Investing in Oregon's Health Care Safety Net

Opportunities and Challenges

Safety Net Advisory Council (SNAC)

Staff support – Office of Health Systems Planning (HSP) Office of Health Policy and Research (OHPR)

Members of the Safety Net Advisory Council

Priscilla Lewis, Co-chair – Providence Health Systems
Craig Hostetler, Co-chair – Oregon Primary Care Association
Bill Thorndike – Medford Fabrication
Jackie Rose – Oregon School-based Health Care Network
Tom Fronk – Benton County Health Department
Vanetta Abdellatif – Multnomah County Health Department
Scott Ekblad – Office of Rural Health
Abby Sears – Our Community Health Information Network (OCHIN)
Ron Maurer – State Representative
Beryl Fletcher – Oregon Dental Association
Jim Thompson – Oregon Pharmacy Association
Tracy Gratto – Coalition of Community Health Clinics
Steve Kliewer – Wallowa Valley Center for Health and Wellness
Matt Carlson – Portland State University

SNAC's CHARGE

- *The Safety Net Advisory Council (SNAC) provides the Governor, the Director of DHS, the OHPR Administrator, the Oregon Health Fund Board, the Oregon Health Policy Commission (OHPC) and the Medicaid Advisory Committee (MAC) with specific policy recommendations for the provision of safety net services for vulnerable populations who experience barriers to accessing care.*

What is the Health Care Safety Net?

"The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care."

Enrolled Senate Bill 329 – 74th Oregon Legislative Assembly – 2007 Regular Session

Patients the Safety Net Serves

- Populations Experiencing Significant Barriers to Accessing Care

(financial barriers only one of many)

- Cultural
- Language
- Transportation
- Geographic
- Homeless
- Higher prevalence of mental illness
- Substance abuse, including meth addicts
- Cognitive impairment/ memory problems
- Decreased functional status
- Health literacy barriers
- Socially isolated
- Financial

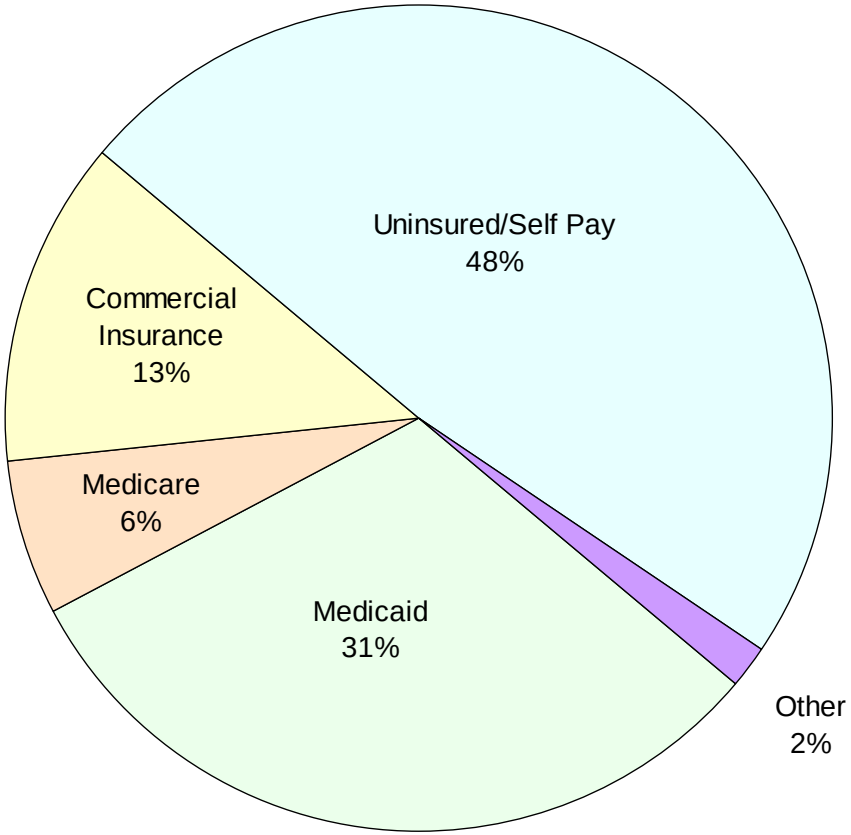
A community's response

- Federally Qualified Health Centers – or Community Health Centers
- School-based Health Centers
- Isolated Rural Health Facilities
- Community Sponsored Clinics
- Hospital Emergency Departments
- Local Health Departments
- Tribal Health Clinics

Core Safety Net Clinics

- **School-based Health Centers** - currently 45 centers in 19 counties
- **Isolated Rural Health Facilities** – currently 17 facilities in 14 counties
- **Federally Qualified Health Centers** - 26 centers with over 150 sites located in 27 counties
- **Community Sponsored Clinics** - (approximate) 14 clinics in 6 counties
- **Tribal Health Clinics** – 10 Clinics in 9 counties

Percent of Patients by Insurance status – (All safety net clinics – SNAC core data)



Numbers of Patients by Insurance Status (All Safety Net Clinics, SNAC core data)

- Medicaid – 83,957
- Medicare – 16,772
- Commercial Insurance – 34,890
- Uninsured/Self Pay – 130,988
- Other – 4,301

- **Total – 270,908**

Types of Services Offered

Type of Services and Intensity Varies Across Safety Net

- Primary and acute care
- Urgent and emergent care
- Mental and behavioral health
- Dental health
- Chronic Care Management
- Interpretation services
- Care Coordination/delivery system navigation
- Referrals to other supportive services
- Transportation

What we don't (but NEED) to know

- Data gaps across the safety net
- We know more about some sectors of the safety net than others*.
- Areas of Need:
  - Hospital ED patient visits for safety net patients statewide
  - Better data on where workforce gaps are, particularly for midlevel providers and ancillary staff
  - Uniform measures, where appropriate, across the system
- A more detailed data set forthcoming and SNAC will continue to work on data gaps

*OCHIN has a sub-set of FQHC's with robust data. A demonstrable benefit of Health Information Technology

Safety Net Advisory Council's Recommendations

- STABLE FUNDING
- CRITICAL INFRASTRUCTURE/ TOOLS
- WORKFORCE

Essential Building Blocks

- There is currently no public fund or financing mechanism to support the safety net. An Investment Fund would support community investment, expand safety net impact and help to assure its strength and viability
- Oregon and the nation are moving toward greater readiness to implement Health Information Technology to improve access, quality, safety and efficiency. The safety net has a role to play but needs assistance with broad-based adoption
- Safety net providers and rural providers in particular, struggle with recruitment, retention and distribution of the health care workforce. Creative and flexible strategies are necessary to fill these gaps.

Recommendations

STABLE FUNDING…

Establish the Safety Net Integrity Fund

- Assist clinics in financial trouble
- Assist with strategic investments to maintain infrastructure
- Invest in new site development or expansion
- Link funds to technical assistance to address specific organizational issues/challenges
- Fund expansions of RX assistance programs
- Fund dental and behavioral service expansion

Critical Investment

"Grow" an investment fund over a 3-year period sustained at $ 3 million per year.

Options for Funding:

- Legislative appropriation
- Public Bond
- Public-Private partnerships
- "Clinic Adoption" model

Recommendations

INFRASTRUCTURE/TOOLS

Support Electronic Health Record Adoption across the Safety Net

- Provide systematic approach to EHR adoption across the safety net
- Assist with capital-intensive start up and ongoing maintenance and technical assistance costs.
- Provide better patient and treatment information. Improve the safety, quality and efficiency of care

Critical Investment

Options for Funding:

- Safety Net EHR Investment Fund – legislative appropriation
- Oregon Style "Utility"- modeled after utility services framework
- State and Federal Partnership – leveraging Medicaid and Medicare $

Recommendations

WORKFORCE

Implement innovative approaches to meet safety net workforce needs

- Rural Locum Tenens Program
- Flexible community health workforce options
- Oregon Health Service Corps (Loan Repayment)
- Updated Tax Credits
- Increase the pipeline of midlevel providers to rural communities

Critical Investment

- **Rural Locum Tenens –** fees, grant funding, legislative appropriation
- **Oregon Health Service Corps –** legislative appropriation
- **Updated Tax credits –** Legislative appropriation
- **Increase Pipeline for Midlevel practitioners –** legislative appropriation, public-private cost-sharing
- **Flexible Workforce Approaches –** Legislative appropriation to fund grant program

An essential piece of the delivery system

- Access for Oregon's most vulnerable patients - providing primary care for a disproportionate number of low-income, chronically ill, racially and culturally diverse Oregonians; many of whom experience homelessness, language barriers, mental illness, geographic isolation and lack of health insurance.
- Laboratories for innovation – especially adept at meeting the needs of complex patients and developing creative and culturally attuned approaches to providing comprehensive and integrated care.
- Essential to primary care capacity – The rest of the health care system could not absorb these patients if the safety net disappeared

Safety Net Advisory Council - Presentation to the Oregon Health Fund Board

Background

Oregon's Health Care Safety Net:

- Federally Qualified Health Centers (FQHC)
- Isolated Rural Health Facilities (IRHF)
- School-based Health Centers (SBHC)
- Community Sponsored Clinics (CSC)
- Local Health Departments (LHD)
- Indian Health Service Clinics (IHSC)
- Hospital Emergency Departments
- Private practices

A Community's Response
Oregon's Health Care Safety Net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous care. Oregon's safety net is comprised of public, private and not-for-profit organizations that provide health care services to uninsured, underinsured and vulnerable persons throughout the state.

Linking these different sectors is a mission or a mandate to provide health care services to people who are in need. Oregon's safety net community shares many strengths and challenges in common but also has a great deal of variation in patients served, revenue sources and business models. Some clinics are private not-for-profit and sponsored by the community; others have some federal funding but can be either not-for-profit or county government operated; still others receive state funds. This complexity presents both flexibility and challenges for policy makers.

A Critical Piece of the Health Care Delivery System
Every day, Oregon's safety net providers have stories to share about people who, without their services, would otherwise go without medically necessary care. Many Oregonians have limited access to primary care and delay seeking help until they are seriously sick or hurt.

Our over-burdened emergency departments have stories to share about patients whose only outlet for medical care is through their doors. These stories describe patients whose conditions could more appropriately be treated in a primary care setting or illnesses and injuries, which could have been prevented or ameliorated if the patient had access to care sooner.

Ideally, the image of a net captures nicely the role of the health care safety net; able to stretch or contract in response to Oregon's economic or health policy climate. In recent years, however, demand for safety net services has risen dramatically requiring the net to expand beyond, in many cases, available resources. Regardless of type or location, safety net providers have stories to share about the challenges they confront with limited resources, increasing demand and escalating health care costs.

This increase in demand is largely driven by the growing number of uninsured individuals or those unable to find a provider willing to receive Medicaid/Medicare reimbursement. However, it is not simply the escalating financial challenges that determines who utilizes Oregon's safety net clinics. Many patients are also struggling with psycho/social barriers. There are a growing number of patients requiring mental health and substance abuse treatment; many are challenged with homelessness or live in geographically isolated areas where access to comprehensive health care services is inadequate.

Oregon's racial and ethnic makeup is becoming increasingly diverse and the safety net serves a disproportionately high percentage of diverse populations as well as individuals living below 200% of the FPL. Safety net providers are seeing greater numbers of patients overall and those patients seeking care are both sicker and are presenting with more complicated conditions.

A Good Investment

If our hospital emergency departments are the "canary in the coal mine" for our health care system, then our safety net clinics help light the way for many who otherwise would not receive the care they need. In addition to responding to this critical need for access to basic health care services, however, Oregon's safety net clinics also serve as laboratories for innovation and experimentation within the delivery system. Care coordination, proactive management of chronic diseases, integration of behavioral and primary care and primary care medical home models have all been launched as pilots within the safety net.

Many safety net clinics are uniquely positioned to redesign the way care is delivered to the populations they serve. These clinics are attuned to the needs of some of the state's most marginalized patients and have developed creative and comprehensive approaches to meeting these needs.

While the safety net has demonstrated itself to be a favorable environment in which to experiment, it is important to ensure that expectations for re-design are compatible with both the needs and the resources of the clinic and the community.

Individualized features of different safety net sectors must be recognized as those that have emerged to best meet the needs of the community. This diversity of sector type, governing structure and financing is both the greatest asset and a confounding element within the safety net - each sector, indeed each clinic, is unique but shares similar challenges with all other safety net clinics across the state.

Because of its range of models, the safety net is complex and difficult to describe uniformly. Nevertheless, it is vital that decision makers utilize a systemic approach for developing supportive policies. Oregon's safety net system is both a critical component of the current system and a place to gain valuable insights on innovative approaches. These lessons can help to inform the process of building a more affordable, effective and sustainable healthcare delivery system for all Oregonians.

The Safety Net Advisory Council advances the following recommendations targeted at **Funding, Critical Tools** and **Workforce** as ways to significantly invest in the safety net. Each of these components are linked and will inform the overall stability of Oregon's health care safety net system.

Who are Oregon's Health Care Safety Net Providers and what do they do?

Safety Net Providers represent a key building block in a re-engineered health care delivery system

The safety net plays an important role in providing access to primary care for very low-income, uninsured, Medicaid and Medicare clients across the state. By definition, the mission of the "safety net" is to serve those who face a variety of barriers to care including economic, geographic or cultural and racial. As a result, the safety net represents an important element of Oregon's primary care capacity.

In addition to being a key access point for many Oregon's most vulnerable and as a result of their mission – the safety net has valuable, demonstrated expertise in serving these populations and over the past two decades has demonstrated a willingness and ability to innovate and drive transformation in the delivery of care.

