2007 Access to Health Care Study

Expanding the Availability of Quality Health Care in Our Community

Public Policy Institute

A Report to the Citizens of Marion County

Summer 2007

The Public Policy Institute of Marion County

The Public Policy Institute of Marion County is a non-profit, non-partisan organization dedicated to advancing public interest, building democracy, enhancing community, and improving the quality of life by involving citizens in the process.

Vision:

To provide leadership in developing and implementing short-term and long-term goals and solutions for an improved community.

Mission:

To give the community a sense of hope and optimism by creating a broad base of community involvement in identifying, researching and establishing dialogue on community-wide issues, and then in recommending and helping to implement timely solutions.

Objectives:

- To provide formal and informal networks for individuals to come together to share their knowledge, resources and experiences.
- To periodically identify a short-term community project that can be accomplished in a 12-18 month period with meaningful results.
- To provide a process where community leaders can work through problems and participate in open discussions, conferences, and seminars.
- To involve a broad range of individuals in the process, to generate dynamic, creative and catalytic leadership in addressing each critical issue, and to provide enduring solutions.
- To create a shared sense of community, in that any issue must be addressed, discussed, and debated in an atmosphere of mutual fairness, respect, civility and sincerity to all others where the highest aspiration is to serve the common good.

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Executive Summary

In September 2006, the Public Policy Institute ***2007 Access to Health Care Study*** Committee began an 8-month process to analyze and evaluate existing conditions and services, and to develop recommendations that can be implemented locally to enhance access to health care in Ocala/Marion County. The process started with a community event to announce the 2007 study topic and was highlighted by a keynote speech from Brian Klepper, President of the Center for Practical Health Reform, a non-partisan national effort to re-establish stability and sustainability in American health care.

Klepper underscored a disturbing national trend outlined by the Kaiser Family Foundation report on employer health benefits, which stated that over the five-year period from 2000-2005 the percentage of employers offering health insurance coverage to their employees had plummeted by 13 percent. He emphasized Florida's risk in this regard due to its high percentage of small businesses – 95% in Florida and Marion County – which are particularly susceptible to the impact of increased health care and health insurance cost, a primary motivator of this trend. Klepper also noted a report from the Florida Office of Insurance Regulation stating that between 1996 and 2004, while Florida's population grew by 3 million people, 130,000 small Florida businesses dropped health insurance coverage as an employee benefit.

Among the most pressing corrective measures suggested by Klepper for this, and the other trends outlined in the study that impact access to health care for residents of Marion County, is the need for transparency throughout the health care and insurance industries. The ***2007 Study: Access to Health Care*** documents the findings of the study committee in concurrence with Klepper's forecast and outlines recommendations identified during the study process to address these key concerns.

During the course of the past eight months, meeting on a weekly basis, the 62 members of the study committee heard from 46 speakers on a broad range of topics related to health care access. As a result of those meetings, the seriousness of the circumstances in which we find ourselves became clear.

Between 2000 and 2005, the number of uninsured residents in Marion County increased 30.3 percent compared to 23.4 percent for the population as a whole. In 2006, there were nearly 48,000 non-elderly uninsured in Marion County representing 20.3 percent of that population below age 65, not including those receiving Medicaid support. Over 37,000 of these non-elderly uninsured residents live within families with one or two full-time workers. Why don't they purchase insurance coverage?

The actuarial firm Milliman calculated that in 2005 total coverage costs annually for a family of four averaged $12,214. In 2006, the Department of Housing and Urban Development (HUD) reported the median household income for a family of four in Marion County as $ 44,900. According to the ***Marion County Health Needs Assessment*** coordinated by the WellFlorida Council, Inc., 30 percent of Marion County households have incomes less than $25,000 compared to 24 percent for the state. These findings demonstrate the financial inability of a

major segment of our population to afford health insurance. This lack of insurance directly impacts access to basic health care.

According to a study released by the National Association of Community Health Centers (NACHC) in Bethesda, Md., and the Robert Graham Center located in Washington, D.C., nearly one in five Americans does not have ready access to a source of primary health care.

In a related issue, many Americans who are covered by health insurance are not prepared for the significant and increasing shortage of primary health care options. The NACHC report, ***Access Denied: A Look at America's Medically Disenfranchised,*** found that 56 million Americans lack access to basic medical care because of a local shortage of primary care physicians. According to WellFlorida Council's 2007 Health Needs Assessment for Marion County, the number of physicians in our county is 30% less than the Florida county average.

In light of these sobering statistics, the scope of this PPI study examines the capacity and effectiveness of public and private providers in meeting the health care needs of the community, defines the policy implications of rising health care costs, identifies infrastructure factors that affect access to health care, and charts a plan of action to support study recommendations. These study recommendations were grouped into the following study sections: the medical professional shortage, gateways to access, primary care needs, medical records transparency, school wellness education and health care, public awareness, and insurance availability.

Major study recommendations include: the need to increase the number of health care professionals in Marion County, a plan for the establishment of a Federally Qualified Health Center (FQHC), the implementation of a regional health information organization (RHIO), support for sustaining Marion County school wellness policy regarding nutrition education, physical education and physical activity, the expansion of public education including awareness of health care options and preventative measures, and the development of insurance alternatives.

This report is a consensus of perspective on complex issues. Study recommendations outline a plan of action to address the gap between the need for health care and the availability of services, disparities related to primary care and specialty care, emergency room staffing and management, and the rising costs associated with pharmaceuticals and medical insurance.

The key study recommendation calls for the establishment of an Access to Health Care Planning Organization (AHCPO) to engage federal, state, and local sources in order to improve access to health care in Marion County. The AHCPO will advocate for the funding needs identified by the critical needs areas outlined in the study and will meet quarterly beginning in the fall of 2007 to implement the recommendations contained in this report. Please contact the Public Policy Institute if you have an interest in participating in this process.

Dyer Michell, Study Chair
2007 Study: Access to Health Care

Scope of Study

Regardless of race, gender, income or insurance status, affordable access to quality health care is a national concern. Even though the United States spends a higher percentage of its Gross Domestic Product on health care than any other industrial nation, there appears to be a growing concern about the gap between the need for health care and the delivery of services, and disparities related to primary care, emergency room staffing and management, specialty care populations, pharmaceuticals, and medical insurance. The purpose of this study is:

- To research the effectiveness of public and private providers in meeting the health care needs of the community
- To determine the causes and policy implications of rising health care costs
- To identify infrastructure factors that affect access to health care
- To study funding sources and other incentives for health care administration
- To understand issues related to the delivery of indigent health care
- To explore any best practices for how other communities have addressed access to quality health care
- To develop recommendations on how Marion County can address the prevalence of and effects of health care on the Marion County population that have no health care insurance
- To develop recommendations to address any identified issues

Highlights

Major Problems

1. The rising cost of health care and health insurance has increasingly pushed businesses, particularly small employers, to reduce or drop their insurance benefits for employees. This has resulted in increased numbers of uninsured and underinsured patients, limited alternatives for primary care, increased mortality and morbidity, and higher health care costs for this group.

Solutions to the Problems

1. Advocate at the state and federal levels for insurance reform designed to increase the availability of public and private insurance, including mandatory coverage for children. Encourage the business community, Ocala/Marion County Economic Development Corporation, Inc. (EDC), and the Ocala/Marion County Chamber of Commerce to consider best practices from other communities and states where three-share insurance program models are in use (government, employer, individual) to reverse employer health benefit losses.

Highlights (Continued)

Major Problems (Continued)	Solutions to the Problems (Continued)
2. A significant and growing shortage of physicians, nurses, and other health care professionals is limiting capacity in the health care system at all care and economic levels, but particularly for the poor, to the degree that health care resources are no longer able to meet the demand for services.	2. Through a broad based task force, develop a regional and national marketing plan designed to promote Marion County and local health care providers to prospective physicians, nurses and other health care professionals. Investigate potential opportunities to attract/grow physician residency programs. Advocate at the state level regarding educational requirements for nursing educators. Expand local educational opportunities for health care professionals. Establish a Federally Qualified Health Center in Marion County at the earliest possible date.
3. The comparatively slow rate of acceptance by much of the health care industry of contemporary automation technologies has limited the ability of the industry to cope effectively with increasing volumes of data and information, and therefore its ability to streamline services and costs to the best advantage for all. This has negatively impacted the efficiency and quality of care.	3. Recommend the establishment of a Regional Health Information Organization in the greater Ocala area. This RHIO should have the capacity to electronically facilitate the exchange of medical records between authorized health care providers, while compiling and maintaining patients' integrated lifetime health records on a secure site. The infrastructure should permit patients to authorize access to these records when it is necessary to facilitate the quality and efficiency of their care.
4. There has been limited success by governmental, social and institutional leadership in promoting positive health lifestyle change and controlling diverse destructive factors. These lifestyle issues have a significant impact on health and on health care demand, cost and capacity.	4. Develop and implement a broad, age specific, public education/marketing program designed to promote cultural change toward healthy living. This should address health system confusion, negative cultural health factors, preventative needs, and access issues. Utilize a multi-tiered approach including all available technologies to communicate information.

Key Findings: Barriers to Access

INADEQUATE HEALTH INSURANCE

- Without health insurance, patients are more likely to postpone or forgo needed medical care and prescription medicines.
- In 2006, there were approximately 48,000 non-elderly uninsured in Marion County, 20.3 percent compared to 19.2 percent for the state.
- Between 2000 and 2005, the number of uninsured residents in Marion County grew 30.3 percent compared to 23.4 percent for the population as a whole.

ABSENCE OF A REGULAR SOURCE OF CARE

- Without access to a regular source of care, patients have greater difficulty obtaining incident care, receive fewer maintenance doctor visits, and have more difficulty obtaining prescription medication.
- Low-income and minority groups in the United States are less likely to have a medical home for primary care and are more likely to use emergency rooms and clinics as their regular source of care.
- Home and community-based services including home health care, adult day care or day treatment, and medical equipment related expenses were considerably higher for Marion County (15.0 percent) compared to Florida (9.5 percent).

CHILD HEALTH CONCERNS

- Marion County has 52 schools with 42,431 students. Marion County has 13 full-time school-based nurses in 13 schools assigned to 7,903 students.
- Obesity is a significant contributing factor in increasing the demand for health care services.
- Approximately 60 percent of overweight children have at least one risk factor for cardiovascular disease such as high blood pressure or high cholesterol.
- In 2005, 14.4 percent of high school students were at risk for overweight and an additional 10.9 percent are overweight.
- In 2005, more than 60 percent of high school students did not participate in any physical education at school. In 2005, 31.3 percent of middle school students did not go to physical education classes at all during an average school week.
- In 2005, approximately 21.9 percent of Florida high school students ate 5 or more servings of fruits or vegetables each day during the past 7 days. In 2005, only 22.0 percent of middle school students reported eating five or more servings of fruits and vegetables per day.
- In 2005, on an average school day, 49.5 percent of middle school students watched television for three or more hours, 20.5 percent used the computer for fun for three or more hours, and 17.1 percent reported playing video games for three or more hours.

Key Findings: Barriers to Access (Continued)

INSUFFICIENT FINANCIAL RESOURCES

- The impact on access appears to be greater for low income and minority populations.
- Minorities are more likely to be enrolled in health insurance plans which place limits on covered services and offer a limited number of health care providers.
- As of December 31, 2006 there were 40,068 Medicaid eligibles in Marion County. The number of Medicaid eligibles in Marion County increased by 7 percent between 2002 through 2006.
- 35.3 percent of Marion County residents live under 200% of the federal poverty level, which equates to a gross annual income of less than $ 41,300 for a family of four.

PROVIDER SHORTAGE

- Access to medical care is limited due to lack of an adequate number of primary care practitioners, specialists, and diagnostic facilities.
- The number of physicians per 100,000 population in Marion County is 156.3 compared to 223.9 for the state of Florida.
- Both nationally and in Marion County, health care providers are frequently affected by the nursing shortage such that even if facilities have available space to provide care they operate below capacity due to the unavailability of nurses, nursing assistants, and patient care technicians.

STRUCTURAL BARRIERS

- These barriers include lack of transparency of patient information, the need for access to a health care home for uninsured and underserved populations, and limited appointment availability including the timeliness of follow-up appointments.
- In Marion County, Emergency Medical Services (EMS) ambulance response times have been lagging for the past three years in urban, suburban, and rural zones.
- Marion County EMS ambulance response times are lagging behind national density matched response times by 25% in the urban zones, 14% in the suburban zones, and 20% in rural zones.

