AHCPR Begins New Survey On Cost and Use of AIDS Health, Social Services

The Agency for Health Care Policy and Research (AHCPR) has launched a major new prospective study of the course and consequences of human immunodeficiency virus (HIV) infection in selected cohorts. The AIDS Cost and Services Utilization Survey (ACSUS) will provide policymakers and researchers with the most comprehensive and dynamic picture yet available of infected persons and their needs at each stage of their illness. ACSUS, which is estimated to cost $7.2 million over 3 years, will add important information to the growing data base of the Public Health Service on HIV illness.

Approximately 2,200 HIV-positive persons, including 200 children, will be followed over an 18-month period that began in April 1991. Women are being oversampled so that they will compose about 15 percent of the final sample. In the total sample, almost 40 percent of the patients will have a diagnosis of acquired immunodeficiency syndrome (AIDS) at the time of enrollment in the survey, and about 60 percent will be HIV positive but without AIDS. Approximately half of the latter group will include asymptomatic persons.

Survey participants will be interviewed at 3-month intervals about their health and functional status and their use of health-related services. Providers identified in each interview will be contacted; data on each enrollee's use of and charges for services will be abstracted from billing and medical records.

While most pertinent studies on the cost of AIDS and use of services focus on hospital treatment only, ACSUS will also include the costs of ambulatory care, nontraditional treatments, and support services. ACSUS will provide data on the extent and type of health insurance coverage held by sampled persons with HIV-related illnesses. In addition, it will provide data on the share of the costs borne by different payers and information on how these change over the course of the disease.

ACSUS Study Design

The ACSUS study population was drawn in a three-stage sampling procedure to select HIV-infected persons into the sample. In the first stage, 10 cities were selected for sampling that include both high- and low-prevalence areas: Baltimore, Chicago, Houston, Los Angeles, Miami, New York, Newark, Philadelphia, San Francisco, and Tampa. These sites were selected to provide geographic variation as well as a diverse patient population with respect to age, ethnicity, and HIV exposure category.

In the second stage, 26 primary medical care providers were selected to include public and voluntary hospitals and their outpatient clinics that serve a relatively high volume of persons with HIV-related illness. In a few cities, practices of primary care physicians were also included.

In the final stage, study subjects have been chosen by a stratified random sampling technique based on responses to a screener questionnaire administered at each of the 26 provider sites. An extensive security system is being used to protect the confidentiality of participating patients and providers.

Study Content

Preliminary findings will be available in early 1992. The final data base, expected to be available in 1994, will include a baseline demographic profile and exposure category for each respondent and sequential changes in insurance coverage, employment, sources and amount of income, living arrangements, social support networks, and family relationships. Use and expenditure data will be available by type of service (including hospital, physician, nursing home, home health service, mental and oral health services, and social services). Importantly, additional patient-specific data will include sequential changes in disease staging, diagnoses, barriers to receiving needed services, functional status, and quality of life.

Uses of ACSUS

Despite its size, breadth, comprehensiveness, and cost, ACSUS is not statistically representative of the U.S. population with HIV-related illnesses. The lack of a national probability sample, however, should not detract from the unique and critical strengths of ACSUS. It is the first multiple-site survey of HIV-infected persons driven by analytic needs rather than the imperatives of program evaluation. It is also the first longitudinal cohort study to ensure its diversity with respect to age, ethnicity, sex, HIV exposure category, range of services used, and sources of payment for those services.

ACSUS findings are best suited to understanding relationships between and among variables; they are less suitable for producing univariate national estimates. For example, ACSUS may not be able to tell us the total number of persons in the United States with HIV- related illness who are Medicaid beneficiaries. However, it will be invaluable in helping us to understand the relationship between public insurance coverage and access to medical care. At the same time, ACSUS will illuminate the transitional stages at which persons once privately insured "spend down" to Medicaid eligibility.

Further research and analysis will draw from the ACSUS data base to describe and understand the differential impacts and costs—fiscal, institutional, and social—of AIDS and other HIV-related illnesses. As approaches to HIV-related illness change in response to demographic, epidemiologic, technologic, financial, and health system changes, the initial study cohort will be supplemented by another cohort to enable ACSUS to be a continuing source of information and insight.

