State Health Watch

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In This Issue

States are challenged in responding to public health crises

For Colorado, it was several major snowstorms in a relatively short period of time; while for Rhode Island, it was the death of an elementary school student from encephalitis. In each instance, state and local officials were hard-pressed to deal with the challenges of responding to the crisis and communicating with their communities. Officials who were involved shared their experiences and lessons learned in a policy laboratory at a forum sponsored by the American Public Health Association as part of National Public Health Week. Federal officials also commented on what transpired and what has been learned about how things can be done better.

Denver director of public health **Christopher Urbina**, MD, MPH, said the most important thing he learned from the series of blizzards is that people in communities must get to know their neighbors. "In instances where the elderly were stranded or they didn't know how to get in and out, they had to know each other," he said. "People were walking around the streets of Denver during that period of time helping each other. People were helping each other dig out their cars and share food.

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Improving mental health and substance abuse care with evidence-based practices

While there are evidence-based practices that could improve the care of those with mental health and substance abuse problems, the nation has yet to systematically implement those practices, according to Mental Health America (formerly the National Mental Health Association) CEO **David Shern**, PhD, who presented his concerns last year at the National Academy for State Health Policy (NASHP) annual meeting.

Fiscal Fitness: How States Cope

Dr. Shern noted that while the science base for interventions has improved, practices significantly lag behind the science base. Although good outcomes can occur if the high prevalence of behavioral disorders is treated early and well, he said, low rates of detection, treatment, effective care, and significant disparities lead to a very high morbidity and mortality burden.

Barriers to implementing evidence-based practices, he said, include work force preparation, work environment supports and incentives, knowledge

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Senior Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, brenda.mooney@ahcmedia.com.
Associate Publisher: Lee Landenberger, (404) 262-5483, lee.landenberger@ahcmedia.com
Managing Editor: Paula Cousins, (816) 237-1833, paula.cousins@ahcmedia.com.
Editor: John Hope, (717) 238-5990, johnhope17110@att.net.
Senior Production Editor: Nancy McCreary.

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Crises

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Actually, that was pretty spectacular."

The second thing Dr. Urbina learned was the importance of having realistic expectations. He said people didn't realize that not everyone could expect to have suburban residential streets cleared when the effort was going to maintaining the major routes. Dr. Urbina's suggestion was that the public needs to become involved in planning much earlier. "If you only have this snowstorm once every 25 or 100 years, do you really want to buy all those snowplows?" he asked. "Do you really want to invest in all that effort if it's going to happen so rarely? I think the public has got to get involved in the debate, in terms of understanding what those expectations are."

From a government perspective, he said, familiarity also applies. All the various elements were able to work well together because they had already set up a plan and had practiced it. He also said governments must make the hard decisions of establishing priorities and sticking to them, no matter how many complaints come from the public. "I think governments need to think and involve the public in that prioritization," Dr. Urbina said. "I think the lessons we've learned from government and the public is that we need to practice and continue to practice."

Demonstrate what you believe

Rhode Island Department of Public Health director **David Gifford**, MD, MPH, spoke about the school health crisis that hit his state right after the Christmas break in 2006. An important lesson that was learned, he said, was that actions speak louder than words. As additional cases of illness were reported, he said, and the number of school districts potentially involved grew, people asked why schools were allowed to remain open. A positive message was sent, Dr. Gifford said, when he continued to send his son to school and people realized, "Look, he's sending his son to school, so it really must be more than just a government official trying to say something about this, but he really believes it."

Dr. Gifford also said when his department and the federal Centers for Disease Control & Prevention took blood samples and throat swabs from some people to better understand who had been infected and how widespread the problem was, people assumed it had something to do with treatment and demanded to be tested.

Dr. Gifford also stressed the importance of drilling and practicing, saying that if Rhode Island officials hadn't been practicing an incident command system, which had been put in place by the federal Department of Health and Human Services, they would not have done as well in this crisis. "All politics are local and all emergencies are local," he declared.

Department of Health and Human Services assistant secretary for health **John Agwunobi**, MD, MBA, MPH, an admiral in the U.S. Public Health Service, called attention to the need for what he called horizontal linkages in and between communities. He praised the utility companies for sending manpower and equipment from around the country to aid in restoring service when there are hurricanes, floods, and other major disruptions. "These horizontal obligations are more important than the vertical, in my humble opinion, when it comes to preparedness," he declared. "Snow plows from across the nation could converge on the place of a storm to

help a local community as it seeks to clear snow."

On the state-to-state level, he said, the Emergency Management Assistance Compact allows people to move from one state to another to help in an emergency, and "it is as important as getting help from the federal government to the state, or from the state to the county. This notion of being able to rely on each other is critical."

