

PUBLIC HEALTH TASK FORCE

Executive Summary

Recognizing that our community is in the midst of a health care crisis, the Public Health Task Force was asked to examine the public health delivery system¹ in Houston/Harris County. We identified the primary causes of the crisis as follows:

- A fragmented public health delivery system with accountability, direction, and funding spread across multiple agencies which do not coordinate, collaborate or communicate effectively together.
- Inadequate access to outpatient preventive, primary, and specialty care for low income and uninsured residents due to limited capacity in the system.
- An unacceptably high and growing number of uninsured residents who obtain their health care in emergency rooms, which is an inefficient use of health care dollars and a waste of scarce resources.

We recommend the following solutions to these problems:

- Create a comprehensive, integrated public health delivery system with control over and accountability for the full continuum of services currently provided through the existing five public agencies.
- Develop a community health information network to link the integrated public health delivery system with private providers.
- Build capacity in community-based outpatient sites to provide preventive, primary, and specialty care.
- Increase the number of insured residents through a variety of public, private, employer-sponsored, and hybrid insurance programs.

The Public Health Task Force

In early 2004, the Greater Houston Partnership, in consultation with County Judge Robert Eckels and Mayor Bill White, appointed a 19-member Public Health Task Force to examine the Houston/Harris County public health care delivery system and make recommendations for improvements. Rob Mosbacher, Jr. was asked to chair the Task Force. The charge to the Task Force was to design a system through which to provide more effective access to, and more efficient use of, available public health resources.

¹ Throughout this report, all references to the “public health delivery system” include population-based public health services provided by the city and county public health departments as well as the full continuum of individual health care services offered by the two health departments, the Harris County Hospital District, Harris County MHMRA, and Harris County Psychiatric Center. Public health services are community-based services geared towards protecting of health of a population as a whole through organized community efforts aimed at prevention of disease and promotion of health. This includes disease, vector and animal control, environmental monitoring and enforcement, food and drinking water safety, laboratory services, health education and promotion, epidemiology and surveillance, health planning and policy development, disease prevention and control and nutrition services.

The Task Force was comprised of 19 members including public officials, public and private health service providers, medical school representatives and business and community leaders. Four working groups were formed to examine the current system in light of the challenges and to recommend improvements in the following areas: finance, services, structure, and technology. Over 200 people participated in the working groups, which met regularly from March through August of 2004. This report is a synthesis of the work product of the four working groups. The Appendix contains the full reports of the working groups and the membership lists of the Task Force and the working groups.

The Health Care Crisis

The Houston/Harris County area is one of the fastest growing regions of the country. We now boast 3.5 million people and the world's largest medical center. People come from all parts of the globe to obtain the highest quality care, based on the latest research delivered with state-of-the-art technology. We have a relative abundance of physicians for a population our size. Virtually every type of health care and every conceivable treatment and procedure is available here.

Notwithstanding this seemingly bountiful supply of services, our community is in the midst of a health care crisis. The challenges of rapidly rising health care costs, an increasing number of uninsured residents, a growing population, a shortage of public resources and limited access to basic and emergency health care services, require a critical examination of our local public health delivery system to ensure that we are optimally positioned to meet these challenges.

The problems we face in the Houston/Harris County public health delivery system are complex, but generally fall into two broad areas.

Fragmentation: Our system is highly fragmented with relatively little coordination or collaboration. Public services are provided through five agencies, among which there is very little coordination, collaboration or communication.

Access to care: Limited capacity means too few people—particularly the uninsured--have access to preventive, primary, and outpatient specialty care services. Because they lack access to care in lower cost settings, the uninsured often obtain care in hospital emergency rooms. This inappropriate use of the emergency room impedes access to specialty care by those who need it and increases the cost of health care for all. Because the uninsured only pay a fraction of the actual cost of their care, if anything, those costs are shifted to others—taxpayers and the insured patients.

If we address these problems, we can make a substantial improvement in our ability to get the highest value and return on investment from our health care dollars.

