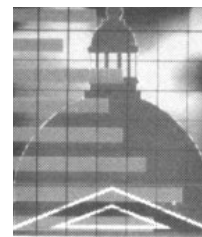


HEALTH POLICY

On Target



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The Information for State Health Policy Program is a national program supported by The Robert Wood Johnson Foundation

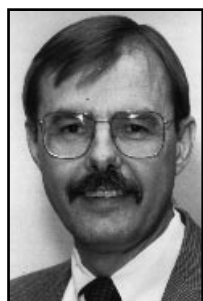
An Interview with Doug Nelson Executive Director, Annie E. Casey Foundation

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Douglas W. Nelson is Executive Director of the Annie E. Casey Foundation and a member of its Board of Trustees. Prior to joining the Foundation in late 1990, he was Deputy Director of the Center for the Study of Social Policy, a Washington, D.C.-based non-profit organization specializing in policy services to children and families. He came to that position after eight years with the Wisconsin government, first as the State Aging Director and later as Assistant Secretary of the umbrella Department of Health and Social Services. He is nationally known for his leadership and advocacy on behalf of family-centered, community-based responses to the needs of at-risk children, vulnerable families, and persons with disabilities. Nelson was appointed by President Carter as an advisor to the 1981 White House Conference on Aging. He has also served as a member of the American Bar Association's Commission on the Legal Problems of the Elderly; as advisor to the National Governors' Association project on Long-Term Care; as a trustee of the Wisconsin Child Abuse and Neglect Trust Fund; and as a program advisor to the Edna McConnell Clark Foundation. In addition, he has served on numerous other boards and commissions.

A frequent lecturer, Nelson has also written widely on a range of social policy issues. Nelson's published works include studies and essays on aging, long-term care, housing, and children and youth.

Mr. Nelson is a graduate of the University of Illinois. He has a Masters Degree in history from the University of Wyoming, and he studied and taught American social history at the University of Wisconsin.

As president of the Annie E. Casey Foundation, what role do you see health information playing in the formulation of state health and human service policy, and how does this role relate to your grantees?

Because of our interest in disadvantaged children and families, the Casey Foundation has always emphasized the critical importance of highly reliable data on health status, health outcomes, and access to health care. Indeed, one of our major goals has been to improve the access to quality care of those groups who are at greatest risk of poor health outcomes -- and that goal can't be achieved without rich and timely data on trends in health status.

As state policy makers assume an increased responsibility for determining and implementing health and human service policy, what role do you believe public interest and advocacy groups and their coalitions should play in determining community and state health and human service priorities?

The dramatic changes now occurring in federal, state, and private health care finance and organization make it imperative that advocates for children redouble their support for objective and comprehensive measures of health status and well-being. This is critical not only for identifying state level policies that negatively impact health outcomes for some vulnerable groups, but also for highlighting and

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NEW PARTNERSHIPS FOSTERED THROUGH WISCONSIN InfoSHP PROGRAM



Ann J. Haney
(Former) Administrator
Wisconsin Division
of Health

I am pleased to provide leadership for the Wisconsin Information for State Health Policy (InfoSHP) Program, which is playing an important role in improving information and use availability for resolving public health policy issues in the state. During its first year, Wisconsin's

InfoSHP Program has been instrumental in creating new working relationships among many diverse groups that are active in health policy and program formation in the state.

We began the InfoSHP Program in Wisconsin by convening a broad-based advisory group to clarify the Program's focus. This advisory group includes the health policy advisor to Governor Tommy G. Thompson, the majority leaders and ranking minority members of the Wisconsin Senate and Assembly health committees, representatives from state agencies that have health-related interests, members of advocacy groups, the university community, business coalitions, and health-care providers.

Based on the efforts of the advisory group, Wisconsin's InfoSHP Program's activities have focused on three broad priority areas:

Pregnant Woman and Infants: The program seeks the coordination of public and private sector efforts to reduce acute care needs by increasing prevention and primary care services and outreach.

Children Ages 1-17: The program seeks the coordination of public and private sector efforts to reduce acute care needs by increasing prevention and primary care services and outreach.

Individuals of all ages with chronic conditions: The program seeks the appropriate use of long-term care services for these individuals.