LINGUISTIC BARRIERS

- Language differences restrict access to medical care for minorities who are not English-proficient.

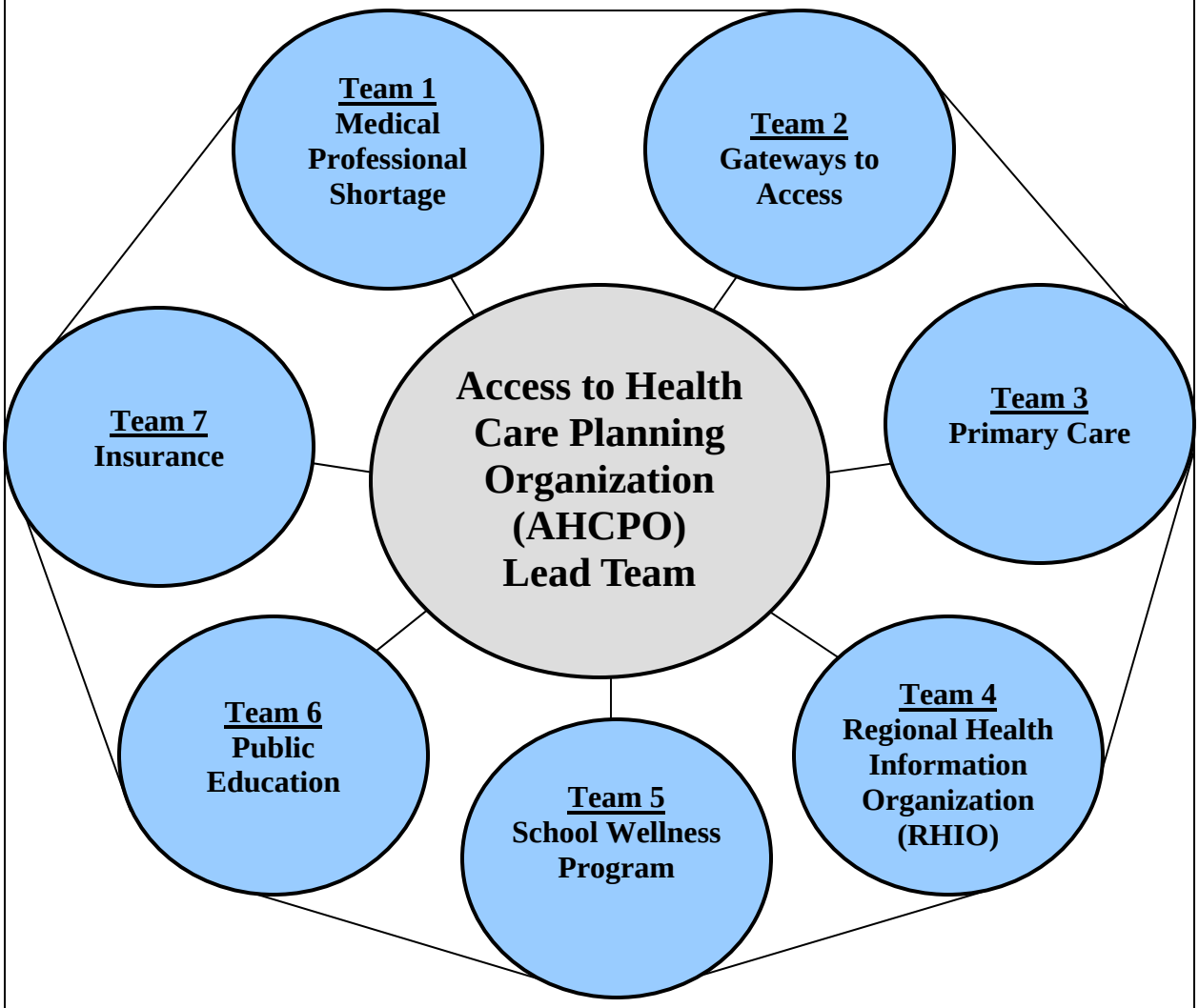
HEALTH LITERACY

- Access to health care is limited when individuals have difficulty or cannot obtain, process, and understand basic health information. This barrier to access is more prevalent in, although not limited to, lower socioeconomic status and education levels.

Source: Demographic data provided by WellFlorida Council, Inc. www.wellflorida.org. Child Health statistical data sourced from Florida Department of Health Current Trends and Statistics for Obesity. www.doh.state.fl.us/Family/obesity/stats.html

Key Recommendations

Access to Health Care Planning Organization (AHCPO)
Organizational Chart:



Key Recommendations

Key recommendations address local actions that can improve access to quality health care that is affordable for both present and future residents of Marion County.

Access to Health Care Planning Organization

To ensure appropriate ongoing consideration and implementation for all study recommendations, the Study Committee recommends the establishment of a continuing Access to Health Care Planning Organization [see AHCPO chart, page 10]. Under this structure, the Lead Team would include, at a minimum, the chairperson from each of the other recommendation teams and representatives from the Board of County Commissioners, Munroe Regional Health System, the Marion County Medical Society, the Marion County Health Department, the Marion County School System, the large and small business sectors, and a patient advocate. Additional members might include representatives from other related organizations and agencies.

The Lead Team would function as the central clearing house/cross fertilization and reporting entity for the other recommendation teams to insure optimum cross communication among all teams. Additionally, recognizing the commonality of funding concerns by all teams, the Lead Team would serve in support of the other teams by identifying, evaluating, prioritizing, and promoting potential funding sources for study recommendations outlined in this report.

Implementation Teams: Key Findings and Study Recommendations

Seven other teams would be established to address major study recommendation categories. Each team would be comprised of PPI study committee members in addition to representatives from the responsible organizations noted in the team implementation agendas defined in the report. The teams would report implementation progress to the AHCPO on a quarterly basis. It is proposed these meetings would begin in the fall of 2007.

Medical Professional Personnel Shortage: Key Recommendations

The number of physicians, nurses and other health care professionals in Marion County should be increased to meet current and future local demand by organizing, designing, and implementing a strategic marketing campaign to recruit these individuals. Advocacy at the local, state, and national levels should be explored to encourage reassessment of the educational and salary requirements for nursing faculty, expand local educational opportunities, provide financial and housing incentives for health care professionals in critical shortage areas, and improve residency partnerships

Gateways to Access Linking Individuals to Care: Key Recommendations

Transportation alternatives throughout Marion County should be coordinated and expanded to better meet current and future demand. Emergency Medical Services and fire rescue response times should meet national density matched response time standards. Public education on proper use of 911 emergency call service should be enhanced. Routes and schedules for SunTran and Marion Transit Services should be coordinated to address access to health care needs. Telemedicine should be evaluated as an alternative to reduce the need for patient transport.

Key Recommendations (Continued)

Primary Care Development : Key Recommendation

A Federally Qualified Health Center (FQHC) should be established in Marion County at the earliest feasible date to provide access to health care and a medical home to the uninsured and underinsured population. With the accomplishment of this goal, the Marion County Health Department and Marion County Medical Society WeCare Program patient qualification levels should be increased from 125% to 200% of the federal poverty guideline. Additionally, these services should be evaluated to determine the benefit in increasing staff and hours of operation.

Regional Health Information Organization (RHIO): Key Recommendation

A Regional Health Information Organization (RHIO) should be developed and implemented in Marion County in order to increase efficiency and quality in the provision of health care through portability of patient information and transparency of outcome data.

School Wellness Program Physical Education/Physical Activity: Key Recommendation

Health and wellness should continue to be emphasized in every school, including: significantly increasing the number of school nurses, continuing improvement of the school nutrition program and wellness education curriculum, implementing technology-based education programs designed to enhance student wellness, reduce obesity, and establish healthy life long eating habits and activity patterns. Utilize low-cost information sharing vehicles such as pod casts, student-focused web pages, and the RHIO.

Public Education: Key Recommendation

Support the development of a community education initiative to encourage individuals to exercise greater responsibility for their own health and more effectively respond to health care deficiencies. Delivery of education objectives should focus on immediate and future access and resource issues and should be age-specific for youth, middle-aged persons, and seniors.

Insurance: Key Recommendation

Explore affordable health insurance options for the uninsured and underinsured by considering best practices including national and state community-based programs [*For additional information, please see Supplement E, page 47-50*].

Study Framework: Access to Health Care Planning Organization Lead Team

KEY FINDINGS:

The Study Committee identified the need to establish a continuing Access to Health Care Planning Organization (AHCPO) Lead Team to function as the central clearing house/cross fertilization group for the seven topic teams illustrated in the organizational chart [See page 10].

STUDY RECOMMENDATION:

Establish a continuing Access to Health Care Planning Organization (AHCPO) to insure communication among all teams and identify, evaluate, prioritize and promote potential funding sources for recommended access enhancement objectives from the various study recommendation topic teams. The seven teams correspond to the study topic sections detailed in the Study Framework.

RESPONSIBLE AGENCY/ORGANIZATIONS:

The team members of the AHCPO Lead Team should include, at a minimum, the chairperson from each of the other recommendation topic teams and a representative from each of the following:

- Marion County Board of County Commissioners
- Ocala/Marion County Chamber of Commerce
- Ocala/Marion County Economic Development Council, Inc.
- Munroe Regional Health System
- Marion County Medical Society
- Marion County Health Department
- Marion County Public Schools
- Large and small business/employer sectors
- Local legislative delegation members or their designees
- Patient Advocate
- Representatives from other related organizations and agencies

Study Framework:
Access to Health Care Planning Organization Lead Team (Continued)

IMPLEMENTATION AGENDA:

The AHCPO will advocate for the funding needs of each of the seven teams wherever possible in regard to:

- Securing private/public grants wherever possible.
- Increasing revenue generation from agency/entity operations (Health Department, RHIO, FQHC, other).
- Acquiring funding from the Marion County Hospital District for professional recruitment/education needs, and FQHC/RHIO support.
- Exploring the feasibility of local funding options for Health Enhancement/ Quality of Life solutions by public referendum for clearly defined applications.
- Identifying and reallocating funding mechanisms that become obsolete as improvements are made.
- Engaging Federal, State, and local sources to fund health care initiatives, in order to improve access to health care in Marion County.

TIME FRAME:

The Access to Health Care Planning Organization will coordinate the implementation of study recommendations at quarterly meetings to begin in the fall of 2007.

Study Committee at Work:
Members discuss recommendation revisions during a Process Meeting in the Founders Hall Board Room at Central Florida Community College, April, 2007.

Study Framework: Medical Professional Shortage Team

KEY FINDINGS:

Access to medical care is limited due to lack of an adequate number of primary care practitioners, specialists, and health care facilities. The number of physicians per 100,000 population in Marion County is 156.3 compared to 223.9 for the state of Florida pointing to a shortage of available medical care practitioners to meet the community demand for health care.

Number and rate of active and licensed medical doctors and doctors of osteopathy, Marion County and Florida, 2007

Region	Number by Type			Rate Per 100,000 Population
	MD	DO	MD/DO Total	
Marion County	470	42	512	156.3
Florida	38,704	3,454	42,158	223.9

Source: Florida Department of Health Division of Medical Quality Assurance, 2007.
Note: MD's and DO's refer to active licensed physicians with a known address within the specified area. MD's and DO's are counted without adjustment for hours worked.
Prepared by: WellFlorida Council, 2007.

STUDY RECOMMENDATION:

Increase the number of doctors, nurses and other health care professionals in Marion County by organizing, designing, and implementing a strategic marketing campaign to recruit health care professionals. Advocate at the state and national levels for reassessing the educational requirements for nursing faculty, expanding local educational opportunities, providing financial and housing incentives for health care professionals in critical shortage areas, and improving residency partnerships.

IMPLEMENTATION AGENDA:

- Organize a working group to design and implement a national marketing campaign to recruit physicians. The community-based campaign should utilize organizations such as the Ocala/Marion County Chamber of Commerce, Ocala/Marion County Economic Development Corporation, Inc. (EDC), and CLM Workforce Connection. Targeted advertisements should focus on the "come play and stay" concept, address "trailing spouse" concerns, and include attraction of bilingual professionals.

- Expand health sciences programs in Marion County elementary and secondary schools to teach students about opportunities in health care. High school curriculum should include prerequisite courses for RN and LPN programs and the bridge format should be expanded to increase the number of qualified nursing student applicants at the associate, baccalaureate and master's degree levels.