—FRED J. HELLINGER, PhD, Director, Division of Cost and Financing, Center for General Health Services Extramural Research, Agency for Health Care Policy and Research.

PHS to Award Healthy Start Funds for Maternal, Child Health in Fall

Approximately 10 areas of the nation will be awarded funds this fall by the Public Health Service (PHS) to improve infant and maternal health under the new "Healthy Start" initiative.

A total of $25 million will be available this year under the new initiative, which is to be carried out in high infant

death areas. Proposed funding for next year is $171 million. The initiative, which will continue over 5 years, is aimed at reducing infant mortality by 50 percent in the 10 areas. Techniques proven through the initiative will be applied in other communities throughout the nation.

The program was announced in the April 17, 1991 Federal Register.

The chosen Healthy Start project areas must have at least 50 infant deaths per year "to assure selection of communities with a sufficient magnitude of the problem to justify concentrating resources" but no more than 200 infant deaths per year "to assure projects of manageable size."

Project areas must also have an infant mortality rate of at least 15.7 per 1,000 live births, which is 150 percent of the national rate, using 5-year averages of official vital statistics data.

The limits mean that large cities as a whole generally would not qualify but neighborhoods within them could; so might several rural counties, or parts of them, that might apply together.

Selection of the 10 areas will be based in part on their commitment and involvement and the integration and increased accessibility of proposed services. In particular, communities will be asked to identify ways to encourage eligible women and children to utilize Medicaid benefits and to maximize other programs such as JOBS and WIC to address a wide array of health and social problems.

Consideration will also be given for innovative education programs designed to increase pregnant women's (and, where possible, future fathers') sense of personal responsibility and encourage them to become involved in comprehensive maternity and infant care as well as in an array of social and educational services. In addition, the areas must show strength in administration, financial management, and program evaluation.

Areas meeting the criteria probably will have significant populations of minorities with high infant mortality. While Mexican-Americans and Asians have lower-than-average infant mortality, the rate for Puerto Rican infants is 40 percent higher than for whites, and the rate for blacks is twice that of whites.

Of the Healthy Start Program Louis W. Sullivan, MD, Secretary of the PHS parent Department of Health and Human Services (HHS) said, "There is no statistic more important to this nation or to me as secretary of this department—and a father—than infant mortality, the risk of an infant dying before reaching a first birthday.

"Each year," he said, "the national rate goes down a bit. I'm pleased it dropped to 9.1 per 1,000 in the provisional data for 1990, but all groups have not participated equally in the decline and these pockets of high infant mortality have held the United States to 24th among the nations. This new program concentrates resources on these pockets, and produces new, innovative approaches as models to help reduce the toll nationally.

"Many approaches will be necessary, addressing specific community needs, and requiring improved coordination of all available resources, both public and private. Each of us has a vested interest in creating a climate of personal, family and community responsibility. Encouraging our nation's young mothers and fathers to choose healthy behaviors is key to reducing many of society's ills for both this generation and the next."

A goal of Healthy People 2000, a Public Health Service-led program to meet national health objectives, is to bring the national infant mortality rate down to 7 deaths per 1,000 by the year 2000.

HHS Assistant Secretary for Health James O. Mason, MD, who heads the Public Health Service, said, "Today, in communities with high infant deaths, the problems are basic—the community can't hire the doctors and nurses needed for prenatal or infant care, or they won't serve without malpractice insurance, or without an escort in a high crime area. The grants can be used to solve those problems.

"If the problem is teens getting pregnant too soon, with no family or spouse for responsible support and encouragement, programs should be aimed at that. If mothers are having low-weight babies because of cigarette smoking, or babies damaged by crack use, drug intervention programs can be aimed at helping them get off these habits.

"I'm very excited about what the impact of this program can be. When we find what works in a particular environment, there'll be a 'spill-over' effect into other communities with similar problems. All will benefit."

