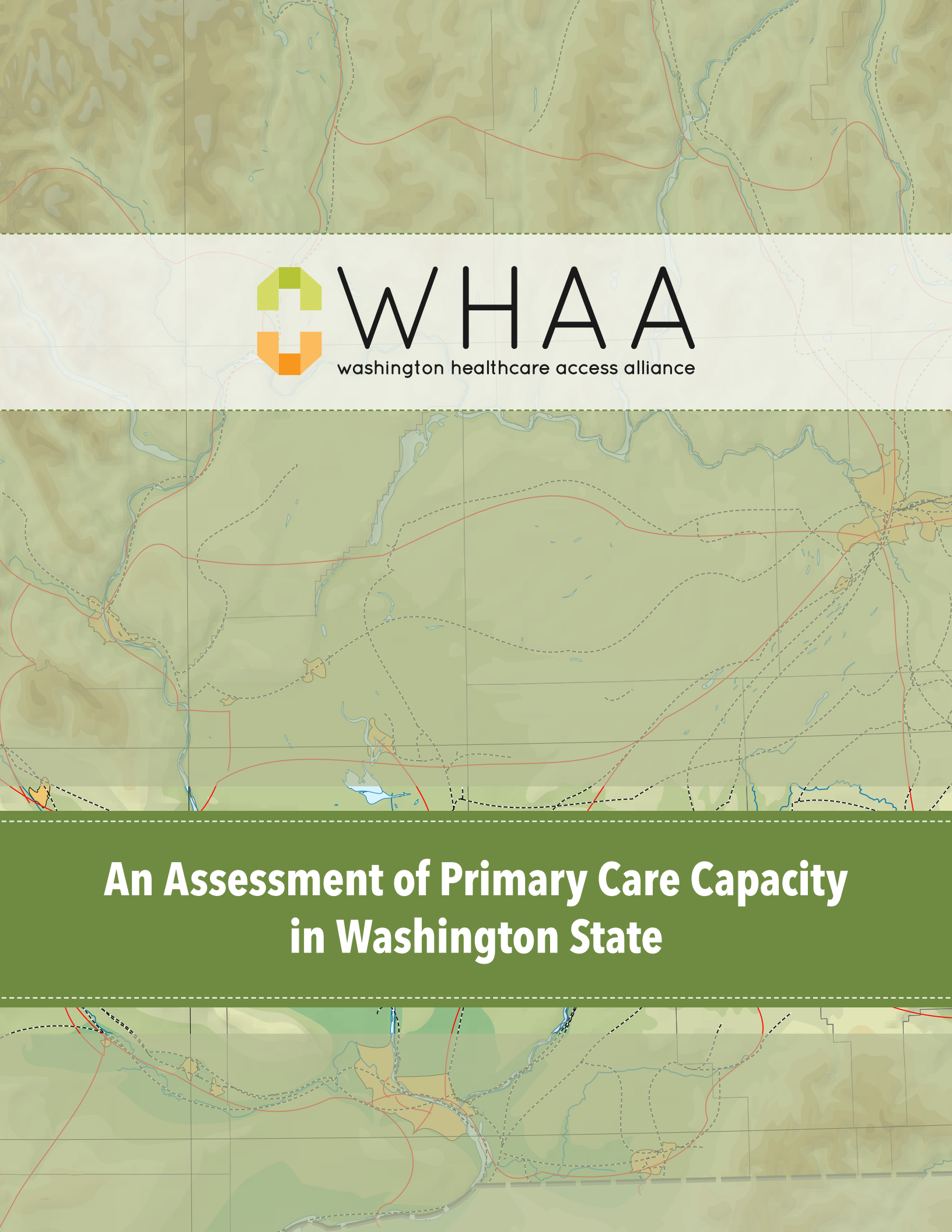
