ACCESS TO HEALTHCARE: IMPACT RECOMMENDATION REPORT

Impact Luncheon: Held September 5, 2017, YWCA Utah
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Categories	Current Resources/Strengths	Gaps/Challenges	Potential Interventions
1. Financial incentives and support	• Thanks to legislation passed in 2017, providers in Utah can now bill for certain telemedicine services.	• Lack of healthcare coverage is the issue that underlies most other gaps and challenges. • Provider reimbursement issues are rampant and complex – impacted by state and federal rules, as well as provider and healthcare system policies. • Cost is THE reason why women don't have insurance when they get pregnant. • Currently in Utah, women without children and without a disability—no matter how low-income—cannot receive Medicaid. They can get primary care services (including some family planning services) through PCN (Primary Care Network). • Low-income women can receive Medicaid when they become pregnant, but are only covered for 60 days after the child's birth. • The lowest income women can also receive Medicaid but only if they have children. • This is not the case of low-income women who are undocumented. The only Medicaid coverage they can get is "emergency Medicaid" for very limited services (birth of a child but no pre- or post-natal care, life-threatening emergencies, etc.). An undocumented woman also cannot get coverage on the	• Need Medicaid to de-bundle services so billing/reimbursement issues are less complicated or more flexible (i.e., with immediate postpartum LARC insertion). • Need Community Health Worker certification in order to get reimbursed so services can be sustainable; Medicaid and private insurance reimbursement critical for these services to be more widely available in Utah. • Need better ongoing coverage system for low-income mothers after a child is born. • Full expansion of traditional Medicaid is needed. • Medicaid expansion through family planning waiver or State Plan Amendment is needed to cover contraceptive care for low-income women. • Overall, need to increase coverage options and decrease cost for all Utahns; THE key issue in access to healthcare.

		ACA exchange. She can get employer-sponsored insurance or buy care directly from a plan or broker. However, these latter two coverage options are usually only for high-income earners. • Community Health Workers in Utah are currently not eligible to be reimbursed by Medicaid (the main funding source in most states). • Under-utilized preventative medicine drives up costs down the line. • Funding for these issues also gets "siloed;" healthcare programs ends up competing with one another for very limited state appropriations. • Need strong consumer advocacy on the private insurance side. Women that do have private insurance still have problems affording and accessing care.	
2. Technology Infrastructure	• University of Utah just awarded a grant to increase telehealth access to postpartum women for postpartum depression treatment– technology and infrastructure is in place across the state. • Intermountain Healthcare growing similar technology capacity. • Utah Telehealth Network, Intermountain, and others have their own systems as well; helps increase rural access. • Community Health Information Exchange (CHIE) is a resource. • Project ECHO at the University of Utah for Medical Education. • Utah Medicaid has some strong policies to support telehealth services and infrastructure.	• There is a disconnect between Electronic Medical Records between providers and healthcare systems (including actual software used); it is difficult for providers to talk to each other about the same patient. Protecting confidentiality is critical and gaining access to information that would help providers improve and coordinate care is challenging. • CHIE barriers – not all providers report information into that system so data not complete; it is missing entire underserved populations. • Data exchange is challenging. • Lack of consistency across insurance companies (especially private payers) regarding how they reimburse for telehealth.	• We need to continue to support and grow telemedicine/telehealth services generally. • Implement evidence-based programs through these telemedicine/telehealth services; online access to these programs is critical moving forward. • Increase education for providers to adopt telehealth technologies. • Bring healthcare systems to the table to discuss possible approaches for connecting medical records in a way that does not threaten patient confidentiality (very complex issue).
3. Creation of economic opportunity		• Utah has gender disparities in higher education completion and wages. Improving women's college graduation rates and full-time employment may improve health insurance coverage and	• A focus on wellness for the whole family helps create economic opportunity.

		health outcomes for women and children.	
4. Capacity building	• Access to telehealth services for psychiatric appointments. • There is a lot of momentum with Community Health Workers (up to 200 across the state); Comunidades Unidas started this with volunteers years ago. • There's a Utah Community Health Worker Coalition now; they have recently standardized a statewide training curriculum and are working on financial sustainability (reimbursement issues). • Health educators in the health system are an important resource. • Looking at integration of mental healthcare with physical healthcare (there are promising pilots from Intermountain).	• Limited mental health services in rural areas. • Still building telehealth services, but haven't used it for substance abuse yet. Some confidentiality concerns with this, but use of these services is growing. • There is "emergency Medicaid" that women can get when they're pregnant even if they are undocumented; it stops there though, and they can't get ongoing coverage or care after giving birth. • There are significant challenges with communication across and between healthcare systems; issues are complex and overwhelming. • It's challenging to work on integrating services because the need of just providing basic services is so great in some communities. For example, in one rural, underserved Utah community, 1 in 3 babies is born with opioids in their system. • There are barriers for children getting behavioral health services in general. We aren't making enough of the connection between physical and behavioral health for children. • Because of Medicaid contracting with behavioral health services, there aren't enough behavioral health providers available. Services are so restrictive that providers can't get help for their patients who don't have insurance. • Because Medicaid behavioral health services are paid/contracted through a separate system from Medicaid physical health services, it can be difficult for these two systems to speak to one another, and for providers to make referrals. • With private insurance, many payers also	• California has started with "health for everyone" (CA Senate Bill 562) and includes the undocumented population. It is a good start that we need to use as a model. In addition, California now covers all children regardless of documentation status, as do 8 other states. Utah could explore something similar, as we have the highest rate of uninsured Latino children in the nation. • The SUPeRAD Prenatal Specialty Clinic in South Jordan provides specialty prenatal care for pregnant women who use substances. Recreating their model elsewhere can improve pregnancy and birth outcomes. Offers Naloxone training for community with free kits. • Providers need to offer best practice services. For providers to understand best practices, more continued education is necessary • Community Health Workers can be a critical piece of preventative healthcare and support, but they need to be eligible for reimbursement to be sustainable. • Improve understanding of roles between Community Health Workers and Health Educators within healthcare systems so these aren't seen as competitive roles. • Create a comprehensive referral system so that Community Health Workers can make sure people get care when needed. These workers provide information, resources, peer support, and referrals for actual healthcare – referrals are key, and we need a better system. • Need co-location of services; a mother needs to be able to get services when she brings her children to get care. Convenience is key for mothers, whether they work outside of the home or not.

