Policy Tools for Building Health Education and Preventive Counseling into Managed Care

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Content: Six policy tools for building health education and preventive counseling into managed care are presented, and the opportunities and barriers to implementing each are described based largely on managed care plans operating in California in 1998. The six policy tools include (1) covering health education and preventive counseling as defined benefits, (2) increasing access to and use of health promotion programs, (3) incorporating health education into disease-management programs, (4) defining quality performance measures for health education and preventive counseling, (5) defining performance targets and guarantees for health education and preventive counseling to hold health plans accountable for providing these services, and (6) building collaboration between public health agencies and managed care on public health education and health promotion. For each of these, the policy option is described, examples of current practice are provided, and the problems and limitations associated with each are discussed.

Medical Subject Headings (MeSH): health policy, counseling, health education, managed care programs, primary prevention

Introduction

What policy tools are available to increase the integration of health education and preventive counseling into managed care? This paper reviews six tools that individually and collectively have the potential to significantly advance the integration of health education into managed care. These tools reflect the experience and lessons learned from integrating preventive screening and immunizations into managed care (particularly in California), the efforts by purchasers to assess and assure quality of care provided by health plans, and recent initiatives to increase collaboration between public health and managed care.

The six policy tools are:

1. covered benefits—defining health education and preventive counseling services as covered benefits in managed care plans;
2. health promotion programs—supporting access to and use of health promotion programs offered by managed care plans;
3. disease-management programs—incorporating health education into disease-management programs offered by managed care plans;
4. quality measurement—defining managed care quality measures for health education and preventive counseling;
5. performance targets and guarantees—defining performance targets and guarantees for health education and preventive counseling to hold health plans accountable for providing these services; and
6. collaboration with public health—building collaboration between public health agencies and managed care on public health education and health promotion.

For each of the above, the policy option is described, examples of current practice are provided, and the problems and limitations associated with adoption of each policy are discussed.

Data Sources

The data were collected as part of the Health Insurance Policy Program, a joint project of the University of California, Berkeley, Center for Health and Public Policy Studies; and the UCLA Center for Health Policy Research, funded by a grant from The California Wellness Foundation. The primary data sources include:

- the 1998 California Behavioral Risk Factor Survey, a random sample computer-assisted telephone interview survey of 4,000 adults, which includes supple-
Covered Benefits

Perhaps the most obvious approach to integrating health education into managed care is to explicitly include health education and preventive counseling services in the defined coverage of benefits offered by health plans. The definition of these benefits can be based, in part, on the recommendations for preventive counseling in the Guide to Clinical Preventive Services. The guidelines define the specific topics about which individuals should be counseled by age and gender. The topics include substance use (tobacco, alcohol, and drugs), diet and exercise, injury prevention, sexual behavior, and dental health. In determining which ones should be covered, the weight of the evidence regarding the effectiveness of preventive counseling in changing health behaviors or improving health should be considered to establish priorities.

If provision of health education is not a covered benefit by a health plan, the most effective way to add it is for purchasers to request that it be covered. For example, employers can request coverage in the health plans they offer to their employees. Congress can amend the Social Security Act to require coverage under Medicare for the elderly and disabled. State legislatures can add coverage under the Medicaid program, the Children’s Health Insurance Program, and other state-funded health insurance programs.

In California in 1997, more than 80% of HMO and point-of-service plans reported covering preventive counseling as a benefit in their best-selling products in the group market. However, rates at which the insured population in HMOs in California report having received preventive counseling about specific health behaviors from a provider in the last three years suggest that this service has not been fully integrated as a routine part of primary care.

Table 1 displays the rates at which Californians enrolled in HMOs in 1998 reported receiving preventive counseling. Coverage of health education services and preventive counseling may be necessary for integrating these services into managed care, but it appears not to be sufficient for ensuring routine provision of these services.

There are several barriers to delivering preventive counseling services in the primary care setting, even when these services are covered benefits. The barriers that are linked to coverage include no direct financial incentive under capitation payment systems to provide these services, and the need for special efforts to build financial reward and bonuses into payment systems to increase counseling rates. It addition, most payment systems do not build into the definition of covered benefits the costs of the time of ancillary personnel who have been trained to advise and counsel patients, including health educators, dietitians, nurse practitioners, exercise physiologists, and alcohol and drug counselors.

