Approved: 1-19-99
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Sandy Praeger at 10:00 a.m. on January 14, 1999 in Room 526-S of the Capitol.

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Robert F. St Peter, M.D., Kansas Health Institute
Ed Fonner, Executive Director, Governor's Public Health Improvement Commission

Others attending: See attached list

Introduction of Bills

Carol Mcdonald, Kansas Dental Board, requested the Committee introduce legislation changing current statutes that would require establishing a practice location for Board notification, an increase in penalty fees for late license renewals, and requesting an appearance of a potential licensee before the Board.

After Committee discussion, Senator Langworthy made a motion the Committee introduce the proposed legislation, seconded by Senator Bleeker. The motion carried.

Senator Hardenburger requested the Committee introduce a Concurrent Resolution requesting the Governor to identify funds available for training and retaining of long-term care staff.

Senator Hardenburger made a motion the Committee introduce the proposed legislation, seconded by Senator Becker. The motion carried.

Kansas Health Institute

Robert F. St. Peter, M.D., briefed the Committee on what the Kansas Health Institute is planning to do in regard to evaluating HealthWave, the state's new Kansas Children's Health Insurance Program (CHIP) which became effective January 1, 1999. He outlined some of the areas of HealthWave that they would like to know about such as effectiveness of outreach and enrollment, adequacy of system structure and capacity, success of service delivery, and effect on children's health status as outlined in his written material to the Committee. (Attachment 1)

Governor's Public Health Improvement Commission

Edwin Fonner, Executive Director, Public Health Improvement Commission, briefed the Committee on two initiatives coordinated by state agencies: (1) the Public Health Improvement Plan, which is directed by the Governor's Commission and coordinated by the Kansas Department of Health and Environment; and (2) the State Initiatives in Health Care Reform program of the Robert Wood Johnson Foundation coordinated by the Department of Administration as outlined in his written testimony. (Attachment 2)

The meeting was adjourned at 11:00 a.m.

The next meeting date is scheduled for January 19, 1999.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 1-14-99

NAME	REPRESENTING
Carol MacDonald	Kansas dental board
Ann Bangle	Kansas Association of Naturopaths
Joe Kring	KDHE
Ed Forner	Governor's Public Health Commission
Robin Hechman	Ks Action for Children
Martha L. Cooper	Kacha
Deb Williams	Governors Public Health Task Force
Greg Tugman	DoB
Charles Benjamin	Kansas Natural Resource Council / Kansas Sierra Club
Sally Finney	Ks. Public Health Association
Robert St-Peter	Kansas Heath Institute
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
LORNA A. PHILLIPS	KDHE
Larrie Ann Brown	KS ASSOC of Health Plans
Michelle Peterson	Peterson Public Affairs Group
LARRY FRAZIER	Board of Pharmacy

Kansas Health Institute

Evaluating the HealthWave Program

Presentation to the
Committee on Public Health and Welfare

January 14, 1999

Robert F. St. Peter, M.D.

Monitoring HealthWave

What we would like to know?

What we will really know?

What We Would Like to Know About HealthWave

Effectiveness of outreach and enrollment

Adequacy of system structure and capacity

Success of service delivery
- access/availability
- utilization
- quality/satisfaction

Effect on children's health status

What We Will Really Know About HealthWave

Health Care Data Governing Board activity

- review other state and national efforts
- convene interested parties in state
- develop comprehensive set of indicators
- assess availability and/or feasibility in Kansas

Potential Sources of Information

Planned:

- SRS indicators required from health plans
- SRS baseline information from enrollees

No current plans:

- Comprehensive evaluation of program
- Survey of participants and/or families
- Survey of health plans and/or providers

Goals of HCDGB Activities

Determine what we are likely to know

Identify lack of critical information

Prioritize/address gaps in data

Position Kansas to obtain evaluation funds

Governor's Public Health Improvement Commission

900 SW Jackson, Suite 620
Topeka, Kansas 66612-1290
Phone: 785-296-1236

PRESENTATION TO SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

January 14, 1999

Edwin Fonner, Jr., DrPH
Executive Director
Public Health Improvement Commission

SPEAKING POINTS:

1. Purpose and Scope of Presentation

2. Overview of Public Health Improvement Plan

   - Background Information
   - What's Wrong With the Current System?
   - Next Steps: What Do We Want to Do?
   - What is the Role of KDHE?
   - Vulnerabilities to Program Success

3. Overview of Robert Wood Johnson Foundation's *State Initiatives in Health Care Reform* Program

   - Background Information
   - Purpose and Terms of Grant
   - Coordination of Health Policy Formulation
   - Technical Assistance in Children's Health Insurance Initiative
   - Enhancing State Health Care Purchasing Strategies and Forming Public / Private Partnerships

4. Role of Legislature

5. Questions and Answers

A collaborative effort funded by the Robert Wood Johnson Foundation and the Kar

PRESENTATION TO SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

January 14, 1999

Edwin Fonner, Jr., DrPH
Executive Director
Public Health Improvement Commission

PURPOSE OF PRESENTATION: The purpose of this presentation is to provide background information and a progress report on two initiatives coordinated by state agencies. Next steps and strategic directions will be outlined, and advice sought from Committee. The initiatives are:

1. *The Public Health Improvement Plan*, directed by the Governor's Commission and coordinated by the Kansas Department of Health and Environment.

2. *The State Initiatives in Health Care Reform* program of the Robert Wood Johnson Foundation coordinated by the Department of Administration.

PUBLIC HEALTH IMPROVEMENT PLANNING IN KANSAS

ORIGINS OF PROGAM: The Institute of Medicine (Future of Public Health), State of Washington, two national foundations, and the University of Washington School of Public Health and Community Medicine led up to the *Turning Point* initiative. The Kansas Health Foundation and a steering committee won funding along with 13 other states.

PURPOSE: The purpose of the program is to establish a new vision transforming and strengthening public health in Kansas. A state wide public health improvement plan is meant to address deficiencies in the state's foundation, redefine roles and responsibilities, and improve collaboration between public and private partners.

PARTICIPANTS: Members of the Governor's Commission, local partnership, and several hundred leaders are participating in this initiative.

CREATING A COMPELLING CASE FOR CHANGE: *WHAT'S WRONG WITH THE PRESENT SYSTEM?*

Health Status – Growing numbers of uninsured weigh on local health departments and indigent clinics. The scope of disease and social problems is growing beyond the capacities of the foundation needed to protect and promote the health of the public. Incomplete surveillance and detection of disease and inadequate consumer education leads to more serious and costly illness. There are no state wide health "summits" in Kansas for exchanging information and setting priorities.

Effective Public Health Organizations – The delivery system is not cohesive. It is fragmented, competitive, and provides limited coordination of care. Roles and responsibilities of state, regional, and local providers and governments are unclear. Local health departments are not providing adequate detection, policy-setting, and assurance of care. Public health functions are not well understood and operate in relative obscurity.

Workforce and Partnerships – Many public health organizations are understaffed and function with staff needing additional education. There is a "disconnect" between local public health organizations and their county commissioners and KDHE. There is a need for better technical assistance from state to local entities. There are few incentives and models for developing partnerships and collaborative initiatives. The absence of coordination and broader vision leads to low morale, discord, and less "user friendliness."

Finances -- Large portions of state agency budgets lack flexibility and have restricted uses. The flow of funds from federal to state to local health organizations are complex and administratively intensive. Local public health organizations are experiencing declining fee income. There is limited support from county and state government for public health. Most funding is allocated to medical care.

Information Systems – There is no framework for unifying information systems and data across organizations. Networks, hardware, software, data are not integrated. This limits the ability to get a clear picture of population health. Many organizations lack basic equipment, skills, and have little if any local information to work with.

Policy and Leadership – There is an absence of coordinated strategic planning and policy formulation at local, regional, and state levels, and between public and private organizations. Turnover and lack of experience impedes leadership potential.

NEXT STEPS IN PUBLIC HEALTH IMPROVEMENT: *WHAT DO WE WANT TO DO?*

Next steps include the following activities:

- Negotiate roles and responsibilities among government public health organizations and other organizations.
- Assess KDHE's capacity to provide core functions and support public health across the state.
- Identify critical issues and decision points, and hold "leadership summits" to formulate solutions.
- Continue developing partnerships and keep current group from fragmenting.
- Develop a communications plan to guide the dissemination of information and plans.

- Develop a strategy for influencing leaders and increasing the chances of successfully implementing needed changes.
- Design New Public Health Delivery System for Kansas.

WHAT IS THE ROLE OF KDHE?

KDHE has an opportunity to serve as a foundation for public health decision-making in Kansas. The agency can ensure accountabilities, provide enabling resources and technical assistance, help mentor public health and medical care workers, and serve as a source of inspiration encouraging healthy lifestyles and a sound environment.

VULNERABILITIES TO PROGRAM SUCCESS:

1. Not appearing on key decision makers radar screen.
2. Not having sufficient resources to complete work plan and implement vision.

