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THE LOCAL HEALTH LINK

Stimulating Shorts from Frankfort

PUBLIC HEALTH PRACTICE IN A CHANGING ENVIRONMENT

-submitted by Rice C. Leach, MD, Commissioner, Dept. for Public Health

This article is the text of a speech Dr. Leach made to the leadership of the U.S. Public Health Service on January 4, 1998 in Bethesda, Maryland.

Thank you for the kind introduction. It is always a pleasure to be back in this area among friends with whom Mireille and I shared so many good times and to have a chance to see Dr. Koop again. I remember the time, he, Jim McTigue, Mireille and I had dinner in Denver several years ago. We ate most of the shrimp in the Rocky Mountain west and I had a chance to get to know Dr. Koop before I met Surgeon General Koop.

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It is also especially meaningful to be invited by the Anchor and Caduceus Society and the Washington, DC, Metro Branch of the Commissioned Officers Association to present the C. Everett Koop Honorary Lecture to the leadership of the United States Public Health Service.

As I am sure you know, public health workers across the country are concerned because "no one really knows what we do." Well, I can tell you that in Kentucky they may not all know what we do but they do know about the Surgeon General and they know about Surgeon General Koop. They don't all agree that tobacco is a drug to be regulated by the Food and Drug Administration, but many remember that hookworm, trachoma, and tuberculosis are much less dangerous today because the Public Health Service helped us solve those problems.

Our governor, Paul Patton, routinely refers to the state and county health departments as "The Public Health Service." It suits me fine that our governor talks about his state system and our national system in the same terms. Speaking of our governor, you need to know that he and our first lady, Judi Patton, have taken personal interest in such important public health issues as domestic violence prevention, breast cancer reduction, and prescription drug abuse. Not only is the governor interested in these issues, he is backing legislative and funding initiatives to do something about them. Having a governor who was a member of a county board of health and who knows what we can do for the state is a valuable asset in these challenging times.

My presentation will describe Kentucky, but the concepts apply across the country.

☞ what are the influences forcing us to change,

☞ how are state and local public health organizations responding to

these changes,

☞ how have my Public Health Service career experiences helped me as commissioner, and

☞ how might these changes impact public health at the federal level?

What are the influences forcing us to change?

In Kentucky it's money. There is less money overall, and there is less money for public health. Taxpayers and legislators are saying, "No more taxes!" Physicians and hospitals want to serve people insured by Medicaid. The Medicaid program needs to cut costs. Private medicine is competing for market share. Money is shifting from public health departments to the private sector, and less efficient operations are starting to suffer.

There are other important influences as well. Our state recently lost 5,000 well-paying garment jobs to overseas factories. Welfare reform may increase demands for public health services. We have turned up an unusual strain of tuberculosis in Clinton County, in the southern part of the state. But overall, it's the money.

How are state and local public health organizations responding to these changes?

Several things are going on at once. As the result of a Medicaid waiver granted in 1995, we are implementing a modified form of managed care for patients insured by Medicaid. Other less frequently discussed changes include community based planning, the Governor's Conference on the Future of Public Health, the strategic plan for public health, reorganization of the health department, and increased emphasis on population based public health.

Medicaid Managed Care

In 1992 then Governor Brereton Jones appointed a Health Care Reform task force to advise him on how Kentucky could slow the increases in Medicaid spending and redirect the savings into programs to serve additional medically indigent Kentuckians. The 1994 General Assembly incorporated substantial parts of the task force's work into a health care reform law. That law required all insurance carriers to offer benefit plans that would enable certain uninsured individuals to purchase health insurance at a reduced rate. The law did not authorize the Medicaid program to expand its coverage until the projected savings had actually occurred.

Two things happened. Several health insurance carriers declined to offer the special benefit package, stopped writing low cost coverage for healthy young adults in Kentucky, and left the state. The other significant event involved the Medicaid program. To achieve savings, the administration requested a Medicaid managed care waiver for the Health Care Financing Administration.

