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EXECUTIVE SUMMARY

In an effort to address concerns regarding the economic well-being of the San Joaquin Valley and the quality of life of its residents, Governor Schwarzenegger established the California Partnership for the San Joaquin Valley. Membership in the partnership includes both state agency secretaries and appointed Central Valley representatives. The partnership was divided into a number of workgroups with the task of contributing to a San Joaquin Valley Strategic Action Proposal that will provide recommendations to the Governor for improving the economic conditions of the San Joaquin Valley. The eight county health departments and agencies were asked to identify issues and provide recommendations to the Health and Human Services workgroup.

Issues of concern identified by the group fell under the general categories of: outmoded public health and healthcare financing systems, inadequate healthcare infrastructure and health professional shortages. Public health agencies in the San Joaquin Valley have experienced a long term pattern of inadequate funding relative to other California regions for a number of reasons, but most notably due to a relatively lower tax base, high rates of poverty and population growth and poor health outcomes.

Healthcare financing concerns in the San Joaquin Valley involve differing, but related, issues: the number of uninsured and underinsured residents, reliance on public healthcare insurance and low provider reimbursement rates. The proportion of Valley children and adults lacking full insurance for all or part of a year is higher than for California as a whole, in part due to the number of workers in low paying or intermittent jobs. The result is that regional safety net providers experience an overwhelming burden to provide healthcare for these residents, with a requirement that is disproportionate to the amount of available resources. Additionally, San Joaquin Valley counties experience a higher Medi-Cal enrollment rate than the rest of the state. Medi-Cal enrollees face challenges in accessing quality healthcare due to an unwillingness of providers to navigate the administrative requirements and accept low reimbursement rates. These low reimbursement rates are reflected in the fact that per enrollee payment levels for Medi-Cal recipients in San Joaquin Valley Counties are lower than the state average and Medicare per enrollee fee-for-service rates average 56-75% of average national rates.

An inadequate health infrastructure will become even more visible as the population continues to grow and federal and state commitment toward managed Medi-Cal strengthens. The Valley has a lower per capita availability of acute hospital beds and a lack of coordinated programs to address the need for outreach and education, chronic disease management and long term care services. Hospital emergency departments are overburdened and rural hospitals are at risk of closure. Community clinics express concerns about an “unfunded mandate” to increase the population they serve, but lack the “brick and mortar” space to respond to the need.

Health professional shortages are well documented in the San Joaquin Valley and are likely a result of the increasing costs of living in the Valley, air quality concerns, fear of professional isolation and low reimbursement rates, coupled with high rates of uninsured and underinsured patients. Shortages impact access to specialty care, behavioral services and dental care, as well as divert funding to high cost “imported” health professionals. Health professional shortages also impact the ability of the eight county public health programs to ensure the health and safety of their communities due to dramatic shortages of public health laboratory directors, physicians, nurses, health educators and epidemiologists.

In this context, the eight county health departments and agencies have drafted the following recommendations under the broad categories of healthcare and public health financing, health professional shortages, and healthcare and public health infrastructure.

Recommendations for Action

Improve Public Health and Healthcare Financing

1. Revise and streamline the procedure for county contracting with the state for public health functions.
2. Develop a point rating system to be used by state agencies to provide a mechanism to enhance review and consideration of funding awards and grants to Valley health proposals.
3. Use growth funds to increase allocations to existing programs based on population in need/health status indicators.
4. Fund and implement single entry point and single application eligibility determination systems for all publicly-sponsored health insurance and service access programs.
5. Request the development of a regional healthcare financing needs assessment which can serve as a resource to determine regional healthcare financing needs.
6. Develop a regional consensus plan for addressing the needs of the uninsured and underinsured that explores innovative healthcare access models, pursues a regional increase in the Federal Medical Assistance Percentage, and integrates federal and state funding streams.

