DRAFT Jackson County Health Care Planning Report
January, 2005

Summary for League of Women Voters – Rogue Valley

Note: This summary was prepared for the LWVRV in support of the effort by members of that organization to develop a report on Rogue Valley health system issues. The final report was in draft form at the time of this summary, and a release date was expected in early 2005 but had not been confirmed. The Health Care Coalition of Southern Oregon thanks the League of Women Voters for their participation in the ongoing process to improve healthcare in our community and region.

Background

In 2001, the Health Care Coalition of Southern Oregon (HCCSO) received a Community Access Program grant from the Health Resources and Services Administration (HRSA). In the first budget period, HCCSO completed a demographic study to define and count the 'under-insured.' The conclusion of the study was that more than 53,000 low income and moderate income residents of Jackson and Josephine Counties had health insurance plans requiring annual deductibles of $5,000 or more.

In year two of the grant, HCCSO committed to convene representatives of key provider organizations to develop an integrated health system plan that would address the immediate and future needs of the medically uninsured and underinsured in Jackson County. Further, the grant proposal noted that the planning process would not conclude with production of only a document, but rather when a resource development plan for provision of sustainable access was adopted by stakeholders.

The planning group was convened in late April, 2003. Since the intent was to develop a plan that would define how health care providers would serve uninsured and underinsured persons, participants were invited from among organizations with direct ties to 'safety net' health services. The planning group initially included representatives of public health, community clinics, hospitals, and medical staff. Representatives of parish nurses, school health, alcohol and drug treatment services, and regional foundations were added after an initial meeting, and the group was subsequently joined by an observer from the Rogue Valley League of Women Voters.

Subjective Assessment

During the first meeting, the planning group agreed to meet monthly and subjectively defined key 'stakeholder' issues and desired outcomes for the planning process. Issues and desired outcomes were categorized into four areas according to the providers present. Key points are:

1) Physicians

- Issues
  - ~ Higher regulatory requirements, risks, caseloads, insurance premiums and charity service levels
  - ~ Lower incentives
- Desired Outcomes
  - ~ Community forum conversations: What do we expect of health care in our community?
  - ~ Decreased pressure, appropriate resource utilization, recognition for effort

2) Hospitals

- Issues
  - ~ Pressure due to Oregon Health Plan reductions, limited patient discharge resources, staff recruitment difficulties and charitable services / write-offs
- Desired Outcomes
  - ~ Vision / direction for entire local system
  - ~ Clarification of roles; appropriate use of resources
  - ~ Acknowledge what can and can't be done

3) Public Health

- Issues
  - ~ Loss of funding for services that had been successful, such as mental health and perinatal/maternal case management
- Desired Outcomes
  - ~ Priorities for service; acknowledge what can and can't be done

4) Community Clinics

- Issues
  - ~ Pressure due to Oregon Health Plan reductions, limited dental services, and 17% of population uninsured (at that time)
- Desired Outcomes
  - ~ Involvement of all business and health care stakeholders in planning
  - ~ Plan for sustaining services through 'good' and 'bad' times
  - ~ Plan for influencing public policy, consumer behavior & public perception

Based on these issues and desired outcomes, the planning group set a course toward identifying system resources, service gaps, significant industry trends, sustainable assets and a development plan.

It is noteworthy that the themes of community forums, broad participation and whole system planning foreshadowed a dramatic shift that was to come five months into the planning process.

The next step taken was development of a continuum of care services for the uninsured and underinsured. In order to better understand which population segments were most in need for certain services, a broad range of services were surveyed according to age groups served: grandparents/seniors; parents/adults; adolescents; children; and perinatal. Available services and service gaps were noted. Service gaps (for uninsured and underinsured persons) of particular concern included:

- senior services in numerous primary, acute and long-term care categories
- dental services for all ages
- mental health crisis services
- pharmacy services for low income of all ages
- access to specialty physicians
- preventive services for adults and seniors

Expanded Focus

After several monthly meetings, the planning group reached a critical point in discussing the magnitude of issues faced. The conclusion of that discussion was: Uninsured persons are personally at risk and pose a significant and growing problem for the local health delivery system, underinsured and other publicly insured persons are growing in number and are at risk regarding access to health services, and commercially insured persons are subject to 'holes' in coverage (e.g. lack of behavioral health services). In summary, the entire system is broken, most persons in the community are at risk due to some inadequate coverage, and planning efforts for persons at risk could appropriately address whole system issues.

