REQUESTING THE HOUSE AND SENATE INTERIM COMMITTEES ON PUBLIC HEALTH, WELFARE, AND LABOR TO STUDY WAYS TO IMPROVE ACCESS TO COMPREHENSIVE PRIMARY AND PREVENTATIVE HEALTH CARE FOR THE UNINSURED AND MEDICALLY UNDERSERVED WHILE REDUCING HEALTH DISPARITIES ACROSS ETHNIC, ECONOMIC, AND GEOGRAPHIC COMMUNITIES IN THIS STATE.

Representative Roebuck
District 20
INTERIM STUDY

1. To determine the medical needs of our most vulnerable citizens.
2. To determine the availability of adequate medical care at the least restrictive point of service.
3. To address the medical needs of the medically uninsured, especially between 19 and 64 years of age.
4. To address enabling factors that influence the health care delivery system in Arkansas.
5. To address the ethnic inequalities in our health care system.
6. To compile this information in a written report to the Arkansas Legislative Council.
7. To develop a Legislative agenda that will address these critical Health Issues for the 2007 Legislative Session.
FACTORS DETERMINING QUALITY OF HEALTH CARE IN ARKANSAS

1. Family income – Poverty level
2. Ethnic factors
3. Geographic factors
4. Medically Uninsured
5. Enabling Services
6. Medical Care Safety Net
7. Medical Literacy
1. The median household income for Arkansas families is $34,246. This is below the federal 200% of poverty level which is $37,700 for a family of four. Source: ACHI 2005 Arkansas Fact Book. Page 4, 12.

2. More than half of Arkansas families make less than $35,000 a year.

3. Fifty percent of Arkansas kids are in the free or reduced school lunch program.

4. Arkansas has 14.8% of households receiving food stamps. Mississippi has 15.8%. The national average is 11.9%.

5. Clark County median income in 2004 was $29,394.00 per household. This is almost $8,000.00 less than federal poverty level for a family of four at 200 percent poverty level.
1. Less likely to receive regular health care for chronic diseases.
2. Less likely to get prescriptions filled.
3. More likely to forego or delay medical care.
4. Less likely to receive preventive services.
5. More likely to utilize hospital emergency services.
6. More likely to be hospitalized.
1. Study estimates that 886,000 African-American deaths could have been prevented in the decade of the 1990's if they had received equitable health care. -- “State News”, American Journal of Public Health, May 2005, Page 31.

2. David Atkins – Agency for Health Care Research and Quality, States that health inequality in the United States causes about 84,000 additional deaths each year.

3. The increasing Hispanic population with language and cultural barriers must be addressed.
ETHNIC FACTORS CONTINUED

4. More medically uninsured.
5. Less likely to seek medical care.
6. Access to health care more difficult in medically underserved areas.
7. Lack of enabling services.
8. Lack of health care facilities in rural economically depressed areas of the state.
Arkansans are healthier and living longer, but when you narrow it down to the minority population, we are still dying at a much faster rate. We still have lots of people, particularly minority population, that do not trust our health system.

Ms. Christine Patterson, Director of the Office of Minority Health and Health Disparities, Division of Health, Department of Health and Human Services.
GEOGRAPHICAL FACTORS

1. Regional economic factors.
2. Lack of primary health care in medically underserved regions of the state.
3. Regional difference in the number of medically uninsured.
4. Lack of rural health care facilities, hospitals and medical clinics.
FEWER HOSPITALS

Cities where hospitals have been sold, merged or closed within the last year.

1. Blytheville
2. Osceola
3. Cherokee Village – Closed
4. Newport – Closed
5. Searcy
6. Gravette – Closed
7. Forrest City
8. Hope

Prior to 2005 several other hospitals have closed.
“The death rate in any given year for someone without health insurance is twenty-five percent higher than for someone with medical insurance. Because the uninsured are sicker, they can’t get better jobs, and because they can’t get better jobs, they can’t afford health insurance and because they can’t afford health insurance they get even sicker.” — “The Moral-Hazard Myth,” by Malcolm Gladwell. New Yorker. August 29, 2005.
The Uninsured in Arkansas
Characteristics of the uninsured—geographic region

- Insurance coverage varies widely by region, affecting the health of communities.

