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Special Focus: Public Health and Managed Care

Public Health and Managed Care: Data Sharing for Common Goals

Changing to a "managed" or capitated system of health care and devolving responsibility for public programs from the federal to the state level have imposed new demands on health information systems and blurred the distinction between traditionally public and private data sources and needs. Many of the changes in health care delivery are being driven by purchasers of care. The corporate sector, which purchases health benefits for its employees, and the public sector, which purchases care for Medicaid and Medicare recipients as well as for employees and pensioners, are both seeking quality, cost-effective care for the money they spend for health benefits.

The fundamental importance of data—its collection, use, sharing—has emerged as one of the key issues at the forefront of this revamped health care delivery system. During the opening plenary session at the Prevention in Managed Care: Joining Forces for Value and Quality conference, which was held in Atlanta in January 1997, William W. McGuire, MD, Chairman, President, and Chief Executive Officer, of United HealthCare

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Dr. David Satcher, Director, Centers for Disease Control and Prevention, and Dr. Bruce C. Vladeck, Administrator, Health Care Financing Administration, exchange ideas during a break at the Prevention in Managed Care conference.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Commentary Commentary Commentary

Public Health and Managed Care: Beyond Coexistence to Partnership

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Open a journal or newspaper. Browse health or business sites on the Internet. Go to a conference. Listen to conversations in the hallways, by the water fountain, or near the elevators. You are sure to hear the words "managed care and public health" being discussed often in the same sentence as "opportunity" or "partnership." Yet just a few years ago, managed care and public health seemed to exist in fixed orbits that could never intersect, and the discussions then fixed on terms such as "roadblocks" or "cross-purposes."

Now the United States is in the midst of a sweeping restructuring of both its private and its public systems of health care. Along with this change is the newly emerging sense of a shared agenda between public health and managed care. Initially, neither side was quite ready or committed to pursuing this agenda, but both are now learning to speak the same language, to respect each other's capabilities, and to sort through conflicting agendas, resources, and goals.

The rapidity of this shift in how our health care delivery system is organized has caught the full attention of public health professionals, who tend to focus on population-based disease prevention and health promotion activities, of managed care insiders, who lean more toward clinical medicine and business issues, of employers and government agencies that purchase health services, and of varied associations and institutions that help develop quality assurance standards and monitor delivery of services. But for awhile it looked as if public health would be left on the sidelines.

Casual observers may not have noticed that the main players in this changing health care delivery system have been rolling up their sleeves and tackling key issues at conferences and meetings over the past several years. Nowhere was this more evident than at the Prevention in Managed Care: Joining Forces for Value and Quality conference, convened in Atlanta, January 1997. Attendees packed the large plenary sessions and breakout workshops; stockpiled handouts from exhibits highlighting public health programs, managed care operations, and quality assurance strategies; and exchanged business cards as they worked to expand their connections.

During his opening keynote speech, Mark D. Smith, MD, MBA, President and Chief Executive Officer, California HealthCare Foundation, captured the essence of the moment: "In the last several years, the attitude of some people in public health about managed care has changed from 'bogeyman' to 'bonanza,' and neither one is realistic. The era of the fragmented cottage industry of medical care is clearly ending; in its place are developing private systems responsible for large populations. These systems bring substantial organizational capacity and clinical competence to the table. Our task, therefore, is to figure out how they and public health agencies can cooperate to serve their mutual interests and those of the public."

During the closing session, Bruce C. Vladeck, PhD, Administrator of the Health Care Financing Administration, reaffirmed this stance: "I think we are in fact at a special kind of juncture in the development of managed care and in the development of public programs relative to managed care. And one that, like most critical junctures in history, contains the potential to go either way, or any of several ways. How it turns out is really going to depend quite critically on what all of us do in the months and very few years ahead."

I see this juncture as a critical one for public health. We have to engage managed care providers as our allies for the public health prevention goals we hold so dear. Chronic diseases and conditions, which include cardiovascular disease, cancer, stroke, and diabetes, pose a formidable burden in terms of morbidity and quality of life and contribute greatly to our nation's escalating health care costs. Managed care offers us the opportunity to emphasize disease prevention and health promotion as never before.

Throughout NCCDPHP, many activities, spawned by these rapidly evolving partnerships with managed care, should bring about solid, long-lasting changes in the way public health accomplishes its goals. Even as we must continue to find ways to help the uninsured,

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Data Sharing

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Corporation, stated "Data—and I say here unbiased data—are absolutely essential to the evolution of a successful health care system in this country. We have to change the behavior of people, and that means the behavior not just of providers, but of payers, of managers, and of end users. This is where data and information can be of maximum value. And optimum success in all of this is going to be achieved by balancing costs, access, and appropriate outcomes in health care."

Joseph W. Thompson, MD, MPH, Vice President for Collaborative Research, National Committee for Quality Assurance (NCQA), told *cdnr* that data are crucial to purchasers of health care: "For data to be valuable," he said, "they must be standardized to allow purchasers to make realistic, apple-to-apple comparisons of one health care delivery system with another, and they must provide purchasers with the discriminatory capacity to tell good health care delivery systems from bad ones." The information gleaned from performance measures, he explained, also gives those responsible for purchasing health care "a chance to evaluate how health plans have improved health within their patient population and to prevent any erosion of services."

To assess the quality of that care, corporate and public purchasers of health care are demanding that providers furnish performance measurement data on their enrolled population. Bruce C. Vladeck, PhD, Administrator, Health Care Financing Administration, a closing speaker at the Prevention in Managed Care conference, noted that "the enormous growth in our managed care enrollments gives us, we believe, a very special and urgent responsibility to hold plans accountable for the quality of the care they are to provide."

Meanwhile, states are moving from the direct provision of medical care toward an increasing emphasis on the public health functions of assessing health status and community health needs, assuring quality medical care is available to the public, and developing timely, informed public health policy. Each of these functions requires access to comprehensive, population-based systems of health data.

Sharing Information Will Yield Cost Savings

"At each level of the health care continuum, there is a heightened need for data on health status, on the prevalence and distribution of health risks, and on the processes and outcomes of care," according to Gail R. Janes, PhD, MS, an epidemiologist with the NCCDPHP's Division of Adult and Community Health. "In addition, all groups involved in providing, purchasing, and assessing health care are operating in an environment that requires that maximal value be obtained for each dollar spent. Given the difficulty and cost associated with developing effective information systems, there is a growing realization that a shared information platform, spanning the public and private sectors, can best and most efficiently address these challenges."

Under the budgetary strictures imposed by managed care, providers must strive to provide high quality care in the most efficient manner possible, under the close scrutiny of their customers, the purchasers. Their information systems must be able to

- Support both administrative and clinical operations.
- Track patient eligibility, health status, and health risks.
- Capture and link patient-specific encounter data to describe episodes of care.
- Support detailed analyses of resource utilization and patterns of care.

Although these data systems primarily support internal operations, purchasers are also demanding that aggregate and plan-specific performance measures of the processes and outcomes of care be reported

> *"For data to be valuable, they must be standardized to allow purchasers to make realistic, apple-to-apple comparisons of one health care delivery system with another . . . ."*

Left to right: Dr. Mark D. Smith, President and CEO, California HealthCare Foundation, Dr. William W. McGuire, Chairman, President, and CEO, United HealthCare Corporation, and Dr. James S. Marks, Director, National Center for Chronic Disease Prevention and Health Promotion, CDC, were among the keynote speakers at the Prevention in Managed Care conference.

in a standardized, consistent format that allows comparison across competing provider groups.

HEDIS (Health Plan Employer Data and Information Set), developed by the NCQA, is the best known, but not the only, of these performance measures. (See related story, p. 9.) The Joint Commission on Accreditation of Healthcare Organizations, for instance, recently announced its own initiative called ORYX (named for a breed of gazelle) to integrate performance measures and other outcomes into its accreditation process. (Though the main focus of ORYX is on hospitals and long-term care providers, there is also a component for health plans and HMOs.)

"Data on health risk behaviors are often not captured, despite the fact that they are needed to appropriately target preventive interventions and to risk-adjust performance measures."

Changing Needs Require New Data Systems

Increasingly, the need to collect, aggregate, and report performance measures is simultaneously driving the structure of health plan information systems and revealing flaws in the systems.

"Currently, the information systems of most health plans are not adequate to the task. Most suffer from weaknesses such as a lack of data on out-of-plan services and outcomes, including those tracked by HEDIS as well as other systems of quality assessment," according to Dr. Janes. "Data on health risk behaviors are often not captured, despite the fact that they are needed to appropriately target preventive interventions and to risk-adjust performance measures. In addition, in the current world of much-merged megaplans encompassing a host of different types and sites of care, many health plans have little access to 'raw' clinical data, but depend on large administrative or claims data systems, which were developed to meet financial needs. The ability of these claims data systems to accurately track quality of care appears increasingly doubtful," she said.

At the Prevention in Managed Care conference, Edward J. Sondik, PhD, Director, National Center for Health Statistics, CDC, framed these issues with a series of questions: "What do we need to manage this new health care system? Where do we find this information? And what are the evolving roles and responsibilities of both the public health sector and the private sector?"

State health agencies and health providers in the private sector also have a host of new data needs. "To better focus their efforts and programs, states must have population-based data on health status, resources, and need," according to Dr. Janes. "They need data that resolve to the local or community level. As budgetary constraints become even more acute, so does their need to assess the effectiveness of programs. Furthermore, as both their Medicaid and indigent populations—for whom they used to care directly—are moved into managed care, they need to define the eligible population and their needs to set the health care goals and priorities for which they will hold managed care responsible."

Dr. Vladeck offered this perspective as part of his closing remarks at the Prevention in Managed Care conference: "Envision yourself in a world two or three years from now where you really have all of these performance measurements such as HEDIS measurements. What do you as a purchaser or as a regulator do with all of this information? How do you aggregate it, how do you evaluate it, how do you standardize it? How do you use it to compare other plans and so forth? This scenario is a reflection not only of how far we've come, but of how far we still have to go."

As significant amounts of data about Medicare and Medicaid enrollees in managed care programs are now being collected, he explained, questions arise related to "what kinds of data should we be collecting, what kinds of systems should we be developing to collect data, and what kinds of standards should we be developing?"

"We also feel very strongly that we have to do this not as some secret cabal on the part of the health professionals," Dr. Vladeck said, "but in a way that increasingly engages better and better informed beneficiaries themselves and increasingly represents their preferences, interests, and concerns in a formal way in our accountability mechanisms and in our evaluation of the performance of plans and other providers."

Balancing Pros and Cons of Data Systems

Like their private sector counterparts, state-based health data systems are also a mixture of strengths and weaknesses. Many are better at defining costs and services than defining populations of interest. Other systems, such as disease and vital statistic registries, contain the outcome data that providers sometimes lack, but they do not have access to the process data, which are better captured by the provider community.

"Population-based surveillance systems, such as the Behavioral Risk Factor Surveillance System (BRFSS) (see related story, p. 12) and the Pregnancy Risk Assessment Monitoring System (PRAMS), are excellent sources of data on the distribution of risk at the state level; they are appropriate benchmarks for plan-specific data on health risk status," Dr. Janes said. Many states also collect and maintain population-based data systems drawn from hospital discharge data. "These are very useful sources of information on resource utilization and patterns of inpatient care, but they are becoming less meaningful as more care moves to outpatient, ambulatory surgery, and home health care settings," she added.

In summary, both the public sector and private health plans and providers have a wealth of information under their control, but no one has the complete set. Finding ways to share data across this traditionally, somewhat inhospitable divide makes sense. Several steps can help meet that goal, according to Dr. Janes. The private sector could

- Combine data on the processes of care with outcome data from public health vital statistic and disease registries to better elucidate and evaluate the continuum of care.

"Envision yourself in a world two or three years from now where you really have all of these performance measurements such as HEDIS measurements. What do you as a purchaser or as a regulator do with all of this information?"

- Risk-adjust those measures using public health's measures of health risk status and benchmark results against state-based values.

The public sector could

- Build the types of high-resolution, population-based data systems they need by augmenting their own data with those of the provider community.
- Improve systems of surveillance by more efficiently collecting the data automatically, at the point of care.

"These improvements would significantly affect the ability of public health agencies to target and evaluate public health interventions. In addition, they would be able to track the quality of care provided to Medicaid patients and to the medically indigent so that they, like the private sector purchasers, could ensure maximum value for their health care dollar," Dr. Janes added.

"It is virtually impossible to integrate data systems that are composed of nonstandardized data elements, coded in disparate ways, and arranged according to incompatible formats. . . ."