Study Framework: Medical Professional Shortage Team (Continued)

IMPLEMENTATION AGENDA (Continued):

- Develop a program to enhance the provision of low-interest educational loan assistance and sponsored "debt-forgiveness' for physicians by local business and industry in partnership with local lenders and hospitals as a relocation incentive.

- Improve and increase rotation/residency programs in coordination with the University of Florida/Shands, Central Florida Community College, University Center partners, Marion County physicians and hospitals.

- Utilize J-visa waiver to recruit foreign physicians.

- Continue to advocate through the federal legislature changes in requirements in order to better "open the door" for international nurses, both practitioners and faculty.

- Appeal to physicians 18-24 months prior to completion of their residency program regarding recruitment through marketing fairs and orientation receptions.

- Hospitals should continue to offer an incentive program for "home grown nurses" to remain in Ocala after graduation.

- Integrate smart-growth concepts throughout the community to provide affordable workforce housing and relocation/residency incentives to essential services personnel* including RN's and ARNP's. *(*See 2006 PPI Affordable Housing Study)*

- Investigate the potential for provision of child care support for nursing students and practitioners on a community-supported basis.

- Local faith-based organizations, businesses, and civic organizations should scholarship nurses to facilitate broad community support in an effort to encourage recent graduates to remain in the community.

- Investigate methods to allow for a substantial increase in the base salary for MSN faculty at community colleges.

- Encourage the creative utilization of retiring and near retirement nurses.

- Encourage physicians to increase time with patients by utilizing physician assistants and ARNP to relieve physicians for more critical diagnostic care.

- The Medical Society, area hospitals, and community relations organizations should sponsor physician orientation conferences and enhance communication among physicians.

Study Framework: Medical Professional Shortage Team (Continued)

RESPONSIBLE AGENCY/ORGANIZATIONS:

- Multiple----Public schools, community colleges, universities, hospitals, health care providers, businesses, Ocala/Marion County Chamber of Commerce, Ocala/Marion County Economic Development Corporation, Inc. (EDC), and CLM Workforce Connection, state and national nursing professional organizations, and community funding sources (impact fees, local, state and federal legislatures, other grants, etc.)

TIME FRAME:

The Access to Health Care Planning Organization will coordinate the implementation of study recommendations at quarterly meetings to begin in the fall of 2007.

Study Framework:
Gateways to Access Team Linking Individuals to Care

KEY FINDINGS:

In Marion County, Emergency Medical Services (EMS) ambulance response times have been lagging for the past three years in urban, suburban, and rural zones. This is a result of an increased call load of more than 2000 new calls each year, increased traffic congestion, longer patient transfer times in hospital emergency departments, and an inability for the current funding of the EMS service to keep pace with explosive growth in demand. The 9-1-1 emergency call system is currently being misused by the public for non-emergency situations and is therefore further burdening overwhelmed emergency management services.

Public transportation services such as SunTran and Marion Transit Services are not currently able to meet the growing demand for access to health care needs in rural and suburban areas.

STUDY RECOMMENDATION:

Transportation alternatives throughout Marion County should be coordinated and expanded to better meet current and future demand. Emergency Medical Services and fire rescue response times should meet national density matched response time standards. Public education on proper use of 9-1-1 emergency call service should be enhanced. Routes and schedules for SunTran and Marion Transit Services should be coordinated to address access to health care needs. Telemedicine should be evaluated as an alternative to reduce the need for patient transport.

IMPLEMENTATION AGENDA:

- Create understanding that emergency response and transport services provided through Emergency Medical Services Alliance (EMSA) and the Ocala/Marion Count Fire Rescue need to be supported and expanded in order to meet the emergency access demands of the population.

- Educate the public regarding proper use of 9-1-1 in order for non-emergency situations to be appropriately triaged so that already overwhelmed emergency departments (ER) are not further burdened and to ensure that relevant emergency transport resources are properly dispatched.

- Refer 9-1-1 calls screened as low acuity to another type of service. Specifically, upon receipt of the incident, the service sends out a nurse practitioner and a medical technician in a full service vehicle and treats the non-emergency patient at home.

- Coordinate routes and schedules for SunTran and Marion Transit Services to improve access to health care through public transportation alternatives.

- Evaluate the feasibility of providing transportation to medical facilities for patients in great need who live in remote areas.

Study Framework:
Gateways to Access Team Linking Individuals to Care (Continued)

- Telemedicine can also be an acceptable substitute for transportation of patients. Access to health care can be enhanced through rapid access to shared and remote medical expertise by means of telecommunications and information technologies.

- Utilize other health care partners, the school system, homeowners associations, and churches to educate youth and other more frequent and likely health care system users regarding the appropriate means to access health care.

- Actively participate with the proposed Regional Health Information Organization (RHIO).

- Implement a pilot Basic Life Support Transport Function in 9-1-1 EMS system to better utilize advanced paramedic capabilities for acute patients.

RESPONSIBLE AGENCY/ORGANIZATIONS:

- Marion County
- Marion County Health Department
- Emergency Medical Services Alliance
- SunTran
- Marion Transit Services
- Central Florida Community College
- Marion County Public Schools

TIME FRAME:

The Access to Health Care Planning Organization will coordinate the implementation of study recommendations at quarterly meetings to begin in the fall of 2007.

Study Framework: Primary Care Team

KEY FINDINGS:

Without a regular source of primary care, patients have great difficulty in accessing timely care, experience fewer doctor visits, are at a higher risk from undiagnosed and untreated disease, and have more difficulty obtaining prescription medication. Low-income and minority groups are less likely to have a medical home for primary care and are more likely to use emergency departments and walk-in clinics as their regular source of care.

STUDY RECOMMENDATION:

Establish a Federally Qualified Health Center (FQHC) to increase the primary care base and provide a medical home for the uninsured and underinsured population. With the accomplishment of this goal, increase the Marion County Health Department and WeCare Community Health Services patient qualification level to 200% of the federal guidelines and evaluate the feasibility of increasing staff and hours of operation of both services.

IMPLEMENTATION AGENDA:

- Implement the strategy for creation of an FQHC through the Heart of Florida Health Center.
- Investigate and implement as feasible a medical campus in northwest Marion County to provide an additional access point for care that will also serve as an educational venue to encourage preventative care and as a platform for specialized care such as a dialysis unit. Encourage the offering of land incentives through a city/county partnership and the development of additional office space to be leased to primary care and specialty care physicians in order to bring services to this underserved community.
- Promote at all levels to reduce the impact of the uninsured and underinsured on the health care system through prevention measures provided by the Federally Qualified Health Center (FQHC) and through promoting and enhancing services provided by the WeCare program and the Marion County Health Department.
- Implement a program to educate health care providers regarding the already existing sovereign immunity protections set forth in sections 768.28 (9) and 766.1115 of the Florida Statutes in order to encourage health care providers to volunteer their time to help care for the uninsured and disadvantaged.

RESPONSIBLE AGENCY/ORGANIZATIONS:

- Heart of Florida Health Center (HFHC)
- Marion County Health Department
- Local hospitals and physicians

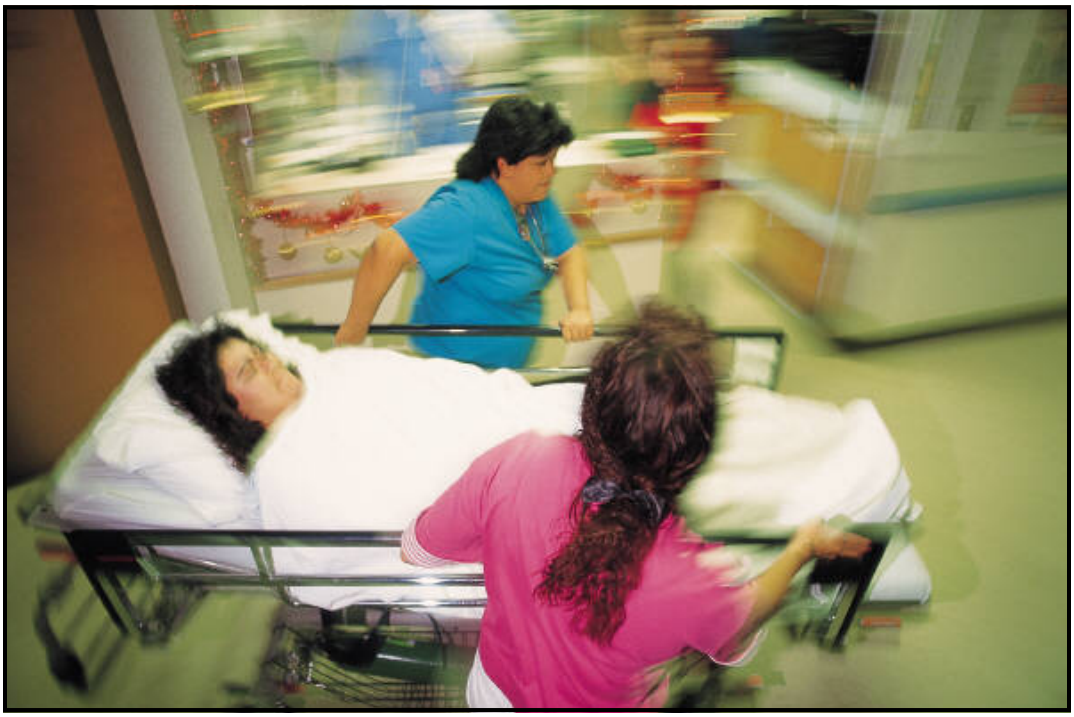
Study Framework: Primary Care Team (Continued)

RESPONSIBLE AGENCY/ORGANIZATIONS (Continued):

- Ocala Regional Kidney Centers
- Marion County
- City of Ocala

TIME FRAME:

- The Access to Health Care Planning Organization will coordinate the implementation of study recommendations at quarterly meetings to begin in the fall of 2007.
- Response to federal application for FQHC expected September, 2007.
- FQHC opening- January 2008.
- Northwest medical campus site planning and development– to be determined.



Study Framework:
Regional Health Information Organization (RHIO) TEAM

KEY FINDINGS:

Most health records in the community are either maintained only in paper form or are maintained electronically in systems that are not accessible outside of the facility where they were generated. This results in much of the relevant patient health care information not routinely being available at other points of care. When relevant records are not available at the point of care: (1) tests are unnecessarily repeated, which is costly and may be detrimental to the patients' health, and (2) medical errors may result. Data regarding patient outcomes and effectiveness of care need to be obtained to provide transparency of information necessary for quality improvement.

STUDY RECOMMENDATION:

Obtain and implement a health information exchange infrastructure in the Greater Ocala area that electronically facilitates the exchange of medical records between authorized health care providers, while compiling and maintaining patients' Integrated Lifetime Health Records. The infrastructure should permit patients to authorize access to these records when it is necessary to increase the quality and efficiency of the health care they receive.

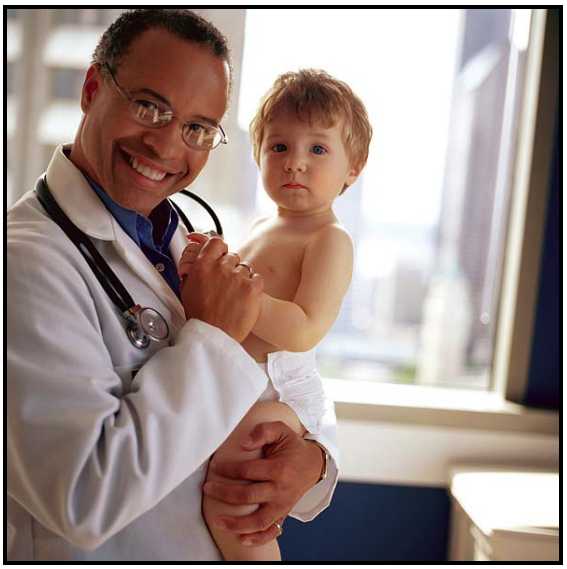
IMPLEMENTATION AGENDA:

- Establish a broadly-based regional health information organization (RHIO) to obtain, implement and manage the operation of the community's health information exchange infrastructure that facilitates sharing health information. It is important that this organization be answerable to the community to ensure it meets the needs of patients, health care providers and the other stakeholders.
- Remove the financial, technological and efficiency barriers to physician adoption of technology necessary to enable health records currently being maintained in paper form to be stored electronically.
- Encourage patients to establish their own electronic Integrated Lifetime Health Records, which will be maintained for them in trust, and authorize access to the records when the patients receive health care.
- Protect the privacy of patient health information held in trust on behalf of patients, including their Integrated Lifetime Health Records, through locally-established privacy and security polices that address patients' concerns, and comply with and implement federal and state HIPAA statutes and standards.
- Develop funding means for ensuring that those who share in the benefits of more efficient delivery of health care equitably share the cost of deploying and maintaining the technology.