Oregon's health care safety net –

- Providing primary care homes
  - for those not yet determined eligible and enrolled in a health plan
  - for those enrolled in a health plan contracting with safety net clinics
  - for those who face barriers to care as noted in the Safety Net definition
- Providing primary care options that fit the needs of certain populations and communities
- Sole providers in isolated rural areas and certain communities
- The delivery system's "insurance" against downturns in the economy
- A laboratory for trying out new approaches to care

Definition of Oregon's Health Care Safety Net

As developed by the NGA Health Care Safety Net Policy Team and the Safety Net Advisory Council.

*The **health care safety net** is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.*

The following is the statutory definition of the Health Care Safety Net, resulting from the Healthy Oregon Act (SB 329).

- **Section 2 (8)** "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.
- **Section 2 (2)** "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance, and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

- **Statement of Principle:**

  Section 3 (16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

Safety Net Advisory Council

Policy Recommendations

Presented to the Oregon Health Fund Board and the Oregon State Legislative Assembly

1. Stable Funding

Establish the Core Health Safety Net Integrity Fund.

- Assist clinics in financial trouble
- Assist with strategic investments to maintain infrastructure
- Invest in new site development or expansion
- Link funds to technical assistance to address specific organizational issues/challenges

2. Critical Tools

Electronic Health Record Adoption across the Safety Net

- Provide systematic approach to EHR adoption across the safety net
- Assist with the capital-intensive start-up and ongoing maintenance and technical assistance costs.
- Provide better patient and treatment information and improve the safety, quality and efficiency of care

3. Workforce

Implement innovative approaches to meet safety net workforce needs:

- Rural Locum Tenens Program
- Flexible community health workforce options
- Oregon Health Services Corps (Loan Repayment)
- Updated Tax Credits
- Provide an increased pipeline of midlevel providers to rural communities.

Safety Net Advisory Council (SNAC)
STABLE FUNDING RECOMMENDATION SUMMARY

Establish a Core Health Safety Net Integrity Fund. In the absence of a stable financing mechanism, the safety net has evolved organically, responding to a variety of economic and political circumstances across the state over a number of years. The strength of this evolution is that different models have evolved to meet the individual needs of different communities, the challenge is that public policy has very limited tools with which to support this critical community investment, expand its impact and assure its strength and viability.

The Safety Net Integrity Fund would provide **a source of capital** for clinics at financial risk of failure and for **additional sites or services in areas of unmet need.** Stable funding will enable Oregon to maintain critical safety net infrastructure in a strategic and sustainable way.

"Growing" Core Health Safety Net Integrity Fund

- **Develop a set of priority investments** including but not limited to: clinics experiencing financial difficulty, establishing sites where gaps exist, assistance with recruitment and retention of workforce and/or the use of transformative technology, assistance with affordable pharmaceuticals.
- **Define expectations** for documentation of outcome measures, matching funds, linkages with community organizations, and commitment to a diverse workforce within the limitations of location.
- **Build a revolving fund** sufficient to provide 1$m in grant funds for year 1, $2m in year 2, $3m for year 3 and sustained at $3m per year for subsequent years. Fund priority safety net investments from the interest. Provide low interest loans to safety net entities that repay the fund..
- **FUNDING** options include but are not limited to:
    - Legislative appropriation – e.g. secure a budget line item for Integrity Fund
    - Public bond
    - Public-Private partnerships,
    - Insurers and health systems adopt sites or clinics for a limited time period to assist them in paying loan
- **Link the funds** where possible with foundation initiatives and matching funds to magnify their impact.
- **Include technical assistance** to assist with issues that are not directly linked to immediate financial stability i.e. business planning, financial management etc.

Anticipated Outcome
The Safety Net Integrity Fund will promote shared responsibility across key stakeholders and communities for providing quality, timely and accessible comprehensive (primary, behavioral, mental and oral) health care to Oregon's most vulnerable populations.

Safety Net Advisory Council (SNAC) - Critical Infrastructure Tools
Electronic Health Record Recommendation Summary

Oregon and the nation are moving toward greater readiness to implement health information technology as a key tool to serve the broader goals of access, quality, safety, improved health and cost reduction. The safety net provides care to many Oregonians who face barriers to care and who often move in and out of coverage and from provider to provider. Policy makers can help assure that electronic health records are available at the time of treatment for safety net patients.

The barriers to broad adoption of health information technology across the safety net are substantial. They include significant start up and ongoing cost. In addition, safety net clinics have much smaller operating margins than the private sector and have less access to capital. In general, what margin safety net clinics do have is funneled back into services.

The SNAC recommends one of the three following options or a combination and that expert analysis be engaged to determine the best methodology and pricing for establishing broad adoption of health information technology across the safety net.

Option 1: Safety Net Electronic Health Record Fund

- **Target set.** 80% adoption rate within 2 years
- Incentives include grants and low interest loans for implementation cost
- Fund established and cost burden broadly shared
- First priority for isolated rural areas and other entities with limited access to capital.
- Participating providers agree to adopt quality and reporting measures
- **FUNDING:** Legislative Appropriation and partner contributions (purchasers, insurers, health systems, community contributions)

Option 2: Oregon EHR Utility (80% adoption rate as with Option 1)

- **Key Principle** – infrastructure managed on a basis similar to water and electricity and other common resources needed by the public at large.
- Utility implements, operates, and maintains EHR infrastructure across safety net including software, hardware, and technical assistance.
- Utility assesses per person per month contributions from Medicaid, private insurers, and clinics acting as surrogates for low income and uninsured
- Safety net focused but is scalable and could be expanded to include 2-10 person physician offices etc.
- Participating providers agree to adopt quality and reporting measures
- All funding bodies participate on a governance body (similar to utility board).

Option 3: State and Federal Partnership

- DHS/CMS/HRSA partner to model integrated safety net EHR funding strategy and set adoption target. See HHS Medicare model.

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/EHR_Summary.pdf

- Identify leveraging linkages between Medicaid, Medicare, Medicaid Transformation Grant, FCC grant, Intergovernmental Transfers, alternatives to PPS, or other mechanisms
- Identify state infrastructure to facilitate EHR adoption and maximize benefit of group purchasing.

Anticipated Outcome

'Potential Impact of Widespread Adoption of Health Information Technologies on Oregon Health Expenditures'.
http://www.oregon.gov/OHPPR/docs/OR_HIT_Impact_Final.pdf

Safety Net Advisory Council (SNAC)
WORKFORCE RECOMMENDATIONS SUMMARY

Addressing concerns for the safety net includes preventing burn-out, addressing maldistribution of workforce, providing tools that will help safety net clinics remain viable and supporting communities in their efforts to evolve models that work. Like the rest of the health care delivery system the safety net is dependent on its workforce. It is especially dependent on mid-levels and physicians who provide supervision, dentists and increasingly, behavioral/mental health professionals. Other physician extenders, care coordinators and community health workers and telemedicine strategies are likely to become increasingly important. Recommendations address community *based innovations, mid-level education and deployment, and recruitment and retention tools*

Community Based Innovation

1. Initiate a rural 'Locum Tenens' Program

- Provide temporary physician and dentist relief for vacation, continuing education etc.
- Potential longer-term access solution for some rural communities.
- Utilize existing OHSU infrastructure – mutual benefits across program.
- Funding: Fees, grant funding, Legislative Appropriation $1 Million start up, $500,000 per biennium for on-going technical support and program maintenance.

2. Promote flexible community workforce approaches

- Expand the range of individuals able to provide emergency services, treat acute or chronic conditions, and provide preventive and health promotion services (e.g. combinations of existing health professionals, community paramedic, Promotora)
- Create a four year, multi-county/multi-community pilot grant program
- Funding: Legislative Appropriation - $ 5 Million over four years.

Mid-level Education and Deployment

3. Increase the number of graduating mid-level professionals practicing in regional networks

- Provides targeted investments in existing educational programs to recruit and train mid-levels willing to work in rural communities and safety net clinics.
- Promotes Regional Network supervision of mid-level practitioners.
- Engage strategic partnerships between educational institutions, AHEC, Office of Rural Health, local health departments
- Incorporate/Coordinate with Oregon Health Service Corp, recruitment funds, technical assistance and other supportive programs
- Funding: Public-Private Partnership – state contribution through Legislative Appropriation to be tapered off over the course of 3-4 Biennium

Recruitment and Retention Tools

1. Establish Oregon Health Service Corps

- Existing loan repayment program has not been updated since 1989 – funded at $ 200,000 per year.
- Renames, updates, and integrates with other programs, adds loan forgiveness.
- Increase funding to cover more professionals as a first priority
- Add additional health professions but not at cost of "thinning the soup.".
- Provides necessary staff support.
- Funding: Legislative 2009-2011 $3,000,000, 2011-2013 $ 5,000,000.

2. Update the Physician Tax Credit

- Oregon's physician tax credit has not been updated since 1989
- Increases the tax credit from $5000 to $10,000
- Provides for the addition of other health professionals
- Funding: Legislative Appropriation

Anticipated Outcome

The health care safety net can recruit, retain, and deploy physicians, mid-levels, and other trained and certified practitioners to meet its health workforce needs.

Public Health & Health Care Reform

Presentation to the Oregon Health Fund Board's Committee on Health Equities

March 4, 2008

Grant Higginson, MD, MPH
Interim State Public Health Officer
Oregon Public Health Division
Department of Human Services

Integration of PH into Reform

- Opportunities:
  - Ensuring balance between clinical care and non-clinical services that promote health
    - Supporting sustainable population-based services
  - Improving effectiveness of clinical care by incorporating evidence-based PH concepts

- Why is it important?
  - Health status improvement = Goal of reform
  - Cost savings

Cost-effective population-based services

- Physical activity
  - Fitness program (Browne); B/C = 2.45
  - Promotion centers (Golaszewski); B/C = 3.23
- Sexually transmitted disease prevention
  - Screening and contact follow-up (Chesson); $5.0 billion in US savings 1990-2003
- School-based health centers
  - Comprehensive services (Guo); Hospitalization costs decreased 85% (~ $1000 per child)

(Select examples only – More data to come)

Health status improvements from population-based services

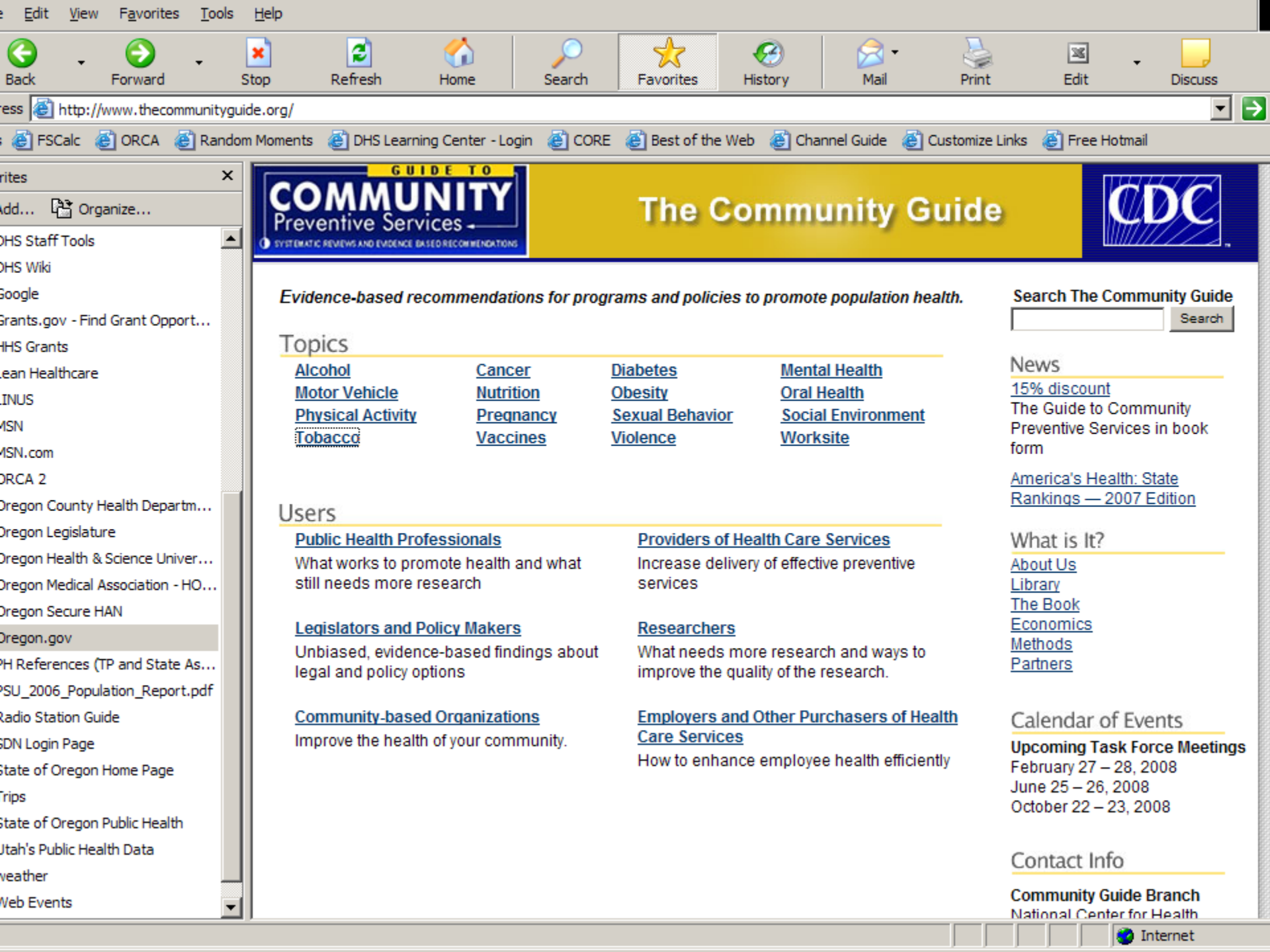
- Immunization
  - 33,000 lives saved and 14,000,000 cases of disease prevented per year (CDC)
- Public Health Nurse Home Visiting
  - 56% fewer health care visits for injuries and 48% less incidence of child abuse (Olds)
- Tobacco Prevention
  - Ed programs reduce teen smoking 20-40% (US SG)
  - 1750 fewer infants exposed to smoke/year (OR TPEP)