Centers for Disease Control and Prevention director **Julie Gerberding**, MD, reminded the audience that when she toured the Katrina shelters, she was struck by the fact that she was seeing the poor, the disabled, the isolated, lonely, and forgotten people—society's most vulnerable people. They were, she said, those who are medically, socially, technologically, environmentally, mobility, and transportation challenged. "When we're thinking about preparedness for the urgent threats," she said, "we should start there first because those are the people that sustain the disproportionate burden of these kinds of events.

Dr. Gerberding also called attention to the current "crisis of complacency," saying she has been trying to nail down what the cause is. "Not knowing what to do is frustrating," she declared, "but not doing what you know is tragic. We are sitting here in a context where we know the things that people need to do, but they are not getting done. We really have to step back and say, 'Why is that? Why are we, as a society and as individuals, unable to sustain our efforts to prepare?'"

The reasons Dr. Gerberding has come up with are that people are too busy or are distracted by other threats. Also, some people are too frightened and some people are too isolated. Some people, she said, may be too confident.

"You can fight complacency with caring," Dr. Gerberding said, "but it's a special brand of caring that we need to focus on. We need to care enough to truly commit as family members, as a community, and as a nation to continuing to build that network of preparedness across all of our communities….We also need to care enough to connect, not just with our families, but with the other people in our community, the people that we might not normally come in contact with through our community organizations, through our churches, through the walks that we are hopefully taking in our neighborhoods, just thinking about the other person a little bit more and maybe having that person be a part of your own family preparedness plan." ■

Are individuals prepared for a public health crisis?

A survey commissioned by the American Public Health Association (APHA) indicates a low-level of preparedness among Americans for a natural or medical disaster or terrorist attack *(see related story, p. 4)*.

While governments have considerable responsibility for people in such events, officials make the point that individuals must be able to look out for themselves and for their neighbors. APHA provides this assessment as a way for people to begin to consider what steps they must take to be better prepared:

1. Does your household have at least a three-day supply of fresh drinking water (1 gallon per person per day, including water for any pets)?

2. Does your household have at least a three-day supply of nonperishable foods that takes into consideration any special dietary needs, babies, or pets (i.e., canned goods, protein bars, dried cereal, and baby formula)?

3. Do you have an emergency response kit that includes first aid items, a flashlight, batteries, matches, a utility knife, a battery-operated radio, a blanket, latex gloves, and extra clothing?

4. Do you have an emergency supply of over-the-counter and/or prescription medications and medical equipment?

5. Are you aware of the potential hazards in your area (i.e., hurricanes, chemical spills, heavy snowfall)?

5. Has your household established a plan for contacting and reuniting with each other in the event you cannot return home during an emergency?

6. Have you established a specific plan for how you would evacuate from your home?

7. Do you know your community's emergency plan and where to get timely information?

8. Do you have extra cash saved in the event your place of work or bank closes for an extended period of time?

9. Do you have important documents, such as personal identification and medical and financial records, stored in a secured location?

APHA also offers this checklist as a means of individuals and communities being able to focus on what must be done to become better prepared:

• One gallon of drinking water per person in my household per day to last at least three days.

• At least a three-day supply of nonperishable foods that takes into consideration any special dietary needs (i.e. canned goods, fruit and protein bars, dried cereal, and nuts).

• Pet food and extra water.

• Formula, diapers, bottles, and

infant medications.

• First aid kit and manual.

• An emergency response kit that includes a local map, flashlight, can opener, battery-operated radio, batteries, matches, utility knife, blanket, latex gloves, hand sanitizer, and extra clothing.

• Eating utensils and personal hygiene items such as paper goods, garbage bags, towelettes, toilet paper, and feminine supplies.

• Prescription drugs and medical supplies such as insulin and blood-pressure monitoring equipment.

• Nonprescription medication such as acetaminophen, ibuprofen, and anti-diarrheals.

• Knowledge of the potential hazards and emergencies in my area (i.e., hurricanes, chemical threats, extreme heat, and heavy snowfalls).

• A designated emergency contact person and meeting place outside of the household in the event I cannot return home during an emergency.

• An established plan for how I would evacuate from my home.

• Ask local officials about my community's emergency response plans and where to get up-to-date information.

• Cash, traveler's checks, and coins.

• Important documents such as personal identification, medical and financial records, and emergency contact numbers.

• Ask my child's school about emergency plans including evacuation locations and how they will communicate with families.

• Ask my employer about emergency plans and drills.

More information on the assessment and ways to be better prepared is online at http://www.nphw.org. ■

APHA: We're not prepared for a 'public health crisis'

Most Americans are not prepared to adequately respond to a public health crisis and many who think they are prepared really aren't. Those are some of the findings of a survey funded by the American Public Health Association (APHA) as part of National Public Health Week.

The survey found that only 27% of American families would be fully prepared with adequate food, water, medications, and other supplies if they were forced to stay in their homes for three days or quickly evacuate their homes in response to a public health emergency. Some 87% of the national respondents realize they are not as prepared as they should be, but many people still believe they are more prepared than they really are. Of concern to public health officials is that 40% of the people said they were more prepared in the recent past (particularly after Sept. 11, 2001), but they have allowed their level of planning and preparation to drift and deteriorate.

