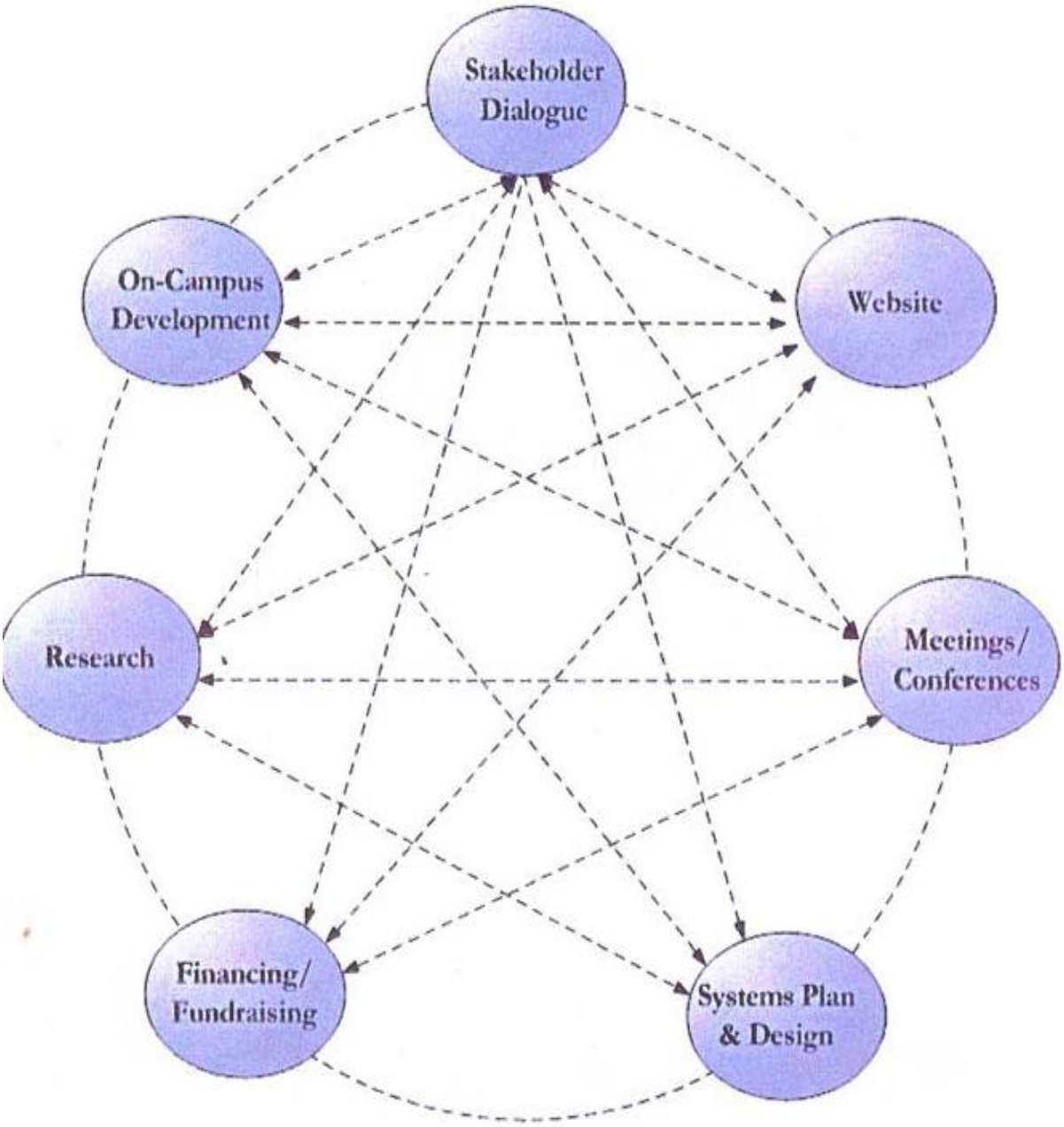
WHAT WE CAN DO LOCALLY

Working papers in the local health care crisis

Sonoma State University Community-Campus Initiative on the Sonoma County Health Care Crisis in partnership with the California Program on Access to Care, California Policy Research Center, University of California Office of the President

Academic Proceedings – SSU Cooperage Conference March 2007



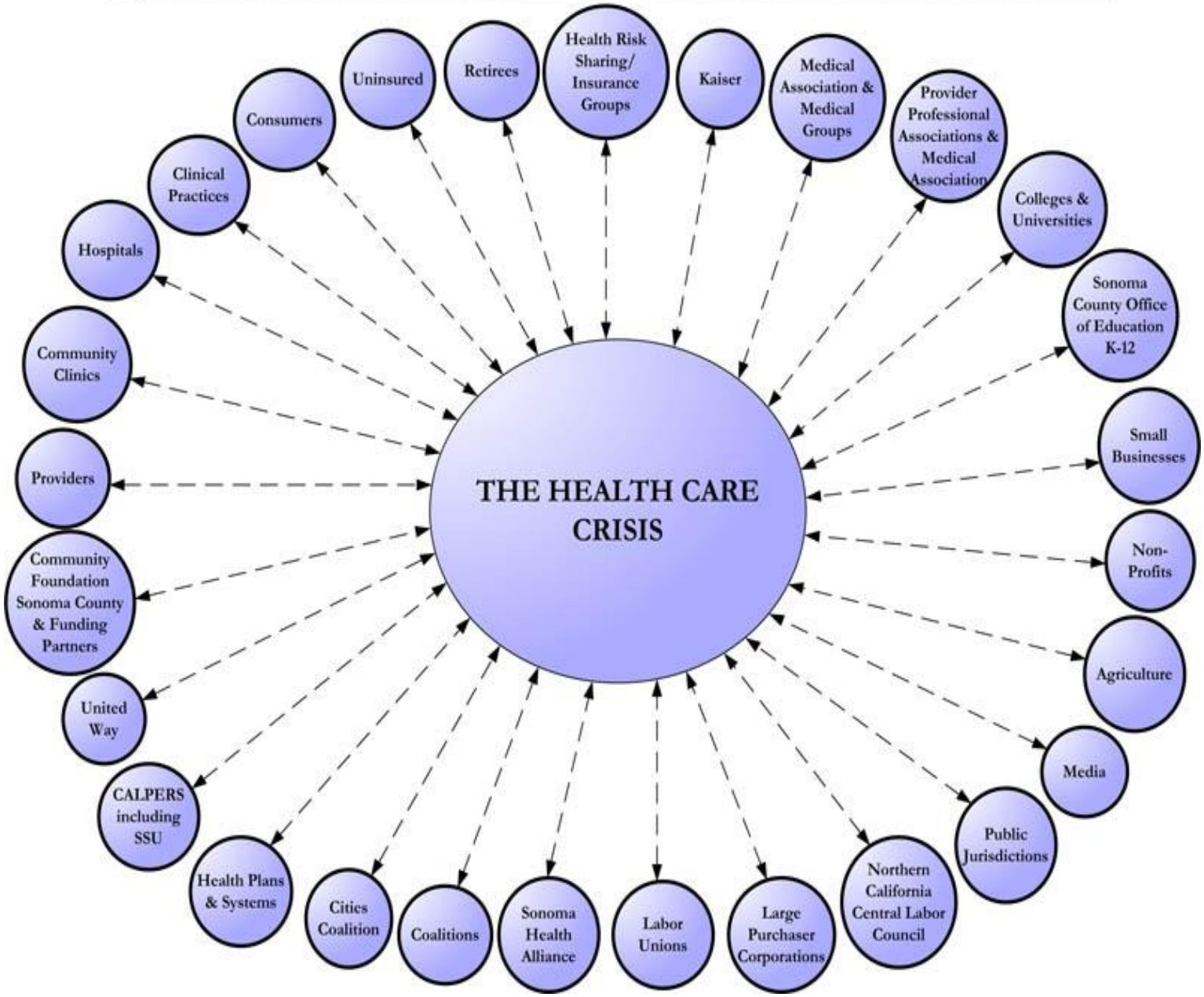
Supported by the Initiative's dissemination project grant
from the California Endowment

Table of Contents

Skip Robinson, Editor; Marsha Calhoun, Co-Editor; Nick Popadopoulos & Skip Robinson, Graphics
Satya Kuner, Webmaster; Barbara Moore, SSU Web Advisor

For further study, please also see the initiative's website:
www.sonoma.edu/programs/healthcrisis

MAJOR STAKEHOLDER GROUPS DEALING WITH THE HEALTH CRISIS IN SONOMA COUNTY



Improving Access to Health Care:

Sonoma County Initiatives

Sonoma State University
Kawahara & Associates
February 2007

Funding provided by the California Endowment and the California Program on Access to Care, University of California, Office of the President

Sonoma County Initiatives to Improve Access to Health Care

"Sonoma County has become a model for the types of problems which the California health care industry is going to continue to encounter over the coming years and also for the types of strategies and solutions that can be developed through dialogue and cooperation. In a sense, Sonoma County becomes a laboratory for action...."

Gilbert M. Ojeda
Program Director, California Program on Access to Care
California Policy Research Center
University of California, Office of the President

I. Introduction and Background

In late summer of 2002, Sonoma State University created a Community-Campus Initiative on the Health Care Crisis in Sonoma County. This initiative was to examine the major factors leading up to the collapse of Sonoma County's second largest HMO, which had 80,000 members. A number of conferences and meetings occurred to identify 22 stakeholder clusters, identify successful collaboratives, and develop strategies to address the factors that disable the local health care delivery system and create disparities in access to health care for Sonoma County residents. A compendium of documents, conference proceedings and articles describing over four years of local discussion and analysis can be found on the SSU website, www.sonoma.edu/program/healthcrisis.

This report, commissioned by Sonoma State University and the University of California, Office of the President, is to further the inventory of health care programs and initiatives that are striving to improve access to health care in Sonoma County. Seventeen interviews were conducted with representatives from local hospitals, community clinics, Medi-Cal groups, workforce development, public health and other consultants to obtain information on initiatives that specifically address the factors identified by local stakeholders as the most critical factors impeding the local health care delivery system. A list of those individuals and their affiliated organization can be found at the end of this article.

II. Identified Factors Affecting Access to Health Care

In 2003-04, the Sonoma State Initiative focused on identifying factors that contributed to the health care crisis. Many of these factors are inter-related and create complexities for policy makers, health care executives and managers and government officials in developing the most effective strategies in resource allocation and service delivery.

The following table briefly summarizes the factors identified by the participants in the Sonoma State Initiative:

I. Coverage	II. Capacity	III. Access/Population
A. Health care premiums continue to increase, resulting in possible decreases in enrollment, employers dropping plans and reducing benefits. B. Uninsured population is increasing. C. Medi-Cal reforms have been proposed at the state level. D. Small businesses may not offer health insurance coverage.	A. Community clinics have limited capacity. B. Hospital costs are rising, causing some to consolidate, change operations. C. District hospitals more vulnerable to poor reimbursement rates, have local taxes generating revenue. D. Health care workforce is changing - fewer specialists, doctor pool is shrinking, technicians, nurses are needed. E. Fewer private practices taking patients in public programs due to low reimbursement rates. F. Sutter training program reduced in capacity. G. Continued over use and inappropriate use of emergency rooms.	A. Location of services is centralized and not accessible to remote parts of the county. B. Language and cultural barriers still exist within the health care system. C. Consumer knowledge is lacking on programs that are available and how to access them. D. Changing demographics in Sonoma County include migrant workers and seniors.

