

HEALTH POLICY: THE FINE LINE

Let's Talk About Pediatric Public Health

Let's begin this column, which is intended to be a public health conversation among pediatricians, with a vignette.

Marisol is an 8-year-old female member of a Spanish-speaking family, sent to the hospital for severe failure to thrive by a pediatrician who had seen her for the first time at a community health center. The family legally emigrated from El Salvador to the United States about 6 years earlier.

None of the family's four children, all born in the United States, have health insurance, nor have any of them been evaluated by a physician within the previous year.

An inpatient work-up indicates a severe milk-protein allergy and requires that Marisol be placed on an elemental formula as her primary source of nutrition. There is also a notable food aversion, for which speech therapy is prescribed on an outpatient basis, and a slight developmental delay that might be best served with regular occupational therapy and close follow-up.

Like the Highlights magazine that probably sits in your waiting room, or a Where's Waldo picture book, this vignette features a game of hide-and-seek. Pressing issues of pediatric public health are not so

subtly embedded in an otherwise straightforward clinical encounter.

This case is not exceedingly rare. We have all seen boys and girls like Marisol, in innumerable variations.

Pediatric medicine has become much more than diagnosis and treatment and memorizing the immunization schedule.

We are now tasked to incorporate a familiarity with the basic tenets of public health into our dispositions and treatment plans.

For example, recognizing formulary idiosyncrasies of a managed care plan, such as preauthorization requirements and tiered prescription rules, is as important as knowing what medication to prescribe in the first place. Understanding eligibility for state Medicaid programs and

the allowable benefits can help you guide quality care and shape the fiscal health of your pediatric practice.

And, being able to proactively consider and answer questions about State Children's Health Insurance Program, Health Savings Accounts, and the Special Supplemental Nutrition Program for Women, Infants, and Children guidelines will benefit your patients and families.

Thus, listening closely to the legislative whispers that come from your state legis-

lators and from Washington can very actively affect your bedside management of patients.

There is a need, perhaps now more than ever, to be keen to political goings-on and the pendulum swings of legislative initiatives.

Efforts to nationalize health care are making front page news; visions of "ownership societies" are shaping public health financing programs; and pressures to rein in state budgets are influencing the welfare of children.

In Marisol's case, some of the questions that come up might include:

- ▶ Is she eligible for Medicaid, and if so, how does she apply?
- ▶ How did she wind up getting to the community health center?
- ▶ How will the family pay for the elemental formula?
- ▶ What services are available to her to get development assistance?
- ▶ And several more...

This column will guide you to become more familiar with the issues and to understand the challenges.

Topics that are often brushed over in pediatric training programs, yet present formidable obstacles when trying to ensure patient compliance and arrange follow-up, will be openly discussed and presented in some detail so as to not overwhelm you, but certainly to put you in a better position to interpret the news you hear and to

translate that information for your patients, families, and colleagues.

My intention is not to awaken some political giant within you and have you marching on the Capitol steps with picket signs. What I present will be informational and nonpartisan. I believe that advocacy at the bedside on a patient-by-patient basis has as much value as dollars in political pockets.

Should you be so motivated from what you read to take additional steps to help enact local, state, or federal changes, then I certainly encourage you.

Monthly, then, here in PEDIATRIC NEWS, this conversation will continue. Many of the issues that children such as Marisol bring to your examining table will be explored.

Practical questions that consider pertinent aspects of pediatric public health policy will be asked and answered in a utilitarian way that will, at the very least, help you treat your patients more effectively and efficiently. ■

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BY BRYAN R. FINE, M.D., M.P.H.

Health Plan Feedback to Physicians Improves Asthma Care

BY JANE SALODOF MACNEIL
Southwest Bureau

SAN FRANCISCO — What health plans tell physicians can make a difference in the quality of care given to poor children with asthma, according to a study of about 4,500 children covered by 18 Medicaid managed care plans in Tennessee and Washington state.

Two types of communication significantly increased the proportion of children with severe asthma who filled their controller prescriptions, Dr. William O. Cooper reported at the annual meeting of the Pediatric Academic Societies.

The first was feedback about how the provider compared to other physicians with respect to quality-of-care benchmarks.

The other was provider notification of an asthma-related hospitalization or an asthma-related emergency room visit by a child in the physician's panel of patients.

"I think there are things that health plans do in the way they interface with providers that could potentially improve coverage for their children," Dr. Cooper of Vanderbilt University, Nashville, Tenn., said in an interview at the meeting, which was sponsored by the American Pediatric Society, Society for Pediatric Research, Ambulatory Pediatric Association, and American Academy of Pediatrics.

The retrospective cohort study re-

viewed records from 2000 to 2002 for 3,058 children in Tennessee and for 1,440 children in Washington state. The children, who were aged 2-17 years, had moderate to severe asthma. They were covered by 11 health plans in Tennessee and 7 plans in Washington state.

Investigator interviews with the plans' medical directors determined that nine plans in Tennessee and five in Washington state provided feedback on quality of care to providers. Fewer plans, seven in Tennessee and three in Washington state, provided notification, Dr. Cooper said.

As an example of feedback, Dr. Cooper offered the following paraphrase of an insurer telling a physician, "In our health plan, 70% of children [with asthma] have controller medications. We looked at your panel of patients and only 30% [do]. Here's how you are doing compared to the other providers."

All told, 1,413 children were in plans that provided neither feedback nor notification, 1,341 in plans that provided only feedback, 215 in plans that provided only notification, and 1,529 in plans that provided feedback and notification.

The study looked at the filling of prescriptions for asthma controllers (inhaled corticosteroids, cromolyn, or leukotriene modifiers) during a 365-day follow-up period.

Dr. Cooper and his coinvestigators at Vanderbilt and the University of Washington, Seattle, reported that children in plans with both components filled their

controllers 17.6 days more on average than children in plans with no feedback.

If the plans had one component, either notification or feedback, the benefit was 10.3 more days of filled controllers.

Notification, by itself, resulted in more than 200 days that controllers were filled on average, the most of any option for the population as a whole.

The effects of feedback and notification were most pronounced for children with more severe asthma, as defined by the filling of three or more β -agonist prescriptions in the 6 months prior to their entering the study.

In this population, only 77.4% of children filled their controllers if their health plans did not provide feedback or notification.

The proportion increased to 81.6% with

notification and 82.1% with feedback to physicians.

When feedback and notification were both used, 85.5% filled their controllers (odds ratio 1.7, compared with children in plans that provided neither form of communication).

The mean days that controllers were filled also increased from 144 with no communication to 181 with feedback to 327 with notification. On average, children in plans with feedback and notification filled their controllers for 225 days. ■



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DR. COOPER

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