I was consulted regarding the impact of a managed care waiver on the public health programs. I advised that a full shift of the Medicaid dollars currently collected would result in a 50 percent staff reduction in local health departments and would significantly reduce our ability to serve the medically indigent and to meet our statutory mandates for disease control, public health education, etc. Such a change would also require a general fund appropriation of up to $25 million to make up for the loss.

The waiver request submitted by the state included a requirement for managed care organizations to meet certain public health objectives set from time to time by the Commissioner of Public Health and a requirement that the state and local health departments be actively involved in the planning and operation of any managed care entity. The administrative language allowed the state to use any of four implementation options: maintain the fee-for-service option currently in place, contract with at least two health maintenance organizations, select a limited number of providers as a demonstration project under the state's procurement authority, or allow providers to develop partnerships to serve populations of persons insured by Medicaid. The waiver was approved in October 1995, two months before Governor Patton took office. His administration elected to use the partnership option.

When the Medicaid department requested staff to assist them in partnership development, I assigned two of our best staff *full time* to the project. The decision to send two such valuable people did not sit well with some of my staff, but I sent them anyway because I wanted to be sure that public health concepts and public health requirements would be part of any managed care initiative. Medicaid contributes $2.5 billion to the state's aggregate health care spending of $9 billion. Getting in on the ground floor of such a large health care program was too good an opportunity to let slip away. I knew the two staff I sent would do excellent work, and I knew that they would be sure that key concepts were included. I also hoped they would do such a good job that the Medicaid department would seek our involvement in other areas of the program.

The assignments paid off. By the

time the first elements of the managed care program went on line November 1, 1997, state and local public health department staff had worked closely with everyone concerned. They had worked with the state Medicaid program, the partnership developers, and with individual hospitals and physicians to negotiate who would do what for whom. Public health was becoming recognized as an essential ingredient in any successful partnership. People who had generally talked *about* each other were not talking *to* each other and trying to work *with* each other. In fact, the physician leaders of the partnerships associated with the medical centers a the University of Kentucky and the University of Louisville commented before the state medical association and the legislative health and welfare committee that they had not only learned much about what public health departments could do but had realized that partnerships needed health department help if they were going to meet the state's expectations. To achieve full payment, partnerships must achieve certain outcomes, such as an increased percent of two year old children immunized on time, timely prenatal care, complete well child care, timely and complete Early Periodic Screening, Detection, and Treatment (EPSDT), and longer cancer survival through earlier screening, detection, and treatment of women-at-risk for breast and cervical cancer. Partnerships were also required to perform specific patient education and public health education objectives.

Each currently operating partnership has negotiated agreements with the local health departments. The agreement in the University of Louisville region emphasizes traditional public health activities such as immunizations, prenatal care, and well child care. The University of Kentucky region developed new relationships in patient and population education and case management for selected persons. There are problems and there are likely to be more; however, so far the groups are working together for the common good. In Kentucky, the Medicaid program expects public health *results* from its investment in clinical services and the partnerships have a chance to build a unique system. Consider the business they can generate if they:

☞ do as good a job for less money, or,

☞ do a better job for the same money, or,

☞ they see more people for the same money,

☞ they do a better job and see more people for the same money,

☞ they do a better job and see more people for *less* money.

If any or all of the above benefits take place, private employers will be lining up to work with them.

The regulations promulgated by the Medicaid department also permit clients of the partnerships to have direct access to health departments for certain public health services like immunizations, sexually transmitted diseases, prenatal care, family planning, and HIV services. The Medicaid department and the health department staff meet frequently to review progress to date, to discuss problems, and to anticipate potential problems so they can be addressed early on.

Planning Activities

In 1992 only a few local health departments were involved in community-based planning, and there was no state public health plan. Early efforts to stimulate formal planning were accepted where public health departments were being forced to change. In general, however, planning efforts were limited to deciding how to spend next year's money. In early 1995 the Department for Public Health worked with the Medicaid department and the state hospital association to develop a regulation governing the use of Medicaid Disproportionate Share funds. That regulation required each hospital receiving those funds to work with their local public health department to develop a plan to care for the medically indigent. At the same time, the state hospital association initiated preliminary discussions on community-based planning among their members and invited the public health department to participate. These two activities were important in bringing about community-based planning and prepared the way for the kind of meaningful discussions that would be needed to implement the Medicaid partnerships. Today over 75 percent of the county health departments are engaged in community-based planning.

