Investing in Oregon's Health Care Safety Net

Opportunities and Challenges

Safety Net Advisory Council

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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

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.

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 Stability Investment 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)

Revised –2/11/08

Policy Recommendation – STABLE FUNDING

Concept Summary:

Establish the Core Health Safety Net Stability Investment Fund.

Establishes a fund to address safety net system needs when there is a statewide downturn in the state and in local economies including but not limited to assisting clinics in financial trouble, making strategic investments to maintain safety net infrastructure, and investing in new sites or expansions where gaps are clearly identified.

This investment fund provides a source of capital in times of need including bridge funding and meeting cash obligations with technical assistance as a component to assist organizations with specific strategies to address underlying issues.

It provides a source of capital for expansion or improvement including facilities expansion or improvement, infrastructure not tied only to economic downturns.

Issue it addresses: *Core safety net providers as defined in SB 329*

- ***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, and that has a mission or mandate to deliver services.... serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare...*
- ***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.*[i]

Rationale

Currently no public fund or financing mechanism exists to help assure this principle is realized. There has been no systemic or statewide investment strategy in the safety net. As a result, the safety net has evolved organically responding to a variety of circumstances across the state over a number of years. This has resulted in both strengths and challenges; the good news is that a network of core providers has evolved to meet the needs of different communities. The challenge is that public policy has limited tools with which to support critical community investment, expand its impact, and to help assure its strength and viability. The Core Health Safety Net Stability Investment Fund would provide such a tool. Recent recession talk and the safety net's inverted relationship to a downturn in the economy underscores the need for such a tool.

How it would work:

Core Safety Net Investment Model:

- "Grow" investment fund sufficient to provide $1m in grant funds for year 1, $2m for year 2, $3m for year 3 and sustained at $3m per year

- Fund priority safety net investments from interest
- "Fund" investments also from low interest loans to safety net entities who "repay" revolving loan fund
- Link funds where possible with foundation initiatives to magnify impact
- Include technical assistance role to address issues that are beyond immediate available of cash ie, financial management, business planning, etc.
- Link to matching funds where feasible
- Administered by DHS with necessary expert staffing in house and/or contracted in regard to loan component, guidelines and administrative rules and with oversight by Safety Net Advisory Council with addition of necessary financial expertise
- Or administered by foundation or other independent entity with necessary programmatic and financial skills

Priority Investments:

- Focus on core investments in safety net infrastructure for the provision of primary care, oral and behavioral health
- Identify and assist clinics experiencing financial difficulty
- Identify communities or clinics to establish sites where gaps exist and a feasible long term plan is adopted
- Assistance with recruitment and retention of workforce and/or the use of transformative technology
- Assistance with availability of pharmaceuticals
- Where commitments to providing documentation of outcomes over time are present
- Where matching funds are present
- Where linkages are established with health districts, public health departments, collaboratives, hospitals, other providers, and health systems as appropriate to the location
- Where other existing programs such as tax credits and loan repayment are utilized
- Where commitments to a diverse workforce are present and realized within the limitations of location

Building The Investment Fund - Options for creating the revolving fund include but are not limited to:

- Legislative appropriation
- Public bond
- Partnership between foundations, community funds, health systems, and insurers, and state with contribution to retire bond or establish fund

- Model "adoption" process whereby insurers and health systems adopt sites or clinics for a limited time period to assist them in repaying loans

Anticipated outcomes:
Greater financial stability for the safety net as a whole and in specific communities. Improved safety net ability to respond to changes in the economy. Gaps in the safety net addressed. Improved core infrastructure among safety net clinics. Shared responsibility across key stakeholders and communities. Stronger component of the roadmap.

Cost and how it might be financed:
"Grow" investment fund sufficient to provide $1m in grant funds for year 1, $2m for year 2, $3 for year 3. In addition loans would be made once the fund was sufficiently established. Investing at this level would make a significant difference in the stability and viability of the safety net over time. Expertise in modeling the size of the fund necessary to achieve this rate of grant and loan allocation is needed.

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

SAFETY NET ADVISORY COUNCIL (SNAC) **Revised 12-12-08**

Policy Recommendation – CRITICAL INFRASTRUCTURE TOOLS

Concept Summary: *

Address ***barriers to safety net electronic health record adoption.*** Provides alternative mechanisms to fund and assure high safety net adoption rate and optimum application of electronic health technology. This recommendation proposes ***three possible strategies***. They may be adopted individually or in combination. They include an Electronic Health Record fund established by legislative appropriation, state and federal partnership, adoption of a shared cost or utility like model to cover adoption and maintenance. This approach will improve quality of care; provide better information for providers and treatment for patients, greater efficiency and coordination across the delivery system and improved ability to monitor public health.

Background:

With the passage of Senate Bill 329 Oregon committed itself to assuring access and coverage to Oregonians and to reforming the delivery system to help assure access, quality, and safety as well as controlling the rate of cost. There is growing conjunction of federal policy and emerging state policy regarding Health Information technology. There is developing federal policy regarding standards for interoperability and both a state and federal focus on privacy issues.

