a regional where they're willing to work with us and bring their expertise, we would have a valuable asset.

One of the things, to accomplish something you almost need a model, as opposed to trying to do something statewide, if you could take Sonoma County and make Sonoma County a model of what could be replicated throughout the state over time, that would be beneficial. And what you're saying is you need executive leadership to be involved, and you need to bring in a powerful associate, whether it be CalPERS or some other powerful associate.

I guess one of the things I'm wondering in terms of Sonoma State is then are we talking about really the unions getting involved as the purchasers that need to look at it from a local perspective? And I think that's actually one of the things that we were talking about in our academic discussions is the fact that at Sonoma State the students have one set of issues and the faculty have another set of issues, and then there are a few other unions that get involved, but the common interest between the student and faculty is an area that hasn't been developed at all.

I was just going to say, we have constituents on the CalPERS board. Everyone gets folks of like mind and go to our board members and we go to people like Doug and say, Doug, we'd love to look at pilot project in Sonoma County and push it from both ends. And in light of the fact that PERS is trying to figure out how to grapple with the cost of care, it would seem to me that this would be in their interest to allocate some resources with local folks to begin to implement the strategy.

One of the things – it doesn't matter if it's the government or an insurance company or whatever. Whoever is writing the check, the question is what's their loss experience? How much money, how big of a check are they writing and how much money is coming in? And my question to PERS is, how is the loss ratios doing? Where are you seeing the problems? Where does PERS see as solutions to lowering the cost? Because I think that you have a statewide perspective that probably none of us in this group have.

The largest cost is our work with Blue Shield has been validated by some work that Tom's group has done that was presented to our board last week that we're tackling. The other one is relative to pharmaceuticals that we're engaged in. Is this stuff going to generate a huge or much more

active role today than it did last year legislatively with the issues at the local level? And I think we're at 1.2 _____

_____ administration project to look at a new method of position profiling and utilization management. That's in the early stages but it's actually underway. We have a regular series of events and some goals to meet in setting in motion this experiment. One of the reasons SL was chosen is that there is no effective HMO, no organized delivery system there, so it's a community in which we will have no conflicts basically around a reimbursement of loyalties or HMO affiliations. And every time we have taken an idea of PERS in the last two years and said we'd like to do this, they've had the same answer: bring the plan in, tell us where the local constituents are. I have taken to them the proposal that the data warehouse that PERS bill to be open to data from other purchasers, to enlarge the data base and to increase the statistical validity of the measurements, and they said, bring us the plan. There's absolutely no door shut now or dialogue. I can't tell you what the outcome will be but PERS has opened the door repeatedly to local initiatives. But they don't have the resources and they are not going to go out and mount these initiatives. They are going to have to come from us.

When you say mount the initiative, what do you mean? Are you talking about the research, the analysis, the data?

I'll use San Luis Obispo as an example. SEIU contacted the unions in San Luis Obispo in the wake of the failure of a couple of the IPA's down there and the costs began to soar, and said, this is an intolerable situation. We're going to have find some way to rationalize the costs of utilization patterns here. Here are some ideas, are you interested? We had meetings which led them to say yes. They, some employers and the docs met and said, okay, put together a plan and we'll go along with it. PERS has been sending representatives to those meetings. But the plan is coming up from –

I would think PERS would expect the health plan to do the utilization.

That's what we should be recording though. I think that what Tom is saying is that one of the opportunities for building this kind of coalition is to at the grassroots level develop a model – it doesn't mean a study – develop a model to go to PERS and talk to them about how this community would like to be a model community in order to be able to demonstrate something.

Does that satisfy - ?

No, establishment of a model doesn't say the same thing as taking the opportunity and going to PERS, who has demonstrated interest previously, and test that model.

The job of the person who is putting it up is to capture what the people are saying, so if you would please, have Karen and Tom try to give you just the wording that will satisfy them. So would you two say what is the wording that would make what Jack is showing there, number 3, how would that wording get right?

Well, what we did was identify a problem in the community and then sought PERS as a partner because of the size of their purchase power.

IB problems in the community in the community, seek PERS as a partner. What else would you two need to have that in satisfaction?

That's what I think was said.

The situation in San Luis Obispo is not like Sonoma. San Luis Obispo has no structure, there's nothing there that puts any framework in the delivery system. Shortage of beds, shortage of doctors. What we did was, because PERS is a big purchaser and PERS is very influential and opinion-making in the community, because of the faculty – it's not only the university that's there, not only Cal Poly but there are three correctional institutions, God help us, with huge employment numbers, that are PERS ___ so there was a lot to work with.