The Healthy Start Program will be administered by the PHS agency Health Resources and Services Administration.

New Reimbursement System For Nursing Homes Slated For Test in Four States

A new approach to nursing home payments developed at the University of Michigan (UM) and the Rensselaer Polytechnic Institute (RPI) may revolutionize the way nursing homes are reimbursed under Medicaid and Medicare.

Called Resource Utilization Groups (RUG), the new system is similar in concept to the Diagnosis Related Groups (DRG) used for Medicare payments to hospitals. The RUG will be the basis of a four-State demonstration project beginning in 1992.

"By replacing Medicare and Medicaid's standard flat fee per resident with an adjustable fee based on the amount of overall staff resources the resident requires, we are creating a fairer, more responsive nursing home system," says Brant Fries, Associate Professor of Health Services Management and Policy at the UM School of Public Health.

"The new system also will encourage nursing homes to accept heavy care residents at all care levels instead of concentrating on low-care high-profit residents," he adds. "That means heavy-care patients won't be backlogged in hospitals as they are now."

Although the RUG system is similar to DRG, there are important differences, Fries explains.

"Unlike hospitals, nursing home residents with the same conditions or diseases can be in the home for a day, a year or 20 years, so basing payments on episodes of care, such as a gall bladder operation, doesn't work."

Instead, the 29 major Resource Utilization Groups are based on the actual amount of nursing, therapy, and aide time spent daily in caring for residents with different conditions.

"We consider the resident's ability to carry out the activities of daily living, such as eating and toileting, as well as physical and mental condition in determining their utilization group," Fries says.

Residents with quite different conditions or diseases might fall into the same group because they all require the same amounts of staff time.

"For instance, residents with tracheotomies, ventilators, or on IVs or suctioning can require nearly five times as much care as the average resident," says Don Schneider, Associate Profes-

sor of Decision Sciences and Engineering Systems at RPI. "Consequently, they are all classified into the 'extensive-care' group." While developing the system, the researchers found that some assumptions made by nursing home staff about care time were incorrect.

"Nursing home staff members said that demented residents required the greatest amount of staff resources. But in fact," Fries notes, "we found that the typical demented resident currently gets about the same amount of staff resources as a resident who is mentally sound but seriously disabled. So, under RUG, nursing homes would be reimbursed similarly for those two types of residents.

"But, if nursing homes offered extensive mental rehabilitation to demented residents," he adds, "they would be placed in a more highly reimbursed group. Thus, the system provides an incentive to nursing homes to provide the best possible care."

There is an enormous range of use of resources, Fries says. The least demanding group is made up of frail residents who need only nursing supervision but have no support system and nowhere else to go. They make up about 15 percent of nursing home residents nationally.

On the other hand, the most dependent residents with major medical and respiratory problems get nine times more care.

"But they represent only 0.2 percent of all residents," Fries says. The pilot version of the system was developed by Fries and colleagues at Yale University in 1981. New York has been using a second version, called RUG-II, since 1986, as has Texas since 1988.

In 1992, Kansas, South Dakota, Mississippi, and Maine will begin using the newest version, RUG-III, in a four-State demonstration project sponsored by the Health Care Financing Administration of the Department of Health and Human Services.

Nebraska, Pennsylvania, and Texas will test RUG-III separately. The RUG-III system may be in use nationwide by the end of the decade, according to Fries.

"In 1980, 11 percent of the population was elderly. The projection is that by 2030, 18 percent will be elderly. More significantly," Fries adds, "the frail elderly, ages 85 and older, is the fastest-growing age group in the United States. Although nursing homes are only one part of the care system for the elderly, it is critical that we design them to encourage efficient, humane, high-quality care."

National Eye Institute Plans Nationwide Study of Age-Related Diseases

The National Eye Institute will fund a nationwide clinical study to track the development and progression of cataracts and age-related macular degeneration, both of which afflict the vision of the elderly.

The Age-Related Eye Disease Study, which the Institute said is the first attempt to follow the natural history of the two eye diseases, will be conducted at 11 research centers using Institute funds. The centers have begun recruiting study participants ages 60 to 75. The National Eye Institute is one of the Public Health Service's National Institutes of Health.

