

- How bad is the problem?
- How did Oregon get to this crisis point?
- How does OHSU help the medically underserved?
- What's next?

A Crisis in Health Care Access

Catalyzing a public dialogue to identify solutions

SNAPSHOT:

> *Oregon's health (2004)*

- 1 in 6** Number of Oregonians who lack health insurance¹
- 19** Percentage of employed Oregonians who are uninsured²
- 210,000** Number of uninsured people in the Portland tri-county area alone³
- 37** State rank for health insurance coverage (1 is best)¹
- 45** Percentage of Oregonians who perceive they are not in good health¹
- 60,000** Number of individuals cut from Oregon Health Plan⁴

SNAPSHOT:

> *OHSU's services to low-income patients (2004)*

- \$42 million** Actual cost to OHSU of unpaid care (after all payments)⁵
- 38** Percentage of total patients discharged from OHSU hospitals who are Medicaid or uninsured⁷
- 45** Percentage of children admitted to Doernbecher Children's Hospital from low-income families
- 200** Number of OHSU community service programs
- 1,025** Oregon children that received specialized dental care (71 percent on Medicaid) from the OHSU School of Dentistry
- 63** Percentage of OHSU School of Nursing midwifery services to Medicaid patients
- 80** Percentage of children in CDCR's Care Coordination Program on Medicaid

Oregon's challenge:

- Oregon's health care system is severely compromised for many people.
- About 1 in 6 people in Oregon are uninsured.¹
- Baby boomer health care needs are surging, straining existing capacity.
- Government payments to hospitals for services to low-income individuals are far below actual costs.
- For nearly a century, OHSU has been providing health care services to low-income and uninsured Oregonians.

Solutions and leadership:

- OHSU is committed to the well being of medically underserved populations, including rural communities.
- OHSU encourages a public dialogue to find equitable and compassionate solutions to the crisis of access.
- No single entity can solve this problem alone; all stakeholders must participate.
- Innovative partnerships are needed.
- Legislative leadership and involvement are essential.
- Oregon needs new approaches. The old ways no longer work.
- Together we can find ways to meet the health care needs of all Oregonians.

SNAPSHOT:

> *The four categories of uncompensated health care services*

Charity Services provided at reduced or no cost to patients without insurance or the personal financial resources to pay; hospitals pay all or most of these health care costs.

Medicaid Government insurance/assistance programs for low-income patients that pay at rates far below actual costs; hospitals cover most of each patient's bill. Coverage may be provided under the standard Medicaid or through the Oregon Health Plan. This is the largest group of needy patients in Oregon and at OHSU.

Medicare Government insurance program primarily for senior citizens; while higher than Medicaid, payments are lower than actual costs. Hospitals cover part of each patient's bill.

Bad debt Unpaid services provided to patients who have been determined to have adequate financial resources but choose not to pay. Different criteria by health systems about what constitutes adequate financial resources sometimes confuse the use of this term.

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A Crisis in Health Care Access

The changing landscape

Across the nation, and within Oregon, there is a growing recognition that the health care system is, at best, dysfunctional and, at worst, poised for a crisis of significant magnitude.

More and more people cannot afford health insurance. Baby boomers have reached the age where their demands on the health care system are surging. Many of these aging patients are on fixed incomes and rely on government insurance and assistance. Even as this patient demographic expands, government payments to hospitals are falling further behind the actual costs of providing this care.

While technology improvements and biomedical research are providing clinicians with powerful new diagnostic and treatment tools, such as advanced imaging devices, they are also imposing significant new capital costs on hospitals and academic health centers.

Exacerbating the precarious situation, a nursing shortage is already compromising access to health care, and new reports indicate there will be a parallel nationwide shortage of physicians as early as 2015.

In short, a statewide health care crisis looms that, if left unchecked, will eventually touch every person living in Oregon. Already, a full 17 percent of Oregonians — that's 1 in 6 people — have no health insurance, an increase of 6 percent since the mid-1990s. More than 19 percent of Oregonians who *are* employed still have no access to affordable insurance.

