

“THE GOVERNOR IS *VERY* INTERESTED”

Or, Cost-Effectiveness Analysis for School Health Screenings

**A Teaching Case From the Strategic Training Initiative
for the Prevention of Eating Disorders**

**Harvard School of Public Health
Boston Children’s Hospital**

Written by Eric Weinberger

**Contact: S. Bryn Austin, ScD
Email: bryn.austin@childrens.harvard.edu
Phone: (001-)(617)355-8194**

STRIPED

**A PUBLIC HEALTH
INCUBATOR**

Strategic Training Initiative for the Prevention of Eating Disorders

TABLE OF CONTENTS

The provided case study narrative document includes:

- 1) Cover page, plus table of contents, synopsis, and acknowledgments (3 pages)
- 2) Cast of characters (1 page)
- 3) Case study narrative "The Governor Is Very Interested" or, Cost-Effectiveness Analysis for School Health Screenings" (11 pages)
- 4) Newspaper report, Columbia legislative session on new fiscal year budget (2 pages)
- 5) Datamon Consulting Checklist (1 page)

The case study text (item 3 above) refers to outside exhibits, including pages from a general-use booklet BMI Screening Guidelines for Schools (2009) distributed by the Massachusetts Department of Public Health (URL: <http://www.mass.gov/eohhs/docs/dph/mass-in-motion/community-school-screening.pdf>), and includes concepts from the teaching case companion technical document Guide to Analyzing the Cost-Effectiveness of Community Public Health Prevention Approaches (2006) distributed by U.S. Department of Health and Human Services (URL: <http://aspe.hhs.gov/health/reports/06/cphpa/report.pdf>)

SYNOPSIS

School-based health screenings could be utilized to enhance detection of weight-related problems such as obesity and eating disorders among youth. As health care costs continue to rise, health care decision makers – governments, schools, parents, insurers – will increasingly request information about the benefits of body mass index (BMI) and eating disorders screening, and subsequent treatment, relative to its cost. "The Governor Is Very Interested" is a view into the work of a state agency in the (fictional) U.S. state of Columbia that is staffed by professionals but is still, as such agencies invariably are, subject to state politics, budgetary constraints, competing priorities, and what may appear to be the whims of politicians, who often say they are responding to the electorate. If the state's leaders want to get health screenings underway for students in the public schools, how does a state public health agency participate? What contribution can cost-effectiveness analysis make?

In this case, the protagonist Nefertiti Nelson, a senior Columbia Department of Public Health (CDPH) official directing budgetary and management affairs, has been given the job of examining the cost effectiveness of BMI and eating disorder screening. With prompting and assistance by the governor's office, she is working her way through a process along with assorted CDPH colleagues with expertise in public affairs, health communications, and data analysis. Soon she and her staff decide that an outside contractor is best suited for the analytical cost-effectiveness work on this project, which means finding and preparing a contractor (Melvin Kuo, whose firm is named Datamon). As the story unfolds, we see the key decision points that the consulting team from Datamon face and the interworking of the politics of spending money to improve the health of the public.

ACKNOWLEDGMENTS AND FUNDING

This teaching case was written by Eric Weinberger for the Strategic Training Initiative for the Prevention of Eating Disorders (STRIPED; www.hsph.harvard.edu/striped) and the homework and in-class activity assignments by Dr. Mihail Samnaliev under the direction of STRIPED director S. Bryn Austin and co-director Kendrin R. Sonneville. We would like to thank reviewers for this case: Debra Franko, Jess Haines, Nancy Kane, Michael Long, Dianne Neumark-Sztainer, LeAnn Hyungi Noh, Susan Paxton, Mihail Samnaliev, and Davene Wright. We also thank Michael Long, Nancy Street, and all the students in Analysis of Public Health Issues (HP 606) at Regis College for their participation in the pilot evaluation of this teaching case. This work was supported by the Ellen Feldberg Gordon Fund for Eating Disorders Research and grants T71-MC-00009 and T76-MC00001 from the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

CAST OF CHARACTERS

In order of appearance

Nefertiti Nelson – *director of the Office of Management and Budgets for the Columbia Department of Public Health (CDPH)*