"These findings indicate we still have a long way to go to improve the nation's readiness for public health emergencies," says APHA executive director **Georges Benjamin**, MD, FACP, FACEP. "No one can predict where the next national disaster, major storm, or disease outbreak will strike, but when it does, it is likely to disrupt basic services, leaving people without electricity, water, food, or needed medications, and we all need to be prepared."

APHA said the survey findings reveal a deeper understanding of why Americans are so ill-prepared and suggest clear strategies for closing the gaps. "The findings help us understand both the nonrational and rational processes at work for most citizens," the report said. "The nonrational side includes the 38% of the public who say that among the reasons they have not planned is that they simply would rather not think about what would happen in a public health crisis, as well as the 44% who do not believe in worrying about things that may or may not happen in the future."

Rationally, according to the survey, many people believe that they are more prepared than they actually are. Among the 27% of the public who believe they are very or fairly well prepared for a public health crisis, fewer than half (48%) actually meet the basic standard of having a three-day supply of food, water, and medications, first aid, and other basic supplies.

Crisis definition needs to change

Persuading more people to become prepared, the researchers said, will take defining a public health crisis in a way that motivates people to action. Rather than a dictionary definition of a public health crisis that only 27% of the public believe is very or somewhat likely to strike their communities, the survey results suggest the importance of defining a public health crisis by its likely causes.

"To make Americans see the importance of planning for a public health crisis, it is important to broaden the discussion to include the potential that severe storms, hurricanes, tornados, blizzards, or outbreaks of common or exotic infectious diseases, and many other disasters have to cause a public health crisis in their community," the report declared. "The public is twice as likely to worry about a natural disaster (37%) as a public health crisis (18%). They may not really know what a public health crisis is, but they have experience with major storms and they readily accept that

storms or other emergencies could cause disruptions in basic services such as electricity, water, transportation, and grocery and drug stores, leading to a public health crisis.

At a Washington, DC, briefing releasing the survey results and hosting a panel discussion on preparedness *(see related story, p. 3)*, Dr. Benjamin said APHA wants to reinvigorate the public and inspire them to retake the first step toward preparedness.

With so few people having the basic three-day supply of essentials available, he said people are allowed to have longer plans for preparedness but the basics need to be taken care of first. "Let's make sure we're prepared for some basic things like snowstorms, ice storms, and some of the things that you've actually experienced in the last couple of months," Dr. Benjamin said.

Looking at how people view the concept of a public health crisis, Dr. Benjamin said terminology is important. "We need to connect the dots so that we educate Americans about preparing for health emergencies and relay our message so that we'll motivate them to improve steps toward preparedness."

The survey took a special look at vulnerable populations, Dr. Benjamin said, such as mothers with children, the homeless, hourly wage workers, food banks, and schools, and assessed their levels of preparedness. "Interestingly enough," he commented, "overall most of these vulnerable subgroups mirrored the lack of preparedness of the general population, but in the public health community we know that these communities and these groups are especially challenging. We know when we simply try to go out for vaccination programs how challenging they are. We can get to the 80% mark and then we try to get that last 20% and it takes extraordinary effort and extraordinary modern resources to get to those populations. Why should preparedness planning be any different from that?"

He cited several examples: Some 58% of mothers with children ages 5 and younger don't have a three-day supply of water on hand for their family, only 61% of people with chronic health conditions have at least a two-week supply of medications, only 18% of employers said they could continue to pay their workers if there was a break in operations, only 15% of hourly workers have saved enough money to buy needed goods for their families if their income were cut off.

"The good news is that it's not hard to prepare," Dr. Benjamin said. APHA has released an on-line assessment and checklist *(see related story, p. 3)* people can use to determine their level of preparedness and become better prepared. He said communities should look at making these tools more available and also at building community checklists through work that has been done by the Department of Health and Human Services. "I think that by putting those two tools together, communities and individuals can assure themselves that they're prepared," he said.

Information on the survey and the assessment and checklist is available on-line at www.nphw.org. Contact Dr. Benjamin at (202) 777-APHA or e-mail georges.benjamin@apha.org. ■

Fiscal Fitness

(Continued from cover)

development and dissemination strategies, policy-maker knowledge, demand side pressures for improvement, and differential values for treatments and outcomes.

System barriers to implementing evidence-based practices that Dr. Shern cited included reimbursement practices not tracking the evidence base; complex categorical funding streams frustrating integrated care; a narrow focus on agency specific budgets in cost containment; policy-makers unaware of evidence-based and informed practices; unavailability of systematic outcome and process data; and differing values for differing outcomes (reduction in hospital use versus normal life in the community).

There also are consumer and family barriers, Dr. Shern said, including the fact that stigmatized disorders inhibit information flow among consumers; research results are complex and difficult to interpret; differential power relationships with providers, particularly for people with mental illnesses; the fact that personal desires may not comport with supported treatments; and difficulty in determining if evidence-based practices are being provided.

