

Harris County

HCPHES

Public Health & Environmental Services

INTEROFFICE MEMORANDUM

TO: Richard L. Raycraft, PhD
Director, Harris County Management Services

FROM: Herminia Palacio, MD, MPH

SUBJECT: Publicly-Financed Health Care Delivery and Public Health

DATE: 8/31/04

As per your request, below please find a brief policy paper regarding possible options for improving coordination and delivery of services among publicly financed health care delivery agencies and public health agencies in Harris County.

BACKGROUND

Overview

There continues to be much attention at the national level on the large numbers of uninsured Americans. To date, there have not been any successful national models to address the problem. Therefore states and local jurisdictions have begun to develop and implement a variety of strategies to try to address the problem at a more local level. Two such recent efforts in the Houston/Harris County metropolitan area are: a) Save our ERs and b) the Greater Houston Partnership (GHP) Public Health Task Force. Both efforts have originated in the private sector. Taken together, these efforts have gathered input from a wide variety of business entities, health care provider organizations (private and public), community organizations, and public health agencies.

Four governmental agencies have received considerable attention in the Save Our ERs report (written by the Lewin Group) entitled "Revisioning the Delivery of Health Care Services to Uninsured Patients in Harris County" and the draft reports issued by the GHP Public Health Task Force. Two of the agencies are publicly-funded health care delivery systems, specifically the Harris County Hospital district (HCHD) and the Mental Health and Mental Retardation Authority (MHMRA) of Harris County. The other two agencies are public health departments, specifically, Harris County Public Health and Environmental Services (HCPHES) and the Houston Department of Health and Human Services (HDHHS).

The mission, key objectives, and target populations of health care delivery systems (including publicly-financed health care delivery systems) differ from those of public health systems (see table below, adapted from Public Health vs. Medicine, Harvey Fineburg MD, PhD, Harvard University School of Public Health).

Health Care Delivery Systems	Public Health Systems
Focus is on individual	Focus is on populations
Emphasize diagnosis, treatment and care for whole patient	Emphasize prevention and health promotion for the whole community
Employ provision of medical care	Employ interventions aimed at the environment, human behavior, lifestyle, and clinical preventive care
Stimulated by needs of patient	Stimulated by needs of community

Additional important distinctions between these two categories include:

	Publicly-Funded Health Care Delivery Systems (HCHD, MHMRA)	Public Health Systems (HCPHES, HDHHS)
Target Populations	Medically underserved, uninsured, underinsured	Entire population
Interventions	Generally delivered on a case-by-case, patient-by-patient basis	Generally delivered on large-scale basis, often based on environmental solutions (e.g. cleaner water, safer food), behavioral interventions (e.g., smoking cessation health education campaigns), and preventive clinical services (e.g. vaccinations to secure community immunity). Frequently delivered on community-wide basis
Individual versus Community Priorities	Individual patient sovereignty (including right to refuse treatment) highly prized	In several areas must explicitly balance risk of potential threat to community health against high value of individual sovereignty
Unique aspects	Charged with providing a continuum of patient care services from primary care to tertiary care	Charged with preparedness and response to bioterrorism and other large-scale public health emergencies

Scope of the Problem

Insurance Rates

Estimates of the number of uninsured non-elderly (under age 65 years old) vary depending on the methods used to derive the estimate. For example, some methods measure lack of insurance at a

single point in time (e.g. currently insured versus uninsured), others measure uninsurance at any point during a specified time interval (e.g. uninsured at any time over the past 12 months), and others try to measure sustained uninsured status (e.g. number of consecutive months without insurance). While each of these methods has its advantages and disadvantages, together they can give a more robust picture of uninsurance in the United States (U.S.) For example, data from the 2002 National Survey of America’s Families (NASF) indicate that 49 million people were uninsured at some time in the 12 months preceding the survey, including 37 million people who were uninsured at the time of the survey and an additional 12 million who were uninsured sometime in the prior 12 months. By comparison, the Kaiser Commission on Medicaid and the Uninsured (“Kaiser Commission”) and the Urban Institute used data from the Current Population Survey to estimate that 43.3 million Americans lacked health insurance in 2002.