Beyond this, there are an unknown (and likely large) number of people who are underinsured

— opting for catastrophic coverage or other least-cost approaches that don't effectively meet their health care needs — and many other individuals and families teeter just one paycheck away from losing their employee-sponsored group coverage.

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The situation is rapidly worsening as the state's enormous budget problems limit new spending and force reductions in existing health care programs, such as the Oregon Health Plan. Oregon hospitals — the point of access for most low-income, uninsured or underinsured patients — are struggling to balance the needs of these burgeoning populations with rising health care costs and resulting unsustainable revenue losses.

The present circumstance suggests that the old ways no longer work for today's challenges. This issue paper seeks to contribute to solutions by presenting information on OHSU's role in providing health care for Oregon's most vulnerable citizens — past, present and future — and by calling for a vigorous and informed public dialogue on the crisis of health care access. Legislators, health care providers, insurers and community leaders must come together to fix a dysfunctional and economically inequitable delivery system that does not adequately meet the health care needs of vast numbers of Oregonians and threatens the stability of Oregon's hospitals. Without intervention, the health care system and associated safety net for low-income and uninsured individuals will continue to unravel, harming untold numbers of people and ultimately scarring Oregon's economy and overall quality of life.

OHSU: A history of service to the medically underserved

For almost a century, OHSU has been a primary source of hospital care for low-income individuals in Oregon. OHSU is also instrumental in improving health care access for the state's rural communities and provides unique specialized critical care services to all Oregonians. As the state's only academic health center, OHSU has historically assumed these roles as part of its founding mission to improve health care in Oregon.

Since their inception in the 1800s, academic health centers nationwide have fulfilled their missions of protecting and enhancing American health — and in the case of OHSU, the health of Oregonians specifically — with a synergistic approach that focuses on education, research and clinical care. Like other academic health centers, OHSU has always helped pay for the cost to provide health care to low-income Oregonians, as well as the many other social benefits to Oregon emerging from its multi-faceted mission. However, OHSU has never had the means to shoulder the entire cost associated with education or clinical care to needy patients. Instead, OHSU has partnered with the state to enhance and support a health care safety net.

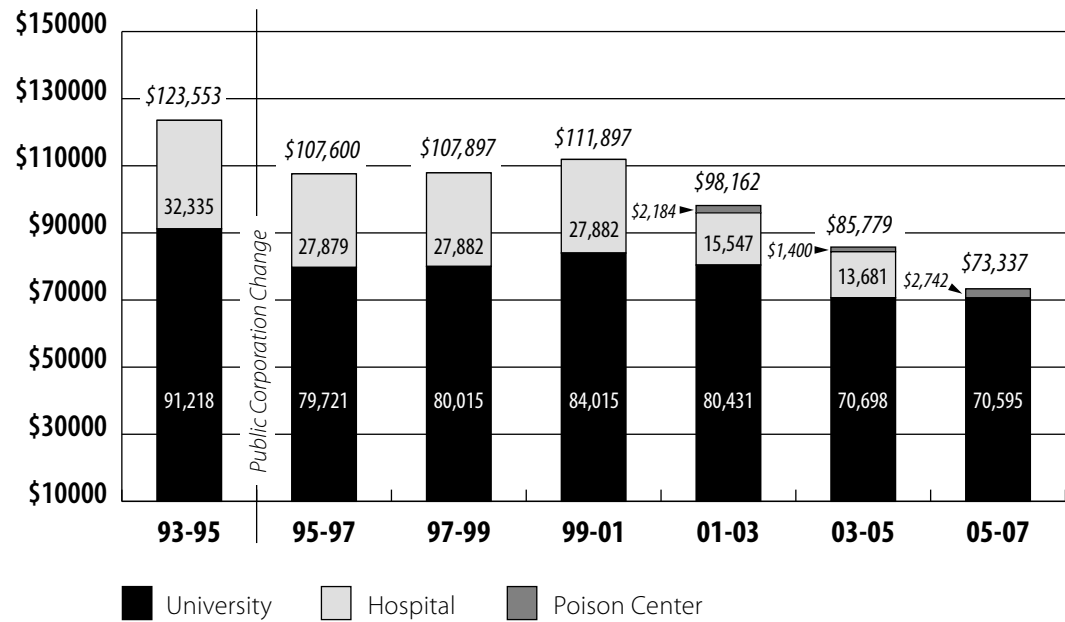
Oregon and OHSU: the roots of the partnership to serve medically needy Oregonians