Research barriers that can interfere with implementing evidence-based practices include a culture of research values that fails to map real world applications by controlling heterogeneity and restricts dissemination of research results to limited channels in peer-reviewed publications; limited systematic attention to implementing research findings; and limited opportunities to meaningfully interact with multiple stakeholders who have an impact on implementation.

"We devote 99% of our investment in intervention research to develop solutions," Dr. Shern said, "and only 1% to investment in implementation research to make effective use of the solutions. Because both implementation issues and implementation solutions are common across widely diverse domains, we have the foundation for effective implementation

practices and for development of a science of implementation."

He tells *State Health Watch* that while there are both potential advantages and disadvantages to evidence-based practices, he believes the advantages outweigh the disadvantages. Dr. Shern notes that in health care, there is considerable variability in the care delivered and it often is not responsive to the population's health. Less than 50% of the care provided meets an evidence-based standard, he says.

Using an evidence-based approach is good, he says, because it provides a structured approach to dealing with a particular problem and eliminates bias that could lead investigators in the wrong direction. "Evidence-based practices have generally been shown to yield better care relative to other approaches," Dr. Shern says. "It offers the hope of introducing into behavioral health care a more standardized approach to reduce the variability."

He says the various barriers to implementing evidence-based practices he identified in his presentation are all important because they work together as a system. Regarding work force preparation, he calls attention to the need to find more responsive ways to train people so they will be more informed about evidence-based care. "This is a high leverage point because it is where we orient people to their careers," Dr. Shern says.

He also cites a need for more information technology support to help clinicians do better assessments and deliver more standardized care with benchmarks.

At the same NASHP conference, **Michael Hogan**, PhD, the former director of Ohio's Department of Mental Health, who has since moved to New York State, talked about what is involved in "selling" evidence-based practices in tight financial times.

"We have learned a lot in Ohio and around the country about what is termed implementing evidence-based practices in mental health," he tells *State Health Watch*. "Most of it is common sense, but many of the implications have not been well thought through or widely applied."

The context of mental health care and the nature of the "evidence" that is emerging tells the story, Dr. Hogan says. In the first place, serious mental illness is very complex and highly personal, since both thinking and feelings are affected. The impact of the illness and therefore recovery may involve aspects of biology, personality, learned behavior, disability, and culture. So, he says, the best care is expert and highly personalized and a patient's environment, such as stability of housing and social/family supports, is often crucial to outcomes.

"Much of the 'evidence' on effective treatment focuses on one or two aspects of this puzzle," Dr. Hogan says, "since 'evidence' in a world of medical research dominated by the randomized trial as a model depends on stripping away variability. So there are few evidence-based practices in mental health as simple as use of beta-blockers after a heart attack. The most research has been done on medication treatments, and it tends to suggest moderately more successful approaches that are likely to make a big difference for some patients/consumers, especially those whose conditions are not complex."

Dr. Hogan says promoting such practice improvements largely requires teaching practitioners new skills, and supporting use of these skills in their work, such as through electronic record systems that prompt for use of suggested treatment strategies.

"The strongest case and highest relevance for evidence-based practices in mental health is for team-based interventions that have many similarities to a chronic care model, although most serious mental disorders are better thought of as long term rather than chronic," Dr. Hogan says. "However, the qualities of these interventions, such as multisystemic therapy for acting-out youth and assertive community treatment for adults with schizophrenia, include variants of, for example, a multidisciplinary team, treatment in the live environment, continuing care with intensity tied to clinical status, and a highly personalized approach, require considerable effort to implement well."

According to Dr. Hogan, what has been learned about implementation of such efforts, or what he calls re-engineering, is wholly consistent with the literature on adoption of innovations. Leadership, adequate support for training, a supportive agency and financing environment, and the presence of ongoing mechanisms for assessing and modifying performance are all crucial, he says, while no single path strategy such as training, financing packages, or mandating compliance is effective.

"In some ways," he tells *SHW*, "the process of introducing evidence-based practices in mental health is like the experience of introducing quality improvement in complex manufacturing environments. But the challenges are far greater than manufacturing. What industrial process approaches the complexity of the human mind? And perhaps even more critically, how are such approaches put in place through highly dispersed, open social systems made up of multiple levels of government, competing regulatory and financing systems, and with thousands of providers working for largely autonomous organizations? The difference for consumers can be life and death, personal success, or long-term disability. The difference for taxpayers is in the billions."

Contact Dr. Shern at dshern@mentalhealthamerica.net and contact Dr. Hogan at (518) 474-4403. ■

Improving use of research in state health policy development

States are essential players in disseminating evidence-based practices and policies that can lead to better health care for their citizens. Health system improvement could be accelerated if there were stronger communications channels between researchers and policy-makers at the state level. That's the conclusion of Health Management Associates' **Jack Meyer** and **Tanya Alteras**, who have developed a conceptual framework supporting effective use of health services research in state health policy-making.

