A Governor's Conference on Iowa's Emerging Health Issues

Conference Proceedings

A Barn Raising for Public Health:

Building on Iowa's Heritage in the 21st Century

June 5-6, 1997
Drake University

Terry E. Branstad
Governor

Christopher G. Atchison
Director, Iowa Department of Public Health

The health
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as a state
depend.

—Benjamin Disraeli

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF PUBLIC HEALTH
CHRISTOPHER G. ATCHISON, DIRECTOR

August 1997

Dear Conference Participant:

On behalf of Governor Terry Branstad, the Drake Center for Health Issues, and the Iowa Department of Public Health, I am pleased to send you proceedings for the Governor's conference titled, **A Barn Raising for Public Health: Building on Iowa's Heritage in the 21st Century**. About 650 leaders from nearly every county in the state attended the conference at Drake University on June 5 and 6, 1997.

Those who attended the conference have reported that they returned to their communities enriched with practical ways they can work collaboratively to improve public health. They developed their leadership skills and learned from other participants about exciting new programs. The conference proceedings should continue this process.

You may recall that on the first day we heard from the experts--speakers and panelists who could provide us with information on emerging health issues and model programs.
On the second day, after a keynote speech on public-private partnerships, participants attended leadership development workshops or breakout sessions where they used the information from the presentations to develop action plans. (These action plans in the form of systematic or tree diagrams are appended to the proceedings.) At the final session, leaders in the public policy arena provided their perspective on ways to strengthen the health delivery system.

We are committed to using the plans developed at the conference and acting on the recommendations for improving public health. The Iowa State Board of Health, the State Preventive Health Advisory Committee, and the Iowa Local/State Public Health Liaison Committee are giving priority to conference participants' input. Our immediate plans include a leadership institute to help community leaders make informed decisions at the local level and a more proactive method for marketing public health. Within the department we are using these proceedings at our annual Iowa State Board of Health retreat.

Finally, you can expect to be informed of the changes. We also will be asking you how you have applied the conference ideas in your community.

Sincerely,

Christopher G. Atchison
Director

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TABLE OF CONTENTS

June 5 - Plenary Session

Sheslow Auditorium - Old Main

8:00-9:00 AM Registration
Continental Breakfast--Old Main, Levitt Hall (Old Main, upstairs)

9:00-9:05 AM Welcome to Drake University and Introduction
R. Barbara Gitenstein, PhD, Provost

9:05-9:30 AM Governor's Remarks on *Strong Families and Healthy Communities: Their Impact on Iowa's Economy*
Governor Terry Branstad

9:30-9:40 AM Opening Remarks
Gary A. Peasley, MD, President, Iowa State Board of Public Health

9:40-10:00 AM Conference Introduction
Christopher G. Atchison, Director, Iowa Department of Public Health

10:00-10:10 AM General Announcements
Suzanne Lemon, Drake Center for Health Issues

10:10-10:30 AM Break

10:30-11:30 AM **Keynote Address:** *Setting the Public Health Agenda for the 21st Century*
John C. Lewin, MD, Chief Executive Officer and Executive Vice President, California Medical Association

11:30 AM-1:00 PM Lunch and Exhibit Displays, *Drake Olmsted Center*

1:00-2:30 PM *Showcasing Local Partnerships, Sheslow Auditorium*
Janan Wunsch, RN, BSN, IDPH, Rural Health Demonstration Project Site Coordinator
Community representatives from local private-public partnerships

2:30-2:45 PM Break

2:45-3:35 PM *Mobilizing the Community for Health*
Chair: **Kathy Beery, PhD**, Division Administrator, Rural and Community Development, Iowa Department of Economic Development
Jim Aipperspach, President, Iowa Association of Business and Industry
Jim Merchant, MD, DrPH, Professor of Preventive and Internal Medicine, Institute for Rural and Environmental Health, University of Iowa
Kathy Clasen, Business Liason for Compliance and Permit Assistance, COMPASS, Iowa Department of Natural Resources

3:35-4:30 PM *Creating Quality in the Health System*
Chair: **Charles Helms, MD, PhD**, Resource Center Director, Institute for Quality Healthcare, University of Iowa
Harry Gill, MD, Medicaid Managed Care Quality Assurance Program Manager, Iowa Department of Human Services
Jeffrey R. Harris, MD, MPH, Acting Associate Director, Policy Planning and Evaluation, Centers for Disease Control and Prevention
Jeffrey A. Ver Huel, MD, Medical Director, Blue Cross Blue Shield of Iowa

Conference Sponsors

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Iowa Department of Public Health
Drake University Center for Health Issues

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**As indicated by the asterisks, public-private partnerships have financially supported this conference.*

Barn Raising Conference
Drake University
Des Moines, Iowa
June 5-6, 1997

JUNE 5, 1995

R. Barbara Gitenstein, PhD, executive vice president and provost of Drake University, opened the conference by welcoming the participants, voicing Drake's pride in its Center for Health Issues, and introducing Iowa Governor Terry Branstad.

Governor Terry E. Branstad

Governor Branstad expressed pleasure at seeing the diversity of people who are interested in the future health and well-being of the people of Iowa. He called attention to the quotation by 19th century British Prime Minister Benjamin Disraeli, cited in the conference brochure: "The health of the people is really the foundation upon which all their happiness and all their power as a state depend," asserting that good health is good for Iowa.

There is an interest in people living in a healthier and safer place, the governor said. "Last year," according to the governor, "Iowa was ranked as the most livable and the healthiest state." He added that the annual Kids Count survey rated Iowa as fifth best in the nation for children, and that the quality of education has been consistently one of the highest in the country.

Governor Branstad said, "The family is the foundation of our state and the building block of society." Many of his efforts, he said, have been aimed at making the family safer, more stable, healthier, and more self-sufficient. When families are strong, so are communities and the state. The success Iowa has experienced has been because of a strong endeavor at the community level.

The governor listed several initiatives, including the Healthy Iowans 2000 program which began in 1991. It was an inclusive process, he continued, involving 80 Iowa health groups and citizen input at public hearings. With the state plan in process, many counties formed their own Healthy 2000 ventures. He mentioned the importance of APEX and Hometown Health, which are collaborations between state government and communities to assess local health care needs. He pointed out that the newly legislative-authorized innovation zones would enable further collaborative efforts.

The governor said he believes that good health is good for the economy because each dollar spent on prevention saves $21 in future medical costs: "The top killers in America are cancer, heart disease, accidental death, and death by homicide. Better diets, reduced tobacco use, use of seat belts, and reducing the crime rate by putting violent criminals behind bars for longer periods can help lower the death rate and improve the health and well-being of our citizens."

Governor Branstad noted that in Iowa, "We have reduced smoking among adults but are seeing a dramatic increase in teen smoking. If we keep kids from smoking at an early age, they may never start." He said tougher penalties needed to be enacted and strictly enforced, with local governments keeping the proceeds from these enforcement activities. However, he said

there was need of a more effective way to get the "don't-smoke" message to young people.

He said, "Iowa is a state blessed with strong communities." The governor mentioned he had recognized more than 25,000 volunteers the previous day and noted that most citizens who donated their time go unrecognized. He said public acknowledgment of such endeavors might help motivate others to volunteer.

The governor believes that real action is at the local level, in the community, and that is where individuals can make a difference, the governor said. He added, "We, at the state level, need to discover what we can do to encourage and support these activities."

The governor thanked everyone for coming and said he was looking forward to hearing about the ideas and information that participants had to offer.

Gary E. Peasley, MD

Dr. Peasley, a board-certified surgeon from Marshalltown and president of the Iowa State Board of Health since 1987, remarked that the board has addressed many public health issues during his tenure. "Once we know the problem, we can evaluate the results of various approaches," he said.

He said that Healthy Iowans was a major effort to improve the health of citizens by using measurable outcomes and quantifiable goals. He pointed out, however, that reaching desired outcomes may not be quite as clear-cut. "We need a further group effort, which is the purpose of this conference," he said. Dr. Peasley used the analogy of making stone soup: Put water in a big pot and add a large number of stones. Then, when other community members stop by, they add ingredients that, alone, would be insufficient. The point, he said, was that even if no one individual has the wherewithal to make soup, the collective additions create a nourishing meal for everyone. He characterized the Volunteer Physician Program as an example.

Dr. Peasley said, "Children are often underserved in multiple aspects. If communities look, they can find such children. Head lice may not be life-threatening; but abuse, violence, drugs, depression, suicide, and loss of self-esteem are critical." Dr. Peasley observed that Iowa must devise ways to help communities and schools bring needed services to where the children are: in the schools.

Christopher G. Atchison

Mr. Atchison, director of the Iowa Department of Public Health, noted that Drake University, the Drake Center for Health Issues, and the conference steering committee truly represented a collaboration of public and private interests. He also thanked conference organizer, Louise Lex, of the Iowa Department of Public Health. He said that the conference presented numerous opportunities for the 650-plus participants, representing 88 counties, to address many issues over the next two days. "The timing is good, because these issues are on everyone's agenda," he said.

According to Director Atchison, the conference theme of a barn raising was chosen because it exemplified community action. "Public health," he said, "began as a community-led effort to address sources of disease such as insects and polluted water. As vaccines were developed, programs were initiated for their dissemination; today we have eliminated smallpox and virtually eliminated polio." He called attention to recent campaigns which have targeted

chronic disease, such as the relationship between tobacco use and lung cancer.

The state public health director discussed the relationship between the medical profession and public health by using an analogy to the microscope and a telescope. He said the microscope of the medical profession looks inward toward individual diagnoses, while the telescope of public health looks outward to discover the larger scheme; and both are necessary to understand the universe. He noted, however, that there are valid grounds for concern about the future of public health. When a recent Harris Poll asked about public health, he said, the majority of respondents thought it pertained either to one's general state of health or to indigent care.

"Iowans," he said, "have consistently demonstrated their willingness to solve problems with their strength of community and dedication to the common good. We have a heritage of community and family, and the belief that together we can forge a better future."

"The dawn of a new century is a natural time to reflect," he continued. "There have been many changes in the way we assure our health and wellness, the way we organize our collective good, and in the system that delivers our health services."

He recalled Gail Sheehy's statement, "The world we face is not the world of our parents." He said a physician making house calls in today's world is merely a Norman Rockwell-esque nostalgia. He went on to say, "We now have systems and corporations of care. We are beginning to understand the interconnectedness of the various components of our lives—lifestyle and our behavioral choices (smoking, eating, exercise), education, the environment, and other factors, in addition to medical care and its cost, that have been called the determinants of health. These interconnections force us to think outside the traditional boxes to ascertain how we should partner to address them."

Changes facing public health are not limited to changes in the health system, he indicated, but also encompass the ramifications of health reform and government reform. He said, "There are more good ideas than there will ever be enough money to pay for." He further stated that we are now seeing devolution of government and a return to the local level because certain issues demand local involvement and commitment. He maintained that a locally-based value system would help obtain better results for social concerns.

The director added, "How things were organized in the past is not how they will be organized tomorrow. In our quest for greater accountability, we are beginning to ask what we are getting for the money being spent on local health care efforts. Devolution requires renewed responsibility at the local level and will provide new opportunities to develop a model that will be responsive to how the community interest will be determined, who will speak for the community, what the responsibilities will be, who will carry them out, and how those in power will be enabled."

"The purpose of this conference," Director Atchison said, "is to discover the principles we hold for health in general and how to devise a construct to utilize them. The health of a community is a shared responsibility. Specific entities must identify and hold themselves accountable for actions each can take. We must focus on community development and accountability; we must continue with Healthy Iowans, APEX, and Hometown Health. However, we must do more than organize and assess. We must take charge and act. Each has been

helpful, but is only preliminary. We must develop our values and community capacities.

"The conference format asks communities to come together as teams. Participants should use this time to share ideas about what they can work together on at home. In this new era, the community is king, and this forum can be its congress."

Keynote Speech—John C. Lewin, MD

Dr. Lewin, chief executive officer and executive vice president of the California Medical Association, stated that these are tough times for health care, because everything is in flux. He want on to say, "But it's always been tough for public health, which has never been at the top of the health care list, except for brief periods."

"In the past two decades," he said, "America has gone through radical changes in its thinking about health care. We are now very conscious about health and the individual's role in wellness. The public reacts strongly to health issues such as 24-hour hospital stays for deliveries. It's not just physicians and hospitals."

He predicted that the 21st century would be a golden age for public health. Yet, at the end of this century, he said, it looks as if, to a large extent, public health goals will still go unrealized. Dr. Lewin observed, "The extension of life span in the last century was due largely to public health issues: sanitation, communicable and chronic disease control, education, and environmental health. Yet, health care gets the focus and the money."

Dr. Lewin characterized himself as an internist who kept returning to public health, claiming that any physician who cares about the well-being of his or her community will be drawn more and more toward public health, because of existing threats:

- More than half a million people in the US have been diagnosed with AIDS, two-thirds of them have died; and 50% of those with HIV don't know it yet. Despite such evidence, fewer than 10% of physicians in a California sample routinely take a sexual history.
- There are 8 million new cases of tuberculosis worldwide, and, each year, 2.9 million people die of it. In the United States, TB has increased by 20% since 1985.
- In 1918, 20 million people died of influenza. Yet each year $25 million is spent to treat flu that could be prevented by vaccines. Also, there is the possibility of another pandemic, because viruses mutate.
- Milwaukee's water supply infected 400,000 of its citizens in 1993; 440 were hospitalized and 100 died.
- Iowa is currently dealing with a hepatitis threat.
- *E. coli* surfaced in meat in Seattle and in juices in California. The Washington Health Department was able to diagnose the problem, but California missed it because the state had eliminated lab screening tests for food.
- The Hanta virus has appeared in 12 states.
- There are 400,000 diagnosed cases of *Chlamydia* and an estimated 3 million undiagnosed cases.

"People tend to think of public health as part of the infrastructure," he observed, "and therefore, they don't need to think about it anymore. But, as we have seen, when it breaks down we realize how important it really is."

Dr. Lewin expressed gratitude for the tools of modern medicine: "We have come

a long way since Voltaire, who said that a physician's role was to entertain the patient while nature effects the cure. ...Despite noteworthy technological accomplishments, we are still drawn back to public health...to prevention."

When he worked among the Navajo Indians, initially Dr. Lewin was outraged by the lack of an intensive care unit. But he soon discovered there were greater, more fundamental problems. In order for one patient to soak his foot for a diabetic ulcer, he had to haul water. Other patients could not come to the clinic for early treatment because of a three-hour commute or lack of transportation. Some died of rheumatic fever (this was in the 1970s). There was a scarcity of penicillin to treat strep throat.

With England's help, he said, Hawaii established a health department in 1850, because it valued community health. After a period of time, conditions began to deteriorate. Plantation owners sponsored health care for their workers, but when that era ended, health care decreased. By the time statehood occurred, public health services were almost nonexistent. In the 1970s–80s, pesticides were discovered in milk and a public outcry over ocean contamination prompted a revival.

During this "Camelot period," he continued, public health was again in the forefront. Community-based efforts reduced child abuse by 50%; gains were made in maternal and child health; and testing, treatment, and education for AIDS began. Hawaii achieved its best health standards in the late 1980s. Under an employer-based health insurance system, 97% of its citizens attained health insurance coverage. But things began slipping again.

If people don't have insurance coverage, he said, "Access takes place at more expensive emergency rooms or tertiary care centers." Hawaii's secret, according to Dr. Lewin, was that people had access to primary care and received early treatment.

He went on to say, "The state put public health in charge of solving the access problem. It was involved in discussions, thereby attaining status as a trusted neutral party." Early in the process, public health jumped the traditional boundaries and made alliances with social services, the school system, and the business community.

In Hawaii, the safety-net providers formed Aloha Care, an HMO which treated high-risk populations. Although privatization eventually occurred, it was truly community-based public health. Yet, he said, as access to care increased and the safety net could not be narrowed further, public health could not seem to find its way out of the primary care and access issues; and it became unwilling to deal with the original challenges that had been neglected for so long.

In California, Dr. Lewin said, managed care is prolific, with 75 % of Californians under age 65 now enrolled in HMOs. Doctors have ceased fighting managed care and have formulated three goals: make managed care work, increase access to achieve universal coverage, and put public health back in the forefront. This shows that physicians are using an appropriate set of clear values to make health care work, he said, and this has resulted in some new partnerships, integrated delivery, and an emphasis on greater quality and outcomes. There has been a 16% reduction in premiums over the last two years. But physicians also have the responsibility of ensuring that patients remain the first priority, ahead of profits, he asserted.

Dr. Lewin cautioned about the downside of managed care. Uncompensated care in the state has risen due to capitation and "cherry-picking," or covering only those who are healthy with a low risk of needing

health care, he said. Because managed care has not solved the problem of access, the uninsured population has increased by one million in the past three years. He said there are good and bad examples of Medicaid managed care in both Hawaii and California.

He believes public health has lost because it winds up caring for those without coverage. But it has started to think about inserting itself in the integrated health delivery system.

According to Dr. Lewin, "We need to look at what the private sector role will be in the future." So far, he said, it has concentrated on unloading the overcapacity in specialization and on converting to a more prevention-oriented philosophy. But Dr. Lewin pointed out that it will also need to hold government responsible for setting the standards. Government's responsibility, he said, is to provide a safety net, to fund core public health functions, and to be a leader in providing population-based data to understand how the health care system is really doing; for example, if managed care is really working. Government also must show accountability for the tax-supported health care it provides.

Dr. Lewin stressed that Iowa should not copy California, but learn from it. When nonprofit health care providers convert to for-profit status, he said, they double their value. The state's Department of Corporations, therefore, requires that, prior to conversion, nonprofit providers put the equivalent of their worth into a foundation. This has resulted in $5 billion in money dedicated to public health..

Dr. Lewin stated that California spends $4 billion annually on the health care needs of 1.5 million uninsured citizens. However, if this money were pooled, it could purchase insurance coverage at current rates for 4 million people. Dr. Lewin believes that these are the kinds of changes that are needed.

Proposition 99, he explained, is a cigarette tax that raises $400-500 million annually for the state with proceeds going back to primary care, health care and education. In addition, the business community has decided that public health values and goals are important, and public health is working with businesses to further common goals.

Dr. Lewin described the union of general health care and public health as a "shotgun marriage—we have to do it." Right now, he said, they are separate worlds. Dr. Lewin described the health policy pillars as access, quality, and cost containment; while the public health pillars are assessment, policy development, and assurance. Because of public health's preoccupation with filling in the gaps in health care, it has not paid much attention to its pillars. "Yet, that is where we must put our first priority," he said.

Dr. Lewin cited the new edition of the Institute of Medicine's *Future of Public Health.* According to this report, public health is in such disarray that it will disappear unless changes occur before the end of the century.

"Secretary of Health and Human Services Donna Shalala has indirectly signified a continuing need for public health activities by proposing Year 2010 National Health Objectives," he said. But there are problems because public health does not have political clout. In public opinion political priorities and health rankings, public health is "out there" somewhere. It takes a disaster to get public health back in the public eye.

"So, how do we impress the public?" he asked. "We do not lack facts. The 10 leading causes of death (heart disease, cancer, cardiovascular disease, etc.) fall under the $1 trillion umbrella of health care costs. In fact, the 10 <u>actual</u> causes of death

(tobacco, diet/inactivity patterns, alcohol, certain infections, etc.) will have to be dealt with outside of traditional health care to be able to expand access to the uninsured, or to deal with other unmet issues such as mental health and long-term care."

"Although we have compelling data," he said, "Americans do not believe that public health principles will change lifestyles. We spent a lot of money on tobacco education, yet teenagers are smoking at a higher rate. The public sees no results, so it does not want to allocate additional funds. We must provide measured results; if we do not have time to perform such assessment, policy, and assurance duties, we will not get money."

Dr. Lewin then asked, "What contributes to health status? A California survey last year listed clean air and water, safe neighborhoods, good schools, good recreation facilities, and well-paying jobs. High quality health care was at the bottom of the list. The latter ranking was higher among individuals who do not currently have access to care."

"Public health is all of these things," he said, "...if we move out of our traditional boundaries and court data to help people see what changes to make to help improve their health status. Therefore, we do not lack clout."

"Another complaint," he continued, "is that we do not have the money to do the job. Should we ask for a tax increase? Sin taxes? The health care delivery system generates $1 trillion per year. One answer would be to combine public health and the health care delivery system, with the savings from an improved system being put back into the community. This is hard to do when the local health care entities are owned by corporations in other states—another reason it's critical for communities to keep hold of what is important in their domain.

"What if we spent one-sixteenth of the budget on prevention? This cannot happen if public health agencies are fighting with the provider side over resources and patient care. We must get around this, because public health will lose that battle. It must be a partnership."

Dr. Lewin called for more dynamic public health leaders. He said, "Physicians have to be more involved in a leadership role, advocating for public health in community health issues. We must have health as our central vision and develop methods to measure our efforts. We must put the access problem under the umbrella. Whatever we do must be politically savvy. We will have to pay salaries comparable to the private side to attract good people to public health positions."

"What do we do in Iowa?" he queried. "Let the marketplace solve the problem for us? That hasn't worked. Let government solve the problem?" In answer, he quoted an acquaintance as saying, "When you get in bed with government, you gotta know you're gonna wake up having had more than just a good night's sleep." Yet government must be involved in setting national policy and standards, he asserted.

Dr. Lewin then presented the following list of "must-dos" devised by those involved in the *Future of Public Health* effort:

1. Engage all components of the community—business, labor, religious organizations—and measure the outcomes.
2. Change the education process. The doctor/patient relationship is being destroyed in managed care, and Dr. Lewin predicted a rebellion. Public health must learn intimately the problems involved in patient care, and private providers must learn more about public health. He also stated that education must cross the boundaries of other disciplines.
3. Create joint research projects.

4. Devise a shared view of health and illness which goes beyond treatment and discharge and which resembles a continuum. Ways need to be developed to literally and statistically improve health by monitoring what has been invested in the continuum.

5. Integrate health care and public health delivery (the previously mentioned shotgun marriage). One key component is public/private collaborations at the community level.

6. Create joint health care assessment measures. By periodically publicizing population-based data, public health will be in a leadership role.

7. Fund public health, particularly efforts related to crime, disease prevention, and education, from related savings in health care. Dr. Lewin believes this is a better statement than the original seventh point in the Institute of Medicine report which proposed a national council to coordinate and perform measures listed in numbers 1 through 6. The coordination, he said, is occurring at the local level, where it needs be.

Dr. Lewin said public health needs to think in terms of the role of policy, and not just in delivering health care.

Dr. Lewin issued this challenge to conference participants: "This is the ideal time to tackle problems in the health care system, to bring all players together, to put health first. It will be hard work. We have the knowledge, the tools, and the ability. But we must seek something short of Camelot, something that is sustainable. But considering what we have before us, it is an economical imperative. It is an ethical imperative. Press on."

Showcasing Local Partnerships Panel

Janan Wunsch, Rural Health Demonstration Project site coordinator for the Iowa Department of Public Health, served as chair of the panel. In her introduction to the panel presentation, she said that she deals with community development to support community health as one aspect of her job. Wunsch pointed out that Iowa has many efforts to address health care issues at the community level: "A majority of counties are involved in some form of assessment and planning. Communities that organize and plan together will be positioned to address change, to increase access, and to promote more effective quality of care."

Representatives from four communities presented information about their collaborative efforts which have led to more efficient use of available resources. The following summarizes this information.

Monroe County

Presenters were Dan Stocker, a banker; Dave Johnson, Albia Industrial Development Corporation; Charlene Crall, school nurse; and Theresa Johnson, education and wellness supervisor at the Monroe County Hospital. All are members of the Monroe County Health Care Steering Committee.

When the steering committee was organized in 1985, it judged the available data insufficient and conducted its own survey to define these priority issues:

- High cost of health insurance
- Mental health
- Wellness center
- Children's issues
- The impact of drugs and alcohol on the community
- Occupational health issues
- Available, affordable senior housing

Panel members said that various efforts are underway to address these problems.

One panel member pointed out that the community is no longer trying to create jobs to attract people, but is, instead, targeting general community development issues. A housing work group wants to open up housing opportunities for everyone, not just seniors. Another panelist stated that wellness has become a public and business concern and observed that large employers offer good health coverage for employees, but start-up and retail businesses frequently cannot afford to provide this benefit.

When children registered for school, the committee surveyed how many families had insurance, were underinsured, or had no insurance. Out of the 535 families responding, 404 had insurance (with several commenting that because of rises in premiums, they did not know how much longer they could retain their coverage); 71 defined themselves as underinsured, and 53 had no insurance (seven of them because of pre-existing health conditions). The committee intends to follow up the survey results with respondents.

In Monroe County, the school nurse and the public health nurse work together closely. The Hepatitis B vaccine was provided for 7th graders, and 90% of the students participated. When grades 9-12 were offered the vaccine for a nominal fee, 68% participated. The survey showed that 90 of the 400 high school students had not had their second MMR (measles, mumps, and rubella vaccine), but only 30 responded.

Cardiovascular disease, cerebrovascular disease, and Alzheimer's disease carry the greatest mortality in the county. Monroe County Hospital defined the cardiac and stroke populations and provided free classes. In addition, it offered an Alzheimer's disease course and is considering one on menopause. The hospital also obtained a grant for a program on smokeless tobacco aimed at third-graders. It offered a stop-smoking class for adults, but only four people signed up.

The local rural electric cooperative sponsored a PSA (prostate-specific antigens) screening for male workers or spouses. Twelve men had positive results. The cooperative also offered osteoporosis lectures for female employees or spouses.

Another result of collaboration is that a local motel owner has offered the use of his pool for the past two years at a small fee for water aerobics classes.

The community also wants to establish a wellness center close to the hospital that could provide meeting rooms and incorporate the use of pools/whirlpools for physical therapy.

When the hospital was approached by the Monroe County Sports Federation for help in hiring a sports coordinator for the area, the staff discovered the high school was offering a part-time position for a teacher/coach. Together the three entities were able to fund a full-time position.

The steering committee intends to bring in other groups to participate in its future endeavors.