Problems Relating to our Large and Growing Uninsured Population

In Houston/Harris County, the high rate of uninsured and underinsured residents poses unique challenges to cost-effective delivery of health services.

- Of our current 3.5 million residents, 1.1 million people, or 31.4% of the population, have no health insurance. The national average is 16%.
- Our uninsured population includes 25% of the children in Houston/Harris County, and 51.7% of our Hispanic population.
- The vast majority of the uninsured in Harris County are working people and their dependents. Approximately 43% have family incomes below \$40,000.
- The fastest growing segment of the uninsured population is the middle class, with household incomes in excess of \$50,000.
- An additional 500,000 residents are underinsured, which means that they have some insurance but not enough to cover all of their health needs. When they need a service that is not covered by their plan, they are effectively uninsured.

People who lack sufficient health insurance or substantial personal resources have relatively few options for obtaining health care. Some of the 1.6 million un/underinsured people in Houston/Harris County turn to public health care providers and to certain private providers who are willing to subsidize care. These providers are often referred to as “safety net providers” or the “safety net system.” The public agencies that make up the safety net system are the Harris County Mental Health Mental Retardation Authority, Harris County Psychiatric Center, Harris County Hospital District, Harris County Public Health and Environmental Services, and City of Houston Department of Health and Human Services. The combined expenditures of these agencies is approximately \$1.5 billion a year. The private safety net providers include CHRISTUS, HCA MemorialHermann, Methodist, St. Luke’s, and Texas Children’s Hospital as well as several small, nonprofit clinics and hospitals. These private providers expend over \$450 million a year in serving the safety net population.

Despite these substantial expenditures, it is estimated that the safety net system is able to meet less than 1/3 of the demand for its services. Capacity is especially limited in preventive, primary, and outpatient specialty care. Outpatient services available to the safety net population including:

- 11 community-based primary care clinics operated by the Hospital District;
- 7 preventive care clinics operated by the City health department,
- 6 preventive care clinics operated by the County health department,
- 3 Federally Qualified Health Centers and
- numerous small nonprofit clinics.

Due to the limited outpatient capacity of the safety net system, many of the uninsured seek care in public and private hospital emergency rooms. Emergency rooms are required by federal law to provide some level of care to all who present themselves, whether or not they have an emergent condition or the ability to pay for care. A recent

study by an economist from the University of Texas School of Public Health showed that the rate of non-optimal use of emergency rooms is greater than 50% by the uninsured population.

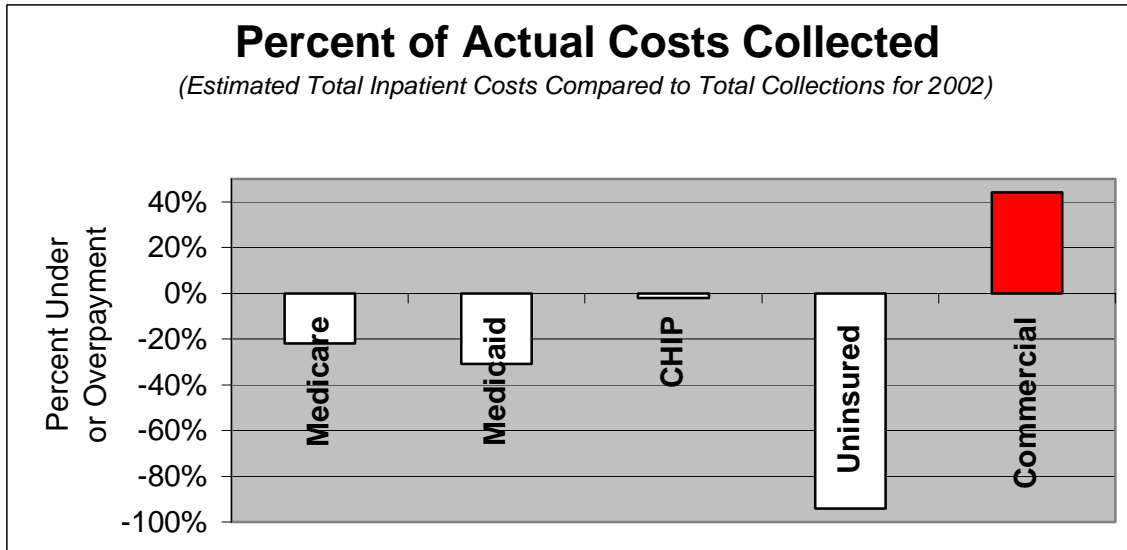
When people seek non-optimal care in hospital emergency rooms, there are adverse consequences that affect the entire community. First, scarce resources—emergency room space and personnel—are expended, which limits the availability of those resources to the rest of the community, including those with true emergencies. As a result, some of our emergency rooms, including our trauma centers, are on diversion over 30% of the time. This means that hospitals are temporarily at capacity and they will accept no patients, regardless of medical condition or ability to pay.

