



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

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TO: John Wiesman DrPH, MPH, Secretary of Health
Washington State Department of Health (DOH)

C. Scott Bond, FACHE, President and CEO
Washington State Hospital Association (WSHA)

FROM: Rural Health Work Group “New Blue H”

SUBJECT: **The New Blue H: A Report on the Findings of the 2014 Rural Health Workgroup, a Partner Project Between the Washington State Department of Health and the Washington State Hospital Association**

Attached is the final report of the Rural Health or “New Blue H” work group. As requested, staff from the Department of Health Office of Rural Health and the Washington State Hospital Association brought together a group of stakeholders to examine barriers and opportunities to maintaining and improving access to health care services in rural communities. The work group split into subgroups representing acute care, primary care and prevention, behavioral health, long term care, emergency medical services/transportation, and workforce to explore the opportunities in these service sectors more thoroughly. This report includes a summary of recommendations that emerged across all of the subgroups, and six appendices that include recommendations by service sector.

As we discussed at the June 30, 2014 meeting staff will continue to move this work forward. Our next step will be to develop a work plan with our stakeholders to prioritize and pursue the recommendations in this document.

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**The New Blue H: A Report on the Findings of the 2014 Rural Health
Workgroup, a Partner Project Between the Washington State Department of
Health and the Washington State Hospital Association**

The Rural Health Work Group was co-chaired by Karen Jensen, Director of Partnerships, Planning, and Performance at the Department of Health, and Jeff Mero, Senior Vice President, Rural System Development at the Washington State Hospital Association. The advisory group for this report was the Washington State Rural Strategic Planning Committee.

Participating organizations:

Critical Access Hospital Network

Dayton General Hospital

Garfield County Public Hospital District

Homecare Association of Washington

Jefferson Healthcare

Odessa Memorial Healthcare Center

Olympic Area Agency on Aging

Pend Oreille County Counseling Services

Rural Health Clinic Association of Washington

Three Rivers Hospital

Washington Association of Community and Migrant Health Centers

Washington Dental Service Foundation

Washington Health Care Access Alliance

Washington Rural Health Collaborative

Washington State Department of Health

Washington State Health Care Authority

Washington State Department of Social and Health Services

Washington State Hospital Association

Washington State Medical Association

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Background

Rural communities are unique from each other. They are also collectively different from urban communities in their population, health needs, assets, geography, and adaptability to health care reform. Rural health care systems mirror the nature of rural communities. Blanket policies in health care payment and regulation at the federal and state level have put rural health care systems in a tenuous situation where adapting to the change may limit access to health care for their communities. Some rural health care systems are in crisis. Federal health policy increasingly prioritizes population health and prevention, without a regulatory framework to promote these activities at the local level. Rural communities need support at state agencies and associations to transform to the care systems envisioned at the federal level. At the end of the day, it is critical to assure people living in rural communities still have access to essential services.

During the Department of Health (DOH) and Washington State Hospital Association (WSHA) annual leadership team meeting in September 2013, the two agencies determined there was a strong need for a clear proposal for how health care in rural communities could change to better meet the needs of each community while responding to healthcare reform. In order to address the emerging concern over access to care for rural populations, this proposal would include new models of care delivery. Though the focus was originally on hospitals, it was determined that this project should consider the continuum of care from prevention and wellness to acute and long term care, with a comprehensive look at how we organize and pay for care. New payment methods or facility models could be suggested. Secretary of Health John Wiesman and WSHA President and CEO Scott Bond charged staff in both organizations with convening a workgroup to develop the proposal.

During the first few meetings, the working group expanded to include several state, federal, and local stakeholders and determined that the following objectives should be considered in this work:

1. Ensure access to integrated, flexible, quality health care services in rural communities, including prevention, 24 hour emergency medical services (pre-hospital and hospital), all primary care, behavioral health, oral health, long term care, home health, home care, hospice, social support services, and others based on community needs.
2. Recognize the urgency of the financial challenges facing some critical access hospitals and rural health clinics and explore interim measures to address them.
3. Enable aging in place.
4. Address rural health disparities.

5. Support rural economies and businesses through strong, local health care services.
6. Achieve the objectives of the Triple Aim in rural communities: better care, better health, lower cost.
7. Ensure the recommendations are aligned with the Rural Health Strategic Plan and emergent proposals from the Public Health Improvement Partnership, the State Health Care Innovation Plan (SCHIP), Regional Accountable Collaboratives of Health, and other emerging initiatives and models for health care delivery in Washington. All recommendations are to be reviewed by the Rural Strategic Planning Committee, which serves in an advisory capacity to the group.

A vision statement adapted from the 2012 Rural Health Strategic Plan and the Washington State Hospital Association Rural Hospital Committee was adopted:

A strong, reliable, community-accountable health care system for rural Washington that ensures those who need care receive the right care, from the right person, at the right time and in the right place. The system provides personal and population health services shaped by the unique needs and resources of each community. The system provides planned access to the full continuum of care -- including physical, oral, and mental health services -- through regional systems that formally link primary and specialty services. The system produces high quality outcomes, promotes community health improvement, and merits the confidence of the community. The leadership to create and support our ideal rural health care system will come from communities and providers working together.

Summary Recommendations

There is much work already happening throughout the state. This report identifies avenues for focusing DOH and WSHA efforts to expand and support existing initiatives while also identifying new proposals. The group identified several sub-groups (see appendices) to investigate more deeply the regulatory and system factors that shape health in rural communities. Through this process, clear themes emerged that threaded through all sub-group discussions. The following five summary recommendations invest the time of both organizations in supporting the development of a comprehensive rural health care system that prioritizes improving access to high quality and appropriate care while reducing health disparities.

1. Develop New Facility Category

In 1989, the Rural Health Care Facility (RCW 70.175) statute was designed to create an alternative facility in rural communities that leveraged the existing facilities and services to better reflect individual community need. The statute was one outcome of the Washington Rural Health Care Commission Report of 1989. No associated payment model was provided.

The work group proposes the modification of state licensing laws to allow for non-continuous care (i.e. 24 hour care) in a licensed hospital. This could lead to hospitals providing less than 24 hour / 7 day a week service and hospitals without inpatient beds. Further review and expertise is

needed to determine how to meet Medicare Conditions of Participation or to propose a new model to the CMS Innovations Center. Also, further review regarding Emergency Response and ties to tertiary facilities is needed. Lessons and findings from the Frontier Extended Stay Clinic model are a relevant foundation for the design of this new facility-type.

Develop New Facility Category		
Short term actions		
DOH	WSHA	Other agencies
<ul style="list-style-type: none"> • Co-lead task force to determine specifics of new facility category in order to propose rule-making on RCW 70.175 to modify licensing laws. • Determine funding stream for new facility and request waivers and support from the Innovations Center where appropriate (CMS and HCA). • Work with other State Offices of Rural Health to garner support for new model. • Commit staff time to regularly review facility license to measure its impact on rural communities and revise as needed. 	<ul style="list-style-type: none"> • Co-lead task force to determine specifics of new facility category and support DOH proposal for rule-making on RCW 70.175. • Determine funding stream for new facility and request waivers and support from the Innovations Center where appropriate (CMS and HCA). • Work with other state hospital associations to garner support for new model. • Work with hospitals to implement new facility category when it is approved. 	<ul style="list-style-type: none"> • Participate in task force to assure that new facility category does not have unintended consequences that would negatively impact the service capability of other community providers.
Long term action		
<ul style="list-style-type: none"> • Assure that the local community approach to finance and delivery ensures rural residents have access to services. • Utilize statute (RCW 70.175) to promulgate rules supporting a new facility type that will better meet the needs of the local delivery systems. 		

2. Promote Comprehensive Local Community Assessment, Planning, and System Development

Local systems are dependent on the culture of their community and the strengths and resources of their local stakeholders. It is critical for the leadership of local health and social services systems including but not limited to, public health, health care providers, long term care, home health, community services, hospice, oral health, and behavioral health, to jointly assess and plan for the health of their community without the impediment of funding and regulatory silos. Additional planning partners to consider who have not been traditionally engaged in health care delivery are schools, employers, civic organizations and economic development agencies. Community engagement in the health care system can deter outmigration for services and support not only the local health care system, but the local economy. As a corollary, this engagement and dialogue will help promote a “Health In All Policies” approach at the local level, further impacting community health. The Department of Health and Washington State

Hospital Association can support the partnerships needed for comprehensive community health planning.

Promote Comprehensive Local Community Assessment, Planning, and System Development		
Short term actions		
DOH	WSHA	Other agencies
<ul style="list-style-type: none"> • Appoint staff person to work with SCHIP to ensure rural perspective in the implementation of the plan and coordinate needs for rural ACHs. • Provide staff time to support local community meetings and public education for health care reform (meeting facilitation, communication tools, find funding, public education initiatives, etc). • Continue to organize state resources for communities by aligning state initiatives and plans and connecting state level coalitions with local work; build resource clearinghouse for communities to use in planning and development. • Require joint assessment and planning for DOH-sponsored program and funding opportunities when appropriate. • Incorporate patient navigator concepts into health care system to better support newly insured consumers in seeking care in appropriate settings. 	<ul style="list-style-type: none"> • Develop community engagement plan and tools for hospitals to conduct joint planning efforts. Provide technical assistance for the deployment of these tools. • Provide advocacy and leadership in community development to rural areas that do not have the adequate infrastructure to implement SHCIP activities or benefit from ACH funding opportunities. • Incorporate patient navigator concepts into health care system to better support newly insured consumers in seeking care in appropriate settings. 	<ul style="list-style-type: none"> • Encourage local chapters/stakeholders to participate in community assessment, planning, and system development. • Incorporate patient navigator concepts into health care system to better support newly insured consumers in seeking care in appropriate settings.
Long term actions		
<ul style="list-style-type: none"> • Keep rural perspective in leadership conversations between statewide organizations. • Build community capacity to self-assess needs and implement needed changes. • Assure that the local community approach to finance and delivery ensures rural residents have access to services. 		