Significant Barriers Pose Challenges to Data Sharing

In spite of agreement on the advantages of linking or sharing information between state health departments and private providers or plans, significant barriers exist. Issues of privacy and confidentiality are critical to patients, providers, and plans. Legislation such as the recently enacted Health Insurance Portability and Accountability Act of 1996 (HIPAA, or Kennedy–Kassebaum) mandates development of mechanisms for ensuring the confidentiality of electronically transmitted patient information.

Managed care providers have concerns about revealing the content of their proprietary data systems. Many feel strongly that their ability to succeed in an increasingly competitive market is tied to information contained in these systems. "Consequently, there is great unwillingness to open them to scrutiny by the state, with its regulatory capabilities, and by their competitors," Dr. Janes stated.

However, managed care providers are beginning to bridge these traditional barriers and concerns. "In Arizona and Minnesota, managed care organizations have started sharing data on immunizations by contributing to a centralized database," Michael R. Rosnick, MD, MPA, Physician-Director, Humana, Inc., Louisville, said. "Also, a large number of managed care providers have agreed to participate in NCQA's Quality Compass by sharing aggregate data," he added, also noting that "data are no longer as proprietary as they once were because everyone is reviewing each others best practices as a result of NCQA measurements."

"Issues of turf—or concerns about relinquishing control of traditional data fiefdoms—play a considerable role in slowing data sharing across state agencies," according to Dr. Janes. These difficulties are compounded by regulatory strictures such as those barring Medicaid agencies from linking claims and vital statistics data in some states.

Lastly, nonstandardization creates problems. Dr. Rosnick noted "the problem goes beyond sharing information. Sharing, extracting, and storing data from very different systems—systems that were often assembled piecemeal to address specific concerns—pose some serious challenges."

Dr. Janes agreed: "It is virtually impossible to integrate data systems composed of nonstandardized data elements, coded in disparate ways, and arranged according to incompatible formats. This is one of the issues that Kennedy–Kassebaum is meant to address."

A number of initiatives are exploring the feasibility of linking or sharing health information between nontraditional partners or in nontraditional ways. The Robert Wood Johnson Foundation, for instance, has funded the Information for State Health Policy Program (http://www2.umdnj.edu/shpp/homepage.htm), to strengthen state infrastructures that

collect and process data, to foster interaction between data-collecting entities within the state, and to distribute data to state policymakers.

As an example of the types of linkages facilitated by this grant program, Wisconsin is now able to link birth certificate, hospital discharge, and Medicaid eligibility data; this linkage permits a variety of useful comparisons, such as the risk profiles of women whose prenatal care was covered by managed care versus fee-for-service Medicaid.

Another example of state-based data sharing is the Affiliated Health Information Networks of New England (http://www.mahealthdata.org), a public-private partnership of purchasers, providers, and insurers of health care, convened by the Massachusetts Health Data Consortium, Inc. Participants in the Affiliated Networks project seek consensus on noncompetitive data issues, and particularly on data standardization, to improve data exchange.

Speaking at the workshop "Data Sharing Partnerships: Roles and Realities," at the Prevention in Managed Care conference, Elliot M. Stone, Executive Director and CEO of the Massachusetts Health Data Consortium, Inc., noted that "our state has a very high penetration of managed care—and their leaders have told us of internal technology problems in producing the HEDIS measures. Few can generate these measures purely from their administrative data systems, and they must instead rely on hybrid systems of administrative data plus medical abstracts. At the same time, the purchasers of managed care are also demanding less paperwork and lower administrative costs. As a result, managed care organizations are looking to technology to simplify administrative processes with their providers and consumers."

The goal of the Consortium's Affiliated Networks project is to design a network, with an Internet-like approach, using nationally accepted standardized data formats, to "virtually" interconnect the databases of public and private organizations. After 2 years, the project's 4 work groups have developed a number of recommendations, including an Emergency Room Data Set, based on standardized protocols for transmission of clinical data and CDC's recommended core data set, Data Elements for Emergency Department Systems (DEEDS) Ver.1. The parent consortium has also been collaborating with public and private agencies since 1978 to develop databases describing inpatient care, outpatient services, and the supply of health professionals.

The Lewin Group, under contract with the Department of Health and Human Services, has developed a registry of these efforts to integrate state data and made it available on the Internet (http://aspe.os.dhhs.gov/statereg/).

NCCDPHP has supported several collaborative projects involving data sharing between managed care and state health departments. In Colorado, Kaiser Permanente used the BRFSS to assess the health risk status of their patient population and to examine how well preventive services were being delivered, compared with BRFSS state-level estimates. In Washington and Minnesota, in cooperation with two large health plans, Group Health Cooperative of Puget Sound and Health Partners, the BRFSS was used to collect plan-specific HEDIS data, which are generally drawn from administrative (claims) data or from the medical chart. (See related story, p. 12.)

Legislation May Lead to Greater Interaction, Sharing

"We hope that the Kennedy–Kassebaum legislation will help bring about more data-sharing," Dr. Janes said. The provisions for administrative simplification focus specifically on establishing standards for electronic transmission of health care data, in support of more efficient claims processing and billing, although these standards will also create data systems that are more easily linked and shared.

"The bill also mandates adoption of unique identifiers for individuals, providers, health plans, and employers," she added. "Unique identifiers will also greatly facilitate linkage of data into comprehensive, longitudinal records, which span time and varied points of service; they also heighten the need for strict security standards and safeguards, which are emphasized in the law."

Lastly, the legislation mandates that recommendations on uniform data standards for patient medical record information be forwarded to the Secretary of Health and Human Services within 4 years. According to Dr. Janes, "This may be one of the most meaningful steps toward developing standardized data systems spanning the public and private health care arenas. Many obstacles and concerns still block the open exchange of data between nontraditional partners such as public health and managed care. Opening up our data systems and profiting from one another's efforts, yet ensuring the privacy and confidentiality of these data contained therein, remain high priorities."

Gail R. Janes, PhD, provided extensive background information for this article.

HMOs Form Network of Research Centers

The rapid growth of managed care coupled with an increased need for public-domain research to be conducted in managed care organizations has led to the formation of an alliance called the HMO Research Network.

The goals of the HMO Research Network are to encourage quality, public-domain research by enhancing the research capabilities of individual HMOs, fostering collaborative research, and influencing the national research agenda, according to Edward H. Wagner, MD, MPH, Director, Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle.

"HMOs are important models for the organization of health care delivery and can serve as laboratories for conducting health services, epidemiological, and clinical research," Dr. Wagner said. "Collaboration among various HMO research programs will bolster the quality of each individual research program and facilitate multisite studies aimed at developing, evaluating, and implementing various aspects of primary and preventive care."

Dennis D. Tolsma, MPH, Director, Prevention and Practice Analysis, Kaiser Permanente, Georgia Region, explained "If your agency or institution has a research project that would be enhanced by access to a large ethnically, racially diverse population mix, then you may find this an excellent resource. Our hope is that the public health community will see managed care as an ally in finding effective strategies for improving the health of our populations." The network will also serve as a means for HMOs to disseminate experience and insights in national health policy and research circles. "The HMO Research Network maintains a public-domain philosophy in that we intend for this information to be shared," he added.

Member organizations include Group Health Cooperative of Puget Sound; Group Health Foundation/ Health Partners Research; Harvard Pilgrim Health Care; Henry Ford Health System; Kaiser Permanente, Colorado Region; Kaiser Permanente, Georgia Region; Kaiser Permanente, Hawaii Region; Kaiser Permanente, Northern California Region; Kaiser Permanente, Northwest Region; Kaiser Permanente, Southern California Region; The Meyers Primary Care Institute; and The Prudential Center for Health Care Research.

For more information, contact Edward H. Wagner, MD, MPH, Director, Center for Health Studies, Group Health Cooperative of Puget Sound, 1730 Minor Avenue, Suite 1600, Seattle, WA 98101; 206/287-2877. Dr. Wagner is currently chairperson of the HMO Research Network.

Tracking Managed Care Disease Prevention Efforts Through HEDIS

Do the key participants in the rapid shift to managed care as the basis for delivering health care sometimes seem to be circling each other like Sumo wrestlers, looking to move swiftly and decisively? In grappling with a vast array of issues, it is possible to lose sight of what the effort is really all about. "Finding opportunities to advance health in any setting is our incumbent goal," according to M. Blake Caldwell, MD, MPH, Medical Director, Office of Managed Care, Office of Program Planning and Evaluation, CDC.

HEDIS, or the Health Plan Employer Data and Information Set, is one vector where the myriad opportunities to improve health converge. HEDIS offers both purchasers and consumers of health care services a method to compare the performance of managed health care plans, not just in terms of the cost of services but in terms of the demonstrated value of services.

Now in version 3.0, HEDIS provides a set of 71 performance standards for selected medical services offered by managed care providers. HEDIS is sponsored, supported, and maintained by the not-for-profit National Committee for Quality Assurance (NCQA), an organization formed to evaluate and report on the quality of managed care plans.

Measurements are not provided for all services—there are practical limits to keep in mind—but for key indicators of quality health care delivery such as access and availability of care and use of services.

"HEDIS is the premier report card, if you will, for managed care in this country," said Jeffrey R. Harris, MD, MPH, Acting Associate Director for Policy, Planning, and Evaluation, CDC, during the opening plenary session at the recent conference, Prevention in Managed Care: Joining Forces for Value and Quality.

Measuring Efforts to Curb Risk Behaviors

"HEDIS is a major force for action within managed care," Dr. Harris noted during his plenary address. "What gets measured gets done. We are seeing this truism prove itself again and again; . . . it's not a coincidence, therefore, that mammography and immunization have both received so much attention from HMOs and have both been a part of HEDIS. Starting about two years ago several of us asked ourselves, why shouldn't smoking—the number one underlying cause of death in this country—be included in HEDIS?"

Discussions among the NCQA, various HMOs, components of the Department of Health and Human Services, including CDC, the Center for the Advancement of Health, and state and local health departments, along with research spearheaded by the Robert Wood Johnson Foundation, were integral ingredients in developing the new measure of counseling for smoking cessation, which NCQA adapted as part of HEDIS 3.0.

Although earlier versions of HEDIS already contained several measures for delivery of other preventive services, the inclusion of smoking cessation activities in version 3.0 represents the first time that HEDIS will evaluate how well managed care providers deliver services aimed at altering high-risk behaviors. Corine G. Husten, MD, MPH, Medical Officer, Office on Smoking and Health, NCCDPHP, CDC, noted that for the first time, information about quality of care measures will come from surveying the patient or client instead of from administrative or chart data. "Now the door is open for surveying the delivery of services tied to other risk behaviors such

"Starting about two years ago several of us asked ourselves, why shouldn't smoking—the number one underlying cause of death in this country—be included in HEDIS?"

as poor diet or physical inactivity," according to Dr. Husten.

NCCDPHP staff also have a stake in other potential HEDIS measures as well. For instance, "The relevance of low birthweight as an outcome of interest in perinatal health is unassailable," stated Vijaya K. Hogan, DrPH, MPH, Medical Epidemiologist, Division of Reproductive Health, NCCDPHP, CDC, adding "but the scientific soundness and feasibility of low birthweight as a performance measure need to be systematically evaluated." Accordingly, CDC, the Massachusetts Department of Public Health, the Massachusetts Department of Health Care Policy and Finance, and the New England HEDIS Coalition, a group of 8 health plans in Massachusetts, are collaborating to assess both the conceptual validity of low birthweight as a measure of the quality of prenatal care and the technical aspects of creating a valid, risk-adjusted measure.

"Never before has there been an opportunity to hold health care organizations and professionals responsible for the care that is delivered or the health status of the population served."

HEDIS Provides Chances to Improve Health

Increasingly, the components of the health delivery system, whether private-for-profit, nonprofit, or public, no longer operate within separate realms but overlap services and goals. As a result, accountability for delivering thorough health care is a prime concern. For instance, at the conference Prevention in Managed Care: Joining Forces for Value and Quality, Dennis D. Tolsma, MPH, Director, Prevention and Practice Analysis, Kaiser Permanente, Georgia Region, said that "today when persons in a managed care organization think of their mission, increasingly they are thinking not only in terms of delivering needed medical services at a patient-initiated office visit but also in terms of their responsibility for the overall health of their client population. A number of the new HEDIS measures reflect that evolution."

James S. Marks, MD, MPH, Director, NCCDPHP, CDC, observed that "Never before has there been an opportunity to hold health care organizations and professionals responsible for the care that is delivered or the health status of the population served."

"Managed care organizations cannot get away from accountability," said Michael R. Rosnick, MD, MPA, Physician-Director, Humana, Inc., Louisville, another conference speaker. "We are accountable to the individual enrollees who can walk away and join another plan, to some degree to regulators, purchasers, individuals . . . , and also accountable to reviewers. Certainly HEDIS is a measure of some level of accountability."

This recognition that what benefits society as a whole will also benefit a health provider in particular bodes well for addressing key opportunities to deliver important public health messages.