Second, the cost of treating a patient in the emergency room for a condition that could have been treated in an outpatient setting is, on average, three times as high. Providers are able to recoup, on average, less than 10% of the cost of care of people who are uninsured. When the cost of delivering the care is tripled because the care is delivered in an emergency room instead of a clinic, the deficit to the provider triples. Providers must recoup their costs, or else they will go out of business. Because the uninsured generally pay substantially less than the actual cost of the services they receive, if anything, the cost of their care must be shifted to those who can pay. For the publicly funded agencies, taxpayers bear most of these costs. For providers with privately insured patients, like the hospital systems, costs are shifted to the private insurers. These insurers pass along the increased costs to their customers, most of whom are employers who sponsor insurance plans for their employees.

Recent figures indicate that insurance premiums for most businesses increased between 15% and 20% in 2004, and according to a new survey, employers expect premiums to increase another 12.9%, on average, in 2005. Employers are forced to choose between absorbing these steady increases in cost or attempting to mitigate those costs. Those unable or unwilling to absorb the increases may raise deductibles or co-pays, they may reduce or eliminate coverage for dependents, or they may stop providing health benefits for their employees, altogether. This dilemma is faced most acutely by smaller businesses, which represent the vast majority of businesses in the Houston area.

As employers cut back or eliminate coverage for their employees, the pool of uninsured increases, thereby shifting the costs from that employer to other employers, or to taxpayers. It is that cost-shifting, or “hidden tax,” that is forcing many employers to further reduce their health insurance coverage. Unless addressed, this scenario will repeat itself over and over again until there are too few insured people to absorb the costs, and that will lead to a system collapse.

The chart below shows the relationship between the cost of care and the amount of payment received by a provider from various sources. The chart illustrates the effect of cost-shifting, and the particularly large burden the uninsured place on the system.



Demographic and economic projections indicate that the uninsured population will continue to increase. The Hispanic population, which is expected to rise from 27.3% to 48% of the Houston/Harris County population by 2015, has a higher rate of uninsurance than the overall population. The growth in our economy is expected to occur in the small business and service sectors, which sponsor employee health insurance less often.

Problems Relating to Our Fragmented Public Health Delivery System

Fragmentation and the resulting lack of coordination, collaboration and communication among public and private safety net providers inhibits our ability to do more with our existing limited resources. The following are examples of this problem:

- We have two public health departments whose scope of work substantially overlaps and between whom there is no formal mechanism for coordination of effort.
- There is no process for developing a community-wide consensus on public health/health care needs and priorities, or for planning service delivery on a community-wide basis.
- Public clinics operated by different agencies are located near each other, but are operated independently, without coordination or collaboration, which results in duplicative services.
- Some providers return unspent grant funds to state and federal agencies, while others provide the services covered by those grants without reimbursement.
- Agencies within our community often compete against each other for the same state or federal funding, undermining each other's chances of securing that funding.
- Eligibility standards and processes vary across providers, including among the public agencies, which is confusing to patients and requires duplication of effort by providers.