As people age, their chances of developing cataracts and macular degeneration increase markedly. More than 1 millon cataract operations are performed annually in the United States, while an estimated 10 million Americans experience visual impairment associated with macular degeneration during their retirement years.

Unfortunately, little is known conclusively about the specific factors that initiate age-related macular degeneration, a sight-robbing deterioration of the retina, or cataracts, a progressive and potentially blinding clouding of the eye's lens.

Several studies already suggest that both cataracts and age-related macular degeneration are associated with various genetic and personal characteristics such as race, smoking, and eye color.

Prospective study participants need not have cataracts or age-related macular degeneration to be enrolled in the project. They will receive two comprehensive eye examinations annually until the year 2000. During this period, researchers will monitor and collect data on how the eye ages.

The study, which will include more than 4,600 volunteers throughout the nation, will continue its recruitment until August 1992. Following this recruitment period, volunteers will have their eyes monitored for at least 8 years.

The study will be coordinated by investigators at each of the 11 sites and two resource centers—a photographic reading center and a statistical coordinating center—in conjunction with Institute staff members. The study center sites are in Potomac and Baltimore, MD, Atlanta, Harvey, IL, Boston, Royal Oak, MI, Albany, NY, Portland, OR, Pittsburgh, PA, and Madison, WI.

PHS Launches Action Plan on Women's Health Issues

A 39-point Public Health Service "action plan" for women's health will focus research and prevention activities on such diseases as breast and cervical cancer, heart disease, and osteoporosis. Also targeted for greater attention are women's smoking, alcohol abuse, and drug use.

The plan was ordered drawn up by James O. Mason, MD, DrPH, who is head of the Public Health Service and Assistant Secretary for Health of the parent Department of Health and Human Services.

Each Public Health Service agency will play a key role in improving the status of women's health.

- The National Institutes of Health will monitor the studies it supports to ensure that women are appropriately represented. NIH will also increase research on conditions such as osteoporosis, Alzheimer's disease, and lupus that have particular impact on women.
- The Centers for Disease Control will work to reduce smoking by women. If current trends continue, the smoking rate for women will overtake the rate for men by the late 1990s.
- The Alcohol, Drug Abuse and Mental Health Administration will focus attention on disorders that affect women disproportionately, including depression and anorexia.
- The Agency for Health Care Policy and Research will fund studies intended to show ways of improving access to health services for minority and low-income women and women with disabilities.
- The Food and Drug Administration will increase educational efforts about medical products of special interest to women, such as oral contraceptives and breast implants.
- The Health Resources and Services Administration will encourage grantees under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 to make services accessible to women.

NCI Offers Fellowships in Cancer Prevention

The National Cancer Institute (NCI) is offering an opportunity for persons with doctoral degrees in medicine, dentistry, public health, or philosophy to train in the emerging discipline of cancer prevention and control with its Cancer Prevention Fellowship Program.

The 2- to 3-year program provides independent research opportunities within the Division of Cancer Prevention and Control (DCPC) at NCI. Many training opportunities are available, including an academic course covering the current principles, methods, and practice of cancer prevention and control.

A new feature of the program is master of public health (MPH) training at accredited schools of public health during the first year for fellows accepted into the program.

Applications are due September 1, 1991. Fellows begin July 1, 1992.

The program provides for

- master of public health training (new feature)
- participation in the DCPC Cancer Prevention and Control Academic Course
- working at NCI directly with individual preceptors on cancer prevention and control projects
- field assignments in cancer prevention and control programs at other institutions.

Funding permitting, as many as 10 Fellows will be accepted for up to 3 years of training. Benefits include selected relocation and travel expenses, paid Federal holidays, and participatory health insurance.

Details on the program and an application catalogue may be obtained from Douglas L. Weed, MD, MPH, PhD, Director, Cancer Prevention Fellowship Program, Division of Cancer Prevention and Control, National Cancer Institute, Executive Plaza South, T-41, Bethesda, MD 20892, telephone (301) 496-8640 or 8641.