3. Implement a Global Budget Pilot Program

Consistent with the guiding principles of the State Health Care Innovation Plan (Appendix C, Section G), which supports providing stable, predictable funding to rural providers while they participate in work to redesign the health care delivery system, the state should solicit proposals from three to five communities to serve as demonstration areas for a “global budget” approach. The offer should be limited to communities where the lead applicant can demonstrate cohesive partnerships with members of the health care delivery system. This might involve identifying a list of essential services to be provided at the local level, with the expectation that the applicant would demonstrate its ability to meet those expectations either through direct service or through service agreements with other providers. To limit financial risk posed by clients to the service provider, this demonstration should feature state or federally based reinsurance for high cost claims. Additionally, this program would require each demonstration to align with their Regional Accountable Communities of Health funded by the SHCIP.

Implement a Global Budget Pilot Program		
Short term actions		
DOH	WSHA	Other agencies
<ul style="list-style-type: none"> Rural Health Section to review current federal funding streams (SORH, FLEX, PCO, SHIP) and other opportunities to determine where funds might be available for pilot projects. Provide infrastructure to contract with communities for pilot project funds. Support and lead where appropriate in new federal grant proposals to fund this work. Propose/support legislation for changes in payment models for rural communities based on evaluation of pilot projects in Global Budget Pilot Program. 	<ul style="list-style-type: none"> Identify and work with communities to implement pilot projects. Support and lead where appropriate in new grant proposals to fund this work. Propose/support legislation for changes in payment models for rural communities based on evaluation of pilot projects. 	<ul style="list-style-type: none"> Encourage rural stakeholders to support pilot approach. Encourage broad based leadership in allocation of funds. Provide letters of support for new grant proposals for this work. Support changes in payment models for rural communities based on evaluation of pilot projects.
Long term actions		
<ul style="list-style-type: none"> Assure sustainable funding for rural health care system. 		

4. Lead in the Development and Sustainability of Telemedicine and Telehealth Services and Remove Current Barriers for the Health Care System

A multitude of barriers and opportunities surround the use of the rapidly advancing field of health information technology and its capabilities for the health care system. Telemedicine presents an opportunity to provide clinical services to remote clients that otherwise may not have access. Telehealth extends technology to support patient and employee distance learning. Because of the remote geography of rural areas, health information technologies can rapidly

advance access to care and educational services in rural communities. There are many innovative uses for telehealth that can support the recommendations of this work group, such as aging in place, integration of care, and alignment with SHCIP. Unfortunately, both telemedicine and telehealth are underutilized assets because of challenges in policy, payment, equipment and broadband capacity, licensure, training resources, and actual implementation. The Department of Health and Washington State Hospital Association can position themselves to be leaders on this issue to support the advancement and innovation for which telehealth has the capacity.

Lead in the Development and Sustainability of Telemedicine and Telehealth Services		
Short term actions		
DOH	WSHA	Other agencies
<ul style="list-style-type: none"> • Designate staff member(s) to coordinate the DOH efforts to support telehealth. • Convene a work group to identify regulatory barriers to telehealth implementation and create a statewide rural telehealth plan. • Support the development and implementation of flexible and forward looking telemedicine practice guidelines by the regulatory bodies. • Develop capacity to support certification and continuing education via telehealth for agency professional development offerings. • Consider supporting passage of an Interstate Medical Licensure Compact. This would simplify licensure of physicians in other states providing services via telehealth while maintaining clear lines of disciplinary authority. • Support legislation to ensure payment for telemedicine services. 	<ul style="list-style-type: none"> • Designate staff member(s) to coordinate with the Department of Health in supporting telehealth and act as a statewide convener on this topic. • Review the existing broadband infrastructure at the rural hospitals and related clinics to create a priority list for infrastructure improvements. • Improve telemedicine capabilities in rural hospitals to reduce the number of inter-facility transports, keep patients in the rural hospital when appropriate, and facilitate care management and post-acute care in the local community. • Support ongoing net neutrality in Federal Communication Commission regulations to allow for telehealth innovations. • Evaluate the formation of a central hub to link rural hospitals to remote specialists. • Consider supporting passage of an Interstate Medical Licensure Compact. • Support legislation to ensure payment for telemedicine services. 	<ul style="list-style-type: none"> • Continue implementing, evaluating, and sharing innovative uses of telehealth, such as telehomecare and teleremote monitoring for those who need assisted living services, teledentistry, telepharmacy, and telepsychiatry including diagnosis, treatment and monitoring of clients. • Develop capacity to support certification and continuing education via telehealth for agency professional development offerings. • Consider supporting passage of an Interstate Medical Licensure Compact. • Support legislation to ensure payment for telemedicine services.
Long term actions		
<ul style="list-style-type: none"> • Robust technological infrastructure in place statewide to support telehealth advancement. • Payment parity in place for telehealth services. • Responsive licensure and regulatory policies that allow facilities to capitalize on emerging telehealth technologies to best meet community needs. 		

5. Invest in a Comprehensive Statewide Evaluation of the Health Care Work Force and its Capacity While Supporting the Transition to a New System of Care

Ensuring residents can access the right health care providers when needed is an important part of reducing health disparities experienced by rural communities. There are many aspects of the rural workforce that can support or limit access to care. Sometimes, one primary care provider leaving a small community is a significant impediment to care for the residents of that community. In the short term, extending existing rural providers and infrastructure can help maintain health care access. EMS is a vital resource in local communities, and a resource that can do more. Empowering EMS workers to engage in community health efforts through community para-medicine and allowing those professionals to augment hospital staff by continuing care once they enter the hospital setting, is just one example of how Washington can leverage current capacity to better meet local health needs. Investing in understanding the capacity of the health care work force, transitioning education programs to meet the shift toward population health, and ensuring proper alignment of state and federal incentives for rural practice can support access while the necessary infrastructure is built to provide for the health care needs of the changing population. Ongoing workforce gaps in rural areas are a consistent challenge. Some ideas below include transitional solutions to maintain access while an evaluation system is put in place to better understand access to health care providers in rural areas.

Invest in a Comprehensive Statewide Evaluation of the Health Care Work Force and its Capacity to Support the Transition to a New System of Care		
Short term actions		
DOH	WSHA	Other agencies
<ul style="list-style-type: none"> • Commit staff time to regularly review and report on scope of practice across professions for opportunities to expand and meet the needs in rural areas. Accommodate for remote areas. • Review use of Community Health Workers/Promatores/Navigators and look at ways to expand the work at DOH to meet the needs of rural communities. • Explore development of a direct incentive program, similar to that of Alaska, to supplement the loan repayment program to encourage rural practice by mid and late-career clinicians. • Support education programs to develop capacity to better train the workforce for population health needs. • Support legislation to reinstate and increase funds for the state loan repayment program. 	<ul style="list-style-type: none"> • Review and understand how hospitals are using community health workers/promotores/navigators to expand their capacity to meet the needs of rural communities. • Work with rural hospital systems and hospital districts to provide current data on the capacity of their workforce to better understand the staffing needs of rural health systems. • Promote, where possible, new and shared staffing models that better leverage existing workforce resources among member hospitals. • Support legislation to reinstate and increase funds for the state loan repayment program. 	<ul style="list-style-type: none"> • Review and understand how local chapters/stakeholders are using community health workers/promotores/navigators to expand their capacity to meet the various health needs of rural communities. • Work with local chapters/stakeholders to provide current data on the capacity of their workforce to better understand the staffing needs of rural health systems. • Support education programs to develop capacity to better train the workforce for population health needs. • Support legislation to reinstate and increase funds for the state loan repayment program.

•		
Long term actions		
<ul style="list-style-type: none">• Establish a sentinel workforce system using data gathered during the licensure process in order to have close to real time data about where health professional shortages exist and better understand the overall capacity of the rural health care workforce.• Use data gathered via sentinel system to better deploy state resources such as loan repayment funds and health professions education development.• Ensure providers are accessible to rural residents.		

Conclusion

Through the work of the six subgroups, clear themes emerged that bridged traditional policy silos to provide a backbone for change to the rural health system. These priority recommendations reinforce the objectives of the work group charter. Through a flexible regulatory structure that prioritizes local needs, joint community planning, global payment options, and an expansion of telehealth services across the state, together with investments in the rural work force, the five priority recommendations support a cohesive and sustainable future for the rural health delivery system. In removing barriers to accessing care in rural communities and investing in systemic change that will lessen health disparities, rural communities will be well positioned to accomplish the vision of the Triple Aim - better health, better care, at a lower cost.

Appendices

Small changes at the policy level can have a big impact. The appendices of this work include specific recommendations in several policy areas, including transportation, hospital and acute care, workforce, long term care, mental and behavioral health care, and primary care and prevention. The solutions outlined in the appendices present a foundation for the summary recommendations, as well as specific steps to support and transition rural health providers to a more integrated prevention and delivery system.