(Select examples only – More data to come)

Effectiveness of public health

- Cost-effective research
- Improved outcomes research
- Intuitively: Healthy people cost less

  Healthy people/communities the goal
- Difficult “sell”
- Standard should be Evidence-Based practice
  - Good research available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Oregon Medical Association - HO...
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Web Events
GUIDE TO COMMUNITY Preventive Services
SYSTEMATIC REVIEWS AND EVIDENCE BASED RECOMMENDATIONS
The Community Guide
CDC
Evidence-based recommendations for programs and policies to promote population health.
Search The Community Guide
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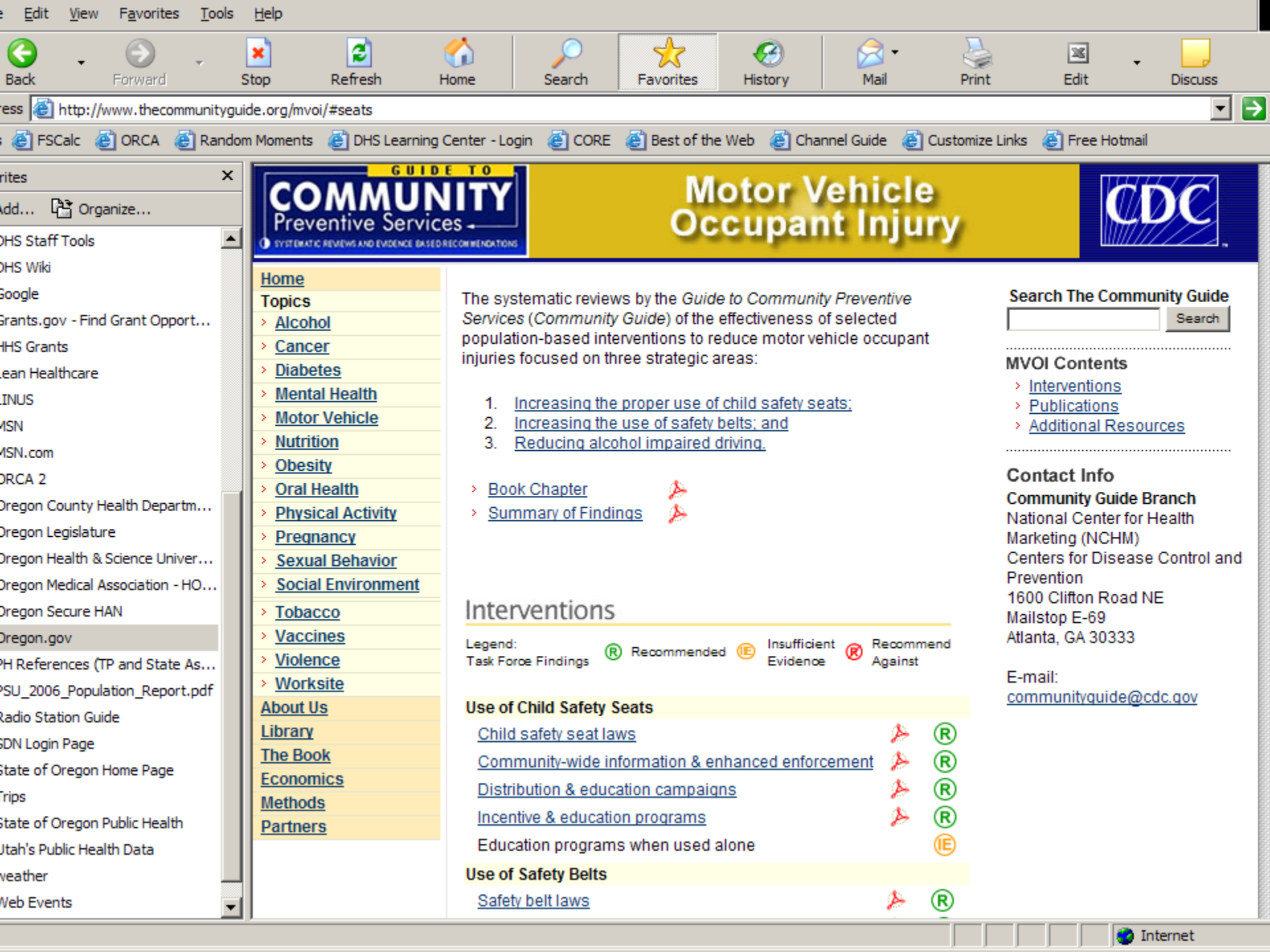
Topics
Alcohol Cancer Diabetes Mental Health
Motor Vehicle Nutrition Obesity Oral Health
Physical Activity Pregnancy Sexual Behavior Social Environment
Tobacco Vaccines Violence Worksite
Users
Public Health Professionals
What works to promote health and what still needs more research
Providers of Health Care Services
Increase delivery of effective preventive services
Legislators and Policy Makers
Unbiased, evidence-based findings about legal and policy options
Researchers
What needs more research and ways to improve the quality of the research.
Community-based Organizations
Improve the health of your community.
Employers and Other Purchasers of Health Care Services
How to enhance employee health efficiently
News
15% discount
The Guide to Community Preventive Services in book form
America's Health: State Rankings — 2007 Edition
What is It?
About Us
Library
The Book
Economics
Methods
Partners
Calendar of Events
Upcoming Task Force Meetings
February 27 – 28, 2008
June 25 – 26, 2008
October 22 – 23, 2008
Contact Info
Community Guide Branch
National Center for Health
Internet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Motor Vehicle
Nutrition
Obesity
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Physical Activity
Pregnancy
Sexual Behavior
Social Environment
Tobacco
Vaccines
Violence
Worksite
About Us
Library
The Book
Economics
Methods
Partners
The systematic reviews by the Guide to Community Preventive Services (Community Guide) of the effectiveness of selected population-based interventions to reduce motor vehicle occupant injuries focused on three strategic areas:
1. Increasing the proper use of child safety seats;
2. Increasing the use of safety belts; and
3. Reducing alcohol impaired driving.
Book Chapter
Summary of Findings
Interventions
Legend: Task Force Findings
Recommended
Insufficient Evidence
Recommend Against
Use of Child Safety Seats
Child safety seat laws
Community-wide information & enhanced enforcement
Distribution & education campaigns
Incentive & education programs
Education programs when used alone
Use of Safety Belts
Safety belt laws
Search The Community Guide
Search
MVOI Contents
Interventions
Publications
Additional Resources
Contact Info
Community Guide Branch
National Center for Health Marketing (NCHM)
Centers for Disease Control and Prevention
1600 Clifton Road NE
Mailstop E-69
Atlanta, GA 30333
E-mail:
communityguide@cdc.gov
Internet

What does integration mean?

- **Expanded population-based, community services outside of the delivery system**
  - More balanced investment in prevention
  - Prioritize services (most bang for buck) but allow flexibility at community level
  - Core support for governmental public health
    - Potential “trap” for marginalizing

What does integration mean?

- Expanded population-based, community services outside of the delivery system
- **Engagement of delivery system in population-based service activities**
  - Delivery system “hook”
    - Community services delivery vs PH vs contracting
  - Involvement in community coalitions
    - Specific diseases / issues
    - Delivery system access / quality

What does integration mean?

- Expanded population-based, community services outside of the delivery system
- Engagement of delivery system in population-based service activities
- **Incorporation of PH concepts into the provision of clinical care**
  - Implement preventive care services recs
  - Adopt Chronic (comprehensive) Care Model
  - Conduct self-evaluation re prevention services

What does integration mean?

- Expanded population-based, community services outside of the delivery system
- Engagement of delivery system in population-based service activities
- Incorporation of PH concepts into the provision of clinical care
- **Systems support to ensure integration is occurring and that it's making a difference**

Supporting integration of public health

- Technical assistance
  - Prioritizing & Identifying evidence-based services
  - Implementing Chronic Care Model, etc
  - Identifying prevention service providers
- Coordination and standards setting
- System-wide data analysis and evaluation

(Role of governmental public health)

- Incentives and/or mandates – Accountability for specific activities and services defined

How do we get to integration?

- Policy and Will
  - Importance of SB 329 process
- Incentives and/or Mandates for specific services and activities
- Systems Support – Public Health function
- Resources
  - For Services and for System Support
- Evaluation
  - Process & Outcomes

Oregon is on the Cutting Edge

Questions ?

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Introduction to the Community Health Worker/Promotor/a Model

Teresa Rios and Noelle Wiggins

Objectives

By the end of the presentation, participants will know more about:

- The historical roots of the CHW model
- Roles and competencies of CHWs
- Recent developments in the CHW field
- The unique contribution can CHWs make to reducing health inequities

Agenda

Introduction	Noelle
The term “CHW”	Tere
Who are CHWs?	Noelle
History of the CHW model	Tere
Roles and skills of CHWs	Noelle
Demonstrated outcomes	Noelle
Recent developments	Tere

Teresa Rios

- Promotora with the El Niño Sano Project, 1988-1991
- Promotora with the La Familia Sana Project, 1991-1994
- Co-founded Oregon Public Health Association CHW Committee, 1994
- Project Coordinator for the Madres en Marcha Project, 1992-1995
- Helped to design and manage the La Comunidad Sana Project, 1995-1998
- Advisory Board of the Natl. Community Health Advisor Study, 1995-1997
- Chair of the APHA CHW Special Primary Interest Group, 2001-2003.

Noelle Wiggins

- Trained and supported CHWs in a rural, conflictive area of El Salvador, 1986-1990
- Directed the La Familia Sana Program, 1990-1995
- Assoc. Dir. of the Natl. Community Health Advisor Study, 1995-1997. Co-authored chapter on Roles and Competencies of CHWs.
- Initiated and managed the Poder es Salud/Power for Health Project, 2002-2005. This CBPR project funded by the CDC investigated whether CHWs who used popular education could successfully promote health and reduce health disparities in the African American and Latino communities.

What is one thing you know or have heard about CHWs?

Community Health Worker

(Rios and Wiggins, 1997)

- Community Health Workers are carefully chosen community members who participate in training so that they can promote health in their own communities.
- Communities can be defined by race/ethnicity, age, sexual orientation, geography, disability status, or other factors.

Community Health Worker
(APHA CHW SPIG 2005)

A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison . . . between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

What caught your attention in the radio play?

Qualities of Community Health Workers (Wiggins & Borbon, 1997)

- Membership in or shared experience with the community being served
- Personal strength and courage
- Friendly, outgoing, sociable
- Patient
- Open-minded/non-judgmental
- Motivated and capable of self-directed work
- Caring, compassionate
- Empathetic

Qualities of Community Health Workers

- Committed/dedicated
- Respectful
- Honest
- Open/eager to grow/change/learn
- Dependable, responsible, reliable
- Flexible and adaptable
- Desire the help the community
- Persistent
- Creative/resourceful

Skills of Community Health Workers

- Communication Skills
- Interpersonal Skills
- Teaching skills
- Service Coordination Skills
- Advocacy Skills
- Capacity-Building Skills
- Knowledge Base
- Organizational Skills

Roles of Community Health Workers

- Cultural mediation
- Health education
- Building individual and community capacity
- Informal counseling and social support
- Advocacy
- Connection to resources
- Direct service (e.g. screenings, material aid)

Demonstrated outcomes of CHW programs

- Improved utilization management
- Increased access to preventive care
- Enhanced patient-provider communication
- Improved compliance with prescribed care
- Preventive health education and behavior change
- Chronic disease management
- Enhanced social support
- Improved understanding within the health care system about community norms and needs
- Addressing the social determinants of health

Recent developments in the CHW field

Thank you!

Language Services – Federal & State Developments

Mara Youdelman
National Health Law Program
Youdelman@healthlaw.org

Presentation to the Oregon Health Fund Board
February 6, 2008

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National Policies

- Title VI, EO 13166, OCR LEP Guidance
- OMH CLAS Standards
- Other federal laws
  - Patient Navigator Outreach and Chronic Disease Prevention Act of 2005
  - Ryan White HIV/AIDS Treatment Modernization Act
  - Homeland Security Appropriations Bill – FEMA

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State Activities

- All states have at least 2 language access laws
  - comprehensive
  - targeted (e.g. emergency room, hospital)
- NHeLP 50 state survey of statutes/regulations related to language access and health care
  - update to be released March 2008

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State Trends

- Health professionals education – NJ, CA, WA
- Healthcare Interpreter Competency Standards
  - Currently – WA, IA, IN, OK, OR
  - Coming attractions – MA, CT, NC
- Requirements on private insurers – CA
- Standardization of pharmacy labels – CA

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Hospitals

- Emergency Room Interpreter Law (MA)
- Hospital Licensure (RI)
- Hospital regulations (NY) + funding

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Title VI at state level

- Enforcement – private right of action
- State agency requirements – CA, MD, DC

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Fiscal Opportunities – Medicaid/SCHIP

- Payments for interpreters, translators – statewide Medicaid/SCHIP Programs – only a handful of states have set up programs to provide direct reimbursement
  - Existing programs – DC, HI, ID, KS, ME, MN, MT, NH, UT, VA, VT, WA, WY
  - Coming attractions
    - CT passed legislation in July
    - TX to start pilot program
    - NC initiating credentialing prior to reimbursement
    - CA – Medi-Cal Language Access Taskforce
- Training of interpreters

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Fiscal Opportunities – Medicaid/SCHIP

- Four models –
  - contract with language service agencies (DC, HI, UT, VA, WA)
  - reimburse providers for hiring interpreters (ID, ME, MN, VT)
  - reimburse interpreters (MT, NH, WY)
  - provide access to language line (KS)

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Fiscal Opportunities – Other

- Private foundations, state dept. of health, joint collaborations
- Bulk purchasing – agencies could allow providers to access language services negotiated by agency to control costs

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Claims Codes for Interpreting

- No CPT code
- *But* CMS HCPCS code exists
  - Interpreter code is T1013

    NOTE: T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. T codes are not used by Medicare but can be used by private insurers.