To address these priority areas, the Center for Health Statistics in the Division of Health (the entity that produces information needed to resolve Public Health Policy issues) is working closely with 10 activity-specific workgroups whose membership includes a wide variety of health policy makers and program managers (the decision makers in the Public Health Policy debate). Currently numbering about 200, workgroup members were selected by, or in many cases, are participants of the formative advisory group. Their collaborative efforts involve the kinds of activities highlighted below:

1. Existing data systems are being modified, new data systems are being developed, and relevant databases constructed by other agencies are being identified and obtained to improve the scope and availability of information available to decision-makers.
2. Linked databases are being developed for each of the three priority areas to provide information about people rather than events (person specific information). This involves working closely with agencies responsible for the linked databases' individual components.
3. Project staff are working with decision-makers to shape the content, format and timing of statewide information products as new data become available.
4. Community-based profiles are being developed for each of the priority areas in response to decision-makers' needs for local-area information.
5. Project staff are working with urban and rural communities as they begin to use profile information and other sources to enhance local decision making in an effort to assess the usefulness of, and further refine the community profiles.

Two examples of fruitful collaboration between those who produce information and the decision-makers who use it are described in the articles that follow.

- The first involves a partnership between the Center for Health Statistics and local decision-makers in two areas of the state to examine hospitalization rates as indicators of local primary care needs. In this first effort, CHS staff showed that several areas of the state (both urban and rural) had high rates of "preventable

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MediGrants and Public Health: A New Paradigm

It appears that change is afoot for the Nation's Medicaid program: responsibility is shifting from the federal to the state level. While state policy makers and providers alike applaud the move—because it puts the operation of the Medicaid program a giant step closer to the populations it serves—public interest and advocacy groups are concerned with the transition and insist on accountability of the system. All are aware the implementation will have aches and pains. The states will now bear the significant burden of assuring the expenditure improves or maintains the desired outcomes. Certainly this can not be accomplished nor effectively monitored without the development of new information systems that link enrollment with outcomes while guaranteeing privacy for the individual.

While the exact nature of the administrative responsibilities states will inherit for the Medicaid program is yet unclear, there is little doubt that success will be measured by targeted outcomes. What will it take to amass the right information to define the eligible population, to define the required minimal services, and to set priorities for desired outcomes? Current systems are categorical: they tell us about costs and services not outcomes!

States will need to form public private partnerships that bring together the key players: Providers, health plans, public interest groups, various executive agencies and legislative committees to determine the desired health needs and outcomes. Information systems will be required to help assure that desired outcomes are achieved and that costs are not transferred to the public in the form of increased public and mental health costs or local property taxes.

MEDICAID MANAGED CARE AND MATERNAL AND CHILD HEALTH OBJECTIVES FOR THE YEAR 2000: Harnessing The Power of Linked Databases to Measure Outcomes According to Insurance Status

Richard Aronson, Peggy Bartels, Susan LaFlash, and Pat Guhleman

As managed care is implemented to control costs in Medicaid (Medical Assistance) Programs across the country, efforts to determine the effect on the health status of eligible women and children have been hindered by insufficient data.

The Wisconsin Medicaid Program initiated a managed care program on a limited basis in 1983. Today, all women and children who receive Aid to Families with Dependent Children (AFDC), disabled non-institutionalized adults, and elderly persons who are Medicaid recipients have the option to receive care either through Health Maintenance Organizations (HMOs) or the more traditional fee-for-service delivery systems. In 1995, the Wisconsin Medicaid Program provided 150,000 recipients in five counties (including all Medicaid/AFDC recipients in Milwaukee County) with health care through HMOs.

The Wisconsin Medicaid Program spends \$204 Million per year on managed care and approximately \$20 million per year is saved by enrolling recipients in managed care programs rather than providing care on a fee-for-service basis. In fact, Wisconsin is nationally recognized for its managed care quality assurance program and effective cost containment. Program goals include assured access to medically necessary health services,

improved quality care, recipient satisfaction and savings to taxpayers.

To measure the progress toward meeting these program goals, the Wisconsin Medicaid Program requires the HMOs with which it contracts to report quarterly and annually on the provision of services, with special emphasis on maternal and child health services. As part of its overall quality assurance and improvement system, Wisconsin uses the self-reported HMO data and fee-for-service claims data to measure and

compare provision in these programs. The results demonstrate that HMOs in Wisconsin provide primary and preventive care to Medicaid recipients more effectively than the fee-for-service sector. (See Figure 2.)

