LEADERSHIP
SouthCoast

A Deliberation on Health Care Access

with

Leadership South Coast and

Leaders in Southeastern Massachusetts Health Care

Prepared by

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SOUTH COAST COLLABORATIVE COMMUNITY DESIGN STUDIO

an initiative of the

Community Foundation of Southeastern Massachusetts

with sponsorship from

The Community Foundation of Southeastern Massachusetts
Healthnet
Senior Whole Health
Saint Anne's Hospital
The Urban Initiative at the University of Massachussetts Dartmouth

at the

Advanced Technology & Manufacturing Center, Fall River, MA

May 2010

SoCo DESIGN
SOUTH COAST COMMUNITY COLLABORATIVE DESIGN STUDIO

COMMUNITY FOUNDATION
of Southeastern Massachusetts

Saint Anne's Hospital
A CARITAS FAMILY HOSPITAL

SOUTHCOAST
HOSPITALS GROUP
Charlton ▪ St. Luke's ▪ Tobey
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SENIOR WHOLE HEALTH

READINGS

Access and Affordability: An Update on Health Reform in Massachusetts
http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2009/May/Access-and-Affordability.aspx

How Is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform
http://www.kff.org/healthreform/upload/7878.pdf

Consumers' Experience in Massachusetts: Lessons For National Health Reform
http://www.accessproject.org/adobe/kffMA.pdf

South Coast Design is a non-profit organization that builds consensus with community stakeholders.

South Coast Design Studio is a capacity-building initiative of the Community Foundation of Southeastern Massachusetts.

A Deliberation on Health Care Access is a civic engagement event designed for Leadership SouthCoast's Curriculum for 2010. Leadership SouthCoast's mission is to provide our region with an ongoing source of diverse leaders, who are prepared and committed to serve as catalysts and sustainers of positive change for the quality of life on the SouthCoast of Massachusetts.

South Coast Design is a member of the Institute of the 21st Century Agoras, a 501(c) (3) non-profit organization, dedicated to the evidence-based practice of the Structured Dialogic Design Process.

Craig Lindell, founder and Chief Executive Officer of Aquapoint also serves as a Director of the regional Economic Development Council and chairs it's long range planning committed as well as citizen's forum dedicated to capital formation in southeastern Massachusetts.

Craig Dutra is president of the Community Foundation of Southeastern Massachusetts. He serves on the advisory board of the Center for Policy Analysis at UMASS Dartmouth. His previous executive leadership also included posts at the United Way, as one of the Boston Mayor's Senior Policy Advisers.

Matt Morrissey is Executive Director of the Economic Development Council of New Bedford. Matt improved government effectiveness at the Public Consulting Group, founded a high-tech start-up, and handled legislative, economic development and outreach issues at the UMass Office of the President. He also serves the SouthCoast Learning Network and New Bedford ACTS.

A Letter from the Chairman of South Coast Design,

I believe that regional development must be driven by deliberative dialogue with the community. South Coast Design builds that deliberative capacity here.

Our certitude in this practice derives from our personal experience. My commitment to it is driven by breakthrough experiences.

Promoting applications of this approach to our most pressing regional challenges is the most important work I will do for the rest of my life. It is nothing less than the transformation of the New England Town Meeting. Join me in making this our preferred mode of community engagement.

Craig Lindell
Chairman, South Coast Design Advisory Board

Leadership South Coast 2010

To Participants in *A Deliberation on Health Care Access*,

Thank you for your commitment to engage the dilemma of access to health care in our region. This event is a structured dialogue of regional leaders in the health care community and the Leadership South Coast Class of 2010. I selected the structured dialogue approach for this event based on my personal experience with the process and its facilitation team.

Southeastern Massachussetts demographics are similar to national demographics. Therefore, we have an opportunity to be a national model in how we address issues such as access, cost, and wellness within the reformed system. Towards that end you will engage the diversity of perspectives about what should be done in a rigorous fashion and network with people that can help make it happen.

Michael Metzler
Executive Director of Leadership South Coast

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Executive Summary

A Deliberation on Health Care Access, outlined herein, is a design for synthesizing the voice of regional stakeholders in health care. The outcome of this work addresses the question of what ought to be done to improve access to health care in the region. The first engagement of this deliberation is with Leadership South Coast and area leaders in the health care community of the region. This event is intended to lead to further collaboration on health care access in the ensuing months.

The selected process of deliberation amplifies the level of engagement of the participants by building trust amidst diverse stakeholder perspectives. Ideally, participation in this event will begin networking on systemic improvement of health care access in the region. The approach of structured dialogue sets forth a collaborative tone, rather than a politicized atmosphere of debate. In this fashion we hope to launch inter-organizational collaborative action in a fashion that is inclusive of the plurality of perspectives.

The overall community engagement model convenes stakeholders representing the diverse interests within the health care system. This first event builds on the perspectives of people working in various roles within the health care system. These invited guests were developed through stakeholder identification of a broader endeavor on health and wellness in the region in 2009.

We will cultivate the insight of these guests addressing:

- What specific problems in access have they personally experienced?
- How can we learn to address these challenges based on what they know works in other places?

