

Women's Health

Successes and Challenges
in Prevention and Promotion



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ABOUT THE NIHCM FOUNDATION

The National Institute for Health Care Management Research and Educational Foundation is a non-profit organization whose mission is to promote improvement in health care access, management and quality.

ABOUT THIS ACTION BRIEF

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INTRODUCTION

Use of preventive health care services and widespread awareness of preventive health guidelines are key to securing the long-term health of women. On December 14, 2004, the National Institute for Healthcare Management (NIHCM) Foundation held a forum to share information on policies and programs on women's health at the federal and state level; research and evidence-based efforts; and successful prevention and treatment options. The forum was part of the Foundation's cooperative agreement with the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB).

NIHCM Foundation convened leaders in women's health from the federal government offices on women's health, including the Department of Health and Human Services' (DHHS) Office on Women's Health, the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Disease Control and Prevention (CDC), along with medical directors and those working on programs related to women's health within health plans. The goal of the forum was to facilitate a dialogue on the successes and challenges faced in the development and implementation of women's health prevention and promotion programs. Work at the federal level was presented from the public sector speakers, and supplemented by comments from other agencies represented in the audience. Health plan presenters shared unique innovations in promoting and delivering preventive care for women through their programs, as well as lessons learned through evaluation of existing programs.

A general theme emerging from the dialogue is the need for the public and private sector to leverage off each other's work. Collaboration is vital to addressing the challenge of how to best communicate what is known about women's health into the hands of women so they are empowered to take action. Public sector participants expressed their willingness to provide knowledge and resources to health plans to educate health care professionals and consumers about the important role of prevention in improving women's health. Health plans are natural partners to disseminate prevention messages because of their connections to women. Despite health plans' access to women, both sectors acknowledged the existence of a disconnect between the federal recommendations on health screening and prevention initiatives from the U.S. Preventive Services Task Force (USPSTF), the actions of health plans, and whether physicians themselves are a barrier to preventive care by not following the recommendations.

While each of these issues is not easily resolved, speakers offered several insights on what they would like to see happen to increase women's awareness and use of preventive care. Health plan medical directors noted that barriers to physician support for preventive care include lack of training in medical school and lack of reimbursement for preventive services, yet they indicated that the plans spend a fair amount of time focused on prevention and communicating recommendations for health screenings to physicians. One possible solution offered is to move to a pay-for-performance system with increased emphasis on health promotion in the form of rewards for physicians that follow established, evidence-based recommendations. Speakers acknowledged that what physicians assess during patient encounters is usually the direct result of what performance measures are in place, and called for increased measurements for physical activity, nutrition and tobacco use to increase the assessments in these areas by physicians.

The major messages from the meeting were the identification of means for collaboration between the government and the health plans. Government agencies appealed to the health plans to work with them by implementing research findings from evidence-based information into practice, and to continue their relationship with the USPSTF by reviewing evidence and nominating topics for review. Programs and research from the federal and state level are a valuable source of information and best practices for health plans looking to develop new programs. Health plans can additionally learn from peers' experiences in implementing initiatives related to women's health. A step in the direction of improved endorsement of preventive care from the perspective of the health plans is for the government to continue the development of prevention tools that can be provided at the point of care to support consistent behavior reinforcement during the critical period of patient-physician interaction. Health plans also requested that the government revise guidelines on nutrition into measurements that are more easily communicable and usable by physicians and patients. Exposure to the work of health plans and government programs in women's health is important as research and recommendations are changed or updated. The conversation initiated by this forum is illustrative of the importance of the collaborative partnership that is critical to ensure that preventive screenings and counseling are widely available to all women.

OVERVIEW OF PUBLIC SECTOR INITIATIVES

Wanda Jones, Dr.P.H., Deputy Assistant Secretary for Health (Women's Health), U.S. Department of Health and Human Services

Rosaly Correa-de-Araujo, M.D., M.Sc., Ph.D., Senior Advisor on Women's Health, Agency for Healthcare Research and Quality

Abby Rosenthal, M.P.H., Office on Smoking and Health, Centers for Disease Control and Prevention

Healthy People 2010

"Healthy People 2010's focus and the success of Healthy People absolutely relies on states, communities, and professional, consumer, industrial and all the sorts of sector groups in partnership to make all of this succeed."

-Dr. Wanda Jones

Providing a brief history of women's health in the U.S., **Dr. Wanda Jones** noted that there have been women's health movements virtually since the founding of our nation. On a 25- to 40-year cycle, there have been efforts led by women focused on safe childbearing and other maternal and child health issues that have contributed greatly to improving the condition of women and children. The most recent movement dating from the 1960s produced the Boston Women's Health Book Collective, or *Our Bodies Ourselves*, a breakthrough since it was the first time women were allowed the opportunity to look at their health through their own value systems. This lens was not recognized at the time by organized medicine, let alone the entire health care system. That modern women's health movement led to a then-General Accounting Office (GAO) mid-1980s study confirming that women and minorities were routinely excluded from research because they were considered too difficult to study. Thus, much of health care research and health care delivery at the time was conducted in the context of an approximately 175 pound white male. Fortunately by 1993 this changed with the National Institutes of Health (NIH) requiring inclusion of women and minorities in research. Now, a decade later, there is a rich array of evidence shedding light on practices that need to be applied differently to men, women and minorities.

Medicine and the health care system in the U.S. are only beginning to reap the benefits of this discovery. In the past century alone, **Dr. Jones** noted that women have gained about 30 years in life expectancy, however, the decline in the death rate of men from cardiovascular disease has far exceeded the decline for women. Men's death rates from cardiovascular disease have tracked with the decline in their rate of smoking over the past 40 years, while women's smoking rates increased during this same time period. Women's smoking rates are now back down, but smoking remains the number one preventable cause of premature death for both men and women.

Looking at the theme of prevention, approximately 2% of the nation's health budget is committed to prevention and promotion. Prevention is critical to the health and integrity of the nation, which has led to the development of four pillars or steps to a healthier U.S. (**Figure 1**). The pillars can be described as follows:

FIGURE 1: PILLARS TO A HEALTHIER LIFESTYLE

Pillar 1: Be active every day

Pillar 2: Develop good eating habits

Pillar 3: Get regular check-ups and preventive health screenings

Pillar 4: Make healthy choices every day

Source: Adapted from Dr. Wanda Jones presentation.