In work supported by The Commonwealth Fund, Mr. Meyer and Ms. Alteras lay out a four-stage research and policy-making framework involving 1) understanding the scope and extent of the problem; 2) developing options; 3) implementing a program or policy; and 4) evaluating the program or policy.

The authors note that while health services research can be used to inform policy-makers about pressing issues; provide them with data and resources needed to develop new programs or reform existing ones; guide the implementation process; and evaluate programs or policies to determine whether they are meeting their goals, putting new and innovative research to work in the policy-making process requires tenacity and understanding on the part of both researchers and policy-makers.

"Effective partnerships between researchers and policy-makers are grounded in sustainable relationships and mutual trust," the authors say. "In a perfect world, research and policy-making would go hand-in-hand. Yet, in practice, communication between researchers and policy-makers frequently does not occur. Some policy-makers are busy with immediate problems and may not be well acquainted with researchers. And some researchers are focused more on academic studies and may be removed from the policy process. While there is no formula to guide communication and knowledge transfer between health services researchers and policy-makers, certain steps can help to ensure an effective, symbiotic relationship between the research and policy-making worlds."

Here's how Mr. Meyer and Ms. Alteras explain the steps in their conceptual framework.

1. Understanding the scope and extent of the problem. At the information-gathering stage, they say, state policy-makers frequently will use existing research to better understand an issue or problem. If a state agency has an existing relationship with a research institution or a research division within the agency, officials will most likely look there first for help.

Before a crisis hits, the authors say, policy-makers should be building and maintaining relationships with researchers to be better informed on relevant key policy issues. Each staff person should have a portfolio of key issues to track and monitor and should identify researchers who are experts in those fields.

Researchers, they say, should develop relationships with the administrative and legislative staff responsible for their issues. "This is the stage where influencing the policy process begins," they say. "Build your audience before you need it." They also recommend that researchers identify issues that are most important to policy-makers in their state and develop strategies for helping them address those issues.

2. Developing options. When developing policy options, according to Mr. Meyer and Ms. Alteras, the relationship between policy-makers and researchers and the exchange of information typically becomes more formal. State policy and program staff frequently commission research to determine the effects of various policy options on target populations, program costs, and costs or savings that the policy may have on other state agencies and programs.

As they develop policy options, policy-makers should remain open-minded, the authors say, allowing the research findings to guide decision making. Policy-makers should recognize there often are limitations to the data that researchers have available to them, and that this may diminish their ability to address certain policy options.

For their part, researchers need to recognize that databases may be limited, particularly when it comes to identifying gaps in services, programs, and unmet needs. They should become familiar with proxy data sets for studying salient state issues as so-called ideal state data may not always be available. Researchers need to be flexible about finding useful data and developing workable research models and should be ready and willing to modify policy options in response to stakeholder feedback.

3. Implementing a policy. While the second stage involved modeling potential outcomes, this stage involves the trial and error of testing policy options and determining their robustness under a wide variety of real world circumstances.

Policy-makers at this stage need to be aware that researchers need to have a different set of skills for the implementation stage than for the policy options development stage. Generally, according to Mr. Meyer and Ms. Alteras, researcher involvement at the implementation stage is limited. A government agency typically takes over, often with consultant assistance. Still, researchers can help analyze the potential effects of choices made

during implementation.

Researchers need to recognize the unique set of skills needed for the implementation stage. Since trial and error are the norm, with mid-course corrections to programs and policies as needed, researchers can prove useful by explaining early results as they occur.

4. Evaluating the program/policy. For this stage of the framework, researchers must have open lines of communication with the state to access the qualitative and quantitative data necessary for a comprehensive and accurate evaluation. The authors say the role of program evaluator often is filled by an institution, such as a university department or think tank, with which the state has an ongoing relationship or perhaps even a standing contract for specific projects. One of the challenges at this stage, the authors say, is to get the evaluation findings on the radar of state officials, ensuring that program administrators and state legislators pay attention to the results, absorb them, and use them. A second challenge involves situations in which interim findings reflect positively on a program, but final data on outcomes or impact do not. Another challenge relates to the appropriateness of a research team or facility engaging in the evaluation process if they have been intimately involved in the program planning.

Policy-makers, the authors say, should avoid the perception of bias by seeking an outside, nonpartisan research team to evaluate a program. A comprehensive evaluation plan should be built into perspective legislation, including collection of baseline data before program implementation. Policy-makers should commit to an ongoing assessment of the program to promote a culture of continuous quality improvement. And they should communicate clearly how they want evaluation findings to be packaged and presented to ensure that findings are understandable and meaningful to the target audience.