III. Local Initiatives

Interviews with seventeen health care professionals, managers, and leaders from major institutions in Sonoma County contributed to the information on local initiatives that promote the access to quality health care. The matrix below cross references the health care factors that contribute to a "health care crisis" and the initiatives that strive to address those factors.

	Uninsured population	Medi-Cal reforms	Limited capacity in clinics	Hospital costs rising, change in operations	Health care workforce is changing	Low reimbursement rates for public programs	Sutter training program	Over use and inappropriate use of emergency rooms	Location of services to remote areas	Language and cultural barriers	Consumer knowledge on available programs	Changing demo-graphics
Sonoma Health Alliance	X	X				X						X
Healthy Kids/Kids Net	X		X					X			X	
Medi-Cal Redesign	X	X	X			X						
St. Josephs Health System	X	X		X	X			X	X	X	X	X
Kaiser Permanente	X	X	X		X		X					
Sutter Residency	X	X		X	X		X					
Redwood Community Health Coalition		X	X					X	X	X		
Workforce Development Roundtable					X					X		X
Workforce Investment Board					X							

A. Leadership

Prior to the Sonoma State Community-Campus Initiative, the Sonoma County Medical Association and the North Bay Employer's Coalition co-sponsored a two-day conference in the spring of 2000, Health Care Summit I, to evaluate the current health care delivery system and to develop a process for improvements based upon collaborative action planning. At this conference, participants identified parallel issues and factors that strain the local health care delivery system. "Our local health care system is under tremendous strain resulting from serious financial pressures, cost of living increases, personnel shortages, changes in reimbursement for Medi-Cal services and outmoded business management practices in times of rising health care costs."[1] The report cites statistics on hospital operating losses, reduction in emergency services, lack of specialty care, increases in population, and diminishing Medi-Cal reimbursement rates.

By January of 2001, the Sonoma Health Alliance was established with the following mission, "(To) promote improved health of the community and create an efficient, sustainable, coordinated health care delivery system in Sonoma County that meets the needs of all participants."

Membership of the Sonoma Health Alliance consists of the three major hospital systems, a consortium of community-based health clinics, district hospitals, representatives from the California State Legislature, private physicians, and county health department staff.

Eleven workgroups were spawned from the Health Care Summit I, including areas focusing on Community Continuity of Care, Consumer Accountability, Equal Access to Medical Care, Information Technology, Lobbying/Legislative Group, Prevention Health Care, Recruitment & Retention of Health Care Personnel, Revenue Improvement Work Group, and Quality Improvement & System Efficiencies.

This initial framework adopted by the Sonoma Health Alliance and ensuing efforts of the workgroup over the past five years has resulted in productive movements forward in the Sonoma County health care delivery system. The most noteworthy initiatives that have resulted from the workgroups include: The Health care Workforce Development Roundtable and the Summer Health care Institute; Healthy Kids Project (Children's Health Initiative); Community Health Improvement projects such as flu immunization and fall prevention for seniors; and Brazelton Touch Points parenting program.

Currently, the main focus for members of the Sonoma Health Alliance is Community Benefits planning and coordination (Senate Bill 697) among Kaiser Permanente, Sutter Medical, and St. Joseph's Health System. This planning process is completed on a three-year cycle.

In addition, to being the catalyst for the Sonoma Health Alliance, the Sonoma County Medical Association has worked with elected officials for legislative solutions to improve Medicare reimbursement. Specifically, SCMA has led a Medicare Reimbursement Campaign to adjust reimbursement rates and prevent Medicare cuts, launched Town Hall meetings, and encouraged physician response.

[1] *Health Care Delivery Summit Report: Position Paper, Volume 1*, Sonoma Health Alliance, August 8, 2001.

Finally, health care planning is conducted by Memorial, Sutter, Kaiser, and the Department of Health Services on a three-year cycle with 2007-2010 as the next planning cycle. In addition, this group conducts an annual update to this three-year plan. The group examines community indicators and compares local statistics against the federal Healthy Community benchmarks and state averages. Through this analysis the planning group identifies issues and selects a health care focus that is coordinated with the planning of the Sonoma Health Alliance.

B. Coverage

Healthy Kids Project

The goal of the Healthy Kids Project of Sonoma County is to increase the health of children through insurance coverage and access to health care. This local initiative has estimated that 8,000 children under the age of 18 are not covered by health insurance, nor do they have a consistent primary care doctor. Opening their doors in March of 2005, the Healthy Kids Project has enrolled 2577 children with health insurance as of June of 2006. By combining public programs such as Medi-Cal and Healthy Families with private insurance programs such as Partnership Health Plan, California Kids and Kaiser Permanente, the initiative can provide health insurance coverage and consumer education for families with income up to 300% of the federal poverty level. Of the private insurance programs, Kaiser Permanente has 61% of the enrollment which is at no cost to the project. In addition, the program has leveraged the efforts of KidsNet which provides immediate health care for acute needs of children who are uninsured and do not have a Medi-Cal home. Over 800 children have been served by over 70 volunteer doctors in Sonoma County through the services of KidsNet.

This model of assuring health care for children, primarily driven through insurance coverage, has successfully exceeded enrollment goals for the inaugural year of operations. One factor that contributes to the high rate of penetration to identify uninsured children is the community partnerships and leveraging of resources among different entities. Certified Application Assistors (CAA) help families apply for health coverage for their children and are located in health clinics, at the county Medi-Cal office, and at other Medi-Cal settings throughout the county. The services provided by CAAs can also draw down reimbursable funds for every child they enroll in Medi-Cal or Healthy Families. In addition, health fairs, such as the one sponsored by Kaiser Permanente, are attended by hundreds of families and offer opportunities to enroll children in health coverage, and provide health education and other resources.

The greatest challenge for the initiative will be to fundraise for the continued premium subsidy payments necessary for a portion of the enrollees. In the five-year business plan, Healthy Kids will need $200,000 next year with a projected growth in enrollees requiring $500,000 to $1,000,000. The lower end of the estimate is contingent upon the high number of enrollees in Kaiser Permanente at no cost to the project.

Currently, major funders to the project include: Sonoma County First Five Commission, The California Endowment, St. Joseph's Pace Ball, St. Joseph's Foundation, local hospitals (Sutter, Kaiser and Memorial), United Way and community contributors to the Sonoma Community Foundation.

To measure the project's progress in enrollment, the project utilizes RefTrack, a locally developed database used primarily by the community health clinics and the outreach and enrollment staff. In addition, the project collects data and receives reports from Medi-Cal, Healthy Families and Partnership Health Plan to monitor enrollment and utilization of health care services.

Medi-Cal Managed Care Planning

The Medi-Cal Managed Care planning group was convened in response to the state Medi-Cal redesign plan issued in 2005. The state plans recommended that Sonoma County establish a managed care system under a neighboring county-operated health system for Medi-Cal beneficiaries. The local planning group, chaired by the County Health Officer, includes representatives from health care providers, Medi-Cal beneficiaries, and county government. Over the past year, the inclusive planning process held public meetings and involved key stakeholder groups through surveys, focus groups, and networking sessions. The overall process included conducting research, analyzing findings and establishing a recommendation for the type of Medi-Cal model most beneficial to Sonoma County. Specifically, the planning group examined the pros and cons of four models, including fee-for-service plan, geographic managed care plan, two-plan model (local initiative and commercial plan choices), and a county organized health system (both start-up and existing plan in neighboring county). Data elements reviewed included state Medi-Cal utilization data and regional Medi-Cal data provided by Partnership Health Plan.

Specific documents, such as meeting minutes, planning group membership, and supporting data can be found on the Department of Health Services website at http://www.sonoma-county.org/health/ph/mmc.

The recommendation of the planning group presented to the Director of Health Services is to become part of the neighboring Medi-Cal managed care health plan, Partnership HealthPlan of California, a county operated health system that has been providing Medi-Cal managed care to 85,000 lives in Napa, Yolo, and Solano counties for over 12 years. In addition, the neighboring counties of Marin, Mendocino, and Lake counties have also decided to join in Partnership HealthPlan's Medi-Cal expansion.

The recommendation for Sonoma County to sign on with Partnership HealthPlan of California is contingent on the resolution of a number of issues including offering appropriate rates to providers, agreeing on an appropriate level of Sonoma residents serving on the governing board, the opening of a new local Partnership HealthPlan office, creating a local advisory body, and resolving various operational issues. Partnership HealthPlan and the county will be working to resolve these issues during the next year of planning.

There was no state or external funding provided for this planning process; however, there may be a need for funding to implement recommendations from the planning group. The county provided minimal funding to support planning through Medi-Cal Administrative Activity reimbursement funds.

Humane Cost Containment Approaches

The issues of spiraling health care costs, corresponding increases in health care premiums for insurance, and low reimbursement rates for doctors and specialists result in fewer individuals covered by health insurance and decreased access for public program beneficiaries and the uninsured. Key stakeholders who are concerned about these issues are health care providers, hospital executives, insurance plans, and community advocates. As a result of the Sonoma State Community-Campus Initiative, many ideas and strategies to address critical factors impairing the local overall health care system were generated (www.sonoma.edu/programs/healthcrisis/ideas-ssu). Some of these strategies are evident in the local work of health care consultants conducting interest-based bargaining between insurance carriers and purchasers; Kaiser Permanente's model of a health plan operating with positive interaction and synergy with doctors and their hospital; partnerships between community clinics and Kaiser to provide specialty

care; and the recent efforts of the Medi-Cal planning group to work with Partnership HealthPlan of California.

These local initiatives employ at least four practices that address the interests of all the parties affected:

1) Prevention and chronic disease management programs that focus on the health and well-being of the patients, with the goal of reducing more costly health care interventions including hospitalization;
2) Decreases in more costly interventions and hospitalizations will keep the costs of health care and premiums to an affordable level;
3) Doctors can practice good medicine driven by patient need and not finances; and
4) Cost savings could be re-invested into the system to help keep a positive balance among all interests in the system.

C. Capacity

Redwood Community Health Coalition and Community Health Clinics

Local community health clinics provide the "safety net" for Sonoma County residents who have no health insurance coverage and for many that are enrolled in public programs such as Medi-Cal. There are seven community health clinics that are located in geographic regions in the county. These clinics are under a consortium organization, the Redwood Community Health Coalition (RCHC), that strives to create stronger systems of health care, including strengthening primary and specialty care and increasing the quality and access to care, resulting in cost-savings and possible re-investment into the system. Specific objectives are to strengthen the infrastructure and leverage resources among clinics and private providers in the community.

The current focus for RCHC and the member clinics is to pursue interactive software that will provide a business practice model and an electronic health record. The proposed model is interactive software between hospitals and providers in the community, similar to business software utilized by the banking industry. Two clinics are already connected to hospitals (Sutter and St. Joseph's). RCHC has released a request for proposals from software vendors, but they do not have an imposed deadline.

RCHC will need continued grant funding for purchase and installment of the new software system, once identified. The clinics do not have adequate reserves for such an investment. A business plan has been developed to educate, promote and solicit investors/funders.

Currently, the clinics are utilizing MediTracks, software that provides management for chronic health conditions such as diabetes, heart disease, and asthma. By collecting and analyzing core clinical data, the clinics have the goal of creating an effective managed care system that can reduce health care costs. In addition, to MediTracks data, the clinics utilize OSHPD (Office of State Health Planning) to study and understand the status of the community's health. Examples of reports include: numbers of uninsured, trends in utilization (migration from southern Petaluma to northern Marin County), issues of access and other indicators that have health policy implications.