■ The first is to be physically active every day, even if that only involves walking. Using a pedometer is the simplest way to determine how active one is on a daily basis (10,000 steps equals around five miles). Walking not only reduces the risk of type 2 diabetes and heart disease, it also contributes to the fight against obesity, and there is growing evidence for the role of physical activity in a wide array of other illnesses.

■ The second pillar is to develop good eating habits and make sure one's mix of calories is appropriate. The usual guidance applies – eat fruits, everything in moderation, avoid excessive amounts of sugar, oils and fats, focus on complex carbohydrates.

■ The third pillar, which follows from the focus on prevention, is to get regular check-ups and preventive health screenings. **Dr. Jones** noted that this is easily taken for granted, and many people think that health insurance is the solution (women with insurance are more likely to get these services). However, the health surveillance data from Canada reveals quite a different message – despite providing universal coverage, Canada still has a health disparity problem similar in magnitude to the U.S. Other barriers to women receiving the appropriate health care include the cultural competence of the system, the capacity of the system to meet people where they are between normal working hours, and the accessibility of services to public transportation.

■ The fourth pillar brings it back to the individual and encourages everyone to make healthy choices every day.

The steps to a healthier U.S., **Dr. Jones** explained, derived from the release of the first Health Objectives for the U.S. in 1990, which were incorporated into the Healthy People 2000 objectives and now into Healthy People 2010 (HP

2010), led by the Office of Disease Prevention and Health Promotion at DHHS. The two overarching goals of all of the objectives are (1) to increase the years of healthy life and increase the quality of life; and (2) to eliminate disparities between populations where a difference in rates or outcomes is documented. These are ambitious goals, and HP 2010 grew to include 467 objectives. HP 2010 is currently under midcourse review and will be trimmed in size as the goals for the decade are modified in light of the realization that data systems have not yet come online to help monitor objectives, as well as other changes that affected where it was thought the nation could go in a decade. With extensive buy-in from communities, HP 2010 has proven to be a tremendous opportunity to bring focus to issues of critical importance to women. In fact, 240 of the 467 HP 2010 objectives are directly relevant to women's health. HP 2010 ties in closely with the work of the USPSTF and the Community Preventive Services Task Force on developing clinical preventive services guidelines.

There are many areas on which communities can focus to help reach and achieve the two overarching goals of HP 2010. One example is the focus area of insurance within HP 2010, which looks at who has coverage and what difference coverage has on access to preventive services. The data within this area shows that insured populations indicate they are much more current on routine preventive services and preventive screenings. Another focus area of HP 2010 where progress is being made is on mental health. While not much is known about promoting, nurturing or sustaining mental health, it is known that access to services makes a difference, including simple screenings in a health setting. The DHHS Office on Women's Health is working with the Office of the Surgeon General to release a series of reports specific to mental health that update the 1999 Surgeon General's Report on Mental Health by taking a very clear sex/gender focus to help better understand where mental health issues differ for women and men. Looking to the future, **Dr. Jones** said, "Healthy People 2010's focus and the success of Healthy People absolutely relies on states, communities, and professional, consumer, industrial and all the sorts of sector groups in partnership to make all of this succeed."

The USPSTF and Women's Health

AHRQ's priorities in women's health reside in enhancing the response of the health care system to women's needs, especially as they relate to prevention and therapeutic outcomes. To make this happen, **Dr. Rosaly Correa-de-Araujo** explained, it is crucial that gender differences in disease manifestation and in response to therapy are understood, and that gender inequalities in health care are

also understood and eliminated. Prevention is a priority area for AHRQ, as is promoting the use of evidence-based information to empower women to make better choices for their care and the care of their families. "Much work has been done to vigorously evaluate clinical research in order to assess the merits of preventive measures, including screening tests, chemoprevention, counseling and immunizations for all and in particular for women."

The U.S. Preventive Services Task Force (USPSTF), hosted by AHRQ, is an independent panel of private sector experts in primary care, prevention and methodology, in an interdisciplinary array of medical specialties. **Dr. Correa-de-Araujo** explained that the USPSTF's mission is to evaluate the benefits of an individual service, and to create age, gender and risk-based recommendations about preventive services that should be routinely incorporated into primary medical care. A second role of the USPSTF is to identify a research agenda for clinical preventive care. In addition, AHRQ has a program called Put Prevention into Practice (PPIP) that also works to implement task force recommendations and increase the appropriate use of clinical preventive services through a variety of resources and tools for clinicians, health care systems, patients and the public in general. The AHRQ website (www.ahrq.gov) provides access to the scientific evidence, the recommendations on the clinical preventive services, and the information on how to implement these recommendations into clinical practice.

The task force evaluates the overall quality of the evidence for a service based on a three-point scale of good, fair or poor. To qualify as "good," **Dr. Correa-de-Araujo** said the evidence must: (1) have consistent results from well-designed and well-conducted studies in representative populations that directly assess the effects of a particular service on health outcomes and (2) have some external validity that can be extrapolated to other populations. The available evidence is then graded according to one of five classifications – A,B,C,D or I – which reflect the strength of the evidence and magnitude of net benefits (the benefit minus harm related to performing a specific screening). The "A" recommendation is the strongest and indicates that the USPSTF recommends that clinicians provide a certain service to eligible individuals because good scientific evidence documents how the service improves important health outcomes and proves the benefits of providing the service substantially outweigh the harms (**Figure 2**).

Dr. Correa-deAraujo recognized that the "I" recommendation can cause disappointment among health care professionals and emphasized that it is important to understand that the USPSTF concluded the evidence is insufficient to recommend for or against routinely providing a particular service. This means that evidence

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*-Dr. Rosaly
Correa-de-Araujo*

is still lacking for a particular service, the quality of the available evidence is still poor, or there are conflicting results about the effectiveness of a screening test, and that the balance between the benefits and the harms cannot be determined. The potential harms of screening refer to the psychological and physical consequences of false-positives, false-negatives, the labeling of a person as having a disease, and the possibility of having a false positive result leading to overtreatment.

AHRQ recognizes that tensions exist in translating the scientific evidence into recommendations that are widely applied by clinicians. AHRQ's challenge is what position to take on many of the screenings for which evidence is inadequate to assess the net benefits and harms of screening. Some experts contend USPSTF should take a neutral role and offer no advice until better quality of evidence is available, while others support the USPSTF actively recommending against the use of interventions where proof it has been adequately studied is lacking.