A joint resolution to form a task force to discuss public health was submitted but not voted on during the 1996 General Assembly. I saw it as an opportunity for the state to have a meaningful discussion of public health without the pressure of a legislative session and took steps to get it done after the session. We found some unobligated funds here and there and obtained approval to use them to fund the Governor's Conference on the Future of Public Health. It was a three day brainstorming session during which elected officials, public health professionals, civil rights leaders, members of the media, ASG Jarret Clinton, and others were invited to share opinions. By the time it was over, there was general concurrence that the long term mission of public

health is the collection, analysis, and dissemination of information, enforcement of public health regulations, and public health education. The conference agreed that community-based planning for public health was the best approach.

My staff was pleased with the outcome because it validated some of our thinking and because we had made plans for a statewide strategic planning initiative. The strategic planning process has held planning meetings, developed a draft document, had regional focus groups review the draft plan and has involved over two thousand five hundred different people so far. The final document is ready and will be submitted early in the 1998 General Assembly for use by all concerned as health policy gets debated.

Departmental Reorganization

The state health department has experienced a 25 percent reduction in staff and a significant reduction in general fund support since I was appointed as commissioner in July 1992. These reductions have driven several changes. First, the amount of out of state travel to meetings has declined significantly. We attend fewer meetings, and we send fewer people when we do attend. There are advantages and disadvantages to diminished meeting attendance. The biggest advantage is that we have more people at home to help, and we spend less money on travel. The biggest disadvantage is less opportunity to share ideas and to learn from colleagues. I am also concerned that some might view our declining attendance as lack of interest and that we may be less likely to receive competitive grants and contracts.

A second significant change at the state level has been to adjust the balance between direct personal preventive services and population-based preventive services. In the late 1960's, the advent of the state Medicaid program created an opportunity to triple the state health dollar by funding an unlimited federal entitlement program. The General Assembly shifted general fund appropriations from the state public health budget to the Medicaid budget with the understanding that public health would make up the funding difference through billings and collections for clinical services. There is no question that local health departments made a lot of money from their cost based reimbursements for direct personal services, that they provided effective personal preventive services, and that public health indicators like infant mortality and communicable disease incidence improved. At the same time, this change in funding source shifted public health from the field to the clinic. Nurses were reassigned to the clinics to generate revenue and public health nursing disappeared from the organizational chart. Specialized clinical programs developed in response to categorical funding and the public health departments focused on the poorest 25 percent of the population--those on Medicaid and those who didn't have health insurance.

While all these positive things were happening through health departments' involvement, teenage pregnancy, substance abuse, domestic violence, homicide, cigarette smoking, sexually transmitted diseases, and the like were increasing among the 75 percent of the population who *did not use the health departments*. Finally, the number of public health workers with the skills, knowledge, and ability to manage a population declined to such a level that in five years I cannot recall a public health nurse responsible for knowing about a specific area of a county.

Years of gradually increasing funding were accompanied by a gradual acquisition of program specific resources and a decline in shared activity. This led to multiple lines of authority, conflicting messages on everything from public health practice to administrative practices and created major inefficiencies through duplication of effort. We have sixty-five information systems that do not communicate with each other and at one time had over 20 forms to fill out if a pregnant woman and her well child presented to a public health clinic as new patients. Reviews by the state auditor, consulting firms, and federal program reviews have confirmed the inefficiencies.

For a few years staff seemed to assume "this too shall pass." However, after the general assembly approved two budgets that did not restore the positions for public health, staff acknowledged that we were going to have to change the way we do business. To their credit, they accepted the commissioner's challenge to put the department together in a way that dealt with functions rather than programs. The basic work was performed *without* direct input from division directors. Previous efforts to have directors redesign programs had led to the conclusion that it was difficult for them to drop any program they were directing. The operating staff designed the new organization, and the leadership staff implemented it. By the time the reorganization became effective in late 1997, several key staff had already begun to work with each other in the new configuration. I like to think that asking those who had to do the work

to design the system had something to do with the relative ease with which we have adapted.