Other barriers not directly linked to coverage include the fact that many physicians have never been trained to counsel or advise patients about health behaviors. In addition, health care providers may not remember to counsel patients and could be helped by reminder or record-keeping systems.

Health Promotion Programs

Another strategy for integrating health education into managed care is to increase the availability and accessibility of health promotion programs that have been demonstrated to be effective in changing health behaviors, reducing risk or preventing disease. In group- and staff-model HMOs (such as Kaiser Permanente and Group Health Cooperative of Puget Sound), health promotion programs are often offered directly by the plan at its facilities. In Independent Physician Associations (IPA) or network-model HMOs, health promotion programs are often made available by community providers (for example, discounts for Weight Watchers or a health club) or are offered by large medical groups at their facilities. Health plans and medical groups often partially or fully subsidize the cost of the health promotion program to reduce financial barriers to access.
In California, more than three quarters of the commercial HMOs offer health promotion programs addressing childhood immunizations, prenatal nutrition, and smoking cessation and tobacco use. In addition, more than half offer programs addressing childhood injury prevention, cervical cancer prevention, reduction of dietary fat intake, adult immunizations, physical fitness and exercise, and breast cancer prevention. However, fewer than half of the commercial HMOs in California offer health promotion programs addressing HIV/AIDS prevention, sexually transmitted disease prevention, alcohol and drug abuse prevention, and mental health promotion.

While health promotion programs addressing a variety of topics are available to most persons in HMOs in California, the problem with this approach has been that utilization of these programs has been extremely low. On average, fewer than 4% of the adults who were enrolled in HMOs in California in 1998 participated in any health promotion program offered through their plan. One strategy for increasing utilization of available health promotion programs offered by HMOs is to encourage providers to integrate referrals to these programs into their care for persons at risk, giving them the same weight as a referral to a specialist or as a prescription for medication. This would signal patients that changing health behaviors is an important part of patient care and treatment.

Another approach is to make other benefits conditional on participation in a behavioral program, for example requiring that coverage for nicotine replacement therapy be conditional on participation in a smoking-cessation program. However, the downside to making nicotine replacement therapy conditional on participation in a behavioral program is that it may limit access to and use of an effective intervention.

An additional approach is to offer incentives to persons who complete health promotion programs, for example, giving women infant car seats if they complete a prenatal nutrition program or refunding the patient’s co-payments at the completion of a program.

### Disease-Management Programs

Increasingly, HMOs are offering disease-management programs for chronic and high-risk conditions in an effort to prevent unnecessary complications and associated hospitalizations, and thus to control costs. An important part of any disease-management program is health education for the patients, about their conditions and how they can manage them. A first step to integrating health education into disease-management programs is to incorporate health education in the guidelines and protocols that health plans use or develop.

In California in 1997, 80% of all commercial HMOs offered disease-management programs to their members. More than half of the commercial HMOs in California offered disease-management programs for asthma, diabetes, and high-risk pregnancy, and more than one third offered programs addressing depression and hypertension. However, fewer than one fifth offered any disease-management programs for osteoporosis, HIV/AIDS, peptic ulcer, prostate cancer, or arthritis.

One of the major problems with integrating health education into disease-management programs is the lack of standardization of the guidelines and protocols HMOs use for their programs. Of the HMOs in California that offer disease-management programs, nearly eight out of 10 use protocols or guidelines; however, more than half of these are developed internally and only nine HMOs reported using any guidelines or protocols developed by outside sources. Thus, there may be considerable variability in the content of and approaches used in disease-management programs across HMOs.

The development of health education standards for disease-management programs is needed. In addition, most HMOs offer disease-management programs addressing only two or three conditions. There is a need to expand access to effective programs addressing all of the major chronic conditions. Another issue regarding access to effective health education programs within a disease-management format is how eligibility for the programs is determined. In some cases, plans may tightly control access to these services to patients who meet specific criteria. Additional research is needed to determine the extent to which both patients and individual health care providers are able to access health education within disease-management programs. Finally, there is a need to evaluate the effectiveness and cost-effectiveness of disease-management programs and to promote adoption of demonstrated best practices across HMOs.

