

Definitions for the Partnering workgroup November 18, 2013

We're here to improve the Public's Health (aka - population health, community health) – the health of all of us in a community as measured by defined metrics

The players:

1. ***The Public Health System*** – consist of the Washington State Department of Health, 35 independent local health jurisdictions and our tribal health partners. Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases. Public health is concerned with protecting the health of the entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world. Our public health system provides a diversity of services including health care provider credentialing, control of communicable disease, food and water protection, laboratory services, immunization and other prevention services, birth and death certificates, disease surveillance and emergency preparedness.
2. ***The Health Delivery System*** – consists of all of the parts of the way health care is delivered in Washington, whether in a hospital, a doctors office a clinic or pharmacy and involves all areas of medicine including primary care, obstetrics, mental health, and rehabilitation services and across the state including hospitals, medical centers including services for primary and specialty care, behavioral health, substance abuse, oral health, and other individual services. Health care is delivered by practitioners in medicine, optometry, dentistry, nursing, pharmacy, allied health, and other care providers. It refers to the work done in providing primary care, secondary care, and tertiary care. A summary of Washington's Health Care System is available from the 2012 Rural Health Strategic Plan.
www.wsha.org/files/2012%20Rural%20Health%20Care%20Report_FINAL2_1.pdf
3. ***Community services, social services and education*** – all play key roles in helping to keep people healthy and prevent disease outside the health care system, and include the YMCA, Boys and Girls Clubs, Senior Centers, faith based organizations, and many others.



Rural Health Care



A Strategic Plan for Washington State

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Background

This is not a coincidence. People with fewer resources are more likely to experience stress and associated health problems, and how they access services depends on how they are able to pay for them. Rural communities have a complex set of circumstances to take into account when planning for community health.

Clearly, there is not one plan or one answer to solve every community's needs. However, the Rural Strategic Planning Committee recognizes that ensuring that all rural residents have access to quality health services is essential to addressing health status disparities (see box) and promoting equity across the state's diverse population groups.

CURRENT INFRASTRUCTURE

Health Care Delivery System

One goal of this plan is to help rural providers and health care systems understand how they can contribute to community health and develop a common vision for reform. A strong health care delivery system that works together to address health disparities is the first step in improving access to care. The following is a basic description of health care facilities and that exist in rural Washington or support health care in rural Washington. Each community has some combination of local services while regional and statewide organizations support statewide population-based rural health. Local organization types are listed below. More information, including a list of regional and statewide organizations can be found at www.waruralhealth.org.

A. Clinics

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) work together with their local rural hospital to provide a comprehensive and functional health care system for the community. These clinics and health centers are both defined and funded through Federal legislation and differ in the scope of services they provide, their funding mechanisms and their governance structure. In addition, health services are also provided by Tribal Clinics and a growing number of free clinics.

What are Health Status Disparities?

- **Economics:** People with fewer resources are more likely to experience newborn health problems, chronic disease, infectious disease, and disabilities.
- **Education:** People with higher quality education are more likely to get better jobs with higher income, live in neighborhoods that are safer and closer to more nutritious food sources with better schools for their children.
- **Environment:** Air, water, and soil quality; housing, transportation, stores, parks, and libraries; social support affect daily choices people make such as walking instead of driving, eating nutritious food, and social activities.
- **Ethnicity:** Structural discrimination, policies that affect opportunities and resources, and social friction can increase stress on the body, which in turn increases vulnerability to disease.

Background

Rural Health Clinics (RHC)

Established by Congress in 1977, RHCs are certified by CMS/Medicare to provide increased access to primary care services in rural areas. A key provision is that the clinics utilize physician assistants, nurse practitioners, or certified nurse midwives at least fifty percent of the time the clinic is open. CMS reimbursement is on an annual cost based basis regardless of which provider provides the service (MD or PA/NP). Medicaid is mandated to provide reimbursement on a similar basis. A RHC may be a for-profit or non-profit organization and may be owned by a local hospital or be independent. Some of the largest RHCs also provide specialty services. There are currently 133 RHCs operating in Washington.