By definition, academic health centers are charged with producing benefits for society, such as educating doctors, nurses and dentists, improving health care through research, providing access to state-of-the-art clinical care and performing outreach. Recognizing their value to all Oregonians, the state government historically provided support to OHSU to help meet the costs of producing these benefits. A partnership between a state and an academic health center is not exclusive to Oregon or to OHSU. It is a national model that recognizes that the social functions and unique benefits produced by an academic health center are an appropriate use of taxpayer money.

But over the last two decades, as Oregon’s fiscal climate has become constrained, state support to OHSU has dropped. Twenty years ago, this support made up roughly one-third of OHSU’s budget; for fiscal year 2006, it has dropped to below 4 percent. While the low percentage also reflects concurrent growth at OHSU, the amount appropriated by the state has also decreased substantially in absolute dollars, as summarized in the graph below.

OHSU State Appropriations

(dollars in thousands)



Note: Includes lottery dollars

Despite years of accumulating state funding cuts, OHSU has worked diligently to maintain services to thousands of low-income and historically underserved patients. OHSU faculty and health care employees have made considerable sacrifices and have volunteered much of their time and expertise to sustain this level of service to low-income individuals. But now, as the number of uninsured and underinsured individuals keeps growing, this level of clinical service is no longer possible.

At the same time, OHSU is unwilling to forego its historical involvement in caring for needy patients. To do so would be to change the institution in ways that would undermine its core mission to improve the health and well being of people in Oregon and would be unacceptable to its employees, leadership and students. But given fiscal realities, the manner in which OHSU is involved with medically underserved communities must now evolve if the institution itself is to thrive.

The public corporation phase: a quick historical footnote

An important historical, and often misunderstood, detail about the long-standing partnership between Oregon and OHSU was the formation of the public corporation in the mid-1990s. By definition, a public corporation is chartered for a public purpose; it provides crucial services using public property and funding but it retains an operational flexibility to contribute to its own support with activities and revenue generated privately. Many other public and a few academic organizations (for example, the University of California) operate in a similar manner.

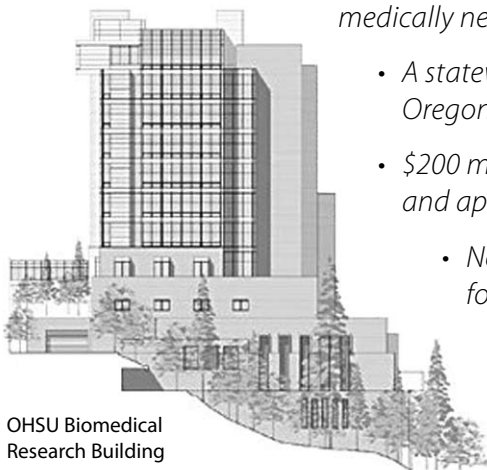
As a public corporation, OHSU assumed responsibility for generating the revenue or other funds needed to support many of its programs and services to Oregon. By definition, however, some of OHSU's educational programs and clinical services are not now, nor will they ever be, self-supporting. Annual state funds to OHSU, for instance, are crucial to help support the operating budgets to educate the next generation of physicians, nurses and dentists and help to offset a part of the costs to provide health care for the low-income and uninsured.

In the wake of continuing declines in state funding, OHSU is striving to generate new revenue to help underwrite these important public service programs. For instance, the construction of new buildings and other capital projects associated with the Oregon Opportunity initiative is part of OHSU's broader strategy to meet the growing demand for health care services from the aging baby boomer demographic in Oregon. New revenue earned by expanding OHSU's ability to treat these insured patients could eventually help somewhat to cross-subsidize aspects of OHSU's mission that are not self-sustaining, like education and services to medically needy populations, although some form of public funding will always be important.

SNAPSHOT

What is the Oregon Opportunity?

