Iowa Collaborativ Safety Net Provider Network

A Framework for Expanding Health Care Access for the Uninsured and Underserved in Iowa

June 2006

Network Mandate

As the number of uninsured continues to rise, states across the country struggle with the challenge of ensuring everyone has access to affordable comprehensive health care.

Recent estimates by the Kaiser Family Foundation show that more than ten percent (300,000) of children and adults in Iowa have no health insurance. Sixty-six percent of Iowa's uninsured are under 200% of the Federal Poverty Level. Added to the uninsured are thousands more underinsured Iowans: individuals and families whose insurance only covers catastrophic incidents.

As an increasing number of employers are forced by growing premiums (driven by perpetual cost shifting) to scale back their insurance coverage and household incomes continue to decline, the challenge becomes increasingly difficult with more individuals and families relying on safety net providers for their health care.

Recognizing the need to find solutions to this burden on families and the economy, the Iowa General Assembly passed and Governor Vilsack signed legislation during the 2005 session creating a network of health care providers who deliver a significant amount of uncompensated care to Iowans.

Through the creation of the Iowa Collaborative Safety Net Provider Network, a framework was developed through which the state's community health centers, free clinics, and rural health clinics could work cooperatively to identify and address the most pressing challenges in providing care to the uninsured and underserved. It is important to note that while these providers all share a common mission of increasing access to health care, the Network was the first organized statewide effort that engaged all three groups in cooperative efforts.

The enabling legislation charged the Network with two primary tasks:

1. Develop Network initiatives for collaboration among community health centers, free clinics, and rural health clinics within the following areas:
    - Training;
    - Information Technology;
    - Financial Resource Development;
    - Referral System for Ambulatory Care;
    - Referral System for Specialty Care;
    - Pharmaceuticals; and
    - Recruitment of Health Professionals.
2. Develop a database of all Iowa CHCs, RHCs, and free clinics.

Year 1 Accomplishments

Task One

Network Creation and Structure

In October 2005, the Iowa/Nebraska Primary Care Association, the association representing community health centers, received a grant through the Iowa Department of Public Health to develop, administer, and staff the Network. To guide the efforts and set the direction of the Network, a six-member Leadership Group comprised of representatives of community health centers, free clinics, and rural health clinics was established.

In addition, an 18-member Advisory Group was also created to provide input to the Leadership Group from a broader perspective. This group is comprised of individuals representing a wide range of organizations including state agencies, universities, health care providers, and insurance carriers.

With this governing structure in place, the Network launched its collaborative efforts in the fall of 2005.

Unmet Needs Assessment

With limited time and resources available to make meaningful progress in all seven areas outlined in the legislation, the Leadership Group determined that the unmet needs of the safety net providers should be prioritized to guide the initiatives undertaken in the first year of development of the Iowa Collaborative Safety Net Provider Network. To assess which initiatives represented the most pressing needs of providers, a survey of all 187 safety net providers was conducted in October 2005. Results of this survey indicated the following three priorities:

1. Pharmaceutical access;
2. Referral system for specialty care; and
3. Recruitment of health professionals.

In addition to the survey, a series of three focus groups with safety net providers was convened to gather additional input on the top three unmet needs and to help focus activities for these three initiatives. Focus group participants affirmed the efforts of the Network thus far and offered significant insights clarifying their needs within each of the three areas. Some common views and opinions were expressed at these sessions. Twenty-three safety net providers attended the sessions.

Pharmacy Access

- Access to pharmaceuticals is a significant unmet need.
- Drugs to treat chronic illnesses are a considerable impediment to providing comprehensive care to patients.
- While Patient Assistance Programs (PAPs) offered by pharmaceutical companies can be beneficial, the resources needed to enroll patients are tremendous, and for many clinics can be cost-prohibitive.
- Cooperative efforts with local community pharmacists are imperative to the success of any Network pharmacy initiative.
- For many uninsured and underserved patients, drugs must be accessible at the provider clinic. Requiring them to go to an off-site pharmacist to obtain drugs is unrealistic.

Specialty Care Referrals

- There is a significant need for oral health and mental health care services.
- Some specialty referral needs noted included optometrists/ophthalmologists, women's health, dermatology, cancer screenings, and neurology.
- When appointments with specialty care providers can be scheduled, additional patient barriers often arise such as transportation and child care.
- Several participants from smaller communities noted very positive relationships with specialists.