- There is no referral system to facilitate clients in accessing the services that are available within the system, or to assist providers in making referrals.
- Lack of a single health record for each patient means that tests are often repeated when patients seek care from different providers, data must be collected, recorded and stored multiple times, and important information may not be transferred when a patient sees another provider.
- Training of and protocols for emergency responders are not standardized, and there is no common radio communication system among first responders.
- Physical and behavioral health (mental health and substance/alcohol abuse) services are offered almost entirely through separate systems, contrary to the now well-accepted understanding of “health” as encompassing both aspects.

Problems Relating to Access to Care

Access to services for preventive, primary, and outpatient specialty care, particularly for people who are uninsured, is a significant problem in virtually every service area because of limited capacity. Population-based public health services provided by the two public health departments are likewise in limited supply, which places the entire population at risk for disease and injury. The following are examples of lack of capacity in our system:

- We have too few outpatient clinics for preventive, primary, and specialty care, and the ones we have generally are not geographically well-dispersed, do not offer weekend or evening hours, have long cycle and wait times, and are inaccessible to many due to limited transportation.
- Hospital emergency rooms provide significant care to non-emergent patients, and are on diversion status 30% of the time.
- The supply of beds for mental health patients in Houston/Harris County is 60% below the national standard for a population of this size.
- We have too few resources devoted to traditional public health work, including animal/vector control, environmental services, laboratory services, epidemiological work and prevention of chronic disease and injury.

Problems Relating to Information Technology

Deficiencies in information technology and information sharing also impede the functioning of our health service delivery system. In today’s environment, information technology is quickly becoming an essential tool for efficient management health delivery systems. In the Houston/Harris County safety net system, the fragmentation among providers, coupled with an environment that discourages sharing of information, are significant barriers to optimal use of information technology. There is broad variation among providers regarding the extent of use of information systems, as well as the types of systems in use, and, in some cases, variations within providers.

The inability to share information across the continuum of care, the mobility of the patient population, and the lack of a common standard for patient identification all contribute to the difficult challenge of delivering health services. This is illustrated when

a provider attempts to care for a patient without the benefit of data from previous encounters. Because prior health information is limited to independent systems, it cannot be integrated into the current patient record. This limitation hinders optimal access to care, the quality of care patients receive, provider efficiency, and productivity. Without an underlying local information infrastructure that supports the sharing of information, it will not be possible to streamline care, achieve efficiency in operations, or even allow for the collaboration needed to respond to emergency events across the county.

The Solutions

The problems with our public health delivery system are significant; addressing them will require a significant commitment of time and resources.

Addressing the Problem of Fragmentation

It is our recommendation that all publicly funded public health and health care services should be provided through a single consolidated entity with control over and accountability for the full continuum of services currently provided through the existing five public agencies. This continuum should extend from population-based public health services to all levels of hospital care, and should include mental, developmental and behavioral health at all levels.

We recognize the magnitude and import of this recommendation, including the practical implications of creating, governing, and operating this entity. However, the structural deficits of the current system are so serious that any improvements we make to the system, including infusion of new funds, is not likely to solve the problems caused and perpetuated by the current structure.

The Services working group, which identified and explained the fragmentation problems, recommended the establishment of a coordinating council to design the processes and systems necessary to overcome fragmentation barriers, including a commitment by providers to institute the processes and systems that are developed. While sound in concept, the success of such a coordinating council depends on the commitment of various agencies to prioritize community goals over agency goals. These agencies have separate governing bodies and missions, and their accountability and allegiance are necessarily agency-specific.

Currently, the Quad Agency, consisting of leadership of four of the public agencies, was formed to address community-wide, interagency issues, but has not addressed the fragmentation problems. Until the agencies are held accountable to the same governing body and “big picture” mission, the larger goals of effective and efficient service delivery across the broad spectrum of services will not be prioritized.