- *Unrelated to OHSU's education mission or its services to medically needy people.*
- *A statewide public/private partnership to help make Oregon and OHSU national leaders in biomedical research.*
- *\$200 million in bonds authorized by the Legislature and approved by voters.*
- *Nearly \$300 million donated privately to OHSU for this initiative.*
- *Funding is legally tied to and must be used exclusively for new buildings, lab space, advanced equipment, and to recruit new biomedical researchers to Oregon.*



OHSU Biomedical
Research Building
Construction underway

OHSU's dollar loss for health care to medically needy patients has reached unsustainable levels

More than one-third of OHSU Health System's patients lacked comprehensive insurance coverage in fiscal year 2004. In 2004, OHSU lost about \$42 million by providing clinical services to uninsured and underinsured people. This includes the offset from state appropriations as well as all other payments for four categories of underserved patients: charity/bad debt, Medicaid (or the Oregon Health Plan) and Medicare.⁵

Understanding the different categories of uncompensated health care services is important because many people think that charity health care is the only type of loss hospitals sustain in caring for low-income or uninsured people. In reality, charity care alone is not even the largest part of OHSU's cost to provide health care to these individuals. Rather, the partial government payments from Medicaid and the Oregon Health Plan account for the bulk of the millions of dollars OHSU loses each year in providing these services.

SNAPSHOT

The four categories of uncompensated health care services

1

Charity

Services provided at reduced or no cost to patients without insurance or the personal financial resources to pay; hospitals pay all or most of these health care costs.

2

Medicaid

Government insurance/assistance programs for low-income patients that pay at rates far below actual costs; hospitals cover most of each patient's bill. Coverage may be provided under the standard Medicaid or through the Oregon Health Plan. This is the largest group of needy patients in Oregon and at OHSU.

3

Medicare

Government insurance program primarily for senior citizens; while higher than Medicaid, payments are lower than actual costs. Hospitals cover part of each patient's bill.

4

Bad debt

Unpaid services provided to patients who have been determined to have adequate financial resources but choose not to pay. Different criteria by health systems about what constitutes adequate financial resources sometimes confuse the use of this term.

OHSU Health System had nearly twice as many Medicaid patients as any other metro health system in calendar year 2004: 27 percent at OHSU with 17 percent and 11 percent respectively at Legacy and Providence. In fact, the proportion of OHSU patient discharges that consists of Medicaid patients alone was about 1.7 times the state average.⁶ On top of this, another 19 percent of OHSU's patients in 2004 were covered by Medicare only which, while paying higher than the Medicaid program, also pays less than the cost to provide this health care.

SNAPSHOT

OHSU's services to low-income patients (2004)

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Legislators and the health care community must act to avert a crisis

Adapting to the changing fiscal and health care landscape while maintaining essential social benefits requires foresight, innovation and new sources of revenue. Together, OHSU, the state, the broader health care community, insurers and patients must craft solutions that are financially viable and compassionate so that medically underserved populations, including rural communities, receive adequate health care now and far into the future. Some elements that may contribute to a statewide solution and/or catalyze additional discussion are presented below.

NEXT STEPS

- Share** *the responsibility*
- Leverage** *existing funds*
- Support** *new delivery mechanisms*
- Develop** *sustainable financing*
- Report** *data consistently*

►► ***Share the responsibility***

among hospitals and health care systems

OHSU's unpaid costs associated with uninsured and underinsured services are, in part, higher than other Oregon hospital systems because OHSU often provides health care to patients who suffer from complicated conditions and acute injuries. Not surprisingly, caring for the most seriously ill patients requires costlier clinical interventions and greater specialty expertise than that needed to care for less complex conditions, such as a simple broken bone or a non-serious illness.

This is an important point because first recognizing and then leveraging the unique strengths of individual Oregon hospitals and health systems and acknowledging their geographic referral patterns are essential steps to finding

a long-term solution to the challenge of universal health care access. Given financial realities, the costs for treating uninsured and underinsured patients must be evenly and logically spread among health care systems and hospitals so that all providers are assuming an appropriate economic share.