The Kaiser Commission and Urban Institute also used data from the Current Population Survey to derive state estimates of insurance status. Of note, **Texas had an estimated 25% uninsured (combined years 2001-2002), compared with 15% nationally (year 2002)**. More Texans also lack health insurance for long periods of time. Specifically, in a comparison of 13 states performed in the 1999 NASF, **Texas had the highest proportion of persons who were without health insurance for at least 12 months (20%), compared with a national average of 11%**.

When comparing trends over time, it is important to compare estimates that were derived using similar methodology to get an accurate understanding of temporal changes. The overall proportion of non-elderly Americans that lacked health insurance nationally remained relatively stable between 2001 (14.1%) and 2003 (15%). This stability reflects a **recent trend toward shifting the burden of purchasing health insurance away from the private sector (e.g. employer-sponsored insurance) to the public sector (Medicaid, State Children’s Insurance Program [SCHIP], and other state programs)**. These trends are illustrated in the table below, produced by the Center for Studying Health System Change.

Source of Coverage	1997	1999	2001	2003
Employer	65.1%	66.0%	67.0%	63.4%*#
Other Private	6.9	6.7	6.0*	5.5#
Public Insurance	7.6	8.3*	8.9	11.9*#
Other Coverage	4.9	4.0*	3.9	4.2#
Uninsured	15.4	15.1	14.1*	15.0

Notes: Other private includes private nongroup insurance and private insurance obtained through someone outside the family. Public includes Medicaid, SCHIP and other state programs but not Medicare. Other coverage includes Medicare, military insurance, Indian Health Service and miscellaneous other coverage.
 * Change from previous round is statistically significant at p < .05.
 # Change from 1997-2003 is statistically significant at p < .05.
 Source: HSC Community Tracking Study Household Survey

Relatively large samples of the population are needed to derive accurate and reliable estimates of health insurance rates. Due to the intense resources and associated costs of conducting large samples, county and/or city estimates of health insurance rates are more difficult to obtain than

state-level and national estimates. The Centers for Disease Control and Prevention (CDC) did conduct increased sampling in certain metropolitan areas, including Harris County. **According to the 2002 CDC Behavioral Risk Factor Surveillance System, an estimated 31% of persons in Harris County reported not having insurance.**

Insurance Costs

Data from the Medical Expenditure Panel Survey indicate that in 2001, the average annual cost for employer-sponsored health insurance in Texas was \$2,925 for individual coverage and \$7,486 for family coverage. The employee contribution averaged 16% of the individual premium, and 26% of the family premium, as shown by the two tables reprinted from The Henry Kaiser Family Foundation below:

Average Annual Cost of Employment-Based Health Insurance-- Single Coverage, 2001				
	TX \$	TX %	US \$	US %
Employee Contribution	473.25	16.2	498.40	17.3
Employer Contribution	2,451.30	83.8	2,390.79	82.7
Total Premium	2,924.55	100.0	2,889.19	100.0

Average Annual Cost of Employment-Based Health Insurance-- Family Coverage, 2001				
	TX \$	TX %	US \$	US %
Employee Contribution	1,961.76	26.2	1,740.66	23.2
Employer Contribution	5,524.38	73.8	5,768.28	76.8
Total Premium	7,486.14	100.0	7,508.94	100.0

Health Care Access

The Kaiser Commission published a report that extensively reviewed 25 years of research studies that evaluated relationships between health insurance, access to care, and health status. The report, entitled “Sicker and Poorer: The Consequences of Being Uninsured”, summarized several key findings, including:

- “The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions);
- Having health insurance would reduce mortality for the uninsured by 10-15%;
- Better health would improve annual earnings by about 10-30 percent (depending on measures and specific health condition) and would increase educational attainment.”