Jack Foy – *chief of staff for Columbia Governor Joan Franklin*

Joyce Kelly – *a senior public affairs officer at CDPH*

Jamie Tosh – *lead analyst in Nelson’s management and budgets office at CDPH*

Melvin Kuo – *managing director of Datamon, a private contractor specializing in data analysis, engaged to perform cost effectiveness work by CDPH*

Also appearing in smaller, nonrecurring roles:

Brian Yerevanian – *health communicator at CDPH*

Muriel Davenport – *a nurse experienced in obesity and eating disorder issues, working as clinical advisor for Datamon’s team on the CDPH contract*

Lucia Ramirez-Tengo – *CDPH officer working in child and adolescent health program areas*

* * *

"The Governor Is Very Interested," or, Cost-Effectiveness Analysis for School Health Screenings

Nefertiti Nelson wondered if she'd get to meet the new governor but she had to settle for her chief of staff, in whose windowless office next to the executive suite the meeting took place. "The governor is very interested in this work," he told Nelson, more than once. "The study you produce will get the governor's personal attention. She's a physician, as you know. She's been concerned about adolescents and eating disorders for a very long time."

"We'll do our best, of course," Nelson had replied. The story of the governor's interest was well-known. Before she ran for her first office, while still an emergency-room pediatrician, a teenage patient in her ward died of complications resulting from an eating disorder. The myth was that the resulting news coverage propelled her move into politics. In truth she had never told the story in public, but somehow everyone in Columbia knew about it.

The chief of staff, Jack Foy, was one of those persons who tended to tell other people what they already knew. Recounting the recent history of health screenings in Columbia's public schools, he described for Nelson, a senior official at the Columbia Department of Public Health (CDPH), the current hodgepodge of practices. No schools screened for eating disorders. Some screened for obesity, which meant that from students' height and weight they calculated body mass index, or BMI. Most that did screen were high schools; but some districts had ventured into the elementary schools. One of those was Foy's own district.

"It's funny," Foy said. "When I got the BMI report from school for my third grader just last month, I didn't understand it. The percentiles, how the information was presented. She'd gone from the 70th percentile to the 50th; did that mean she was less healthy? I mentioned it to the governor. She asked to see the form. Turns out that my daughter's in the perfectly normal range! But it took the governor of the state of Columbia to tell me that."

"Not all families in Columbia have that advantage," Nelson responded, perhaps too drily. Her colleague from public affairs squirmed a little as she said it. But, as ever, Foy was affable. "Exactly. So imagine what it would mean for all the kids in all the schools if we redesigned the form, revamped obesity screening and maybe added something for eating disorders, and we communicated to parents and families what they really needed to know about their kids' health."

Foy was affable, but darkened once during the meeting, if just for a half-second. In charge of CDPH's Office of Management and Budgets, Nefertiti Nelson, bless her, didn't always say the right thing. But it was her colleague from public affairs who caused the shift in Foy by blurting out at one point that many professionals in the field were skeptical about BMI screening and its use in preventing or reducing obesity. She mentioned a literature review from the United States Preventive Services Task Force, in 2007.

"Well, obviously we'll want to hear that point of view," Foy said, in a tone that suggested that would be among the last things he wanted to hear, "but I think at this stage it's important that we think holistically."

"Holistically?"

"The whole view. The whole child. BMI screening puts a major issue in public health in view of all our citizens. First comes awareness, then prevention. The governor supports that approach. I understand it's rather like what your people did recently with the billboards." Foy was referring to a CDPH anti-obesity campaign. "They showed the whole state the problem right there in pictures. Getting us ready for the next step, or, in other words, what are we going to do about it?"

Nelson wondered if Foy's boss, the governor, would have put it so blithely about "the problem right there in pictures." Highway billboards of overweight kids had been the single most controversial act in the history of her agency.

"We should have BMI screening for all, not some," Foy was saying. "But it might help to think of it as the price to pay to get eating-disorders screening, too, which all of us want. There's a lot we need from you, Ms. Nelson."

"What do you mean?"

"We're going to take some heat. Some new required program in schools is never what people first want to hear. We'll take the heat. But you give us numbers. Does screening—just obesity, or both if we include eating disorders—save lives? How many? Does it reduce health costs? By how much? And whose costs anyway—the state's? A family's, their insurance company's, which if it does, might mean premiums level off, or at least not rise too much? There's a very big picture here."

