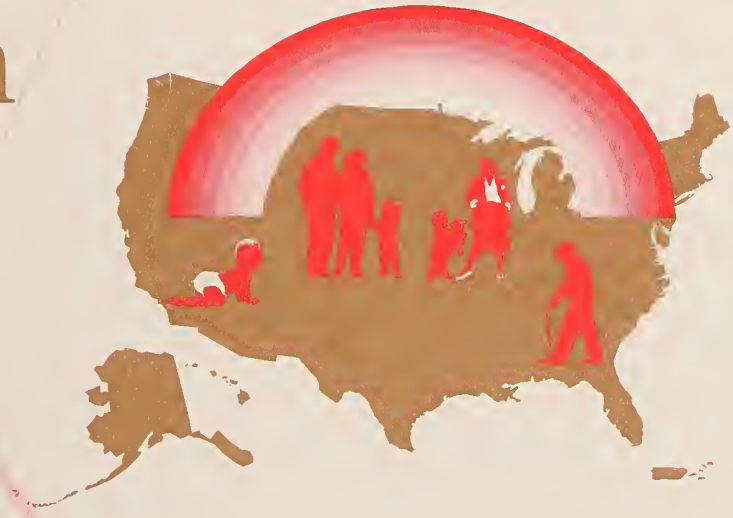
April 1998

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

Substance Abuse Resource Guide

Managed Care and Prevention



When we dialog about the health and well-being of this country, we quite naturally talk about prevention. But today, we must also talk about managed care. As the lead Federal agency for substance abuse prevention, CSAP cannot afford to separate prevention from managed care. Bringing them together will assist in developing a seamless, quality health care delivery system.

Prevention and managed care organizations agree that substance abuse is a devastating problem that adversely impacts upon our children, family members, communities, and our country. We can collaborate with this mutual agreement.

The field of prevention has come of age and is ready to move into new alliances and collaborations that will reinforce the importance and credibility of the profession. The information in this resource guide will help prevention professionals understand that their skills and leadership are essential to complete the evolutionary cycle from managing health care costs to managing the health of our citizens.

Nelba R. Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health Services Administration

Karol L. Kumpfer, Ph.D.
Director, CSAP
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Studies, Articles, and Reports

JOURNAL ARTICLES

The Partnership for Community Health in the Lehigh Valley: A Model for Healthcare Reform

Watkins, S.H.

Lehigh Valley Magazine, pp. 14-18, 43 pp.
(Available from Lehigh Valley Magazine, 242 Uncas Street, Bethlehem, PA 18015-1237; 610-691-8833)

The Partnership for Community Health in the Lehigh Valley is unique in that it is the only healthcare reform effort of a partnership of healthcare providers that is not affiliated with the health insurance industry. It is being used as a national model for healthcare reform. The partnership began in 1992 with nine area medical centers with three goals in mind: 1) to assess the community's health needs in 1993; 2) to form a cooperative managed care plan for 50,000 low income residents of the Lehigh Valley; and 3) to develop a coordinated system of health and human services for children and families. So far this Partnership has been successful and the goal is to extend beyond the seven hospitals and into the community.

Rx: Social Reconnaissance

Foundation News
31(4): 24-29, July/August 1990

Social reconnaissance is a new approach to grantmaking implemented by Kaiser's Health Promotion Program, and being copied by organizations all over the country. The goal of this grassroots grantmaking approach is to combat the biggest health problems in local communities, as determined by the residents of that community. Kaiser then makes a grant to a broad-based coalition or a well-established community service organization.

Kaiser makes an initial assessment of the socio-medical needs of a community, as determined by the residents of the community. This approach has been used successfully in the South and is currently being tried in Washington, DC. Based on the results of the South and DC, Kaiser plans to move on to the Northeast and Midwest.

Managing Managed Care: Steps to Thriving with Managed Mental Healthcare Arrangements

Durban, C.L.; Durban, P.K.; et al.

Employee Assistance: Solutions to the Problems
4(10): 28-30, May 1992

The effects of managed care on employee assistance programs (EAP's), private practice providers, and institutional providers are discussed. EAP's need to conduct a professional assessment, be willing to adapt, learn new skills to be effective in a managed care environment, educate members on ethical beliefs and values, work on prevention practices to ensure that the EAP will not be taken over by an insurance company or other organization, provide substantial outcome data to managed care providers that make them accountable for clinical decisions they make, and

seek support from and collaboration with other EAP providers. Private practice providers should diversify, perhaps by teaching and providing consultation in their practices, to solidify a broader source of revenue and satisfaction. Providers must learn to be more cost effective while providing quality clinical services, and they may need to put more emphasis on goal-directed, problem-solving orientation; empowering clients; retraining in short-term therapy techniques; and redirection into intermittent psychotherapy. Private practice providers also may need to retool their marketing strategies. It is suggested that hospitals and other institutional providers take the following steps to thrive through managed care's influence on mental health services: (1) enter the market at all points of continuum care; (2) be geographically diverse; (3) cut costs to the bone; (4) eliminate or de-emphasize boutique service; (5) examine the medical staff and make sure practice patterns are in line with the payor's philosophy; (6) create a seamless interface for patients, families, employers, insurers, physicians, and managed care utilization review personnel; (7) adopt a data-driven approach to mental health and substance abuse treatment; (8) continuously measure outcomes in all mental health and chemical dependency services.

Penny-Wise, Pound Foolish?

Gorski, T.T.

Addiction and Recovery
12(3): 24-25, May/June 1992

Relapse prevention is of serious concern to managed care providers responsible for containing the cost of chemical dependency treatment, since 47 percent of patients treated in private treatment programs will return to chemical use within the first year following treatment; 40 percent of these will have short-term, low-consequences relapses and will rapidly return to recovery, whereas 60 percent of relapsers will have long-term, high-consequences relapses that require costly treatment. Fifty-three percent of chemically dependent patients do recover. The recovery and relapse rates for chemical addiction improved significantly since the introduction in 1935 of abstinence-based recovery methods. Relapse prevention therapy is improving the chances of recovery for relapsers. Many managed care providers are establishing cost control strategies that refuse to pay for repeat treatments with methods that have failed. It is suggested that what is needed is the widespread implementation and support of specialty treatment programs for relapse prone people.

Social Science Theory in Health Education: Time For a New Model?

Goodman, R.; Burdine, J.; et al.

Health Education Research
8(3): 305-314, 1993

In the health education field there is a difference between the way theory is taught and the way it is used in practice. Also, there is a question as to how theory should actually be used. The academic perspective on theory and the current use of theory in health education practice are explored using examples. Then an ecological planning approach for health education practice is explored. In conclusion, suggestions for strengthening health education practice are proposed.

Grassroots Participation in Healthcare Reform

Cranshaw, R.

Annuals of Internal Medicine
120(8): 677-681, 1994

Concerned citizens have responded to the healthcare crisis by developing the health decisions movement. American Health Decisions, a national consortium of 21 State organizations, leads a grass roots discussion network of community meetings committed to education and consensus on the ethical, technological, legal, and economic issues of health policy. The movement is described here, and potential roles for physician cooperation and participation in forging functional, community-based health policy are delineated.

A New Approach to Alcoholism

Del Toro, I. M.; Larsen, D. A.; et al.

Journal of Mental Health Administration
21(2): 124-135, 1994

The authors of this article describe in detail an approach to alcoholism detection which brings together chemical dependency, mental health, and primary care services. The article mentions alcoholism prevention, but the context is primarily early intervention. They do, however, include identification of patients with emotional/behavioral problems in order to provide crisis-oriented intervention. The project model included a masters level social worker with community resources, as well as those within the HMO, to provide the services necessary. The conclusion of the authors is that placing this team in the primary care facility is advantageous to both the patient and the medical team.

The Integration of Public Health and Medicine

Rundall, T. G.

Frontiers of Health Services Management
10(4): 3-24, Summer 1994

The author examines President Clinton's American Health Security Act and other efforts to integrate medical care and public health service delivery systems. An overview of the changes in both areas during the past few decades shows technological advances in medicine that add small increments to health at a high cost, and relatively few resources are distributed to broad public health promotion or disease prevention programs. Continuing the present approach to medical care not only perpetuates a system that does more and more for fewer and fewer people, but it denies the reality of the transformation in the distribution of illness and disability in the country. As the population ages the healthcare system must address treating long-term chronic conditions and be more responsive to prevention services. The integration of medicine and public health requires assigning responsibility for public health in a reformed system; defining roles of the public and private sectors for public health matters; fulfilling the public health mandate; determining if the implementation work accomplishes its goals; and raising funds to pay for public health services. An integrated system is the country's best hope not only for improving the health of all citizens, but for closing the "health gap" between socioeconomically disadvantaged groups and the rest of the population.

Collaboration in the Carolinas: An In-depth Look at American College of Healthcare Executives' Healthcare Demonstration Project

Crystal, B.

Healthcare Executive
10(1): 17-20, January/February 1995

In 1992 the American College of Healthcare Executives started the Healthcare Leadership Demonstration Project to identify and mobilize community healthcare leaders who could work together to influence healthcare policy and delivery in their communities, also known as the Carolinas Project. It is comprised of two

pilot projects: the Midlands Partnership for Community Health in Columbia, SC and the Partnership for Community Health of Robeson County in Lumberton, NC. The goals, successes, obstacles, and future goals are discussed.

The Effect of Retirement on Mental Health and Health Behaviors: The Kaiser Permanente Retirement Study

Midanik, L.T.; Soghikian, K.; et al.

Journal of Gerontology
50(1): S59-S61, 1995

To assess the short-term effect of retirement on mental health and health behaviors of members of an HMO, aged 60-66, the authors compared mental health and health behaviors of members who actually retired (N=275).

Controlling for age, gender, marital status, and education, the authors found that retired members were likely to have lower stress levels and to engage in regular exercise more often than those who did not retire during the study period. Retired women were more likely to report no alcohol problems as compared to women still active in the labor force.

There were no differences between the groups on self-reported mental health status, coping, depression, smoking, alcohol consumption, and frequency of drunkenness. These findings underscore the importance of assessing positive benefits associated with retirement and call for further evaluation of whether these benefits persist over time.

Integration of Medical Care and Worksite Health Promotion

Stokols, D.; Pelletier, K. R.; et al.

Journal of the American Medical Association
273(14): 1136-1142, 1995

This article is an extensive discussion of the merits of worksite health promotion in the context of health reform and the rapid changes in the healthcare system. While the article is in the *Journal of the American Medical Association* and, therefore, is focused on physicians, it also focuses on employers and employee assistance plan administrators. The article only occasionally references substance abuse directly, but rather focuses the discussion on smoking cessation, health risk appraisal, and stress management. Substance abuse is referenced within this context. The authors have reviewed the history of worksite health promotion programs and their limitations. They outline a large number of programmatic challenges to integrating such programs with the medical care system, but do not view those challenges as insurmountable. Some of the challenges they note are: access to hard-to-reach populations, integration of health promotion into corporate benefit plans, protecting employee privacy and job security, developing more comprehensive approaches to worksite wellness, addressing the health consequences of the current environment of downsizing, and improving methods for evaluating the health outcomes and cost-effectiveness of these programs.

Prevention and Managed Care: Opportunities for Managed Care Organizations, Purchasers of Healthcare, and Public Health Agencies

Morbidity and Mortality Weekly Report
44 (No. RR-14): 1-12, 1995
(Available from MMWR Series, Mailstop C-08, CDC, 1600 Clifton Road, NE, Atlanta, GA 30333; 404-332-4555)

The rapid, extensive changes in the healthcare system in the United States provide public health agencies with new opportunities for prevention-oriented

relationships with the private healthcare system. Managed care organizations (MCO's) are rapidly becoming a major source of healthcare for the beneficiaries of both employer-funded care and of the publicly funded programs, Medicaid and Medicare. In addition, MCO's represent organized care systems that often focus their efforts on defined populations and are accountable for desired outcomes, including prevention activities. In recognition of the potential role of managed care in prevention, in January 1995, the Centers for Disease Control and Prevention (CDC) formed a Managed Care Working Group to develop recommendations for CDC for fostering the incorporation of prevention practices into managed care. This report presents these recommendations and approaches for their implementation, as well as background and case examples.

Primary and Secondary Prevention Services in Clinical Practice: Twenty Years' Experience in Development, Implementation, and Evaluation

Thompson, R. S.; Taplin, S. H.; et al.