The new organization reestablished a public health nursing organization, and centralized the administrative, population, and clinical activities. Surveillance, analysis, and planning are part of Epidemiology and Planning. The approach strengthens the focus on the population and is more efficient but it requires greater internal communication and planning for Medicaid Managed Care and strategic planning for public health.

Relationships with Others

Working well with those you expect to do the work for you is critical. When I reported to Kentucky as an outsider, I brought one strong asset and one strong liability. My asset was that as a newcomer, I didn't know what was going on so I didn't have any biases. Within a few weeks some had determined that I didn't know what was going on because I was a newcomer and was, therefore, a liability. I was certain that the long term mission of public health was in regulatory activities, population based public health, and clinical services to the uninsured. Because of that I kept insisting that we define core public health issues in ways people could understand and that we figure out how we were going to pay for it before we got too busy fighting to keep the Medicaid business. For a long time, many of the 4,500 state and county workers thought just the opposite. These discussions were not easy; some were confrontational; and at one time, some folks were talking about asking the new governor to replace me.

It has taken five years of discussion and sincere effort to understand each other, but it has paid off because state and county staff have a better understanding of the other's requirements and they all understand that everyone will have to make unpleasant changes for the benefit of the system. Best of all, we have general concurrence on where we want to go and what steps we should take to get there.

Benefits of a Public Health Service Career

My career as an officer in the United States Public Health Service provided invaluable experience. Acquiring that experience involved thirteen moving vans, fifteen houses, seventeen assignments, and occasional economic losses. It enabled me to practice general and internal medicine, made me responsible for a tuberculosis register of 800 cases and a tuberculosis ward with 25 active cases. It made me chief of clinical staff of a large and small hospital, made me operations officer of a telecommunications project and exposed me to space age planning. It made me chief operations officer for all health care programs on the Papago Reservation and for the Aberdeen Area of the Indian Health Service and it made me chief executive officer of a large hospital. The Public Health Service enabled me to serve as a physician on a state hospital association board of directors and on a state lung association. It made me a training program coordinator and a recruiter, it sent me to Panama and Guam as a public health advisor and to Texas as a physician for thousands of illegal immigrants. It enabled me to obtain a master's degree in health services administration, board certification in two specialties, and board eligibility in a third. It involved me in civilian preparations for Desert Shield and Desert Storm, and it allowed me to work closely with the medical programs of the United States Army, Navy, and Air Force. I represented the Public Health Service to the American Hospital Association, the Armed Forces Institute of Pathology, the National Library of Medicine, and the Uniformed Services University of the Health Services. It sent me home as a commissioner of public health and for a while it let me be acting commissioner of mental health. It even let me be sued and defend my management decisions in depositions by plaintiffs' attorneys. Finally, it gave me employment, medical care, and a future after being told I had a malignant melanoma as an intern. It gave me everything I asked of it, and it continues to give through a generous retirement.

The Public Health Service provided patients who taught cross cultural medicine, and it required me to spend many hours with everyday citizens, many of whom did not speak English or have decent housing or jobs. It required me to find out how to get along with people who didn't understand what we were trying to do, to get along with people who objected to what we were trying to do, and to get along with people who wanted to report the bad news about what we had done or had failed to do.

As a commissioned officer of the United States Public Health Service, I had an opportunity to participate in nearly everything that goes on in health care in the United States, and I was able to serve with some of this country's most dedicated health care professionals.

How These Changes Might Impact Public Health at the Federal Level

I predict that federal public health program directors are going to have to be much more responsive to state needs just as my department has had to become more responsive to the requirements of local health departments. I think that federal

public health programs are going to have to be much better coordinated internally than they have been in recent years. Pulling that off--without a Public Health Service, without a Surgeon General, and without a public health workforce with substantial personal experience working directly with states, counties, clinics, and average citizens--is going to be a bigger problem than it was years ago.