Appendices

I. Transportation

Background

The transportation work group of the DOH and WSHA Rural Health Work Group presented its findings regarding the health care transportation system in rural Washington State. While a number of facets about health care transportation were discussed, the primary focus of this work is on the pre-hospital Emergency Medical Services (EMS) system. Non-emergent transportation resources, while somewhat limited, are present in rural communities. These resources are primarily provided through the Washington State Health Care Authority's non-emergency transportation brokerage system.

Access to health care systems is a key factor in rural Washington State. Access to health care for rural communities requires the presence of a stable transportation system. This is particularly true for people who must travel long distances for health care resources. Health care transportation resources are separated between emergency health care and non-emergency health care.

Local Emergency Medical Services (EMS) provides emergency health care transportation. EMS in rural communities is most often provided by volunteer workers. Rural communities lack sufficient funding to sustain a fully paid EMS workforce. Communities that do have paid EMS workers are more often supported by local EMS property taxes. The ability to maintain a paid workforce with a fee for service revenue stream is challenging. Therefore, rural communities must rely upon a volunteer workforce to sustain an emergency response system.

Volunteer services continue to experience difficulty in maintaining adequate staffing. There are a number of reasons that contribute to the challenge, including:

1. An aging population.
2. Job opportunities moving from rural communities to more urban areas.
3. Increased training demands for EMS workers.
4. Family commitments and responsibilities.

The decreasing number of volunteer EMS workers contributes to limited emergency response resources in a rural community. All rural EMS agencies have cooperative agreements with neighboring agencies that provide back-up when local resources are unavailable. While these agreements do address occasional gaps when local resources are unavailable, they result in longer response times. Adding to the strain on capacity, local ambulance services also provide

non-emergency ambulance transport in rural communities. These transports are typically from the local hospital to a patient's residence, skilled nursing facility or a hospital in another city.

The need to move patients between rural hospitals and urban health care centers poses a challenge for rural EMS systems. Washington's system of care for trauma, heart attack and stroke increases the demand on rural EMS resources. The clinical care provided to the acutely ill or injured patient frequently exceeds the level of training of local EMS resources. In such instances, rural health systems have two options available to them. They are:

1. Assigning a Registered Nurse (RN) from the local hospital to accompany the patient in the ambulance in order to continue advanced care; or
2. Using Helicopter EMS (HEMS) staffed with Critical Care RN's to move the patient to the urban center.

Option 1 poses a staffing challenge for rural hospitals that already have limited staffing available. Replacing the RN who accompanies the patient results in additional unrecoverable cost for the hospital. RNs who do not regularly work on the ambulance are increasingly hesitant to ride on the ambulance from a safety perspective. Additionally, some rural hospitals lack sufficient staff to release a nurse to accompany the patient as this would leave the hospital without a nurse on duty.

Using HEMS is an option for patients who are acutely injured or ill and require ongoing care by a specially trained RN. Washington State has a robust HEMS system in place. All HEMS providers have capable staff with access to the most current equipment and resources. HEMS' ability to respond to and transport patients is affected by weather and topography. During the winter months (October through March) weather conditions frequently hamper the ability of helicopters to respond and transport. Moreover, the Cascade Mountains represent a significant barrier for helicopters. However, most of the HEMS operators in the state also use fixed-wing aircraft. Moving a patient from the rural hospital to a suitable airport or landing strip creates a demand on local, volunteer ground EMS resources.

Non-emergency transportation that does not require an ambulance can be provided by a number of resources. These include:

- Local transit companies.
- Transport services coordinated through the State Health Care Authority (HCA) transportation brokerage system.
- Privately owned and operated wheelchair transport companies.
- Local Taxi companies.
- Public transit system.

Current State of Health Care Related Transportation in Washington State

Ground Ambulance

Ground ambulance services in most rural communities are provided by volunteer EMS providers. The general characteristics of these services include:

- Limited number of staff available to respond on EMS calls.
- Limited number of ambulance vehicles.
- Primarily use certified Emergency Medical Technicians (EMT) and Emergency Medical Responders (EMR).
- The number of certified paramedics is limited in rural communities. In fact, there are eight counties (Adams, Columbia, Douglas, Ferry, Lincoln, Garfield, Stevens, and Wahkiakum) that do not have paramedics responding with the local ambulance service.
- Core group of people who have a long-time association with the EMS agency.
- Sporadic coverage. In some communities, staff is unavailable during normal working hours. Coverage improves after the work day and during the night and weekends.
- Initial training of EMT's requires an average of about 175 hours of class and practice time.
- Ongoing education requirements for EMT's average 12 hours per year. In order to meet this requirement, local EMS agencies hold one ongoing education session each month. There is also a concurrent hands-on session that is held with each didactic session.
- Difficulty in recruiting new volunteer EMS workers.
- Reliance upon paramedic services in urban centers when a patient requires Advanced Life Support (ALS) care. Rural EMS ambulances frequently rendezvous with paramedic ambulances between the patient's location and the receiving hospital.
- Sporadic cellular telephone coverage in some rural areas of the State.

Air Ambulance

HEMS is widely distributed throughout the state. Washington State is fortunate to have a committed group of air ambulance operators who have access to strategically placed helicopters across the state to provide coverage to both urban and rural communities.

Weather and topography create the need to rely upon fixed wing aircraft when conditions prevent safe helicopter flight. Using fixed wing aircraft requires use of the rural ground ambulance service to move the patient from the hospital to the airfield.

Non-Emergency Transport

Non-emergency health care transport services span a broad range of service and are coordinated via Washington's Health Care Authority's non-emergent transportation service broker system. This system is a statewide system that has five brokers who provide service to 13 different regions in the state.

Resources that are made available to the user include:

- Bus passes;
- Mileage reimbursement and fuel cards;
- Sedans and vans;
- Wheelchair accessible vehicles;
- Volunteer networks; and
- Lodging and meals.

To qualify for these services, the individual must:

- Have a current Services Card issued by the Health Care Authority.
- Have no other way to reach their medical appointment.
- Make sure the medical service is covered by the Medical Assistance Program.

The transportation brokerage system provides an excellent resource for qualified individuals. For those people who do not qualify for the brokerage service, there are fewer resources. Private specialty transport services operate in some larger rural areas of the state. More often, these services are concentrated in urban areas where economies of scale allow more efficient operation of the service. In cases where the transportation brokerage system is not available for the individual and where private specialized transport companies do not operate, individuals rely upon family, friends or taxi service to obtain health care.

Recommendations

Providing pre-hospital EMS in rural Washington State presents a number of challenges and opportunities. Rural EMS agencies rely upon volunteers to staff ambulance and aid vehicles. Rural hospitals rely upon these resources for delivering patients as well as transferring patients to urban centers. In some cases, rural hospitals actually operate the ambulance service. The transportation work group submits the following recommendations regarding health care transportation in rural systems.

1. Improve recruitment strategies for volunteer EMS providers in rural areas through the development of a volunteer EMS workforce recruiting program. Included in this strategy should be improvements to the way that EMS training is delivered. DOH should provide EMS educators with additional resources and mentoring to increase student success in initial EMS training courses. Distributive learning methods for EMS education such as Web-based and telehealth technologies should be identified and expanded to mitigate time and travel barriers for students in rural areas. **Requires time, technical support and resources from DOH. Distributive learning techniques permitted as/of 2011.**

2. Implement a retirement program for volunteer EMS providers. A similar program exists for volunteer firefighters. Extending the opportunity to all volunteer EMS providers will serve as a recruiting incentive. Like their peers in the fire service, the non-fire EMS providers receive a small payment for service when engaged on an EMS response. This is not a full or part time paid position. This payment recognizes their volunteer activity with the EMS agency. **Requires Statutory Change (RCW 41.24).**
3. Conduct more Emergency Medical Responder (EMR) certification courses in order to build ambulance driver capacity. **Requires recruitment of new Senior EMS Instructors (SEI). Achieving SEI status requires additional time and work.**
4. Create county wide ambulance service through EMS taxing districts. This will generate funds to staff and deploy ambulances throughout the rural community. **Requires new levies; taxpayer resistance is a barrier.**
5. Create staffing models that utilize paid and volunteer EMS providers. This will address resource capacity through 24/7 staffing with paid personnel. **Requires additional funding, potentially via new levies; taxpayer resistance is a barrier.**
6. Establish paramedic “fly-car” program. Utilize paramedic in hospital E.D. when not engaged on an EMS response. A paramedic “fly-car” is a response unit that is staffed with one certified, paid paramedic who responds with the local Basic Life Support (BLS) ambulances. If the paramedic is needed in order to provide paramedic level care, the paramedic accompanies the patient in the ambulance. If the paramedic is not needed, they return in service and are available for the next response. The paramedic can be assigned to additional duties such as training and education when not engaged on an EMS response. **Requires new/additional funding from DOH or local districts; taxpayer resistance is a barrier.**
7. Create a messaging campaign that helps tell the story of rural EMS and the value that the EMS system contributes to the rural health care system and community. Increase connections between EMS and local providers to promote integration of services and generate new ideas for community services. **Requires time, effort and technical assistance.**
8. Improve cellular (cell) phone coverage in rural Washington State. There is significant variability in cell phone coverage throughout rural Washington. Improving cell phone coverage will improve access to EMS in rural communities. **Requires cellular telephone carriers to agree with the expansion of existing service.**