I could be wrong about this – I hope I'm wrong about this. My perception is that what we're talking about is that there's a lot of fat resistance and fat cats maybe at Sutter who are overcharging this and that. And we want to get small purchasers to get together so that they can – I want a better deal for us. And I support that, that's fine. But I don't think that really goes to addressing – I mean that's only going to be a fix for a few years. That doesn't address the much deeper structural problems that exist in the health care system. So the question is, does anybody have a mind – I hear a little bit of it from Tom and from nobody else – to actually deeply challenge the way health care is structured and delivered? It's profoundly wrong, and that's really where the source of our problem is.

Except that I think I see a connection and that is that I agree with philosophically around the systemic problem with our health care system. There's also the problem of overuse and utilization and based on county by county, so there's a connection, it's twofold. And I don't think that there's a disconnect, that we do this or we do this. In fact, I think we could put those two ideas together because they're connected.

How do you frame those two things in response to the question, which is: How does Sonoma County – how do you do this coalition building? And what you're saying is that one of the things you need to do is to get collaboration – from whom – to remodel what the delivery system is?

The purchasers have to become much more informed about what's possible and get a lot more uppity about what they want.

I heard kind of three different levels of the issue in the discussions this morning. One was kind of the education prevention issue on the front end, there's the acute care issue and then there are the chronic care issues. And it seems to me when we're talking about purchasers of health care, we're really talking about primarily people who want acute care of one sort of another and maybe also chronic care, but when you're talking about the education and prevention end of things, I'm not sure how much the established health care institutions are realistically going to take either a leadership role or a funding role in that area. It seems to me that you're really talking about educational processes where you really need a different kind of relationship to what's going on in the education community in order to get to the root of those kinds of lifestyle issues.

I firmly agree. There's three basic areas: acute care, chronic care, prevention. I think our health care system does a pretty decent job of acute care, it does a really inadequate job with chronic

care and it totally fails with prevention. And the question is – and the people who are running the ship now, I don't know, the doctors, insurance companies, whoever it is – are failing. And I think an uppity influence of purchasers if they have enough clout can demand, this is what we want, you ought to do it. They're the bosses, they're buyers, they're the clients.

But no single purchaser is big enough to dictate even the terms of the debate, let alone the outcome. That's my thesis. That we have so fragmented the purchasing system that none of us, even PERS, as big as it is, would not if you had a realistic conversation with PERS about their impact in Sonoma County, they would look at the landscape, look at the provider community, the rest of purchasers and say look, unless there's a coalition, unless you add to our purchasing leverage the following large populations, we're not going to get anywhere. The fight with Sutter is significant has a political precedent but it's going to result in fairly marginal savings. And it's because the carpenters haven't joined, the longshoremen haven't joined, we haven't got the rest of the purchasing community going into Sutter and saying, me too.

I'm not sure what I think should be going on in terms of chronic care, but the question I'm raising is CalPERS the most appropriate partner to get involved with K-12 education and do what has to be done there in terms of prevention.

Number one, what I'm hearing is talking about the government sector, and that's not the majority of the health care sector. And what I'd like to explain to people is that if you understood how a health plan was written, you'd come to a conclusion that Saturday Night Live people could come up with that material. I mean it's just really one of the most bizarre methods that a health plan is designed and complexities of it, and one day I could give you a nice long lecture of it, but you wouldn't believe me if I were to tell you. But when I look at this, I'm now turning around and looking at this problem from the perspective of a shop steward. And as perspective of a shop steward, which was 10 years ago, I'm hearing how is management going to do this, how is management, how is management or purchasers or whatever? I'll tell you something is that person who is making the decision of when you're going to down and talk to the doctor, are they going to go to the emergency room, are they going to buy the purple pill. And I think that if we're going to be looking at any kind of model, we need to look at it from the perspective of how the consumer is going to purchase, buy and act about anything they do. And then if we look at it from that model, then it's a lot easier for the purchasers and the health plan administrators or whoever to design plans that will direct consumers in the right direction. So I'd like to see us go from that direction.

If I can check in just for a moment, so Jack can be part of the discussion I'm taking on trying to do a job of putting things up here. Before I go that way, I'm just wondering what I have observed would be that there are a certain number of people that are actively part of the discussion and others who haven't spoken yet, and I'd encourage, if you'll permit me to do both your recording and just a little bit kibitzing, it would be good to make sure that everybody sitting here speaks.

We have somebody who's waiting to ask a question.