Journal of the American Medical Association
273(14): 1130-1135, 1995

This article reviews the 20-year history of the Group Health Cooperative of Puget Sound's development and provision of clinical preventive services. It is often touted as a model of managed care and prevention, including substance abuse prevention, although the only clear connection to substance abuse prevention is smoking cessation programs. The approach used by the Cooperative is population-based, targeting the individual level of primary care and multiple infrastructure levels of care, resulting in a synthesis of clinical medicine and public health approaches. It uses demonstration projects, coalitions, or policy development activities at the community level. Lastly, the article includes a series of tables listing the critical elements for prevention; criteria to examine primary and secondary prevention issues; and critical intervention strategies aimed at predisposing, enabling, and reinforcing factors. This discussion is focused on health maintenance organizations and other managed care organizations and managers.

The Ups and Downs for Children with Chronic Illnesses

Smyth, M.; Haas, D.; et al.

Managed Care Quarterly
3(4): 91-95, 1995

Children with chronic illnesses have the same basic need for preventive care as their healthy peers. In Michigan, a Medicaid Physician Sponsor Plan was established to provide that care for this special population. Incentives and barriers for both physicians and families were identified as well as the advantages to providing care in a managed care delivery system.

Use of Medical Care After a Community-Based Health Promotion Program: A Quasi-Experimental Study

Cousins, M.; McDowell, I.

American Journal of Health Promotion
10(1): 47-53, 1995

The purpose of this study was to assess the effects of health promotion on the use of medical care services in a community setting. A quasi-experimental, multiple time points, case-comparison group design was used in a community health center in Ottawa, Canada. The sample used was 520 volunteer participants in a health promotion program and 932 matched comparison subjects. The health promotion program consisted of a

weekend workshop on health behaviors, lifestyle assessment, and identification of weekly goals for change. This was followed by 18 months of support (5 group sessions, weekly telephone calls, and optional individual sessions). Computerized data on healthcare use 6 months before, 18 months during, and 6 months after the program was obtained from Ontario's Universal Health Insurance Plan (OHIP). These data were used to determine the number and system costs of visits made by participants and comparisons. When controlling for baseline differences through analysis of covariance, program participants were found to have higher costs and more visits for ambulatory care during the first year ($p<.01$) and second year ($p<.05$) of follow-up. Participants used significantly more diagnostic services than comparisons during both years of follow-up. Participants were also more likely to use more counseling and psychotherapy services in year 1 (relative risk, 1.53; 95 percent confidence interval, 1.28, 1.81) and year 2 (relative risk, 1.57; 95 percent confidence interval, 1.31, 1.89). No differences were found between participant and comparison groups in visits for medical consultations and assessments or preventive services. In conclusion, no evidence shows that this health promotion program reduced use in the population over the 2-year follow-up period.

Taking the Pulse of the Community

Felix, M.; Burdine, J. N.

Healthcare Executive
10(4): 8-11, July/August 1995

This article discusses the seven components of designing and implementing a population-based community health status assessment. The seven steps are: 1) selling the idea; 2) developing a methodology; 3) gathering information; 4) interpreting the data; 5) translating the analysis to policy; 6) communicating the findings; and 7) supporting continued efforts.

The Social HMO's: Meeting the Challenge of Integrated Team Care Coordination

Macko, P.; Dunn, S.; et al.

Journal of Case Management
4(3): 102-106, Fall 1995

Four social health maintenance organizations (social HMO's) implemented care coordination programs in 1985 to integrate acute and long-term care for aged Medicare beneficiaries. The team approach to care coordination has been the key concept of the model at all four sites. Team members include the primary care physician, the care coordinator, inpatient and medical office staff, geriatric nurse practitioners, home care nurses and social workers, contracted community-based care staff, and, at three of the sites, volunteers. This article describes how care coordinators work with the healthcare teams in the social HMO's.

Awakening the Sleeping Giant: Mainstreaming Efforts to Decrease Tobacco Use in an HMO

McAfee, T.; Wilson, J.; et al.

HMO Practice
9(3): 138-143, September 1995

Group Health Cooperative (GHC) of Puget Sound is developing, within a framework of quality improvement, a comprehensive population-based approach to decreasing the prevalence of tobacco use. Broad organizational support has been obtained, centralized support is being integrated with clinic-level activity, local ownership of outcomes is encouraged with empowerment of healthcare teams, and

support for community and policy-based activities is being provided. GHC's smoking prevalence has decreased from 25 percent to 15.5 percent over the past decade, while the State of Washington's prevalence declined from 23.7 percent to 21.8 percent.

Health Plans Helping Smokers

Kotke, T.

HMO Practice
9(3): 128-133, September 1995

Tobacco use is the leading cause of preventable mortality in the United States. Therefore, healthcare organizations have an important role to play in the control of tobacco use both among their plan members and in the communities that they serve. To be effective, they need to adopt a policy that all tobacco users will be identified and provided with advice to quit smoking (or chewing) at each contact with a healthcare professional. This same policy ought to be adopted for parents of pediatric patients. The policy can be implemented by defining tobacco use as a "vital sign" and periodically assessing implementation rates with a chart review. Patients who express an interest in quitting should be supported through individual or group follow-up. To make clinical interventions more effective, to counteract tobacco promotion that is directed at youth, and to protect the health of non-smokers, HMOs will want to support local and regional tobacco control coalitions that are taking action against tobacco promotion and are promoting smoke-free public areas.

Tobacco Use Prevention and Reduction

Yox, S. B., (Ed.)

HMO Practice
9(3): 123-127, September 1995

This article is a report on the meeting on tobacco use and prevention and reduction sponsored by The HMO Group and the Centers for Disease Control and Prevention. The meeting focused on designing plans that would improve HMO delivery systems and developing strategies that would impact laws and policy regarding tobacco control. Summaries of other conference participants' presentations and recommendations are included.

Behavioral Medicine, Clinical Health Psychology, and Cost Offset

Friedman, R.; Sobel D., et al.

Health Psychology
14(6): 509-518, November 1995

Behavioral medicine interventions, if correctly combined with primary medical care, can result in significant healthcare cost savings, according to an article published in a recent issue of *Health Psychology*. According to the authors, recent attempts at medical cost savings have tended to limit patient access. However, this supply side perspective overlooks the potential savings from reducing demand for services, say the authors.

For example, research has shown that up to 74 percent of medical complaints brought to internists have no diagnosable organic etiology—rather, a variety of psychosocial factors were involved. Careful application of behavioral interventions in such cases can reduce costs by eliminating the need for expensive and needless medical testing, while providing better outcomes for patients.

The authors identify six "pathways" by which behavioral medicine interventions can save money.

Bridge Over Troubled Waters

Novotny, T. E.; Nitzkin, J. L.

American Journal of Preventive Medicine
12(4): 1-2, 1996

This special supplement to the *American Journal of Preventive Medicine* is dedicated to collaborative research among schools of public health, State and local health departments, and community-based organizations. It is believed that such a collaboration could be important in sustaining the science base of public health practice in this new environment. Collaborative arrangements could serve as the "bridge" necessary for threatened agencies and programs to cross over the "troubled waters" of privatization and diminishing governmental support.

Cost-Effectiveness of the Transdermal Nicotine Patch as an Adjunct to Physicians Smoking Cessation Counseling

Franks, F. K.

Journal of the American Medical Association
275(16): 1247-1251, 1996

The objective of this article is to determine the incremental cost-effectiveness of the transdermal nicotine patch in helping adults in primary care settings stop smoking. The design used is a decision analysis model from the perspective of the payer with effectiveness data taken from two meta-analyses of the effectiveness of physician counseling for smoking cessation; nicotine patches were included in one meta-analysis and excluded in the other. The main cost and outcome measures are listed by: quit rates with patch, physician counseling alone, and physician counseling and use of the nicotine patch. The cost involved in the use of the nicotine patch included extra time for counseling (5 minutes at U.S. $80/hr) and the actual cost of the patch ($112/mo for 2 mos.). Future quit rates were taken from the Centers for Disease Control and Prevention and quality-adjusted life years (QALY) saved were calculated. The main findings confirmed quit rates at 1 year were 2.5 percent for no intervention, 4.0 percent with physician counseling alone, and 7.9 percent with physician counseling plus the nicotine patch. The cost of each QALY saved depended on the age and ranged from $4,390 to $10,943 for men and from $4,955 to $6,983 for women. Cost effectiveness was more sensitive to the baseline quit rate, the physician-counseling-only quit rate, and the discount rate. The addition of the nicotine patch to physician counseling for smoking cessation in primary care settings was relatively cost-effective.

Effect of Managed Care Felt in Every Medical Field

Marwick, C.

Journal of the American Medical Association
276(10): 768-769, 1996

As managed care organizations (MCO's) become commonplace in the field of medicine, physicians not only in patient practice but also in medical education, clinical research, and public health are grappling with the challenge they present. The task is hardly started, it will not be easy, and it will not be accomplished overnight. This is the overall message from several forums that have addressed the impact of managed care on the future of medical practice. Among these aspects were the following:

Education: Teaching hospitals are developing ways to instruct students in the skills they will need to practice in a managed care environment.

Clinical research: The advent of managed care and the national emphasis on reducing the cost of healthcare is forcing reevaluation of the traditional means of funding clinical research, in part from fees charged for patient care.

Public health: As health departments find their resources drying up, they are contracting with MCO's to furnish many services they can no longer provide.

Managed Care in the Public Sector

Goplerud, E.

Behavioral Healthcare Tomorrow
5(2): 71-73, 1996

This article describes the Federal role as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) for managed care relative to behavioral health. SAMHSA will track the development and impact of managed care nationwide and support projects to develop quality standards, create training modules, evaluate costs and outcomes, and analyze utilization and cost data.

Navigating Healthcare Reform: Prevention in Managed Care

Tolnai, E.A.

Prevention Forum
16(2): 6-10, 1996

Historically, the medical system in the United States has been concerned with the treatment of acute illness. Little if any thought has been given to other services that have increasingly begun to be included under the label Behavioral Healthcare. As a result, many individuals still see health insurance as a way to defer the cost of illness rather than as a method of enhancing or maintaining health, which are the goals of prevention. The White House Domestic Policy Council in 1993 conservatively estimated healthcare costs at $3 trillion a year. These costs are continuing to rise. It is difficult to estimate what impact our Nation's move toward managed care will have on the field of behavioral health. However, it is important for providers to understand the possible implications that choosing to enter a system of managed care could have on the way substance abuse prevention services are delivered. In order to understand the implications, providers must first understand the system. This article traces the history of and distinguishes the different types of MCO's.

Prevention in Managed Care: A Look at the National Picture

Jacobi, B.

Prevention Forum
16(2): 8, 11-13, 1996

This article summarizes the current national status of managed care and substance abuse prevention and is designed to provide substance abuse prevention professionals with an overview. The author notes that currently there is no predominant way for inclusion of substance abuse prevention services in managed care. However, with healthcare systems beginning to develop "demand-side management," reducing the need for treatment services through early and effective intervention, the managed care industry is more receptive to substance abuse prevention than before. The author maintains that substance abuse prevention belongs in both the health promotion and the clinical service areas of managed care organizations (MCO's). She recommends that the Single State Authority take the lead in determining a minimum set of substance abuse prevention services to be provided through MCO's. She suggests that financing of prevention services will be through multiple sources in the future—through multiple MCO's, State, Federal

and local government sources. MCO's are beginning to move toward capitation for prevention services through contracts with prevention providers. The author closes with a brief overview of three State or local efforts to integrate substance abuse prevention in MCO's—Oregon; Pima Health System in Tucson, AZ; and the Group Health Cooperative of Puget Sound, Seattle, WA.

Proxies for Healthcare Need Among Populations: Validation of Alternatives—A Study in Quebec

Birch, S.; Eyles, J.; Newbold, K. B.

Journal of Epidemiology and Community Health
50(5): 564-569, 1996

The objective of the article is to compare the use of non-mortality based proxy for relative needs for healthcare among regional populations with a mortality based proxy for population relative needs and to evaluate the additional value of a proxy based on a combination of non-mortality and mortality based proxies. The design of the analysis is cross sectional data on mortality, socioeconomic status, and self assessments of health taken from registrar general records; a population census; and a population health survey from the 15 health regions in Quebec, Canada. The main outcome measure is the levels of correlation of indicators, based on mortality data, socioeconomic data, and combined data with a standardized indicator of assessed health. Justification of "deprivation weights" reflecting variations in socioeconomic status among populations should be based on empirical support concerning the performance of such weights as proxies for relative levels of need among populations. The socioeconomic proxy developed in this study provides a closer correlation to the self assessed health of the populations under study than the mortality based proxy. The superior performance of the combined indicator suggests that the development of social deprivation indicators should be viewed as a complement to, as opposed to a substitute for, mortality based measures in needs-based resource allocation exercises.