9. Revise the reimbursement model for EMS service from a transport-only reimbursement model to a service delivery model. Reimbursement for ambulance service is typically guided by the medical necessity for ambulance transport and the final patient destination. With the exception of medically necessary transports to skilled nursing facilities, the predominant destination is the hospital. Ambulance services are reimbursed only when they transport to one of these two health care facilities. Many national experts recognize that this is a reimbursement philosophy that has outlived its utility. The current reimbursement logic creates an incentive for all patients who are encountered in the outpatient part of hospital setting to be transported to an acute care hospital's emergency department. While the direct cost of transport represents less than 1 percent of Medicare expenditures, the expenses associated with the patient being transported to the E.D., E.D costs, tests, etc. represent a much larger expense. If the reimbursement methodology recognized alternative destinations (e.g., behavioral health treatment centers, clinics/urgent care, and sobering centers), the overall health care cost might be reduced and ambulance providers would recoup the cost of providing transports to facilities other than hospitals. This is only accomplished through revisions in the methodology established by the Centers for Medicare and Medicaid Services (CMS) and other health insurance providers. This will require federal and state legislative actions to accomplish. The benefit will most likely be a slow reduction in the overall health care costs by making sure only the acutely ill and injured patients are transported to hospital E.D.s. **Requires rule and policy change at the federal (CMS) level.**

10. Develop a procedure that allows alternative destinations for patients who do not require hospitalization (sub-acute behavioral patients, chronic inebriates, etc.). **Requires change in Medical Program Director policies and EMS system policies and procedures. Efforts are currently underway.**

11. Improve access within the rural health system to minimize the need for transport. Improve and enhance telemedicine capabilities in rural hospitals to reduce the number of inter-facility transports and keep patients in the rural hospital when appropriate. Conduct routine health care appointments via telemedicine to minimize the need for lengthy travel to physician and other health care provider appointments. **Requires statutory change.**

II. Hospital and Acute Care

Background

The Hospital and Acute Care subgroup aims to address sustainable access to essential health services in rural Washington. The recommendations included in this report seek to provide greater value to both patients and payers through increased flexibility for local communities. Ultimately, Hospital and Acute Care services in Washington State should reflect a regulatory and policy framework with sufficient flexibility to allow a locally driven and sustainable approach to community health needs.

Payment Fragmentation

Current fragmentation in care delivery mirrors the fragmentation in payment. Hospital and acute care providers often struggle to provide needed community services because those services are insufficiently reimbursed. Payers (including the state) should be encouraged to treat rural health systems as systems. We propose the modification of regulations and payment mechanisms and support investments in key care management and business operations strategies including, but not limited to HIE, EHR, telemedicine, care coordination, and the development of regional systems and medical homes. In many communities the hospital and primary care base are both owned and operated by Public Hospital Districts (PHD). In other areas, the district may operate both the hospital and a nursing home, or the clinic and an ambulance service. Current practice is to break payment streams into component parts and to negotiate payment for the pieces separately (in some cases, there's no negotiation—SNF care, for example). The PHD is required to “own” multiple provider numbers to secure payment and comply with multiple payment systems and rules. This adds to administrative complexity and burdens for local hospitals so that they may maintain provision of core services.

The current payment system is similarly plagued by misaligned incentives. Hospitals are paid for care delivered, not for the many preventative health programs that they undertake to prevent community members from needing care in the first place. Any savings from avoided admissions are realized by the payers alone, while the lost revenue threatens the financial viability of the hospital and, in turn, its ability to respond to community care needs. While rural hospitals across the state are engaged in innovative efforts to improve patient care community health and their financial efficiency, they do so at their own financial risk. For example, investments in care coordination activities hurts inpatient cost recapture for the hospital.

New Facility Options

Many remote communities could be well-served by a facility that offered primary care, urgent care, lab services, diagnostics (including radiology, ultrasound and CT), two or three 48-hour observation beds, behavioral health services (crisis and respite), respiratory therapy, physical therapy, occupational therapy, and transitional care and family support. A key question for

consideration then becomes: What's the difference between this "licensed hospital" and a clinic? If a new facility is licensed as a clinic, services provided by this facility and any other clinic it operates won't be eligible for "provider-based" payment from Medicare. One answer might be in the range of services provided—for example, the facility might offer limited surgical care (a lightweight ambulatory surgery center), limited 48 hour monitoring and observation services, rehab therapies (respiratory, physical, transitional care) and Emergency/Urgent Care services. In offering this array of services that are more robust than a clinic but do not include inpatient beds, such a facility could retain the financial advantages of hospital licensure while being more responsive to the care needs of the local community.

Recommendations

1. State licensing laws and/or regulations should be modified to allow for less than continuous care in a licensed hospital. This could lead to (1) hospitals providing less than 24 hour/7 day a week service; (2) hospitals without inpatients. Further review is needed to determine if (a) Medicare would recognize such a facility as meeting its Conditions of Participation; and (b) what expectations should the state have about Emergency Response in such a facility? This model would be limited to existing Critical Access Hospitals and could begin with a demonstration project with 3-5 facilities. **Requires DOH to utilize RCW 70.175 to promulgate rules to support a new facility type. Would also require DOH review of Conditions of Participation and Emergency Response requirements. Would require advice from CMS certification team, and proposal to the Innovations Center. Lessons from the Frontier Community Health Integration Program and the Federal Extended Stay Clinic may be relevant in this area.**
2. The state should invite three to five communities to step forward to serve as demonstration areas for what would be a "global budget" approach. The offer should be limited to communities where the lead applicant can demonstrate cohesive partnerships with members of the health care delivery system, or where the principal applicant can meet expectations for service agreements to provide services beyond their current scope. This might involve the state identifying a list of essential services for which it requires local access with the expectation that the applicant would demonstrate its ability to meet those expectations either through direct service or through service agreements with other providers. To limit financial risk posed by clients to the service provider, this demonstration should feature state based reinsurance for high cost claims. **Requires DOH and HCA cooperation to allow global payment for Medicaid services and CMS waiver or proposal to Innovations Center for Medicare payments.**
3. WSHA should ask for the state's support to seek a modification to CAH Cost Allocation regulations to allow for a return on investment in integrated community services, including prevention, wellness, care coordination and school health. Current cost

allocation rules prohibit investment in these activities (investing in care coordination hurts inpatient cost recapture). **Requires CMS waiver or proposal to Innovations Center.**

4. The state Medicaid Program should institute gain-sharing incentives to rural providers to reward efficiency gains and to recognize savings achieved through local delivery system improvements. **Requires new or re-allocated funding within Medicaid.**
5. Washington State should consider seeking authority from CMS to expand the PACE (Program for All-inclusive Care for the Elderly) to rural areas. This would require some re-insurance protection, and, again, could be tested in a handful of communities currently served by a CAH or clinic. **Requires CMS approval and establishment of a reinsurance program.**
6. Promote use of telemedicine to allow access to tertiary care within remote sites. Telemedicine not only ensures timely access to appropriate care, it reduces cost to the facility, health care system and patient through prevented travel and lost time. **Requires investment and technical assistance on behalf of DOH and statutory change (such as HB 1448 which did not pass in 2014) to ensure telemedicine services are appropriately reimbursed.**
7. Promote expansion of the paramedic role beyond the pre-hospital setting. Allow paramedics to continue seeing incoming patients once they enter the Emergency Department, and in the community post-acute stay or otherwise to assist with care transitions and prevent unnecessary emergency department visits. The Washington Administrative Code (WAC) defines the environment in which certified EMS personnel can function. WAC 246-976-182 (1)(a) stipulates that a certified EMS provider may only work in the pre-hospital emergency setting or while transporting patients between health care facilities. This language restricts the activities of the EMS provider and prohibits functioning within the hospital, clinic, urgent care center, or community. This poses a challenge for rural hospitals that are already short staffed. **Utilizing EMS personnel to augment hospital staff provides additional resources that can engage in patient care within the walls of a hospital or clinic, or in community settings. Requires rule change to WAC 246-976-182 (1)(a). Additionally, the scope is dependent upon, and allowed in part, by the EMS provider adhering to the oral or written patient care protocols of the MPD (RCW 18.71.205 (6))**

III. Workforce

Background

The workforce subgroup of the joint DOH/WSHA Rural Health Work Group project presented its findings regarding the healthcare workforce in rural Washington. The overall health of rural residents is determined by the interplay of biological, social and environmental factors. However, ensuring residents can have access to healthcare providers when needed is an important part of reducing health disparities experienced by rural communities. While the group discussed many aspects of the rural workforce, the primary focus was on extending existing rural providers and infrastructure. Ensuring proper alignment of state and federal incentives for rural practice also emerged as a theme.

Recruitment and retention

Rural healthcare facilities serving the main domains of primary care – medical, dental and mental health – experience difficulty recruiting and retaining clinical staff. Reasons for recruitment challenges include a lack of local training opportunities, perceptions of less pay than in urban communities, professional isolation and few providers interested in rural living. In both urban and rural areas, providers also leave the health care professions due to burnout and suicide. Rural areas are typically served by general practitioners such as family medicine physicians. Due to the skewed specialist to primary care physician ratio in the U.S., these generalist physicians are in high demand and harder to recruit in both rural and urban areas. These staffing difficulties lead to many unideal outcomes including disrupted patient/provider relationships, the use of expensive temporary staff and long wait times for patients.

Loan repayment and scholarship programs are two main mechanisms currently used to direct providers to practice in medically underserved communities. However these programs exclude mid and late-career providers who do not have educational debt. Often rural and frontier practice locations are better suited to experienced providers but loan repayment is only attractive to new graduates.