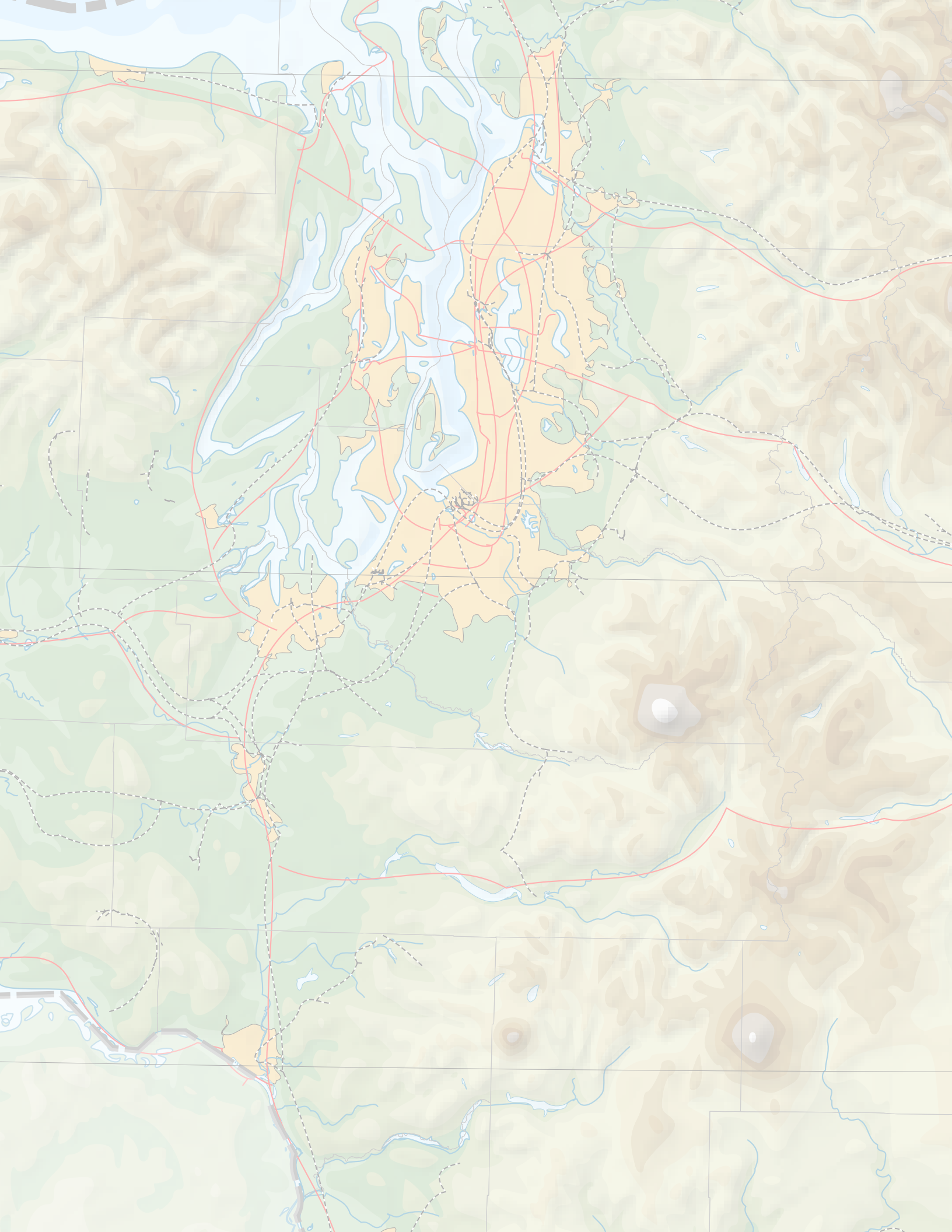