After agreeing to this new, whole-system charge, the planning group decided to focus on four broad service areas (primary, acute, transitional and long-term care) in support of a vision for a healthy community. The planning group agreed to develop a draft vision and to convene focus groups to further discuss service gaps, root issues and strategies for each service area.

Draft Vision Statement

The planning group adopted a motto and a draft vision for the developing community health model. The motto is:

> "Building a healthy community one home at a time."

The draft vision statement is:

> "The Southern Oregon region offers a sustainable system of care such that being and staying healthy in our community is possible using available resources."

The group drafted several key principles in support of the vision:

- Community ownership
- Well-being of the community
- Goals and measures
- Physical health and behavioral health are intertwined
- Partnerships and collaborations
- Prevention and education are key to reducing costly medical interventions
- Patients in treatment are partners in successful health outcomes and a healthy system

Recognizing the emphasis on prevention and wellness, the planning group added a fifth category to the four previously defined service areas: Healthy Choices. The idea behind this was that consumers need to have access to information and services that will allow them to participate in their own wellness. It was agreed that development of this new category would involve convening a diverse group of community members at a later date.

Incorporating Other Community Plans

After drafting the vision statement, the group agreed to review existing agency and organizational strategic plans in the community for relevance to health system planning. Among the strategic plans reviewed were public health, mental health, alcohol and drug, school health, children and families, hospitals, and the Area Agency on Aging. In addition, group members reviewed the Walker Fund report and the Providence community assessment survey. Key points came from the latter two, with the Walker fund report noting substance abuse treatment as a priority, and the Providence survey recognizing primary care access, prescription assistance and frail elderly as the top unmet needs.

(Note: Very late in the process, as the final report was being developed, the planning group facilitator became aware of availability of materials from a previous community health planning process conducted through the Chamber of Commerce in 2001. As a result, release of a full final report was delayed from December 2004 to early 2005 to allow time for review and possible incorporation of materials from the previous effort.)

Focus Groups

After conducting internal discussions on primary, acute, transitional and long-term care services in the community, the planning group identified a diverse pool of potential focus group participants to further develop the needs, root issues, opportunities and strategies for

each area. Focus group participants were provided with a brief summary of issues (as defined by the planning group) related to their services areas. The issues were divided into three categories:

- Access (ability to pay; geographic/linguistic/cultural barriers)
- Capacity (availability of services)
- Asset Coordination (cooperation; coordination of care w existing assets)

The focus group discussions were guided by a three part agenda:

- Part I – Identify successes, trends and data required to verify needs
- Part II – Discuss service gap implications and opportunities for significant change
    - ~ Hypothesis: gaps and unmet needs will point to larger 'system' needs that could become priority areas for community action.
- Part III – Develop strategies for developing present assets to meet actual needs

Significant outcomes from the focus groups included:

Successes and strengths of the local health delivery system:
While recognizing shortages in some service areas and for some age groups, focus group participants acknowledged that Jackson County has generally excellent personal and organizational assets in health care. Specifically, we have a broad range of health care services and facilities, significant creative use of limited resources by providers, exceptional charitable service delivery, and many cooperative relationships among organizations. These assets are representative of hundreds of small 'successes' that take place daily. In addition, VolPACT, school-based health centers, coordinated COPD interventions (for congestive heart failure), and the midwifery clinic are among larger scale successes.

Trends of concern:
- demographics…aging, high % Medicare population in Southern Oregon;
- 50% > 65 yrs have 2+ chronic diseases; Alzheimer's population growing
- care-giver (workforce) shortages & turnover
- decreasing federal & state resources
- rising malpractice / defensive medicine costs
- increasing / unrealistic expectations of technology & science
- life preservation efforts resulting in longer lives & more resource requirements for persons with complicated medical conditions and/or severe disabilities
- obesity, especially among the young
- mental health issues among the young

Data issues:

Data is available from most health care organizations and care-givers. However, the data is fragmented and is typically not used collectively to…

- identify or confirm community health needs,
- evaluate community-wide outcomes, or
- measure collective quality and value of care delivered.