Okay but just for a moment, before we go farther, is this correctly drawn or do you want to clarify this in any way? I'm trying to capture it but there's a lot going on real fast. So build a

model in Sonoma County, challenge the basics, acute care, chronic care, prevention and maybe a B+, a C- and –

A-/D.

A minus, D and F. Involve PERS in dialogue, a possible partner. Study the purchasing system. Consider combining large populations. Improve K-12 and 13-24 education on health care, if I understood you right – I'm not sure I did – and study individuals and their thoughts and acts. Tom, you've got a clarification you wanted to put in?

No.

Are there any more clarifications?

Consider alternative providers.

To my mind, all these good ideas have to fit within a legal regulatory format that is the present state of law in California. And the way to do that, it seems to me, is to create a delivery system that is thoroughly legal with the values that you're describing here. So probably what we're talking about here is a delivery model that is designed consciously by the governing committee of that model to meet those values. Values are necessary to reflect the needs of ultimately the customers. So you've got to build a model, you've got to take a chance and build a model, build a delivery system that can then hopefully meet the requirements of the purchasers because they do the things, they reflect the values and accomplish the cost savings that we think we can do. So it seems to me we ought to be able to go to fairly quickly to do we have enough resources in this community to build a model that can go to PERS and say, look, we're prepared to build a model – let me finish the thought and I'll summarize it if you like. PERS, would you be interested in becoming a purchaser of this model and leading the other employers to join you so that we have some clout and ability to deliver on this model? So does that make sense?

All I wanted to do is see if we're getting, your point is develop a legal and regulatory format and work to reflect participant values.

You need a structure.

It's not a format.

So the model has to meet the regulatory legal requirements of California, and essentially you're talking about a provider panel. You need doctors and hospitals and allied health professionals that can _____

Are you talking about a plan, an IPA?

If you have any hopes of offering the purchasers the kind of integration with these values, you've got to give them a provider panel.

Something they can purchase.

And then legally you probably have to come up with a health plan as well that meets the Knox-Kidd Act.

We have somebody who's been waiting.

You guys, I mean this is fun, this is exciting but I'm sitting here and I'm thinking – wait a minute, there's a whole bunch of folks out there that don't work. How are we going to get health care for them? How are we going to get an increased quality of life for people who live on disability because it's really hell trying to live on disability. How are we going to make stuff happen for people that for migrant care, there's all sorts of other populations. And while this is nice, I'm really concerned. There are huge segments that we're not thinking about here and just to simply think, well, we can tack them on – no. If we're going to build something, they need to be part of it from the very get-go and they need to be built into the infrastructure and not just, well, we'll go to PERS and if we have some left over then we'll provide for these folks. We need to be putting them in at the very get-go.

And also to private industry. Because not everyone is a government employee.

On behalf of the clinics of Sonoma County, they would love to be part of a system like this because it means their existing role will be enhanced. So you've got six federally qualified health centers who would love to be part of this model.

But I guess what I'm talking about, though, is the people themselves. And what are we going to do for people – I mean there's all sorts of reasons that people do not go to community health clinics and we all probably know many of those. So what are we going to do to make sure that we're including, that we're not letting the people – and when we start talking about rationing and when we start talking about appropriate utilization, I'm sorry, for many of these folks going to the emergency room is their primary way of doing something. We may all go, oh, but that just screws up the cost, but wait a minute – what are we going to do to reach those people in ways that are truly effective for what they themselves ___?

What you're saying is the definition of this subject is a model for Sonoma County. It's not a model for the subsets of the population. So what you've just said is to be sure that all of the populations are included in the development of the model.

So my question then is, if we take something like this to PERS and we say – and yes, this is going to pick up people who are not employed, who are not being part of private industry. We're going to try and cover everyone in Sonoma County. What is going to be PERS' response to that?

You can't add people to PERS. They have to be state employees.

What I'm asking is –

PERS will only participate as a purchaser.

Hold on for a moment. Let's just get it straight. Carolyn, I want to make sure I'm getting you right. First of all, as Karen was suggesting, build a model for Sonoma County including all residents. Second of all, before I turn the page here, to consider the needs of those who don't

work and can't work and involve them from the get-go. And then two other people brought up elements of there are clinics that want to be involved, private industry that would want to be involved, etc.

My question with PERS is that no, I know people can't be added to PERS. I know that, Tom. My question is, will PERS be willing to be a major purchaser if we are figuring in all these other groups?

If it will improve services to their current beneficiaries, I'd say the answer is yes. Improved services to their beneficiaries and costs and puts a searchlight on the quality of care, the answer is probably yes.

