GOVERNMENT OF THE DISTRICT OF COLUMBIA

Building on Success to Create a Model Health Safety Net for District Residents

Government of the
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Around the country, a growing number of public health departments are transitioning from health care providers to health care purchasers and safety net managers. According to an April 2001 article by the American Public Health Association,[1] more than half of the health departments surveyed have contracted out at least one service formerly delivered by the departments. The most commonly privatized services are those performed by public hospitals and clinics. A study of public hospital transitions across the country published by The Henry J. Kaiser Family Foundation reported that between 1985 and 1995, 293 public hospitals were privatized and an additional 165 closed. A more recent study by the Urban Institute assessed the impact on five communities (Milwaukee, WI; Boston, MA; Hillsborough County, FL; San Diego, CA; and Philadelphia, PA) that had undergone the privatization or closure of their public hospitals. Three of the communities have instituted comprehensive, community-based, primary care delivery systems (Milwaukee, WI; Boston, MA; and Hillsborough County, FL) and two (San Diego, CA; and Philadelphia, PA) increased services provided by their existing public delivery system.[3] The study surveyed public health officials, health care providers, and advocates in each location and found no indication that the privatizations and closures had resulted in diminution of access to health care or residents' health status; indeed, most noted that access had improved with the expansion of primary care delivery. Additional communities including Los Angeles, CA and St. Louis, MO have also closed hospitals and focused on building more integrated systems. In fact, as transitions from health care provider to contractor continue, public health dollars are increasingly used to expand primary care and community-based clinical delivery networks and increase access to necessary health services.

A Critical Time for Change

One of the District's greatest failures is its inability to significantly improve the health of its residents. One of the most significant factors driving privatization efforts in other communities is each locality's proportion of uninsured residents. A study by the New York Academy of Medicine of 20 community initiatives for the uninsured reported that "The large and increasing number of uninsured … have led many communities to design and implement a number of innovative approaches to health services for this population." The Urban Institute study notes that uninsurance can not only harm local economies and decrease the value of workforces but can also drive up the costs and impact of free care for providers and local government. This is true in the District with its high uninsurance rate of 14 percent of persons under age 65. The Urban Institute study reported that uninsurance rates were equally high in Hillsborough, San Diego, Philadelphia and Boston when their health system reform efforts began. St. Louis, which implemented a newly focused program four years ago, had an uninsurance rate of 15 percent in 1998.

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1 Keane C, Marx J, Ricci E. *Privatization and the Scope of Public Health: A National Survey of Local Health Department Directors.* American Journal of Public Health; 2001; 91:611-617

2 Economic and Social Research Institute. *Privatization of Public Hospitals.* The Henry J. Kaiser Foundation; 1999

3 Bovberg R, Marsteller J, Ullman F. *Health Care for the Poor and Uninsured After a Public Hospital's Closure or Conversion.* The Urban Institute, Assessing the New Federalism; Occasional Paper Number 39

4 Andrulis D, Gusmano M. *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* The New York Academy of Medicine; 2000

In addition to its high uninsurance rate, despite spending over a billion dollars on health services annually, the District has consistently ranked at the bottom for many key health status indicators. Unlike many communities turning to private sector providers to improve health status, the District has, and is developing additional, baseline data that will be tracked to assess program results. The lack of access to effective primary and preventative care is evidenced by the fact that District residents still suffer disproportionately from treatable and often preventable diseases. One critical example of this is the fact that African American men in the city are dying 10 years earlier than the national average. As of 1998, the leading causes of death in the District were:

heart disease and strokes (291 and 58 deaths per 100,000 people compared 208 and 60 nationally);
cancer (258 deaths per 100,000 people compared with 202 nationally);
HIV/AIDS (47 deaths per 100,000 people compared with five nationally); and
pneumonia and influenza (44 deaths per 100,000 people compared with 13 nationally).

The occurrence and severity of all of these conditions can be significantly decreased through education, screening, and early intervention. Equally important are the District's high rates of:

substance abuse (16 deaths per 100,000 people compared with six nationally);
infant mortality (15 deaths per 1,000 births compared with seven nationally) -- District babies are 30 percent more likely to be born dangerously underweight;
untreated diabetes -- over twice as many diabetes cases in the District end up in renal failure compared with the national average; and
high blood pressure -- over three quarters of District residents surveyed reported having been told more than once by their health provider that they had high blood pressure.