Dubuque's Childhood Lead Poisoning Prevention Program

Presenters: Mary Rose Corrigan, city public health specialist, and Kathaleen Lamb, city senior housing inspector.

When Iowa mandated rental housing code enforcement in 1981, the housing agency asked local public health representatives to participate in the inspection process. Because an estimated 5,000 Dubuque houses contain some lead paint, the coalition obtained a grant from the Iowa Department of Public Health in 1994 to start a childhood lead poisoning prevention program targeting

children ages 6 and under (9.5% of the population).

Initial tasks included training staff, purchasing a computer, and updating the housing code to permit enforcing the removal of lead paint in a house where a child was at risk. The organizers made a successful presentation to the community commission for permission to use a portion of the city's federal block grant for these items not covered by the state grant: purchase of three special vacuums to loan to property owners; funding two regional conferences to educate the public, realtors, parents, and property owners; creation of a fund from which to loan a maximum of $3,000 to property owners identified as housing poisoned children; and provision of free paint to income-qualified property owners. The coalition conducted risk assessments in all properties being rehabilitated.

Presenters said that the program has widened its base considerably. It partnered with the Visiting Nurses Association to perform medical case management on lead-poisoned children. Visiting Nurses is now computer-linked with the housing and public health agencies and has applied for its own grant. Area physicians' offices provide ongoing testing of poisoned children. A local youth-empowerment foundation has helped with community education. The program also works with the board of realtors and the Old Home Enthusiasts group.

Representatives from Housing and Urban Development (HUD) and the Centers for Disease Control and Prevention (CDC) spoke at Dubuque's coalition-sponsored conferences. HUD was impressed with the program and provided an unsolicited grant application. The program allied with other groups for matching and in-kind funds. As a result, the coalition was awarded $3.69 million for three years. Under the grant, the program plans to do blood, soil, and dust sampling at the beginning and the end of renovation and wants to have results documented by researchers.

The coalition found it must constantly remind the community that lead poisoning is a health issue as well as a housing issue: As a family's housing improves, its health improves. In addition, the panel pointed out that parents must be educated that remodeling projects can be a health hazard to children.

The coalition wants to expand and become part of a primary prevention program—to screen houses before children become lead-poisoned. It wants to be successful with its grant and program, and to become a model for other communities.

The coalition concluded that people must "let go of pieces of the pie," because the problem is too big to solve alone. By letting go, coalition members were able to combine personnel, funding sources, input, and resources. They were successful because they benefited from the expertise of each of the stakeholders; and together, they were able to do what each could not do alone.

Webster County Community Action Network

Presenters: Jim Patton, Webster County Extension director; Martha Hoard, adjunct faculty, Buena Vista University; and Randy Kuhlman, senior staff member, Trinity Regional Hospital. All are members of the Community Action Network Steering Committee.

Webster County has a population of approximately 40,000, of whom 30,000 live in the county seat, Fort Dodge. When Trinity Regional Hospital and United Way formed the network in 1995 to work on a health and human service survey, a number of independent community efforts were already underway including the following:

Fort Dodge was one of 17 US cities participating in Community Solutions for Rural Health. The Iowa State University (ISU) Extension office, the ISU Social and Behavioral Center for Rural Health, and the Iowa Department of Public Health's Office of Rural Health were assessing the health and human services needs of 700 people. Another grant funded a needs assessment of more than 100 county youth, and there was a youth health survey being conducted in the high school. Each group was aware of what the others were doing, and there was no duplication of efforts.

Trinity Regional Hospital donated $200,000 toward a start-up coalition and assigned Randy Kuhlman as staff to keep the effort going. The hospital also sponsored a conference at which the 116 attendees were asked if they wanted to continue working on the issues raised. One of the first concerns was, "What is community health?"

The coalition defined itself as a "community" (broad-based) "action" (representing its primary purpose) "network" (working with existing organizations/ agencies). It felt strongly that solutions needed to come at the local level and took its time to clarify goals and develop a common language. Its mission statement is "Working together to build a healthier community."

The steering committee realized the need to define health as more than just sick or well, and focused on the major areas of youth, families, and seniors. As an ongoing vision of service, committees are investigating several key issues.

The network developed a computer database to inventory the 150+ organizations and agencies which were already providing services in Fort Dodge. Through a collaborative effort, the network recently hired a full-time grant writer. A newsletter has kept the community informed about its efforts.

The steering committee admitted the concept of collaboration is "scary," because organizations are used to competing with each other for services, recognition, and grant funds. Small coalitions had worked together for a number of years, but to do something as a community was a new paradigm.

The steering committee's procedure was to define the issues, prioritize them, and begin. In the process of entering community information into their database, members discovered they really did not know what services were being provided to whom or by whom. The database enabled them to see what gaps existed.

The presenters stressed the need for information and communication. They stated that community apathy is a big issue, as is looking at health from the old medical model (individually) instead of holistically (the community). A network goal is to find a way to measure outcomes as proof of the viability of their efforts.

Clinton County Gateway Initiative 2000

Presenters: Paul Willging, executive director of the Clinton Substance Abuse Council; Tom Krogland, coordinator for the Clinton Community School District; and Denise Schrader, executive director, Clinton County Visiting Nurses Association.

The Substance Abuse Council that was the precursor to Clinton County Gateway Initiative 2000 began when three local businessmen decided to do something about substance abuse problems in Clinton. They viewed health holistically, and recruited other members to expand their expertise.

The group does not care why people come to the collaborative table, because members claim to be able to engage the newcomers in the process. No partner ever joined and later

dropped out. The Clinton County panel members listed their steps to collaboration:

- Come to the table; come again, and again, and again.
- Choose leaders and facilitators with passion, energy, and skill who have no overriding interests other than their belief in collaboration.
- Develop a philosophy.
- Assess your local needs.
- Incorporate a model to deliver those services.
- Implement your plan.
- Plan for sustainability.
- Celebrate your success.
- Reach out and expand your collaboration.
- Always perfect your evaluation tools.

The group has met every month since February 1989. In the beginning, all the members did was talk. They discovered the following three most common barriers: (1) turf issues, (2) turf issues, (3) turf issues. Because no money was involved for the first two years, it gave the coalition time to build trust.

Members said that today there is not a service provided in the five-county area that is not a result of the collaborative effort. The services designed are driven by local needs. The group has targeted key issues and increased funding by not duplicating existing efforts.

The presenters specified their criteria for success:

- Thorough communication. Repeat something until everyone understands; this is vital to clarity of vision.
- Collaboration and purpose of vision. When communicating, work to identify the decision-making process, and try to reach consensus.
- Relationships and trust. Both items are important for reducing barriers and receiving cooperation.
- Mix of stakeholders. This is the key to success.
- Intense commitment. Participants must be active to be effective. Time and commitment are important resources.

Members of the Clinton County initiative also discovered that when grants are received and the program issues are worked through, "natural" providers surface.

Mobilizing the Community for Health Panel

Chair Kathy Beery, PhD, division administrator, Rural and Community Development, Iowa Department of Economic Development, related that conference panelists were asked to address issues related to establishing public/private partnerships, barriers to collaboration, defining issues and building consensus, and how communities could manage competing priorities.

James A. Merchant, MD, DrPH, Professor and Head, Department of Preventive Medicine and Environmental Health at the University of Iowa, informed attendees about the following three ventures involving the university:

1. The Health of the Public Program is a recently completed collaboration on rural health care and prevention among three rural communities in Franklin, Palo Alto, and Howard counties, and North Iowa Mercy; as well as the university's Institute for Rural and Environmental Health.

The program goals included using population-based methods to help develop rural community-based health care organizations to provide quality primary health care; developing community-based prevention plans; and providing university students and faculty members as researchers.

The coalition formed a community-wide

advisory council composed of all stakeholders to survey available secondary health outcome data that previously was not readily available. A short, postal questionnaire to collect primary health outcome data achieved a 60% response rate. After analysis, focus groups helped prioritize needs, enabling the coalition to develop a plan of action. This has resulted in ongoing processes in each of the counties.

2. The *Iowa Health Fact Book* is a collaboration between the university and the Iowa Department of Public Health. It is accessible through the Internet and has some interactive capabilities, and can be downloaded and inserted in grant applications.

The university is soliciting input from communities regarding what additions would be helpful to address community health needs. Future possibilities include annual updates, additional demographic and census data, and resources for community health planning, and others, depending on available funding.

3. Another resource directory, *The University of Iowa's Continuing Commitment to Public Health,* provides specific data about business and agriculture, communities and government, education, health professionals, special learning opportunities, and telemedicine.

Dr. Merchant submitted his conclusions:

- Population-based methods are necessary to construct reliable/valid approaches to community health assessment.
- Primary and secondary health outcome data can be collected with technical assistance at low cost.
- Numerous state and university resources/databases are available to communities; others will become increasingly available via the Internet.

Leadership, Dr. Merchant said, sustained participation by key health stakeholders, and communication within the community are critical for success.

Jim Aipperspach, president of Iowa Association of Business and Industry and past director of United Way of Central Iowa, remarked that businesses are interested in health, because they cannot thrive unless their employees are healthy. When people are not feeling well, they are not productive.

He asked, "How do communities operate? What shifts are taking place?" In answer, he offered a list compiled by the National Civic League:

- From homogeneity to diversity.
- From a focus at the federal level to a focus at the local level. This change has resulted in an ongoing process in each of Iowa's counties.
- From thinking about government to thinking about governments, about the process of building communities.
- From the power of the few to the power of the many.
- From the tolerance of privilege to the intolerance of privilege, providing greater inclusiveness.
- From fighting to cooperating—working until you find win/win solutions.
- From a talking style of leadership to a listening style.

At the same time, he noted some complementing realities:

- Fewer public dollars are available to deal with important societal issues.
- Challenges, problems, and solutions are becoming increasingly the responsibility of local and regional communities.
- There is an ever-greater emphasis on the integrity and effectiveness of local governments.
- Collaboration and interdependence will be watchwords for local and regional action.

- New tools must be used to enable people and organizations to agree on a plan and then work together to achieve it.
- Community power in the past was concentrated among a few, but is now more widely distributed. More people must come to the table to solve problems.
- Community populations will become increasingly more diverse.

According to Aipperspach, each community is unique, but there are some generalities. Shifts seem to be toward more inclusiveness. Coalition membership must include people of influence as well as those most affected by the problems. Staff leadership must include cultural diversity, especially of those previously most disenfranchised.

Jim Aipperspach closed by citing the United Way's position on building community:

- Helping children and families to ensure that all people are valued and that they enjoy secure, healthy and supportive relationships.
- Emphasis on literacy and self-sufficiency, ensuring everyone has the education, skills and support to participate fully in society.
- Safe, thriving neighborhoods.
- Ensuring all have adequate housing and opportunity for employment.
- Health and wellness.
- Respect for diversity.

Panelist **Kathy Clasen**, the business liaison for compliance and permit assistance at the Iowa Department of Natural Resources, said that her department regularly deals with specific public health issues, two of which were at the top of a survey mentioned by Dr. Lewin: clean air and water. Other major issues include the following:

- Wastewater. Many community sewage treatment plants now are at or are coming to capacity. Unless a plant can expand, the community cannot grow. However, many communities face multiple roadblocks to expansion.
- Livestock confinement.
- Capping of agricultural drainage wells.
- Some air problems associated with agriculture (particulates and gravel roads).
- Contaminated land or land with decreased ground yields due to chemical use.

To the question, can we have clean air and water and a booming economy? Kathy Clasen answered, "Yes." She said, "Growth in the US is greatest in the plains states." She concluded her presentation by commenting, "We must find the most economical technologies and work together."

Creating Quality in the Health System Panel

Chair Charles Helms, MD, PhD, director of the Resource Center, Institute for Quality Healthcare, said the public's concern about the quality of health care is a major issue. He raised the following questions: Do we have tools to measure quality of care? How much emphasis should we put on traditional public health services (e.g., epidemic control, environmental protection, health promotion, disease prevention) versus acute medical care? How do we apportion the responsibility for assuring essential health services are provided to all, particularly among special population groups? The panelists, all experts in health policy, Dr. Helms said, would approach the quality issue from different perspectives.

Jeffrey Ver Huel, MD, medical director of Wellmark Blue Cross and Blue Shield of Iowa, spoke from a payer's point of view. He said that in the late 1970s, utilization review was one means to assess quality. In the 1980s, cost was used to measure quality. In 1993, the government initiated the "quality of care" concept for Medicare. The major emphasis now is accountability. America in the 1990s is dealing with the industrialization of medicine, the business side of the health care industry; and terminology and philosophies used in industry are now being applied. "Yet the physician-patient relationship remains the heartbeat of the profession," Dr. Ver Heul said.

Another key concept, he said, is performance. Certifying health plans is very process-oriented, using measures to issue report cards. The Healthplan Employer Data and Information Set (HEDIS) was developed by the National Committee on Quality Assurance. Originally based on claims data, it was prone to error. Blue Cross Blue Shield was one of 21 plans that participated early in the design of HEDIS measures. However, when analyzing why the Blues did not score well, they discovered the measures did not match their plan benefits; for example, some measures had no corresponding coverage.

According to Dr. Ver Heul, the most important quality concept is outcomes. The survival of a health care plan revolves around whether the population served is better off because of what the plan does. The Blues fund a number of programs such as immunization, drug abuse prevention, and smoking cessation to improve health. The key to judging success in any venture is outcome. Dr. Ver Heul observed that many questions have not been answered such as: What should be considered a good outcome? How should it be measured? How should it be maximized?

Harry Gill, MD, Medicaid Managed Care Quality Assurance Program manager, Iowa Department of Human Services, remarked that Medicaid has always been plagued by insufficient information about quality. He also believes outcomes are the key to quality assurance, and Medicaid is developing its own system which utilizes HEDIS measures.

Nationwide, managed care is contracting with entities which are willing to be held accountable for the services they provide. Dr. Gill noted that one strength of managed care is in prevention, because it costs less than treatment. Savings have been realized through cost-containment strategies, but utilization management remains controversial. Proposals such as drive-through deliveries and outpatient mastectomies do not provide a good picture of what managed care can accomplish, he asserted. Managed care's weakness, Dr. Gill said, is that it is not structured well enough to be able to handle populations with special health care needs, because there is no consensus on how these risks can be calculated.

Jeffrey R. Harris, MD, MPH, acting associate director, Policy Planning and Evaluation at the Centers for Disease Control, pointed out that, of the leading non-genetic causes of death in the United States in 1990 (tobacco, diet/exercise, alcohol, sexual behavior, motor vehicles, drug use), only tobacco (at 400,000 deaths and one-fifth of the total) is measured by the HEDIS data set. "Therefore," he asked, "Does HEDIS deserve a place on public health team?"

Dr. Harris admitted he has a vested interest in the answer, because he spent the previous two years helping develop HEDIS 3.0. HEDIS 3.0 has 75 measures, 14 of which apply to quality of care. Some of its

strengths are that it is highly focused; it measures important processes that are linkable to health outcomes, such as functional status of older adults, low birthweight, chronic care measures such as use of beta-blockers after a heart attack; and it includes a smoking measure.

He said that its weaknesses, from a public health standpoint, are that it omits populations that switch health plans; those who are not in capitated health plans (75% of the population, including those in fee-for-service and preferred provider organization or PPO plans, and the uninsured); and that it also omits a number of important health issues. In addition, he pointed out that, though unintentional injuries were the leading cause of death in 1994 of individuals under the age of 35, HEDIS does not deal with those.

Dr. Harris discussed the following quality monitoring systems that public health agencies already have available and that could be more widely used:

1. *Vital statistics.* Dr. Harris provided information on overheads showing 1994 death data from vital statistics (see Appendix C). Using vital statistics, one Medicaid agency in Oklahoma installed fire detectors in homes and reduced fire-related deaths by 80% the first year. An HMO in Seattle used the data to reduce head injuries by giving kids bicycle helmets.

2. *Behavioral Risk Factors Surveillance System (BRFSS).* This state-based telephone survey of adults is ongoing every month and covers some clinical preventive services as well as behavioral risk factors. It also reaches the uninsured population.

Dr. Harris pointed out that BRFSS and HEDIS can combine information. In Colorado, Kaiser hired the public health department to measure the HMO's success with mammograms and pap smears, he said.

3. *State and Local Area Integrated Telephone Survey (SLAITS).* This is a new state- and county-based telephone survey of households being developed by the CDC. It is a subset of the National Health Interview Survey (NHIS) and covers health status, health insurance, access to care, and use of services.

Concluding his remarks, Dr. Harris said that HEDIS does have a place on the public health team; however, it does not come close to fully meeting data needs because it leaves out too many populations and health issues. The next step, he suggested, is to take other systems and fully utilize their capabilities. He advised, "The main thing is to go ahead and select a team and get started."

The following statements were in response to questions from the audience.

Dr. Ver Huel noted it has been proven that immunizations do help, so most grant proposals on immunization that are received by Blue Cross and Blue Shield were funded. The company also looked for sensible proposals that would make a difference such as drug abuse prevention and smoking cessation.

Dr. Gill commented that an ideal public health partner for a Medicaid agency would be able to provide statistics for items like immunization status and screening measures.

Dr. Harris related that viable HEDIS measures had to demonstrate relevance, feasibility, and scientific strength. He also pointed out that the number of measures will eventually increase, but that the attrition rate due to weeding out is high. The selection of measures is much harder work than it would seem, he concluded.

JUNE 6, 1997

Keynote Speech—Gail L. Warden

Mr. Warden, president and chief executive officer of Henry Ford Health Systems in Detroit, stated that managed care and public health can be catalysts for the success of both interests. Consequently, he believes there can be a viable partnership.

Transformation in Health Care Delivery

He said it is important to understand the transformation in delivering health care to patients. Many of these changes, he said, are directly related to public health. The emphasis on individual outcomes has been replaced by population-based outcomes; fragmented services have been replaced by a continuum of care; and episodic patient contact has been replaced by longitudinal patient contact. He said, "We cannot merely focus on treating illness; we must learn to manage health and provide education about risk." The focus has changed from acute inpatient treatment to an emphasis on primary care and prevention, but there remains a constant competition for dollars that could be used for technology and treatment.

Quality measures also are changing, Warden noted. The institutional gauges propounded by the Joint Commission on Accreditation of Health Care Organizations have given way to community measures such as the benefit to the population served. Perceived quality has yielded to outcome measures and a plethora of report cards. Quality assurance information is yielding to "Value = Access/Effectiveness/ Satisfaction." Curing illness, he remarked, is evolving into reducing morbidity and mortality, which allows one to see where the targets and obstacles are.

On the financing side of health care delivery, competition among providers is being replaced by competition among financing/delivery systems. He said that insurance companies previously bore the risk; but now, providers assume that responsibility. As this occurs, he believes that prevention becomes even more paramount.

Competing for resources is changing to aligning incentives, Warden said. His company's HMO has coverage for 900,000 individuals, and is trying to educate primary care physicians to understand the advantage of primary care guidelines.

Cost containment is yielding to "economic discipline." Most of the fat has been wrung from the system, so insurers have moved away from cost containment, Warden observed. Opportunities now relate to how to manage a population, improve the clinical process, and reduce duplication. When that is accomplished, economic discipline will be achieved, he believes.

Reimbursement on a cost basis is changing to a price basis (based on what purchasers will pay).

Health Systems Domain

An integrated health care system, Warden explained, offers a full range of services and can be depicted as a vertical triangle with nine sections segmented horizontally, each slightly larger as one progresses downward (see Appendix D). The tip of the triangle is tertiary services. The section below is acute care, followed by specialized hospitals, and the fourth is long-term care. The fifth pertains to ambulatory/specialty, multi-specialty, and high tech; the sixth, ambulatory/primary care; and the seventh is

home health services. Health and lifestyle services are next, he said, and the base of the triangle represents health care financing. Cost reduction and increased patient satisfaction and quality result from trying to get the patient at the right level of care at the right time and being able to move from one level to another in a seamless way.

Partnerships

The groups within an integrated system are characterized by true economic partnership with each other, with public health and other agencies, and with the predominant focus being on primary preventive care. This system, Warden asserted, is the organization of the future, providing economic discipline can be achieved and new strategies learned from public health can be integrated.

Factors that influence the health system domain, and which, in turn, are influenced by the health system include housing, personal health risks (such as smoking, drugs, guns), the environment, exercise, diet, worksite health risks, and education. The larger social system includes community prevention services and environmental controls.

In Michigan, public health agencies at the state, county and city levels have an important role in helping the Henry Ford Health System link with other agencies to improve health. Characteristics of a viable partnership include the following:

- Shared vision.
- Clearly defined objectives and measurable performance targets. There is a need to have "dashboard" indicators to monitor all the time. This requires having measures in place up front, not at the end.
- Trust and respect for each other.
- Proportionate share of benefits and the burden.
- Willingness to take risks to achieve something that transcends the limits of both partners.

Warden pointed out that partnerships fail because of lack of trust, perceptions that partners are not benefiting equally, loss of autonomy, lack of mutually accepted performance measures, lower levels of management not being involved in the vision in the early stages, and failing to understand needs. Just because two chief executive officers agree on something does not necessarily mean it will happen, he said.

Warden characterized the following as engines driving partnerships:

- Policies directed at one sector impact the other.
- Medicaid managed care, which will not work in most states unless the public health department specifies its population needs and details what services will respond to those needs. (Warden cited a Centers for Disease Control and Prevention study in which 26 states identified this as a problem in getting Medicaid managed care on track.)
- Public health clinics (the local safety net). One Detroit managed care program found ways to support and "adopt" the clinics instead of competing with them.
- Changing roles and expectations are making one sector's knowledge more relevant to the other.
- Frequently, managed care organizations and preferred provider organizations do not know enough about prevention benefits and how to design programs around them. Public health expertise can help organizations do a much better job.

- Fiscal, professional, and political constraints make it difficult for each sector to accomplish its mission alone, especially along the lines of documentation of needs and results. Minnesota's mandate for improving community health stated each HMO must have a plan for working with the local health department on prevention. The state found there are centers for excellence and some where the whole issue has been ignored.

Warden asserted that challenges in partnerships include using a population-based approach in tandem with the instability of enrolled populations, which may have as high as 30% turnover annually in managed care.

Another challenge, he pointed out, is regulatory intervention in managed care. It may be well-meaning, but every time a regulation is passed (e.g., prohibiting drive-through deliveries), it hinders trying to work through the programs. An alternative may be to consider how home health agencies can support shorter hospital stays for normal deliveries.

Convincing employers that prevention benefits do not have to be an add-on can be problematic. One insurance purchasing cooperative in California withheld 2% of premiums from a managed care organization until it proved it was working with public health to incorporate preventive services.

Another problem is inconsistencies in managed care organizations' prevention guidelines and the resulting inability to rate them using HEDIS measurements. Many organizations also lack experience in treating and assuming risk for high-risk populations.

Citing an article by Gil Omenn, dean of the University of Washington's School of Public Health, Warden listed three components of a population-based approach:

- Clinical preventive services, such as immunization, screening tests, and counseling by physicians and other health professionals;
- Social, economic and regulatory policies that promote healthy behavior, reduce hazardous risk exposure, and promote healthy standards of living;
- Community-based, essential public health services; monitoring health indicators; educating the public about health risks; and reducing health risks from air, water, food, workplace, consumer products, and recreational hazards.

When these components are in place, Warden said, a plan can treat a population in a broader social and environmental context and can recognize some of the special needs of that population. Some needs are mandated by geography but, more often than not, by factors such as the age of the patient (mothers and children versus seniors) or specific health problems such as diabetes. The Henry Ford Health System's Michigan product for the over-65 population has been successful because it has addressed strategies of prevention and education. Public health plays an important role in identifying what the needs are and in suggesting interventions.

There are partnership opportunities between public health and health plans, such as incorporating public health disciplines in the education of health professionals. Warden said public health needs to (1) persuade primary practitioners to think from a population-based standpoint and incorporate formal prevention programs in practice; (2) take advantage of information systems available; and (3) provide information on how to talk to patients about preventive strategies such as smoking-cessation or alcohol abuse.

Warden cited research on the predisposing, enabling, and reinforcing factors that would induce patients and doctors to respond to preventive health guidelines. In 1981, a group health cooperative with which he was associated launched a massive education effort. Since then, its insureds have experienced a 32% decrease in late-stage breast cancer; an increase to 91% in immunization rates among 2-year-olds; a 44% increase in bicycle safety helmet use; and a 10% decrease in adult smokers. These results came from doctors talking to patients and parents about what they need to do.

Warden said partnerships need to share information on best practices in health promotion and disease prevention. The strategies, he said, are more important than the benchmarks. Examples include immunization rates, screening rates, tobacco-use prevention and cessation, child safety, domestic violence, and alcohol use, among others.

Collaboration possibilities, he said, also exist on community health initiatives. For example, public health departments and provider communities are working together on programs about sexually-transmitted diseases in San Francisco and on tuberculosis in New York.

Warden urged collaboration of lobbying efforts. He said providers and public health must work together to make an impact on such issues as tobacco initiatives, immunization registry, firearms, services for the homeless, and recreational safety.

He also urged exploring the potential for health services delivery partnerships, such as the adopt-a-clinic concept..

Collaboration possibilities on performance measurement include cooperation on licensure and accreditation programs such as National Committee on Quality Assurance, trying to improve relationships at both state and national level, standardizing data reporting such as HEDIS, initiating dialogues with purchasers, and educating the public about how and why measurement is meaningful.

Warden cited an article by Don Berwick, who heads the Health Care Quality and Improvement Institute, in the *Annals of Medicine*. Berwick listed the following partnership principles:

- Focus on integrating experiences, not just structure.
- Learn to use measurement for improvement, not measurement for judgment.
- Develop better ways to learn from each other, not just to discover "best practices."
- Reduce total costs, not just local costs.
- Compete against disease, not against each other.

If a partnership is to be successful, it is essential, Warden said, to foster communication among the partners at all levels; to facilitate coordination of diverse perspectives, resources, and skills; and to clarify boundaries between independent missions and shared missions so the parties feel they are in control.

Warden believes partnerships are possible, and he wished Iowa well in moving forward.

Warden made the following statements in response to questions.

