State Health Watch

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In This Issue

Denver Health's success at integrated care lauded as 'learning laboratory'

Denver Health—Colorado's largest health care safety net provider—is being lauded as a model system for promoting a culture of continuous quality improvement, adopting new technology and incorporating it into everyday practice, taking risks and making midcourse corrections, and providing leadership with accountability. Because it has accomplished these objectives and others in a straightforward way that could be adapted elsewhere, the Commonwealth Fund is promoting Denver Health as a "learning laboratory."

Denver Health president **Patricia Gabow**, MD, tells *State Health Watch* the biggest issue for other jurisdictions wanting to learn from what Denver Health has accomplished is to find the political will that is needed to make changes. "So many groups that have come to visit us say politically they could never do it," she says. "As with so many other issues, we know what we should do and we just need to find the political will to do it. We've been very lucky here in Denver that we've always had the political will."

Denver Health is a comprehensive and integrated health care system that provides primary and specialty care, emergency medicine, and acute

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States take new direction in encouraging healthy lifestyles for Medicaid recipients

It's well accepted that a key strategy for improving population health is for people to adopt healthier lifestyles. Is there anything state governments can do to encourage citizens to live healthier? A new Center for Health Care Strategies report evaluates efforts in Florida and Idaho to provide incentives to encourage people to adopt healthy behaviors.

Fiscal Fitness: How States Cope

Florida implemented its innovative policy to reward Medicaid recipients up to $125 per year for engaging in specific wellness and healthy behaviors in 2006. And Idaho introduced a reward-based program in 2007 to promote well-child visits, tobacco cessation, and weight management.

Report author **Jessica Greene** of the University of Oregon tells *State Health Watch* that state Medicaid agencies have not traditionally sought to influence recipients' health-related behaviors. Wellness programs such as smoking cessation are not universally covered by Medicaid programs. So encouraging

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The Newsletter on State Health Care Reform

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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: Gary Evans, (706) 310-1727, gary.evans@ahcmedia.com.
Editor: John Hope, (717) 238-5990, johnhope17110@att.net.
Senior Production Editor: Nancy McCreary.

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Denver Health

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hospital care to residents of Denver and the Rocky Mountain region. Its mission is to provide access to quality preventive, acute, and chronic health care to all the citizens of Denver regardless of ability to pay; to provide emergency medical services to the region; to fulfill the community's public health needs; to provide education for patients and health care professionals; and to engage in research.

Denver Health serves some 25% of all Denver residents, including one-third of the children in the city. The organization is the largest health care safety net provider in the state and is its largest Medicaid provider. In 2005, uncompensated care provided by Denver Health totaled $285 million or 42% of total patient charges. As in many other safety net systems, Denver Health's population is largely uninsured and disproportionately comprised of members of minority groups.

Inherent tension seen

According to Dr. Gabow, the balance between individual community health center site autonomy and uniformity of system process is an inherent tension. She tells *SHW* that while administrative complexity could be an issue, Denver Health has been fortunate to have stable executive leadership. "Creating a system this complex from scratch is a challenge," Dr. Gabow says. "For someone trying to model our system, administration would be a challenge."

The single biggest challenge facing the system, Dr. Gabow says, is the ever-increasing cost of uncompensated care. But she says she remains convinced that to have high-quality, low-cost care, it is necessary to move to an integrated care model. Dr. Gabow concedes the system lacks some elements, primarily home health and long-term care components.

Commonwealth Fund program officer **Rachel Nuzum**, lead author on the Denver Health report, praised the system's integrated model. "What they are doing is consistent with what the Commission on a High Performance Health System is looking at in terms of a continuum of care," she tells *SHW*. "Some might argue that it's not good to have such a high percentage of uncompensated care patients in one facility, but Denver Health has found a way to make it work for them."

Among the key success factors in the Denver Health story, Ms. Nuzum says, are the commitment to information technology (IT), leadership from the top down that has involved all employees in continuous quality improvement, and a good understanding of the organization's target population.

"A comprehensive overall [system] is difficult without a leadership that is ready to take it on and go with continuous improvement," she says. "Patricia Gabow has been a huge driver in Denver Health's success but short of cloning her, we hope that as the stories filter out and others read about it, they will realize that it's not that different from where their institution is and will be interested in trying to follow Denver Health's lead."

In 2003, Denver Health started to transform itself and create a culture of continuous improvement. A Commonwealth Fund report says the organization adopted specific new processes and tools. Thus, it systematically applied the principles of "team manufacturing," based on Toyota's approach to streamlining its operations and eliminating waste. To develop appropriate in-house expertise, it invested in the training

of 50 staff members in adapting industrial techniques to the health care setting. As a result, five strategic "value streams"—access, inpatient flow, outpatient flow, operating room flow, and billing—were selected as targets for the initial redesign effort.