I came in at the end of the era when Public Health Service officers served significant tours as line providers in hospitals, clinics and health departments before going on to higher management and policy levels. Those opportunities and the opportunity to serve in a variety of organizations had nearly disappeared when I retired. It concerns me that so few people in public health understand the varying operational requirements of the people who actually do the service delivery. I worry that many in public health may not have the variety of experiences necessary to deal with the profound changes that are just around the corner. For example, do we know what to do if a substantial shift of Medicaid funds to the private sector requires private entities to achieve many of the federal public health objectives previously accomplished by health departments? Are the federal public health entities prepared to deal with coalitions that include the private sector along with state and local health departments? Will the existing rules allow this to happen? Are there rule changes that we should be considering now?

I am concerned that we are not working as well as we can to understand each other. In April 1996 state officials from three different regions were invited to Chicago to talk about outcome based programs. The meeting announcement suggested that this would be a collaborative effort to get states and federal programs on the same wave length. After a short time, it became apparent that the meeting was designed to get the states to support existing federal programs. Many, including colleagues from other states and others in the Kentucky delegation, thought the priorities and programs should be different. We were disappointed at the apparent lack of federal interest in our ideas. Guys, us home boys and girls elect the people that appropriate the funds you manage, and we meet them in places you don't. We see them over a beer at the races or at a problem solving meeting in front of the mayor and county officials. All of us in public health need to invest the time, energy, and patience required to be sure that we understand each other in this new environment so we can avoid situations where local officials complain about the way the federal folks do things. Today's funding and service delivery problems are nothing compared to what is going to happen as more and more baby boomers run out of gas and expect government to help them. The fight for dollars will not be fun, especially if we are not singing from the same song sheet.

I think those managing federal programs would be well advised to look for ways to relieve the states of overlapping efforts that don't improve the outcomes. Kentucky spends approximately $12 million collecting and analyzing public health information. Much of this effort duplicates the work of others and a lot of it is in response to federal grant and contract requirements. At my level it looks like the various components of the federal system have developed data requirements, data systems, and computer programs independently of each other rather than through a collaborative effort. This situation is not unique to Kentucky. The Association of State and Territorial Health Officers (ASTHO) has appointed a task force to work with federal agencies to address this issue.

Consider the following: Why do HIV, Hepatitis B and STD data have to be managed differently when they are all sexually transmitted diseases? Why do women's health issues like prenatal care, family planning, breast cancer, and cervical cancer have to be managed so differently when they all involve the same systems at different phases of a woman's life? Why can't well child care, immunizations, and communicable diseases be managed with the same system? The Indian Health Service figured out how to do that on the Papago Reservation nearly thirty (30) years ago. Surely we can do as well.

Federally mandated meetings are an increasing concern in Kentucky. Isn't it possible to hold meetings in travel hub cities instead of in places that add a day to travel time? Do we really need so many meetings? Can meeting times be shortened by having preliminary sessions via video conference or by requiring participants to read the material ahead of time? Has anyone looked at the total cost of all these meetings and related it to the benefits?

In closing, let me suggest that you read Fitzhugh Mullan's *Plagues and Politics* and the Furman book on the history of the public health service. I read both of them in preparation for a presentation on the history of public health and have become convinced that the answer to our future mission is clearly defined in our past. You will see that early on, we were out there, on the line, in the trenches, working side by side with everyday

people doing what they thought was important. By being there with them working on their problems, there was no question about whether or not the Surgeon General and the Public Health Service were worth keeping. We can regain that public commitment to our work if we remember that:

- We are here to launch the next generation.
- We are here to give them roots so they know where they came from and wings to get where they are going.
- We are here to help people be well.
- There is no such thing as "your side of the canoe is leaking."
- All of us are working for the common good, and
- All of us will be better off if each of us gives in to win.

Thank you for asking me to be part of 109th Anniversary of the Commissioned Corps of the United States Public Health Service and, as it turns out, to be the first batter up in this 200th anniversary of the Public Health Service. May each of us in our own way do our part to ensure that it will be here for the 200th anniversary of the Commissioned Corps and 300th anniversary of the Public Health Service.