### Quality Measurement

Another tool for increasing the integration of health education and counseling into managed care is to define receipt of appropriate health education as part of quality care. To begin to measure receipt of health education services is to signal its importance to health plans and providers. The best example of this is the recent addition of a quality measure addressing physician advice to quit smoking to the National Committee on Quality Assurance Health Plan and Employer Data and Information Set (HEDIS). This measure assesses the proportion of adult smokers or recent quitters in a health plan who received advice to quit smoking from a health plan professional in the plan during a visit in the past year.
Purchasers of health plans, including employers, Medicare, and state Medicaid agencies can build requirements for the collection of data that measure receipt of health education into their contractual agreements with managed care plans. The preventive counseling services recommended by the U.S. Preventive Services Task Force can serve as a starting point for developing measures addressing counseling to promote physical activity and a healthy diet and to prevent motor vehicle injuries, household and recreational injuries, youth violence, low back pain, dental and periodontal disease, HIV infection and other sexually transmitted diseases, unintended pregnancy, and gynecologic cancers.1

Every effort needs to be made to incorporate more preventive counseling measures into HEDIS and other managed care quality initiatives. Priority for measure development should be given to those areas of counseling where there is good evidence to support the recommendation that counseling specifically be considered in a periodic health exam and where the evidence of effectiveness is from at least one properly randomized controlled trial or was obtained from well designed controlled trials without randomization.1 Counseling services meeting these criteria include counseling

- all patients, including pregnant women, who use tobacco to stop its use;
- to use nicotine patches or gum as an adjunct to counseling;
- to limit dietary fat intake;
- to breastfeed infants; and
- to use fluoride supplements to age 16 in areas with inadequate water fluoridation.

A significant limitation of relying on quality measurement to increase provision of preventive counseling is that most of the quality measures being developed and implemented apply only to HMOs and are not assessed in preferred provider organization or indemnity plans. This is a significant disadvantage as a high proportion of the population in California and other states receives health care through non-HMO plans.

Performance Targets and Guarantees

The fifth policy tool available to integrate health education and counseling into managed care is for purchasers to negotiate specific targets for improving performance on the counseling measures during the next year. Some purchasers even go the next step and place a percentage of the premium at risk for meeting negotiated targets. For example, an employer or a state Medicaid program could negotiate an improved performance target for advice to quit smoking as part of their contractual negotiations with each plan. If a plan had an advice-to-quit rate of 55% this year, they may agree to a performance target of 57% the following year. The goal of negotiating performance targets is one of continuous quality improvement.

In California in 1997, advice-to-quit-smoking rates varied across HMOs from 52% to 71%. The Pacific Business Group on Health (PBGH, the largest private purchasing coalition in the U.S.) negotiated a performance target and guarantee to improve performance on advice-to-quit rates with each health plan for the next contract year. Performance measurement is not limited to those who are enrolled in plans through PBGH, but is representative of all of a health plan’s enrollees, including those who are enrolled through Medicaid and Medicare.

Performance guarantees involve the negotiation of a fixed percentage of the premium at risk for meeting the performance target. The guarantee may take the form of either a premium bonus or a withholding. Pacific Business Group on Health places a total of 2% of premium at risk for meeting several dozen performance targets, including advice to quit smoking. Initial experience suggests that the institution of performance targets and guarantees has improved health plan performance across a broad set of preventive service measures.5

There is no reason that a similar approach could not be implemented across the entire health care system. Not only can purchasers negotiate performance targets and guarantees with health plans, but health plans can negotiate them with IPAs and medical groups, and they in turn can negotiate them with individual providers. At the plan level, performance guarantees may be most effective with group- or staff-model HMOs, as these managed care plans have much more direct control over their physicians as salaried employees. In IPA- and network-model HMOs, it is much more difficult for the health plan to achieve quality improvements, as it must work through several intermediaries to affect physician behavior. These plans, in many respects, are more like “puppeteers without strings,” unless they build strings into their contractual relationships with medical providers.