Sutter Residency Program

Two years ago, Sutter Family Practice had reduced their out-patient services by 30% at the Family Practice Center. This reduction in services impacted all of the other clinics in the county. In order to accommodate the dramatic increase in patients, Southwest Community Health Center (SCHC) leased a small office space from Sutter at their Chanate Road facility. This move was followed by a series of planning meetings between Sutter, SCHC, and Kaiser that has resulted in an initiative to sustain the local residency program. This partnership has the goal of keeping the residency program viable by reducing costs and insuring access to the medically underserved.

In the course of these planning meetings, the partners have defined roles and responsibilities. Sutter will continue to recruit and employ the residents and pay for the cost of faculty; SCHC will provide the out-patient clinic services and setting; and Kaiser will provide training for specialty care at either the Kaiser campus or at the Chanate campus. The partners are currently working out the financial, legal, and operational procedures. There is discussion about the transfer of all patients of the Family Practice Center patients to SCHC with July 2007 scheduled for transition of responsibilities.

The cost of providing care to patients through a teaching program will be covered primarily through Medi-Cal reimbursements and other third-party payers. SCHC will be responsible for the cost of the operation of the clinic excluding the faculty and the residents' salaries. The planning group is working on a business plan to determine if the Medi-Cal funding alone will be sufficient to cover the cost of the program. In addition, the group will research whether there is an opportunity for additional federal funds to support the expansion of services to the community. Financial support is needed for working capital to cover the delays in payments from Medi-Cal when starting a new service, and to cover the relocation of the residency program into a new facility.

The SCHC uses expected patient volume, payer mix, and historical and projected reimbursement rate data to develop financial projections. In addition, SCHC utilizes population data, mostly from FactFinder.gov, to evaluate demographics of the community and to determine where services are most needed. The evaluation questions for SCHC are:

1. What are the unmet health care needs of the community we serve?
2. What is the anticipated volume of those Medi-Cal services?
3. Is SCHC being directly responsive to the highest priority needs of the community?

Southwest Health Center Expansion

In addition to the Sutter Residency Program partnership cited above, the Southwest Community Health Center has plans to create a centralized, multi-service health and wellness campus in Santa Rosa.

Southwest Community Health Center has identified property and established a proposal for 25,000 square feet within a 150,000 square foot campus adjacent to St. Joseph's campus on Fulton and Guerneville Roads. SCHC will provide a dental clinic, house adult day services, the Sutter Residency program, mental health services, and other specialty care and add primary care services for approximately 10,000 patients. In addition to these health services, SCHC has proposed partnerships with the WIC Program, Medi-Cal, alcohol and drug services, the Food Bank, and the Center for Well-Being.

One key objective for this initiative is to raise $2 million in a capital campaign within 18 months beginning October 2006. Of this $2 million, over $500,000 has already been raised through grants from the Tides Foundation, California Health Care Facilities and Financing Authority, the Finley Foundation, and private donations.

Kaiser Permanente

Kaiser's stated mission is to improve the health of their members and the communities they serve. Kaiser has many strategies to achieve this mission and their community presence has increased through partnerships with community health clinics, other hospitals in the community, and other public programs. To support the safety net, Kaiser has granted $100,000 to community clinics this past year. In addition, a grant for information technology was given to the Redwood Community Health Clinics (consortium) so that member clinics would have an interfacing clinical and business software to strengthen their infrastructure as a collection of community health clinics.

Kaiser's Community Grant Program focuses on providing expanded access to health care services for underserved populations, developing infrastructure, partnerships and leadership training, educating future health care professionals, and funding community agencies that support the creation of healthy lifestyles for children. Locally, Kaiser's Community Grant Program has supported funding for Certified Application Assistors and clinic infrastructure. The program would like to fund more partnerships, via a United Way model that looks for collaborations that are outcome-based. A recent program that was funded by Kaiser under the Healthy Eating/Active Living Community Health Initiative (HEAL-CHI) is a $1.3 million grant awarded to a collaborative in the Roseland School District of Santa Rosa to address childhood obesity by providing garden-grown fresh vegetables and nutritional education, and increasing the number of neighborhood parks in a densely urban pocket that has previously been neglected.

Workforce Development

In addition to the internal residency programs of Kaiser and Sutter hospitals, a collaboration of health care providers, providers of higher education, and non-profits form the Health Care Workforce Development Roundtable. This group has been successful in obtaining grants that address the community's workforce needs for licensed and ancillary health personnel by providing specialized training in a local setting. Most recently, the Roundtable completed a two-year grant funded by the State Community College's Chancellor's Office to offer a Summer Health Care Institute for 20 young people interested in pursuing health care careers. This Institute targeted bi-lingual Spanish students to fulfill a recruitment need of many health care providers in Sonoma County. In addition to the Chancellor's office, the three major hospitals, Memorial, Sutter, and Kaiser, and The California Endowment provided funding.

At the state level, the Governor's Office has issued funding to expand nursing programs, an important decision for local programs that are impacted and cannot take more new students. The major limitations of the training system are the lack of Master's level nursing instructors and the limited clinical slots at the hospitals. The local system is able to mitigate this problem by staggering enrollment of students.

The Santa Rosa Junior College has an active interest in health care training. In addition to the nursing program, SRJC has just developed a Medical Assisting Program, Phlebotomy Program and a Medical Interpreter Program (focusing on Spanish language). Some programs, such as the Psychiatric Technician

Program and the Community Health Worker Program, are under-enrolled. Other programs, such as the Radiology Technician and Dental Hygiene programs, are at capacity. To increase the array of programs, SRJC has been partnering with other community colleges to provide long distance learning. Examples are respiratory therapist training with Napa Community College, sonography training with Foothill College in San Mateo, and medical surgical technician training with Skyline College.

Another key partner in the workforce development arena is the Workforce Investment Board (WIB) staffed by the County of Sonoma, Human Services Department. Over the years, the WIB has received state and federal funding to address nursing shortages. In the final year of a two-year grant, the WIB is working with SRJC to provide 60 students with an associate degree in nursing.

Because the WIB is composed of local business people with a primary interest in workforce development and the connection to the economic vitality of the county, monitoring of the workforce needs of a variety of industries occurs regularly. To assist with this, data from the Employment Development Department, local economists, and the Economic Development Board is collected and analyzed by staff. Key stakeholders in the health care industry are the Hospital Council, SRJC, Red Cross, Empire College, and the Health care Workforce Development Roundtable.

D. Access/Population

St. Joseph's Health System

St. Joseph's Health System, Community Health Clinics and Programs offer an array of community health services that target specific populations in Sonoma County communities.

Two programs for seniors, House Calls and Home Sweet Home, provide medical care and personal care services to frail elderly seniors who have limited access to care due to impaired mobility, lack of health insurance, or a lack of funds to pay for health care services. Seniors are a growing population in Sonoma County, and the program goal is to maintain the health of senior adults, avoid premature placement in assistive living and senior homes, and prevent unnecessary emergency room visits. Specifically, Housecalls provides information and advocacy on MediCare Part D, and provides medical services by a registered nurse, family nurse practitioner or certified medical assistant. Findings of the Housecalls staff are that some seniors are insured, but not accessing available services or not purchasing/taking medication. In addition, there is a service gap between mental health and primary care services for seniors.

Another population that is served by St. Joseph's Community Health Clinics and Programs is agricultural workers. "Promotores de Salud," trained community health promoters, provide peer education and facilitate access to dental, medical, preventative, and children's health services. In addition, Mi Via, an electronic (portable) medical record, is in the fourth year of implementation. Mi Via is a secure web-based health record that is for single individuals and up to 8 family members. Providers can access and upload diagnostics, Medi-Cal charts, and other health documents. The site links to community resources and clinics in geographic areas so that patients can find health services in most communities. In addition, there is a link to MedLine, providing consumer information on medication. Originally offered to agricultural workers, Mi Via is now being expanded to the homeless population, another mobile population, serviced by St. Joseph's.

To address shortages in dental services, St. Joseph's has a dental clinic providing comprehensive dental services to children ages 4-20 years and emergency services to adults under the Medi-Cal and Denti-Cal programs, Child Health and Disability Program, and CaliforniaKids.

Increasing access to health care is addressed by many approaches in the St. Joseph's system. The various programs include: a mobile health clinic that travels to remote parts of the county to provide medical care to low-income families, Promotores and Certified Application Assistors who are hired to assist in education and enrollment into public programs and health coverage, and two urgent care centers located in Rohnert Park and Santa Rosa that prevent unnecessary use of the emergency room.

E. Thoughts on What Is Still Needed Locally

The following bullets are a composite of suggestions and thoughts regarding what might move the local system further in the pursuit of increase access and quality of health care as noted in the interviews of local leaders, administrators and managers.

- The Community Health Clinics need more visibility constituting the 2nd largest primary health care providers only behind Kaiser.
- Sonoma County needs a stronger policy voice at the state and federal levels.
- More providers (specialists and primary care) are needed in the community through a concerted effort on recruitment and retention.
- Information clearinghouse for best practices, health policy studies.
- Mechanisms to promote public discussion on universal health care; create groundswell from public to create political will; consider hands-on advocacy training.
- Models of health care, including strategies for funding from other jurisdictions and states.
- Examine health care systems of the Veterans Administration and Federal Employees Health Plan.
- Involve the Board of Supervisors in examining universal health care in the county; examine models such as San Francisco, San Mateo, and Santa Clara.
- Kaiser, Sutter, and Memorial need to continue to collaborate to increase capacity and access to specialty care, ancillary and diagnostic services, and hospital services for the uninsured and underinsured in our community.
- Compare and contrast Sonoma County models to other health care delivery systems in other counties.

F. Conclusion

The health care leadership of Sonoma County has a strong history of partnership and collaboration. In addressing the multi-faceted health care system and the inter-relationship of the many factors that affect access for community residents, many different approaches have been implemented enlisting the participation of policy makers, managers, and staff of health care, education, social services, and workforce development.

However, these local initiatives cannot work alone or in isolation of the broader policy considerations of the state and federal government. Unless there is a concerted effort to involve state and federal

policymakers, elected officials, business leaders, and institutions in taking responsibility to address the inequities of health care, the local jurisdictions will always be the responsible parties creating solutions that are reactive to the changing economics and politics of health care.

Armed with the knowledge of how these local initiatives complement each other and create a local model, health care leaders need to examine the health care systems of other jurisdictions and band together to influence the policy discussions currently gaining momentum at the state and national levels. Leveraging the strength contained in the various local consortiums, coalitions, and collaborations is a powerful proposition when enlisting local state and federal elected officials. Constant learning and re-positioning on strategic priorities is necessary in an ever-changing political and economic environment.

Based upon the findings in this report, Sonoma County has demonstrated the will to bridge the gaps in health care access locally. The stage has been set where the priorities and actions that will bring the local health care system to a healthy homeostasis are continuously refined for the future, a future that will hopefully include a broader dialogue with more stakeholders.