Mr. Meyer tells *State Health Watch* that one of the barriers to better communication and working relationships between policy-makers and researchers is that a number of researchers fail to package their findings highlights in ways that policy-makers can easily understand and use them. "Researchers too often come up with 300 pages of solid and interesting material," he says. "No matter how interesting it is, it's hard for a very busy policy-maker to make use of it. I'm not suggesting that researchers cut corners. But they need to remember to summarize, highlight, extract key findings, and make policy recommendations."

Policy-makers, Mr. Meyer tells *SHW*, need to be better at cultivating relationships with researchers and not just call for help with an emergency that has a 24-hour deadline. "Take the time to get to know people and have some reciprocal obligations," he says.

According to Mr. Meyer, his four-step framework need not be followed in order, recognizing that some researchers won't want to do all four stages.

The report can be downloaded at www.cmwf.org/publications/publications_show.htm?doc_id=437168. Contact Mr. Meyer at jmeyer@healthmanagement.com or telephone (202) 785-3669. ■

Lessons learned from California's insurance expansions for kids

California officials have learned much in recent years about how to provide health insurance for children. The California HealthCare Foundation (CHCF) says the state has significantly expanded enrollment in its Medi-Cal and Healthy Families programs and many counties have developed Children's Health Initiatives to cover those children who are ineligible for state programs. As a result, the number of uninsured children in California has dropped by nearly 20% over the last five years.

CHCF senior program officer **Len Finocchio** says while there is popular support for continuing to expand coverage until all children in California have insurance, nearly 1 million remain uninsured. A CHCF November 2006 issue brief synthesized key lessons from successful initiatives and from potential reforms that have been identified but not yet implemented.

Mr. Finocchio tells *State Health Watch* that he believes his findings often can be generalized to other states, especially to the degree that their policies and procedures need to be simplified. "I'm sure there is a lot of work for other states to do."

The lessons in expanding children's coverage have been grouped into three categories—**simplify, automate,** and **follow the leaders.**

• **Simplify.** While there are several California public programs whose aim is to insure children, not all eligible children enroll, and those who do initially often fail to renew their coverage. Mr. Finocchio says part of the problem is that each of the programs has its own eligibility rules, documentation requirements, and application processes that vary from county to county, offering a daunting challenge to the average family. Proven ways to simplify public health insurance programs are to simplify federal and state policies on eligibility; streamline the application, enrollment, and renewal processes; and reach out, redesign the paperwork, and provide assistance.

• **Automate.** "The effective use of

information technology [IT] can improve enrollment processes so that information flows more quickly and efficiently and the enrollment steps are presented coherently," Mr. Finocchio says. "Efficiencies gained through IT solutions are not a substitute for policy reforms that would actually reduce unnecessary complexity." Mr. Finocchio refers to an independent study that found that applicants and administrators prefer electronic applications to paper ones. "Computerized forms are designed to eliminate many common mistakes found in applications that are completed by hand," he says. "Every required field must be completed before submission and small discrepancies (such as zip codes that don't match the county of residence) must be addressed. Six improvement techniques Mr. Finocchio suggests are to improve enrollment efficiency with electronic applications; integrate state and county data systems, taking older technology into account; use technologies that provide real-time connection to key enrollment databases; move toward on-line enrollment; ensure that policy keeps pace with technology, and vice versa; and foster political will for a statewide technology strategy.

• **Follow the leaders.** Mr. Finocchio says some California counties have achieved extraordinary results with innovative coverage programs. They have been particularly effective at forming collaborations to consider the needs and suggestions of everyone involved, including families, eligibility workers, health plans, community-based organizations, hospitals, and schools. Four reforms that can work are working together; delivering the right marketing message to the right people in the right places at the right time; creating inspiring goals and realistic plans to achieve them; and taking a customer service approach to health plan enrollment.

There are obstacles that must be overcome, Mr. Finocchio says, if states are to expand health coverage for children. First, the application and enrollment process has an important influence on families' decisions to apply for coverage. And another important factor in determining whether families apply for coverage is their perception of and experience with the program. Thus, a study of consumer decision making found that many more families would enroll in Medi-Cal if they believed that doctors would treat them with respect and that someone in the doctor's office spoke their language.

The ease with which families can get access to care is another important attribute of coverage programs. "Children don't just need health insurance," Mr. Finocchio says, "they need access to providers." Given that in California there are 46 Medi-Cal providers per 100,000 beneficiaries, well below the federal minimum standard of 60-80 providers, enrollment in Medi-Cal and Healthy Families can improve access to physician services, but does not eliminate access problems. The most basic requirement, according to the issue brief, is a sufficient supply of doctors who accept public health insurance as payment, including specialists and dentists. Also, children in remote rural areas need adequate transportation to care sites.

As more children enroll, Mr. Finocchio says, public health insurance programs will need additional funding. Rather than the typical state general fund and federal match, there may be a more efficient way to organize and finance the system, he says, and the state should consider potential savings in managed care, look for economies of scale, and reduce costs by streamlining administrative processes.