Federally Qualified Health Centers (FQHCs) and FQHC Look-Alike Clinics

FQHC designation allows a health center to receive federal grant funds to support clinic operations and allows the health center to receive cost-based reimbursement under Medicaid and Medicare. To receive an FQHC designation, health centers must succeed in a competitive federal grant application process, and must demonstrate compliance with specified requirements (e.g. the FQHC must serve a federally-designated Medically Underserved Area or Population, the majority of the Board of Directors must be patients of the FQHC, etc.). Designation of FQHC look-alike status does not involve a competitive process because the Look-Alike status does not entitle the health center to federal grant dollars. Look-Alike status does entitle the center to cost-based Medicaid and Medicare reimbursements.

By 2002, there were 843 FQHCs and 97 look-alikes in the U.S. Combined, these clinics served 12.5 million persons (11.3 million in FQHCs and 1.2 million in look-alikes). Nevertheless, this represented only 25% of the estimated 50 million low-income persons without a regular source of care that year. Among patients seen at the FQHCs in 2002, 39% were uninsured, 34% had Medicaid, 15% had private insurance, 7% had Medicare, 2% had SCHIP, and 2% had another source of public financing. Between 1985 and 2002:

- The proportion of FQHC operating revenues comprised of federal grants (the principal source of payment for uninsured care) decreased from 51% to 25%. This was accompanied by a decline in the proportion of uninsured among FQHC patients from 49% to 39%.
- The proportion of operating revenues comprised of Medicaid payments increased from 15% to 36%. The proportion of persons with Medicaid among FQHC patients increased from 28% to 35%.

Emergency Department (ED) Use and Insurance Status

Nationally, ED visits increased about 16% from 1996-1997 to 2000-2001. Over $\frac{3}{4}$ of the increase in ED visits was due to an increased per person use, compared with $\frac{1}{4}$ attributable to an increase in the size of the general population. ED visits by privately insured patients increased by 24% (compared with only a 4.7% increase in the number of persons with private insurance during the same interval). ED visit use by Medicare patients increased by 10% (compared with a 4.1% increase in the number of Medicare beneficiaries). ED visits by uninsured patients increased by 10% (compared with little or no change in the number of uninsured patients). Interestingly, there was no change in the number of ED visits by Medicaid patients, despite a 10% increase in Medicaid enrollment. **Overall, 50% of the increased ED visits during this time period were made by privately insured patients (and about two-thirds by privately insured plus Medicare patients). Only 11% of the overall increase in ED visits was attributable to uninsured patients.**

As noted by researchers at the Center for Health System change, however, “the increase in visits by uninsured patients could have serious implications for crowding in public hospitals and other safety net institutions that treat a disproportionately high number of uninsured patients.” This warning is borne out locally. According to the report issued by the Lewin Group, Inc (commissioned by Save Our ERs), while HCHD accounted for only 14% of all ED visits county-wide, among these HCHD visits, 65% were made by uninsured patients. In comparison, among ED visits at other hospitals (84% of county-wide ED visits) only 24% of the visits were made by uninsured patient visits.

SUMMARY OF SAVE OUR ERs (LEWIN GROUP) REPORT AND GREATER HOUSTON PARTNERSHIP PUBLIC HEALTH TASK DRAFT REPORTS

Save Our ERs (Lewin Group) Report

Defined Problem

The problem, as defined by Save Our ERs and as articulated in the Lewin Group Report is that:

“Harris County’s emergency care system has become increasingly burdened by growing emergency department (ED) volume, particularly among uninsured and Medicaid nonemergent patients to whom EDs are substitutes for more appropriate, yet frequently unavailable, community-based primary care”.

Save Our ERs Recommendations

The Lewin Group report discussed 3 policy options which build on each other.

