Recommendations from the Health Equities Committee

Policy Recommendations on Benefit Design that Reduce Health Disparities

1. **Promote equitable and fair sharing of health care costs.** Health insurance coverage with high deductibles and out-of-pocket costs disproportionately hurt low-income individuals ability to obtain needed care, further contributing to health disparities. Equitable cost-sharing policies take into account and attempt to minimize the uneven impact that cost-sharing arrangements may have on health care access.
    - Include public contributions for those with low incomes to purchase health insurance, sliding fee scales for premiums, and limits on copayments and other out-of-pocket costs so that people at the lowest income levels will face only nominal charges. Premiums are the preferred form of cost-sharing for public programs because people can regularly budget those costs.
    - Benefits should be extended to all Oregonians that protect against devastating financial losses and bankruptcy due to unforeseen catastrophic illness or injury.
    - Utilization and quality data should be regularly accessed to determine if cost-sharing policies are worsening or increasing health disparities. For example, cost sharing thresholds should be evaluated to determine when and if those thresholds become barriers to necessary care.
    - Design public programs for health care assistance that do not disenroll beneficiaries or deny primary care services to people who do not pay required cost-sharing costs but rather, maintain health coverage while taking action to collect debt. Oregon's experience with administratively disenrolling individuals from its Medicaid program who did not meet cost-sharing requirements led to massive loss of coverage with adverse affect. Results from the baseline Oregon Health Plan (OHP) cohort survey indicate that nearly one half (45%) of the OHP Standard population experienced disrupted or lost coverage in the first 10 months after the OHP redesign in 2003. OHP beneficiaries who lost coverage reported significantly worse health care as well as medication access and had significantly higher medical debt than those with stable coverage.[1]

2. **Remove any financial barriers and increase reimbursement for preventive services, chronic disease management, patient education programs and after-hours/walk-in primary care.** The benefit program designed should improve access to and utilization of appropriate services in an integrated health home and support community-based organizations to assist in health promotion. The benefit program should also reward patients who actively participate in their own care, through incentives for patients who follow through with the medical treatment plan agreed upon with their health care provider. Encouraging patients to receive treatment for early disease in the less expensive outpatient setting, rather than waiting until disease progression requires requires extensive inpatient care will benefit both individuals and society. The state

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should also encourage providers to expand availability to patients (e.g. operating during evening and weekend hours?). Patient education programs can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. For example, patient education programs have been found to be effective in reducing racial and ethnic disparities in pain control.

3. **Support direct reimbursement for Community Health Workers (CHWs) for publicly sponsored health programs.** Community Health Workers (CHWs), also known as promotores/as, Community Health Representatives (CHRs), lay health advisors, and outreach workers, among other names, are trained members of medically underserved communities who work to improve health outcomes. CHW programs have proven effective in teaching disease prevention, reducing barriers to care, improving patient-provider communication, and improving community health. Oregon can stimulate these programs by providing a variety of funding sources, including direct reimbursement. Establishing direct reimbursement may involve developing a certification system for CHWs. Any certification system should be designed and governed by CHWs and CHW advocates**.**

4. **Retain and utilize the Oregon Health Resources Commission (HRC) to analyze the cost-effectiveness of medical technologies and health services. The HRC should analyze the cost-effectiveness and health equity benefits of alternative and complementary medicine including, but not limited to, traditional Chinese medicine for the inclusion of such health services in the benefit design of publicly sponsored health programs.** Many diverse communities in Oregon are not limited to allopathic medicine as the only form of treatment for illness. This is especially true for communities that have specific cultural sensitivity or preference for a type of alternative or complementary medicine that may reduce health disparities. At the same time, finite public resources should be spent on medical technologies and health services that are evidence-based.

5. **Ensure that Oregonians have access to affordable evidence-based alternative and complementary medicine.** As noted above, alternative and complementary medicine can reduce health disparities by providing culturally specific approaches to improving health. These types of health services should also be vetted by the same standards as allopathic medicine and promoted in the commercial market of health care as allopathic medicine.