WHAA

washington healthcare access alliance

An Assessment of Primary Care Capacity in Washington State



AN ASSESSMENT OF PRIMARY CARE CAPACITY IN WASHINGTON STATE

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RotaCare Free Clinic – Renton

Safe Harbor Free Clinic

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Snake River Community Clinic

SOS Health Services of Walla Walla

Swedish Medical Center

The Olympia Free Clinic

Trinity Neighborhood Clinic

Upper Valley Free Clinic

Volunteers in Medicine of the Olympics

Washington State Department of Health Primary Care Office

West Sound Free Clinic

Yakima Union Gospel Mission

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INTRODUCTION

Washington Healthcare Access Alliance was established in 2008 to provide leadership and support to the healthcare safety net, prioritizing the work of free and charitable healthcare efforts. Since before that time, the Washington State Primary Care Office has worked to sustain and grow Washington's free clinic network. The Primary Care Office helped craft the mission, vision, policies, and structure of Washington Healthcare Access Alliance, and has been essential to the organization's stabilization.

Several important Washington Healthcare Access Alliance programs were developed with Primary Care Office funding and guidance, including quality of care guidelines, technical assistance, community assessments, data collection, and the annual Washington Free and Charitable Care Conference.

The Primary Care Office has assisted Washington communities looking to form free clinics, beginning with community conversations, continuing through clinic opening, and beyond. Washington Healthcare Access Alliance wishes to thank the Washington State Primary Care Office for being a consistent leader, partner, and ally in this work.

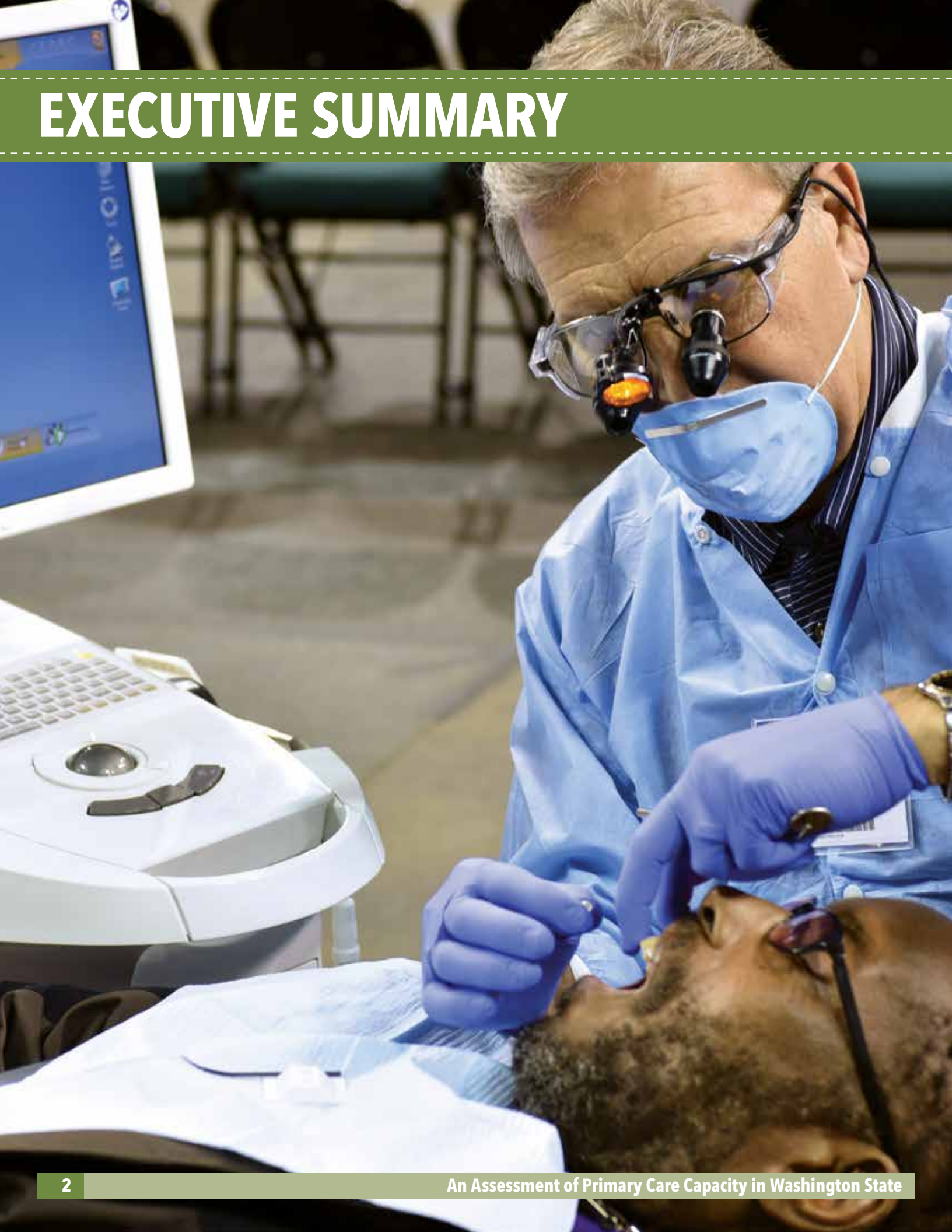
This report was created to provide an overview of primary care capacity in Washington State, to set priorities for future action. An advisory committee of diverse area experts was consulted in regard to structure, content and sources. Data included was collected from a wide range of public, private, for- and nonprofit partners in the fields of healthcare, economics, education and social services. Our report provides a broad overview of the state of healthcare in Washington State, as influenced by the economic and political environment at this time.