Sonoma County Initiatives to Improve Access to Health Care

Interview Participants

Carl Campbell, Kaiser Permanente

Elizabeth Chicoine, Community Action Partnership, Roseland Clinic

Cliff Coates, Department of Health Services, Healthy Kids, Medi-Cal Redesign

Damon Doss, Petaluma Health Care District

Dana Ellersby, Sutter Medi-Cal

Kathy Ficco , St. Joseph's Health System

Karen Fies, Workforce Investment Board

Rick Flinders, Sutter Family Practice

Naomi Fuchs, Southwest Community Health Clinic

Barbara Graves, Department of Health Services

Supervisor Mike Kerns, Sonoma County Board of Supervisors

Andrea Learned, St. Joseph's Health System

Mary Maddux-Gonzalez, Department of Health Services, Sonoma County Medical Association

Nancy Oswald, Redwood Community Health Coalition

Rita Scardaci, Director, Department of Health Services, Sonoma Health Alliance

Bob Shirrell, Consultant

Stephanie Thompson, Santa Rosa Junior College, Health care Workforce Development Roundtable

Increasing Access to Care for the Medically Underserved: Four County Models with Implications for Sonoma County

Annette Gardner, PhD, MPH
Principal Investigator
Institute for Health Policy Studies
University of California, San Francisco
March 26, 2007

EXECUTIVE SUMMARY

Counties have significant responsibility for the health of their populations yet they are greatly hampered by barriers to health care over which they have limited control, such as the lack of specialists and the high number of uninsured adults. Despite these constraints, all four study counties (Fresno, Humboldt, Santa Cruz, and Solano) have numerous access initiatives underway and are considering tackling the difficult challenge of providing insurance coverage for low-income adults. Funding for these efforts is piece-meal and project driven though there has been strong public and private support in recent years. In addition to undertaking diverse access initiatives, their IT infrastructure continues to evolve albeit in a piece-meal fashion. Similarly, these counties are on the path to integrated systems of care and are focusing primarily on integrating mental health services in primary care settings.

The presence of a coalition dedicated to planning and implementing countywide access initiatives may be a key factor in overcoming these barriers. A coalition approach affords counties the ability to secure resources and implement access initiatives they might not otherwise undertake. These coalitions are built on strong stakeholder relationships, high commitment to increased access, attention to local needs, and staffing to support these activities.

The comparison among the four counties corroborates an earlier UCSF finding that great capacity and willingness to increase access to care for the medically undeserved resides at the county level. Though there are differences in the resources that counties bring to bear, there are specific strategies and models that can be adopted by others. For example, expanding insurance coverage for some adult populations, such as In Home Support Service (IHSS) workers, may be feasible in rural counties. Additionally, partnering with academic institutions and adoption of telemedicine may increase access to specialty care. Clearly there are limits to what counties can do; however, they can provide the means and the motivation for addressing intractable problems in innovative ways.

INTRODUCTON AND DESCRIPTION OF STUDY

Obtaining regular health care is a problem for many Californians. Key barriers include linguistic, cultural, racial, ethnic, geographic, economic, and organizational factors, such as uneven distribution of services. Lack of insurance coverage strongly correlates with reduced access to care. The uninsured—6.6 million Californians[1]—tend to use fewer preventive services and delay seeking appropriate care.[2] Typically, services and insurance coverage are viewed as competing approaches. However, strengthening the health care safety net alone will not address all the barriers to health care.[3] Nor does having health insurance guarantee access to health care if services are lacking. Our research attempts to reframe the debate by increasing our understanding of the different approaches that collectively reduce the barriers to care at the local level.

California counties bear significant responsibility for the health and wellbeing of their residents. As mandated by Section 17000 of the California Welfare and Institutions Code:

> *"Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."*

There is significant diversity in how counties meet the health care needs of vulnerable populations. Some counties have a county-run health care delivery system while other counties contract out these services. Some counties have a public Medi-Cal managed care plan, such as a Local Initiative or a County Organized Health System, and are well positioned to offer insurance coverage to new target populations. However, there are some commonalities or ways in which counties can leverage their resources and mobilize their communities to expand access to care for the medically underserved. For example, thirty-four rural counties participate in the County Medical Services Program (CMSP) for the medically indigent, which affords these counties some voice in the pProgram.

In 2002, UCSF conducted a series of interviews with agency representatives from 12 "innovator" counties in California to inventory their programs to increase access to health care for the uninsured. Access to health care was high on the county agenda and it was being addressed through a variety of innovative approaches, including the Healthy Kids insurance program, which has been replicated in 20+ counties. In 2002 and 2004, we administered a 58-county survey to inventory county access initiatives and identify the factors that contribute to these initiatives. Our findings indicated that a combination of factors, including presence of a public Medi-Cal plan, an access coalition, a public health care delivery system, and discretionary funding (tobacco settlement and/or Prop 10 funds), was important for undertaking innovative approaches such as coverage expansions. However, innovation wasn't limited to those counties with significant resources. Rural, fee-for-service Medi-Cal counties were also proposing health insurance approaches in 2004.[4]

To better understand the factors that facilitate adoption of polices and programs in counties with fewer resources, such as a county-run health care delivery system, we conducted phone interviews with representatives from four counties with populations under 1 million that have mobilized stakeholders and created the infrastructure to tackle barriers to health care for the medically underserved. The findings focus on several key areas that comprise a county's access strategy or model, including: financing, an access coalition, IT infrastructure, and access initiatives currently underway and/-or being proposed.

The purpose of this study is to inform Sonoma County's efforts to identify successful local efforts to strengthen the county--level health care system. The Sonoma Grand Jury recently issued a report on the county's health care systems and barriers to access and recommended further research and deliberation on an integrated approach to shoring up its health care system. This study affords us an opportunity to assess capacity to increase access to care in counties that have limited resources but a strong commitment to increase access to care for its residents.

Methods

One-hour phone interviews were conducted with 3 or 4 representatives in four counties—Fresno, Humboldt, Solano, and Santa Cruz—in December 2006. Informants included representatives from the county health agency, the local access planning coalition, the Medi-Cal managed care plan, if applicable, and private sector providers and/or health insurance plans. We focused primarily on counties similar to Sonoma County in size (under 1 million people) ~~and~~ that had been involved in countywide planning activities focusing on access, such as a Children's Health Initiative (CHI). Informants were asked to describe the following features of their county:

- Gaps in access to care, i.e., transportation, specific populations;
- Key players and their roles, i.e., health plans, county agencies, CBOs, academic institutions;
- Nature of the collaboration among stakeholders, i.e., shared responsibility;
- Funding for access initiatives, i.e., public and private sources;
- County-wide model or approach used, i.e., strategic planning process;
- Inventory of current access initiatives;
- Planning, allocation, and monitoring of resources;
- Type and role of information systems, i.e., data systems, enrollment systems like One-e-App; and
- Future plans – what they are intending to do in the next 2-3 years to integrate health care services.

All interviews were analyzed for crosscutting themes.

FINDINGS

The four study counties, while being unique in history, culture, and economic base, share some important features, such as high stakeholder willingness to address gaps in access. The following describes in brief the four study counties and their health care systems for low-income residents:[5]

- **Fresno County:** Located in the Central Valley, Fresno County is largely a rural and agricultural county that has a large Latino community. It has a population of 874,000 people, approximately 18% of which is uninsured. It is a Medically Indigent Services Program (MISP) county and it contracts out services for the medically indigent to Community Medical Centers. Medi-Cal managed care services are provided through two commercial plans, Blue Cross and Blue Shield;

- **Humboldt County:** Located on the Northern California coast, Humboldt County is a rural county. It has a population of 128,000 people, approximately 16% of which is uninsured. It is a CMSP county and services are provided through non-county clinics and private hospital ERs. Medi-Cal services are delivered through a Fee-For-Service (FFS) model;

- **Santa Cruz County:** Located on the Central Coast, Santa Cruz County is a partially rural county within close proximity to the Bay Area. It has a population of 251,000 people, approximately 12% of which is uninsured. It is a MISP county and provides services through county-~~-~~operated health clinics and private hospitals. Medi-Cal services are provided through a County Organized Health System (COHS) model (Central Coast Alliance for Health); and

- **Solano County:** Located between San Francisco and Sacramento, Solano County is mostly a suburban county. It has a population of 404,000, approximately 7% of which is uninsured. It is a

CMSP county and services for the medically indigent are provided by county and non-county clinics. It is a COHS county (Partnership Health Plan of California).

For more information on each county, its population, access issues, program for the medically indigent, access coalition, county model, funding and integration of services, please see **Table 1** below.

County Access Issues

Though the four counties include rural and urban counties and vary in size and population, they share some of the same access issues, notably **lack of insurance for low-income adults** and **lack of specialty services,** such as dental care and mental health. Three of the four counties have geographic barriers and transportation issues. Lack of primary care services is more pronounced in Fresno County and Humboldt County than the other two counties. There are some differences in the underserved populations, such as farm worker access issues (Fresno) and Medicare populations (Santa Cruz).

The barriers to addressing these gaps are significant, particularly the **lack of flexibility in existing programs for low-income populations**, such as MISP/CMSP, Medi-Cal, and Medicare. The four study counties have minimal discretion in how they can leverage limited public resources though there have been some opportunities in recent years, such as funding for outreach and enrollment of children in new and existing health insurance programs.

County Access Initiatives

Similar to our 2002 and 2004 county access studies, we asked representatives to indicate the type of access initiatives that were being undertaken in their counties. As described in **Table 2** below, the four counties are making the most progress in children's coverage expansions, outreach/enrollment, consumer education, facilities expansions, adoption of IT, and coordination of existing health services, most notably mental health services. Access initiatives for adults, such as coverage expansions and reforms to the county programs for the medically indigent, tend to be in the "proposed" stage. The following discusses these initiatives in more detail.

1) **Insurance for Children:** All four counties have recently launched health insurance programs for children who are not eligible for existing public programs; three counties (Fresno, Santa Cruz, and Solano) have comprehensive Healthy Kids programs and one county (Humboldt) has launched CalKids, a limited insurance product. These programs tend to be part of a Children's Health Initiative or CHI, which also includes outreach and enrollment activities targeted to children and their families.

2) **Insurance for Adults:** Except for Solano, which has insurance coverage for the In Home Support Service (IHSS) workers, the three other counties are in different stages of developing insurance programs targeting different adult populations. Fresno is seeking to insure farm workers and Santa Cruz is seeking state SB 1448 funding to cover indigent adults. In Humboldt County, a task force is exploring the feasibility of a community health plan, which would expand coverage to uninsured adults. Coverage of IHSS workers is also being discussed.

3) **County Indigent Program Reforms:** While there are barriers to reforming a county's program for the medically indigent, such as insufficient financing, these programs offer some opportunities. Three of the counties have activities proposed or underway. Some of these changes are more modest than others. Santa Cruz hopes to expand its Medi-Cruz program to extend eligibility to six months and

make it more like an insurance program. Solano is working with Kaiser Permanente to increase access to specialty care, and Humboldt is looking to include behavioral services. Solano's experience with the reversal of earlier reforms is noteworthy.

4) **Outreach, Enrollment, Retention in Insurance Programs:** All four counties have programs underway that are in tandem with the launch of their child insurance program.

5) **Consumer Education:** Similarly, all counties have activities to educate people on their insurance options and/or use of services underway, with these activities being combined with outreach and enrollment activities.

6) **Facilities Expansions:** All counties have initiatives underway to expand county and/or non-county clinics, such as adding new sites, hours of services, etc.