"Talking about preventive care but not doing much about it may be true in a lot of organizations. However, at the same time, the combination of the increased emphasis on the National Committee on Quality Assurance, the development of report cards, and HEDIS' new COMPASS report will facilitate comparison between organizations." He cited Minnesota legislation mandating the provision of quality information, and added that one of the reasons the California group initiated the

2% premium withholding was to send a strong message about prevention.

Regarding what goals public regulation should have, specifically in reference to legislative reactions to proposals such as drive-through deliveries, he believes people using such legislation as a political expedient are not the ones who should be deciding the issue.

He said, "When there is dialogue between what a consumer feels is right, what the provider thinks is feasible, and any perspective the state may have, the outcome will be a lot better. True, the mother should not be sent home too early or if there is not support available. But, in many cases she may want to go home before 48 hours. Henry Ford has a good working and education relationship with mothers, and the result was that mothers could stay 48 hours but could go home earlier if the doctor and mother agreed."

Regarding how to develop better relationships between public health and managed care organizations, Warden advised that the first step is to discover which group is influencing the thinking in managed care organizations (in Michigan, it is the state HMO association). The second step is to search for enlightened persons within the managed care organizations and attempt a dialogue with them.

He also thought it was necessary to create forums to bring the involved parties together. For example, the development of some monitoring/reporting mechanisms in Michigan came as a result of a facilitated dialogue at an educational forum for public health, managed care, and the state medical society personnel.

He said, managed care is not against preventive care, but, at the same time, it has other challenges. Each needs to understand the other's difficulties, then talk about what each can do to resolve them.

Plenary Session, Strengthening the Health Delivery System

Chair Tom Slater, president of the State Public Policy Group, noted that several questions presented in the break-out sessions related to defining quality in health. He said, "There is an inherent conflict: individual freedom/choices versus public health and safety aspects. We have to figure out how to define quality at the community level and decide how it relates to the public as well as in personal cases. Also, there is the question of Public Health vs. public health--Public Health with a large capital letters or public health with small letters." ["Public Health" refers to state and local public health agencies, and "public health" refers to the entire spectrum of groups and organizations working to ensure the health of the community or a population.] He observed that less than 1% of the nation's budget is for public health, but as we move toward systems at the community level, more dollars and resources need to be focused on public health. He said, "We have to understand the economics of service delivery."

Slater noted that on the community side, there is a continuing struggle regarding collaboration, which has been defined as interest groups giving something up for the benefit of the whole. "Communities," he contended, "need to think about methods for collaboration among groups ranging from public health providers to private-sector providers. The challenge is to develop a system and data that translate to the well-being of the community."

Panel member **Stephen C. Gleason, DO**, Des Moines family practitioner and White House advisor on health issues, was substituting for Senator Tom Harkin. Dr.

Gleason represented the perspective of a family physician and leader of a physician group at Mercy Hospital Medical Center which has been very much encouraged by the healthier communities movement. He observed that, "At times, it seems the punitive focus of government and the economic focus of health care achieve a paradoxical result that may fail the public health." Government must be responsible for providing a helping hand to those who need it most. Communities, business professionals, labors and others also must help fill in the gaps.

At the same time, payers must still keep up their end of the bargain—delivering baseline health care. Government as a payer should increase payment for preventive activities. With adequate research, screening and preventive activities, health care costs could be decreased and the money used for other social needs of the community.

Dr. Gleason contended, "Our social fabric and ethic of caring demand adequate financing of critical activities. However, government and insurers cannot do it alone, and charity care is not enough."

Dr. Gleason went on to explain that the term, "health care," artificially limits the concept of health. Law enforcement, drug addiction prevention, education, and nutrition are all health; and no one entity can address all these challenges. "It takes neighbors helping neighbors," he said. "All other endorsements pale in comparison to the endorsement of the community."

Dr. Gleason concluded his remarks with a quotation by Victor Hugo: "One can resist an invasion of armies, but not an idea whose time has come." Healthier communities, he believes, is that idea.

Panel member US Senator **Charles Grassley**, thanked participants for spending two days discussing public health issues: Getting communities involved in health care is an important goal. Though much has already been done, there is still room for improvement, he said.

Senator Grassley said that the current transition in public health is driven by factors beyond public health. Iowa's recent hepatitis alert is only one example of the need for a strong public health sector, he said.

The Senate Finance Committee has as an objective preservation of the rural health care infrastructure. He indicated that most measures related to this infrastructure which are expected to pass in the next month, were also passed two years ago. They will pass again, the senator said, and they will be signed into law.

He went on to observe that the public health sector is under increasing strain from dwindling resources. However, until quality acute care is available to all, public health will be unable to concentrate on its central role of protecting and improving community health.

Senator Grassley highlighted the importance of preserving the rural health care infrastructure and maintaining clinical and emergency care services in local communities through community hospitals.

He has introduced a number of measures to assure that no Iowan lives too far from a hospital. The Medicare-Dependent Hospital Bill, he said, will help facilities receiving more than 60% of their patient care reimbursement from Medicare. There are 45 such hospitals in Iowa, and the bill should help level the playing field for some of them. He has also introduced a number of bills to give critical access hospitals and sole community hospitals better reimbursement from Medicare.

Senator Grassley noted that the key to quality and successful acute health care is to keep community hospital doors open. He

said, "We are talking about maintaining a quality of life in rural America, and these are basic institutions not only for preserving the public health infrastructure but for other aspects of the community as well." The loss of a hospital, he believes, is tragic for a community. The initiatives he mentioned and other measures will help protect the acute care pipeline for Iowa by recognizing the unique challenges rural areas face in providing quality health care.

Another bill the senator introduced would reform the Medicare average adjusted per capita cost reimbursement or AAPCC. Iowa's reimbursement rate is so low, he said, that virtually no managed care options for seniors are available. "Iowans are looking for the same advantages of managed care, if they want to join, as those seniors elsewhere in the country; and provider-sponsored organizations should be available in Iowa," he contended.

Locally-based providers, he said, are more likely to want a strong public health component to health care. Improving the Medicare reimbursement rate will strengthen local providers and the entire community. He said, "Such efforts fall outside the definition of public health. But if the local acute care system fails, a bigger health care burden falls on public health providers."

The senator suggested that the public health community expand its reach by developing partnerships with community agencies, such as those dealing with aging. Congregate meal sites for seniors could provide information on health promotion, wellness programs, and the benefits of exercise. He also said that existing networks could participate in public health initiatives to improve health status.

According to Senator Grassley, any discussion of public health should include substance abuse, especially among youth. He is forming a statewide anti-drug coalition to supplement existing efforts, involving business, the clergy, parents, young people, educators, medical professionals, social workers, law enforcement personnel, and other concerned citizens. He urged anyone to contact him if they were interested in joining this important effort.

Panel member Congressman **Greg Ganske** remarked that public health is very important, and used an example from his own experience in a foreign country--drinking water from a tap without fear of becoming sick.

The congressman discussed several legislative proposals. The Congressional Committee on Health and the Environment, he said, will be voting on Medicare, and perhaps Medicaid bills during the upcoming week. Since the Medicare system has only a few years of solvency left, there is a huge potential impact on aging baby-boomers. The president and congress have agreed to save $115 million in Medicare costs. He pointed out that there is the potential to save some funds in Medicaid to use for children's health care. "But can one save $115 million and still have quality and maintain quality in the system?" he asked.

He presented a brief outline of the current Medicare bill, explaining that spending will go up, just not quite as fast as if no changes were made. The bill provides two broad options. The first is to retain a fee-for-service structure and effect some savings by, for example, initiating a prospective payment system for home health benefits and hospital outpatient services, and by reducing physician payments. The alternative is enrollment in Medicare Plus, which encompasses a Medicare HMO or a medical savings account. But the latter option would require an increase in the AAPCC (average adjusted per capita cost reimbursement). This payment is very high in larger metropolitan areas but is too low in

Iowa to add many options such as prescription or vision benefits. The bill also includes a number of patient protections such as a lay person's definition of emergency care and a non-gag rule for medical providers.

Medicaid is important to Iowa, the congressman said, and the revised formula will be more fair for states like Iowa. He observed, "We might be able to start a program for additional health care benefits for children; it is possible that Iowa will see additional $100 million for child health care over the next five years." If we did nothing other than use that money to buy health policies for children, we could cover 40,000-50,000 Iowa children for those five years, he said.

Panel member **Robert Kelch, MD**, dean of the University of Iowa College of Medicine, explained that the college recognized its curriculum was not addressing the needs of modern medicine, the new emphasis on primary care as well as preventive medicine and public health issues. It therefore created a new generalist curriculum which emphasizes these issues. He thanked the practitioners at the 190 practice sites throughout the state which helped with this effort.

He said, "We need to manage health instead of disease." And he called for an increased awareness of public health. He went on to say that the Department of Rural Medicine and Environmental Health and the graduate program in Hospital and Health Administration were aligned to create a School of Public Health. (Two days previously Dr. Kelch had announced that Dr. James Merchant would be head of the new school, which will be under the College of Medicine.)

Reallocation, the dean believes, is the key word for society today. The US leads the world in how much is spent on health care but does not have the best ranking in the health of its citizens. The dean asserted, "This paradox must be corrected. We have a highly competitive, cost-conscious, partly profit-oriented health care system. But despite well-meaning intentions, I am not confident that the system will reallocate resources to meet our public health needs."

The College of Medicine, he said, must form a partnership with citizens, public health officials, and legislators to enact policies to ensure a level playing field for adequate reallocation of funds to provide for public health.

Panel member **Merle Pederson**, counsel for Principal Financial, related that his company works extensively with regulatory and compliance-related issues. He said that, among the collaborative issues raised by various insurance entities, the overarching issue is the dual and potentially conflicting federal regulation of health plans and the consequences in terms of costs to individuals. "For every 1% increase in premium costs, approximately 200,000 fewer people will purchase a policy. This demonstrates we have a very cost-conscious consumer public," he noted.

Pederson discussed the recent evolution of regulation by the federal government contained in the Health Insurance Portability Act. For the first time, he said, the federal government has set comprehensive standards to regulate individual and small group plans. Iowa has already enacted comprehensive reforms affecting those plans.

Another federal proposal, Pederson said, would carve out state mandates for certain small employers to band together to purchase insurance under a federal charter. Insurance companies, however, are concerned about keeping the pool of employees together for the purposes of provision of benefits and regulation by the

state. Yet other initiatives relate to health plan accountability standards and utilization review, and grievances, among others.

It is ironic, Pederson observed, that health care is really a local market issue, and this trend of federal intervention seems to be inconsistent. "We need to work toward a level playing field—for instance, similar consumer protections and equal solvency standards—for organizations that involve both providers and insurers," he contended.

He also noted that mandates result in increased direct costs. In 1970, there were 48 health care mandates nationwide; by 1995, there were more than 920. These mandates, he believes, drive up the cost of care and ultimately impact access to the system. Insurance trade groups are most concerned with creating a level playing field, coordinating regulation at federal and/or state level, and the costs associated with mandates and regulation.

Panel member State Senator **Mary Kramer**, vice president of human development for Wellmark Blue Cross and Blue Shield of Iowa and speaker of the Iowa Senate, described community health "as more than a collection of healthy individuals. It also involves what we do with that collection of healthy individuals, what kind of synergies are created," she said.

Senator Kramer contended that "We have to believe we can influence our own health before we can change our behavior about it. ...Part of the problem is that people do not believe they can impact their own health, much less the health of a community of persons. Therein is a huge challenge to both public-policy makers as well as health providers. A preliminary step is the understanding that we can impact our own health. It is not all in our genes. There are many dichotomies. In public policy, the question is where is the fine line between personal freedom and individual responsibility?"

Iowa legislators, Senator Kramer said, have made "continuous improvement" regarding health reform. Facilitating managed care in the insurance market should be next. She observed, "We in the center of the nation have had the opportunity to watch other parts of country and see what can go wrong with managed care, and shame on us if we do not take advantage of it."

Senator Kramer went on to say, "Our state has the most people over 85, and the third highest number of those over 65. Therefore, our quality of life must be pretty good. We have a strong heritage. Let's not mess up our air and water. Our history of community is one where for generations neighbors have looked after each other and this community has evolved into a great system of health-care-providing. Let's help those people do what they do well. Our aim is to strengthen the health delivery system. Part of that strength comes from very healthy, strong individuals. Let us wish and work for the same thing for our fellow citizens."

In preface to the question-and-answer session, Chair Tom Slater informed the conference attendees that Dr. Douglas Wakefield from the University of Iowa and Bob Mulqueen from the Iowa State Association of Counties were also available to answer questions.

When asked about how insurance companies determine what benefits to offer, Merle Pederson explained that his company works closely with its employer-customers. Local markets also dictate what is desired, and this varies from region to region. Mandates dictate; beyond that, the issue is medical necessity. What encompasses wellness changes at times, but the most desirable benefits seem to be prenatal care, childhood immunization, a health basics program, diabetes and asthma programs, and

routine dental care. "There is also a strong interest in wellness," he noted.

Tom Slater announced that, "We have built a barn—or at least we realize we must get it started." He asked Senator Grassley if there would be enough resources or federal commitment of resources to "paint" it, noting that the $33 million appropriated from the USDA's Fund for Rural America and PrimeCarre is a good start. Senator Grassley confirmed that the fund was financed and under a budget agreement, with a growth of about 3% over the next five years, amounting to slightly more than $33 million.

Congressman Ganske stated that two other programs are important: Community Health Centers and Rural Health Clinics. He also has a strong interest in Medicaid and Medicare reform legislation.

Senator Kramer liked the community-based concept. She noted that Polk County has a Healthy Polk 2000 campaign, which got a lot of publicity and community input and set some measurable goals. She wondered if we could pilot some similar initiatives immediately or replicate some things that are currently going on. Since health care is local; she wondered how we could foster that as a state.

Dr. Wakefield commented that we must think about the local community and the reality of how many health plans actually take advantage of preventive options, or how many employers are willing to pay for them. At the same time, he said, we must think about managed care programs and Medicare/ Medicaid: "Each payer is trying to minimize the payment per episode of care. This stratagem reduces the ability to cost-shift the care of the uninsured, underinsured, and expansion of education. It is a fragmented approach, with everyone trying to diminish their individual contributions, and does not consider community health as a whole."

Regarding the perception of public health being for those who cannot afford it otherwise, Dean Kelch thought the issue was very complex: "We're in a market-driven health care industry now, where employers carry a lot of weight if they're paying the premiums. If employees pay a portion of the costs, they too have a significant interest. It is up to us to educate ourselves regarding what really is a good health plan. Should we really buy one that does not have benefits that are cost-effective?" The dean thought that insurers would have to pay attention if they want their customers to be satisfied with their products.

Dr. Gleason pointed out that there are other good things going on in Medicare, with the president and congress adding some prevention activities—diabetes screening, mammograms, PSAs (prostate-specific antigens), or colorectal screens. "There is another reality," he said. "Just because the government does not pay for something does not mean the cost is not there or that pain and suffering do not continue. Unless we bolster the public health prevention activities at the community level, some people fall through cracks."

Senator Kramer noted that the customer does drive what insurance benefits are offered. "One size does not fit all," she observed. Prenatal care is a popular option among Blue Cross Blue Shield employees because they're young and 80% of them are women. In contrast, The Maytag Company is mostly male and older and therefore has different needs. "If health care is local," she said, "we need employer-customers at the table as a part of the discussion on what constitutes a healthy community and how it is tied to economic development."

Congressman Ganske thought Merle Pederson had raised an interesting point about how free markets fit into public health. He said, "Public health is not just for

the poor. No one here today would say that government has no role in regulating health care. We as a society have made a decision that the market is not the all-controlling part," he observed.

One problem is that the courts and congress gave an exemption from state regulation to plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). This means that state laws have no control over policies affecting 55% of the insured individuals in the US "We are trying to figure out the role of the federal and state governments in this issue, but we do need to ensure certain baseline quality standards," he asserted.

Merle Pederson explained further that state legislation only reaches 25% of the Iowa market. Roughly 50% are in self-insured plans that fall under ERISA and another 25% are Medicare/Medicaid. Therefore, only a small portion of the plans must comply with state regulations.

Tom Slater asked Senator Grassley his views on integration of the public health and private health sectors, if they would merge together in this changing system, and what this would mean from the perspectives of policy and the marketplace. The senator thought the two should not be merged. Public health certainly means taking care of those who are not taken care of elsewhere, but that is not its most important role. He said, "We must have a safe environment that the public can continue to take for granted. Second, the public trust must be maintained."

Dr. Wakefield remarked that if one separates the delivery of services to individuals from services to communities, public health has a tremendous role in gathering data, disseminating information, and educating. He stated that environment, safety and education issues cross other agency boundaries. He agreed we should not merge everything.

Congressman Ganske mentioned that public health has saved more lives around the world than any individual physician or surgeon, and it is paramount that adequate funding of government programs is maintained in conjunction with private public health programs.

Closing Remarks

Christopher Atchison, director of the Iowa Department of Public Health, thanked Tom Slater and the panel, Louise Lex and her public health colleagues, the Drake Center for Health Issues, and the conference steering committee. Director Atchison's final message was that both the conference organizers and presenters provided information, but the attendees provided teamwork and partnership.

In a bygone era, he said, barn raising occurred regularly among neighbors, not occasionally. He went on to say, "This meeting proves that this barn-raising heritage is alive and flourishing in Iowa."

He listed the following four conference themes:

- Population health is important to overall health;
- Public health represents all of the sciences and professions that can work to improve community health;
- Public and private organizations are recognizing the imperative of improving community health.
- Partnerships are being formed.

"The solutions of the past," he said, "are inadequate for the future. We need new innovations. The community is both where the agenda is occurring and where the engine is driving the change."

He noted the attendance by heads of other state agencies who are committed to change, as well as the presence of several members of the Iowa General Assembly.

He said that Dr. Peasley informed him that these proceedings will be on the agenda for this summer's board of health retreat. He also looked forward to the governor's continued interest and support as well as that of the Iowa Legislature members on these issues.

Director Atchison hoped attendees heard a message to empower them when they return to their communities and which will impact the future of public health. "Sometimes," he said, "one person can make a difference, with just one act. We began this meeting with a reflection on Iowa's pride. We will close this conference with how one person can make a difference."

He then showed *The Power of One,* a short video demonstrating a number of individuals acting alone who made a difference.

After the video, he challenged conference participants to continue the work started at the conference by asking, "If one person can make a difference, how powerful is a community?"

RECOMMENDATIONS FROM THE BREAKOUT SESSIONS

Participants who had not registered for the Leadership Development: Tools of the Trade workshop sessions were assigned by county to breakout sessions on two focus areas: "Mobilizing the Community for Health" and "Creating Quality in the Health System." Purpose of the breakouts was to gain input from community leaders and to develop a basic outline for strengthening public health by working on an action plan. In making the assignments, conference planners grouped counties by regions to encourage networking and sharing common concerns. A map of the regions is appended to the report.

There were 16 breakout sessions held; eight were focused on "Mobilizing the Community," and eight were focused on "Creating Quality in the Health System." There was a range of 6 to 24 participants in attendance at each session. The groups were given a list of issues that was developed from the conference keynote addresses and panel discussions. The groups were free to add to this list. Each group, with the help of a facilitator and a reporter from the Iowa Department of Public Health, set out to develop a systematic or tree diagram around a public health issue. The diagram is a continuous quality improvement (CQI) tool which may be used to graphically break a broad goal into increasing levels of detailed action items for achieving the stated goal. When completed, the diagram outlines the action, who will be responsible for taking the action, when it will happen, and how it will be tracked for its status. In the limited time available for developing the diagram, participants could not finish their diagrams. The process, however, resulted in issue discussions with recommendations for taking action, either at the local or the state level. The diagrams are included in the appendix.

In bringing the groups together at the conference and in reviewing the notes of each session, it became clear that there was a tremendous amount of overlap between the two focus areas of the breakout sessions. Therefore, the following set of recommendations represents a compilation of all 16 sessions.

In order to create quality in the health system, we need to mobilize the communities in Iowa.

Recommendations:

I. Develop a system/method for marketing public health.

- Reach private providers, the community and business.
- Include the Preventive Health Advisory Committee and the Local/State Public Health Liaison Advisory Committee in the marketing system that is developed.
- Know what public health is and where it is going.
- Address misconceptions about public health such as the perception that public health serves only the indigent.
- Clarify that public health is for the whole community.

- Use models to help inform, to develop common definitions, to demonstrate how public health fits into the continuum of care, and to promote best practices and exemplary programs.
- Demonstrate the cost effectiveness of health promotion and prevention.
- Address the conflict between personal freedom and health care cost, e.g., helmet laws and control of smoking.

II. Leadership development - Public health must be an advocate and a leader to achieve quality outcomes.

- Community leaders need tools to make informed decisions at the local level. These tools include community development, data analysis and collaboration skills to assist in reducing barriers such as turf issues, and the rationale for needs assessment.
- A leadership institute could provide for this training and the director of the Department of Public Health should play a key role in that institute.
- Local boards of health need to be more active participants in assuring that the health care needs of the community are met.

III. A lifetime of a continuum of care should be the goal of an integrated delivery system that includes public health.

- The Department of Public Health needs to collaborate internally across divisions and bureaus and reduce the number of conflicting messages and the duplication of technical assistance
- Public health needs to identify its role in integrated health care delivery systems. Currently, public health's role is unclear.
- As a provider of uncompensated care, the transition from direct service provider cannot jeopardize access to quality health care for underserved or special populations. A minimum set of services for all Iowans should be established.
- Minimum standards of care guidelines must be established and monitored by local boards of health.
- The overlap of programs and service delivery areas creates a challenge for networking. The department needs to explore the possibility of eliminating the overlap or develop a means to assist local agencies to network within the current boundaries.
- Quality indicators that are responsive to local and community needs, as opposed to personal care, should be adopted and implemented. A decision needs to be made as to who defines quality at the local level.
- Common outcome measures for public and private health services should be defined and the integrated delivery system, of which public health is a part, should develop incentives for holding service providers accountable.
- A central data repository needs to be developed that differentiates between private and public data reporting.
- Creative funding sources such as managed care profits should be found that could be directed to preventive health programs.

APPENDICES

APPENDIX A

KEYNOTE SPEAKER BIOGRAPHIES

John C. Lewin, MD, is chief executive officer and executive vice president of the California Medical Association and a family physician in private practice. He was formerly a clinical professor of international health at the University of Hawaii's School of Public Health. He has served on numerous state and national boards and commissions, including the Physicians' Leadership Committee for National Health Care Reform and the Association of State and Territorial Health Officers' Health Care Reform Task Force. He received national recognition from the Association of State and Territorial Health Officers when he was honored with the Arthur T. McCormack Award for excellence in public health, and from the American Medical Association with the Justin Ford Kimball Award for the ability to build consensus on health care issues.

Dr. Lewin served as Hawaii's Director of Health from December 1986 to July 1994. He resigned to run in a closely contested race for governor of Hawaii. Afterward, he established a small consulting firm to help physicians succeed and help them regain legitimate authority in the rapidly changing health care environment. Last year, the AMA presented Dr. Lewin with the Nathan Davis Award as public physician of the year for his contribution toward the prevention and treatment of HIV/AIDS and Hepatitis B.

Dr. Lewin received his MD degree from the University of Southern California and completed his internal medicine internship and residency at Los Angeles County—University of Southern California Medical Center.

Gail L. Warden is president and chief executive officer of Henry Ford Health System in Detroit, one of the nation's leading vertically integrated health care systems. He is an elected member of the Institute of Medicine of the National Academy of Sciences and serves on the institute's Governing Council. He is a member of the Robert Wood Johnson Foundation Board of Trustees and is vice chair of the Hospital Research and Educational Trust, and is slated to become its chair in 1998. He currently chairs the Department of Veterans Affairs Associated Health Progressions Review Committee and is a member of the National Commission on Civic Renewal. He is also a member of the boards of Comerica Band and Medicus Systems Corporation. In 1995, he was chair of the American Hospital Association Board of Trustees.

At Henry Ford Health System, Mr. Warden has spearheaded affiliations to optimize the health care services and insurance programs delivered to Detroit-area residents. In 1994, the National Committee for Quality Health Care awarded Henry Ford the first national Quality Health Care Award for Health Care Integration. In 1993, Henry Ford received the Healthcare Forum and 3M Health Care 21st Century Innovators Award for its creative planning process. Also in 1993, Mr. Warden received the CEO Award from the American Hospital Association's Society for Healthcare Planning and Marketing.

Mr. Warden is a graduate of Dartmouth College and holds a master's degree in health care management from the University of Michigan.

