State Health Watch

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In This Issue

The foot soldiers and officers of state health policy see the future through a glass, darkly, this month in State Health Watch. *We have asked those who make policy and visualize it to give us their views on the direction public health should take and what the future looks like to them.*

The future may well look like the present, but better

The coming years in public policy are a proving ground for making the lives of Americans better. But how to get there? There is no consensus. But there are plenty of hardworking health care workers who have their own ideas about how the path should look. Their views range from the conventional to overhaul. But they agree on one thing: The system as it is a solid jumping-off place that can be used to change public health and policy-making for the better . . . cover

Keep the drama. Mental health policy is on the road to parity

Small gains, through hard work and attention to detail, could well be the way to achieve the goals of mental health policy. Whether it is tackling day to day policy-making goals or targeting managed behavioral health care or increasing capitation in public health, the policy-makers that *State Health Watch* spoke to each have their own views of the future of their health care niche and each has a plan to get there. . . . . cover

To see into the future of health policy, take a cue from the present

The Future of State Health Policy

In the world of predictions, it's too easy to be wrong. People don't particularly care to offer up a vision of five to 10 years down the road for nearly any subject, especially publicly funded health care. Who needs the public humiliation? Is the reward of being right in the coming years worth the risk of being visibly wrong?

It doesn't take much craning of the neck to see the future is too unstable to predict. Just take a look at the short, unhappy life of the ergonomics rules breathed into life by the Clinton administration only to be quickly brushed aside by the Bush administration. Though politicians, Hill staffers, and tens of thousands of aides and bureaucrats across the 50 states make health care policy their life's work, most would agree what seems likely today may well be in the rearview mirror of policies-that-might-have-been tomorrow.

The jobs of government and the health care industry also include extrapolating into the future. It involves a fair amount of educated

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Mental health policy development unclear

The Future of State Health Policy

Views on how mental health policy is likely to develop over the next five to 10 years vary depending on the perspective of who is doing the predicting. From dramatic change to calm waters, predictions and their responses are as unpredictable as political change.

Chris Koyanagi, an analyst with the Bazelon Center for Mental Health Law in Washington, DC, tells *State Health Watch* that she expects current policy trends to continue without any dramatic changes.

"We'll certainly continue action regarding mental health parity, but I don't foresee anything like a sweeping parity bill for the entire country. If anything, there will be only small gains," she says.

However, Mary Graham, senior policy advisor for the National Mental Health Association in Alexandria, VA, says she is hopeful that work on parity will be completed in the next several years and "we will have met our goals." Ms. Graham says she is particularly hopeful that action will move more quickly on the federal side.

Another issue on Ms. Koyanagi's radar screen is managed behavioral health care. She sees a trend toward a

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CHIP likely to seek family coverage, stress retention

While the future of the State Children's Health Insurance Program will be decided to some degree by political considerations over the next five to 10 years, policy analysts interviewed by *State Health Watch* identified some clear indications for future direction, including a move toward family coverage and a greater emphasis on improving the prospects for retaining enrollees. Jocelyn Guyer, analyst for the Center for Budget and Policy Priorities, sees continuing state efforts to move from coverage just for children to coverage for families 4

Public family planning clinics may be financially stressed

New research by the Alan Guttmacher Institute indicates that one-sixth of U.S. women rely on publicly funded family planning clinics. Jennifer Frost, senior research associate for Guttmacher, tells *State Health Watch* that analysts had estimated the usage was that high, but hadn't had hard data before 7

IOM says safety rules need major overhaul

The second report from the Institute of Medicine of the National Academies paints a grim picture, saying the nation's health care industry has foundered in its ability to provide safe, high-quality care consistently to all Americans. 'Reorganization and reform are urgently needed to fix what is now a disjointed and inefficient system,' the report says 9

2001 reader survey

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Future

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guessing, but ideally there are hard numbers to back up these educated guesses. And that's how many of *State Health Watch*'s futurists came up with their visions of the future that highlight this month's issue. The National Academy for State Health Policy (NASHP) in Portland, ME, for instance, has taken the Institute of Medicine's (IOM) estimation that medical errors are the eighth-leading cause of death in America. (See related story, p. 9.)

The IOM says medical errors lead to between 44,000 and 98,000 patient deaths annually. Those figures are hard and high enough for the academy to be concerned about. Its vision of the future: Reduce the errors and save lives. NASHP officials predict the loss of life, and also of dollars, will drop when the errors are reduced. But first, it needs to get a handle on what constitutes a medical error.