Epi Epistles

ANNUAL VITAL STATISTICS REPORT 1996: Notice of Change in Racial Classifications

The forthcoming *Kentucky Annual Vital Statistics Report 1996* as well as other Kentucky State Center for Health Statistics reports will incorporate a change in presentation of data by racial classifications from white and nonwhite to white+other and black. This change has been necessitated by the discovery of a systematic, but slight, error in the calculation of birth and death rates by racial classification in the *Kentucky Annual Vital Statistics Report* from 1992 through 1995.

The Health Data Branch (a.k.a. the State Center for Health Statistics) receives yearly population estimates from the Kentucky State Data Center, University of Louisville, the sole source of population estimates used to calculate rates in all Branch databases and publications. For many years, the Data Center has provided estimates in two racial categories, white and nonwhite. Although racial classifications for vital events themselves (births, deaths, marriages, and divorces) are more specific (e.g., white, black, Amerindian, Chinese, etc.), these categories have consistently been collapsed in order to calculate rates appropriate to the white and nonwhite denominator populations. Thus, white and nonwhite rates have been published in the *Kentucky Annual Vital Statistics Report* for many years.

When the Branch received the estimates for 1992, we noticed discrepancies from what we had expected, and questioned their accuracy. We were then informed that the Data Center had changed its population model to produce estimates by two new classifications, black only, and white plus all other. We requested that we be able to continue to receive estimates by the white and nonwhite classifications in order to maintain consistency with past years. Subsequently, we received a slightly revised population file from the Data Center, and were led to believe that the file had been reformatted to fit our request. Believing we had files in the white and nonwhite classifications, we unsuspectingly used them and subsequent estimates as usual through 1995.

When the Branch began to provide health assessment data to local health departments in 1996, several departments asked if we could provide data for the black population exclusively. Early last year, in anticipation of our conducting a five year analysis of birth, death, and other data, we requested estimates of the white+other and black populations for 1991 through 1995 from the Data Center. After a series of vague communications with Data Center staff, we finally received estimates according to the white+other and black estimation model. The 1992-1995 estimates were identical to what we had thought to be white and nonwhite estimates, thus confirming that the estimates we had been using since 1992 had been misidentified. Obviously, the discovery of the misidentification of the population estimates meant that there had been a systematic error in the rates by racial classification in the *Annual Vital Statistics Report* and other Branch reports since 1992.

Those who had requested that we provide statistics for the black population alone had reasoned that the true black indicators were masked within the nonwhite classification, and, if they could be isolated, would yield rates higher than those for the general nonwhite population for many indicators, such as death rates, teenage birth rates, and others. It was generally assumed that our nonwhite statistics, when used as a surrogate for the black, presented a picture better than reality. In fact, however, by basing our nonwhite rates on the ratio of vital events for the entire nonwhite population to the smaller black population base, in areas where a sufficient number of events involving nonwhites other than blacks occurred, the resulting rates were higher than what was true for either the entire nonwhite population

or the black population alone.

Fortunately however, due to the demographics of the nonwhite population, the error has been very slight in all but a few areas. In most Kentucky counties, the numbers of nonwhite persons and vital events involving individuals who are not black are so rare that the published nonwhite rates are virtually, if not exactly, identical to the black rates. According to the 1990 census, 89.6% of nonwhite Kentuckians were black, and in many counties, the nonwhite and black populations were virtually identical. In recalculating 1995 birth and death rates for the black population alone for comparison to the published nonwhite rates, it was found that only 9.5% (559 / 5,892) of nonwhite births and 2.2% (61 / 2,754) of nonwhite deaths were to nonblacks.

In order to get a more precise measure of the magnitude of the error, a test of statistical significance was conducted comparing the 1995 crude birth and death rates for Kentucky, the fifteen ADDs, and the 120 counties by the two classification models: white to white+other, and nonwhite to black. No statistically significant differences were found at the 0.05 level between the white and white+other crude birth rates, white and white+other crude death rates, or nonwhite and black crude death rates. The only significant differences were between the nonwhite and black birth rates, and these were in only seven areas: Kentucky in aggregate, the Kentuckiana ADD, the Northern Kentucky ADD, the Bluegrass ADD, Jefferson County, Kenton County, and Fayette County. Only two of these areas, the Northern Kentucky ADD and Kenton County, exceeded a difference of 2.5 births per 1,000 population. Statewide, the black rate was 19.1, and the nonwhite rate was 21.1, a difference of 2.0 births per 1,000 population.

