Oregon's Healthcare Safety Net

A Report to

Governor, Theodore Kulongoski

The Oregon Health Fund Board

The Oregon State Legislature

Drafted by the Safety Net Advisory Council (SNAC)

August 2008

THEODORE R. KULONGOSKI
Governor

November 13, 2008

To: Legislators and Members of the Oregon Health Fund Board:

I am pleased to share the attached report on **Oregon's Healthcare Safety Net** produced by the Safety Net Advisory Council.

As many of you know, we have an increasingly large number of uninsured Oregonians. Even those Oregonians who have coverage may have difficulty accessing care. The many barriers to timely and affordable care include lack of coverage, geographic isolation, language and culture, mental illness, and homelessness. The safety net has emerged over time in response to these needs in communities across Oregon.

Over the years the safety net has been an important part of Oregon's healthcare delivery system, providing care to many. This has been true in economic good times as well as in the bad times. However, the scope, nature, issues, and needs of the safety net have not been widely known. As we address and consider the issues raised by the faltering economy and the recommendations of the Oregon Health Fund Board, it is important to learn more about the safety net and its role in providing health care access throughout the state.

The Council was created by the Governor's Office to advise policy makers. Its members have experience and knowledge of the larger health care system as well as the safety net itself. As Governor, I appreciate the dedication of the Council members and commend this report to you for your review.

Sincerely,

THEODORE R. KULONGOSKI
Governor

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Safety Net Advisory Council Charge

The Safety Net Advisory Council (SNAC) provides the Governor, the Director of DHS, the Oregon Health Policy and Research (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.

Primary staff support - Joel Young and Marian Blankenship, Office of Health Systems Planning. In partnership with Office of Health Policy and Research (OHPR), Division of Medical Assistance Programs (DMAP) and Office of Finance and Policy Analysis (FPA)

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Oregon's Health Care Safety Net

EXECUTIVE SUMMARY

~Vision~

Community-based, patient-centered care provided by the right clinician,
in the right place at the right time and available to all Oregonians.

We are all aware that we have a health system in crisis. It has largely been a system based on employer insurance. Many people don't have health insurance and others, who may have it, still have difficulty getting in to see a doctor. Oregon currently has over half a million people, or 15.6% of the population who are uninsured and others who are underinsured. Even for those who have access, the health outcomes aren't what they could be when the U.S. is compared to other developed nations. This has been a problem long in the making. Certain chronic diseases are very common and drive up the cost of healthcare. We know there are significant differences in health status depending on what group someone is a part of. Differences in health status may reflect geographic, ethnic, income-related or other unique characteristics. These problems are inter-related and will take concerted effort to adequately understand and address them.

Most of us are familiar with hospitals and emergency rooms, managed care organizations; medical offices including primary care and specialty care, and alternative care providers. Some of us may be less familiar with the health safety net, another key component of the system in the United States for delivering primary care. The term "safety net" may not be unfamiliar and is used in other areas besides healthcare. In general it refers to strategies to address both anticipated and unanticipated limitations in the design and implementation of various programs. Healthcare is not unique. No matter how much thought is given to its design we acknowledge that it cannot solve all problems all the time.

It is this fact of life that is behind the emergence of the health safety net and the particular role it plays as part of the health care delivery system. The purpose of this report is to share information about a significant part of Oregon's health care safety net. We do not address in any detail the critical part of the safety net that is focused primarily on mental health and addictions. That is for another place and time.

Key Components of Our Healthcare Delivery System

- Primary Care
- Specialty Care
- Hospital
- Mental Health and Addictions
- Alternative
- Oral Health

What is the Safety Net? A Community's Response

Oregon's Health Care Safety Net has been created by communities across Oregon responding to 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 organizations is a mission to provide health care services to people who are in need. While the lack of health insurance coverage is a prominent barrier among safety net patients, it is not the only barrier to healthcare access. Many who seek out the health care safety net confront geographic, language and literacy, racial/cultural, social and other economic barriers. Oregon's safety net providers share strengths and challenges in common but also present wide variation in the kinds of patients they serve and the services they provide. They also differ by funding sources and business models.

Several kinds of safety net organizations provide care to a substantial number of Oregonians. Oregon has 86 Federally Qualified Health Centers or Community Health Centers (CHC) in 44 cities and 25 Counties. School-based Health Centers (SBHC) are located in 45 sites in 19 counties and there are 18 planning sites for new SBHC's currently underway. Isolated Rural Health Facilities (IRHF) are a sub-set of Rural Health Clinics and are the single medical practice for their community in 17 sites in 14 of Oregon's most rural and frontier communities. Community Sponsored Clinics (CSC) are typically free and volunteer-based clinics that are supported almost entirely by the community. An estimated 13 such clinics are located at 30 sites, in 6 counties throughout Oregon.

Safety Net Clinics provide a range of services. Most offer acute and primary care. Many offer affordable pharmacy, disease management, prevention and wellness as well as mental/behavioral and primary oral health services. Others also provide a variety of enabling services such as translation, assistance with transportation and childcare.

A Critical Link in the Chain of Health Care Delivery

Every day, Oregon's safety net providers have stories to share about people who otherwise would go without medically necessary care. Many Oregonians have limited access to primary care and delay seeking help until they are seriously sick or hurt. Over-burdened emergency departments also have stories to share of patients whose only outlet for medical care is through their doors. They describe patients with illnesses and injuries that could be better treated in a primary care office. In addition to the human costs of a broken health care system, lack of access to basic primary care presents real economic costs to our state.

In 2006, Oregon's safety net system cared for over 270,000 patients. This care included 720,000 primary care visits, nearly 150,000 mental/behavioral health visits and nearly 110,000 oral health visits.[i] Oregon's health care delivery system provides significant primary care capacity, absorbing nearly 23% of Medicaid patients and an equal percentage of the uninsured. Safety net providers also fulfill critical public health functions. Vulnerable and underserved individuals are

able to receive essential immunizations, treatment for communicable diseases and are assisted in managing their chronic diseases, helping to promote and assure healthy communities.

And it is not just as a "fail safe" that we are served by the safety net system. Safety net providers benefit the entire delivery system as innovators at the clinical practice level. The safety net serves a disproportionate number of racial and ethnic minorities and is a leader in adopting programs and practices that increase access and reduce health status disparities. As "laboratories" of innovation and experimentation there is much to be learned from their experience.

Valuable *and* Vulnerable

In spite of their capacity and leadership around clinical practices, safety net clinics by the very nature of their mission are inherently fragile. The safety net system experiences a counter-cyclical relationship between Oregon's economic health and the demand for their services among the uninsured. A strong economy results in more lives covered by employer-sponsored health insurance and a reduction in the number of uninsured but not in primary care workforce demand. A weak economy has the inverse effect; fewer lives are covered both through commercial insurers and often through public programs, resulting in a greater demand for low cost/no cost care. To further compound this relationship, times of economic downturn are associated with elevated rates of psychological and social support needs. Consequently the demand for safety net services, with its emphasis on removing barriers to care is further amplified. It is reasonable to assume that just as there will always be economic cycles there will always be a role for the safety net in Oregon.

With fewer resources to work with, the safety net is made more vulnerable by dynamics that affect the entire health system. It is dependent on an adequate affordable workforce supply. It is especially dependent on primary care mid-level practitioners and physicians and increasingly must rely on mental/behavioral and oral health clinicians. The maldistribution between physicians electing to pursue specialty vs. primary care is well documented. This is compounded by an unequal distribution between clinicians choosing to work in urban rather than rural areas and in non-safety net practices in urban settings.

Although the safety net serves one of the most transient and seriously ill subsets of the population, many safety net providers have limited or no Health Information Technology (HIT). The cost of HIT is prohibitive for clinics that produce little or no reserves or profit margin, and generally allocate all resources toward direct services. In addition to capital outlay, safety net clinics must address a temporary loss in productivity while it is implemented. They also need training and technical assistance while implementing electronic records to maximum benefit of patients and providers. These are formidable barriers for organizations already operating with limited resources.

Many safety net patients have multiple chronic conditions and require a high degree of coordinated care. Obtaining access to specialty referrals can be a challenge for safety net providers and their patients. Likewise, while the Oregon Prescription Drug Program and other low-cost pharmacy options are improving access to affordable medications, there is still a divide between available resources and need.

Increasing numbers of safety net patients require mental/behavioral and oral health services. Compounding this issue, the state's Community Mental Health Program, the mental health equivalent to the health care safety net, is also dramatically under-resourced, compounding the pressure on the health care safety net system.

Safety net providers must undertake a balancing act of fulfilling their mission while managing limited and shifting resources. Serving vulnerable populations throughout Oregon, the safety net itself, is a fragile system and one that is at risk.

Essential to Health Reform

As Oregon decision-makers undertake the formidable task of broad-based health reform, the role of the safety net (its capacity, strengths and challenges) should help to inform their thinking. There are convincing social and economic arguments in favor of investing in Oregon's health care safety net, both as an interim step and as a key element of a long-term strategy.

A recently released Geiger report, estimates that a $250 million dollar federal appropriations increase to Community Health Centers nationally would yield healthcare for an additional 1.8 million patients, with a four to one return on investment. Under this relatively modest investment, Oregon could expect to see $4,200,000 in new revenues, 6,400 new patients served, 110 additional jobs and $9,400,000 in total economic activity generated.[ii] The report suggests that because of a Community Health Center's ability to quickly turn new funds into health care, community services and employment, investment in CHC's represents an opportunity to provide economic stimulus to hard hit communities while promoting access to health care to vulnerable individuals and families.

It is also widely recognized that timely access to a primary care provider can yield substantial savings by diverting patients from unnecessary and/or costly use of the emergency department. ED diversion certainly saves the system financially but more importantly, it lessens the suffering of underserved and often very ill Oregonians by creating avenues for them to receive the care they need at the time they need it.

There is a reciprocal relationship between support for the safety net and benefits to the larger health care system and ultimately, the citizens of Oregon. Other states understand this relationship and have built dollars into their budget. Oregon's safety net clinics do not enjoy similar economic stability. Oregon policymakers have demonstrated strong support for the School-based Health Center (SBHC) model of care. Similar initiatives focusing on other components of the safety net could also yield positive results for Oregon. Without this broader policy and resource investment the full potential of the safety net is not realized

In sum, the safety net is meeting the needs of some of the state's most vulnerable patients, while working to provide care that is culturally appropriate and aimed at removing an array of psychological, social, and environmental barriers. The demand for safety net services is growing and likely to increase as a result of the current economic downturn. While broad reform is critically needed and all stakeholders within the health care system will need to transform - including the safety net - this process will take time. In the meantime, the safety net will be filling gaps and working to provide quality care with unpredictable and unstable resources. It is

an acutely vulnerable segment of our state's health care delivery system that needs the attention of policy makers.

To this end, the statewide Safety Net Advisory Council (SNAC) has developed the following set of recommendations. They represent the areas of greatest need for support and stabilization of the healthcare safety net. These recommendations have been presented to the Oregon Health Fund Board for its consideration.