OVERVIEW OF ROBERT WOOD JOHNSON FOUNDATION *STATE INITIATIVES IN HEALTH CARE REFORM* PROGRAM

BACKGROUND INFORMATION

The *Accountability in Health Care Purchasing Workgroup*, meeting from 1995 to the present incubated the ideas and grant proposal submitted to the Alpha Center and the Robert Wood Johnson Foundation. This public private partnership (comprised of state agencies, large Kansas employers, physicians, health plans, HCFA, the state PRO, hospital and business health associations, and other decision-makers) also spearheaded the *Consumer Assessment of Health Plans* survey, and a dialogue between purchasers and providers.

PURPOSE AND TERMS OF GRANT

This is *Round Three* of a funding initiative meant to enhance the capacity of state governments to formulate sound health policies, make data-based decisions, and successfully pursue initiatives to enhance coverage for uninsured and improve the abilities of employers and government organizations to purchase cost effective health care. The grant will initially run for 18 months under the coordination of a steering committee and the Department of Administration.

COORDINATION OF HEALTH POLICY FORMULATION

Strategies will be developed for creating more comparable data and coordinating policy formulation and decision-making across state agencies.

TECHNICAL ASSISTANCE IN CHILDREN'S HEALTH INSURANCE INITIATIVE

Technical assistance will be provided to the Children's Health Insurance initiative and Title XIX so that outreach, benefits coordination, enrollment, and use of services is cost effective and produces good outcomes.

ENHANCING STATE HEALTH CARE PURCHASING STRATEGIES AND FORMING PUBLIC / PRIVATE PARTNERSHIPS

A public / private partnership will be formed to explore how large employers can create more uniformity in requests-for-proposal submitted to health plans, contract guidelines, and data for evaluation of health services utilization by plan enrollees.

ROLE OF LEGISLATURE

QUESTIONS AND ANSWERS

PUBLIC HEALTH IMPROVEMENT PLANNING IN KANSAS

National Program. ***Turning Point: Collaborating for a New Century in Public Health*** is a program of the Robert Wood Johnson and W.K. Kellogg foundations. The goal of the program is to transform and strengthen the public health infrastructure in the United States so that states, local communities, and public health agencies may respond to the challenge to protect and improve the public's health in the 21st century. The University of Washington, School of Public Health and Community Health is administering two-year $300,000 grants in 14 states. The National Association of County and City Health Officials is administering three-year $60,000 grants in 41 local partnerships in these states. The Kansas Health Foundation provided $300,000 in funding for the Kansas state partnership and two local groups -- the Reno County Community Health Coalition and Wyandotte County Community Health Partners.

Kansas Initiative. The Kansas state and local partnerships are pursuing a set of progressive steps to unify public health in the state and move the system beyond the status quo. The goal is to create an actionable plan which, as it is being implemented, will transform the Kansas public health infrastructure, build its capacities, and respond to current and emerging public health challenges.

This strategic development process includes the following steps: assessing and redefining the public health mission, roles, and responsibilities in Kansas; recasting the relationships between public health, medical care, environmental protection, and other stakeholders; sustaining collaboration; identifying organizational, financing, statutory, technology, and other structural changes needed to strengthen capacity; and planning for progressive change.

Time line. By early 1999, we will comprehensively assess the Kansas public health system, and its component parts. Throughout 1998 and by mid 1999, we will explore alternatives for improving, transforming, or reinventing the Kansas public health system (in whole or in part). By mid-1999, we will use the knowledge gained to create an information-based and attainable vision of the future of public health in Kansas. By late 1999, we will create a comprehensive plan, strategies, and inter-organizational processes to re-define the public health system and its linkage with medicine. The plan will address overall structure, the system's component parts, and inter-organizational dynamics. By late 1999, a mechanism for communicating, formalizing relationships, and sustaining collaboration will be set in motion to implement the plan.

Outreach. Consensus-building and collaboration between diverse organizations requires *more* communications than usual. Our goal is to establish a statewide public health improvement process that will be guided by both a broadly representative statewide strategic development initiative and the implementation experiences of our local partnerships, with each component informing the other. This goal envisions health-related associations, medical practitioners, managed care organizations, and other private sector interests actively involved in identifying and addressing community health priorities.

Periodic Meetings. The Governor's *Public Health Improvement Commission* meetings are held on a monthly basis. Public health workers, all other healthcare professionals, students, association representatives, business leaders, and the public are encouraged to participate.

Dialogue. Workgroups will be implemented to foster on-going discussions with Kansas leaders. Discussions will include a program overview, identification of key issues, group reaction to others' views of problems, solution identification, group reaction to others' views of solutions, identification of feasible options, consensus development on implementation strategies, and pursuit of solutions.

ASSESSING CORE PUBLIC HEALTH FUNCTIONS IN KANSAS LOCAL HEALTH DEPARTMENTS, 1998

SURVEY FINDINGS PRESENTED TO THE
GOVERNOR'S PUBLIC HEALTH IMPROVEMENT COMMISSION

SEPTEMBER 14, 1998

BY: Kansas/Turning Point Staff

ASSESSING CORE PUBLIC HEALTH FUNCTIONS IN KANSAS LOCAL HEALTH DEPARTMENTS, 1998

INTRODUCTION

Recent testimony before the U.S. Senate by the president of the National Association of County and City Health Officials (NACCHO) was a deflating *de ja vu* for the public health community. Assessing the readiness of the nation's local public health departments to respond to epidemics and bioterrorism, phrases like "*the piecemeal nature of local, state, and national surveillance systems*," "*the inadequate state of readiness*," "*the need to enhance communications*," and "*the pressing need to provide local agencies with adequate resources and training to respond to emerging infections*" echoed through the Senate chambers.[1]

This testimony marked the 10th anniversary of the Institute of Medicine's *The Future of Public Health* report in which was stated,

> "*...this nation has lost sight of its public health goals and has allowed the system of public health to fall into disarray.*"[2]

While some would conclude that little has changed at the national level, what is the status of the public health infrastructure in Kansas? The following report provides some insights from the perspectives of 96 of the state's local health officers.

FOCUS OF STUDY

This is the first of several assessments supporting the Kansas Public Health Improvement Planning (*Turning Point*) initiative. Information is provided on the extent to which core public health functions are effectively being carried out in jurisdictions served by local health departments in Kansas. The following results are based on assessments made by county health officers responding to surveys they completed in June 1998. Surveys were completed by 96 of the 98 local health departments in Kansas. The survey response rate was 98 percent.

Delivery of core public health functions by local health departments was the topic of the survey. These core functions are defined as:

> *Assessment -- "What should be done."*[3] Collecting, analyzing, and disseminating information on the health of the community.
>
> *Policy Development -- "What will be done."* Developing comprehensive public health policies and identifying priorities.
>
> *Assurance -- "How best to accomplish these ends."* Encouraging actions by other entities, regulating such action, or providing services directly.

Six survey questions addressed *Assessment*, six addressed *Policy Development*, and eight questions addressed the *Assurance* function. (See **APPENDIX 3** for a list of the survey questions.) A local health department was judged to be effectively providing the core functions to the population in its jurisdiction if four "*yes's*" were marked for each of the Assessment and Policy Development questions, and six "*yes's*" were marked for the Assurance questions. This conclusion is based on criteria defined by Turnock, Handler, and Miller.[4]

These survey data provide a set of guidelines within which local public health infrastructure needs are assessed and improved. Gaps in core public health functions can be pin pointed by geographic location and county population size. Results from future surveys will be comparable to benchmark measures presented here.

PROVISION OF CORE PUBLIC HEALTH FUNCTIONS AT THE LOCAL LEVEL

The U.S. Public Health Service in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* set an ambitious target for local public health departments.[5] They stated in Objective *8.14* that 90 percent of the U.S. population should be effectively served by local health departments by the year 2000. A national survey conducted in 1995 estimated that only 22 percent of the nation's local health departments were effectively delivering core public health functions to *29 percent* of the U.S. population.[6]

Kansas is falling far short of the national objective and may be less effective than local health departments in other states. Only *three* of the 96 responding health departments in Kansas indicate they are effectively serving 491,140 of the state's population of 2,572,150. *Survey results indicate that 3 percent of the responding 96 local health departments effectively serve 19 percent of the state's population.* One of the three health departments is located in a rural community in central Kansas, while the other two health departments are located in northeastern Kansas.

The median percentage of survey questions answered with a "*yes*" in Kansas was 45 percent. Comparable results in Illinois were 56 percent in 1992 and 86 percent in 1994. One quarter of the local health departments in Kansas answered 30 percent or less of the questions with an affirmative response (i.e., the 25th percentile). One quarter of the local health departments answered 60 percent or more of the questions with a "*yes*" (i.e., the 75th percentile).

Less than forty percent (38.5 percent) of responding health departments report effectively providing *surveillance* functions, while 37.5 percent report effectively providing the *policy development* function. Only 5.2 percent effectively provide *assurance* functions.