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National Activities

- 2007 – SCHIP reauthorization (House CHAMP bill, Senate SCHIP bill)
- 2008 –
  - Minority Health bills (HR 3014, S 1576/HR 3333)
  - Medicare or other health bills?

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National Efforts

- NHeLP convenes national coalition of stakeholders to develop consensus agenda
- Statement of Principles offers guiding framework
  - 5 domains – access, funding, education, quality improvement, accountability
- Resources
  - Language Services Resource Guide for Healthcare Providers
  - national surveys of hospitals, internists, and CHCs
  - funding information – Medicaid/SCHIP, Medicare

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Principles' Endorsers

Aetna
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physician Assistants
American Association of Physicians of Indian Origin
American Civil Liberties Union
American College of Physicians
American Counseling Association American Hospital Association
American Medical Association
American Medical Student Association
American Nurses Association
American Psychiatric Association
American Psychological Association
American Public Health Association
Asian American Justice Center
Asian Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
Association of Clinicians for the Underserved
Association of Community Organizations for Reform Now
Association of Language Companies
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
California Association of Public Hospitals and Health Systems
California Health Care Safety Net Institute
California Healthcare Association
California Healthcare Interpreting Association
California Primary Care Association
Catholic Charities USA
Catholic Health Association
Center for Medicare Advocacy Center on Budget and Policy Priorities
Center on Disability and Health
Children's Defense Fund
Cuban American National Council
District of Columbia Language Access Coalition
District of Columbia Primary Care Association
Families USA
Family Voices
Greater N.Y. Hospital Association
HIV Medicine Association
Institute for Reproductive Health Access
The Joint Commission
HIV Medicine Association
Institute for Reproductive Health Access
Joint Commission on the Accreditation of Health Care
La Clinica del Pueblo
Latino Caucus, American Public Health Association
Latino Coalition for a Healthy California
Massachusetts Medical Interpreters Association
Medicare Rights Center
Mexican American Legal Defense and Educational Fund
Migrant Legal Action Program
Molina Healthcare
National Asian American Pacific Islander Mental Health Association
National Asian Pacific American Families Against Substance Abuse
National Asian Pacific American Women's Forum
National Association of Community Health Centers
National Association of Mental Health Planning and Advisory Councils
National Association of Public Hospitals and Health Systems
National Association of Social Workers
National Association of Vietnamese American Service Agencies
National Center for Law and Economic Justice
National Committee for Quality Assurance
National Council of La Raza
National Council on Interpreting in Health Care
National Family Planning and Reproductive Health Association
National Health Law Program
National Immigration Law Center
National Hispanic Medical Association
National Latina Institute for Reproductive Health
National Medical Association
National Mental Health Association
National Partnership for Women and Families
National Respite Coalition
National Senior Citizens Law Center
National Women's Law Center
Northern Virginia Area Health Education Center
Physicians for Human Rights
Presbyterian Church (U.S.A.) Washington Office
Service Employees International Union
Society of General Internal Medicine
Summit Health Institute for Research and Education
USAction

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Conclusions

- There are lots of ways to provide language services creatively, effectively and cost-efficiently – *see* "Promising Practices" reports
- More can be done –
  - Education of health professions students and continuing education
  - Medicare/private ins. reimbursement
  - More Medicaid funding
  - More resources – workforce, training/testing, translation, etc.

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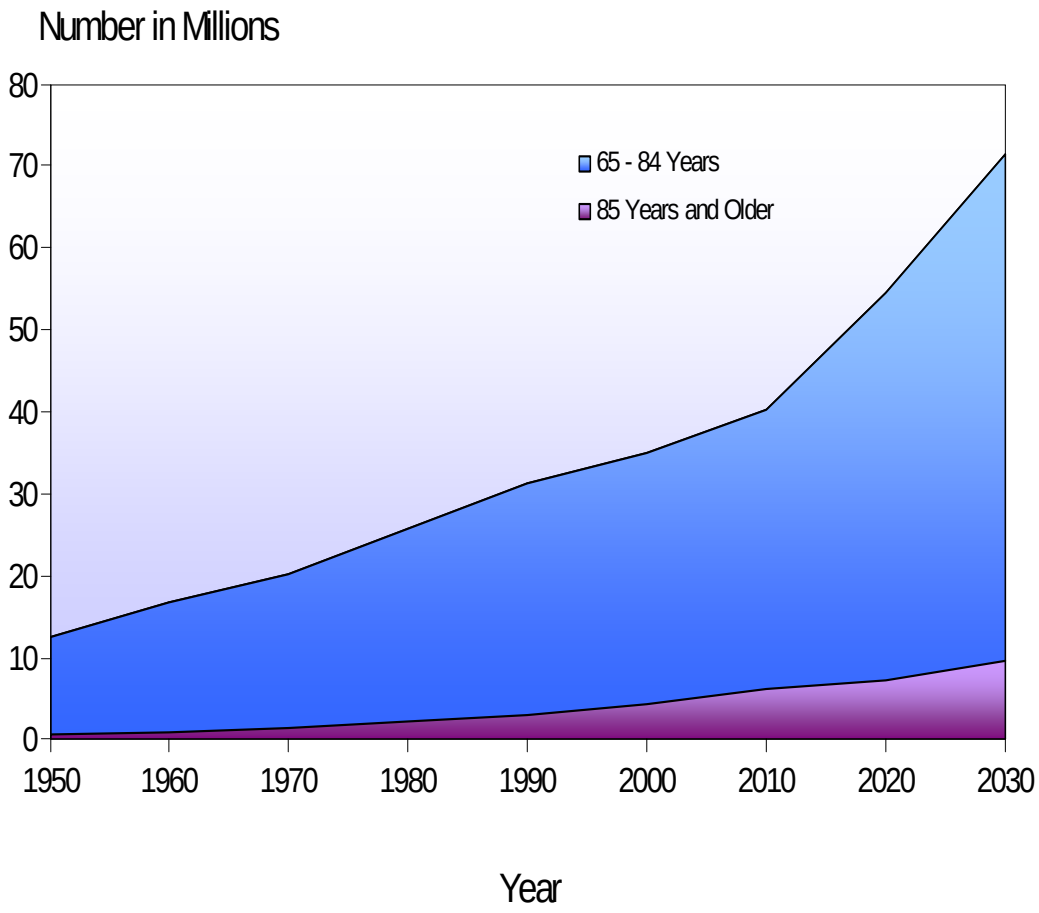
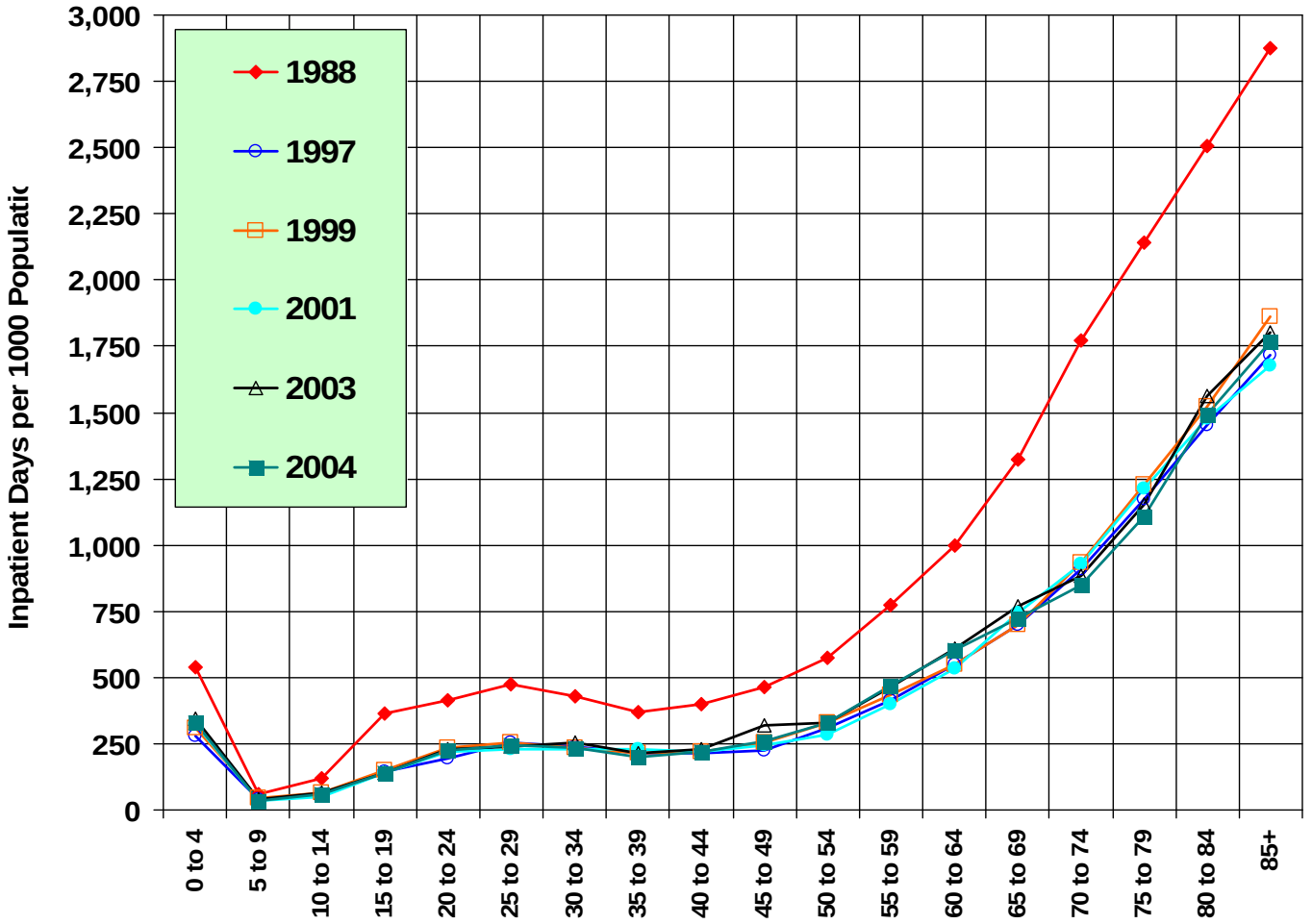
Oregon Physician Workforce

Lisa Grill Dodson, MD
Director
Oregon Area Health Education Center

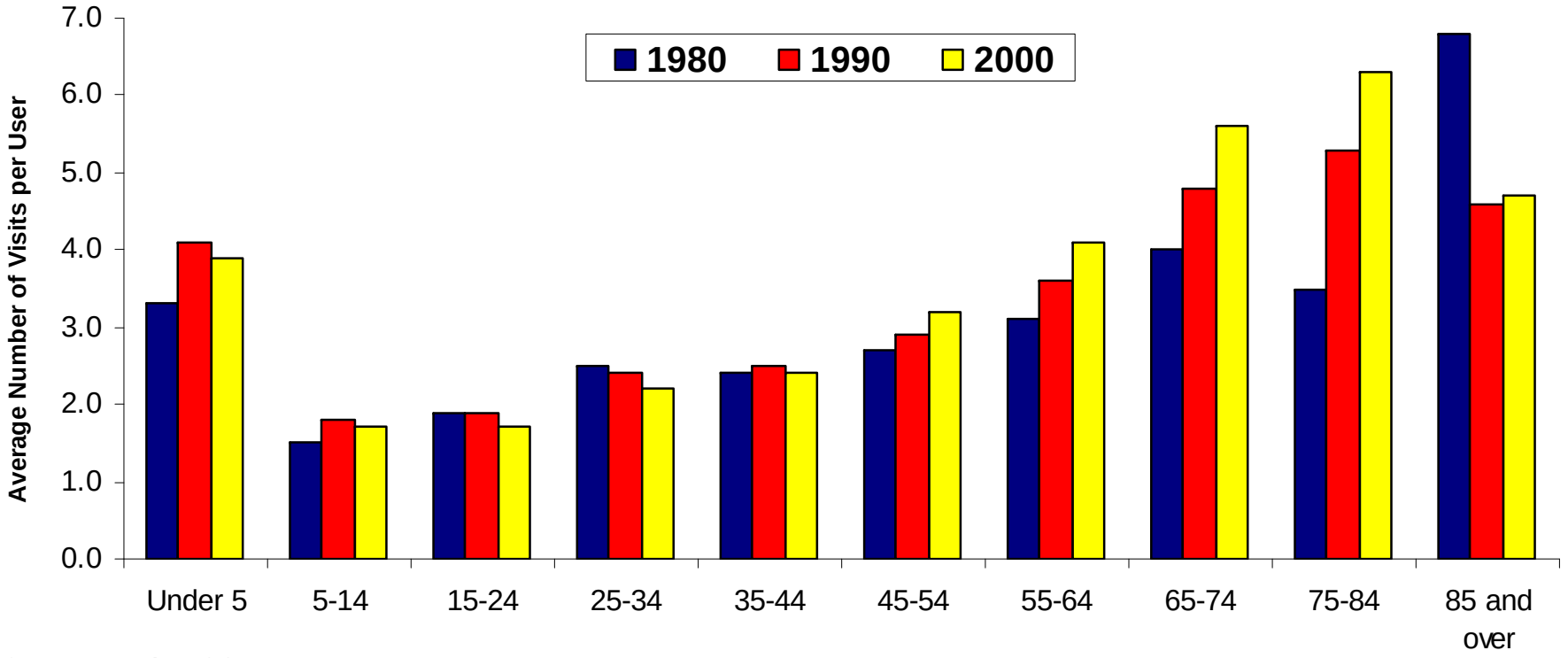
Population 65 Years of Age and Older: US 1950-2030



Oregon Inpatient days



Estimates of Ambulatory Care Visits to Physician Offices and Clinics, 1980-2000



Source: NAMCS
Prepared by NY Center for Health Workforce Studies

Health Care Workforce Projections

- Shortages in nursing, dentists, physicians, most allied health
- Aging of both the population and the workforce
- Increased rate of departure from the workforce (retirement, career change, other)
- Incorrect projections & concern in the 1980's about a surplus
- Lack of any centralized planning for health workforce

Additional Workforce Challenges

- Maldistribution
  - Geographic
  - Economic
  - Specialty
- Diversity
- Gender issues
- Generational differences
- Specialization and voluntary practice limitations (including within specialties)
- Higher tuition, high debt loads
- Long pipeline with lots of leakage
- Intangibles (prestige, delayed gratification, lifestyle)

Challenges for Healthcare Provider Education

- Insufficient numbers (and types) of students are in the pipeline
  - Production nearly constant over several decades
  - Health care educators are also aging
  - The educational model has historically been inefficient and relatively inelastic
- Decline of education mission in teaching hospitals/Academic Medical Centers
- Competition for students
- Teachers pay not in line with practice income
- Increasing education costs
- Decreasing willingness of health systems to engage in education activities
- Need for community based teaching (often non-reimbursed)
- Antiquated financial aid system

K-12, CC, College, University

- Barriers
  - Control of “quality” through admissions, enrollment limitations
  - Measures of prose and numeracy literacy for college graduates have declined in the last decade.
  - Only 55 percent of four-year college students complete a baccalaureate degree within six years.
  - Achievement gaps between white and Asian students and black and Hispanic students actually grow larger during the college years.
  - Employers assert that the college graduates they hire are not prepared for the workplace
  - Debt:
    - $10,600 for graduates of public institutions
    - $16,000 for graduates of private, non-profit colleges and universities
  - K-12 and higher education systems operate independently of one another.