Dr. Caldwell sees the addition of smoking cessation measures to HEDIS as bolstering the framework for more opportunities for improving health. "To me, having a physician counsel and support a patient to quit an addictive behavior makes sense. We have opened the door to making physicians, and the health plans they work for, accountable for counseling patients about altering risky behaviors."

Joseph W. Thompson, MD, MPH, Vice President for Collaborative Research, NCQA, explained that "As HEDIS continues to evolve, additional prevention-oriented and population-based measures

will be included." He cited adolescent immunizations—which will include hepatitis B starting next year—hypertension control, and counseling about hormone replacement therapy for postmenopausal and perimenopausal women as examples.

Prevention Favors Standard of Care Issues

Because health plans are going to be held to the HEDIS standard, managed care providers are certain to run into issues related to measuring the impact of prevention-based interventions and accountability to the bottom-line issues of money.

"The difference in terms of a population approach [versus clinical treatment] is that you're not satisfied with just doing lots of activities but rather you're asking 'does the activity get me to where I'm going?' Does it make a difference and will it be cost-effective?" said Neal S. Sofian, MSPH, Vice President of Program and Business Development with Lexant, a Monsanto Life Sciences company, at the Prevention in Managed Care conference.

"One big concern in the managed care environment right now hinges on long-term versus short-term benefit and price and payback," Mr. Sofian stated, "but it's really a standard of care issue, not a cost payback issue. I think as HEDIS starts demanding that smoking cessation, for example, be included as part of the process of delivering health care services, this question about short-term cost benefit will go away in some prevention areas. You practice preventive medicine because it's the right thing to do. It's what good health care is all about."

Jeffrey P. Koplan, MD, MPH, President, The Prudential Center for Health Care Research, told *cdnr* that "There are four major reasons prevention will be done: it is a fundamental principle of managed care; preventive actions are equated with quality care and most plans want to be seen as quality providers; providers want to perform well on HEDIS measures; and, as a distant fourth, economic estimates from the literature support prevention."

In the NCQA's 1996 annual report, *Widening the Quality Circle* (available on the Internet at http://www.ncqa.org/ar96.htm#prevention), Dr. Harris explains that "most clinical preventive services are good buys. Mammography is a good example: it costs about $30,000 per year of healthy life saved. That is a good buy compared with other things we do regularly in the treatment business. I think the good news is that HEDIS has focused on some good buys, such as mammograms, Pap tests, and immunizations. There are certainly more to come, like measures that stimulate smoking cessation."

Opportunities for Advocacy Remain Largely Untapped

NCQA's Dr. Thompson sees additional opportunities for public health professionals to advance their prevention agenda: "Clearly public health is on the right track and can serve as leaders in this area. That said, public health needs to add some advocacy roles to its traditional portfolio of activities. Public health has traditionally served as a provider of information, but it should now become much more involved in assisting purchasers of health care to evaluate quality of care."

"For example, public health can become a facilitator in helping Medicaid directors and purchasers of health care for state, city, and local employees make purchasing decisions based on data about quality of care issues," Dr. Thompson said.

BRFSS Proves Adaptable Means to Collect Managed Care Data

The Behavioral Risk Factor Surveillance System (BRFSS)—the venerable state-based telephone surveillance system that CDC helped initiate in the early 1980s—is now generating crucial, reliable state-level data about access to and satisfaction with health care services delivered by managed care providers. In some cases, health providers are turning to public health agencies for their help with surveillance and data analysis.

The BRFSS, which is conducted monthly in every state, is clearly established among public health agencies as a major source for state-by-state information about health risk behaviors for disease, receipt of preventive services, and health status. The questionnaire consists of three parts:

- Core questions used by all states.
- Standard sets of questions on selected topics that states may choose to add.
- Questions developed by individual states on issues of special interest.

Every state uses a similar method of selecting respondents and the same core questions; consequently, the BRFSS allows comparisons between states and between individual states and the nation. In addition, because many of the same questions are asked each year, nationwide and state trends in health-related behaviors can be monitored.

This capability is crucial in measuring the effectiveness of health promotion efforts. The BRFSS survey has also proven useful in other ways, such as enabling states to collect information on the percentage of uninsured adults in their jurisdictions.

"Health maintenance organizations have started using the BRFSS to learn about their clients' health risk behaviors and use of clinical services," according to Betsy L. Thompson, MD, MSPH, Medical Epidemiologist and Managed Care Coordinator, Division of Adult and Community Health, NCCDPHP, the organizational unit within CDC that manages the BRFSS.

Dr. Thompson guided the development of new BRFSS questions designed to measure how changes in health care financing affect the receipt of preventive services. "These modifications to the BRFSS provide previously unavailable state-based information about health care coverage, access, and utilization; more specifically, these new modules collect information about access to and satisfaction with health care," she explained.

BRFSS Can Provide Key Information for HEDIS

The BRFSS can also provide crucial information needed for HEDIS—the Health Plan Employer Data and Information Set—regarding the delivery of preventive services such as physician counseling about smoking, mammography screening for breast cancer, Pap tests for cervical cancer, or eye examinations for persons with diabetes. (See related story, p. 9.)

One key CDC project is studying how well the BRFSS works to collect data for selected HEDIS measures within managed care settings in two states, Minnesota and Washington. "The intent is to see how well the specificity and sensitivity of self-reported BRFSS data work compared with that gathered from administrative and medical records files, which have been the primary sources of HEDIS data," according to Dr. Thompson. Specifically, this program is using the BRFSS to assess the delivery of mammography screening among women aged 52–64 years and diabetic retinopathy screening for persons with diabetes aged 18–64 years.

Raymond Boyle, PhD, Research Associate, Group Health Foundation, Minneapolis, said that "for certain preventive behaviors—eating well, smoking cessation, exercising—we find that the BRFSS allows us to collect information effectively and with much less effort."

He noted that "In Minnesota, at least, our HMO members are comfortable being surveyed, and they were also willing to share information about their eye exams and mammography screening with interviewers." Dr. Boyle also pointed out that managed care providers are interested in collaborating with public health agencies to improve the overall health of the population.

On the other side of this partnership, John Oswald, MPH, Director, Center for Health Statistics, Minnesota Department of Health, affirms that "the logistics of using the BRFSS to collect data for HEDIS measures and the partnership with managed care are working very well."

Mr. Oswald also stressed that "we do not want to create new surveillance systems when established public health methods of collecting state-level data can fill the need to collect population-based data for other purposes, such as for HEDIS and employer measures."

According to Mr. Oswald, adapting the BRFSS to collect data for HEDIS makes sense for another reason: it is cheaper than creating a new system and it costs less to administer than it would to abstract data from medical and administrative records.

He also sees the potential to employ other traditional public health data systems—for instance, those used to collect data on cancer, occupational health, and prenatal care and birth outcomes—as the partnership between managed care and public health evolves.

Using 'Before and After' Data to Establish Benchmarks

Another study is using the BRFSS to, in effect, get a before and after picture of how the rapidly changing health care delivery system will affect the services received by uninsured and underserved minority populations in New York, North Carolina, and Colorado.

Christopher Maylahn, MPH, Program Research Specialist, Division of Chronic Disease Prevention and Adult Health, New York State Department of Health, told *cdnr* that this study is focusing on how these populations are being affected by the shift of many public health functions to managed care providers, changes in eligibility for Medicare and Medicaid enrollment, and welfare reform.

"Because minorities have higher incidences of diabetes and asthma than do the population as a whole, because both cause complications that are much more costly to treat than to prevent, and because both conditions require access to ambulatory care, we are using a modification of the BRFSS survey to capture information about care for these conditions at several points in time," according to Mr. Maylahn.

"The key is that the CDC in partnership with states has built the capacity to do these surveys of emerging health issues. A number of potential questions can be answered by seeing what happens when these populations move to managed care," he said.

"The key is that the CDC in partnership with states has built the capacity to do these surveys of emerging health issues. A number of potential questions can be answered by seeing what happens when these populations move to managed care."

Tracking Delivery of Medicaid, Managed Care Services

An analysis to determine how well selected preventive services are provided by capitated versus noncapitated Medicaid is under way in Colorado, Missouri, and Oklahoma. Initially, the 1996 BRFSS was administered to a random sample of 1,000 Medicaid-eligible women whose services are delivered by both managed care and fee-for-service arrangements.

Marilyn Leff, MSPH, Director, Survey Research Unit, Colorado Department of Public Health and Environment, explained that information from the BRFSS, specifically from the preventive counseling modules, "helped us to establish a baseline for these populations last year. We used the BRFSS to collect state-specific information about receipt of preventive services and how access to these services may change depending on the type of provider."

Ms. Leff also pointed out that Kaiser Permanente has contracted with the Colorado Department of Public Health and Environment to administer the BRFSS to a sample of its enrollees. "Kaiser Permanente is using the BRFSS data to drive its prevention program by looking at health risks for its members versus those for the state population," she noted. In addition, other managed care organizations have used county-level BRFSS data for assessing health risks in the Colorado communities they serve.

Reliance on the BRFSS Expected to Grow

Experts from both managed care and public health concur that the role and significance of the BRFSS will expand as their traditional areas of responsibility blend and overlap.

Joseph W. Thompson, MD, MPH, Vice President for Collaborative Research, National Committee for Quality Assurance, told *cdnr* that "Performance measures within HEDIS are holding plans accountable for appropriate use of preventive services and risk reduction. This represents a real opportunity to benefit from the surveillance activities historically performed through the BRFSS and public health efforts. Although these efforts are not now interchangeable, opportunity exists for greater synergy in the future."

"We look forward to exploring all possibilities of linking the performance measures of the health care delivery system with those of the public health system," he added.

"The BRFSS will become even more indispensable with the growing need to evaluate new systems of care for the insured and access to care for the uninsured," predicts Adele L. Franks, MD, Assistant Director for Science, NCCDPHP. "Because the BRFSS is adaptable and established in each state, it is well-suited for monitoring the rapidly changing health care environment at the state and local level."

For additional information, contact Betsy L. Thompson, MD, MSPH, Managed Care Coordinator, Division of Adult and Community Health, NCCDPHP, CDC, MS K–30, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-5283.

Commentary

▸ *Continued from page 2*

we must engage strategically and fully with a health care system that is increasingly becoming population focused.

This shift in focus has gained momentum during the 1990s. From 1990–1996, the number of Medicaid beneficiaries enrolled in managed care has increased sixfold, and the number of persons receiving their health care from managed care has doubled (Figure 1). If you consider that up to 75 percent of the American population could be receiving their health care coverage from managed care providers, we clearly have much to gain by helping those who deliver health care to recognize the critical importance of chronic diseases on their ability to control costs.

But our opportunity to advance our cause of disease prevention and health promotion is not limited to working with managed care providers, who are subject to many other influences as well. We must also engage the purchasers of health care—private employers, our own state Medicaid agencies, and government—to assure that their standards and contracts emphasize prevention and public health responsibilities.

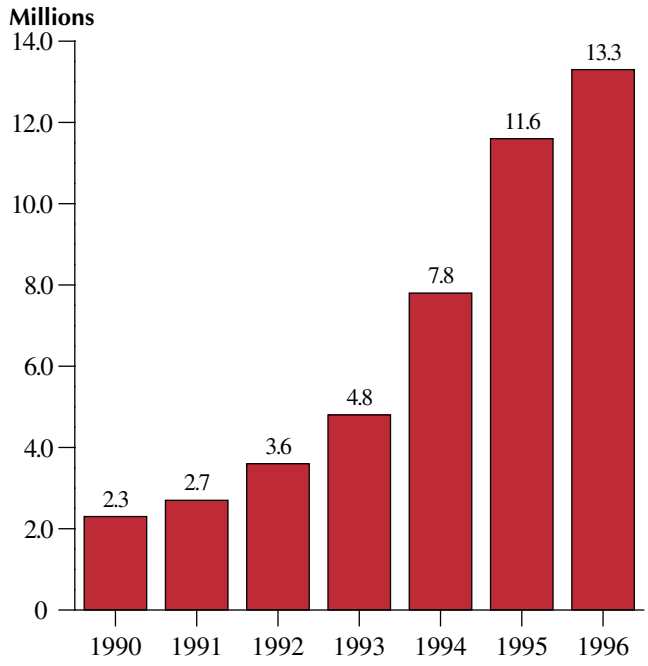
Managed care companies will increasingly provide only those services that are required of them. They will not be able to provide services that their competitors do not also provide.

Part of our expanding role will be to work with IPAs to ensure that they are strong proponents of disease prevention and health promotion, so they, in turn, emphasize these public health tenets to managed care organizations that are vying to include them as provider groups.

Though managed care is very important, it is not the only component. We must expand the public health model of building and nurturing coalitions to encompass all components of the new health care system.