1. Option 1 entails: a) having private hospitals build new urgent care centers near their EDs, b) converting several existing community clinics to FQHCs or FQHC look-alikes, and c) improving hospital billing and collections.
2. Option 2 assumes all components of Option 1 plus: a) adding 7 new FQHC and FQHC look-alikes, b) building new outpatient specialty clinics and urgent care centers, c) establishing a limited referral network between hospitals and ambulatory care centers to refer nonemergent patients from EDs to ambulatory care sites, d) expanding the county telephone nurse triage system, d) establishing a new coordinating board to oversee all FQHCs and FQHC look-alikes, and e) transferring selected women and children’s patient care services from public health agencies to HCHD.
3. Option 3 proposes a “Coordinated Community Health System” by assuming all components of Options 1 and 2 plus: a) adding a county-wide coordinated network of ambulatory care access points (including 5 FQHCs, 9 FQHC look-alikes, additional outpatient specialty clinics and urgent care centers as per HCHD 2015 strategic plan, additional school-based health services and education), b) consolidation of city and county health departments, and c) establishing a high level independent governance structure. The recommended Board would be comprised of “senior leaders with acknowledged credentials from the medical community, business community leaders, not-for-profit community leaders, and others as deemed appropriate”. The recommended Board would also have: a) “sufficient independence from day to day political pressure to operate effectively, but be accountable for results, b) “an independent and reliable funding base”, and c) “a leadership succession strategy”.

Greater Houston Partnership Public Health Taskforce Draft Reports

Defined Problem

The problem, as defined by the GHP Public Health Task Force is that:

“The result of the current structure is a fragmented public health and publicly financed health care system that (1) has both duplications of effort and gaps in services at the same time; (2) requires five separate administrative infrastructures; (3) is difficult to navigate and therefore difficult for clients to access; (4) is not structured to interact effectively with the

private, nonprofit and educational institutions that are essential partners in serving the community; and (5) requires inter-agency competition for resources used to serve the same population. Furthermore, the system as a whole is inadequately funded to meet the demand for services, which exacerbates all of the above-mentioned factors.” *[Note, “five” administrative structures are referenced because the GHP draft reports include the University of Texas Harris County Psychiatric Center (HCPC) in its re-structuring schema]*

GHP Recommendations

The GHP Public Health Task Force divided itself into several subcommittees, each of which has issued draft reports, pending issuance of a single final report. This document will focus of the recommendations made in the Draft Report of the Structure Committee, as it is the report written by the GHP Public Health Task Force leadership members and is the report that recommends the most sweeping organizational change to the existing agencies. The GHP draft report recommends the creation of “a single consolidated structure with adequate public funding for, control over, and accountability for the full continuum of services currently provided through the existing five public agencies.” The GHP draft report recommends implementation in 3 stages, with planning beginning by January 1, 2005, obtaining the necessary legislative authority during the 2007 legislative session, and implementing the plan by January 1, 2008. Full implementation of the new consolidated entity is to be accomplished in 3 stages as follows:

1. Stage 1: Appoint an 11 member task force by January 1, 2005, to be confirmed by Harris County Commissioners Court and Houston City Council. The Task Force should include HCHD representatives and “recognized leaders in the public and mental health fields”. The Task Force should “be sufficiently funded in its start-up phase to retain an executive director, staff and professional expertise necessary to carry out its work.” In addition loan staff from the five existing agencies would be assigned support the Task Force under the direction of its executive director.
2. Stage 2: The “Task Force should be constituted as the Public Health District of Houston/Harris County”. There would be contractual agreements between Houston and Harris County to fund and support the activities of the Public Health District. Harris County and Houston “will have to address and agree on the process for selecting members of the District’s Board.” The District should integrate, by contract the delivery of health services now provided by HCHD, MHMRA and HCPC. The District should consolidate the public health functions of the County and City health departments.
3. Stage 3: Establishment and operation of the new consolidated entity, with issues of governance, funding and organization proposed by the District to the County and City for approval.

POLICY ANALYSIS

There is wide consensus that Harris County faces an extraordinary challenge in trying to adequately meet the system demands posed by the high percentage (and total number) of uninsured persons in our area. The efforts of groups such as Save Our ERs and the Greater Houston Partnership Public Health Task Force make a valuable and welcome contribution to public policy deliberations on these complex issues.

The key problems identified by both Save Our ERs and the GHP Public Health Task Force center on ensuring that the medically underserved and uninsured have access to appropriate health care services. The proposed strategies can be categorized into three main components:

- Expanding capacity by building more ambulatory care facilities (and by inference, expanding the pool of health care providers willing and able to staff these facilities)
- Increase financing (e.g. additional federal dollars via FQHC funding, new insurance products, other yet unspecified mechanisms)
- Consolidation of 4 to 5 existing agencies (HCHD, MHMRA, HCPHES, HDHHS, ± HCPC) into a single new consolidated entity managed by a new Governing Board.