Oregon has recently been presented with two significant opportunities to develop the necessary health information technology infrastructure. The state received over $5 million through the Oregon Medicaid Transformation Grant to develop a personal health record model for the Medicaid population. Additionally, Oregon was awarded over $20 million by the FCC to fully implement broadband connectivity for rural areas.

In essence the message is clear – 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 has a key role to play in each of these initiatives and policy makers can assure it has the necessary resources to do so.*

It must be underscored that while this is new territory for most, it is particularly unfamiliar to many safety net providers. Furthermore, there is no way to ensure that the investment will be no-risk or even low-risk to begin with. Health information technology is capital intensive and will require both a significant investment up front as well as on-going technical support.

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* *A note on workforce* – it is clear that we need an "e" workforce to go along with e-health technology and its associated implications for clinical practice if we are to realize the promise of health information technology. *It is recommended that the Oregon Health Workforce Institute assess the state of e-health related needs* and work with education institutions and employers, to assure the availability of individuals with necessary skills, certifications, and degrees.

The Safety Net Advisory Council strongly urges the state to engage expert analysis of the electronic health record/personal health record funding options to review the literature and assist with developing the most viable funding option. With that caveat, the SNAC suggests the following alternate approaches.

Summary of Alternative Funding Strategies: (Consider and adopt singly or in combination)

- Create a ***safety net EHR investment fund*** through a legislative appropriation matched by local collaboratives, health systems, and insurers sufficient to capitalize an 80% safety net adoption rate. Also include low interest loans, revolving loan fund for future adopters, initial pay for performance steps

- ***State and federal partnership*** leveraging Medicaid and Medicare dollars to invest in clinic network models to bring down cost and support adoption through volume purchasing, subsidies for acquisition, and integrated quality improvement and patient safety strategies

- Define an ***Oregon style "utility" model*** for funding the cost of EHR adoption, beginning with the safety net and expanding to other parts of the health system. Incorporate technical assistance, quality improvement, patient safety, and primary care renewal elements.

Rationale:

- **Across all providers** – hospitals ahead of curve, health systems clinics 52.2% adoption rate, solo clinician practices 19.3%, 2-4 clinicians 25.1%
- **Safety net** – Public and FQHC clinics (20.4%)
- by each safety net sector – FQHCs 29.6%, SBHC in Public category 20.4%, RHCs likely less than 15% (arbitrary percentage)
- Churning of individuals on and off Medicaid and across health plans and providers
- the need for more systematic approaches to comprehensive EHR adoption
- Government, federal, state, and sometimes local obtain and/or leverages resources for those providers without the margin to invest
- Important to identify critical criteria for a comprehensive funding strategy
- Potential for some strategies to help facilitate adoption across the entire system
- Some resources and solutions unique to the safety net are needed

Safety Net:

- Includes school based health centers (SBHC), Federally Qualified Health Centers (FQHCs) (otherwise known as Community Health Centers), Rural Health Clinics especially those known as Isolated Rural Health Centers (IRHC), and volunteer clinics

- Together these clinics provide services to the uninsured and represent a significant part of Medicaid capacity
- Increasingly a larger percentage of Medicare clients, with the exception of SHBCs, will be seen by those clinics who currently comprise the core safety net
- While the primary emphasis of this analysis and recommendations is on the core safety net it is important to recognize that many small to medium offices also provide some level of care to a similar population
- Some EHR solutions or strategies may be focused on the core safety entirely or in other cases scale may suggest integrated_solutions_across a broader portion of primary care

Barriers to adoption:

- **Across all providers** – initial system cost, initial temporary productivity loss, risk of failure, ongoing cost, confusing array of products, lack of expertise, ok with the way it is, someone needs to lead the charge
- Lack of state HIT roadmap "target end-state architecture vision – in process but not at "use" stage
- **Safety net specific** – Generally similar especially regarding cost and productivity loss but with much less income and operating margin then private sector, less access to capital
- Without the same ability to generate additional margin, safety net provider funding strategies involve financing EHR through reduced services to uninsured Oregonians
- Within the safety net, not all "lines of business" are equal: – FQHCs (and associated SBHCs) have the greatest exposure to EHR through OCHIN (an Oregon based clinic controlled network); SBHCs not associated with FQHCs have limited exposure and resources. RHCs especially isolated rural ones are concerned with the full range of barriers and limited time and resources to attend to EHR. Volunteer and free clinics, in addition to other barriers may face the challenge of recruiting additional volunteer and in-kind resources to maintain an EHR. In addition, ability to adopt inversely related to percentage of uninsured clients served.