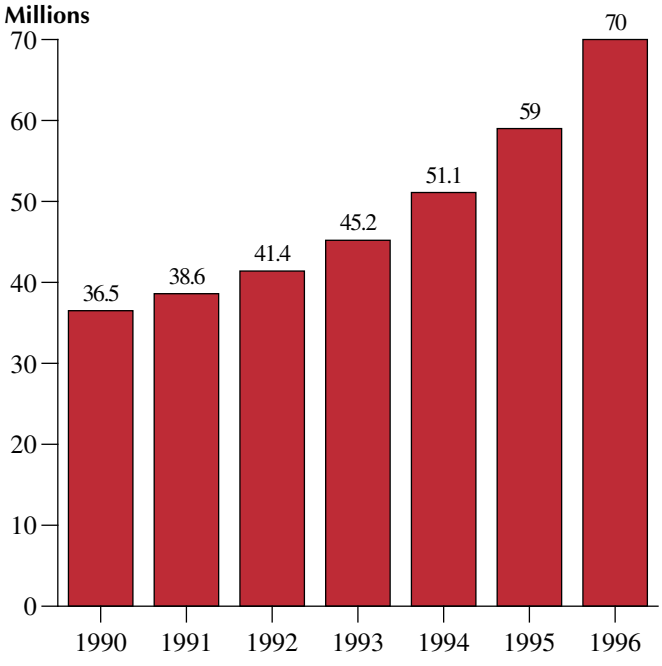
Figure 1. Tracking the Shift in Health Care Delivery—1990–1996

Medicaid Beneficiaries Enrolled in Managed Care



Source: Center for Health Policy Research.

Number of Persons Receiving Health Care from HMOs



Sources: GHAA's National Directory of HMOs Databases (1988–1994); 1995 estimate based on InterStudy Competitive Edge HMO Industry Report 6.2, Sept. 1996; 1996 projection from HMO & PPO Trend Survey, AAHP, 1996.

Abbreviations + Acronyms + Initialisms = Alphabet Soup

Something similar has probably happened to most of us at some time or another. We are attending a conference or workshop and our take on the lingo—or the "alphabet soup"—being bantered about is not quite on the mark.

During a recent meeting of the CDC Managed Care Forum, Joel R. Greenspan, MD, MPH, Division of STD Prevention, National Center for HIV, STD, and TB Prevention, CDC, recalled his reaction upon hearing a speaker at a recent Washington Business Group on Health conference discuss STDs. "I was initially quite excited that this group was dealing with sexually transmitted diseases, or STDs as we call them. Then I soon realized that the STDs they were referring to meant short-term disabilities," he related.

Mark D. Smith, MD, MBA, President and Chief Executive Officer, California HealthCare Foundation, recounted a similar experience during his keynote opening address at the Prevention in Managed Care: Joining Forces for Value and Quality conference. "A couple of years ago, I attended an all-day meeting in Minnesota between family planning agencies and Minnesota-based HMOs. We reached a point in the conversation where it seemed to me that people were talking about two completely different things. It took me awhile to realize that when one person in the room had said 'AGI,' the family planning people thought the speaker meant the 'Alan Guttmacher Institute,' and the HMO representatives thought they meant 'adjusted gross income.' And so we were having this conversation on two completely different levels."

Although this use of shorthand can lead to confusion, our insatiable appetite for collapsing words into potentially bewildering abbreviations, acronyms, and initialisms means that alphabet soup will be a permanent entree. Depending on whose bowl you dip into, deciding what the letters in your spoon really mean can be a problem.

The following list, which is by no means complete, is an introductory menu of common terms we are likely to encounter as the realms of public health, clinical medicine, for-profit providers, and purchasers of medical services—both business and government—strike up a dialogue. Note that not all of these truncations have multiple meanings, at least not yet.

AAHP—American Association of Health Plans
AAPCC—adjusted average per capita cost, American Association of Poison Control Centers
AFDC—Aid to Families with Dependent Children
AGI—adjusted gross income, Alan Guttmacher Institute
AHA— American Hospital Association, American Heart Association
AHCPR—Agency for Health Care Policy and Research
AMA—American Medical Association, against medical advice
AMC—academic medical center
ASL—accreditation status list, ankylosing spondylitis lung, average speech level
ASR—accreditation summary report, atrial septal resection
ASTHO—Association of State and Territorial Health Officials
BRFSS—Behavioral Risk Factor Surveillance System
CDC—Centers for Disease Control and Prevention, Control Data Corporation, cardiac diagnostic center
CMP—competitive medical plan

CPM—Committee on Performance Measurement, chronic progressive myelopathy (plus 8 other clinical terms)
CPR—computerized patient record; cardiopulmonary resuscitation; customary, prevailing, and reasonable
DHHS—Department of Health and Human Services
DME—durable medical equipment, director of medical education
DOH—department of health
DRG—diagnosis related group
EMRSS—electronic medical record storage systems
EOB—explanation of benefits
EPO—exclusive provider organization, Epidemiology Program Office
ERISA—Employee Retirement Income and Security Act
FFS—fee for service
HCFA—Health Care Financing Administration
HCPP—Health Care Prepayment Plan
HEDIS—Health Plan Employer Data and Information Set
HIO—health insuring organization
HMO—health maintenance organization
HHA—home health agencies
HOPD—hospital outpatient department
HRSA—Health Resources and Services Administration
GAPS—Guidelines on Adolescent Preventive Services
IPA—Independent Practice Association, intrapulmonary artery
IS—information systems, in situ, international standard
ISN—integrated service network
IT—information technology
JCAHO—Joint Commission for the Accreditation of Healthcare Organizations
LAN—local area network
MCO—managed care organization
MCWG—managed care working group
MHIP—Medicare Hospital Information Project
MMC—Medicaid managed care
MS—mail stop, mental status, mean score, mitral stenosis
NACCHO—National Association of County and City Health Officials
NAIC—National Association of Insurance Commissioners
NAMCP—National Association of Managed Care Physicians
NBCH—National Business Coalition on Health
NCHS—National Center for Health Statistics
NCQA—National Committee for Quality Assurance
OD—office of the director, occupational disease, overdose
PCCM—primary care case management
PCP—primary care physician, *Pneumocystis carinii* pneumonia, phencyclidine (angel dust)
PHP—prepaid health plan
POS—point-of-service, patient opinion survey
PPO—preferred provider organization, peak pepsin output
PRO—peer review organization
PRWORA—Personal Responsibility and Work Opportunities Reconciliation Act
PSO—provider-sponsored organization
QARI—Quality Assurance Reform Initiative
RFI—request for information, recurrence-free interval
RFP—request for proposal, right frontoposterior
STD—sexually transmitted disease, short-term disability
TAC—technical advisory committee, toxicant analysis center
VBAC—vaginal birth after cesarean
WAN—wide area network
YRBSS—Youth Risk Behavior Surveillance System

(For the record, an abbreviation is a shortened form of a word, e.g., VA for Virginia; an acronym is a word formed from the initial letters or main parts of a compound term, e.g., laser or snafu; an initialism is a string of letters formed from the initial letters or main parts of a compound term that do not make a word, e.g., CDC.)

Programs Engage in a Host of Activities

NCCDPHP and Managed Care: Forging Alliances, Refining Strategies, Seeking Results

"CDC's involvement with managed care does not constitute a wholesale endorsement of the many flavors of managed care in existence," stated Betsy L. Thompson, MD, MSPH, Medical Epidemiologist and Managed Care Coordinator, NCCDPHP. "It does signify our understanding that this is an unprecedented opportunity to have access to the general population for intervention research, improvement of health care delivery, and disease prevention and health promotion activities."

"The fact that the originators of HEDIS chose to begin measuring quality with prevention measures is more than remarkable; it may signify the first time that public health standards, such as breast and cervical cancer screening or diabetic retinal examinations, were considered of major importance by organizations other than public health or specialty groups," according to Dr. Thompson. "It's important to recognize who was participating in those initial discussions—large employers and health care purchasers as well as managed care leaders, not public health leaders."

NCCDPHP staff have observed this groundswell of interest in prevention and acted to seize these new opportunities to expand the center's disease prevention and health promotion efforts. Each of the center's 8 divisions and offices currently conducts managed care activities that are either related to that component's mission or serve a crosscutting function that supports other initiatives. Highlights of these activities follow.

Adult and Community Health Programs Help Anchor Managed Care Activities

"NCCDPHP's Division of Adult and Community Health (DACH), deals with a variety of crosscutting and wide-ranging issues—including the Behavioral Risk Factor Surveillance System, cardiovascular disease, and aging—as well as broad-based community health initiatives such as the Health Promotion and Disease Prevention Research Centers Program. Because of these roles, this division has taken the lead in promoting and coordinating NCCDPHP's managed care activities," according to Suzanne M. Smith, MD, MPH, Chief, Health Care and Aging Studies Branch, and former Managed Care Coordinator, NCCDPHP.

Examples of this leadership include coordinating the center's managed care working group, providing technical assistance on managed care activities, providing training in managed care principles for NCCDPHP and state chronic disease partners, and serving as the key contact for persons seeking information on the center's managed care activities. DACH has also assisted in developing national performance measurements for managed care by providing technical support and coordination for new HEDIS measures developed by the National Council for Quality Assurance and the Foundation for Accountability. (See related articles, pp. 9, 12.)

In addition, DACH staff are collaborating with managed care and other organizations on several specific projects that promote the prevention, diagnosis, and treatment of chronic diseases in a managed care setting.

Assessing How Childhood Experiences Affect Adult Health

Supported by an NCCDPHP cooperative agreement, the Adverse Childhood Experiences Study is being conducted by the Emory University Department of Pediatrics in collaboration with Kaiser Permanente.

This study, which assesses the impact of adverse childhood experiences on adult health status decades later, collects information on health risk behaviors, disease incidence, utilization and costs of medical care, quality of life, and mortality. It then assesses adversities during childhood, such as having been exposed to abuse.

"Early results show that adverse childhood experiences are common and have strong, long-term influences on teenage pregnancy, smoking, alcohol and illicit substance abuse, obesity, risk of sexually transmitted diseases, risk of sexual assault, depression, suicide attempts, high utilization of health care, and numerous other issues of public health importance," according to Robert F. Anda, MD, MS, Medical Epidemiologist, DACH, who serves as a technical advisor.

Considered a cornerstone for Emory Universities' comprehensive child abuse prevention program, this study has also caught the attention of key decision-makers in the Kaiser Health Plan. David Lawrence, MD, Kaiser's National CEO, has dedicated $2.4 million in Kaiser Health Plan funds to develop family-based health care beginning at birth for children born at Kaiser hospitals in four cities. After study findings were presented at a recent national meeting, Patricia Salber, MD, Kaiser's Physician Director of National Accounts, stated, "These results are going to change the way we practice medicine."

Dr. Salber and other Kaiser physicians are working on a proposal to sponsor a program in which CDC-trained and supervised physicians would spend 2 or 3 years working at Kaiser Permanente on the epidemiology and disease surveillance of childhood-related adult health problems.

Understanding Prevention in Older Women

This 3-year collaborative project with Group Health Cooperative of Puget Sound, Seattle, was designed to improve the participation of older women in preventive health services in a managed care setting. The project originated from the NCCDPHP Women's Health Working Group and has been funded by CDC's Office of Women's Health. Lynda A. Anderson, PhD, Public Health Educator, Health Care and Aging Studies Branch, DACH, and Dr. Smith are technical advisors on the project, now in its third year.

The Understanding Prevention in Older Women study focuses on 4 areas: hormone replacement therapy, colorectal cancer screening, smoking, and physical activity. Dr. Anderson said that the project "is a great example of successful collaboration, both between CDC and a managed care organization and among different parts of NCCDPHP, including the Office on Smoking and Health and the Divisions of Adult and Community Health, Cancer Prevention and Control, Nutrition and Physical Activity, Reproductive Health, and Diabetes Translation."

One major component of this project has focused on decision-making and provider counseling regarding hormone replacement therapy among older women. The *1996 Report of the U.S. Preventive Services Task Force* recommends that all "perimenopausal and postmenopausal women be counseled about the potential benefits and risks of hormone therapy."

However, Dr. Anderson says, "In our recently completed survey of 1,180 women at Group Health Cooperative, we found that 27 percent of women aged 50–65 years reported receiving no information from their health care provider about the risks or benefits of hormone replacement therapy, and an additional

14.5 percent reported receiving too little information." The project is developing an intervention to help women make informed decisions about hormone replacement therapy.