As described in the background section above, there is good evidence that lack of health insurance is associated with decreased access to health care services and with poorer health outcomes. Provided the new facilities offer health care services that are accessible and affordable to the uninsured, then this strategy has the potential to positively impact the “access to care” branch of the uninsurance pathway. Furthermore, if the expansion also entails the offering of an appropriate array of medical services (e.g. primary care, urgent care, specialty care) then the expansion has the potential to make a substantial contribution to improving the “health outcome” branch of the uninsurance pathway.

Clearly, the facility expansion component and the increased finance component are closely linked. The facility expansion component will likely require a substantial capital investment, as well as increased financing to sustain the ongoing operational costs associated with capacity expansion. The Save Our ERs report and the GHP draft reports give some estimate of the anticipated costs associated with facility expansion, however the reports do not include a comprehensive funding plan.

Health care financing is a complex issue. Resources are influenced by factors such as the availability of federal and state grant funds, changes in eligibility criteria for joint state-federal programs such as SCHIP and Medicaid, the availability of local tax revenues, and health care market forces (e.g. trends in insurance premium costs, negotiated provider reimbursement rates, variety of insurance products offered). Given the reality that there is no infinite source of health care financing dollars, further intensive work needs to be done regarding potential financing options before policy makers can fully evaluate the potential benefits and risks of specific policy options.

Both the Save Our ERs report and the GHP draft report recommend consolidation of existing local governmental agencies into a single new entity to be governed by a new governing structure. Up until this recommendation, the reports have focused almost exclusively on health care delivery issues such as insurance status, clinic facilities, ED use, etc. The Save Our ERs report does mention the transfer of select patient-care services (specifically maternity care and well-child care) from public health agencies into HCHD. From a policy perspective, this recommendation has merit because these are services that HCHD can and does already deliver well, and because locating these services in public health agencies is not crucial to the public health enterprise.

Neither report addresses the population-based interventions that comprise the key focus of our local public health agencies (HCPHES, HDHHS). Moreover, neither report characterizes how consolidation of the two health departments into the new large entity will make a substantial contribution to expanding health care services for the uninsured.

The Institute of Medicine (of the National Academies) is a well-respected private non-profit organization specifically created to provide the nation with “science-based advise on matters of biomedical science, medicine, and health”. In 1988 the Institute of Medicine (IOM) published a sentinel report entitled “The Future of Public Health”. That report “**defines the mission public health as fulfilling society’s interest an assuring conditions in which people can be healthy**”. A follow-up report, “The Future of the Public’s Health in the 21st Century” was issued by the IOM in 2003. The report confirmed the definition of public health as previously articulated, and in addition endorsed and adopted the **vision of public health as “healthy people in healthy communities”** as described in the U.S. Department of Health and Human Services “Healthy People 2010” report.

The IOM report on public health in the 21st century takes a comprehensive look at the complex issues of health in the U.S. Several key areas discussed are highlighted below:

- Regarding the relative contributions to improved health status given health-related expenditures the report states: “Although data on the relationship between investments in health and health outcomes are not fully adequate at this time...several trends are worth noting because the may help explain why the nation seems to fall short of its potential” to improve heath status. “The vast majority of health spending, as much as 95 percent by some estimates...is directed toward medical care and biomedical research. However, there is strong evidence that behavior and environment are responsible for more than 70 percent of avoidable mortality...It then follows that the nation’s heavy investment in the personal health care system is a limited future strategy for promoting health.”
- Regarding present and future changes needed for a healthy nation, the IOM report states “Action and change are needed to:
 1. Adopt a **population health approach** that builds on evidence of the multiple determinants of health;
 2. Strengthen the governmental public health infrastructure - the **backbone** of any public health system;
 3. Create a new generation of **partnerships** to build consensus on health priorities and support community and individual health actions;
 4. Develop appropriate systems of **accountability** at all levels to ensure that population health goals are met;
 5. Assure that action is based on **evidence**;
 6. Acknowledge **communication** as the key to forging partnerships, assuring accountability, and utilizing evidence for decision making and action.”