- In Arkansas in 2004, estimates of uninsured rates ranged from a low of 6% of residents in central Arkansas (Pulaski County) to a high of 23% in the north central mountain counties.

Almost 1 in 4 Arkansans of all ages in north central Arkansas did not have health insurance coverage in 2004.

Employers are often not able to continue to offer health insurance if employees cannot afford the premium. “My husband and I tried to have insurance for our employees. We paid for the insurance and took it out of their payroll. The employees did not like that. Now we don’t offer insurance.”

Participant, Arkansas Small Employer Focus Group, 2005

2005 Arkansas Fact Book: A Profile of the Uninsured
1. 17.2% of Arkansans are medically uninsured.
2. 456,000 Arkansas citizens.
3. Most uninsured are between ages 19 and 64.
4. Prior to age 19, they are covered under ARKIDS A, ARKIDS B and Medicaid.
5. After age 65, they are covered under Medicare.
6. Most uncompensated health-care cost is for patients between 19 and 64 years of age.
Summary of Bo Ryall’s Testimony
Arkansas Hospital Association

- As numbers of uninsured increase, amount of uncompensated care increases.
- The uninsured are sicker, and, thus, more expensive to care for, when they do access the health care system.
- Emergency rooms are used as safety-net by the uninsured.
- By 2003, the number of uninsured admitted to hospitals in Arkansas had increased to 30,063. This is a 69% increase in three years.
- In 2004, Arkansas hospitals provided $307,483,117 in uncompensated care. The Arkansas Hospital Association reported in the Arkansas Democrat-Gazette, November 13, 2005, that state hospital bad debts totaled $531 million and $207 million in charity care.

2. This amount is probably over $500 million in 2005.

3. UAMS Hospital emergency room uncompensated care was $40 million dollars. Dr. Smith, Director, UAMS Hospital.

4. Baptist Medical System – total for year from five hospitals $99,253,000.

5. Arkadelphia Baptist Hospital – 2005 is projected to be $3,192,000.

6. This uncompensated treatment cost the medically insured family an additional $941.
MINIMIZE UNCOMPENSATED HEALTH CARE

1. Must provide a medical safety-net system to treat patients at the least restrictive level of care.

2. Must continue to stress the need for increasing and improving health care preventive programs.

3. Must provide incentives to reduce the number of uninsured.

4. Must place more burden on the individual to be more involved in treatment to reduce the cost of medical care.

5. Consider incentives to employers to keep employees health insurance.

6. Enhance medical literacy through outreach programs.
LACK OF ENABLING SERVICES

1. Transportation
2. Case Management
3. Language – availability of translators
4. Medical Literacy
6. Medical personnel and clinic facilities.
1. Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Source U.S. Department of Health and Human Services.
2. The consequences of inadequate health literacy include:

A. Poorer health status
B. Lack of medical care knowledge
C. Impaired comprehension of medical information
D. Lack of knowledge about medical conditions
E. Lack of understanding and use of preventive services
F. Poorer self-reported health
G. Poorer compliance rates with treatment modalities
H. Increased hospitalization
I. Increased health costs
3. Weiss and colleagues state that the average annual health care cost of persons with very low literacy may be four times greater than for the general population.


4. The Institute of Medicine in 2000 determined that out of twenty things necessary for health care to improve, literacy affects all twenty.