SAFETY NET ADVISORY COUNCIL RECOMMENDATIONS

to the Governor, the Oregon Health Fund Board, and Legislators

1. **Stable Funding – Safety Net Stability Fund**
   Establish the Health Safety Net Fund
   - Strategic investments to maintain infrastructure
   - New site development or expansion
   - Technical assistance to address specific organizational issues/challenges
   - Assist clinics with financial stability strategies

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:
   - Establish Rural Locum Tenens Program
   - Provide Flexible community health workforce options
   - Provide an increased pipeline of midlevel providers to rural communities
   - Implement Oregon Rural Health Services Corps (Updated Rural Health Services Loan Repayment Program)
   - Strengthen rural practice incentives by updating the tax credit program

4. **Equitable Inclusion on Accountable Health Plan (AHP) Panels**
   All AHP panels will include safety net entities on their provider panels
   - State to assure that safety net providers are included on Accountable Health Plans provider panels
   - Safety Net providers to be engaged as participants in Accountable Health Districts

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Section I

INTRODUCTION

The image of a net captures nicely the role of the health care safety net; a chain of individual links acting together to “catch those that might fall”. Like a net that expands or contracts to hold safe what is placed within it – the health care safety net responds to the demands for service placed on it by changes in the national, state and local economic and health policy environment. In recent years however, demand for safety net services has grown dramatically. This steep increase in demand has stretched the safety net - in many cases to the limit of available resources and in some cases beyond them.

Definition of the “Safety Net”

The following definition of the Health Care Safety Net was developed as an outgrowth of the National Governors Conference:

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.

A Continuum of Care: Oregon’s Health Care Safety Net
Safety Net providers span the continuum of care and include the following organized and recognized providers:

- Federally Qualified Health Centers –or- Community Health Centers (CHC)
- Isolated Rural Health Facilities (IRHF)
- School-based Health Centers (SBHC)
- Community Sponsored Clinics (CSC)
- Local Health Departments (LHD) * Those LHD’s that operate primary care clinics (CHC)
- Indian Health Service Clinics (IHSC)
- Hospital Emergency Departments
- Community Mental Health Providers

In addition to organized providers of safety net services, many private providers supplement the safety net through their individual contribution of charitable services and care, doing so with little or no expectation of compensation.

Barriers to Care

It is not only the escalating financial challenges influencing who utilizes Oregon’s safety net services; patients struggling with cultural, psychological, social and environmental barriers seek their health care from the safety net. In addition, there are a growing number of patients

requiring mental health and substance abuse treatment; many struggle with homelessness or live in geographically isolated areas where access to physical, behavioral/mental and oral health care services is insufficient. Oregon's racial and ethnic makeup is growing increasingly diverse and the safety net serves a disproportionately high percentage of culturally and racially diverse individuals. Safety net providers are seeing greater numbers of patients and those patients whom they are seeing are sicker and are presenting with more complex social and medical needs.

Growing role of safety net providers

In response to this growing need for accessible, affordable comprehensive primary health care services, Oregon's safety net system serves as a loose continuum of health care organizations. These organizations share the common goal of providing comprehensive healthcare to groups of Oregonians who otherwise have no alternative to using the emergency department for their health care needs. Oregon's health care safety net is playing an increasingly larger role within the overall delivery of health care services and as such, needs to be better understood, supported and sustained.

Recognition of Oregon's Safety Net Providers

Throughout the 2007 Legislative session, many advocates partnered with policy makers and Legislators to ensure that the health care safety net is recognized as a critical component of broad-based health reform efforts.

The following is the statutory definition of the Health Care Safety Net, resulting from the Healthy Oregon Act (SB 329), 74th Legislative session.

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.[iii]

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.

* Please note the “Line of Business” summaries for core safety net sectors in the appendix section.

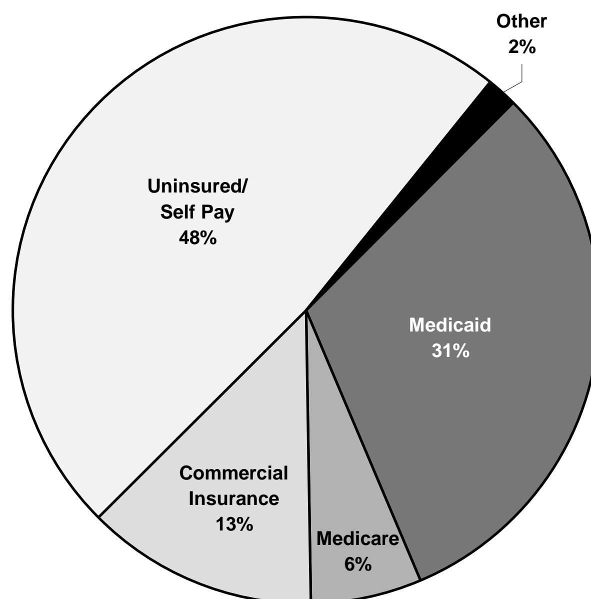
PROFILE OF THE SAFETY NET

Safety net clinics providing urgent or primary care services are represented in every county in the state.

Serving Low Income and Uninsured

In addition to having a mission and/or a mandate to provide health care services regardless of a patient’s ability to pay, Oregon’s core safety net providers are especially skilled to meet the needs of vulnerable and underserved populations. Safety net clinics have adopted practices to meet the special needs of their patients. They are attuned to cultural and language differences and work to remove barriers by providing interpretation, culturally appropriate health education, transportation and other supportive social services. Many safety net clinics provide comprehensive case management and wherever possible, work to coordinate care and remove barriers.[iv]

Safety Net Clinics - Unduplicated Patients by Insurance Status: CY 2006*



- Medicaid – 83,957
- Medicare – 16,772
- Commercial Insurance – 34,890
- Uninsured/Self Pay – 130,988
- Other – 4,301
- Total – 270,908

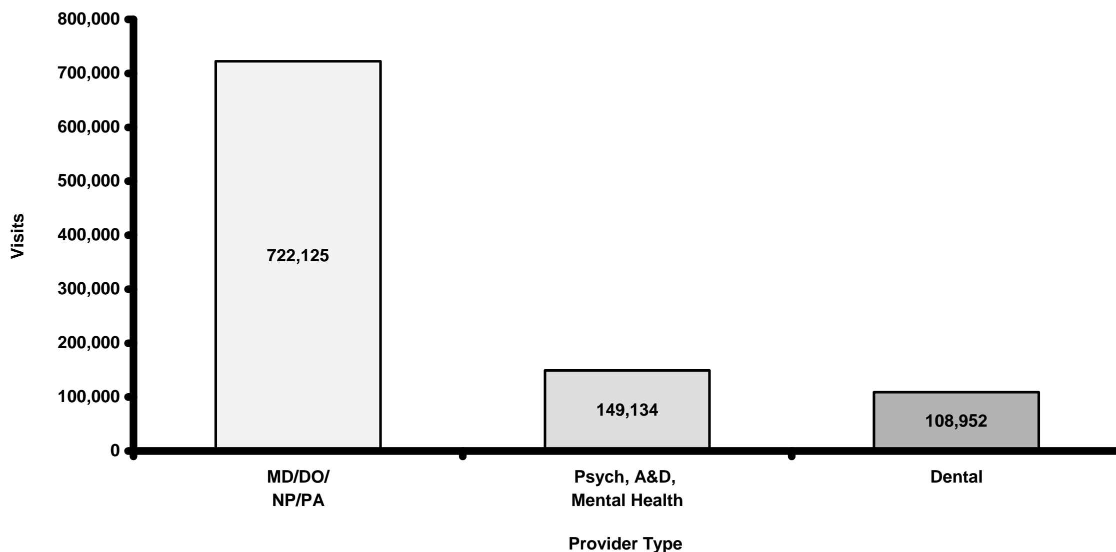
**Please refer to Appendix 1 for footnotes and further explanation of data collection*

Demand and Capacity: Operating Environment of safety net providers

We know more about certain segments of the core safety net than we do about others. Due to federal reporting requirements we have a fairly robust set of data describing Community Health Centers (CHC). Rural Health Clinics (RHC) collect some data, though not entirely congruent with those submitted by CHC's. Different sectors have the need and the ability to collect varied information. For example, Community Sponsored Clinics (CSC) routinely collect information about their volunteer and in-kind donations, whereas other sectors of the safety net do not use as many volunteers and thus do not collect data. Safety net clinics that have Health Information Technology are better able to collect and report quality measures than those clinics that do not have adequate technological infrastructure. These variations make it challenging to measure across the entire safety net spectrum.

Inspite of these challenges however, we do know that Oregon's health care safety net represents significant primary care capacity. The health care safety net serves 23% of the Medicaid population and nearly equal numbers of uninsured.

Safety Net Clinics -Visits By Selected Provided Type, CY 2006*



**Please refer to Appendix 1 for footnotes and further explanation of data collection*

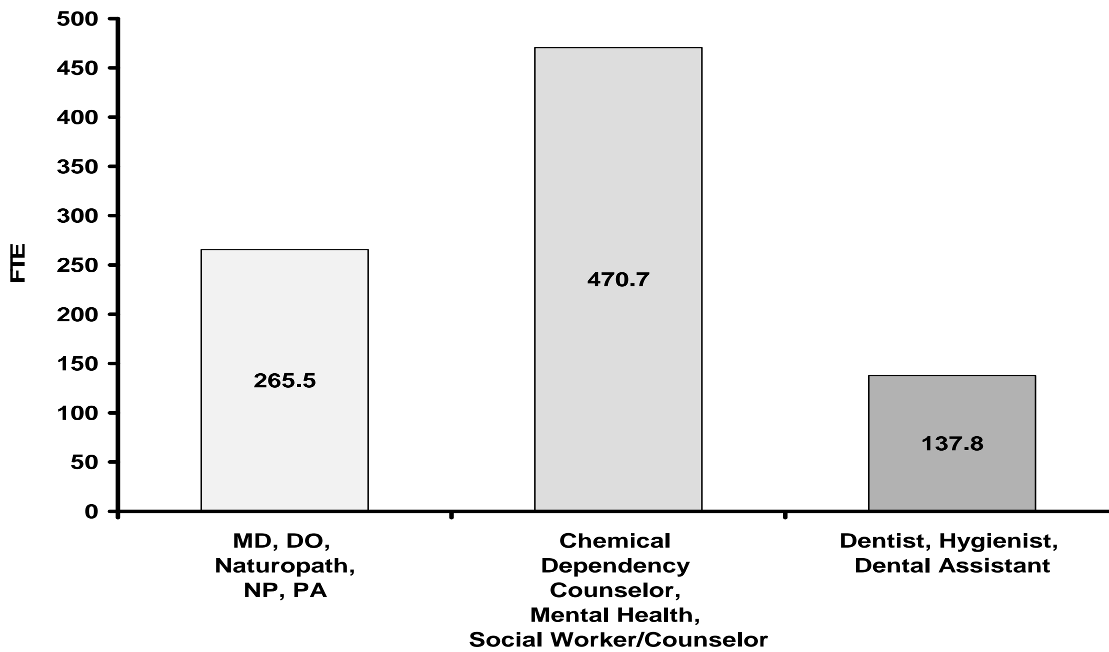
Safety net services provided by an array of licensed and lay staff

Oregon has nearly 3.7 million people living within its 36 counties. It is estimated that there are 576,000 residents who are uninsured and of those, 12.6% are children. In addition, there are approximately 910,000 Oregonians who receive Medicaid, Medicare or both.[v] Oregon's demographics are shifting; Oregonians are aging and are becoming increasingly ethnically and racially diverse.[vi]

As part of the broader health care safety net, many private practices, health facilities and clinicians provide donated care. The 2007 Oregon Physician Workforce Survey conducted by the Office for Oregon Health Policy and Research (OHPR) found that 72% of physicians report

providing some level of charity care with 40% of physicians reporting 1 to 10 hours of charity care per month and 15% reporting more than 10 hours per month.[vii] It is difficult however, to consistently and reliably capture the amount of donated care throughout the state and it varies geographically as well as year to year. Adequate data reflecting the demand for services and the workforce and financial capacity to meet the demand is a challenge across the safety net system.