In order to present the most accurate information, the Health Data Branch will calculate future rates according to the white+other and black racial classifications, consistent with the classifications of the denominator populations. However, as this analysis has shown, with a few exceptions, reasonably reliable comparisons between most white and white+other rates, and between nonwhite and black rates can be made. (Incidentally, the five year analysis currently underway will be based on rates calculated according to the new white+other and black classifications, so accurate comparability will be possible for many major health indicators from 1991 through 1995 and beyond.)

For 1997, the State Data Center plans to issue population estimates in three categories: white, black, and all other. Such a disaggregation will allow greater user flexibility in handling the "other" population, but may also necessitate a major redesign of the *Annual Vital Statistics Report* and other publications.

Anyone desiring more information about the change in racial classifications may contact George Robertson at 502-564-2757 or by e-mail at grobert1@mail.state.ky.us.
-submitted by George Robertson, Division of Epidemiology and Health Planning

LANCING DEVICE CONTRACT AVAILABLE:
Last year, the Division of Laboratory Services developed and distributed "Specifications for Lancing Devices Used in the Clinic Setting". These devices are used to obtain fingerstick / heelstick capillary blood specimens for testing in local health departments. The specifications require a device which will allow for the collection of an adequate specimen while minimizing the risk of cross-contamination between patients and protecting the staff from accidental needle sticks.

In an effort to make an acceptable lancing device accessible to local health departments at the lowest price, a County Health Department Combined Services Contract has been established. The contract has been awarded to Grogan's Healthcare Supply for the "Soft Touch Safe-T-Stix" single use, disposable lancet. Local health departments are encouraged to utilize this device and take advantage of the pricing provided by this distributor. Use of this device is not mandatory; however, the device utilized must meet the specifications as indicated. Ordering information is outlined below.

Manufacturer: Boehringer-Mannheim Corporation
Product Name: "Soft Touch Safe-T-Stix" single use, disposable lancet
Product Number: BMD951
Product Price: $29.00 per box of 200 lancets (includes shipping and handling)
Contact: Alan Grogan
Phone: (606) 254-6661 or 1-800-365-1020
Delivery: Via UPS or Grogan's own regularly scheduled trucks

If you have any questions, please feel free to call Theresa Renn or Reita Jones at (502) 564-7996; or Donna Clinkenbeard at (502) 564-4446.
-submitted by Reita Jones, Division of Epidemiology and Health Planning

Lab Lines

MICROFLO PLUS™ TEST STRIPS ARE RELEASED
Medisense, the manufacturer of the Precision QID Glucose Testing System, has released the new Precision QID test strips called MICROFLO PLUS™ TEST STRIPS (L/N 97412-02). Medisense has noted some problems when trying to use the new improved test strips with the old controls. To avoid potential problems we recommend ordering the newly formulated controls (L/N 97411-02) along with your first order of new test strips.

Medisense cites the following Customer benefits with the MICROFLO PLUS™ TEST STRIPS:
➢ Test procedure remains unchanged
➢ Test strip design has been changed to include a new key hole channel in the sample area
➢ The test system is now approved for neonatal testing
➢ The hematocrit range has been expanded to 20 - 70%
➢ The sample size has been reduced by 30% (now 3.5 µL)
➢ The test strips have been calibrated to give 8-10% higher glucose test values*.

*Medisense explains this change in calibration was made to achieve direct correlation between the Precision QID fingerstick glucose test results and the lab venous test results. Medisense says generally a 10-12% difference was observed between the fingerstick tests results obtained with the Precision QID and the venous test results obtained in the lab. By raising the Precision test calibration by 8-10% the Precision QID test results should generally correlate with the lab venous test results.
-submitted by Donna Clinkenbeard, Division of Laboratory Services