For the "I" recommendations, **Dr. Correa-de-Araujo** explained, the USPSTF implies that clinicians continue to build their work on the effectiveness of a screening testing or counseling, so the task force will be able to reevaluate its recommendation. An "I" recommendation where insufficient evidence impedes the task force from making an "A" recommendation is recommending clinical breast exam (CBE) without mammography as an effective means of breast cancer screening. No screening trial has examined the benefits of CBE alone. Therefore, it is important that scientists and clinicians design studies and build upon the evidence to be able to effectively recommend for or against this type of screening. The task force also finds there is insufficient evidence to

recommend for or against teaching or performing routine self-breast exam. Although thousands of women find out they have breast cancer through self-examination, the evidence available is not enough to determine whether self-examination reduces breast cancer mortality. In fact, this practice has been associated with the risk of false positive results, making it difficult to establish the balance between harms and benefits. Clinicians who actually choose to advise women to perform breast self-examinations or who perform routine CBEs to screen for breast cancer should understand the current limitations imposed by the literature. They should continue to build on the evidence and document their success stories with the medical and scientific communities.

Dr. Correa-de-Araujo encouraged clinicians to continue to help the work of the USPSTF in interpreting the scientific evidence by building on the quality of the evidence. Between 2002-2004, USPSTF made recommendations for many women's health-related conditions, including for breast, cervical, ovarian, lung and colorectal cancers, coronary heart disease, thyroid disease, gestational diabetes, osteoporosis, depression, diabetes and family/intimate partner violence. The task force plans to release recommendations over the next year on several other topics of relevance to women. The USPSTF uses a rigorous process with recommendations based on the balance of benefits and harms, under the realization that making evidence-based recommendations practical for clinicians is challenging when gaps in evidence exist. However, the utility of these recommendations for clinicians to inform their patients of risks and benefits of screenings through a shared-decision process is invaluable. The collaboration among scientists, clinicians, experts involved in the task force and AHRQ, is vital for the continued benefit the USPSTF recommendations provide to women's health.

FIGURE 2: USPSTF WORDING RECOMMENDATIONS

A: Strongly Recommend

Good evidence, benefits substantially outweigh harms

B: Recommend

At least fair evidence, benefits outweigh harms

C: USPSTF Makes No Recommendation

Fair to good evidence, benefits and harms closely balanced

D: Recommend Against Routine Use

Ineffective or harms outweigh potential benefits

I: Insufficient Evidence

Lack of evidence on clinical outcomes

Poor quality of existing studies

Good quality studies with conflicting results

Source: Adapted from Dr. Rosaly Correa-deAraujo presentation.

Prevention Works: Smoking and Cessation

What works in terms of prevention for tobacco is unknown, except for very comprehensive community programs. While it is not possible to simply tell people not to smoke, we can assist them to quit smoking through secondary prevention programs, or cessation programs, by which people can improve their quality of life. **Abby Rosenthal** shared the message from the Surgeon General's report on tobacco and women, which is that tobacco is a women's issue and there is a need to get that message out. Tobacco use among women is an important issue, illustrated by the considerable effects of tobacco on women, such as conception delay, infertility, infant perinatal mortality, or low-birth weight (especially in low-income women where an estimated 15% to 30% of low-birth weight

babies are tobacco-related). The HP 2010 objectives contain a benchmark of 12% smoking in women, which is almost half of what it is today. Prevalence hovers around 22%, with much higher prevalence in minorities and low-income populations (Figure 3).

Tobacco costs have not been tracked as extensively as costs for other conditions (e.g., diabetes and hypertension) where health care systems know how much it costs to treat people. However, tobacco use is not being coded by clinicians, thus there is no way to track the costs of treating patients who use tobacco. CDC encourages health plans to ask clinicians to use the tobacco dependence ICD-9 code (305.1) to record the patient's tobacco habits. **Ms. Rosenthal** noted that to aid in this process and begin to dispel myths about women who smoke, CDC has developed a video, "The Seven Deadly Myths," which explores the common myths and empowers women to become or stay smoke-free. Urging physicians to play the video in their waiting rooms is a step to address the problem of smoking in women. CDC acknowledges tobacco dependence as a chronic condition requiring repeated intervention and promotes offering patients who smoke and are willing to quit a treatment identified as effective, whether it is counseling or approved medication. For those unwilling to quit, CDC recommends physicians offer a brief intervention to increase patients' motivation to quit. Sixty eight percent (68%) of people who try to quit do so without assistance, and CDC finds most people still think the best way to quit is without assistance. Yet there are ways clinicians can help. CDC calls on health plans to look at two of the new Health Plan Employer Data and Information Set (HEDIS) measures, one asking whether patients received support and assistance to

quit smoking and the second whether they received a medication to help them quit. Health plans can use these measures as a baseline and set targets to make progress within their individual plan. "We really think that whole systems have to make smoking cessation a priority if we're really going to get the kinds of change that we think we need to happen."

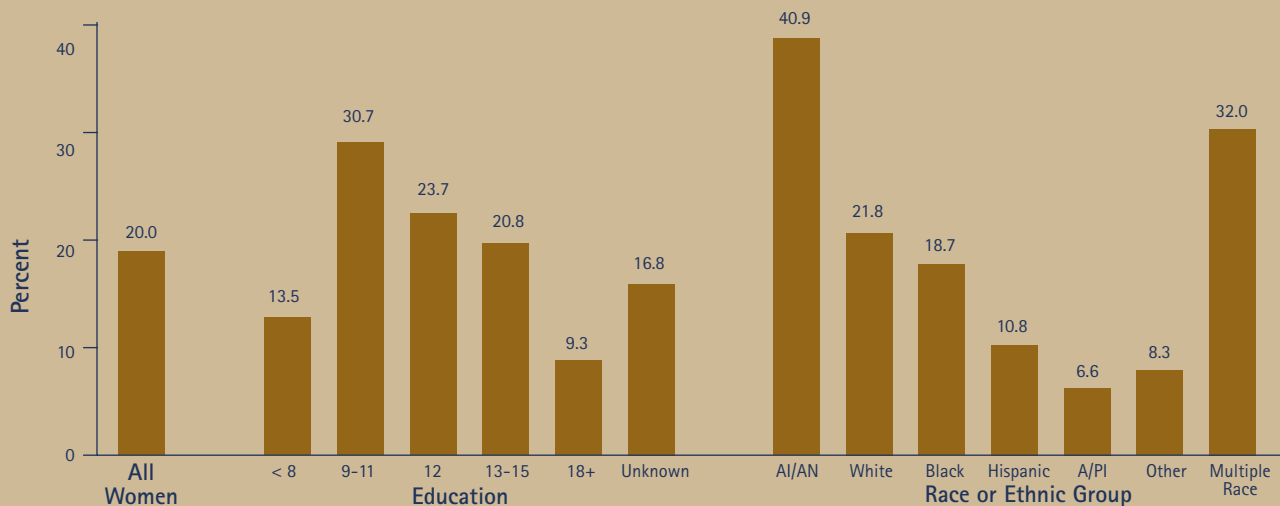
Another way in which CDC is working to promote smoking cessation is by working with programs and developing implementation strategies for reducing the patient out-of-pocket costs for tobacco treatment. One model program that has led to a national smoking cessation effort comes out of Group Health Cooperative of Puget Sound. The program, begun in 1990, provides screening, advice, behavioral support and offers nicotine replacement therapy (NRT) as a covered benefit. They have been successful in identifying 90% of their tobacco-using population by putting the ICD-9 305.1 code on their encounter form. Through an extensive effort to recruit smokers into treatment, about 10% of identified smokers complete their "Free and Clear" program annually, a telephone-based cessation program, with a 30% quit rate. CDC also has worked with the Office of Personnel Management (OPM), which negotiates health insurance for federal employees, to send out a carrier letter encouraging health plans to provide more comprehensive coverage for tobacco control. This prompted the Blue Cross Blue Shield plan covering federal employees to change from a \$100 annual limit on coverage to now cover counseling and medication on an annual basis.