"There are unquestionably some challenges to providing adequate insurance coverage for California's children, including funding and access to providers," Mr. Finocchio concludes. "However, there are also opportunities for improvement. Examples of successful initiatives at the state, county, and agency levels offer basic lessons to guide future efforts ***(see related story, p. 10)***. Heeding them can help California make substantial progress toward providing accessible health coverage to children throughout the state."

Mr. Finocchio tells *State Health Watch* that a lack of political will often is a barrier to making coverage improvements, as are the disparate ways that people must enroll in various programs, either electronically or by hand. "If there were an overarching state leadership for change it would happen," he declares.

Mr. Finocchio says the key success factors for California to expand coverage included automated enrollment, outside groups developing innovative processes and pressuring the state to use them, a strong advocacy presence, and the presence of individual legislators and governors who want to be sure that kids have coverage.

He tells *SHW* the push for universal coverage for kids has been under way in his state for five or six years and has reached the point that there is a sense of inevitability that California will provide coverage for children even if plans for still-broader coverage fail. He says when universal coverage of children is achieved, CHCF will look at the system in place and how well it provides access to care and will work with the state government to make it as user-friendly as possible.

The issue brief is available on-line from www.chcf.org. Contact Mr. Finocchio at (510) 587-3131. ■

Programs share lessons learned in improving coverage for children

A pilot Express Lane Eligibility program implemented in the 2003-04 school year allowed families to apply for California's Medi-Cal and Healthy Families programs at the same time as the National School Lunch Program, which has similar income eligibility requirements.

The California HealthCare Foundation (CHCF) says that since 56% of the state's uninsured children already participate in the school lunch program, the approach seemed to offer a straightforward way to identify large numbers of children and enroll them in public insurance programs. The three-year pilot included seven school districts in six California counties.

Some 15% of all applicants forwarded to the counties for processing were eventually enrolled into full-scope Medi-Cal. But there have been some disappointments, CHCF says. Thus, while in the program's first year, 42% of free lunch-eligible children consented to forwarding their information to Medi-Cal for processing, that number dropped to less than 15% in the second year. CHCF says the biggest problem was that many of the applications forwarded to social service agencies for processing were from people who were already enrolled in Medi-Cal.

According to an evaluation, the pilot taught the importance of working toward a simpler, more seamless, and more streamlined enrollment system for all children's health and health insurance programs, and the clear benefits of establishing a single health insurance program for families that covers all children.

Another innovative program, the Child Health and Disability Prevention Program Gateway, allows doctors and clinics who provide health screenings through the program to pre-enroll uninsured children in temporary full-scope Medi-Cal for up to 60 days.

CHCF says the program is notable for its use of an electronic application permitting enrollment transactions from the provider site. Providers enter minimal information (name, address, date of birth, and gross family income) through an Internet or point-of-service interface, and the Gateway program conducts an automated check against the Medi-Cal Eligibility Data System, returning an eligibility determination message to the provider within seconds.

Children without insurance are granted temporary Medi-Cal coverage. In 2006, more than 600,000 children went through the program and were enrolled in temporary Medi-Cal.

CHCF says the gateway policy also includes a second step designed to link children who receive temporary Medi-Cal coverage to continuous Medi-Cal or Healthy Families. As part of the pre-enrollment process, families are asked whether they wish to receive a joint Medi-Cal/Healthy Families application by mail to apply for continuous coverage for their children. They must return the application before the temporary coverage expires to be evaluated for continuing coverage. Program data show a significant drop-off in numbers between families requesting an application and those who return it.

CHCF says evaluation on this point is challenging given the available data. However, most observers agree that many families of eligible children fail to return the joint application because of the extra work it involves and the difficulty in completing the complex paperwork. The program, the report says, has demonstrated the power of an automated file clearance system and the limitations of a two-step application process. ■

Innovative program improves children's health

The innovative Children's Health Initiative in Santa Clara, CA, has been shown to increase children's access to and use of medical and dental care and to improve their health status, according to a program evaluation conducted by the Urban Institute's **Embry Howell** and Mathematica's **Christopher Trenholm**.

The program has two parts—a Healthy Kids insurance product that covers children in households with income up to 300% of the federal poverty level who are ineligible for the Medi-Cal and Healthy Families insurance programs, and a comprehensive outreach campaign that finds uninsured children and enrolls them in the appropriate program.

The evaluators say there have been few studies directly addressing the relationship between children's health insurance and health status. One reason is that children generally are healthy and much of the care they receive is geared toward preventing future illness. "Still," they say, "by ensuring that children receive needed medical and dental care on a timely basis, health insurance coverage can provide some immediate benefits to their health."

An earlier program evaluation found that Healthy Kids dramatically increased children's access to and use of medical and dental care. Overall,

the proportion of children receiving a medical visit in the past six months rose from 32% without Healthy Kids to 54% with the program. That increase reflected a near doubling of the proportion of children who received a preventive visit (25% to 43%) and who received a sick visit (18% to 30%), and a doubling in those who received a specialist visit (5% to 11%). That evaluation also found that Healthy Kids significantly improved children's access and use of dental care, reduced their unmet needs, and raised parents' confidence that their children could receive needed care.