The Robert Wood Johnson Foundation Community Snapshots Study: Introduction and Overview

Ginsburg, P. B.

Health Affairs
15(2): 7-20, 1996

Teams of researchers visited 15 communities—selected to reflect a range of healthcare market development, regions, and population size—to obtain a "snapshot" of health system change. The study found that organizational change is pervasive, even in those communities that do not receive attention in the trade press, but that much of the change has not yet affected consumers. While the forces driving change are similar across the communities, the responses—and the shape of change—differ in important ways. Factors leading to the differences include the size and capabilities of existing healthcare organizations, the community's experience with managed care, and the political and business cultures of the community.

Will Wellness Ever Really Catch On?

Caruthers, D.

The State of Health Care in America 1996
(A supplement to *Business & Health Magazine*)
14(4): 55-58, 1996

Although Americans recognize the importance of wellness and prevention, the commitment is missing. Successful

wellness programs should be well-defined, well-promoted throughout the organization, bought into at the highest level of management and adequately funded. Promoting a wellness program is also key. Examples of successful and unsuccessful wellness programs are included.

Bringing Prevention Home

Zablocki, E.

Healthplan
37(2): 28-35, 1996

This article discusses how managed care physicians, quality improvement experts, and direct mail specialists offer advice on how to reach members with a message of prevention. Health plans across the country are searching for new and better ways to communicate directly with members who would benefit from preventive care, such as: targeted mailers to women who need mammograms, refrigerator magnets to keep track of a child's medical appointments, and rewards to members who complete health status surveys. Health plans are doing more than simply showering their members with messages of prevention. They are measuring the effectiveness of various communication methods to find out what works best in promoting health behavior as preventive care. Based on years of experience and research, staff are continually refining the things they do in an effort to have the greatest impact on their members' health and well being.

Forging a Relationship With Managed Care

Poignand, C.

Prevention Forum
16(2): 14-17, Spring 1996

The push toward managed healthcare is changing the nature of healthcare delivery in the United States. Since the demise of President Bill Clinton's National Healthcare Reform plan in 1993, an increasing number of States are looking to incorporate managed care models in their healthcare systems to contain the escalating costs of Medicare and Medicaid. By the year 2000, managed care enrollment is expected to include 90 million people, growing from the current enrollment of 50 million people. The Federal Government is currently engaged in fiscal downsizing reminiscent of corporate America in the first half of the decade. With the downsizing also comes the fear that direct funding for substance abuse will diminish. Substance abuse preventionists are beginning to look to managed care as a logical future partner through which to deliver their services. Regardless of the fate of governmental support, forging relationships with managed care organizations (MCO's) will, at the very least, broaden the financial base of prevention services.

Enriching the Life of the Community

Lawton, C.

Healthplan
37(4): July/August 1996, pp. 28-35

This article profiles the Kaiser Permanente Watts Counseling and Learning Center in Los Angeles, CA, which was the first recipient of the Community Leadership Award of the American Association of Health Plans (AAHP). The various programs and criteria that made the Watts Center this year's recipient of the award are presented.

Integrating Community Services for Prevention

Salzman, P.

Behavioral Health Management
16(4): 9-13, July/August 1996

Northeast Health Systems, Inc. initiated the merger of five social service agencies in Boston's North Shore area, bringing them together under the management of Health and Education Services, Inc. (HES), a behavioral healthcare network designed to integrate services and focus on long-term wellness. HES' mission is to offer comprehensive mental health and substance abuse services, with prevention and continuity of care as primary themes. To carry this out, HES is committed to prevention, community partnerships, an integration of medical and behavioral health services, and individuals and communities taking and active role in managing their own health.

Redrawing the Line

Friedman, E.

Healthcare Forum Journal
39(5): 11-14, September/October 1996

The author, a healthcare writer, lecturer, and policy analyst, discusses physicians' increased responsibility when it comes to prevention and early intervention.

Coalitions Learn To Work Prevention into Managed Care

Drug & Crime Prevention Funding News
3(23): 1-10, November 20, 1996

At a managed care workshop hosted by the Community Anti-Drug Coalitions of America (CADCA), leaders in the field of prevention participated in the ongoing dialogue of how substance abuse and mental health fit into the managed care arena. Nancy Kennedy, Dr.P.H., director of CSAP's managed care activities, offered suggestions for prevention leaders on how best they can understand managed care and integrate substance abuse prevention into the managed care field.

SAMHSA: Adapting to Fit Managed Care

Douglas, D.

Managed Healthcare News, pp. 20E, November 1996

In order to help administrators and providers keep up with changing healthcare systems in 1995 the Substance Abuse and Mental Health Services Administration (SAMHSA) implemented a managed-care initiative. The goal of SAMHSA along with CMHS, CSAT, and CSAP is to provide quality assurance and network accreditation guidelines, performance monitoring systems which are sensitive to consumers and families, and materials which help the government and community-based service providers arrange and handle contracts with managed-care systems. The obstacles to achieving these goals are discussed. A tracking system developed by the Policy Resource Center and the George Washington University Center for Health Policy Research which consolidates information including prevention is also discussed.

Family Fund: A Manual on the Conversion of Nonprofit Healthcare Organizations into For-Proft Corporations

Consumers Union/Community Catalyst
1997, 91 pp.
(Available from the Community Catalyst, 30 Winter Street, 10th Floor, Boston, MA 02108; 617-338-6035)

This manual is part of the Community Health Assets Project, a national effort seeking to protect nonprofit charitable assets and to assure that community health needs are addressed in the conversion of nonprofit healthcare institutions to for-profit corporations. The project is a joint effort of Consumers Union and Community Catalyst. The project gratefully acknowledges support from: the California Wellness

Foundation, the Commonwealth Fund, the Public Welfare Foundation, the California Consumer Protection Foundation, and the Rockefeller Foundation.

Enhancing Patient Outcomes Through an Understanding of Intercultural Medicine: Guidelines for the Practitioner

Scott, C. J.

Maryland Medical Journal
46(4): 175-180, April 1997

As cultural and ethnic diversity increase within American society, physicians face new challenges in recognizing patients' culturally defined expectations about medical care and the cultural/ethnic dictates that influence physician-patient interactions. Patients present to practitioners with many mores related to concepts of disease and illness, intergenerational communication, decision-making authority, and gender roles. In addition, many cultural groups follow folk medicine traditions, and an increasing number of American seek treatment by practitioners of alternative therapies before seeking traditional western medical attention. To facilitate patient assessments, enhance compliance with healthcare instructions, and thus achieve the best possible medical outcomes and levels of satisfaction, practitioners must acknowledge and respect the cultural differences patients bring to medical care environments.

Is Altruism Killing Prevention?

Chapel, T.J; Stange, P.V.

Healthcare Forum Journal
40(5): 46-50, September/October 1997

Altruism may be hazardous to the health of prevention programs. Unless prevention activities are tied to operational objectives and corporate strategy, they will not survive. This article reviews a study funded by the Centers for Disease Control and Prevention (CDC) that studied the eight healthcare systems and health plans—the public health approaches they had adopted, the staff and funds devoted to them, collaborations in the community, and their motivations for embracing public health strategies. The results of the study provide insight into ways health systems can adopt public health models.

Reports and Papers

Clinician's Handbook of Preventive Services

Staff of the Office of Disease Prevention and Health Promotion (DHHS), 1994, 337 pp.

(Available from the U.S. Government Printing Office, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954; 202-783-3238)

The *Clinician's Handbook* is a user-friendly manual in two sections—children/adolescents and adults/older adults. Each section includes multiple chapters on screening tests, immunizations/prophylaxis, and counseling. Each of the 60 chapters includes basic steps of performing the service, a description of the burden of suffering from the target condition, the recommendations of major authorities, and listings of patient and provider resources. Parts of the handbook contain sections on counseling for alcohol and drug abuse problems, and tobacco, including smoking cessation. This manual is designed for use both by practicing clinicians and students.

The Virtual Hospital (developed by the University of Iowa) now offers an on-line version of the *Clinician's Handbook* at the following address:
http://vh.radiology.uiowa.edu/Providers/ClinGuide/PreventionPractice/TableofContents.html

Prevention: A Cornerstone of Managed Care

Chambers, D.; Crews, V., et al.

Alcohol, Tobacco and Other Drug Prevention Services Position Unpublished Paper, November 1995

(Available from the Ohio Department of Alcohol and Drug Addiction Services, 280 North High Street, 12th Floor, Columbus, OH 43215; 614-752-8356)

The goal of managing healthcare is to provide quality care in a cost-efficient manner. In primary healthcare, preventive medicine is the key to reducing the need for cost intensive treatment services. Inclusion of similar preventive strategies in healthcare is equally important. Alcohol, tobacco and illicit drug-related illnesses and related problems exact a heavy toll on healthcare costs. This paper gives an overview of preventive services and ways to integrate preventive services in managed healthcare. The paper also includes an example of managing a targeted population's healthcare.

Prevention Interventions Against Substance Abuse: What CSAP Has Learned About Activities and Costs

Stoil, M. J.; Hill, G. A.; Winn Jr., F. A.; Kennedy, N. J.

1996, 12 pp.

(Available from Conwal Inc., 6858 Old Dominion Drive, Ste. 200, McLean, VA 2210)

This report covers Center for Substance Abuse Prevention (CSAP) findings on program implementation; successful prevention activities; and cost and financing of prevention. The sources of the evidence for findings are identified, and implications of the findings for future prevention efforts are suggested.

Transforming Healthcare Delivery

1994, 19 pp.

(Available from the American Hospital Association, American Hospital Association Resource Center; 1 North Franklin, Chicago, IL 60606; 312-422-3000)

Healthcare leaders are feeling both elated and apprehensive these days. On the one hand, you're gratified that America has finally acknowledged what you've known for years: The healthcare system needs serious fixing. On the other, you're concerned about what national reform will ultimately mean for your hospital, your patients, and your community. Federal or State legislation can deal with the financing care for the uninsured, restructuring insurance markets, and changing the regulatory environment. But laws and regulations alone cannot create the kind of healthcare system we want. That's up to the providers at the local level. Each health organization will respond to the changing healthcare environment in its own unique way, depending on the reform initiatives taken at the State level, the market conditions in its region, and the needs and traditions of the community. This publication is designed to help you and your leadership team in the planning process by clarifying the characteristics that networks should have in common, the implications of those characteristics for your institution's mission, goals, culture, and governance, and the attitude shifts that underlie new delivery systems. Also included are a glossary of terms, a summary of the American Hospital Association's position on healthcare reform, and a "consumer's guide," to help you in explaining reform to their communities.

Benefits of Integrating Strategies in Different Settings

Pentz, M. A.

In: American Medical Association State-of-the-Art Conference on Adolescent Health Promotion Proceedings, pp. 15-33, May 1992

(Available from the National Center for Education in Maternal and Child Health, 2000 15th Street North, Ste. 701, Arlington, VA 22201-2617; 703-524-7802)

This article is a review of research on the effects of current disease prevention and health promotion strategies used with adolescents in school, community, and medical settings to conclude whether four of the strategies for primary prevention and health in adolescents are feasible. The four strategies are: 1) teaching adolescents how to maintain and promote their health, and how to avoid health-compromising behavior; 2) improving adolescent access to healthcare by developing services in settings normally frequented by adolescents; 3) building adult motivation and support for adolescent health promotion through community campaigns and education aimed at adult self-awareness as role models for adolescent health behavior; and 4) improving adolescents' environment for health through policy changes aimed specifically at providing more comprehensive health education in schools, and at improving social and economic conditions in communities that would enable adolescents to learn and grow. Much of the research focuses on the effects of adolescent drug abuse, prevention programs on drug use, and the effects of adult and youth heart disease prevention programs on tobacco and alcohol use.

School-Based Health Centers and Managed Care

Department of Health and Human Services, Office of Inspector General
Publication Number: OEI-05-92-00680
July 1993, 21 pp.