"There's a big knowledge gap," Jill Rosenthal, NASHP policy analyst, tells *SHW*. "Research will lead to more best practices, leading to fewer errors. We just don't have a good baseline right now. There is no national reporting system for medical errors and most states don't have a system. Without a baseline, it's not good to judge. I think the baseline will change, but a lot of work has to be done to clarify what we mean by medical errors."

In less than five years, Ms. Rosenthal predicts, a baseline that is credible will be formed, leading to fewer errors and fewer deaths. "States feel strongly that they need flexibility to adapt their system to meet current needs. I think states would be amenable to a core set of requirements, then go above that to meet other issues. States do not want the federal government to impose reporting requirements without their input."

Medicaid expenditures from the recent past help frame a vision of the future for the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, both in Washington, DC. Armed with Medicaid enrollment figures from 1997 and 1998, the two groups predict Medicaid spending will grow in the coming years, as much as 10% in the near future due to rising health care costs, most particularly prescription drug costs.

"The Congressional Budget Office projects federal Medicaid spending to grow by an average annual rate of 8.6% from 2001 to 2011," according to the groups' recent publication — *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward*. "The reasons behind both actual and projected cost increases include enrollment growth, escalating prescription drug costs,

demands for higher provider payments, health care price inflation, and states' increasing use of [Disproportionate Share]-like funding mechanisms."

The future is unlikely to ever shake the doubts thrown in its path by the economy. At times, the economy is stable and predictions are easier. But the country, and perhaps the world, is entering a period of increasing economic doubt. Will these Medicaid figures hold up in the coming years?

"You can't forecast that with real precision," John Holahan, one of the paper's authors, tells *State Health Watch*. "Now hitting the Medicaid program is what is coming out at the end of a boom. . . . If it slows, more people will be eligible and we'll get more enrollment and states will be under budget pressures. What will they do? They may not have revenues to keep up. We may see states constraining enrollment; eligibility thresholds could be constrained."

In this scenario, Mr. Holahan adds, "Health care inflation is going up, enrollment is going up, with a big hit from prescription drug costs. It could hit the Medicaid program pretty hard."

States will continue to use upper payment limit arrangements to draw down more federal funds, according to the Kaiser Commission. "As states seek new revenues from all sources, the Medicaid program has been identified as a way to obtain additional federal funds to replace state matching funds. While Congress has curbed the practice, states are allowed some continued use of this financing tool. The current economic slowdown is likely to encourage states to use these and similar mechanisms for more revenue."

Turning Point, a project by the National Association of County and City Health Officials in Washington, DC, has set its sights higher than the next two or three years as it seeks to make fundamental changes in a health care and policy-making system that it sees as having gone off course. The future to Turning Point participants is one in which integrates as much input into the public's health as possible. Because the public and many policy-makers do not understand the current health care system, Turning Point contends the current system has fallen into what its officials call "a state of chronic financial neglect" and cannot protect Americans from major causes of death and disease. To change this pattern of neglect and illness, state and federal health policy need to include more and more input from all corners of society, Turning Point officials say.

"We need to know more across communities, not just states," Vincent Lafronza, Turning Point National Program office director, tells *SHW*. "How do people go about assessing and monitoring and reporting collaboratively, and move away from just tracking diseases?"

The public health care system's future for Turning Point *(for more information about the project, go to www.naccho.org/project30.cfm)* is a place in which more voices affect policy than are currently allowed.

"The most important theme of this kind of work, and other national movements, is seeing the return of civic engagement as opposed to looking at disease-based models of institutional work," Mr. Lafronza says. ■

Annual Percent Change in Medicaid Enrollment Expenditures, and Expenditures per Enrollee 1990-1998

Source: The Urban Institute/Kaiser Family Foundation, Washington, DC.

CHIP likely to seek family coverage, stress retention

While the future of the state Children's Health Insurance Program (CHIP) will be decided to some degree by political considerations over the next five to 10 years, policy analysts interviewed by *State Health Watch* identified some clear indications for future direction, including a move toward family coverage and a greater emphasis on improving the prospects for retaining enrollees.

Jocelyn Guyer, analyst for the Center for Budget and Policy Priorities in Washington, DC, sees continuing state efforts to move from coverage just for children to coverage for families.

"Research has shown that when you cover parents, it facilitates enrollment of kids," she tells *SHW*. "And Health and Human Services Secretary Tommy Thompson is clear that the most important thing you can do to improve children's coverage is to enroll their parents."

Ms. Guyer cites experiences in Missouri and New Jersey that support the notion. "When Missouri just covered kids, they had only some success, even with outreach efforts. But when they extended coverage to parents, enrollment shot up. The same thing happened in New Jersey."