National Conference on Epilepsy

According to Dr. Smith, we currently lack an integrated approach to epilepsy and seizure disorders that takes advantage of effective strategies from public health, clinical disciplines, and organized systems of care to improve the health and quality of life of persons with epilepsy and seizure disorders. She adds, "Because such an integrated approach is lacking for many other chronic conditions as well, epilepsy can serve as a model for a rational approach to chronic disease in a managed care setting." However, she says, for this approach to succeed, the following questions must first be answered:

- How should organized health care systems respond to persons with conditions such as epilepsy?
- What should health care system members know to address their own needs?
- What skills do providers need to be culturally competent?
- What needs to be done to get epilepsy, or other chronic diseases, on the agenda of health care systems?

"Living Well with Epilepsy," a meeting planned for September 1997, will bring together public health and managed care personnel, clinicians, and consumers to address these issues and set objectives for improving the health of persons with epilepsy and seizure disorders. Discussion will include access to the health care system and model programs in managed health care systems.

"These various managed care activities represent a promising start. We expect that the scope of our managed care programs will expand to cover a host of issues related to quality of life as well as delivery of health services," noted Dr. Thompson.

For additional information, contact Betsy L. Thompson, MD, MSPH, NCCDPHP Managed Care Coordinator, Division of Adult and Community Health, NCCDPHP, CDC, MS K–30, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-5283.

Collaboration with Managed Care Vital to Adolescent Health

Fostering collaboration between managed care and health programs for adolescents is vital to improving the health of young people and to increasing the availability of effective prevention services. Over the past 2 years, as part of a managed care initiative, NCCDPHP's Division of Adolescent and School Health (DASH) has coordinated several key activities to explore the implications of managed care for school and adolescent health.

Managed Care Working Group Offers Direction

"Our managed care working group was formed in June 1995 to provide direction, to serve as a sounding board for new ideas, and to review specific proposals and products," said John Santelli, MD, MPH, Medical Epidemiologist, DASH.

As one of its initial projects, the group has compiled a working paper that reviews published and unpublished materials on managed care, school health, and adolescent health. "This paper summarizes current understanding about school and adolescent health services and the potential role of managed care in efforts to promote adolescent health; it also suggests roles for CDC in addressing the rapidly evolving health care environment for adolescents," Dr. Santelli noted.

Research Projects Find Support for Collaboration

Among the research related to adolescent health and managed care is a key informant study conducted in 1996. Through a series of interviews with policymakers, researchers, and practitioners in managed

Dr. Mary Vernon and Jenny Osorio (standing) of NCCDPHP's Division of Adolescent and School Health, lead discussions during a workshop at the Prevention in Managed Care conference.

care, school health, public health, and adolescent health, the study collected qualitative information about issues affecting adolescent health and health promotion, issues facing managed care organizations, the potential for managed care organizations to promote adolescent health and to build partnerships with schools, and the role of CDC in fostering collaboration.

Dr. Santelli noted that the study found considerable support for potential collaborations between schools and managed care organizations to promote adolescent health. Among the study's major findings were the following:

- Barriers to promoting adolescent health within MCOs include lack of awareness of specific adolescent needs, a medical model for services, and marketplace incentives.
- CDC can foster interaction between MCOs and schools by supporting collaborations, conducting surveillance of clinical preventive services, conducting research on prevention effectiveness, and educating managed care staff about school and adolescent health programs and nontraditional approaches to health promotion.

Planning and Policy Development

The managed care initiative supporting adolescent health has addressed several planning and policy issues, including these:

- Developing, supporting, and evaluating the American Medical Association's Guidelines on Adolescent Preventive Services (GAPS) in a variety of health care settings—school-based health centers, community health centers, MCOs, and private practices.
- Developing new HEDIS standards for adolescents and school-age children. HEDIS 3.0 includes measures for adolescent preventive health visits, vaccine-specific and combined immunization rates among adolescents, chlamydia screening, prevalence of current smoking, prenatal screening for hepatitis B surface antigen and HIV, teenage pregnancy, and control of insulin-dependent diabetes.
- Exploring the potential for partnerships between school health and managed care. At a workshop "School Health and Managed Care: Partnerships for Prevention," during the Prevention in Managed Care conference, Dr. Santelli said "such collaborations make sense, but we still have a long way to go."

National Panel on Managed Care and School and Adolescent Health

A panel of national experts on managed care and school and adolescent health is being established to define issues, review ideas for surveillance systems, suggest new directions for collaboration, and review proposals for working with MCOs. The first meeting will be in September 1997.

For more information, contact John Santelli, MD, Division of Adolescent and School Health, NCCDPHP, CDC, MS K–33, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-3212, fax 770/488-3112; E-mail: jfs8@cdc.gov.

Emphasizing Partnerships Between States and MCOs to Fight Diabetes

NCCDPHP is focusing on building successful partnerships between states and MCOs as a primary means of reducing the burden of diabetes in the United States. According to Frank M. Vinicor, MD, Director, Division of Diabetes Translation (DDT), "Diabetes is a chronic health condition which, because of its commonness, seriousness, treatability, and preventable expense, is of great concern to managed care organizations. Thus, CDC has defined a broad strategy for developing epidemiologic and programmatic public health activities with managed care organizations." Among these activities are convening a symposium on diabetes and managed care and establishing diabetes surveillance systems in MCOs.

"Diabetes is a chronic health condition which, because of its commonness, seriousness, treatability, and preventable expense, is of great concern to managed care organizations."

Symposium Showcases Results

In September 1996, CDC and the HMO Group held a symposium intended to establish more effective partnerships between managed care organizations and state diabetes control programs for preventing and controlling diabetes and its complications. Forty state diabetes control programs and 16 HMOs were represented at the conference. The Honorable Newt Gingrich, Speaker of the House, who has a strong interest in diabetes control, gave the opening remarks.

The symposium provided CDC an opportunity to highlight some successful partnerships between diabetes control programs and HMOs.

- Project IDEAL is striving to demonstrate that a collaboration between a large MCO, such as HealthPartners, and a state health department can improve care for persons with diabetes and related chronic illness. Begun in 1994, IDEAL is funded by a cooperative agreement from CDC.
- A working group representing the Texas Department of Health, MCOs, employer organizations, pharmaceutical companies and retailers, and government agencies produced quality assurance standards for diabetes care under managed care in Texas.
- Diabetes control programs and MCOs in Washington and Oregon are working together to collect data and establish surveillance systems.

Patricia E. Thompson-Reid, MPH, Program Development Consultant, DDT, said that "the conference succeeded in bringing together state diabetes control programs and managed care organizations and in fostering a better understanding of the value of partnerships with the private sector in providing optimal care for persons with diabetes."

Several new partnerships have been established as a result of the symposium. The California State Department of Health Services has developed guidelines for care for persons with diabetes and is sharing them with MCOs in the state. The Massachusetts, New Hampshire, Rhode Island, Maine, and Connecticut diabetes control programs and several regional HMOs have formed the New England Consortium. This group is developing a campaign to promote the use of the glycosylated hemoglobin test, which shows a person's average blood glucose level for a 4-month period. New York is working with HMOs to develop a supermarket nutrition project.

The Honorable Newt Gingrich, Speaker of the House, delivered the opening remarks at a symposium that CDC and the HMO Group convened to explore how managed care organizations and state diabetes control programs can work together more effectively.

For more information, contact Patricia E. Thompson-Reid, MPH, Division of Diabetes Translation, NCCDPHP, CDC, MS K–10, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-5017; E-mail: pet0@cdc.gov.

Setting up Diabetes Surveillance

NCCDPHP is collaborating with 3 managed care organizations—The Lovelace Institutes, United Health Care, and Group Health Cooperative of Puget Sound—to design and implement diabetes surveillance systems. These surveillance systems will use pharmacy, laboratory, outpatient, and inpatient data sets to collect information on the prevalence of diabetes, the prevalence of indicators of complications (e.g., lower extremity disease), total hospitalizations and hospitalizations for selected diagnoses, and tests and procedures performed (e.g., glycosylated hemoglobin tests, dilated eye examinations).

Linda S. Geiss, MA, Acting Section Chief, Surveillance Section, Epidemiology and Statistics Branch, DDT, is directing the project. According to Ms. Geiss, "These surveillance systems should help managed care organizations identify opportunities for quality improvement of diabetes care and develop strategies to reduce the burden of diabetes and its complications."

For additional information, contact Linda S. Geiss, MA, Division of Diabetes Translation, NCCDPHP, CDC, MS K–10, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-5041; E-mail: lsg2@cdc.gov.

CDC Teams with Managed Care to Prevent Tooth Decay

By age 17, 84 percent of adolescents have experienced an average of 8 cavities. In 1995, nearly 6 percent, an estimated $45.8 billion, of all personal health expenditures were spent on dental services. A substantial proportion of these services are related to repairing teeth damaged by tooth decay. Although effective preventive regimens exist, access to clinical prevention care can be difficult for many population groups, especially those whose primary source of payment for dental services is out-of-pocket.

For more than 50 years, water containing fluoride at a level of 1 mg/L has been known to be highly effective in reducing

tooth decay, whether or not one has access to dental care. "The estimated cost for water fluoridation during a person's lifetime is equivalent to the cost of repairing one cavity, about $40. Yet, as of 1992, only 62 percent of those served by community water systems in the United States received water that provided optimal levels of fluoride. As the use of other fluoride products—toothpaste, rinses, tablets—has increased, many communities don't feel the need to have fluoride in their public water supply," said Barbara F. Gooch, DMD, MPH, Dental Officer, Division of Oral Health.

CDC, Kaiser Study Effects of Fluoridated Water

To update data on the effectiveness of fluoridation, CDC has started working with Kaiser Permanente, Northwest Division, to study differences between the disease and treatment experiences of those who consume fluoridated water and those who do not.

Kaiser Permanente, Northwest Division, was chosen primarily for two reasons. First, its dental plan, which uses a group model for dental services, covers some 165,000 members. Second, it covers residents living in Portland, Oregon—one of the largest U.S. cities without fluoridated water—and in Salem, Oregon, and Vancouver, Washington—two cities that have had fluoridated water for more than 30 years.

"Using addresses and water district information, we first separated our members who reside in areas that receive optimally fluoridated water from those who live in nonfluoridated areas," said Alex White, DDS, DrPH, Senior Investigator, Kaiser Permanente, Northwest Division. "Then controlling for factors that might influence treatment (e.g., mobility, socioeconomic status, kind and length of plan participation, age, sex, care provider), we compared children and adults on selected outcome measures. Such measures may include the frequency of certain restorative procedures (root-canal treatment, crowns, multiple-surface amalgams) or of tooth loss and replacement."

Study Results Will Broaden Community Perspective

The project, expected to take about 1 year, will analyze both paper and electronic data from patients who maintained their continuous eligibility in the health plan from January 1990 to December 1995. "About 60,000 members aged 6 years and older met this criterion," said Dr. White. "Kaiser Permanente, Northwest Division, will use this information to determine, from a broader community perspective, if there are any differences between our members with and those members without fluoridated water and to develop prevention strategies to help members at a higher risk for dental disease."

"CDC will use this information to enhance and target strategies developed for the PHS Strategic Plan for Water Fluoridation to meet the *Healthy People 2000* objective—to provide optimal levels of fluoride to at least 75 percent of people served by community water systems," said Dr. Gooch. "The data will also help decisionmakers responsible for dental programs in state and local heath agencies and dental administrators of managed care organizations."

For more information, contact Barbara F. Gooch, DMD, MPH, Dental Officer, Division of Oral Health, NCCDPHP, CDC, MS F–10, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-6055, fax 770/488-6080; or Alex White, DDS, DrPH, Senior Investigator, Kaiser Permanente, Northwest Division, 3800 North Kaiser Center Drive, Portland, OR 97227-1098; 503/335-6765, fax 503/335-2424.

Managed Care Activities Focus on Assessments, Guidelines for Reproductive Health

"Debates of such issues as the shift of reproductive health services that are reimbursed by Medicaid into a private managed care environment, the role of

obstetrician-gynecologists as primary care providers in some HMOs, and the recent findings of the cost-effectiveness of family planning services in preventing the high costs of unintended pregnancy have highlighted the critical importance of understanding the potential impact of managed care on the health of reproductive-aged women," according to Lynne S. Wilcox, MD, MPH, Director, Division of Reproductive Health.

CDC is supporting managed care projects related to quality of care indicators and research in a managed care setting as some public health functions are moved to the private sector. (See related story, p. 9.) A cooperative agreement with the Center for Health Policy Research at George Washington University, Washington, D.C., is currently examining existing state Medicaid managed care contracts and compiling information about reproductive health services specified by those contracts. This information, in turn, will be available for states to use as they move toward providing reproductive health managed care services for Medicaid populations.

"When high-risk, disadvantaged populations begin receiving care from private managed care providers, public health departments will need to emphasize their role of assessment," Dr. Wilcox explained.