7) **Increase in Providers:** Two counties (Fresno and Solano) have initiatives underway to train and/or attract more providers. The other two counties (Humboldt and Santa Cruz) are considering ways to attract providers, particularly specialists. For example, the Medical Society in Humboldt County is leading an effort to form a multi-specialty group practice to help recruit and retain physicians.There are diverse options here, such as partnering with academic institutions to train more doctors, applying for designations such as Health Professional Shortage Area, which can be used to attract providers, and working with health care organizations to attract specialists.

8) **Adoption of IT Systems:** There has been significant public and private support to develop information systems to house, track and share data among providers. Two counties (Fresno and Santa Cruz) have implemented One-e-App systems to enroll people in social services. Humboldt is implementing One-e-App. Solano has implemented CalWin, a system to determine eligibility in social services. Please see the discussion below for a description of other IT activities underway in the four counties.

9) **Coordination of Existing Health Services:** All four counties have efforts underway to coordinate some aspect of their health care delivery system, particularly the integration of behavioral health services in a primary care setting. This may continue to be an area of emphasis as counties allocate their Proposition 63 funds under the Mental Health Services Act.

In sum, there are limited differences in the type of initiatives being undertaken by the four counties. There is greater diversity within each type, with the four counties considering or undertaking different approaches to attract specialists, cover different adult populations, and develop their IT infrastructure.

Financing Access Initiatives

Funding for access initiatives comes from many different sources and tends to be project-driven. Public funding includes state support for outreach and enrollment in existing public insurance programs, federal support via the Healthy Communities Access Program, and local First 5 (Prop 10) funding for CHI activities. Funding for the medically indigent comes from a combination of county general fund support (GFS) and Realignment (state) funding. Private foundation support has been strong, including premium assistance for children's coverage programs, safety net provider support, and technical assistance for coverage expansions. While grant funding affords coalitions the opportunity to expand in new directions, such as quality improvement and workforce development, it isn't sustainable. Except for Solano, which

has dedicated Tobacco Settlement funds to improve access to health care, funding in the remaining three counties is piece-meal and project-driven.

Access Coalitions

Our 2004 survey findings indicated that upwards of 26 counties had access coalitions to plan and launch access programs. While many of these coalitions focused on children, such as the Children's Health Initiatives (CHIs), some were broader in focus. In Sonoma County, multiple stakeholders have been convening since 2002 to discuss barriers to access and potential solutions. These countywide efforts hold great potential for developing an integrated approach to access to care, overcoming some of the barriers to policy adoption.

All four study counties have coalitions to plan and implement access initiatives. Three of the four coalitions (Humboldt, Fresno, and Santa Cruz) were funded under the federal Healthy Communities Access program grant program, a program that has played a major role in coalescing or evolving coalitions throughout the US.

There are some differences in coalition age and maturity, with the oldest coalition, the Solano Coalition for Better Health, dating back to 1988, and the newest coalitions, Fresno Healthy Community Access Partners and Health Improvement Partnership of Santa Cruz County, being launched in 2003. The Community Health Alliance of Humboldt-Del Norte was launched in 2000.

The coalition's age reflects in part it~~'~~s "maturity" or the degree to which the organization is perceived to be the lead agency of access initiatives in the county, as well as the development of infrastructure to plan, fund, and implement access programs. As the most mature coalition, the Solano Coalition for Better Health is the primary agency for the county's access initiatives and is responsible for directing county Tobacco Settlement dollars to access initiatives. All stakeholders are represented. It has a 3-year strategic plan and submits its recommendations to the county Board of Supervisors for approval. Additionally, it partners with the county on securing funding for diverse initiatives and provides input on the county's program for the medically indigent. At the other end of the spectrum, Fresno Health Community Access Partners, the newest of the four coalitions, is one of a few coalitions in the county that focuses on access though it may be evolving into the lead agency. It includes members from the safety net provider community and has developed infrastructure to plan and implement access programs, such as launching a Healthy Kids product. The coalitions of the other two counties, Humboldt and Santa Cruz, are in between these two counties in age and development: they're recognized as ~~a~~ lead agencies~~y~~ that work~~s~~ in partnership with the county, they represent all the health care stakeholders, and they have a track record of achievements, as well as the infrastructure to plan and pursue new activities. However, they rely on grant funding and are still developing some of their infrastructure, such as developing a strategic planning process. They are established but they are not as mature as Solano's coalition.

Except for Fresno's coalition, which is comprised primarily of safety net providers, these coalitions tend to represent all the health care stakeholders, including providers, the county health or public health agency, community based organizations, foundations, and insurers. While broad-based participation may be important, coalition representatives emphasized the need to have sustained participation by the *leadership* of these organizations.

These coalitions are an important vehicle for planning and implementing access initiatives, providing the infrastructure and staffing that other agencies could not do on their own. There are similarities in the type

of initiatives undertaken by these coalitions, such as children's coverage expansions and outreach and enrollment activities. These entities are also able to address the unique issues in their respective communities. For example, Humboldt's coalition launched an employee assistance program (EAP). Santa Cruz focuses on the Locality 99 issue or low Medicare reimbursement for rural counties. Fresno focuses~~d~~ on IT and the implementation of One-e-App. Last, Solano is increasingly involved in health disparities.

While all four coalitions must address ongoing resource constraints and episodic issues like competition among stakeholders, there are many factors that facilitate the success of these organizations, including: 1) high stakeholder commitment and involvement, particularly among the CEOs from participating organizations; 2) a good track record of accomplishments; 3) agreement on coalition goals; 4) established relationships among participants; and 5) staff support to convene meetings, facilitate communications, and support planning process.

In sum, these organizations are an important vehicle for undertaking diverse initiatives in a coordinated manner across the health care community. Stakeholder participation and the processes for supporting this participation is key. There is the potential for these coalitions to evolve into the hub organizations for the~~a~~ county's access initiatives, contributing to program sustainability, ongoing stakeholder commitment, and ability to address gaps in access.

Expanding County IT Capacity

Health care providers continue to expand their information technology to increase access to services, be it the adoption of telemedicine in rural areas or the implementation of a health record exchange (HRE) to better track clinic patients. While these efforts may be piece-meal, there is the opportunity to integrate them and create a countywide infrastructure that greatly enhances quality of care and reduces the barriers to access. We asked the four study counties to describe the diverse IT initiatives underway in their counties as well as coalition involvement in these initiatives.

As described in **Table 3,** IT capacity is uneven, with the four counties being in different stages of implementing IT systems at the county and/or provider level. Most are evolving toward having a centralized data system though they are coming at it from different directions and building on different IT applications. The four counties are farthest along in implementing One-e-App which is due in large part to the support from the California Health care Foundation. Telemedicine capacity appears to be provider driven, and is used in rural areas where there is limited access to providers. Similarly, electronic information systems to exchange information are limited to individual providers though two counties have cross-provider applications (Santa Cruz and Solano).

The Future: Developing Cost-Effective, Integrated Systems of Care

As county-wide access initiatives, such as coverage expansions, and IT systems evolve, there is great potential for coalitions and their partners to reduce the systemic barriers to access, such as a fragmented health care delivery system. For example, all four counties are focusing on integrating behavioral health with primary care, due in large part to Prop 63 or the Mental Health Services Act.

Some of these initiatives may also contribute to identifying approaches to leverage public funding and identify cost-containment strategies. For example, Santa Cruz's coverage expansions resulted in a shared

risk funding model among providers. However, the four study counties are in the early stages of identifying new cost-containment strategies that could free up resources.

Conclusion

Counties have significant responsibility for the health of their populations yet they are greatly hampered by access issues over which they have limited control, such as lack of specialty providers and the high number of uninsured adults. Despite these constraints, all four study counties have numerous access initiatives underway and are considering tackling the difficult challenge of providing insurance coverage for low-income adults. In addition to undertaking diverse access initiatives, county IT continues to evolve albeit in a piece-meal fashion. Similarly, counties are on the path to integrated systems of care and are focusing primarily on integrating mental health services in primary care settings. A coalition approach affords them the ability to secure resources and implement access initiatives they might not otherwise undertake. These coalitions are built on strong stakeholder relationships, high commitment to increased access, attention to local needs, and staffing to support these activities.

The comparison among the four counties corroborates an earlier UCSF finding that great capacity and willingness to increase access to care for the medically undeserved resides at the county level. Though there are differences in the resources that counties bring to bear for health care for low-income populations, there are specific strategies and models that can be adopted by others. For example, expanding insurance coverage for some adult populations, such as In Home Support Service (IHSS) workers, may be feasible in rural counties. Additionally, partnering with academic institutions and adoption of telemedicine may increase access to specialty care. Clearly there are limits to what counties can do; however, they can provide the means and the motivation for addressing intractable problems in innovative ways.

Acknowledgements

Funding for this study was provided by the University of California, Office of the President, California Program on Access to Care.

For more Information

Annette Gardner, PhD, MPH
Principal Investigator
(415) 514-1543
Annette.gardner@ucsf.edu

Table 1. Four County Models to Increasing Access to Care for the Medically Underserved

County	Access Issues	Underserved Populations	Policy Issues	Medically Indigent Program	Access Coalition	County Model	Funding Strategy	Integration of Services
Fresno (Pop. 874,000 Medi-Cal managed care - commercial plans)	Lack of primary care and specialty services; Lack of insurance for low-income adults; Transportation .	Uninsured adults, particularly farm workers.	Limited county support; Does not have a Local Initiative or COHS; Medi-Cal eligibility restrictions; Llimited public and private commitment to expand coverage.	MISP Program. County contracts with Community Medical Centers to provide services to those who meet MISP criteria. Funded by Realignment and county GFS.	Fresno Healthy Community's Access Partners (HCAP) represents safety net providers. Goals: 1) Expand outreach/enrollment; 2) Implement One-e-App; 3) Children's health insurance; 4) Adult insurance (farm workers). Founded in 2003.	Decentralized—multiple collaboratives and coalitions, such as Fresno Metro Ministry, HCAP Coalition, California Health Collaborative.	Piece-meal or by the program. Limited county funding. First 5, HRSA, and grant funding.	See HCAP Goals re countywide programs. Potential to integrate mental health services.
Humboldt (Pop. 128,000 Fee-For-Service Medi-Cal)	Gaps in adult care and coverage; Shortage of providers—primary care, mental health, dental and specialists; Transportation;.	Growing Hispanic population; Ggeographically insolated populations.	Lack of flexibility in existing programs for low-income populations, i.e. CMSP, and funding streams; Stakeholders issues, i.e. mistrust of government by employers.	CMSP Program. Non-county clinics and hospital ER provides bulk of services. Funded by Realignment and county GFS.	Community Health Alliance of Humboldt-Del Norte (CHA) includes all health care stakeholders. Focuses on outreach/enrollment, coverage expansions, EAPs, chronic care, workforce and IT. Founded in 2000.	Shared with CHA taking the lead on access efforts and the County Dept. of Public Health taking the lead on some initiatives as well.	Have a strategic plan and fundraising committee.	Pilot program with clinics to address shortage in mental health providers. County is launching TM mental health services in several locations.
Santa Cruz (Pop. 251,000 County Organized Health System)	Large uninsured adult population; Llack of primary care, dental services, and tertiary care services.	Uninsured adults; Medicare populations (limited LTC facilities).;	Inadequate reimbursement for Medicare B services; Rrising medical costs and limited resources for Medically Indigent; Reimbursement for undocumented; Medicaid policy changes.	MISP Program. Medi-Cruz. sServices provided at county and non-county clinics. Funding from county GFS and Realignment. Anticipates launching Medi-Cruz (service expansion) and is seeking SB 1448 funding.	Health Improvement Partnership of Santa Cruz County (HIP). Comprised of public and private health care leaders. Focuses on 4 areas: 1) access to care, 2) promoting IT in health settings 3), community health and 4) chronic disease management. Founded in 2003.	Shared responsibility – HIP and county. The Safety Net Coalition and Central Coast Alliance also undertakes countywide initiatives.	Piece-meal. No overarching strategy. Have identified potential funding sources.	Diabetes registry initiative, a quality program that is evolving into a chronic disease management initiative; IT in tandem with insurance; Adult health insurance.
Solano (Pop. 404,000. County Organized Health System)	Low-income adults not eligible for Medi-Cal/CMSP; Lack of specialty services; Some geographic barriers.	Uninsured adults	Lack of flexibility in existing programs for low-income populations, i.e., CMSP; Insuring the undocumented; Restrictions on dental and mental health services, i.e., low reimbursement.	CMSP Program. Services provided by county and non-county clinics. Shifted program from Partnership Health Plan to Blue Cross. Funded by Realignment and county GFS.	Solano Coalition for Better Health. Focuses on 1) assure access to quality care; 2) eEliminate disparities in health status; 3) promote community and individual wellness. Founded in 1988.	Solano Coalition is lead agency. Includes all stakeholders. Has strategic plan for allocating Tobacco Settlement funds, which is reviewed by county Board of Supervisors.	Shared responsibility. County is responsible for CMSP and Co. GFS. Coalition responsible for Tobacco funds, grants, and First 5. Depends on the initiative.	Virtual Clinic Network, an information sharing system; Integrating mental health services in primary care services; Frequent Users project.