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Policy Recommendations on Providing Incentives for Healthy Individual Lifestyle Choices

- **Individuals purchasing healthcare with the assistance of a state subsidy will be provided with a Wellness Account where the state will deposit cash incentives for behaviors that will promote the individual's health. Some examples include:**
    - Developing a wellness plan with provider
    - Meeting weight loss goals established in partnership with a provider
    - Participating in a smoking-cessation program
    - Getting recommended tests and procedures
    - Chronic disease management activities

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Policy Recommendations on Data Collection and Quality Initiatives

In Oregon there is such a dearth of data related to race, ethnicity, and primary language in healthcare that it difficult to identify, let alone address, disparities in healthcare access, healthcare utilization, disease status, and/or quality of care. Where data exists, sources of are difficult to combine or compare due to differences in definitions and data collection protocols.

- **All healthcare providers and health plans participating in the Oregon Health Fund Program must be required to collect and report data on race, ethnicity, age-appropriate sexual orientation, gender, disability status, and primary language. These measures need to be included when assessing quality and ensuring transparency.**
- **In its role as convener and collaborator, the Quality Institute should be responsible for:**
    - **Training provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources, increase cultural competency, and reduce provider discomfort with collecting this kind of information from patients.**
    - **Developing a Health Disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.**
    - **Aligning resources to support quality healthcare across all demographic populations in Oregon.**
    - **Disseminating meaningful and accurate information on health quality and utilization of healthcare resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.**

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Health Equities Committee Policy Recommendations on Eligibility

- *It is a long held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.*

- *As consistent with current practices in the private marketplace, no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.*

In order for these two recommendations to be realized, the Committee felt that policy implementation options should be considered by the Oregon Health Fund Board.

For example, a preferred option from the Committee would be: *to establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the Oregon Health Fund Program for non-qualified [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] Oregon residents who are unable to afford purchasing health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the "play or pay" requirement of the employer mandate.*

The Committee recognizes that this option faces the following challenges:

- If revenue comes solely from businesses rather than community support—it may still prove to be economically infeasible;
- The administration of such a program may require limited state funds for implementation;
- Creating two entirely different programs based on eligibility creates equity issues;
- This program could be construed as implicit support for individuals who are not authorized U.S. residents; and,
- Businesses may oblige the "play or pay" requirement for "recognized" workforce and avoid "unrecognized" workforce unless the state actively identified individuals in the latter group.

However, the Committee also maintains this recommendation for the following reasons:

- The Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- No specific federal waiver would be needed if federal funds are not being utilized;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion;
- Businesses that heavily rely on a largely immigrant workforce will be included in the employer mandate and would also directly benefit from participation;

- If the Oregon Primary Care Benefit Plan is within the Oregon Health Fund Program it would combine all value-based purchasing advantages; and,
- Is less voluntary in design for employers and would therefore possibly prove to be more economically sustainable.
- The state would continue to benefit from federal dollars that support the CAWEM program, providing reimbursement for emergency hospitalization costs, including childbirth.

The alternative policy options the Committee considered:

Non-qualified Oregon residents may purchase their own health coverage either through the private market or through the exchange and are ineligible for direct state contributions.

Challenges:

- Oregon Health Fund Program would not be "universal" in that low-income non-qualified Oregon residents excluded;
- This option doesn't address the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- The "play or pay" amount from businesses employing non-qualified workers not provided to those workers.

Advantages:

- No specific federal waiver would be needed;
- Option takes 'hot button' issue of immigration off the table as something that may stymie or present a roadblock to bipartisan agreement for comprehensive plan; and,
- This option would be consistent with current public programs such as the Oregon Health Plan and the Family Health Insurance Assistance Program (which requires citizenship documentation).

All Oregon residents are to be eligible regardless of federal qualifications for state contributions to low-income individuals through the Oregon Health Fund Program.

Challenges:

- No federal match would be available for these individuals and the program would be reliant on state contribution only;
- Inserts 'hot button' issue of immigration into the comprehensive plan that may stymie or present a roadblock to bipartisan agreement; and,
- Inconsistent with the Oregon Health Plan that requires citizenship documentation.

Advantages:

- Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- Addresses both the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,

- The “play or pay” amount from all businesses going to all workers regardless of federal qualification.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Establish an 'Oregon Primary Care Benefit Plan' within the health insurance exchange alongside the Oregon Health Fund Program whereby foundations, providers, managed care groups, targeted employers, counties, cities and others may continually contribute funds, on a voluntary basis, that will be appropriated to provide subsidies to individuals that do not qualify for state contributions but are unable to afford purchasing health care without them.