Finally, NCCDPHP is involved in an intracenter collaboration with the National Center for HIV, STD, and TB Prevention to develop Reproductive Health Guidelines. "These guidelines, developed with the input of more than 20 national organizations, will serve as a basis for establishing recommendations for essential services for Medicaid managed care contracts," Dr. Wilcox stated. At present, there are no such recommendations on the scope and critical elements needed for the delivery of reproductive health services.

For more information, contact Lynne S. Wilcox, MD, MPH, or Lisa M. Koonin, MN, MPH; Division of Reproductive Health, NCCDPHP, CDC, MS K–21, 4770 Buford Highway, Atlanta, GA 30341-3724; 770/488-5188, fax 770/488-5967.

Partnerships with MCOs Offer Venue for Improving Nutrition, Increasing Physical Activity

Nutrition and physical activity are two key areas that dramatically affect our nation's health and well-being. The opportunity for CDC to expand these disease prevention and health promotion activities by working with MCOs should yield long-term dividends for improving our nation's health.

Monitoring Nutrition Trends Among Our Youths

In a society of convenience and junk food consumers, are our kids getting the nutrition they need? That is one of the questions that NCCDPHP's Division of Nutrition and Physical Activity (DNPA) is asking HMOs to help answer by identifying and monitoring nutrition trends among their pediatric patients.

CDC is currently working with researchers at the Harvard Pilgrim Health Care (HPHC) to implement a pilot surveillance system, entitled "Health Maintenance Organization Nutrition Surveillance System" (HMONSS) as an ongoing means of evaluating the nutritional status of children within middle-income populations.

"CDC has been using the Pediatric Nutrition Surveillance System (PedNSS) since 1973 to collect anthropometric, hematologic, and infant feeding data from state health departments to identify young children at risk of nutritional and health problems and to describe trends in pediatric undernutrition, obesity, and anemia within a low-income population," said Kelley S. Scanlon, PhD, Epidemiologist, DNPA. "The PedNSS data are collected through federally funded maternal and

"When high-risk, disadvantaged populations begin receiving care from private managed care providers, public health departments will need to emphasize their role of assessment."

child health programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)."

"From these data, we have detected an increase in pediatric obesity, a decrease in childhood anemia, and improved growth status among Asian refugee children," she added. "We are excited about the HMONSS pilot because it provides an opportunity to compare child growth, obesity, and anemia trends within middle-income populations with the trends we observe among low-income children—working with HMOs allows us to collect this information."

"We are retrieving data for 1996 from the HPHC automated medical record on the height, weight, birthweight, and blood counts from more than 22,000 children, aged 0–5 years, from middle-income populations, "said Matthew Gillman, MD, a pediatrician and internist with HPHC. The automated database houses the actual medical record, including doctor's notes, diagnoses, measurements, and lab studies that are coded for each patient.

"Once we have tested the system and obtained the 1996 data, we will provide data prospectively for 1997 and beyond, as well as retrospectively for 1980 through 1995" he added. "Both the prospective and retrospective data will allow us to examine trends over time and to compare results from our patients, mostly children of middle-income populations, with those that CDC has collected since the 1970s from children of low-income populations."

The HMONSS pilot will be tested from October 1, 1996, through September 30, 1998. Abstracting data from the 1980s allows trends in growth, anemia, and obesity to be monitored for an 18-year period. This information will help public and private health care providers to develop program interventions geared toward promoting healthy behaviors among young persons.

"We hope this program to monitor trends in children from middle-income populations will eventually be used by HMOs nationwide. If trends prove similar to those children from low-income populations," said Dr. Scanlon, "program interventions may include follow-up iron treatment and nutrition education for patients with or at risk for anemia to further reduce the prevalence of iron deficiency anemia among children. Follow-up is important because iron deficiency anemia is linked to impaired cognitive development in children."

"Also, by monitoring trends in overweight, we can look at trends and make recommendations to lower the risks of our young persons from becoming obese adults," she added. Adult obesity is linked to a higher risk of cancer and high blood pressure and to an increased risk of developing cardiovascular disease—the number one killer of Americans.

For more information, contact Kelley S. Scanlon, PhD, Epidemiologist, Division of Nutrition and Physical Activity, NCCDPHP, CDC, MS, K–25, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-5702, fax 770/488-5473; or Matthew Gillman, MD, Department of Ambulatory Care and Prevention, Harvard Medical School and Harvard Pilgrim Health Care, 126 Brookline Avenue, Suite 200, Boston, MA 02215; 617/421-6011, fax 617/859-8112.

Joint Initiative to Promote Healthy Eating and Physical Activity

CDC and the American Association of Health Plans (AAHP) have formed a partnership to promote regular physical activity and healthy eating through selected managed care providers. A major initiative of this partnership is a worksite demonstration project, designed to identify specific audience lifestyle characteristics and other consumer market information. The project includes targeted, motivational print materials that promote increasing consumption of fruits and vegetables, lowering intake of dietary fat, and increasing moderate physical activity.

The managed care plans participating in this pilot program are Blue Cross and Blue Shield of Georgia; Medica Health

Plans, Minneapolis; Keystone Health Plan, Camp Hill, Pennsylvania; and OmniCare Plus, Detroit.

"Subsequent collaborations will likely result in recruiting additional managed care plans and worksites to implement the revised intervention, as well as using other communication channels to promote healthy eating and physical activity," said Fred Fridinger, DrPH, CHES, acting team leader, Communications Unit, DNPA. "This unique collaboration of public health, health communications, medical care, and the business community is working to reach at-risk persons with appropriate physical activity and nutrition messages," he added.

For more information, contact Nicole Kerr, RD, MPH, Division of Nutrition and Physical Activity, NCCDPHP, CDC, 4770 Buford Highway, NE, MS K–46, Atlanta, GA 30341-3724; 770/488-5820, fax 770/488-5473.

Preventing and Reducing Tobacco Use

Tobacco use—the leading preventable cause of morbidity and premature mortality—accounts for a substantial portion of overall medical care costs in the United States. A new partnership emerged at a 1995 conference on reducing and preventing tobacco use sponsored by the CDC and the HMO Group. Representatives from HMOs gathered to plan and improve projects in tobacco control in the primary care setting and through public policy approaches.

"The government recognizes that HMOs have great potential to make real change in an area like tobacco, for HMOs have the delivery systems capable of supporting prevention activities," said Jeffrey R. Harris, MD, MPH, Acting Associate Director for Policy, Planning, and Evaluation, CDC. "Three areas where the government and HMOs can work together are developing guidelines to provide a framework for care; gathering information for surveillance and needs assessment, as well as for monitoring outcomes; and coordinating collaborative intervention programs—especially at the health policy level."

One such surveillance measure is a new addition to HEDIS 3.0 to assess the proportion of health care providers that counsel their patients to quit smoking. (See related story, p. 9.) Government, academics, and HMO researchers worked together with the National Committee for Quality Assurance, the developers of HEDIS, to establish this important smoking measure.

Because 25 percent of the population continue to smoke, HMOs can play an important role in promoting the prevention and cessation of tobacco use. They can employ a number of effective treatments to increase cessation rates. For instance, having a health professional advise a smoker to stop increases cessation rates by 30 percent, and using nicotine replacement therapies can double cessation rates.

"More than 80 percent of smokers first tried a cigarette before the age of 18, and more than 90 percent first tried a cigarette before the age of 20. Tobacco control efforts, therefore, must focus on preventing young people from starting to smoke and helping addicted smokers of all ages to quit, "said Michael P. Eriksen, ScD, Director, Office on Smoking and Health. Dr. Eriksen cites 6 areas where HMOs can help reduce tobacco consumption:

Prevention—HMOs can be more involved in developing public policy aimed at preventing adolescents from beginning to use tobacco. HMOs also can become involved in school and community programs to educate young people about the health hazards associated with tobacco use and can counsel their adolescent patients about tobacco.

Treatment—HMOs should determine the prevalence of smoking by their members and treat smoking status as a vital sign assessed at every visit. They should educate

Having a health professional advise a smoker to stop increases cessation rates by 30 percent, and using nicotine replacement therapies can double cessation rates.

pregnant women who smoke about the risks they may impose to themselves and to their unborn children and provide cessation and counseling programs to help them quit smoking. Basic benefits packages should include nicotine replacement therapy and cessation counseling. HMOs should also be involved in research projects to evaluate the effectiveness of cessation methods, particularly among adolescents.

Clean Indoor Air—HMOs should adopt smoke-free policies for their facilities and become more involved in passing state and local ordinances for clean indoor air. Managed care providers also should encourage parents to provide a smoke-free environment for their children.

Advertising—HMOs can use counteradvertising to discourage tobacco use among teens. Also, HMOs should consider either offering magazines with no tobacco advertising in their waiting rooms or marking such ads with antitobacco stickers.

Economic Incentives—HMOs can participate in efforts to demonstrate the economic impact of tobacco on the health care system. HMOs also may play a role in state campaigns to raise tobacco excise taxes.

Product Regulation—HMOs can become more active in supporting the regulation of tobacco products.

Counteradvertising Through HMOs

CDC is currently collaborating with the HMO Group on a counteradvertising project titled "Demonstration of Community Paid Counteradvertising Campaigns Supporting Prevention and Cessation of Tobacco Use." The project is intended to increase HMOs' use of print, radio, and television counteradvertisements in their communities.

To date, two HMO Group members have received funds: Kaiser Colorado and Group Health Northwest. Both HMOs added funding to the project and are targeting antismoking campaigns to youths in their media markets. Once the campaigns are completed, the HMOs will conduct postcampaign surveys to determine the recall of the ads among the target audience and to assess their influence on the attitudes and behaviors of young persons regarding tobacco use.

CDC has recently begun collaborating with the Robert Wood Johnson Foundation on an initiative entitled "Addressing Tobacco in Managed Care" to encourage HMOs to adopt of innovative approaches for promoting prevention and cessation of tobacco use. It seeks to capitalize on the guidelines on smoking cessation from the Agency for Health Care Policy and

In Hawaii, the state medical association and health department teamed with an insurance company and a managed care provider to create this sticker for flagging tobacco ads that appear in waiting room magazines.

Research and the new HEDIS measures on smoking to provide MCOs with suggested methods and a tangible incentive for helping individuals stop or not start smoking.

"Working together to implement public health programs and policies that prevent teens from smoking and help smokers to quit benefits everyone," said Dr. Eriksen. "Each year about 400,000 deaths in the United States are attributed to cigarette smoking, and the medical costs associated with smoking exceeds $50 billion. Our work with managed care organizations has just begun, and the long-term benefits will be well worth the hard work by all."

For more information, contact Julie A. Fishman, MPH, Health Policy Analyst, Office on Smoking and Health, NCCDPHP, CDC, MS K–50, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-5701, fax 770/488-5767.

Reaching At-Risk Populations for Cancer Screening

NCCDPHP has a seasoned track record in collaborating with outside partners for its various initiatives. This experience should yield more dividends as CDC expands its cancer-related research and programmatic initiatives with managed care organizations. "Both the public and private sector have a lot of successful strategies they can share with each other," said Nancy Nowak, RN, MPH, Program Consultant, Division of Cancer Prevention and Control (DCPC).

Much of this expanded involvement with managed care involves breast cancer, which is the most common nondermatologic cancer among American women and second only to lung cancer as a cause of cancer-related deaths.

"In 1991, CDC established the National Breast and Cervical Cancer Early Detection Program, which Congress authorized through the Breast and Cervical Cancer and Mortality Prevention Act of 1990. One of our main challenges is reaching low-income, underserved, and uninsured women aged 50 years and older," said Ms. Nowak. "For 6 years, we have established partnerships to provide screening services with state and local health departments, national nonprofit organizations, and managed care organizations. We have found that some of our partner's programs are more successful than others in reaching our target audience."

Assessing Strategies Is a Key Function

Starting in 1996, CDC began to evaluate which strategies worked best for guiding its various partners on developing or improving their breast cancer screening programs. That assessment yielded a guide, *Reaching Women for Mammography Screening . . . Successful Strategies of the National Breast and Cervical Cancer Early Detection Program for Grantees*, which details strategies used among selected populations, and a research paper, Collaborating with Managed Care Organizations for Mammography Screening and Rescreening, Guidance for National Breast and Cervical Early Detection Program Grantees, which discusses how managed care affects clinical preventive services, what health plans are doing regarding prevention, and how to foster collaboration.

Hands-On Experience Comes from Collaborations

CDC staff have received hands-on experience and knowledge of the managed care process through work details at managed care facilities. A collaboration with The Prudential Center for Health Care Research led to the development of a *Manual of Intervention Strategies to Increase Mammography Rates* in managed care. The manual, intended to be a resource for both managed care providers and public health agencies, includes tools for developing assessments and interventions, a summary

of selected intervention research studies, and an accompanying user's guide. Another collaboration with United Health Care of Georgia focused on projects related to Pap screening and quality assurance. "These experiences should further the collaborative spirit between MCOs and CDC," said Barbara A. Reilley, RN, PhD, DCPC's managed care coordinator.