Several important issues emerge when applying the IOM report framework to a policy analysis of the Save Our ERs report and the GHP Public Health Task Force draft reports. For example, the problems defined in the reports are almost exclusive focused on health care services delivered on an individual basis (e.g. medical care). The limited focus on health care delivery is indeed a reasonable approach to take given the key issues the groups set out to address (e.g. ED visits among the uninsured, access to health care, etc.). The recommended solutions, however, extend far beyond the scope of health care delivery systems – specifically involving substantial changes to the organizational and governance structures of public health agencies. Absent, however, is an accompanying discussion about the potential impact of these changes as it pertains to assuring “healthy communities” in Harris County. In addition, with respect to local application of the action

items described by the IOM:

1. HCPHES and HDHHS share a commitment to developing and implementing a variety of population health approaches to ensuring healthy people in a healthy Harris County. Among our responsibilities to population health are the protection of the quality of our air, water, and food. Local public health agencies can and do contribute unique expertise and experience to our collective societal efforts to ensure the conditions in which Harris County communities can be healthy.
2. A number of events and issues have sharply focused attention on the need to strengthen the governmental public health infrastructure at the federal, state, and local level. These include, but are not limited to:
 - the events of September 11, 2001 and subsequent anthrax attacks
 - the emergence of new and highly contagious diseases such as Severe Acute Respiratory Syndrome (SARS)
 - increased concerns that recent avian flu activity might trigger a world-wide influenza pandemic
 - increased recognition about the links between environmental exposures and chronic diseases such as asthma
 - increased recognition that population health approaches are needed to address the epidemic of obesity among our children if we are to avoid an unprecedented prevalence of chronic diseases in tomorrow's adults
3. There are multiple examples of new and/or strengthened partnerships across many sectors of our society, as we all have a vested interest in the health of our communities. Examples of these partnerships include:
 - The Quad-Agency Group. After a temporary decrease in activity due to transitions in agency leadership, the Quad-Agency group has now reconvened. The enthusiasm and commitment to interagency collaboration is illustrated by accomplishments that occurred at the first meeting of the new group, for example:
 - a commitment to meeting at least monthly (with a regular schedule already set) and agreement to meet more frequently on an *ad hoc* basis to address specific issues
 - consensus regarding key elements of a shared web-based eligibility program that would offer patients the opportunity to complete the eligibility process for all four agencies at their initial point of contact.
 - Steps to a Healthier Houston/Harris County Consortium: This is a community collaborative with diverse representation, including HCPHES, HDHHS, HCHD, Houston Independent School District (ISD), Galena Park ISD, YMCA, St. Luke's Episcopal Charities, American Diabetes Association, and numerous other agencies. The consortium has adopted bylaws and elected officers. Through a consensus process, the consortium has decided to focus the next 12-18 months of activities on preventing and/or reducing obesity and its associated health consequences.
 - Environmental Public Health Tracking Network: This collaborative is designed to provide a local response, surveillance and research resource to evaluate and mitigate the adverse health consequences of specific environmental exposures. The collaborative is lead by the HDHHS and funded by the CDC. Partners include HCPHES, Baylor College of Medicine, University of Texas School of Public Health, MD Anderson Cancer Center, Rice University, University of Houston Air Quality

Modeling Group, the Texas Commission on Environmental Quality, Methodist Hospital, and others.

- Preparedness and response to bioterrorism and other public health emergencies: HCPHES and HDHHS serve as the principal agencies for these activities in Harris County. The two agencies have developed prior joint response plans (e.g. the Houston/Harris County Smallpox Mass Vaccination Plan). Currently, they are actively engaged in a variety of joint preparedness functions such as updating and revising emergency response plans, preparing joint grant applications, and participating collaboratively in a number of bioterrorism preparedness activities. While HCPHES and HDHHS serve as the backbone for these endeavors, they enjoy the strong collaboration of multiple partner agencies (e.g. the Harris County Office of Homeland Security and Emergency Management, the Houston Office of Emergency Management, the Harris County Fire Marshal's Office, the Houston Fire Department, the Harris County Sheriff's Office, the Houston Police Department, multiple area hospitals, etc.)