Health Professional Shortages

7. Promote and create incentives for the development of regional approaches for funding and staffing public health laboratories. To help maintain the current public health workforce, modify the baseline pay rates ata all levels of public health to be competitive and more closely aligned with private sector rates.
8. Increase state funded scholarship and training opportunities available to residents of the San Joaquin Valley from the California Department of Health Services (CDHS) Public Health Laboratory Director Training Program. In addition, provide stipend waivers to Valley health departments for CDHS sponsored public health training programs.
9. Seek modifications of existing professional practice standards to increase the scope of allowable care provided by both paraprofessional (e.g. dental hygienists) and professional (e.g. nurse anesthetists) classifications. Encourage and promote reciprocal licensing for dentists with other states..
10. Seek regulatory changes to expand the range of reimbursable behavioral health services
11. Seek legislation to fund and support implementation of a San Joaquin Valley Promotora Academy.
12. Seek support through the California Partnership for the San Joaquin Valley to advocate for changes in the Federal Health Professional Shortage Area scoring methodology.
13. Expand the capacity for public health education at all University of California/California State University campuses.
14. Establish a School of Medicine at the University of California, Merced campus as soon as possible.

Healthcare and Public Health Infrastructure

15. Target and fund the San Joaquin Valley as a technology incubator for electronic medical records, telemedicine, voice over internet programs, video translation and other related new technology.
16. Establish medical “enterprise zones” throughout the region to offer tax credits and other financial incentives for providers to retain, open and expand services to underserved populations.

As shown in Table 1, the region also has lower per-capita income, lower high-school graduation rates, greater unemployment, and a greater proportion of children under age 18 living in poverty than does California as a whole. A recent Congressional Research report found that the San Joaquin Valley is a region of severe economic distress with lower per capita income and higher unemployment and poverty rates than the Appalachian Regional Commission area.[4] These patterns are closely linked to both the historical and current development of the region, as it relies on agriculture and other typically low-wage industries as the backbone of its economy. In this context, there are cumulative effects of poverty for many Valley residents, expressed by issues such as food insecurity, substandard housing, poor access to health care and health insurance, low educational attainment, and persistent poverty from generation to generation. Beyond the impacts of population growth on the region's healthcare and social service infrastructures, it is anticipated that as this relatively young population ages and new immigrants acculturate, there will be additional burdens on the health care system.

Leading Health Indicators

Since 1979, the US Department of Health and Human Services has tracked a number of indicators of the nation's health. Healthy People: 2010 established national priorities around health and health care with the goals of increasing life expectancy and quality of life, while eliminating health disparities by race/ethnicity, gender, education, income, disability, geographic location or sexual orientation. Included with these priorities are 10 leading health indicators that are used to measure progress towards meeting the overall Healthy People: 2010 goals.[5] CVHPI examined overall health system performance in the region by comparing the national objectives for the 10 leading health indicators with current health status and indicators of change in the San Joaquin Valley and then comparing them to California and the nation.[1]

Table 2 summarizes overall results by comparing mean current indicator values for the San Joaquin Valley to California, the nation, the Healthy People 2010 target, and prior years. The findings provide little room for optimism that the San Joaquin Valley will meet the objectives. Currently, San Joaquin Valley residents have met the 2010 targets for adolescent tobacco use, adolescent immunization, and usual source of care for children and seniors. For each of the other indicators, where a comparison was possible, available data indicate little or no change and in some cases negative movement since prior available measures. The one exception to this pattern is that the rates of childhood, adolescent and elder immunizations improved in recent years.

Using conservative standards for drawing comparisons, Table 2 also indicates that health status in the San Joaquin Valley appears to be worse than for California as a whole on six of the indicators: adult overweight and obesity, adult tobacco use, motor vehicle deaths, air quality, flu shots for elders, and access to prenatal care. Specific data relevant to each of these comparisons are shown in Tables 3-6 and Figures 3-4. (Tables 3-6 and Figures 3-4 are located in the Appendix of this report.)