FUNCTIONS MOST LIKELY / LEAST LIKELY TO BE PROVIDED

The percentages of local health officers in Kansas affirming that they effectively deliver each of the 20 public health practices (as defined in the 20 survey questions) are presented in **Table 1**, column 2. Kansas percentages are compared with those from the U.S. survey (column 1). Percentages for the 20 survey questions were also ranked to determine which public health practices were most likely or least likely to be provided effectively in Kansas.

The practices *most likely* to be provided in Kansas are the following:

	Percent Responding Affirmatively
Timely investigations of adverse health events (Ques.#3)	87.5 percent
Availability of necessary laboratory services(Ques.#4)	80.2 percent
Network of supporting relationships (Ques.#7)	79.0 percent
Provision of reports to media regularly (Ques.#20)	70.8 percent

The practices *least likely* to be provided in Kansas are the following:

	Percent Responding Affirmatively
Implemented all mandated programs (Ques.#16)	6.3 percent
Evaluate the effects of services in the community (Ques.#17)	14.6 percent
Programs are monitored and resources are redirected (Ques.#18)	21.1 percent
Organizational self-assessments conducted (Ques.#14)	25.0 percent
Resources allocated using an action plan (Ques.#12)	25.0 percent

CORE PUBLIC HEALTH FUNCTIONS AND POPULATION DENSITY

Survey results were grouped by the density of population residing in the jurisdictions served by respondents. Percentages of affirmative responses for the 20 core functions questions were averaged in each population density category. These averages are displayed below. (See **APPENDIX 2 STUDY METHODS** for definitions of population density.)

	AVERAGE PERCENT "YES"			
Population Density	All Ques.	Assessment	Policy Development	Assurance
Frontier Counties	38.3 %	45.1 %	38.2 %	33.1 %
Rural Counties	40.6 %	46.1 %	45.1 %	32.7 %
Densely Settled Rural	53.8 %	54.6 %	64.5 %	44.4 %
Semi Urban Areas	56.9 %	52.1 %	73.0 %	46.9 %
Urban Areas	75.0 %	83.3 %	86.7 %	52.5 %

Three relationships are worth noting. First, residents in more densely-settled jurisdictions are more effectively provided with core public health functions than residents in less populated areas, in the eyes of the local health officers. Second, in less densely-settled areas, the *assessment* function is regarded as being most effectively provided, whereas in urban areas and densely-settled rural areas, *policy development* is considered most effectively provided. Third, the *assurance* function is always the least likely to be considered effectively provided.

Table 1 display average percentages for each survey question and each of the five population density categories. Generally, more densely populated areas provide higher percentages of core public health practices. However, in some cases, densely settled rural areas provided more core practices than local health departments in semi urban areas.

Kansas data shown in **Table 1** are very similar to the U.S. sample. The U.S. sample, however, consistently has higher percentages than Kansas local health departments grouped together. There are two public health practices for which U.S. scores far outweigh Kansas: implementation of all mandated programs (83 percent for the U.S. sample vs 6.3 percent in Kansas), and performance of organizational self assessments (50 percent for the U.S. sample vs 25 percent in Kansas).

CORE PUBLIC HEALTH FUNCTIONS AND COUNTY POPULATION SIZE

Survey results were also grouped according to the number of residents in the jurisdictions served by the responding local health departments. Percentages of affirmative responses for each of the 20 survey questions were averaged by population size (see **Table 2**). These averages are also summarized below by seven population size categories:

	AVERAGE PERCENT "YES"			
Population Size	All Ques.	Assessment	Policy Development	Assurance
Less than 2,500	51.9 %	62.5 %	52.1 %	43.8 %
2,500 to 4,999	34.2 %	38.2 %	34.7 %	30.7 %
5,000 to 7,499	35.8 %	40.7 %	36.1 %	32.2 %
7,500 to 9,999	52.1 %	66.7 %	66.7 %	30.2 %
10,000 to 39,999	49.4 %	47.4 %	60.7 %	42.5 %
40,000 to 99,999	55.7 %	64.3 %	64.3 %	42.9 %
100,000+ Residents	77.5 %	87.5 %	95.8 %	56.2 %

Patterns of variation in the Kansas survey data are similar when grouped by population size or population density. However, as a group, health officers serving populations of fewer than 2,500 residents considered themselves to be providing core functions more effectively than health officers in jurisdictions with populations between 2,500 and 7,500 residents. This may be because they know most all of the local residents and are more aware of needs (see **Table 2**).

Comparable percentages from Turnock's[7] Illinois database indicate that Illinois local health departments serving populations of less than 25,000 effectively provided an average of 79 percent of the core public health functions. Illinois averages for populations between 25,000 to 50,000 residents, 50,000 to 100,000 residents, and over 100,000 residents were 86.6 percent, 86.5 percent, and 82 percent, respectively.

WRITTEN COMMENTS

Health officers were asked to write comments in response to the following question: *What is the single most important issue facing your health department that prevents you from accomplishing your mission?*

Comments were written on nearly every returned survey. The most-frequently cited issues relate to scarcity of adequate financial resources, insufficient staff, and lack of time to perform needed functions. Selected comments are quoted in **Appendix 1**.

Most Frequently Stated Issues

Insufficient Finances	52 comments
Scarcity of Qualified Staff	23 comments
Not Enough Time to Perform Work	19 comments
Local Health Department Role Not Understood	10 comments
Dependence on Revenue from Delivery of Personal Health Services	7 comments

Other Frequent Comments

County Tax Lid is an Impediment to Providing Needed Services	Fewer than 5
Competition from Hospitals and Physicians	Fewer than 5
Administrator Wears Multiple Hats	Fewer than 5
Fragmentation of Services	Fewer than 5

ADEQUACY OF PRACTICE PERFORMANCE MEASURES

Survey respondents were asked to provide a rating for the following question: *How strongly do you agree or disagree that your responses to Questions 1 to 20 accurately characterize the effectiveness of your local health department in addressing public health's three core functions?*

Nearly 53 percent of the respondents in Kansas either agreed or strongly agreed with this statement, while 30 percent disagreed, and 17 percent strongly disagreed. This compares with 66 percent, 15 percent, and 19 percent, respectively, in Dr. Turnock's 1995 U.S. survey. Respondents from local health departments located in frontier counties and densely populated rural counties tended to disagree or strongly disagree with this statement more than respondents from urban, semi-urban, and rural areas.

VALUE OF REPEAT MEASUREMENT

A survey similar to the one conducted in Kansas has been conducted twice in Illinois -- first in1992 and repeated in 1994.[8] The percent of core functions effectively addressed in Illinois local health departments increased between the dates of the two surveys. The survey researchers believe that repeating the survey raised the level of attention paid to core public health functions in Illinois' local public health jurisdictions:

> *"Respondents to the 1994 survey reported that IPLAN* (Illinois' Core Functions survey) *and the Assessment Protocol for Excellence in Public Health (APEXPH) were strongly positive influences on their practice performance."*

The survey results reported here are simply a proxy of more in-depth assessment activities to be conducted in the Kansas *Turning Point* initiative. The capacity of state government and the private sector to provide certain core functions to Kansans also warrants study. There is also merit in enhancing the capacity of state and local health officials to jointly conduct assessment activities. Dr. Turnock states,

"Where state and local public health networks operate collaboratively to identify and address statewide public health capacity-building needs, APEXPH and other tools are likely to be viewed more positively and used more readily."[8]

DISCUSSION

Many local health officers in Kansas had an opportunity to review the preliminary survey data in July and August, 1998. From one region to the next, health officers consistently pointed out vulnerabilities in the Kansas public health infrastructure that are consistent with survey results.

The patchwork nature of local public health funding is considered ineffective and even burdensome from an administrative perspective. Little support exists for preventive services, and as long as figures on the cost effectiveness of public health are lacking, public health is considered a non-essential function. Local health departments are seen as providers of last resort, isolated from local government and the health care delivery system, and providers of low revenue services. Increasingly, local public health departments compete with physicians and local hospitals. Yet, as competition grows, their fee-based revenues dwindle, and increasing numbers of uninsured Kansans rely on local pubic health services. Ironically, despite the poor showing compared with Illinois and the rest of the country, some Kansans have even expressed concern that these survey results overstate the extent to which core functions are effectively provided to Kansans.

REFERENCES

[1]National Association of County and City Health Officials. "NACCHO President Testifies Before Senate Committee, Advocates Public Health Infrastructure Funding," in *NACCHO News*, July/August 1998: 1,18-19. Washington DC.

[2]Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine. *The Future of Public Health.* National Academy Press. 1988. Washington DC.

[3] Turnock, B.J., Handler, A.S., Miller, C.A., "Core Function-Related Local Public Health Performance," *Journal of Public Health Management and Practice.* July 1998.