One thing that sets Denver Health apart from some other safety net hospitals has been its willingness to build infrastructure for high performance in information technology and work force. Since 1997, the organization has invested $275 million in health-oriented information technology, which has enabled establishment of a centralized data warehouse that integrates both clinical and financial data and allows for standardized reporting. A single imaged electronic record format is used across the entire system so that any provider can retrieve a patient's information in real time.

Dr. Gabow tells *SHW* that when people 10 years ago talked about integrated delivery systems, they merged hospitals and bought medical practices. But that's not an integrated model, she says. "IT is very important to our seamless movement of care," she says. "Even though we are safety net providers, we've put $275 million into IT since 1997. We have a single imaged electronic health record across the whole system with a common patient identifier."

The investment in IT also is important, Dr. Gabow explains, because Denver Health is a teaching institution. A standardized approach of care, she says, can't be taught individually to each intern or resident. Rather, it comes through computerized order entry. And the only way to end health care disparity is through standardized care. "We know that 20% of all tests ordered are because the doctor didn't have information they need."

To ensure that it has a capable work force, Denver Health has implemented a four-part strategy including a talent bank, an interview tool that measures "talent intensities," training for key leaders regarding selection, and an employee-engagement survey.

While there are many factors that contribute to the overall high quality of care that Denver Health provides to its patients, the Commonwealth Fund Commission on a High Performance Health System cites these attributes that other health systems might consider replicating:

Denver Health is an integrated system, endowed with appropriate tools. An infrastructure exists to provide coordinated care to the community and there is a commitment to adopting new technology and incorporating it into everyday practice.

Denver Health provides a culture of improvement, peopled by dedicated staff. Decisions are data-driven and feedback loops allow for continuous quality improvement. There is willingness among the leadership to take risks and make midcourse corrections.

Innovation at Denver Health has strong support at the top. Leaders at Denver Health clearly communicate their vision that high-quality care derives from a high-quality system. The leadership and staff are bound by a common mission that reflects this vision. The leadership has adopted a market-based strategy with a clearly defined target population. Their approach, which requires strict accountability, aligns incentives to encourage the systems approach.

Despite many challenges, the report says, Denver Health remains fiscally sound and a leader in delivering health care. Although it is a safety net system, it is not a place of last resort, but rather a place of first choice. Denver Health has been named one of the top 50 hospitals in the U.S. in four of the categories in *U.S. News & World Report*'s "America's Best Hospitals," and has received awards from numerous professional organizations for such things as information technology use and its efforts to improve immunization rates among low-income Denver children.

First steps to integrated system

In an article in the Jan. 21, 2003, *Annals of Internal Medicine*, Dr. Gabow said the first move to functional integration occurred when community health center internists and pediatricians began inpatient attending rotations and medical and pediatric residents were assigned to the large community health centers. Medical residents remained at the same clinic throughout their training. In 1998, a family medicine residency program was implemented with similar integration. These efforts, she said, created a new level of integration across the continuum of care.

Pharmacy services also were separated. A patient with a given diagnosis at the hospital campus community health center had access to different pharmaceutical agents than a similar patient at an off-campus center. To rectify that situation, a common pharmaceutical formulary was established for the community health centers and the hospital. Likewise, another area of separation was access to capital. Capital and construction dollars for the community health centers had been limited to the small amount in a federal grant. Under the reorganization, capital equipment for the entire Denver Health organization is prioritized by the senior executives during the budget process on the basis of need and strategic priorities.

"Denver Health is now fully integrated organizationally and functionally, horizontally and vertically," Dr. Gabow wrote. "The horizontal integration is achieved through one

administrative team and shared processes and care protocols across all community health center sites. Vertical integration is achieved since the system links the emergency (911) pre-hospitalization service, a 349-bed hospital, 10 community health centers, 13 school-based clinics, public health department, substance abuse and mental health treatment, a poison center, an advice line, and a managed care insurance product. Physicians are key to the continuum of care. All full-time physicians at Denver Health are salaried employees, have hospital admitting privileges, and are faculty of the University of Colorado School of Medicine."

Primary care, including obstetric care and dental care, is available within Denver's medically underserved neighborhoods and most primary care visits occur within the patient's neighborhood. Patients also benefit from easy access to specialty care since all adult and pediatric medical and surgical subspecialty services are available at the hospital campus.

Download the Commonwealth Fund report at www.commonwealthfund.org/publications/publications_show.htm?doc_id=509163. Contact Dr. Gabow at (303) 436-6611 and Ms. Nuzum at (202) 292-6722. ■

Fiscal Fitness

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healthy behaviors is a new direction for Medicaid agencies.

Ms. Greene says policies to reward healthy behaviors have emerged as part of a national trend in health care toward consumer direction. Consumer-directed health care encourages consumers to take charge of their health and health care by promoting personal responsibility and cost conscious decision making. In Medicaid, she says, there are a growing number of consumer-directed policies that emphasize recipient control over Medicaid dollars. These policies include giving disabled and frail elderly recipients monthly allowances for purchasing personal care services and supplies in what are known as Cash and Counseling programs and the new Health Opportunity Accounts, which are savings accounts for purchasing health care services, coupled with a high-deductible version of Medicaid.