Table 2: County Access Initiatives (Underway, Proposed, No Activity), 2006

County	Insurance for Children	Insurance for Adults	County Indigent Program Reforms	Outreach, Enrollment, Retention in Insurance Programs	Consumer Education, e.g., use of services	Facilities Expansions, e.g., new clinics	Increase in Providers, e.g., specialists	Adoption of IT Systems, e.g., One-e-App	Coordination of Existing Health Services
Fresno	**Underway** (Healthy Kids.)	**Proposed** (farm workers.)	**No Activity**	**Underway** (as part of Healthy Kids.)	**Underway** (patient navigator program, OERU, transportation initiative.)	**Underway** (clinic expansions, Community Medical Centers is consolidating services.)	**Underway** (UCSF medical education program to train more doctors.)	**Underway** (One-e-App, Cal Win.)	**Underway** (HCAP stakeholder monthly reporting.)
Humboldt	**Underway** (CalKids.)	**Proposed** (IHSS coverage being discussed and a community health plan to insure adults is being considered.)	**Proposed** (include behavioral health services.)	**Underway** (as part of CalKids effort.)	**Underway** (as part of OERU activities, IPA-lead diabetes registry.)	**Underway** (non-county clinic expansions.)	**Proposed** (working with HSU and other stakeholders to attract specialists, formation of multi-specialty group.)	**Underway** (One-e-App is being implemented and other IT expansion are being discussed.)	**Underway** (integration of mental health services in primary care clinics. Other MHSA activities.)
Santa Cruz	**Underway** (Healthy Kids.)	**Proposed** (IHSS, submitted SB 1448 proposal to cover indigent adults.)	**Proposed** (Medi-Cruz Plus or changes to MI program to extend eligibility to 6 months.)	**Underway** (outreach coalition with 40 CAAs. OERU proposal submitted.)	**Underway** (Safety Net Coalition focuses on this. Done at clinics.)	**Underway** (clinic 330 expansion grant to add new sites.)	**Proposed** (looking at designations and J1 Visa program)	**Underway** (One-e-App)	**Underway** (Pilot project where MH staff see patients in primary care clinics.)
Solano	**Underway** (Healthy Kids.)	**Underway** (IHSS.)	**Underway** (working with Kaiser to increase access to specialty care.)	**Underway** (SKIP program.)	**Underway** (SKIP informs people of insurance options.)	**Underway** (county and Community Medical Centers have expanded their facilities.)	**Underway** (county has hired additional staff and there is partnership effort with Toro University.)	**Underway** (CalWin.)	**Underway** (Integrated behavioral health program or MH services in primary care setting.)

Table 3: County IT Systems

County	Centralized data system for archiving health information?	One-e-App or comparable system to connect people to services?	Do providers use telemedicine?	Do providers have an electronic information exchange system?
Fresno	**No.** Have individual data collection programs and has developed a County Assessment Annual Report.	**Yes.** One-e-App has been launched.	**Yes**. Some individual physicians in rural Fresno and Sequoia Community Health Clinics use telemedicine to provide optometry screening.	**No.** Limited cross-provider IT adoption. Community Medical Centers will be implementing electronic medical records in 2007.
Humboldt	**Yes.** Diabetes registry, which is being expanded to include other conditions. A Coalition Task Force is focusing on other IT expansions.	**Yes.** Implementation of One-e-App is underway.	**Yes.** Open Door Community Health Centers has opened a telemedicine center.	**No**. There are individual electronic medical records in provider offices but nothing across providers.
Santa Cruz	**Yes.** County has implemented EPIC electronic health record system, which would provide common repository. There are other data sets, i.e., County Organized Health System has one.	**Yes.** One-e-App has been launched. Will expand to include adults in 2007.	**No**. Being considered on a limited basis.	**Yes.** Providers have Elysium, a clinic messaging system. Axolotal is another system.
Solano	**No.** Has separate systems like Virtual Clinic Network and works with CHIS data.	**No.** Need to address interface issue with CalWin.	**No.**	**Yes.** Virtual Clinic Network which includes Medi-Cal, CMSP and uninsured visits at all clinics and hospitals.

Endnotes

1. Snapshot: California's Uninsured, 2006 Edition. California Health Care Foundation. Oakland, CA. 2006

2. Hadly S. Sicker and poorer: the consequences of being uninsured. Med Care Res. Rev. 2003:60(2 suppl): 3S-75S.

3. Cunningham, P, Hadley J. Expanding care versus expanding coverage: how to improve access to care. Health Affairs. (Millwood). 2004. Jul-Aug:23 (4):234-44.

4. Gardner A, and Kahn JG. Increasing Access to Care for the Uninsured: Considering the Options in California Counties. Journal of Health Care for the Poor and Underserved. 2006. November:17 (4): 830-850.

5. Health insurance coverage data and population data for the four counties are from the 2005 California Health Interview Survey (CHIS). UCLA Center for Health Policy Research.

Addressing Health Care Access in Sonoma County -- 2007-08
Power Point Presentation at Sonoma State University:
March 3, 2007

Gil Ojeda, Director
California Program on Access to Care
University of California
Office of the President

Point of View

- 35 years in health care delivery and research
- Past national, state-level, and community advocate
- Advisor to the lLegislature and the uUniversity; past advisor to community groups and public HMO's
- Analyst in the health sciences, public policy, and the competitive marketplace
- Resident of Sonoma County since 1995

Elements of California's Health Care Marketplace

- Regional market issues: "Mmost health care is local & regional"
- Rural & urban imperatives: "Mmost problems & their solutions are situational"
- Public & private sector roles: "Tthere's a fabric of relationships & conflicts; dialogue is key"
- Regulation vs. market competition: "Ccontinuum from the prison to the jungle to the game preserve"
- Delivery of care & the public's health: "Ddriven by demand, but limited by resources"
- Diversity & Age: "California's minorities & the aged often generate program imperatives"

The Art of Public Solutions

- Allocation of public resources: "Ddriven by public budgets, private roles, profits & political advantage"

- Relative power of constituency groups: "Hhealth plans, providers, employers & health care advocates"
- The gGovernor & the lLegislature: "Tthe Governor is now the leading player since he has acted"
- Natural allies & strategic partners: "Mmust be guided by common goals, opportunities, and intentionality"

Federal Support: The Post Nov '06 Change in Posture to ABC: "Anything but California"

- Coming debates on Medicaid & Children's Health Insurance (S-CHIP): "Ffunding authorizations, overlapping mandates & a rush to reduce entitlements"
- Changes to Medicare: "Pproposed rate reductions, prescription drugs plans, & the shift to managed care"
- Access to care for underserved: "Mmore community clinic support, higher likelihood of direct support for uninsured"

The Coming Storm?
California's Leading Edge Health care Issues

- Increasing cost of employer based coverage: "Iincreased premium inflation, economic slowdown, expanded self & temporary employment"
- 6.5 million uninsured: "Iis increasing again; public solutions being debated"
- Ethnicity and income-driven disparities: "California's diversity & the unemployed as key factors in health outcomes"
- Managed care/HMO's: "Many are doing well by avoiding risk & competition; in a balancing act for State collaboration and oversight"
- Physicians and hospitals-at-risk: "Llower reimbursements, higher financial risks, system inefficiencies"
- Nursing and specialist shortages: "Sstill out of control, worsened by recent policies; few short-term, some long-term solutions"

- State budget deficits: "L~~l~~ast year & this year, may compromise efforts to expand coverage to millions of uninsured"

Health Care Reforms: County Roles in Expanding Coverage

- Healthy Kids programs implemented throughout state including in this county
- Board appointed task force considering stand-alone or multi-county options for managing all Medi-Cal enrollees
- Sutter inpatient closure places current County indigent care arrangements in jeopardy. Can Memorial Hospital step up?
- Continued loss of physicians from county jeopardizes any efforts to preserve or expand health care coverage.
- State level, "shared pain," ~~,~~ effort to bring local low & middle income uninsured, including undocumented, under coverage has chance for passage in 2007-08. Will county's public and private sectors be ready?
- Cooperative dialogue among the various sectors, including Kaiser Health Plan, offers best hope for county's successful expansion under framework of new state reform plan

Considerations as We Go Forward

- What part of the problem are we trying to fix OR do we think we can fix it all?
- Who are the natural institutional allies for health care reforms or are consumers, employers & other ~~-~~health care advocates ready to go it alone?
- What can we do locally in the short term?
- How can we leverage s~~S~~tate & federally mandated changes?

APPENDIX A

Collaborative Humane Cost-Containment Project – Developing an Overall Sonoma County Perspective

Developed by Skip Robinson Ph.D.,
edited by Adele Amodeo MPH,
and contributed to by Art Warmoth, Ph.D.,
Georgia Berland M.A., Tom Moore,
and Carolyn Epple Ph.D.

I. COORDINATING PRIMARY AND SECONDARY PREVENTION AND COALITION-BUILDING

A. Integrate public health efforts; coordinate among health plans and private provider institutions, including nonprofit hospitals with community benefit obligations – such efforts to include primary and secondary prevention, health education, health promotion, coordination of benefits, promotion of medical care cost-offset effects – aiming for significant effects toward the goal of developing system-wide vitality of all Sonoma County residents (lower costs; higher quality; broader access; consistency with developing a healthier Sonoma County).

> "Coordinate [more] among health care and social service and housing providers to integrate health and social services and case management, and to identify and fill gaps in health care access for the uninsured. This would include Sonoma County projects such as Frequent Users of Health Services Initiative (FUHSI), Health Care for the Homeless clinic development, and possibly the Social Security Benefits Assistance Project (if it is funded) among others." *Georgia Berland*

B. Plan and operate a [collaborative – multi-institution] "full court press" with prevention/early intervention/health education/health promotion on [at least] three primary chronic conditions (in their case management and cost management – diabetes, coronary problems, and respiratory problems [perhaps also "children's problems"]) by community public health departments and agencies, employers, health plans, community health groups, media, schools, churches/synagogues/mosques/meditation halls working together to foster shared priorities.