Cost/benefit

- 2003 median earnings
  - high school diploma was $30,800
  - Bachelors degree $48,800 (+38%)

- postsecondary students
  - more than half attend school part-time;
  - 40 percent work full-time;
  - 27 percent have children
  - More incumbent workers and more adults

Economic Development Benefits of healthcare employment

- Employment income
  - each primary care physician employs 3-5 directly.
  - additional employment of technicians and professionals
- Direct benefit of the revenues generated by the physician staying in the community – with the multiplier effect of those dollars.
- Direct economic benefit to businesses that depend on the existence of the physician
  - Local Hospital and Long Term Care
  - Local Pharmacy
  - Local medical supply vendor
- Savings related to the cost of travel to medical services elsewhere

Additional economic benefits

- The existence of medical services in the community is necessary to attract other industry and employment.
- If rural residents leave their community for medical care, they also spend other dollars outside of their community (medical and nonmedical expenses)
- Having medical professionals in rural communities typically contributes to community improvement overall (school, government, services etc.).
- Improved overall health outcomes:
  - Increase of one primary care physician per 10,000 population results in
    - 6 percent decrease in all-cause mortality
    - 3 percent decrease in low birth-weight
    - 3 percent decrease in stroke mortality

Health care *is* economic development in rural and underserved communities

- Oklahoma Physician Manpower Training Commission 25 yr report:
  - $100 million educational costs
  - $18 million scholarships
  - $11 million administrative costs
  - Expenditure of $130 million resulted in $3.6 billion to economy, $2.7 billion in rural
  - If even 15% were physicians who would not have been there otherwise, return is $445 million

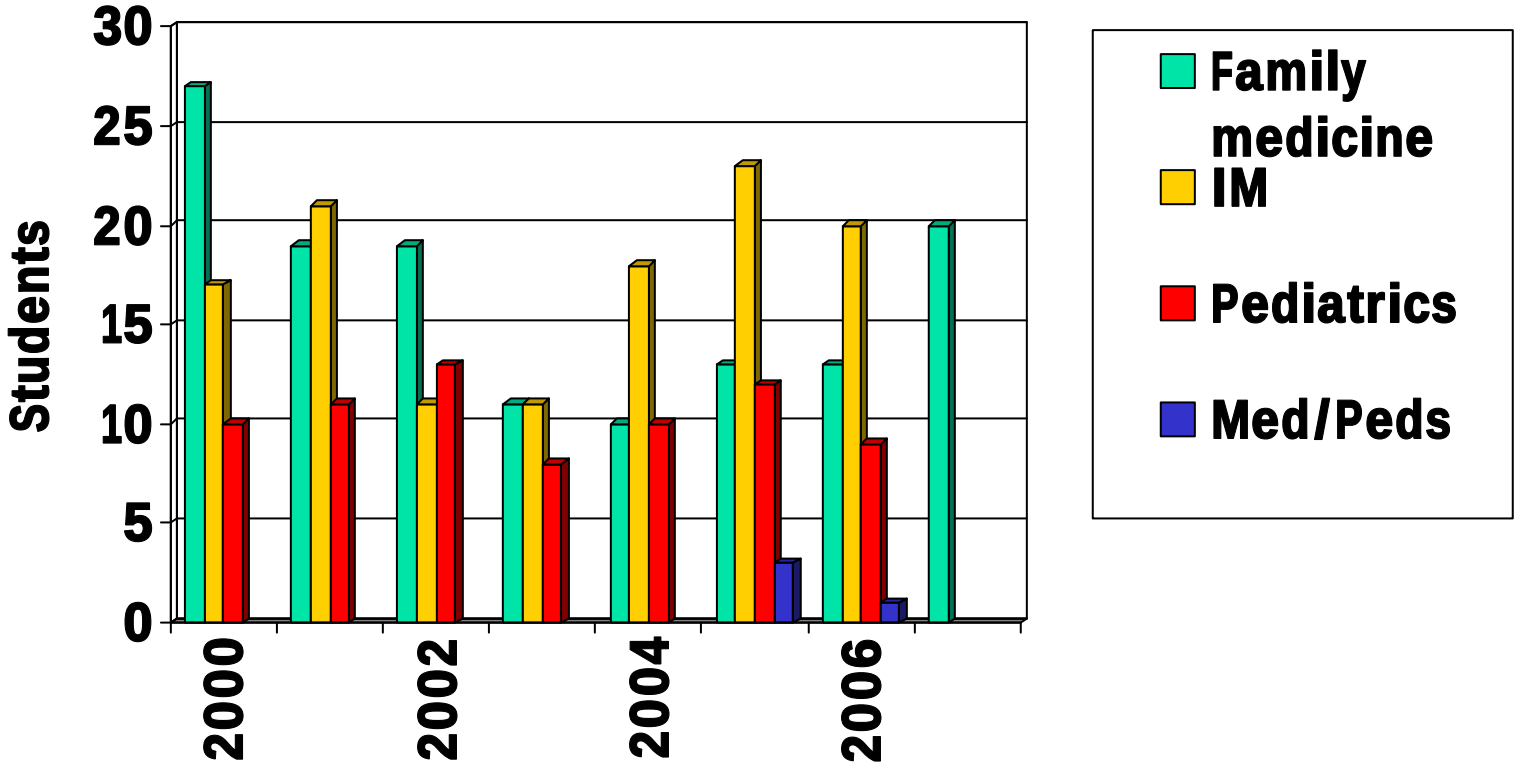
More Economic development

- Documented economic benefit of a family physician in Oregon = $853,2262 per year
  Source: Graham Center for Healthcare Policy
- Additional income generated at other local health care organizations such as hospitals and nursing homes.
- National Center for Rural Health Works at Oklahoma State University asserts that where there is a rural hospital, "….This report clearly documents the importance of a rural physician. The physician generates approximately $1.5 million in revenue, $0.9 million in payroll and creates 23 jobs."

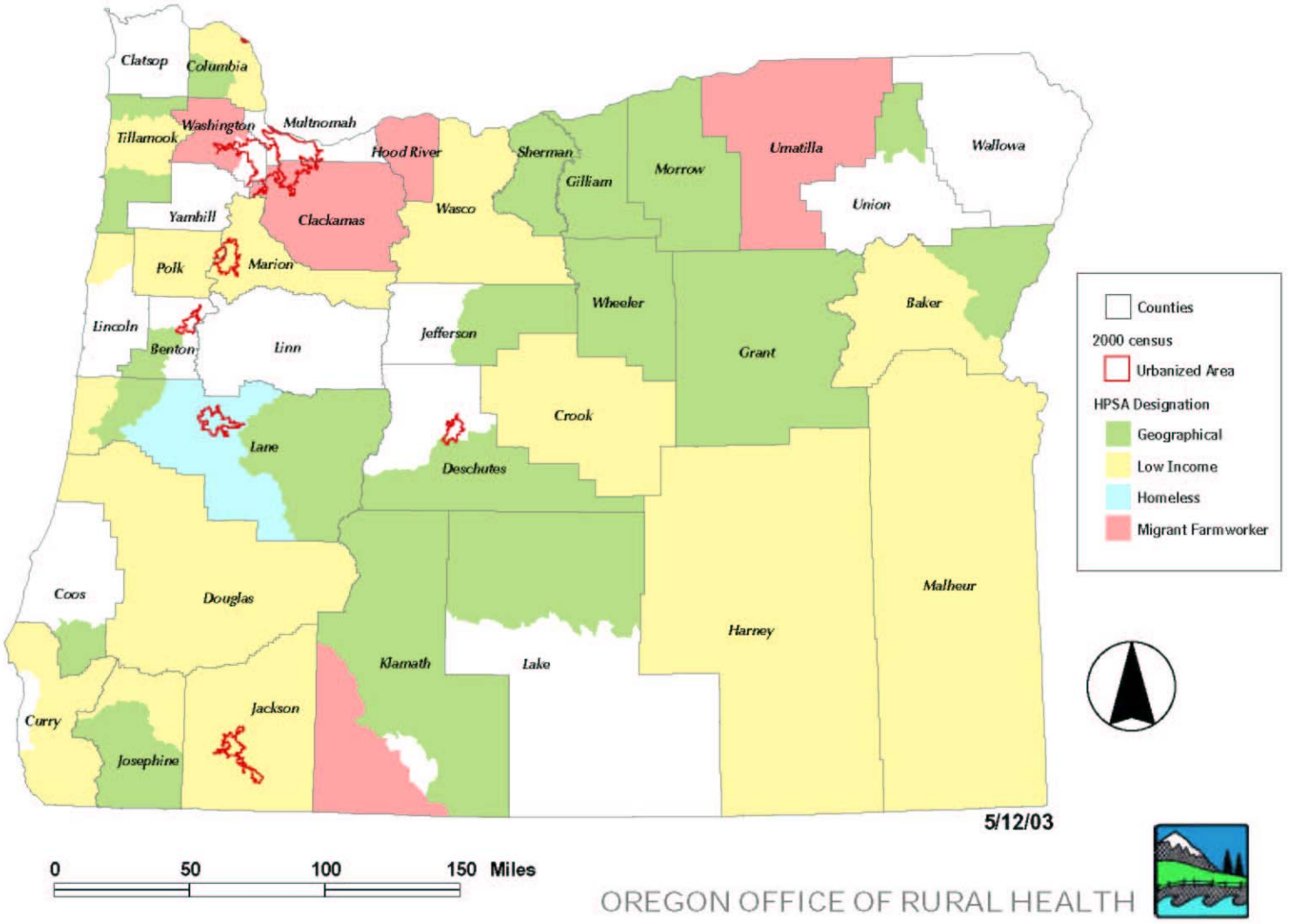
What the heck is an AHEC?

- Developing the pipeline of healthcare providers for underserved populations
  - K-12 pipeline
    - YHSC, Multicultural Youth for Health, HOSA,health careers clubs and camps
  - Medical, dental and nursing school programs
  - Support for rural physicians and hospitals and their communities
  - Advocacy