For those health plans considering changing their coverage policy, CDC offers a document outlining the importance of

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-Ms. Abby Rosenthal

FIGURE 3: PREVALENCE OF CURRENT SMOKING AMONG WOMEN AGED 18 YEARS OR OLDER, ALL WOMEN, BY EDUCATION, AND BY RACE/ETHNICITY - UNITED STATES 2002



Source: National Health Interview Survey, United States, 2002.

the benefit, what should be included and examples from groups with experience putting them in place. CDC has seen only a 3% to 5% use of the benefit, despite fears that every tobacco user will use it. An additional resource supported by CDC, in partnership with the National Cancer Institute and Cancer Information Service, is state Quitlines, which supplement health plans' tobacco cessation benefits. Quitlines are routed through a toll-free national access number, and every state is funded to start or expand its Quitline. **Ms. Rosenthal** encouraged health plans to work with their states to get people referred and also to receive feedback in terms of how effective the Quitline has been in addressing the needs of the referrals. CDC can assist with negotiating for Quitline services, which have shown 10% to 20% rates of smoking abstinence. Even in states where there is no Quitline, access to services is still available through the national line, which routes the calls to the National Cancer Information Service.

All of these programs, initiatives and resources are important to ensure the appropriate impact is being made on women about the value of quitting smoking to their overall health. Other areas where work continues is in increasing the price for tobacco, producing counter advertising and developing programs to prevent smoking in children and teens, such as CDC's "Got a Minute?" North Carolina also has Medicaid coverage for tobacco dependence treatment, and is working with the physician community to promote this, along with a major media campaign. Every state now has a CDC-funded tobacco control program with a coordinator position in its health department, in addition to funding for the Quitlines. CDC also works in other areas of women's health, and is home to the WISEWOMAN program, which serves under- or uninsured women age 40 to 64 in 10 sites around the country. There are also breast and cervical cancer screening programs in place, run through CDC's National Breast and Cervical Cancer Early Detection Program. More information on all of these CDC programs, as well as smoking cessation materials, is available at www.cdc.gov.

Other federal agencies are also working on women's health initiatives. **Sabrina Matoff**, Office of Women's Health, HRSA, shared "Bright Futures for Women's Health and Wellness." This initiative provides tools for providers to interact with their adolescent and adult female patients with a series of steps, including self-assessment questions, goal-setting and resources for further information surrounding physical activity and healthy eating. HRSA has also published "Women's Health USA 2004 Databook," with statistics on several women's health indicators. HRSA continues to work with other agencies involved in women's health that are part of the Community Health Center Network and are focused on prevention.

Ellen Hutchins, Division of Perinatal Systems and Women's Health of the MCHB, HRSA, explained the types of women's health grants currently funded by MCHB, including: programs offering screening for depression, family violence and alcohol, and the Division's public/private partnership with the American College of Obstetricians and Gynecologists (ACOG), which funds a resource center for fetal and infant mortality review. **Karen Hench**, program director for Perinatal Health at MCHB, shared the Division's work on demonstration programs to improve screening interventions for domestic violence during the perinatal period, which they hope will help in collecting new data to address what women seek when faced with this crisis and who they reach out to for help. They are also developing tools for employers regarding breast feeding, after finding initiation rates of breast-feeding in the U.S. of about 75%, but finding that the rate drops to 30% after women return to work. The hope is that these tools help employers understand the cost savings of supporting breast-feeding or developing a breast-feeding program, both in health care costs and recruitment and retention costs. These materials are expected to be completed by mid-2005 and will include resources for training human resource personnel and outreach consultants. Other tools under development in perinatal health include resources focusing on mental wellness and adaptation during the period of pregnancy and post-partum, especially understanding how to fill in gaps in the information women receive and better prepare them to deal with physical and emotional changes that have an affect on their relationships during this time period. **Lisa King**, the Women's Health Program Director at MCHB, explained the currently-funded women's health projects underway, which include 15 statewide initiatives to develop more competent systems of care for women, and new risk-reduction initiatives focusing on overweight and obesity in women of color.

Marsha Henderson, Office of Women's Health, Food and Drug Administration (FDA), shared the success of FDA's "Take Time to Care" program, a national campaign focusing on safe medication use and diabetes. The program coordinates about 400 national organizations, including health professionals, drug stores and businesses, to distribute millions of pieces of information using the media on various topics related to diabetes. Pueblo, the federal information clearinghouse, has selected "Take Time to Care" materials to be promoted in the IRS tax form mailing to four million Americans. FDA Office of Women's Health has also been approved to create charts for consumers with all approved products for topics such as depression, hormone therapy, lipid control, headaches or smoking cessation. FDA has worked with about 20,000 drug stores to engage them in the process of educating consumers by using FDA charts on tobacco cessation products. FDA plans a media campaign around the

charts, and believes their value-added is the ability to bring scientifically-based information on a product to the consumer, rather than the vendor perspective, that is representative of the risks and benefits of products, and then to promote counseling on the risks and benefits if they choose a particular product. FDA materials are available at www.fda.gov.