(Available from the Office of Inspector General, Office of Management and Policy, 330 Independence Avenue, SW, Washington, DC 20201; 202-619-0089)

This inspection describes school-based health centers and their degree of coordination with managed care providers. It was found that school-based health centers increase access to healthcare for adolescents, however, little coordination exists between managed care providers and school-based health centers. Efforts to coordinate demonstrated potential benefits for adolescents, managed care providers, and school-based health centers. Although school-based health centers and managed care are rapidly expanding, the Department of Health and Human Services has no focal point coordinating departmental programs and activities in these areas.

Negative Moods as Correlates of Smoking and Heavier Drinking: Implications for Health Promotions

Horm, J.; Schoenborn, C.A.

Advance Data, Vital and Health Statistics, National Center for Health Statistics, No. 236, Nov. 1993, 13 pp.

(Available from the National Center for Health Statistics, 6525 Belcrest Road, Hyattsville, MD 20782; 301-436-8500)

This report presents prevalence estimates for the U.S. population for five negative mood states (frequency of being depressed, lonely, restless, bored, and upset) drawn from the classic Bradburn Balance Scale and used in earlier population-based studies of mental health. The report then describes the relationship between each of these moods and cigarette smoking and heavy drinking. It goes on to examine the

relationship between a total negative mood score (an additive score composed of responses to all five items), and smoking and drinking, individually and combined. The term "negative mood" is used throughout the report to describe these five measures of negative effects.

How Employers Are Saving Through Wellness and Fitness Programs

Kerber, B. A. (Ed.)

1994, 221 pp.

(Available from American Business Publishing, P.O. Box 1442, Wall Township, NJ 07719; 732-681-1133)

There has been a steady increase by employers to emphasize preventive medicine and wellness programs aimed at heading off medical problems before they occur. This report helps workplaces learn how to improve their employees' health, productivity, and morale, thereby improving the company's fiscal health, and decreasing absenteeism and medical costs.

Beyond Insurance...Building Primary Care Systems for Children and Youth

Grayson, H.

Special Report, Fall 1994, 4 pp.
Center for Health Policy Research
(Available from the Child and Adolescent Health Policy Center, The Johns Hopkins University, School of Hygiene and Public Health, Department of Maternal and Child Health, 624 North Broadway, Baltimore, MD 21205; 410-550-5443)

Even if healthcare reform improves insurance coverage for children and their families, significant nonfinancial barriers to care will remain. One approach to eliminating those barriers is the creation of "systems" of primary care for children and youth. In April 1994, the Johns Hopkins University Child and Adolescent Health Policy Center (CAHPC) and the Federal Maternal and Child Health Bureau invited child health experts and local, State, and Federal policymakers to consider the issues involved in building such systems. This paper, by CAHPC director Holly Grason, is based on presentations and discussions at the Workshop On Assessment and Development of Primary Care for Children and Youth: An Agenda in Healthcare Reform.

Maternal and Child Health Programs Policy Research Brief: Quality, Quality Assessment, and Quality Assurance Considerations for Maternal and Child Health Populations and Practitioners

Grayson, H.; Guyer, B., 7 pp., 1995

(Available from the Child and Adolescent Health Policy Center, The Johns Hopkins University, School of Hygiene and Public Health, Department of Maternal and Child Health, 624 North Broadway, Baltimore, MD 21205; 410-550-5443)

This policy brief tries to combine several different outlooks related to quality concepts, practices, and problems as they apply to maternal and child health. Definitions, domains, and levels of assessment are summarized and discussed. Information on mechanisms by which these concepts are implemented is also provided.

Healthwise Handbook: A Self-Care Manual for You

Kemper, D.

1995, 329 pp.

(Available from Healthwise, P.O. Box 1989, Boise, ID 83701; 208-345-1161)

This book was designed to help consumers and their doctors work together to manage health problems.

Included are basic guidelines on how to recognize and cope with over 180 of the most common health problems based on medical information from leading medical and consumer publications, with review and input from doctors, nurses, pharmacists, physical therapists, and other health professionals.

Promoting Health at Work: Substance Abuse Prevention and the New Workplace Realities

A Report to Business from the February 1995 Workplace Expert Panel hosted by the Center for Substance Abuse Prevention (CSAP)

(Available from Washington Business Group on Health, 777 North Capitol Street, NE, Suite 800, Washington, DC 20002; 202-408-9320)

Trends affecting America's workplaces in the 1990's increase the urgency of effective prevention of alcohol and drug abuse. Traditional approaches to intervention focusing on "problem employees" may be inadequate to fully address the issue in many businesses, but effective strategies are being identified. This Report to Business summarizes an examination of these trends by experts on worksite issues convened by CSAP.

Managed Care and Low-Income Populations: A Case Study of Managed Care in Oregon

Gold, M.; Chu, K.; Lyons, B.

Henry J. Kaiser Family Foundation and the Commonwealth Fund. July 1995, (pp. xi, xiii, 9, 27, 32). Washington, DC

(Available from the Commonwealth Fund, One East 75th Street, New York, NY 10021-0400; 212-535-0400)

This case study provides a full description of the Oregon Health Plan's (OHP) Medicaid component, first implemented in February 1994, following approval of the State's Federal 1,115 demonstration waiver. The study is of Phase I, which was well underway. Phase II, which had the mental health and substance abuse service components, was just beginning. The study provides a clear discussion of the early implementation and the environment in which the mental health and substance abuse services are being implemented. It also raises some of the key implementation issues that will be faced in Phase II. Since Oregon is currently the State having done the most to integrate substance abuse prevention into managed care, this study is useful in providing a larger context for that implementation. This study was developed primarily for those interested in Medicaid and the impact of managed care on those served by Medicaid.

Guidelines for Adolescent Prevention Services

Department of Adolescent Health, American Medical Association, 1996, 9 pp.

(Available from the Department of Adolescent Health, American Medical Association, 515 North State Street, Chicago, IL 60610; 312-464-5000)

Changes in adolescent morbidity and mortality during the past several decades have created a health crisis for today's youth. Unintended pregnancy, STD's including HIV, alcohol and drug abuse, and eating disorders are just some of the health problems faced by an increasing number of adolescents from all sectors of society. This health crisis requires a fundamental change in the emphasis of adolescent services—a change whereby a greater number of services are directed at the primary and secondary prevention of the major health threats facing today's youth. School and community organizations have responded to the need for change

by increasing health education programming. Primary care physicians and other health providers must respond by making preventive services a greater component of their clinical practice. GAPS is a comprehensive set of recommendations that provides a framework for the organization and content of prevention health services.

Injury Control – A Critical Component of Managed Care

Martinez, R.

National Highway Traffic Safety Administration, 1996, 10 pp.

Presentation at The American Association of Health Plans 1996 Institute, New Orleans, LA

This report gives a background of the National Highway Traffic and Safety Administration, including a brief history of the agency and current statistics of motor vehicle crashes that are considered to be an injury prevention and control mission. Though the article is not specific to substance use or abuse there is valuable information about the cost of injury, current changes in the healthcare system, relevance that injury prevention has to healthcare providers, integrated injury control, prevention approaches, how managed care fits in with injury prevention, and the initiatives that the National Highway Traffic and Safety Administration has developed.

Interaction Between Managed Care and Prevention Resources: A Preliminary Analysis of Eight Models

Stoil, M. J.; Hill, G. A.

1996, 12 pp.

(Available from Conwal, Inc., 6858 Old Dominion Drive, Ste. 200, McLean, VA 22101; 703-536-3200)

Casual observation suggests that many managed healthcare providers are active in health promotion and preventive care. Preliminary results from a survey in progress of prevention in the managed care environment led to identification of eight distinct models of interaction between managed care and prevention. These eight models differ on the basis of the scope, duration, and locus of responsibility for performance of prevention activities, and on the locus of responsibility for planning and decision making in prevention.

Management Organization: Request for Proposal

Topeka, Kansas. Department of Social and Rehabilitation Services, May 10, 1996, pp. 3, 7-11

(Available from Kansas Alcohol and Drug Abuse Services, 610 SW 10th Street, Topeka, KS 66612; 913-296-3925)

This document is a Request for Proposal (RFP) for a contract that will be let to a nonprofit entity to develop and monitor approximately $15 million in contractual arrangements for a statewide continuum of prevention centers and treatment providers. The purpose of this effort is to facilitate the "union of substance abuse prevention and managed care" (p. 1)—the Kansas Alcohol and Drug Managed Care Model. This model consists of seven management processes, including designing and pricing the prevention and treatment system, developing performance based outcomes and review systems, implementing a state-of-the-art management information system, and other management efficiencies. The Kansas system is based upon the Hawkins-Catalano risk and protective factors model. In addition, the project requires the following three priority outcomes: "a reduction in alcohol, tobacco and other drug abuse by youth, a delay in first alcohol, tobacco and other drug abuse by youth, and an

increase in attitudes opposed to alcohol, tobacco and other drug abuse."(p. 10)

America's Youth: Managed Care's Most Valuable Population

Barlow, T.

As presented at Working with America's Youth Conference, July 22, 1996, 9 pp.

(Available from Pacific Region Educational Laboratory, 828 Fort Street Mall #500, Honolulu, HI 96813-4321)

In this presentation, the importance of comprehensive prevention services for youth in the managed care health system is discussed. Topics addressed are: why an integrated health system is critical for addressing the problems of children, youth and parents; what the mission and concepts of managed care include; how to implement comprehensive promotion and prevention strategies in addressing youth problems including substance abuse, teen pregnancy, violence, health issues, eating disorders, and suicide; what the promotion of positive youth development, innate mental health and resiliency includes; and what steps are necessary to achieve an integrated community-based multicultural managed healthcare system.

Cultural Competence Guidelines in Managed Care Mental Health Services for Latino Populations

Final Report of the National Latino Behavioral Health Workgroup

December 1996, 43 pp.

(Available from Western Interstate Commission for Higher Education, P.O. Box 9752, Boulder, CO 80301-9752; 303-541-0250. Publication No. 3B85)

Latinos require consideration of their unique cultural and clinical characteristics in order to maximize cost effectiveness, quality, and access of services. Many Latino organizations are concerned about how major shifts in healthcare services will affect all populations, particularly Latinos. Some of their major concerns are: cost-cutting; restructuring of services; relocation of services; services provided by non-Latino mental health professionals; consumer lack of knowledge about healthcare system; and, language barriers interfering with access to resources. Guiding principles and guidelines for cultural competence in managed care for Latino populations are outlined and discussed.

Managing Managed Care: Quality Improvement in Behavioral Health

Edmunds, M.; Frank, R.; et al. (Eds.)

1997, 53 pp.

(Available from the National Academy Press, 2101 Constitution Avenue, NW, Washington, DC 20418; 800-624-6242)

Managed care has produced dramatic changes in the treatment of mental health and substance abuse problems, known as behavioral health. This volume offers an assessment of managed care for behavioral health and a framework for purchasing, delivering, and ensuring the quality of behavioral healthcare. It presents the first objective analysis of the powerful multimillion-dollar accreditation industry and the key accrediting organizations. Evidence-based conclusions about the effectiveness of behavioral health treatments are drawn, and recommendations that address consumer protections, quality improvements, structure and financing, roles of public and private participants, inclusion of special populations, and ethical issues are made.

Standards for Accreditation of Managed Healthcare Organizations

National Committee for Quality Assurance

1997, pp. 97-101
(Available from the National Committee for Quality Assurance, 2000 L Street, Ste. 500, Washington, DC 20036; 202-955-5697)

The National Committee for Quality Assurance is one of the accreditation agencies for managed care organizations (MCO's). These standards cover the full scope of an MCO's organization and management, utilization control, quality assurance, credentialling, members' rights, etc. Included is a specific set of standards for prevention. These standards focus on four broad areas: establishment of a program to decrease the incidence, prevalence, and residual effect of behavioral health disorders; distribution of the programs and updating its practitioners; regularly encouraging its members to use preventive behavioral healthcare programs and services; and annually monitoring and evaluating at least 4 of 25 screening and educational interventions. The 25 interventions are organized into 5 groups, based on the life cycle from infancy through aging, and include a separate group for family and community educational interventions. Alcohol and drug abuse is specifically identified for adolescents, adults, and the elderly (including prescription drug dependence). Many of the other interventions identified are related disorders or risk factors for substance abuse.