Wisconsin is now tracking its progress toward meeting public health objectives for the Year 2000 through a project that measures

health outcomes among population groups according to insurance status. Much of the information for monitoring this progress comes from several linked databases, including birth and death records; hospital inpatient discharge reports; and Medicaid claims, HMO data and eligibility files. (See Figure 3.)

Begun in 1992, the project was initiated by the Division of Health as a collaborative effort involving its Bureau of Health Care Financing, Medicaid/Managed Care Program; the Bureau of Public Health, Maternal and Child Care Section, and the

Wisconsin HMO/FFS Report

- Compares AFDC Populations in HMOs and FFS
- Uses Claims Data (FFS) and Utilization Data (HMOs)
- Targets Key Maternal and Child Health Services:
 - ✓ Immunizations
 - ✓ Healthcheck (EPSDT) Screens
 - ✓ Primary and Specialty Care
 - ✓ Prenatal Care

Figure 2

(continued on page 4)

Objectives for the Year 2000

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Center for Health Statistics. The purpose of the project is to measure the outcomes for selected maternal and child health objectives from the document *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000*. This document was created in 1989 by an independent group of more than 150 individuals representing consumers, business persons, elected officials, health professionals, government and community advocates to address the most significant health risks in the state and improve the health status of Wisconsin citizens.

The Maternal Child Health objectives selected for the project include low birth weight, infant mortality, maternal cigarette smoking, suicides, and adolescent births. Information taken from the linked databases on these areas is compared according to insurance status (e.g. Medicaid fee-for-service; Medicaid managed care; private insurance; and, the uninsured). In addition, the project will use comparable data for the statewide population. (See Figure 4.)

Interpretation of the information gathered through this project requires an understanding of the following data-related issues:

- using multiple data sources to measure outcomes related to a particular objective;

- defining differences between the Medicaid managed care and fee-for-service populations;
- comparing the Medicaid population and other insurance categories; and
- relating objectives to available data.

The project covers the years 1991 through 2000 and will allow Wisconsin to form significant responses to critical questions about how specific groups (including Medicaid managed care recipients) fare relative to the rest of the state in terms of Maternal Child Health-related public health objectives.

This project provides vital answers to questions about the health status of certain populations. In addition, it demonstrates how linked databases, when properly harnessed, can be a powerful tool for measuring health outcomes. ■

The Wisconsin Medical Assistance Program is administered by the Bureau of Health Care Financing, Division of Health. The Center for Health Statistics and the Bureau of Public Health are also part of the Division of Health.