APPENDIX B

PRESENTERS

Jim Aipperspach, President, Iowa Association of Business and Industry
Christopher G. Atchison, Director, Iowa Department of Public Health
Kathy Beery, PhD, Division Administrator, Rural and Community Development, Iowa Department of Economic Development
Terry E. Branstad, Governor, State of Iowa
Kathy Clasen, Business Liaison for Compliance, Permit Assistance, Iowa Department. of Natural Resources
Greg Ganske, MD, US Congressman, State of Iowa
Harry Gill, MD Program Manager, Medicaid Managed Care Quality Assurance, Iowa Department of Human Services
Stephen C. Gleason, DO, Mercy Hospital Medical Center, White House Health Advisor
Charles E. Grassley, U.S. Senator, State of Iowa
Jeffrey R. Harris, MD, MPH, Acting Associate Director, Policy, Planning and Evaluation, Centers for Disease Control and Prevention
Charles Helms, MD, PhD, Resource Center Director, Institute for Quality Healthcare, University of Iowa
Robert Kelch, MD, Dean, College of Medicine, University of Iowa
Mary Kramer, Iowa State Senator
John C. Lewin, MD, Chief Executive Officer and Executive Vice President, California Medical Association
James A. Merchant, MD, DrPH, Institute for Rural and Environmental Health, University of Iowa
Ron Mirr, The Higher Plain, Inc.
Bob Mulqueen, Public Policy Analyst, Iowa State Association of Counties
Nancy A. Norman, Associate Director, Social and Behavioral Research Center for Rural Health, Iowa State University
Gayle Olson, Extension Field Specialist, Henry County, Iowa
Gary A. Peasley, MD, President, Iowa State Board of Health
Merle Pederson, Counsel, Principal Financial Group
Jane Schadle, RN, MS, Iowa Department of Public Health
Tom Slater, President, State Public Policy Group
Casey Smith, Information Management, Iowa Department of Public Health
Jeffrey A. Ver Huel, MD, Medical Director, Wellmark Blue Cross Blue Shield of Iowa
Douglas Wakefield, PhD, Associate Vice President for Clinical Affairs and Interim Head, Graduate Program in Hospital and Health Administration, University of Iowa
Gail L. Warden, President/CEO, Henry Ford Health System
Ralph Wilmoth, Bureau Chief, Information Management, Iowa Department of Public Health
Janan Wunsch, RN, BSN, Iowa Department of Public Health

Clinton County
John Krogman, Coordinator Clinton Community School District, Clinton
Denise Schrader, Executive Director, Clinton County Visiting Nursing Association
Paul Willging, Clinton Substance Abuse Council, Clinton

Dubuque County
Mary Rose Corrigan, RN, Public Health Specialist, City of Dubuque
Kathaleen Lamb, Senior Housing Inspector, City of Dubuque

Monroe County
Charlene Crall, RN, Albia School District, Albia
Dave Johnson, Economic Development, Albia
Theresa Johnson, RN, Monroe County Hospital, Albia
Dan Stocker, Chairman, Health Care Steering Committee, Albia

Webster County
Martha L. Hoard, EdD, RN, Chair, Community Action Network
Randy Kuhlman, Administrative Director, Community Action Network
Jim Patton, Board Member, Community Action Network

Breakout Sessions Facilitators and Reporters, Iowa Department of Public Health

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Doreen Chamberlin
Roger Chapman
Peggy Clarahan
Debbi Cooper
Russell Currier, DVM, MPH
Mariana Dubbert
Ron Eckoff, MD, MPH
Lorrie Graaf
Mike Guely
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Diane Heckman
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Carl Kulczyk
Carolyn Jacobson
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Leann Larson
Binnie LeHew
Pam Lutz
Barb Nervig
Mary O'Brien
Janet Peterson
Susan Pohl
Emily Roepsch
Ed Schor, MD
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Debbie Synhorst
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Carol Voss
Connie Waller
Melvin Ward
Janice Edmunds-Wells
Sally Wiarda
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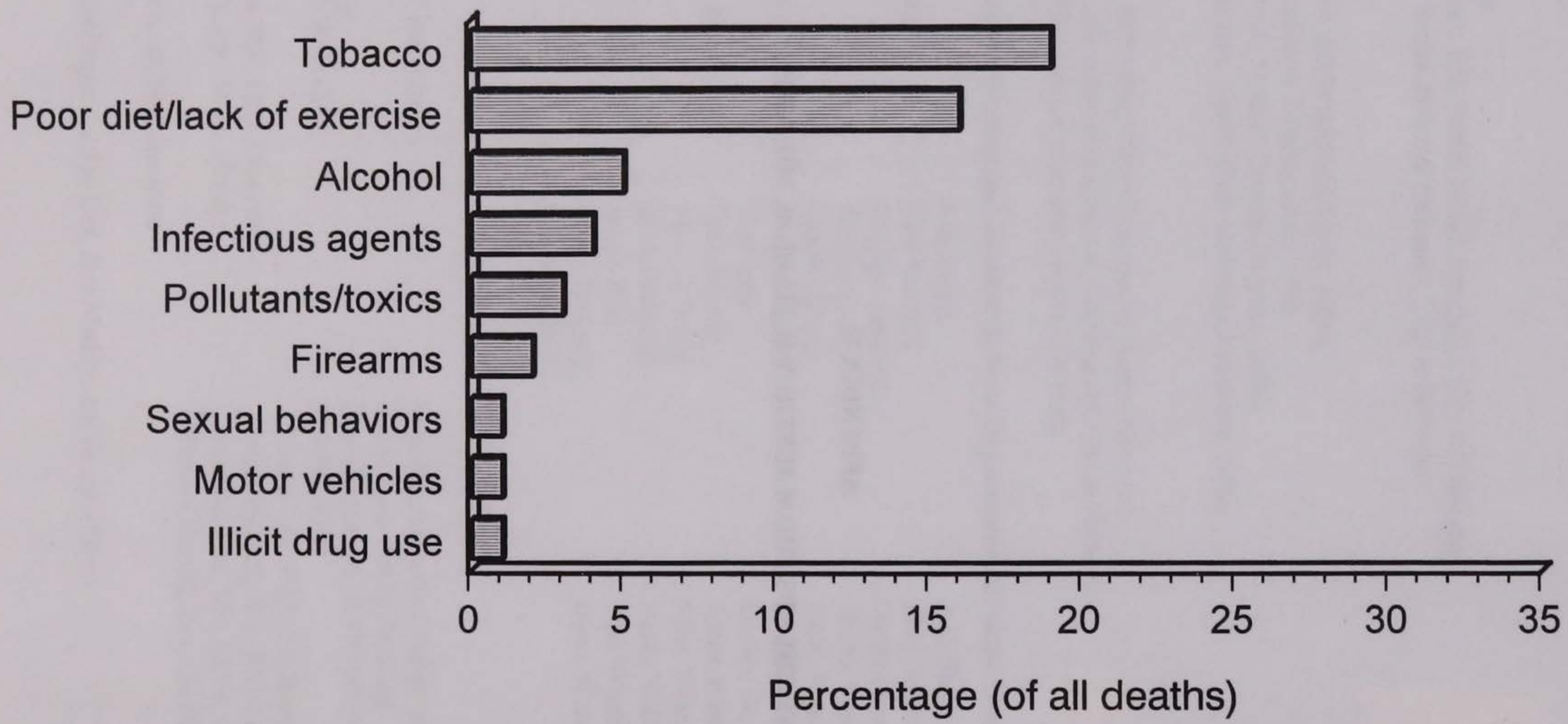
Conference Proceedings: Louise Lex, Dee Maddy, and Martha Perry

APPENDIX C

OVERHEADS FROM JEFFREY R. HARRIS, MD, MPH

Risk Factors Related to Causes of Death
United States, 1990*



*McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA* 1992; 270:2207-12.
Note: Shading denotes conditions and behaviors addressed by NCCDPHP.

10 Leading Causes of Deaths by Age Group - 1994

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 6,854	**Unintentional Injuries 2,517**	**Unintentional Injuries 1,595**	**Unintentional Injuries 1,913**	**Unintentional Injuries 13,898**	**Unintentional Injuries 13,452**	HIV 18,359	Malignant Neoplasms 43,588	Malignant Neoplasms 89,251	Heart Disease 610,330	Heart Disease 732,409
2	Short Gestation 4,254	Congenital Anomalies 714	Malignant Neoplasms 543	Malignant Neoplasms 510	**Homicide 6,116**	HIV 12,117	Malignant Neoplasms 16,843	Heart Disease 33,621	Heart Disease 69,335	Malignant Neoplasms 376,186	Malignant Neoplasms 534,310
3	SIDS 4,073	Malignant Neoplasms 518	Congenital Anomalies 241	**Homicide 416**	**Suicide 4,956**	**Homicide 6,888**	**Unintentional Injuries 13,560**	**Unintentional Injuries 8,768**	Bronchitis Emphysema Asthma 10,335	Cerebro-vascular 134,340	Cerebro-vascular 153,306
4	Respiratory Distress Synd. 1,567	**Homicide 473**	**Homicide 158**	**Suicide 318**	Malignant Neoplasms 1,740	**Suicide 6,354**	Heart Disease 13,243	HIV 7,636	Cerebro-vascular 9,577	Bronchitis Emphysema Asthma 87,048	Bronchitis Emphysema Asthma 101,628
5	Maternal Complications 1,296	Heart Disease 285	Heart Disease 129	Heart Disease 198	Heart Disease 992	Malignant Neoplasms 5,056	**Suicide 6,375**	Cerebro-vascular 5,355	Diabetes 7,784	Pneumonia & Influenza 72,762	**Unintentional Injuries 91,437**
6	Placenta Cord Membranes 948	HIV 199	HIV 110	Congenital Anomalies 193	HIV 641	Heart Disease 3,520	**Homicide 4,531**	Liver Disease 5,043	**Unintentional Injuries 6,432**	Diabetes 42,600	Pneumonia & Influenza 81,473
7	**Unintentional Injuries 889**	Pneumonia & Influenza 178	Pneumonia & Influenza 57	Bronchitis Emphysema Asthma 86	Congenital Anomalies 463	Cerebro-vascular 802	Liver Disease 3,698	**Suicide 4,296**	Liver Disease 5,530	**Unintentional Injuries 28,314**	Diabetes 56,692
8	Perinatal Infections 828	Perinatal Period 114	Benign Neoplasms 54	HIV 72	Bronchitis Emphysema Asthma 232	Liver Disease 733	Cerebro-vascular 2,717	Diabetes 3,689	Pneumonia & Influenza 3,505	Nephritis 19,666	HIV 42,114
9	Pneumonia & Influenza 559	Septicemia 91	Bronchitis Emphysema Asthma 41	Benign Neoplasms 47	Pneumonia & Influenza 221	Diabetes 682	Diabetes 1,785	Bronchitis Emphysema Asthma 2,676	**Suicide 2,812**	Alzheimer's Disease 18,217	**Suicide 31,142**
10	Intrauterine Hypoxia 537	Benign Neoplasms 79	Anemias 38	2 Tied	Cerebro-vascular 183	Pneumonia & Influenza 647	Pneumonia & Influenza 1,508	Pneumonia & Influenza 1,985	HIV 2,186	Septicemia 16,439	Liver Disease 25,406

US30TT94

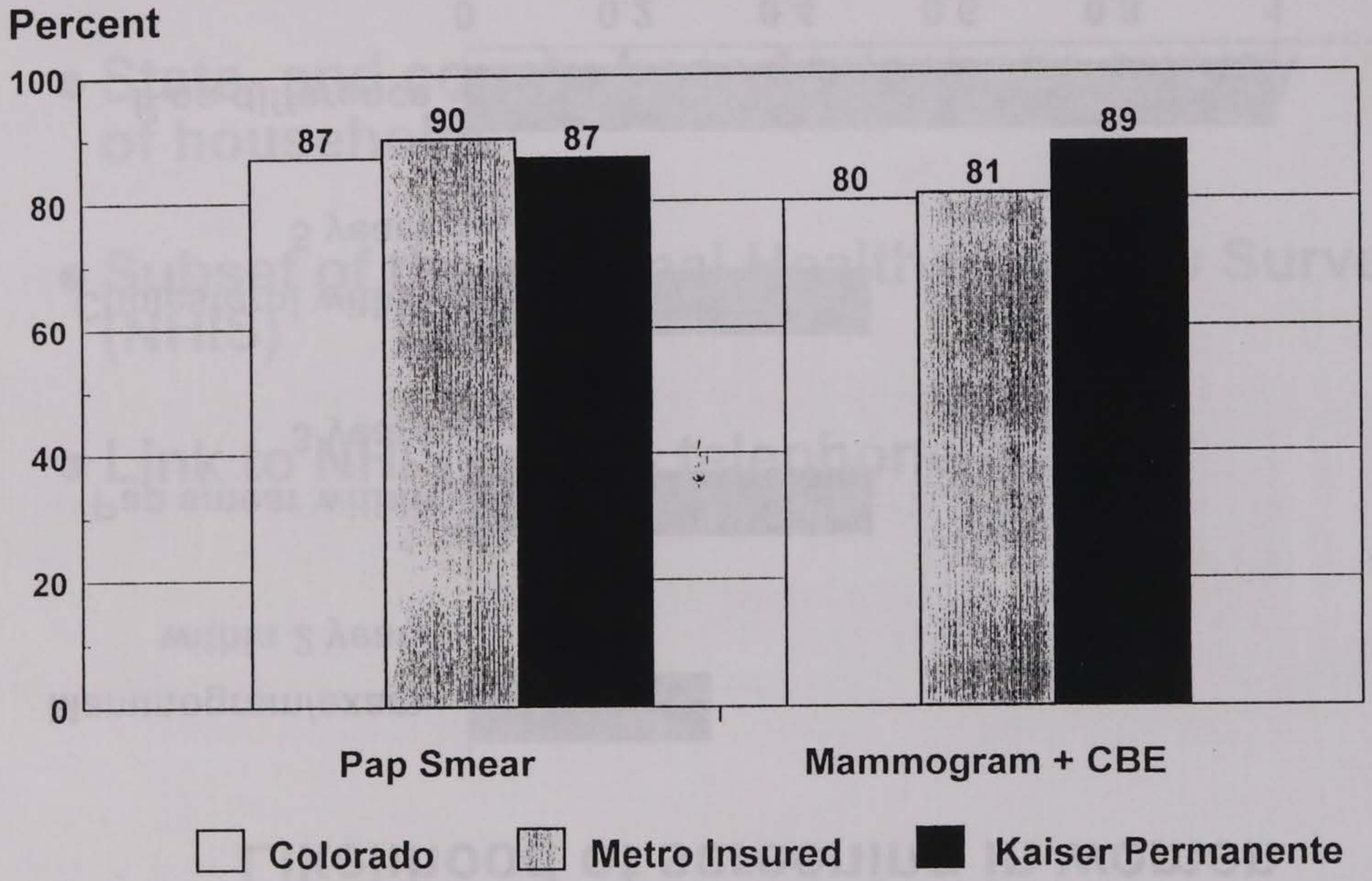
Behavioral Risk Factor Surveillance System (BRFSS)

- State-based telephone survey of adults
- Ongoing--every month
- Covers
  - Health status--very limited
  - Behavioral risk factors
  - Clinical preventive services

Editor's Note: For more information about Iowa's BRFSS data, contact A.J. Wineski at 515-281-3763. His e-mail address is awineski@idph.state.ia.us

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

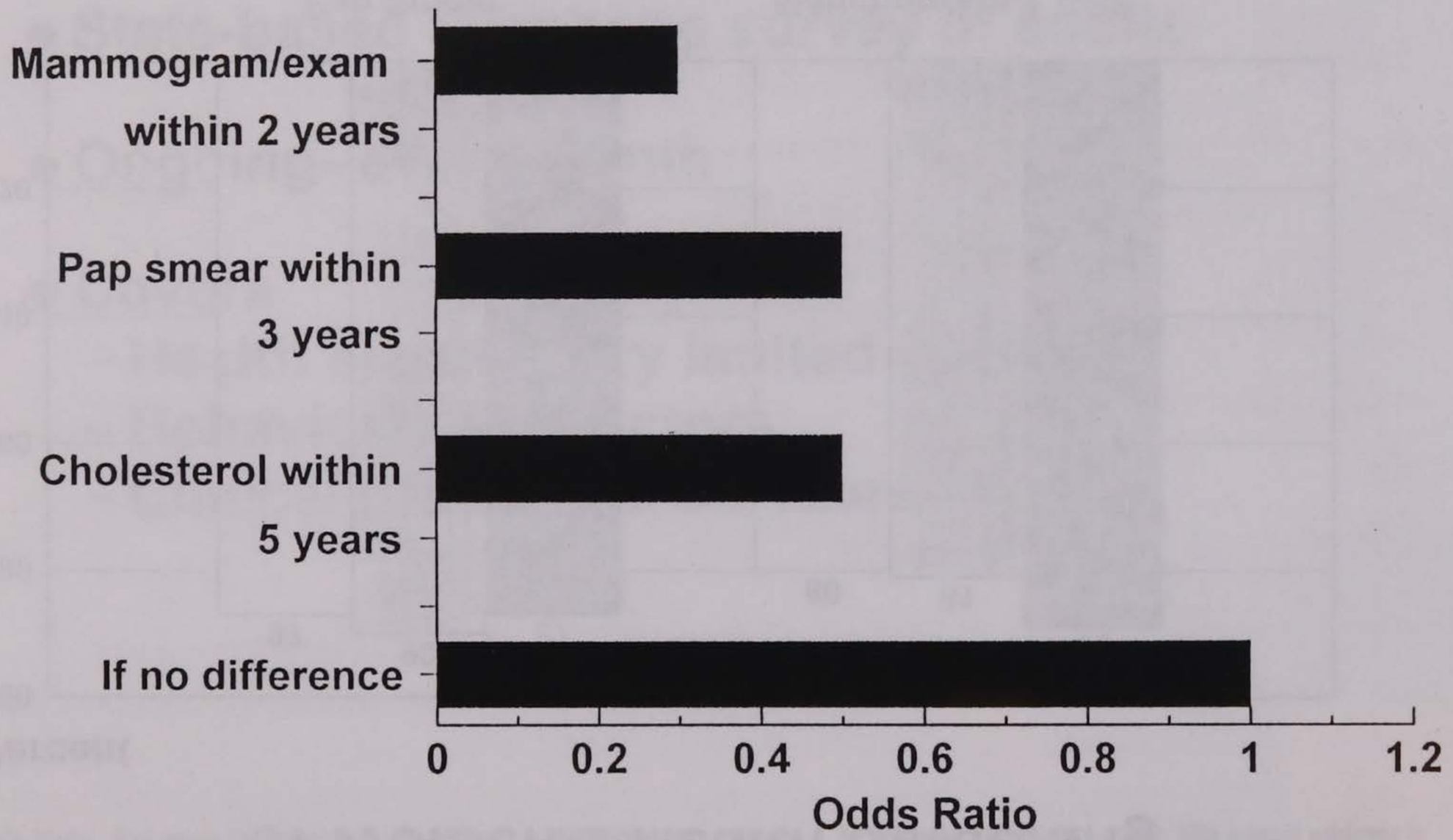
The BRFSS and Managed Care Estimates of Women's Health Screening



Survey Research Unit, Health Statistics Section
Colorado Department of Public Health and Environment

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Uninsured vs. Insured:
Likelihood of screening in women



Adjusted for age, race/ ethnicity, education, employment, and income

Source: MMWR 1995;44:219-25

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Editor's Note: This table shows that women who are uninsured are less likely to have mammograms/exams, pap smears, and

State and Local Area Integrated Telephone Survey (SLAITS)

- State- and county-based telephone survey of households
- Subset of the National Health Interview Survey (NHIS)
- Link to NHIS avoids telephone bias

Editor's Note: Iowa is one of two states piloting SLAITS. The survey was conducted in June and completed July 31, 1997. Results are expected in November 1997. For more information, contact Phyllis Blood (515-281-4435). Her e-mail address is pblood@idph.state.ia.us

CDC
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SLAITS Covers

- Health status
- Health insurance
- Access to care
- Use of services

CDC
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APPENDIX D

OVERHEADS FROM GAIL L.WARDEN

Public Health and Health Plans: Can There be a Viable Partnership?

June 5-6, 1997
Drake University

Henry Ford Health System

Gail L. Warden
President and CEO
Henry Ford Health System

The Premise

Managed care and public health can be a catalyst for each other to be successful. Therefore, there can be a viable partnership.

Overview

- Setting the stage
  - Transformation of health care
  - Health systems and social system domain
  - Characteristics of viable partnerships and why partnerships fail
- Engines driving formation of partnerships
- Challenges in partnerships
- The first step: A population-based approach
- Partnership opportunities
- Making the partnership a success

Notes

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Henry Ford Health System

Notes

Transformation of Health Care Delivery

Patient Care

Individual outcomes	→ Population-based outcomes
Fragmented services	→ Continuum of care
Episodic patient contact	→ Longitudinal patient contact
Treating illness	→ Managing health/risk education
Acute, inpatient focus	→ Primary care/prevention focus

Transformation of Health Care Delivery

Quality

Institutional measures	→ Community measures
Perceived quality	→ Outcome measures /report card
Quality assurance data	→ Value=Access/Effectiveness /Satisfaction
Illness/cure	→ Reduce morbidity and mortality

Transformation of Health Care Delivery

Financing

Competition among providers	→ Competition among financing/delivery systems
Insurance companies take risk	→ Providers take risk
Competing for resources	→ Aligned incentives
Cost containment	→ Economic discipline
Cost-based reimbursement	→ Price-based reimbursement

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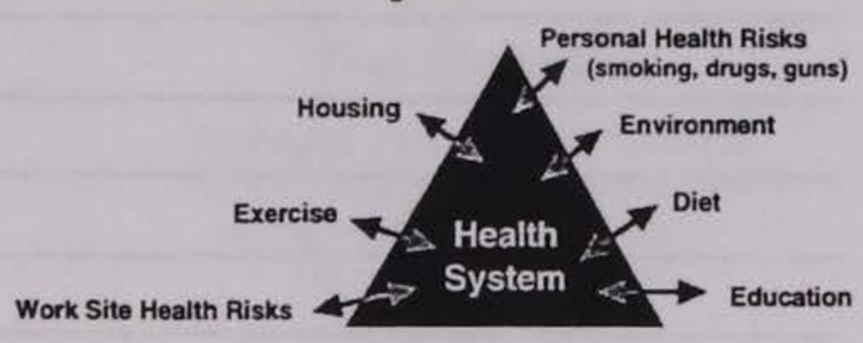
Notes

Health Systems

Health System Domain



Characteristics of a Viable Partnership

- Shared vision
- Clearly defined objectives and measurable performance targets
- Trust and respect for each other
- Proportionate share of benefits and burden
- Willingness to take risk to achieve something that transcends the limits of both partners

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Why Partnerships Fail

- Lack of trust
- Perceptions that partners aren't benefiting equally
- Loss of autonomy
- Lack of mutually accepted performance measures
- Lower levels of management not involved in vision and fail to understand the need
- Conflicting new ventures with other partners

Engines Driving Partnerships

- Policies directed at one sector impact the other
  - Medicaid managed care
  - Public health clinics
- Changing roles and expectations are making one sector's knowledge more relevant to the other
  - Prevention benefits
- Fiscal, professional and political constraints make it difficult for each sector to accomplish its mission alone
  - Documentation of results
  - Minnesota's HMO mandate on improving community health

Challenges in Partnerships

- Lack of a population-based approach to health care
- Instability of enrolled populations
- Regulatory intervention in managed care
- Convincing employers of the value of prevention benefits
- Inconsistencies in managed care organizations' prevention guidelines
- Lack of experience in treating and assuming risk for high-risk populations

Notes

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A Population-Based Approach

The Three Components

- **Clinical preventive services:** Immunization, screening tests, counseling by physicians and other health professionals
- **Social, economic and regulatory policies** that promote healthy behavior, reduce hazardous risk exposure, and promote healthy standards of living
- **Community-based, essential public health services,** monitoring health indicators, educating the public about health risks and reducing health risks from air, water, food, work place, consumer product and recreational hazards

– Omenn, 1993

Partnership Opportunities

Public Health and Health Plans

- Incorporating public health disciplines in the education of care givers
- Incorporating clinical preventive services in primary care
- Sharing best practices in health promotion and disease prevention
- Collaboration on community health initiatives
- Collaboration on measurement of plan performance

Partnership Opportunities

- Incorporating clinical preventive services in primary care
  - Prevention benefits
  - Development of preventive service guidelines
  - Identifying predisposing, enabling and reinforcing factors
  - Measuring improvement
    - 32% decrease in late-stage breast cancer
    - 89% of 2-year-olds with complete immunizations
    - 44% increase in bicycle safety helmet use
    - 10% decrease in adult smokers

Notes

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Partnership Opportunities

- Sharing best practices in health promotion and disease prevention
  - Immunization rates
  - Screening rates
  - Tobacco use prevention and cessation
  - Child safety
  - Domestic violence
  - Alcohol use
  - Others

Partnership Opportunities

- Collaboration on community health initiatives
  - Define roles and responsibilities of each organization for specific programs
    - STD in San Francisco
    - TB in New York
  - Collaboration on lobbying efforts
    - Tobacco initiatives
    - Immunization registry
    - Firearms
    - Services for the homeless
    - Recreational safety
  - Health services delivery partnerships
    - Adopt-a-clinic concept

Partnership Opportunities

- Collaboration on measurements of plan performance
  - Cooperation on licensure and accreditation programs
    - NCQA
  - Standardized data reporting
    - HEDIS
  - Dialogue with purchasers
  - Education of the public

Notes

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Making the Partnership a Success

- Foster communication among the partners at all levels
- Facilitate coordination of diverse perspectives, resources and skills
- Clarify the boundaries between independent missions and shared missions so the parties feel they are in control

Henry Ford
HEALTH SYSTEM

Notes

APPENDIX E

CONFERENCE EXHIBITS

Poster #1
Title: **Public Health Education and Research at the University of Iowa**
Barb Scott

The University of Iowa has pursued public health through preventive medicine, environmental health assessment and health delivery organization. An expanded mission to develop broad public health education, service, and research through a School of Public Health is the vision for the 21st century.

Poster #2
Title: **State Health Registry**
Michele West

The State Health Registry is a statewide registry and facility for conducting surveillance and evaluating the health of Iowans through the SEER Cancer Registry and the Iowa Birth Defects Registry. The addition of the Agricultural Health Study will monitor the health of Iowa's agriculture workers and families.

Poster #3
Title: **Iowa Injury Prevention Center and University of Iowa Trauma Service**
John Lundell

The Injury Prevention Center and the Trauma Service at the University of Iowa are organized to facilitate education, research, and care in injury prevention and control for Iowans. The mission is to provide the capabilities to monitor injuries through surveillance, control injuries through prevention, treat injuries through acute care, and restore function through rehabilitation.

Poster #4
Title: **Outreach Support to Rural Emergency Medical Service Providers**
EMSLRC (Emergency Medical Services Learning Resource Center); Jacqueline Heinle, Burn Treatment Center; Trauma Service and Dr. James Torner

This poster addresses the varied facets of outreach support provided by the EMSLRC, BTC, Trauma Service, and emergency telemedicine for care of the trauma patient. Activities include educational and prevention activities as well as telemedicine consultation.