The Agenda

8:15– 9:00	Reception
9:00– 9:15	Overview
9:15– 9:30	Introductions
9:30–10:30	Problems in Access 1
10:30-10:45	Break
10:45-11:30	Problems in Access 2
11:30-12:30	Solutions to Access 1&2
12:30- 1:15	Lunch & Reflections
1:15- 2:15	Themes & Distinctions
2:15- 2:30	Break
2:30- 4:00	Leadership Directives
4:00- 4:30	**Learning & Priorities**

Problems in Access 1 – Participants sitting in 12 groups of 4 (2 invited guests and 2 LSC members per group) will articulate and discuss actual experiences of our guests in difficulties with health care access. LSC members will draft statements for the wall and key points of the discussion for a report. Participants then rank which statements to share first.

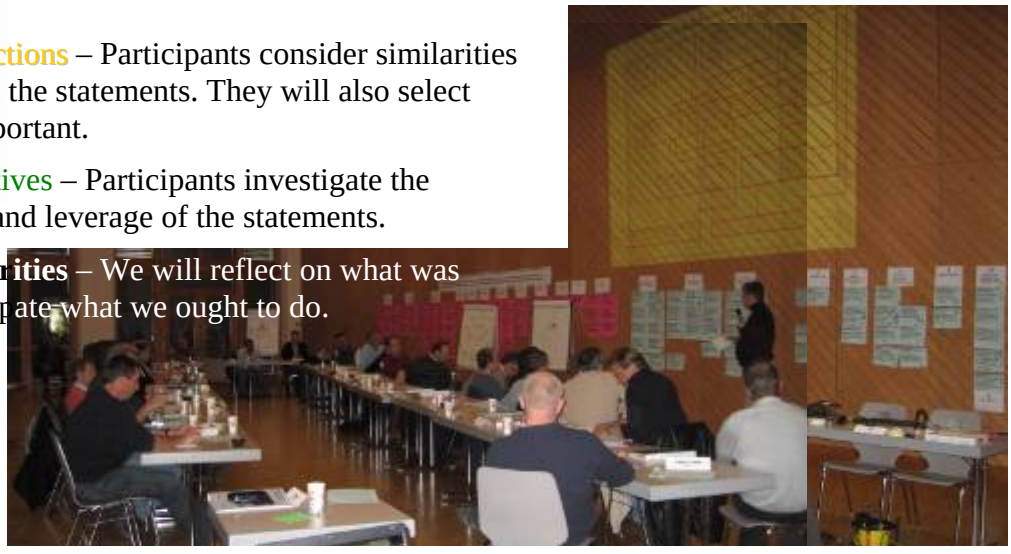
Problems in Access 2 – *The groups share their statements with the whole group. Guests from other groups request clarification.*

Solutions to Access 1&2 – *Participants sitting in 7 groups of 7 discuss proven and promising solutions to problems in access which they know about, then share.*

Themes & Distinctions – Participants consider similarities and differences in the statements. They will also select ones they feel important.

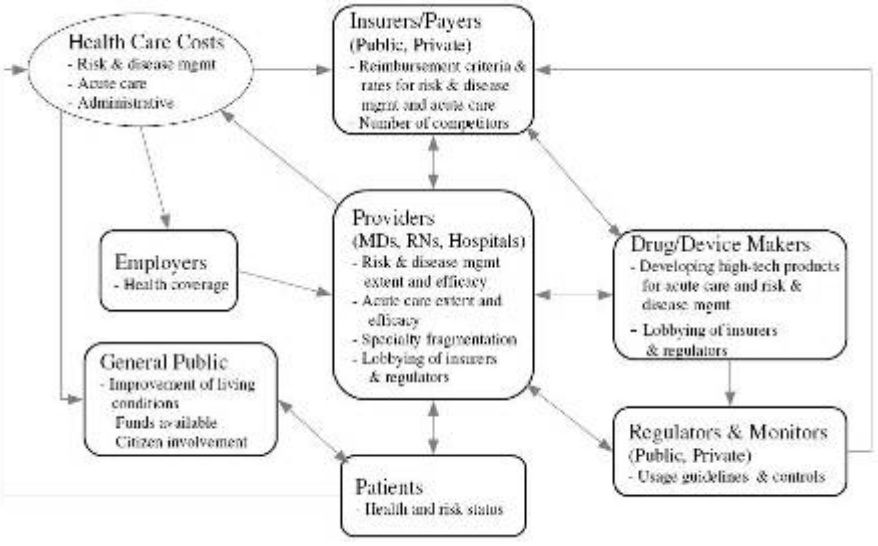
Leadership Directives – Participants investigate the interdependency and leverage of the statements.

Learning & Priorities – We will reflect on what was learned and anticipate what we ought to do.



Stakeholders in Health Care

A Deliberation on Health Care Access begins by engaging the viewpoints of people within the regional health care system. In this session we primarily enage people within the "provider" box in the diagram below.) The members of Leadership South Coast program are primarily representing "the public." LSC members may also have personal experience or knowledge of access to care issues either from a "patient" perspective, perhaps someone they know. So too, there are LSC members which work within the healthcare system and may be also be able to offer some perspective from the provider's perspective.