OHSU primary care output

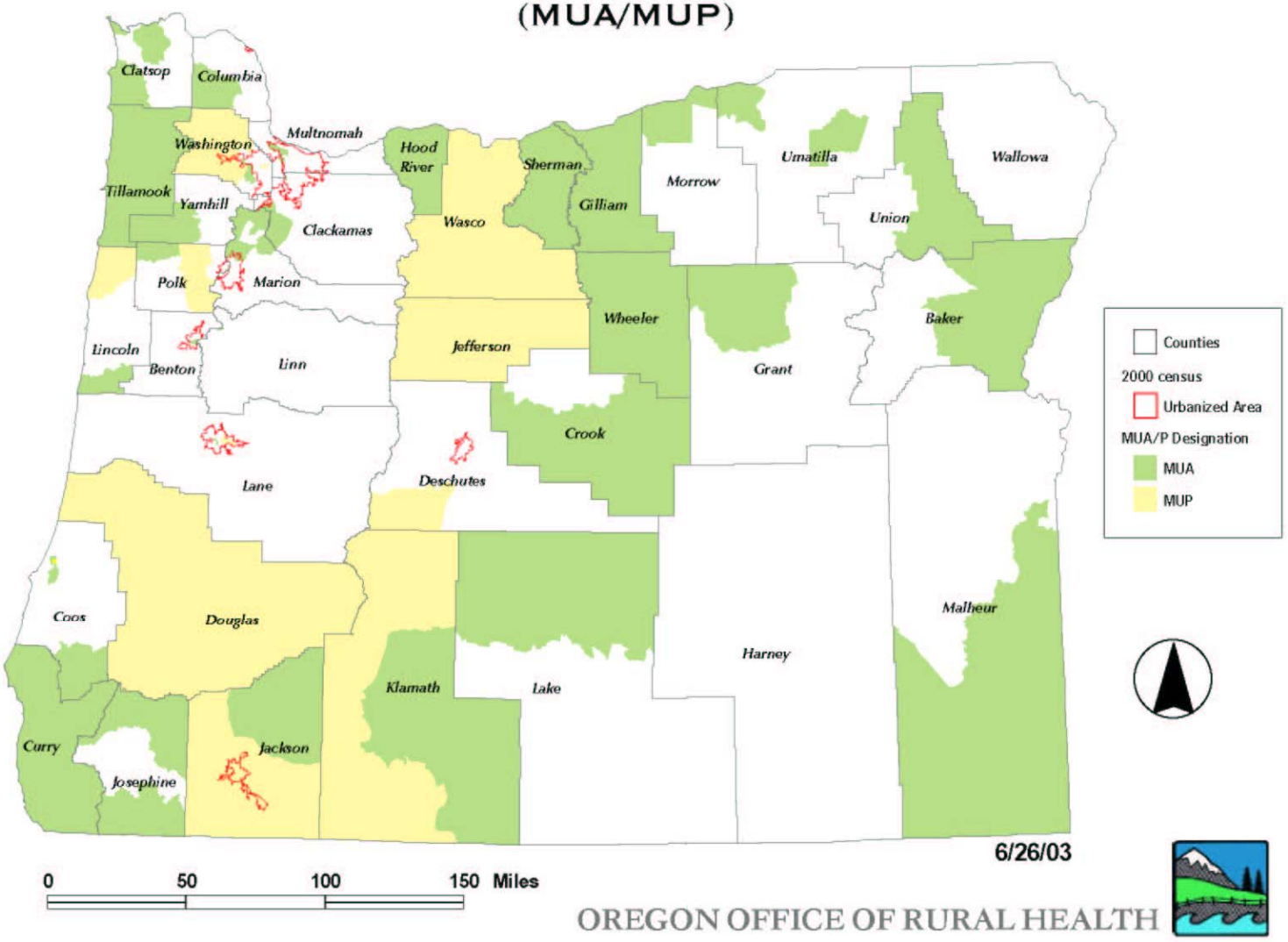


Oregon Primary Care HPSAs



OREGON OFFICE OF RURAL HEALTH

Oregon Medically Underserved Areas/Populations (MUA/MUP)



OREGON OFFICE OF RURAL HEALTH

Oregon

- For the two year period between January, 2005 and December, 2006, **1,255** physicians were projected to leave the Oregon workforce
  - 6% Retiring
  - 4% Leaving Oregon
  - 2% Changing Careers
  - 1% Temporary Leave of Absence
- OHSU graduated approximately **200** new physicians during the same period

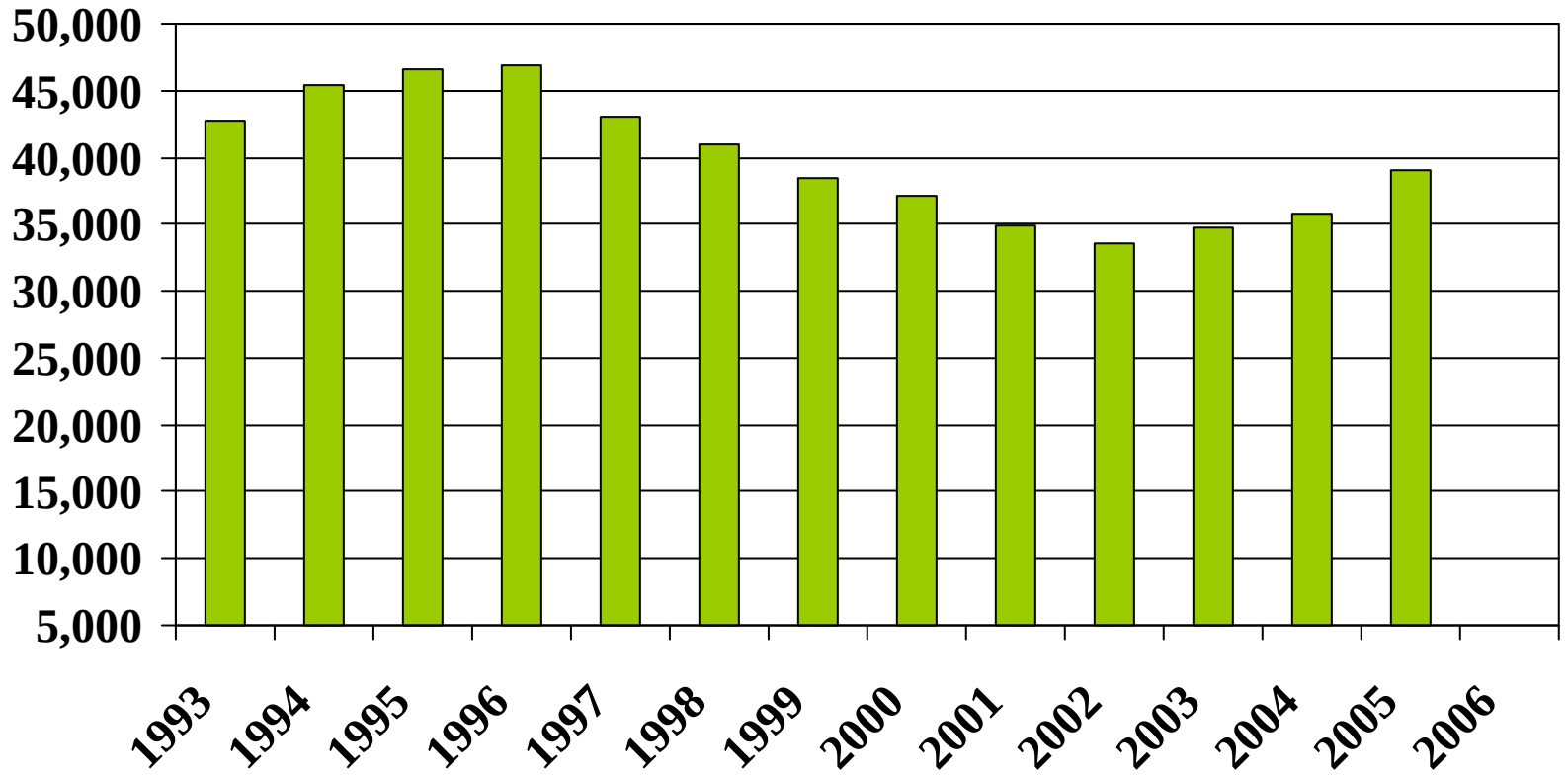
Oregon specific workforce issues

- One academic medical center, no mandate, declining public support
- Oregon ranks:
  - 13th in physicians per capita (above US ave)
  - 43rd in MD & DO enrollment per capita
  - 43rd in keeping students in state for med sch
  - 39th in medical residents/fellows per capita
- We are an *importer* of physicians

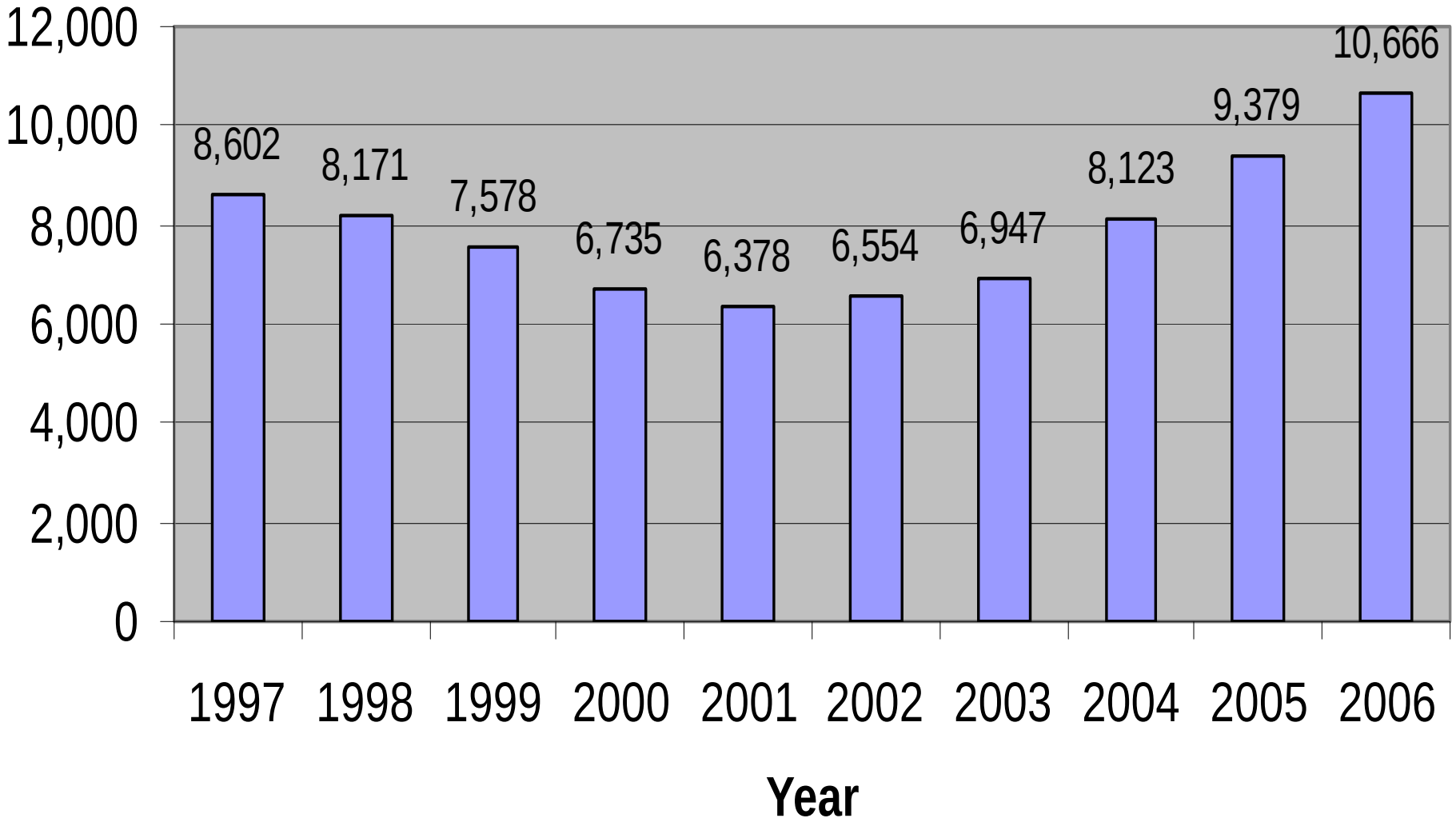
Oregon recruiting

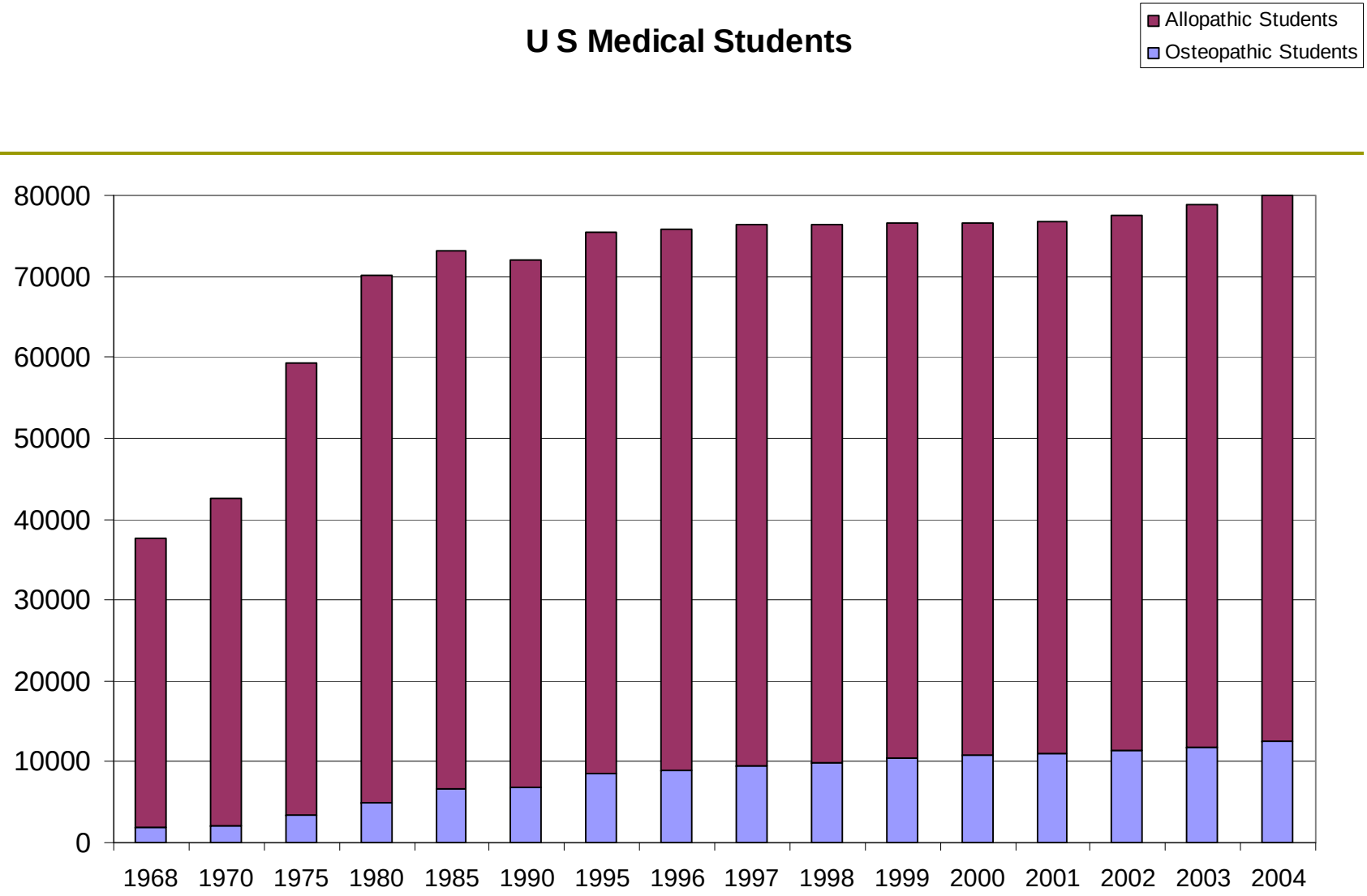
- We have been an importer of physicians but the bloom is off the rose:
  - “malpractice crisis” state (HB 3630 “medical malpractice reinsurance act” not sustainable)
  - Low reimbursement rates
  - Doonesbury parodied our education system 2005
  - Cost of living, esp. housing, moderately high
  - Licensure issues