Poster #5
Title: **Institute for Rural and Environmental Health**
Mary Lewis, Institute for Rural and Environmental Health, Department of Preventive Medicine and Environmental Health, University of Iowa College of Medicine

The University of Iowa Institute for Rural and Environmental Health (IREH) is an internationally recognized rural and environmental center for research, education, and service. Throughout its many programs, the IREH maintains a special emphasis on the adverse health effects that threaten agricultural and other rural populations. Part of the University of Iowa College of Medicine's Department of Preventive Medicine and Environmental Health, the IREH is the core of three national

research centers—the Environmental Health Sciences Research Center, the Great Plains Center for Agricultural Health, and the Injury Prevention Research Center—as well as Iowa's Center for Agricultural Safety and Health. Numerous research and service projects, such as WORKSAFE IOWA, an outreach program providing consultation and information services in occupational medicine and industrial hygiene, bring the Institute's expertise to bear on occupational and environmental health problems in industry, agriculture, and the everyday lives of Iowans.

* A demonstration of Internet use of the *1997 Iowa Health Fact Book* by Laurie Walkner, Kevin Kelly, and Steve Troester provided hands-on experience using an interactive approach to health data.

Poster #6
Title: **Iowa's Center for Agricultural Safety and Health (I-CASH)**
Kelley Donham, DVM, Director; Kendall Thu, PhD, Associate Director
The Iowa legislature established Iowa's Center for Agricultural Safety and Health (I-CASH) in 1980. The center's mission is to coordinate public and private resources in Iowa to establish services and programs that improve the health and safety of farm families. I-CASH is a partnership of the University of Iowa, Iowa State University, the Iowa Department of Public Health, and the Iowa Department of Agriculture and Land Stewardship. For more information, call or write to Kelley Donham, I-CASH Director, Institute of Rural and Environmental Health, University of Iowa, Iowa City, Iowa 52242-5000. Dr. Donham's phone number is 319/335-4438, and his fax number is 319/335-4225.

Poster #7
Title: **Delivery of Comprehensive Care for Sickle Cell Disease in Iowa**
Raymond Hohl, C. Thomas Kisker, Richard Nelson, Susan Abel, Sharon McMillan, Iowa Hemoglobinopathy Screening and Comprehensive Care Program; University of Iowa College of Medicine, Departments of Pediatrics and Internal Medicine, Child Health Specialty Clinics, Iowa City, IA.

The Iowa Hemoglobinopathy Screening and Comprehensive Care Program (CCP), in collaboration with child health specialty clinics (CHSC) and community care providers, is establishing an effective program which interacts closely with local health care providers in providing comprehensive, community-based, culturally appropriate medical care despite Iowa's rural setting and relatively low prevalence of sickle cell disorders (SCD). Since many patients reside 100-150 miles from a CCP, a shared management approach with community medical staff, outreach clinics, and extensive interagency collaboration has proven beneficial. Since inception of the program in 1987, there have been no deaths attributed to failure of penicillin prophylaxis, and the immunization rate is 100% for children with SCD ≤ two years. This success is attributed to extensive interagency collaboration with local health departments, physicians, home care agencies, and visiting nurse associations.

Poster #8
Title: **Iowa Barriers to Prenatal Care Project**
Jane Borst and Dr. Edward Schor at the Iowa Department of Public Health; Dr. Herman Hein, Professor of Pediatrics at the University of Iowa and Director of the Statewide Perinatal Program; Dr. Mary Losch, Director of the Barriers Project; and Natalie Roy, Project Coordinator.

Since 1991, the Iowa Barriers project has captured data on prenatal care experiences among a broad cross-section of women delivering babies in all Iowa hospitals. The project seeks to learn whether or

not women had problems obtaining prenatal care during their pregnancy. Other information gathered, such as cigarette use, desirability of pregnancy, and feeding practices, are important for health planners or those concerned with improving the health status of Iowa's women and children. Because it is designed as a census rather than a sample survey, there are hundreds of data points for every county each year. This allows the monitoring of variables down to the zip code level. Specific data requests are welcome and encouraged (no fee). The barriers project is sponsored by the Iowa Department of Public Health and is a cooperative venture among Iowa's maternity hospitals, the Statewide Perinatal Program, and The University of Iowa Social Science Institute.

Poster #9A
Title: **Iowa Infant Mortality Prevention Center**
Mary O'Brien, Iowa Department of Public Health

This poster exhibit addresses the prevention of infant mortality by focusing on accomplishments of the Infant Mortality Prevention Center. Some of these accomplishments include community-liaison-building, a Sudden Infant Death Syndrome (SIDS) Awareness Campaign, and improved infant death reporting, among many others. The center seeks to identify sources of infant mortality and morbidity and to take direct action within the community to resolve these issues. This poster includes information about subcommittees that work relentlessly toward making a difference with mothers and children in Polk County and in Iowa. The center is funded by a private/public partnership between the Iowa Department of Public Health, Blue Cross and Blue Shield Foundation, and the Polk County Healthy Polk 2000 committee. The center has been in operation since 1992.

Poster #9B
Title: **Statewide Perinatal Care Program**
Dr. Herman Hein, Director

The Iowa Statewide Perinatal Care Program was started in 1973 to improve perinatal outcomes in Iowa. The basic concept of the Perinatal Program is to share the expertise of the University of Iowa with all perinatal providers in the state so that mothers and babies can receive the best care as close to their homes as possible. A perinatal team consisting of Dr. Hein, a neonatologist; Dr. Frank Zlatnik, an obstetrician; Kathy Papke, an obstetric nurse; and Maria Lofgren, a neonatal nurse, provide patient care assessments in all Iowa hospitals that deliver babies. Then, based on the assessment, the team provides an educational program designed to meet the needs of each hospital. Although the program is entirely voluntary, all Iowa hospitals participate. This program is co-sponsored by the Iowa Department of Public Health and represents one of the few integrated models of public health which is supported by a major university and a state health department.

Poster #10
Title: **Home and Community Care Planning for Children with Special Health Care Needs**
Brenda R. Moore, RN, ARNP and Richard P. Nelson, MD

Home and Community Care Planning (HCCP) is a family-centered care coordination service of the Child Health Specialty Clinics (CHSC), Iowa's Title V program for children with special health care needs. The goals of HCCP are to assure that family-centered, care coordination services are available to Iowa children and youth with severe chronic illness or disability and to link resources such as Medicaid financing and maternal and child health services with community programs.

Poster #11
Title: **Institute for Quality Health Care**
Tanya Uden-Holman, PhD

A regional quality assessment and enhancement health care organization network dedicated to enhancing the quality of health care services provided to the public. The institute serves as a resource for community health and public health assessment. It collects, analyzes, and distributes regional data for comparative reporting and benchmarking, and it provides educational programs for health care professionals and community members.

Poster #12
Title: **Telemedicine and Tele-education: Extending health services to rural and underserved populations**
Michael G. Kienzle, MD, Associate Dean for Clinical Affairs, Associate Professor of Internal Medicine, Principal Investigator, National Laboratory for the Study of Rural Telemedicine, University of Iowa

The National Laboratory for the Study of Rural Telemedicine began at the University of Iowa (UI) in 1994 with a contract from the federal government. One accomplishment of the project has been to connect 10 hospitals to the UI via a high-speed telecommunications network. Today, over 1,000 rural health care practitioners have used the services offered over this telemedicine network. Included in the telemedicine network are Burlington Medical Center, Genesis Medical Center in Davenport, Grinnell Regional Medical Center, Henry County Health Center in Mt. Pleasant, Jefferson County Hospital in Fairfield, Keokuk Area Hospital, Muscatine General Hospital, Ottumwa Regional Health Center, Van Buren County Hospital in Keosauqua, Washington County Hospital, and the University of Iowa. Some of the many services offered to these hospitals over telemedicine include tele-radiology, interactive video consults, access to the UI's "Virtual Hospital," (see poster 18 description) and emergency room support for rural physicians.

Poster #13
Title: **Self-reported Illness and Health Status Among Gulf War Veterans: A Population-Based Study**
David A. Schwartz, MD, MPH, Bradley N. Doebbeling, MD, MS, James A. Merchant, MD, DrPH; Drue H. Barrett, PhD, and the Iowa Persian Gulf Study Group. University of Iowa.

This study assesses the prevalence of self-reported symptoms and illnesses among military personnel deployed during the Persian Gulf War (PGW) and compares the prevalence of these conditions with the prevalence among military personnel on active duty at the same time, but not deployed to the Persian Gulf (non-PGW).

A cross-sectional interview survey of PGW and non-PGW military personnel from Iowa was conducted. The study instrument consisted of validated questions, validated questionnaires, and investigator-derived questions designed to assess relevant medical and psychiatric conditions.

A total of 4,886 study subjects were randomly selected from one of four study domains, nine PGW regular military, PGW National Guard/Reserve, non-PGW regular military, and non-PGW National Guard/Reserve), stratifying for age, sex, race, rank, and branch of military service.

Conclusions: Military personnel who participated in the PGW have a higher self-reported prevalence of medical and psychiatric conditions than contemporary military personnel who were not deployed to the Persian Gulf. These findings establish the need to further investigate potential etiologic, clinical, pathogenic, and public health implications of the increased prevalence of multiple medical and psychiatric conditions in populations of military personnel deployed to the Persian Gulf.

Poster #14
Title: **Mobile Home Fire Safety: The Need for Smoke Detectors and Fire Extinguishers**
Andrew Rocca, Fire Marshall, Iowa City Fire Department, and Jackie Heinle, RN, University of Iowa Hospitals and Clinics Burn Treatment Center

The University of Iowa Burn Treatment Center and the Iowa City Fire Department were awarded a $17,500 Community Development Grant. The goal of this grant was to purchase smoke detectors and fire extinguishers for all mobile homes within the corporate city limits. Education was provided on proper installation, maintenance, and usage of the equipment. Fire prevention and safety was also included in the education.

Poster #15
Title: **Smoking Cessation Planning for Pregnant Women**
Rebecca Jacobs, RNC, MA, Advance Practice Nurse, Children's and Women's Services

Attempting to quit smoking is difficult for many, including the pregnant woman who has an immediate need for setting a quitting date. This poster presentation offers helpful hints in reducing the significant physical withdrawal effects from nicotine. Suggestions are also given to assist the woman in dealing with the emotional cravings she experiences. Quitting smoking is a "process" and not an "event"; therefore, physical and emotional support is offered in this poster presentation.

Poster #16
Title: **Comprehensive Lung Cancer Treatment for Iowans**
Kemp Kerstine, MD, and Jennifer Swearingen

This is a client-focused plan of care, that partners community health care providers with University of Iowa Hospitals and Clinics resources for the identification and treatment of lung cancer. Utilizing an algorithm for a growing high-risk patient population in Iowa, the partners hope to educate community practitioners to the various treatment options available to improve survivability.

Poster #17
Title: **Pharmacy: Caring for the People of Iowa**
Gilbert S. Banker, Dean; Lloyd E. Matheson, Jr., Associate Dean for Professional Programs; Jay D. Currie, Associate Professor (Clinical); and Randy P. McDonough, Director of Student and Alumni Services, University of Iowa, College of Pharmacy

Pharmacy is in the midst of broad philosophical and practice change. Pharmacists are taking a more active caregiving role to assure that patients receive the maximum benefit from their medications. This is especially critical for the large elderly population in Iowa. The College of Pharmacy at the University of Iowa is producing graduates ready to meet this challenge. The college's programs help the pharmacists of Iowa make this transition to care for patients, including those in underserved rural

areas. This poster reviewed how the College of Pharmacy through its various programs is improving the health care of Iowans.

Poster #18
Title: **The Virtual Laboratory**
Mary Gilchrist/Jane Getchell and Nelson Moyer, University of Iowa, Hygienic Laboratory

The Hygienic Laboratory is moving forward with customer services by employing the Internet for delivery of public health laboratory services. Not only will the Hygienic Laboratory's home page furnish the public and health provider with current information on a variety of health-related issues, it also will be expanded into the realm of the Virtual Laboratory. The Virtual Laboratory will provide customers with the ability to order sample collection kits and track sample analyses through the laboratory to the final report using bar codes. It will make available e-mail consultation and video-imaging analysis for microbiological consultations, virtual publishing on the World Wide Web, scheduling of sample submissions, as well as other services which will enhance the public health of the citizens of Iowa.

* A demonstration of the Virtual Laboratory accompanied the poster.

Poster #19
Title: **Nursing Intervention for Alzheimer's: Family Role Trials**
Meridean Maas, PhD, RN, FAAN, Principal Investigator, University of Iowa

This study is designed to test effects of specialized units for care of Alzheimer's patients. Fourteen sites in Iowa have been designated for the study.

Poster #20
Title: **A Community Wish Becomes an Educational Reality: A Community Task Force, Community College, and University Partnership**
Jean King, MS, RN, and Judi Donahue, MS, RN, University of Iowa (UI) College of Nursing and Iowa Lakes Community College

This project relates to the need for registered nurses to be prepared at the baccalaureate level for positions in management, community health, ambulatory care, and education. Distance-learning strategies are employed to link the UI College of Nursing and Iowa Lakes Community College for RNs who are unable to travel for education but who can achieve a BSN degree from the UI College of Nursing.

Poster #21
Title: **Gerontological Research at the UI College of Nursing: Gerontological Nursing Interventions Research Center**
Toni Tripp Reimer, PhD, RN, FAAN; Principal Investigator, University of Iowa (UI) College of Nursing

The Gerontological Nursing Interventions Research Center at the UI College of Nursing is one of six federally funded sites. The purpose is to extend knowledge about health problems of elders and resulting nursing interventions. Examples include patient education, medication management, caregiver interventions and wound care. The center links the College of Nursing with the Colleges of

Medicine, Law, Liberal Arts, Pharmacy and Dentistry to provide outreach to educators, clinicians and consumers throughout the state of Iowa.

Poster #22
Title: **Special Care for People With Special Needs**
Dr. Jed S. Hand, The University of Iowa College of Dentistry

The University of Iowa College of Dentistry faculty and students work together in the Special Care Clinic and in extramural settings to provide comprehensive oral health care to frail and elderly patients. The Geriatric Mobile Unit reduces barriers to dental care often faced by nursing home-bound elders. Learning to care for patients in settings that vary from the traditional prepares tomorrow's dentists to better respond to the community.

Poster #23
Title: **Greene County Medical Center Cardiovascular Risk-Reduction Program**
Denise Promes and Jacque Andrews

The Greene County Medical Center Cardiovascular Risk-Reduction Program is a community-based program to increase awareness and reduce cardiac risk factors among the citizens of Greene County. A central feature of the program is to reach target audiences at their worksites or through worksite collaboration. Three major initiatives incorporate this objective: (1) a county-wide, multi-week, worksite-based exercise program called "GET IN STEP" involving nearly 500 participants; (2) a short-term "buddy system" exercise program called "Adopt a Couch Potato," involving 100 pairs of participants who are focused on a single, typically sedentary month (February); and (3) a "Lunch and Learn" series of eight session held in the center of the downtown business area, easily accessible to workers, with local eating establishments providing low-fat lunches at minimum cost, and speakers on topics from risk factors to nutrition to exercise and stress management. The program reaches an average weekly audience of 50.

Poster #24
Title: **Community School Nurse: A Community Partnership**
Elly Mack, Marshalltown Medical and Surgical Center

The Community School Nurse Program is a free service to modify or remove any health-related barriers to learning, to promote an optimal level of wellness for students and families, and to extend the school nurse services into the home.

Poster #25
Title: **The Mahaska-Keokuk-Monroe County Partnership**
Kim Dorn, Mahaska County Homemaker Health Aide Service

The Mahaska-Keokuk-Monroe County poster depicts the concept of working together to more effectively serve the three counties via a district health department with a focus on prevention and an emphasis on the core functions of public health. The district health department has produced benefits for those in the three-county area, and it has achieved this success by using a win/win approach.

Poster #26
Title: **Home Town Health Project**
Susan B. Klein, Iowa State University Extension Service

This display depicts the Home Town Health Project, a community health-planning model used in several counties in Iowa and nationally. The display shows the method used to accomplish the necessary steps in effective community-based health planning. Cooperating agencies are listed as well as information on how a community can access the Home Town Health Project.

Poster #27
Title: **Center for Designing Food to Improve Nutrition**
Suzanne Hendrich, PhD, and Pamela J. White, PhD, Iowa State University

This poster exhibit illustrates advancement in the prevention agenda goal of keeping Iowans healthy by describing some of the most exciting research related to improving food supply health benefits. Three projects are highlighted: (1) a study of the health effects of soy in women, especially during the menopausal transition; (2) development of "naturally-hardened" margarine and shortenings based on novel soybean oil varieties; and (3) making pork healthier to help prevent atherosclerosis. The Center for Designing Foods to Improve Nutrition is funded by the federal government through USDA special grants and has the mission of improving human nutrition by modifying plant and animal fats and enhancing the availability of newly recognized protective food components in the human diet. The center has been in operation since 1988 at Iowa State University.

Poster #28
Title: **Partners with a Healthy Vision for Scott County**
Lawrence E. Barker, Director, Scott County Health Department

The Partners with a Healthy Vision for Scott County display brings together the skills and experiences of community organizations and agencies in forming a Scott County Public Health Leadership Committee. The purpose of the partners' program is to blend the strengths from both the "deficiency-oriented" model and the "capacity/asset-building" model with the community's public health infrastructure to create a Public Health Transformation Model. The Public Health Transformation Model will direct the development of a Community Health Implementation Plan to enhance the community's capacity to understand and address the current and future demands and responsibilities found in the public health arena. Through partnering and working together as a community with a common vision, the partner initiative can better meet public health needs of the total community.

Poster #29
Title: **Buena Vista County Coalition**
Karole Graen, Buena Vista Public Health Nursing

The Buena Vista County Coalition poster depicts two circles of information-sharing to promote improved health and social issues in Buena Vista County. The focus is on developing leadership in the immigrant community and guidance and exchanging information.

Poster #30
Title: **The Cardiovascular Coalition Billboard Project**
Mary Krieg, Healthy Polk 2000

During the months of March and April, the Cardiovascular Coalition (CVC) coordinated an effort to place 10 billboards in strategic locations throughout Polk County which said, "Cool kids and cool camels don't smoke." This effort was enhanced by the donation of the space for the billboards by Universal Outdoor; hence, the emphasis on public/private partnerships. The billboards were created from an original design by Alicia Van Ausdall, a local graphic artist. Members of the CVC and Channel 13's Mary Milz interviewed sixth-graders at Holy Trinity School who had seen the billboards to assess their impact. The kids thought the billboards were great, and the response from the community has been very positive.

Poster #31
Title: **Healthy Polk 2000: Breast Cancer Initiative**
Colleen Lemkuil, Polk County Health Department

This poster depicts community linkages that have enabled Healthy Polk 2000 to achieve its goal of reducing breast cancer deaths. Members of the cancer committee, the breast cancer coalition, and community providers are highlighted.

Poster #32
Title: **Carroll County Cardiovascular Risk-Reduction Project: A Community Coalition Effort**
Peg Buman, St. Anthony Regional Hospital and Nursing Home

This poster illustrates the goal of the Carroll County Cardiovascular (CV) Risk-Reduction Project which is to significantly limit the prevalence of CV risk factors for Carroll County residents. Success will occur through the development of integrated and coordinated, community-based strategies which target multiple risk factors in a number of sites.

Project initiatives include population-based interventions related to nutrition, tobacco use, physical activity, and CV screening. Intervention strategies are intended to reduce CV risk-factors by using holistic perspective and by reducing fragmentation and duplication of services.

Poster #33
Title: **Central Place Family Resource Center**
Yvonne Welshhons, Southeast Polk Community School District

Southeast Polk Schools made a commitment in 1993 to develop a center that would serve youth and families while also helping to meet basic developmental needs of children. In July 1995, Central Place Family Resource Center opened with the goal of helping children and families solve problems through linkages with a wide range of social services and access to referral agencies. Central Place can connect the families of the Southeast Polk school district with social service agencies, health providers, schools, churches, food programs, and other community organizations.

Poster #34
Title: **Calhoun County Board of Health Public Service**
Jane Condon, Calhoun County Department of Health

This display demonstrates five components of the Calhoun County Board of Health's service—home care, community health promotion, immunization, local tax usage, and employees. Groups of colored discs are arranged in columns. Each disc represents the percentage of increase or decrease in each area since 1970. The relevance to community health nursing is a visual exhibit of services and trends for educational staff, governing bodies, and the general public. This information is periodically revised so it remains up to date. Calhoun County's public health services are available to those in need without lengthy study or analysis. The display allows assessment and broadens the scope of program evaluation.

Poster #35
Title: **A Five-County Local Partnership Project in Northwest Iowa**
Dick Sievers, Jan Cain, Cynthia Harpenau, Mid-Sioux Opportunity, Inc.

LOCAL PARTNERS (to date): Mid-Sioux Opportunity, Inc., Head Start, Area Education Agency 4, Orange City Municipal Hospital and Clinic, Hawarden Community Hospital, Floyd Valley Hospital, Plymouth County Public Health, Sioux County Public Health, Sioux Center Community Hospital, Sioux County Board of Supervisors, WIC, and Maternal/Child Health.

AREA SERVED: Five counties in northwest Iowa: Lyon, Sioux, Plymouth, Cherokee, and Ida

OBJECTIVES ARE TO

- Analyze existing needs-assessment data from all related sources to determine areas of common concern and potential gaps in information.
- Analyze existing health promotion and prevention strategies and develop common approaches as well as new ones.
- Develop county health committees comprised of service providers, clientele businesses, schools, and local government to provide for ongoing communication and planning activities.
- Develop a health planning and coordination staff position to assist with long-range planning, project oversight and community input.
- Analyze, propose, and develop technology-related services to determine increased utilization of the Iowa Communications Network and other related technology to improve service delivery, training, and long-range planning.
- Develop common needs-assessment tools and implementation strategies.
- Assist in developing common evaluation strategies to assure cost-effectiveness and quality service delivery.

Poster #36
Title: **Love Our Kids License Plates**
Roger Chapman, Iowa Department of Public Health

Iowa's newest license plate will add a splash of color to any vehicle and will display concern for the safety of Iowa's kids. Proceeds from the sale of these license plates will be used to support injury prevention activities throughout the state. The initial cost of the plate is $35 in addition to the regular registration fee. Love Our Kids license plates became available July 1, 1997.

Poster #37
Title: **Clayton County Heart Healthy Council**
Fran Zichal, Central Community Hospital, Elkader

This poster depicts the activities of the Clayton County Heart Healthy Council, funded through the Iowa Department of Public Health. The mission of this county-wide council is to offer heart-healthy activities in a county with a high prevalence of heart disease. Three work groups--nutrition, physical activity and screening-- developed a menu of services for people of all ages in rural Clayton County.

Poster #38
Title: **Healthy Dubuque 2000**
Mary Rose Corrigan, RN, Healthy Dubuque 2000 Steering Committee

This poster describes the Healthy Dubuque 2000 health planning process and includes future challenges and initiatives through the Healthy Dubuque 2000 plan.

Poster #39
Title: **Health Care Access Network, Inc.**
Paula Cramer, Project Coordinator

The Health Care Access Network, Inc., operates nine free neighborhood clinics in Des Moines and central Iowa. Each clinic offers primary care services weekly to those who are uninsured or underinsured. There are no charges for these services. The sites are completely staffed by volunteer physicians, other health care providers, and non-medical personnel. Health Care Access Network, Inc., provides a tax-exempt structure, facilities, supplies, and support staff to enable health care providers to volunteer their services to the underserved. The network also may be used as a model for additional neighborhood clinics to be established later. The network is funded in part by the Robert Wood Johnson Foundation and by the Blue Cross Blue Shield of Iowa Foundation.

James Blessman, MD, is founder and president of the organization. For more information, contact Paula Cramer at 515/965-6810 or by fax at 515/965-6807.

Poster #40
Title: **Student Community Primary Care Initiative**
Mary Pat Wolhford-Wessels, MA, MS, University of Osteopathic Medicine and Health Sciences

The University of Osteopathic Medicine and Health Sciences in Des Moines has developed a state-funded project designed to attract primary care physicians to areas of Iowa where a shortage of such doctors exist. The Student Community Primary Care Initiative, or SCPCI, offers a combination of financial incentives and a flexible academic curriculum to encourage young doctors to pursue primary care medical careers in the state's small towns and rural areas. At a time when local and national leaders are emphasizing the strategic importance of primary care in the battle to control health care costs, and at a time when a great number of Iowa communities need general practitioners, this program provides one remedy for the ills plaguing health care in rural areas of the state. For more information on the program, call 515/271-1614.

Poster #41
Title: **The Use of a Health Risk Appraisal in Medical Education**
David Spreadbury, PhD, University of Osteopathic Medicine and Health Sciences

This innovative program is designed to enhance a commitment to wellness and health promotion. The faculty at the University of Osteopathic Medicine and Health Sciences believes that the most effective education in nutrition and lifestyle requires personal involvement beyond the regular curriculum. To investigate this assumption, the university began offering a health-risk appraisal to all freshman students in the fall of 1995. After careful analysis, the researchers selected PWP 400 (updated to the PWP2000), an instrument developed by Wellsource. This instrument incorporates a questionnaire and testing of strength, flexibility, aerobic fitness, and blood chemistry. The study design includes a second testing of participants prior to graduation. Other program components assist students in weight loss and in tracking, scoring, and rewarding positive lifestyle behaviors. The long-range objective is to measure the effect of the program on physician behavior and the effect on patient outcomes.