Figure 3

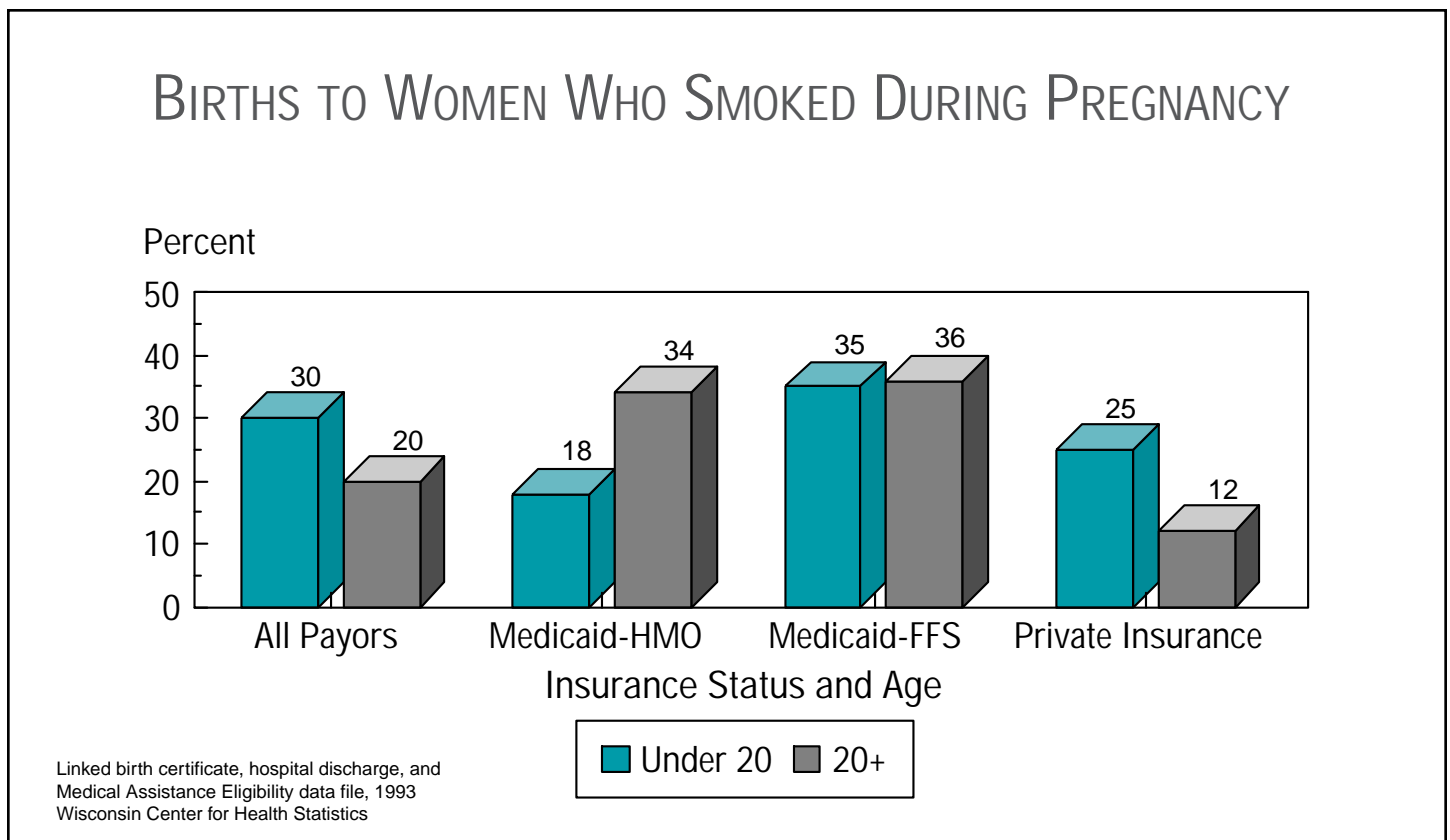


Figure 4

This publication is prepared by the National Program Office of the Information for State Health Policy Program under a grant from The Robert Wood Johnson Foundation. The purpose of the program is to strengthen state data infrastructures as well as facilitate interaction, discussion, presentation, and the dissemination of data to health policy makers for decision making.

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We would like to thank Mr. Doug Nelson and Ms. Ann Haney for their contribution to this effort. In addition, Mr. Dan Dwyer and the staff of the Division of Health and Human Services within the Division of Health in the State of Wisconsin provided valuable assistance to us in the preparation of this issue of *Health Policy On Target*.

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PARTNERSHIPS IN ACTION

*Daniel P. Dwyer, Ph.D., Director,
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Milwaukee, Wisconsin*

In the fall of 1991, I was invited to participate in an inter-agency workgroup (IWG) to guide the activities of a Robert Wood Johnson Foundation initiative in Wisconsin. The purpose of the Wisconsin Information for State Health Policy Program was to transform health "data" into "information" that would be meaningful to persons who work in the health care field. The goal of this workgroup was to establish a process through which health policy leaders could collaborate with health information specialists. Each would learn from the other: the information specialists would develop an understanding of the kinds of data, the necessary level of detail, and presentation methods that would enhance the application of information to policy and program development. Policy leaders would develop a clear understanding of the data available, its limitations, and how it could be used to develop a more coherent and focused health policies and programs.

As the director of a primary care clinic in a family practice residency training facility at St. Mary's Hospital in Milwaukee, and also the director of a research and development project at the same site, I am well acquainted with the fascination and frustrations that health data systems hold for researchers, policy makers, and health care practitioners. Data information about program successes, health care system shortfalls, changing demographics and the implications of new technologies – inform our policy proposals, programming decisions, network developments, facility planning, and research.

The inter-agency workgroup concept promised the opportunity to work with data specialists as they collect and package information, increasing the likelihood that the facts I received would be applicable to my work. For many reasons, data systems often fall short.