Study Framework:
Regional Health Information Organization (RHIO) Team (Continued)

TIME FRAME:

- Register the non-profit corporation with the Secretary of State (Spring, 2007).
- Recruit membership and elect the initial Board of Directors (Fall, 2007).
- Install initial pilot technology (Spring, 2008).
- Technology production release 1.0, community-wide (Fall, 2008).
- The Access to Health Care Planning Organization will coordinate the implementation of study recommendations at quarterly meetings to begin in the fall of 2007.



Study Framework:
School Wellness Education:Physical Education & Physical Activity Team

KEY FINDINGS:

There is a significant need for increasing the number of school nurses to provide primary care and support health/wellness in every school. In addition, there is need for continued improvement in the school nutrition program and wellness education curriculum to enhance child wellness, reduce obesity, and establish healthy lifelong eating patterns.

STUDY RECOMMENDATION:

Advocate at all levels to adopt education policy that provides a nurse in every school, improves the school nutrition program and wellness curriculum, and requires designated time for wellness education programs and physical activity in every school every day.

IMPLEMENTATION AGENDA:

- Support implementation of the MCPS Wellness Policy [See excerpt on page 42: I. Chapter 2.00 – School Board Governance and Organization, Page 1-5, ©EMCS] and extend the recommendation to include private schools and home schools as appropriate for those curriculums.
- Support implementation of scheduled time designated specifically for wellness education programs and physical activity in every school every day.
- To provide education to the maximum number of students at a relatively low cost, utilize low-cost information sharing vehicles such as pod casts, student-focused web pages, and the RHIO.

RESPONSIBLE AGENCY/ORGANIZATIONS:

- Marion County Public Schools
- Central Florida Community College and other community educational institutions
- Marion County Health Department
- Local hospitals
- Medical Society

TIME FRAME:

- The Access to Health Care Planning Organization will coordinate the implementation of study recommendations at quarterly meetings to begin in the fall of 2007.
- The School Wellness Education Team should meet with Marion County Public School and Marion County Health Department administration at the earliest date and begin planning for the implementation of study recommendations during the 2008-2009 school year.

Study Framework: Public Education Team

KEY FINDINGS:

There is a general lack of public knowledge and education regarding the health care system, the availability and location of medical services, the proper use of medical services, the benefits of prevention/wellness services, and the availability and cost of insurance. Language differences also impede access to medical care for minorities who are not English-proficient. Additional disparities may be linked to age and income.

STUDY RECOMMENDATION:

Develop and implement a community education initiative to effectively respond to health care deficiencies. Delivery of education objectives should focus on immediate and future access issues and should be age-specific for youth, middle-aged persons, and seniors.

IMPLEMENTATION AGENDA:

- Develop a focused public education program using professional assistance as necessary to impact disease prevention, wellness, and lifestyle change through a multi-level approach with an emphasis on available technology to communicate information.
- With administrative approval and support, schools can offer preventive health courses, i.e., nutrition, exercise, body care, drug education, etc.
- Utilize mass media i.e., internet, radio, television, print media. Also, offer planned courses on specific diseases and medical issues i.e., stroke, cardiac care, diabetes, etc.
- Utilize community volunteer organizations such as Prestige 55 to focus on health education courses for disease recognition, palliative care, Hospice, and the importance of aging changes.
- Utilize key community access/meeting locations such as faith-based organizations, schools, hospitals, medical offices, the health department, and the work place for grassroots style educational programs.
- Focus on rural needs and inclusion of dental, vision, mental, and medical care.
- Develop and implement a public education and training campaign to increase awareness of public access sites to establish appropriate medical home identification prior to the need for treatment including the creation of a mascot as a method to disseminate health care information to educate the public.
- Promote on-line consultation to maximize efficiency (i.e. “Symptom Checker” with a Google map link to the nearest appropriate health care location).
- Coordinate education and treatment for individuals with psychiatric illness and chemical dependency needs.
- Interface with IFAS/University of Florida Extension Services to promote health education and nutrition programs in Marion County Schools.
- Incorporate community wide advertisement of services and care locations to national/ international visitors and general public to enhance awareness of services provided within the community thereby improving public perception of the area.
-

Study Framework: Public Education Team (Continued)

RESPONSIBLE AGENCY/ORGANIZATIONS:

- Marion County Public Schools, CFCC, and other community educational institutions
- Marion County Health Department
- Local Hospitals and Medical Society
- Local faith-based and community organizations
- Local media outlets (print, internet, cable, and radio) and marketing/advertising agencies
- Local government
- Ocala/Marion County Economic Development Corporation, Inc. (EDC)
- Ocala/Marion County Chamber of Commerce

TIME FRAME:

The Access to Health Care Planning Organization will coordinate the implementation of study recommendations at quarterly meetings to begin in the fall of 2007.

Study Committee at Work:
Members including (clockwise from left) Adele Bongiovanni, Judy Brown, Patti Griffiths, Jillian Ramsammy, and Dr. Steve Gilman discuss recommendation revisions during a Process Meeting in the Founders Hall Board Room at Central Florida Community College, April, 2007.

Study Framework: Insurance Team

KEY FINDINGS:

Without health insurance, patients are more likely to postpone medical care and more likely to forgo needed medical care and prescription medicines. In 2006, there were approximately 48,000 non-elderly uninsured in Marion County, 20.3 percent compared to 19.2 percent for the state. Between 2000 and 2005, the number of uninsured residents in Marion County increased 30.3 percent compared to 23.4 percent for the population as a whole. Prescription drugs accounted for nearly 19 percent of all Medicaid expenditures in Marion County compared to only 9 percent for all of Florida.

STUDY RECOMMENDATION:

Provide access to affordable health insurance to the uninsured and underinsured.

IMPLEMENTATION AGENDA:

- Establish a community organization to advocate at local, state, and national levels for insurance reform, support initiatives to enhance and improve available coverage, and to identify incentives for providing coverage for all.
- Explore Best Practices from state programs with three-share program models (government, employer, and the individual share coverage costs) currently operating to encourage participation in health insurance for all businesses, individuals, and families – i.e., Muskegon Community Health Project, California Health Care Reform Plan, and Cover Tennessee [*For additional information regarding three-share models, please see Supplement E, page 47-50*].
- Provide support of initiatives and additional options for persons who do not qualify for health care benefits for reasons beyond their control – i.e., pre-existing conditions and cancellation of coverage due to involuntary and voluntary termination of employment.
- Educate the uninsured and underinsured on existing programs.
- Work with insurance providers to determine the feasibility of providing financial incentives for preventive and wellness care.
- Support medical malpractice insurance reform in order to decrease the burden imposed on physicians by volatile malpractice premium rates and to promote reasonableness in the amount of premiums charged.

Study Framework: Insurance Team (Continued)

RESPONSIBLE AGENCIES/ORGANIZATIONS:

- Legislative representatives
- Business Owners: private and corporate
- Ocala/Marion County Economic Development Corporation, Inc. (EDC)
- Ocala/Marion County Chamber of Commerce
- CLM Workforce Connection
- Other community stakeholders

TIME FRAME:

The Access to Health Care Planning Organization will coordinate the implementation of study recommendations at quarterly meetings to begin in the fall of 2007.

Supplement A: FQHC Defined

Heart of Florida Health Center
Primary and Preventive Care for the "Working Poor" in Marion County
Overview: Federally Qualified Health Centers (FQHCs)

What is an FQHC?

Federally Qualified Health Centers (FQHCs} are authorized under section 330 of the Public Health Service Act and are sometimes referred to as "330 grantees" or more commonly called, "Community Health Centers (CHCs)". These terms, Federally Qualified Health Centers, Section 330 Grantees and Community Health Centers, are used interchangeably. FQHC will be used for the purpose of this presentation.

FQHCs are funded by the ***Health Resources Services Administration (HRSA)*** to provide quality primary healthcare services to medically underserved populations, or people with limited access to healthcare services. They must serve a federally designated ***Medically Underserved Area (MUA) and/***or ***Medically Underserved Population (MUP)***. Marion County has been so designated. A high percentage of FQHC patients are uninsured and live at or near the federal poverty level (FPL). Many are recipients of Medicaid. Seventy-six percent (76%) of Florida FQHC patients live at or below 200% of the FPL, $40,000 for a family of four. There are 37 FQHCs in Florida. Table 1 provides an analysis of Florida FQHC patient insurance status.

Table 1: Source of Insurance and Percentage for Florida FQHCs

Uninsured	56.8%
Medicaid	25 %
Medicare	5.9%
Other Public	2.9%
Private insurance	9.5%

Percents may not sum to 100% due to rounding
Source: BPHC Section 330 Grantees Uniform Data System (UDS) 2004

Federally funded FQHCs are independent, non-profit, community based organizations run by a Board of Directors that is responsible for setting organizational policies. They must comply with federal ***Program Expectations*** outlined by HRSA that states that basic primary care services must be available to all, without regard for ability to pay. They must have a Board approved sliding fee schedule that is tied to the FPL making services affordable for low income people and for the uninsured. The minimum charge for a visit at most Florida Community Health Centers is around $15-$20. However, if a patient is unable to pay the requested amount, the patient cannot be denied services. FQHCs are required to accept patients with ***Medicaid and Medicare*** coverage and ***private insurance.***

During their first three years, FQHCs receive federal grant monies to help defray initial start-up expenses. They also benefit from ***enhanced reimbursement*** under the ***Prospective Payment System (PPS)*** that helps them overcome some of the cost incurred in providing uncompensated care to the uninsured. In 2004, Florida Federally Qualified Health Centers provided approximately *$100 million* in uncompensated care.

Supplement A: FQHC Defined (Continued)

What Healthcare Services Are Provided At FQHCs?

Federally Qualified Health Centers must offer ***comprehensive primary healthcare*** services across all life cycles including primary medical care, health screenings, prenatal care, family planning, pediatrics, immunizations, emergency medical services, vision services, diagnostic X-ray and laboratory services, dental services, and mental health/substance abuse counseling services. They work with a variety of community organizations to ensure that all these required services are covered either in-house or under contract. They also offer a comprehensive array of ***"Enabling Services"*** designed to reduce the barriers to healthcare that are experienced by many patients. Language services, transportation, outreach, case management, education and other support services make healthcare more accessible for those who need them most.

In 2004, Florida's FQHCs saw ***588,288 patients*** with almost ***2.4 million medical, dental and mental health encounters*** at ***172 sites*** across the state in some of Florida's most rural and inner city communities. To accomplish this they employed 3,568 people including physicians, dentists, nurse practitioners, physician assistants, nurses, medical assistants, pharmacists, case managers, outreach workers and other support staff.

Who Are FQHC Patients?

Many FQHC patients are economically disadvantaged, uninsured and face substantial social challenges and barriers to affordable healthcare. The lack of financial resources and health insurance places major limitations on the availability of healthcare services for many people. Increasingly, physician's offices do not accept Medicaid patients or the uninsured. Moreover, many FQHC patients work in low paying jobs with few, if any, benefits and cannot afford to miss an afternoon of work to see a clinician. Most physicians' offices are open between the hours of nine and five. When working people, particularly low paid hourly workers, are sick, they often have to choose between risking the loss of needed employment, forgoing care for themselves or their loved ones, or turning up at the emergency room after work hours. None of these options are good ones. Many Florida FQHCs offer evening and weekend hours making services more accessible to the populations they serve. They also offer linguistically and culturally competent care. Twenty-eight percent {28%} of Florida FQHC patients self-identify as best being served in a language other than English.

Nearly 10% of Florida FQHC patients are privately insured and have options about where to go for healthcare. They choose to use FQHCs because of the number and scope of services offered, the quality of care received and the enabling services that help make healthcare more accessible to them.

"Special Populations"

Some FQHCs receive Section 330 funding to serve ***"Special Populations"*** that include the following HRSA categories: ***migrant and seasonal farm workers***, ***the homeless***, ***school children and their families*** and ***residents of public housing***. These FQHCs are required to meet the same program expectations as all other 330 organizations with the added expectation that they will make the extra effort required to make their healthcare services available to these challenging populations.

Supplement A: FQHC Defined

What Is The Difference Between A Federally Qualified Health Center (FQHC) And A County Health Department (CHD)?