Colleen Sonosky, assistant director with the Center for Health Services Research and Policy (CHSRP) at George Washington University in Washington, DC, tells *SHW* she also sees CHIP growing over the next five years, noting there will be waiver requests for more family coverage.

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"I'm not sure if there will be a legislative change, but states will try to do a lot through the waiver process to include more families. It's going to grow," she says.

Tied to the notion of family coverage is an effort to make CHIP work better with employer-based coverage. According to Ms. Guyer, "It's hard now [to bring the two types of coverage together] because only kids can be covered. States only can use CHIP funds to help families purchase employer-based coverage if it is cost-effective — that is if the employer-based family coverage costs less than covering just the children under CHIP."

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>
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>
> *Analyst*
> *Center for Budget and Policy Priorities*
> *Washington, DC*

Another element of the program Ms. Guyer says is ripe for attention is retention of coverage for children once they are enrolled.

"States and advocates have been focused on signing children up," she explains.

"Now they're beginning to realize that's only half the job. They're seeing that a lot of the positive changes that have been made at the front end [to facilitate increased enrollment] need to be applied to retention," Ms. Guyer points out. "More conferences have been focusing on the retention problem that's arisen because states and advocates understandably were working most on enrollment. Reforms like simplified applications have not been carried over to retention."

Ms. Guyer says the problem with retention can be seen in the experience of one state where families that are up for renewal simply reapply because the forms for retention are so complicated compared to those for an initial application.

CHIP funding also is on the minds of policy analysts. Ms. Guyer says that what happens with the nation's economy will affect the program.

"If there's a recession, that will be new territory for CHIP because it's not an entitlement. It's not clear how states will deal with it in a less friendly fiscal environment," she says.

Within the next five to 10 years, Ms. Guyer says, the whole public policy issue of a financing mechanism for CHIP should be addressed because it is becoming clear that some states need more money than they are receiving, and others need less.

"The current reallocation process is very political. It's hard to move money around to meet the need. We need to figure a better system to have funds flow to the states that can use them," she adds.

Will the basic program structure be changed? CHSRP's Anne Markus, senior research scientist, says that's a possibility since during the last campaign, President Bush indicated an interest in moving the program to a block grant, consistent with early discussions when it was being designed.

For states that have expanded Medicaid to cover more children, there could be serious implications in

the block grant approach unless changes were made to Medicaid.

Ms. Markus predicts that if states were given more flexibility in program design, they would use that power to make their children's health insurance program look more like commercial programs than like the "very generous" Medicaid program.

Support for greater state flexibility has been voiced by the National Governors Association, Ms. Sonosky says. "They've been lobbying for changes in Medicaid and CHIP so that states would be given the money to work with."

She says that while efforts could be made through legislation or regulations to establish standards for purchasing services through managed care, it is not likely that issue will be taken up because it would not lead to greater state flexibility.

More outreach needed

Ms. Markus says attention should be paid to the need for more outreach efforts to enroll children in insurance programs. "There are still a lot of kids eligible who are not enrolling, and we need more outstationing and other outreach activities."

Since CHIP was established for 10 years and the program is currently in the fourth year, Ms. Sonosky says it's hard to tell what will happen when authorization runs out. "I don't think states could continue it on their own," she says.

"They would need federal money to help them continue. Such a large investment has been made already that I hope they don't terminate it after 10 years. CHIP is linked to what happens to Medicaid. Policies for each affect the other," Ms. Sonosky explains.

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Mental health policy

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managed care approach in public programs, but generally not through for-profit companies. She also sees more capitation in public programs and adds that she would like to see managed care reforms so better data will become available and there is more accountability.

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Tom Bryant, MD, secretary of the National Association of County Behavioral Health Directors in Washington, DC, points out that most of the seriously mentally ill patients in the United States are in the public systems operated either by counties or states.

"Treating the seriously mental ill and drug addicts isn't a profit center, so there's very little for-profit competition. Three to five years ago, the main issue was managed behavioral health care. People were trying to cope," he points out. "That wave has passed, and people have pretty much figured out how to cope, although that doesn't necessarily mean it's a good system."

Islands of innovation

Ms. Koyanagi says that while services for adults are in bad shape, those for children are even worse. "There are small islands of innovation and hope, but I think things are going to gradually get worse, especially involving people in contact with the justice system. There are some demonstration projects going on, but no systematized change."