Licensure

The group's discussion of licensure challenges and opportunities exposed several issues, some specific to rural and some applicable to all providers regardless of practice location.

Physician assistants (PA) practicing in remote sites are allowed to reduce their supervision time from 25 percent to 10 percent but must obtain special permission of the Medical Quality Assurance Commission or Board of Osteopathic Medicine and Surgery. PAs with interim licenses are not allowed to practice in remote sites. Anecdotally, Department of Health staff members have found rural sites prefer advanced registered nurse practitioners over PAs because ARNPs can practice without physician oversight.

Many rural communities use volunteer emergency medical technicians to staff their emergency services system. There are extensive training requirements for these volunteers. Overall, rural residents willing to be volunteer EMTs are becoming harder to find for many reasons, including the training commitment.

Recent legislation and rule development affecting medical assistants has created confusion at some rural facilities about what tasks these providers are allowed to do. Before the changes MAs may have been performing tasks outside what was allowed by state law and rule.

The setting of limits on certain types of licenses, especially pre-hospital providers, means there is wasted capacity in some communities. Paramedics, who are extensively trained in some areas of patient care, are not allowed to work inside a hospital. In a rural area this reduces staffing flexibility.

Telehealth and telemedicine

Telehealth and telemedicine applications are already starting to make inroads into rural areas, particularly in mental health and radiology. There is great potential in rural Washington to expand these services. There remain challenges with licensure, reimbursement and technology infrastructure that must be addressed through legislation.

Current work

The Department of Health and other state agencies are currently working in these three areas.

Recruitment and retention

The Rural Health Section of the Department of Health is directly involved in the recruitment of primary care, dental and mental health providers for the state's rural employers. The recruitment staff person works mainly to fill physician, dentist, nurse practitioner and physician assistant openings. Section staff members also coordinate several incentive programs that operate in both rural and urban underserved areas. Current healthcare workforce programs include:

- J-1 Visa Waiver Program
- National Health Service Corps Loan Repayment and Scholarship Programs
- Washington State Health Professional Loan Repayment Program

The department participates in a healthcare workforce collaborative called the Washington Resources Group. Other participants include the Washington Association of Community and Migrant Health Centers, the Washington Student Achievement Council, the regional National Health Service Corps program staff and the Area Health Education Centers. The collaborative promotes rural/underserved practice and the loan repayment programs to eligible clinicians and health professions students. Workforce at free clinics in Washington is supported by the Volunteer and Retired Provider Malpractice Insurance Program.

Licensure

Allopathic and osteopathic physicians both have a full scope of practice; however they are separately licensed by the Medical Quality Assurance Commission and Board of Osteopathic Medicine and Surgery. This can cause issues for PAs who have an allopathic or osteopathic credential and need to work with a physician licensed by the opposite authority. The physician assistant rules are currently being revised with the intent to modernize PA licensure. These changes have the potential to allow for quick transfers by PAs between MD and DO supervisors. This will be an advantage to rural areas where flexibility in response to staff changes can be important in maintaining access to care.

Telehealth and telemedicine

The creation of a robust telehealth and telemedicine system that increases access to care in rural areas requires many foundational steps before significant progress can be made. Issues needing resolution include practitioner licensure, technological infrastructure and adequate reimbursement. Work in Washington is ongoing in several of these areas.

Telemedicine physicians frequently treat patients located in states other than where the physician lives. Currently, a physician or his/her employer must ensure that the clinician is properly licensed in each state where practice occurs. This is a time-consuming and expensive process. Department of Health staff members have been actively working with others from across the United States to draft a potential solution. The proposed Interstate Medical Licensure Compact would simplify the licensure process for physicians who practice in multiple states via telemedicine among other outcomes. If the legislature authorizes participation in the compact, it would allow both the Board of Osteopathic Medicine and Surgery and Medical Quality Assurance Commission to lower the licensure time and cost barriers to physician practice of telemedicine. In conjunction with other efforts to promote telemedicine, this could have the net effect of increasing access to care in rural Washington.

Washington's rural counties have lower access to high quality Internet connections compared to the urban counties. These technological gaps will need to be addressed in some fashion before there can be strong use of telehealth. There are also federal threats to telehealth innovation in the Federal Communication Commission's proposed changes to net neutrality policies. Telehealth technologies are in the start-up phase when innovation is key. A non-neutral network could lead to the great potential of telehealth never being realized.

Legislation to address the equal reimbursement of telemedicine services was considered during the 2014 session but did not pass. It is possible that the bill will be reintroduced during the next session.

Recommendations

The workgroup recommends the following strategies to address the health care workforce needs of rural communities.

Recruitment and retention

1. Add 1FTE to the DOH Rural Health Section recruitment and retention staff. This will allow the Department to broaden direct recruitment work to include behavioral health providers, physical and occupational therapists, registered nurses and other needed rural health professionals. This would also increase the ability of the staff to work on retention measures such as disseminating best practices and monitoring retention of providers participating in loan repayment programs. **Requires resources from DOH.**
2. Support the development of additional teaching health centers/family medicine residency programs in rural Washington. **Requires participation of University of Washington School of Medicine and Pacific Northwest University of Health Sciences along with potential appropriation by the legislature or identification of alternative funding mechanisms.**
3. Reinstigate funding at the pre-recession level for the Washington State Health Professional Loan Repayment Program. Consider broadening types of health professions that can be eligible to include mental health providers. **Requires legislation to reinstitute funds to this program.**
4. Explore development of a direct incentive program to supplement the loan repayment program to encourage rural practice by mid and late-career clinicians. Alaska has implemented a possible model program. **Requires DOH resources to develop a white paper regarding program development. Eventually would require legislation and an appropriation if the white paper finds the proposal justified.**

Licensure

5. Examine the RCWs that control the health care professions to ensure that providers are able to practice at their highest level as according to the most recent evidence regarding safety and quality. Look for innovative ways of expanding scope of practice to maximize staffing flexibility in rural facilities while maintaining safety and quality. **Requires potential legislation and subsequent rule changes.**
6. Streamline the transition of military-trained health care professions to civilian licenses. **Complete crosswalk between military training and civilian licensure requirements**

and consider if some requirements can be waived or shortened in light of relevant military training. Changing licensure requirements would require legislation.

7. Promote Volunteer and Retired Provider Program to rural retiring healthcare professionals. Continue paying license fees and malpractice insurance for program participants. **Request increased funding to this program to allow for increased license fee coverage and more staff time to manage the program.**
8. Evaluate reasoning behind not allowing PAs who hold interim permits to work in remote sites. Look at research to determine whether the department should support legislation that would allow PAs with interim permits to work in remote sites. This would allow faster transition after graduation to practice in rural areas. **Requires staff time from DOH.**
9. Support the development of community or integrated paramedicine programs in rural areas. **Could require statutory and rule changes to expand scope of practice address licensure, supervision, and liability issues.**

Telehealth and telemedicine

10. Washington should pursue participation in the proposed Interstate Medical Licensure Compact. **Participation will require the legislature to pass compact language, which could be sought in the 2015 session.**
11. Evaluate broadband internet capacity across Washington or identify previously done evaluations in order to identify gap areas and promote building the infrastructure necessary for telehealth/telemedicine implementation. **Requires staff time.**
12. Increase uptake of telehealth and telemedicine technology in rural Washington. **Create a joint workgroup between DOH/HCA/DSHS to define telehealth, create standards, and address reimbursement and licensure. Consider innovative use of telehealth such as using rural EMS providers to conduct in-home telehealth visits connecting home-bound patients with distant providers.**

IV. Long Term Care

Background

For the purposes of this report, long term care includes institutional care, residential, and in-home care. Institutional care refers to nursing homes, residential care to assisted living and adult family homes, and in-home care means home health services and home care services.¹ Home health services are provided by licensed home health agencies and are medically-oriented. They must be prescribed by a physician, and require a need for skilled care from a nurse or a physical or speech therapist. Home care is primarily non-medical assistance with activities of daily living, such as bathing, dressing, feeding, medication reminders, and transportation. Social work, case management, care coordination, durable medical equipment and other services may be part of home health or home care depending on the payer and patient's needs.

Providing long term care services in rural areas is challenging for many of the same reasons identified in other sectors: workforce shortages, limited access to required training, travel distances and costs, inadequate reimbursement, and regulatory barriers. Additionally identified were lack of coordination between different types of providers, and lack of knowledge about the resources available due to our traditional siloed approach to planning and service delivery.

Work group members identified adult family homes and assisted living as particularly lacking in rural areas, especially for people on Medicaid. Nursing home options continue to shrink as critical access hospitals (CAHs) close their nursing homes. Today, only six of the 39 CAHs have nursing homes, and most of them operate at a significant loss (annually over \$300,000 for one CAH and \$1 million for another). However, the impact of these closures on communities is somewhat mitigated by CAHs using swing beds for long term care and the state's commitment to providing long term care in home and community settings like adult family homes and assisted living.

Home health services are also not readily available in rural areas, nor are they used to their full capacity. Reasons for this include:

- Regulatory barriers in Medicare, Medicaid, and state certificate of need requirements.
- Lack of knowledge about home health services and eligibility in communities, particularly for care coordination.
- Inadequate reimbursement, particularly in rural areas where longer travel times and costs are not taken into account in reimbursement rates. Medicaid reimbursement rates have been stagnant for 10 years, while Medicare rates are continually subject to cuts. At the same time, the cost of care continues to increase including the cost of medical supplies, travel, and technology upgrades.