It came out so fast, Nelson struggled to write it all down.

"People get the wrong idea," Foy finished with. "They think it's one horrible tragedy every now and then they read in the paper. You and I know it's much more than that. There's a cost to society, a cost to our state. You folks will put a price on that."

The meeting ended, Nelson and her colleague in public affairs, Joyce Kelly, walked the several blocks back to their office at CDPH, reviewing the hour spent in Foy's suite. It wasn't just the governor whom Foy described as "very interested" in screening high school students. Obviously, that group included their top official at CDPH, the state commissioner of public health, the governor's latest appointee. It also included the Democratic and Republican leaders in the State Senate, delighted to have found a nonpartisan issue for which they could pledge their bipartisan support, when in the current political climate there was so little else in the chamber the opposing parties could agree upon. "This is our moment," the majority leader himself told Foy, in Foy's retelling. "The consensus and the will are there to make Columbia a national leader in tackling childhood obesity."

"What did he mean by 'national leader'?" Nelson asked Kelly. "Fourteen other states screen for BMI. Do you think he was mixing up the two? Thinking obesity screening and eating-disorders screening are the same?"

"It's quite possible; pretty likely, actually. One of our jobs will be making the distinction clear."

"You mean us—CDPH?"

"Sorry, I misspoke. Foy's job. Not yours or even mine, thank God."

"I just wonder—" But Nelson didn't get to finish the thought before Kelly interrupted. "This governor knows what eating disorders can do to people. A dead girl in the ER, she knows the price of delayed treatment only to end in the most tragic result there could be. Also the most expensive. If the majority leader or Senate don't understand that much yet, believe me, they will."

"It's complicated," Kelly added, a bit more softly. "The governor's here, the Senate's over there, we're somewhere in between. Mixed metaphor here, but, you know, we tease it out, one thread at a time."

Back at the department, Nelson and her colleagues in the budget office started worrying, as they always did, about costs. The price of screenings didn't appear to be something that came up when Foy and the majority leader conferred; when Nelson put the question directly to him—

"Will there be an appropriation to pay for it?"

—the affable Foy had managed to suggest there could be \$50,000 in the bill for CDPH.

But CDPH wouldn't be the only agency with costs. There were, after all, 152 public school districts across the state, and significant costs would inevitably accrue to all of them; Foy hadn't discussed that aspect. Nelson and her budget analysts went through some of those possibilities the next morning. Who would administer the screenings, any screening? The lone nurse for each high school,

for whom it would be an all-consuming task for between one and three weeks, depending on the size of the school, not to mention the time pulled away for the inevitable training session, or sessions?

Teachers—would they be involved, to relieve the burden on the nurse? But they had even less training or inkling of what would be demanded of them. Would CDPH hire and train its own screeners and send them around the state to spare the school staff altogether? And how much would that cost? Fifty thousand dollars in the bill wouldn't be nearly enough.

Then there was the question of what you *did* once you amassed this gold mine of information—in the aggregate, and individually for students and families. This came up in a second, sprawling session at CDPH the next day, with the MPHs and health communicators joining the budgeteers. “You don't just send home numbers to families,” one of the communicators said. “It has to be accompanied by useful information, like what to do next to stay healthy, or become healthier. And that's not a one-size-fits-all message.”

“Even before sending home the numbers and the practical information, there's the question, what does it all mean? Now that we know the BMI for every high school student in the state—“

“—every *public* high school student—“

“... every *public* high school student, what programs do we offer or sponsor that logically follows from those results?”

“And how much does it all *cost*,” said Nelson's lead analyst, Jamie Tosh, once discussion switched back to the budgetary folks, “as compared to what savings of any kind does it produce?”

“Yes,” agreed Nelson. For the benefit of the health communicators and epidemiologists in the room, she explained the trade-off: “What we call front-end versus back-end. Front-end is what it costs to do screenings—one screening, two of them, more, none. Back-end is costs saved by preventing obesity, thanks to BMI screening, or preventing eating disorders, since most of all we want the second screening, too. If you don't catch any of it early, it's expensive.”

“Well, how do you measure *that*?” asked one of the health communicators, who had never been in a room with the department's cost-analysis people. “Are you talking dollars saved?”