Mr. Bryant also expresses concern about the "interface between mental health/substance abuse and the justice system" but sees more hope. "There are a lot of people who have been inappropriately placed in the justice system. I expect to see a lot of progress in this area in five years."

The analysts sometimes have difficulty seeing how things may change in 10 years. "A lot depends on when the slide in our mental health system hits the public between the eyes," Ms. Koyanagi says.

"Right now, we're keeping a lid on the crisis, but at some point, it has to burst into public consciousness. Right now, we're at the bottom of the heap in human services programs. It's going to implode eventually if we don't deal with mental health services," she adds.

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Analyst
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The problem is not only a lack of resources, she says, because what money there is often goes to "old ideas that have their own constituencies," meaning that groups that want to innovate have to find new resources each time.

While states had hoped that managed care organizations could

help them cut through political problems, they can't fund innovation, Ms. Koyanagi says.

Ms. Graham also points to the problem of a dearth of adequate resources. "There are a lot of states with funding problems, and we may see more lawsuits over states not meeting their obligations for the welfare of their citizens."

She expresses concern that because of the lack of adequate funding, managed care payments to clinicians are too low and "we are losing some of the best people from the system." Mr. Bryant predicts funding changes to more block grants covering mental health and substance programs together.

For better and less

Ms. Koyanagi cites 24-hours-a-day programs and those providing long inpatient stays and residential placements for children as only a couple of examples of old ideas that still receive significant funding.

"In the 1970s and '80s, there was a lot of enthusiasm for partial hospitalization," she says, "but we've learned that rehabilitation programs work better and cost less. I don't know if we'll be able to deal with these issues in 10 years. It's more likely that by then we'll be forced to grapple with them."

Ms. Koyanagi says there are many clinical services in different types of settings as well as less traditional approaches that can provide good value.

"Things like peer support groups work very well but don't get funding. And solid, evidence-based treatments don't exist in almost any community.," she says. "We keep following established patterns of practice because the people who work in them understandably want to keep on making a living."

An issue that Ms. Koyanagi predicts is going to emerge over the next few years is how the nation will deal with women who are going to work as a result of welfare-to-work activities but have children with serious disabilities.

"It's hard to find specialized care for these children, and this issue is going to become more apparent as welfare-to-work moves on to people who will have a harder time getting back to work," she says.

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Ms. Graham says she would like to see more integration of mental health and substance abuse systems.

"The public and policy-makers need to be more educated that these things are treatable and the cost to society is great," she says. "People bounce between the two systems and get worse care. Clinicians should be cross-trained so they can deal with both."

While dual-disorder (mental health and substance abuse) diagnoses are very common, Mr. Bryant says, a block grant approach makes it all but impossible to comingle funds and provide an integrated service.

"Research shows that integrated services work best. The federal officials aren't malevolent when they raise funding issues. The law has established differences in accounting at the federal level," he explains. "You can find good treatment programs for co-dependent disorders funded at the local and state levels, but not at the federal level."

Mr. Bryant says one bright spot, although it has its own problems, is the development of new antipsychotic drugs that have fewer negative side effects, meaning that patients who are treated with them can be placed in work or educational situations that are more appropriate for them. The problem is that these new-generation drugs cost a lot more in a system that is already short on funds.

A problem for providers arises through the Balanced Budget Act of 1997 that requires a choice of providers in any plan submitted. "Lots of rural areas are lucky if they have one provider," Bryant explains. While Medicaid has been allowing waivers to get around this requirement, such waivers don't continue, and agencies must reapply each time.

Political decisions

Electoral politics also plays a part in what decisions will be made. "A lot will ride on what happens in the next congressional election in two years, the next presidential election, and state elections," Koyanagi says. "If the political winds are against us, if people continue to bury their heads in the sand, we'll have more simplistic solutions that sound good in sound bites."

[Contact Ms. Koyanagi at (202) 467-5730, ext. 18, Ms. Graham at (480) 513-4540, and Mr. Bryant at (202) 234-7543.] ■

Public family planning clinics may be financially stressed, says report from Guttmacher Institute

New research by the Alan Guttmacher Institute in Washington, DC, indicates that one-sixth of U.S. women rely on publicly funded family planning clinics.

Jennifer Frost, senior research associate for Guttmacher, tells *State Health Watch* that analysts had estimated the usage was that high, but hadn't had hard data before. Her research also describes the characteristics of the women who use the clinics and the different levels of services provided by clinics and private providers.

Ms. Frost says the level of usage could challenge public clinics financially and, "If policy-makers believe that it is important that women get a wide range of services, they'll need to see that they are adequately funded. This is definitely a defense for publicly funded clinics."