Safety Net Clinics - Paid Clinical Staff by FTE, CY 2006*



Continuum of Safety Net services

Oregon's safety net is at its core a community-based system, comprised of diverse organizations. The type and intensity of services varies across the safety net based upon community needs and resources, however they may include many of the following:

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

Emergency Departments act as the final safety net

Every day, Oregon's safety net providers have stories to share of people who without their programs, would otherwise go without medically necessary care. Many Oregonians have limited access to comprehensive primary care services and delay seeking help until they are seriously sick or hurt.

Over-burdened emergency departments also have stories to share about patients whose only source of health care is through their doors. They describe patients whose conditions could more appropriately and efficiently be treated, or perhaps prevented, in a primary care setting. Cuts in the Oregon Health Plan in 2003 led to a 20-percent increase in emergency department visits by the uninsured, and a nearly 50-percent increase in hospital admissions of uninsured emergency patients.[viii] Woven within these stories is the financial relationship between the rising rate of uncompensated care resulting from Oregon's many un- and underinsured residents and the escalating health care costs across the system due in part, to cost shift.

CRITICAL ISSUES WITHIN THE SAFETY NET

Regardless of type or location, safety net providers confront similar challenges in meeting the needs of complex patients. Limited resources, increasing demand and escalating health care costs place strain on an already fragile system. In addition, there are other critical issues that must be highlighted when considering Oregon's health care safety net system.

Technological Infrastructure and the Safety Net

It is well established that investments in technological infrastructure are critical tools for improving the quality of care, coordination and efficiency across the health care delivery continuum. Such tools are especially important for Oregon's health care safety net providers who generally serve a more transient group of patients who are also in poorer health. Electronic health records (EHR) allow tracking and sharing of patient demographics, utilization patterns and clinical information. As a tool for communication, EHR can help reduce the likelihood of duplication and/or medical error. In addition, EHR capture data that help to describe both clinical and population-based trends and is important in tracking the health status of Oregonians.

Unfortunately, the cost of Health Information Technology (HIT) is prohibitive for the majority of Oregon's safety net clinics, as the payer demographics experienced by safety net clinics produce little or no margin, and these clinics generally direct all resources toward direct services. In addition to capital outlay, HIT imposes challenges around ongoing use and the temporary loss in productivity while it is implemented. Many safety net clinics do not have the necessary infrastructure and technical support needed to utilize the technology at a level that provides a return on investment. **While a powerful tool for managing care, improving health, conducting research and developing data-driven policies, the cost of deploying and sustaining HIT on a clinic-by-clinic basis is financially out of reach for many safety net providers.**

Oregon has recently been a beneficiary of several promising grant opportunities related to HIT. The state Department of Medical Assistance Programs received a Medicaid Transformation

grant, enabling the state to pilot Personal Health Records for Medicaid clients. In addition, the Oregon Health Network, with the Telehealth Alliance of Oregon as the lead organization, in collaboration with the Oregon Association of Hospitals and Health Systems and other organizations recently received funding from the Federal Communication Commission in the amount of over $20 million dollars over a three-year period. The grant will support critical infrastructure improvements and broadband expansion to rural Oregon that will interconnect Oregon's existing health information networks into a "network of networks," allowing all rural hospitals and clinics access to high-speed internet and to participate in a wide variety of telehealth services.[ix] Additionally, Our Community Health Information Network (OCHIN), a non-profit safety net information technology organization received three federal grants in the past year, targeting its safety net partners. These are promising opportunities and can be built upon with adequate support for high quality health information technology across the safety net system.

Safety Net clinics can benefit from HIT collaborative model

OCHIN is a not-for-profit health information technology organization that supports safety-net clinics. OCHIN has developed a robust, secure business management and electronic health record system that enables 15 Oregon clinics to experience the value of sharing information and data at the point of care. Doctors, nurses, and other clinicians all use the system and have gained efficiencies — there's no more looking for paper charts or deciphering handwritten notes. Lab orders and patient workflow are more streamlined. Medication orders are safer, as information on which drugs a patient is taking is immediately available for clinicians, pharmacists and can be printed with instructions (in plain language) for the patient. Remote access to patient records and medical histories allows clinicians to easily track patients after hours. On-call providers can track lab results needing urgent intervention. Electronic after-visit summaries are useful for communicating to specialists and hospitals can be made available anywhere a patient may travel. Online charting tools are helping clinicians make decisions based on best practices and evidence-based medicine. And the elimination of duplicate and unnecessary testing are increasing overall clinical efficiency and reducing the financial burden for individuals, families and communities without compromising quality.

Quality, Transparency and Patient safety

In general, quality, transparency and patient safety initiatives are not uniformly employed or documented across the safety net system. This is an area of needed development in order to better understand the overall performance and stability of Oregon's safety net.
While it is critical that all members of the health care system are transparent in reporting safety, quality and cost information, it is equally important to recognize that many safety net clinics do not have the needed technological infrastructure to implement measurement systems and track important data. Furthermore cost, quality and patient safety data needs to be understood within the context of the populations that are served. Safety net patients are generally more transient, have complicated economic and social challenges, and are sicker and more high-risk patients than the commercial patient mix.

Quality improvement efforts within the safety net should be sensitive to the unique features of the safety net population and reward efforts that reduce disparities and improve patient

outcomes.[x] Safety net providers must have additional resources and technical support in order to implement and evaluate quality, transparency and patient safety initiatives.

The following example demonstrates the kinds of quality initiatives that are possible with adequate HIT, technical support, and a commitment to innovation and quality improvement. It cannot be over-emphasized that in order for quality initiatives such as these to be sustainable, reforming how and what services are paid for, is essential.

HIT and Clinical Innovations promote Quality Improvement

Klamath Health Partnership (KHP) has undertaken several quality improvement initiatives. A dedicated registered nurse provides case management to chronically ill patients - an evidence-based initiative supported by OHSU's Oregon Rural Practice-based Research Network. KHP has established a primary care medical home pilot team consisting of 2 full-time family practice physicians, 3 clinical support staff and a nurse case manager. Patients are empanelled through assignment to a primary care provider thus ensuring continuity of care and reducing delays. In addition, KHP has invested in a practice management and electronic medical record system through OCHIN and has established qualitative health outcome measures based upon the Bureau of Primary Health Care standards of practice. Providers will be evaluated on a semi-annual basis and will be paid according to their performance in these key areas.

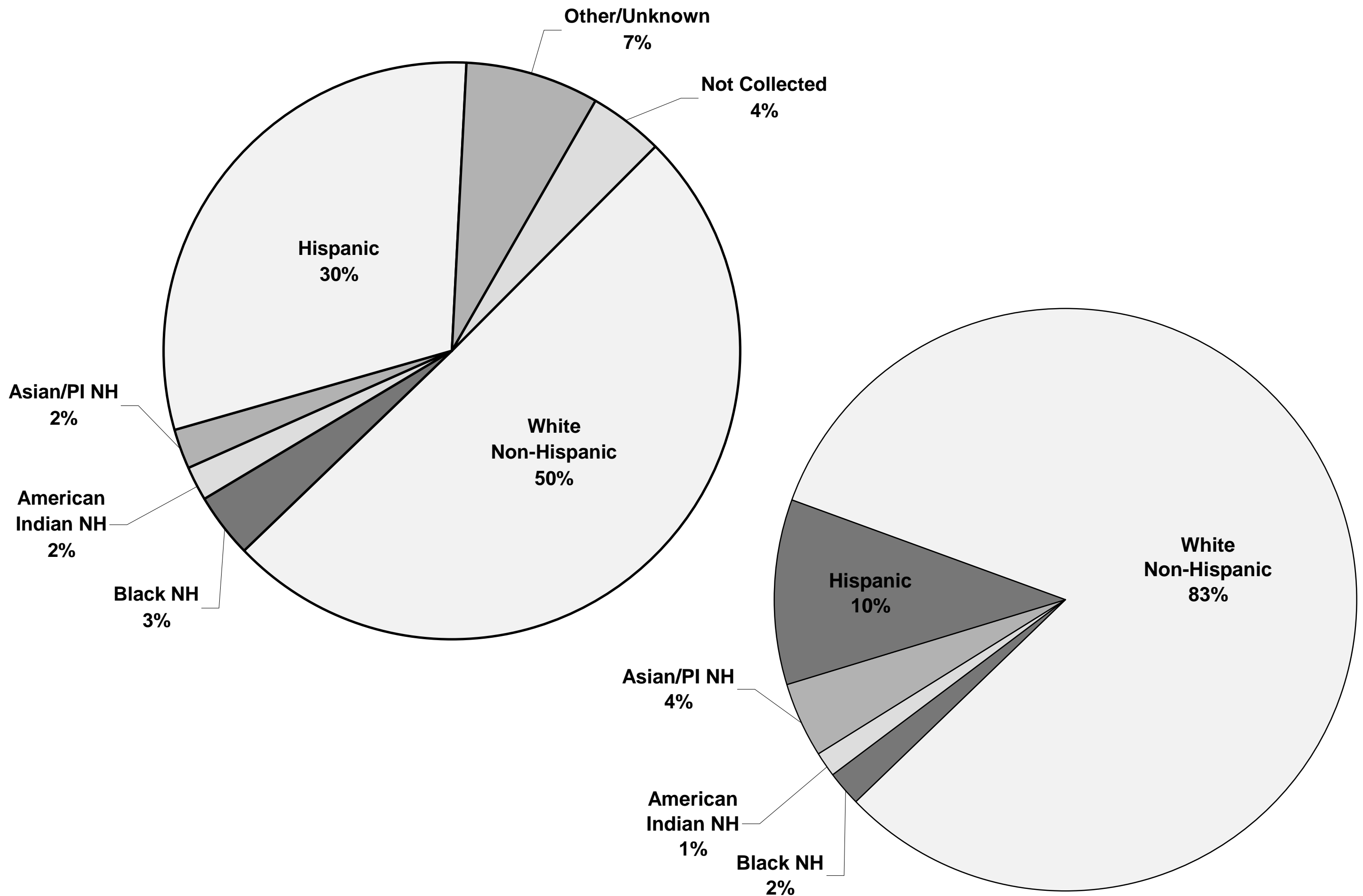
Geographic Coverage

10 of Oregon's 36 Counties are classified as frontier (6 or fewer people per square mile). Rural and frontier areas in Oregon do not have the same access to primary, secondary or tertiary health care services as those living in urban areas. Rural residents in Oregon face higher chronic disease, accidental and violent death rates than urban residents and rural women experience higher rates of birth risk factors.[xi] Vulnerable and underserved populations encounter greater obstacles in rural counties, which often have limited health care resources. Transportation, distance, insufficient community resources and extreme difficulty recruiting and retaining health care professionals are all felt distinctly by rural communities in general and the rural safety net system, in particular. Many safety net clinics, both rural and urban are experiencing significant growth in their Latino population, while also confronting an aging community with more complex medical needs. Frontier safety net clinics confront the added demand of often being the only emergency care provider in their community, with no hospital or professional backup. Access to primary care is a growing concern across Oregon's delivery system but a concern of increasing magnitude for many rural communities.

Addressing Disparities

Disparities in access to appropriate, quality and affordable health care services contribute to far worse outcomes in health for certain populations of Oregonians. Racial and ethnic minority groups, homeless individuals, severely mentally ill, undocumented residents, migrant seasonal farm workers, those living in poverty, and those living in rural and frontier regions are less likely to get the care they need, when they need it and experience a higher incidence of certain health conditions as a result. Nationally, as in Oregon, vulnerable populations are disproportionately represented among safety net patients.