To help spur a statewide dialogue on health care access, OHSU has begun the difficult process of refining the rules around which it accepts low-income and uninsured patients transferred from other health systems. This effort will clarify how OHSU's unique clinical abilities, including trauma and tertiary expertise, can most efficiently contribute to preserving a health care safety net across Oregon.

The ultimate goal of the still-evolving OHSU policy is to provide transparency on the issue of transfer patients, and to encourage other hospitals and health systems to adopt similar policies that, taken together, will enhance the health care safety net for needy Oregonians without a resulting disproportionate financial loss to one institution. This approach will ensure that in the future, patients feel comfortable accessing emergency or other clinical care at neighborhood or county hospitals while turning to OHSU for

specialty or other services unavailable in the local community. It will also help define the appropriate capacity of each health system to provide health care to the medically needy.

▶▶ ***Leverage existing funds***
by building on old and new partnerships

OHSU is working to leverage scarce dollars in ways that maximize the number of underserved people receiving health care. Such programs may serve as catalysts for the establishment of new health care delivery models that better serve low-income populations. A few representative projects are discussed below.

OHSU is aggressively identifying federal programs and funds to supplement state funding for low-income health care. For example, working with the local community, OHSU was able to designate the OHSU Family Medicine Center at Richmond as a “Federally Qualified Health Center Look-Alike.” About half of the patients at the Richmond clinic are uninsured or covered by Medicaid. The OHSU Family Medicine Center at Scappoose was also designated a federal rural health clinic by the U.S. Department of Health and Human Services. These designations come with enhanced federal funding, allowing more low-income, elderly and special-needs patients to be treated at these clinics.

The OHSU Family Medicine practice at Gabriel Park became one of the latest practices to participate in Oregon’s Medical Home program. The medical home program works to support health care providers in offering comprehensive care to children with special health care needs and their families.

Doernbecher Children’s Hospital is committed to treating needy children and partnering with the state and with private donors in this humanitarian mission. Doernbecher covers unpaid costs of about \$5 million each year from providing health care to uninsured or underinsured children. To help address the funding shortfall, the Doernbecher Children’s Hospital Foundation is creating a special private fund that will allow the hospital and the Department of Pediatrics in the OHSU School of Medicine to care for needy children with conditions that require Doernbecher’s unique expertise. For fiscal year 2005, the hospital board allocated \$1.4 million specifically to help fund specialty care for children whose parents are unable to insure them.

OHSU School of Nursing faculty and students provide health care services for families and children with low incomes. For instance, the school’s primary care clinics in Elgin and Union counties have approximately 4,850 patient visits per year, of which 37 percent are uninsured or Medicaid. About 800 students each year visit the school’s Health Network for Rural Schools in eastern Oregon and half have no insurance or are insured only through Medicaid or the Oregon Health Plan. The School of Nursing midwifery service performs 500 deliveries and sees approximately 3,200 patients per year, 63 percent of which are underinsured.

OHSU dental students and faculty volunteer in dozens of venues around the state, providing screenings, education and care for children, including: Albina Head Start, Beaverton Rotary Dental Care, Clackamas County Community Health Clinics, Give Kids A Smile, health clinics in Hood River and Medford, the HIV Coalition and others.

The School of Dentistry participates in the annual event known as Give Kids A Smile, a public awareness program sponsored by the Multnomah Dental Association. Working with the school nurses from the Multnomah Education Services District, the Multnomah County Health Department and the Multnomah Dental Society, more than 140 children from low-income families visit the dental school and receive free comprehensive dental care on the first Friday of February. Further, the School of Dentistry provides free dental sealants for underserved children in cooperation with Multnomah County Department of Dental Health.

In all, OHSU is involved with about 200 clinics and programs that leverage public funding such as the OHSU Child Development and Rehabilitation Center (CDRC) Care Coordination program (CaCoon). This program contracts with county health departments throughout Oregon to provide expert public health nursing services and support to families of children with special health care needs in the communities where they live. Approximately 80 percent of the children served in the CaCoon program are on Medicaid, 7 percent are uninsured and 6 percent have unknown insurance status.