Healthy Polk County 2000 Video
Dennis Countryman, Polk County Health Department

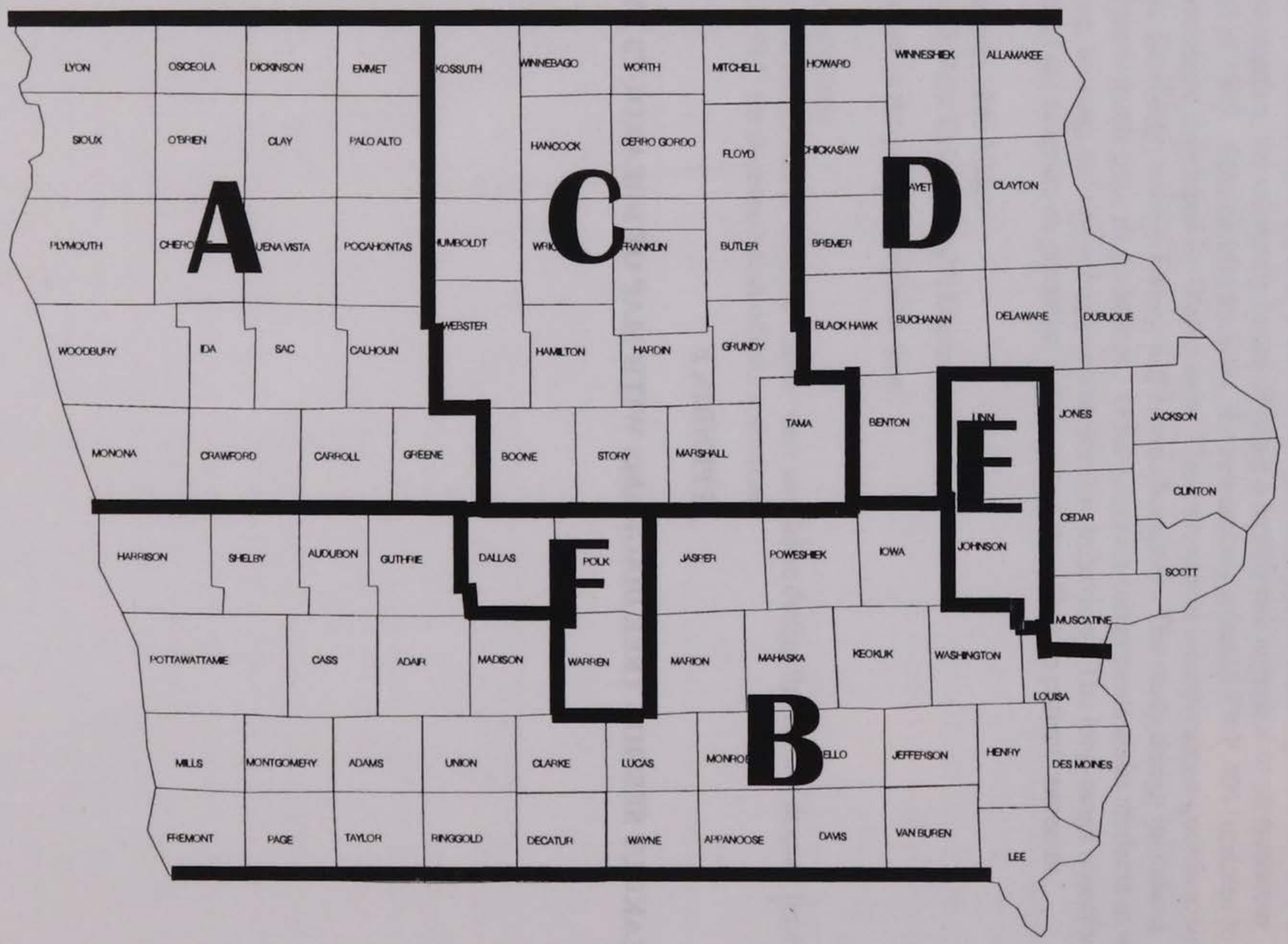
The video was shown in the poster exhibition area.

*Computer Demonstrations
The Drake Room and Room 313 at Omsted Center were available during the exhibit display times (11:30 AM to 1:00 PM) for demonstration of data resources.

APPENDIX F

BREAKOUT SESSION TREE DIAGRAMS WITH MAP OF BREAKOUTS BY REGION

Iowa Breakout Regions



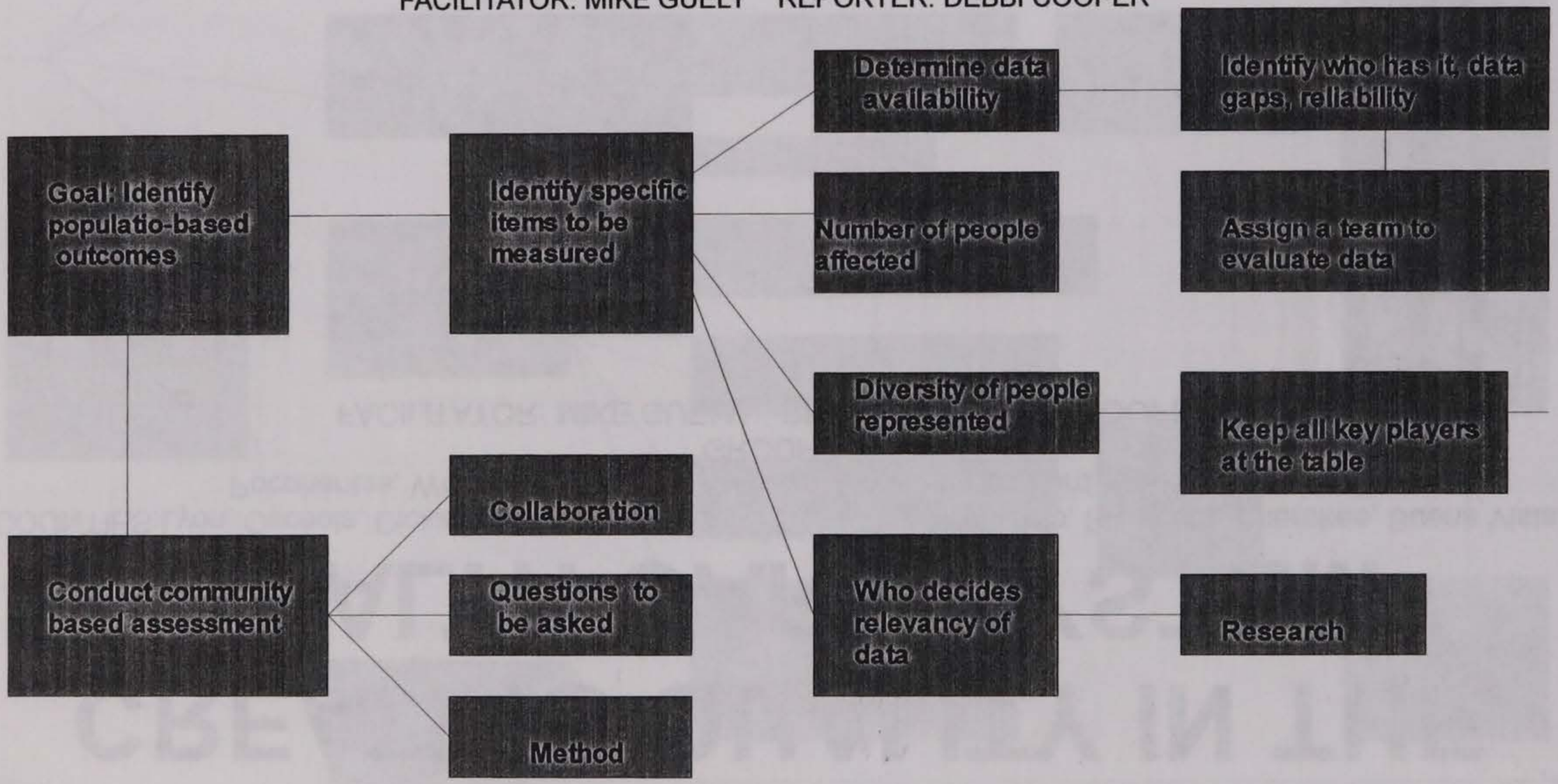
Barn Raising June 5 & 6, 1997, Des Moines, Iowa

CREATING QUALITY IN THE HEALTH SYSTEM

COUNTIES:Lyon, Osceola, Dickinson, Emmet, Sioux, O'Brien, Clay, Palo Alto, Plymouth, Cherokee, Buena Vista, Pocohantas, Woodbury, Ida, Sac, Calhoun, Monona, Crawford, Carroll, Greene

GROUP A

FACILITATOR: MIKE GUELY REPORTER: DEBBI COOPER

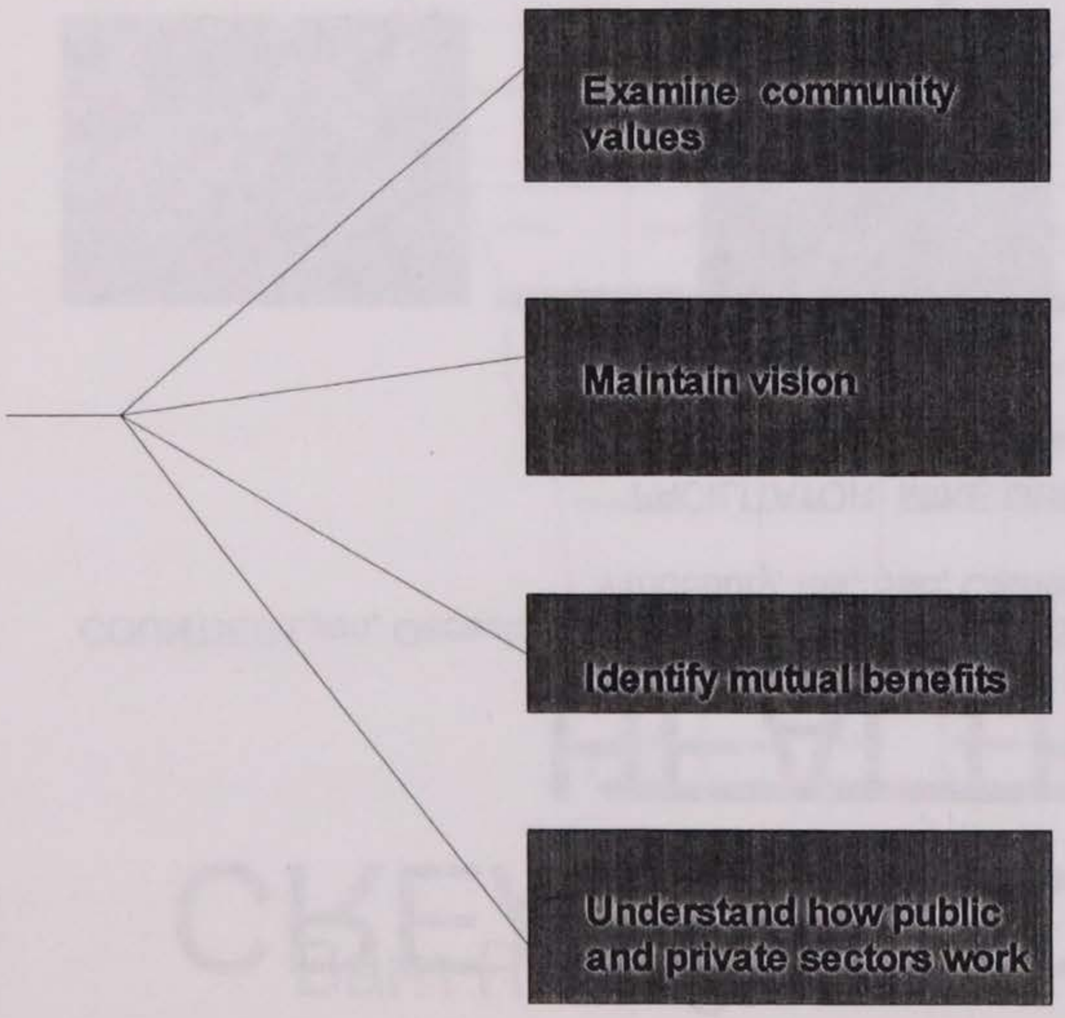


CREATING QUALITY IN THE HEALTH CARE SYSTEM

COUNTIES:Lyon, Osceola, Dickinson, Emmet, Sioux, O'Brien, Clay, Palo Alto, Plymouth, Cherokee, Buena Vista, Pocohantas, Woodbury, Ida, Sac, Calhoun, Monona, Crawford, Carroll, Greene

GROUP A

FACILITATOR: MIKE GUELY REPORTER: DEBBI COOPER

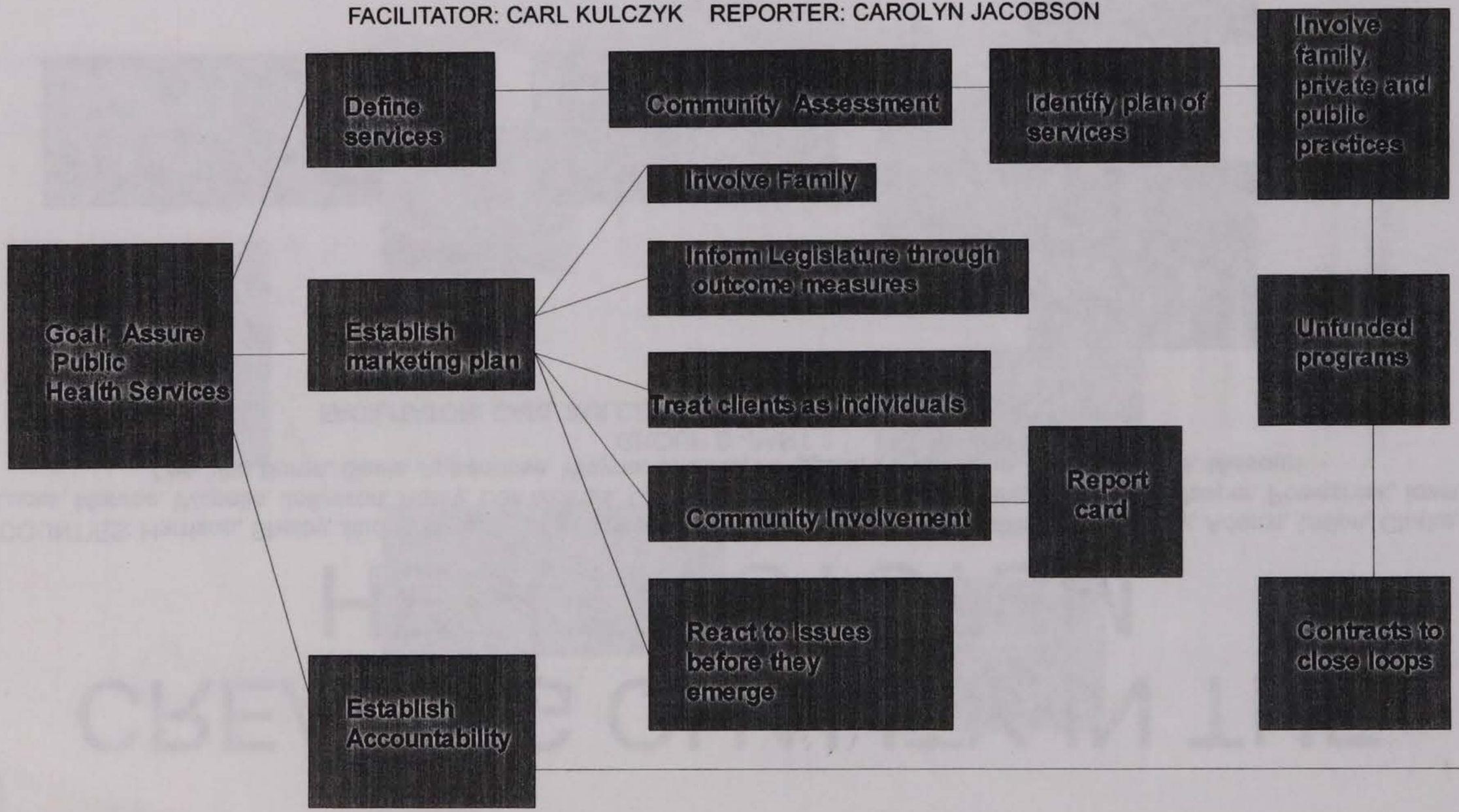


CREATING QUALITY IN THE HEALTH SYSTEM

COUNTIES: Harrison, Shelby, Audubon, Guthrie, Pottawattamie, Cass, Adair, Madison, Mills, Montgomery, Adams, Union, Clarke, Lucas, Monroe, Wapello, Jefferson, Henry, Des Moines, Louisa, Washington, Keokuk, Mahaska, Marion, Jasper, Poweshiek, Iowa, Lee, Van Buren, Davis, Appanoose, Wayne, Decatur, Ringgold, Taylor, Page, Fremont, Cole, Missouri

GROUP B

FACILITATOR: CARL KULCZYK REPORTER: CAROLYN JACOBSON



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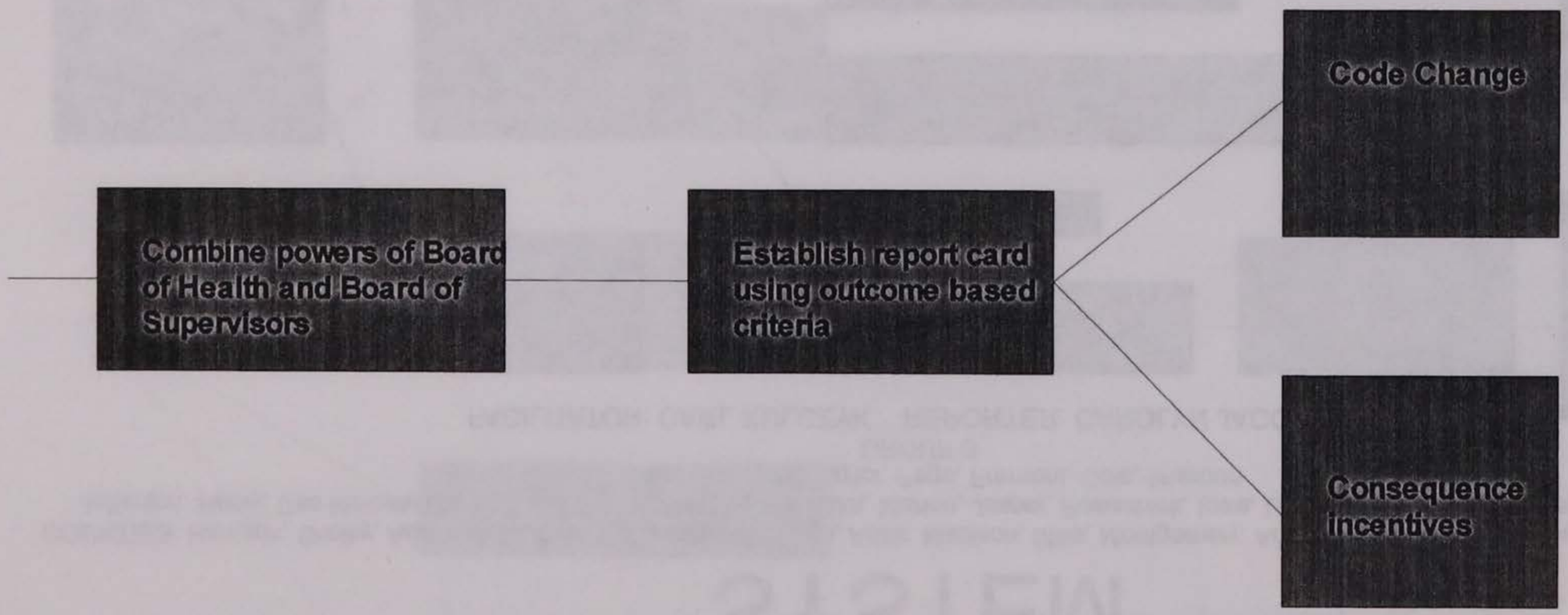
GROUP B -PART 2

FACILITATOR: CARL KULCZYK REPORTER: CAROLYN JACOBSON

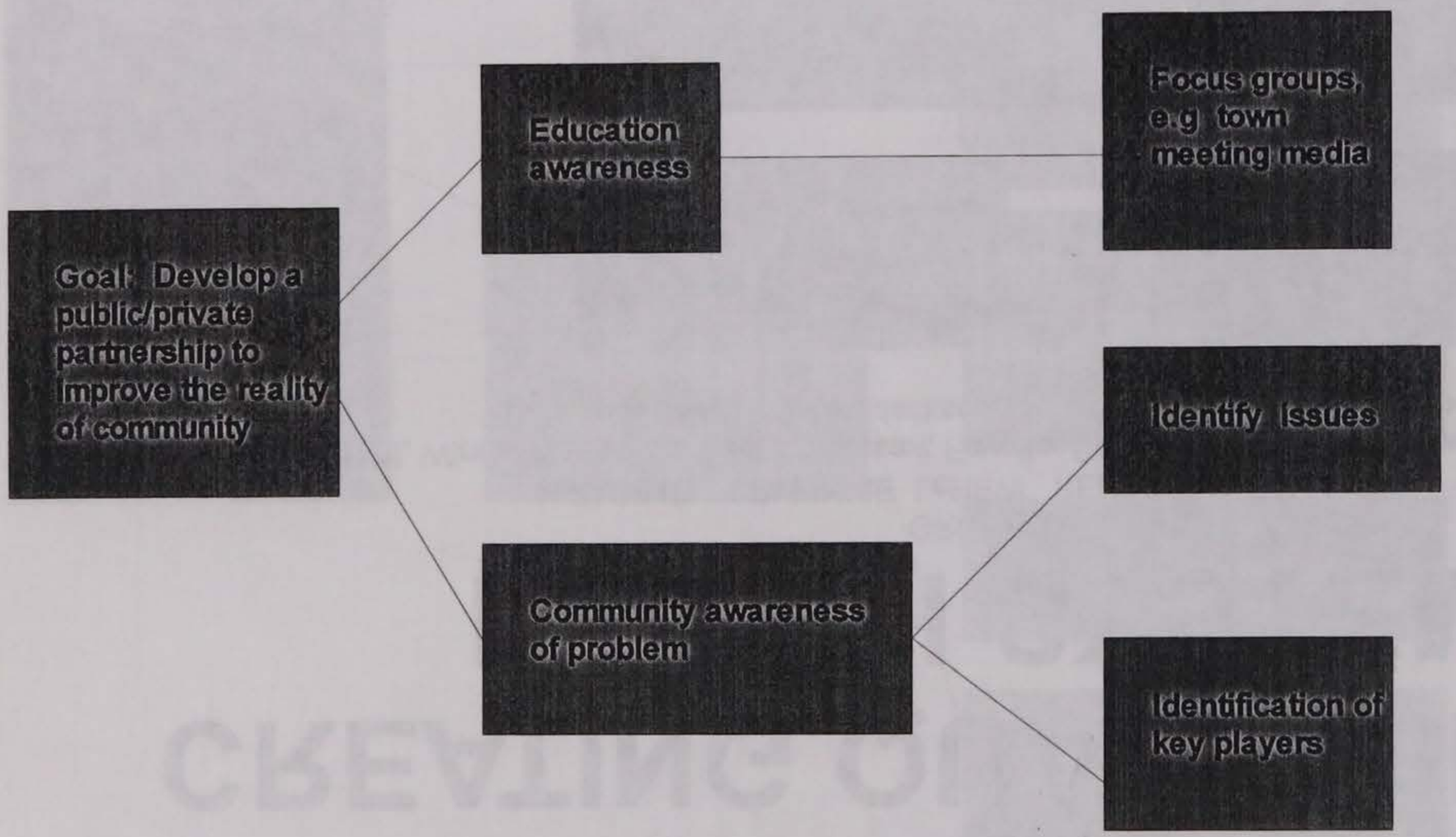


CREATING QUALITY IN THE HEALTH CARE SYSTEM

COUNTIES: Kossuth, Humboldt, Webster, Hamilton, Boone, Story, Marshall, Tama, Grundy, Hardin, Wright, Franklin, Butler, Floyd, Cerro Gordo, Hancock, Winnebago, Worth, Mitchell