“It can be that,” Nelson said. “That's cost-benefit analysis. There's also CEA, cost-effectiveness analysis, when we measure health outcomes.”

The murmur that arose in the room suggested that, among the non-budget folks, there hadn't been the sense that these two approaches weren't the same.

Jamie Tosh provided an example for the season, since it was early October. "Say you immunize people in a workplace for flu. You might be more interested in outcomes like 'influenza cases averted' than dollar amounts. That's CEA."

"There's also something we call QALYs," Nelson added, "quality-adjusted life years. How many healthier years do our kids gain if we do this screening?"

"Sounds like magical thinking," the health communicator, Brian Yerevanian, said. "How do you measure the quality of a year of life? It's hard to wrap my head around."

"It's the basis of cost effectiveness analysis, Brian," Nelson said. "We do it more often than you think."

"Doesn't feel like it matters all that much, to be honest," Yerevanian said. "The governor wants it, the majority leader wants it, the minority leader is on board too. So we have to make it happen."

Nelson chose to sidestep the provocation. "Our next step is the CEA," she declared. "Personally, I find it fascinating. They do these BMI screenings in nearly half the schools anyway. Imagine if they're done properly. How much would it cost? What would we learn? This guy Foy in the governor's office, he was so pleased by some outside confirmation that his daughter was in good physical shape. I was touched, actually."

"That's his job, Nefertiti," Yerevanian said. "To have everyone who enters his office leave as if they've been touched personally by the governor's grace. Which isn't to say she or he is wrong, or that this screening is a craven bending to the winds of politics in the chamber. I have no view on the matter." He stood up. "Like everyone in the room, I want only what's best for the children of Columbia. My own skepticism is as nothing. When will we have the results of your analysis?"

"Probably in two months," Nelson replied. "First I have to figure out who will do the job for us."

*

Foy was on the phone to Joyce Kelly, saying something about the majority leader and health screenings. "Wait a minute," Kelly said. "Let me patch Nefertiti in on this call."

When she was on the line, Foy continued: "So the majority leader is now saying maybe two screenings is too expensive, maybe just one, maybe the BMI since a lot of schools do it anyway. That's not gonna fly here, you can imagine. The governor wants to know how the eating disorders screening will go, how expensive it's going to be."

"It's a questionnaire," Nelson replied. "It's a sheet of paper." Nelson swiveled around in her office chair, to face her cork-board where many such items were pinned. She started to read one of them, the ED questionnaire, called SCOFF, aloud. "Do you make yourself SICK because you feel

uncomfortably full? Do you worry you have lost CONTROL over how much you eat? Have you recently lost more than ONE stone”—Nelson broke off to explain how this Anglicism translated to 14 pounds—“in three months? Do you believe yourself to be FAT when others say you’re thin? Would you say that FOOD dominates your life?”

At the other end of the line, there was a pause. “That’s a screening?” Foy asked.

“It’s five questions,” Nelson replied. “All yes or no.”

“And what do you do with it? You get a certain number of yes replies, and a letter goes home to the parents?”

Nelson hesitated. Yes, that was likely the case: a letter home to parents. But it didn’t address the follow-up questions or consequences—would schools refer cases to physicians, call in parents for counseling, train staff to address individual cases internally? Probably none of those. She gave a safe answer instead.

“Something like that. I can have someone on our staff who really knows this stuff explain it.”

“Seems cheap. Seems easy. I’m suspicious. What’s the catch?”

“There isn’t one. Please tell the governor.”

Joyce Kelly took over the call, while Foy explained how the legislative process would work. BMI screening was already in the omnibus spending bill that was guaranteed to pass. The majority leader, once reassured (Foy promised!) that eating disorders screening posed no significant expense, would propose amending his own legislation by adding a phrase three words long—“and eating disorders”—every time “BMI” and “screening” appeared in a sentence together, right between the two words. He had the votes for that, too.

“By the way,” Kelly asked, “just how much money is in the bill?”

“One hundred eighty-plus million,” Foy replied. “Whatever it was last year, plus 1.5 percent.”

“No, I mean for BMI.” Foy’s figure would have been for all public health, for all Columbia, in the next fiscal year.