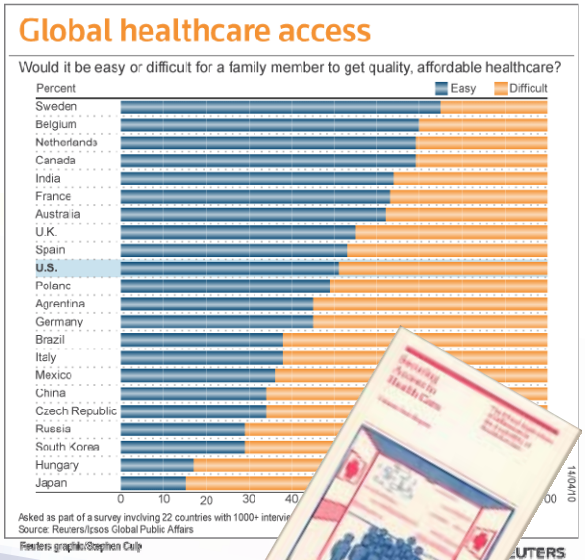


Stakeholder Roles & their Interaction from Achieving Health Care Reform in the United States: Toward a Whole-System Understanding

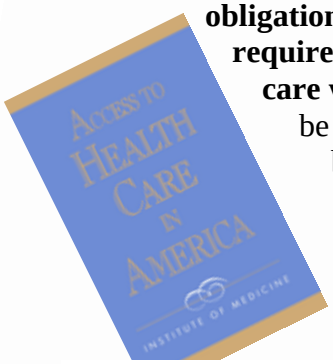
On Access: Urgency & Meaning

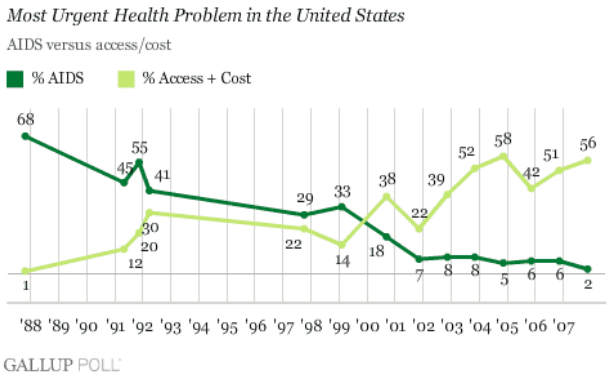
On April 15, 2010 Reuters released the results of an online poll which indicated the U.S. ranked 10th . According to a Gallup Poll the concern with access and cost began to outrank AIDS as the top health concern in the U.S. and as of 2008 access outranks cost. So what does 'access' mean?

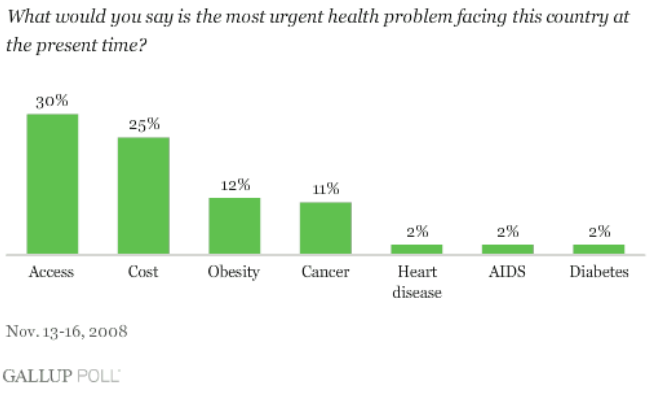
In 1993 in *Access to Health Care in America*, an Institute of Medicine Committee defined access as **"the timely use of personal health services to achieve the best possible health outcomes."** The definition combines 'use' as well as 'outcomes'.



Prior to that the IOM report suggests that the most extensive definitional work on access and the related concept of equity was mounted by the 1983 President's Commission for the Study of Ethical Problems in Medicine and Biomedicine and Behavioral Science Research. They concluded that society had **'an ethical obligation to ensure equitable access to health care which requires that all citizens be able to secure an adequate level of care without excessive burdens.** This social obligation was to be balanced by individual obligation, the burden to be shared by the public and private sectors, and cost containment not based on access. The positioning as 'an ethical obligation' was a step away from the positing of health care as a right set forth in the 1952, the President's Commission on the Health Needs of the Nation – taking a 'moral view.'

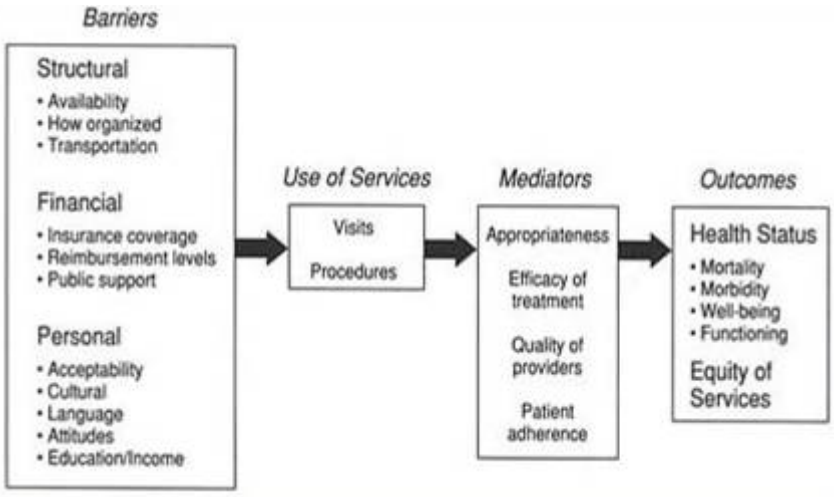






A Model of Access

The 1993 IOM Committee put forth the following model for the pragmatic purpose of developing indicators about access. This Committee selected 15 indicators tracking: 5 objectives around birth, preventable disease, early finding of treatable disease, managing chronic disease, and getting timely and appropriate treament:



Objective 1: Promote Successful Birth Outcomes
Objective 2: Reduce Vaccine-Preventable Childhood Disease Incidence
Objective 3: Detection and Diagnosis of Treatable Diseases Early
Objective 4: Reduce the Effects of Chronic Disease and Prolong Life
Objective 5: Reduce Morbidity/Pain via Timely, Appropriate Treatment

Objectives of Access

The Healthy People 2020 initiative outlines 10 more specific objectives for access:

Increase the proportion of persons with:

AHS HP2020–1: …health insurance. ✓ (97% in Massachusetts via state reform.)
AHS HP2020–2: …persons covered for clinical preventive services.
AHS HP2020–3: …a usual primary care provider.
AHS HP2020–4: …access to rapid response prehospital emergency medical services.
AHS HP2020–6: …a specific source of ongoing care.
AHS HP2020–9: …receiving appropriate evidence-based clinical preventive services.

AHS HP2020–5: Increase number of States with prehospital/hospital pediatric care guidelines.
AHS HP2020–7: Reduce the proportion of individuals that experience difficulties or delays in obtaining necessary medical care, dental care, or prescription medicines.
AHS HP2020–8: Reduce the proportion of hospital emergency department visits in which the wait time to see an emergency department physician exceeds the recommended timeframe.
AHS HP2020–10: Increase the proportion of practicing primary care providers.

Beyond Coverage

We're covered…

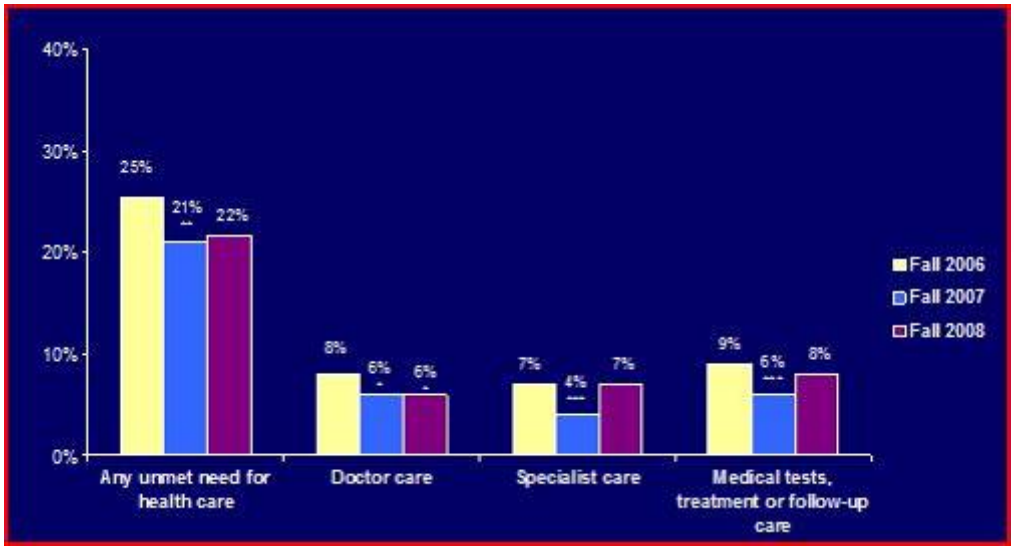
> "Because of our reform, over 97% of Massachusetts residents are insured—the highest rate of coverage of any state in the nation."
>
> Governor Deval L. Patrick
> Massachusetts Is a Health-Reform Model
> Wall Street Journal Opinion Section
> October 15, 2009

But…

- 1 in 5 adults reported difficulties obtaining care because providers were not accepting new patients or not accepting their insurance type.
- Early gains in affordability eroded with increasing costs
- 22% with unmet need and worsening trend.
- Evidence of increased barriers to care as demand increased.

> Sharon K. Long, Urban Institute
> Access and Affordability: Update on Health Reform in MA
> August 19, 2009

Unmet Need for Health Care for Any Reason



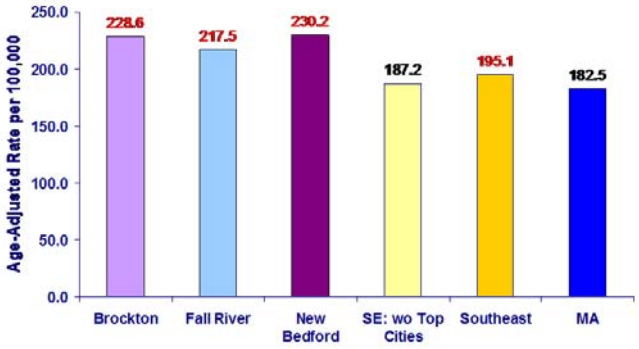
Southeast Region Outcomes
Challenges

Residents of larger communities like Brockton, Fall River, and New Bedford have poorer socio-economic and health outcomes than the state.

- Brockton, Fall River, and New Bedford have poorer birth outcomes and much higher teen birth rates.