Safety Net Clinics Unduplicated Patients by Race/Ethnicity, CY 2006*



Oregon Population 2006

** Please refer to Appendix 1 for footnotes and further explanation of data collection.*

Unlike many States, Oregon does not offer uninsured pregnant women a program of expanded coverage for pregnancy related services. Several years ago, the Federal government made available to Oregon and other states increased flexibility, which would allow extension of benefits during pregnancy under the OHP, gaining federal participation.

With the exception of two pilot counties, Multnomah and Deschutes, which began providing coverage in April 2008, Oregon has not taken advantage of this opportunity to expand coverage. As coverage for pregnancy related care is related to race, ethnicity and income, and as access to prenatal care helps assure health birth outcomes, expansion would reduce a significant health and health access disparity.

Oregonians representing certain racial/ethnic groups confront both greater disparities in access to health care and worse health outcomes. For example, American Indians/Alaska Natives in Oregon (2006) were more than twice as likely to be uninsured than those reporting to be White or African American. Additionally, those reporting to be Spanish, Hispanic or Latino were more than twice as likely to lack insurance as the non- Hispanic population.[xii]

Health disparities are also documented in persons with serious mental illness. This group of residents dies significantly younger than the general population. Recent evidence reveals that the rate of serious morbidity (illness) and mortality (death) in this population has accelerated. In fact, persons with serious mental illness (SMI) are now dying 25 years earlier than the general population. Their increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as, substance abuse, smoking, obesity and insufficient access to medical care.[xiii]

While it is essential to focus on the broad social, economic and environmental contributors to health disparities, we do know that access to timely, appropriate and culturally competent care produces better outcomes.[xiv] In addition, the specialized skills and enabling services such as interpretive services, case management, transportation, counseling and childcare provided by safety net clinics have been shown to decrease disparities in care and improve health outcomes.[xv] A 2006 report by the Commonwealth Fund found that enrolling members of ethnic/racial minority groups into a medical home reduced or eliminated certain disparities in health outcomes.[xvi] Many safety net clinics through out Oregon are actively engaged in piloting medical home models and undertaking targeted strategies to reduce health disparities.

Reducing health disparities is an area where the mission-driven core safety net has demonstrated itself to be a leader.

Safety Net Providers Lead the Way Toward Ending Health Disparities

All but two Community Health Centers (CHCs) in Oregon are involved in at least one of the Health Disparities Collaboratives, and thus have registries for numerous chronic illnesses. Examples include Cancer, Diabetes, Asthma, Cardiovascular Disease, and Depression.

For a decade, Multnomah County Health Department has used federal money to improve birth weight by closely caring for the social, emotional and medical needs of pregnant women -- the past two and a half years focusing on African Americans. No babies born to the program's mothers have died since 2001, and the county's African American low-birth-weight rate has fallen from 12 percent in 2000 to 10.8 percent in 2004

Managing Limited Workforce

In Oregon, as across the nation, there is a shortage of health care professionals across the workforce spectrum including doctors, mental health professionals, dentists, nurses and ancillary professionals. Of significant concern to Oregon's safety net system is the disproportionate numbers of physicians who are electing to pursue a specialty outside of primary care. While the majority of patient visits are to primary care providers, fewer and fewer U.S. medical students

are choosing primary care specialties. Between 1997 and 2005, the number of U.S. graduates entering family practice residencies dropped by 50%.[xvii] In 1998, half of internal medicine residents chose primary care; currently, about 80 percent become subspecialists or hospitalists.[xviii] The American Academy of Family Physicians predicts that Oregon will need 44% more FPs in 2020 than we have now. That is 490 family practitioners; Oregon currently produces 27 FPs per year.

These trends are occurring at a time of growing need for primary care for an aging population with an increased prevalence of chronic disease. Moreover, many nurse practitioners and physician assistants who could join the primary care workforce are instead going to work in wealthier specialty practices. Primary care practices in the United States now depend on luring physicians away from other countries. This insufficient number of graduating primary care physicians suggests increasing difficulty for safety net providers in filling their primary care workforce needs.

Furthermore, Oregon's health care workforce is insufficiently diverse and does not reflect the state's population. Less than 3% of Oregon's physicians report Hispanic, Spanish or Latino heritage but Oregon's population is comprised of nearly 10% individuals representing these groups. This lack of representation in the healthcare workforce is seen, though less strikingly, among African American and multi-racial physicians as well.[xix] This data suggests both workforce implications as well as quality of appropriate care for diverse populations. The lack of diversity in Oregon's physician workforce has an impact on the safety net system, which disproportionately serves racial/ethnically diverse patients.

Safety net clinics generally and rural safety net clinics in particular, confront significant obstacles in recruiting and retaining an adequate health care workforce. Nationally there are 264 people for every physician. In urban Oregon there is a physician for every 327 people, while in rural Oregon there is one physician for every 819 residents (source: Office of Rural Health). While this is a concern shared broadly by rural health care delivery systems, there is even a more limited pool of health care providers who are interested in practicing in a rural safety net setting. The loss of a provider in a rural safety net clinic, because of the extreme difficulty in recruiting a replacement, often means the loss of healthcare for that community.

Reimbursement for providers at safety net clinics is lower than private settings, the patient mix is more complex and the infrastructure is often fragile – in short, safety net clinics are less resourced than the private sector and struggle to compete for health care providers.

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

If our hospital emergency departments are the "canary in the coal mine" of our imperiled 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, 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.

Health reform dialogues generally and the Healthy Oregon Act, in particular have generated a lot of interest in the "primary care medical home – or integrated health home" as a central component of payment and delivery system reform.

In March 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association – representing over 300,000 physicians, released a set of joint principles for a "Patient-Centered Medical Home" or Primary Care Medical Home.[xx] The concept of a Medical – or "Integrated Health Home" and aligned strategies has captured the interest of diverse stakeholders and will help to guide the development of the Health Fund Board's plan for universal access to health care for all Oregonians.

Safety net clinics are uniquely positioned to redesign the way services are delivered to the populations they serve. Many safety net clinics are piloting innovative delivery models. CareOregon, the state's largest Medicaid Managed Care organization, which covers nearly 100,000 Oregonians, is supporting 5 primary care renewal (PCR) pilots through its' Care Support and System Innovation (CSSI) grant process. In addition, the Oregon Primary Care Association (OPCA), is building on lessons learned from CareOregon's pilots and is providing technical assistance and training for 8 additional CHCs to implement elements of the primary care home (PCH).

Primary care home/renewal strategies include team-based care, whereby a physician works alongside other critical members of the team such as a nurse, a case-manager or patient navigator, and a behavioralist to provide comprehensive and well-coordinated care, especially for patients that are suffering from multiple chronic conditions. Other strategies include patient-directed development of health goals, evidence-based decision-support tools to help guide clinical decision-making and strategies for ensuring more convenient access through systems such as same day access and expanded hours. Other components include expanded options for communicating with patients, such as utilization of email and a variety of telehealth options.[xxi]

Of central importance to the success of these initiatives is a re-alignment of incentives to reimburse practitioners for the full-range of services they provide (instead of focusing payments on brief visits with a billable provider) and further integrates and pays for prevention and wellness services within primary care. In its 2007 report, A Roadmap for Health Care Reform, the Oregon Health Policy Commission emphasized the need for payment reform to provide incentives for cost-effective care that improves health outcomes and further stated that safety net providers along with broader community health collaborations must be at the table to ensure that these discussions include community innovation.[xxii] In the absence of fundamental reform of the way health care is reimbursed, primary care medical home efforts will both fail to gain traction and will be unsustainable.

Integrated model of care assists vulnerable patients

Central City Concern's Community Engagement Program (CEP) is a comprehensive, multidisciplinary recovery program designed to meet the needs of people who are chronically homeless with co-occurring mental health, addictive disorders and/or physical health care concerns. Case managers draw from their training and experience in recovery and mental health care to assist clients in obtaining primary and mental health care, affordable housing suitable for their recovery needs, attend and engage in appropriate treatment programs and receive employment counseling and training. In short, the program helps people in all aspects of reclaiming control of their lives.

Safety Net Clinics Supported By Broad-based Community Collaboration

Many safety net providers have participated in targeted learning collaborative's and quality improvement initiatives to support their service delivery and outcomes. Safety net providers are benefited by participating in learning communities and from engagement with diverse community health partnerships.

Across Oregon, there are broad-based community health collaborative efforts emerging to help shore up safety net providers and improve community health, particularly for vulnerable residents. Many communities are working to reorganize the way that health care is coordinated and provided at the local level. Common goals among these collaborative efforts are to promote health, increase access and improve quality of health care by coordinating comprehensive (physical, behavioral, mental and oral) health services and leveraging existing resources.[xxiii]

Community health collaboratives often convene diverse community members, incubate new ideas and partnerships and coordinate service delivery across the continuum of care. These efforts provide complimentary and needed community involvement and help to build local ownership of responsibility for providing care to underserved residents. Strengthening partnerships across the community is helping safety net providers coordinate their efforts and leverage community resources most effectively.

Community Collaborative Leverages Local Resources to Support Safety Net Providers

100 % Access Healthcare Initiative in Lane County has convened over 50 key local partners to improve access to health care for uninsured residents in Lane County. As one of its core initiatives, 100% Access has helped to foster stronger relationships and coordination across safety net providers, including; Community Health Centers of Lane County, School-based Health Centers, Volunteers In Medicine and the Whitebird Clinic. Together, they have collaborated to establish baseline data, referral information and are now looking to coordinate specialty referrals more effectively across the clinics. In 2007, safety net clinics received $500,000 in direct support from 100% Access, which has developed a "Community Investment Fund" dedicated toward supporting and expanding access to health care.

A Short Primer on Safety Net Funding

The income for **mainstream primary care clinics** includes payments from insurance companies, Medicare, Medicaid and from individuals who can afford to pay for care out of their own pockets. Mainstream providers may be for profit or non-profit. In most cases there is a sufficient margin of profit and/or the potential for reinvestment capital. Investments may be part of their business portfolio.

Nearly all **safety net entities** are public or non-profit and depend on grant dollars and/or community in-kind donations to a substantial degree. Safety net providers serve a population far less able to make significant out of pocket payments, and have limited revenue from insurance companies. With the exception of volunteer clinics, safety net clinics receive some degree of Medicaid revenue and lesser amounts of Medicare dollars. They often have limited staff available to bill payers. The net result is that they are more likely to have limited cash on hand and far less likely to be able to save for future expansion, facility replacement, or unanticipated expenditures. Their ability to solicit funds for these purposes through community fund-raising varies according to the resources in their communities.

Resources supporting the operations of safety net health care providers are highly variable across types of safety net providers and within each type. Generally, community sponsored clinics depend on a mix of philanthropic and other local sources. Community health centers rely on Medicaid, federal grants, private insurance, fund-raising and Medicare to a limited degree. RHC's rely on Medicaid and Medicare, and private fees. Some may benefit from local health districts. SBHC's rely very heavily on local funding and State grants. Medicaid and Medicare payments based on the federal CMS Prospective Payment System (PPS) reimburse FQHCs and RHCs. In general this federal policy was intended to improve access and availability of providers in underserved areas of the states. (More information on PPS can be found in appendix 3).

An example of variability of income by source can be found within community health centers participating in the OCHIN HIT collaborative. In 2007, Medicaid charges as a percentage of all charges ranged from over 70% to 10%.

The single largest funding stream for the health care safety net is federal. This may be through Medicaid payments or through Federal 330 grants made primarily to community health centers that are 100% federal dollars with no requirement for state match. Federal dollars are matched by state general funds as they are for all providers in the Medicaid program.