"Improving Medicaid recipients' health and well-related behaviors is important for the long-term health of recipients," Ms. Greene wrote. "Unhealthy behaviors have become the top cause of mortality and morbidity in the United States. Tobacco use, obesity, and misuse of alcohol account for more than one-third of all deaths in the country. The prevalence rates of these unhealthy behaviors are particularly high for those with low incomes and minorities. If Medicaid agencies are successful in improving recipients' health-related behaviors, not only will long-term health outcomes improve, but there could be substantial cost savings to Medicaid."

Variable program success seen

Ms. Greene says that while some private sector studies have indicated efforts to promote one-time health behaviors with financial rewards are generally successful, there has been less consistent success in changing fundamental lifestyle behaviors such as smoking cessation and weight loss. Few studies have followed up with participants to assess whether the behavioral changes were sustained over time, she says. Two studies demonstrate that when incentives continue over a relatively long time frame (10 months), they still are effective. But after the incentives have stopped, studies consistently find that the program effect disappears within one year. "These findings suggest that permanently changing lifestyle behaviors such as smoking and exercise will be a challenge for Medicaid reward programs," she says.

Florida's program created opportunities for all Medicaid recipients to earn rewards by engaging in healthy behaviors. Officials selected 19 behaviors for earning rewards. They included simple wellness behaviors, participation in programs seeking to change fundamental lifestyle behaviors, and appropriate use of the health care system. The eight simple wellness behaviors chosen were checkups such as dental and vision exams and well-child visits, immunizations, and cancer screenings. The rewards for appropriate use of health care are for those who don't skip any primary care appointments and those who comply with prescribed maintenance medications. To encourage fundamental lifestyle changes, the plan rewards initial and six-month participation in alcohol and drug treatment, smoking cessation, weight loss, and exercise programs. Participation in disease management programs also is rewarded.

In Idaho, the Medicaid agency developed its Preventive Health Assistance program to encourage recipients to be responsible for their own health and well-being and to provide a financial safety net for recipients required to pay a monthly premium. Thus, money earned through wellness behaviors can be used to pay the new Medicaid premium. A Wellness Preventive Health Assistance program is specifically for children who are required to pay a monthly premium. Eligible children are rewarded for having an annual well-child visit and being up-to-date with immunizations. The

Behavioral Preventive Health Assistance program is intended to encourage lifestyle changes for all Medicaid recipients who use tobacco or who are either underweight or obese, based on Centers for Disease Control and Prevention criteria.

How large must a reward be?

Ms. Greene and her colleagues say it will be important for Medicaid agencies to better understand how large a reward is needed to change wellness and fundamental lifestyle behaviors for Medicaid recipients. Florida decided to cap rewards at $125 per year, allowing recipients to spend about $10 a month on health-related products. Once the upper limit was established, the state decided that rewards for annual behaviors would be $25, semiannual behaviors would earn $15, and more frequent behaviors would earn $7.50. Florida officials said they will monitor the frequency with which each reward is redeemed and will adjust the amounts as necessary in the future.

Because the Idaho plan was developed as a way to help recipients pay a new $10 monthly premium, the amount that can be earned is equal to the premium amount.

The researchers say some studies have examined the importance of the type of reward on influencing healthy behaviors. Those studies compared cash incentives with gift certificates. They found that cash incentives consistently resulted in higher rates of simple wellness behaviors than did gift certificates, although gift certificates still were quite effective.

Cash incentives were not considered by either Florida or Idaho as they designed their programs. Both agencies said they wanted to be sure that recipients could only buy products and services that were themselves healthy. Thus, Florida Medicaid recipients can use their reward money to buy approved pharmacy products not covered by Medicaid such as cough medicine, vitamins, dental supplies, first aid, and other specified over-the-counter products. All pharmacies that accept Medicaid are able to redeem the reward payments from recipients' accounts using the existing Medicaid pharmacy point-of-sale system.

While the state Medicaid agency had expected that recipients would be able to use reward money to pay for health care costs not covered by Medicaid, developing a debit card that limited the types of acceptable purchases would have taken longer than the Medicaid reform implementation time frame allowed. As a result, the state decided to use the existing pharmacy billing system so recipients could buy over-the-counter (OTC) pharmacy products. A limited debit card is to be introduced some time in the future.

The Idaho Medicaid agency wanted recipients to be able to use reward money to pay for health related courses, gym memberships, tobacco cessation supplies, and sports equipment for participating in a sports activity. To facilitate that much flexibility, the agency worked to develop community partners willing to accept recipient vouchers that can then be billed to Medicaid. Participants can request vouchers to buy health-related supplies or enroll in a health program by calling the agency. For children who are not up to date on their premium payments, the incentive balance is automatically allocated to covering the premium cost.