Challenges:

- Not a guarantee of shared responsibility "play or pay" payment by businesses that employ non-qualified individuals;
- Voluntary basis of revenue source may provide an inadequate long-term economic feasibility, particularly if large industries such as hospitality and/or agricultural choose not to participate;
- If not financially viable, fewer people will be covered, violating universality due to enrollment caps;
- Creating two entirely different programs based on eligibility creates equity issues;
- State resources would be necessary for administrative costs due to eligibility determinations; and,
- Could be construed as implicit support for individuals who are not authorized U.S. residents.

Advantages:

- Comprehensive plan would be "universal" in that all Oregon residents eligible;
- No specific federal waiver would be needed and no foreseeable problems with federal match;
- This option avoids contentious immigration debate that could weigh down the comprehensive plan because new state dollars will not be appropriated for non-qualified individuals;
- This option would be consistent with the Oregon Health Plan (which requires citizenship documentation) for state contributions;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- This option allows a myriad of interested parties the opportunity to contribute to reduce the number of uninsured Oregonians

Health Equities Committee Final Recommendations on Policy Options that Promote Language Access

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each (ORS 415-056-0005).

Goal: To ensure health care services respectful of and responsive to the cultural and linguistic needs of Oregonians.

1. Take advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations that may be able to utilize and build on technologies being developed for telemedicine or telehealth.
    - State wide pool would include partnerships including but not limited to hospitals, clinics, language bank companies, video interpreter services, and community services, etc.
        i. As an example, partners in the pool could pay according to their percentage of services used the prior year.
    - Coordinate with statewide technology efforts, such as Telehealth, to build future infrastructure for the statewide pool, including video remote interpreting for Deaf people.
    - In planning for interpreter services, include organizations specific to ASL interpreters (such as the Oregon Registry of Interpreters for the Deaf), and disability/Deaf organizations (such as the Women with Disabilities Health Equity Coalition, and the Oregon Association of the Deaf) to ensure inclusion of video remote interpreting for ASL signers.

2. Seek federal matching funds for interpreter services through Medicaid. This targets provider organizations that serve Medicaid patients by making interpreter services affordable.
    - Promote video remote interpreting (and other telehealth technologies) as a viable option for health care providers.
    - Through a state plan amendment, make interpreter services a covered service rather than an administrative service, thereby eliminating the disincentive for providers to see non-English speaking patients.

3. Use state regulation to impose mandates with funds to off-set subsequent costs:

- Any plan that participates in the Oregon Health Fund Exchange must pay for interpreter services.

4. Create education partnerships so that more health professionals are also certified interpreters.
   - May be able to utilize existing partnerships through the Health Care Workforce Institute or other existing groups that work toward certification of interpreters.
   - As much as possible, interpretation must be included in the health professional's job description, protecting the employee's time and reflecting their dual roles.

Definitions based on the Healthcare Interpreter Oregon Administrative rules:

- "Limited English Proficient" (LEP) is a modifier used by the federal government to describe a person with limited English proficiency. "Person with limited English proficiency" means a person who, by reasons of place of birth or culture, speaks a language other than English and does not speak English with adequate ability to communicate effectively with a health care provider.
- "Health Care" means medical, surgical, or hospital care or any other remedial care recognized by state law, including mental health care.
- "Interpreter Services" is listening to a message of one language and providing an oral rendition of the same message in another language. An interpretation is to be complete and accurate and relay the meaning of the message from one language to the other, considering the context and the meaning of the whole phrase and not each word as if it were "standing alone" without context.
- "Health Care Interpreter" means a person who is employed as an interpreter working in health care who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into English, and who is readily able to translate the written or oral statements of other persons into the language of the person with limited English proficiency. Health Care Interpreter further means any individual paid as an interpreter working in health services, including mental health. As used in this section, the term "employed" means anyone who performs or is utilized as a health care interpreter whether it be in an hourly or salaried position, contractor, volunteer, or intern

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The Wellness Account is modeled after Enhanced Benefit Accounts (EBAs) that are currently being implemented in several state Medicaid programs and are generally used to pay for covered Medicaid services. Enhanced Benefit Accounts pay for benefits provided in addition to a beneficiary's Medicaid coverage, as an incentive to engage in healthy behaviors.