FQHCs are sometimes confused with CHDs that are located in each of Florida's 67 counties. CHDs are funded by the State of Florida to maintain public health and safety by promoting healthy lifestyles and monitoring and preventing health risks including the spread of disease. Many Florida CHDs, including the Health Department here in Marion County, offer primary healthcare services in addition to their "public" health role. The provision of primary health care does not mean CHDs are FQHCs, a designation that can only be granted by the federal government. There are however FQHCs in Florida that are part of a CHD. These "hybrid" organizations must comply with the same federal expectations as all other FQHCs, including the governance requirement stipulating that the health center must be run by a separate, private non-profit community Board of Directors, 51% of whom must be patients of the FQHCs services. They must also comply with state requirements for CHDs.

Marion County Data:

General Characteristics

Median age is 45 years
85.1% are white
African American & Hispanic population each equal approximately 9%
8.9% speak a language other than English at home

Who are the "working poor" in Marion County

Average age of 45 years
81% White
32.6% work for small companies
50.7% of their children receive free or reduced lunch
Per capita income is $20,937

Marion County Demographics

Per Capita Income	$20,937
Median Household Income	$36,537

Determining the Target Population In Marion County

Total Population – 302,001

Persons below 125% FPL approximately 18.7% or 56,287, currently served by Marion County Health Department

Supplement A: FQHC Defined

Persons below 200% FPL approximately 29.24% or 88,305

The gap consists of approximately 32,018 between 125% and 200% FPL who do not have access to primary care with a sliding fee scale

Migrant farm workers designated as target population in Marion County by HRSA

Source: Excerpted from "Community Health Centers in Florida-A Guide to Understanding Florida's Federally Qualified Health Centers and 330 Expansion Opportunities", pages 1-9. The document is available in its entirety at www.fachc.org.

Formation of Heart of Florida Health Center

July 2006
MRMC strategic planning efforts re patient flow and capacity led to focus on under insured and uninsured patients – no "medical home" resulting in use of ED for primary care and increased LOS due to physician concern over follow up care.
Site visit to Langley Health Care Center – Sumter County

August – December 2007
Several meetings with key community players for education re FQHC concept, application process and federal requirements

January 2007
Presentation of FQHC concept and potential models to PPI:
Langley CHC satellite clinic in Marion County
Public entity model – CHS and Marion County Health Department

February 2007
Decision to pursue new access point grant at the next funding cycle – expected to be Fall 2007

March 2007
President's Poor County Initiative – Marion County named one of 200 poorest US counties. Grant award "almost guaranteed", but deadline May 23 – only 200 counties may apply. Grant writing - preparation normally a 6 month process.

March, April, May 2007
Workgroup formed to spearhead application process; MRMC, ORMC, MCHD, MCMS, plus help from others as needed for particular sections of application. WellFlorida Council assisting with writing grant application.

April 17
1st FQHC Board meeting -- Decision to form new 501c3 corporation rather than use CHS – Heart of Florida Health Center chosen as new name – CHS will turn over assets when grant awarded.

Supplement A: FQHC Defined

April 24
2nd Heart of Florida Board meeting
Total of 9 Board members recruited – plan to have eleven members initially – may expand Board later. HFHC articles of incorporation approved, bylaws approved pending incorporation.

May 15, 2007
HFHC Board Meeting
FQHC application approved for submission.
Bylaws and FQHC Agreement with Marion County Health Department approved.

May 18, 2007
Application completed and submitted to HRSA on May 18.

Current Activities
Award notice expected September 2007 – then have 120 days to become at least minimally operational. Board of Directors will continue to meet monthly and will have formal training as well as continue to plan for initial start-up operation in January 2008.

Federally Qualified Health Center-Project Abstract:

The Heart of Florida Health Center (HFHC) is a collaborative public entity model between Heart of Florida Health Center, Inc. and the Marion County Health Department (MCHD). The primary site of the HFHC will be an existing episodic care clinic that is currently funded and operated by the two local hospitals. Heart of Florida Health Center will take possession of all existing equipment and furnishings upon FQHC designation. To ensure success both hospitals will continue financial support. The building, owned by Marion County, will continue to be provided as in-kind support. HFHC, through the collaborative agreement, will also provide primary health care services at the four fixed Health Department sites and existing mobile clinic.

The target population for HFHC is the uninsured and underinsured working poor at or below 200% federal poverty guidelines who currently have little or no access to primary medical care, dental care or behavioral health services. Two physicians, a dentist, a licensed mental health counselor and other support staff will be added to increase access for this target population.

Supplement B: The Greater Ocala Health Information Trust

THE GREATER OCALA HEALTH INFORMATION TRUST: A REGIONAL HEALTH INFORMATION ORGANIZATION

The development of a Regional Health Information Organization in the greater Ocala area is a necessary foundation stone in building a better healthcare system for our community. This organization will be tasked to accomplish two fundamental goals on behalf of the patients and the healthcare system itself.

The first task will be to establish a *Health Information Exchange (HIE)*, defined as an electronic communication and data sharing system within the healthcare community. It is through this electronic system that labs, x-ray reports, hospital and physician records can be deposited into a patient's community medical record (see iLHR below) for future withdrawals by any other provider the patient sees for their medical care. With similar confidence and technologies utilized by the online financial institutions, this Medical HIE will provide medical records that are more complete, more secure, and more available to the patient when they are truly needed.

The second goal of the RHIO will be to establish a Medical Record Bank or Trust that empowers patients by electronically collating all available and appropriate medical information about each patient from all participating healthcare sources through the local Medical HIE. Much like a safety deposit box would house a lifetime of important financial information, this electronic data-bank will contain as much medical information as available about a person's healthcare experiences across the span of their lifetime into an *Integrated Lifetime Health Record (iLHR)*. This will provide a single source of relevant medical information accessible by the patient and any medical provider or institution the patient allows under the established rules of patient privacy (HIPAA).

1. The Health Information Exchange

In order to effectively collate information from the many healthcare sources in our community, a health information exchange must be established to collect and disperse this information quickly accurately, and securely. Much like our current financial institutions are transmitting money and account information electronically, our healthcare system must adopt available technologies to advance the delivery of medical information. Based upon a centralized database of the Health Information Trust (i.e. a collection of our community's iLHRs), electronic interfaces need to be established between all participating medical providers to

[1] PUBLIC LAW 104-191: AUG. 21, 1996; HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Supplement B: The Greater Ocala Health Information Trust (Continued)

deposit and withdrawal this information to the Trust accounts. Utilizing the established and developing electronic protocols of secure electronic health information exchange, the HIE will act as a digital hub of medical information for our community. The HIE will become a new electronic infrastructure that will allow many of the following advances to take place in our community's healthcare system:

- The automatic transmission of hospital data to community physician offices, such as history and physicals, discharge summaries, operative reports.
- Electronic order entry and resulting of laboratory data from local and regional labs.
- The delivery of radiology results and possibly images to participating providers.
- Secure electronic messaging between patients and their providers.
- Secure electronic messaging between medical providers.
- Electronic prescribing of medications to reduce medication errors.
- Provide access to medically dictated reports from community physicians who do not currently use and electronic medical record.
- Encourage the migration of physicians to electronic medical records through the use of a community electronic medical record system.
- Improve access to medical information as a patient transitions through medical facilities in the community, e.g. from the physician office, to the hospital, to a rehabilitation facility, and back to the physician office.

While the successful implementation of both a Medical Record Trust and Health Information Exchange will dramatically improve the functioning of our healthcare, it will also provide the opportunity to improve the health of our patients and our community itself. The improved collection of medical information and data will allow medical providers to diagnose and treat individual patients more rapidly, more efficiently, and more effectively. By reviewing data from groups of patients, more rapid, efficient, and effective medical care can be provided in the event of disease outbreak, natural disaster, or terrorist attack. Additionally, aggregate and de-identified information can be used to understand the health of our community as a whole, enabling medical providers many opportunities of care that do not exist today. Such advances might include:

- Improved insight into the natural progression of disease

[1] PUBLIC LAW 104-191: AUG. 21, 1996; HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Supplement B: The Greater Ocala Health Information Trust (Continued)

- The ability to intervene earlier in populations with developing or worsening chronic diseases such as diabetes or congestive heart failure
- The ability to better address prevention of illness and chronic disease in our community.

2. The Medical Record Trust and The Integrated Lifetime Health Record

In order to better serve the patients' needs in our community, the committee recommends the development of a Medical Record Trust to establish, maintain, and secure the privacy and appropriate use of every patient's Integrated Lifetime Health Record (iLHR). This Trust should be governed by a non-profit community organization with board/committee members comprised of participating stakeholders within the RHIO. This organization should exist separate from any one stakeholder in order to best serve the needs of the community at large. Medical information about a patient is electronically stored in a physically and electronically safe computer database that aggregates information about each participating patient in our community. For as many medical institutions (labs, physician offices, hospitals, etc.) that participate in this process, the patient will automatically collect the information about their care into their iLHR. The release of this information to medical providers and institutions will be under the control of the patient or healthcare surrogate (as directed by the patient), and will be accessible through a secure website. Patients will be able to review their information on this site and validate its accuracy or simply review their treatments. When the patient seeks care from another participating medical provider, they need only give permission for that individual to access their record and the iLHR information will be instantly available to them. Because the medical information is automatically integrated and/or included under medically directed online forms, the information is not dependent on any one individual (including the patient) to maintain, thus improving its completeness. A complete medical record across a patient's lifetime that is securely and readily accessible by medical personnel will no doubt improve many aspects of our healthcare system:

- Improve communication of medical information between providers as well as patients to providers
- Improve the overall accuracy of a patient's medical record
- Decrease medical errors due to incomplete or incorrect information

[1] PUBLIC LAW 104-191: AUG. 21, 1996; HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Supplement B: The Greater Ocala Health Information Trust (Continued)

- Decrease duplication of tests and services
- Increase available patient information to emergency medical providers when it is most needed for prompt and accurate care
- Increase a patient's ability to actively participate in their medical care
- And lastly decrease our community's spending on healthcare through the above mentioned improvements.

[1] PUBLIC LAW 104-191: AUG. 21, 1996; HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Study Committee at Work:
Members discuss recommendation revisions during a Process Meeting in the Founders Hall Board Room at Central Florida Community College, April, 2007.

Supplement C: Behavioral Health

Behavioral Health vs. Mental Health: Where does Behavioral Health Fit?

Behavioral Health is a psychiatric illness that necessitates clinical treatment.

- Internal Medicine
- Psychiatrist/Psychologist
- Therapist
- Outpatient Service
- Residential
- Hospitalization
- Baker Act

Mental wellness is how a person thinks, feels, acts, when faced with a life situation. Mental health is how people look at themselves, their lives, and the other people in their lives, evaluate their challenges and problems, and explore choices.

- Mental illnesses are common and impact about 26% of Americans 18 and older which translates to nearly 58 million people
- In the US, mental disorders account for 15% of the overall burden of disease from all causes, more than cancer and second only to cardiovascular conditions
- Services for persons with severe illnesses have evolved as a separate specialty system which
  - is not well integrated with general health services
  - requires specialty interventions to treat and support persons with disabling conditions
  - requires access to a broad range of categorical services (*e.g.*, housing, employment, income support)
- Until the last 10 years, adults with severe illnesses were thought to have a poor prognosis
  - services did no emphasize choice among meaningful alternatives
  - current thinking embraces recovery from illness as an *expected* outcome
  - involves active participation in care
- For children with severe emotional disturbances – full range of needed services and supports have not been available
  - continued reliance on residential services
  - poorly developed treatment and support technologies
  - continuing recognition of the importance of prevention
  - over reliance on psychotropic medications that were not evaluated with children

Source: Louis de la Parte Florida Mental Health Institute/ University of South Florida

Supplement C: Behavioral Health (Continued)

Delivering Behavioral Health Services

Carve out designs – arrangements in which behavioral health services are administered separately from physical health services.

Integrated designs – arrangements in which the administration of physical and behavioral health care are integrated (even if behavioral health services are subcontracted, in effect, creating a "sub-carve out").