Section 330 of the Public Health Service Act defines federal grant funding opportunities for organizations to provide care to underserved populations. Types of organizations that may receive 330 grants include: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs and may also include Urban Indian Centers and Tribal Organizations. While appropriate for some communities specific grant requirements mean that 330 grants are not available to all communities. Grants are intended to assist with the cost of services to the uninsured and are renewable based on

performance. Grants are also offered periodically for service expansions. They are very competitive nationally and within Oregon.

Other than State resources dedicated to SBHC, Oregon has not historically provided state grant funding to the health care safety net. The Oregon legislature began to make a commitment of resources to SBHCs nearly 20 years ago with an initial commitment of $212,000 for four clinics and expanded to 47 clinics and $3,100,000 by the 2005-2007 biennium.

Local communities have been very important sources of support for the safety net. County government, school districts, community health collaboratives, hospitals and health systems, and community benefit plans of insurers and other community partners have all made contributions and are part of the support system for the safety net.
The good news is that many have recognized the critical role of the safety net at local, county, state, and federal levels. What is troubling is that the variability of funding by location, by clinic, and by type of safety net provider has made for an unstable business environment. It is difficult and challenging to create new clinics. It is critical that we develop an increasingly supportive state policy framework that mirrors commitments made at local and federal levels. State policy, minimally, needs to marshal the resources that enable it to help stabilize funding, to target strategic investment according the needs of vulnerable populations, and as complement to the rest of the healthcare system.

The Oregon Health Fund Board (OHFB) is looking at related areas as it develops its recommendations. Covering additional people will make a financial difference to the safety net. There will be reimbursement for those who are currently being seen but are uninsured and have no source of payment. It will help keep safety net providers as part of the access equation. It will not address the need for new centers or service expansions where they are needed. It will not address all the needs of those parts of the safety net that are less oriented to billing for services. It will not provide all of the necessary resources for organizations with limited capital to fully respond to a new vision for the delivery system

The Safety Net within Broad Health Reform – SB 329 and the Oregon Health Fund Board

Some Assumptions

It is sometimes assumed that if universal coverage is available the safety net will not be needed. Mainstream providers will pick up the slack because reimbursement will be improved and will be available for the uninsured. While this perspective is understandable and has some truth to it, it is based on several assumptions that Oregon history and experience indicates are not entirely accurate:

- It assumes that the availability of reimbursement and its amount will be sufficient to convince providers to see newly covered individuals.
- It assumes that there are enough providers located in the right places who can competently serve individuals with special needs.
- It assumes that all providers will render the range of enabling services that are needed and will be able to provide them from the beginning of universal coverage.

- It appears to assume that coverage equals access.

Oregon learned from the beginning with the Oregon Health Plan that these assumptions were flawed. Indeed safety net entities have been a critical part of the access equation since the beginning.

It is true that planning through the OHFB process has placed great emphasis on the integrated health home, which to some degree mirrors elements in place in the safety net. It is also true that if an individual mandate is included more people will be covered than would otherwise be the case. Many critical moving parts are envisioned to help assure coverage, access, quality, safety, and cost containment. These represent important elements of a long-term process.

During planning and implementation it will be important to ensure the financial viability of the safety net as a "transitional" component. In any system, it is recognized that a "failsafe" is necessary to meet the needs of vulnerable populations.

Federal dollars available for state match through the PPS system; discounts through the 340B prescription drug program, and other federal dollars will be an important element of revenue for the new system.

The new delivery system will require change and risk-taking by all, including the safety net, in order for the overall benefits to be realized and for a more coherent and sustainable system to be established. This is a critical underlying assumption that must be shared broadly. It is important for policy makers and providers to note however, that the "pockets" of safety net providers are not deep.

The challenge of planning and responding to the changing geographic and population needs will remain as dynamic a reality in the new system as it is in the current one. The safety net will continue to be a valuable public policy tool helping to enable a responsive delivery system. This is especially true in regard to areas of the state where more market-based providers are less likely to locate. Safety net clinics are best prepared to provide care in areas with vulnerable and/or sparse populations. Safety net clinics tend to be in and of the community and as such are likely be an outgrowth of community involvement and investment in providing access and improving health.

Summary

Oregon's health care safety net provides essential capacity for providing care to underserved patients and Oregonians who reside in underserved areas of the state. The safety net currently provides primary care access to 23% of current Medicaid clients and a nearly equal percentage of the state's uninsured. Because safety net providers have a mission and a mandate to serve vulnerable populations, they have developed expertise around removing barriers to care and providing culturally and linguistically appropriate services. In addition, the safety net, through a variety of reimbursement methodologies, brings essential federal resources to the State. Finally, safety net clinics have demonstrated their ability and willingness to be "living" innovation labs for many of the leading initiatives in health care today, in spite of the fragility of their infrastructure and resources.

Policymakers undertaking the complex work of broad-based health care reform understand that the health care safety net is an integral part of the delivery system. Along the path to transforming the broad health care system, incremental steps must be taken to assure the ongoing viability of the safety net to provide care for vulnerable Oregonians. A stable funding stream, broad-based adoption of Health Information Technology and strategies that support recruitment and retention of the health care workforce are critical and interconnected investments. These strategic investment opportunities will shore up the existing infrastructure and will help to design a safety net that can most effectively contribute to a system of universal access to health care for all Oregonians.

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Section II

Safety Net Advisory Council Recommendations to the Governor, the Oregon Health Fund Board and the Oregon Legislature

SAFETY NET ADVISORY COUNCIL (SNAC): STABLE FUNDING – SAFETY NET STABILITY FUND

Background

Invest for rapid access expansion and to stabilize essential care in vulnerable communities - In the absence of a single financing mechanism, the safety net has evolved organically, responding to a variety of economic opportunities and political circumstances across the state over the past two decades. Different funding models have evolved to meet the individual needs of communities and to reflect the variety of resources available.

As a result the safety net maximizes and leverages a relatively broad portfolio of funding sources: federal, state, private grants, transaction fees, and significant donations of volunteer time and goods. The strength of this model is that safety net providers create and often leverage multiple funding streams to support operations.

A recent Geiger Institute report estimates that every one-dollar invested in community health centers generates three dollars in Federal and other third party reimbursement and an average of 6 to 9 dollars in overall economic benefit to the community. The study went on to calculate that in Oregon, a one million dollar investment in community safety net clinics would generate 4.2 million dollars in new third party revenue, 9.4 million dollars in total economic activity, create 110 new jobs and provide longitudinal primary care to 6400 new patients.[xxiv] This study supports the long held belief that safety net investment is a prudent strategy to maximize limited health care funds.

The vulnerability to this unstructured funding model is that in any single community an economic downturn that impacts even a single funder can quickly jeopardize the ongoing operations of critical safety net providers. As we have seen recently in Clackamas County, this can happen with little advance warning. In addition, in most small communities few options exist for emergency funding stabilization while other funding streams are identified. This issue is compounded by the very thin operating margins that most safety net providers operate within. Very few safety net providers have sufficient operating reserves to weather even a ninety-day interruption in a funding source

The challenge in Oregon is that despite the critical role of safety net providers and economic evidence that safety net investments show a positive return - there are no dedicated funds to prime and support this critical community investment tool.

The Safety Net Integrity Fund will assist in expanding and preserving the safety net and maintaining community-based patient-centered services for those who face barriers to care. The Integrity Fund will provide a source of capital for safety net clinics to rapidly expand to meet system capacity challenges, draw down new sources of funding and ensure the viability of essential services in vulnerable communities. The funds could be used to support rapid expansion for additional sites or services in areas of unmet need.
A stable source of seed funding will enable Oregon to "grow" the health care safety net in a strategic and sustainable way maintain critical infrastructure and "grow" the health care safety net in a strategic and sustainable way.

Recommendation #1

Establish the Core Health Safety Net Stability Fund

1. Develop a set of priority investments including but not limited to:
    - Expanding essential comprehensive (physical, mental/behavioral, oral health) primary safety net services in vulnerable communities.
    - Establishing safety net sites where gaps exist with matching community investments.
    - Assist essential safety net providers experiencing financial and other difficulties.
    - Assistance with recruitment and retention of workforce and/or the use of transformative technology.
    - Assistance with affordable pharmaceuticals.
    - Emergency Preparedness Planning.

2. Define expectations
    - Documentation of outcome measures.
    - Matching funds.
    - Linkages with community organizations.
    - Commitment to a diverse workforce within the limitations of location.

3. Build a revolving fund sufficient to provide $2 Million in grant funds for year 1, $4 Million in year 2, $6 Million for year 3 and sustained at $6 Million per year for subsequent years. The Integrity Fund will:
    - Fund priority safety net investments from the interest.
    - Leverage resources for capital facilities investments.
    - Provide low interest loans to safety net entities.

    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.*

4. Link the funds where possible with foundation initiatives and matching funds to magnify their impact.

5. 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 Stability 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 – HEALTH INFORMATION TECHNOLOGY

Background

Health Information Technology represents an **essential tool for providing continuity of care across the comprehensive health care delivery system.** Broadly adopted and interoperable HIT systems will allow vital patient information to be shared and improve the quality and safety of care. HIT reduces fragmentation of our health care delivery system by getting information to the right place and in the right hands for the right reason. In addition, HIT supports and promotes the aggregation of health information to impact population health, biosurveillance and public health measures.

Oregon and the nation are moving toward greater readiness to implement health information technology. Decision makers recognize that it is a key tool for realizing 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 costs and clinics are rarely able to afford to maintain the infrastructure to use the HIT well. 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.

Recommendation #2

It is essential that policymakers pursue the goal of building a comprehensive Health Information Strategy statewide.

- SNAC recommends prioritizing support for broad HIT adoption among safety net providers.
- SNAC further recommends that expert analysis be engaged to determine the best methodology and pricing for establishing broad adoption of health information technology across the safety net.
- SNAC recommends considering one of (or in combination) the three following options:
  - **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, Medicaid contractors, 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

Background

Baby boomer retirements will have an especially strong impact on the safety net and rural areas in particular. Specific issues need to be addressed such as assuring an adequate provider "pipeline," preventing burn-out of existing providers, addressing misdistribution of workforce, providing workforce 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. Health care extenders such as community health workers, locally or regionally developed practitioner models, and telemedicine strategies are likely to become increasingly important. SNAC's recommendations seek to acknowledge and address workforce challenges across the safety net system, however SNAC recommends incentives/programs be prioritized based on geographic locations, recognizing the magnitude of need in frontier and rural areas.

Recommendation #3

Implement innovative approaches to meet safety net workforce needs.

Community Based Innovation

1. **Initiate a rural 'Locum Tenens' Program**
   - Provide temporary physician and dentist relief for vacation, continuing education etc.
   - Develop a model that meets the needs of behavioral and mental health practitioners.
   - Provide 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).
   - Create a four-year, multi-county/multi-community pilot grant program.
   - Funding: Legislative Appropriation - $ 5 Million over four years.

Mid-level Education and Deployment

1. **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 Rural 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 Rural Health Service Corps**
   - Existing Rural Health Services loan repayment program has not been updated since 1989 – funded at $ 200,000 per year.
   - Renames, updates, and integrates with other programs, adds scholarships and loan forgiveness.
   - Increase funding to cover more providers 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 Million and 2011-2013 $5 Million.

2. **Update the Provider Tax Credit**
   - Oregon's provider 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.