C. Significantly expand community/stakeholder/academic dialogue to increase coalition-building. [Consider funding year-long or multi-year educational and developmental programs.]

D. Do collaborative community-wide studies: What components of a community tend to make the community especially healthy/unhealthy? Practically, what can the community and its systems do to promote and improve community health?

> "Such a study and a related community action project (identifying many such components) and selecting water issues as [one] first action priority is underway by the Center for Social Change of the Sisters of St. Joseph; and considerable prior work on identifying such components was done by Memorial Hospital's Community Benefit Division, building on the Healthy Communities movement nationwide." *Georgia Berland*

E. (Big question: What does community public health mean in an age of jihad, 5 point hurricanes, 7-8 point earthquakes? How does that change the most important priorities, numbers, community building?)

F. Further community-wide study: Expand discussion among campus, community, media, and public schools to raise issues about food grown and food served, multiple growing pressures.

G. Include study of health and mental acuity effects of the severe cuts in school PE, cuts in community facilities, cuts in county public health department programs, cuts in community health group funding, cuts in other critical community resources.

> "The issue of food grown and served in schools is being addressed through various programs of UC Cooperative Extension at the County, as well as in the Master Gardeners program. Also, the Quantum Agriculture Project circulates information on more holistic approaches to agriculture. Certainly discussions of the effects of budget cuts are and should be taking place everywhere, and coordinating responses and advocacy is always a good idea. The new North Bay Spokescouncil is a group trying to coordinate such efforts across disciplines." *Georgia Berland*

Question: What might an overall model budget for health care crisis work fundraising look like? How could it be helpful to those involved?

II. INTEGRATING QUANTITATIVE FACTORS

A. Conduct independent actuarial review of health plan renewal pricing and offers, including thorough analysis of review results, including independent health actuarial perspective as part of the renewal pricing negotiations.

B. Employ sophisticated "utilization analysis" to understand patterns of care and find most-needed changes in local approaches. Analyze "ambulatory-care-sensitive" hospital discharge data.

C. Implement "adjusted risk-sharing across 'total' populations" to assist in modest moderating the volatility of risk "unknowns," a method by which health plans on a given "case" share

certain risks about the composition "mix" of their covereds/insureds once a group enrolls for the next plan year.

D. Explore government-subsidized re-insurance programs to bring high-risk populations into group or county insurance "pools."

E. Institute and upgrade systems to prevent unnecessary hospitalizations, including thorough review of emergency room procedures/issues/plans.

F. Explore government-subsidized re-insurance programs to assist in bringing high-risk populations into group or county insurance "pools" and in developing an adequate full-inclusion equation.

G. Collaboratively study, upgrade, and institute systems to prevent unnecessary hospitalizations, including thorough review of emergency room procedures/issues/plans, according to recent research findings. Explore a variety of administrative cost savings, including more standardized insurance protocols to prevent unnecessary health service delays.

H. Explore "direct contracting." Better quantify the costs and methods for completing health care "access." Take action to implement.

I. Explore a variety of administrative cost savings, including more standardized insurance protocols to prevent unnecessary health service delays and simplify providers' "back office". Consider methods for "more equitable adjustment" of care reimbursement rates, especially "costs" reimbursed/paid to hospitals, doctors, and other health professionals who require reimbursement for services performed (for example, reimbursement rates from health plans to small hospitals and doctor reimbursement rates for "public" patients).

J. Better quantify the costs and methods for completing health care "access." Develop a draft master equation given x and y designs. Take action to implement

K. Consider methods for "more equitable adjustment" of care reimbursement rates, especially "costs" reimbursed/paid to hospitals, doctors, and other health professionals who require reimbursement for services performed (for example, reimbursement rates from health plans to small hospitals and doctor reimbursement rates for "public" patients). (Continue to push for more urban rather than rural Medicare, etc.. reimbursement rates.)

L. "Consider changing hospital fee-for-service funding to 'budgeted system' in which payers pay same amount for same service."

M. In public schools and non-profits, drop use of "TSA in lieu of medical" and other cash versus medical options. [Check current legal cases on this.]

III. DEALING WITH PRESCRIPTION DRUGS

A. Investigate programs for significant prescription drug cost reductions/discounts, including possible "re-importation" of prescription drugs from Canada, et al. Study operating models in such states as New Hampshire, Minnesota, Wisconsin, and Massachusetts, and their cities, such as Springfield, plus stay up to date with plans developing in Sacramento. Continue to explore "piggy-backing" on federal group discounts.

B. Analyze emerging data on other means of significantly reducing prescription drug program costs.

IV. RE-DESIGNING HEALTH PLAN, HEALTH SYSTEM, OPERATIONS DESIGN

A. Improve coordination/management of chronic care "high utilizers." (Rule of thumb: 10-20 percent of health plan participants are responsible for 80-90 percent of health care costs.)

> "The FUSHI project has been studying this issue for Sutter and Memorial for a year now. The very broad-based collaborative they developed has collected lots of excellent data, and their proposal for implementing response for this population – integrated case management across health and social services along with special training for clinicians and social service staff – is now being submitted." *Georgia Berland*

B. Institute and upgrade systems to prevent medical errors. (Note: This is very institutionally focused, mostly on hospitals or large group practices.)

C. Consider implementation of "Point of Service" design (in general or in such special applications as for covered outpatient mental health services). Explore expanded utilization of the "staff model" Health Maintenance Organization (such as Kaiser plus an IPA HMO).

D. Consider development together of a county-wide health care district, including potential for more rational regional planning.

E. Consider wider development of multi-employer and multi-sector health plans.

F. Plan, negotiate, and implement more sophisticated information technology systems both within institutions and across/between them.

G. Consider expanding use of "national model" county programs to treat such Sonoma County-sensitive problems as those of the aged and those with HIV-AIDS.

> "Sonoma County has a very focused HIV prevention and treatment effort, understood to be a national model." *Georgia Berland*

H. Improve access to health care for all the uninsured, immigrants, homeless persons, and similar populations. (Develop systematic modeling to estimate costs and trades.)

I. Further develop health care language services for those for whom English is not a primary language.

J. Develop more adequate health care transport services for those who need them. (Reinstate those recently cut.)

V. REDUCTIONS IN DANGERS OF ECOLOGICAL/ENVIRONMENTAL POISONING

A. Analyze and remediate local ecological environmental public health hazards.

B. Develop high-profile consumer resource access and training in ecological systems and problems, both in person and online.

C. "Assess and address toxicity exposure among homeless people, those living in substandard housing, and those of low income (sometimes known as 'environmental racism')." *Georgia Berland*

VI. ADDRESSING ISSUES OF EDUCATION, TRAINING, RETENTION, AND ALLOCATION OF SCARCE RESOURCES IN THESE CRITICAL SHORTAGES OF HEALTH PROFESSIONS PERSONNEL

A. Take careful analytic note of those health professions in growing critical short supply. Understand the components of current/short-term/longer-term shortages of health professionals. Go to work.

1. Get information from the Office of Statewide Health Planning and Development on health manpower projections.

2. Work with the Pew Center for the Study of the Health Professions at University of California San Francisco for the latest data.

B. Significantly increase "academic articulation" in health care curriculum, study, careers, and re-training planning and funding for very high quality (and sufficiently high quantity) training among public educational and health service institutions in and around Sonoma County.

1. Specifically encourage increased study and dialogue within and between the Sonoma County Office of Education, Santa Rosa Junior College, Sonoma State University, and other educational institutions, plus local hospitals, clinics, other health care delivery systems, and labor unions, which can all work in tandem.

2. Work with labor unions to assist in creating "career ladders."

C. Develop compelling strategies and tactics for retaining health care professionals here in Sonoma County.

D. Employ strategies to significantly reduce hospital and long-term-care facility reliance on "registry" nurses.

E. Champion accelerated and intensified graduate and certificate study in and around Sonoma County – in the traditional fields of health care, in health care public policy development, and in complementary/alternative/integrative medicine.

F. "Offer specific training to clinicians and health and social service providers on such issues as pain management (planned by FUHSI), benefits access, etc." *Georgia Berland*

VII. FURTHER BROADEN THE SYSTEMATIC STUDY OF THE CRISIS AND ITS AMELIORATION – CONSIDER FUNDRAISING

A. With adequate funding, do a systematic review of recent health care literature on community collaboration, data projects, prevention projects, and "humane cost-containment" in the U.S. and abroad – and on Healthy Counties and Healthy Cities initiatives. - Interview experts. Show how advances can be incorporated here and adapted to Sonoma County. Test ideas with local focus groups. Consistently place all learnings in writing and graphics - and place these on local health care educational websites for community learning. Develop hypertext links between them. Consider CDs and print.

B. Through the Initiative Seed Grant, increase offerings of cooperation and planning to and among Sonoma County leaders and institutions in the solicitation of foundation, government, and local funding for developing and implementing advanced approaches to health care service and organization in Sonoma County, our home.

C. "Support existing collaborative efforts to develop needed programs and resources, such as the Sonoma Health Alliance, FUHSI, Health Care for the Homeless, Court Homeless Protocol Project, Center for Social Change, Volunteer Center's training and resource development assistance, Hepatitis C Task Force, Health care Workforce Development Roundtable, Area Council on Aging, Children's Health Access Coalition, Redwood Community Health Coalition, health care careers training initiatives in the Sonoma County Office of Education and schools, the Santa Rosa Junior College, Sonoma State University, other educational institutions, and the efforts in many other local organizations and coalitions." *Georgia Berland*

APPENDIX B: **PUBLIC FORUM TO ADDRESS COUNTY HEALTH CARE CHALLENGES**

Published on March 3, 2007 © 2007- *The Santa Rosa Press Democrat*

BYLINE: KATY HILLENMEYER THE PRESS DEMOCRAT PAGE: B1

Community and health care leaders are providing poor children with health insurance, delivering cost-effective primary care in rural community clinics, and sustaining a family practice training program that attracts high-caliber doctors.

That's the conclusion of a report a Sebastopol consultant will present today at Sonoma State University, where health care analysts and leaders will address the question: ``What can we do locally to solve health care crises in our communities?"

The report and today's forum come in the wake of a series of public meetings trying to determine the impact of the planned closure of Sutter and highlights health care success already in place.

``People don't know how much is solidly in place in the county," said Skip Robinson, who has led a five-year SSU partnership with the community to address health care crises.

“Those people who are saying, `Sutter's leaving, everything's falling apart,' will be heartened by the good things going on."

Robinson and his collaborators launched the initiative in 2002 as a response to the collapse of the 78,000-member Health Plan of the Redwoods.

Many of the same pressures that forced HPR into bankruptcy influenced Sutter's plans to discontinue hospital inpatient care in Santa Rosa, setting the stage for former rival Memorial Hospital to take over most of those services.

The problems are familiar, and threaten to reduce availability and affordability of medical care throughout the region. They include:

* Inflation of health insurance premiums, threatening to overtake workers' wages and prompt more employers to discontinue health benefits.

* Anticipated loss in coming years of doctors, nurses and other health professionals, as many retire and others find the cost of living and doing business here too high.

* Expensive overuse of emergency rooms for conditions better suited to primary care clinics, which drives up costs for the privately insured to make up for uncompensated care.