¹ These services are different from [health homes](#) which are settings for coordinated primary and behavioral health/substance use services, usually for patients with one or more chronic health conditions and on Medicaid.

The Long Term Care subgroup developed their recommendations with two primary intentions:

- Preserve access to long term nursing home, residential care, home health services, and home care services in rural areas, and increase resources for these services where needed;
- Support aging in place by providing long term care for people in their own communities, at home where possible, and in coordination with other health and social services.

Recommendations

1. Expand care coordination and transitional care services to all people who need them. Develop policy and use local planning processes to ensure services are provided efficiently and not duplicated by multiple entities. Providers could be rural health clinics, hospitals, home health services, Medicaid health homes, area agencies on aging, or others based on the resources in the community. Care coordination and transitional care services must include non-clinical services, such as assistance with transportation, meals, caregiver support, and other psychosocial factors impacting health and use of services.

Requires:

- **Policy changes and additional funding to pay for care coordination for public and private payers who don't already pay for it or where payment is inadequate, or the service is inadequate to achieve the goals of care coordination.**
- **Local/regional planning and coordination to identify or develop the most effective and efficient, non-duplicative care coordination providers based on local/regional resources.**
- **Development of standardized definition of care coordination services and training to avoid perpetuating disparities in rural/urban services and health outcomes.**
- **Explore state or other certification to support consistent and quality services across rural and urban areas.**

Note: Work in some of these areas is already underway, but not necessarily from a rural perspective or in rural areas, or for all payers or people. DOH needs a better understanding of what's already happening with care coordination in rural areas in Washington and other states, as well as at other state agencies and organizations, such as DSHS Aging and Long Term Support Administration (ALTSA), Health Care Authority, WSHA Partnership for Patients, Qualis, etc.

2. Include long term care providers, area agencies on aging, and ALTSA regional representatives and resource developers in local and regional health care systems planning along with public health, hospitals, primary care, and behavioral health. Ensure rural and long term care providers and policy makers are included in regional planning

for the State Health Care Innovation Plan's (SHCIP) Accountable Communities of Health. **Requires dedicated staff time and specific initiatives for partnership-building between these organizations at the state and local level, with particular attention to the latter, and rural-specific representation on SHCIP planning and implementation teams.**

3. Increase understanding and utilization of services provided through ALTSA Home and Community Services and home health services in rural communities. **Requires technical assistance and a communication plan from DOH staff in partnership with ALTSA and the Home Care Association of Washington, and culture change among local providers.**
4. Support the development of tele-home care services, including tele-monitoring, possibly reimbursed on a per patient/per month basis. **Requires further exploration of tele-home care services, a payment mechanism and associated statutory changes, and coordination with ALTSA and CMS and other regulators and providers of home care and home health services. The telemedicine bill, HB 1448, does not cover tele-home care services.**
5. Maintain long term care beds as needed in communities. Explore sustainable reimbursement through changes to or waivers of regulations and cost allocation policies that increase costs or decrease reimbursements unnecessarily. Suggestions include a unified cost report for CAHs with skilled nursing facilities (SNFs) and other services, expanding CAH cost-reimbursement to CAH SNFs, maintain swing beds as an option. **Requires further study to identify potential statutory and regulatory changes, and coordination with CMS, Aging and Long-Term Support Administration (ALTSA), DOH Facilities and Certificate of Need.**
6. Increase availability of adult family homes and assisted living in rural areas. **Requires identification of gaps in this level of care in rural areas and work with ALTSA resource developers.**
7. Use home health care coordination and management to the full extent, including long term care management. Provide services in the home where feasible. **Requires changes to the federal and state statute and regulations and possibly the Medicaid waiver:**
 - **Address home health reimbursement issues, including an add-on for mileage/travel costs.**
 - **A waiver from federal regulations such as “face to face” and “homebound” for home health care eligibility.**

- **Addition to home health services of a one-time nursing visit benefit to help with medications reconciliation and transition from hospital to home.**
 - **Review certificate of need requirements for home health services for opportunities to expand home health services in rural areas. Certificate of Need RCW 70.38.015, WAC 246-310.**
8. Work with DSHS, ALTSA and SEIU and other workforce development and training programs to increase access to long term care worker training in rural areas, via telehealth and more on-line training. Address workforce shortages by cross-training therapists and nurses from hospitals for home health care as hospital census decreases and more health care is provided in the home. **Requires additional resources and technical assistance from DOH, licensure changes. This relates to work force and telehealth recommendations.**
 9. Build upon exemptions granted to professions such as RNs and medical assistants for long term care worker certification. This model could serve as the basis for other multi-purpose certifications/licenses to address the multiple and duplicative training requirements. **Requires DOH licensure review and changes to requirements. Relates to work force recommendations.**
 10. Address gaps in physical and occupational therapy workforce. Medicare requires nursing, PT, or speech before they can authorize OT or social services. Medicare home health benefit doesn't include a one-time nursing visit, e.g., to help with med reconciliation, set up at home for transitional care. **Requires changes at CMS.**
 11. Develop/provide/replicate training for specialty care where needed, e.g., Yakima obesity coalition, dementia care, etc. **Requires additional funding and technical assistance, work with ALTSA.**

V. Mental and Behavioral Health

Background

Washington's current publicly-funded behavioral health system is complicated and contains many barriers to accessing services. Some of the barriers center on limitations for eligibility for services (only Medicaid-eligible individuals can receive services through the publicly-funded system) and limitations based on severity of condition. Other limitations are based on state and federal law; for instance, at what point can an individual be involuntarily detained due to concerns about a mental illness concern.

In rural areas, these problems are exacerbated due to lack of personnel, especially specialists like psychiatrists. Access to adequate mental health services for children was recently the subject of a lawsuit that resulted in an out-of-court settlement that calls for the reorganization of children's mental health in the state.

Access to mental health services from private sources is also restricted in Washington State based on insurance coverage, access to qualified providers, and acuteness of conditions.

Lack of Mental Health Providers in Rural Areas

Services in the publicly-funded system are coordinated through 11 (eleven) Regional Support Networks (RSNs). The RSNs contract with service providers to deliver mental health services. The services can vary between RSNs based on the amount of funding available and the qualifications of individuals providing services.

Four principal factors contribute to the challenge of caring for persons with mental illness in rural settings: (1) limited access to mental health providers, particularly psychiatrists; (2) lack of coordination and information sharing among continuum of providers often due to lack of information technology/data systems, regulations/statutes, or trust among providers; (3) a shift to increased public financing of treatment, accompanied by declining private coverage, budgetary constraints in publicly funded systems, managed care policies and practices, and the large number of uninsured individuals; and (4) limited utilization of available mental health services because of stigma or limited awareness of mental disorders.

Additional workforce challenges:

1. Difficulties in recruiting and retaining staff often due to concerns over compensation and difficulty in recruiting to rural areas; moreover, the significant demands and stress related to crisis work leads to turnover and burnout.
2. Rural agencies are challenged by clinicians who complete their training/licensing in rural areas and then move to urban areas to practice.
3. Limited access to relevant and effective training; trainings in Evidence Based Practices (EBP) are often offered infrequently and only in one location.
4. Financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.
5. Lack of familiarity with resilience- and recovery-oriented practices.

6. Insufficient numbers in the behavioral health workforce to respond adequately to the changing needs of the rural population; moreover, rural communities lack the population needed to sustain specialists, requiring local providers to train for a wide variety of conditions and patient populations.
7. Insufficient array of skills needed to assess and treat persons with co-occurring or co-morbid conditions.

Inpatient Treatment Bed Capacity

- Limited availability of beds to meet the current need, Washington has 8.3 hospital psychiatric-care beds for every 100,000 people — ranking the state 49th in the countryⁱ; access to facilities that can accept patients with co-morbidities is severely limited;
- Rural patients are required to travel long distances to nearest beds creating a burden for support systems and both patient and caregiver/family;
- Hospitals are dis-incentivized from adding capacity by the insufficient reimbursements associated with psychiatric beds; there are numerous challenges to creating a sustainable line of service for these providers;
- Evaluation and Treatment bed certification creates significant staffing challenges;
- Burdensome CMS clinical record requirements.

Outpatient Treatment Capacity

- Limited or no access to outpatient mental health care due to provider shortage, particularly psychiatrists;
- Limited availability of affordable housing options, including transitional, living, supportive living and “halfway houses” to support recovery in a safe environment;
- Many clinics must subsidize poorly reimbursed crisis services through outpatient services, reducing available resources for additional staff, training, etc.;
- Treatment of mental illness shifted to primary care practitioners which can result in a number of practice and professional constraints such as: insufficient mental health training in medical school or residency; limited time for additional education required for managing challenging cases; insufficient skills in mental health; failure to detect a mental disorder, heavy patient case load; lack of time for counseling and related therapies; and lack of specialized backup.

Transportation Concerns

- Patients often have limited or no transportation. And in rural areas, this is exacerbated by the frequent lack of public transportation options;
- Patients are required to travel outside of their community to access services. Burden can result in need to take time off work, arrange childcare, or seek transportation from friends and family;
- Provider shortages can result in increased travel burden for providers serving multiple counties or larger rural service areas.

Crisis Intervention/Triage Services/ Substance Abuse Services

- Workforce and treatment capacity insufficient to meet demand.
- Need for better integration between behavioral health and local public safety.
- A changing profile of the people in need of services, which includes increased co-occurring mental illnesses and substance use disorders, medical comorbidity, rapidly evolving patterns of licit and illicit drug use, and involvement in the criminal justice system.