If the teachers like it, the other employers like it –

It's inconceivable to me that we can address that without a single payer system. So then that's the point, really. Are we going to fall short of maybe – what we're doing here?

Then you need to be recommending that, Bob. It's a legitimate ingredient to building a coalition. If one of the coalitions of what Sonoma County says is its model is to model something that would be local "national health insurance." That would have to be the goal.

Isn't it enough that we can do a whole lot better than what we're doing now?

Well, there is the risk of dividing and conquering. I mean, essentially what's happening here is that the middle class is feeling the pinch. And maybe we could fix that and then we don't have to deal with the poor for another few decades. It's pretty big stakes.

I don't mean to say I don't care about the indigent or the other people we're talking about. But if you go to the first thing I wrote down, the premise that was raised that this should be for working people, we've spent the last 40 minutes discussing a premise based on working people. That's the first thing we wrote down when we started this conversation. I do not mean to imply that we should not include something for the non-working or the disabled or something of that nature. But we spent 40 minutes on trying to develop something, or at least that's the way it started. That was the first thing that we wrote down.

That was one thing, but it wasn't mutually exclusive I don't think.

I'm kind of thinking of slicing it up from a somewhat different direction in the sense that I suspect that in many ways the economics of prevention as a system, the economics of acute care as a system, and the economics of chronic care as a system are different. And therefore I agree with the principle of the people advocating of having a rational coherent payer. At the same time, I wonder whether the economics of these three components aren't so different that you would want a different political process as well as a different economic structure in order to deal with these kind of three phases of health care. And the idea of a single payer kind of implies that there's an important political role, which means obviously there's an important role for government and the political process. The only question that I'm raising is that might we expect government to take a somewhat different role in dealing with each of these areas?

Stepping aside from my notetaking for a minute and responding to the last couple of comments, it seems to me that government of course is not only a purchaser but also is a purchaser and is the provider of last resort at the county and state level for the folks who are not working. And I don't know if we sort of decided whether they are a part of this purchaser coalition or not but it seems to me, both from the point of view of having something functional and also towards an interest in moving towards a model that could be a basis for a single payer or could just be a basis for something that's working. There are city and county and state and federal employees represented, some of them are here, certainly a lot of them are in Sonoma County. It seems that it makes sense to include them in the equation.

There's no reason why the federal employees health benefit program couldn't be invited to participate as a purchaser. Members of Congress from California have been encouraging this for a long time but as far as I can tell, nobody's responded. And there's no reason why Medicare couldn't come in too as a purchaser.

What about Medi-Cal and the County Hospital?

Well, the County Hospital is a provider. They're not a purchaser.

If you went to a fully budgeted system instead of fee for service, you could put all the money into a pot and have a virtual soup. But that won't happen. But there's no reason why you can't ask them to participate and unless there are policy issues, and I'm unaware of any, work out the details.

You're talking about a virtual single payer and I think one of the things that information management technology offers is that we didn't have a decade or two ago is the possibility of doing more things on a virtual model rather than necessarily having to be totally –

It's a long way from perfect, and the single payer systems are a long way from perfect as well. But both of them are significant steps above where we are now.

Sometimes in board meetings it's helpful in the conversation to throw out a draft resolution. I'd like to do that. I'd like to suggest that we endorse the creation of the Health Trust of Sonoma County, a fictional entity that is a legal entity. Let's just call it the Health Trust of Sonoma County. And the goal of the Health Trust is to take advantage of the existing resources that we have and restructure them in a way that better serves our needs. What does that require? It would require obviously hospitals. Low-cost primary care-oriented hospitals that believe in these values. So what do we have in this county that would meet that model? Well, we have district hospitals in Sonoma, in Sebastopol, in Healdsburg. We've got Warrick Hospital here that is at present a low-cost primary care-oriented hospital. So we have four hospitals that we could play with. We need physicians. What kind of physicians do we have that would accept these values? We have the Valley of the Moon IPA already formed, a group of multispecialty medical group around serving Sonoma, Learn How to Live with HPR – wonderful physicians. Around the hospital in Sebastopol we have the SKIPPY doctors. Again, primary care focused, cost effective. They've done fabulous things with utilization management, comparing, contrasting members of their own group, educating them on how to live within cost constraints – terrific group. You've got the Sutter Medical Group in the county that the president of the Sutter Medical Group, Dr.

Durbin, said to me, “We have no problem with HPR, we’ve learned how to manage care, live within the cost constraints of HPR, and Medicare – we like the Medicare Advantage program.” So what I’m saying is if you start serving the community, you start realizing we’ve got lots of very talented people here that probably like these values and would be willing to implement them, so we need a model to bring them all together. So let’s call that the Health Trust, and then start adding the components that we all think would make that a better system. But we’ve got the essence of a model right here.