Root issues:
The list of identified health care service gaps and delivery issues is too lengthy for any summary. More informative are the implications, or root issues, associated with many of the present gaps and issues. The following list is certainly not exhaustive, but gives an appreciation of the range of issues and multiple levels at which problems must be addressed:

- Money: we, as a community, do not know the real cost of health care; all elements of cost, including volunteerism, should be measured and reported
- Uninsurance
- Segmentation of outside financial resources; in particular, poor mechanisms for blending funding to meet multiple, related needs
- Fragmented data sources: data exists in many places & forms, but few have access or know how to use collective data productively on behalf of the community.
- Regulatory burdens in numerous medical service areas; in particular, regulations are institutionally focused on 'protecting' or 'serving' patients, and do not support development or delivery of family and community ability to create solutions and serve patients (e.g. state pays very little to keep elderly persons at home, but pays high rates to place elderly in nursing homes).
- Lack of preventive care incentives: Some insurers have hired nurse case managers, but most plans pay only for treatment. Medicare is structured with service limitations that serve as disincentives for prevention. In order to treat some issues, providers must find other issues that can be reimbursed (e.g. treat smoking problem to address pneumonia, or colon health to address prostate problems).
- End-of-life / futile care
- Consistency in provider care delivery
- Medication prescription coordination among providers and public health
- Community / patient view of hospitals as resources for medical and psycho-social needs
- Lack of coordinated medical transport system other than Emergency Medical Services
- Unmet needs and limited support for behavioral health
- Lack of coordinated education and service delivery effort for community members caring for elderly family members

Strategies:
Focus group participants were asked to consider what strategies might be effective in addressing some of these root issues. Again, the following strategies are not exhaustive, and many additional thoughtful ideas were expressed during focus group sessions. However, these strategies do represent some potentially significant ideas and action steps

for measuring and improving value in local health care delivery, shifting the burden of solutions from providers to the whole community, and transforming health care delivery one step at a time:

- Establish a collective data function to…
  - ~ Identify community-wide health needs,
  - ~ Evaluate health outcomes,
  - ~ Measure collective quality and value of care delivered, and
  - ~ Use charity care services results as leverage for grant funding

- Assess the real cost of preventive / early intervention care not being delivered due to reimbursement and time constraints on providers…
  - ~ Develop a time-limited, voluntary, community-wide assessment survey for physicians/providers to use regarding what patients need when they visit provider offices versus the stated reasons for visits. (Based on yearly depression screen program used by PMG)
  - ~ Use results to project monetary values of prevention / early intervention for identified disease states that are not being treated.
  - ~ Use results as leverage for regulatory waivers, cooperative redefinition of payer benefits, and possible care delivery experiments

- Develop a community-wide approach to divert psycho-social care cases away from hospitals and into lower cost, community-based support groups and / or public services.

- Develop a proactive, community-based approach to reducing end-of-life / futile care costs…
  - ~ Establish community 'values' regarding end-of-life / futile care;
  - ~ Measure and publicize the high costs of such care;
  - ~ Work with community members to define an acceptable approach for incorporating advanced directives or similar instructions into the basic care plan for all persons in the community

- Coordinate development of a community vision and plan in support of appropriate in-home care …
  - ~ Involve all organizations involved in transitional (including adult day care) & long-term care services (including disability services) as well as affected families, family support services, and durable medical equipment providers;
  - ~ Identify and measure potential improved family care-giver and patient health outcomes and cost savings based on existing research;
  - ~ Plan for necessary, cost-effective support systems to serve patients and keep family members functioning well in community;
  - ~ Use cost savings and business productivity projections and coordinated care plan methodology as leverage to get state funding waivers.

Conclusion

As the Oregon Business Council Health Task Force recently stated in its health initiative white paper, 'A New Vision for Health Care,'

> *We have a serious problem in Oregon: our healthcare system is not working. The "symptoms" of the problem are apparent to everyone: rising costs, inconsistent quality and limited access to care for many Oregonians. There is an urgent need to take action to address these problems.*

Jackson County does face deeply rooted, complex problems in health care. However, we have outstanding local assets in the people and organizations that provide health and related services to our community. Other communities throughout the United States are succeeding in addressing health system issues similar to those in Southern Oregon. It is time for this community to come together in a sustained, multi-sector effort to define what we want from health care and what we will do to fulfill that vision.

We need a commitment from health care, business, education, government and faith community leaders to move forward with a solution development and implementation process. As evidenced by the participants in our focus groups, many in our community understand the changes that need to occur in specific service areas or are willing to participate in solution development. Community leaders must now collectively call for transformation in our local health delivery system and invite willing community members to join in the effort to build a healthy community, one home at a time.