Beyond the general picture drawn by these findings, a number of areas need special attention. Although target objectives for mental health and responsible sexual behavior could not be measured directly by available data, there was evidence of problems with mental health services indicated by suicide rates that exceeded the state average, as well as high and growing rates of sexually transmitted diseases. Further, for these and most other indicators, when it was possible to conduct comparisons by race/ethnicity, insurance status, gender or urban/rural residence, the San Joaquin Valley counties showed disparate outcomes that mirrored or exceeded the group differences observed in state and national level sources.

In addition to the Healthy People 2010 measures, a number of other indicators underscore health status issues for the San Joaquin Valley. Health in the Heartland, reported rates of teen births and infant mortality that were higher than California as a whole, and excessive deaths in one or more of the region's counties from cancers, infectious diseases, diabetes, coronary heart disease and motor vehicle accidents.[6] This same pattern was also noted in the County Health Status Profiles 2006.[7] Figure 5 shows that all Valley counties, except for Madera County, had age-adjusted all-cause mortality rates notably higher than California as a whole. San Joaquin Valley counties also tended to have higher rates of diagnosed chronic conditions such as diabetes, hypertension, obesity, and asthma than most other parts of California.

The distribution formula for these funds is based on the 1991 percentage of population in poverty. The funds dedicated to physical health issues are divided into two general categories, Community Health and Indigent Health. However, each county may determine the use of the funds for the local health programs, so long as the use conforms to the historical patterns. Community Health Realignment, in general, is used to support programs such as immunizations, communicable disease control, public health nursing, some environmental health programs and administration. Indigent Health Realignment funds are, in general, used to offset the county obligation under Welfare and Institution Code 17000.

Separate from Realignment, each county has multiple contractual relationships with the State outlining the use of funds for categorically defined programs, and to pass through funding from the federal government. These can include Maternal and Child Health programs, HIV, Tuberculosis, and tobacco education, Black Infant Health, and many others depending on the identified needs. Counties are eligible for funds based on population, level of disease, historical funding patterns, or other methodology. Each county contract with the State (there can be anywhere from 25 to nearly 100 contracts in each county depending on the size and complexity of the county) has different reporting formats, standards, and timeframes which greatly increase the administrative overhead costs for each program, and negatively impact the funds available for direct service. Although the multiple and disparate contractual and programmatic requirements drive higher overhead costs in many cases, the state contracts also restrict the amount of overhead they are willing to reimburse. Therefore, in order to maintain the same level of service to the community, counties must subsidize these state and federal programs with more and more of their own scarce resources. This also creates "programs silos" which are not conducive to efficient administration.

Without entering into the extended and complex debate about the inequity of Realignment funds, and other contractual funding distribution, there is consensus that the relatively lower tax base, higher population growth, higher rates of poverty, and poor health outcomes in the San Joaquin Valley have exposed a long-term pattern of inadequate funding in public health, when compared with other regions of the state.

Table 7 shows total county expenditures on all non healthcare related public health services (health promotion, disease prevention, infectious disease monitoring etc) per low income resident in 2003-2004.[8,9] Some caution must be applied in comparing county expenditures for public health, because of differences in accounting and demographics. By comparing expenditures on the basis of population below the Federal Poverty Level, the table accounts for one of the most important demographic differences between state regions. The table shows that the San Joaquin Valley counties are spending less than other regions of the State. With about 5% of their total county budgets devoted to public health for both San Joaquin Valley counties and other regions of the state, these differences in expenditure levels are more reflective of variations in capacity to address public health concerns than political decision-making.

The comparisons in Table 7 also do not take into account the potential for economies of scale in public health initiatives. Important system components, such as public health laboratories, need to be developed and staffed, irrespective of county population or poverty rate. Large urban counties are better able to absorb these expenditures in their overall budgets.

As noted by the California Performance Review in 2005, completing multiple contracts has become unnecessarily burdensome, complex, and time-consuming for localities.[10] With lower overall budgets per population in poverty, and smaller total budgets compared to other regions of California, the contracting process between the San Joaquin Valley counties and the State assumes even greater importance.