* Inadequate reimbursements to hospitals and providers.

``As long as you have this disequilibrium in our health care system and rising costs, there will always need to be ... stakeholders and leaders who try to create the equilibrium," said Julie Kawahara of Kawahara and Associates, a Sebastopol consulting firm, who will present a 15-page report today documenting local health care leaders' recent collaborative successes.

Examples include:

* Healthy Kids Project of Sonoma County, which by June 2006, little more than a year after it started, had enrolled and insured 2,577 children from families earning up to 300 percent of the federal poverty level.

* A two-year grant that funded a Summer Health Care Institute for 20 young people interested in pursuing health careers. The institute targeted bilingual Spanish students to help fill local health care organizations' recruitment needs.

* St. Joseph Health System's House Calls and Home Sweet Home programs, which help frail seniors with impaired mobility and lack of insurance or funds for medical services to live independently longer and avoid unnecessary emergency room visits.

* The partnership of Southwest Community Health Center, Sutter, Kaiser Permanente and Memorial that is keeping a nationally acclaimed family practice residency program vibrant.

Presenters also include St. Joseph Health System chief executive George Perez, Sonoma County Medical Association President Dr. Phyllis Senter, and Gil Ojeda, director of the University of California think-tank project on health, the California Program on Access to Care.

Of greatest interest to policymakers, educators and medical professionals may be a panel discussion introduced by UCSF health analyst Annette Gardner, who studied four California counties -- Humboldt, Solano, Santa Cruz and Fresno -- as models of how Sonoma County might strengthen community coalitions.

The counties are similar in population to Sonoma County and have sought innovations to meet the lack of insurance for low-income adults, lack of specialty, dental and mental health services, transportation and geographic barriers to care, and underserved groups including agricultural workers and Medicare recipients.

Coalition leaders from Fresno, Santa Cruz, Solano and Humboldt counties will be on hand today to detail their approaches to leveraging limited health care funding and human resources.

``What works well is the networking and sharing and trading of stories among counties," she said.

You can reach Staff Writer Katy Hillenmeyer at 521-5274 or katy.hillenmeyer@pressdemocrat.com.

FREE FORUM The public is invited to a free forum today titled ``What Can We Do Locally: Health Care Crisis in Sonoma County," from 10 a.m. to 2 p.m. in the Sonoma State University Cooperage. The conference can be viewed via a live video stream at www.sonoma.edu/programs /healthcrisis/. Documents resulting from five years of analysis of health care access in the county are available at the online site.

APPENDIX C:

The New York Times

February 5, 2006

A Hot Trend on Campus: Majoring in Health Care

By ALAN FINDER

Eighteen months after the University of Colorado created a department to prepare undergraduates for a broad range of careers in health care, from medicine to physical therapy to physician assistant, that department already has 1,200 students, making it the second most popular on campus.

A similar program at Stony Brook University, on Long Island, has grown to 370 graduating students last year from 35 four years ago. And at Marquette University, which in 1997 became among the first to offer a basic science degree in human health, the course of study has become more popular than any other.

"It's the fastest-growing major that this campus has ever seen," said William E. Cullinan, associate chairman of the department of biomedical sciences at Marquette, in Milwaukee. "It just exploded beyond anyone's imagination."

Flagship state universities, and private institutions other than the elite, have long drawn large numbers of working- and middle-class students with a pragmatic bent. But university officials say the current generation is particularly attuned to selecting majors with strong career possibilities.

Add to that the plentiful supply of jobs in the growing health care industry, and a result is that health science programs have been taking off not only at Colorado, Stony Brook and Marquette but also at more than a half-dozen other universities across the country, even as disciplines like philosophy, religious studies, humanities and Spanish stagnate or decline on the same campuses.

Whether called biomedical sciences, as at Marquette, or integrative physiology, at Colorado, the majors are devised to give undergraduates a fundamental education in science and health that can lead to a vast array of careers, as optometrists, pharmacists, physical and occupational therapists, radiological technicians and many others, even as doctors.

"At a state university you have kids who are often economically challenged, and this is the stepping stone to a professional life," said Debbie Zelizer, the director of Stony Brook's health science program.

About 70 percent of that program's students are members of racial or ethnic minorities, Ms. Zelizer said, and many are the first generation of their families to go to college.

Beyond job possibilities, students are enthusiastic about these majors because of the appeal of helping people and the excitement of scientific advances in diagnosing and treating disease, experts say.

"My best guess is that the interest we are seeing now is because of the ability of science to address questions we have never been able to face before," said Dr. Paul G. Ramsey, dean of the School of Medicine at the University of Washington. "There is an attraction to help people in a way we've never been able to before."

Some universities developed a health science program after reconsideration of what kind of undergraduate training they should offer students interested in clinical fields like physical therapy, occupational therapy and physician assistant. These once required only a bachelor's degree but now generally call for graduate degrees as well.

Many students find appeal in the new programs because the specialties to which they can lead are various.

Leighton Williams, a 21-year-old senior at Stony Brook, said he had not heard of health science before arriving there. But he gravitated to the major, Mr. Williams said, because of the array of career opportunities it offered.

"It gave me the opportunity to have more than one option as a health care professional," he said.

He is still unsure which specialty he will select, although he may become an anesthesiology technician. He hopes to go to medical school someday, but first he wants to work after graduation.

"Having a skill, that's what attracted me the most to the major," he said. "For me to be able to work and help out at home, that was very important."

Vanessa Fernandez, 22, who graduated from Stony Brook last spring, is spending a postgraduate year in health science there to gain certification as a nuclear medicine technician. Ms. Fernandez plans to work for a few years in nuclear medicine, which involves injecting patients with radiological substances for diagnostic imaging. After that, she says, she may want to go to medical school.

Or, given her options, maybe not. She said her experience in health science had "made me doubt my plans of going on to medical school."

"It's really challenged me, and it's shown me that you can get very far without going to medical school," she said. "It's very respectable."

Whatever the university, the programs generally require basic courses in biology, chemistry and math. But unlike students with majors in conventional biology, for example, those in health science do not take many advanced courses in botany or invertebrate biology, concentrating instead on human biology.

While the various programs tend to share goals and offer comparable courses, however, they do differ in some ways.

At Stony Brook, which was recently awarded a foundation grant to prepare a manual and a formal presentation to explain its program to other universities, health science students spend their first three years taking liberal arts and basic science courses, and then devote their senior year entirely to courses within the major. At Colorado, in contrast, students can take the introductory course in integrative physiology as early as their freshman year.

So new are the programs as a whole that the Association of Schools of Allied Health Professions does not yet collect data on the number of students they have attracted. But evidence of their growth is hardly scarce.

At Ohio State University, the School of Allied Medical Professions introduced a health science major four years ago. It drew 34 students the first year and now has 250.

"We had an expectation just in talking to students that it might be a popular program, but we've been surprised at just how popular it has become," said Deborah S. Larsen, the school's interim director.

At Quinnipiac University in Hamden, Conn., where only 10 students majored in health science five years ago, the number is now about 100, said Edward R. O'Connor, dean of the university's School of Health Sciences.

At the University of South Alabama in Mobile, which claims to have been one of the first to create an undergraduate major in biomedical sciences, more than two decades ago, about 40 percent of the 40 or so students who graduate from the program each year quickly go on to

medical school, said Julio F. Turrens, associate dean of the university's College of Allied Health Professions. (That appears to be a much higher proportion than in most health science programs. Only 4 of last year's 370 graduates in health science at Stony Brook, for instance, went to medical school, said Craig Lehmann, dean of the university's School of Health Technology and Management.)

To be sure, not every university is ready to adopt the model. Emanuel D. Pollack, senior associate dean of the College of Liberal Arts and Sciences at the University of Illinois at Chicago, said the university had not introduced a health science major, out of concern that it would be too broad and unfocused.

"We've largely avoided the generic approach," Dr. Pollack said.

But the programs' students say the breadth is an asset.

Stephanie M. Bohlen, a 19-year-old freshman at the University of Colorado, was so taken by the introductory course in integrative physiology — a study of human systems from cells to circulation — that she decided to major in it.

Ms. Bohlen, a middle-distance runner on Colorado's track team, thinks she may go to medical school or become a specialist in exercise physiology.

"That's one of the reasons I thought it would be a great major to pick," she said. "There are so many different directions you could go with it."

APPENDIX D: A Proposed Sonoma County Health Care Data Project to Assist Needs Assessment, Cost Containment and Health Plan Design

Gilbert Ojeda, Director
UC California Program on Access to Care
University of California Office of the President

Context

- The aftermath of the collapse of Health Plan of the Redwood
- Dramatic double-digit increases in employer provided health plans
- Increases in co-premiums, co-pays and deductibles
- Continued increases in the uninsured, particularly among the working poor
- Reduced capacity by gGovernment, state and county, to address growing demand

The Need for Data in Solution Formulation

- Public-based data for assessing overall public health needs
- Data to support major funding from the sState in these lean and competitive times
- Data to assist non-profit clinics and hospitals in their efforts to secure public resources, foundation funds, and individual contributions
- Data for purchasers to protect health benefits and contain costs
    - Private and public employers
    - Unions

Kinds of Data Available

- State--level hospital discharge data
- Annually assembled county-based data for sState public health mandates
- Data collected by employers and unions based on health plan utilization
- The sState--level California Health Interview Survey of over 80,000 individuals from 2003
- Data from area health providers, including Kaiser Health Plan

What Can We Do?

- Bring together a task force of local resident experts and other interested parties to create a Sonoma County Health Care Profile
- Secure a modest level of funds and in-kind support from local foundations, companies, and public entities to create the First Annual Profile
- Create a data tool ~~which~~ that will assist private and public decision makers and the public in making decisions regarding local health care
- Complete a first-stage project
- Go after a planning grant from out--of--area funding sources to support a proposed network of organizations and individuals to support a multi-year,

county--based effort

The Initiative sincerely thanks . . .

2007: All who brought this final conference together and to its participants

October 2005: The Seed Grant's dinner meeting participants, interviewees, and recorders

2005: Sponsors of the Initiative's Seed Grant Program

- California Program on Access to Care, University of California Office of the President
- Sonoma State University President's Office
- The California Endowment
- Integrative Medical Clinic, Santa Rosa
- North Bay Central Labor Council

2002-2004: Conferences co-sponsors and community partners:

- Sonoma State University: Provost's Office;
  School of Social Sciences;
  School of Science and Technology;
  School of Business and Economics;
  Hutchins School of Liberal Studies;
  Departments of Psychology, Nursing, Kinesiology, Mathematics, Anthropology/Linguistics, and Biology;
  School of Extended Education's Conflict Resolution Certificate Program;
  Office of Community Based Learning;
  Health Professions Advisory Committee;
  Pre-Health Club

- Santa Rosa Junior College
- Community Foundation Sonoma County
- Service Employees International Union Local 707
- California School Employees Association
- Kaiser Permanente Santa Rosa
- California Teachers Association
- North Bay Central Labor Council
- Association of California Health Care Districts
- SEIU Local 707 Nurses Council
- ViewCraft, Inc.
- The Vasconcellos Politics of Trust Network

Thanks also to Sonoma State University faculty, staff, and administration, to staff at the California Program on Access to Care, University of California Office of the President, and to all the participants and committee and conference attendees who contributed to this community-campus effort.

MAJOR STAKEHOLDER GROUPS DEALING WITH THE HEALTH CRISIS IN SONOMA COUNTY