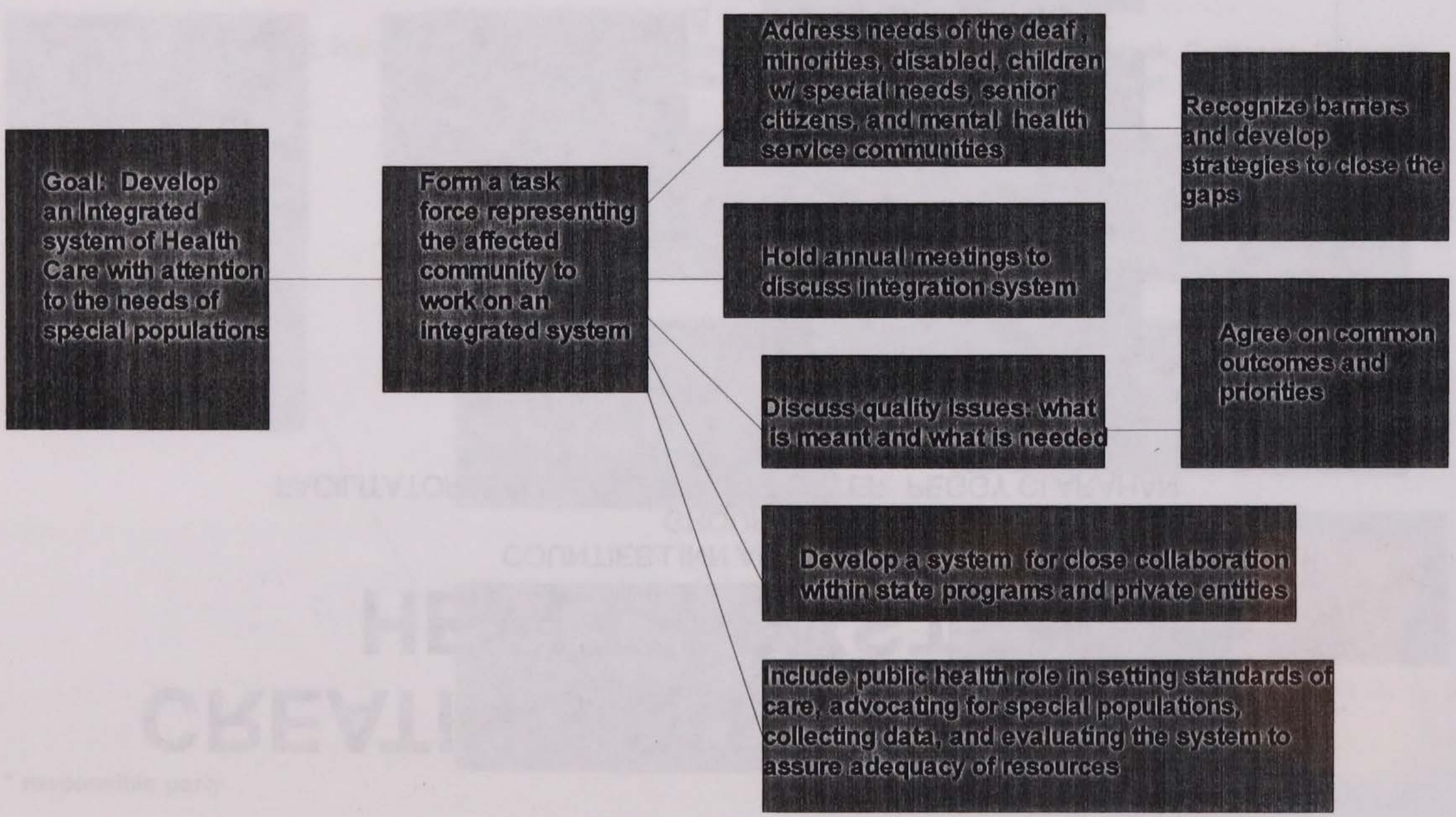
GROUP C

FACILITATOR: TOM WUEHR REPORTER: MARY HARLAN



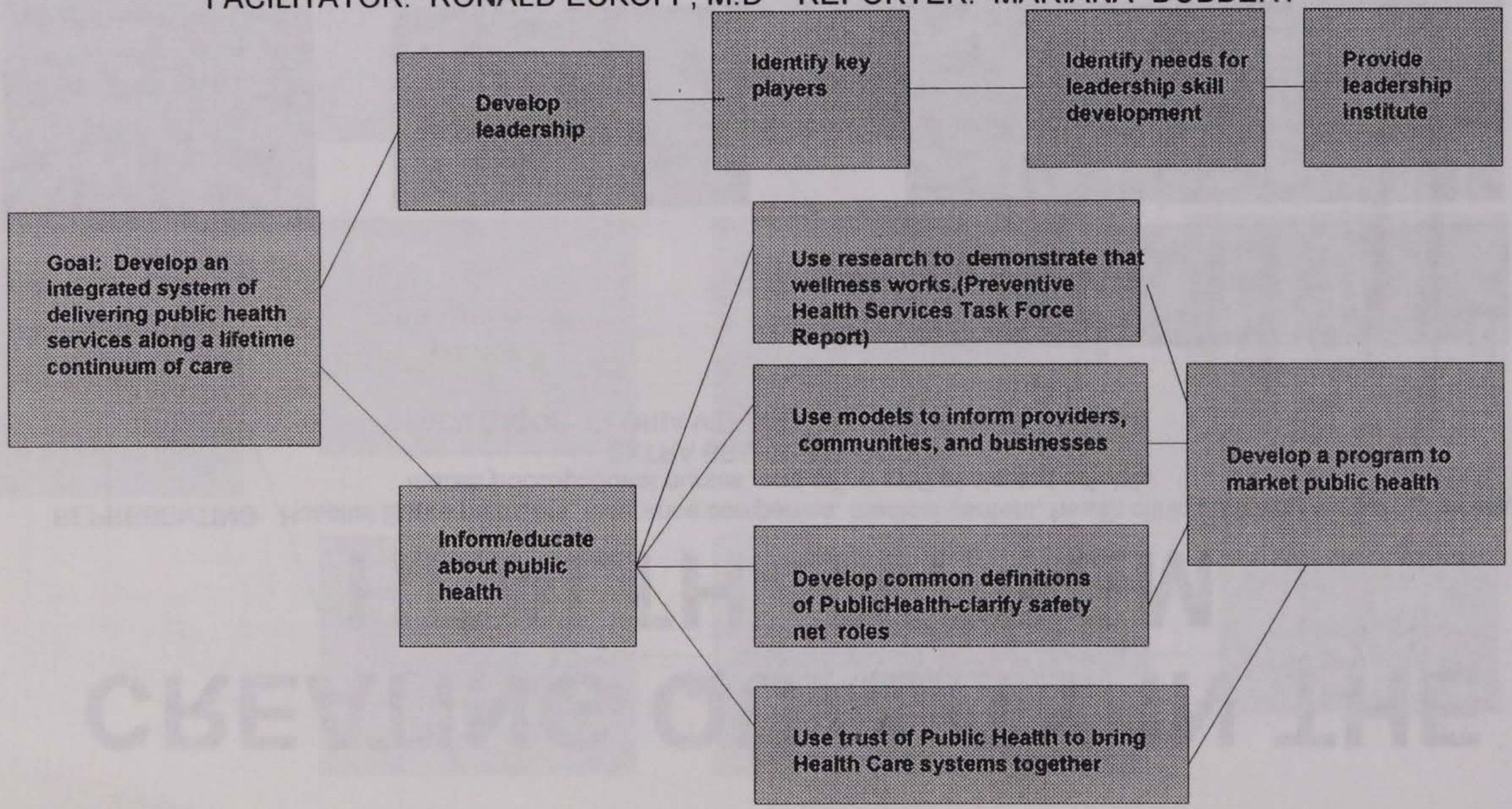
CREATING QUALITY IN THE HEALTH SYSTEM

Counties:Polk, Dallas, Warren
GROUP F
Facilitator: Janice Edmunds-Wells Reporter Kathy Williams



CREATING QUALITY IN THE HEALTH SYSTEM

COUNTIES: Polk, Dallas, Warren
GROUP F
FACILITATOR: RONALD ECKOFF, M.D REPORTER: MARIANA DUBBERT



CREATING QUALITY IN THE HEALTH SYSTEM

REPRESENTING: Hospital Board members, insurance companies, medical centers, health clinics, visiting nurses agencies, industry/occupational nurses, and office staff of elected officials
EXTRA BREAKOUT GROUP
FACILITATOR: GLORIA VERMIE REPORTER: SUSAN POHL

Goal: Provide primary health services for all Iowans by examining what is successful and dare to change what isn't

Develop a plan including existing processes and resources and implement the plan

- In development and planning. Partner with government agencies, business, and health care-affiliated organizations
- Gather and merge relevant data on other related efforts. Set a time line of one year for planning with implementation to follow
- Identify barriers to planning and implementation and then address them
- For implementation and evaluation: Include customers, health care providers, federal and state policy makers, insurance industry, as well as private agencies and organizations

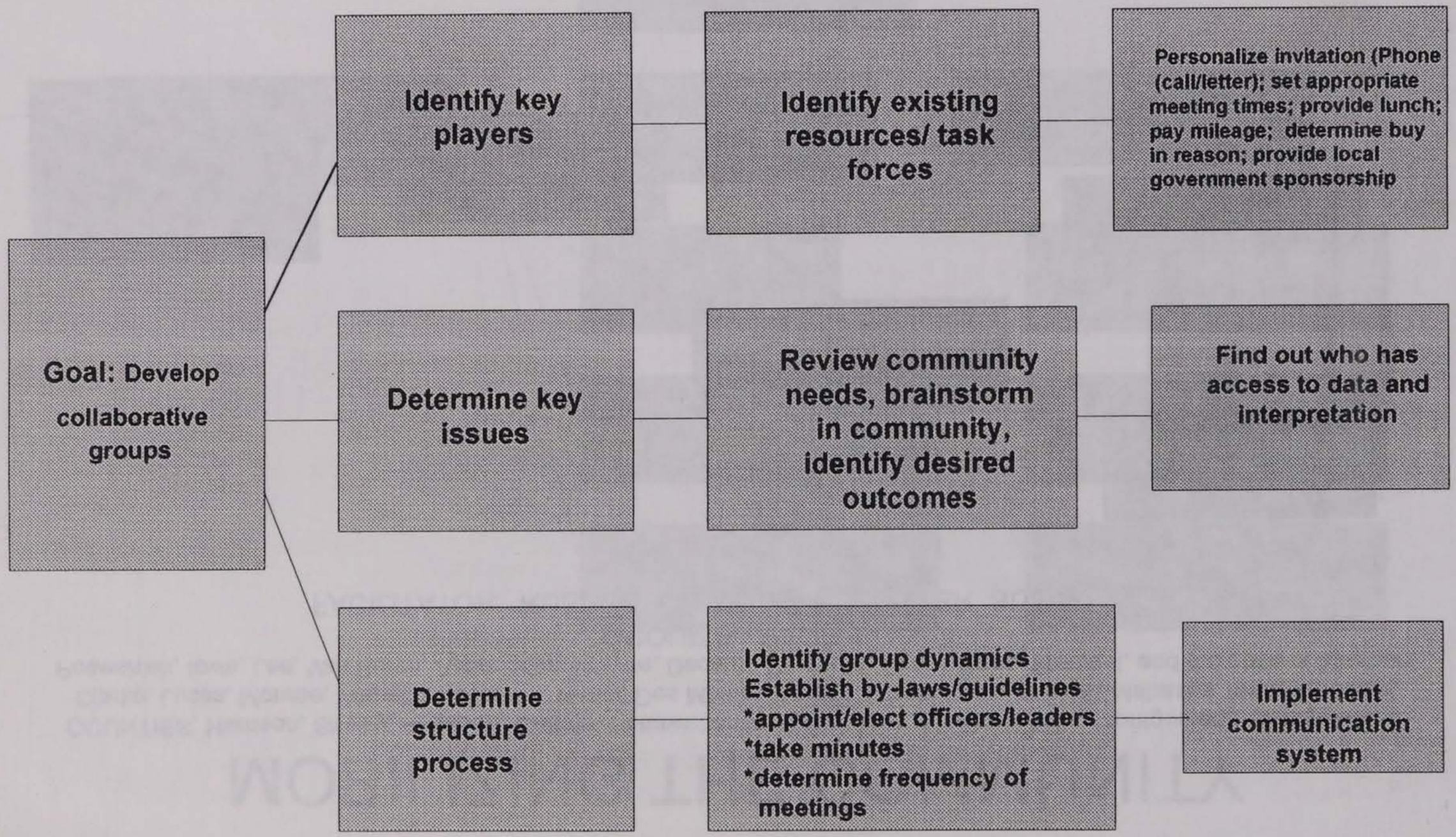
Address needs of those who fall through the gaps (i.e., children and elderly)

MOBILIZING THE COMMUNITY

Counties: Lyon, Osceola, Dickinson, Emmet, Sioux, O'Brien, Clay, Palo Alto, Plymouth, Cherokee, Buena Vista, Pocahontas, Woodbury, Ida, Sac, Calhoun, Monona, Crawford, Carroll, Greene

GROUP A

FACILITATOR: MELVIN WARD REPORTER: CAROL VOSS

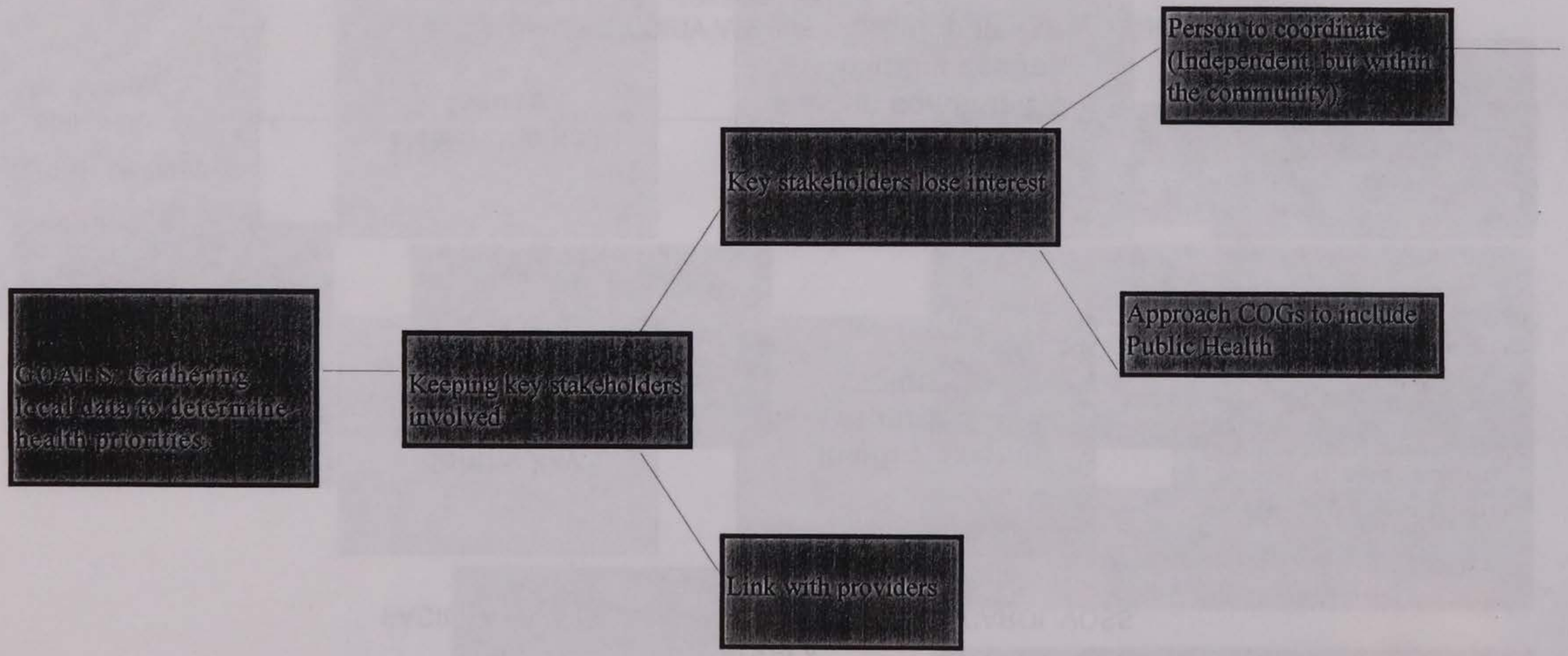


MOBILIZING THE COMMUNITY

COUNTIES: Harrison, Shelby, Audubon, Guthrie, Pottawattamie, Cass, Adair, Madison. Mills, Montgomery, Adams, Union, Clarke, Lucas, Monroe, Wapello, Jefferson, Henry, Des Moines, Louisa, Washington, Keokuk, Mahaska, Marion, Jasper, Poweshiek, Iowa, Lee, Van Buren, Appanoose, Wayne, Decatur, Ringgold, Taylor, Page, Fremont, and the state of Missouri.

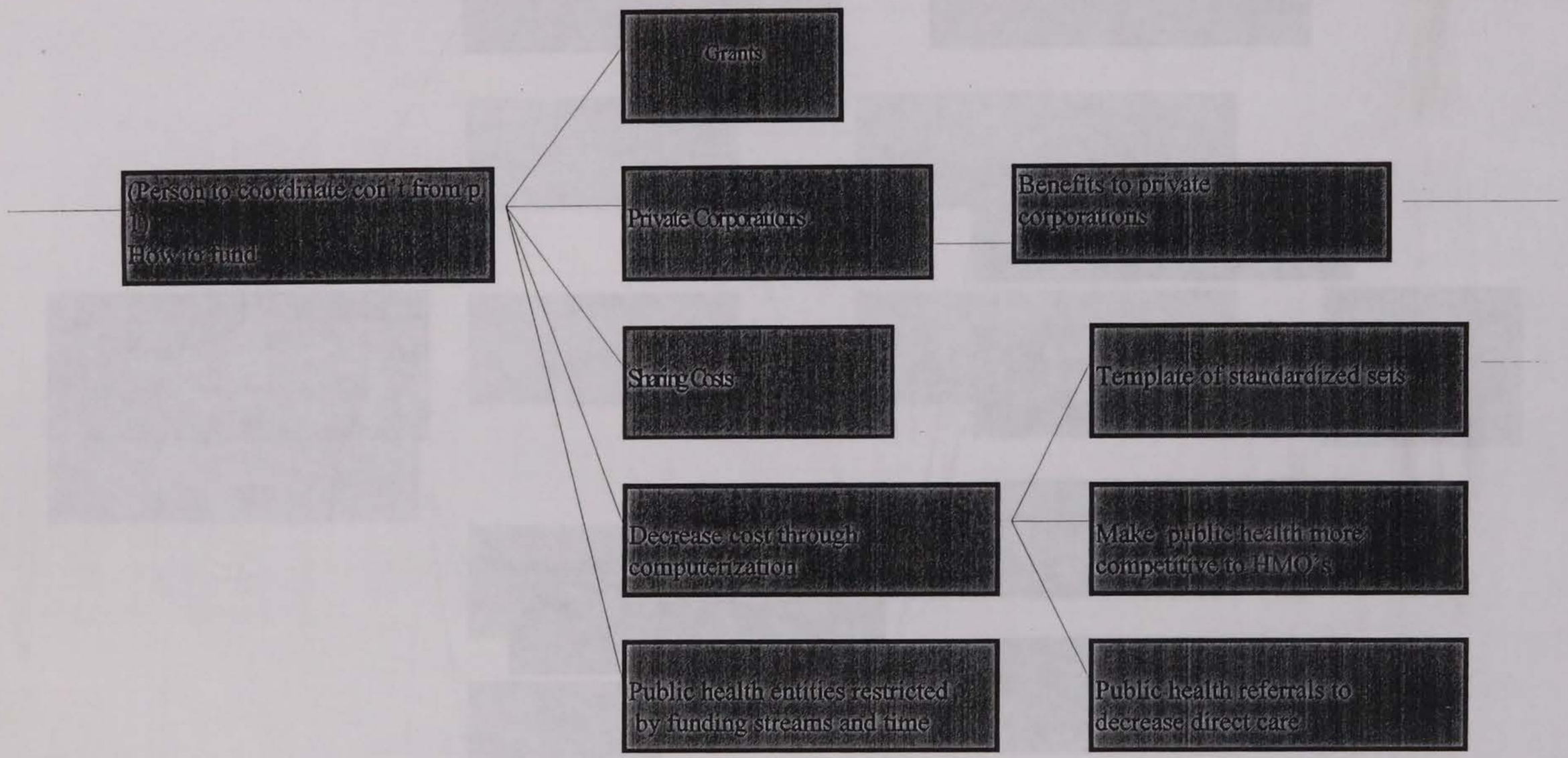
GROUP B - PAGE 1

FACILITATOR: RUSSELL CURRIER REPORTER SUE IRVING



MOBILIZING THE COMMUNITY

Group B- 2



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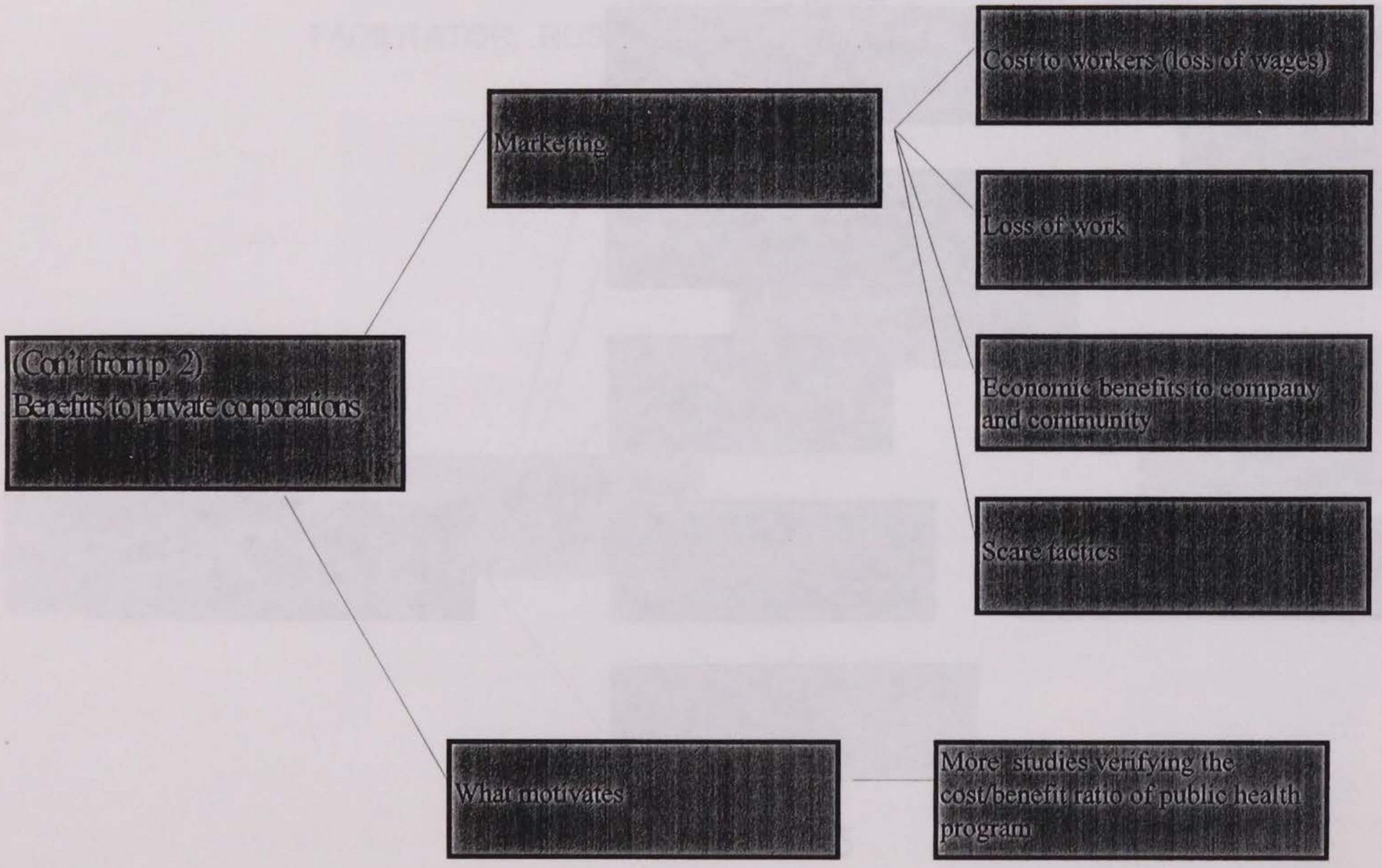
Group B- 3



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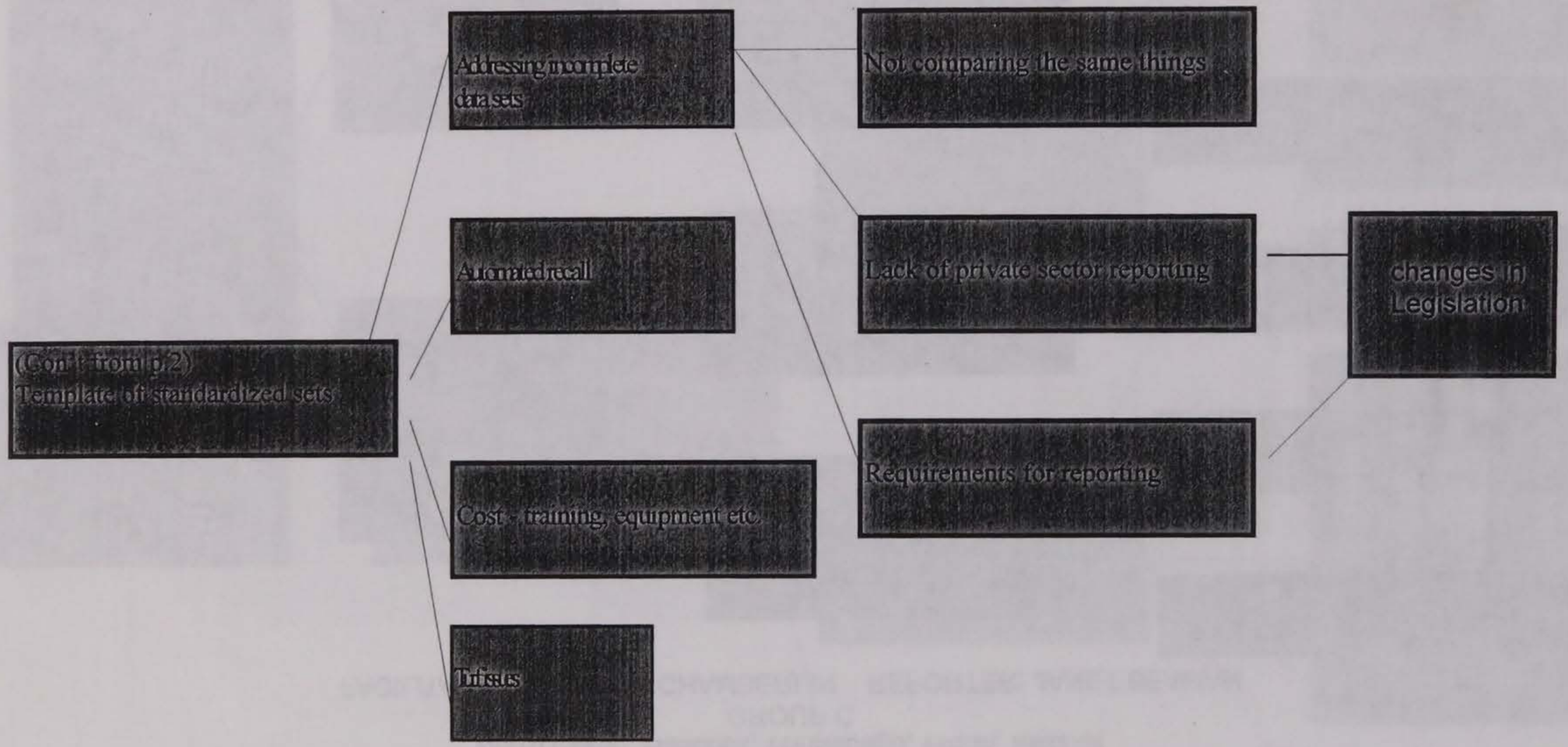
Group B- 4