I am keenly interested in the ongoing application of the InfoSHP Program process as well as the development of information products identified through the IWG debates. One of the first applications of the InfoSHP Program approach of working with policy makers to define and present information for health policy development dealt with ambulatory-care-sensitive conditions. Staff of the Center for Health Statistics in the Wisconsin Division of Health, in concert with an IWG subcommittee and their health care provider and data specialists, developed indicators of the adequacy of primary care. In areas of the state where indicators suggested that primary care adequacy could be improved, staff presented their finding to local professionals working in community health, primary care and maternal/child health. The provider communities responded to this previously unavailable information by examining their practice patterns and procedures, and designing ways to more appropriately and less expensively meet the health care needs of their patients.

I have personally used the results of the InfoSHP Program study of ambulatory-care-sensitive conditions at the clinic to evaluate the effectiveness of our prevention programs and to assess the needs of our patient population as a community.

As we continue our collaborations, the inter-agency workgroup is maturing. Information system experts have come to understand the struggles of county health policy workers and the trials that confront home care nurses and long term care administrators. Clinic managers, physicians and health educators now better appreciate both the promise and the limitations of information technology. ■

The Interagency Working Group is composed of representatives from the Governor's Office, the Legislature, state agencies, public interest groups, and health care providers:

GOVERNOR'S OFFICE
Health Policy Advisor to the Governor

LEGISLATURE
Chair and ranking minority member for the Senate Health, Human Services, and Aging Committees
Chair and ranking minority member for the Assembly Health Committee

STATE AGENCIES
Department of Health and Social Services
Department of Development
Department of Public Instruction
Department of Regulations and Licensing
Office of the Commissioner of Insurance

PUBLIC INTEREST GROUPS
Black Health Coalition of Wisconsin
Center for Public Representation
Coalition of Wisconsin Aging Groups
Great Lakes Inter-Tribal Council
Hispanic and Migrant Services
Medical College of Wisconsin
University of Wisconsin-Madison Comprehensive Cancer Center
University of Wisconsin-Madison Medical School
University of Wisconsin-Milwaukee School of Nursing
Wisconsin Manufactures and Commerce
Wisconsin Maternal and Child Health Coalition
Wisconsin State AFL-CIO

HEALTH CARE PROVIDERS
Association of Wisconsin HMOs
Rural Wisconsin Hospital Cooperative
State Medical Society of Wisconsin
Wisconsin Association of Homes and Services for the Aging
Wisconsin Council of Local Public Health Administrators
Wisconsin County Human Service Association
Wisconsin Homecare Organization
Wisconsin Hospital Association
Wisconsin Nurses Association
Wisconsin Primary Health Care Association

Nelson Interview

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promoting those state initiatives that promise more positive impacts on at risk populations.

What role should public interest and health advocacy groups play in determining which information is required to monitor specific policy decisions?

Advocates should hold state policy makers accountable for knowing what is happening to the health and developmental status of a state's infants and children. At a minimum, this means having a capacity to measure over time trends in birth outcomes, in achievement of early childhood developmental milestones, in the incidence of preventable diseases, and in child and youth mortality rates. Moreover, states ought to collect this data in a manner that provides for the identification of trends in child health status by geography, race, and income level.

How have you as the President of a major philanthropy, used information to help you understand a policy issue and your options?

It's fair to say we have used information on the health status of children to define our Foundation's mission, our target groups and our strategic priorities. In an important sense, I like to think of the Casey Foundation as being in the business of promoting innovative public and private responses to these children and families that the data tells us are experiencing the poorest health and development outcomes.

Are there specific examples where health information has made a difference in your framing of a public policy response to an issue? Are there areas where state and community information could have facilitated deliberations if it were available, or had been presented in a more useful and timely form?

Data on health access and health outcomes have driven a significant number of the Casey Foundations initiatives and investments. Information

on the unmet or inefficiently met mental health needs of youth in distressed inner city neighborhoods, for example, is what inspired our Urban Children's Mental Health Initiative. Similarly, the data on sexual activity rates, STDs, and adolescent pregnancy shaped the Foundation's Plain Talk Initiative to protect the health and well-being of sexually active teenagers.

How can state data agencies and consortiums help community and state leaders monitor the effects of public policy and assure the system's effectiveness?

To be most useful for state and community policy makers, state health information systems need to be timely, longitudinal and geocodable in a way that supports neighborhood-level planning and action. Ideally, of course, health data sets should be designed to interface with other demographic and program information to enhance policy decisions about targeting and intervention design.

Given the recent trend for improved accountability in the delivery of services and measuring system performance, who should have the responsibility to provide quality information to consumers and the public? Who should be involved in this process? How can coalitions assure the information is used in the shaping of public policy?