		separate behavioral health from physical health, despite mental health parity assurances in the ACA, so it can still be burdensome for providers and patients to find a behavioral health provider.	Need moms to be screened when kids see the pediatrician. Providers must be equipped to do this, have capacity for it, and have good referral systems. • Increasing and building integration of mental and physical healthcare is critical. • Women need to be presented with all the information; women and providers need to see the bigger picture of how all their health issues are interconnected. People see a lot of different providers for different things, and it needs to be more coordinated.
5. Advocacy and shaping attitudes	• HER contraceptive pilot project was successful and has gotten a lot of media. Makes it more acceptable and less-threatening to share reproductive health information, and it uses a respectful approach. • Department of Health working more on well women visits because it is well-established now that preventative care impacts a lot of other areas. • Department of Health is about to do focus groups with women across the state about barriers and how to improve ability to get to these visits. • Internet and social media helps with educating community. It is a low-cost way to disseminate info to a lot of people; it can be a good way to start shaping and normalizing healthcare conversations with young people. • Can be perceived as a safe place to get information for some underserved populations. • Radio can be a good resource for Spanish-speaking Latino community as well. • Department of Health has a well-established public media campaign – "Power your Life." About a holistic health approach – all the issues combined.	• We don't value prevention when it comes to healthcare. We put out fires instead. No comprehensive structure or approach or plan. • Still hard to make a case for why all children should be covered by health insurance in this state, let alone moms/parents. • There are still too many policymakers who think of reproductive healthcare as a luxury rather than a right. • There is a stigma and blame, especially with substance use disorder, but still an issue with mental healthcare as well. • There is a stigma for undocumented women not able to get care because of current political climate. They can't even get prenatal care, let alone after their baby is born. • Accuracy of the information people get online can always be improved. • Many children aren't seeing good modeling by parents getting care because parents aren't covered. • We tend to silo these issues – opioids, mental health, chronic disease, birth control, etc. They are all interconnected in people's lives and should be in our healthcare systems.	• Need to now implement Family Planning Elevated (expansion of HER Salt Lake Contraceptive Initiative). The hope is that this starts to normalize preventative healthcare that impacts women down the road (not just during reproductive years) and with health issues unrelated to reproductive healthcare. • Increase public education to reduce shame and stigma around postpartum depression and related issues, and the same with mental health and substance use issues. • Related campaign needed around taking care of mom = taking care of baby/children/family. Not selfish for women to take care of themselves. • Need to shape messaging so we aren't silo-ing issues. Need "poster children" for these issues in order to make it real for people, funders, and policymakers. Focus on how these issues integrate/overlap in one person or family's life and paint that picture more effectively. • Also need to frame issues as "family issues." • One possibility is to collaborate so that a number of issues are combined in the way they all focus on the early years, under the umbrella of toxic stress/adverse childhood

			experiences/trauma. There are various approaches to the health of mom, children, and the whole family that can be connected to these issues. • Perhaps the Intergenerational Poverty (IGP) framework is another approach (problem, however, is that the state's IGP definition excludes immigrants and refugees). • Get more men involved with women's and children's healthcare; dads need to know who the pediatrician is. Women often overseeing men's healthcare too – they carry a lot of the burden for whole family's care. Social media campaign around this. • Basic awareness and education is still needed to help people understand the healthcare system, and to understand the link between mental and physical health. • Perhaps Department of Health can expand their public awareness and education efforts to include some of these other things – its focus is on women being as healthy as they can before getting pregnant or between pregnancies. • We need to include domestic and sexual violence information in all of these efforts. These issues are all interconnected, and people don't always recognize that – need providers to ask questions and raise awareness. • Apps can help educate people. • Focus on wellness and holistic approach for the whole family.
6. Laws, policies, and regulations	• Access to telehealth and online services are important avenues to increase access to healthcare, and key to increasing access for women and other underserved populations. • Utah is one of the leading states in the country looking at confidentiality laws and regulations to increase and expand access to telehealth services.	• There is an ongoing tension between policymakers wanting data-driven approaches and paying for the actual cost of getting and analyzing that data. • Addressing confidentiality concerns for increasing access to telehealth services is an ongoing challenge. We are making progress but still working on this as a	• Pass a full Medicaid expansion bill in Utah. • Pass Representative Ward's family planning bill during the 2018 Regular Session. • Need people working on different issues to work together to present a comprehensive case/picture to legislators rather than