Reports and Articles from NCADI and the Office of Managed Care

Screening for Alcoholism

National Institute on Alcohol Abuse and Alcoholism, *Alcohol Alert*. 4 pp., No. 8, April 1990
(Available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686. Inventory Number PH285)

Recent studies show that physicians often do not recognize and treat alcoholism. This makes it clear that there is a definite need for effective and accurate alcohol screening procedures. Alcohol screening would identify individuals who have begun to develop or are at risk for developing alcoholism. Sensitivity and specificity are key properties for a valid screening instrument. Several alcohol screening instruments are discussed.

Cost-Effectiveness and Preventive Implications of Employee Assistance Programs

Blum, T. C.; Roman, P. M.

Georgia Institute of Technology, School of Management, 45 pp., 1995
(Available from the Center for Substance Abuse Prevention, 5600 Fishers Lane, Room 920, Rockwall II Building, Rockville, MD 20857; 301-594-0788)

This report reviews a wide range of cost-effectiveness studies that indicate the value of employee assistance programs (EAP's) in dealing with alcohol and drug problems. The appropriate role of EAP's and their contribution to cost-effectiveness through prevention is considered. In addition, numerous studies that demonstrate the cost-effectiveness of EAP's are examined.

Substance Abuse Prevention: It's Your Business

Beckham, M.; Seidler, S. (Eds.)

1993, 8 pp.
(Available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686. Inventory Number MS483)

On May 11-12, 1993, the Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration, U.S. Public Health Service, convened a public policy issues forum entitled "Substance Abuse Prevention: It's Your Business" in cooperation with the Washington Business Group on Health. The forum brought together employers, labor representatives, community prevention specialists, employee assistance professionals, and public health officials to discuss the role of business, industry, and labor in primary prevention of substance abuse and to develop recommendations for action. Included are highlights of the discussion at the issues forum.

Guidelines for Health Promotion and Education Services in HMO's

Mullen, P.; Zapka, J. G.

U.S. Deptartment of Health and Human Services, 1982 ,142 pp.

(Available from the Center for Substance Abuse Prevention, Office of Managed Care, 5600 Fishers Lane, Room 920, Rockwall II Building, Rockville, MD 20857; 301-594-0788)

When the HMO Act was enacted in 1973, the benefits of health education were largely theoretical, reflecting the lack of funding for rigorous evaluations and reliance on medical technology as the primary means of achieving improvements in health. Now, recognition of the limits of technology and of the importance of environmental and behavioral factors in the health equation is beginning to transform our thinking about healthcare. This report was written to help answer the questions being asked by HMO administrators, medical directors, and boards of trustees: What is the definition and scope of health education and promotion? How effective are these services? How are programs best organized? What are the administrative issues that must be taken into account? And, how is the quality of an HMO's health education and promotion programs assessed?

Single-Specialty Substance Abuse and Addiction Prevention and Treatment

Kennedy, N. J.

As presented at the Primary Care Behavioral Healthcare Summit November 8, 1996

(Available from the Center for Substance Abuse Prevention, Office of Managed Care, 5600 Fishers Lane, Rockwall II Building, Suite 920, Rockville, MD 20857; 301-594-0788)

This paper discusses the importance of encouraging the participation and leadership of primary care physicians in designing and implementing behavioral health promotion and disease prevention strategies. Among the topics discussed are: SAMHSA's Managed Care Initiative; factors influencing health/well-being; health education; the cost of substance abuse; prevention planning; cultural diversity; and early intervention.

Guidelines for Alcohol, Tobacco, and Other Drug Problem Prevention in Managed Care Organizations

U.S. Department of Health and Human Services, June 30, 1995

(Available from the Center for Substance Abuse Prevention, Office of Managed Care, 5600 Fishers Lane, Rockwall II Building, Suite 920, Rockville, MD 20857; 301-594-0788)

This document is included in training provided to healthcare delivery system organizations. The training is focused on the larger system but includes very specific guidelines for managed care

organizations and hospitals. This guideline was developed by CSAP with the assistance of expert consultants in the areas of prevention, health promotion, mental health and substance abuse services, and managed care. The guidelines are divided into 11 categories: needs assessment, planning, management, communication/ coordination, member access to substance abuse prevention services, substance abuse prevention practice and programs, personnel, follow-up, hospital liaison, community involvement, and evaluation and documentation. Each guideline includes organization and service delivery guidelines, as well as suggested activities.

Agencies, Groups and Organizations Interested in Prevention and Managed Care

Accreditation Organizations

Accreditation Association for Ambulatory Health Care
9933 Lawler Avenue
Skokie, IL 60077-3708
Tel: 847-676-9610
Fax: 847-676-9628

American Managed Behavioral Healthcare Association (AMBHA)
700 13th Street, NW
Suite 950
Washington, DC 20005
Tel: 202-434-4565
Fax: 202-434-4564
http://www.ambha.org

Council on Accreditation for Families and Children
1520 8th Avenue, Suite 2202B
New York, NY 10018
Tel: 212-714-9399
Fax: 212-967-8624
e-mail: dhonorol@aol.com

Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Boulevard
Oakland Terrace, IL 60181
Tel: 630-916-5970
Fax: 630-792-5005
http://www.jcaho.org

The Medical Quality Commission
3010 Old Ranch Parkway
Suite 205
Seal Beach, CA 90740
Tel: 202-296-0120
Fax: 202-296-0690
http://www.tmqc.org

National Committee for Quality Assurance
2000 L Street, NW
Suite 500
Washington, DC 20036
Tel: 202-955-5697
Fax: 202-955-3599
http://www.ncqa.org

Consumer and Family Groups

American Association for Protecting Children
c/o American Humane Association
63 Inverness Drive E
Englewood, CO 80112-5117
Tel: 303-792-9900
Fax: 303-792-5333
http://www.amerhumane.org

Center for Patient Advocacy
1350 Beverly Road
Suite 108
McLean, VA 22101
Tel: 703-748-0400
Fax: 703-748-0402
http://www.patientadvocacy.org

Coalition for Health Care Choice and Accountability
1341 G Street, NW
Suite 200
Washington, DC 20005
Tel: 202-347-4350
Fax: 202-347-4351
http://www.amerchiro.org

Families USA
1334 G Street, NW
Washington, DC 20005
Tel: 202-628-3030
Fax: 202-347-2417
http://www.familiesusa.org

The Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314-7971
Tel: 703-684-7710
Fax: 703-836-1040
http://www.ffcmh.org

National Association for Children of Alcoholics
11426 Rockville Pike
Suite 100
Rockville, MD 20852
Tel: 301-468-0985
Fax: 301-468-0987
http://www.health.org/NACOA
E-mail: NACOA@health.org

National Association for Rights Protection and Advocacy
c /o Judy Lavine
P. O. Box 16311
Rumford, RI 02916
Tel: 401-434-2120
Fax: 401-431-0043
http://www.connix.com/~narpa

National Council on Patient Information and Education
666 Eleventh Street, NW
Suite 810
Washington, DC 20001
Tel: 202-347-6711
Fax: 202-638-0773
http://www.social.com/health/nhic

Culturally Diverse Organizations with a Managed Care Focus

Asian Pacific American Consortium on Substance Abuse
1610 NE 66th, #2
Portland, OR 97213
Tel: 503-257-9117
Fax: 503-254-3637

Asian & Pacific Islander American Health Forum
942 Market Street, 2nd Floor
San Francisco, CA 94102
Tel: 415-954-9965
http://www.igc.apc.org/apiahf

The Center for Cross Cultural Health
410 Church Street, SE
Minneapolis, MN 55455
Tel: 612-624-4668
Fax: 612-625-1434
http://www.umn.edu/ccch

National Asian Pacific-American Families Against Substance Abuse, Inc.
300 West Cesar Chavez Avenue
Suite B
Los Angeles, CA 90012
Tel: 213-625-5795
Fax: 213-625-5796
http://www.igc.apc.org/apiahf/napafasa.html

National Coalition of Hispanic Health Services Organization
1501 16th Street, NW
Washington, DC 20036
Tel: 202-387-5000
Fax: 202-797-1353
http://clnet.ucr.edu/community/cossmho.html

National Council of LaRaza
1111 19th Street, NW
Suite 1000
Washington, DC 20036
Tel: 202-776-1761
Fax: 202-776-1792
http://www.nclr.org

National Indian Child Care Association
279 East 137th Street
Glenpool, OK 74033
Tel: 918-758-1463
Fax: 918-758-1498

National Indian Child Welfare Association
3611 SW Hood Street
Suite 201
Portland, OR 97201
Tel: 503-222-4044
Fax: 503-222-4007
http://www.nicwa.org

National Indian Health Board
1385 South Colorado Boulevard
Suite A-707
Denver, CO 80222
Tel: 303-759-3075
Fax: 303-759-3674

National Medical Association
1012 10th Street, NW
Washington, DC 20001
Tel: 202-347-1895
Fax: 202-842-3293

Summit Health Coalition
1424 K Street, NW
Suite 500
Washington, DC 20005
Tel: 202-371-0277
Fax: 202-508-3826
E-mail: summit301@aol.com

Washington Asian Pacific Islander Families Against Substance Abuse
606 Maynard Avenue
South #106
Seattle, WA 95104
Tel: 206-223-9578
Fax: 206-623-3479

Federal Agencies

Agency for Health Care Policy and Research
2101 East Jefferson Street
Suite 600
Rockville, MD 20852
Tel: 301-594-6662
Fax: 301-594-2168
http://www.ahcpr.gov

Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30333
Tel: 404-639-3311
Fax: 888-232-3299
http://www.cdc.gov

Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244
Tel: 410-786-3000
Fax: 410-786-4005
http://www.hcfa.gov
E-mail: questions@hcfa.gov

Health Care Resources Administration
5600 Fishers Lane
Rockville, MD 20847
Tel: 301-443-1550
Fax: 301-443-5461
http://www.hcra.gov

Indian Health Service
Mental Health/Social Service Programs Branch
505 Marquette NW
Suite 1502
Albuquerque, NM 87102
Tel: 505-764-0036
Fax: 505-764-0446
http://www.ihs.gov

National Institute on Alcohol Abuse and Alcoholism
Division of Clinical and Prevention Research
6000 Executive Boulevard-Willco Building
Bethesda, MD 20892
Tel: 301-443-3860
Fax: 301-480-1726
http://www.niaaa.nih.gov

National Institute on Drug Abuse
Division of Epidemiology and Prevention Research
5600 Fishers Lane
Rockville, MD 20857
Tel: 301-443-6504
Fax: 301-443-2636
http://www.nida.nih.gov
E-mail: Information@lists.nida.nih.gov

National Institute of Mental Health
Office of Prevention
5600 Fishers Lane
Room 9C-25
Rockville, MD
Tel: 301-443-3533
Fax: 301-443-8022
http://www.nimh.nih.gov

Office of Inspector General
Office of Management and Policy
330 Independence Avenue, SW
Washington, DC 20201
Tel: 202-619-0089
Fax; 202-619-1487
http://www.hhs.gov

Managed Care and Healthcare System Agencies

Academy of Managed Care Pharmacy
1650 King Street
Suite 402
Alexandria, VA 22314
Tel: 800-PAP-AMCP
Fax: 703-683-8417
http://www.amcp.org

American Association of Health Plans
1129 20th Street, NW
Suite 600
Washington, DC 20036-3421
Tel: 202-778-3265
Fax: 202-331-7487
http://www.aahp.org

American Health Care Association
1201 L Street, NW
Washington, DC 20005
Tel: 202-842-4444
Fax: 202-842-3860
http://www.ahca.org

American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611
Tel: 312-422-2922
Fax: 312-422-4796
http://www.aha.org

American Managed Behavioral Healthcare Association
700 13th Street, NW
Suite 950
Washington, DC 20005
Tel: 202-434-4565
Fax: 202-434-4564
http://www.ambha.org

American Medical Specialty Organization
5120 Goldleaf Circle
Suite 1000
Los Angeles, CA 90056
Tel: 213-290-7640
Fax: 213-290-7637
http://www.amso.com

The Healthcare Forum
425 Market Street
16th floor
San Francisco, CA 94105
Tel: 415-356-4300
Fax: 415-356-9300
http://www.thfnet.org

Institute for Behavioral Healthcare/CentraLink
1110 Mar West
Suite E
Tiburon, CA 94920
Tel: 415-435-9821
Fax: 415-435-9092
http://www.centralink.com

National Association of Community Health Representatives
Yakama Nation CHR Program
Highway 3A Fort Road
Toppenish, WA 98948
Tel: 509-865-5121, ext. 466