It seems to me that states ought to be held responsible for assuring the collection of health status data (through both direct collection and reporting requirements on providers) on at least those commonly accepted measures of physical well-being (such as, pre-natal care, infant mortality, birth weight, modal childhood development measures, disease incidence, etc.). The role of public interest and advocacy groups is, first, to insist on the collection of this core data and then to assure its communication to citizens, the media, and policy makers. The state public/private coalitions that have become Kids Count grantees illustrate one way of trying to make sure this kind of information helps drive public policy.

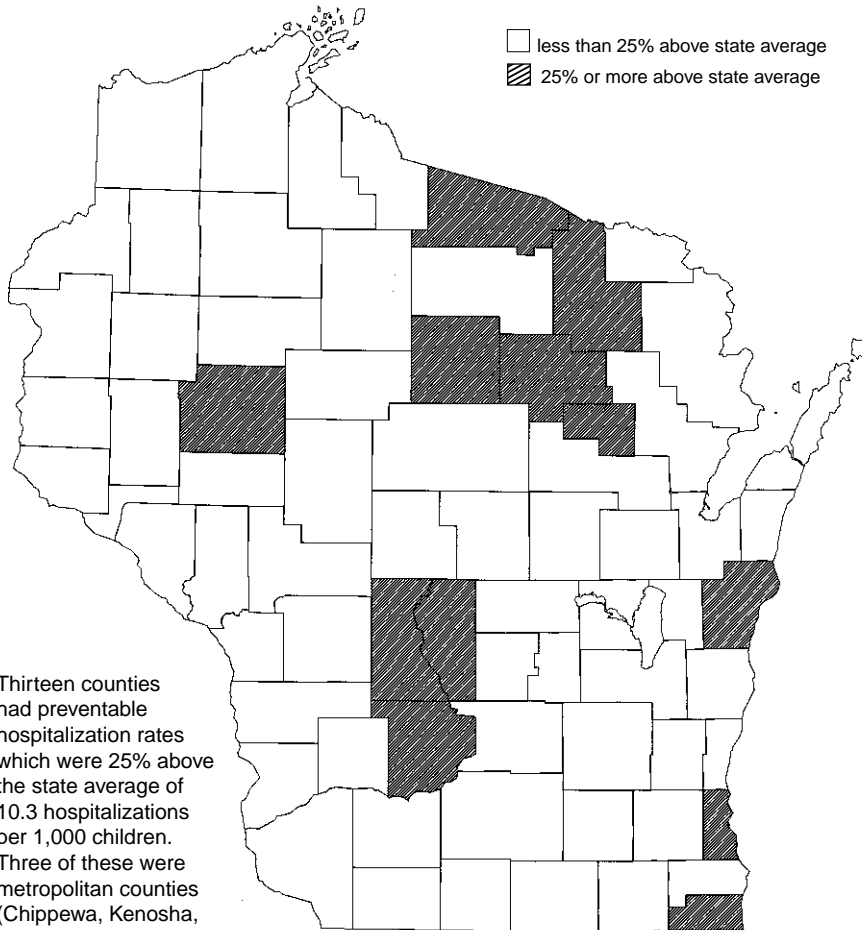
It appears the congress will delegate to the states responsibility for various federal programs under capped appropriations for Medicaid and block grants. What process would you like to see employed to hold states (or their designees) accountable for their performance? What process would you like to see employed to hold health plans and providers accountable?

In exchange for the new degree of flexibility and autonomy being extended to states, the Congress ought to require every state to provide some common core of data on care provided, eligibility, participation, and changes in health status and health outcomes. Without at least this minimum expectation for performance reporting, it's hard to see how the Federal government could pretend to have any accountability role for the expenditure of federal health care-related tax dollars. To assure access and quality of health care, states will need to monitor each health plan and each community for similar issues. The public will demand these same assurances from their elected state officials.

As we move deeper into the Information Age, there is a growing need to improve the communication of health information. What do you see as effective tools (electronic or written) or methods for the dissemination of this information? As a major funder of community organizations, what are your concerns about access to priority-setting information, and about monitoring effects of policy changes in states and communities?