But there’s no purchasers there.

And then, if that model forms, with the encouragement of the purchasers, and if the purchasers like it, I would assume that they would reward the model with their business, and that business hopefully will be less expensive than the Sutter Memorial costs. Maybe it will be comparable to Kaiser, maybe it will be less than Kaiser depending on how successful we are in implementing many of the very good suggestions that you put on the table.

Could I take just a moment now? I’m finding things are moving so quickly, it’s great to see that I put up a whole page without checking into see if I’m getting it right – (END OF SIDE A) (SIDE B) Let me get this straight now. So you would say, serve the underserved.

The employed might not have health insurance either.

They’re related but different.

Bob, let me get this straight. You would say, serve the underserved with a single payer, not speaking beyond that frame but am I getting it accurately now? I’m not sure I am.

All I was trying to say was that if we are really trying to solve the whole problem, we need to look at the single payer. If we are trying to figure maybe a smaller piece of it that maybe we can whittle down and do something valuable with – but that has potential downsides.

Okay, so if we’re going to solve the whole problem, take single payer. Is that right?

Yes.

And that would include serving the underserved. Okay, next one. Consider whether, this is stated neutrally, consider whether the plan or the ideas that are being discussed would be for the working or the not working too. That seems to be, not to advocate one or the other but that’s a question. Next one – economic and political principles of acute, chronic and preventive care may be different and may call for different roles, different approaches. Is that correct, Art? Okay. Government is part of the purchasing community and to be included in the coalition, or at least to be considered for the coalition. Okay, Medicare, Medi-Cal, county hospitals, all could be involved and included. Is that correct?

District hospitals too.

Wait, you’ve got payers and providers mixed up there. I’m confused. Medicare and Medi-Cal are payers and hospitals are providers. What’s the point in connecting those two?

So it would be the district hospital boards and the County Board of Sup. as opposed to the hospitals themselves I think is what folks are getting at. Yes, those institutions and those levels of government but maybe not the provider level. It's whoever's paying. Does that help?

District hospitals are providers.

But there's a payer attached to those district hospitals, which is the district hospital boards.

As employers?

As payers.

They write checks all the time.

Well, they purchase health care because they have employees.

But they're also – Medicare, Medicaid –

The people who come are patients.

How about this to allow us to move on: Consider – consider is a good general word – consider payers attached to Medicare, Medi-Cal, county district hospitals, because all could be in some way involved. Moving right along. Can this be a “virtual” single payer – I think you brought it up, and not to get into a definition necessarily but perhaps you'd like to say a word. When you say virtual single payer it got my ears up and interested. Do you want to go further or should we just leave it at that?

After the word single – just add –

Skip, right now all the payers pay different amounts. There's no common hospital price, there's no common physician price, there's no common price for drugs, for lab tests or anything else. We're scattered all over the lot. We would come close to a single payer check on the health economy if everybody paid the same price. That would be a step without everybody surrendering eligibility, the terms, or making any other adjustments. If we just got to a common price, the common negotiating framework, that would come close.

And to add to that, and if we can't do that, at least make it so that the people who can least afford it aren't paying the most.

Well, we stopped some of these outrages of the Sutter billing of the uninsured at prices which are bankrupting them and leading to aggressive collection cases, which has now become commonplace.

Let's insist that the Health Trust has moral and honorable billing practices.

The other problem with the Health Trust concept that I see is it's only the providers. I think a trust has to start with purchasers.

Let's call into being a hypothetical Health Trust in Sonoma County, including local hospital districts, local IPAs, use local service, talent and collaboration. Is that accurate?

It's to prevent a delivery system that can then respond to the desires of the purchasers. We have to work together. They have to be aligned and the economics have to be aligned and the values have to be aligned.

You couldn't get a payer that had enough –rhetorical question – that had enough negotiating clout that it could beat the plans around and say this is what we want? And you said no.

Economics alliance, something else was aligned –

A delivery system, economics aligned.

The values and the economics have to be aligned. The purchasers and the delivery system.

Okay, the last one was single payer okay if all just paid the same price. And in paren I put (and stop outrages).

I think the connection between the one before and this thing about the virtual single payer is the kind of thing that Tom and others have been advocating about the transparency of information, and the possibility of getting the data and making it available partly as a result of the efficiencies of information management technology. So if you get enough information and get it out there, then the value of moving toward the virtual single payer becomes something that's easier for the public to understand.

Use the transparency of information available through the efficiency of information technology.