These CDC activities are also related to managed care and cancer prevention:

- Publishing research that evaluates the extent to which newly eligible Medicaid clients receive breast and cervical cancer screening services in a managed care setting in Oregon. (See related article, p. 33.)
- Evaluating the effectiveness of a public-private partnership to increase the use of breast and cervical cancer screening services by older women in Washington.
- Investigating factors associated with the cause of death among men previously diagnosed with prostate cancer.
- Working with Kaiser Foundation Research Institute to evaluate barriers to participant compliance in a flexible sigmoidoscopy screening program.
- Negotiating to expand prostate and colorectal cancer research by conducting studies in managed care settings to validate the effectiveness of prostate specific antigen testing for prostate cancer and sigmoidoscopy and fecal occult blood testing for colorectal cancer.

Dr. Reilley added that "We expect additional research and program initiatives in breast, cervical, colorectal, prostate, and skin cancers to increase significantly."

For more information, contact Barbara A. Reilley, RN, PhD, Division of Cancer Prevention and Control, NCCDPHP, CDC, MS K–52, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-3020, fax 770/488-4760.

States Geared up for Managed Care Activities

Nowhere is the impact of the changing health care delivery system being felt more than throughout the states. Many states have already developed impressive portfolios that demonstrate their effectiveness at dealing swiftly and effectively with the changes and challenges wrought by the shift of many core public health functions to managed care providers. The following examples of state activities offer a small sample from their range of activities.

Survey Aims to Bridge Gaps at 3-State Intersection

Despite the efforts and intentions of an individual clinician, a particular insurance plan, or a managed care provider, the sum of all residents within a defined community care is always more than the total number of persons covered by health insurance. Typically, no one is charged with making contact with those who have been left out, particularly in poor, minority, and rural communities.

A collaborative effort of health care providers, public health authorities, and local groups has been established in a 3-state, 4-county region at the intersection of New York, Massachusetts, and Connecticut (the Berkshire Taconic Region) to deal with such issues. Called Sickness Prevention Achieved Through Regional Collaboration (SPARC), its goal is to improve the health of the 636,000 area residents, many of whom have moderate or low incomes, by increasing their use of clinical preventive services. SPARC has targeted 10 clinical preventive services, all considered effective by the U.S. Preventive Services Task Force: childhood immunizations, adolescent immunizations, Pap tests, mammography, blood

pressure screening, cholesterol screening, tetanus/diphtheria booster, fecal occult blood test/sigmoidoscopy, pneumococcal vaccine, and influenza vaccine.

"We are concerned with the barriers to obtaining these services," according to Christopher Maylahn, MPH, Program Research Specialist, Division of Chronic Disease Prevention and Adult Health, New York State Department of Health. "We hope to learn how to increase the proportion of the general public who have received these recommended services and to develop SPARC into a comprehensive community-based model program," he explained.

SPARC has developed a regional network of health care providers and community-based organizations to improve access to clinical preventive services, to track clinical prevention activities, and to develop the capacity for accountability in delivering these services. "These activities are consistent with our public health mission, working in tandem with managed care providers and other community-based groups, to ensure that preventive services are delivered," he said.

A key issue is knowing how many individuals are receiving clinical preventive care and how utilization rates are changing over time. Ideally, this information would come from the providers of clinical preventive services, but establishing such a reporting system would be a lengthy, expensive undertaking. An alternative is to collect this information through telephone interviews of random samples of the adult population.

The New York State Department of Health, Massachusetts Department of Public Health, Connecticut Department of Public Health, CDC, and SPARC together have committed $90,000 to support such a survey in the four counties of the Berkshire Taconic Region. "In addition to assisting SPARC in its planning and evaluation efforts, the SPARC Disease Prevention Survey will demonstrate a quick, inexpensive method for obtaining this information in local communities that takes advantage of the capacity within state health departments to conduct population-based telephone surveys," Mr. Maylahn noted.

For more information, contact Christopher Maylahn, MPH, Division of Chronic Disease Prevention and Adult Health, New York State Department of Health, 523 Tower Building, Empire State Plaza, Albany, NY 12237-0620; 518/474-0512.

Private, Public Partnership in Georgia Counties Paves the Way for Universal Coverage

An alliance between the Cobb and Douglas public health departments, two counties that border the city of Atlanta, and Promina Northwest Health System, Inc.—the chief for-profit health care provider there—has yielded dramatic changes in health care coverage not only for insured persons but also for the uninsured and transient populations.

Local health care reform helped lead to the creation of this partnership, developed as the result of "both sides recognizing what each can do best," stated Virginia G. Galvin, MD, MPH, District Health Director, Cobb-Douglas Health Unit, Marietta, Georgia, during a presentation at the CDC Managed Care Forum. She cited these economic benefits to each side:

- Decreased duplication of services. "We are not competing in any markets."
- Increased access to economies of scale. "We can take advantage of the bulk buying power available to the private sector for ordering supplies."
- Reduced use of high-tech care with an increased use of primary care. "We aim to reduce reliance on high tech, ER-type treatments by having access to care through community health centers."

- Increased capacity of primary care and prevention services. "We both are striving to keep people healthier."
- Decreased health care costs to employers, which serve as an incentive for them to expand, recruit, and locate in the area. "Our chamber of commerce can cite this as an advantage to businesses."

Several fundamentals underscore the success of this partnership. The public health departments have clout in the partnership because they already know the challenges to providing health care and prevention to the population; a network of sites owned and maintained by county government exists; the cost-basis for services is less than that in the private sector; and they possess the skill to identify and respond to community health emergencies, thereby limiting their impact on both the overall and the capitated population.

This partnership resulted from much effort, deliberation, and negotiation. "One tenet of this partnership was that both the Cobb and Douglas County Boards of Health and Promina Northwest Health System would remain intact, autonomous entities," Dr. Galvin said. Consequently, determining who should do what led to considerations such as the following:

- Clearly define roles and responsibilities.
- Develop standard practice procedures for all levels of providers.
- Determine which partner has purchasing advantages to maximize savings.
- Convene a working group to address data-related issues.
- Define lines of authority for supervising personnel.

Some issues, such as eligibility, financial screening, and fee schedules, are clearly the domain of both boards, Dr. Galvin noted.

Next, a transition team worked through issues that involved training, team building, quality of care, defining services and determining gaps, marketing, and "defining 'deal-breakers' that could activate an out-clause for either partner."

When it was time to develop the actual contract that summarized the pertinent agreements between the two sides, clear communications and trust were paramount. "In the course of our negotiations, we finally threw the attorneys out of the room and hammered out the agreements," according to Dr. Galvin.

She cites a checklist of results so far: "Public and private sector participants are working together on medical management standards for the system through PROMINA's Care Management Committee. Physicians at the boards of health are being credentialed for inclusion in PROMINA's managed care contracts. The number of patients seeking primary care services at the board of health sites is steadily growing. Renovation of board of health sites is now under way with in-kind contributions from PROMINA. Referrals for specialty care are being made from the public to the private sector."

"We now have a chance to see how universal access and universal coverage to preventive and primary care will affect a community's health status," she said.

For more information, contact Virginia G. Galvin, MD, MPH, District Health Director, Cobb/Douglas Health District, 1650 County Farm Road, Marietta, GA 30060-4009; 770/514-2330.

Wisconsin Strengthens Working Relationship with Managed Care Organizations

Within the Division of Health, Wisconsin Department of Health and Family Services, the Chronic Disease Program, under the leadership of Patrick L. Remington, MD, MPH, Chief Medical Officer and Chronic Disease Epidemiologist, and Susan Wood, BS, Program Director, is exploring a number of managed care initiatives, including these:

- Developing guidelines for the care of patients with diabetes in managed care settings.
- Using the Behavioral Risk Factor Surveillance System to expand surveillance in Dane County, in collaboration with managed care organizations, a health care purchasing alliance, and local health departments.
- Monitoring the performance of the state's managed care organizations on HEDIS indicators for mammography and Pap testing.
- Incorporating prevention and early intervention strategies into policy proposals for redesigning Wisconsin's long-term care system, which will use a managed-care delivery system.

The Wisconsin Department of Health and Family Services is also working with the Wisconsin Network for Health Policy Research of the University of Wisconsin Medical School to develop collaborative models of chronic disease prevention and population-based health promotion for Wisconsin. A major objective of this initiative is to better define the roles that various groups can play in improving the health of the population. Ms. Wood notes, "We hope to establish an ongoing dialogue and relationship with representatives of the private and voluntary sectors to explore mutual roles and responsibilities for chronic disease prevention and to help us define the priorities for government as we enter the next century."

This effort will initially focus on tobacco use and smoking cessation, an issue that represents a rare juncture of circumstances with respect to improving the overall health of the population: smoking is a major, well-recognized threat to the public's health; a substantial proportion of smokers report a desire to quit smoking; and interventions have proven effective in helping smokers quit. However, in recent studies, only about half of smokers report having been asked about their smoking by a primary care physician in the previous year, and less than half report being advised to quit.

The Agency for Health Care Policy and Research has recently released *Clinical Practice Guidelines, Number 18: Smoking Cessation*. This document includes a set of recommendations for health care administrators, insurers, purchasers, and public policymakers on how best to support and promote the use of these guidelines in clinical settings. The Wisconsin Department of Health and Family Services and the Wisconsin Network for Health Policy Research are sponsoring a day-long invited forum on September 25, 1997, in Madison to explore the key organizational, financial, and public policy implications of these recommendations and to draft a consensus statement on ways to encourage broad-based implementation of these recommendations throughout the state.

Participants representing health care providers, managed care organizations and other insurers, medical group practices and integrated delivery systems, employers and health care purchasing coalitions, professional and voluntary associations, and public sector representatives will attend the forum.

According to Ms. Wood, this project will also serve as a model for future consensus-building projects on other critical issues in chronic disease prevention, such as preventing young people from starting to smoke and encouraging life-long physical activity.

Dr. Remington notes, "We know that health care providers share our goal of reducing the burden of chronic disease. Combining our population-based skills with their health care systems and resources provides a tremendous opportunity for making positive changes in the health of the Wisconsin public."

For more information, contact Anna M. Degelau, Project Manager, Project ASSIST, Wisconsin Department of Health and Family Services, 1414 East Washington Avenue, Room 240, Madison, WI 53703-3044; 608/266-8322.

Oregon Evaluates Use of Clinical Preventive Service by Medicaid Enrollees

During the past decade, the plight of uninsured and medically underserved Americans has emerged as a pressing social, economic, and political issue. Recent Medicaid managed care programs are beginning to demonstrate how best to reduce medical care costs and increase access to care among this population. With the assistance of Medicaid waivers, states are allowed the opportunity to design, implement, and evaluate experimental, pilot, or demonstration projects that will promote program objectives.

The Oregon Health Plan is one such demonstration project in health care reform. When the plan was implemented in February 1994, Oregon expanded Medicaid financial eligibility criteria from 57 percent to 100 percent of the federal poverty level. The Oregon Health Plan extends health coverage to uninsured Oregon citizens by prioritizing medical services and by using a system of capitated managed care to deliver these services.

Medicaid recipients must use clinical preventive services for the Oregon Health Plan to succeed. However, staff were concerned that clinical preventive services would be omitted under the plan's system of capitated managed care. For this reason, staff of the Oregon Health Plan, the Oregon Health Division, and NCCDPHP conducted a study to determine whether the delivery of clinical preventive services increased when medically underserved citizens were provided health coverage under capitated managed care. Mammography screening was used as the chief indicator of receipt of these services.

Study results indicated that mammography rates increased dramatically among women only one year after they enrolled in the Oregon Health Plan. These increases were particularly remarkable because this group of women had many of the characteristics associated with low rates of mammography: low income, unemployment, low-education attainment, and high prevalence of smoking. The study also found increases in rates for all other clinical preventive services that were measured.

Another finding was that the plan improved the delivery of clinical preventive services, but not to the level of the state average. Reasons why some women still did not receive mammography included being unaware that the service was covered under the Oregon Health Plan, believing that mammography was unnecessary, and not being referred for mammography.

The researchers concluded that providing health coverage is only the first step toward ensuring that a population receives needed health services. To increase the use of mammography among the plan's population, they recommend that managed care organizations

- Educate health care providers about the importance of mammography for all women between the ages of 50 and 69 years.
- Encourage their members to have routine check-ups and implement office reminder systems.
- Ensure that new enrollees are informed that mammography screening is covered under this health care plan.