HEALTH PLAN INITIATIVES

Pamela Graber, M.D., Medical Director, Anthem's Healthy Woman Program; and Virginia Watson-Rouslin, Senior Product Manager, Product Development, Anthem Blue Cross Blue Shield

Judith S. Black, M.D., Medical Director, Senior Products, Highmark Blue Cross Blue Shield

Maria Martins-Lopes, M.D., M.S., Medical Director, Women's Health, Horizon Blue Cross Blue Shield of New Jersey

Carol Mondello-Settle, M.P.H., Manager of Women's Health, Wellpoint Health Networks

Raising Anthem's Healthy Woman

Virginia Watson-Rouslin introduced Anthem's Healthy Woman (AHW) program, begun in 1998 as a unique collaboration between Anthem's health care management and marketing/sales divisions and selected pharmaceutical companies. Anthem recognized the need to expand its focus on women's health beyond the scope of the traditional HEDIS measures. AHW grew out of the premise that women are the primary health care decision-makers not only within their families, but also at employers. Data illustrated heart disease as an increasingly serious problem for women, so Anthem decided to launch AHW with a focus on addressing the lack of awareness and information women receive about their health.

The program kicked off with five events in Cincinnati featuring **Dr. Bernadine Healy** (a cardiologist and formerly head of NIH). Anthem also published inserts in all the major city magazines on women's health and piloted a series of newsletters co-branded with Procter & Gamble on women's health issues. This proved to be a valuable experience, according to **Ms. Watson-Rouslin**, due to Procter & Gamble's understanding of the consumer, which was a perspective Anthem needed to understand in the infancy of the program. In addition to the primary focus on heart disease, AHW also focuses on other women's health issues such as depression, osteoporosis and incontinence. The initial public events generated positive

publicity among those who attended, yet the return on investment (ROI) was difficult to measure.

In 2000, AHW moved from large public events to smaller worksite wellness focused events held for large employers such as banks, hospitals and department stores, with around 200 women in attendance at each event. The events were still centered around a national speaker and offered onsite cholesterol and blood pressure screenings. Employers were pleased with the results and there was significant improvement in the numbers of women attending. However, Anthem felt the ROI was not what it hoped. The target audience for the events changed again, this time to large brokers who sell health insurance directly to employers. Anthem's sales divisions are allotted a certain number out of the 10 events held across the Midwest to make available for their top brokers, who then extend invitations to women decision-makers at their prospective accounts or employer clients, often the human resource or benefit managers. Anthem works with hospitals in each city who provide the cholesterol, blood pressure, glucose, body mass index (BMI), body fat and depression screenings to attendees. According to **Ms. Watson-Rouslin**, "The other thing that made this better than just your basic health fair was having one of Anthem's medical directors on site – **Dr. Pamela Graber** – actually talking to women about their results." **Dr. Graber** discusses with attendees the screenings and additional factors that may affect their health that are not readily apparent from computer calculations, such as family history and their daily physical activity.

AHW events have evolved such that brokers compete for the events each year. Speaker panels include well-known individuals, such as Susan Dentzer of the NewsHour with Jim Lehrer, **Dr. Holly Atkinson**, author and physician and **Barbara McFarland**, a psychologist, author and motivational speaker, rather than celebrities who have had a disease. Following the events, **Dr. Graber** provides aggregate reports from the event to the brokers, who send follow-up emails to guests, and lists of hospitals and vendors. The hospital exhibits and screenings have also increased from the initial events, and additional Anthem vendors are now invited, such as massage therapists, fitness clubs and weight-loss counselors. The participants report that the events help instill the advantages of being proactive and taking care of themselves.

While women said they enjoyed the events, more concrete aggregate data on the success of the program needed to be tracked to determine Anthem's ROI. **Dr. Graber** noted that 86% of women attending the events rated their overall satisfaction with the event at a 9 or 10 on a 10-point scale. As a result of the activities offered at the AHW events, women reported they were more likely to exercise, change their diet or promote wellness at work,

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*—**Ms. Virginia Watson-Rouslin***

"If we can get women to ask this question [what types of exercise they can do] and the physician community to give advice, we are going to have more of us exercising."

-Dr. Judith Black

which was exactly Anthem's goal. Human resource and benefit managers are uniquely positioned within their companies to communicate the importance of women's health by sending ripples of wellness activity out to the community sparked by their experience at the event. To further track whether these women actually make the changes they set out to after the event, Anthem began to conduct telephonic follow-up surveys to inquire about their progress initiating wellness activities within their workplace (Figure 4). Out of the three events from which Anthem was able to follow-up with attendees, an average of 12% of women across 74 companies had some sort of wellness activity underway, 23% had started a new activity and 13% said they had an activity planned.

HP 2010 reports only 34% of companies with less than 50 employees offer a comprehensive health promotion program, with the goal to increase this to 75% by 2010. The results of the data compiled by AHW on worksite wellness indicate there is a long way to go to increase wellness promotion in the workplace. However, this program illustrates the value of educating women on their current health status and the importance of modifying their personal health behavior to ensure their future health. Anthem has chosen this program as one route to improving women's health by empowering women to

take charge of their own and their coworkers' health by implementing activities at their workplaces.

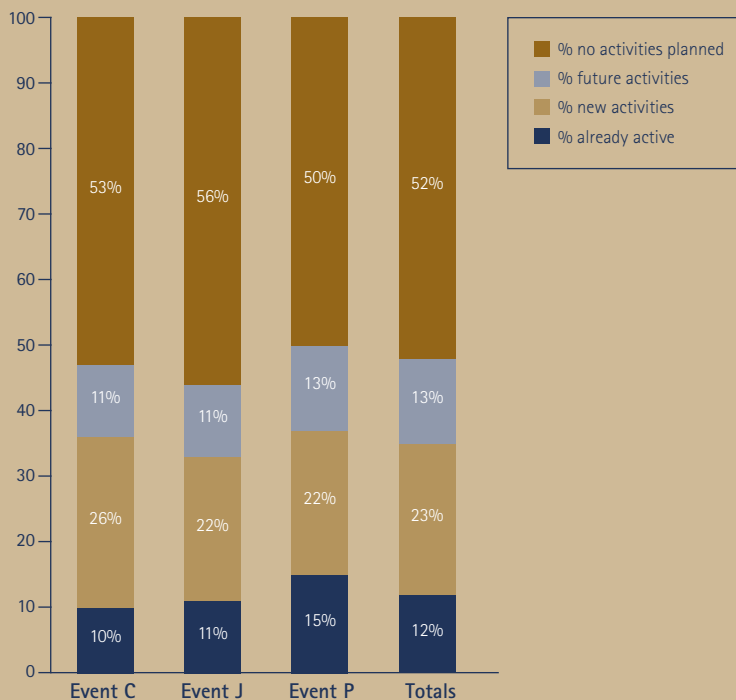
Health Plan's Partnerships and Health of Older Women

One size does not fit all for women's health, stressed **Dr. Judith Black**, thus an array of programs and initiatives need to be tailored when talking about addressing women's health. Highmark insures over 300,000 Medicare beneficiaries, more than half of whom are women, and has tailored several health programs to meet the needs of their female members. Their preventive health programs include telephone smoking cessation, lifestyle improvement programs and community-, hospital- and worksite-based programs. Highmark started offering the program at seven HealthPLACE centers in Pennsylvania, but found that members in rural counties could not always access services, so Highmark worked with community health centers and hospitals to offer the programs. Another program, Blues On Call, offers support for older women on chronic condition management, and decision support for arthritis, advance-care planning and breast cancer.