Federal Level Policy Recommendations

- Examine and realign federal funding streams to better coordinate financing for behavioral health services
- Coordinate cross-agency efforts to support research initiatives, including making data available to research grantees
- Develop a minimum set of quality measures for behavioral health services in public sector managed care
- Require states with Medicaid waivers to monitor quality of care

State and Local Purchaser Level Policy Recommendations

- Incorporate values and principles within managed care RFPs, contracts, and monitoring activities
- Explore use of Administrative Service Organizations with the state retaining risk, as opposed to full-risk MCOs
- Include customized provisions for individuals with serious disorders (individualized service planning, risk adjusted rates, intensive care management, family support services)
- Incorporate a broad flexible benefit design
- Broaden definition of services to include supports for consumers and families
- Ensure funding to cover services to family members
- Develop provider network standards and a realistic rate structure, and ensure inclusion of culturally and linguistically diverse providers
- Identify all appropriate cross-system financing sources and create mechanisms for shared funding
- Invest in service capacity development
- Develop risk arrangements including the use of risk adjusted rates
- Require that a specific proportion of capitation rates be allocated to behavioral health care in integrated arrangements

Source: Louis de la Parte Florida Mental Health Institute/ University of South Florida

Supplement C: Behavioral Health (Continued)

MCOs and Providers Practice Recommendations

- Track MCO penetration rates and compare with prevalence estimates
- Screen individuals at high risk of emotional disorders (*e.g.*, children in child welfare system, children whose parents are receiving mental health or substance abuse services)
- Train primary care practitioners to identify individuals with behavioral health disorders and make appropriate referrals

Features of Managed Care That Promote Access

- Broad array of services and supports
  - Clubhouses, employment mentors, respite care, family support, crisis services, home-based services
- Individualized Service Planning Process
  - Creation of a service planning team with the consumer and family; recognition of strengths and needs
- Reduction of service authorization procedures
- Broaden definition of medical necessity and ensure that the criteria are interpreted broadly
- A well specified care management model for individuals with serious mental health problems
- Offer fiscal incentives for implementation of evidence-based practices
- Accountability
  - At MCO level, monitor the quality of care offered by providers using behavioral health quality indicators
  - Involve consumers and families in assessing quality
  - Monitor racial and ethnic disparities in access to and utilization of behavioral health services
- Providing decision-making support to consumers
  - Offer real choices to consumers about treatments and providers
  - Provide information about the benefits and risks of different treatment options
  - Provide decision support mechanisms
  - Peer support programs
  - Advance directives
  - Illness self-management practices and programs

Source: Louis de la Parte Florida Mental Health Institute/ University of South Florida

Supplement C: Behavioral Health (Continued)

  - Preserve patient-centered care in coerced treatment
  - Minimize risks in involuntary treatment A well specified care management model for individuals with serious mental health problems

- Pay for peer support and illness self-management programs
- Provider consumers with comparative information on the quality of care provided by practitioners and organizations, and use this information when making purchasing decisions
- Remove barriers to and restrictions on appropriate treatment that may be created by co-payments, service exclusions, benefit limits, and other coverage policies

Source: Louis de la Parte Florida Mental Health Institute/ University of South Florida

Supplement D: School Wellness – Program & Policy

Federal legislation mandates that all school districts in the nation have a Wellness Policy in place by July 1, 2006. The Marion County Public Schools (MCPS) Wellness Policy has been designed to serve as a best practice in achieving the physical education and physical activity requirements set forth by the state of Florida. The 2006-2008 Wellness Policy evaluation process will evaluate the implementation and ongoing activity under the Marion County Public Schools Wellness Policy adopted as a result of the federal legislation mandate.

Implementation, process and evaluation activities will begin September 1, 2006. This project will culminate with a final presentation of a written report to the Marion County Public Schools Department of Health, Wellness and Physical Education on or about June 30, 2008.

The 2006-2007 school year will be the first year of implementation of the components of the new Wellness Policy. As such, the evaluation objectives for 2006-2007 will focus on process objectives that determine if key components of the Wellness Policy have initially been implemented. 2006-2007 will also be a baseline data collection year. The 2007-2008 school year will be the first in which targeted outcome objectives are evaluated.

The 2007 Access to Health Care Study Recommendations support implementation of the MCPS Wellness Policy [See excerpt below: *I. Chapter 2.00– School Board Governance and Organization, Page 1-5, ©EMCS*) and extend the recommendation to include private schools and home schools as appropriate for those curriculums.

I. Chapter 2.00– School Board Governance and Organization, Marion County, ©EMCS

Wellness Program

I. Philosophy and Commitment

The School Board of Marion County believes that:

- Good health fosters student achievement and student attendance.
- Children and youth who begin each day in good health are more likely to complete their formal education.
- Healthy staff members more effectively perform assigned duties and model appropriate wellness behaviors for students.

Therefore, the Board is committed to provide school and worksite environments that promote health eating, physical activity, and healthy lifestyles. The following policy encourages a multifaceted wellness program that is sensitive to individuals, family and community needs.

II. Nutrition Education

A. To teach, encourage, and support healthy eating for all students of Marion County School District.

B. To provide District approved nutrition education that is consistent with state educational goals and standards.

C. To integrate nutrition education into other areas of the school curriculum, including:

1. Nutrition knowledge
2. Nutrition-related skills
3. Food & Nutrition Services

D. To provide professional development to deliver an accurate nutrition education program.

E. To provide nutrition education information to families and the broader community to positively impact students and the health of community.

III. Nutrition Guidelines for All Foods on Campus

A. School Meals and Campus Foods

1. To provide school meals, including breakfast, lunch, and after school snacks that meet the USDA Federal Regulations and Dietary Guidelines.

B. Competitive Food Sales

1. To ensure that a la carte (snack) items meet District Nutrition Standards.
2. To follow District Nutrition Standards for content and portion size of food and beverages sold in vending machines during the school day.
3. To ensure that vending machines where student meals are served or eaten shall not include Food of Minimal Nutritional Value (FMNV), including carbonated beverages (USDA Federal Regulation 210, Appendix B, Section c.).

C. Rewards/Incentives

1. To provide rewards and incentives that promotes the health of students and reinforces health eating habits.
2. To encourage non-food rewards and incentives as the first choice to promote positive behavior.
3. To provide a recommended list of healthy choices with appropriate portion sizes for foods used as reward.

D. Fundraising Activities

1. To ensure that school sponsored fundraising activities involving food sales meet the District Nutrition Standards.
2. To encourage school fundraising activities that promotes physical activity.
3. To provide a recommended list of ideas for acceptable fundraising activities.

E. Celebrations/Parties

1. To provide healthy food choices that meets District Nutrition Standards to all students participating in a party or celebration during the school day.
2. To provide a recommended list of healthy choices with appropriate portion sizes for celebrations and parties in the classroom.

IV. Physical Education & Physical Activity

A. School Accountability and Assessment of Physical Education and Student Physical Activity

1. To follow the nationally recognized guidelines for physical education and physical activity.
2. To utilize the FitnessGram© to access the health related physical fitness of each student.
3. To annually assess each school's physical education and physical activity program for adherence to curriculum standards.
4. To provide district-approved, research-based assessment tools and techniques for evaluation and assessment.
5. To provide teacher to student ratios within the national safety guidelines.
6. To ensure, whenever possible, that state certified physical education instructors teach all physical education classes as recommended by national guidelines.

B. School Requirements and Opportunities for Physical Education & Physical Activity

1. To provide a physical education program that included the development of positive attitudes toward wellness and physical activity, safety guidelines, responsible behavior in physical activity settings, appreciation for a variety of physical activities and understanding of the relationship between physical activity and wellness.
2. To offer a regularly scheduled, comprehensive program designed to provide students with the knowledge and skills necessary to promote and protect their health, in accordance with the Marion County Pupil Progression Plan.
3. To provide opportunities for physical activity in other subject area classes.
4. To encourage physical activity opportunities as rewards during the school day in addition to physical education.
5. To encourage physical activity, knowledge and self-management skills needed to maintain a physically active lifestyle in the health education curriculum.

6. To provide opportunities for school-wide events, such as field days or walk-a-thons, that promotes physical activity.
7. To provide at least 20 minutes of physical activity during the extended day program.
8. To eliminate withholding physical activity as punishment.
9. To encourage parents to promote physical activity and to participate in physical activity with their children.

C. Professional Development & Staff Wellness Opportunities

1. To provide professional development for physical education teachers annually.
2. To provide training for staff, other than Physical Educators, involved in the direct supervision of children during structured physical activity time.
3. To encourage all district employees to participate in the Wellness Program.

V. Wellness Steering Committee

A. Marion County Public Schools (MCPS) shall form and maintain an ongoing district level School Health Advisory Council (SHAC).

B. The district level SHAC shall serve as an advisory council to the School District Superintendent. The primary responsibility of the SHAC is to support the Superintendent's efforts to address issues relating to the assessment, implementation, and evaluation of the MCPS Wellness Policy.

1. Program Planning
2. Parent and Community Involvement
3. Advocacy for Coordinated School Health
4. Recruitment of Community Health Resources
5. Fiscal Planning
6. Evaluation, Planning, and Quality Control

C. The SHAC shall be patterned after CDC's Coordinated School Health Program (CSHP) which focuses on the following eight major components:

1. Health Education
2. Physical Education
3. Health Services
4. Food and Nutrition Services
5. Counseling and Psychological Services

1. Healthy Promotion for Staff
2. Family/Community Involvement

D. Membership of the SHAC may include though not be limited to: school district staff, Marion County Health Department staff, family members of students, health care workers, community organizations that serve youth, religious organizations, the media, business leaders, concerned citizens, and students.

E. The Marion County Public School's Department of Health, Wellness and Physical Education (HWPE) under the direction of the Coordinator of Health, Wellness and Physical Education will provide technical and administrative support for the SHAC.

VI. Assessment

A. Health, Wellness and Physical Education (HWPE), with advisory support from the SHAC, shall coordinate the needs assessment processes.

B. Each school site in the District shall complete annually the CDC's research-based School Health Index as an assessment and planning tool to improve the effectiveness of the school health and safety policy programs.

C. Each school site shall use the FitnessGram© as an assessment and measurement tool for student performance.

VII. Implementation

A. The Superintendent shall implement the MCPS Wellness Policy. The Department of Health, Wellness and Physical Education (HWPE) and the SHAC shall develop and update the action plan for implementation for the MCPS Wellness Policy.

B. The Superintendent shall require a Wellness Committee at each school site to assess, implement, and evaluate programs at the school level.

C. In its school improvement plan, each school shall have student health, nutrition, fitness, and physical activity goals, consistent with the MCPS Wellness Policy.

D. The Superintendent shall direct Health, Wellness and Physical Education to report on the status of implementation activities to the Superintendent and to the SHAC.

VIII. Evaluation

A. An Independent Evaluator shall conduct an annual evaluation of MCPS Wellness Policy.

B. The Independent Evaluator and the SHAC shall develop strategies for evaluating the performance of the MCPS Wellness Policy.

C. The formal evaluation process shall incorporate research based evaluation tools and techniques.

Source: I. *Chapter 2.00– School Board Governance and Organization, Page 1-5, ©EMCS*

Supplement E: Three-Share Program Models– Muskegon Community Health Project

MUSKEGON COMMUNITY HEALTH PROJECT

Muskegon Community Health Project (MCHP) which opened its doors in 1994 is a non-profit organization that thinks like a for-profit business, especially when it comes to leveraging technology to enhance quality, improve efficiency and lower costs. With the initial goal of moving toward a state of community wellness, the MCHP is now recognized as one of the most innovative and successful incubators for health initiatives in the nation, hosting a variety of collaboratives, service programs and initiatives.

The nationally recognized MCHP **Access Health** model is an example of the power of linking people with the resources to nurture and nourish sustainable health access initiatives. By using a combination of local health status data, ongoing risk assessment information, studies, surveys and public forums, community members took on the challenge of developing a local health coverage plan that has been featured in the New York Times, Wall Street Journal, Forbes Small Business, and many other major national publications.

Access Health, a program developed by MCHP, is an innovative approach to the challenge of providing health coverage to uninsured working families in Muskegon County. Over 400 local small businesses and 1,500 people annually participate in this unique effort aimed at helping people and business get access to affordable coverage.

This unique, three-share model distributes the benefit cost equally between employer, employee and the community, enabling small and mid-sized businesses to provide a comprehensive mainstream benefit plan that includes local physician services, in-patient hospitalization, out-patient services, emergency services, behavioral health, prescription drugs (formulary), diagnostic lab and x-rays, home health and hospice care.

A shining example of a community-based solution to a national problem, the Health Project, through its Community Health Ventures affiliate, is helping other communities across the nation develop similar programs and is providing information to the U.S. Congress about the role of models of this type in addressing the needs of America's uninsured.