Although primary care is not defined beyond medical care, this report focuses on mental and oral healthcare, as well.

Data Sources and Limitations

All information utilized for this report is publicly available. Some data referenced was obtained directly from the authoring organizations, and was not posted online. It should be noted that data included relates to circumstances before, during and following implementation of the Affordable Care Act (ACA), which complicates interpretation of the ACA on access. Whenever possible, comparative data is provided.

EXECUTIVE SUMMARY



Objective

In October 2014, thousands of Washington residents from 230 unique zip codes waited overnight to receive free medical, dental and vision services at Seattle's KeyArena. The Seattle/King County Clinic, an event planned and implemented by Seattle Center, had been met with considerable doubt as to need and community participation. Would patients even show up? Hadn't the Affordable Care Act already addressed healthcare for everyone?

Over a four-day period, 3,400 patients were served by licensed healthcare volunteers. Some patients attended the event for multiple days. Whole families arrived from across the state, standing in line from 8 pm to 6 am just to get in the door. Many reported sleeping in their cars to have a tooth extracted, or to receive a pair of glasses. The need exceeded clinic capacity, and hundreds of patients were turned away (Seattle Center Foundation, 2014).

In October 2015, the Seattle/King County Clinic was again operationalized, and 4,010 patients received care. When asked why they sought care at the free clinic event, 31.4% of the patients reported not having insurance, and an additional 21% stated that they couldn't otherwise afford care (Seattle Center Foundation, 2015).

Washington is a wealthy state. A 2014 Wallethub report ranked Washington tenth in the nation for GDP per capita (Bernardo, 2014). Washington employers include some of the largest companies in the country—Microsoft, Amazon, Boeing, Starbucks, Costco—and yet thousands of residents need to wait in line overnight for health-care services.

This report is intended to provide a broad overview of primary healthcare access and capacity to inform policy and programming that addresses the needs of Washington's underserved communities. Included is state-specific information related to key issues, special populations, resources, and recommendations.

Health and access indicators for all counties are also included. Together with the statewide data, these indicators provide information about the range in health and healthcare access status across Washington.

Findings

Socioeconomic inequality, geography, and provider distribution contribute to barriers to primary care access in Washington State. Wealth and economic opportunity are unevenly distributed. Many small, rural counties are burdened with high levels of poverty and unemployment, and have few healthcare resources. Due to Washington's geography, travel between communities to access healthcare or employment can be difficult. These factors impact health and healthcare access, particularly for low income residents in rural communities. Across the state, significant health disparities persist.

Racial and ethnic minority groups are disproportionately underserved by the healthcare system. Distribution of race among patients seeking care in safety net settings does not reflect the racial distribution of the population. This can be seen in the patient distribution by race for individuals who sought care at the 2014 Seattle/King County Clinic event, compared to the distribution of race in Washington State (**Table 1**).

TABLE 1–Seattle/King County Patient Distribution by Race

	White, Non-Hispanic	Black/ African American	American Indian and Alaska Native	Asian and Pacific Islander	Hispanic of Any Race	Native Hawai'ian or Other Pacific Islander	Two or More Races
2014 WA Population	70.4%	4.1%	1.9%	8.2%	12.2%	.7%	4.5%
2014 Seattle King County Patient Population	31%	14.5%	1.5%	15.7%	16.7%	2.9%	4.3%

(Seattle Center Foundation, 2015)

Rural counties show high rates of mortality for multiple, treatable illnesses and face multiple access barriers to care. When age-adjusted mortality for diabetes, cardiovascular disease, pneumonia, chronic, lower respiratory disease, and chronic liver disease and cirrhosis is rated to identify the highest five counties for each disease, overlap of two or more diseases is frequent (**Table 2**).

TABLE 2–Age-Adjusted Mortality by Disease by Highest Five Washington State Counties

County	Diabetes	Cardiovascular Disease	Pneumonia	Chronic Lower Respiratory Disease	Chronic Liver Disease and Cirrhosis
Adams				■	
Asotin	■		■		
Benton	■				
Chelan					■
Columbia		■		■	
Cowlitz	■			■	■
Douglas				■	
Franklin	■				
Grays Harbor			■		
Island			■		
Lewis		■	■		
Okanogan		■			■
Pacific		■			■
Stevens		■		■	■
Walla Walla	■				
Whitman			■		

(Washington State Department of Health, 2015)

Medicaid was expanded in Washington following implementation of the Affordable Care Act (ACA). Nevertheless access to care continues to be a challenge. Patients persistently seek basic care in safety net settings because they are ineligible for healthcare insurance, cannot afford copays or deductibles, or are unable to find a local Medicaid or Medicare provider (**Table 3**).