“Let me get back to you on that,” Foy said. Later that day, a PDF copy of the omnibus spending bill’s page 293 came in to Kelly’s inbox, which she printed. Section 36 mandated, in a list of ten items from (a) to (j), several new initiatives and programs; next to the second item (“b”) where Kelly hoped to see, at a minimum, fifty thousand dollars, Kelly saw, in parentheses, the following: “(\$30,000).”

As I should have expected, Kelly said to herself, and forwarded the email to Nelson.

“We got thirty grand to do CEA,” Nelson announced to her staff at the next meeting.

“What about doing it ourselves?” asked one of the analysts. “Wouldn’t that be cheaper?”

“Should we do a cost-effectiveness analysis of doing cost-effectiveness analysis?” Nelson replied, to laughter. “If we do it ourselves, I gotta have a 0.50 FTE for six months and that will cost plenty more. Our convening and admin costs will come out of the general fund. We’re going to do this for nothing, basically.”

“So who are we hiring for this plum assignment?” another analyst asked.

Jamie Tosh mentioned a firm they had used in the past, named Intuition.

“I don’t like that name,” Nelson said. “Seems to me if you’re trying to base a decision on data, using someone called Intuition is a bad omen.”

“Well, if that’s the case,” Tosh said, and named another firm, “what about Datamon?” The others laughed. “Who comes up with these names anyway?”

“Datamon is good,” Nelson said, “but let’s get the RFP out and see who bids.”

*

The Request for Proposals went out, three bids came in and were vetted; the winning bidder was indeed Datamon. Soon Nelson was sitting down in a conference room close to her office with Melvin Kuo, managing director of Datamon Consulting, to discuss the project. It was seen as a good sign that Kuo came bearing a checklist¹ that, from the get-go, he seemed determined to review mechanically.

Until, after twenty minutes, when they were still on item 1 (“Define the study question(s)”), Nelson moved gently to cut him off.

“It would be very helpful if your analysts came back to us with the fine-tuning. I can say we want to do CEA for BMI alone; BMI and eating disorders together; or nothing; for grades 2, 5, 8, and 11, except that we wouldn’t do ED for the second graders. That we want to do the screening in the spring of the current school year, reporting by June 1. That the individual results will go to parents, and aggregates to the school, the school district, and CDPH. For better or worse, we won’t have control or insight into what parents at home do with the information.”

“Are questionnaires an option? For the parents? Can we survey them?” Kuo asked. Nelson replied that she didn’t know.

“Knowing intent is very important,” Kuo said. “You get the results from the screenings. You said who the results go to, like parents and the district. What happens with that information, what health decisions are made, that we can measure? Or is it just for show?”

¹ See Datamon memo: *Checklist for eating disorder screening CEA*, case study narrative document page 12.

Nelson seemed to be biting her tongue a lot these days. But Kuo, who came in and so far seemed to be mechanical and undeviating, showed a deft touch. “Let’s discuss item 4, Perspectives,” he said, and added: “Perspective seems clear. You have a basically unfunded mandate. Government isn’t giving you money to give to schools. Or giving money to schools directly. Costs will fall on them—individually, or the district. Our analysts will frame it both ways.”

“We have costs too,” Nelson said. “Training, promotion, materials, coordinating—dollars we’d devote to other things, if we weren’t instructed to do this one.”

“Opportunity costs, then. Also in that category, the cost of diverting nurses to screen whole schools. On the basis of 3.5 minutes to do a student height and weight for BMI, and 2 minutes for the eating disorders questions—”

“Have you seen the ED screening, Melvin?”

In what seemed by now a familiar ritual, Nelson found herself reading aloud from the SCOFF questionnaire. “Some of these questions are going to result in silence. Or tears. Or long breaks between words. Two minutes... that’s just nuts. You might have to allow five to ten for some kids.”

“Aha,” was what Kuo said in reply.

“Also I wouldn’t assume the BMI screens will be a piece of cake. Weighing adolescents in school—have you tried it?”

Nelson had begun her conversation, or interview, hoping to stay general, but having delved so deep into the granular or particular, decided a shift was necessary. One of her strengths was delegation; skillfully, she steered Kuo into a smaller room with Jamie Tosh to pursue further questioning. The main thing, to Nelson, was that the deal was done. Datamon was signed up; their contract would arrive in the morning by courier. Depositing Kuo with Tosh, Nelson had a last question for him: “How did you coin the name Datamon, anyway?”