▶▶ ***Explore new delivery mechanisms***
such as the OHSU/Salvation Army partnership

Another element of a long-term solution to the problem of inequitable health care access is the development of new paradigms that fill service gaps — such as when a sick but homeless person is too ill to be alone on the street, and must be admitted to a hospital because there is no other option, even if such a level (and cost) of care is not clinically needed.

One example of how innovative thinking can address these challenges is the recently announced partnership between The Salvation Army and OHSU. A new 15-bed “infirmarium model” serves homeless patients who are not sick enough to be in a full-service hospital, but who do not qualify for a long-term care facility. This six-month pilot project will provide information that will help in the establishment of similar clinical care efforts throughout Oregon. Another example is the Southwest Community Health Center, a clinic operated twice a week by OHSU medical students, resident physicians and other health care professionals on a rotating basis. The clinic provides basic health care services and referrals on a sliding-scale fee based on income.

▶▶ ***Develop sustainable financing***
for long-term security

While much can be accomplished with legislators, community leaders and health care providers working together in a transparent manner, the core challenge is that funding for low-income health care access cannot be contingent on fluctuating fortunes of the state that result in the necessity of significant structural change each biennium. Sustainable and secure funding for programs that work effectively and cost-efficiently must be identified, prioritized and linked to parameters that objectively define success. Aspects of this are likely to include increasing insurance payments for hospital and trauma care services and ensuring sustainable funding for the Oregon Health Plan or an appropriate alternative.

►► ***Standardize data collection*** *to aid decision-making*

Current efforts to solve the health care access crisis are somewhat complicated by inconsistent data reporting by hospitals and health systems across Oregon. Decision making cannot be based on an apples-and-oranges statistical foundation. Thus, adoption of a uniform methodology for the collection and analysis of data related to uncompensated hospital costs is essential.

Conclusion

As a founding member of Oregon's health care community, and as the state's academic health center, OHSU is committed to advocating for the well being and health care of Oregon citizens. Given the current growth in the number of underserved and the increased cost of providing care to these men, women and children, combined with diminishing financial resources, no single solution will address the challenges and ensure health care access for uninsured, underinsured or otherwise medically needy people. OHSU looks forward to catalyzing and participating in a vigorous statewide dialogue to identify and implement solutions to the crisis of economically inequitable health care access.

For more information, please visit:
www.ohsu.edu/underserved

Footnotes

- 1 Data from Oregon Progress Board 2005 Benchmark Performance Report.
- 2 Robert Wood Johnson Foundation 2005 report: "Characteristics of the Uninsured: A View from the States."
- 3 Data from City Club of Portland 2004 report: "Examining the Health Care Safety Net."
- 4 The Business Journal, April 15, 2005, citing data from Oregon Dept. of Human Services for period February 2004 to April 2005.
- 5 The \$42 million is calculated based on unpaid hospital costs. Hospital costs are the expense a hospital or other provider actually incurs to perform a service. Such data are not generally widely released and vary widely across hospitals and health systems based on salaries, technology investment, patient acuity and many other factors. In contrast, hospital charges are the amount that any given provider charges for specific procedures and clinical services. These public domain data differ by hospital due to type of service, mission, technology, patient mix and subspecialty expertise. Costs are always less than charges at all hospitals; the extra revenue subsidizes health care for underinsured or uninsured people (a practice referred to as "cost shifting.") Based on hospital charges, \$192 million was not paid to OHSU in 2004 (charity/bad debt – \$58 million; Medicaid – \$134 million). OHSU does not typically report these numbers because it is misleading; providers don't expect to be paid fully for all charges and the actual loss, as opposed to foregone revenue, a hospital experiences due to uncompensated care is only the difference between its costs to provide any given service and the payment it receives for that service.
- 6 Data submitted to and compiled by Oregon Association of Hospitals and Health Systems (OAHS).
- 7 Data are for OHSU fiscal year 2004; compiling data over the calendar year results in 34 percent.



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OHSU includes the schools of dentistry, medicine, nursing, and science and engineering; OHSU Hospital and Doernbecher Children's Hospital; numerous primary care and specialty clinics; multiple research institutes; and several outreach and community service units.

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