Michael, you haven't said boo so now it's your turn.

I was just going to speak in favor of Gaiza's proposal because everything I've worked on, like back in '92 I convinced Sonoma County to form a trust for housing for county employees and we funded it a penny an hour and it grew into a multimillion dollar fund because there was a corpus, there was a body, there was a legal entity. And then all the elaboration came over time but there was an aggregate, it's like a nucleus for a raindrop. I know that we're working on workforce housing now, we're on the verge of forming another trust for the entire county and that's going to be the aggregator of funds. And so to me, what Gaiza is proposing, all this is going to be vaporware in terms of ideas unless we have something that's going to aggregate. And all the rest is going to be figured out over time. We're not going to figure it out in days or weeks. It's going to be over a large length of time. But you need that _____, turbulent, quick _____ gravitational field starts aggregating energy and ideas and resources once you form the legal entity. So I would speak in support of Gaiza's motion.

And in the historical example, Michael, it was 1 cent per hour.

For every hour a county employee worked and those pennies add up. Very quickly.

The other proposal we made is that 1/10 of 1% of the health premiums be set aside for the development of cost in quality measures. And it runs into the millions – you couldn't spend it fast enough.

I saw this figure again. Quarter cent sales tax generates \$17 million a year in Sonoma County. And the Santa Rosa Junior College just floated a bond for \$250 million to expand classroom capacity, refurbish the library, and to build out health facilities so that they can have dental care. So they've got money. Those are things that just passed, taxpayers approved in Sonoma County, for things like libraries and schools, \$250 million. So to fund a health trust, if we need extra capital and we've designed a good model and it satisfies the teachers and CalPERS, why wouldn't the citizens want to participate in building that out?

I think that when we start going in on tax, coming from the broker world right now I know that in the broker world they see a lot of red flags, right here. And so if you're going to do a tax, which requires 2/3 votes, you cannot do anything unless you get everyone in the community to buy in there. Now I also see a lot of things in the brokerage world that would love this kind of stuff. And so it has to be put in a communication where everyone in the community will go behind it and then the concept of even 1/8 of a cent tax or 1/16 of a cent tax or something, a very small amount of money, it doesn't take that much money to turn things around. And I think then you would have a real supported thing but I think that we really need to reach out beyond just government employees and the unemployed. And I'm going to stress it again. We're forgetting about the business world here. And they are the ones who are going to move and shake this. We really need to include them.

I just I want to understand this, I have an opinion but I just want to understand it for the moment. You're saying with the broker world, the business world, you suspect that they would be willing to veto anything that was proposed unless people got the community widespread around it which would mean interaction with those worlds to get them on board.

You've got to bring them in just like you were saying the homeless, got to bring them in round one or they will veto it. So you need to bring them in.

I have an, since I don't live in Sonoma County I feel like I shouldn't dictate too much but I do have a question for your health trust model. And that is, is the trust providing care or is it negotiating on the part of – do you have purchasers joining the trust and then having the trust negotiate.

It's theoretical.

But who would be the controlling?

I would recommend that the trust itself be publicly accountable in that it would be a not-for-profit entity that is publicly accountable. And the critical components of this, the most difficult parts to put together into this, would be the hospitals and the doctors – probably the doctors in this town. So the legal vehicle for this is we've got three publicly elected districts already. If each of the districts elected representatives of their own to the leadership, to the governance committee of this health trust, then you've got hospitals on board and answerable to the district citizens elected. The doctors should have some say because ultimately they're going to

implement the values that we hope they will and that is practice the kind of cost effective medicine that Tom is going to help them practice, and so doctors should be aboard. And of course employees, community citizens should be on board. Legally this could all be put together outside of the county. I would not think that the Board of Supervisors should play a role in this. I would argue against that because they really are, I bet you they'd bless this because you've got the Board of Supervisors from Sonoma, if this serves the constituency in Sonoma they'd be very happy with this. The representative from West County, Sebastopol, if it serves that community would be very happy with this. If it serves Healdsburg and residents up there, they would be very happy with this. So we've got three of them, the majority of the Board of Supervisors are already in favor of it, I assume, if it works. So the Health Trust I think has to be made up of a mix of publicly accountable individuals to stand the test of having wide, broad, countywide political support.

I have a question. I just want to check in for a minute.

As part of getting the broad community support, you've got to have the major people who are interested in this and that would represent labor as well.

You can't forget labor.

I don't know, because I came in a few minutes late, I don't know if you heard, Bob, since you came in a little while ago, of the PERS announcement today at the meeting. If you have we'll go on. If you haven't –

No, I was gone.