[4]Turnock, B.J. "Assessing Performance of Public Health Core Functions: The State of the Art and Options for Kansas." Paper submitted to the Governor's Public Health Improvement Commission. April 1998.

[5] U.S. Public Health Service. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Washington DC; U.S. Department of Health and Human Services, Public Health Service; DHHS Publication No. (PHS) 91-50212. 1991.

[6] Turnock, B.J., Handler, A.S., Miller, C.A., "Core Function-Related Local Public Health Performance," *Journal of Public Health Management and Practice.* July 1998.

[7] Turnock, B.J. Unpublished data from University of Illinois at Chicago survey of Illinois local health departments.

[8] Turnock, B.J, *et. al.* "Capacity-Building Influences on Illinois Local Health Departments," *Journal of Public Health Management Practice*, 1(3):50-58. 1995.

TABLE 1.
PERCENT RESPONDING "YES" TO CORE FUNCTIONS QUESTIONS:
U.S. SAMPLE, KANSAS, and COUNTIES BY POPULATION DENSITY

Survey Questions (In order #1 to #20)	Turnock U.S.	Kansas (96)*	Frontier (31)*	Rural (34)*	Dense Rural (18)*	Semi Urban (8)*	Urban (5)*
Community needs assessment process	53	42.7	38.7	35.3	44.4	50	100
Behavioral risk factor surveys	29.2	28.1	25.8	17.6	44.4	25	60
Timely investigations of adverse health events	93.6	87.5	83.9	94.1	83.8	75	100
Necessary laboratory services available	89.3	80.2	77.4	76.5	88.9	75	100
Analysis of determinants, resources, & populations impacted	45	40	32.2	35.3	38.9	62.5	80
Analysis of preventive & screening services	22.8	20.8	12.9	17.6	27.8	25	60
Network of relationships	82.6	79	74.2	73.5	82.3	100	100
Inform elected officials	73.2	68.8	61.3	64.7	77.8	75	100
Prioritize community health needs	52.7	47.9	29	44.1	61.1	75	100
Implemented community health initiatives	68.8	47.9	32.3	47.1	61.1	62.5	80
Community health action plan	39.6	37.5	16.1	26.5	66.7	75	80
Resource allocation per action plan	36.6	25	16.1	14.7	38.9	50	60
Resources deployed to meet needs	37.3	26	12.9	15.2	38.9	75	60
Organizational self-assessment	50.3	25	16.1	20.6	38.9	25	60
Provision/linkage of services for priority needs	64.1	68.4	67.7	69.7	77.8	62.5	40
Implemented all mandated programs	82.9	6.3	3.2	5.9	11.1	0	20
Evaluations of effect of services in the community	30.5	14.6	16.1	11.8	11.1	25	20
Programs monitored & resources redirected	42.3	21.1	22.6	6.1	38.9	25	40
Public provided information regularly	78.8	63.5	61.3	55.9	66.7	75	100
Provide reports to media regularly	68.5	70.8	64.5	70.6	72.2	87.5	80

* Number of survey respondents.

TABLE 2.
PERCENT RESPONDING "YES" TO CORE FUNCTIONS QUESTIONS: U.S. SAMPLE AND KANSAS COUNTIES BY POPULATION SIZE

Survey Questions (In order #1 to #20)	Under 2,500 (8)*	2,500-4,999 (24)*	5,000-7,499 (19)*	7,500-9,999 (8)*	10000 39999 (28)*	40000 99000 (7)*	100K plus (4)*
Community needs assessment process	62.5	29.2	22.2	75	34.6	71.4	100
Behavioral risk factor surveys	50	12.5	11.1	50	30.8	57.1	50
Timely investigations of adverse health events	87.5	83.3	94.4	100	80.8	85.7	100
Necessary laboratory services available	87.5	75	77.8	75	80.8	85.7	100
Analysis of determinants, resources, & populations impacted	62.5	20.8	27.8	62.5	34.6	57.1	100
Analysis of preventive & screening services	25	8.3	11.1	37.5	23.1	28.6	75
Network of relationships	87.5	70.8	72.2	75	84	100	100
Inform elected officials	50	75	50	75	69.2	85.7	100
Prioritize community health needs	37.5	20.8	33.3	87.5	57.7	71.4	100
Implemented community health initiatives	62.5	25	33.3	75	65.4	28.6	100
Community health action plan	37.5	8.3	16.7	50	53.8	71.4	100
Resource allocation per action plan	37.5	8.3	11.1	37.5	34.6	28.6	75
Resources deployed to meet needs	37.5	8.3	5.9	25	38.5	42.9	75
Organizational self-assessment	0	25	16.7	37.5	30.7	14.3	75
Provision/linkage of services for priority needs	87.5	66.7	72.2	42.9	76.9	57.1	50
Implemented all mandated programs	0	4.2	5.6	0	11.5	0	25
Evaluations of effect of services in the community	25	12.5	16.7	12.5	11.5	14.3	25
Programs monitored & resources redirected	37.5	12.5	11.1	12.5	28	42.9	25
Public provided information regularly	87.5	50	66.7	37.5	69.2	71.4	100
Provide reports to media regularly	75	66.7	11.1	75	73.1	100	75

* Number of survey respondents.

APPENDIX 1. SELECTED WRITTEN COMMENTS

The following comments were submitted by survey respondents answering the following question: *What is the single most important issue facing your health department that prevents you from accomplishing your mission?*

FINANCES

Limited financial resources to maintain services, keep and attract qualified personnel, expand on existing programs, and establish new initiatives to meet the needs in a changing population, particularly in relation to language barriers and cultural diversity.

Money -- Locally and at the state level. I have one RN, one LPN, and one-forth of a secretary to meet the needs of 3,300 people in a rural county where driving 50 miles per day to see a client is the norm.

Money -- All this takes time, materials, etc. that are not even closely met by state formula funds.

Funding is primarily available for direct service delivery, but not for the infrastructure to support the core functions, i.e., management information systems, planning and evaluation, legal, public relations, and community involvement.

Finances -- I don't have the financial resources to conduct surveys and studies. The Kansas Health Foundation provided money to do a community health assessment approximately five years ago, but the funds were given to the local hospital. I utilize the reports KDHE generates that are specific to my county to help with core functions.

There's not enough money to expand services we'd like to implement and not enough space provided by our local officials to expand and offer further programs.

The focus seems to be on money rather than the well-being of the general public. The local governing body generally has a lack of interest in health-related issues unless they directly affect them. They seem to view community behaviors as those things that need to be taken care of by each family and public health is not to be involved.

Our commissioners give this department 1/2 a mill which amounts to approximately $44,000. They see no reason to increase this amount. Our commissioners' feelings are: If the state wants you to do this, the state can pay for it! Our staff has not had a raise in three years.

These restraints limit our ability to provide staff and resources needed -- no funding assistance, no change in the state formula, and no change in the mill levy (it's under the tax lid).

In our county, the tax lid is a very big problem for our department. We had our budget cut by $14,000 and lost our state formula funding. Getting out from under the lid has been taken to a vote in the past but has been voted down.

Financial resources that are not tax-based. Farmers and ranchers in a rural setting are quite conservative and still hold a strong voice in governmental decisions in this county.

Funding -- Overcoming the Board of Health (i.e., county commissioners) who don't feel health is really important enough to adequately fund. We had some severe cutbacks in staff in 1997 due to lack of funds.

Funding -- Our county commissioners are very reluctant to put more tax dollars into the health department. We are expected to provide health services based on revenue generated, not community health needs.

Time and money -- Not enough of either one! What we have accomplished has only been achievable because we are a member of the Southcentral Coalition for Public Health, and work in a team effort.

LACK OF TIME AND NEED TO PROVIDE PERSONAL HEALTH SERVICES

We aren't funded or equipped to handle core public health functions. We must provide personal health services for fees to operate at all.

As the only nurse on staff, most of my time is directed towards administering patient-oriented clinics (immunizations, family planning, WIC). I am unable to do much other "extra curricular" work.

We are a small health department and the lack of administrative time to address core public health issues is a key factor. Our community health assessment is in process, but it's hard to find time to sit down and plan.

So many relationships, actions, etc. are completed informally. Our county has not participated or completed a community health assessment. Time and money are probably the two most important issues that do not allow core public health functions to be completed. We have become one-on-one service oriented.

Time and money allotted to public health have been given to personal care services. Public health core functions have taken a back seat.

Time! I do administration, clinic, child care licensing, TB, and KAN Be Healthy.

Lack of enough staff to meet the needs. The administrator is an RN, who not only has to do administration, but also must work and assist in the clinic.

We are a very small health department and must stretch our time and money to meet current needs. we work closely with local doc's and try to do our best with what we have.

LACK OF UNDERSTANDING OF PUBLIC HEALTH

Lack of understanding of the role of the health department. This leads to inadequate funding, conflicting expectations, and reduced effectiveness.

The most important issue is being able to communicate the significance of public health to the community and for the community to internalize the importance of public health in their daily activities.