Current approaches to funding

- **Across all providers** – self-finance from profit or operating margin, loans
- **Safety Net** – federal and foundation grants, capital fund drives, loans, county general fund (for those that are also FQHCs), collaborative approaches such as OCHIN, reducing capacity to serve
- Federal grants relating to HIT adoption
- Note limitations of grants
- Note uneven resources and fragmented strategies across the safety net
- Pay for performance at early formative and explorative stages
- Lack of incentives slows adoption rate across all primary care

Cost and Potential Financing

Suggested criteria for consideration of options:

- Broad based stakeholder participation – purchaser, insurer, consumer
- Approach addresses needed changes in clinical practice to assure optimum outcomes from EHR implementation
- Targets penetration percentage across safety net and primary care
- Linkages to other EHR related initiatives are established
- Provides key elements for systemic solution
- Provides solutions that may be applied retroactively, to include early adopters
- Not overly complex
- EHR products are certified
- Concepts include technical assistance for EHR selection
- Concepts provide technical assistance for optimizing EHR utilization
- EHR selection and implementation is closely linked to clinicians and evidence based clinical practice
- Concepts assure EHR is integrated into quality improvement and patient safety practice
- Concepts assure Rural EHR network capacity across large rural areas of the state and multiple small clinics

Alternative Funding Approaches:

A. Safety net EHR fund

- State incentive package or menu including grants, low interest loans, revolving loan fund for future adopters, initial pay for performance steps
- Cost for 80% safety net adoption rate over 2 years estimated
- Cost burden is shared by state general funds, purchasers/insurers/health systems share, and local partners share
- Legislature appropriates EHR Safety Net adoption fund
- Other purchasers contribute to grant and/or loan pools
- First priority for grants for isolated rural areas and other entities with very limited access to capital
- Minimum requirements for access to fund determined including pay for performance indicators
- Grants and loans fund amount based on loans sufficient to accomplish desired adoption rate
- No interest loan repayment over 5 years for individual adopters using the loan component

B. State and Federal partnership

- DHS/CMS/HRSA partner to model integrated safety net EHR funding strategy. Per member per month cost is determined for Medicaid and uninsured individuals and partners share cost proportionately, Medicaid for Medicaid, and DHS and HRSA for uninsured. Incorporating set of expectations for quality improvement and EHR adoption, e.g. use of health center controlled networks and/or application service providers could be additional elements of such collaboration – See HHS description of demonstration using Medicare wavier authority as a potential model for Medicaid. (http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/EHR_Summary.pdf)
- Partners set adoption target and primary care renewal related targets
- Partners establish leveraging linkages between Medicaid Program, Medicare Program, Medicaid Transformation Grant, FTC grant, and Intergovernmental Transfers, alternatives to PPS, or other mechanisms
- Identify statewide infrastructure to facilitate EHR adoption and maximize benefit of group purchasing such as health center controlled networks and/or application service providers to bring down cost and support adoption through volume purchasing, subsidies for acquisition, implementation assistance, and integrated quality improvement and patient safety strategies

C. Oregon EHR Utility

Key principle – access to and funding for electronic health technology could be on a basis similar to water, fuel, and other similar resources needed by the public at large

- Elements common to utility services, according to M.A.Rappa* include necessity, reliability, usability, utilization, scalability and exclusivity although in various public models exclusivity may be not be utilized in favor of a more competitive arrangement.
- utility operates and maintains access to the needed resource and distributes cost across all "users" including initial implementation and ongoing costs or only initial implementation costs
- The ultimate beneficiaries are low income and uninsured Oregonians. In this model stakeholders act on their behalf providing the initial necessary capital with both the stakeholders and patients deriving benefit
- Concept is scalable to the safety net and based on success could be expanded to include all 2-10 person offices, and beyond that to all health systems

C(i) Utility Adoption Goals

- Statewide goal could be set 80% of all core safety net providers and/or broader Medicaid primary care adoption of EHR within 2 years
- Implementation costs for 80% safety net adoption rate within 2 years can be estimated at________.
- Implementation costs for 80% adoption by all Medicaid providers within 2 years can be estimated at________.

C(ii) Utility Core Structure

- Initial capital fund financed by a commercial bank – at XX dollars
- Entity selected to manage distributed payments and services payments on line of credit
- Cost is distributed across Medicaid, Medicare (?), private insurers, and clinics on a per person per month basis including costs for the uninsured
- All funding entities participate in governance body (non profit or semi-independent stage agency, e.g. EHR commission?)
- Patients/consumers also participate on governance body
- Initial capital acquisition costs distributed over 5 year pay-off period?
- Entity provides group of EHR transformation services including technical assistance at implementation, implementation and optimization of primary care home care management elements and related patient safety and quality improvement elements.
- Participating providers agree to implement A Certification Commission for Healthcare Information Technology (CCHIT) certified EHR
- Participating providers agree to adopt and implement quality measures as determined by project governance
- Initial focus on safety net then expansion to all primary care
- Safety Net to goal adoption cost estimate and utility related income estimate needed
- Medicaid to goal adoption cost estimate and utility related income estimate needed

Anticipated outcomes of EHR adoption:

- "The driving force for adopting advanced health information technologies is the potential it provides for improving the quality and safety of health care." From a report produced by Office of Health Policy and Research in 2007 **Potential Impact of Wide spread Adoption of Health Information Technologies on Oregon Health Expenditures**
- "The net potential savings in Oregon from the widespread adoption of advanced health information technologies are between $1.0 and $1.3 billion annually. This level of savings would yield a net reduction of 4.3% to 5.9% on Oregon's health expenditures. Such savings are possible within 12 years with aggressive implementation efforts."
- "For uninsured patients the payers are predominantly the physicians, **safety net clinics** and hospitals that end up financing the uncompensated care they provide. When services are avoided, the costs of uncompensated care rendered to the uninsured absorbed by physicians, hospitals and other providers would be lower."
- **Policy makers** – data to make good policy, less cost, greater value
- Good products combined with good practice, quality improvement, safety, and technical assistance leads to:
- **Patients** – better care, safer more affordable care, and information on their care