Managing or preventing osteoporosis is a major concern for all women, but especially older women whose lifestyles can be greatly affected by this disease. The Highmark Osteoporosis Prevention and Education (HOPE) program is an eight-week program developed by Highmark in 1999 to help members reduce fracture risk and improve quality of life through lifestyle modification. It is a multidisciplinary program of exercise, education about nutrition and medication, social support and stress management. Participants meet two days a week for two hours with team members: a registered dietician, an exercise physiologist, a group support facilitator, a program administrator, a medical director and a pharmacist. Highmark found that participants had improved knowledge, strength, flexibility, balance, fitness and nutrition. HOPE was then revised to a one day a week program for six weeks to make it more accessible to seniors, with one hour of strength training and one hour of lecture or activity.

Fitness programs have been an important component of Highmark's focus on older women's health. Beginning in 1999 in various forms at senior centers or hospitals, Highmark's fitness program now reaches 30,000 of Highmark's senior members through the Silver Sneakers program. The national Silver Sneakers program reaches 1.4 million individuals in the U.S. with 20,000 participants per day. It is no additional cost to Highmark's members, and they can visit any of the 130 fitness centers in the network in Pennsylvania or at any of the 800 fitness centers across the country. Members are more likely to participate if there is a fitness center within five miles of their home,

FIGURE 4: COMPANIES WITH NEW, FUTURE OR CURRENT WELLNESS ACTIVITIES AFTER AHW EVENT



Source: Adapted from Virginia Watson-Rouslin and Dr. Pamela Graber Presentations.

so Highmark worked to add more centers, especially in areas with high African-American populations (survey data indicated a lower participation rate). Early survey results of Highmark's Silver Sneakers participation found that 69% are women, 69% are overweight or obese and 74% never before had a fitness center membership. In addition, 69% were counseled by their physician to exercise more.

The concern for Highmark is whether the physicians counseled their patients on what type of exercise they should be doing. **Dr. Black** stressed the importance of women asking their doctor what types of exercise they can do. "If we can get women to ask this question and the physician community to give advice, we are going to have more of us exercising." An initial internal study completed in December of 2004 showed a 10% decrease in claims costs in a cohort of 11,000 participants in Silver Sneakers compared to a similar cohort within the health plan that was not participating in the program. The program has been extremely well-received in the community and is recognized by members and non-members alike. HOPE and Silver Sneakers emphasize to women that it is never too late to start caring about their health and doing something to improve it.

World Class Clinical Quality: Horizon Blue Cross Blue Shield New Jersey Women's Health Program

Dr. Maria Martins-Lopes explained that learning a behavior takes about seven attempts before it is modified. This reality influences Horizon Blue Cross Blue Shield of New Jersey's (BCBSNJ) proactive approach to women's health by providing education, technological outreach and forming partnerships with local and state initiatives. Horizon BCBSNJ began with the Healthy Woman Newsletter, produced quarterly (reaching approximately 1.2 million women) and including articles pertaining to health issues for every age group. Horizon BCBSNJ sends out bilingual reminders for annual exams, and has instituted outreach phone calls for screenings using interactive voice response (IVR). Through IVR, the caller can be linked to a vendor who can schedule appointments for screenings during regular business hours.

The data collected through the system has aided Horizon BCBSNJ's efforts to identify gaps in health care, especially the reasons women were not planning on receiving health screenings. For example, Horizon BCBSNJ found that:

- 57% of the population they surveyed had a mammogram and 43% had not. Of the 43%, 68% were planning to have a mammogram and 32% were not

- 51% had not received a pap test. Of those, 72% were planning to have one and 28% were not

The main reason women gave was not having the time for the appointments. Horizon BCBSNJ is working to connect these people immediately to schedule appointments through the IVR system, hoping to eliminate a step in the process and thereby overcome one of the main barriers identified. Through this analysis, Horizon BCBSNJ learned that physicians are not always recommending the screenings to their patients. The perception of members surveyed was that their physicians did not recommend a pap test 37% of the time and mammograms 49% of the time (**Figure 5**).

This illustrates the problem of fragmentation of care for patients who are seeing several physicians – the primary care physician (PCP) may assume that the OB/GYN has done the pap test or the mammogram, and the PCP may not have this full information in the chart. To address this challenge, Horizon BCBSNJ developed "All About You," which educates consumers to have discussions with their physicians. Horizon BCBSNJ compiles a list of members for each physician, which might include those who have not received a pap test or a mammogram, or who are not receiving pharmaceuticals (from a claims' perspective) they should probably be receiving. So when a patient visits her physician, information regarding areas on which the physician should be following-up are part of her patient record. This allows the physician to better coordinate care, address the issues, and take every opportunity to discuss her health and ensure she is receiving the appropriate preventive measures and medications.

Horizon BCBSNJ also recognized the value of communicating healthy behaviors beyond the patient-physician relationship. **Dr. Lopes** explained, "We formed a number of partnerships because we, too, realized that it wasn't just the health plan that could create change." The American Cancer Society and Horizon BCBSNJ teamed up to increase awareness of breast cancer in Newark through the "Let's Talk Sister to Sister," a faith-

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-Dr. Maria Martins-Lopes

FIGURE 5: TECHNOLOGICAL OUTREACH: MAMMOGRAM/PAP SMEAR BARRIER ANALYSIS

Reasons for Not Having a Mammogram:

- Too Busy - 52%
- Painful Procedure - 21%
- Afraid of Results - 17%
- Doctor **did not** recommend - 37%

Reasons for Not Having Pap Smear:

- Too Busy - 47%
- Painful Procedure - 8%
- Afraid of Results - 9%
- Doctor **did not** recommend - 49%

Source: Adapted from Dr. Maria Martins-Lopes presentation.

based program to assist with screening, detection and act as a cancer support group. Joining forces with New Jersey News, Horizon BCBSNJ has worked on a variety of initiatives and on-air discussions on cardiovascular disease in women, and raising awareness of the disease as the number one killer of women. Understanding the importance of beginning health education at an early age, Horizon BCBSNJ has led a number of efforts in New Jersey schools, including a program called "Shape It Up," a partnership with local schools and the Rutgers University School of Pharmacy. This is an educational program from kindergarten to fourth grade, and includes teaching healthy lifestyles, the food pyramid and how to read food labels. They find that children take the messages home and begin questioning their parents and grandparents, which can lead to even more change in the home.