Respondents who were surveyed showed no consistent preference between rewards in the form of OTC pharmacy products and payment of health care costs not covered by Medicaid. More respondents said their child would enroll in an exercise program when the reward was payment for the sports program. And that sentiment was echoed in focus groups.

The researchers found that educating recipients about the incentive programs is a challenge given the population's low literacy skills and the difficulty in reaching many recipients by mail. Florida staff said introducing the program was a greater challenge than they expected because the program differs fundamentally from other Medicaid initiatives.

The report says both Florida and Idaho had the foresight to separate education on the incentive program from education on overall Medicaid reform, thus reducing the sheer quantity of information recipients had to process. Both states relied on recipient mailings to introduce the program. Despite developing materials at a fourth-grade reading level and doing some pretesting with recipients, the Florida Medicaid agency found there was substantial confusion over the universal form included in the mailing. The form is used to document enrollment in a health-related program, but a number of recipients used it to try to enroll in the incentive program (for which enrollment is automatic). The agency no longer includes this form with the incentive program mailings and has made some changes to improve the clarity of written materials.

Both states established call centers for fielding incentive program calls and have made key program documents available on the Internet. "At this juncture, it is unclear whether the current efforts will adequately inform recipients about the incentive programs," Ms. Greene says. "Without recipient awareness and understanding of the incentive program, offering rewards will not be effective for catalyzing promotion of healthy behaviors. One recommendation is to use periodic account balance mailings as an opportunity

to reinforce the key components of the program."

The states have found it is easier to track wellness visits than lifestyle behavior changes. Both states are providing incentives for children who have an annual well-child checkup and are up-to-date on immunizations. These types of behaviors plus screening tests and other preventive visits are easily identified using CPT codes in claims data.

While changing lifestyle behaviors such as tobacco use and physical activity levels hold the greatest potential for Medicaid savings, there are no existing programs to track whether Medicaid recipients make lifestyle changes or participate in relevant programs to support change. "Tracking and rewarding behavioral accomplishments is far more difficult administratively than rewarding members who participate in programs that support behavioral change," Ms. Greene says. "Both Florida and Idaho have opted to reward participation in such programs. Both have developed forms that require program representative signature (and in one case a physician signature) to serve as triggers for crediting recipients' accounts."

Florida was able to take advantage of its existing pharmacy point-of-sale system for the incentive program. An account was established for each recipient with only minor adjustments needed to the existing system. The system was easy to implement, the researchers found, and the result was that Florida recipients were able to purchase OTC pharmacy products with their reward money using their Medicaid card. There are limitations, however. If, for instance, the agency wants to increase the reward level for a given behavior to try to increase participation, it is questionable how much money to buy pharmacy products would be attractive to recipients.

In contrast, Idaho was unable to create an electronic billing system for the incentive program. They have developed a manual billing process in which recipients present a voucher to a participating vendor. The vendor submits the voucher to Medicaid to be reimbursed for the cost of services. The report says the Medicaid agency has faced some difficulty in getting major national chain pharmacies and stores to be willing to become program vendors because of the paper process.

The researchers suggest that when states develop incentive programs, they should be mindful of barriers Medicaid recipients face in engaging in healthy lifestyles. There were three key barriers repeatedly mentioned in parent focus groups and surveys in Florida—accessing dental services, transportation, and the high cost of sports-related programs.

Ms. Greene tells *SHW* the type of incentive program states use will likely vary from state to state depending on local needs and conditions. However, she says, there can be learning from one state to another in terms of recipient education, barriers to participation, and the options that are available for different types of programs.

In looking at key success factors in implementing an incentive program, Ms. Greene cautions against underestimating the difficulty involved in getting recipients aware of the program and how it operates.

"The reality is that there are a lot of dimensions we don't know enough about," she says. "We don't know how much a reward needs to be to be effective and what services recipients should be able to purchase."

Because so little is known about the long-term impact of incentive programs and whether recipients continue their healthy behavior after the incentive is removed, she says it's very important that all programs be evaluated. Noting that many states believe they don't have the time or resources to support evaluations, Ms. Greene says it would be nice if federal waivers would include an evaluation requirement.

Download the report from www.chcs.org/publications3960/publications_show.htm?doc_id=507380. Contact Ms. Greene at (541) 346-0138 or e-mail jessicag@uoregon.edu. ■

Medical 'homes' improve access, quality, and equity

Responses to the Commonwealth Fund's 2006 Health Care Quality Survey demonstrate the importance of having stable insurance, a regular health care provider, and a medical home for improving health care access and quality among vulnerable populations. Over the past 20 years, the survey report says, much work has been done to identify and develop a set of indicators to best capture components of a medical home. The report defines a medical home as a health care setting that provides patients with timely, well-organized care and enhanced access to providers.

The concept of a medical home was first introduced by the American Academy of Pediatrics and has been described as a place where health care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In medical home practices, the report says, patients develop relationships with their providers and work with them to maintain a healthy lifestyle and coordinate preventive and ongoing health services.