WHO Updates International Health Book for Travelers

The World Health Organization (WHO) has issued its updated annual guide, "International Travel and Health, Vaccination Requirements and Health Advice."

The 94-page guide provides authoritative advice on the medical and personal precautions needed to protect the health of travelers. Addressed to physicians, tourist agencies, airlines, and shipping companies, the book presents the latest information on general precautions to be taken by all travelers, health risks specific to different geographic areas, vaccinations recommended or advised, and vaccinations legally required for entry into each country in the world. Although the main emphasis is on prevention, country-specific information on common diseases may also help physicians track the cause of illnesses acquired abroad.

For malaria, epidemiologic details are given for all countries with endemic areas, including notes on geographic and seasonal distribution, altitude, and status of resistance. Further information on geographic risks alerts readers to the main arthropod-borne, food-borne, and water-borne diseases commonly found in different parts of the world.

Some of the important health hazards for travelers, including sexually transmitted diseases and risks from food and drink, and what can be done to prevent them, are also explained.

The book is available for $12.60 from WHO Publications Center USA, 49 Sheridan Ave., Albany, NY 12210.

AHCPR to Fund Study on How to Recognize A Heart Attack

The Agency for Health Care Policy and Research (AHCPR) of the Public Health Service has announced a study to see how people can best be taught to recognize when they are having a heart attack—the leading cause of death in the United States.

The goal in teaching people to recognize symptoms of heart attack has gained importance since the development of drugs to dissolve blood clots in the coronary arteries. This thrombolytic therapy can save lives and minimize damage to the heart—if given within 6 hours of the first signs of heart attack. But many people do not get to a hospital in time.

The study will be carried out in the Seattle area by the King County, WA, Department of Public Health under an initial AHCPR grant of $790,440, to be followed by further funding for a 3-year total of approximately $1.5 million.

The project will test different strategies and messages for teaching people in Seattle and King County to recognize signs of heart attack and to seek medical care promptly.

Researchers led by Mickey S. Eisenberg, MD, PhD, of the University of Washington School of Medicine, will compare the effectiveness of various approaches by examining the volume of calls to a 911 emergency telephone number and how long patients' heart attacks have progressed when they seek care. A total of 16 local hospitals are involved in the study.

Outpatient Visits Continue 11-Year Rise in American Hospitals

For every day of care provided to inpatients in 1990, hospitals recorded 1.5 outpatient visits, latest figures from the American Hospital Association (AHA) show. The statistics come from AHA's National Hospital Panel Survey, which tracks trends among some 2,000 community hospitals.

Outpatient visits began topping inpatient days of care in 1985. In that year, hospitals surveyed by the panel recorded 243.4 million outpatient visits and 226.1 million inpatient days. The 6-percent growth in outpatient visits for 1990 continues a trend that has been almost uninterrupted since 1970. Since then, surveyed hospitals have recorded a decline in outpatient visits only once, a 0.3-percent drop in 1979. The trend reflects hospitals' response to government and employer desires to cut health care costs, as well as consumer wishes for more convenient care.

Other trends from the AHA Panel Survey

- The overall hospital operating margin dropped from 5 percent in 1989 to 4.8 percent in 1990. If hospitals relied only on revenues from patient care, they would have ended the year in the red. Contributions, investments, and other nonpatient revenue made up the difference. These nonpatient sources totaled 5 percent of all hospital revenues in 1990.
- Admissions of patients ages 65 and older increased by 1.7 percent, continuing a 3-year trend. The gradual aging of the population fueled the increase.

• Admissions of patients under age 65 dropped by 1.6 percent, the ninth year in a row that the number has declined. The average length of a hospital stay decreased slightly for both those under age 65 and those older.

• The number of births in hospitals increased 1 percent. The increase was much lower than the jumps of 2.8 percent in 1987, 5.2 percent in 1988, and 3.1 percent in 1989. On average, newborns stayed in the hospital 2.8 days, down slightly from 1989 but down dramatically from an average of more than 4 days in the 1960s and early 1970s.