The survey found that contraceptive and other reproductive health care services are offered by more than 7,000 publicly funded clinics, nearly 28,000 private practice obstetricians/gynecologists, many of the more than 40,000 private family practice doctors, and other sources such as private clinics, military- or school-based care, and hospital-based care not included in the public family planning clinic network.

The number of women ages 15 to 44 who received family planning services in the prior year increased from 19.8 million in 1982 to 20 million in 1988 and 21.9 million in 1995, reflecting both population growth and changes in the percentages of women obtaining family planning services.

Among women who reported having used family planning services during the past year, approximately one-third obtained one or more of these services in a clinic or nonprivate setting. Overall, this percentage increased from 31% in 1982 to 36% in 1988 and remained at 36% in 1995.

"That these patterns persisted, even when we controlled for women's characteristics, indicates that the provision of specific services to women who visit different types of providers is related in part to provider type itself. Either women choose different types of providers because they are seeking different types of services, or providers of different types are simply more or less likely to offer certain services."

Jennifer Frost

Senior Research Associate
Alan Guttmacher Institute
Washington, DC

Ms. Frost tells *SHW* that although the data used are old (1982 through 1995) the issues have not changed. "Later data collected on clinic clients have shown the populations have not changed, and we don't believe the care has changed."

A recent Guttmacher Institute report highlighting the accomplishments of the public-funded planning clinics indicated they serve one in four women who obtain birth control from a health care provider, one in seven women of reproductive age who receive Pap smears and pelvic examinations, and account for one in four HIV tests and one in three visits for other sexually transmitted disease (STD) services among women of reproductive age.

Frost's survey found that younger women were significantly more likely than older women to have obtained reproductive health care from family planning clinics, even when the effects of all other background variables and women's risk for unintended pregnancy were controlled for.

In addition, unmarried women, minority women, those with less education, poor women, and those who had no health insurance or were covered by Medicaid were significantly more likely than women in the reference categories for each group to have obtained care from publicly funded family planning clinics.

"The odds of using a clinic were highest for those covered by Medicaid or having no health insurance," Ms. Frost says in her study. "Such women were three to 3.6 times as likely as women with private insurance to have received reproductive health care from family planning clinics."

The results indicate that among women obtaining any care, those who got care from family planning clinics were significantly more likely to receive contraceptive services than were women who obtained care from private doctors and HMOs. Similar results were found for care for STDs but not for receipt of preventive

gynecologic or pregnancy-related care. For the latter services, clinics did not differ significantly from private physicians, except that women getting care from non-Title X clinics were significantly less likely to have obtained preventive gynecologic care than were women going to private doctors.

"That these patterns persisted, even when we controlled for women's characteristics, indicates that the provision of specific services to women who visit different types of providers is related in part to provider type itself," Ms. Frost writes. "Either women choose different types of providers because they are seeking different types of services, or providers of different types are simply more or less likely to offer certain services."

Ms. Frost tells *SHW* it was "a surprise that women who went to clinics got a broader range of services than those who went to private physicians."

Age an important predictor

The study's analyses suggested which characteristics of women were most important in determining the type of contraceptive or reproductive service they will obtain (among those obtaining any care). Age was the more important predictor of the receipt of contraceptive, pregnancy-related, and STD-related services, but was not important in predicting receipt of preventive gynecologic care.

Non-Hispanic black women were less likely than non-Hispanic white women to have obtained contraceptive services, but were more likely to have obtained preventive gynecologic care.

Hispanic women who obtained any care were significantly less likely than white or black women to have obtained preventive gynecologic care, as were less-educated women compared with college-educated women.

Poverty status had little impact on what services women obtained once other variables were accounted for. Women without any health insurance were significantly less likely than women with private insurance to have obtained contraceptive services or preventive gynecologic care. Those covered by Medicaid are significantly more likely than privately insured women to have received contraceptive services, pregnancy-related care, and STD care.

"With growing numbers of uninsured women in America, growing minority and immigrant populations, as well as a mandate to serve women's multiple reproductive health care needs, the role of publicly funded family planning clinics in meeting those needs is likely to increase. Given these changes, clinics may face financial challenges in continuing to deliver the wide range of service that they are mandated to provide."

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Washington, DC

"Almost half the clinic clients got a range of services," Ms. Frost says, "while only one-quarter of private physician clients got contraceptive care plus other care. Our research confirms that women who go to clinics get more than just contraception. Policy-makers think that's all the clinics do, but they are mandated to do a lot more."