Survey respondents who say they have a medical home reported four key features: they have a regular provider or place of care, they have no difficulty reaching their provider by phone; they have no difficulty getting advice or care on weekends or evenings; and they say their office visits are always well organized and on schedule.

Only 27% of adults ages 18-64 reported having all four indicators of a medical home. The survey report says many providers don't offer medical care or advice during weekends or evenings. Thus, only two-thirds of adults who report having a regular provider or source of care say it is easy to get care or advice after hours. And compared with other populations, Hispanics are least likely to have access to after-hours care.

Among adults who have a regular doctor or source of care, African Americans are most likely to have a medical home that provides enhanced access to physicians and well-organized care. Some 34% of African Americans have a medical home, compared with 28% of whites, 26% of Asian Americans, and just 15% of Hispanics.

Uninsured least likely to have one

The uninsured are the least likely to have a medical home. Only 16% of the uninsured receive care through a medical home and 45% don't have a regular source of care.

The vast majority of adults with a medical home (74%) always get the care they need, compared with 52% of those who have a regular provider but don't have a medical home, and 38% without any regular source of care or provider.

The researchers say when minorities have a medical home, racial and ethnic differences in terms of access to medical care disappear. Some 75% of whites, African Americans, and Hispanics with medical homes reporting getting the care they need when they need it.

The survey also found that using reminders for preventive care is associated with higher rates of preventive screening. The use of reminders substantially increases the rates of routine preventive screenings, such as cholesterol screening, breast cancer screening, and prostate cancer screening, it says. Thus, 82% of adults who received a reminder had their cholesterol checked in the past five years, compared with 50% of adults who did not get a reminder. Men who received a reminder were screened for prostate cancer at twice the rate (70%) of those who did not get a reminder (37%).

When minorities have a medical home, the researchers said, their access to preventive care improves substantially. Regardless of race or ethnicity, about two-thirds of all adults who have a medical home receive preventive care reminders.

More than half of insured adults (54%) received a reminder from a doctor's office to schedule a preventive visit, compared with only 36% of uninsured adults. When minority populations are insured, they are just as likely as white adults to receive reminders to schedule preventive care. Even among the uninsured, having a medical home affects whether patients receive preventive care reminders. Two-thirds of both insured and uninsured adults with medical homes receive preventive care reminders, compared with half of insured and uninsured adults without medical homes.

The researchers report that adults with medical homes are better prepared to manage their chronic conditions and have better health outcomes than those lacking a medical home. Only 23% of adults with a medical home report their doctor or doctor's office did not give them a plan to manage their care at home, compared with 65% of adults who lack a regular source of care.

Thus, among hypertensive adults, 42% of those with a medical home reported that they regularly check their blood pressure and that it is well controlled, while only 25% of hypertensive adults with a regular source of care, but not a medical home, reported this. Likewise, adults with a medical home reported better coordination between their regular providers and specialists. Among those who saw a specialist, 75% said their regular doctor helped them decide whom to see and communicated with the specialist about their medical history, compared with 58% of adults without a medical home.

Unfortunately, the researchers say, community health centers and public clinics, which care for many uninsured, low-income, and minority adults, are less likely than private doctors' offices to have features of a medical home. Patients who use community health centers or private clinics as their usual source of care are less likely than those who use private doctors' offices to have a medical home. Only 21% of adults using community health centers or public clinics reported that they have a regular doctor, have no difficulty contacting their provider by telephone or getting care or medical advice on weekends or evenings, and reported that their doctors' visits are always well organized and running on time. In contrast, 32% of patients who use private doctors' offices reported all features of a medical home.

Difficulty in getting medical advice or care in the evenings or on weekends is more pervasive in community health centers and public clinics than in private doctors' offices or clinics, they say.

The researchers say the survey results "suggest that all providers should take steps to help create

medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes, as they care for patients regardless of ability to pay. Improving the quality of health care delivered by safety net providers can have a significant impact on disparities by promoting equity and ensuring access to high-quality care.

Lead researcher **Anne Beal**, MD, Commonwealth Fund assistant vice president for the Program on Quality of Care for Underserved Populations, tells *State Health Watch* that a major problem in providing a medical home for more people is that the current reimbursement system doesn't encourage that sort of wraparound services in a fee-for-service environment. "Conceptually," she says, "providers have wanted to provide medical homes to their patients for some time."

Incentives toward providing medical homes, Dr. Beal says, will come from insurers, contracts with major purchasers, patients who voice expectations for a particular standard of care, and providers who are looking for a better way to practice medicine.

She says some demonstration projects through the Centers for Medicare & Medicaid Services show "real promise." However, Dr. Beal notes that all plans need to become involved in providing incentives and support for medical homes because doctors often work with five or six plans and could not provide a medical home for some patients but not for others. "To work," she says, "the entire practice will have to go through a system redesign.

Asked to comment on the Commonwealth Fund recommendation that community health centers do more to become a medical home for patients, National Association of Community Health Centers senior vice president **Dan Hawkins** tells *State Health Watch* the report points out how much all providers, including community health centers, have to do to become true medical homes.