Staff Spotlight

"Spirit of Christmas"
The ***"Spirit of Christmas"*** flourished at the **Whitley County Health Department.** Employees there collected 85 Food Baskets for the *Home Health Team* to distribute to their clients during the Christmas Holidays. The employees at **Whitley County Health Department** also collected toys and clothing through their *"Angel Tree"* for at least 90 children in the county. The staff of *Healthy Start* have collected additional toys and clothing for another 100 children. At the recent Christmas Dinner employees collected enough food for 5 food baskets as they came to the dinner. All of this was done through the generosity of the staff who have a genuine love and concern for their clients. **Whitley County Health Department** employees deserved a thanks from the community in which they serve, however they expressed to their ***Director, Ray Canady*** that they would prefer to have no publicity about their efforts to make Christmas a little merrier for others. Just doing it and having that good feeling of helping others was enough for them. **Congratulations Whitley County Health Department.**
-submitted anonymously, Whitley County Health Department

Training Tidbits

Training Opportunity: The Pediatric Pulmonary Centers (PPCs) of the University of Alabama at Birmingham, the University of Florida, Tulane University, and Louisiana State University-Shreveport are pleased to announce they will be hosting the fourth biennial pediatric pulmonary conference:

"ADVANCES IN PEDIATRIC PULMONARY CARE: INTERDISCIPLINARY APPROACHES TO ASTHMA AND HOME CARE OF TECHNOLOGY DEPENDENT CHILDREN"
to be held May 7-8, 1998 at the famous Peabody Hotel in Memphis, TN. The American Lung Association's Tennessee Chapter will cosponsor the meeting.

Presentations by the faculty of the Pediatric Pulmonary Centers and invited speakers will include:
➢ asthma medications
➢ hands on practice sessions with various asthma equipment
➢ asthma triggers
➢ guidelines on diagnosis and management of asthma from the 1997 Expert Panel Report
➢ American Thoracic Society guidelines for care of the child with a chronic tracheostomy
➢ home ventilation
➢ home options for enteral support
➢ technology supported children in the community
➢ smoking cessation
➢ interdisciplinary teams
➢ family centered care
➢ Bright Futures: Health Supervision for Children with Chronic Illnesses
➢ Improving adherence

A unique feature of this conference will be the opportunity for participants to attend "train the trainer" sessions and receive materials to educate others in their practice settings.

Fee for attending the conference is $100 for the full conference, $50 for one day, and $75 for Title V affiliated attendees. CME/CEU credit for physicians, nurses, respiratory care practitioners, dietitians, and social workers will be applied for. This conference is supported by the

Maternal and Child Health Bureau, Health Resources and Services Administration, Department for Health and Human Services.

For further information:
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RTC Training Courses Offered - FY 1998: The Regional Training Center (RTC), Atlanta, GA, will be conducting fifteen (15) training courses for local health department (LHD) personnel during the current fiscal year. These efforts are being coordinated through the Department for Public Health, Training and Development Branch. These are one-day sessions, and there is no fee for those individuals attending these courses. As you will notice, the training locations are being spread to more regions of the state to make the offerings more accessible to all LHD staff in an effort to reduce costs and to make it easier for staff to attend these trainings.

Information concerning the first ten (10) courses has already been mailed to District Training Coordinators and single county LHDs. The remaining mailings will be forwarded to LHDs approximately four (4) months prior to each training course. Course dates, locations, and titles are listed below.

3/27/98 Somerset
- Current Reproductive Health Issues-RNs

3/27/98 Lexington
- Evaluating Your Program

4/3/98 Owensboro
- Abnormal Pap Smears

4/17/98 Lexington
- Family Violence

4/24/98 Bowling Green
- HIV / AIDS Update

5/1/98 Lexington
- Orientation for New Family Planning RNs

5/21-22/98 Lexington
- Current Reproductive Health Issues-Clinicians

5/29/98 Ashland
- Counseling Adolescents

6/12/98 Dawson Springs
- Handling Difficult People

6/19/98 Morehead
- TB: Meeting the New Challenge

Should you have any questions regarding this information, please contact Bob Hurst at (502) 564-4990.

Videos on Loan: If you have any outstanding videotapes on loan for more than three (3) weeks, please return them to me at the address given in the Editor's Note. Thank you for your cooperation.

EDITOR'S NOTE:
Please submit articles, staff spotlight nominees, or suggestions for the newsletter to:
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