Under an EBA, a process is established for verifying achievement or completion of the desired outcomes. Recipients or providers typically provide the verification. Once verified or established, recipients have access to account funds enabling them to access additional services or products identified by the Medicaid program

Recommendations from the Health Equities Committee

Policy Recommendations on Elements of the Medical Home and Primary Care Renewal that Reduce Health Disparities

1. Definition of Medical Home/Primary Care Home: A system of care that provides coordination of multiple, disparate elements of care for a patient. This does not assume that all care is provided within the walls of a clinic.

2. Elements of the Medical Home model that have been demonstrated to reduce health disparities and must be encouraged in any medical service organization purporting delivery of a Medical Home include:
    a. Patient Centered Care focus
        i. Extended office hours: evenings and weekends
        ii. Alternative access to providers such as telephone consultations and email exchanges.
        iii. Automatic reminders of recommended visit schedule and appointment times.
        iv. Mental Health and Chemical Dependency Integration
        v. Emphasis on chronic disease management and preventive care
        vi. Coordination with community based social organizations, peer support networks and organizations that integrate social determinants of health into care including public health as appropriate
    b. Population based care: The Medical Home should include systems to coordinate care of all patients in the practice outside of office visits.

3. For some populations, a medical home may be best provided outside of the traditional primary care service delivery system and a definition of medical home should not exclude organizations based on service-delivery type but should include coordination of care by a licensed medical provider.

4. The Medical Home needs to be integrated and viewed in the context of the social and education system, hospital and specialty care system and public health system in a community.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

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Recommendation from the Health Equities Committee Concerning Outreach

A media-only approach to outreach for the Oregon Health Fund Board is not an adequate response to reducing health disparities in health insurance status in Oregon.

1. A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.
    a. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.
    b. The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach.
    c. The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.

100% enrollment of individuals who are eligible to participate in the Oregon Health Fund Board is the object and resources and interventions must be targeted towards this goal.

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Policy Recommendations on Preventing Health Disparities through Targeted and Culturally-Specific Programs of Health Promotion and Chronic Disease Prevention/ Management.

As identified by the Delivery System Committee of the Oregon Health Fund Board, there are few incentives in the current health care system to prevent disease and truly promote a healthy population. Even fully-capitated managed care organizations do not always see direct benefit from investing in prevention efforts that pay off in the long run because of movement in and out, and between, healthcare plans. The Oregon Health Fund program has the opportunity to save money with long-term prevention investments that improve the overall health of Oregonians as they move in and out, or between plans, while remaining in the overall Health Fund Program.

1. The Health Equities Committee recommends an on-going, substantial investment in public health activities that will prevent disease, and promote the health of Oregonians. We believe that part of this investment should be directed towards using culturally-specific approaches to disease prevention and health promotion.

a. *Initiatives that target health disparities should be guided by members from the communities experiencing health disparities.*
    i. *The Quality Institute and the Public Health Department would provide data to support decision-making on establishing funding and program priorities.*
    ii. *Priorities will likely vary by region.*
    iii. *Multiple granting approaches should be used:*
        1. *Planning grants should be made available for regional collaboratives to develop around a proposed intervention.*
        2. *Competing grants should be designed to encourage creativity and collaboration.*
        3. *Non-competitive continuation grants should be available to maintain funding support for programs that have demonstrated success at meeting the goals of the grant.*
        4. *Emerging Issue grants should be available for communities to develop strategies and interventions around newly identified problems impacting population health.*
b. *Regional collaboratives consisting of social service organizations, culturally-specific organizations, healthcare organizations, and other community partners and community-based organizations would apply for grants that address targeted disparities with community-driven and implemented approaches.*
    i. *Matching regional funds may be required.*

ii. *Funding should be administered in a way that supports the necessary steps to achieving targeted outcomes, and the outcomes themselves. Data & evaluation support will be provided through partnership with Public Health.*
iii. *Effective programs will be shared and problem-solving will be facilitated through convening regional collaborative leadership (in person or virtually) on a quarterly basis in learning collaboratives.*

Health focused community-based organizations have been very successful and providing culturally-specific programs that promote health, prevent disease, and help manage chronic diseases. These programs are overly reliant on federal grant priorities and struggle with sustainability. Providing a truly integrated healthcare home for multicultural communities requires a stronger relationship between these organizations and primary care clinics that serve vulnerable populations.

2. The Health Equities Committee recommends designing a contracting mechanism that will empower primary clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services.