- **Providers**- patient and treatment information when needed and greater capacity to manage care on behalf of their patients
- Create the groundwork enabling movement of patient information between providers **(Health Information Exchange)**
- **Public health** – monitoring and improving population health

SAFETY NET ADVISORY COUNCIL (SNAC)

Revised 2-12-08

Policy Recommendation WORKFORCE

Concept Summary:
Rural Locum Tenens Program*

Public Policy Goals:

1. Provide temporary coverage to rural healthcare providers during vacations and continuing medical education
2. Sustain medical and dental service delivery when local providers are away from their respective rural communities
3. Provide longer term medical and dental services to rural communities without medical care services or those that have lost medical care services
4. Expose medical residents and OHSU faculty to the realities and opportunities of rural medical and dental practice

Taken from the Latin "to substitute for", locum tenens providers are physicians who provide temporary medical services for a specific length of time. This can vary from a few days to allow for vacation or continuing medical education, to several months for medical leave or interim coverage between providers.

The Rural Locum Tenens Program seeks to assist rural communities, physicians and dentists by providing reasonably priced, high quality, reliable relief coverage so that these providers may have time away from their practices for continuing education, vacation, health or other personal reasons or family time. In addition this model may provide longer-term services to communities without medical or dental care and may be linked to supervision of mid level networks in certain areas of the state.

Issue it addresses:
Multiple factors jeopardize adequate healthcare coverage for rural communities in Oregon and nationwide.

- Inadequate number of medical and dental school positions (Oregon and nationally)
- Inadequate number of residency positions (Oregon)
- Declining enrollment of students from rural backgrounds (nationally, somewhat less so in Oregon)
- Declining student interest in primary care specialties (nationally, less so in Oregon but still a problem)
    - Rapidly rising debt load limits interest in lower paying specialties and areas among health profession students (medical, nursing, allied health)
    - Low reimbursement rates for primary care specialties
    - Admissions policies that favor students unlikely to go into rural practice

* Concept initially developed by a work group of the Oregon Health Workforce Institute – SNAC is appreciative of their effort

- Declining state support for the public and education missions of OHSU (Oregon is 45th out of 48 in per student funding among medical schools who receive public funding)
- Changing demographic of medical school graduates
    - Approaching 50% women
    - More dual career families (w/spouse needing to be in urban area for job)
    - Trend toward medical careers with less call, more scheduled hours
    - Less willingness to commit to long-term practice location
    - Increased number of job changes over career
    - More employed physicians, no desire to run a small business
- Rural physician population older than urban population
- Rural population older, and aging faster than urban
- More dependent on Medicaid/Medicare, more uninsured in rural leading to reduced reimbursement and marginal profitability of rural practices
- Vulnerable infrastructure in rural communities (schools, social, economic)
- Inadequate loan reimbursement/forgiveness opportunities

Due to these and other factors, attracting physicians and dentists to live and practice in rural communities is getting harder. Graduating physicians find they can have less call, better income, and better opportunities for spouse and children by choosing non-primary care, urban jobs. This is compounded by the increased workload that then falls to those who do choose to go to rural areas.

Rural practices and hospitals have difficulty covering the needs of their community on a 24 hour, 7-day per week basis due to the limited numbers of providers present in the community. Many rural communities do not have sufficient medical staff to allow physicians or dentists time away for vacation, continuing education and other important activities to prevent burnout and increased turnover. In addition, the broad scope of practice inherent in rural practice can make finding temporary coverage difficult or prohibitively expensive. Commercial locum tenens agencies charge fees substantially higher than can be afforded by rural physicians, whose incomes and practice revenues are not sufficient to support those costs.

How it would work:
Utilizing OHSU faculty, fellows and residents will make available a high quality, well-trained workforce for rural communities; provide coverage at a lower cost with broader scope of practice than is often available from commercial sources. Benefits to OHSU and the faculty are enhanced practice opportunity and maintenance of skills for participants, additional income opportunity to departments and physicians, and the opportunity for young physicians and dentists to experience rural life and practice without an initial full-time commitment (which may enhance recruitment opportunities for these communities).

As the only current academic health center in Oregon, OHSU holds much of the responsibility for training physicians and dentists to meet the needs of all Oregonians. Faculty, fellows and residents can participate as locum tenens providers on a part-time

temporary basis as part of their regular duties, or as extra income producing work. Because OHSU already verifies credentials of its physicians, communities do not sustain any extra expense to perform these essential tasks. Academic health center based programs exist in other areas, such as University of Kansas and University of New Mexico.