Indicator	MA Total (n=76,824)	Brockton (n=1,541)	Fall River (n=1,196)	New Bedford (n=1,391)	Southeast (n=14,681)
Adequate Prenatal Care (Kotelchuck index)	84.0	74.6	85.7	77.4	83.6
Cesareans	32.3	36.7	34.4	27.7	34.6
Low Birth Weight (<5.5 lb)	7.9	11.5	7.9	10.6	8.3
Breastfeeding	79.3	77.3	44.7	54.5	71.5
Public Pay for Prenatal Care	32.6	60.8	61.9	59.1	34.7
Smoking during pregnancy	7.1	10.2	18.4	16.1	10.2

Better Outcome (significantly different from state) Worse Outcome (significantly different from state)



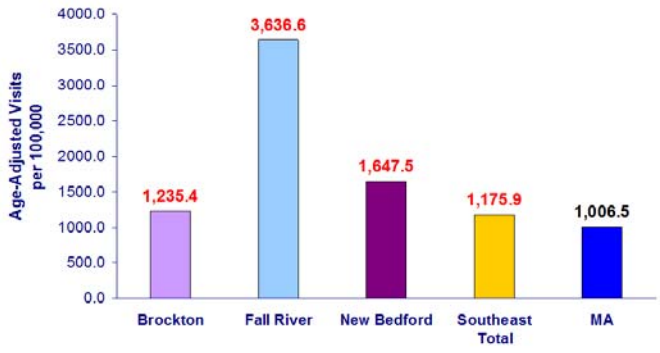
Fall River has a higher obesity percentage.

Heart disease (chart at left) and diabetes mortality rates are higher for Brockton, Fall River, and New Bedford.

- Admission rates to substance abuse treatment rates are higher for Brockton, Fall River, and New Bedford. (chart at right)

- Firearm death rates and HIV mortality are higher for Brockton and New Bedford.

Indicator (Crude Rates per 100,000)	MA Total	Brockton	Fall River	New Bedford	Southeast
Substance Abuse Treatment Program Admissions Rate	1,601	2,551.6	3,426.1	3,057.1	1,724
Substance Abuse Treatment Program Admissions Rate--Alcohol	661	1,142.8	1,239.7	1,071.9	821
Substance Abuse Treatment Program Admissions Rate—Cocaine	62	121.5	183.5	208.5	88
Substance Abuse Treatment Program Admissions Rate—Heroin	609	792.1	1,406.9	1,297.3	504



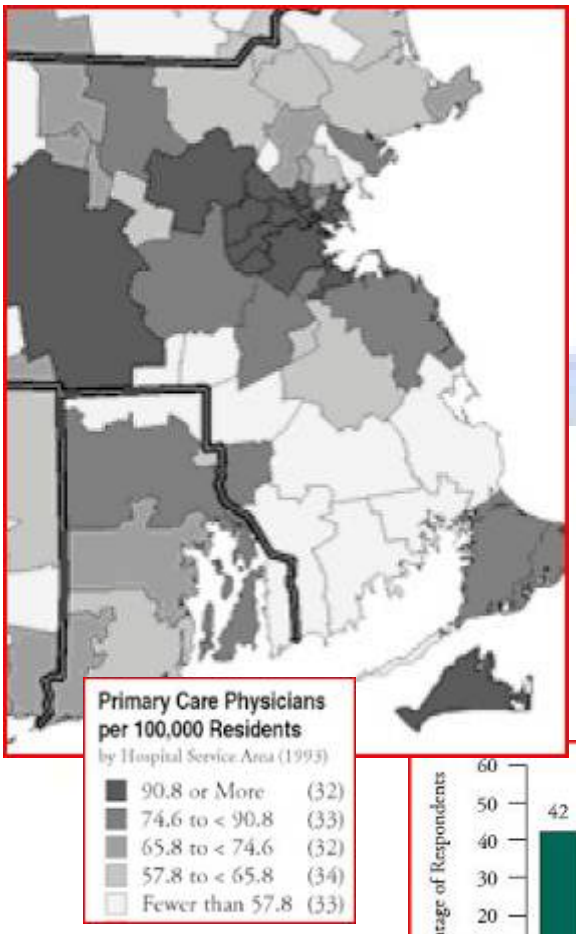
Asthma ER rates (chart at left) and high STD incidences in the Southeast and the top three cities are higher than the state.

Smoking during pregnancy is higher in Fall River, New Bedford, and Taunton.

Southeast Massachusetts Regional Health Dialogue Department of Public Health, 6/7/2007

Southeast Region Barriers: Physician Shortage

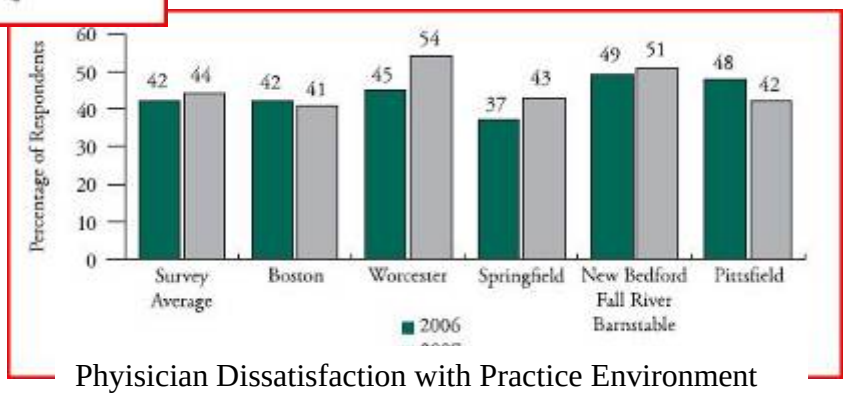
In addressing the aforementioned outcomes challenges, The Dartmouth Atlas of Health Care: The New England States, 1996 that Southeastern Massachussetts has a comparative disadvantage with respect to the New England in availability of primary care physicians (see map left). The Massachusetts Medical Society 2007 Physician Workforce Study indicates that in the ensuing decade the overall situation in Massachussetts became severe.