Kuo’s answer made her and Tosh laugh. First the “company” was just him—Melvin the Dataman, as he was known in grad school. Then two buddies joined him, becoming the “datamen.” A year later, two women were hired, but having become known in the city as the “Datamen” they didn’t want to risk dropping from view by an act of rebranding. “So we shifted an ‘o’ in place of the ‘e’ and lo, we were Datamon.”

*

The team Datamon assembled was to include a programmer, for coding, a junior analyst to start straightaway on a literature review, and one of Kuo’s partners, a Ph.D. like himself, to run the group. The Datamon folks were sharp. Many questions began descending, via email, on Jamie’s group at CDPH.

What was the time-frame for QALYS? A four-year electoral cycle might suit the governor’s staff, but four years wasn’t much of a span for worthwhile health outcomes usually measured in decades, or a lifetime. In four years, half the kids would still be in school! What about the risk of false positives, not to mention false negatives? And more.

Two days into the assignment, Datamon decided it needed a medical advisor, perhaps an M.D. but a nurse experienced in obesity and eating disorders would also work; someone they could bring in for an hour at a time when they met (on the phone would be fine) to guide them for each route they proposed to go down analytically. The value of this service became clear when the nurse called in to the first meeting to hear the group brainstorming for “Screening Day” at a typical Columbia public school and heard one of the Datamon team say:

“So we’ll need three scales in the gym, three stations like voting booths with a curtain in front of them, a nurse and two helpers so there’s one adult per station or scale—“

Ever so gently, the nurse, Muriel Davenport, steered them down the actual path, as it was done in most Columbia schools where BMI screening already took place. Privacy was paramount, also personal comfort—so no gyms, no kids or others milling around the dedicated space. Regarding staff for the BMI screening, you’d want one person measuring height and weight and another paying sole attention to accurate recording. Some kids were going to be upset about getting weighed; some would try to get out of it. Someone would need to be available for them, and not just scribbling down figures. None of it was assembly-line work.

When she said it, it seemed obvious, and it led the Datamon team to consider what other expertise they needed. Perhaps someone who had done similar screenings in another state? They could fly him or her in to Hamilton for a day, sharing the time and expense with CDPH, for that person to walk them through all the little steps they would surely overlook. By the end of the day they had found someone in Massachusetts, where BMI screening in the schools began in 2007, and who as a prelude to her visit e-mailed a booklet, “Comprehensive Growth Screening Program for Schools”² as a starting-point, or perhaps it was a re-starting point.

A week into the project, Kuo was home on a Sunday afternoon watching TV, aimlessly flipping through channels hoping for some athletic contest he could enjoy without having to pay too much attention. But he stopped at a PBS documentary about the new health care reform, as it appeared to be

² Department of Public Health *BMI Screening Guidelines*; <http://www.mass.gov/eohhs/docs/dph/com-health/school/bmi-screening-guidelines-for-schools.pdf>

covering a family that even with health insurance was struggling to keep up with their medical bills. They had a high deductible, which was one problem, but also the daughter in the family had an issue for which diagnosis was troublesome and a long time coming, involving multiple doctor visits, one hospitalization, out-of-pocket expenses for uncovered items, and much more.

But the program wasn't about Obamacare. Kuo realized it only slowly, as the story went on about missed school days, missed work for the parents taking the girl to appointments and so on. The documentary was, instead, about eating disorders.

"Christ," Kuo said softly to himself, thinking of his cost-effectiveness study for his new client, the state's public health department. They'd brainstormed for hours about all the foreseeable costs *to the system*—the schools, the department, the screeners—but never given thought to this whole other dimension, the cost to students and families. Should they? Reaching across his sofa for his smartphone, Kuo texted the team: *Check out Channel 2. Right now.*

Next morning the first email waiting in Jamie's inbox was from Kuo, and it said: "Worried about false positives for families that incur high bills and the insurers, not so much for school district or state department inflicting misleading diagnosis. False negatives problematic too. Really have to build it into the assessment." Forwarding the email to Nelson, Tosh appended her own observation:

"Yup, Datamon gets it."