New Book on Health of Disadvantaged Offered

"Health Status of the Disadvantaged: Chartbook 1990," a succinct, comprehensive reference on health-related statistics of disadvantaged people, has been released by the Health Resources and Services Administration of the Public Health Service.

Offering charts, tables, and interpretive commentary, the new 148-page publication presents current data by which the status, progress, and some of the problems of the disadvantaged can he identified and assessed.

First published in 1974, the book is the fourth edition of its kind. It assimilates data from a number of sources in five broad categories: demographics, health status, use of services, financial expenditures for health services, and enrollment in health professions training programs. The chartbook is a distiliation of a more detailed sourcebook to be published later.

Copies may be obtained from Dr. Clay Simpson, Division of Disadvantaged Assistance, Health Resources and Services Admininistration, Room 8A-09, 5600 Fishers Lane, Rockville, MD 20857; telephone (301) 443-2100.

Hopkins Opens American Indian and Alaskan Native Health Center

The Johns Hopkins School of Hygiene and Public Health has opened the Center for American Indian and Alaskan Native Health to launch a focused, multi-departmental approach to disease and injury among these peoples that draws on the resources of the entire school.

Some of the major health problems among the Indians and Alaskans include injury, infectious diseases, diabetes, obesity, heart disease, suicide, alcoholism, teenage pregnancy, and diarrheal diseases, according to center director Mathuram Santosham, MD, MPH.

He said that injuries are the leading cause of death among American Indians and their injury death rate is three times greater than the American population as a whole.

Hopkins investigators have conducted studies of diarrheal diseases among the White Mountain Apaches since 1970. These studies have led to the first use of oral rehydration therapy (ORT) in a community-based program in the United States.

Another major study recently completed with the Navajo tribe was a vaccine efficacy trial against *Hemophilus influenzae* type B (Hib). The bacteria causes meningitis in American Indian infants at rates from 10 to 50 times those of other U.S. children. If not checked, the disease can cause brain damage, deafness, blindness, and death.

The school also is working with Navajo leaders to develop strategies against AIDS and substance abuse, which are not problems among the Navajo but which the tribe wants to prevent.

Rural Communities Suffer Poor Mental Health Care

Living in rural areas and small towns in the United States today may have special appeal for many people, but for those with mental illnesses, the experience can be difficult, perhaps painful.

First-hand accounts at a public hearing sponsored by the National Institute of Mental Health (NIMH) of the Public Health Service in Marshall, MN, called attention to the need for more research to address the special mental health problems of rural Americans.

The public testimony will be used by NIMH to build the mental health needs of rural Americans into its research agenda.

Researchers in certain rural areas affected by the farm crisis of the l980s have reported increases in depression and interpersonal problems, suicide, domestic violence, alcohol abuse, and homelessness. According to NIMH, rates for depression, for example, have doubled among some rural populations, and teen suicide is now the second leading cause of death among adolescents nationwide.

"Effective prevention and treatment are difficult to provide in rural areas," said one NIMH official.

Many rural residents at the hearing spoke about their experiences.

A teenager talked about her attempted suicide and pleaded for experts to do something to deal with the increasing suicide rate among youth. A woman with a mental disorder who lives in a small town described the problem of getting treatment and her struggle coping with the stigma that surrounds mental illness in her community. Mental health experts discussed the special problems of providing access to care in rural areas, particularly financing for treatment.

Witnesses also spoke of obstacles such as large geographic distances, severe weather conditions, scarcity of mental health professionals, and often higher poverty rates in their remote towns. And, they said, the traditional rural value that stresses self-reliance makes it difficult for them to seek treatment.

Environmental Conference Proceedings Available

Proceedings of the Fourth National Environmental Health Conference are now available to the public.

The conference, sponsored by the Agency for Toxic Substances and Disease Registry and the Centers for Disease Control of the Public Health Service and the Association of State and Territorial Health Officials, was held in San Antonio, TX, June 20-23, 1989.