>50% of physicians in New Bedford, Fall River and Bourne are dissatisfied with the current practice environment, the second worse in the state and the trend is worsening (see chart below).

73% of health system managers in those cities report difficulty filling vacancies and that the applicant pool is inadequate and the trend worsens.

…current physician shortages may have impacted access to care for patients, who reported longer waits for medical appointments…1/3 of physicians altered services or adjusted staff to address patient demand. In particular it is especially difficult in New Bedford (on both accounts.)



Phyisician Dissatisfaction with Practice Environment

- Access to primary care physicians worsens.
- Ability of a physician to refer patients to specialists is more of a problem.
- The number of people who waited more than two months to see a primary care physician jumped from 10 percent in 2005 to 16 percent in 2006. New patients have longer wait times to see a physician.
- "…while there was no uniform effect on specialist wait times, there was a large increase in wait times for primary care providers." (Healthcare Economist – 6/9/2009)

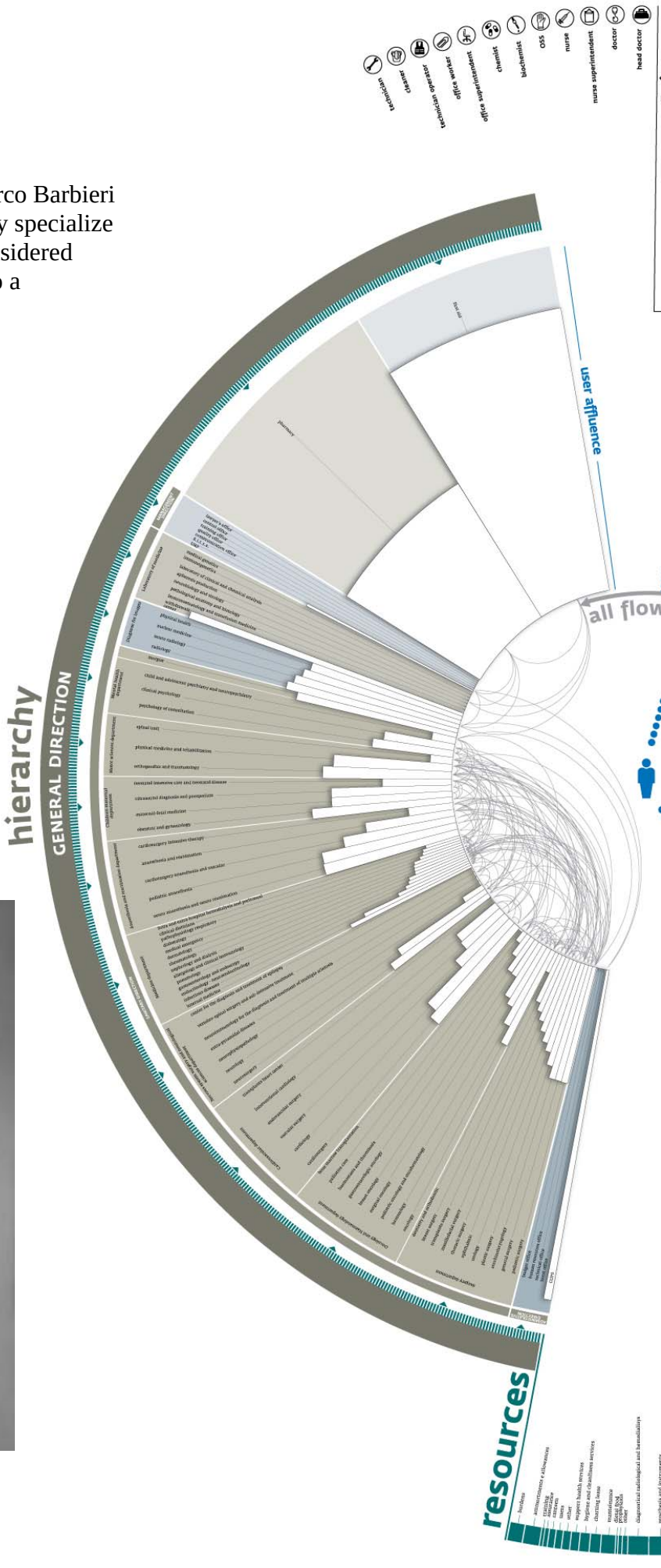
Navigating the Labyrinth

This is a diagram of a Hospital System by Marco Barbieri and his associates at Density Design Lab. They specialize in visualizing complexity. This diagram is considered a simplified view. What map do people new to a health care system use? If there were a map available, can they understand the jargon, the language it is written in, and the seemingly convoluted paths? Does it make sense to them culturally and is the interface at the gateways culturally attuned? How much time does it take to figure out?

How many people must be coordinated to get the care they need? And who will do it?