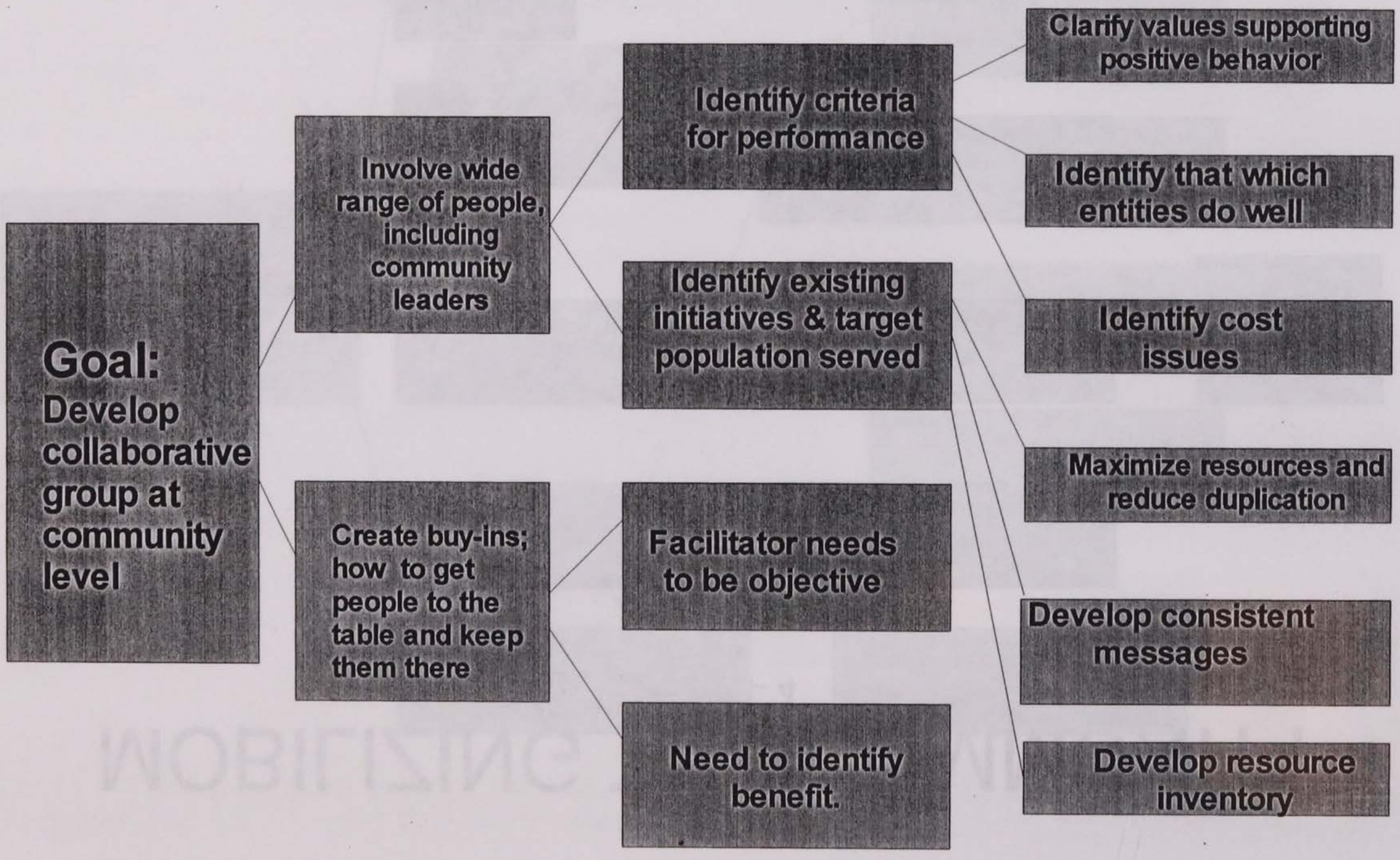


MOBILIZING THE COMMUNITY

COUNTIES: Kosouth, Humboldt, Webster, Hamilton, Boone, Story, Marshall, Tama, Grundy, Hardin, Wright, Franklin, Butler, Floyd, Cerro Gordo, Hancock, Winnebago, Worth, Mitchell

GROUP C

FACILITATOR: DOREEN CHAMBERLIN REPORTER: JANET BEAMAN



MOBILIZING THE COMMUNITY

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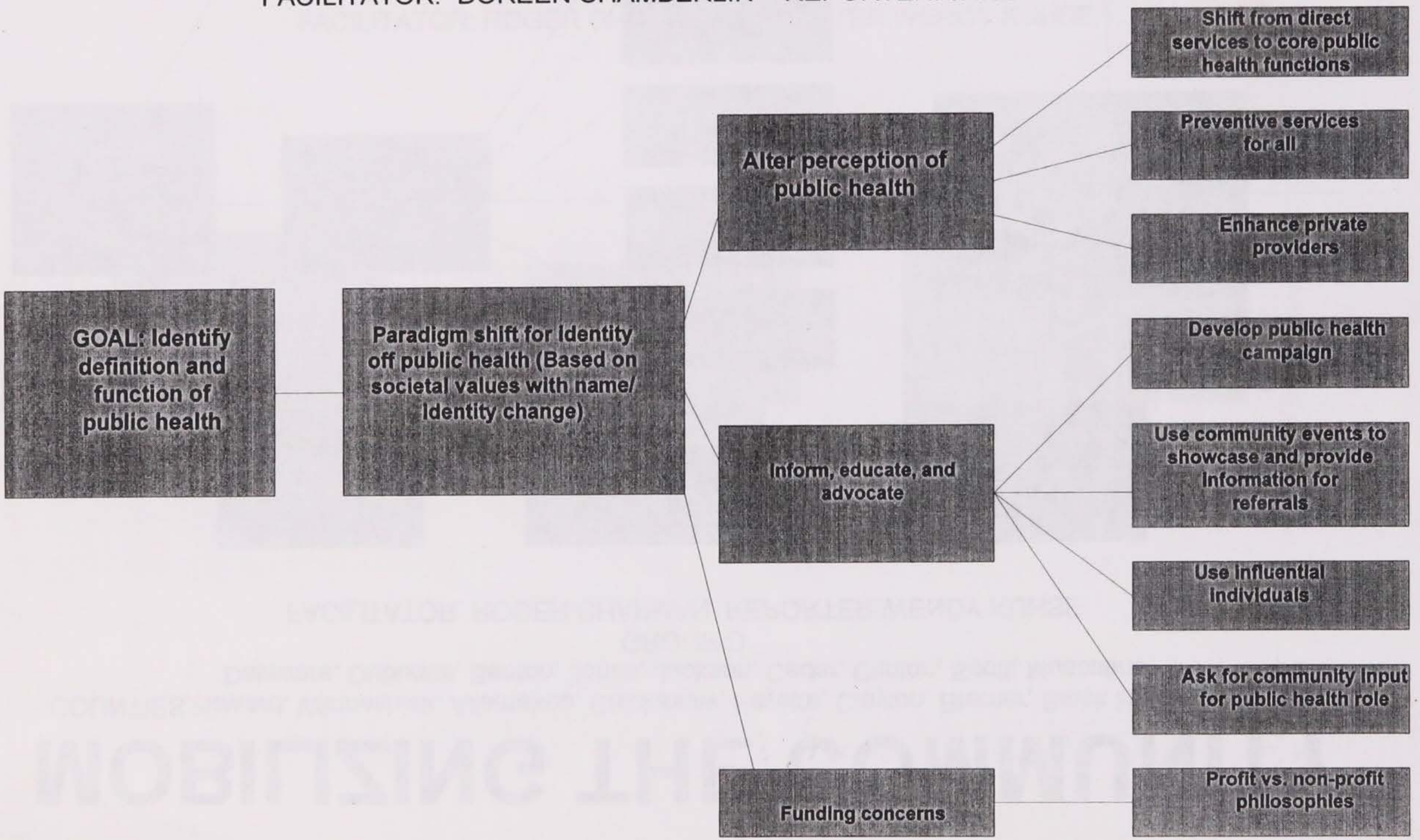
GROUP C -PART 2

FACILITATOR: DOREEN CHAMBERLIN REPORTER: JANET BEAMAN

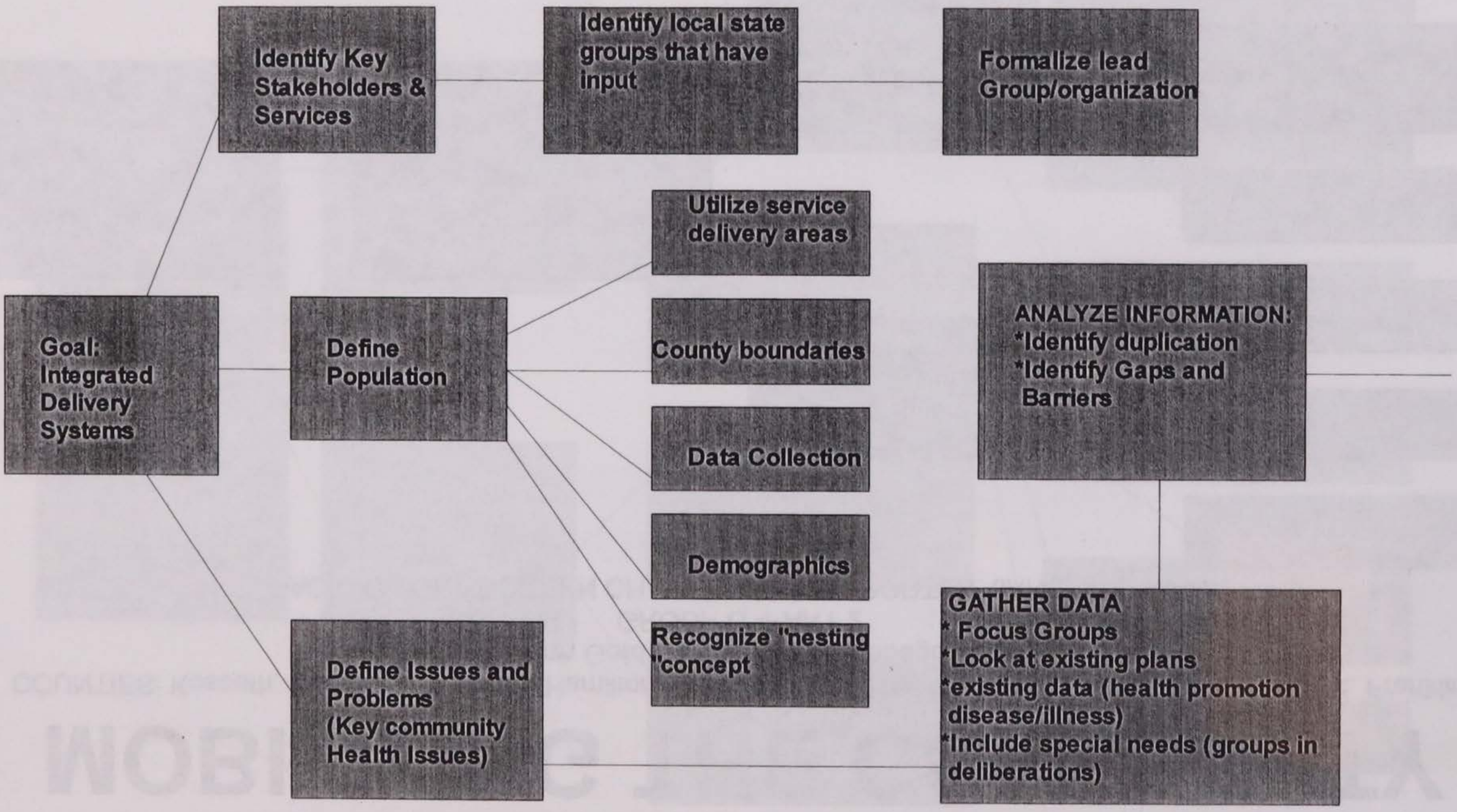


MOBILIZING THE COMMUNITY

COUNTIES:Howard, Winneshiek, Allamakee, Chickasaw, Fayette, Clayton, Bremer, Black Hawk, Buchanan, Delaware, Dubuque, Benton, Jones, Jackson, Cedar, Clinton, Scott, Muscatine

GROUP D

FACILITATOR: ROGER CHAPMAN REPORTER:WENDY KUHSE

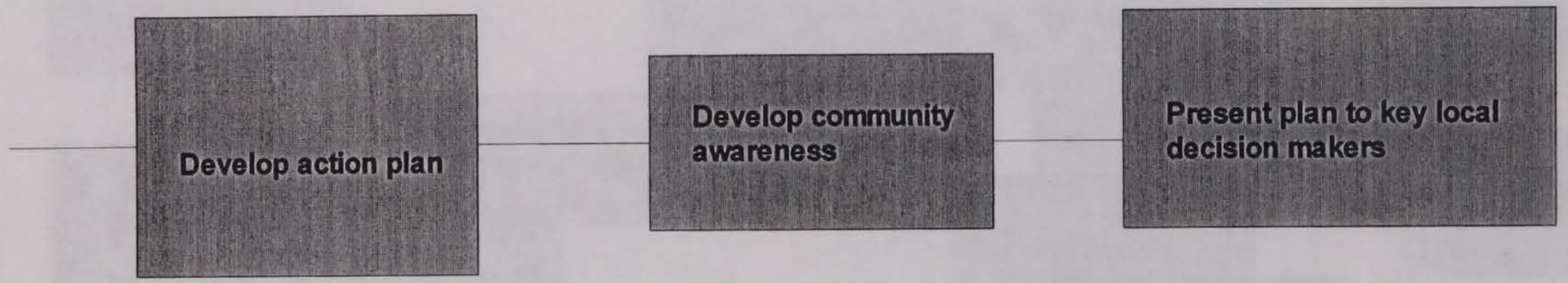


MOBILIZING THE COMMUNITY

COUNTIES:Howard, Winneshiek, Allamakee, Chickasaw, Fayette, Clayton, Bremer, Black Hawk, Buchanan, Delaware, Dubuque, Benton, Jones, Jackson, Cedar, Clinton, Scott, Muscatine

GROUP D-PART 2

FACILITATOR: ROGER CHAPMAN REPORTER:WENDY KUHSE

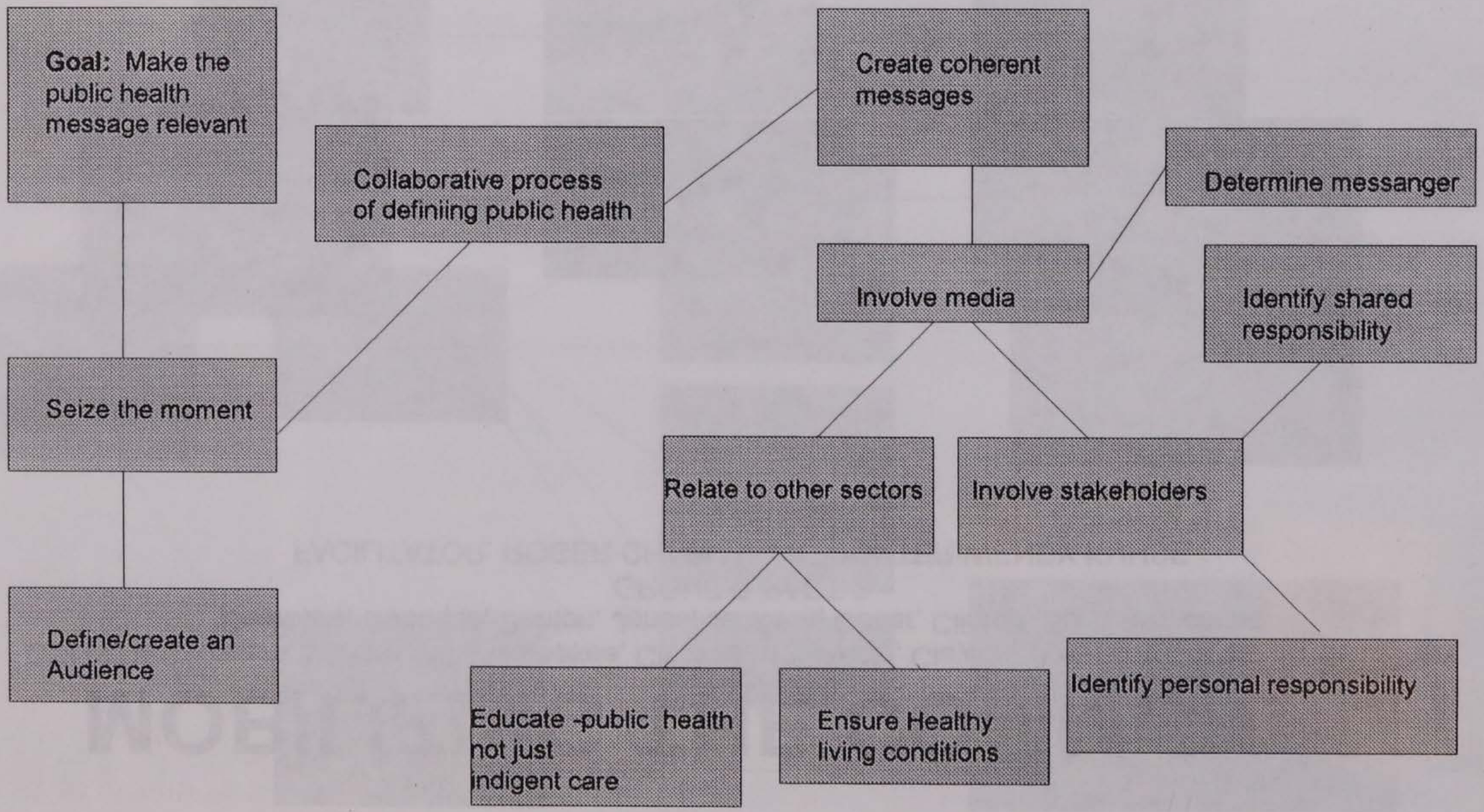


MOBILIZING THE COMMUNITY

COUNTIES: Linn and Johnson

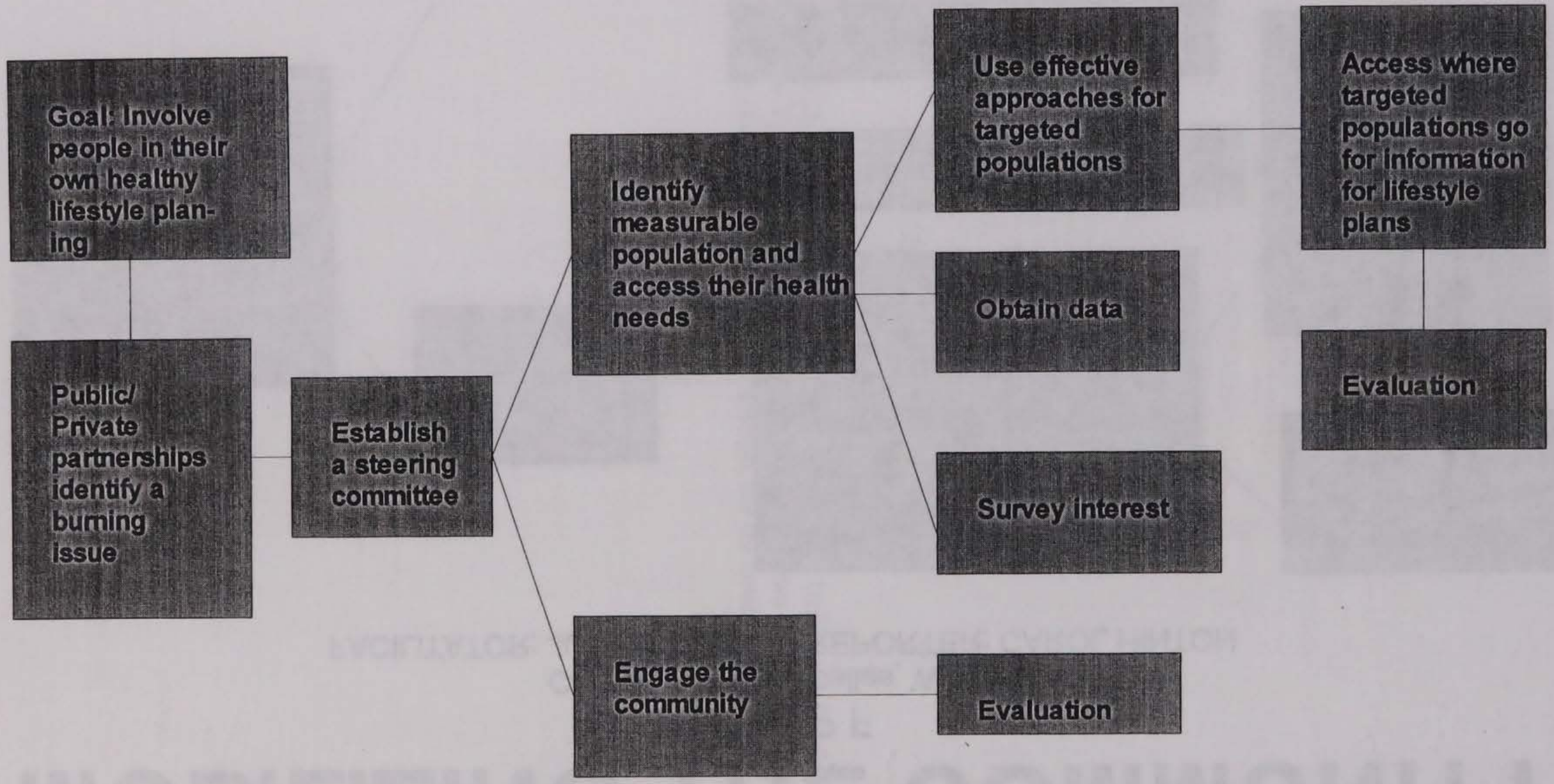
Group E

FACILITATOR: Ed Schor, M.D. Reporter: Emily Roepsch



MOBILIZING THE COMMUNITY

GROUP F
COUNTIES: Polk, Dallas, Warren
FACILITATOR: DEBBIE SYNHORST REPORTER: LEANN LARSON

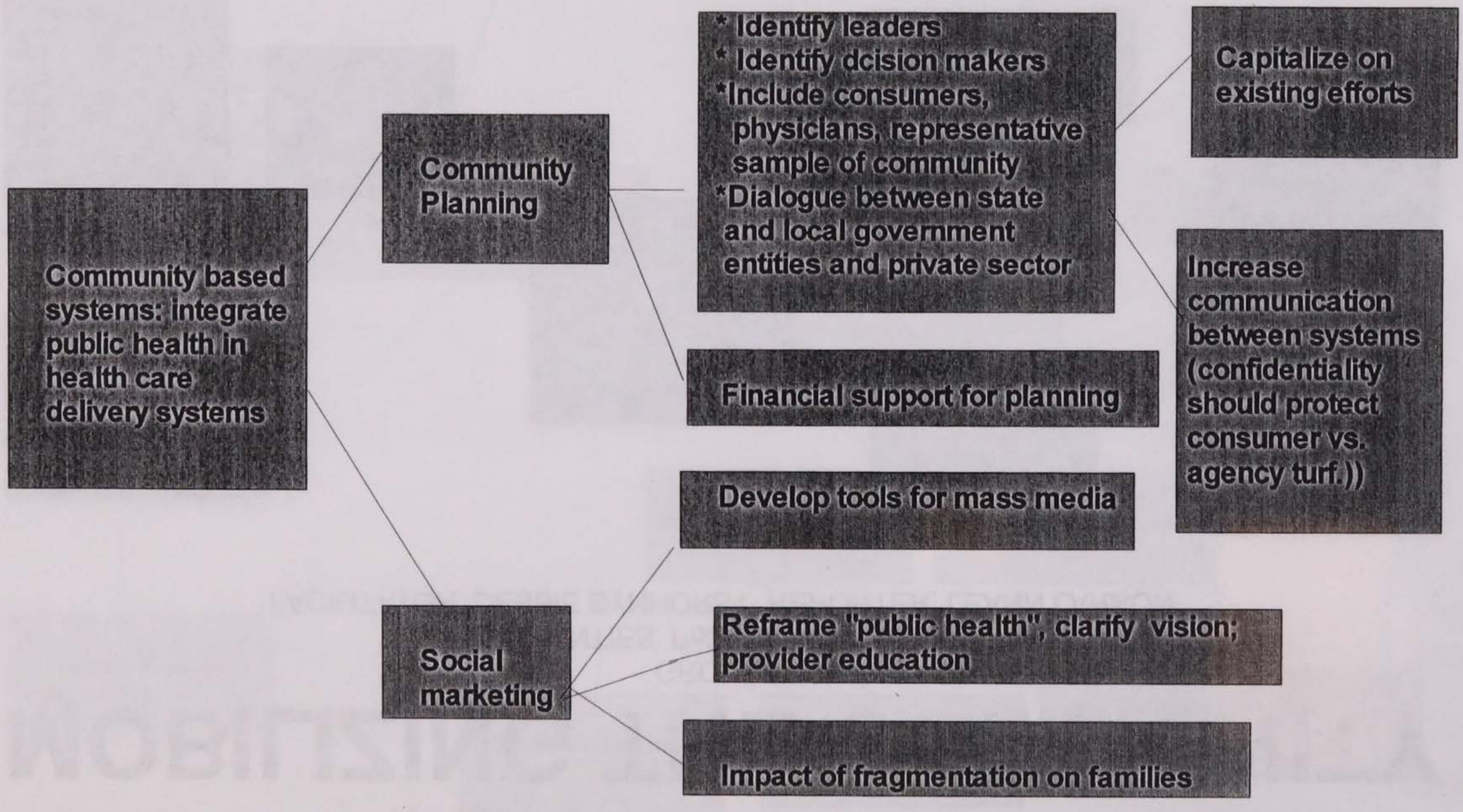


MOBILIZING THE COMMUNITY

GROUP F

COUNTIES: Polk, Dallas, Warren

FACILITATOR: JUDY SOLBERG REPORTER: CAROL HINTON



ACKNOWLEDGMENTS

The Governor's Office, the Iowa Department of Public Health, and the Drake University Center for Health Issues would like to thank Wellmark Blue Cross and Blue Shield of Iowa for printing the conference proceedings and Kim Jones, Kimbuck 2 Graphic Design, for the cover design.

A Barn Raising for Public Health: Building on Iowa's Heritage in the 21st Century

A Governor's Conference on Iowa's Emerging Health Issues

June 5-6, 1997

Conference Proceedings

Iowa Department of Public Health
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319-0075

Drake Center for Health Issues
Drake University
Pharmacy Building
Des Moines, Iowa 50311-4505