Horizon BCBSNJ is working to expand their current women's health programs for the future, including addressing chlamydia screening awareness and prevention. They are also coordinating a campaign to educate consumers on preterm labor prevention and encouraging them to visit their OB/GYNs early to identify their risk and ways to prevent preterm labor. Horizon BCBSNJ also plans to focus on depression screening and management going forward.

Wellpoint's Chlamydia Screening Reminder Campaign

An important component of health education at all levels, explained **Carol Mondello-Settle**, is conducting a needs assessment. In polling the Blue Cross Blue Shield plans under Wellpoint, Inc., now in 13 states, to better understand some of the challenges in implementing a women's health program, the message returned was the importance of knowing the population. While it is important for a large health plan such as Wellpoint to implement a national women's health initiative, it is also important to understand the population at the regional level and to work with state and federal governments throughout the process. Without collaboration, the work would be even more difficult.

Wellpoint conducts monthly quality improvement (QI) work group meetings with representatives from each brand or affiliate. The Chlamydia Screening Reminder Campaign grew out of a recognized need to improve the chlamydia screening rates of the health plans under the umbrella of Wellpoint after a review of the plans' HEDIS scores for screening compared to national rates. On a national level, commercial health plans were screening 30% of their members, while Wellpoint screening rates were under 18% for the 16 to 20 age group. To address this disparity, Wellpoint developed a QI strategy to improve

the rate of screening of sexually active women between the ages of 16 and 26 for the next HEDIS measurement year. The focus of the programs is two-fold – partnering with physicians and targeting members.

The first step in involving physicians is educating them of the problem – that of reported chlamydia cases among women, 46% are 15 to 19 years old and another third are 20 to 24 years old. Left undetected and untreated, it is the leading cause of pelvic inflammatory disease (PID) and contributes to infertility, ectopic pregnancy, chronic pelvic pain and susceptibility to HIV. Women with chlamydia are three to four times more likely contract HIV (most women are unaware of this statistic). The goal of the Wellpoint program is to teach physicians about early detection via screening and treatment and how it can significantly reduce complications. In working with both patients and physicians, Wellpoint found barriers to screening for chlamydia (**Figure 6**).

After identifying the barriers, the corporate strategy to increase screening rates was to first implement the

FIGURE 6: BARRIERS TO CHLAMYDIA SCREENING, BY BOTH PHYSICIANS AND PATIENTS

Physicians:

- Lack of awareness about its prevalence
- Difficulty explaining how the disease is transmitted and discussing the importance of routine screenings for sexually active young women
- Unease about performing pelvic exams, especially on very young women (Wellpoint immediately addressed this by informing physicians of an easier urine test, in which pelvic exams are bypassed entirely)

Reasons for Not Having Pap Smear:

- Perception to seek treatment only when symptomatic
- Concerns among teens about confidentiality of testing (especially regarding their beliefs about sexuality and STDs, when they worry the doctor might tell their parents they have been tested)
- Uncomfortable with pelvic exams (as are doctors)
- Resistance to having a pelvic exam, especially if they have never had one

Source: Adapted from Ms. Mondello-Settle's presentation.

program in Blue Cross of California. To do so, Wellpoint worked with the California Chlamydia Coalition, other health plans, family-planning agencies and public health agencies – to define strategy and identify available resources, then create a corporate-wide QI work group to develop a framework for Wellpoint's affiliates. Wellpoint targeted physicians based on the barriers identified, and conducted physician and member mailings. The member mailings were based on claims data looking at those young women within the 16 to 26 age range who were sexually active, based on their use of oral contraceptives or having had a pregnancy test. For some of the affiliates, this was taken a step further using telephonic outreach normally used for pap test reminders, and adding a section where women could opt to listen to a message about the importance of chlamydia screening. Wellpoint also added articles in member and provider newsletters.

In the process of implementing the program, Wellpoint came across a roadblock in Georgia convincing physicians to sign on to the program. Georgia has the highest rate of reported cases of chlamydia among women in mainland U.S. (Alaska has the highest rate). Using the model of Blue Cross of California, Blue Cross Blue Shield of Georgia (BCBS of GA) developed similar strategies to address the problems there, including polling affiliate and network physicians for ideas on improving their HEDIS rates for chlamydia. They then convened an advisory panel of state and local health officials and private physicians to review the information gathered from the physicians to determine how to improve their clinical guidelines for chlamydia screening. BCBS of GA tailored the intervention based on what was learned in California and implemented it on a more regional level. In the initial implementation, Georgia encountered many barriers unique to their region and the physician attitudes of the region:

- 39% of physicians in the network disagreed with screening all sexually active young women between the ages of 16 and 26
- However, 61% of physicians surveyed from the network would change their opinion if the plan could prove that increased contact by the health plan and by the physicians would actually increase the chance that young women would seek screening
- Views that screening young women is unnecessary (e.g., if a young woman is married, then she is monogamous and does not need to be tested for a STD)

To address the physician concerns, the Georgia plan took the materials developed for the physicians and members to their internal review committee of legal counsel, clinical review, sales and marketing. This internal review caused additional barriers to arise, including opinions

that commercial members are not at risk for STDs (a concern only for the Medicaid population). Another challenge was the view that if the plan sent information to young members indicating that if they are sexually active they need to be screened, this might imply the plan is condoning sexual activity and trigger confidentiality problems and HIPAA violations when the plan's customer service fields calls from parents who have seen the chlamydia mailings sent to their daughters. In Georgia this was also a problem for the employer groups, with one group actually asking the plan not to send the mailing to their young members.