Federally Qualified Health Centers (FQHC)

FQHCs are designated under the 1996 Health Centers Consolidation Act (Section 330 of the Public Health Service Act) as Community Health Centers who serve low income and underserved populations to include: migrant, homeless, and school based populations, and public housing residents. FQHCs provide a scope of services to include: primary medical, dental, and mental health, case management and enabling services. Services are provided on a discount fee schedule and no one is refused services based upon inability to pay. FQHCs receive federal funds for operations, with limited capital grants to support infrastructure, access to 340B drugs, malpractice coverage under the Federal Tort Claims Act and cost based reimbursement for their Medicaid patients.

There are currently 26 FQHC organizations operating over 160 delivery sites (both rural and urban WA). FQHCs must be governed by a board of directors and have 51% consumer representation. FQHC Look-alike designation requires an entity to meet all requirements of the FQHCs but these entities do not receive a federal 330 grant. FQHC look-alikes receive cost based reimbursement for services provided to Medicaid clients.

Free Clinics

Free clinics are private, non-profit, community or faith-based organizations that provide health services through the use of volunteer health professionals or in partnerships with other health providers. There are 39 free clinics providing services across the state. 11 of these are in rural communities.

Tribal Clinics

There are 29 federally recognized tribes in Washington State. Health services to American Indians and Alaska Natives are offered in both urban and rural areas of the state. Services range from basic health care to advanced, and often include integrated behavioral health services. Many tribal clinics are functioning as FQHCs and all are qualified as FQHC look-alikes. Funding streams are varied and include Indian Health Service, Medicaid, Medicare, commercial insurance, and private pay. Many tribal clinics are starting to see non-natives in addition to native populations in their clinics.

Background

B. Hospitals

Ready access to emergency care at all hours is critical to a well-functioning medical care delivery system. In most of rural Washington, Critical Access Hospitals (CAHs) are the main point of entry for emergency care. Rural hospitals vary in size and services they provide, but all provide 24 hour coverage. Additionally, many operate rural health clinics and nursing homes.

Critical Access Hospitals

There are 38 CAHs in WA State. They range in size from very small “frontier” hospitals to larger hospitals that can support specialty activity. The smallest hospitals serve populations of less than 8,000 residents and are typically unable to support obstetrics, surgery, or anesthesia. While the inpatient volumes may be limited to less than one patient per day, the CAH designation is vital to maintaining the presence of health care in the community. The largest CAHs in Washington have population bases large enough to support significant specialty activity. This means in most cases they have the volume to keep at least two practitioners busy in each specialty and can provide on-call coverage. Their primary care complement is also more likely to include pediatricians and internists as well as family practitioners.

Sole Community Hospitals

There are 3 designated sole community hospitals in WA State. They do not fit the criteria of Critical Access designation, but are still rural hospitals who serve much of the same population as Critical Access Hospitals. Most Sole Community Hospitals provide specialty care in addition to primary care services, and operate as the backbone of care services in the community.

C. Local Governmental Agencies

Public Hospital Districts (PHDs)

There are 56 PHDs in Washington State. 42 of these operate hospitals, while the others operate emergency services, clinics, and other local health care provisions. Under Washington law, localities may form PHDs for the purpose of “delivering health to their communities... Hospital districts are authorized not only to operate a hospital, but to deliver any service to help people stay healthy-physically, socially and mentally.” The majority of Washington’s rural hospitals are structured as PHDs and governed by boards. These governing boards are elected by the citizens served by the hospital district.