Ms. Frost says that women's reproductive health care needs are complex and driven by a variety of personal characteristics, and different providers meet the needs in differing ways. Researchers are not able to assess whether the services provided are adequate and fill the needs of all women, and also cannot assess whether women who report having received no services actually had an unmet need for them.

"But use of contraceptive services has risen over time, as has the percentage of older women obtaining such services. Moreover, publicly funded family planning clinics, particularly those supported by Title X, play an especially important role in serving women and in providing them with a wide range of contraceptive and reproductive health services," she adds.

Financial challenges ahead

"With growing numbers of uninsured women in America, growing minority and immigrant populations, as well as a mandate to serve women's multiple reproductive health care needs, the role of publicly funded family planning clinics in meeting those needs is likely to increase," Ms. Frost continues.

"Given these changes, clinics may face financial challenges in continuing to deliver the wide range of services that they are mandated to provide. Policy-makers and program planners should consider these factors when allocating public expenditures for these programs," she says.

[Contact Ms. Frost at (831) 763-9575.] ■

IOM says that safety rules need a major overhaul

The second report from the Institute of Medicine (IOM) of the National Academies paints a grim picture, saying the nation's health care industry has foundered in its ability to provide safe, high-quality care consistently to all Americans. "Reorganization and reform are urgently needed to fix what is now a disjointed and inefficient system," the report says.

To spur an overhaul, Congress should create an innovation fund of $1 billion for use during the next three to five years to help subsidize promising projects and communicate the need for rapid and significant change throughout the health system, the report adds.

Just as a solid commitment of public funds and other resources supported the ultimately successful mapping of the human genome, a similar commitment is needed to redesign the health care delivery system so all Americans can benefit, says William Richardson, chair of the committee that wrote the report and president of the W.K. Kellogg Foundation in Battle Creek, MI.

"Americans should be able to count on receiving care that uses the best scientific knowledge to meet their needs, but there is strong evidence that this frequently is not the case," Mr. Richardson says.

"The system is failing because it is poorly designed. For even the most common conditions, such as breast cancer and diabetes, there are very few programs that use multidisciplinary teams to provide comprehensive services to patients. For too many patients, the health care system is a maze, and many do not receive the services from which they would likely benefit," he adds.

The report says clinicians, health care organizations, and purchasers — companies or groups that compensate health care providers for delivering services to patients — should focus on improving care for common, chronic conditions such as heart disease, diabetes, and asthma that are now the leading causes of illness in the United States and consume a substantial portion of health care resources.

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>
> Joanne Turnbull, PhD
>
> *Executive Director*
> *National Patient Safety Foundation*
> *Chicago*

These ailments typically require care involving a variety of clinicians and health care settings over extended periods of time. But Mr. Richardson says physician groups, hospitals, and health care organizations work so independently of one another that they frequently provide care without the benefit of complete information about patients' conditions, medical histories, or treatment received in other settings.

The committee's previous report, *To Err is Human: Building a Safer Health System*, found that more people die from medical mistakes each year than from highway accidents, breast cancer, or AIDS. But Richardson says findings in that report amounted to only the tip of the iceberg in the larger story about quality care.

The IOM calls America's health system "a tangled, highly fragmented web that often wastes resources by providing unnecessary services and duplicating efforts, leaving unaccountable gaps in care and failing to build on the strengths of all health professionals."

The report calls for immediate action to improve care over the next decade and offers a comprehensive strategy to do so.

The report envisions a revamped system that not only is centered on the needs, preferences, and values of patients, but also encourages teamwork among health care workers and makes much greater use of information technology.

The IOM committee suggests more emphasis on electronic records, communicating with patients by e-mail, and automated medication order entry systems that can reduce errors in prescribing and dosing drugs. However, the report recognizes that many policy, payment, and legal issues would have to be resolved before much headway could be made.

To initiate across-the-board reform, the IOM says the federal Agency for Healthcare Research and Quality should identify 15 or more common health conditions, most of them chronic. Then health care professionals, hospitals, health plans, and purchasers should develop strategies and action plans to improve care for each of these priority conditions over a five-year period.

The report also calls on the U.S. Department of Health and Human Services (HHS) to monitor and track quality improvements in six key areas: safety, effectiveness, responsiveness to patients, timeliness, efficiency, and equity. In addition, the secretary of HHS should report annually to Congress and the president on

progress made in those areas, the report says.

The study was sponsored by the IOM, National Research Council, the Robert Wood Johnson Foundation, the California Health Care Foundation, the Commonwealth Fund, and the U.S. Department of Health and Human Services. The National Patient Safety Foundation (NPSF) in Chicago welcomed the second report, saying it emphasizes how important it is to make care safer for patients.