For more information, contact Nancy G. Clarke, Managed Care Coordinator, Health Promotion and Chronic Disease Prevention, Oregon Health Division, Suite 730, 800 Northeast Oregon Street, Portland, OR 97232; 503/731-4273, fax: 503/731-4082; E-mail: nancy.g.clarke@state.or.us

Q & A Forum: Anticipating the Emerging Issues

Five years ago, few experts predicted, at least publicly, that public health and managed care would start to work side-by-side, in partnership in some cases, to deliver health care. Given the rapid changes in the health care delivery system that have taken place the past 5 years, what could be coming during the next 5 years?

To anticipate these trends, *cdnr* asked 3 managed care experts who have contrasting backgrounds to share their opinions. The respondents are Kathy Cahill, Director, Managed Care Office, Centers for Disease Control and Prevention; Michael R. Rosnick, MD, MPH, Physician-Director, Humana, Inc., Louisville; and Jeffrey P. Koplan, MD, MPH, President of The Prudential Center for Health Care Research, Atlanta, and former Director, National Center for Chronic Disease Prevention and Health Promotion.

Q: *What are the emerging issues that no one is yet talking about but that you feel will have the most impact during the next 5 years?*

Ms. Cahill: As rapidly as things are changing, I'm not sure that one can accurately predict what will occur during the next 5 years in health care. But I do see some trends unfolding.

Public (Medicaid) and private purchasers are increasingly demanding more quality for lower cost; consequently, purchasers will continue to be a major driver in the marketplace. Purchasers and public health agencies must work jointly to ensure that prevention benefits are part of the quality equation.

One challenge will be to determine how well public health data—*Healthy People 2000* objectives, Behavioral Risk Factor Surveillance System and other surveillance systems—work to compare and benchmark preventive health services so purchasers can determine quality of their plans as compared with local, state, and national health status.

The aging of the population will have a profound impact on the health care system. We will be watching the growth of Medicare managed care to see if it increases as dramatically as it has for Medicaid managed care. Public health agencies, health care purchasers, and managed care health plans will have new opportunities to build systems of care that promote healthy living and quality of life for the aging "baby boomers."

Dr. Rosnick: As concerns about rising health care costs continue, the choice will be between increasing the role of managed care or increasing governmental rationing of health care. As this debate unfolds, there will be renewed recognition that it is not the need to ration care (i.e., limit who gets appropriate and necessary care) but a need to rationalize care. Managed care will become a ready provider of rationalized care and will be more complex than the "vanilla" HMO of the recent past and present. It will incorporate some aspects of alternative

health care delivery and provider-based organizations brought together with the utilization management, quality management, and service functions of large information-based organizations.

Electronic medical records will enhance the ability of providers to communicate with each other and to measure the quality of their care both as individuals and as members of organized groups. Centralized data warehouses will improve the ability of organizations, both commercial and public health, to fulfill the preventative and disease management needs of the populations they serve. Issues surrounding the confidentiality of this information and the control of the types of information available will be resolved.

Primary research in health care will shift to private-university and private-public partnerships. The not-for-profit organizations will find these collaborations a beneficial way to return to the public the value for their tax-free status. For-profits will join to remain competitive. As these alliances develop, the focus of research will shift from the current basic sciences toward improvements in delivery of health care and provider and patient educational techniques.

Dr. Koplan: I think that some reemerging issues will require serious attention. First, we have to address the continuing profound lack of knowledge and understanding of both public health regarding managed care and managed care regarding public health. To engage in a symbiotic relationship, each sector will have to address its ignorance and misconceptions and then seek substantive areas of collaboration.

We must also promote public discussion of the neglected issues of equity and access in our health care system. We still have a large segment of our population who are either uninsured or underinsured. Public health, managed care, and other health care players need to bring this issue back into public policy discussions and promote realistic solutions.

Q: *How will traditional public health roles change under managed care and what new roles do you see developing for public health agencies and for managed care providers?*

Ms. Cahill: Public health agencies will continue to have responsibility for carrying out the core functions of public health as defined by the Institute of Medicine in 1988. Still, the capacity to adapt to a changing environment will be increasingly important to public health agencies and organizations. Anticipating other community changes such as new disease threats, consumer demands for quality and oversight of the health care system, and increasing demands for data and information from policymakers and the public will also drive the public health agenda during a time of limited resources and increased scrutiny on government agencies.

Purchasers and providers of health care services will want to include evidence-based and cost-effective disease prevention and health promotion strategies as part of their benefit plans. Public health can provide experience and insights to help them evaluate and compare these strategies.

New information regarding genetics and recently discovered biologic risk factors will affect health promotion information and will fuel the public debate on medical ethics and society values. All the major forces in health care delivery will have to sort through the ramifications of these issues.

Dr. Rosnick: Public health will retain responsibility for surveillance and population health status. However, to the degree that managed care or other organized delivery systems are responsible for populations of individuals, some of the authority may be delegated to those entities. Identification of key health issues, environmental health, and disease outbreaks will remain in the public health purview. As some of the work done by public health (e.g., immunizations) is shifted to managed care delivery systems, public health will become more responsible for coordinating such activities (e.g., responsible for the data warehouse containing immunization status). Public health's role will shift to the training of managed care in the areas of expertise such as patient outreach and education.

Individuals will not be more willing to take responsibility for the relationship between their behavior and its consequences. Some of the costs associated with lifestyle choices will be shifted to the individuals, whether through increased taxes on items such as alcohol and tobacco or through increased premium rates for those choosing unhealthful habits. Although the ethical issues surrounding the genetic screening of individuals will not be entirely resolved, there will be an enhanced ability to identify individuals at risk for an increasing variety of diseases and an increased capacity to intervene appropriately.

Dr. Koplan: The meaning of "traditional" regarding public health roles is ambiguous and varyingly interpreted. Regardless of what is traditional, we have an opportunity to redefine public health for a new century and beyond. Indigent care is not a traditional public health role, but some in public health cling to this function. Public health should ensure that there is equitable quality care which emphasizes prevention. Public health can serve an oversight function. I see public health agencies as having a great opportunity to make a population perspective part of the culture within managed care organizations. Instead of having to work piecemeal with individual providers, public health can now work with the large managed care systems in a city or region and thereby have a chance to advance their agenda, improve preventive care for large population groups, and perhaps find new venues for collaborative program implementation and research.

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Health Observances

- ***Hemochromatosis Screening Awareness Month*—July**
  Hemochromatosis Foundation
  518/489-0972
- ***National 5 a Day Week*—September 7–13**
  Produce for Better Health Foundation
  800/4-CANCER
  302/738-7100
- ***National Cholesterol Education Month*—September**
  National Heart, Lung, and Blood Institute Information Center
  301/251-1222
- ***Breast Cancer Control Month*—October**
  American Cancer Society
  800/ACS-2345
  404/320-3333
- ***National Campaign for Healthier Babies Month* —October**
  March of Dimes Birth Defects Foundation
  914/997-4600

12th Chronic Disease Conference Slated for December 3–5, 1997

The 12th National Conference on Chronic Disease Prevention and Health Promotion will convene in Washington, D.C., at the Washington Hilton and Towers, from December 3–5, 1997. Plenary sessions and various workshops will cover issues related to cancer, diabetes, heart disease, nutrition, oral health, physical activity, and tobacco. As in previous conferences, interaction between federal, state, and local health departments, voluntary health agencies, professional organizations, and other groups will allow participants to forge new working relationships and to build and strengthen coalitions and partnerships for the prevention and control of chronic diseases as we move into the 21st century.

The conference is targeted to federal, state, and local public health professionals; members of affiliated health professional associations; partners in prevention and control activities and programs; leaders from health management organizations; physicians, nurses, nutritionists, physical activity specialists, and health educators; and academic and research staff from educational institutions.

The Centers for Disease Control and Prevention and the Association of State and Territorial Chronic Disease Program Directors are jointly developing and sponsoring the conference. For information about registration, contact Professional and Scientific Associates, 2635 Century Parkway, Suite 990, Atlanta, GA 30345;1-800/772-8232 or 404/633-6869, fax 404/633-6477; E-mail: psaatl@aol.com; AOL: psa atl; or via CDC/WONDER: psai contractor. For hotel reservations: 202/797-5782.

Social Marketing Celebrates 25 Years

To commemorate the 25th year of social marketing, *Social Marketing Quarterly*, a peer reviewed journal targeted to social marketers, health educators, and public health professionals, has published a 71-page issue featuring the insights of noted authorities. Single issues or subscriptions are available, and subscriptions include a one-year membership in the Society for Social Marketing.

For more information, contact *Social Marketing Quarterly*, c/o Best Start Social Marketing, 3500 East Fletcher Avenue, Suite 519, Tampa, FL 33613; 813/971-2119 or 1-800/277-4975; E-mail: beststart@mindspring.com.

1997 Cancer Conference: Integrating Public Health Programs for Cancer Control

The Centers for Disease Control and Prevention, the Association of State and Territorial Chronic Disease Directors, the Association of State and Territorial Directors of Health Promotion and Public Health Education, the American Cancer Society, and the National Cancer Institute have joined forces to sponsor the 1997 Cancer Conference: Integrating Public Health Programs for

Cancer Control. Conference objectives include providing participants an opportunity to share experiences and insights; to develop and apply strategies for an integrated approach to cancer control; to maximize limited resources while increasing program outcomes; to use unique and innovative strategies for outreach to minority, underserved, and older populations; to use data for program planning and management; and to apply quality assurance measures to improve program outcomes.

The conference is slated for September 2–5, 1997, at the Westin Peachtree Plaza, Atlanta. For information about registration, contact Laura S. Timperio, Professional and Scientific Associates, 2635 Century Parkway, Suite 990, Atlanta, GA 30345; 1-800/772-8232 or 404/633-6869, fax 404/633-5756; E-mail: psaatl@aol.com; AOL: psa atl; or via CDC/WONDER: psai contractor.

National Diabetes Education Program Under Way

The National Diabetes Education Program, a joint initiative of the Centers for Disease Control and Prevention and the National Institutes of Health, was formally announced to the professional diabetes community at the American Diabetes Association annual meeting on June 22, 1997, in Boston.

The collaborative partnership will seek to improve the treatment and outcomes of persons with diabetes, to promote early detection, and, ultimately, to prevent the onset of diabetes. The program will initially focus on increasing awareness that diabetes is serious, common, costly, and controllable. Target audiences include the general public; people with diabetes and their families; health care providers; and, purchasers, payers, and policymakers.

For more information, contact Faye L. Wong, MPH, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, MS K–10, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-5037; E-mail: flw2@cdc.gov.

Proceedings from Oral Health Conference Available

NCCDPHP's Division of Oral Health announces the availability of the background papers and proceedings from the National Strategic Planning Conference for the Prevention and Control of Oral and Pharyngeal Cancer that was held on August 7–9, 1996, in Chicago. This conference was a collaboration between the Division of Oral Health, NIH's National Institute of Dental Research, and the American Dental Association.

The background scientific review and subsequent recommendations represent the culmination of a 4-year effort to develop a coordinated national effort to prevent oral cancer and to reduce the morbidity and mortality of this disease. These documents are available to download in PDF format from the Internet at http://www.cdc.gov/nccdphp/oh.oc/htm. For more information, contact Barbara Z. Park, RDH, MPH, Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, MS F–10, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; 770/488-6056, fax 770/488-6080; E-mail: bzp0@cdc.gov.

Health Observances

- ***Family Health Month*—October**
  American Academy of Family Physicians
  800/274-2237
  816/333-9700
- ***National Dental Hygiene Month*—October**
  American Dental Hygienists Association
  312/440-8900
- ***National School Lunch Week*—October 13–17**
  American School Food Service Association
  800/728-0728
  703/739-3900
- ***National Health Education Week*—October 19–25**
  National Center for Health Education
  212/334-9470
- ***National Youth Health Awareness Day*—October 22**
  National Federation of State High School Associations
  816/464-5400

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NCCDPHP Internet website: http://www.cdc.gov/nccdphp/nccdhome.htm

Check Out the NCCDPHP Internet Site for Chronic Disease Health Resources

The NCCDPHP website is constantly growing. If you have not yet visited it, or if you have not been back for some time, check out the latest postings on a variety of disease prevention and health promotion subjects that include adolescent health, maternal and child health, adult and community health, cancer prevention and control, diabetes, nutrition, physical activity, oral health, and tobacco and health. This issue of *cdnr*, as well as other back issues, plus many of the other varied NCCDPHP publications, are available for viewing and downloading. Other resources include information about surveillance tools, such as the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, and cancer registries.

The NCCDPHP website will soon be undergoing a major redesign. Access is available at http://www.cdc.gov/nccdphp/nccdhome.htm or through the main CDC website at http://www.cdc.gov.

Look for these topics in upcoming issues of *cdnr*

Heart Health Programs • Comprehensive School Health • Cancer Screening Initiatives