SAFETY NET ADVISORY COUNCIL (SNAC):
EQUITABLE INCLUSION ON ACCOUNTABLE HEALTH PLAN PANELS

Recommendation #4

All AHP panels will include safety net entities on their provider panels

1. State to assure that safety net providers are included on Accountable Health Plans provider panels.

2. Safety Net providers to be engaged as participants in Accountable Health District.

Anticipated Outcome:
Safety net providers will be represented equitably on Accountable Health Plan provider panels and as participants in AHD. This will help to support sustainability and provide safety net providers with the opportunity to participate in regional data gathering and decision making processes.

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CORE MEASURES

Data for this report was collected across the safety net system including all Community Health Centers (CHC), all Isolated Rural Health Facilities (IRHF) – a subset of Rural Health Clinics, all School-based Health Centers (SBHC) and seven Community Sponsored Clinics (CSC). This task posed substantial challenges due to variations in how different sectors report data. In addition, available technical support and health information technology to assist with collecting the data varies widely among different safety net sectors and clinics. This data represents a baseline representation of four measures that capture information across the entire safety net system. Each measure requires explanation and footnoting, nevertheless, they represent a reasonable approximation or "preponderance of the data" to allow further description and better understanding of Oregon's health care safety net system and the patients it serves.

For all of the measures, the data collected is for CY 2006 with the exception of two Community Sponsored Clinics (CSC) that reported data for CY 2007 and for School-based Health Centers (SBHC) and one CSC that reported data for FY 2005-2006

#1 Unduplicated Patients by Insurance Status

- This measure includes CHC, SBHC, CSC and IRHF.
- Data was not available for 5 of 17 IRHF and for 4 of 11 CSC.

#2 Visits By Selected Provider Types

- This measure includes data from CHC, CSC and SBHC.
- Data was not available from IRHF or for 4 of 11CSC.

#3 Paid Clinical Staff by FTE

- This measure includes CHC, SBHC, CSC and IRHF. Data was not available for one IRHF or for 4 of 11 CSC.
- Naturopath's are not included in Federally Qualified Health Center data.
- "Mental Health" includes staff who provide mental and behavioral health services as well as case management.

#4 Unduplicated Patients By Race/Ethnicity

- This measure includes CHC, SBHC, CSC and IRHF.
- Data was not available for 5 of 17 IRHF or 4 of 11 CSC.
- "NH" = Non-Hispanic.
- "Other/Unknown" includes:
  4,810 CSC patients
  14,642 FQHC patients
  407 SBHC patients
- "Not Collected" includes all IRHF patients

Appendix 2

BACKGROUND – OREGON HEALTH PLAN TO THE PRESENT

Originators of the Bottle Bill, the Initiative Process, the Death with Dignity Act and the Oregon Health Plan (OHP), Oregonians are not afraid to try new and sometimes controversial policies. The Oregon Health Plan was visionary in that it sought to expand the categories traditionally covered by Medicaid and aimed to control costs, assure access and achieve efficiencies through the development of an evidence-based prioritized list of essential services combined with managed care for OHP clients, wherever possible.

The OHP, in combination with a strong economy, helped reduce the number of the state's uninsured in the years following implementation in 1994. At one point the OHP covered nearly 100,000 individuals who previously had no coverage and limited access to care.[xxv] Two years after the implementation of the OHP, the percentage of uninsured had dropped from 18% in 1992, to 10.6% in 1996. In 2004, policy makers stopped enrolling new clients into the OHP Standard benefit. In addition to fewer individuals enrolled, the types of benefits and services available to OHP Standard patients were also reduced or eliminated. By 2006, the percentage of Oregonians without insurance had risen to 15.6%.[xxvi]

At the same time the number of Oregonians covered by the OHP has been shrinking, the number of those who receive employer-sponsored health insurance has also been on the decline. Nationally, between 2000 and 2007 the percentage of employers offering health insurance coverage declined by 9 percentage points from 69 percent of employers to 60%.[xxvii] These developments have culminated in additional pressure on Oregon's safety net system to provide more care to more people who have no health insurance coverage.

The safety net has expanded over the past decade, largely due to federal expansion of Federally Qualified Health Centers across the country and increased state support for School-based Health Centers. In 2001, Oregon had 13 FQHC's with 76 clinic sites. In 2007, this number had grown to 26 FQHC's with 160 clinic sites across the state. Additionally, the 2007 Oregon Legislature awarded 18 new SBHC planning grants.

Even this growth however, has not been able to keep pace with the rising numbers of Oregon's uninsured, many of which are sicker and require more complex care. **Safety net clinics report that they are beyond the capacity of their current resources and are being sought out by more individuals than they are able to serve in a timely way.**

Appendix 3

PROSPECTIVE PAYMENT SYSTEM

Under federal statute Community Health Centers and Rural Health Clinics are afforded the prospective payment system (PPS) for Medicaid reimbursement. PPS is designed to support two specific federal policy goals:

- Assuring access for residents of rural areas.
- Assuring that federal grant resources provided to fund care to the uninsured are not consumed subsidizing Medicaid services.

To support these goals, Congress passed the Rural Health Clinics Act in 1977 to support services provided in underserved rural areas and to facilitate the use of physician assistants and nurse practitioners. Federally qualified health center (FQHC) status was created in 1990 in Medicaid, with Medicare following.

Initially RHC and FQHC status brought a form of cost based reimbursement designed to assure these federal goals. RHC and FQHC were permitted to establish an all inclusive, single encounter cost, and to bill Medicaid and Medicare encounters at this rate, independent of the intensity of services provided. This rate was recalculated annually and subject to State audit and retrospective adjustment. While Oregon Medicaid placed no upper limit on this rate Medicare is limited by national urban and rural rate caps.

To remedy procedural and financial issues arising out of cost based reimbursement PPS was initiated in 2001. PPS provides prospective per visit reimbursement indexed on a historic average visit cost, adjusted annually by a national inflation index (the physician component of the Medicare Economic Index). Other than the initial relationship to the historic cost / encounter, the per visit rate is no longer tied to actual cost, and can be expected to grow at a predictable rate.

In a Medicaid managed care environment PPS includes periodic "wraparound" payments meant to reimburse a CHC or RHC for the difference between their per-visit average cost and payments received from a manage care plan.

With the OHP in 1994 Oregon sought and was granted a waiver from the cost based reimbursement obligation for FQHC and RHC for services provided to Medicaid clients enrolled in managed care. Between 1996 and 2000 Oregon made partial, representative payments in an IGT funded effort initiated by Multnomah, Clackamas and Tillamook Counties. With PPS in 2001 Oregon began fully funded wrap payments using State funds as match.

The PPS system, as implemented in Oregon, appears to accomplish several things. The intent of federal policy is substantially met and CHC and RHCs are better able to respond to the needs of the communities they serve.

Appendix 4

SAFETY NET LINES OF BUSINESS

A. Community Health Centers

B. School-Based Health Centers

C. Community Sponsored Clinics

D. Isolated Rural Health Facilities (a subset of Rural Health Clinics)

4A. COMMUNITY HEALTH CENTERS (CHC)

Success Stories

From 1999-2002, the ER volume in the Pioneer Memorial Hospital in Prineville was increasing an average of 8.5% annually. Following the opening of Ochoco Community Clinic in 2002, the hospital ER volume declined 11.3% in 2003.

What is a Federally Qualified Health Center/Community Health Center?

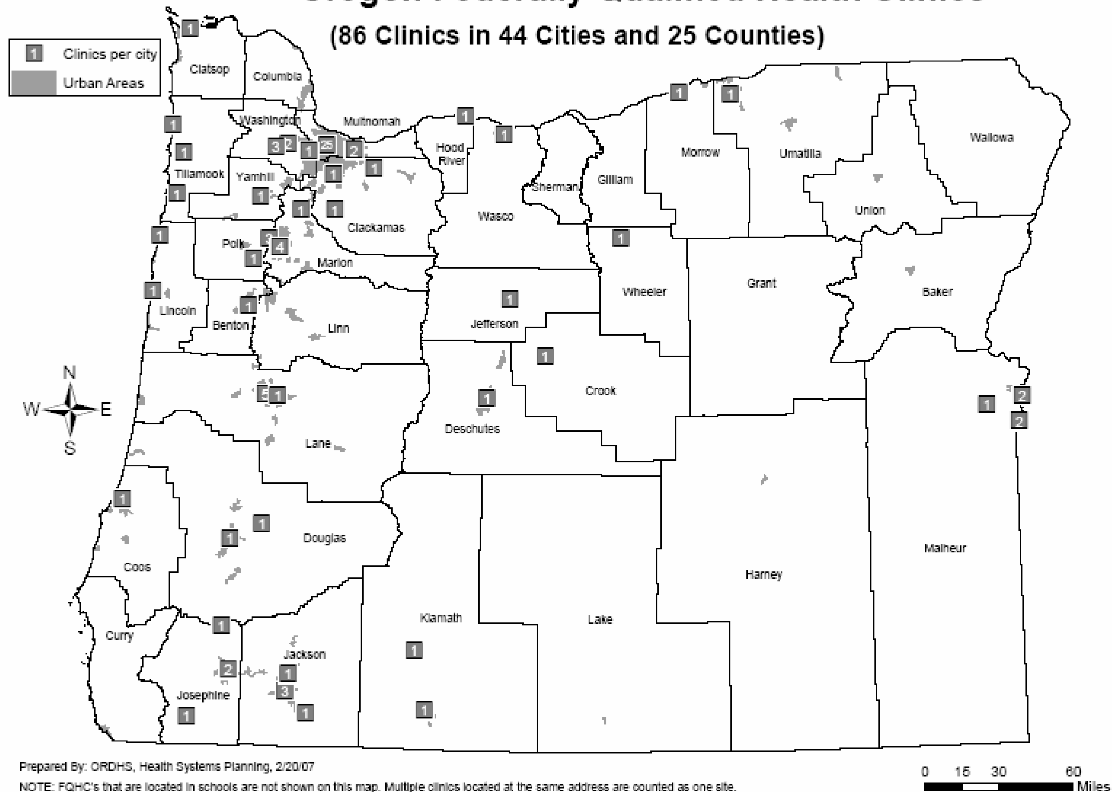
The term "Federally Qualified Health Center" refers to three different types of clinics: Health Centers, FQHC "Look-Alikes" and outpatient health programs/facilities operated by tribal organizations. FQHC's can be non-profit, tax exempt corporations or public agencies, such as a county health department. FQHC's are oriented toward addressing barriers to care, such as homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance and financial barriers. FQHC's receive a federal grant, which provides seed money to leverage state and local resources. FQHC's are required to provide primary care for all life-cycle ages and are governed by a majority consumer board.

Who is a "typical" Community Health Center Patient?

Of the over 235,000 Oregonians served by CHC's in 2006:
38.5% were children, while 61.5% were adults and nearly half were ethnic minorities (Hispanic/Latino, African American, Asian/Pacific Islander, and Native American). 47% of CHC patients are uninsured and 95% are below 200% FPL.

What services do Community Health Centers provide?

- General primary medical services
- Prenatal care and post-partum care
- Preventive medical and dental care
- Mental health treatment/counseling
- Substance abuse treatment/counseling
- Hearing screening
- Vision screening
- Pharmacy
- Preventative Services
- Enabling Services such as: medical and social case management, childcare, transportation, interpretation/translation, supportive counseling, health education and outreach.



How are FQHC/CHC's supported?
Federally qualified, 330 Grant that pays a portion of the uninsured cost, Prospective Payment System - enhanced reimbursement for Medicaid clients, Medicare enhanced reimbursement, commercial insurance patients, 340 B pharmacy discounts, and individual/corporate and foundation fundraising.