Limited or no integration between mental health, chemical dependency and primary health care

- Historical fragmentation that has divided the mental health system from the physical health system has meant that collaboration between primary care and specialty mental health care and/or chemical dependency is a challenge.
- Lack of integration remains a barrier to improving quality, outcomes, and efficiency of the delivery of care.
- Having three separate delivery systems and four separate funding streams to take care of patients' medical, mental and substance abuse needs can result in high costs, low satisfaction, reduced access and poor outcomes, including premature mortality.
- A continual escalation of demands on the workforce to change their practices, including the adoption of best practices and evidence-based interventions.

Ineffective payment structure

- Increased public financing of treatment due to Medicaid expansion, accompanied by declining private coverage/managed care policies and practices, and the large number of uninsured individuals results in scarce resources for local providers.
- Fragmentation and silos between physical health, mental health and chemical dependency in clinical practice are mirrored in the fragmentation of funding streams.
- Budget constraints, cuts and realignments in publicly funded systems –economic challenges like never before.
- No system in place to move to scale innovative practices and systems change efforts that promote recovery.

Lack of medication management

- Limited access by primary care providers to consultation regarding types and dosage of medications used for treatment of mental illness conditions.
- An increase in the use of medications in treatment has not been accompanied by appropriate practice supports, with the resultant demand that the workforce be knowledgeable and skilled in managing medications.
- Decisions about psychotropic medications to be driven by cost rather than effectiveness.

Data/Information sharing obstacles

- Providers and care teams do not have access to stable data systems for sharing patient health information and for monitoring quality and performance measures that support the goals of whole-person care and accountability for health outcomes.
- Rural behavioral health providers lack health information technology and do not fit easily into the CMS requirements for electronic health record meaningful use support.
- An expansion of requirements to implement performance measures and to demonstrate patient outcomes through data.

Obstacles for rural primary care providers and patients when specialized mental health professionals are available

- Lack of expertise of when to refer patients to a mental health specialist.
- Stigma and concerns about the patients' acceptance of the diagnoses and future impact on insurability.
- Patient reluctance to use mental health providers due to concerns of confidentiality or lack of anonymity in rural communities.
- Rural patients suffering from mental disorders may be less likely to perceive a need for mental health care.

Overall complexity, contradictory nature of the regulatory framework

[Senate Bill 6312](#), is a first step to integrating state Medicaid contracting for physical and behavioral health services, a move that will help the state provide better care to more people at a lower cost over time. Passed by the legislature during the 2014 session, SB 6312 creates "behavioral health organizations" (BHO) to replace current Regional Support Networks (RSNs). It also expands the Adult Behavioral Health Systems Task Force (task force), which was created last year. The task force is directed to provide recommendations on substantially reforming and integrating the funding of the adult behavioral health system in a preliminary report by December 15, 2014, and a final report by December 15, 2015. The task force recommendations include:

1. The means by which services are purchased and delivered for adults with mental illness and chemical dependency.
2. Guidance to the Health Care Authority (HCA) and the Department of Health and Human Services (DSHS) on creating common regional service areas for state purchasing of behavioral and physical health services.
3. Key issues for accomplishing integration of chemical dependency into managed care contracts by April 1, 2016.
4. Strategies and key issues to address to move toward full integration of medical and behavioral health services by January 1, 2020.
5. Review of Department of Social and Health Services (DSHS) and Health Care Authority (HCA) performance measures and outcomes.

6. Review of criteria for reviewing applications to become a BHO and applications for BHOs to become early integration adopters.
7. Recommendations on the creation of a statewide behavioral health ombuds office.
8. Scope of the services offered by the state chemical dependency program.
9. Obstacles to sharing health care information.
10. The extent to which there are variations in commitment rates in different jurisdictions.
11. Availability of effective means to address recovery and prevention in behavioral health.
12. Availability of crisis services, including behavioral health boarding outside licensed treatment beds.
13. Best practices for cross-system collaboration among stakeholders.
14. Public safety practices regarding persons with behavioral health needs with forensic involvement.

Based on recommendations from the task force and Washington counties, the Health Care Authority and the Department of Health and Human Services will establish joint regional service areas and contract for mental health and substance abuse services in these areas by April 1, 2016. The bill retains the current regional support networks' right of first refusal to serve the newly established regional service areas. The entities serving the new regional service areas will be called "behavioral health organizations."

In the long term, the bill requires that mental health, chemical dependency, and medical services for Medicaid clients be fully integrated in a managed care health system by January 1, 2020. This means the five managed health care organizations serving Medicaid clients will be newly responsible for enrollee services for chemical dependency and chronic mental health. The regional support networks' role will significantly change.

Finally, the bill includes a provision to encourage expansion of inpatient mental health capacity. Under SB 6312, Certificate of Need requirements are suspended in fiscal year 2015 for hospitals that convert existing licensed hospital beds to provide psychiatric services, including involuntary treatment services. This waiver does not apply to hospitals adding new psychiatric beds.

Recommendations

1. Assure that the Adult Behavioral Health Systems Task Force's recommendations address rural disparities, specifically access barriers such as provider shortage and high rates of medical comorbidity and rapidly evolving patterns of licit and illicit drug use in the rural setting. Rural providers must be given a voice in the task force. This includes but is not limited to input regarding the actuarial study, the development of a single information system, and flexibility in program guidelines to reflect the needs of rural communities. **Requires rural participation in task force activities and coordinated input in the stakeholder feedback process by rural counties and providers.**

2. The legislature's recent funding of three additional Evaluation and Treatment facilities is an important first step, however it will not be enough to fully address capacity issues. The state should continue to expand E&T capacity and work to raise the number of inpatient psych beds available. Raising capacity alone will be insufficient if done without sufficient reimbursements to ensure a sustainable line of service. **Requires additional funding. The process of raising capacity in rural hospitals will be eased by waivers or changes to CMS staffing regulations.**
3. Revise privacy laws to allow mental health and primary care providers to collaborate on care and communicate patient information more effectively. Integrated communication could increase the quality of care, reduce adverse prescription drug interactions, and lead to other beneficial outcomes. **Requires statutory change and review of federal law.**
4. Allow flexible funding streams for treatments covered by Medicare and Medicaid. Flexible funding streams, or global payments for the total cost of care for a patient, remove funding limits for the treatment of individuals in order to provide a full range of medical and nonmedical services. Such a structure is designed to eliminate the cycle of patients receiving limited, incomplete treatment, which leads to the need for additional care for the same issue. This cycle of care is not only more costly in the long-run than flexible funding streams, but it can contribute to adverse patient outcomes. Clinical fragmentation will persist as long as funding for physical health, mental health and chemical dependency services remains siloed. **Requires policy change by HCA/Medicaid and possible CMS waiver.**
5. Work with providers and academic institutions to develop more evidence-based practices (EBPS) specific to rural areas, or to adapt current EDPs to the rural delivery system. This includes increasing awareness and training specific to rural culture. **Requires additional time and resources from DOH.**
6. Increase reimbursements to providers. Current rates are too low; increases in reimbursements could attract and retain quality providers. In particular, higher compensation is needed for DMHPs and crisis workers who face unique challenges, stress and high turnover. Low reimbursement rates for chemical dependency make recruitment and retention difficult. As Washington moves forward with integrated care models, increased reimbursements will help to ensure rural communities can staff all needed members of a care team. **Requires additional state funding.**
7. Increase the number of providers able to care for clients with mental health needs by allowing for expanded roles for current providers and expanding training and educational opportunities. Specifically:
 - a) Develop and expand training opportunities for primary care providers to recognize and respond to behavioral health issues that present in primary care.
 - b) Develop an expedited mechanism for clinicians already practicing to obtain co-occurring training and credentialing.

- c) Develop an outreach system for education on evidence-based practice and continuing education. **Requires time and technical assistance from DOH and WSHA and may result in policy changes.**
8. Washington State should continue its efforts to enact telehealth legislation to ensure services delivered via telehealth technology receive reimbursement. **Requires additional resources and support from DOH; statutory change to guarantee reimbursement.**
9. Address significant discrepancy between the funds allocated to assist mental and behavioral health care providers in accessing health information technology (HIT), as compared to other health providers. This lack of equality leads to fragmented and incomplete care. The Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L. 111-5) was passed in 2009 and is intended to increase the adoption of HIT and support electronic sharing of clinical data among health care stakeholders primarily through electronic health records (EHRs). The HITECH Act provides financial incentives for health care providers to use HIT. It was asserted that mental and behavioral health providers were less able to benefit from these incentives than their “traditional medicine” counterparts. **Requires additional funding.**
10. Enhance workforce development and recruitment e.g.: Focus on outreach to high school students and college students regarding their interest in the psychology field. Tie in with current programs reaching youth, such as the Youth Health Service Corps, and Project Hope. **Requires additional time and resources for DOH/AHECs.**

VI. Primary Care and Prevention Recommendations

Background

The primary care work group of the joint DOH/WSHA Rural Health Workgroup presents its findings regarding the prevention and primary care system in rural Washington State. While a number of issues were discussed, the focus of this work is on a larger vision that communities have access to the full continuum of prevention and primary care. Services are driven by patient and community outcomes, and it is critical to maintain access to high quality care for all residents of rural Washington. Provider and payer incentives must reward the most cost effective and high quality delivery of care.