In support of the creation of a single, consolidated entity, we offer the following:

- The detailed, problem-specific recommendations of the Services working group to the problem of fragmentation revolve around increasing coordination, collaboration, and communication among agencies. A comprehensive,

coordinated structure enables us to achieve these goals. This is a benefit we have been unable to realize in our current, fragmented system, despite good faith efforts to do so.

- The Technology working group's recommendation to develop a sophisticated community-wide information network will be less expensive and easier to implement and the fragmentation and political barriers to information-sharing will be reduced if the five public agencies operate as a single entity. In addition, there is urgency in IT implementation because of federal funds made available for local projects.
- A comprehensive, coordinated structure will foster greater accountability. In the current environment, ideas are shared between agencies, agreed upon, and often not implemented because of lack of funding and oversight.
- Such a structure provides the incentive to invest resources at the appropriate and most effective levels because the system reaps the benefits of proper allocation, and pays the price for improper allocation.
- The new entity will be well positioned to take advantage of funding opportunities in virtually every area of health service, without internal competition. As funding priorities at the state and federal levels change, the system will be in a position to take full advantage of these opportunities, resolving the difficulties experienced by our congressional delegation because of competing requests.
- Coordination with the many educational, private and non-profit entities on which the publicly funded health service delivery system depends, and which make up a significant part of the community's safety net, will be streamlined.
- Duplication of functions will be avoided and the entity will realize critical economies of scale, particularly in administrative areas, allowing redeployment of resources within the system to provide more services.
- This structure is consistent with The Lewin Group's recommendation that such an arrangement is necessary if our community hopes to make meaningful progress in addressing the multi-faceted issues associated with our large and expanding uninsured population. This structure resembles the well-regarded public systems in Chicago/Cook County, Indianapolis/Marion County, and Denver.

Making Better Use of Information Technology

There are opportunities to compensate for some of the problems relating to fragmentation through the use of enhanced information technology systems by creating a community health information network. The envisioned network would serve members, providers, and patients through the delivery of a "utility" like computing infrastructure, which would enable its customers to participate at multiple levels based upon their needs. In addition to meeting security and privacy standards, the computing infrastructure would

provide patient-centric health information and decision support tools on an anywhere, anytime basis. This will require an initial investment in building such a system, but over time its on-going operations should be funded with revenues generated through its market-based offering of services. Similar networks exist in other communities and are reported to relieve many of the problems noted in our system.

The community health information network will resolve some of the problems relating to the inability of providers to communicate with one another, which is a major barrier in the current system. It will not resolve the problems associated with the agencies' individual decisions to use different internal systems, including software for patient records, billing, and eligibility. In fact, if the agencies continue to use disparate internal systems, the network will be burdened with the cost of integration of those systems, in addition to the cost of facilitating the sharing of information among entities and with private providers. A restructured service delivery system will make more effective and efficient use of a community health information network as a single entity.

Expand Capacity in the System and Make New Strategic Investments

The lack of capacity in the delivery system combined with the large and growing number of uninsured people are creating a sort of financial "death spiral" that must be altered or the system will collapse. In order to relieve pressure on emergency rooms and serve more people in lower cost settings, we must expand capacity substantially. We must also explore every reasonable option for strategic investments in new, more affordable insurance programs or products that can directly impact the number of uninsured people in our community.

With respect to expanding capacity, we recommend the following:

- Increase outpatient capacity within the Hospital District. Currently, the Hospital District operates 11 community-based primary care clinics. We should implement the Hospital District's plan to add capacity by increasing operations at existing community health centers, building 9 additional centers, and adding new specialty/diagnostic outpatient clinics. The capital costs for these projects are estimated to be \$240 million.
- Urgent care centers. These centers located throughout the community can serve as lower cost alternatives to people without access to outpatient care, especially in the evenings and on weekends when people might otherwise turn to emergency rooms. The estimated start-up costs for six centers are \$20 million per center.
- Federally Qualified Health Centers (FQHCs). Several clinics are in the process of obtaining FQHC designation, and it is in our common interest to support these centers until they become financially viable. FQHCs have the ability to become the health home, and primary care provider, for many of the uninsured. They will need support from the community in an amount estimated to be \$3 million a year (for 14 FQHCs) so they can provide care to people who are uninsured and

otherwise might seek care in the emergency room. A community philanthropy fund has already been established for this purpose.