What is the payor mix of CHC patients?

- Uninsured/Self Pay – 47%
- Medicaid – 34%
- Commercial – 11%
- Medicare – 6%
- Other 2%

Did you know?
30% of community health center patients are served in a language other than English and nearly 95% are below 200% FPL.

Return on Investment:
CHC's employ over 2,500 Oregonians through direct and indirect employment and provide over $237 million in statewide economic output. Nationally for Medicaid, the average monthly cost

for a CHC patient was 31% lower than that of a patient who was not served by a CHC. Studies show that CHC's helped improve infant mortality rates, prenatal care, reduce low birth weight, and control chronic disease and disability.[xxviii] CHC's provide a high quality of care, with studies showing an improvement among patients in diabetes management, a higher likelihood of cancer screening for women, and a higher rate of childhood immunizations.[xxix] Furthermore, access to CHC's significantly reduces use of emergency rooms.[xxx]

4B. SCHOOL-BASED HEALTH CENTERS (SBHC)

Success Stories

"Four years ago a particular group of girls was identified as high risk for pregnancy. The RN here started a girls support group for that group, which lasted a year. Since then, there has been only one pregnancy in those girls, and that girl is a senior this year. That makes 8 girls who will have made it through high school before parenting. Knowing those girls, that is a major success!" SBHC Provider

"TE walked in last Tuesday with bad 2nd degree burns on his hand and foot that he had received the Saturday before. He had received no medical care. I have been working with him daily since then on debriding and bandaging. It took his Dad 3 days to buy the silvadene cream I rx'd, and he still hasn't bought sufficient bandaging supplies to care for him at home. They have health insurance but it doesn't cover much, so he had to wait for payday to buy the meds. Without the SBHC TE would have received NO care until the wounds were infected, then they would have sought care in the ER. This is his dominant hand and even with daily care I am worried about the scars puckering - let alone what his hand would have looked like with an infection there! But with TE's daily visits here, his hand and foot are healing well." SBHC Provider

What are School-Based Health Centers?
School-Based Health Centers (SBHCs) are primary care clinics that are located in a school. They provide developmentally appropriate physical, emotional, behavioral and preventive health care regardless of ability to pay. Because they are located in schools, SBHCs overcome many of the barriers to health care access encountered by low income and uninsured students. SBHCs are staffed like a local doctor's office with a receptionist, office assistant, or nurse, clinical provider (nurse practitioner, physician assistant, or physician), and at some sites, qualified mental health professionals. In essence, SBHCs bring the medical clinic into the school so school nurses and staff can refer students. Students avoid health related absences and get support to succeed in the classroom.

Who are typical School-based Health Center Patients?
Typical patients are school-aged children. SBHC's are located in elementary, middle and high schools throughout the state. 59% of SBHC patients are female and 45% of SBHC patients are uninsured.

What services are provided by School-based Health Centers?

- Primary health care
    - *Routine physical exams*
    - *Diagnosis and treatment of acute and chronic conditions*
    - *Treatment of minor injuries*
    - *Vision and dental screening*

- Prevention messages and health education
- Mental health service
  - *Grief therapy*
  - *Help with peer pressure*
  - *Bullying and suicide prevention*

OREGON SCHOOL-BASED HEALTH CENTERS 2008

WASHINGTON COUNTY
Merlo Station HS
*Forest Grove
*Tigard HS

COLUMBIA COUNTY
Lewis & Clark ES
*Rainier
*St. Helens HS
*Vernonia

MULTNOMAH COUNTY
Binnsmead MS
Cleveland HS
George MS
Grant HS
Jefferson HS
Lane MS
Lincoln Park ES
Madison HS
Marshall HS
Parkrose HS
Portsmouth K-8
Roosevelt HS

UMATILLA COUNTY
Pendleton HS
Sunridge MS

YAMHILL COUNTY
Willamina HS

CLACKAMAS COUNTY
Oregon City HS
*Canby HS
*New Urban HS

WASCO COUNTY
*The Dalles Wahtonka HS

MARION COUNTY
Hoover ES

UNION COUNTY
La Grande HS

LINCOLN COUNTY
Newport HS
Taft HS
Toledo HS
Waldport HS

POLK COUNTY
*Falls City

BAKER COUNTY
Baker HS

GRANT COUNTY
*TBD

BENTON COUNTY
Lincoln ES
Monroe ES/MS

WHEELER COUNTY
Mitchell K-12

LANE COUNTY
North Eugene HS
Sheldon HS
South Eugene HS
Springfield HS
Winston Churchill HS

COOS COUNTY
Marshfield HS

Total number of Certified SBHCs = 45
Total number of Planning Phase I Sites = 17

Counties with Certified SBHCs
Counties with Certified SBHCs and Planning Phase I Sites
New Counties with Planning Phase I Sites

DOUGLAS COUNTY
Roseburg HS
*Douglas HS

CURRY COUNTY
*Brookings-Harbor

*Indicates location of Planning Site
**Indicates location of Advanced Planning Site

KLAMATH COUNTY
*Gilchrist School

JOSEPHINE COUNTY
Illinois Valley HS
Lorna Byrne MS
*Evergreen ES

JACKSON COUNTY
Ashland HS
*Butte Falls/Prospect
Crater HS
Jackson ES
**Jewett ES
Oak Grove ES
Phoenix ES
Washington ES

DESCHUTES COUNTY
La Pine K-12 Campus
*Bend
*Redmond

JEFFERSON COUNTY
Madras HS

Oregon State Public Health Division, DHS, Office of Family Health, Adolescent Health Section, School-Based Health Center Program, 971-673-0252

As of January 2008

How are SBHC's supported?
Funding may come from State/local/city funds, community and foundation grants, fundraising, school districts &/or in-kind donations, fees and billing for patient services. Some SBHC's are part of an FQHC system (which may be a government or a not-for-profit organization), others part of a county health department, local Health Systems or 501 c 3 organizations

Did you know?
40,000 children have access to an SBHC. Nearly 21,000 unduplicated clients made 69,000 visits.

Did you know?
18 SBHC Planning Grants have been awarded by the legislature in 2007.

Return on Investment:
Studies show SBHC's reduce absenteeism, tardiness and school discipline problems. An Oregon SBHC patient survey (2007) demonstrated that 53% of students reported NO class time missed while using the center. 68% of students reported that without the center they would have missed at least one class to go to a traditional clinic. Furthermore, an additional $3-4 is leveraged through local public-private partnerships for every $1 of state funds invested in SBHC.[xxxi]

4C. COMMUNITY SPONSORED CLINICS (CSC)

Success Stories
Pastor Mary Overstreet long envisioned a free health clinic in her neighborhood, where many people go without health insurance, needed medical care and medications. Her relief-work after Hurricane Katrina brought her together with Dr. Jill Ginsberg, and they made the dream a reality. Since August 2006, volunteer staff and medical providers have treated over 1200 patients, offering free health care and medications to neighborhood residents in need.

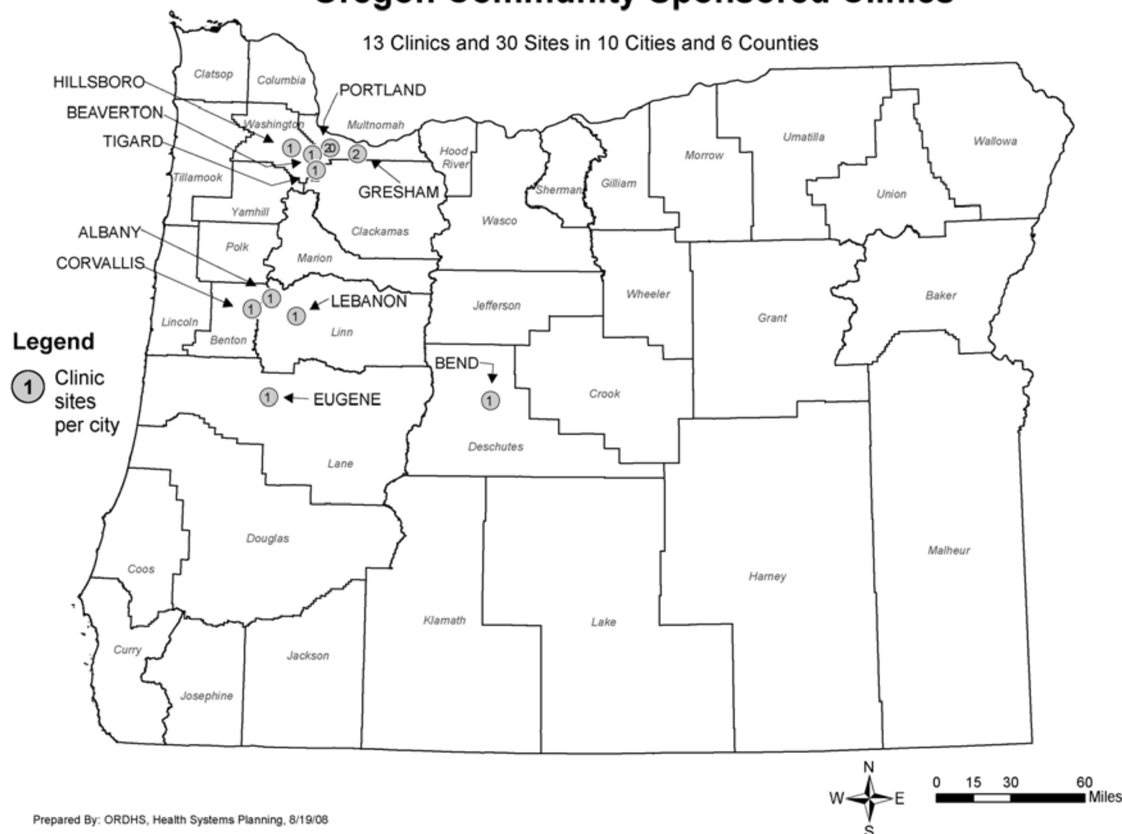
JE walked into the clinic one rainy evening distraught about being turned down for a job with the US Postal Service. He didn't pass his physical due to high blood pressure and had no resources to obtain the medical care he needed. Six weeks after his examination and a $4.00 prescription, JE delivers mail daily to his neighborhood clinic.

What are Community Sponsored Clinics?
Community Sponsored Clinics are a unique and less well understood part of the health care safety net. Some Community Sponsored Clinics, such as the Volunteers in Medicine (VIM), have substantial organizational infrastructure while others, less so. The common feature among all of the Community Sponsored Clinics is that their local community in the form of grants and donations predominantly supports them. They are mission-driven and community-based in their focus. It is difficult to track the number of Community Sponsored Clinics throughout the state because they do not receive state or federal funding, lack common reporting requirements and may look quite different from one community to another.

What services do CSC's provide?
The scope of service varies between clinics but is predominantly primary and acute medical care. Most clinics provide free medications and/or assistance with pharmacy assistance programs (PAP) along with referral coordination support for services they are unable to provide. Some clinics also provide dental, vision and specialty care.

How are CSC's supported?
Community sponsored clinics are 501 c 3 non-profit organizations. They are primarily sponsored by community and foundation grants and through local donations of services and supplies.

What is the payor mix of CSC patients? (7 clinics reporting)
Uninsured/Self Pay – 99%
Other – 1%



Did you know?
An overwhelming majority of CSC patients are uninsured and are living below 200% of the Federal Poverty Level.

Did you know?
Community Sponsored Clinics engage hundreds of volunteers and thousands of volunteer hours each year.