Source: Dr. Chad Rodgers, Little Rock, Arkansas, Physician
The Institute of Medicine, in 2000, decided that out of twenty things necessary for health care to improve, literacy affects all twenty. Fifty-six percent (56%) of Arkansans are functionally or marginally illiterate. In Lee, Phillips, and Chicot counties, 80-89% of the population functions at level two literacy or below. Lower health literacy leads to lower health outcomes and less healthy behaviors. Low level literate patients are twice as likely to be hospitalized when they access the health care system. Poor health literacy costs health care system $50-73 billion a year.
Summary of Dr. Charles Cranford’s Testimony
Area Health Education Centers (AHEC)

- There are seven AHECs in Arkansas, each covering a multiple county service area.
- Mission is to improve the supply and distribution of health care providers while serving as an education setting for UAMS students.
- AHECs were a safety-net for 83,000 patients in 2004.
- Reimbursement is on a sliding scale fee with 68% of the patient base either Medicaid or non-paying patients.
In 2004, 17% of Arkansans, 455,798 individuals lacked health insurance.

Rate of uninsurance is higher in rural areas.

Uninsurance is a leading cause of bankruptcy filings.

Lack of health insurance is related to both more expensive and less efficient care.
In fiscal year 2005, 32,309 patients were seen in the UAMS emergency department.

In fiscal year 2005, UAMS had $40 million in unreimbursed charges from the emergency department alone.

$13.5 million of the $40 million resulted from visits where the emergency department was being used as a clinic facility.

UAMS has difficulty meeting the demand for care in its clinics.
Arkansas Health Care Access Foundation (AHCAF) was established by the Arkansas Medical Society in 1989 in order to provide free medical care to the indigent.

1,870 providers, including 1,200 physicians, in the state participate in this program.

The various providers of uncompensated and charity care don’t really work together; with no centralized office for coordinating charitable and uncompensated care.
Community Health Centers (CHCs) provide, or make provisions for, affordable and accessible comprehensive, continuous primary medical, dental, mental health, prevention, and enabling services to everyone, regardless of ability to pay.

- 123,790 patients served in 2005
- 56% at 200% FPL or below
- 57,896 or 47% are medically uninsured
- 99,991 underserved (Medicare, Medicaid, Uninsured) patients

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12 CHCs with 58 health center locations in medically underserved areas (73 out 75 counties are full or partial medically underserved)

CHCs can save the state 30% on the dollar if Medicaid patients are treated within the CHCs as opposed to seeking care in the ER. In 2005 data reported (by NACHC) this amount could have equated to 189,500,122 for unnecessary emergency visits.

CHCs are partially federally funded by the Department of HHS, Bureau of Primary Health Care, to help offset the costs for serving the uninsured of which CHCs serve 11% of the total Arkansas uninsured, but could serve more with state general revenue.
Arkansas Poorest Counties Map

- 40.5% or higher of population below 200% poverty - NO CHC
- 40.5% or higher of population below 200% poverty - With CHC
- 35.3% or higher of population below 200% poverty - NO CHC
- 35.3% or higher of population below 200% poverty - With CHC

No CHC in 25 counties with 40.5% ↑ of the population below 200% of poverty (dark red counties)
- Based on the President's Growth Initiative II

No CHC in 36 counties with 35.3% ↑ of the population below 200% of poverty (dark red and dark yellow counties)
- Based on “A Nation's Health at Risk III” - NACHC

Note: There are a total of 58 health center locations - (5 communities have more than one service site)

September 2006
Established in 1989 by the Arkansas Medical Society to make health care available to those that do not qualify for other health service providers.

The AHCAF has served nearly 80,000 eligible Arkansans since 1990.

AHCAF staff received more than 12,000 calls in 2005 from people without money to pay for medical care. Source: Arkansas Medical Society Journal
We estimate that between 250,000 and 300,000 Arkansans would qualify for this program if it were available. Source: “Saving Starfish”, Arkansas Medical Journal, April 2006

Services are provided by physicians, dentists, pharmacists, and other medical providers at no charge to patients.
Summary of Dr. Paul Halverson’s Testimony
DHHS, Division of Health, County Health Units

- Emphasis should not merely be on increasing the number of clinics. Instead, find system related solutions to health issues with an emphasis on prevention and behavioral causes of disease and death.