Just checking to make sure that you had that piece of the puzzle.

I'd be happy to tell him after we're done here. That way we don't take time away from the group.

Any closing comments you're just passionate about getting up on the board that we don't have?

We need to set up a structure that is all inclusive, that tries to find a way to solve the problem in Sonoma County. Not worry about California – in Sonoma County.

Let me object to that. You're not going to build a win-win situation for all the players in this system. If you set that as a standard you spend all your time trying to massage the bad feelings and the economic interests of people and organizations that do not have, may not have a legitimate role in a rational delivery system. I think you ought to set your targets on getting things done and if they want to come along, okay. If they don't, if they don't like it, then they fall by the wayside. But community efforts have died a thousand times because they tried to keep some politically powerful or economically embedded interest happy at the long-range expense of the community. And I'll give you a good example. The Pacific Business Group on Health, which is held up primarily as a very progressive purchasing group – and it is if you look at the business communities generally – frankly, it does not have a lot of interest in the health and welfare of workers. It is terribly concerned about the bottom line of its corporate membership and they do not have any union representation in their organization. And I think it would be a mistake if the

unions went there because if they did, they'd get increasingly absorbed by the passions of the fundamentally labor-hostile community. The work that has to be done here, the tasks that you have to lay out, are going to take away economic interest from some people and some organizations, and you're going to wind up saying to some organizations, your behavior is not acceptable, your economic goals are not acceptable, your values are not acceptable, you don't belong in this system. Either change your ways or forget about it. I hate to see you burden yourself with this everybody has to get in under the tent mentality because that means if everybody gets in under the tent, nothing will get done.

What are the next steps?

Karen, what are your thoughts?

You asked my opinion. I think it would be to get started and build a coalition with those people who want to start the coalition. If you wait for everybody it's not going to happen. You have an interested constituency or a set of them, get them started, get in the room, and get going. And I think that the model makes sense.

The Health Trust makes sense?

Yeah, to me it does, yes.

Keys and I have spoken before about a joint powers authority in the health trust. A health trust doesn't have to be a joint power authority.

Correct. That can be a totally separate entity.

Absolutely. But the degree of collaboration among district hospitals in order to be able to be a cohesive voice in this county would be enhanced, the first step I think would be enhanced, if they among themselves created a joint powers agreement, set a governing committee and then made decisions to –

That's a separate constituency.

They could part of the health trust without having to do that.

Michael is raising an issue that Karen is asking us to address. What are the next steps? What we have is get started with those who want to be in the coalition and again, get started. Anything more?

Is this going to be under the auspices of SSU? Who's going to be the convener, kind of the mother ship for this to kind of work with? Because it just can't be defined unless – it's not going to work just like an e-mail group. It needs to be –

So again, get started, auspices, convener, mother ship –

Why don't we set a couple of dates by which to have decisions on certain sorts of pieces or something accomplished, a few deadlines and goals. And even if we don't make it, at least we're moving.

I'm a pretty hands-on person and I really like to know when I'm putting one foot in front of the other. And I think a couple of things come to mind. Who's in? Who's not in that should be in? So we do some targeting around who's not at this table that should be, or who really could allocate some time and resources to do work? Some people can and some people can't and we accept that. And once we establish that group, letters need to go out to pull this together.

Let me back you up for one minute. I think this is a group made up of diverse interests. I would think you would want to get to your first question, which is who the convener is going to be, even if it's a temporary convener. But somebody needs to put the group together so that they can start asking your questions. And if you invite somebody who's not in this room, what are you going to tell them? So I think what you really need to do is convene a group, say this is what you want to do, start laying out what your objectives are, who you want to invite – and it can be quick and it doesn't have to be the Constitution or the Declaration of Independence. You just need to be able to say, when you go and you talk to a group of physicians, what is it. You have to define it. And we're starting to do that here but I'm not sure what you would tell anyone who's not in the room, based on what we've just said here today. So I think that's what you need to do. We need to start putting some subsets under all of these major categories.

I don't think anyone knows here that the United Way has totally reconsidered the way for Napa, Sonoma County, they've totally reconsidered the way they give out money for health care and the new executive director, who is a serious businessman who is devoting his life now, he's made a lot of money, has set aside a fund within the United Way for this kind of thing. They'd be a natural convener for this stage if you want – and he is willing to do this. Mike Casper is willing to serve as a convener for this stage of community collaborative thinking. I think that district hospitals would be another natural. District hospital could be a convener if they formed the _____

Does it make sense that the university that called this meeting take the lead for the next meeting and invite your United Way person and they would then take the lead on it? But I'm not sure what they would be convening if they weren't a participant here today.