Source: Muskegon Community Health Program, © 2004. http://www.mchp.org

Supplement E: Three-Share Program Models–*Continued*
Cover Tennessee: Program Summary

COVER TENNESSEE

Creating health insurance options for uninsured Tennesseans.

www.CoverTN.gov or 1-866-COVERTN

Accessible

- State facilitates the market to bring health coverage costs within reach
- Make affordable coverage options available to children, chronically ill and working people

Effective

- Pay for what's most cost effective: preventive care, primary care, generic drugs
- Pay for what works: pay for best practices, disease management

Personal Responsibility

- • Everyone should pay something
- • Individuals should be responsible for behavior that affects their health

Cover Tennessee includes 5 programs:

Three Insurance Plans:

- CoverKids – comprehensive coverage
- AccessTN – comprehensive coverage
- CoverTN – basic health coverage

Pharmacy Assistance for the Uninsured:

- CoverRx – affordable medication

Prevention, Healthy Lifestyles, and Personal Responsibility :

- ProjectDiabetes
- Coordinated School Health

"The cost of health care is outpacing economic growth and causing each of us to reach deeper into our pockets. The result is that the growing number of uninsured in Tennessee has become an issue that can no longer be ignored."

"I am proud of our new initiative, Cover Tennessee, precisely because it will bring health insurance within reach for working Tennesseans, uninsured children and uninsurable adults. Cover Tennessee is fundamentally different from the approach we have taken to health insurance in the past."

"We don't have it in our power to provide free health insurance to everyone without limits. But we can offer access to health insurance for those who want it. It's a reasonable first step, and I believe we are on the right track." -- Tennessee Governor, Phil Bredesen

Source: Cover Tennessee, Department of Finance and Administration
26th Floor, TN Tower, Nashville, TN 37243
1-866-CoverTN http://www.covertn.gov/summary.pdf

Office of the Governor
ARNOLD SCHWARZENEGGER
THE PEOPLE'S GOVERNOR

01/08/2007 GAAS:009:07 FOR IMMEDIATE RELEASE
Source: http://gov.ca.gov/index.php?/print-version/press-release/5057/

Gov. Schwarzenegger Tackles California's Broken Health Care System, Proposes Comprehensive Plan to Help All Californians

With 6.5 million Californians uninsured for all or part of the year - more than any other state in the nation - Gov. Arnold Schwarzenegger today shared his comprehensive plans to reform California's broken health care system by addressing the hidden costs that result in billions of dollars in higher premiums and taxes.

In a speech before hundreds of stakeholders, Gov. Schwarzenegger articulated why the broken system is in desperate need of repair.

"More than 60 emergency rooms have closed over the past decade because they didn't want to keep treating people without insurance. Unpaid medical bills mean billions of dollars in hidden taxes for the rest of us because those services all have to be paid for. So we pay higher deductibles, costs for treatment, premiums and co-pays," said Gov. Schwarzenegger "Companies stop offering coverage, which leads to more people without insurance and the whole cycle keeps repeating. Nearly three million people in California whose jobs do provide coverage turn it down because they think they're healthy and don't need it, or they don't want to pay their share of ever-higher premiums. We have to aim high and attack the entire system from top to bottom. We can create a model the rest of the nation can follow."

Gov. Schwarzenegger also talked about the drain on the state's economy caused by health care premiums growing more than twice as fast as prices overall or workers' earnings, as reported in a recent study by the Health Research and Educational Trust and the Kaiser Family Foundation.

A recent New America Foundation white paper estimates the average family pays about $1,186 a year in "hidden taxes" through health insurance premiums to cover the uninsured. According to the Centers for Disease Control and Prevention, chronic illnesses - such as cardiovascular disease, cancer and diabetes - are responsible for $445 billion in direct medical costs and $409 billion in lost productivity nationally.

The Governor's health care reform proposal will reduce the hidden tax, lower costs, support better care and create a healthier California through three essential elements of reform:

- Prevention, health promotion, and wellness
- Coverage for all Californians
- Affordability and cost containment

Continued on next page...

Supplement E: Three-Share Program Models–*Continued*
California Health Care Reform: Press Release, Page 2 of 2

"The Governor's plan recognizes that health coverage for all Californians will benefit all Californians," said California Health and Human Services Secretary Kim Belshé. "Just as all sectors of society share in the benefits of coverage for all Californians, we have to share responsibility across the board. Fixing our broken health care system requires changes from all of us - individuals, government, doctors and hospitals, insurers and employers."

All of the details of the Governor's plan are found at www.gov.ca.gov. The Governor's proposal is built on "shared responsibility, shared benefit" where every segment of the healthcare system realizes a benefit and has some responsibility. Highlights include:

Securing health coverage: All Californians will be required to have health insurance coverage. Coverage must be substantial enough to protect families against catastrophic costs as well as minimize the "cost shift" that occurs when large numbers of persons are receiving care without paying the full cost of that care. By ensuring all Californians are insured, this proposal will stop burdening those with health coverage from paying the bills of those without insurance.

Guaranteeing coverage: Insurers will be required to guarantee coverage so that all individuals have access to affordable products. Californians will no longer live in fear of losing their health coverage.

Encouraging personal responsibility for health and wellness: Implement "Healthy Action Incentives/ Rewards" programs in both the public and private sectors to encourage the adoption of healthy behaviors. Californians, who take personal responsibility to increase healthy practices and behaviors, thereby reducing their risk of chronic medical conditions and the incidence of infectious diseases, will benefit from participation in this groundbreaking program.

Providing low-income individuals affordable coverage: Very low-income Californians will be provided expanded access to public programs, such as Medi-Cal, and lower-income working residents will be provided financial assistance to help with the cost of coverage through a new state-administered purchasing pool.

Increasing Medi-Cal rates significantly: To reduce the "hidden tax" associated with low Medi-Cal reimbursement and to encourage greater provider participation in the Medi-Cal program, increase Medi-Cal rates for providers, hospitals and health plans.

Improving insurer and hospital efficiency: Require health plans (HMO's), insurers and hospitals to spend 85% of every premium dollar on patient care.

Enhancing Tax Breaks for Individuals and Employers for the Purchase of Insurance: Align state tax laws with federal laws by allowing persons to make pre-tax contributions to individual health care insurance Health Savings Accounts. In addition, require employers to establish "Section 125" plans so that employees can make tax-sheltered contributions to health insurance and save employers additional FICA contributions.

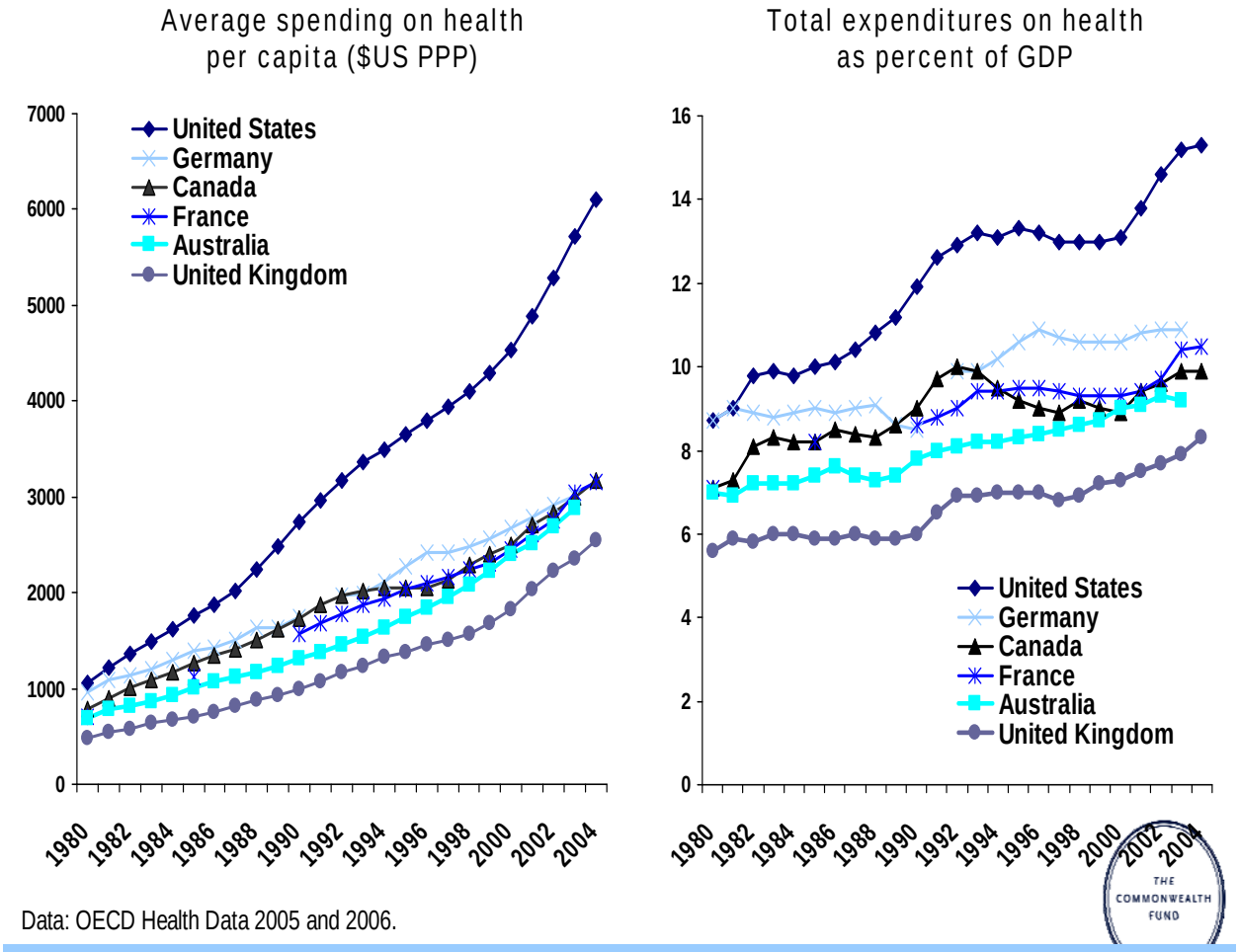
Contributing to the cost of coverage: Increased Medi-Cal rates and eliminating the uninsured will direct $10-$15 billion in new money to hospitals and doctors. Therefore, a coverage dividend of 2% on doctors and 4% on hospitals will be assessed to help cover the increased Medi-Cal rates. Employers of 10 or more (small businesses, which make up 80% of California business, are exempt) who do not provide coverage will pay an "in-lieu fee" of 4% of payroll. Without this fee, the system will see "crowd-out," a system creating an incentive for employers to drop coverage.

"My proposal is a beginning. I look forward to a vigorous and open debate. Everything will be on the table and I want to hear from everyone. If we have the will - and I believe that we do - we can heal our broken system," said Gov. Schwarzenegger.

Supplement F: Health Care Spending– A Global View

EFFICIENCY

International Comparison of Spending on Health, 1980–2004



Data: OECD Health Data 2005 and 2006.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006 73

Source: ***Health System Performance in Selected Nations: A Chartpack****, May 2007.*
Compiled by: Katherine K. Shea, Alyssa L. Holmgren,Robin Osborn, and Cathy Schoen.