National Association of Insurance Commissioners
444 North Capitol Street, NW
Suite 309
Washington, DC 20001
Tel: 202-624-7790
Fax: 202-624-8579
http://www.naic.org

National Organizations

American Bar Association
1800 M Street, NW
Washington, DC 20036
Tel: 202-662-1000
Fax: 202-662-1032
http://www.abanet.org

American Health Decision
(A National Coalition of Community Groups Concerned about Healthcare Ethics)
2525 NW Lovejoy
Portland, OR 97210
Tel: 503-223-8811
Fax: 503-241-5437
http://www.ahd.org

The Association of Maternal and Child Health Programs
1350 Connecticut Avenue, NW
Suite 803
Washington, DC 20036
Tel: 202-775-0436
Fax: 202-775-0061
http://www.amchp.org

Child Welfare League of America
440 First Street, NW
Suite 210
Washington, DC 20001
Tel: 202-638-2952
Fax: 202-638-4004
http://www.cwla.org

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
Tel: 202-628-8787
Fax: 202-662-3560
http://www.childrensdefense.org

International Association of Psychosocial Rehabilitation Services
10025 Governor Warfield Parkway
Suite 301
Columbia, MD 21044
Tel: 410-730-7190
Fax: 410-730-5965
E-mail: iapsr33@aol.com

Join Together
A National Resource for Communities
Fighting Substance Abuse
441 Stuart Street, 6th Floor
Boston, MA 02116
Tel: 617-437-1500
Fax: 617-437-9394
E-mail: info@jointogether.org

National Association for Health Data
254-B North Washington Street
Falls Church, VA 22046
Tel: 703-532-3282
Fax: 703-532-3593
http://www.nahdo.org

National Association of Community Health Centers, Inc.
1330 New Hampshire Avenue, NW
Washington, DC 20036
Tel: 202-659-8008
Fax: 202-659-8519
http://www.nachc.com

National Association of County and City Health Officials
440 First Street, NW
Suite 450
Washington, DC 20001
Tel: 202-783-5550
Fax: 202-783-1583
http://www.naccho.org

National Association of Psychiatric Health Systems
1217 F Street, NW
Suite 301
Washington, DC 20004-1105
Tel: 202-393-6700
Fax: 202-783-6041
http://www.naphs.org

National Association of State Alcohol and Drug Abuse Directors, Inc.
808 17th Street, NW
Washington, DC 20006
Tel: 202-293-0090
Fax: 202-293-1250
http://www.nasadad.org

National Association of State Mental Health Program Directors
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Tel: 703-739-9333
Fax: 703-548-9517
http://www.nasmhpd.org

National Community Mental Healthcare Council
12300 Twinbrook Parkway
Suite 320
Rockville, MD 20852
Tel: 301-984-6200
Fax: 301-881-7159

National Council on Alcoholism and Drug Dependence
1511 K Street, NW
Suite 433
Washington, DC 20005
Tel: 202-737-8122
Fax: 202-628-4731
http://www.ncadd.org

National Drug Prevention League
10911 Billingsgate Road
Columbia, MD 21044
Tel: 410-884-1679
Fax: 410-884-1684

National Health Council
1730 M Street, NW
Suite 500
Washington, DC 20036
Tel: 202-785-3919
Fax: 202-785-5923

National Lesbian and Gay Health Association
1407 S Street, NW
Washington, DC 20009
Tel: 202-939-7880
Fax: 202-234-1467
http://www.nlgha.work

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
Tel: 703-684-7722
Fax: 703-684-5968
http://www.nmha.org

National Prevention Network
808 West 17th Street
Suite 410
Washington, DC 20006
Tel: 202-293-0090
Fax: 202-293-1250
E-mail: smcgencey@nasadad.org

National Rural Health Association
One West Armour Boulevard
Suite 301
Kansas City, MO 64111
Tel: 816-756-3140
Fax: 816-756-3144
http://www.nrharural.org

National Treatment Consortium, Inc.
444 North Capitol Street, NW
Suite 200
Washington, DC 20001
Tel: 202-434-4780
Fax: 202-434-4783
E-mail: NTC@SSO.ORG

National Women's Resource Center
515 King Street
Suite 410
Alexandria, VA 22314
Tel: 703-836-8761
Fax: 703-836-7256
http://www.nwrc.org

North American Primary Care Research Group
P.O. Box 8729
Kansas City, MO 64114
Tel: 800-274-2237, ext. 6474 or 816-333-9700, ext. 6474
Fax: 816-333-3884
E-mail: napcrg@stfm.org

Public Health Foundation
1220 L Street, NW
Washington, DC 20005
Tel: 202-898-5600
Fax: 202-898-5609

Wellness Councils of American Community Health Plaza
7101 Newport Avenue
Suite 311
Omaha, NE 68152-2175
Tel: 402-572-3590
Fax: 402-572-3594
http://www.welcoa.org

Primary Care Associations

National Parent Information Network
University of Illinois at Urbana Champaign
Children's Research Center
51 Gerty Drive
Champaign, IL 61820-7469
Tel: 217-333-1386
Fax: 217-333-3767
http://www.npin.org

Provider Associations

American College of Nurse Practitioners
1090 Vermont Avenue, NW
Suite 800
Washington, DC 20005
Tel: 202-408-7050
Fax: 202-408-0902
http://www.nurse.org/acnp

American College of Physicians
Independence Mall West
Sixth Street at Race
Philadelphia, PA 19106-1572
Tel: 800-523-1546
Fax: 215-351-2869
http://www.acponline.org

American Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304
Tel: 703-823-9800
Fax: 703-823-0252
http://www.counseling.org

American Nurses Association
600 Maryland Avenue, SW
Suite 100 West
Washington, DC 20024
Tel: 202-651-7000
Fax: 202-651-7001
http://www.nursingworld.org

American Psychiatric Association
1400 K Street, NW
Washington, DC 20005
Tel: 202-682-6000
Fax: 202-682-6850
http://www.psych.org

American Psychological Association
750 First Street, NE
Washington, DC 20002
Tel: 202-336-5500
Fax: 202-336-6069
http://www.apa.org

American Public Health Association
1015 15th Street, NW
Washington, DC 20005
Tel: 202-789-5600
Fax: 202-789-5661
http://www.apha.org

American Society of Addiction Medicine
4601 North Park Avenue
Arcade Suite 101
Chevy Chase, MD 20815
Tel: 301-656-3920
Fax: 301-656-3815
http://www.asam.org

Association of Physician Assistant Programs
950 North Washington Street
Alexandria, VA 22314
Tel: 703-548-5538
Fax: 703-684-1924
http://www.apap.org

Center for Community Responsive Care, Inc.
90 Cushing Avenue
Boston, MA 02125
Tel: 617-265-4400
Fax: 617-265-7060

Employee Assistance Professionals Association (EAPA)
1800 North Kent Street
Suite 907
Arlington, VA 22209
Tel: 703-522-6272
Fax: 703-522-4585
http://www.eap-association.com

National Association of Alcoholism and Drug Abuse Counselors, Inc.
1911 North Fort Myer Drive
Suite 900
Arlington, VA 22209
Tel: 703-741-7686
Fax: 703-741-7698
http://www.naadac.org

National Association of Lesbian and Gay Addiction Professionals
c/o PRTA
440 Grand Avenue
Suite 401
Oakland, CA 94610
Tel: 510-465-0547
Fax: 510-465-0505

Therapeutic Communities of America
1611 Connecticut Avenue, NW
Suite 4-B
Washington, DC 20009
Tel: 202-296-3503
Fax: 202-518-5475
http://www.echonyc.com/~wftc/tca.html

Resource Organizations

Association for Worksite Health Promotion
60 Revere Drive
Suite 500
Northbrook, IL 60062
Tel: 847-480-9574
Fax: 847-480-9282
http://www.awhp.com

Association of Medical Education and Research in Substance Abuse
c/o Center for Alcohol and Addiction Studies
Brown University
Providence, RI 02912
Tel: 401-444-1817
Fax: 401-444-1850
http://center.butler.brown.edu/amersa/amersa-profile.html

Bazelon Center for Mental Health Law
1101 Fifteenth Street, NW
Suite 1212
Washington, DC 20005
Tel: 202-467-5730
Fax: 202-223-0409
http://www.bazelon.org

Center for Policy Alternatives
1875 Connecticut Avenue, NW
Suite 710
Washington, DC 20009
Tel: 800-935-0699
Fax: 202-986-2539
http://www.cfpa.org

Center for Studying Health System Change
600 Maryland Avenue, SW
Suite 550
Washington, DC 20024-2512
Tel: 202-484-5261
Fax: 202-484-9258
http://www.hfchange.com

Center on Addiction and Substance Abuse at Columbia University
152 West 57th Street
New York, NY 10019
Tel: 212-841-5200
Fax: 212-956-8020
http://www.casacolumbia.org

The Commonwealth Fund
One East 75th Street
New York, NY 10021-0400
Tel: 212-535-0400
Fax: 212-606-3500
http://www.cmwf.org

Depression and Related Affective Disorders
Meyer 3-181
600 North Wolfe Street
Baltimore, MD 21287-7381
Tel: 410-955-4647
Fax: 410-614-3241
http://infonet.welch.jhu.edu/departments/drada

Evaluation Center @ HSRI
2336 Massachusetts Avenue
Cambridge, MA 02149
Tel: 617-876-0426
Fax: 617-492-7401
http://www.hsri.org

Faith Community
National Anti Drug and Violence Campaign/Congress of National Black Churches (NADC/CNBC)
1225 I Street, NW
Suite 750
Washington, DC 20005
Tel: 202-371-1091
Fax: 202-371-0908

Gateway Foundation
819 South Wabash
Suite 300
Chicago, IL 60605
Tel: 312-663-1130
Fax: 312-663-0504
http://www.omhrc.gov/mhr2/orgs/9500703.htm

Hazelden Foundation
15245 Pleasant Valley Road
Center City, MN 55012
Tel: 800-257-7800
Fax: 612-257-1055
http://www.hazelden.org

Health Outcomes Institute
2001 Killebrew Drive
Suite 122
Bloomington, MN 55425
Tel: 612-858-9188
Fax: 612-858-9189
http://www.ahc.umn.edu/mbbnet/company_folder/hoi.html

Health Watch
Information and Promotion Service, Inc.
3020 Glenwood Road
Brooklyn, NY 11210
Tel: 718-434-5411
Fax: 718-434-5048

Healthy Mothers, Healthy Babies Coalition and POWER
409 12th Street, SW
Washington, DC 20024
Tel: 202-863-2458
http://ericps.ed.uiuc.edu/npin/reswork/workorgs/healthy.html

Legal Action Center
236 Massachusetts Avenue, NE
Suite 505
Washington, DC 20002
Tel: 202-544-5478
Fax: 202-544-5712

Managed Care Information Center
3100 Highway 138
Wall Township, NJ 07719-1442
Tel: 800-516-4343
Fax: 908-681-0490
http://www.themcic.com

National Academy for State Health Policy
50 Monument Square
Suite 502
Portland, ME 04101
Tel: 207-874-6524
Fax: 207-874-6527

National Alliance for the Mentally Ill
200 Glebe Road
Suite 1015
Arlington, VA 22203-3754
Tel: 800-950-NAMI (6264)
Fax: 703-524-9094
http://www.nami.org

National Association of Community Health Representatives
Yakama Natron CHR Program
Highway 3A Fort Road
Toppenish, WA 98948
Tel: 509-865-5121, ext. 466

National Clearinghouse for Alcohol and Drug Information (NCADI) PREVLINE
P.O. Box 2345
Rockville, MD 20847-2345
Tel: 800-729-6686
Fax: 301-468-6433
http://www.health.org

National Clearinghouse for Primary Care Information
8201 Greensboro Drive
Suite 600
McLean, VA 22102
Tel: 703-821-8955, ext. 248
Fax: 703-821-2095
http://www.bphc.hrsa.dhhs.gov

National Health Council
1730 M Street, NW
Suite 500
Washington, DC 20036
Tel: 202-785-3910
Fax: 202-785-5923

National Nurses Society on Addictions
4101 Lake Boone Trail
Suite 201
Raleigh, NC 27607
Tel: 919-783-5871
Fax: 919-787-4916
E-mail: NNSA@mercury;interpath.com

National Technical Assistance Center for Children's Mental Health
Georgetown University Child Development Center
3307 M Street, NW
Suite 400
Washington, DC 20007
Tel: 202-687-5000
Fax: 202-687-1954

Pacific Business Group on Health
33 New Montgomery Street
Suite 1450
San Francisco, CA 94105
Tel: 415-281-8660
Fax: 415-281-0960
http://www.healthscope.org

Physicians for Prevention
University of Florida Brain Institute
P.O. Box 100244
Gainesville, FL 32610-0244
Tel: 904-398-3553
Fax: 352-395-0730
http://pfprevention.com

Public Health Foundation
1220 L Street, NW
Washington, DC 20005
Tel: 202-898-5600
Fax: 202-898-5609

Research and Development Institute
10303 Northwest Freeway
#508
Houston, TX 77092
Tel: 713-686-3717
Fax: 713-686-4145
E-mail: qumartin@aol.com

U.S. Mexico Border Health Association
6006 North Mesa
Suite 600
El Paso, TX 79912-4655
Tel: 915-581-6645
Fax: 915-833-4768
http://www.paho.org

Washington Business Group on Health
777 North Capitol Street, NE
Suite 800
Washington, DC 20002
Tel: 202-408-9320
Fax: 202-408-9332
http://www.wbgh.com

Managed Care Glossary of Terms

Access—an individual's ability to obtain healthcare. The ease of access is determined by components such as the availability of services and their acceptability to consumers, the location of healthcare facilities, transportation, hours of operation, cost of care, and cultural proficiency.