Donated Volunteer Services: Community Clinics, CY 2006*

- # of Volunteers: **979**
- # of Volunteer Hours/Month: **5,942**

**Footnotes: Includes 4 Community Clinics from Multnomah and VIM Bend (CY 2007); VIM Eugene (FY 2005-2006).*

Return on Investment:
CSC's are custom-designed and developed by communities to meet identified health care needs using the community's unique health care assets and resources. These clinics are able to leverage local resources, such as volunteers, donated space and individual contributions, to support their efforts. This is a unique way to create a collective response to health care needs at the local community level.

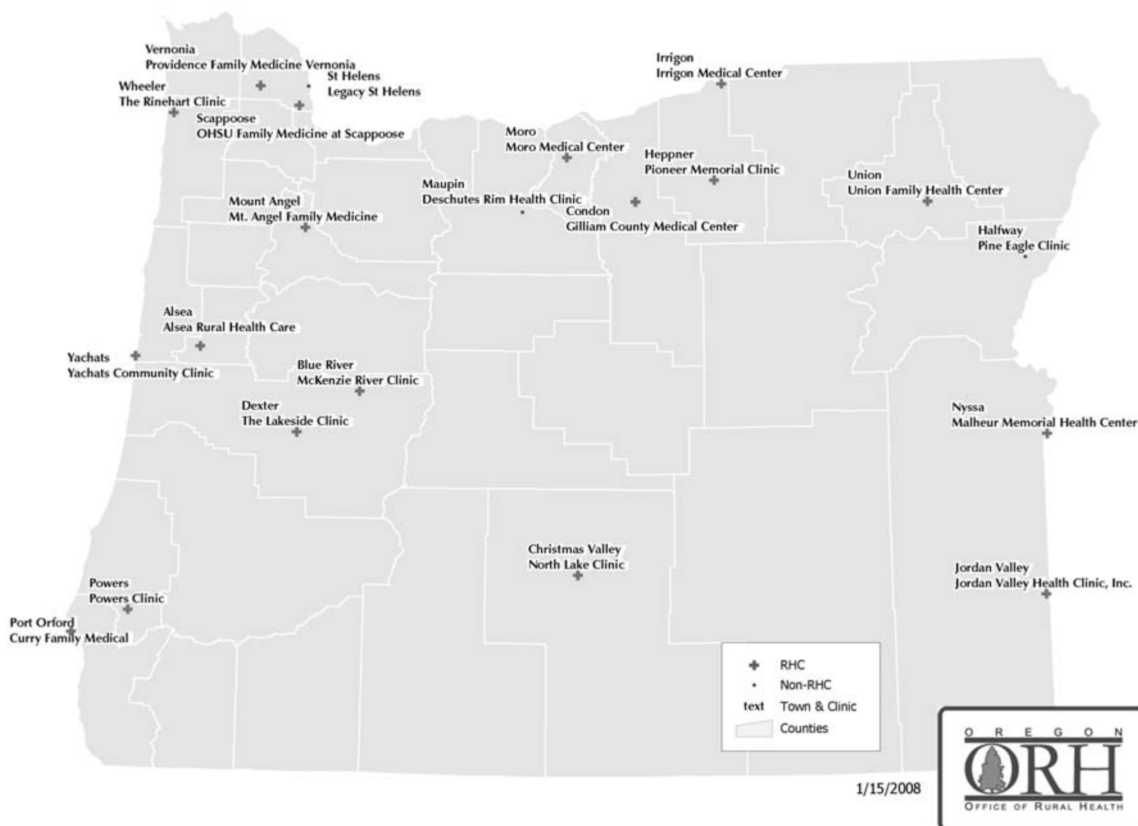
4D. ISOLATED RURAL HEALTH FACILITY (IRHF)

Success story
A physician in one eastern Oregon rural health clinic observed "little Jimmy or Suzy always has the ear-ache or fever when Mom picks them up from daycare at 5:03pm, after traditional business hours". Too many patients had only the neighboring community emergency room as an option, which was too often over/misused. Compounding the problem, some insurance won't pay for ER visits without a bona-fide emergency. He began running a Saturday morning clinic in 2001. He was always full, so he began looking for a provider to work Sundays. Finally, in 2007, that new provider came aboard. The dedicated providers at this clinic now see patients 8-7 weekdays, 9-4 Saturdays, and 11-4 Sundays. The philosophy of this rural health clinic is quick access ("let's do today's work today"), appropriate care at the appropriate level, and keeping people healthy and out of the hospital.

What is an Isolated Rural Health Facility (IRHF)?
IRHF's are private non-profit or public primary care clinics located in rural Oregon communities. They are a subset of federally certified Rural Health Clinics. By definition IRHFs are the sole source of access for primary care in the community, do not receive any Public Health Service Section 330 monies and are not school-based clinics. "Isolated Rural Health Facility" is currently a conceptual designation, as no benefit is accrued by virtue of being an IRHF.

Who is a typical IRHF patient?
There is a great deal of variance among patients who seek out Isolated Rural Health Facilities. IRHF patient demographics reflect the demographics of the population living in the IRHF's service area. Rural populations are typically older, lower income, have higher morbidity and are more likely to be under- or uninsured. Among these are Oregonians who work in the "hospitality" sector such as restaurant staff, hotel workers and housekeepers. Still others are young people with no more than a high school diploma in a small community where the only available jobs pay minimum wage and don't provide health insurance benefits. IRHF's see farmers and ranchers with a family to support in an industry where the market fluctuates wildly from year to year, as well as loggers and fisherman who are working in some of the most dangerous occupations but cannot afford health insurance. The common link among these patients is that many are uninsured or under-insured and are living in remote rural communities where there is only a single source of access to primary care services.

What Services are Provided?
The scope of services provided by IRHFs can vary greatly but, at a minimum, all IRHFs provide outpatient primary care and basic laboratory services. Some IRHFs also provide mental health, vision, dental, pharmacy, visiting nurse and other health care services, depending upon the needs of the community and the financial feasibility of offering such services.



How are IRHF's Supported?

- Federally sponsored, cost-based reimbursement for Medicare clients and enhanced Prospective Payment System reimbursement for Medicaid clients; commercial insurance. Some IRHFs also receive health district tax revenues, grants and/or donations.

Patients by insurance status – CY 2006 (11 of 17 clinics reporting)

- Commercial Insurance – 43%
- Medicare – 20%
- Medicaid – 18%
- Uninsured/self pay – 16%
- Other – 3%

Return on Investment

Information about formal schedules of discounts is available from 14 of the 17 Isolated Rural Health Facilities. Of those fourteen IRHF, 12 (85%) provide a schedule of discounts for their uninsured patients. Seven of the IRHFs reported having a chronic disease registry for at least one type of chronic disease. Eleven of the IRHF reported having some type of community outreach activity, which include things such as weight watchers club, flu shot and pneumonia

clinics, vaccines for children and other services delivered in the school setting, sports and employment physicals, blood drives, health talks for seniors and other populations and health screenings.

Appendix 5

HEALTH CARE SAFETY NET CORE DATA TEMPLATE

SNAC Core Data	
Clinic Group or Clinic Name	
Total # Clinics	
Data Year	
# Unduplicated Patients By Insurance Status	Medicaid
	Medicare
	Medicaid and Medicare
	Commercial Insurance
	Self Pay
	Uninsured
	Other
# Unduplicated Patients By Economic Status	<100%
	100-199%
	200%+
	Unknown
# Visits By Provider	Allopathic MD, DO, PA, NP
	Chiropractic
	Natural Medicine/Naturopathic
	Acupuncture
	Behavioral Health (Psych, A&D, Mental Health)
	Dental
	Health Education
	Other
# Clinics Providing Enabling Services	Transportation
	Translation
	Outreach
	Health Education
	Medical Case Management
	Social Case Management
	OHP Enrollment
	WIC
	Referrals
	Lab Work
# Unduplicated Male Patients by Race - Option 1	White/Caucasian
	Black/African American
	American Indian/Alaskan Native

	Asian/Pacific Islander Multiple Race Other/Unreported/Unknown
# Unduplicated Male Patients by Ethnicity - Option 1	Hispanic/Latino Non-Hispanic/Latino Unreported/Unknown
# Unduplicated Female Patients by Race - Option 1	White/Caucasian Black/African American American Indian/Alaskan Native Asian/Pacific Islander Multiple Race Other/Unreported/Unknown
# Unduplicated Female Patients by Ethnicity - Option 1	Hispanic/Latino Non-Hispanic/Latino Unreported/Unknown
# Unduplicated Gender Unstated Patients by Race - Option 1	White/Caucasian Black/African American American Indian/Alaskan Native Asian/Pacific Islander Multiple Race Other/Unreported/Unknown
# Unduplicated Gender Unstated Patients by Ethnicity - Option 1	Hispanic/Latino Non-Hispanic/Latino Unreported/Unknown
# Unduplicated Male Patients by Race - Option 2	White/Caucasian Non-Hispanic Black/African American Non-Hispanic American Indian/Alaskan Native Non-Hispanic Asian/Pacific Islander Non-Hispanic Hispanic/Latino Other/Unreported/Unknown
# Unduplicated Female Patients by Race - Option 2	White/Caucasian Non-Hispanic Black/African American Non-Hispanic American Indian/Alaskan Native Non-Hispanic Asian/Pacific Islander Non-Hispanic Hispanic/Latino Other/Unreported/Unknown
# Unduplicated Gender Unstated Patients by Race - Option 2	White/Caucasian Non-Hispanic Black/African American Non-Hispanic American Indian/Alaskan Native Non-Hispanic Asian/Pacific Islander Non-Hispanic Hispanic/Latino

	Other/Unreported/Unknown
# Unduplicated Male Patients By Age	0-18
	19-64
	65+
	Unknown
# Unduplicated Female Patients By Age	0-18
	19-64
	65+
	Unknown
# Unduplicated Gender Unstated Patients By Age	0-18
	19-64
	65+
	Unknown
# Interpreted Visits By Language	Spanish
	Russian
	Vietnamese
	Other
Paid Staff By FTE	Acupuncturist
	Administrative
	Chemical Dependency Counselor
	Dental
	IT Support Staff
	MD/DO/Naturopath*
	Medical Assistant/LPN
	Mental Health
	NP/PA
	Pharmacist
	RN
	Social Worker/Counselor
	Other
Donated Volunteer Services	# Volunteers
	# Hours/Month
Estimated Value ($) of In-Kind Contributions By Type	Medications
	Office Equipment/Supplies
	Clinic Equipment/Supplies
	Volunteer
	Other

SNAC Quality Data	
Clinic Group or Clinic Name	
Total # Clinics	
Data Year	
# Clinics that utilize the following Health Information Technology	Disease Registry
	Practice Management
	Electronic Health Record
	Decision Support Tools
# Clinics that have a formal QA plan process	
# Clinics that are accredited by any formal accreditation body	

SNAC Financial Data	
Clinic Group or Clinic Name	
Total # Clinics	
Data Year	
Total Operating Cost for Year ($)	
# Unduplicated Patients	
Revenue Amount ($)	Federal Government
	State Government
	Local Government
	Commercial Insurance
	Patient Payments
	Grants and Donations
	Other
Total Daily Cash On-Hand Averaged Over Year for Non-Profit Clinics ($)	
# 501(c)3 Clinics	
Amt Contributed by County to Meet Operating Expenses for Local Health Department Clinics ($)	
# Local Health Department Clinics	

Appendix 6

ENDNOTES

[i] Please refer to Appendix 1 for footnotes and further explanation of data collection

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[xxi] AAFP, AAP, ACP, AOA, "Joint Principles of the Patient Centered Medical Home" (2007)

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