Recognition of what a local health department and KDHE does, and even where the health department is located. We have radio shows, articles, etc. and people "just don't get it." A statewide campaign may work better.

The need to let the public know that our services are for the whole population, not just the destitute, as so many think.

There is a lack of interest by county commissioners, who have control.

COMPETITION

The hospital administrator is trying to undermine new programs I plan to initiate. She feels that the health department is in competition with the hospital.

Hospitals are wanting to take over health department functions. They will do this as a profit making opportunity.

The county extension office and my office have worked together to try to organize a group so we could perform CHAP. The hospital chose to do its own thing, so we didn't get to first base.

Physicians are most generally cooperative, but there are a few areas that they consider our services "in competition" with their private practices. For example, they request that we not provide flu and pneumonia shots through the health department.

The community believes the only important entity is our hospital. The new administration at the hospital believes public health is a threat to their income. Therefore, we have done away with important preventive programs.

STAFFING

Staffing -- Small health departments do not have the administrative hours needed to do core public health functions. The administrator is very involved in direct care of our population.

Being the only nurse in our office, I'm kept busy with "hands on" and don't have time for surveys and assessments, etc.

Funding for people resources -- We receive less than $12,000 a year for core public health functions. It's difficult to accomplish anything.

We would like to employ an ARNP to enhance our services. The commissioners do not understand the importance of having one.

OTHER COMMENTS

Fragmentation -- It's difficult pulling together the hospital and doctors into the network. Small town hospitals and doctors are threatened by public health, needlessly, but old feelings die hard.

Lack of focus at all levels -- Federal, state, and local.

We need more assistance from KDHE with "tools" to help with the evaluation process and analysis. Is there is form or procedure to assist with the self-evaluation process? I've been an administrator for almost 20 years and really appreciate continuing education that addresses these core public health issues.

APPENDIX 2. STUDY METHODS

Survey and Respondents. The *Core Functions Survey* used in Kansas was developed by the University of Illinois at Chicago and the University of North Carolina. The survey was mailed to directors of 98 local health departments in Kansas during June 1998. The 22-question survey was accompanied by a cover letter from the Governor's Commission and a fact sheet summarizing the public health improvement initiative. Results may be comparable with several other states undertaking public health improvement planning via the *Turning Point* initiative (e.g., Virginia, Illinois, and Alaska).

Health Departments in Kansas. The state's 98 health departments cover all 105 Kansas counties. Ten Kansas counties are members of multi-county health departments -- Southcentral Kansas (5 counties), Northeast Kansas (3 counties), and the Bi-county Health Department. Responses from these health officers were combined into their respective multi-county jurisdiction.

Response Rates and Follow-Up. Completed surveys were returned by health officers representing 96 local health departments, yielding a 98 percent response rate. (This compares with Dr. Turnock's 59 percent response rate in 1995 where 298 surveys were returned of 503 local health departments sampled across the U.S.) Respondents answered virtually all of the survey questions. Fewer than 10 surveys did not have written responses to Question #22. The research team conducted telephone follow-up to encourage complete and accurate response.

Analysis of Survey Data. Respondents were prompted to answer questions 1 to 20 with a "*yes*," "*no*," or "*I don't know*" response. An affirmative response to each of the survey questions indicates that the health department effectively provides a core functions-related service. The percentages of all local health departments responding with a "*yes*" were calculated for each of the 20 survey questions covering core public health functions. These percentages were compared with results from outside Kansas. Percentages were also calculated for local health departments grouped by their county population and the area's population density.

Local health departments responding favorably to a majority of the questions in each of the response categories were judged to be in substantial compliance with recommended public health practices. This "effectiveness" rating was determined by four "*yes's*" for each of the six Assessment and Policy Development questions, and six "*yes's*" for the eight Assurance questions.

Written comments were also categorized according to the nature of the issue(s) cited by the respondents. **Table 3** contains the more frequently-mentioned issues. Selected written comments were copied into **Appendix 1** for further review by readers.

Comparison Groups. Responses from the Kansas survey were grouped by the population size and density of their jurisdiction. (Populations in multi-county health departments were averaged.) Population groups were: under 2,500 residents, 2,500 to 4,999, 5,000 to 7,499, 7,500 to 9,999, 10,000 to 39,999, 40,000 to 99,999, and 100,000 or more residents. Five categories of population density were used: frontier (fewer than 6 residents per square mile), rural (6 to 19.9 residents per square mile), densely-settled rural (20 to 49.9 residents per square mile), semi-urban (50 to 149.9 residents per square mile), and urban (150 or more residents per square mile).

Confidentiality. No record-specific responses from the survey will be released. Publishable survey data will only be in aggregate form. The identities of any local health departments will not be released.

APPENDIX 3. SURVEY QUESTIONS

ASSESSMENT

1. For the jurisdiction served by your local public health agency, is there a community health needs assessment process that systematically describes the prevailing health status and needs of the community?

2. In the past three years in your jurisdiction, has the local public health agency surveyed the population for behavioral risk factors?

3. For the jurisdiction served by your local public health agency, are timely investigations of adverse health events, including communicable disease outbreaks and environmental health hazards, conducted on an ongoing basis?

4. Are the necessary laboratory services available to your local public health agency to support investigations of adverse health events and meet routine diagnostic and surveillance needs?

5. For the jurisdiction served by your local public health agency, has an analysis been completed of the determinants and contributing factors of priority health needs, adequacy of existing health resources, and the population groups most impacted?

6. In the past three years in your jurisdiction, has the local public health agency conducted an analysis of age-specific participation in preventive and screening services?

POLICY DEVELOPMENT

7. For the jurisdiction served by your local public health agency, is there a network of support and communication relationships which includes health-related and non-health-related organizations, the media, and the general public?

8. In the past year in your jurisdiction, has there been a formal attempt by the local public health agency at informing elected officials about the potential public health impact of actions under their consideration?

9. For the jurisdiction served by your local public health agency, has there been a prioritization of the community health needs which have been identified from a community needs assessment?

10. In the past three years in your jurisdiction, has your local public health agency implemented community health initiatives consistent with established priorities?

11. For the jurisdiction served by your local public health agency, has a community health action plan been developed with community participation to address priority community health needs?

12. During the past three years in your jurisdiction, has the local public health agency developed plans to allocate resources in a manner consistent with the community health action plan?

APPENDIX 3. SURVEY QUESTIONS (Continued)

ASSURANCE

13. For the jurisdiction served by your local public health agency, have resources been deployed as necessary to address the priority health needs identified in the community health needs assessment?

14. In the past three years in your jurisdiction, has the local public health agency conducted an organizational self-assessment?

15. For the jurisdiction served by your local public health agency, are age-specific priority health needs effectively addressed through the provision of, or linkage to, appropriate services?

16. In the past three years in your jurisdiction, has there been an instance in which the local public health agency has failed to implement a mandated program or service?

17. For the jurisdiction served by your local public health agency, have there been regular evaluations of the effect that public health services have on community health status?

18. In the past three years in your jurisdiction, has the local public health agency used professionally recognized process and outcome measures to monitor programs and to redirect resources as appropriate?

19. For the jurisdiction served by your local public health agency, is the public regularly provided with information about current health status, health care needs, positive health behaviors, and health care policy issues?

20. In the past year in your jurisdiction, has the local public agency provided reports to the media on a regular basis?

ADEQUACY OF PRACTICE PERFORMANCE MEASURES

21. How strongly do you agree or disagree that your responses to Questions 1 - 20 accurately characterize the effectiveness of your local health department in addressing public health's three core functions (Assessment, Policy Development, & Assurance)?

OTHER

22. What is the single most important issue facing your health department that prevents you from accomplishing your mission?

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41 (1992): 565–68.

Public and Private Health Initiatives in Kansas

Edwin Fonner, Jr.

This article summarizes several health initiatives in Kansas that are being forwarded by way of public/private partnerships. Consensus is being shaped on the standardization of health data and use of actionable indicators. Statewide public health improvement planning is also being pursued. A group of large employers and state agencies are creating a basis for group purchasing, consumer assessments of health plans, and coordinated public policy formulation. Key words: *collaboration, health care purchasing, health information, insurance coverage, public health, public/private partnership*

Moving from *They* to *We*

There is an ebb and flow to the cliches used in health care, but *collaboration*, *public/private partnership*, and *change agent*, while overused, are likely to endure for some time. The day has been dawning over the last five years, transforming these from abstract notions to active paradigms. More leaders are enlivened by social change and organizational transformation. Work loads are shifting from reactive to proactive. Perspectives are moving from organization-centric to systemic. Embracing change is becoming popular, even normal. It is in this regard, sharing this enthusiasm, that several public/private health initiatives in Kansas are reviewed here.