- Expand mental health capacity. Capacity can be expanded by co-locating mental health services in HCHD and FQHC clinics.
- Increase the number of safety net providers. The public agencies can accomplish this by entering into mutually beneficial partnerships with each other and with private providers in ways that extend or expand service provision. We can increase the number of safety net providers by developing innovative, low cost training programs, enabling a volunteer provider network, and developing programs that provide incentives to professionals to serve the safety net population.
- Increase the number of school nurses and school based clinics. School nurses play a very useful role in helping diagnose and treat most primary care issues at a school and help relieve pressure on emergency rooms. Due to budgetary issues, some of these positions are being eliminated. We believe the number of school nurses should be increased, not cut. We also believe the use of school facilities to provide clinical space for people in the neighborhood may be a short term way to increase capacity without additional expenditures in bricks and mortar. With additional school based clinics, students can obtain care during the day and their parents may be cared for at night.
- Utilize the skills of retired and volunteer physicians: With appropriate liability protection, retired and volunteer physicians represent a significant alternative pool of medical expertise that could be used around the community. We recommend working with the local medical societies and the state to maximize the engagement of retired and volunteer physicians.

With respect to increasing the number of insured people, the following options should be considered:

- Medicaid waiver pursuant to H.B. 3122. The objective of this program is to increase the number of people covered through Medicaid by using local tax dollars to draw down additional federal dollars. A statewide task force, chaired by a Hospital District employee, is charged with developing the program, which is not expected to be in place before 2006. If successful, this program could leverage \$110 million local tax dollars already being spent to draw down \$160 million in federal funding, and provide insurance to as many as 110,000 more people in Houston/Harris County (~10 % of current uninsured population)
- Premium assistance programs. Some of the existing publicly sponsored insurance programs, such as CHIP and Medicare Part B, require premium payments from enrollees. Generally, these premiums are small, but because

of the limited resources of the elderly and CHIP-eligible families, the premiums may be barriers to enrollment. The total cost of the CHIP premiums for all of the 93,000 Harris County children enrolled in CHIP in the past year is just under \$10 million, or \$105/child/year. While the State should restore funding to CHIP, if that does not occur, to the extent that the premium is a barrier, it is in our collective interest to use local funding to cover the premiums so that children will stay insured. CHIP draws down \$2.59 for every state dollar invested, and as the chart of cost of care payment rates demonstrates, CHIP is a relatively strong payer. These are powerful incentives for keeping children on CHIP.

- Subsidized private indemnity insurance products. The community should develop an insurance product for 10,000 people with a limited set of benefits focusing on prevention and primary care, priced at \$125/month plus reasonable co-pays. This premium rate is substantially lower than the rates available in the individual insurance market because this rate is set for a 10,000 person risk pool, and it is substantially less than the total cost of many employer-sponsored plans. For persons with incomes up to 300% of the federal poverty level, a premium subsidy of up to \$100 a month or appropriate sliding scale would be available. The subsidized cost of the program is estimated to be \$30 million over three years, or \$100/person/year.
- Small employer insurance products. The legislature has changed the law regarding the ability of small employers to purchase group health insurance to assist them in obtaining lower rates. More work must be done in this area to ensure that small employers are actually able to realize the benefits of the new legislation.
- Add uninsured people to existing plans. There are efforts under way throughout the country to develop programs that allow people to buy in to public and private plans for which they are not currently qualified. Texas is behind the curve in developing such programs, and this community has the incentive to take the lead in this effort. Large employers, including the City and County, may be able to offer buy-in programs.
- State restoration of CHIP mental health benefits. The legislature has reduced mental health care coverage for children. Outline benefits of restoring coverage.
- Encourage business to include mental health coverage. Businesses should be encouraged to provide equal coverage between mental health and medical and surgical benefits. The minimal cost is offset by the reduction in overall medical costs.