The main limitation of performance targets and guarantees in the present system is that they are limited to those health education and counseling services for which quality measures have been developed and on which data are routinely collected. There is also very little experience, and even less that has been rigorously evaluated, on how high the financial incentive needs to be set to produce a measurable improvement in performance, nor how far and how fast health plan performance can be expected to improve. A great deal more research is needed to inform policy development in this area.5

Collaboration between Managed Care and Public Health

The sixth approach to integrating health education and preventive counseling into managed care is to increase collaboration, at both the state and local levels,
between managed care organizations and public health agencies around public health education campaigns and health promotion interventions. In 1996, the Association of State and Territorial Directors of State Health Promotion and Public Health Education Programs conducted an assessment of all 50 state health promotion divisions in state health departments. The assessment found that in 25 states, the state health promotion division was working with managed care organizations to implement community health promotion interventions; in 22 states the health promotion division was working with managed care to develop health promotion guidelines for managed care organizations; and in 11 states, managed care and the state division of health promotion were working together to collect data and assess quality for health promotion and public health education.

One approach to increasing collaboration has been implemented in the state of Minnesota, which requires health plans holding Medicaid managed care contracts with MinnesotaCare to submit a collaboration plan to the state describing how they will assist public health agencies in achieving public health goals. There are also examples from other states where managed care organizations have worked together to pass bicycle helmet legislation, or have pooled resources to implement a health promotion campaign, or have worked together to submit a joint grant for a health education program. In many of these cases, the collaboration between managed care organizations and public health departments enabled them to pool their resources and skills to accomplish more than either one could have achieved separately.

Examples of other state models include these:

- Oregon, which requires that the HMOs with state Medicaid contracts participate in two statewide health promotion activities addressing immunizations and one addressing tobacco, breast cancer, or diabetes
- Maine, which has formed a statewide managed care work group between the HMOs and the state health department to collaborate around health promotion

The experiences at the state level also suggest that collaborations will be most successful if the projects address issues of interest to HMOs, such as HEDIS measures, data (including the use of the Behavioral Risk Factor Survey data), coverage of clinical preventive services (including preventive counseling), and helping nonprofit health care organizations to meet their community benefit requirements. The topics most likely to be the subjects of collaborative efforts between public health and managed care include tobacco use and smoking cessation, diabetes prevention and management, physical activity and exercise, and breast and cervical cancer screening.

A major barrier to collaboration is lack of trust between public health and managed care, including perceptions associated with government bureaucracies and regulators on the one hand and concerns about the profit motive on the other. Other important barriers include lack of support for collaboration among public health officials, lack of knowledge of managed care in public health, and the instability of the changing managed care marketplace.

Conclusion

There are many opportunities and many challenges to increasing the integration of health education and preventive counseling into managed care. While there are many opportunities for purchasers in the private sector and in state and federal government to increase coverage for health education services and preventive counseling in managed care, there are obstacles to delivering these services that may require additional provider training, implementation of information and reminder systems, and the development of financial incentives for providing counseling.

Most HMOs offer their members access to health promotion programs. The present challenge is to increase utilization of the health promotion programs offered by the plans, which may require increased outreach to patients, increased referrals by providers, and the use of incentives for both providers and patients.

Many HMOs have begun offering disease-management programs that include patient education and counseling. However, there are many obstacles associated with the lack of standardized protocols, the limited number of conditions for which disease-management programs are generally available in managed care, and the lack of health education standards for plans to adopt.

There are many opportunities to expand measures of quality of care for health education and preventive counseling. However, few systems are in place to measure receipt of these services and it has been difficult to get them added to existing quality measure sets.

In managed care plans where quality measures addressing preventive counseling are being assessed, there are opportunities to go the next step to develop performance targets and guarantees. However, there is little experience or research to guide the development of the most effective approaches to implementing this policy tool.

Finally, there are many opportunities for public health to collaborate with managed care to promote the health of members. However, there are numerous obstacles that need to be overcome to make this work to the advantage of both parties, including building trust and developing leadership on both sides of the relationship. In addition, very little research is available on
the relative effectiveness of these six approaches for integrating health education and prevention counseling in managed care to increase access to and utilization of these services. Additional research comparing the relative costs and effectiveness of these different approaches would be helpful to health plans in making decisions on how best to spend their health education resources.

References