Anticipated outcomes:

For rural physicians and dentists:

- Affordable practice relief for vacation, continuing education or illness
- Supplemental assistance during busy times
- Ability to keep office open and staff employed
- Revenue produced when office would otherwise be closed
- Recruitment

For locum tenens physicians and dentists:

- Opportunity to experience rural practice without having to commit long term to one location
- Income to relieve financial burden
- Skill enhancement
- Flexible scheduling and part-time work availability

For rural communities:

- Ability to obtain 24 hour/7 day medical services
- Recruitment
- Economic development, keeping medical care in the community
- Opportunity to showcase community to potential physicians and dentists.
- Infrastructure development

For OHSU:

- Support for rural communities
- Training opportunities for faculty, fellows and residents
- Academic faculty skill enhancement and maintenance
- Support for community physicians who provide teaching service to OHSU

Cost and how it might be financed[*]:

Fees generated by the program will provide the majority of the funding. To keep fees low enough to be helpful, however, there is a need for additional support. The Area Health Education Center at OHSU received grant funding for program planning and development. Additional funds will be sought from the Legislature for start up costs, administrative overhead, and technical assistance for communities seeking locum tenens services. Funds will also be sought to provide a program subsidy for services provided in medically underserved areas. These funds, if obtained, can be used to sustain the first 2-3 years of start up for the program. A sliding scale fee will be developed in order to keep the costs low enough to be feasible.

[*] These cost projections were undertaken prior to the inclusion of dentists into the locum tenens program and will need to be re-thought to incorporate this addition.

The start-up costs for a locum tenens program at OHSU would be $1 million for the first biennium. On-going funding will decrease once the program is up and running as fees and revenues generated by the provision of medical services will offset most program costs. There will likely be the need for $500,000 of state funding per biennium to subsidize locum tenens services to communities that cannot cover the costs (e.g. rural communities with no local hospital).

Concept Summary:*

Support of Physician Assistants and Nurse Practitioners to Meet the Rural Primary Care Medical Needs of Rural Oregon

Public Policy Goals:

1. Recognize the reality that the limited present and future supply of primary care physicians will have added adverse impact to rural Oregonians.
2. Provide an increased pipeline of physician assistants and nurse practitioners educated to provide primary care services in rural communities.
3. Due to the shorter length of training, be able to quickly increase the supply of qualified primary care providers for rural communities.
4. Utilize existing public health or other community infrastructure to provide a "home" for supervising physicians
5. Link effort to achieving specific health outcomes through training of mid-levels in integrated primary care and public health approaches

Provide targeted investments in existing physician assistant and nurse practitioner educational programs to provide incentives for the recruitment of students from rural areas through pre-awarded loan forgiveness (pending successful completion of the training program) and expanded rural rotations for these and other students.

Provide incentive funds for local health departments or other entities to hire a physician, supporting up to four to eight physician assistants that would serve the more remote parts of the participating counties or regions. Physician assistants are a good fit for remote, low population communities that are unable to attract or support a physician. If two or more counties partnered in such an arrangement it would likely be more sustainable over time. This local network concept could entertain other partners such as rural hospitals to help spread the cost and contribute to sustainability. Formation or utilization of an existing health district might provide a framework for this relationship.

This employment arrangement may also relieve the burden of cost of the physician's malpractice coverage, as s/he would be the employee of a public agency. Note: Tort Liability situation is up in the air as the result of the recent State Supreme Court decision

* Note: This concept was originally developed by a rural health work group of the Oregon Health Workforce Institute (OHWI). It has been modified in some ways to further clarify the concept. The Safety Net Advisory Council appreciates the OHWI commitment to developing ideas to address workforce needs.

that the tort liability cap is too low. This is an issue that will have to be addressed and is broader in implication than this particular proposal.

While nurse practitioners and certified nurse midwives do not require the supervision of a physician in order to practice in Oregon, that supervision is required to comply with federal Rural Health Clinic (RHC) regulations. The same arrangement could be utilized for nurse practitioners and certified nurse midwives working in rural health clinics. Similar partnerships to those noted above in regard to physician assistants could be developed. The health district model could facilitate a regional approach to addressing rural workforce needs.

This model could be further developed to link the work of community health workers, community paramedics and public nurses into a coordinated team to assure the provision of necessary care and health promotion and preventive services.

Issue it addresses:
This concept would address the economic challenges faced by rural areas of the state in providing for health and healthcare related services. It would help address some of the challenges faced by rural health care and rural public health.

Oregon has been one of the national leaders in the training, licensure and deployment of physician assistants and nurse practitioners. Presently approximately 650 physician assistants are licensed in Oregon. Of these, approximately 300 practice in primary care throughout the state, one-third of who are working in the Portland metropolitan area. There are presently approximately 2,750 advanced licensed nurses (nurse practitioners, certified nurse midwives, Certified Registered Nurse Anesthetists) actively licensed in Oregon.

Several national trends indicate a future significant shortage of primary care physicians:

1. Inadequate numbers of medical students in the educational pipeline to meet the projected needs of a growing and aging population and to replace physicians who will retire in the coming ten years.
2. Fewer and fewer medical students choosing primary care specialties due to many causes such as lower income and demanding life style.
3. The time lag of at least 8 years (four years of medical school and four years of residency) to add additional primary care physicians.

Communities often shy away from considering physician assistants due to the additional cost of the supervising physician.