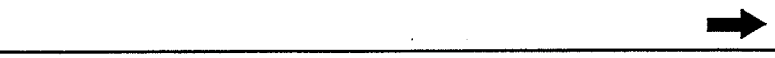
Recruitment of Health Professionals

- The State of Iowa's Volunteer Health Care Provider Program (which provides liability coverage for qualified providers volunteering in free clinics) holds great potential; however, lack of funding for the program often results in extensive delays in approving coverage for providers.
- Using outside recruiters often results in a mismatch, wherein providers have unrealistic expectations of rural health care practices.
- Primary care physicians are in very short supply in rural and urban areas.

Pharmaceutical Access - Strategic Planning Efforts

With pharmaceutical access overwhelmingly identified as the top priority, the Network focused on developing a strategy to address this need first. The challenge for the Network was to create a workable solution with limited resources that would have a significant impact on patients of all three diverse provider groups.

The George Washington University, School of Public Health and Health Services was retained to conduct research on various types of statewide and community pharmacy initiatives across the country. With this research as the basis for developing a pharmacy strategy, a meeting of pharmacy experts was held in spring 2006. Meeting participants included representatives of the University of Iowa, College of Pharmacy; the University of Minnesota, College of Pharmacy; Drake University, College of Pharmacy and Health Sciences; and the George Washington University.



During this meeting, a draft safety net **pharmacy vision** was developed to expand access to pharmaceuticals for individuals below 200% of the Federal Poverty Level. This vision includes a coordinated effort with safety net providers, retail pharmacists, and academic centers with Schools of Pharmacy (University of Iowa, Drake University, and University of Minnesota) to develop a preferred drug list, a subset of which patients would pay and another subset would, if funded, have the greatest impact on the costliest diseases. This approach does not rely solely on the use of sample medications and industry-based pharmacy assistance programs, but emphasizes the use of an **Affordable Drug List** and **Expanded Drug List.** Participation of community pharmacists and the state pharmacy association will be integral to the ultimate success of this model. This approach has had a very enthusiastic response from Rural Health Clinics and Free Clinics who are frustrated with the considerable obstacle access to pharmaceuticals causes their patients.

Specialty Care Referral - Strategic Planning Efforts

Preliminary development of the specialty care referral strategy will include observing the experience of the Polk County effort which is managed by the Polk County Medical Society and the Health Access Partnership. This effort is striving to develop an organized referral process involving a large number of providers in an urban community. The lessons learned from this experience will offer insights to other Iowa communities.

In most communities, it is agreed there is an informal system already in place for specialty referrals, but it tends to be very labor intensive for both the safety net primary care provider and for the specialty care provider. There are no provisions under the current system to spread that load more evenly among more providers. Future efforts will focus on building upon what currently exists and is working. Efforts will be made to determine if there is a way to utilize any capacity that exists at the University of Iowa and Des Moines University.

Health Professional Recruitment - Strategic Planning Efforts

The health professional recruitment initiative was started in the first year with additional development and implementation planned for year two. The need for this initiative resonated loudly with safety net providers as a critical need. Resources in year two and subsequent years will be dedicated to increasing efforts to identify the most effective professional recruitment resources available to rural health clinics and community health centers. Free clinics are very much in need of expediting the Volunteer Heath Care Provider Program application and approval process for volunteering providers to obtain professional liability coverage provided by the State.

The implementation of these three priority initiatives begins to build a solid foundation for a system of care that will result in more Iowans having medical homes, which has proven to be a more cost-effective alternative to the uncoordinated systems currently in place. In addition, hundreds of studies conducted around the country have consistently demonstrated that having access to regular medical homes for delivery of preventive and treatment services is critical to improving patient health outcomes.

Task Two

Data Gathering

The second task outlined in legislation required the Network to gain a better understanding of the structure and operations of existing health care safety net providers through data collection and analyses.

With the assistance of Community Health Associates, a health care consulting firm, data templates were developed to gather basic information on both current provider capacity and demographics of patients seen by the clinics such as age, gender, race/ethnicity, insurance status, and reason for visit. With an awareness that these providers are already required to collect and submit varying levels of data to state and federal agencies, the Network templates were created to complement existing data collection requirements without adding unnecessary additional data gathering, while at the same time ensuring the requirements of the legislation are met.

Beginning in fall 2006, all safety net providers will be asked to begin providing specific data sets on a quarterly basis. With this information the Network will have the capacity to generate aggregated reports providing detailed demographic information on patients currently served through the safety net.