"The nation's community health centers welcome this report, in particular because it states in the clearest terms that achieving equity in health care involves both the availability of affordable comprehensive insurance coverage and the presence of a committed, regular source of care," he says.

Centers 'shine' in some areas

Wile community health centers applaud the report and its findings, they are concerned that in the analysis they were lumped together with other public clinics that may not be able to share community health centers' commitment to being a medical home, Mr. Hawkins says. "Clinics rely on volunteer staff, for instance, and may not be able to provide all the attributes of a medical home," he says. Thus, while there was criticism of community health centers for not providing after-hours care, Mr. Hawkins says it is a requirement of the community health center program that they have coverage after hours. He said that is an item that is evaluated as part of funding grants to the centers and all centers in the program have arrangements for after-hours coverage and admitting relationships with one or more hospitals.

"With 40% of health center patients uninsured, securing such services is often difficult," Mr. Hawkins says, "because centers don't have the resources to pay for services that are provided to their patients."

He also says he wished the Commonwealth Fund had looked at other factors that have been recommended by physician groups as being part of a medical home. One such factor that centers excel at, he says, is providing care continuously over time and across changes in health status and insurance coverage. "Health Centers shine on those criteria," Mr. Hawkins tells *SHW*. Another important criteria, he says, is that a medical home is linked with other health care services in a community. He notes that most community health centers now provide dental care and mental health services on-site and also have close relationships with other community services such as job training and enrollment in social service programs.

Download the Commonwealth Fund report at www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814. Contact Dr. Beal at (212) 606-3854. Contact Mr. Hawkins at (301) 347-0400. ■

SCHIP sails on with a narrow focus

Founded in 1997, the State Children's Health Insurance Program (SCHIP) has evolved from broad-based efforts to raise general program awareness to a tighter focus on specific hard-to-reach groups, researchers report.

A new Mathematica Policy Research survey of the evolution of SCHIP outreach efforts has lessons learned that policy-makers can apply to other public health care programs as well.[1]

Mathematica researchers **Susan Williams** and **Margo Rosenbach** report that over the years, states have shown creativity and adaptability in developing a wide range of strategies to promote SCHIP enrollment, including providing assistance in the application process and educating families about

appropriate use of services.

"As the program has matured and the fiscal environment has tightened, states have learned what efforts are successful and have tailored their approaches accordingly," they report.

Before SCHIP was enacted by Congress, states did little to actively market Medicaid or other public programs to children and adults. But Title XXI explicitly gave states limited funds for administrative costs, including marketing activities. And the legislation required states to describe outreach efforts in their plans and to document their progress in annual reports.

The initial efforts at state and local levels were intended to educate families about SCHIP, answer their questions, and assist them with program enrollment. Later, using evidence from focus groups, hotline referrals, surveys, and other sources, states learned important lessons about how to reach eligible uninsured children and their families. Responding to the lessons learned, they shifted from broad efforts intended to establish name recognition to more targeted approaches directed at families who were eligible but not enrolled.

Closing gaps

In a report published in *Health Care Financing Review*, Ms. Williams and Ms. Rosenbach give the first national assessment of how states have adapted their outreach campaigns to close the gaps in reaching hard-to-reach populations, looking at target populations, messages, communication methods, and organizational strategy. They note that early evidence about the large proportion of uninsured children who were potentially eligible for Medicaid but not enrolled reinforced the need for effective outreach for SCHIP as well as Medicaid.

So outreach could become entrenched at the grass-roots level, many states established funding mechanisms to help community-based organizations conduct outreach.

Gaining access to families

Many states also found that outstationing their workers to conduct outreach and application assistance at community-based organizations, schools, or health-care provider sites gave them access to families who were eligible but not enrolled.

In addition to reaching out in different ways to those who were eligible for SCHIP but were not enrolled, states saw a need to ensure timely renewal and appropriate use of services for current SCHIP enrollees. Communication with current enrollees has become known as "inreach" and is a key to improving retention.

The analysts say studies have shown that roughly 50% of all enrolled families drop coverage during the renewal period, even though they continue to qualify under a state's eligibility criteria. "Some experts suggest that helping those who already have insurance retain their coverage may be an important and cost-effective method not only for reducing the uninsured rate, but for improving the continuity and quality of people's health care," they say. "States have found that it is less expensive to retain eligible enrollees than to have them drop off the program and later reapply after a break in coverage. In addition, continuous coverage through SCHIP saves money because enrollees use fewer services over time."

Enrollment freezes heightened the need for clear communication to families in states that were not able to maintain open enrollment due to fiscal constraints, the study found. Seven states—Alabama, Colorado, Florida, Maryland, Montana, North Carolina, and Utah—froze SCHIP enrollment at differing points in time. While some of the states discontinued outreach efforts, others redirected communication efforts to inform current enrollees about the freeze to ensure they protected their eligibility.