How it would work:

- County wide or multiple county public health commitment is made to provide the home for network supervision
- Similar commitments are made if rural clinic, rural hospital or other entities commit to network supervision

- Entity partners with educational institutions to provide options for rural rotations and other approaches to enhance the likelihood of placement in their communities and education program target is established
- Educational institutions recruit and enroll
- Area Health Education Centers participate through health career approaches at the elementary and secondary level
- Office of Rural Health links loan repayment program to students at beginning of program and monitors relationship
- Steering committee comprised of stakeholders provides a home for the overall strategic partnership
- Effort is evaluated by external parties against predetermined outcome indicators

Cost and how it might be financed:

1. Legislature provides targeted investment appropriation to existing physician assistant and nurse practitioner educational programs to facilitate the recruitment of students from rural areas and to expand rural rotations.
2. Funds are added to loan repayment program to address commitment provided to recruited students

http://www.ohsu.edu/ohsuedu/outreach/oregonruralhealth/providers/upload/loan-repayment-faq.pdf

3. Legislature provides matching implementation funds to encourage local health departments to participate and provide the necessary supervision and coordination
4. The deployment of physician assistants and nurse practitioners to rural communities comes with the added costs of paying for a supervising physician and his/her malpractice exposure costs.
5. Cost is shared by legislature through its appropriation for loans and other incentive costs, public health in-kind and general fund costs or health district revenue, and other community participants
6. State total cost participation is limited to initial four year period and extended another four years pending evaluation activity
7. State participation is front loaded and tapered off over the life of the project with potential longer term commitment limited to education appropriation and incentive funds for new areas of the state
8. Cost categories include loan repayment and/or forgiveness commitments, mid-level supervision, education institution recruitment funds, Area Health Education participation, technical assistance from Office of Rural Health or other sources
9. Cost to be projected

Anticipated outcomes:

- Additional mid-levels would help address rural workforce needs
- Educational institutions would increase the flow of trained mid-levels in the pipeline and would have confidence in the availability of resources to make this happen

- The cost burden would be distributed across more entities and limiting the burden on any single entity
- Effort would be linked to identified health outcome and access indicators

Concept Summary: *

Oregon Health Services Corps (OHSC).

Strengthen Oregon's Recruitment and Retention Tool Chest through the implementation of an Oregon Health Services Corps (building on the existing limited loan repayment program) making it available to the workforce communities the safety net depends on: physicians, mid-level practitioners, dentists and dental hygienists, and behavioral and mental health practitioners including but not limited to psychiatrists, psychologists, social workers, and treatment specialists. Provide a high level of coordination and integration with other programs addressing workforce needs. This recommendation will provide resources for communities, helping them to compete for available individuals regionally and nationally. This program should be seen as a **companion to the Tax Credit program** described in another recommendation brief. Both programs are part of Oregon's recruitment and retention tool chest.

Public Policy Goals:

Provide a sustainable supply of qualified health professionals to underserved Oregon communities to maintain and improve the health of the community while contributing to economic development.

Issue it addresses:

The loan program was originally created in 1989 although awards were not made until 1994. Since then 122 health professionals have been awarded loan repayment. Of the 122 38% are physicians, 38% are nurse practitioners, 22% physician assistants and 2% are pharmacists (added in 2005). Dentists were added to the program in 2007; the first opportunity for a dentist to be awarded loan repayment will be in 2008. Of the 122 awardees, 20% are currently receiving payment and 38% have fulfilled their obligation and completed the program and 42% either declined or forfeited their award. **Funding remains at $400,000 per biennium**, the level originally appropriated in 1989 **and** with the additional eligible professions added.

Given projected workforce needs the amount appropriated, the amount available for each health professional, and the range of health professionals included is insufficient to attract the range of workforce needed. Loan repayment and related support services are not generally available to other necessary parts of the workforce. That includes behavioral health practitioners other than those covered above and dental hygienists.

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*Note: This concept follows closely but not exactly recommendations developed by a Rural Health Policy Work Group staff by the Oregon Health Workforce Institute. The Council appreciates the work of this group and its focus on an area of critical need.

The federal government makes loans and scholarships available through the National Health Services Corps. Physicians, nurse practitioners, physician assistants, dentists, mental and behavioral health professionals, certified nurse midwives, and dental hygienists are eligible for loan repayment or a limited number of scholarships based on practice site scores. They must agree to serve in underserved areas and fulfill a minimum service commitment. Currently Oregon has about 60 practitioners who benefit from this program. Federal funds are limited and must be distributed across the 50 states. Available loans are far fewer then the need nationally and locally. It is an important resource for Oregon but is limited in its ability to meet Oregon's needs.

How it would work:

Eligibility: Similar to Oregon's current program but adding mental health professionals and dental hygienists. While the workforce shortages in rural communities are especially critical and require prioritization, there should be the potential for adding eligibility for certain high need urban areas based on poverty level, health disparities, and other indicators once the rural program is adequately and sustainably funded. This determination should be undertaken in consultation with the Office of Rural Health, Office of Health Policy and Research and Department of Human Services.

Program Parameters: Similar to current LRP. Potentially extend years and total eligibility amount. Target an actual number of loan repayers based on projected size of rural network we would like to sustain. Loan repayment can be pegged at 80% covered equally over four years and the remaining 20% as a bonus for an additional two years of service in a designated underserved area.