Applicants to US allopathic medical schools

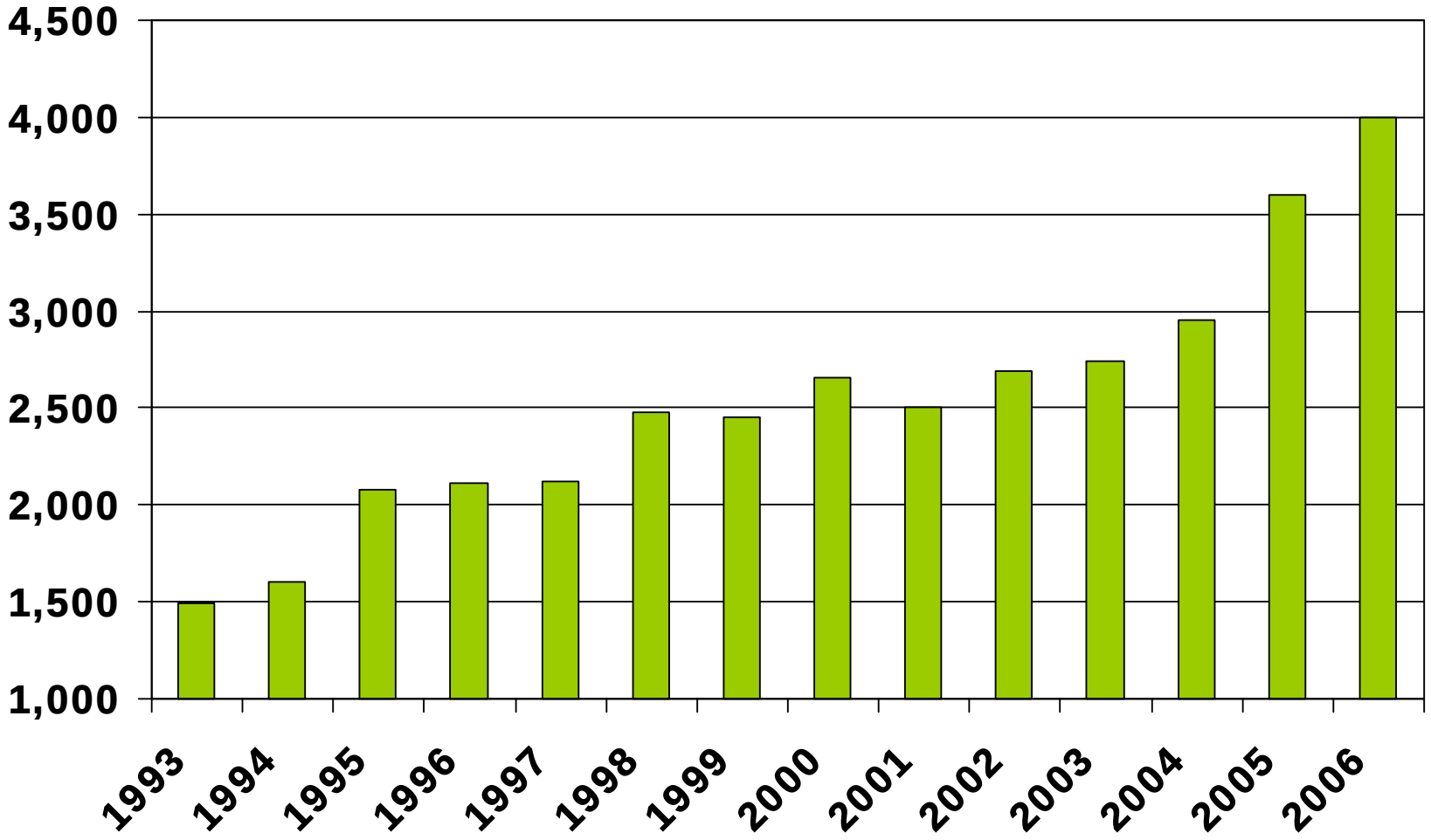


Applications to Dental Schools 1997-2006

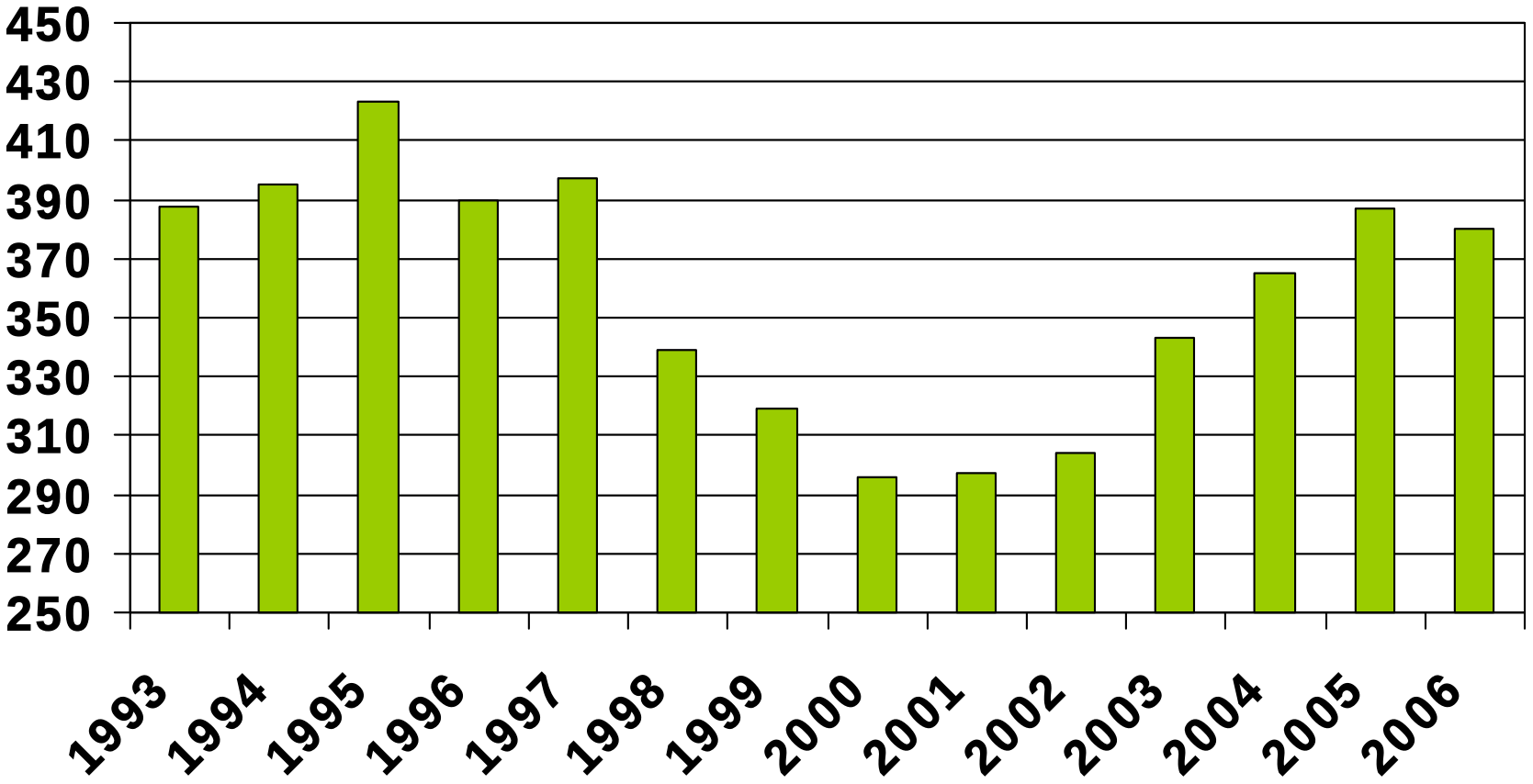



U S Medical Students
Allopathic Students
Osteopathic Students
80000
70000
60000
50000
40000
30000
20000
10000
0
1968
1970
1975
1980
1985
1990
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004