Adjusted Community Rating (ACR)—community rating impacted by group specific demographics and the group's prior experience. Also known as *prospective rating*.

Administrative Services Only Organization (ASO)—healthcare organization provides administrative support services only for a self-funded plan or startup MCO.

Adverse Selection—a term used to describe a situation in which a carrier enrolls a poorer risk than the average risk of the group.

Ambulatory Care—healthcare services provided on an outpatient basis. No overnight stay in a hospital is required. The services of ambulatory care centers, hospital outpatient departments, physicians' offices and home healthcare services fall under this heading.

At Risk—situation where a healthcare organization is vulnerable to providing or paying for the delivery of more services than is paid through premiums or per capita payments.

Average Payment Rate—the money that the Health Care Financing Administration can pay an HMO.

Behavioral Health—emotional, mental and psychological well being of individuals, allowing them to function at their optimal level in their personal lives, and within their families and communities.

Behavioral Healthcare—continuum of services for individuals at risk of or suffering from mental, addictive or other behavioral disorders.

Benefit Package—the types of healthcare services to be provided to consumers. Usually contractually determined by the primary payor while the secondary payor usually arranges for the provision of the defined services.

Capitation (Cap)—in the strictest sense, a stipulated dollar amount established to cover the cost of healthcare delivered for a person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a healthcare provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.

Carve In—an arrangement in which an employer contracts with a single provider of a managed care system to provide the employer's workers or enrollees with comprehensive healthcare that includes vision care,

mental health services, and addiction services at a predetermined fee.

Carve Out—an arrangement in which an employer eliminates coverage for a specific category of services (e.g., vision care, mental health services, psychological services, or prescription drugs) and contracts with a separated set of providers for those services according to predetermined fee schedules or capitation agreements.

Case Management—a process whereby covered persons with specific healthcare needs are identified and a plan that efficiently utilizes healthcare resources is formulated and implemented to achieve the optimum patient outcome in the most cost-effective manner.

Case Manager—an experienced professional (e.g., nurse, doctor, or social worker) who works with patients, providers, and insurers to coordinate all services deemed necessary to provide the patient with a plan of appropriate healthcare.

Case Mix—the overall clinical diagnostic profile of a defined population, which influences intensity, cost, and scope of services typically provided.

Case Rate—a predetermined "package rate" for delivery of a specified set of procedure or services to a specified population.

Certificate of Authority—the state-issued operating license for an HMO.

Certificate of Need—certificate of approval issued by a governmental agency to an organization that proposes to construct or modify a healthcare facility, incur a major capital expenditure, or offer a new or different health service.

Claims Review—the method by which an enrollee's healthcare service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

Closed Panel—PPO (see below) in which enrollees can only use a specified group of providers in order to receive benefits.

Coinsurance (Copayment)—percentage of covered expenses the insured party must pay for healthcare services above and beyond the deductible.

Community Oriented Primary Care—an approach to primary care that uses epidemiologic and clinical skills in a complementary fashion to tailor programs to meet the particular health needs of a defined population.

Community Rating—a method of determining a premium structure that is influenced not by the expected level of benefit utilization by specific groups, but by expected utilization by the population as a whole.

Consumers—individuals who receive behavioral healthcare services. Preferable to the terms "clients" and "patients."

Coordinated Care Networks—term used by the Federal Government to describe managed care.

Coordination of Benefits (COB)—provisions and procedures used by third-party payers to determine the amount payable to each payer when a claimant is covered under two or more group health plans.

Cost-Based Reimbursement—method of reimbursement in which third parties pay providers for services provided based upon the documented costs of providing that service.

Cost-Sharing—health insurance practice which requires the insured person to pay some portion of covered expenses (e.g., deductibles, coinsurance, and copayments) in an attempt to control utilization.

Cost-Shifting—charging one group of patients more in order to make up for underpayment by others. Most commonly, charging some privately insured patients more in order to make up for underpayment by Medicaid or Medicare.

Covered Days—maximum number of days for which an insurer will imburse for services rendered. Days may be limited per episode of illness, per year, per lifetime, or per length of policy.

Credentialling—the process of reviewing a practitioner's credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for clinical privileging are met.

Demand-Side Management—use of health education, wellness, and client empowerment to assist members to make cost-effective healthcare decisions, decreasing unnecessary healthcare utilization and costs.

Drug Utilization Review—a review to establish the medical appropriateness of medications given by providers to patients for particular medical conditions; performed by peers with feedback and education given to the providers, as appropriate.

Dual Diagnosis—identification of dual diseases, disorders, or injuries, commonly used to describe individuals diagnosed with both mental disorders and addictive diseases.

Enrollment—the total number of covered persons in a health plan. Also refers to the process by which a health plan signs up groups and individuals for membership, or the number of enrollees who sign up in any one group.

Exclusive Provider Organization—the patient must remain in the network to receive benefits (out-of-network care results in payment by the patient); a plan regulated under State insurance statute that provides coverage only for contracted providers and does not extend to non-preferred provider services.

Gatekeeper Model—a situation in which a primary care provider, the "gatekeeper," serves as the consumer's contact for healthcare and referrals. Also called *closed access* or *closed panel*.

Group Model HMO—a healthcare model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physician and contracting with hospitals for care of their patients.

Health Care Financing Administration (HCFA)—the Federal agency responsible for administering Medicare and overseeing States' administration of Medicaid.

Health Insurance Organization—HIO's act as fiscal intermediaries between State Medicaid agencies and healthcare

providers. They receive a per capita payment from a Medicaid agency to finance the care of Medicaid enrollees. As with HMO's, they assume the risk of a loss if the payment is inadequate to cover a beneficiary's healthcare expenses. Unlike HMO's, however, HIO's typically do not deliver care. Since 1985, Congress has subjected HIO's engaged in full-risk contracting to the same regulatory standards as HMO's. HIO's who do not offer a comprehensive set of services, however, face fewer regulatory requirements. States contracting with HIO's for a less than comprehensive set of services must only address such issues as the terms of the capitation arrangement, re-negotiation, and distribution of shared savings.

Health Maintenance Organization (HMO)—an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. There are four basic models of HMO's: group model, individual practice association, network model and staff model.

Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO:

1. An organized system for providing of people
2. An agreed upon set of basic and supplemental health maintenance and treatment services, and
3. A voluntarily enrolled group of people.

Health Plan Employer Data And Information Set (HEDIS)—a core set of performance measures to assist employers and other health purchasers in understanding the value of healthcare purchases and evaluating health plan performance.

Horizontal Integration—merging of two or more firms at the same level of production in some formal, legal relationship. In hospital networks, this may refer to the grouping of several hospitals, the grouping of outpatient clinics with the hospital or a geographic network of various healthcare services. Integrated systems seek to integrate both vertically with some organizations and horizontally with others.

Individual Practice Association (IPA) Model HMO—a healthcare model that contracts with an entity, which in turn contracts with physicians, to provide healthcare services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.

Integrated Health Organization—a single entity serving as an integrated delivery network that is fully responsible for obtaining and managing payer contracts, assuming healthcare risk, collecting revenue, and asset control by lease or ownership.

Integrated Service Delivery (ISD)—a generic term referring to a joint effort of physician/hospital integration for a variety of purposes.

Integration—a concept describing how previously separate organizations, functions and/or caregivers are blending their service and operations to function more efficiently and effectively in offering a seamless system of care within which consumers can easily move.

Managed Care—a system of healthcare delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective healthcare.

Managed Care Organization—A generic term applied to a managed care plan; may be in the form of an HMO, PHO, PPO, EPO, or other structure.

Managed Healthcare Plan—one or more products that integrate financing and management with the delivery of healthcare services to an enrolled population; employ or contract with an organized provider network which delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and use an information system capable of monitoring and evaluating patterns of covered persons' use of healthcare services and the cost of those services.

Management Services Organization—a legal entity that offers practice management and administrative support to physicians, or that purchases physician practices and obtains payer contracts as a PHO; can be wholly-owned, a for-profit subsidiary of a hospital, a hospital/physician joint venture, or a private joint venture with physicians or hospital physicians; offers a menu of services through shared practice management (group purchasing discounts, practice management, consulting, information newsletters and educational seminars, computer/info systems, marketing, employee leasing for office coverage, claims processing).

Maternal and Child Health Programs (MCHP)—a State service organization to assist children under 21 years of age who have conditions leading to health problems.

Managed Care Organization (MCO)—a generic term applied to a managed care plan; may be in the form of an HMO, PHO, PPO, EPO, or other structure.

Medical Necessity—the evaluation of healthcare services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.

Member Assistance Program—a human risk management program that focuses on lowering behavioral and healthcare costs by proactively reducing demand for treatment. Also known as demand reduction or demand management program.

Morbidity—an actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

Mortality—an actuarial determination of the death rate at each age as determined from prior experience.

Network Model HMO—an HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his/her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.

Organized Delivery Systems—proposed networks of providers and payers that would provide care and compete with other systems for enrollees in their region. Systems could include any providers and/or sites that offer a full range of preventive and treatment services.

Outcome Measures—assessments that gauge the effect or results of services provided to a defined population.

Outcome measures include, the consumers' perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.

Payor—the party that purchases the health services provided to consumers, including employers, government agencies, and insurance companies.

Per Member Per Month (PM/PM)—the unit of measure related to each effective member for each month the member was effective. The calculation is: number of units/member months.

Point-Of-Service (POS) Plan—a health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. Point-of-service can be provided in several ways:

An HMO may allow members to obtain limited services from non-participating providers;

An HMO may provide non-participating benefits through a supplemental major medical policy;

A PPO may be used to provide both participating and non-participating levels of coverage and access; or various combinations of the above may be used.

Practice Guidelines—systematically developed statements on healthcare practice that assist providers and consumers in making decisions about appropriate healthcare for specific situations or conditions. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care.

Preferred Provider Organization (PPO)—a program in which contracts are established with providers of healthcare. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (fewer copayments) for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons are generally allowed benefits for non-participating providers' services, usually on an indemnity basis with significant copayments. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee-for-service basis.

Prepaid Health Plan—contract between an insurer and a subscriber or group of subscribers whereby the plan provides a specified set of health benefits in return for a periodic premium.

Physician-Hospital Community Organization—similar to a physician hospital organization with the addition of community governance representation.

Physician-Hospital Organization—an IPA (individual practice association) associated with a hospital, often initiated by the hospital, which provides management services; features a contracting mechanism for obtaining "covered lives," generally with 50:50 physician and hospital control and hospital financing; Pros: Doctors retain autonomy, it is a step toward full integration/basis for capitation experience; Cons: strains relationships with independent physicians; can be hazards from utilization control, division of revenue, and panel selection.

Preventive Care—comprehensive care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including risk assessment appraisals, routine physical

examination, immunizations, and well-baby care.

Primary Care—basic or general healthcare, traditionally provided by family practice, pediatrics, and internal medicine.

Primary Care Case Management—case management that requires a gatekeeper to coordinate and manage primary care services, referrals, pre-admission certification, and other medical or rehabilitative services; the primary advantage of PCCM for Medicaid eligibles is increased access to PCP while reducing use of hospital outpatient departments and emergency rooms; (encourage within Medicare Choices to provide PCP coordination for patients being treated by a wide variety of specialists but who no longer have a PCP for oversight).