*

At CDPH headquarters, Nefertiti Nelson was feeling some pressure. In charge of an unpredictable element within a sensitive statewide issue that, it was clear, was meant to unfold fairly predictably, she sought counsel once again from her colleague Joyce Kelly in public affairs. It was possible, Nelson suggested, the CEA would suggest there was no discernible improvement to health when you did BMI screening, or eating disorders screening, or both. And what then, when the governor was so very *interested*?

Kelly was reassuring, more or less. "First of all, it's out of our hands. The CEA is what it is, or will be what it will be, and all we need to be sure of is that we did it right. Second thing, leave politics to the pros. Believe me, Jack Foy will do whatever Jack Foy does, which is what the governor wants him to do, and that's regardless of any reports we produce in CDPH."

"Then why I am anxious?" Nelson asked.

"Because it matters!" Kelly laughed. "You know what they say about legislation and sausage-making? Well, for the first time, you got to see the sausage get made. That's enough to make people plenty anxious."

“I feel like I’m in a hall of mirrors,” Nelson said. “The problem looks different every time I turn. Someone just told me the principals will be happier if they’re shown that treatment could reduce absenteeism and improve test scores. The principals! They weren’t on my radar.”

“People get so hung up on the screening, they don’t even start thinking about the treatment,” Kelly said. “And what happens when you delay treatment. But insurers do. They see something like screening, and say it’ll cost us money right now, but none of the long-term savings are coming our way since it’ll take 5, 10, 20 years to really see the impact and reduced costs for health care. And yet we paid for it.”

Kelly’s phone was ringing. “A healthy citizenry ain’t cheap,” she concluded.

I guess, Nelson replied, and walked up one floor to where some of the subject-area experts in public health had their desks. She wanted to know if one of them, Lucia Ramirez-Tengo, had gotten in touch with the governor’s office to bring Jack Foy up-to-date on eating disorders screening and SCOFF.

“Oh, he’s quite the expert now, Nefertiti,” Ramirez-Tengo said. “You know what he was telling me? That since SCOFF can be self-administered, which way did we propose doing it? The student self-referring—he used that term!—or better done one-on-one at the school with a trained responsible adult administering the test; might that be more ethical and clinically useful? I told him I’d bring the question to the cost-effectiveness folks in the department.”

“Well, in that case it’s a good thing I came up here,” Nelson said.

“He said to say hi to you. He said to tell you the governor was very interested in everything, all of it. He said you’d get a kick out of that.”

For a second there was silence; then the two women burst out laughing. And found it hard to stop.

* * *

The website of the *Hamilton Daily Caller*, Columbia's oldest daily newspaper (since 1799)

- Home
- News
- Opinion
- Markets
- Tech
- Politics
- TV
- HDC Video

New 2015 Spending Bill Reflects New State Priorities

By Prudence DeWitt – December 8, 2013 07:28 EST

Dec. 8 (HDC) – On the first day of debate on the proposed \$809 million omnibus spending bill for the 2015 fiscal year, State Senate majority leader Damion Tebbit (D-South Hamilton) highlighted the significant improvements to the state's roads, bridges, schools and other infrastructure contained in the legislation.

“Everything here is an investment in Columbia's future,” stated Tebbit while introducing the bill on the Senate floor. “Our 20th century infrastructure needs upgrading to prepare Columbians for the 21st century. We can't let the opportunity go by.”

Expanding on his remarks, Tebbit noted the still-lingering effects of Hurricane Sandy on the state's shoreline and coastal towns, and said, “We have to take climate change into account when approaching these decisions. We have damaged roads and state buildings we're going to repair, and some we're not, because we know the next storm won't be that long away and will wipe them out again. There is sophisticated planning going on in all departments, thanks to Governor [Joan A.] Franklin and our partners in the federal government, and as legislators the best thing we can do is pass this bill and get the money to where it is most needed, most useful, and gains the greatest results or impact.”

Also contained in the legislation is the state's proposed \$189.2 million expenditure for public health and health care delivery for FY 2015, much of it directed toward clinics in impoverished urban and rural districts throughout the state, including three in Hamilton, one of which, in East Point, has been closed since storm damage from Sandy over one year ago.