"Harming patients is a critical indicator that quality improvements are needed. You can't have a quality system that is not safe," says Joanne Turnbull, PhD, executive director of the NPSF.

"To create safe systems, we need multidisciplinary teams that work together to identify and implement solutions," she says. "We need a commitment to continuous learning and continuous training, and we need to more quickly move from theories and concepts to applications and system improvements."

Ms. Turnbull says the NPSF has involved patients and family members who've experienced medical errors in their efforts to improve health care safety.

"We've learned a tremendous amount about what they expect and need as they deal with so many unfortunate consequences," she says. "We must value patients' perspectives, and adopt better principles of patient-centered care if we're going to make care safer."

Earlier this year, the NPSF developed its own "Statement of Principle" to encourage better communication with patients. The statement was mailed to nearly every hospital CEO and board trustee across the country. It urges health care professionals to be open and honest in their communication with patients and families, and to share information about errors in a timely and proactive manner. ■

Clip files / Local news from the states

This column features selected short items about state health care policy

University administrators criticized for urging stem cell research

LINCOLN, NE—Three top University of Nebraska administrators have drawn criticism from pro-life activists for signing a letter urging federal funding for human embryonic stem cell research.

L. Dennis Smith, University president, Harvey Perlman, University of Nebraska-Lincoln chancellor, and Harold Maurer, University of Nebraska Medical Center chancellor, were among more than 110 who signed.

Signers included three leading organizations in higher education, as well as presidents and chancellors from many of the nation's top universities.

Maurer said he endorsed the letter because of the great promise offered by embryonic stem cell research.

"In the future, there's going to be a combination of new knowledge and technology that's going to be important to health care prevention and treatment," he said. "Embryonic stem cell research falls into that."

But Nebraska pro-life activists said the letter will create more controversy for the university, which already is under fire for research that uses tissue from aborted fetuses.

"For these three university administrators to sign on to this is kind of like in your face," said Julie Schmit-Albin, executive director of Nebraska Right to Life. "People are going to be just as opposed to using embryos as they are to using aborted baby brains [for research]."

—*Lincoln Journal Star*, March 29

Montana state House kills prescription drug credit

HELENA, MT—The state House has killed a bill to give older Montana residents an income-tax credit to offset their prescription drug purchases.

On a 43-57 vote, the House voted down House Bill 534 by Rep. Holly Raser (D-Missoula). The measure would have provided an income-tax credit of up to $200 per year for senior citizens who have prescription drug bills that aren't covered by Medicaid.

Raser told the House that during the campaign last year, the rising cost of prescription medications was a key issue. While the Legislature has addressed most other concerns of their constituents, lawmakers have yet to tackle the prescription drug problem, she said.

The measure would have cost $10.4 million per year, if all those eligible for the credit applied, and just over $1 million if 10% of eligible seniors applied. Eligible taxpayers could have taken a tax credit of 50% of their prescription drug costs, up to the $200 a person annual cap.

Raser proposed paying for the bill with interest earned from the state's tobacco trust fund. And she put off the bill's effective date until 2003, when the trust will garner interest not yet directed to other programs. But those concessions did not save the bill.

"Using tax policy to run human services is a very bad idea," said Rep. Karl Waitschies (R-Peerless).

—*Billings Gazette*, March 27

Florida considers electronic surveillance of its elderly in nursing homes

TALLAHASSEE, FL—Floridians worried about an elderly mother or a favorite uncle at a nursing home may soon have a new way of keeping tabs on their relatives.

Florida may become the first state to allow the electronic surveillance of nursing home patients. A provision — permitting the so-called "granny cams" — is contained in House and Senate bills moving through the Legislature this spring. Advocates say the proposal, which would allow families or guardians to pay for and set up the surveillance systems in their relatives' rooms, is another step in improving the quality of care in the homes.

"In a perfect world, we wouldn't need this," said Republican state Sen. Ginny Brown-Waite, sponsor of the Senate nursing home bill.

Raising questions of privacy and further litigation, nursing home operators say the surveillance could make it even harder to find qualified workers for their homes. Others suggest constant monitoring will damage the personal bonds between residents and caregivers.

"We're inadvertently bringing in Big Brother to watch us to the point where it will be detrimental to the welfare of nursing homes," said Eddie Bursztyn, representing Claridge House, a North Miami nursing home.