Primary Care Provider or Primary Care Physician (PCP)—a physician whose practice is devoted largely to internal medicine, family/general practice, and pediatrics; an OB/Gyn may be considered a primary care physician, and some networks provide a focused retraining for OB/Gyn so that they may enter into risk contracts for a population of female patients.

Provider (Participating Provider)—individuals and/or organizations who directly deliver prevention, treatment, and maintenance services to consumers within the defined plan. Depending upon the arrangement, usually involves contracts.

Provider Service Organization/Provider Sponsored Network—a formal affiliation of healthcare providers organized and operated to provide a full range of healthcare services; a term used in draft language of the 1996 budget discussions of House and Senate proposals that would allow Medicare to contract directly with PSN's on a full-risk capitated basis in a way that would "cut some HMO's out of the middle" depending on the ultimate language; the degree to which PSN's must be subject to the licensing, financing, and insurance considerations, as regulated by State insurance commissioners, will determine the number of providers to qualify, as compared to the more rigid HMO standards under which provider networks must currently qualify; no bill has been currently passed to grant operation to PSN's.

Quality-Adjusted Life-Year—measurement unit to define health outcomes that result from medical or surgical care, expressed in terms of the number of years of life in a less-desirable health condition as compared to years of full health; if the quality of life for a bed-ridden patient is 50 percent with a life expectancy of 10 years, the measurement would be 5 quality-adjusted life-years; as the U.S. system of medicine becomes more focused on termination of life when the quality of life or chance of long-term survival is low, more attention will be given to this measurement.

Quality Assurance (QA)—a formal set of measures, requirements, and tasks to monitor the level of care being provided. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing effectiveness and may measure care against preestablished standards.

Report Card On Healthcare—an emerging tool that can be used by policymakers and healthcare purchasers, such as employers, government bodies, employer coalitions, and consumers, to compare and understand the actual performance of health plans. The tool provides health plan performance data in major areas of accountability, such as

healthcare quality and utilization, consumer satisfaction, administrative efficiencies and financial stability, and cost control.

Risk Analysis—the process of evaluating expected healthcare costs for a prospective group and determining what product, benefit level, and price to offer in order to best meet the needs of the group and the carrier.

Risk Sharing (at-risk-contracting)—a variation of a risk-based reimbursement system in which any financial profits or liabilities are "shared" between two or more entities in a contractually defined manner, thereby spreading the risk of unplanned financial loss resulting from underestimation of service needs.

Service Utilization—a description, usually statistical, of the level, frequency, and necessity of services actually used by consumers. Generally, aggregated into population measures, rather than individual consumer measures.

Shared Risk: See risk sharing.

Social Health Maintenance Organization—federally funded Medicare demonstration project for the elderly; provides comprehensive health and long-term care benefits to Medicare beneficiaries; unlike other Medicare-enrolling HMO's care in a social HMO is reimbursed at 100 percent.

Staff Model HMO—a healthcare model that employs physicians to provide healthcare to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.

Utilization Management (UM)—the process of evaluating the necessity, appropriateness, and efficiency of healthcare services; a review coordinator or medical director gathers information about the proposed hospitalization, service, or procedure from the patient and/or providers, then determines whether it meets established guidelines and criteria, which may be written or automated protocols approved by the organization; a provider or IDN that proves it is skilled in UM may negotiate more advantageous pricing, if UM is normally performed by the HMO but could be more effectively passed downward at a savings to the HMO.

Utilization Review—the evaluation of the medical necessity and the efficiency of healthcare services, either prospectively, concurrently, or retrospectively; contrasted with utilization management in that UR is more limited to the physician's diagnosis, treatment, and billing amount, whereas UM addresses the wider program requirements.

Vertical Integration—organization of production whereby one business entity controls or owns all stages of the production and distribution of goods or services. In healthcare, vertical integration can take many forms, but, generally implies that physicians, hospitals, and health plans have combined their organizations or processes in some manner to increase efficiencies, increase competitive strength, or to improve quality of care. Integrated delivery systems or healthcare networks are generally vertically integrated.

Wraparound Services—services that address consumers' total healthcare needs, in order to achieve health or wellness. These services "wrap around" core clinical interventions, usually medical. Typical examples include such services as financial support, transportation, housing, job training,

specialized treatment, or educational support.

Healthcare Acronyms

AAHP	American Association of Health Plans
AAPC	Adjusted Average Per Capital Cost
AAPPO	American Association of Preferred Provider Organizations
ACR	Adjusted Community Rate/Rating
AFDC	Aid to Families and Dependent Children
AHCPR	Agency for Health Care Policy and Research
AHEC	Area Health Education Center
AHP	Accountable Health Plans
ALOS	Average Length of Stay
AMBHA	American Managed Behavioral Healthcare Association
APR	Average Payment Rate
APWA	American Public Welfare Association
ASO	Administrative Services Only/Organizations
BC/BS	Blue Cross/Blue Shield
BHMCO	Behavioral Health Managed Care Organization
CCN	Coordinated Care Networks
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHIN	Community Health Integrated Network
CMHC	Community Mental Health Centers
COA	Certificate of Authority
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COGME	Council on Graduate Medical Education
CON	Certificate of Need
COPC	Community Oriented Primary Care
CPR	Customary, Prevailing, and Reasonable Charges
DRG	Diagnosis or Diagnostic-Related Groups
DSH	Disproportionate Share Hospital
DSM	Demand-side Management
DUR	Drug Utilization Review
EAP	Employee Assistance Program
EMR	Electronic Medical Record
EPA	Exclusive Provider Arrangement
EPO	Exclusive Provider Organization

EPSDT	Early and Periodic Screening, Diagnostic, and Treatment Program
ERISA	Employee Retirement Income Security Act
FACCT	Foundation for Accountability
FFS	Fee-for-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
GPRA	Government Performance and Results Act
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HIAA	Health Insurance Association of America
HIO	Health Insurance Organization
HIPC	Health Insurance Purchasing Cooperative or Coalition
HMO	Health Maintenance Organization
HRQL	Health-related Quality of Life
IDN	Integrated Delivery Network
IDS	Integrated Delivery System
IHO	Integrated Health Organization
IMD	Institutions for Mental Disease
IPA	Individual Practice Association
ISN	Integrated Service Networks
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MCO	Managed Care Organization
MEWA	Multiple Employer Welfare Association
MIS	Managed Information Systems
MSO	Management Services Organization
NAIC	National Association of Insurance Commissioners
NASADAD	National Association of State Alcohol & Drug Abuse Directors
NASMHPD	National Association of State Mental Health Program Directors
NCQA	National Committee for Quality Assurance
NMHCC	National Managed Healthcare Congress
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PHCO	Physician-Hospital-Community Organization
PHO	Physician-Hospital Organization
PHP	Prepaid Health Plan
PM/PM	Per Member Per Month
POS	Point of Service

PPO	Preferred Provider Organization
PSN	Provider Sponsored Network
PSO	Provider Service Organization
QA	Quality Assurance
QALY	Quality-Adjusted Life-Year
SED	Seriously Emotionally Disturbed
SHMO	Social Health Maintenance Organization
SMI	Seriously Mentally Ill
SSI	Supplemental Security Income
UCR	Usual, Customary and Reasonable
UM	Utilization Management
UR	Utilization Review

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Please let us know what specific topics on managed care you would like to see in future managed care resource guides.
(Check all that apply.)

_____ Accreditation, Licensing — "Report Cards"
_____ Clinical & Population-Based Outcomes
_____ Community Coalitions & Linkages with MCO's
_____ Consumer Empowerment
_____ Contracting
_____ Costing Preventive Services
_____ Cultural Diversity
  ___ Hispanic/Latino
  ___ African Americans
  ___ Asian/Pacific Islander
  ___ American Indians/Alaska Natives
  ___ Gay, Lesbian, Bisexuals and Transgendered
  ___ People with Disabilities
  ___ Other (Please specify: _____)
_____ Dual Diagnoses
_____ Employee Assistance Programs
_____ EPSDT
_____ Integrated Delivery Systems
_____ Legal Issues
_____ Marking Strategies
_____ Medicaid
_____ Medicare
_____ Mental Health Promotion Strategies
_____ Patient-Provider Communications
_____ Prevention Protocols
_____ Primary Care Provider Training
_____ Rural
_____ School-Based

We would like to request any articles, studies and/or reports that are not included in the current monograph or could be used in upcoming monographs.

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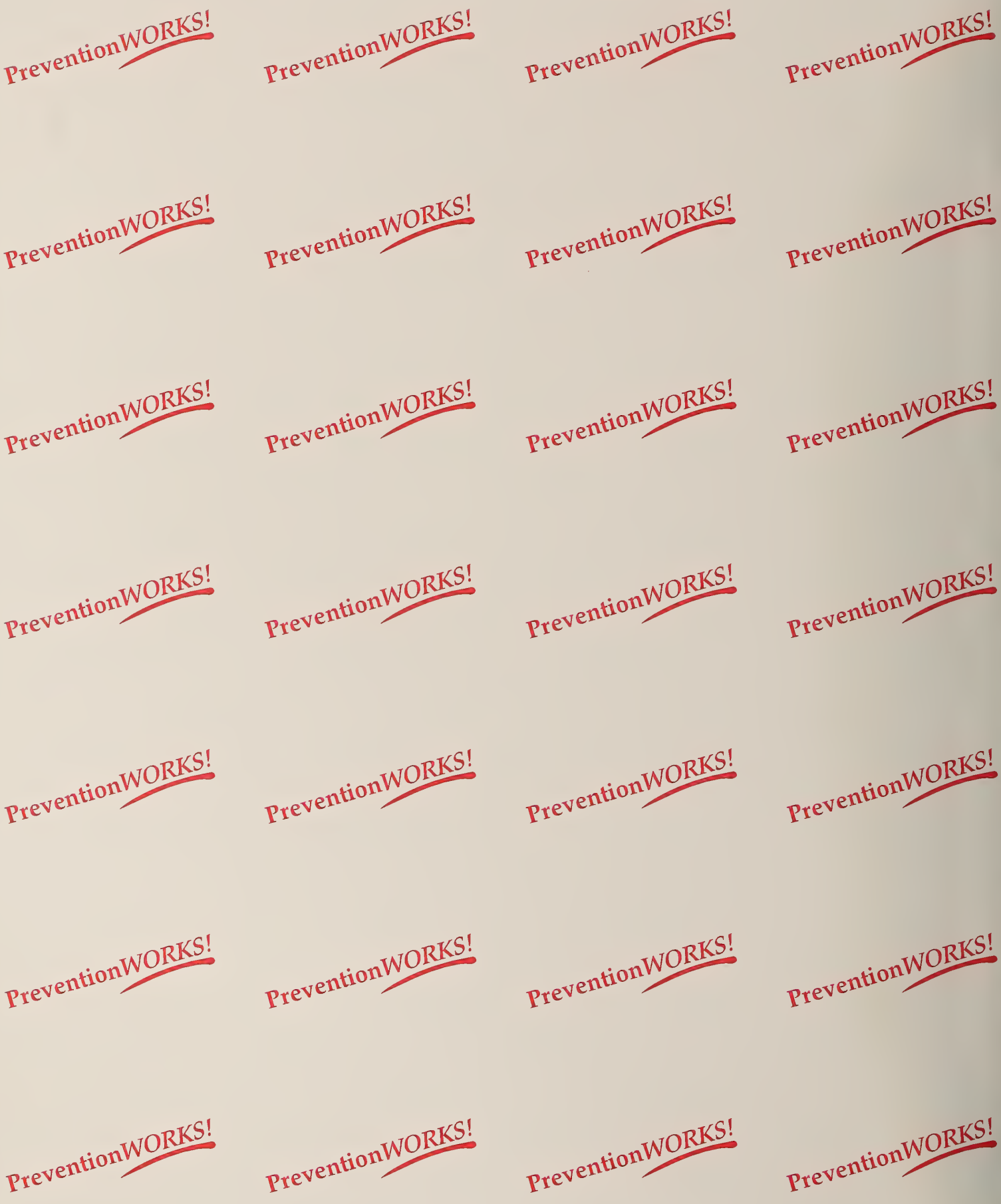
Center for Substance Abuse Prevention
Office of Managed Care
5600 Fishers Lane
Rockwall II Building, Suite 920
Rockville, MD 20852



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