Penalties/Enforcing Provisions: Current LRP

Evaluation/Monitoring: Use Return on Investment (ROI) methodology to determine whole community benefit: calculate number of patients seen; determine retention rates (including how many remain in the same location and how many continue to serve underserved populations); obtain feedback from sites, communities and students. Provide data on outcomes to the Oregon Health Workforce Institute (OHWI). Secure OHWI participation in evaluation activities.

Administration: Office of Rural Health (stronger rural community connection) and/or Oregon Office of Health Systems Planning (HSP) where National Health Service Corps (NHSC) related expertise and coordination resides. The loan repayment administration should remain with the Oregon Student Assistance Commission (OSAC). Additional staffing of at least 1 FTE would be needed to assure the success of this program.

Additional Innovations and Linkages:

- Add robust communication and training component (technical assistance) over and above loan Repayment.
- A truly comprehensive program would include loan forgiveness as well as loan repayment. Loan forgiveness programs make the loans to students, and then

"forgives" repayment of those loans if the newly trained provider practices in identified areas of need. Loan repayment simply grants $ to be used to pay off student loans regardless of their source. Loan repayment is a short-term strategy; loan forgiveness is a longer-term strategy that enables us to cultivate rural Oregonian health professional students/providers.

- Integrate with clinical practice support resources (locum tenens, telehealth, protocols, rural health outreach, health professional training, Oregon Rural Practice-based Research Network, etc.).
- Link OHSC to Area Health Education Center (AHEC) pipeline activity at the high school level (link loan repayment information to pre-med students, pair students with loan recipients, create high school college- level memberships and other membership categories, etc.). This is in part a "branding" process to build a pipeline of future OHSC and to build sense of belonging to something important.
- Work out a mechanism to provide partial loan repayment to locum tenens providers who work in underserved areas of Oregon.
- Tie OHSCorps as a "community menu option" with strong technical assistance to support deployed practices and encourage provider retention.
- Add community generated incentives to OHSC membership; for example, in order to qualify for state support, a local community may have to provide an in-kind match that could consist of an equipped clinic/office facility, housing for the locum tenens and/or full-time provider and a community board of directors/advisors

Anticipated outcomes:

- Rural Oregon and the safety net is better able to compete with urban areas and other states
- Incentives are sufficient to draw needed professionals to rural areas and to the safety net

Cost and how it might be financed: Legislative appropriation

<u>**Assumptions**</u>**:**

Average physician/dentist/pharmacist educational debt = $130,000
Target 10 <u>new</u> physician/dentist loan repayment candidates per year =
Year 1 = 25% X 80% X 10 =$260,000
Year 2 = 25% X 80% X 20 =$520,000
Year 3 = 25% X 80% X 30 =$780,000
Year 4 = 25% X 80% X 40 =$1,040,000

Average other health professionals (nurse practitioners, physician assistants, radiographers, etc.) = $50,000
Target 20 <u>new</u> loan repayment candidates per year
Year 1 = 25% X 80% X 20 =$200,000
Year 2 = 25% X 80% X 40 =$400,000
Year 3 = 25% X 80% X 60 =$600,000
Year 4 = 25% X 80% X 80 =$800,000

Note: *Doesn't yet include costs for behavioral health, dental hygienists, or other providers or any additional staffing costs*

Projected Biennial Costs: with additional 1.0 FTE for the ORH and additional 1.0 FTE for OSAC
2009-2011 Biennium: $1,900,000 (includes some administrative costs)
2011-2013 Biennium: $ 3,900,000

Concept Summary:

Update Oregon's Tax Credit program

Increase tax credit amounts originally established in 1989 and include additional eligible provider categories to attract and retain the workforce that communities and the safety net depend on: physicians, mid-level practitioners, dentists and dental hygienists, and behavioral health practitioners including but not limited to psychiatrists, psychologists, social workers, and treatment specialists.

Issue it addresses:

This program was initiated in 1989. Eligible professions include physicians, podiatrists, nurse practitioners, physician assistants, and dentists, EMT's, optometrists and certified registered nurse anesthetists. Practitioners are eligible for up to $5K/year and most are able to claim the maximum amount. Approximately 1,750 received the benefit last year at an estimated biennial of $14.6 million. **Maximum per year of tax credit has not been modified** since the beginning of the program. A number of professionals important to rural Oregon and the safety net are not eligible.

How it would work:

The following modifications to the benefit are proposed:

- Increase the tax credit maximum from $5,000 to $10,000 per year.
- Broaden eligibility for **dentists** and add provisions to include **behavioral and mental health providers** to the program with proportional tax credits.
- The emergency medical technician (EMT) tax credit should be revised to include **first responders**. Eligibility requirements should be changed so that professional EMTs who also volunteer their services are not excluded. A bill was introduced in the 2007 legislature that did not pass and would have corrected that unintended exclusion.
- Add community paramedics and other community health workers identifying proportional tax credit maximums

Anticipated outcomes:

Rural areas of Oregon and the safety net will be more competitive with urban areas and other states in attracting necessary workforce.

Cost and how it might be financed: Legislature passes bill incorporating changes and appropriating dollars. Impact of changes to tax credit provisions needs to be determined.