Entitled "Environmental Issues: Today's Challenge for the Future," the 326-page volume of proceedings contains 47 presentations from the conference covering a wide spectrum of important environmental issues that include epidemiology and laboratory methodologies, individual environmental hazards, ethical and legal issues, communication and risk assessment, psychosocial factors, and institutional programs.

A few single copies are available without charge to State and local government agencies from the Office of Policy and External Affairs, ATSDR, MS E-28, 1600 Clifton Rd., Atlanta, GA 30333.

Copies may be purchased for $17 domestic and $21.25 foreign from the

U.S. Government Printing Office, Washington, DC 20402-9325.

HRSA Updates Area Resource File Data Base

The Health Resources and Services Administration's (HRSA) Bureau of Health Professions has completed updating of the Area Resource File (ARF), a computerized data base containing a wide variety of information on health facilities, health professions, health status, economic activity, health training programs, and socioeconomic and environmental characteristics for each of the nation's 3,080 counties. It is updated semiannually.

The latest version includes 1989 physician data from the American Medical Association; 1988-89 enrollments in schools of nursing, pharmacy, dental auxiliary, veterinary medicine, and podiatric medicine; 1988-89 osteopathic medicine graduates; 1989 hospital data from the American Hospital Association; 1987 mortality; 1988 local area personal income; 1989 Bureau of Labor Statistics labor force estimates; and 1990 population of veterans.

Plans are also underway to add special codes to aid in identifying rural areas to assist in work on rural and minority health.

Information regarding the Area Resource File can be obtained from the Office of Data Analysis and Management, HRSA, telephone (301) 443-6920.

Neighbor Networking Helps Depression, NIMH Learns

Nonprofessional helpers can be taught and then pass on to others different ways of thinking and acting to improve a depressed person's outlook and coping ability, according to a study funded by the National Institute of Mental Health (NIMH) of the Public Health Service.

The research, reported by Dr. William Vega of the University of California at Berkeley, suggests that it may be possible to reach large numbers of people early in the course of a potentially devastating mental illness, like depression, before it becomes so severe that intensive treatment by a health care professional is needed.

NIMH calls the public health significance of this study enormous because of the amount of suffering and disability that depression causes nationwide. The study demonstrates methods of helping aimed at decreasing that toll.

It was found in the study that low-income Mexican-American women suffering from depression could be helped by "servidoras," other Mexican-American women already active in helping roles in their communities. The servidoras were especially valuable because of their close cultural ties, particularly with regard to etiquette and interpersonal customs.

None of the women was seriously depressed at the beginning of the study, but some showed mild symptoms of depression. All were considered to be at high risk for serious depression because the disorder is relatively common among Mexican-American women ages 35-50, particularly if they are immigrants and of low socioeconomic status.

Researchers found that the helpers were effective in preventing more serious depression in those women who were mildly depressed. Further, those who more actively participated showed a greater decline in depressed feelings.

One of the project's most meaningful results is its demonstration of the usefulness of natural networking through community ties in preventing depression and other mental illnesses.

HRSA Publishes Report on Modeling, Forecasting

The Bureau of Health Professions (BHPr) of the Public Health Service's Health Resources and Services Administration has published the summary report of its Workshop on Modeling and Forecasting for the 1990s.

The workshop, sponsored by BHPr's Office of Data Analysis and Management, focused on the desirability of using a common framework of economic and health sector assumptions for all Bureau modeling and forecasting efforts.

The 43-page report summarizes the formal presentations and structured discussions of the more than 50 health services researchers from Federal and State government agencies, universities, and private research firms at the workshop.

The workshop's keynote address, agenda, schematics of BHPr models, selected references, and participant feedback are appended.

Single copies of the report may be obtained from the Office of Data Analysis and Management, BHPr, Room 8-47 Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857; telephone (301) 443-6936.

Erratum in Prenatal Paper

The title for table 2 in the article, "Problems in Estimating the Number of Women in Need of Subsidized Prenatal Care," that appeared in the May-June 1991 issue on page 335, should have read: "Four methods of estimating the number of births to women below 100 percent of poverty level, 1987, Region IV States."

Public Health Reports regrets the error.

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