Now facing barriers from the physicians, employer groups, and even dissension within their own plan, BCBS of GA developed a second plan to address chlamydia screening. They created and distributed a general health brochure to women from 18 to 26 rather than 16 to 26, focusing on other screenings in addition to chlamydia. To encourage physician buy-in to the screening program, they enhanced physician education materials with proven studies about the importance of identifying and screening women with risk factors, stressing early detection and treatment as key to reducing complications caused by chlamydia. Finally, BCBS of GA educated their sales and marketing teams on the importance of HEDIS scores as the basis for how employer groups choose a health plan.

Wellpoint's message to others implementing women's health programs is to consider regional differences and allow for program flexibility at the regional level. As Georgia found, what works at the corporate level may not work on the regional level. At the same time, do not reinvent the wheel and work with coalitions of public and private sector organizations wherever possible to ensure the message is repeated from a variety of sources within the community, not only the health plan. It is also vital to take account for the social climate because attitudes and beliefs about teen sexuality and STDs are deeply rooted. On a health plan level, it is so important to know the audience and assess needs and risk, since time and time again health plans are faced with issues equally sensitive as this one. **Ms. Mondello-Settle** concluded, "Be innovative – this health plan wasn't just going to stop this intervention because physicians and people within the plan, or even employer groups, had difficulty with it – they were going to get the message out, it just had to be with a different vehicle."

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–Ms. Carol Mondello-Settle

NIHCM Foundation distributed a paper, "Women's Health: Prevention and Promotion" which contains a list of federal, state and community programs on women's health in addition to web-based resources. See <http://www.nihcm.org> to download a copy of the issue paper. Below is a list of additional resources for women's health information.

NAME	WEBSITE
Agency for Healthcare Research and Quality - Office of Women's Health - U.S. Preventive Services Task Force - Women's Health Highlights	http://www.ahrq.gov/research/womenix.htm http://www.preventiveservices.ahrq.gov/ http://www.ahrq.gov/research/womenh1.htm
Association of Maternal and Child Health Programs	http://rtckids.fmhi.usf.edu
Association of State and Territorial Health Officials - Maternal and Child Health	http://www.astho.org/?template=maternal_child_health.html
Centers for Disease Control and Prevention - Health Topic: Women's Health - Office on Smoking and Health	http://www.cdc.gov/doc.do/id/0900f3ec802271b0 http://www.cdc.gov/tobacco
Food and Drug Administration - Office of Women's Health	http://www.fda.gov/womens/default.htm
Health Resources and Services Administration - Office of Women's Health - Maternal and Child Health Bureau - Bureau of Primary Care, Office of Minority and Women's Health	http://www.hrsa.gov/womenshealth/ http://mchb.hrsa.gov/ http://bphc.hrsa.gov/OMWH/default.htm
Highmark Blue Cross Blue Shield - Highmark Osteoporosis Prevention and Education (HOPE) Program	https://www.highmark.com/hope/
Horizon Blue Cross Blue Shield of New Jersey - Horizon Healthy Woman	http://www.horizon-bcbnsj.com/members_resources_healthywoman.asp?urlsection=members
Indian Health Service - American Indian and Alaska Native Women's Health	http://www.ihs.gov/MedicalPrograms/MCH/Wh.asp
Institute of Medicine - Women's Health	http://www.iom.edu/topic.asp?id=3712
Jacobs Institute of Women's Health	http://www.jiwh.org/content.cfm?sectionid=64
Kaiser Family Foundation - Women's Health Policy - Statehealthfacts.org: Women's Health	http://www.kff.org/womenshealth/index.cfm http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Women%27s+Health
Maternal and Child Health Library - Knowledge Paths <i>Postpartum Depression</i> <i>Preconception and Pregnancy</i>	http://mchlibrary.info/products.html http://mchlibrary.info/KnowledgePaths/kp_postpartum.html http://mchlibrary.info/KnowledgePaths/kp_pregnancy.html
National Association of County and City Health Officials - Maternal and Child Health	http://www.naccho.org/topics/HPDP/mch.cfm
National Business Group on Health - Women's Health	http://www.wbgh.org/prevention/women.cfm
National Conference of State Legislatures - Children, Women and Reproductive Health	http://www.ncsl.org/programs/health/mchmain.htm

NAME	WEBSITE
National Governor's Association Center for Best Practices - Maternal and Child Health	http://www.nga.org/center/topics/1,1188,D_3782,00.html
National Indian Women's Health Resource Center	http://www.niwhrc.org
National Institutes of Health - Office of Research on Women's Health - NIH National Heart, Lung and Blood Institute: The Heart Truth	http://www4.od.nih.gov/orwh/ http://www.nhlbi.nih.gov/health/hearttruth/
National Women's Health Network	http://www.nwhn.org/
National Women's Health Resource Center	http://www.healthywomen.org/
National Women's Law Center - Women's Health	http://www.nwlc.org/display.cfm?section=health
Society for Women's Health Research	http://www.womenshealthresearch.org/
Substance Abuse and Mental Health Services Administration - National Mental Health Information Center	http://mentalhealth.samhsa.gov/
The Commonwealth Fund - Underserved/Minorities: Women's Health	http://www.cmwf.org/topics/topics.htm?attrib_id=9110
The Women's and Children's Health Policy Center at the Johns Hopkins Bloomberg School of Public Health	http://www.jhsph.edu/WCHPC_/index.html
U.S. Department of Health and Human Services - Healthy People 2010 - Minority Women's Health - National Women's Health Indicators Database - Office on Women's Health - The National Women's Health Information Center	http://www.healthypeople.gov/default.htm http://www.4woman.gov/owh/minority.htm http://www.healthstatus2000.com/owh/ http://www.4woman.gov/owh/ http://www.4woman.gov/
U.S. National Library of Medicine and National Institutes of Health - Medline Plus: Women's Health Topics	http://www.nlm.nih.gov/medlineplus/womenshealth.html
Wellpoint, Inc. Anthem Blue Cross Blue Shield - Women's Health Information Area - General Preventive Care Guidelines - Health Promotion and Disease Management Programs	http://kentucky.anthemhealth.com/topic/womens http://www.anthem.com/jsp/antiphona/bcbs/secondary.jsp?site=bcbs&tstate=KY&role=member&tsecp=HealthInfo&tsecs=HealthInfo.PreventiveCare http://www.anthem.com/jsp/antiphona/bcbs/secondary.jsp?site=BCBS&tsecp=HealthInfo&tsecs=HealthInfo.HealthPrograms&tstate=KY&role=member
Blue Cross Blue Shield of Georgia - Healthy Living: Women's Health	http://www.bcbsga.com/healthyLiving/womensHealth/



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