To determine whether the documented gains in medical care translated into health status improvements, the researchers examined Healthy Kids' effect on three children's health measures as reported by parents: 1) children's health status, ranging from poor or fair to good or excellent; 2) whether children had health problems limiting their ability to function normally; and 3) the number of school days the children missed in the past month (for ages 5 and older). To have the most confidence that any gains seen in children's health were due to the program, the researchers limited their findings to children who did not enroll in Healthy Kids specifically because of an illness or some other type of immediate medical need.

They found that even among children who enrolled in Healthy Kids for a nonmedical reason, the program led to significant improvements in health. After participating in the program for one year, the proportion of children reported by their parents to be in fair or poor health fell by one-third, from 18% to 12%. And Healthy Kids significantly reduced the number of missed school days. Thus, the proportion of children missing three or more school days in the past month fell from 11% without Healthy Kids to just 5% with the program. However, Healthy Kids did not reduce the proportion of these children with a functional limitation caused by health, although that group was just 3% of children who enrolled in Healthy Kids for a nonmedical reason.

The researchers said the study shows that providing health insurance to very disadvantaged children has improved the health status of those children in Santa Clara County in a short period of time, according to reports from the children's parents. Many of the children never had coverage before enrolling. "As a result of providing comprehensive coverage, the program has improved the current health status and school attendance of some of California's most vulnerable children," the evaluation said. "The study adds to a small but growing body of evidence concerning the potential short-term benefits of health insurance coverage for children's health." ■

Expanding CHS helps minority access to care

Policies to reduce uninsurance and expand community health center capacity should increase access to care for low-income people, as measured by having a usual source of care and an ambulatory care visit in the past year, according to a Center for Studying Health System Change (HSC) study published last year in *Health Affairs*.

Study lead author **Jack Hadley**, an HSC senior fellow and a principal research associate at the Urban Institute, tells *State Health Watch* that expanding community health center capacity has a positive effect on minority population access to care. "In principal," he says, "it should help close the access gap between whites and minorities."

Mr. Hadley says the greater expanded access to care for minorities may be related to population locations.

Bigger drops in coverage seen

In the study's simulation, expanded community health center funding resulted in small increases in access to care, with Spanish-speaking Hispanics registering the largest improvements in access. However, minorities also experienced bigger drops in insurance coverage and the net result was no improvements in the access measures for Spanish-speaking Hispanics and slight decreases in access for whites, English-speaking Hispanics, and African-Americans. Access gaps either remained the same or worsened slightly for English-speaking Hispanics and African-Americans relative to whites.

According to Hadley, racial and ethnic minorities consistently have higher rates of uninsurance than whites, by almost twofold for African-Americans and roughly threefold for Hispanics. And recent

This issue of *State Health Watch* brings you news from these states:

data have indicated the gap is increasing.

Since racial and ethnic minorities used community health centers more than do non-Hispanic whites, federal investments in those centers would be expected to narrow differences in access, although a growing gap in insurance coverage between whites and racial/ethnic minorities could frustrate that goal.

Mr. Hadley tells *SHW* that this study expands on earlier work using Community Tracking Study data. Simulations in the study were based on statistical models that treat both insurance coverage and safety net capacity as endogenous (internal) variables, but used an improved measure of safety net capacity: total community health center grant revenues per poor person within a five-mile radius of survey respondents.

The study is important, he says, because there are those who worry that expanding insurance coverage would be too costly and making greater use of community health centers would be a more controllable approach.

Measures can work

"This analysis suggests that policies to reduce uninsurance and expand community health center capacity will increase low-income people's access to care, as measured by having a usual source of care and an ambulatory care visit in the past year," Hadley says. "Moreover, minority groups' access appears to be more responsive to changes in insurance coverage and community health center capacity than non-Hispanic white's access. Thus, if policy changes were targeted equally to all low-income people, the gaps in access between whites and non-whites should be reduced. However, although eliminating uninsurance would have a sizable impact on minorities' access levels, it would not eliminate access gaps completely."

Analysis represents basic access

While the simulations suggest the Bush administration's community health center expansion might have offset much of the adverse effects on access of recent increases in uninsurance, Hadley emphasizes that the measures analyzed in the study represent only the most basic forms of access. "Although they are important indicators of access to primary and first-contact care, they might not capture variations in access to specific types of care, such as specialists, prescription drugs, expensive therapeutic procedures, or hospital care, or the total amount of care received," he says. "Investigating the relationships between insurance status and community health center capacity on these additional access measures is important for obtaining a complete picture of the extent to which community health centers fully substitute for insurance coverage."

A study abstract is available on-line at http://content.healthaffairs.org/cgi/content/abstract/25/6/1679. Contact Mr. Hadley at jhadley@hschange.org or telephone (202) 261-5438. ■