—*Miami Herald*, March 27

Ohio's group home program overhaul running into trouble

WASHINGTON, DC—Ohio's effort to revamp a group-home program for the mentally retarded and developmentally disabled is "bogging down," said a federal official who oversees the initiative.

Nonetheless, the federal government has given the Ohio Department of Mental Retardation and Developmental Disabilities until June 24 to correct problems, after which the state could see federal dollars for the program suspended.

Ohio currently receives a federal Medicaid waiver to run the residential care facility program, which lets about 2,800 mentally retarded and disabled people live in small group homes instead of in institutions. The state puts nearly $35 million annually into the program and receives about $49.9 million in federal money.

The Ohio program first drew federal fire last year, when an audit by the Health Care Financing Administration concluded that "Ohio has not met its obligations to assure the health and welfare of its waiver participants."

An April 21, 2000, letter to the state from Cheryl A. Harris, the financing administration's associate regional administrator in Chicago, said incidents involving group home residents "are not effectively reported, investigated, or corrected. There does not exist an effective system for preventing, identifying, and remedying incidents of abuse and neglect, or for assuring adequate care and coordination of services."

This latest extension to correct problems is the fourth granted Ohio since that audit was released.

"I am concerned that your last progress report shows that many of the time lines you have established for the process of redesigning your waiver have not been met," said Sina Ann Mercado, the health care administration's regional operations branch manager for Medicaid, a health care program for the poor. Ms. Mercado made her comments in a recent letter granting Ohio another three-month extension of the waiver.

—*Columbus Dispatch*, March 30

Idaho senator says it is time to face fiscal reality

BOISE, ID—Senate Republicans overwhelmingly voted to slap a cap on subsidized health care for children of the working poor and ordered the Health and Welfare Department to drastically curtail efforts to let those families know they are eligible for the help.

The provision, part of the $800 million Medicaid budget, now goes to the House.

Sen. Robert Lee (R-Rexburg), who has been on a yearlong crusade to find some way of checking the growth of the Medicaid budget, argued that the department's aggressive campaign to identify children eligible for the Children's Health Insurance Program has turned up four times as many who qualify for Medicaid.

After starting off extremely slowly with just a few hundred children in 1997, participation in the past two years has skyrocketed to more than 10,000 children, whose families are too poor to afford health insurance but not poor enough to qualify for Medicaid. At the same time, the promotional effort has been credited with uncovering tens of thousands of new Medicaid participants.

By capping the participants in the children's health care program and then doing as little as possible to let people know the program exists, Mr. Lee said the state can rein in the explosive expansion of Medicaid rolls. Medicaid is costing taxpayers $204 million in state general tax revenue and another $516 million in federal money this year.

"We must face fiscal reality," Mr. Lee said, mirroring comments he made earlier in convincing legislative budget writers to endorse the approach. "It has the potential of really bankrupting the state."

—*Idaho Statesman*, March 30

State Health Watch

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Louisiana argues about a two-year moratorium on building new hospitals

BATON ROUGE, LA—A proposed moratorium on new hospitals is dead for the legislative session in the face of heavy opposition from doctors and residents of rural communities. Authors of Senate and House legislation, pushed by the Louisiana Hospital Association, said Wednesday it is evident that more study is needed on the volatile issue.

Proponents argued a two-year moratorium on new hospitals would protect people's access to quality hospital care. Others said it was an effort to protect existing hospitals from healthy competition. "My main purpose was to get this dialogue going," said Sen. Tom Schedler, chairman of the Senate Health and Welfare Committee (R-Slidell). "I think the debate should rage."

Mr. Schedler's committee heard testimony for more than two hours on the controversial issue, then deferred action, which locks up the bill up in the committee. Rep. Rodney Alexander, House Health and Welfare Committee chairman (D-Quitman), said there was no sense in proceeding with his House bill.

—*The Baton Rouge Advocate*, March 29

Kentucky officials pass increase for state's Passport Health Plan

LOUISVILLE, KY—The Kentucky Cabinet for Health Services has agreed to an 8% funding increase for Passport Health Plan, the managed care Medicaid organization that covers about 115,000 people in the Jefferson County area.

In announcing the agreement, for the fiscal year that starts July 1, the cabinet said Passport has saved the state $30.4 million this fiscal year.

Passport is the only organization of its kind in Kentucky, administering care and providing special programs – such as a 24-hour nurse line — for its members. Outside the Jefferson County area, the state manages the Medicaid program and has been running a deficit.

"We think we've been doing a good job," Robert Slaton, executive vice president for University Health Care, which does business as Passport, said on behalf of his board.

—*The Courier-Journal*, March 30