Concept Summary:

Flexible Workforce Approaches for Rural Oregon

Build flexible responsive community health infrastructure by establishing multiple community or regional networks and targeting key outcomes. Expand the range of individuals able to provide emergency medical services, treat or assist with treatment of certain acute and chronic conditions, and provide preventive and health promotion services. Provide the necessary education, certification, and clinical oversight. Adopt necessary payer policies. The use of Para-professionals must be fiscally sustainable.

Requires partners co-creating an environment where sufficient individuals are licensed and/or trained and certified and able to do what needs to be done complemented by communities and regions that partner with each other to provide the necessary supporting infrastructure of supervision, coordination, administration, and financing. Local government and public health departments, hospitals, clinics, ambulance companies, local advocates make up the critical mass of energy, experience, and commitment. State government has a role to play as well. Many factors contribute to the success of such partnerships.

- This means focusing on what can be done without physicians, nurse practitioners or physicians assistants *directly* providing = emergency services, certain non-urgent acute care, certain preventive services, health education, care coordination and linking this capacity to necessary and affordable clinical oversight
- Training programs and certifications can enable EMTs to provide certain medical services, preventive services, and health education
- Public health and other nurses can perform this array of activities with additional certification as EMT and depending on the person, training in preventive care and health education and/or can provide some level of coordination of these resources
- Community Health Workers can provide care coordination, case management functions, and health promotion with appropriate training and certification as well as EMT functions in some communities
- Use Community Access Project "Pathways" model to manage toward specific individual health outcomes in support of clinical and public health strategies http://www.chap-ohio.net/documents/PathwaysManual.pdf
- Research on community health workers is not deep but some does exist and is suggested of positive outcomes in some areas
- Extensive recent HRSA workforce study provides much information to support design efforts - see http://bhpr.hrsa.gov/healthworkforce/chw/default.htm#preface
- Globally and national pilots and models have been implemented or are being designed and provide information to inform design efforts http://ircp.ncemsi.org/

- Public health, educational institution, managed care organization and others have shown interest in the development of such models
- State and local public health departments to work together to facilitate analysis regarding prevalence of conditions and risk factors can help target geographic areas and specific populations
- Depending on the communities or regions a clinical team could consist of physician, nurse practitioner, public health nurse, EMT/community paramedic, and community health worker.
- Specific certifications or combinations of training and licensing would depend on the needs identified, the resources available, and the level of community and regional commitment
- Deployment to specific communities would be based on identified community need
- The administrative "home" could be a public health department, hospital, FQHC, RHC, SBHC, or other mutually agreed upon entity capable of providing administrative support.

Issue it addresses:
Rural areas have limited resources to address a range of health related needs including responding to emergencies, providing routine care, managing chronic disease, and preventing illness and injury. At the same time hospitals and public health resources have been limited for similar economic reasons. Rural communities have responded to these kinds of needs through attempting to recruit and retain the traditional roles of physicians, mid-levels, first responders and emergency medical technicians, and in some cases, public health nurses and other staff, each with their own relatively limited scope of practice or program. The increasing cost of health care makes it ever more challenging to maintain a basic infrastructure for health and healthcare in rural and isolated areas of the state. A vital and healthy rural Oregon helps assure a higher quality of life for all Oregonians.

How it would work:
Provide initial grants for up to 4 multi-county and/or multi-community pilots:

- Maintain commitment for minimum of 4 years
- Applicants must include support or participation of local health departments, community collaboratives, AHEC, RHCs, critical access, A, B, hospitals, FQHCs, SBHC, volunteer clinics, EMS providers as relevant
- Community or other educational institutions participate and provide necessary training and certification
- Year 1 state provides 80% grant, year 2 - 60%, year 3 - 50% year 4 - 40% year 5 and on maximum state participation 30%
- Maximum ongoing state participation 50% if health district or other similar mechanism established and maintained or the area is isolated and rural
- Progress assessment at the end of each year, two year preliminary outcome assessment and four years evaluation
- If evaluation is positive existing commitments are maintained and new areas selected

- Options for administration include DHS, Local Public Health Departments, Office of Rural Health, Higher Education or a combination.
- Evaluation could utilize community based participatory research models
- Potential partnership with Oregon Rural Practice Based Research Network http://www.ohsu.edu/orprn/

Anticipated outcomes:
- Use of more expensive and difficult to recruit physicians are used to optimal benefit coordinating the delivery of care across rural areas of Oregon
- Local healthcare and public health resources are more effectively utilized to create desired health outcomes
- More options for local residents to earn a living and contribute to their communities are created
- The needs of Oregon's rural communities and the resources of higher education are more effectively aligned to mutual benefit

Cost and how it might be financed: Through legislative appropriation. Model cost would decline over time to minimum state subsidy level. If successful at achieving outcomes model could be expanded to other areas of the state. See above.

Ball Park Estimated Cost to Imply Order of Magnitude

- $2,000,000 year 1
- $1,500,000 year 2
- $1,000,000 year 3
- $1,000,000 year 4
- 4 year total = $5,000,000

Cost elements include:
- Staffing cost depending on mix
- Staffing cost depends on existing mix
- Curriculum and instruction
- Clinical supervision
- Locum tenens as needed
- Travel
- Higher education related
- Assessment and evaluation
- Administration
- Insurance
- Facility related