- Prevention is key—”focus of our system really ought to be on trying to create an environment in which people don’t become sick with disease and need expensive medical care.” We spend 3% of our health care dollars on prevention and protection.

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In the U.S., we spend 97% of our health care dollars dealing with those that already have disease.
Arkansas Association of Charitable Clinics (AACC) is composed of 23 independent clinics located throughout the state, the first of which opened in 1972.

Patients are typically low income with no Medicaid, no Medicare and no health insurance.

Most clinics use 200% of the Federal Poverty Level (FPL).

Typical charitable clinic holds hours two to four times per month, usually in the evenings.

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Summary of Chuck Morrison’s Testimony
Continued

- In 2005, the clinics had 44,000 patient visits.
- The charitable clinics are funded by private contributions and receive almost no federal or state government money.
Office of Minority Health was established in 1985

When you look at age adjusted death rates, African Americans are dying at a higher rate than Caucasians for the following diseases: heart disease, cancer, diabetes, stroke, HIV/AIDS and infant mortality.

African Americans still mistrust the medical community.

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Summary of Christine Patterson’s Testimony
Continued

Racism and discrimination still exist and should be dealt with because they affect access to the health care system.
There are 1,115 license Advanced Practice Nurses (APNs) in the State of Arkansas; 633 of these nurses have prescriptive authority.

Arkansas is a rural state and has a problem with health care access.

In Arkansas, the ratio of primary care providers to patients is 1 to 3,000. If APNs were considered primary health care providers, the ratio of primary care providers to patients in the State of Arkansas would drop to 1 to 2,000.

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A national study found that, if APNs were used efficiently in primary health care, it could result in a savings of up to $8 billion.
We truly have a crisis in oral health in Arkansas.

Survey indicates that more than 50% of the children in Arkansas have or have had tooth decay.

In the southeast region of the state, minorities have more than 75% of children afflicted with tooth decay.

Ten percent of the children have emergency dental needs. This is also true for our senior citizens.

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Summary of Dr. Lynn Mouden’s Testimony
Continued

- Neither Medicaid nor Medicare pays for dental coverage for adults.
- The single most effective method to reduce dental decay is to add to the fluoride already in our water up to the optimum amount that will reduce dental decay.
- Failure to get the fluoridation bill (House Bill 2627) out the Senate Health Committee was considered by the “Arkansas Times” as the worst legislative mistake or blunder in the 2005 session.
There are 15 non-profit, citizen governed mental health centers in Arkansas.

They are regulated by the Division of Behavioral Health of DHHS.

Total Arkansans treated in FY 05 was 73,471; this included children and youth up to the age 21 and all adults above age 21.

An increase in the numbers and severity of mental illness in young children.

Difficulty in acquiring and maintaining professional staff with cultural diversity.
Summary of Dr. Glen Mays’ Testimony
University of Arkansas for Medical Sciences
College of Public Health

- Nationally, only about 3% of our health spending goes to preventive services, with the remaining 97% going to the treatment of disease.
- In Arkansas, we are currently spending a little over $50 per capita, on local public health and preventive services delivery. We need to be spending closer to $70 per capita.
- Our local public health agencies in Arkansas are really only delivering about half of the recommended chronic disease screenings.
Amount of Care Provided by Safety Net Providers

**AR Health Care Access Foundation:**
- In 2005, 3,000 Arkansans enrolled in this program.
- Amount of Services Provided in 2003-2004 was $542,636.

**Arkansas Health Education Centers:**
- In 2004, over 160,000 patient visits.
- Over 83,000 Arkansans rely on AHECs for care.
Amount of Care Provided by Safety Net Providers continued

Community Health Centers:
- More than 50,000 or 11% of the uninsured used CHC services in 2004
- Total patients served in 2005: 123,790

Charitable Clinics:
- In 2005, over 44,000 patient visits
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