Direct Provider Awards

With limited time in the first year to achieve significant direct impact on providers and patients through the three Network initiatives, the Leadership Group determined that a portion of the first year Network funds should be directly allocated to safety net providers to increase access to care. Of the $425,000 Network budget, $265,000 was reallocated for direct provider awards: $120,000 for free clinics; $120,000 to rural health clinics; and $25,000 to community health centers.

All safety net providers were made aware of the funding opportunity through mailings, newsletter articles, and personal outreach by the Leadership Group. Of the 187 eligible safety net providers, 152 submitted requests for funding, including 26 free clinics, 114 rural health clinics, and 12 community health centers. Funds will be disbursed equally among the clinics and centers within each provider group.

To adhere to the intent of the legislation, providers were requested to use their awards to expand access in one of the seven collaboration areas. Funds will be disbursed to clinics in summer 2006.

Vision for Years 2 & 3 – Planned Activities

During the 2006 legislative session, the Iowa General Assembly allocated an additional $425,000 to the Network. With these funds the Network will have the capacity to make significant progress on the pharmacy initiative, further develop and implement the health professionals recruitment and specialty care referrals strategies, and begin gathering and analyzing data from the safety net providers.

Planned activities in each area include:

Pharmacy

- Outreach to community pharmacists and Iowa Pharmacy Association
- Formation of Advisory Pharmaceutical & Therapeutics Committee to develop formularies
- Provider/patient education strategies developed, including web-based opportunities
- Policy issues and implications identified and evaluated, e.g., IowaCare
- Explore funding opportunities for the Expanded Drug List and centralized access to Patient Assistance Programs
- Explore opportunities to expand the federal 340B pharmacy program to other providers
- Best practices identification and review
- Proposal prepared by fall 2006 for 2007 legislative session

Specialty Care Referrals

- Form Work Group
    - Best practices identification and review, including Health Access Partnership in Polk County
    - Proposal prepared by fall 2006 for 2007 legislative session

Health Professionals Recruitment

- Collect and post on Network website available recruitment resources (e.g., 3RNet)
- Work with Iowa Department of Public Health to explore streamlining of Volunteer Health Care Providers Program for free clinics
- Form Work Group
    - Review past history of recruitment efforts and learn from common experiences
    - Explore opportunities to enhance recruitment efforts and staffing at clinics, including:
        - Fellowship program
        - *Locum tenums*
    - Best practices identification and review
    - Proposal prepared by fall 2006 for 2007 legislative session

Data Gathering and Analysis

- Finalize data templates and instruction guides

- Disseminate templates, instructions, and introductory letter to all safety net providers with first template completed for July/August/September quarter
- Compile and analyze data
- Develop and disseminate reports with findings
- Continue gathering quarterly data

Key Issues for Future Development

Sustainability of the Network

Currently, the Iowa Collaborative Safety Net Provider Network is funded solely through a State appropriation. To make meaningful progress on the three initiatives in year two, it is expected that a greater proportion of the budget will need to be allocated to those efforts. This will result in fewer dollars being available for direct provider awards.

The future of the effort will require proof of its viability to potential funding partners which include the business community, health insurance providers, hospitals and local governments, and philanthropic foundations that fund this type of effort.

Ability of the Network to Respond to Changes in Iowa's Economy and State and Federal Health Financing Sources

Looking to the future, there are many challenges that indicate the burden on safety net providers will only increase. As the cost of health care continues to rise, many businesses find it necessary to scale back employee health care benefits. Similarly, federal and state entitlement programs face dramatically rising costs, often resulting in policy changes with the potential impact of creating more uninsured.

In this environment, providers, stakeholders, and other health care experts acknowledge the need for safety net providers will not diminish. It is clear that efforts such as the Iowa Collaborative Safety Net Provider Network that seek cost-effective, cooperative solutions are needed now more than ever. The Network holds a tremendous opportunity to increase access to health care services through its efforts.

Conclusion

The accomplishments of the Network's first year are considerable. Building on these accomplishments will result in an effective system of care for the uninsured and underserved through which a more appropriate utilization of primary care providers can be achieved, thereby reducing costs generated through the inappropriate use of hospital emergency departments. Most importantly, the success of these efforts will lead to long-term improvements in the lives and health of thousands of Iowans who depend on having regular access to the health care services provided by Iowa's safety net providers.