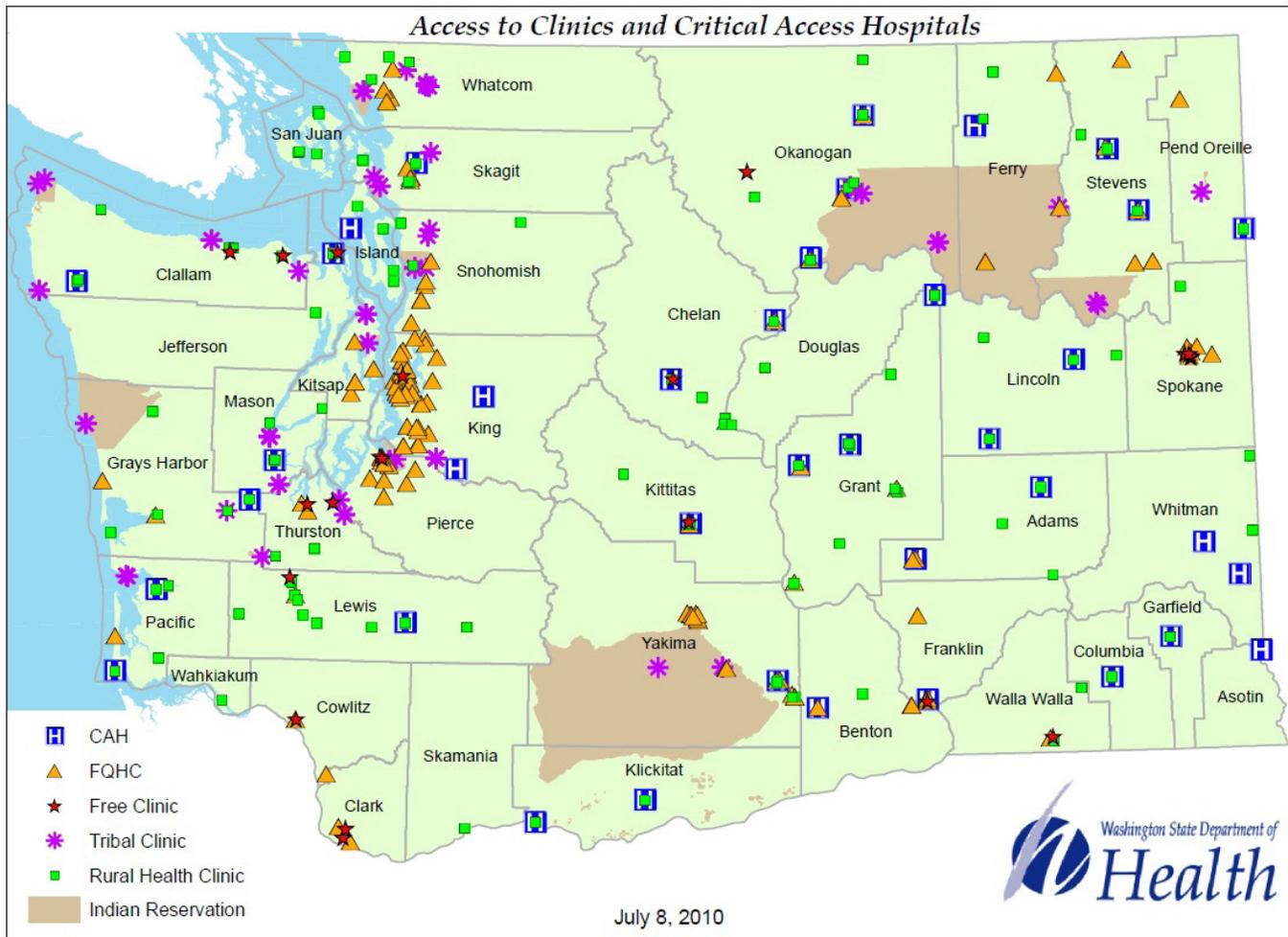
Local Health Jurisdictions (LHJs)

There are 35 LHJs serving 39 counties in Washington. Local Health Jurisdictions are responsible for population health, the part of the health care system that seeks to understand the underlying determinates of health, and use this knowledge to prevent disease and injury and improve overall community health. Local Health Jurisdictions, as governmental agencies, are tasked with a long list of duties mandated by statute, such as the protection of food and drinking water safety, proper disposal of hazardous wastes, and a wide range of communicable disease control responsibilities. In addition, LHJ’s carry out locally defined priorities, such as health care access, public health nurse home visiting, and nutrition support programs.

Background

Emergency Medical Services (EMS)

EMS are operated in each community differently. Some are paid for by local taxes while others are paid for by local hospitals. Some are shared by more than one community. They are critical to stabilizing patients in emergency situations and providing transportation to local hospitals or tertiary facilities.



FINANCE AND PAYMENT

Reimbursement and Special Programs

The Critical Access Hospital (CAH) program and other enhanced payment programs have prevented the closure of a number of rural hospitals and stabilized the financial situation of many others. While these programs are critical to the survival of the CAHs, they still do not cover all of the costs of the rural hospitals. Even with cost based reimbursement for Medicare and Medicaid patients, revenues still fall short of expenses.