Next Steps

The scope of our recommendations is monumental, but we believe they are necessary to meet the monumental challenges with which we are faced. Successful implementation will require detailed planning with significant financial support for the planning process alone.

With respect to the creation of a comprehensive, integrated health service delivery system, we recommend that a successor task force, to be known as the Houston/Harris County Health Task Force (“H/HCH Task Force”), should undertake this work beginning no later than January 1, 2005. The H/HCH Task Force should:

- Develop a detailed implementation plan for the integrated system consistent with the vision of the system described in this report and explained in greater detail in the Structure working group’s report.
- Move toward integration, beginning with the creation of a public health district, as set forth in the Structure group’s report.
- Comprise approximately 11 members, all of whom should serve without compensation, and should be confirmed by Harris County Commissioners’ Court and the Mayor of Houston, to whom it should report quarterly.
- Include representation from the boards of the Hospital District and MHMRA and public health.
- Be sufficiently funded in its start-up phase to allow it to retain an executive director, staff, and professional expertise necessary to carry out its work. This should include loaned staff from the five existing agencies.

Ultimately, the proposed structure may require voter and legislative approval of a new entity to take responsibility for the work now carried out by the five agencies. Because the system will be developed in a step-by-step basis over an extended period of time, likely at least five years, current governing bodies such as the Hospital District’s Board of Managers and the MHMRA Board should remain in place as we move toward the consolidated system. The initial steps should be undertaken through joint efforts implemented through contractual arrangements.

As mutual confidence among all agencies and among elected officials and community leaders develops in both the consolidation process and the results of the coordination efforts, more complete consolidation will likely occur. It is important at the outset, however, to set out the ultimate goal—a comprehensive, coordinated publicly funded public health and health care system governed by a consolidated entity that is accountable to the public.

The restructuring of the public agencies into a comprehensive, integrated system is a long-term goal. We must commit to that goal today, but recognize that there is much work to be done as we move toward its realization. The working group reports contain important recommendations for change, many of which can and should be implemented immediately through the efforts of the H/HCH Task Force. Implementation will improve the current system, and in most cases, the suggested improvements will facilitate our attainment of the longer-term goal of a comprehensive, integrated system. Work that must proceed immediately includes:

With respect to intermediate solutions to access and fragmentation problems, we recommend that the H/HCH Task Force follow up with the Services working group who has agreed to continue to address these problems. On November 5, 2004, that group will present a report that identifies immediate opportunities to resolve some of these issues which do not depend on restructuring, establishment of an information network, the infusion of significant funds, or legislative fixes. It is anticipated that the opportunities they will identify will require funding in the form of dedicated staff to work with the group to implement changes. It is our recommendation that the public and private providers support and encourage their staff in working on these opportunities within the scope of their work responsibilities.

With respect to the creation of a community health information network, we recommend that the H/HCH Task Force pursue the creation of such a system, including retaining the professional expertise necessary to design and price the system.

With respect to increasing the number of insured people and seeking additional funding to build system capacity, we recommend that the H/HCH Task Force be charged with the responsibility for fully developing the concepts outlined in this report, including the financing mechanisms for each program, and for prioritizing implementation among the many possible programs.

Conclusion

The work of the Public Health Task Force has provided a detailed view of the current state of the public health system in Houston/Harris County. The problems of fragmentation and access, which are exacerbated by the large and growing number of uninsured residents, permeate this community. If nothing is done, the system itself is destined to collapse. Although the magnitude and implications of recommendations proposed are vast, there is a real opportunity to address the problems that the current system has not been able to tackle. The time is right for change and there is a willingness among the providers and leaders in this community to take on these challenges. Cities across the country are facing similar problems and finding ways to deal with them. It is incumbent upon this community to do the same.