Well, they don't have anything at stake. I'd rather see an organization with something really at stake act as a convener.

I've looked at the organizations who have a major stake in this and ask them, would they help fund something like this? Not a one of them has come forward. They cannot, they do not have the money. United Way recently –

I'm wouldn't say turn down their money. I'm just talking about the convening structure. Sonoma State College is convening it, is that agreed?

I didn't hear what was the question. Karen was asking you who you were asking.

My suggestion is that they convene a meeting made up of constituencies who aren't here so that you can explain it and then either pass it along or continue it.

But I'm still not sure who you were suggesting or whether you were suggesting.

I wasn't suggesting –

I'd like to add the United Way's links to help the organization to this group or any would be a powerful additional force. It may make sense for them to host a meeting, maybe here or jointly, do it jointly if you guys are involved.

I think that the United Way is a source of funds and what they're saying, from what I'm hearing, is that they would love to see something like this facilitated or get started. Clearly, Sonoma State College has started the process with this meeting and if we could infringe upon your generosity to use Sonoma State College to at least get the group started. If this group doesn't go forward with momentum and what have you, then shame on us. But we already got a small home and we're comfortable and I think that's what the question is – where should the first meeting be, who should be the beginner to bring the other people to the table?

And then you can determine whether you're going to pass the mantel when you have enough people in the room to determine who's even it. Because I think as Tom was saying earlier and what I was agreeing with is, you need to see who's interested and then begin. You need to spread out.

You ought to have an agenda for the first meeting of action. Are we going to have another meeting and proceed to commence to begin? Somebody needs to draw up a plan, some design and say, is this okay? No? Okay. Is this okay? Yes? You will exhaust interest rapidly if you don't.

Why don't we draw up a draft of the trust.

It already exists. Just for a second before we do that, I'd like to propose as well that in some form the Community Foundation of Sonoma County be involved. They were one of the funders of the meeting. They are involved, they are concerned and we have one of our senior faculty members who is a trustee of the Foundation and he is interested as well. Art?

I was just going to say that you and I are not necessarily Sonoma State University but if you're willing to carry the ball another step I will be willing to support you and it sounds like there are enough good ideas that we could pull something together and talk to some people like Mike Casper and the Community Foundation and set up another meeting.

Connie Codding is interested. She's tired of being begged for nickels and dimes. The Codding Foundation.

Actually she and Susan Moore are talking about setting up another specifically women's issues foundation.

Health care districts, don't forget them.

Did you want something else, Michael?

No, I was just going to volunteer to work with Gaiza and anybody else who is interested on a subcommittee to put together – to me there should be something that people could come and react to.

So we have volunteers here of Michael and Gaiza and Norm. We've got a committee and we've got an agenda.

Anyone in the medical profession?

Bob said he would.

We'll have a compilation fairly quickly –

I'd like this gentleman on board too.

Actually Bob and I are talking constantly. Bob, if you'd be willing to work with us, we'll continue our dialogue.

Let's all be clear, what this is is to get some kind of structure together so the next meeting can be very productive.

Right. So that you come into a room and you say, this is what's been proposed.

And this is the starting grounds, yes.

Otherwise you'll spend another day doing this.

And I'm adding something that's a fact already. We already intend to put together – Jessica, we've got to expand her research money – we're going to put together all the notes from this weekend, and in that process we can put it in the distillery and we'll either get alcohol or we'll get a condensed set of principles that have been proposed – or both. It may be quite an elixir. So we'll have maybe two or three different approaches – Bob's distillation of ideas, Gaiza and Mike and Norm.

I think you've got a committee.

Tell me what you were thinking about the health care districts. We've got to have them involved?

Volunteers for the subcommittee.

And not just the hospitals, you were talking earlier about having countywide representation. You have five health care districts in the county so basically that would be providing countywide representation. Damon Dawes down in Petaluma would be a tremendous asset.

I talked to Damon last night about participating in something like this and Damon said his relationship with Memorial is so tight that he would feel uncomfortable because they have a long-term management contract with Memorial and Memorial calls the shots down there. Memorial is pumping a lot of money into that hospital and David Amin runs that hospital. If

anyone is not going to do well with this model, or parts of it, it will be David Amin and Memorial Hospital.

I'll work with Jack, we'll find some other districts.

Rather than have a continuing discussion on that, we're overtime. Anything more that you'd like to get into? Do you want to report to the other group or do you want to go home?

Go home.

Okay. Wonderful.

END OF TAPE