While Kansas may be described as fiscally conservative and politically centrist, it is not insular. People are open-minded, take pride in their communities, think independently, and value a Western-style individualism. ("With Adversity to the Stars" is the state motto.) Mainstream thinking is as alive here as anywhere else in the country. Some types of change (e.g., managed care penetration) have taken hold more slowly, but that's not necessarily viewed as a liability. Kansans are thoughtful in their deliberations and direction-setting. The medium for achieving consensus and adopting sound strategies may be more viable here than elsewhere. While complexities and some resistance to change exist, there may not be the same degree of pluralism and entrenched interests as in some other areas.

Background

During the mid-1980s, the Wesley Medical Center (a tertiary care not-for-profit health care provider in Wichita) sold its inter-

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ests to Columbia/HCA. Two foundations were funded with proceeds from the sale: the Kansas Health Foundation (KHF) and the United Methodist Health Ministry Fund. Both organizations have funded numerous initiatives focusing on public health, health education, and the needs of vulnerable populations in Kansas. KHF is unique among its peers across the country because of its exclusive interest in public health and its per capita resource allocation to prevention and wellness.

Resulting from deliberations with a number of leaders and legislators, KHF funded the start-up of a policy and research institute in the state capital. The Kansas Health Institute (KHI) received an initial five years of funding in 1995. KHI's objective is to provide data-based information to assist with policy formulation, to facilitate collaboration, and to foster better working relationships within the academic research community and among decision makers. The institute has helped add to the state's policy formulation capacity by creating fellowships in the state insurance department and Medicaid program. Among the numerous active public/private partnerships in Kansas, those in which KHI is involved are described here.

The Health Care Data Governing Board

The state's Health Care Data Governing Board was legislated into existence in 1993 to help develop standards and comparative data for evaluating health care costs and quality. Chaired by the secretary of the Kansas Department of Health and Environment (KDHE), the board is made up of leaders from state associations (hospitals, nurses, homes for the aged), the medical society, Blue Cross/Blue Shield, regent's universities and medical school, the American Association of Retired Persons (AARP), Medicaid, the insurance department, and KHI. The board has broad authority to acquire *any* health-related data needed to accomplish its mission. Data have been collected on hospitals, long-term care, and home health agencies, physicians, physician assistants (PAs), nurses, and dentists, along with measures of population health status. KDHE's Office of Health Care Information provides staff to the board.

The board's main challenges relate to reaching consensus and allocating limited resources to meet constituents' expectations. Use of record-level data to examine the performance of providers has received considerable attention. A Data Users Task Force formed by the board has recommended reshaping *the process* for identifying and taking action on strategic issues impacting Kansas health information needs. Three recommendations made to the board in 1997 are summarized in a document entitled *A Framework for Establishing Health Data Initiatives*[1]:

1. Stimulate information sharing and learning in board meetings with regular briefings from staff, peers from other states, and Kansas health care leaders. Idea exchange is intended to sharpen focus, structure dialogue, and sensitize participants to others' decision-making responsibilities.
2. Manage high-priority projects with a close-ended time line, a clearly blueprinted solution, and established accountabilities.
3. Given resource limitations, use sampling methods and demonstrations to prototype the use of decision-support

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data and indicators. Focus on raising individual's confidence in the appropriate use of record-level data.

Resulting from these recommendations, the board held a day-long retreat in mid-1997 to reexamine its priorities. Consensus was reached that future data collection efforts should focus on measuring the impact of managed care and other health insurance initiatives on health status in Kansas. The board's Data User Task Force was reconstituted to assist in this work. Task force members have been recruited from all sectors of health care to network among peers and serve as conduits to the Board, gathering feedback, harvesting ideas, and defining data acquisition strategies to facilitate decision making.

Public Health Improvement Planning

Evaluations of the Kansas public health system have been conducted periodically since the landmark 1988 Institute of Medicine report, *The Future of Public Health*.[2] In 1996, a Kansas Steering Committee was formed by concerned public health, nursing, and health care leaders. KHI facilitated the committee's work and conducted a feasibility study to determine support for statewide public health improvement planning (PHIP). The Steering Committee decided to pursue funding for PHIP through a nationwide effort to enhance states' public health capacity. The national effort, called *Turning Point: Collaborating for a New Century in Public Health*, is jointly sponsored by the Robert Wood Johnson and W. K. Kellogg Foundations. It is a national grant for which 45 state partnerships in collaboration with hundreds of local communities competed for funding.

The essence of Turning Point PHIP in Kansas is a two-year strategic development process to "reengineer" public health.

The Kansas state partnership and two county partnerships (Wyandotte and Reno counties) are among 14 states and several dozen local partners to win two to three years of grant support. Including $300,000 of matching funds from KHF, over $720,000 will be used for PHIP in Kansas. Governor Bill Graves appointed a commission to guide and oversee the program. The commission consists of nine individuals with long-standing leadership roles in Kansas education, law, managed care, nutrition, hospital delivery, and medicine. Commission members' skills and interests complement the project's public health focus. KDHE will manage the process, commission special studies, facilitate communications, and create project work products.

The Turning Point partnership in Kansas emphasizes (1) transforming and strengthening the public health infrastructure for community health improvement, (2) forming tighter linkages with clinical medicine and a broadly defined group of stakeholders, and (3) supporting local public/private partnerships (those both funded and unfunded from the grant). The essence of Turning Point PHIP in Kansas is a two-year strategic development process to "reengineer" public health. Four elements are critical to program success:

1. *Assess the public health system.* Identify where enhancements to infrastruc-

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ture (i.e., financing, organizational structures, governance, education, systems, and statutes) are needed. Identify administrative inefficiencies, time-consuming "handoffs" between management layers, and areas for better matching technology to needs.

2. *Study partnerships and communications.* Evaluate the scope and quality of relationships within the Kansas public health system, and linkages with other state and local community stakeholders. Point out areas for enhancing the frequency, richness, and effectiveness of communications.
3. *Formulate "change prescriptions" for public health.* Identify from the range of possible improvements where best practices can be replicated in the state, where incremental efficiency improvements are needed, and where broader streamlining and transformational processes may be required.
4. *Shape consensus around an attainable vision to guide future efforts.* Craft a vision to improve public health in Kansas, shape consensus around the vision, and form a base of political support to enhance capacity and ensure effective management, policy development, and delivery.

At the end of the process, an actionable plan will be crafted for redefining public health in Kansas. The plan will address the overall structure of public health, its component parts, and interorganizational linkages that need to be created. Pilot projects and demonstrations will be created to help facilitate implementation.

The Accountability in Health Care Purchasing Work Group

A group of private organizations and public agencies purchasing health care for employees, dependents, and Medicaid and Medicare populations in Kansas began meeting as a workgroup in mid-1996. The Accountability in Health Care Purchasing Work Group was spearheaded by the chair of the state senate Public Health and Welfare Committee and the executive director of benefits and compensation for the state's largest utility company, Western Resources, Inc. Inspiration for the workgroup came from the Milbank Memorial Fund's *Reforming States Group*. Workgroup members represent large purchasers of health care (private corporations and state employees), two business health coalitions, health plans, care providers from hospitals and physician groups, the Health Care Financing Administration's (HCFA) Region VII Office, Medicaid, the state peer review organization (PRO), KDHE, the insurance department, the governor's budget office, the University of Kansas, Department of Health Services Administration, and KHI (see Figure 1). The author has helped to facilitate group activities.

The workgroup is a voluntary entity meeting regularly to incubate ideas, reach consensus, and implement strategic initiatives. Participants value more unified approaches to identifying problems, measuring health plan performance, and allocating resources. Standardizing health data, formalizing collaboration, and continuing market-driven dialogue on continuous quality improvement are among the group's priorities. The mission