Applicants to OHSU by Year



Oregon Residents Applying to Medical School

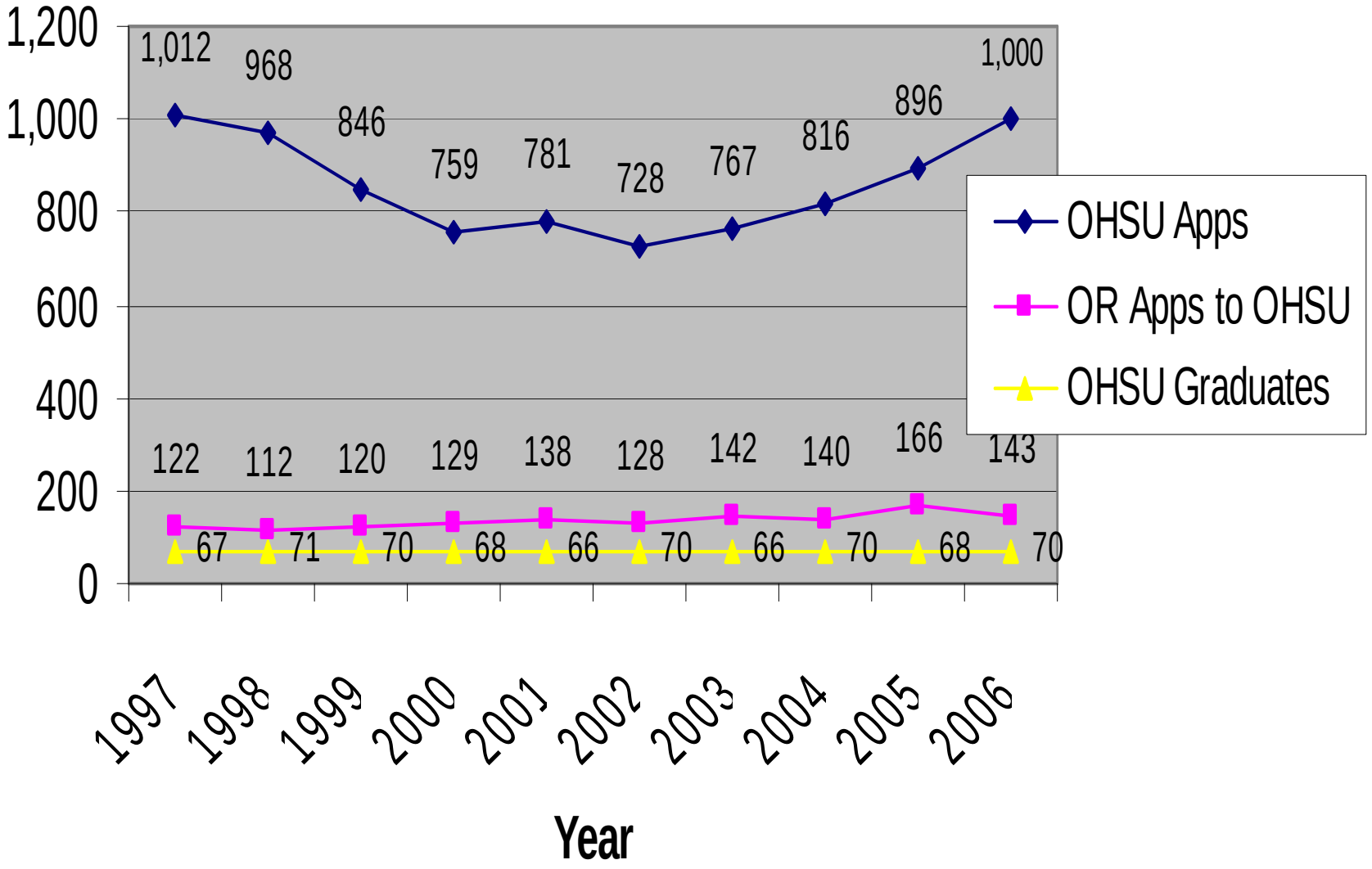


OHSU School of Medicine
Class of 2011

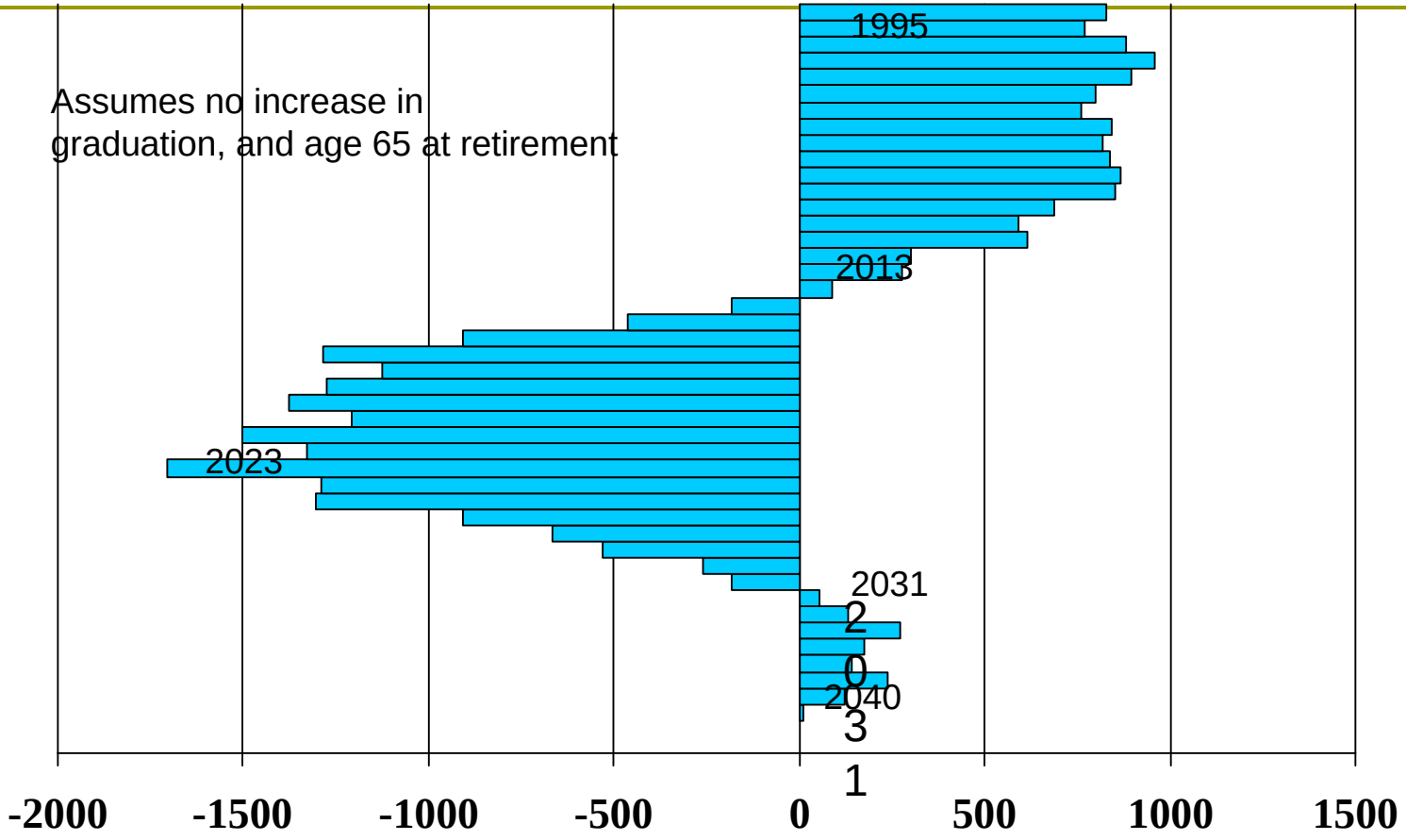
- **Students:** 120 ave age 26, ave GPA 3.61 (science GPA 3.58) 21 previously applied
  - Female 64
  - Male 56
  - Oregon Resident 84 (up from <50% 2003)
  - Non-oregon resident 36

- **Race/ethnicity** (students may select more than one category)
  - African American or Black 3
  - American Indian/Alaska native 1
  - Asian or Asian Indian 19
  - Mexican American/Chicano(a) 3
  - Other Spanish/Hispanic/Latino 1
  - White 93
  - No response 6

OHSU Dental Applicants/Graduates 1997-2006



US Dentists: projected net addition to the workforce



OHSU funding

- 69th out of 74 publicly supported medical schools (AAMC 2004) and last in support per medical student among Western Colleges (2005).

- OHSU SOM Tuition and fees (2007)
  - Oregon residents: $30,277 ($25,068 tuition)
  - non-residents: $40,675 ($35,466 tuition)
  - Projected 10-25% increase in tuition for 2008 as a result of the loss of the tort cap

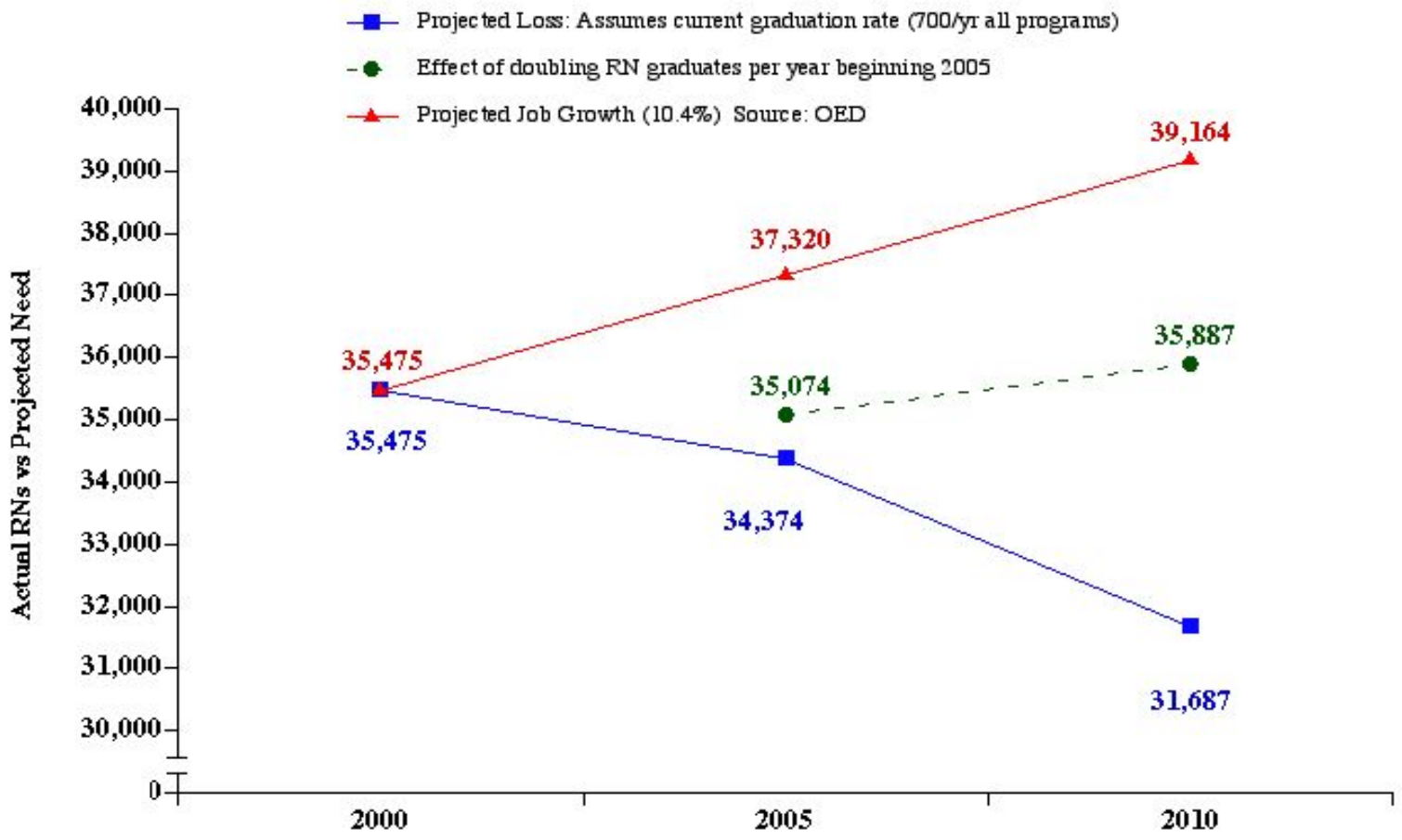
- OHSU SOM state appropriation has decreased by approximately 20 % over a period in which class size has been increased by 20%. (from 95 to120)
  - Reduction of class size to 115 in 2008 (tort cap issue)

Age of RN Population

	1980	2000	2004
Average Years	40.3	45.2	46.8
< 30 years	25.7%	9.1%	8.1%
< 35 years	41.4%	18.3%	16.6%
< 40 years	54.0%	31.7%	26.6%
> 40 years	48.7%	68.1%	73.4%

Source: National Survey of Registered Nurses, BHPr, HRSA

Projected Decline in RNs due to Retirement, Projected Growth in RN Positions, and Effect of Doubling RN Graduation Rate Beginning 2005*



*Data Source: NWHF Report, 2001

Oregon RN Workforce Projections

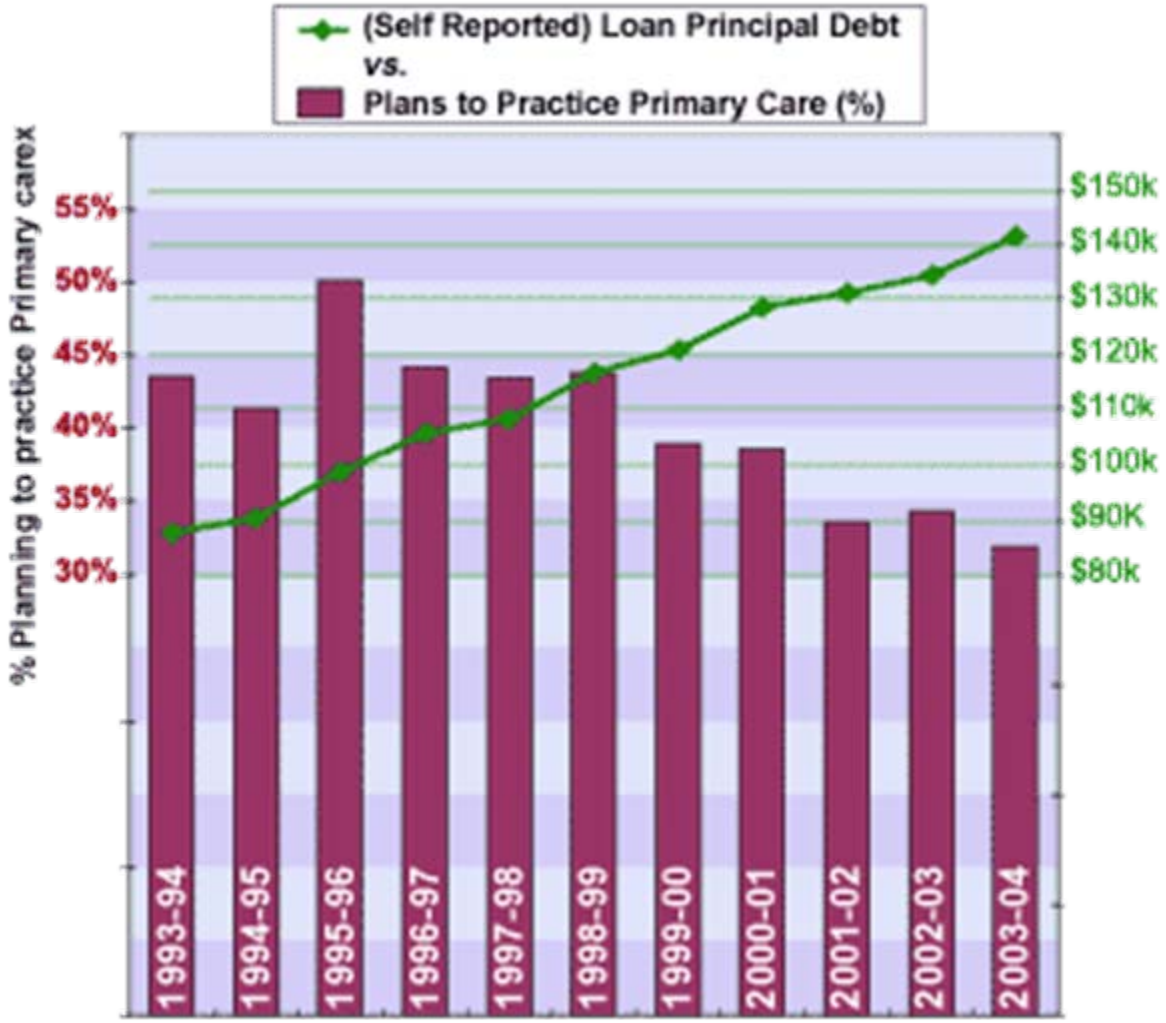
- A nursing faculty shortage is projected in Oregon.
  - 65 FTE faculty project retirement by 2010 -- roughly 1/3 of the faculty in Oregon.*
  - A shortage of nursing faculty will result in fewer nursing students graduating each year.
- A 20% shortfall of RNs in Oregon is projected by 2010 if we do nothing to combat the shortage. **

**Source: "When, Not If: A Report on Oregon's Registered Nurse Workforce", Oregon Center for Nursing, 2005*

***Source: NWHF, 2000*

Effect of debt on specialty choice

Source: AACOM



So

Women in medicine

- 1980: 10% practicing MD's, 23% students
- 1990: 15% 34%
- 2000: 23% 42%
- 2005: 29% 47%

- 72% of women MD's under 50 work full-time

Source: AAMC

Gender differences

- Women under 50
  - 72% work fulltime
  - Average 54 hours/wk (adjusted for part time)
  - Value time for family, personal time (82%)
  - Value flexible schedules (54%)
  - Value limited/no call
  - Desire less practice management responsibility
- Men under 50
  - 97% work fulltime
  - Average 59 hr/wk (adjusted for part time)
  - Value time for family, personal time (66%)
  - Less concern re: flexibility (26%)

Source: AAMC

Trends

- Additional specialization within specialty, decreased scope of practice
- Delayed entry into job market
  - Locum tenens
  - Additional training
- Part-time/job sharing
- Team care
- Medical home (continuity of place, rather than person)
- Non-traditional employment
- Planned job changes
- Shift-based work
- Phased retirement

What can we do?

- Advocate
  - Funding (K-12 and Higher Ed)
  - Financial aid/keep tuition low
  - Loan repayment options for service in underserved area
  - Admissions policies that don't exclude underserved/underrepresented populations
  - Integration of K-12 and Higher Ed curriculum
  - Real world education exposure for health career students
  - Expanded class sizes,
  - Universal healthcare coverage
- "Workforce education is economic development" is our political mantra