Public health practice involves using a broad range of tools to accomplish improved outcomes in population health. Among these tools is the provision of preventive clinical services such as immunizations, HIV testing and counseling, and Tuberculosis (TB) clinical evaluation and treatment. It is important to understand that these preventive clinical services are provided in the context of more comprehensive programs designed to impact population health. For example, the purpose of a TB clinic visit is not solely to make the patient better (as is the focus of health care delivery systems), but rather to ensure that the patient is rendered non-contagious in order to protect the patient's community (work place, home, school, etc.). Similarly, obtaining community immunity through a rigorous immunization program is crucial to reducing the risk of large infectious disease outbreaks.

Neither the Save Our ERs report nor the GHP Public Health Task Force draft reports discuss the potential loss to the community of taking public health agencies (whose target population is the entire population) and consolidating them into a new agency created for the express purpose of addressing health care delivery access issues among the uninsured and medically underserved.

POLICY RECOMMENDATIONS

It is unlikely that a single solution will meet the complex health-related needs (both health care delivery needs and public health needs) of our communities. The following recommendations are made in an effort to make real progress toward the vision of "health people in healthy communities."

Transfer of Select Functions from HCPHES to HCHD

Consider transfer of specific functions, as appropriate, to more closely align with overall agency objectives and function (i.e. distinguish between services that are predominantly health care delivery system services and services that are predominantly public health services). For example, HCPHES currently provides family planning services, low-risk prenatal care services, well-child visit clinical services, and children's dental services. HCPHES has provided these services with the objective of filling in gaps in system with limited overall capacity, and by virtue of historical state funding mechanisms. Objectively, however, neither of these select services is integral to broader public

health programs. Moreover, all of them would fit well in the context of primary care services offered by health care delivery systems. Transfer of these select services to HCHD would be a viable policy option for better coordinating health care services that target uninsured and medically underserved populations.

Expansion of Select HCPHES Preventive Clinical Services

A number of preventive clinical services are integral to comprehensive public health programs. These include, for example: a) screening and treatment for sexually transmitted diseases (as a component of a comprehensive STD elimination program), b) HIV testing and counseling (as a component of a comprehensive HIV prevention and education program), and c) immunizations (as a component of a comprehensive community immunity campaign). These programs currently do not have sufficient funding to meet community need. Expansion of these preventive clinical services in the context of comprehensive public health programs would be a viable policy option to improve community health.

Develop a Web-Based Eligibility System Interface

As mentioned above, the Quad-Agency group achieved consensus on the key elements of a shared eligibility interface. The objective of the shared eligibility interface would be three-fold: 1) to create a system that has multiple points of access and appears “seamless” from the perspective of the patient, 2) to create a system that would meet agency-specific and program-specific eligibility needs, and 3) to preserve patient choice regarding services they seek and the dissemination of their personal information. The Quad Agency group agreed to support cross-training of agency eligibility staff to ensure the process worked well for patients of all four agencies.

The key elements recommended by the Quad-Agency group are:

- A web-based system, preferably one that was programmed to accept data from other electronic sources (such as the HCPHES electronic medical record).
- A system that allowed the eligibility process to be completed for one to four of the agencies (as directed by patient preference) at a single access point.

To illustrate the concept, if a patient named Mr. X presented to an HCPHES TB clinic, the HCPHES eligibility screening would be performed and Mr. X would then be asked if he also wanted to undergo eligibility screening for HCHD, MHMRA and/or HCHD. Assuming Mr. X answered yes to HCHD only, then all of the common eligibility information (e.g. name, address, etc.) would populate the HCHD eligibility screen. If the HCHD eligibility process required additional information, the HCPHES eligibility worker would collect the information from Mr. X and complete the HCHD eligibility process.

For proposed solutions to be ultimately successful on a community-wide basis, the realized benefits should outweigh both anticipated and unintended consequences. Policy makers should explore and evaluate a number of options to achieve desired objectives.