The researchers say the ongoing evolution of SCHIP outreach has had a spillover effect on traditional Medicaid enrollment. State refinement of messages to emphasize eligibility for and the value of health insurance led not only to increased SCHIP enrollment, but also to increased Medicaid enrollment. Many families who applied for SCHIP coverage were found to be eligible for Medicaid, thereby increasing overall rates of public insurance coverage.

Learning from experience

While there hasn't been any formal

evaluation of SCHIP outreach effectiveness, Ms. Williams and Ms. Rosenbach say their study has shown how states assessed their own efforts and learned from their experiences. They say that for policy-makers seeking to increase enrollment in other public programs, such as the Medicare prescription drug program, such a longitudinal assessment of state efforts under SCHIP provides valuable lessons. Thus, early outreach efforts may include universal strategies to reach the general population, whereas later efforts may involve selected strategies aimed at specific, high-priority populations.

To better gauge the effectiveness of state outreach strategies under SCHIP, they say, future research is needed to explore quantitative approaches that can be used to measure the impact of outreach strategies on enrollment rates overall and within specific target populations. Thus, because most states have used statewide mass media and local one-on-one outreach efforts in combination with each other, little is known about the relative success of the strategies. Little also is known about the return-on-investment of specific outreach strategies relative to various enrollment simplifications such as using joint applications, mail-in or Internet applications, or reduction of documentation requirements.

Reference

1. Williams SR, Rosenbach ML. Evolution of state outreach efforts under SCHIP. *Healthcare Financing Review* 2007; 28(4):95-107. ■

Program helps docs improve prescribing for Medicaid patients

A program funded by Eli Lilly in 19 states is improving the quality of care Medicaid patients receive by aligning physician prescribing of mental health medications with national, evidence-based best prescribing practices.

The Behavioral Health Pharmacy Management Program, carried out by Comprehensive NeuroScience Inc. and state agencies, evaluates Medicaid pharmacy claims for all mental health medications to identify prescribing patterns that are inconsistent with national evidence-based prescribing practices. The program educates doctors who deviate from the best practices.

Some of the inconsistent prescribing patterns addressed include duplicative prescribing of medication by different doctors for the same patient; premature, rapid switching from one medication to another; failure of patients to fill their prescriptions in a timely manner; prescribing multiple medications from the same therapeutic class; and prescribing above or below recommended dosing levels.

Since its implementation, the program has resulted in 190,000 prescriber and 1.3 million patient care improvement interventions nationwide. In addition to information about specific patients, doctors receive regular information bulletins about special topics related to mental health medications, such as behavioral health medication for children. Doctors who continue to experience the same issues over time are offered a peer consultation to discuss prescribing practices.

"We know that educating physicians on prescribing patterns for drugs that treat mental illness is an excellent way to improve the overall quality of mental health treatment within our Medicaid program," says Michigan Department of Community Health director **Janet Olszewski**. "Through this project, many opportunities for coordination of care have been identified, resulting in improved quality of care and enhanced quality of life for [people] with mental illness."

Each program is customized to meet the needs of the participating states. Comprehensive NeuroScience provides these examples of program results:

• **Michigan**. The Michigan Department of Community Health's Pharmacy Quality Improvement Project demonstrated improvement in the quality of care provided to Michigan patients with mental illness. The project is planned as a three-year educational program that analyzes the prescribing of mental health medications for Medicaid adult and child members and identifies prescribing patterns that are inconsistent with evidence-based guidelines. An impact analysis was performed comparing claims cost before and after the program and showed a 22% reduction in claims and a 21% reduction in cost from May 2005 through January 2006.

• **Missouri**. An analysis of the Missouri Mental Health Medicaid Pharmacy Partnership Program covered 1,911 Medicaid recipients whose physicians received notification for at least one of the program's quality indicators during two consecutive written communications. Individuals similar to those patients were selected for a comparison group. The study compared the two groups six months pre-intervention and six months post-intervention.

The researchers found that hospital admissions for those in the intervention group decreased by 43%, compared to a 1% decrease in the comparison group. A 1,813 decrease in total hospital days was recorded

for the intervention group, compared to a 688-day decrease in the comparison group. And a $1,238 decrease in cost per person for the intervention group was seen, compared to a $312 decrease in the comparison group.

"We had two landmark findings," says Missouri Department of Mental Health chief clinical officer **Joseph Parks**. "First, that focusing on improving quality really is an effective way to control costs. And second, even though we were only focusing on improving prescription practices for psychiatric medications, we found greater savings in reductions of costs of hospitalization, outpatient treatment, and other medications. You really have to look at the total health care impact to understand what a difference improving quality can make. The partnership is a model for reducing hospitalizations, containing pharmacy costs, improving prescribing practices, and maintaining open access to psychiatric medications through collaboration and education."