The complexity of navigating the system itself can be a barrier to access.

djcodrin freedigitalphotos.net



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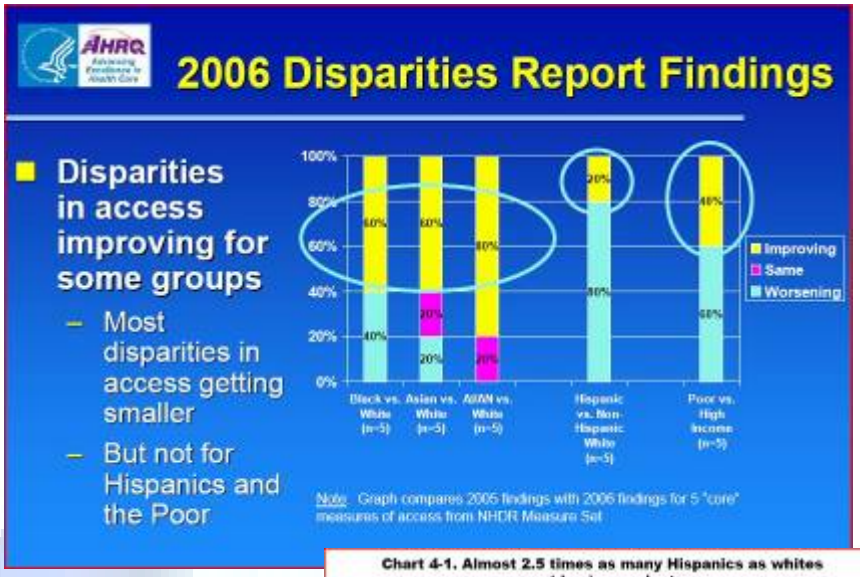
Access Disparities

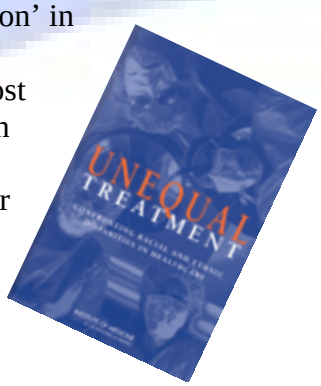
In 1998 the President launched the Initiative to Eliminate Racial and Ethnic Disparities in Health. Concluding:

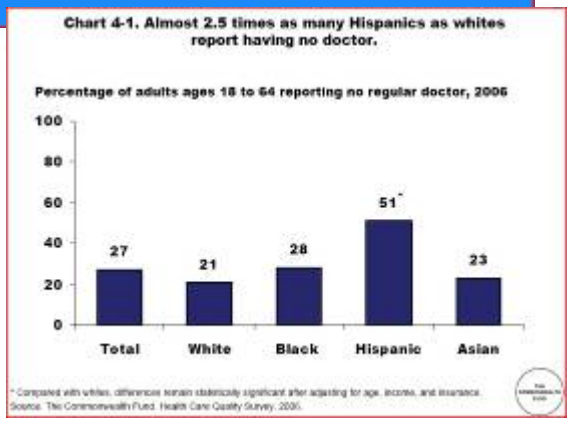
- Hispanics, Poor worse off on 90% of access measures.

- Blacks, Asians worse off on 33% of access measures.

Although the Federal position on access evolved from viewing it as a right to a 'social ethical obligation' in the context of ethnic and minority disparities the most frequent use of "access", in the 2003 report Unequal Treatment, is in the chapter on Civil Rights.







Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level, Kaiser Family Foundation

ACCESS & UTILIZATION									
MA Dimension Score[2]: Better than Average	U.S. All Women	Massachusetts Rates							MA DISPARITY SCORE[4]
		All Women	White, non-Hispanic	All Minority[3]	Black, non-Hispanic	Hispanic	Asian and NHPI	American Indian/ Alaska Native	
No health insurance (%)	17.7	11.2	9.6	17.5	12.9	25.8	14.2	-	1.82
No personal doctor/health care provider (%)	17.5	9.8	7.7	17.1	12.3	23.8	15.9	-	2.23
No routine checkup in the past two years (%)	15.9	9.3	9.4	9.8	5.8	8.0	15.5	-	1.04
No dental checkup in the past two years (%)	28.7	19.0	16.7	30.1	30.3	31.5	26.8	-	1.80
No doctor visit in the past year due to cost (%)	17.5	9.8	8.3	15.0	13.4	18.6	11.2	-	1.80
No mammogram in the past two years for women ages 40-64 (%)	25.5	16.3	15.9	21.1	22.4	14.5	-	-	1.33
No Pap test in the past three years (%)	13.2	9.2	7.9	16.4	10.5	16.6	22.2	-	2.08
Late initiation of or no prenatal care (%)	16.2	10.2	7.6	16.5	20.0	17.0	13.9	11.5	2.18

Summary Impressions of the Situation

What is the situation?
In Massachusetts only 3% are not insured, but 22% have problems in access. Waiting times are getting worse. Nationally Latinos and the poor are worse off on 90% of access measures, blacks and asians 33%.

The situation in Southeast region is particularly difficult due to a shortage of providers which is severe and becoming critical. 50% of physicians in Southeast cities are dissatisfied with their work environment and 75% of people hiring physicians report difficulty in filling positions.

What is access?
"The most urgent health problem this country faces" according to Gallup Polls. The most valued aspect of health care for the sick according to Price Waterhouse Coopers (see chart below.)