	• Recent telehealth bill allows providers to bill for certain services; it was a big step forward. • Statewide coalition is working on Community Health Worker certification and standardization for training and reimbursement – will be a policy proposal soon. • Perceived risk to Affordable Care Act at federal level has helped increase how informed people are about it, as well as their support for it. Same with Medicaid issues. • Last year, there were some promising national standards and efforts to increase access to care in private insurance and Medicaid (called 'network adequacy' standards, which essentially put up parameters for insurance companies like establishing appropriate time/distance standards for getting care, wait times etc.).	state. • CHIE data input and exchange; need to consider mandate for providers to participate, because without a requirement to input data, it is an incomplete system. • Policymakers tend to not prioritize mental health, reproductive health, and substance use care. These issues are still stigmatized and sidelined or seen as "additional" rather than core healthcare services. • Immigration policy impacts women's willingness to get care depending on their citizenship status; they have significant and well-founded fear about risking their safety in order to get services. • Access to care for undocumented women and families is getting more rather than less challenging. Utah driving privilege card issue at state level, on top of recent announcement about DACA being rescinded at the federal level – getting harder and scarier to get services. • It has been difficult to get healthcare systems to support the broader incorporation of community health workers because standardization of training, practice, and reimbursement policies are not currently in place. • Legislators hear so many separated, compartmentalized stories and requests for appropriations for a very limited amount of resources. Government agencies, community groups, and organizations must compete against one another for specific line items. This discourages collaboration and more efficient use of resources. Both legislators and those looking for funding feel caught in an endless cycle. • Efforts to adopt national network adequacy standards in Utah have stalled.	competing on individual line items. • Coordinated Health related editorials before and during the legislative session to enhance constituent knowledge of the issues. • Consider a mandate for providers to provide data to CHIE. • Re-engage efforts to adopt national network adequacy standards in Utah

		Without these, we do not have measures or standardized regulations to monitor access to care across insurance plans and little means of enforcement. So, women can sign up for an insurance plan but still not have the right kind of doctor in their network, or they may have a hard time accessing a doctor, hospital, or clinic.	
7. Research and data	• Utah Population Database (UPDB) is great for research purposes. • All Payer Claims Database (APCD) exists and has the potential to be useful. • Legislators value data-driven approaches and do want data. • Local authorities are required to enter uniform data into system for substance use; it is not "real time" but is helpful. • Health centers have Uniform Data System (UDS); they have been collecting data for years, specific to demographics and health outcomes. • The UDS is publicly available and has mapping capability. • Through the Guttmacher Institute and model they've developed, we now have good data and numbers showing how many unintended pregnancies are prevented through family planning, as well as what that means in costs savings to states. • Utah study coming on cost savings/economic case for Community Health Workers.	• UPDB data are not available in real time; cannot be used to inform timely policy decisions. • APCD also not easy to use and does not include people who do not have insurance and those who pay for services directly. • UDS does not collect real-time data (about a year behind). • Significant funding and staff capacity is needed to have access to databases and effectively use the data; this especially impacts underserved populations. • Very difficult to get disaggregated data for various populations in order to make policy case to legislators (e.g., race/ethnicity, gender). We don't have the data we need to back up our requests. • Not enough county level data to look at these issues and how they impact people by race, gender, etc. This makes initiatives and tracking changes impossible. Small sample sizes are the issue when we start to drill down for more detailed analysis, so we cannot draw reliable conclusions for specific underserved populations. • Even when data is being collected about underserved populations, we're often not using/analyzing it because lack of funding to do so. • There is an ongoing tension between policymakers wanting data-driven approaches and paying for the actual cost of getting and analyzing that data.	• Single payer system allows other countries to look at data across providers and across the patient's life span. • Funding to increase the size of various surveys helps with sample sizes and data analysis capabilities. • Link UPDB to UDS (if possible) because we're missing some of the most vulnerable and underserved populations in the UPDB data. • More generally, UDS data could be a source for future research.

		• We don't have a clear picture of what upstream success is. Hard to measure prevention/preventative services. Takes time and hard to track and costs more; it is hard to show effectiveness.	

This Impact Recommendation Report was compiled, drafted, and refined by Erin Jemison (Director of Public Policy, YWCA Utah) and Dr. Susan R. Madsen (Orin R. Woodbury Professor of Leadership & Ethics, Woodbury School of Business, Utah Valley University). For questions, contact Dr. Madsen at uwlp@usu.edu. For additional information, see the following websites: Utah Women & Leadership Project (www.utwomen.org) and YWCA Utah (https://www.ywcautah.org/).