• **New Jersey.** The New Jersey HealthyLiving Behavioral Pharmacy Management program is a collaborative project within the state's Department of Human Services Division of Medical Assistance and Health Services and the Division of Mental Health Services. Although the program has just started, positive trends reportedly have been seen in the area of children's mental health. ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Nebraska may up newborn testing, restrict opt-outs

LINCOLN—Nebraska is poised to dramatically increase the number of diseases for which newborns are screened, all the while holding fast to a policy that forbids parents from opting out of the testing. The state Department of Health and Human Services is considering a proposal that would increase from eight to 26 the number of diseases for which newborns are tested. Currently, 41 states screen for more than 20 disorders. Nebraska is one of a handful of states that does not allow parents to decline newborn testing. Some parents object on religious grounds to the tests, which require five drops of blood drawn from a heel. Parents have recently pushed, to no avail, for lawmakers to give them the same choice to opt out that is offered in most other states. Over the last few years they have lost two court cases challenging the rule, and a bill before lawmakers last session fizzled. "The child's protection comes first, and the state has a right and obligation to protect the child," said **Julie Miller**, manager of the state's newborn screening and genetics program.

—Associated Press, 8/27/07

Kansas taps inspector to detect Medicaid fraud

Topeka, Kansas — When Kansas legislators earlier this year came up with a package of health care reforms, it included the creation of an inspector general to root out Medicaid waste and fraud. The Kansas Health Policy Authority Board has hired Robin J. Kempf as inspector general to audit, investigate, and conduct performance reviews for the Medicaid program, MediKan and the State Children's Health Insurance Program. "The health policy authority takes very seriously its role as good stewards of state resources. With Robin's experience and knowledge, she will make an excellent asset to our team as we work to improve health and health care in Kansas," said **Marci Nielson**, the authority's executive director. Kempf's position must be confirmed by the Senate after the legislature convenes in January. She has been associate general counsel for the Kansas Board of Regents since 2005, a role she also played from 2001 to 2003. Before Ms. Kempf's work with the board, she was a university professor in China and an auditor for the Kansas Legislative Division of Post Audit. The authority was set up in 2005 to review health care issues and oversees all health insurance purchasing plans for the state, including Medicaid, MediKan, and children's insurance. It also is drafting health reform options for the Legislature next year.

Medicaid, which provides insurance for people with low incomes, averages about 250,000 people a month. There are about 4,000 people enrolled in MediKan, which covers adults with disabilities who don't qualify for Medicaid but are eligible for services under the state general assistance program. It also provides limited medical benefits for those whose applications for federal disability are being reviewed.

The children's insurance program provides health coverage for youngsters who don't qualify for Medicaid and has about 35,000 participants. Medicaid covers children younger than 18 in homes where family income is up to 100% of the federal poverty level—$20,650 for a family of four. The insurance program covers up to 200% of the poverty level.

—Associated Press, 8/21/07

Will universal health coverage be a reality in New York State?

ALBANY — New York Gov.

Eliot Spitzer's administration will hold five public hearings on providing universal health insurance coverage in New York, which has about 2.5 million residents without it and spends more per person on medical care than any other state. Spitzer announced in January that his administration would develop a plan for affordable health insurance for everyone. At the same time, the state is seeking a consultant to analyze proposals. A panel of experts will help the insurance and health commissioners, who are required to submit recommendations to the governor by May 31, 2008.

"We must ensure that we spend our health care dollars efficiently and effectively so that every New Yorker can afford health insurance and access the quality of care they need to live longer and healthier lives," **Richard Daines**, MD, health commissioner, said in a statement. But the key question will be how New York pays for it.

"Really the trick is going to be, as we all understand, is how we finance it," said **William Van Slyke**, a spokesman for the Healthcare Association of New York State, which supports the concept of universal coverage. "Everybody that's got a hand in this has got to be part of the solution," said Van Slyke, whose organization represents hospitals and health systems.

According to census data from 2006, 16.5 million New Yorkers have health insurance coverage and 9.3 million of them are in employer-sponsored plans. More than 7.2 million people are in government health care programs. About 400,000 people purchase insurance przivately. The New York Health Plan Association, which represents managed health plans, thinks the state should reform requirements for products in the individual and small-group health insurance markets to make them more flexible and look at the use of taxes and surcharges to finance the system, said spokeswoman **Leslie Moran**.

United Hospital Fund president **James Tallon**, one of the experts, said capturing the 2.5 million uninsured people is urgent for the health care system, and few issues are more important in economic development than health care costs. The fund is a health care research and policy group. "Uninsured people are a huge structural flaw in the health care system because they generate costs without a source of paying for them," he said.

Other experts on the panel are Mark Scherzer, legislative counsel for New Yorkers for Accessible Health Coverage; Stan Lundine, former lieutenant governor under ex-Gov. Mario Cuomo, a Democrat; and attorney Elizabeth Moore, a partner with Nixon Peabody and former counsel for Cuomo. The web site for development of the plan is www.partnership4coverage.ny.gov.

—Rochester Democrat and Chronicle, 8/15/07 ■