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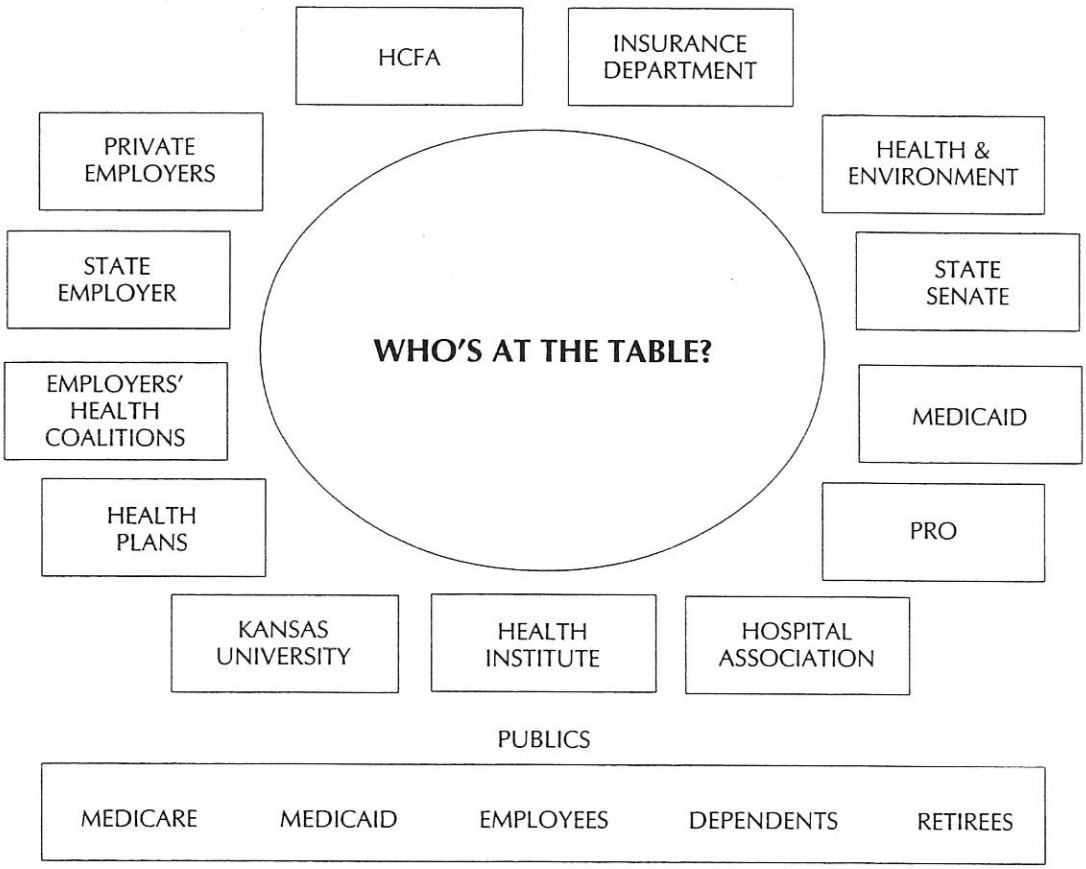

Figure 1. The Accountability in Health Care Purchasing Work Group.

statement is: *To use information on health care, health care outcomes, and health coverage to advance the ability of purchasers to make well-informed decisions and improve the health status of covered populations.*

From time to time the group adjusts its focus from studying issues to implementation. Inclusiveness is the underlying theme. Efforts are ongoing to extend the workgroup's reach to more participants. One of the group's strengths is that several of the participating organizations have both an executive-level policy leader and an operations director involved in the initiatives.

The workgroup's discussions during 1998 are focusing on gaining consensus among large employers, health plans, providers, and government agencies regarding standardized health data. Three related efforts, described below, are also underway:

1. The Purchaser–Provider Dialogue: a series of discussions being facilitated

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between medical directors of health plans and employee benefits managers of large employers.
2. The Consumer Assessment of Health Plans Survey: A statewide survey measuring quality from the perspective of employees, dependents, Medicare recipients, and Medicaid enrollees.
3. Enhancing Health Policy Development in Kansas: An initiative to coordinate policy formulation, planning, and evaluation across state agencies and the private sector.

The Purchaser–Provider Dialogue

The *Accountability in Health Care Purchasing Work Group* was the impetus behind a series of discussions among human resources directors of 15 large Kansas employers and medical directors of 6 of the state's largest health plans. These discussions, held in 1997, have been centered around employers and plans with offices in Topeka and Kansas City. The group is cochaired by employee benefits directors from the state of Kansas and Farmland Industries, Kansas City. The Mid-America Coalition on Health Care has facilitated the initiative. Participants convened as a large working group, then as three subgroups focusing on specific areas of common interest. Topics for discussion in the subgroups included (1) standardizing data for more uniform performance measurement across health plans, (2) ways to facilitate better cooperation between employers and health plans, and (3) worksite wellness and health promotion initiatives. The objective of the subgroups is to identify and discuss areas of concern, and come to some conclusions about how employers and health plans can cooperate to accomplish mutual objectives.

At the end of six months, results of the discussions were summarized and adopted as a consensus statement with six key points:

1. Employers, providers, and health plans must collaborate, educate each other, and come to agreement on ways to contain costs, ensure quality, and improve population health status. Costs will continue to climb and fragmentation will be perpetuated if there is an absence of consensus and one group has unrealistic expectations of the other.
2. The collective and individual responsibilities of employers, health plans, and providers must be identified. An approach must be developed to involve more employers, as well as to include providers in further discussions. Health plan medical directors must encourage more continuity in contractual relationships so that their providers can better manage care and meet employers' performance objectives. Employers should consider writing contracts with their health plans that extend for a three- to five-year period to really let managed care take effect.
3. Many employers do not understand how the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS) measures meet their needs. Employers expressed great interest in aggregate measures of the health status of their own employees and dependent populations. Employers, providers, and health plans should come to some agreement on a minimum data

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Employers should invite health plans to assist in defining the philosophy and objectives of wellness programs for employees and dependents.

set that is actionable, mutually beneficial, and implementable with a cost-effective information system.

4. Creation of a minimum data set should include some measures of quality, outcomes of care, resource consumption, and consumer satisfaction. The effectiveness of initiatives focusing on prevention and early detection of high-risk conditions should also be measured. Employees should be provided with incentives to utilize health services appropriately.
5. Employers and health plans should identify ways to better integrate the variety of benefits plans available to employees and dependents. The provision of medical benefits should be integrated with disability management, employee assistance programs (EAPs), health risk appraisals, wellness initiatives, pharmacy benefits management, and disease state management. Development of measures should follow national measurement efforts already underway. Expensive administrative reporting requirements should be simplified.
6. Employers should invite health plans to assist in defining the philosophy and objectives of wellness programs for employees and dependents. Employers' requests for proposals (RFPs) for managed care coverage should provide for worksite wellness and health promotion.

The final recommendation of the Purchaser-Provider Task Group was to extend its existence for six more months. Efforts to set an agenda, gain funding, and regroup for more pointed, actionable deliberations in 1998 are underway.

The Consumer Assessment of Health Plans Survey

A Kansas partnership was formed through the Accountability in Health Care Purchasing Work Group in 1997 to participate in the demonstration and evaluation of a national survey spearheaded by the U.S. Agency for Health Care Policy and Research (AHCPR). The survey, called the Consumer Assessment of Health Plans Study (CAHPS), allows consumers to evaluate their health plans. Consumers can rate the overall quality of their health plans, relationships with their providers, the perceived quality of care, availability of education and preventive services, the plan's administrative burden, and continuity of care. Survey data are comparable across managed care, point-of-service, and preferred provider plans. Data from Medicaid and Medicare beneficiaries, government workers, and private sector employees are also comparable.

The Kansas partnership provided the most broadly representative CAHPS survey sample in the United States in 1997. The Kansas Health Care Commission (purchasing health care for state employees, dependents, and retirees), Western Resources, Cessna Aircraft Company, Medicaid, and the Kansas Foundation for Medical Care (KFMC) sur-

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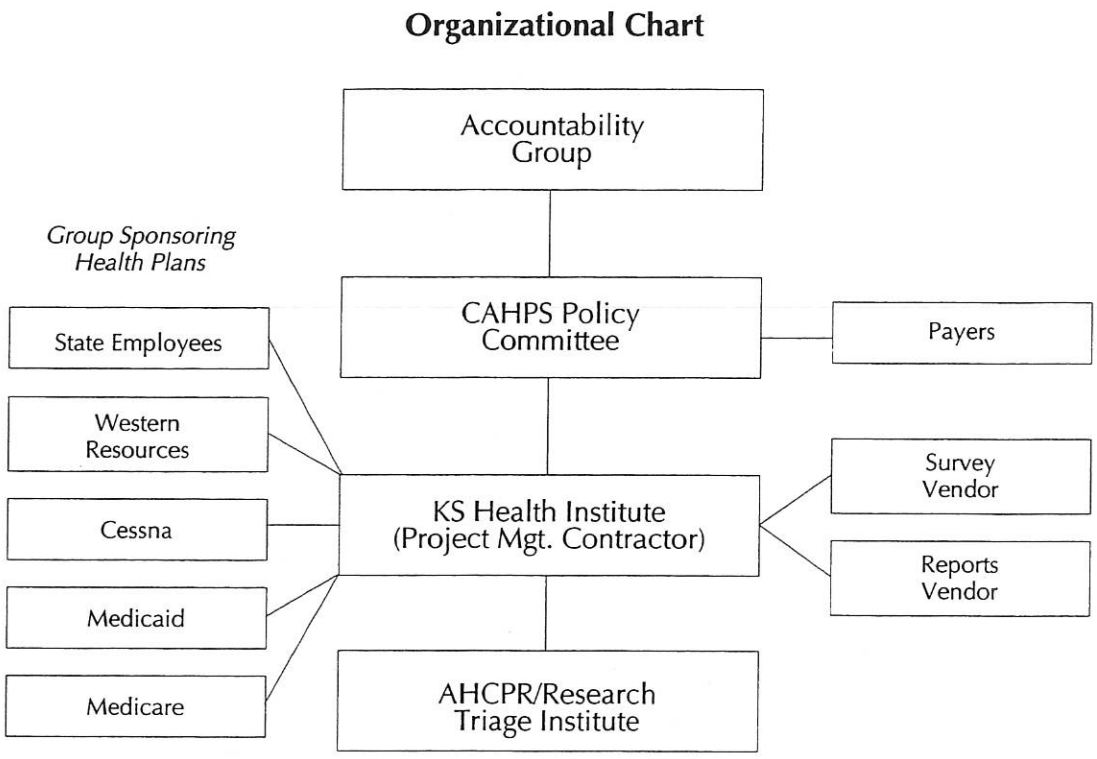

Figure 2. Consumer assessment of Health Plans Study: Kansas Demonstration and Evaluation, in collaboration with the Agency for Health Care Policy and Research.

veyed their respective populations (see Figure 2). KFMC (the state's PRO) surveyed Medicare and Medicaid beneficiaries under contracts with the HCFA and Medicaid. The KDHE Office of Health Care Information, KFMC, and KHI provide ongoing project management and technical support. AHCPR's national demonstration team was led by the Research Triangle Institute (RTI).