An increase of \$8.1 million from the previous fiscal year budget for health, the bill allocates slightly larger sums for family planning services (\$6.9 million from \$6.2 million), and for counseling and other programs for children and families, as requested by Governor Franklin.

Formerly a pediatrician in South Hamilton, Gov. Franklin has expressed concern about the absence or quality of mental health services for residents particularly impacted by Sandy; a call to her office for comment was not returned. Asked about the governor’s involvement in the proposed public health and health care allocations, an aide replied, “Governor Franklin is interested in all things health-related, and always wishes we had more resources to spend on worthy programs.”

To contact the reporter on this story: Prudence DeWitt in Hamilton at PDeWitt@hamdailycall.com;

To contact the editor responsible for this story: Jonathan Prince at JPrice@hamdailycall.com;

About

- [About Hamilton Daily Caller](#)
- [Careers](#)
- [Advertising](#)
- [Press Room](#)
- [Trademarks](#)
- [Terms of Service](#)
- [Privacy Policy](#)

Support and Contact

- [Customer Support Contact](#)
- [Feedback](#)
- [Help](#)
- [Sitemap](#)

Stay Connected

- [Twitter](#)
- [Facebook](#)
- [Linked In](#)
- [google+](#)
- [StumbleUpon](#)

©2012 HAMILTON DAILY CALLER. ALL RIGHTS RESERVED.

To: Nefertiti Nelson, Director, Office of Management and Budgets, Columbia DPH

From: Melvin Kuo, Managing Director, Datamon Consulting

Re: Checklist for Planning Cost-Effectiveness Study for Columbia DPH

CHECKLIST FOR EATING DISORDER SCREENING CEA

Decision	Check When Complete
1. Define the study question.	<input type="checkbox"/>
2. Who will use the results of the study? Why does the client want cost-effectiveness analysis results? (e.g., community groups can use the data to educate on policy changes, policy makers can use the analysis to help them choose between competing policy options, etc.).	<input type="checkbox"/>
3. What is the perspective of the study? That is, are we considering the cost of eating disorders to the individual with the illness or to the society?	<input type="checkbox"/>
4. What is the intervention time frame? This period should sufficiently cover program start-up phase and full-program implementation. For example, consider the following: program start-up and ongoing costs and school schedule. The screening will take place once a year.	<input type="checkbox"/>
5. What is the analysis time frame? How long should we wait to see change in outcome of interest if the intervention is successful? For prevention strategies, the time frame should capture all potential costs, harms, and benefits of the program. However, we must consider how realistic and feasible data collection will be (i.e., very few outcomes might be detectable within a short period after screening, but very long-term follow-up is not feasible).	<input type="checkbox"/>
6. Identify data on cost to be collected: <i>a) Consider cost of illness (COI)</i> CDC defines COI as "the value of the resources that are expended or foregone as a result of a health problem." ¹ Think of COI as the cost incurred by a society or an individual due to untreated or prolonged illness. The cost can be divided into two categories: direct and indirect (e.g., Direct costs: Hospitalization, medication cost, emergency room use; Indirect costs: Loss of productivity due to illness due to absenteeism).	<input type="checkbox"/>
7. Identify data on cost to be collected: <i>b) Consider cost of treatment (intervention)</i> Cost of treatment indicates the price of intervention of interest. For this assignment, the proposed intervention is school-based screening programs. For example, consider labor cost of the people who will be carrying out the screening (school nurses, teachers), the cost of training necessary to execute the screening, cost of procuring paper survey material or setting up software for online surveys, etc.	<input type="checkbox"/>
8. Identify relevant health outcomes within each of the following time frames: short term (e.g., one month), intermediate (e.g., one year), and long term (e.g., 10 years or lifetime). a) Rank the outcomes we identified above on the level of appropriateness for CEA. b) How feasible is it to obtain data on the outcomes we've identified? If too difficult, what are alternative outcomes that will still reflect our outcome of interest? What assumptions are we are making regarding the alternatives as proxies for outcome of interest?	<input type="checkbox"/>

¹ "Cost Analysis: Cost of Illness | CDC Econ Eval Tutorials (E)." Centers for Disease Control and Prevention. <http://www.cdc.gov/owcd/eet/Cost/fixd/3.html>.