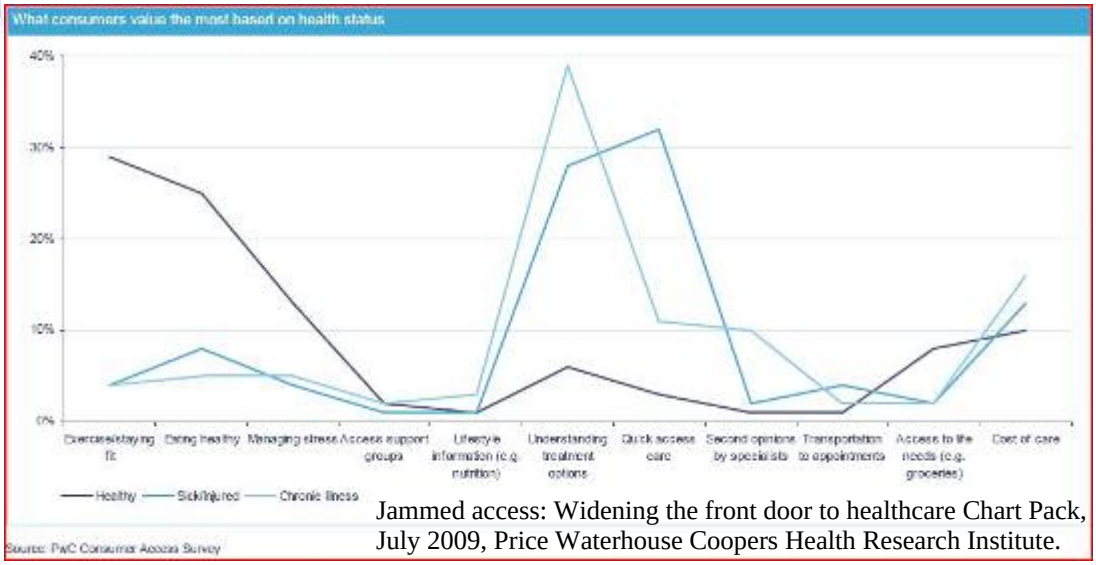
Access is a set of specific objectives: good birth outcomes, prevention through vaccination, early diagnosis of treatable diseases, ameliorating effects of chronic diseases, and reducing morbidity and pain in a timely fashion.

Access is targeting specific regional outcome differences attributable to access disparities. In Southeastern Massachussetts this especially concerns differences in successful pregnancies, heart disease, diabetes, substance abuse, violence, HIV, Asthma, and smoking.

Access is moving people into more regular relationships with care providers by eliminating barriers based on cultural, ethnic, racial, gender, andlinguistic differences; affordability, mobility or fear, or derive from poor communication or health literacy.

Access is a 'moral stance'

and equal access a 'Civil Right'.

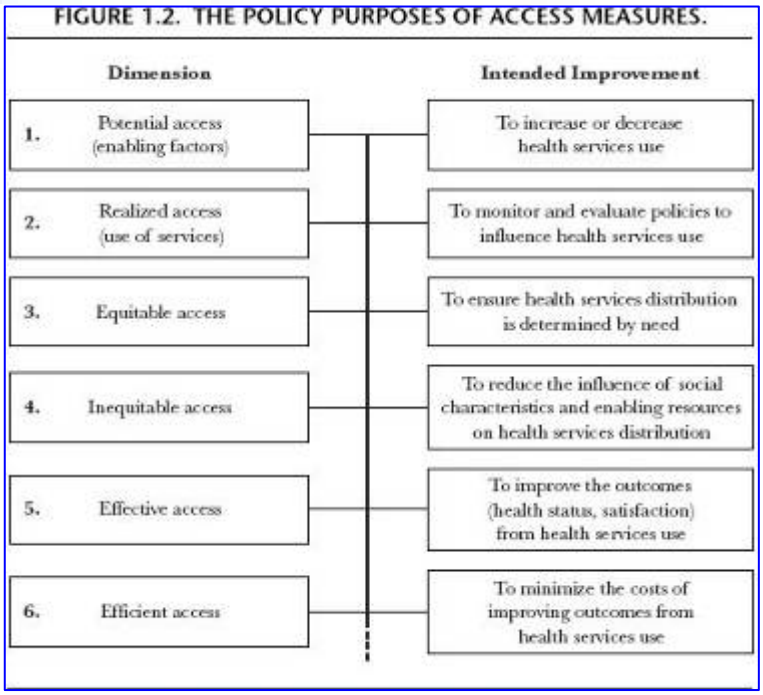


Jammed access: Widening the front door to healthcare Chart Pack, July 2009, Price Waterhouse Coopers Health Research Institute.

This set of snapshots about the situation in access is not comprehensive, it is impressionistic. The purpose of it is to elicit the perspectives of the participants in our deliberation on access.

We have not yet discussed promising solutions, policies, initiatives. One way of framing approaches is as addressing enabling factors, utilization, equitability, inequitability, effectiveness and efficiency of access. We will address these in a briefing to follow.

Background on the deliberation experience is available online. Once you've agreed to attend you will be sent a link to the website for this event. We will employ the Structured Dialogue Design (SDD) process for our deliberation. SDD uses proven methods and software tools for collaboration.



From Improving Access To Care In America: Individual and Contextual Indicators, Ronald M. Andersen, Pamela L. Davidson in *Changing the U.S. Health Care System: Key Issues in Health Services Policy*, Third Edition 2007 By Ronald Andersen, Thomas H. Rice, Gerald F. Kominski.