Challenges and Opportunities

The work group identified the following challenges and opportunities facing rural communities. They include:

Prevention Challenges

- Local public health is underfunded
- Lack of alignment between public health and clinical care

Patient Access Challenges

- Office of the Insurance Commissioner's network adequacy rules may reduce access to the full continuum of care for rural residents. Rural primary care providers may not have anywhere to refer patients needing specialty services.
- Currently only some preventive services are paid for by insurance plans, and all insurances subject patients to deductibles for primary care "sickness" services. This is an access issue for those with limited resources seeking primary care. Primary care services for both "sickness" and "wellness" should not be subject to deductibles.
- Patients need more support for decision making in a time of significant health care culture change. Patients who have not had insurance or access to primary care in the past may not know how the system works and where to access appropriate care. In-person-assister funding ends in December 2014. Navigator funding subject to approval for 2015.
- Some patients will continue to be left out of the traditional health care system, despite wide improvements in access to care, including Medicaid expansion. In particular, those between 139 and 200 percent of the federal poverty line and undocumented immigrants need to know about the free clinic resources available to them.

Administrative & Payment Challenges

There is not a sustainable payment model for Rural Primary Care. There have been many past challenges to payment:

- Because of the specific program finance models, there is no room for cost shifting for FQHCs and RHCs, so they must get paid costs to provide care for the Medicaid population;
- RHC and FQHC Medicaid Recoupment and Reconciliation processes contribute to this lack of sustainability;
- Current Medicaid reconciliation and recoupment process has a four year delay. This presents challenges of budgeting and overall stability. Process needs to be more timely.
- Enhanced capitation payment rates need to be updated to reflect current rates and transparency of what rates are based on.
- Health care payment system is based on face-to-face visits rather than Patient Centered Medical Home Principles.
 - Some chronic care patients would benefit from additional provision of care management.
 - RHC payments only allow face-to-face visits with a provider (no nurses or care coordinators, no email or phone care).
- Primary care organizations and providers know how to be creative, but are working in current regulations with limited grant funding available for creative solutions. There needs to be more sustainable funding support for piloting programs.

Health Information Technology Challenges

- Small primary care practices struggle to afford an EMR, keep track of updates and training and it only provides an upper level look at data. Even those clinics that afford an electronic health record may lack the expertise to pull meaningful population measures due to the vendor's product limitations or staff skill levels or both. The EMR falls short as a tool to support patient management.
- The administrative burden of "meaningful use" doesn't support outcome-based care and ends up being an extra task with no incentive to look at outcomes.

Oral Health Specific Challenges

Oral health is an essential component to overall health. For example, diabetes and periodontal (gum) disease are chronic conditions that commonly occur together and exacerbate each other. There is a growing body of evidence that periodontal disease adversely affects blood sugar control which can lead to diabetic complications. Additionally, untreated tooth decay impacts children's development and ability to pay attention in school.

These challenges are exacerbated in rural communities in which access to oral health care is limited.

- Oral health care access is limited in rural communities in general;
- Oral health is essential and linked to physical health and mental health, however, oral health is frequently not included in systems aimed at improving whole-person health;
- Missed opportunities to prevent oral disease can lead to unnecessary healthcare expenditures. The Washington State Hospital Association found that dental complaints were the number one reason uninsured patients sought care in emergency rooms, resulting in over \$36 million in charges over an 18-month period.

Provider Sustainability Challenges

- There are not enough primary care providers in the nation to fit the needs of the current system. There are not enough medical education family practice training options and debt loads are too high for students who want to practice in primary care.
- The state loan repayment program, which is crucial for recruitment and retention for providers who want to take lower paid positions, has taken many cuts and needs to be made whole again.

Recommendations

1. Communicate and support implementation of the Washington State Plan for Healthy Communities with rural community leaders. **Requires improved communication between groups and technical assistance from DOH.**
2. Support the work of those around the state in better aligning the work, knowledge, and resources of public health and clinical care. (State Health Innovation Plan, Agenda for Change, Rural Strategic Plan, Public Health Improvement Partnership etc). **Requires increased time and coordination between stakeholder groups.**
3. Adopt the federally established essential health benefits into state regulated plans on the exchange to further align Washington State's reform efforts with federal efforts under the Affordable Care Act. DOH should pursue increased partnership with the Washington Health Benefit Exchange Board. **Requires work with the Exchange Board and policy change going forward.**
4. Stay educated on implementation of network adequacy rules. Assure implementation of rules supports rural communities. **Requires point person and coordinated plan.**
5. Continue to promote enrollment in the expanded Medicaid program & enrollment in the marketplace to make sure all patients are covered. Continue patient education on

insurance options and appropriate sources of care. **Continue state investment in positions that assist patients in making health care insurance and access to services decisions. Work with Health Benefit Exchange leadership to support in-person assister training for Navigators and to prioritize funding for these Navigators for 2015. Align with the efforts of HCA on Medicaid expansion.**

6. All primary care services in all facility types paid for by health insurance plans approved by the exchange should not be subject to deductibles. **Requires statutory changes or waiver options.**
7. Continue to invest in programs that support primary care service delivery, including interpreter service. Provide funding at a level commensurate with the demand for those services. Medicaid expansion has increased demand for these services. Evaluate the expansion of alternatives to in-person interpretative services, such as telephonic interpretation, or interpretation through audio-visual links as telehealth services are provided. **Requires staff time for review of the current process to determine if it is meeting current needs and how it could be improved to meet the increased demand (WAC 388-271- LEP services; WAC 388-03 qualification of interpreters). Improvements to telehealth infrastructure may be required to facilitate alternative delivery methods.**
8. Promote systemic linkages between the traditional health care system and the free clinic network, in order to expand access to care for individuals not eligible for Medicaid or able to afford subsidized health care coverage. **Requires staff time from DOH and WSHA.**
9. Review new designs for payment for the reconciliation process. An enhanced capitation model provides predictable payments, without the instability of recoupment. A streamlined, timely reconciliation process will ensure compliance with federal requirements that RHCs and FQHCs are paid at least the federally required minimum. (Social Security Act, Section 1902, bb(6)(B); See FQHC/RHC Alternate Payment Methodology Report. **Requires review and potential adoption of FQHC/RHC Alternate Payment Methodology Proposal 4 and change to Health Care Authority interpretation of Federal Regulations. Look at other state models for refinement of reconciliation process.**
10. Preserve access to primary care by allocating state funds to cover a permanent “bump” in Medicaid payment (same as first half of year 2014 Federal Medicaid expansion payment bump) for the future for certain primary care services. While this does not directly impact Rural Health Clinics and FQHCs, it helps independent primary care providers in rural

Washington and stabilizes the whole system, increasing access to care. **Requires 2015 legislative approval for permanent funding. Also requires time and effort to evaluate initial 2014 payment increase to understand impact. (There was not an official bill for this, just a budget request for 2014 session).**

11. Broaden the workforce of providers to the care team utilizing appropriate connection modalities (telephone, email, etc.). Require state health insurance and health insurance plans approved by the exchange to pay for telehealth services. **Requires statutory change. Reintroduce legislation in 2015 session. [OR Admin. R. 410-130-0610 passed in 2009 for comparison.](#)**
12. Implement a per-member, per-month enhancement payment system not based on visits. Through per member per month payment system, reimburse for patient centered medical home team based delivery of care.
 - a. Require state health insurance and health insurance plans that are approved by the Exchange to have an insurance code to pay for care management services, following Medicare's lead (newly paid starting Jan 2015) for top level medical home certification. **Requires statutory change.**
13. Align with priorities of State Health Innovation Plan (Appendix C). Set aside funds for pilot projects that reward providers/organizations for high quality, cost-effective outcome based care. **This could occur through the reinstatement of HSR Grant Program through Office of Rural Health; Support from RCW 70.175.130; [SHCIP.](#)**
14. Support development and transformation of the medical home so that patients develop a relationship with the entire medical home team not just physician. Increase use of Community Health Workers to assist with implementation of the medical home. Additionally, train Community Health Workers to address oral health, encourage people whose oral health may be impacting their overall health to talk with their primary care team, and link those in need of oral health care to dental providers. **Support/maintain Community Health Workers program at DOH. Increase funding to allow for broader work in this area.**
15. Statewide, support incentives in the SHCIP to improve population level reporting. Nationally, tie meaningful use requirements to NCQA medical home requirements to give them more meaning for population level reporting and streamline data entry requirements. **Requires alignment with SHCIP and staff time for examination of HITECH/ARRA. [Review other states' legislation around meaningful use requirements.](#)**

16. Engage primary care teams to address oral health during medical visits in the same manner in which they address other components of health: assess risk, deliver preventive messages, and refer those in need to treatment resources. **Requires increased engagement with oral health providers and primary care workforce; technical assistance and staff time.**
 17. Provide oral health training resources and tools to primary care providers through the regional health extension program. **Requires staff time and resources.**
 18. Utilize the training and coaching support of the Washington Dental Service Foundation. Encourage providers, health systems, and other organizations interested in engaging in oral disease prevention. **Requires increased coordination and communication.**
 19. Support and increase capacity of programs that incentivize providers to work in rural and underserved areas and to provide volunteer care for patients not served by the traditional health care system. Requires secure funding and staff time for regular program evaluation:
 - a. Reinstate funding for State Loan Repayment Program (WAC 250-25)
 - b. Evaluate and increase capacity of Volunteer Retired Provider Program (WAC 256-564)
 - c. Increase capacity of health care pipeline programs for students who want to pursue health care careers.
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