This data indicates that city residents are not receiving critical services. The city needs a health delivery system where a combination of health care centers and individual practitioners, located in every neighborhood, provide a quality and comprehensive "medical home" for every District resident. The District must also integrate its disease prevention, health promotion and tracking services to ensure that both medical and public health services work together in achieving a comprehensive safety net that dramatically improves the District's poor health statistics.

Developing and Implementing a New Way of Delivering Care

In addressing health statistics like those faced by the District, communities like 22 highlighted in the Urban Institute and New York Academy of Medicine reports are channeling increasing amounts of their public healthcare dollars into community-based primary and comprehensive care and are closing or privatizing their public hospitals. The studies evidenced several key factors in localities' decision making:

Returning to core public health functions by choosing to buy rather than provide services. In each of the communities studied by the Urban Institute, as well as in Los Angeles and St. Louis, the health providers, community advocates, and civic leaders interviewed noted that there was little call in their communities "to go back to the public hospital system. Almost all [respondents] saw the public hospitals as inefficient or unable to thrive in a competitive era." On the contrary, in most instances health services are generally regarded as improved. While the purchasing mechanisms may differ among the communities studied – fee-for-service care (San Diego, St. Louis) or "managed care-like" (Boston, Hillsborough, Milwaukee) – all focus on services

provided by community-based clinics, private hospitals, and integrated healthcare networks. At least two communities have almost fully privatized the management and delivery of health services for uninsured residents. Boston HealthNet is operated by Boston Medical Center, a private local health system with limited public oversight, and Saint Louis ConnectCare is incorporated as a nonprofit organization with an independent board of directors. While the Hillsborough County Department of Health and Social Services retains oversight of their safety net system, the delivery of services is contracted out to four health care systems that provide comprehensive services in each system's quadrant of the County. The NY Academy of Medicine report noted that "Many communities were able to use these initiatives as opportunities to build relationships between governments and the private sector …These new negotiated agreements have reshaped the way in which the private sector has assumed responsibility for the uninsured."

HEALTH SNAP SHOT:
HILLSBOROUGH HEALTH PLAN

Hillsborough County Health Plan was born in 1991 out of the Board of County Commissioners' desire to provide comprehensive medical services to the county residents (including Tampa, FL) and the determination to stem the rapidly escalating health costs that threatened the public hospital's survival and the County's ability to provide this critical care. Funded with a county sales tax, the Plan provides outpatient and inpatient care, mental health, dental and eye care, and pharmaceuticals delivered by four private health networks. The networks were selected through a competitive RFP process that required each applicant to be a fully integrated health care system that provides all required health services. Hillsborough provides care to over 27,000 unisured residents with family incomes at or below the federal poverty level. Over its nearly 10 years of operation, Hillsborough HealthCare has significantly reduced ER use and hospital admissions for manageable illness.

De-emphasizing hospital services in favor of outpatient care. While many of the communities that closed public hospitals did so without other health care safety net enhancements, the more successful transitions occurred in communities where corresponding increases in primary care and disease prevention services were put into place. In Philadelphia and San Diego, community clinic services were somewhat expanded to provide additional scheduled and walk-in services. In Boston and Hillsborough, comprehensive contracts were implemented replacing hospital-based care with comprehensive networks that included a choice of community-based health providers, specialists, and inpatient care. Health services in Hillsborough and Milwaukee also include prescription coverage. Boston Medical Center's management notes that giving uninsured residents HealthNet Pilot Plan cards has been "empowering." Rather than simply receiving care at crisis points from a hospital emergency room, providing participants with cards and selecting primary care providers gives individuals "a sense of belonging" and aids them in playing an active role in ensuring their own quality of health. Philadelphia has also experienced improvements in primary care access since the closure of Philadelphia General Hospital in 1977. Recent data indicates that between 1983 and 2000, expansion of Philadelphia's community-based clinical capacity has helped decrease the number of adults without a regular source of medical care by over 40 percent.[5]