Additional Resources

- **AcademyHealth** *is the professional home for health services researchers, policy analysts, and practitioners, and a leading, non-partisan resource for the best in health research and policy. AcademyHealth promotes interaction across the health research and policy arenas by bringing together a broad spectrum of players to share their perspectives, learn from each other, and strengthen their working relationships.*
  http://www.academyhealth.org

- **The Agency for Healthcare Research and Quality (AHRQ)** *is the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. As one of 12 agencies within the Department of Health and Human Services, AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision-making.*
  http://www.ahrq.gov/

- **The Center for Practical Health Reform (CPHR)** *is home to a national health care reform effort —non-partisan, not-for-profit, and multi-constituency— that has attracted the participation and support of nationally prominent individuals and organizations from business, health care, and consumer groups.*
  http:///www.cphr.com

- **The Commonwealth Fund** *is a private foundation working toward a high performance health system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.*
  http://www.commonwealthfund.org/

- **Henry J. Kaiser Family Foundation** *is a non-partisan, non-profit, private operating foundation focusing on the major health care issues facing the U.S. with a growing role in global health.*
  http://www.kff.org/

- **Louis de la Parte Florida Mental Health Institute, University of South Florida-Department of Mental Health Law and Policy:** *The mission of the Department of Mental Health Law and Policy (MHLP) is to provide research, consultation, and training needed to help improve services that have implications for the justice system, behavioral health systems, and public policy. An ongoing goal of the MHLP is to build partnerships, including those at the University of South Florida and with professional colleagues and organizations outside USF, including state and federal agencies and national foundations. These partnerships provide an important vehicle for developing new knowledge, testing out models, sharing information, and learning from our diverse constituents.*
  http://mhlp.fmhi.usf.edu/web/mhlp/index.cfm

Additional Resources (Continued)

- **The Robert Graham Center:** *In July 1997, the American Academy of Family Physician Board of Directors approved the development of a "Center for Policy Studies in Family Practice and Primary Care" to be located in Washington, DC. It was envisioned that the Center would be responsible for research and analysis to inform deliberations of the Academy in its public policy work and to provide a family practice perspective to policy deliberations in Washington, DC. (Referenced work: G.E. Fryer, S. M. Dovey, and L. A. Green. (2000). "The Importance of Having a Usual Source of Health Care." American Family Physician 62 (2000): 477.*
  http://www.graham-center.org/x243.xml

- **The Robert Wood Johnson Foundation** *is the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Robert Wood Johnson Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change.*
  http://www.rwjf.org/

- **WellFlorida Council, Inc.,** *is a private, non-profit 501 (c)-3 located in Gainesville, Florida since 1969 (operating under it's former name, the North Central Florida Health Planning Council) and one of only 11 local health councils in the state of Florida.*
  http://www.wellflorida.org/

Glossary of Health Care Terms

Source: AcademyHealth, www.academyhealth.org

Access

An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g. discrimination, language barriers). More specifically, access can be defined as the as the potential and actual entry of a population into the health care system and features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources, and needs that patients may bring to the care-seeking process. Actual entry into the system is described by utilization rates and subjective evaluations of care. Ability to obtain wanted or needed services may also be influenced by the distance one has to travel, waiting time, total income, and whether one has a regular source of care.

Ambulatory Care

All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay. See also ambulatory setting and outpatient.

Ancillary Services

Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy that are provided in conjunction with medical or hospital care.

Behavioral Health

An umbrella term that includes mental health and substance abuse, and frequently is used to distinguish from "physical" health. Health care services provided for depression or alcoholism would be considered behavioral health care.

Board Certified

Status granted a medical specialist who completes a required course of training and experience (residency) and passes an examination in his or her specialty. Individuals who have met all requirements except examination are referred to as "board eligible."

Catastrophic Health Insurance

Heath insurance that provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all, or a specified percentage of, medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

Glossary of Health Care Terms (Continued)

Source: AcademyHealth, www.academyhealth.org

Clinic
A facility, or part of one, devoted to diagnosis and treatment of outpatients. "Clinic" is irregularly defined. It may either include or exclude physicians' offices; may be limited to describing facilities which serve poor or public patients; and may be limited to facilities in which graduate or undergraduate medical education is done.

Community-based Care
The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.

Community Health Center
An ambulatory health care program (defined under section 330 of the Public Health Service Act) usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs; sometimes known as a "neighborhood health center." Community health centers attempt to coordinate Federal, State and local resources in a single organization capable of delivering both health and related social services to a defined population.

Consumer
One who may receive or is receiving health services. While all people at times consume health services, a consumer, as the term is used in health legislation and programs, is usually someone who is not associated in any direct or indirect way with the provision of health services.

Demand
In health economics, the amount of a good or service consumers are willing and able to buy at varying prices, given constant income and other factors. Demand should be distinguished from utilization (the amount of services actually used) and need (which has a normative connotation and relates to the amount of goods or services which should be consumed based on professional value judgments).

Dental Health Services
All services designed or intended to promote, maintain, or restore dental health including educational, preventive, and therapeutic services.

Disability
Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation.

General practice
Form of practice in which physicians without specialty training provide a wide range of primary health care services to patients..

Glossary of Health Care Terms (Continued)

Source: AcademyHealth, www.academyhealth.org

Group Practice
A formal association of three or more physicians or other health professionals providing health services. Income from the practice is pooled and redistributed to the members of the group according to some prearranged plan (often, but not necessarily, through partnership). Groups vary a great deal in size, composition, and financial arrangements.

Health
The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. Most attempts at measurement have been assessed in terms of morbidity and mortality.

Health Education
Any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conducive to health.

Health Insurance
Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or group basis.

Health Maintenance Organization (HMO)
An entity with four essential attributes: (1) An organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of; (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons; and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

Health Planning
Planning concerned with improving health whether undertaken comprehensively for a whole community or for a particular population, type of health service institution,, or health program. The components of health planning include data assembly and analysis, goal determination, action recommendations, and implementation strategies.

Health Risk Factors
Chemical, physiological, psychological, or genetic factors and conditions that predispose an individual to the development of a disease.

Glossary of Health Care Terms (Continued)

Source: AcademyHealth, www.academyhealth.org

Home- and Community-based Services (HCBS)
Any care or services provided in a patient's place of residence or in a non-institutional setting located in the immediate community. Home- and community-based services may include home health care, adult day care or day treatment, medical equipment services, or other interventions provided for the purpose of allowing a patient to receive care at home or in their community.

Home Health Care
Health services rendered in the home to the aged, disabled, sick or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA), home health agency, county public health department, hospital, or other organized community group and may be specialized or comprehensive.

Hospice (Palliative Care)
A program which provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency.

Hospital
An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and non-surgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short-term or long-term), as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general, and other specialties, such as maternity, pediatric, or ear, nose and throat), and by type of ownership or control (Federal, State, or local government; for-profit and nonprofit).

Indigent Care
Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for Federal or State programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.

Licensed/licensure
A permission granted to an individual or organization by a competent authority, usually public to engage lawfully in a practice, occupation, or activity.

Long-term Care
A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled or retarded) in an institution or at home, on a long-term basis.

Glossary of Health Care Terms (Continued)

Source: AcademyHealth, www.academyhealth.org

Malpractice

Professional misconduct or failure to apply ordinary skill in the performance of a professional act. A practitioner is liable for damages or injuries caused by malpractice. For some professions like medicine, malpractice insurance can cover the cost of defending suits instituted against the professional and/or any damages assessed by the court, usually up to a maximum limit. To prove malpractice requires that a patient demonstrate some injury and that the injury be caused by negligence.

Managed Care

Any form of health plan that initiates selective contracting to channel patients to a limited number of providers and that requires utilization review to control unnecessary use of health services.

Managed Care Organization

Any method of health care delivery designed to reduce unnecessary utilization of services, and provide for cost containment while ensuring that high quality of care of performance is maintained. *Source: Coventry Health Care of Kansas, Inc.*

Medicaid (Title XIX)

A Federally aided, State-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care.

Medically Underserved Population

A population group experiencing a shortage of personal health services. A medically underserved population may or may not reside in a particular medically underserved area or be defined by its place of residence. Thus, migrants, American Indians, or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used to give priority for Federal assistance (e.g., the National Health Service Corps).

Medicare (Title XVIII)

A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Mental Health

The capacity in an individual to function effectively in society. Mental health is a concept influenced by biological, environmental, emotional, and cultural factors and is highly variable in definition, depending on time and place.

Glossary of Health Care Terms (Continued)

Source: AcademyHealth, www.academyhealth.org

Need

In health services, need has a normative connotation (i.e., the amount of a good or service which should be consumed). Because of the technical nature of medical care this value judgment is generally made by the health professional, rather than the consumer of these services. In health planning, need is the appropriate amount of health facilities and services required for a given area.

Nurse Practitioner

A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. *Nurse: An individual trained to care for the sick, aged, or injured. A nurse can be defined as a professional qualified by education and authorized by law to practice nursing.*

Policy

A course of action adopted and pursued by a government, party, statesman, or other individual or organization; any course of action adopted as proper, advantageous, or expedient.

Preventive Medicine

Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g. exercise or prophylactic surgery). In particular, the promotion of health through altering behavior, especially using health education, is gaining prominence as a component of preventive care.

Primary Care

Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.

Provider

Hospital or licensed health care professional or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.

Public Health

The science dealing with the protection and improvement of community health by organized community effort.

Quality of Care

Defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of

Glossary of Health Care Terms (Continued)

Source: AcademyHealth, www.academyhealth.org

Quality of Care *(Continued)*
providers); quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

Risk/Risk Factor
Risk is a term used by epidemiologists to quantify the likelihood that something will occur. A risk factor is something which either increases or decreases an individual's risk of developing a disease.

Supply
In health economics, the quantity of services provided or personnel in a given area.

Survey
The systematic collection of information. A population survey may be conducted by face-to-face inquiry, by self-completed questionnaires, by telephone, email, by postal service, or in some other way. The generalizability of results depends upon the extent to which those surveyed are representative of the entire population and the applied methodology.

Underinsured
People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of pocket expenses that exceed their ability to pay.

Uninsured
People who lack public or private health insurance.

Utilization
Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Use is also expressed in rates per unit of population at risk for a given period.

Vision Health Services
All services designed or intended to promote, maintain, and improve vision health including educational, preventive, and therapeutic services.

Wellness
A dynamic state of physical, mental, and social well being; a way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weakness; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle.

Study Topic Related Acronyms

- **AHCPO** Access to Health Care Planning Organization
- **CHS** Community Health Services
- **CHD** County Health Department
- **EDC** Ocala/Marion County Economic Development Corporation, Inc.
- **FQHC** Federally Qualified Health Center
- **FPL** Federal Poverty Level
- **HFHC** Heart of Florida Health Center
- **HIE** Health Information Exchange
- **HIPAA** Health Insurance Portability & Accountability Act, 1996
- **HMO** Health Maintenance Organization
- **HRSA** Health Resources Services Administration
- **iLHR** Integrated Lifetime Health Record
- **LPN** Licensed Practical Nurse
- **MCHD** Marion County Health Department
- **MCMS** Marion County Medical Society
- **MCO** Managed Care Organization
- **MCPS** Marion County Public Schools
- **MRMC** Munroe Regional Medical Center
- **MUA** Medically Underserved Area
- **MUP** Medically Underserved Population
- **ORMC** Ocala Regional Medical Center
- **PPS** Prospective Payment System
- **RHIO** Regional Health Information Organization
- **RN** Registered Nurse

2007 Access to Health Care Study Resource Speakers

Brian R. Klepper, Ph.D.	**The Center for Practical Health Reform**
Dyer Michell	**Study Committee Chair/ PPI Board of Directors**
Melvin Seek, M.D.	**Ocala Critical Care and Kidney Group**
Jeff Feller	**WellFlorida Council, Inc.**
Paul Duncan, Ph.D.	**University of Florida**
Clara Badano-Merlino	**Blue Cross Blue Shield of Florida**
Carlton (Dyke) Snipes	**Agency for Health Care Administration**
David Willis, M.D.	**Study Committee Member, Family Physician**
Nathan Grossman, M.D.	**Marion County Health Department**
David Elliot, M.D.	**Study Committee Member, Pediatrician**
Sherri Lewis	**Community Health Services**
Pam Syester	**WeCare**
Cy Huffman, M.D.	**Munroe Regional Medical Center**
Frank Biondolillo, M.D.	**Munroe Regional Medical Center**
Art Osberg, M.D.	**Ocala Regional Medical Center**
Vickie Sullivan	**Munroe Regional Medical Center**
Jeffrey Baiocco	**Ocala Regional Medical Center**
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Dave Palmer	**Emergency Medical Services Alliance, Inc.**
Don Darley	**Emergency Medical Services Alliance, Inc.**
Chief Jimmie Enderle	**Emergency Medical Services Alliance, Inc.**
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Carla DeFrank	**Merillat Corporation**
Pat Reddish	**Signature Brands, LLC**
Ray Strickland	**Lossing Strickland Insurance Group/ Benefit Advisors**
Wayne NeSmith	**Florida Hospital Association**
Robert Dobson	**Milliman, Inc.**
Roger Boothroyd, Ph.D.	**Louis de la Parte Mental Health Institute, USF**
Pat Robinson	**Louis de la Parte Mental Health Institute, USF**
Mary Armstrong	**Louis de la Parte Mental Health Institute, USF**
Russell Rasco	**The Centers**
Bob Weinhold	**Ten Broeck Hospital, Ocala**
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Matt Lane	**Marion County Public Schools**
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Segismundo Pares, M.D.	**Hospice of Marion County**
Allen McMichael, J.D.	**Stripling, McMichael, and Stripling, P.A.**
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Erin Rosaasen	**WellFlorida Council, Inc./ University of Florida**
Christine Bates	**WellFlorida Council, Inc./ University of Florida**

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The Public Policy Institute of Marion County is dedicated to advancing public interest, building democracy, enhancing community, and improving the quality of life by involving citizens in the process.

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