There are all sorts of emerging electronic and on-line opportunities that should be encouraged to make more detailed health data more immediately available to health analysts, policy makers, advocates, and researchers. Nevertheless, it remains important for certain groups (like Kids Count grantees) to translate that data into conventional formats that are accessible and useful for broad public audiences. Locations and facilities that support timely access to both published materials and electronic queries by the public are needed in order to assure that their resources are being used wisely. ■

Preventable Hospitalization Rate by County of Residence for Children Under 18 Years of Age, Wisconsin 1993



Thirteen counties had preventable hospitalization rates which were 25% above the state average of 10.3 hospitalizations per 1,000 children. Three of these were metropolitan counties (Chippewa, Kenosha, and Milwaukee) while the rest were non-metropolitan counties.

Figure 1

hospitalizations” among children. (See Figure 1.) Preventable hospitalizations are hospitalizations for conditions that could be prevented or ameliorated with effective, accessible primary care. These results were then shared with local decision-makers in the high-rate areas, including clinic managers, public health nurses, hospital planners, and physicians, via user-friendly packages of information that featured charts, maps, and highlights of relevant findings. The decision-makers asked for further analysis of the information to “zero in” on the problems with primary care indicated by the

high hospitalization rates. This follow-up analysis is being used to target new efforts to improve primary care delivery in high rate areas.

- The second effort involves a collaboration among three state bureaus to assess Wisconsin’s progress toward meeting its public health objectives for the Year 2000, especially among the state’s Medical Assistance fee-for-service and managed-care populations. The second example involves a partnership among the Bureau of Health Care Financing (which administers the Wisconsin Medical Assistance

Program), the Bureau of Public Health (which is responsible for statewide planning of public health efforts in the state), and the Center for Health Statistics (the information producer). These three bureaus, all in the Division of Health, have different missions but share an ongoing interest in assessing and improving the health of Wisconsin citizens. In the past, the Bureau of Health Care Financing and the Bureau of Public Health (which both provide partial funding for some Center for Health Statistics data collection and analysis) have been involved in the Center for Health Statistics information production chiefly by reviewing outlines and drafts of articles and reports. However, through this InfoSHP Program-fostered partnership, staff of all three bureaus have worked together to take the many steps needed to assess progress toward meeting public health objectives for the special maternal and child health populations served by the Wisconsin Medical Assistance Program. Because Wisconsin has expanded the use of managed care for its Medical Assistance population, it has become especially important to assess how Maternal and Child Health indicators differ for the managed-care population vs. the fee-for-service population.

In both projects, analyses and information products have been designed and shaped to suit the needs of decision-makers. These initial efforts of the Wisconsin Information for State Health Policy Program are proving that it is possible to create collaborative working relationships between information producers and a wide variety of health decision-makers. As the State Health Officer for Wisconsin, I am convinced that these ongoing partnerships are crucial to making well-informed decisions in a health care climate of rapid and radical change. ■

Finding InfoSHP on the Web

Our full address is [HTTP://WWW2.UMDNJ.EDU.SHPP/HOMEPAGE.HTML/](http://WWW2.UMDNJ.EDU.SHPP/HOMEPAGE.HTML/)

Alternatively, our homepage may be located by searching the Web using Netscape or Mosaic in the following manner:

- 1 Search for: UMDNJ (Located at [HTTP:WWW.UMDNJ.EDU/](http://WWW.UMDNJ.EDU/))
- 2 Select UMDNJ Web Services
- 3 Select Schools
- 4 Within Schools, choose Robert Wood Johnson Medical School
- 5 Within the category Programs & Departments, choose Information for State Health Policy Program
- 6 Now set a bookmark so that you may easily find our location each time.

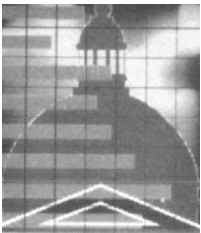
The *Robert Wood Johnson Foundation* and its *National Program Office* are pleased to announce the availability of the *Information for State Health Policy* homepage hosted within the University of Medicine and Dentistry of New Jersey.

The *Information for State Health Policy* site was created to increase awareness of the Information for State Health Policy program, to serve as model for the use of electronic communication to disseminate health information by state agencies, and to provide information on health issues and activities of this program's state grantees.

The *Information for State Health Policy* site is intended to help interested parties (inclusive of health care policy makers, state officials, health care employees, health providers, insurers, consumers, etc.) locate Model Reports and Standards for health statistical information, experience electronic query submittal, and locate related health information resources.

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