Curbing uncontrolled increases in local costs and maximizing limited public health dollars. Each of the localities surveyed by the Urban Institute reported concerns in the 1990's that "public hospitals were too costly and that public operation made it hard to survive in increasingly

5 Philadelphia Health Management Corporation. Southeastern Pennsylvania Household Health Surveys; 2001

Selected Health Indicators Among Adults (age 18+) in Philadelphia

		1983	1987	1991	2000
Adults without a Regular source of care	*Percent*	11.0%	11.5%	11.3%	9.9%
	Estimated Number	185,700	186,300	179,200	104,600
Adults without an ambulatory medical visit for a year or more	*Percent*	18.9%	16.3%	15.0%	14.9%
	Estimated Number	319,000	264,100	237,800	156,600

competitive [hospital] markets." While it has been 20 years since Los Angeles closed one of its public hospitals, the County's health system continues to be challenged by high rates of uninsurance – over 25 percent (twice the national average) – and poverty – approximately 46 percent of Los Angeles' uninsured have family incomes below 125 percent of the federal poverty level. To more effectively serve this population, and avoid bankruptcy, five years ago Los Angeles implemented a public and private collaborative system utilizing a Medicaid waiver to redirect local and federal funding to support a network of community-based clinics located throughout the county. In increasing access to primary care, Los Angeles has been able to reduce the number of public hospital beds by 28 percent. St. Louis's public hospital closed in 1997 after multiple efforts failed to convert it to a self-sustainable private entity. The Hillsborough County Health Plan was designed and implemented through a community consensus process that determined that the skyrocketing uncompensated care costs threatening to bankrupt its public hospital could be stemmed through a competitive process that established regionalized, managed care-like, fully integrated health care systems.

Establishing a sustainable safety net that ensures access to care and improves health outcomes. Boston, Hillsborough, Los Angeles, Milwaukee, Philadelphia, San Diego, and St. Louis -- all set goals of building their primary care capacities in ways that will sustain a continuing decrease in their communities' dependence on hospital-based charity care. While several of these are only now beginning to assess the impact their hospital and clinical transitions have had on their health status, at least two – Milwaukee and Hillsborough -- have developed data that suggests they are headed in the right direction. Milwaukee's system is currently undergoing a thorough outcomes evaluation but initial findings indicate that emergency room visits have significantly declined and the annual cost per member has decreased by $700. Additionally, the amount of claims submitted due to inpatient and emergency care resulting from unmanaged diabetes and asthma has decreased by approximately 50 percent under Milwaukee's revamped safety net system. Los Angeles has experienced a 27 percent decrease in ER inappropriate use.

Since its initiation 10 years ago, the Hillsborough County plan has maintained a thorough utilization review process. During this period, emergency room use has decreased dramatically and admissions due to various treatable illnesses have improved significantly.

Chronic Disease Admissions Since Implementation of Heath Reform in Hillsborough County (% of all admissions)[6]

	1992-1993	1996-1997	1999-2000
Diabetic Complications	26%	3%	.03%
Asthma	9%	1%	.03%
Gall Bladder	10%	2%	.01%
Trauma		8%	.06%
Cancer		10%	8.00%

The average length of inpatient stay was also reduced by 50 percent. Each of these health improvements was achieved while Hillsborough was also able to improve service efficiencies and decrease per patient monthly costs by more than 50 percent from over $600 to below $300.

Conclusion

Each of these factors, and the experiences of communities that have already undergone comprehensive public health system reforms, are critical elements of the District's decision to dramatically transform its health care safety net. Hillsborough, one of the longest operating and most comprehensive efforts to transition from a system that depends on hospital-based care for its uninsured residents to community-based health centers, has demonstrated its ability to improve health outcomes while reducing exponentially growing costs. Initial analysis from Milwaukee also indicates that emergency room use, one effective indicator of the need for alternative systems, is decreasing. Consumer feedback surveys in St. Louis, Hillsborough, Milwaukee, Boston, and other communities indicate high levels of patient satisfaction.