Renewable contracts will be awarded to health care clinics that partner with culturally-specific social service organizations (including organizations that focus on Persons with Disabilities, GLBT populations, homeless youth or adults, and populations with low literacy and illiteracy) to provide an integrated health care home. Clinics that have established in-house capacity for culturally-specific approaches would not be required to contract out for services already being rendered.

a. *Partnership must include contractual financial agreements.*
    i. *Social service organizations will provide culturally-specific approaches to health promotion, self-management for chronic diseases, and disease prevention. These approaches may include:*
        1. *peer-to-peer health education programs*
        2. *Community Health Workers*
b. *Contracts will be based on a rate, adjusted to reflect the needs of the population, for serving a specified number of individuals in that population.*
    i. *Organizations will be accountable on measures of process and outcomes that will reflect realistic timelines of:*
        1. *preventing chronic disease*
        2. *promoting population health*
        3. *chronic care management*
        4. *attention to health literacy*
        5. *accessibility to patients*
c. *Contracts can be administered directly through the Health Fund Program or through a managed care organization.*

Recognizing that not every organization providing an integrated healthcare home is focused on serving vulnerable populations, an alternative should exist to renewable contracts that will enable a provider to purchase community-based and/or culturally-specific services.

3. The Health Equities Committee recommends that high-value community-based health promotion, disease prevention, and chronic disease management services, be eligible for direct reimbursement.

a. *Accountable health plans must reimburse a broader range of health professional including, but not limited to, Community Health Workers, and a broader range of services including, but not limited to, peer-led disease management support groups in culturally specific programs to maximize the health and function of individuals, families and communities.*

Final Recommendations

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Health Equities Committee Policy Recommendations on Citizenship Documentation Requirements for Participation in OHP-like Programs

1. *The Health Equities Committee recommends investigating the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2006.*
2. *Oregon would request returning to previous documentation methodology employed by the Department of Medical Assistance Programs. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.*

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Policy Recommendations on Improving the Health Care Workforce and Reducing Health Care Disparities

1. Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels. Oregon's health care provider shortage is also challenged by the population's growing diversity and the need to provide culturally and linguistically competent care.

2. Increase financial aid in health professional schools for students needing more financial aid of the right kind (grants, scholarships, loan forgiveness). Ultimately, our patients pay the price when there are insufficient providers from backgrounds similar to theirs. Geographic, economic, educational, and cultural factors, with their effects on patient mortality, underscore the critical need for providers from disadvantaged backgrounds and with superior cultural sensitivity training, to improve health care for the underserved throughout Oregon. They will then be able to serve those who are now underserved, improving access to care. In addition, these individuals will function as role models for youth in their communities.

    a. Expand reduced tuition to Oregon residents pursuing careers at Oregon healthcare educational institutions with additional incentives for underrepresented populations.
    b. Offer loan forgiveness for providers who practice in underserved areas in Oregon or with underserved populations in Oregon.

3. Strengthen the pipeline to health profession schools; intervention needs to start early and focus on retention. Support mentoring program models that have been demonstrated to be effective in retaining students. We feel strongly that educational and experiential support in pre-college, college and in health professional schools will enable more applicants from disadvantaged backgrounds to apply, gain admission and graduate into the healthcare workforce.

4. Recommendation 3 must include convening all entities that are currently working on pipeline development issues so that efforts are coordinated, streamlined, and strategic in planning for the future needs of Oregon's population.

    a. The Oregon Health Care Work-Force Institute would be ideally suited for the role of convener.

   b. Entities that should be convened include, but are not limited to, Allopathic and Naturopathic providers, dentists, mid-level providers, nurses, behavioral health professionals, allied and Community-Health Workers.

5. Improve the climate for diversity at individual health professional schools by mandating cultural (including sexual and gender minorities, persons with disabilities, and other vulnerable populations) and linguistic competence throughout the institution. This in turn will mean better patient satisfaction and medical compliance, with decreases in morbidity and mortality related to chronic diseases over time. Providing culturally competent services that maximize health and functionality results in lower spending on health care, as well as increased income from a more productive workforce.

6. Utilize existing agencies to establish and report on diversity goals for health & hospital systems and healthcare training institutions to the Oregon Health Fund Board on a biennial basis.

7. Support Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.

8. Mandate a minimum level of educational credits for healthcare providers that must earned in coursework specifically designed to increase cultural competence and/or awareness.

   a. This can be part of initial licensure or as part of continuing education.