Between May and December 1997, nearly 15,000 surveys were administered across Kansas. Overall response from the random sample of employees, dependents, Medicaid enrollees, and Medicare beneficiaries exceeded 50 percent. Project costs were kept to a minimum because all of the work was performed by the Kansas/CAHPS partners. Surveys were mailed to employees of Western Resources, Cessna Aircraft Company, and the state in Wichita, and to Medicare and Medicaid beneficiaries in the Kansas City area. The Medicare sample crossed the state line and included Missouri beneficiaries and the Missouri PRO. A statewide sample of Medicaid enrollees was also drawn and polled by phone.

State employees, Medicaid enrollees, and Medicare beneficiaries are receiving printed reports with side-by-side evaluations of their health plans. The reports include definitions

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of plans, worksheets for individual plan selection, overall ratings of plans, and detailed evaluations of various features of the plans. RTI and the University of Kansas, Department of Health Services Administration are evaluating how well CAHPS works and the extent to which the information influences consumer decision making and plan selection. Western Resources and Cessna Aircraft Company are using the survey results for future negotiations and health plan selection.

While Kansas health plans have been kept informed, the CAHPS initiative has been independent of health plans' own customer satisfaction survey efforts. However, health plans contracting with the state Medicaid program will be required to adopt CAHPS in the future, as is also the case with health plans serving Medicare beneficiaries across the country. Members of the Kansas/CAHPS partnership and the Accountability in Health Care Purchasing Work Group see considerable merit in using CAHPS as a basis for more structured and coordinated dialogue with health plans serving all Kansans. Aside from survey results, there are a lot of issues to be discussed. Differences in the benefits packages across employers affect comparability of CAHPS results. Also, the inability to identify specific hospitals and physicians in the survey minimizes providers' ability to utilize survey results for targeting quality improvement activities. The Kansas Employer Coalition on Health, instrumental in the effort to launch CAHPS in Kansas, is examining how it can facilitate administration of future CAHPS surveys to broad groups of Kansas employers. Future involvement by health plans will also be influenced by the extent to which the National Committee for Quality Assurance incorporates CAHPS data into its accreditation process.

Enhancing Health Policy Development in Kansas

A cooperative effort is underway to enhance health policy formulation in Kansas by securing funding through the Robert Wood Johnson Foundation's State Initiatives in Health Care Reform 1997 program. Submission of the proposal is being led by the Office of the Governor and the University of Kansas, Department of Health Services Administration. A Steering Committee comprised of state agency leaders and members of the Accountability in Health Care Purchasing Work Group is directing the effort. Members of the Kansas partnership include chairs of the Senate Public Health and Welfare Committee, the House Health and Human Services Committee, and the Joint Committee on Health Care Reform Legislative Oversight. Also included are leaders from the Kansas Department of Social and Rehabilitation Services (managing the Title XIX and Title XXI programs), the Kansas Insurance Department, the Kansas Health Care Commission, KDHE's Office of Health Care Information, HCFA's Region VII Office, and KHI. Participants from the private sector and associations will be invited to participate once funding is secured.

The program goal is to invoke a visible, sustainable process for formulating, coordinating, and evaluating health policies to improve access to affordable health insurance and quality health care in Kansas. Coordination among government agencies and the private sector would be enhanced to respond to gaps in health services access and insur-

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ance coverage stimulated by changes in the marketplace and federal initiatives. Assistance in policy formulation, strategy development, and program evaluation would be available to leaders responsible for expanding children's health insurance coverage and integrating health care purchasing among larger public and private sector purchasers. Special studies of the state's health insurance markets would also be conducted. Three objectives are guiding Kansas partners' attempts to launch this collaboration.

Objective 1: Low-income uninsured children

Objective 1 is to assist Medicaid in effectively and efficiently expanding health insurance coverage among low-income uninsured children in Kansas by providing staff support for policy formulation, strategic planning, and program evaluation. Proposed policy work would be linked to Medicaid's roll-out of the *Children's Initiative*, the Title XXI program to enhance insurance coverage for children. Emphasis will be placed on evaluating (1) the effectiveness of outreach and enrollment efforts, (2) the provision of appropriate services and benefits to children, (3) program impact on health status, and (4) evidence of "crowd out" in the private insurance markets. (Crowd out involves substituting publicly funded health insurance for policies that otherwise would have been purchased in the private market.) Studies of fee adequacy and ways to emphasize prevention would be conducted, as needed.

Objective 2: Coordinating health care purchasing

Objective 2 is to increase the value of public funds spent on health services and health insurance by coordinating health care purchasing among the state's largest organizations, other public agencies (for example, among the state's 300 school districts), and selected large employers. State purchasers include the Kansas Health Care Commission (responsible for purchasing health care and disability coverage for 90,000 state employees, dependents, and retirees) and Medicaid (covering 180,000 enrollees). Program staff would help identify key issues and facilitate communications among partners committed to working together. Employer-sponsored group purchasing models like the Minnesota Business Health Care Action Group would be evaluated for adoption in Kansas.

Objective 3: Studies and strategies

Objective 3 is to conduct studies and develop strategies for improving available and affordable health insurance for small groups and individuals, possibly through pooled or cooperative purchasing strategies. A more in-depth examination of the Kansas insurance market for small groups and individuals has received a high priority among Kansas partners. Estimation of the prevalence of uninsurance in Kansas, changes over time, and development of evidence and reasons for the lack of coverage are essential to policy makers and employers. Are the uninsured ineligible because they were laid off, forced into early retirement, or did they simply refuse coverage? Are out-of-pocket expenses increasing for employees? Do the insured have serious gaps in coverage? What is the feasibility (e.g., technical, legal, or financial) and desirability of implementing a health insurance purchasing cooperative in Kansas? These and other questions form the basis for systematic inquiry in Kansas and the region.

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A critical number of concerned and proactive Kansas leaders are contributing time and guiding these health initiatives. These leaders face serious challenges collectively and on their own. They have a vision of closer collaboration in policy and strategy formulation. They understand that uncoordinated efforts may be doomed to failure. The benefits expected of effective public/private partnerships in Kansas include:

1. *Economic value to Kansas*. Cost structures for state government would be lowered by consolidating or regionalizing public health functions. Available and affordable health insurance for more Kansans would strengthen the state's competitive stance. Improved cost management would increase the value of public dollars spent on health care. Employers' costs would be lowered and employee benefits enhanced.
2. *Health status gains.* The health status of children, other vulnerable populations, service workers, retirees, and dependents should be impacted. An evidence-based approach would be fostered for measuring health status gains and evaluating outcomes of disease management. More uniform data reporting should be one of the principal results of public/private sector cooperation.
3. *Intergovernment and private sector cooperation.* Coordination will help Kansas organizations adapt to changes in the marketplace more effectively. Promoting a more consistent interface between state agency chiefs, state legislators, and private employers will ensure that future health initiatives will be supported and responsibly implemented.

Bringing people together, while challenging, is inherently satisfying, necessary, and fun. Most leaders welcome the opportunity to collaborate. There is great opportunity for a confluence of effort among public health departments, managed care organizations, medical schools, and clinical medicine. Interagency coordination (between state agencies and from state-to-local) is a requisite for greater government accountability to the public. Government leaders in Kansas seek greater coordination with the private sector, as well. Small employers are asking to join partnerships in cooperation with larger organizations. There has never been a better time to move from reactive to proactive problem solving, and given the prevalence of multiple agencies with fragmented responsibilities, to develop an overarching power strategy for community health improvement.

REFERENCES

1. Kansas Department of Health and Environment, Office of Health Care Information. *A Framework for Establishing Health Data Initiatives.* Paper presented to Health Care Data Governing Board by Data Consumers Task Force, Topeka, Kansas; 1997.
2. Institute of Medicine, Committee for the Study of the Future of Public Health. *The Future of Public Health.* Washington, DC: National Academy Press, 1988.

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