The District's new **DC Healthcare Alliance** will move the city from *a healthcare provider* into the role of *healthcare purchaser.* Through this new safety net system and Department of Health's effective contract management, the city will achieve its goals of:

HEALTH SNAP SHOT:
MILWAUKEE COUNTY GAMP

*The Milwaukee, WI, **G**eneral **A**ssistance **M**edical **P**rogram (GAMP) was created in 1998 following the closure of public Doyne Hospital. To move from a provider to a purchaser of care, the County established a comprehensive health care system for its lowest income uninsured residents. The system includes all of Milwaukee County's 13 hospitals, 15 primary care clinics, 240 specialty care providers, and 25 pharmacies. GAMP operates as a modified managed care system where the clinics serve as primary access points and as care managers. Contracts provide for primary, specialty, and inpatient care; home health services, prescriptions and durable medical equipment. Providers are also required to provide access to urgent care. GAMP currently provides health services for 21,000 residents. In addition to having achieved significantly better cost management, the Program has received high consumer satisfaction ratings.*

Decreasing use of hospital emergency rooms and increasing use of primary care by ensuring that District residents have "medical homes" in their neighborhoods that provide comprehensive health services. Nearly 90 percent of the care provided by DC General Hospital

6 Bean P. *Hillsborough HealthCare:Embracing Change For Better Results.* County Administrator, National Association of County Administrators; December 2000

(DCGH) is delivered on an outpatient basis through its emergency room, primary and specialty clinics. The Alliance system will maintain this capacity at DCGH and provide additional access points throughout the city. Echoing Hillsborough and Milwaukee's results in decreasing ER use, the Alliance contract includes goals of reducing ER use by 10 percent, decreasing inappropriate hospitalizations by 10 percent and increasing primary care visits by 10 percent.

Providing quality inpatient and specialty services by purchasing care from existing facilities that have excess capacity will help maximize public resources. Managed care and the ability to treat more conditions in outpatient settings has decreased the demand for inpatient care and resulted in hospitals throughout the District having excess capacity. According to the DC Hospital Association, the District currently has 12 acute care hospitals, including Children's Hospital. Respondents to the Urban Institute interviews indicated that (particularly in the early years) when Milwaukee and Philadelphia's public hospitals closed, and Boston's hospital privatized, access to inpatient care did not decrease. Officials with Saint Louis ConnectCare also indicate that access has not decreased.

Encouraging public/private partnerships to expand care in underserved communities and enhancing the capacity of existing providers. The Alliance contract allows the District to focus on the services it most effectively provides and leave health care delivery to private sector professionals. Through this new safety net system the District will also free up resources to develop public/private partnerships that will expand the number of community health centers in underserved neighborhoods. To expand access to primary care Los Angeles combined its public funding streams, including a Medicaid waiver, to add contracted private community-based providers to its existing network of public health centers. The Hillsborough system, like DC Healthcare Alliance, provides medical care through private providers.

Increasing accountability through service delivery and utilization contracts that track and assess results and with effective contract management through the Department of Health. The District's health contract establishes measurable health improvement goals including patient outcomes that will be tracked and assessed to improve the system. One hallmark of Hillsborough's health system has been its ability to learn from its experiences and improve its plan through utilization review tracking and assessments. The District will contract with an independent firm specializing in utilization review to ensure that the Alliance contract is operating effectively and is truly leading to health status improvements.

In sum, building on the experiences of Boston, Hillsborough and Milwaukee, St. Louis, Los Angeles and other communities, the District is implementing a comprehensive, fully integrated health care safety net system that combines community access to primary care and pharmaceuticals with inpatient and specialty care. These and other communities have used their public dollars to purchase expanded primary and integrated services. The District's plan is ground-breaking in that it goes far beyond any of the systems highlighted in the Urban Institute and NY Academy of Medicine report through its implementation of a complete and fully integrated system that combines expanded primary care with access to pharmaceuticals, as well as dentistry, specialty, emergency, trauma, and inpatient care. Additionally, building on the experiences of Milwaukee, Los Angeles, and Boston, the District is committed to using its new Medicaid funds in implementing an 1115 waiver that will enable the city to combine increased insurance coverage with the Healthcare Alliance system's expanded safety net delivery system. When implemented, this system will also provide fully integrated school health, medical care for the District's corrections population, and targeted services funded through federal grant programs.