TABLE 3–2015 Seattle/King County Clinic Patients–Why come here rather than another community source?

Reasons for Seeking Care in Free Clinic Setting	Percent
No Insurance	31.4%
Free, Can't Afford Otherwise	21.0%
Insurance Doesn't Cover Needed Services	16.0%
No Answer	13.7%
Have Insurance, Still Can't Afford Costs	10.5%
Other	4.0%
Don't Have Healthcare Provider	1.5%
Simpler Process (No ID, Little Paperwork)	1.1%
Can't Find Provider to Take Medicaid/Medicare	0.3%
Can't Take Time Off During the Week	0.2%
On Wait List to Get Care Elsewhere	0.2%

(Seattle Center Foundation, 2015)

When access indicators for eligible Medicaid dental utilization, prenatal care within the first trimester, and percent of the population living in poverty are compared across the five lowest ranking counties, some overlap for these indicators is evident (**Table 4**).

TABLE 4–Access Indicators by Five Lowest Ranking Counties

Access Indicator	Lowest 5 Rates of Eligible Medicaid Dental Utilization	Lowest 5 Rates of Prenatal Care in First Trimester	Highest 5 for Percent of Population Living in Poverty
Adams			■
Douglas		■	
Jefferson	■		
Kittitas		■	■
Lincoln		■	
San Juan	■		
Skamania	■		
Spokane		■	
Wakhiakum	■	■	■
Whitman	■		■
Yakima			■

(Washington State Department of Health, 2014)

Healthcare providers are unequally distributed across Washington, resulting in large rural areas without an adequate healthcare workforce. Barriers to mental and dental healthcare persist, and include provider shortages, particularly in rural communities, and a lack of providers willing to accept Medicaid patients. A higher percentage of Washington State residents report living with mental illness than the national average.

Significant barriers to healthcare exist for Washington's underserved communities. Many strengths upon which positive change can be built are also present. Washington's safety net system includes Project Access organizations, federally qualified health centers, free and charitable clinics, tribal health clinics, rural health clinics, critical access hospitals, private providers, and veterans administration clinics. Due to unique legislation that addressed primary barriers to healthcare volunteerism, Washington has over 1,200 licensed healthcare professionals engaged in free care to vulnerable populations.

Many new partnerships and innovative programs are emerging, including a new medical school and enhanced connections between rural communities and mental health training programs. Decision makers are yet challenged to better understand the future of healthcare in Washington. This document and the ensuing recommendations are intended to support their work:

1. Expand Medicaid eligibility or alternative coverage, as may be legally applicable, to provide access to care for all income-eligible residents, regardless of immigration status

2. Increase Medicaid reimbursement rates for medical and dental providers

3. Invest in coordinated workforce planning

4. Expand medical, dental and mental health residency and internship opportunities in rural and underserved communities

5. Continue to strengthen public mental health funding

6. Mitigate the impacts of socioeconomic status as an important determinant of health

WASHINGTON STATE CHARACTERISTICS

Washington State occupies 66,582 square miles in the northwest corner of the lower 48 United States. The Pacific Ocean is the state's western boundary. The many inlets of Puget Sound create a large inland saltwater shoreline. The Columbia River and its major tributaries drain the eastern half of the state and provide water that makes agriculture possible in a largely arid region.

Most of the state's urban areas and population lie west of the Cascade mountain range and along the Puget Sound basin. Though the western part of the state has many rural areas, rural communities are predominantly located east of the Cascades.

Washington's 39 counties are organized into 35 local health jurisdictions, defined as the "action arms" of public health, with statutory responsibility for the design and delivery of health programming. Washington State's local health jurisdictions can be seen in **Figure 1**. In addition, there are 29 federally recognized Native American

FIGURE 1–Local Health Jurisdictions in Washington

(Washington State Department of Health, 2015)

tribes, most of which provide public health and healthcare services to their members. The five largest local health jurisdictions are located in the largest urban areas of the state and serve the majority of the state population.

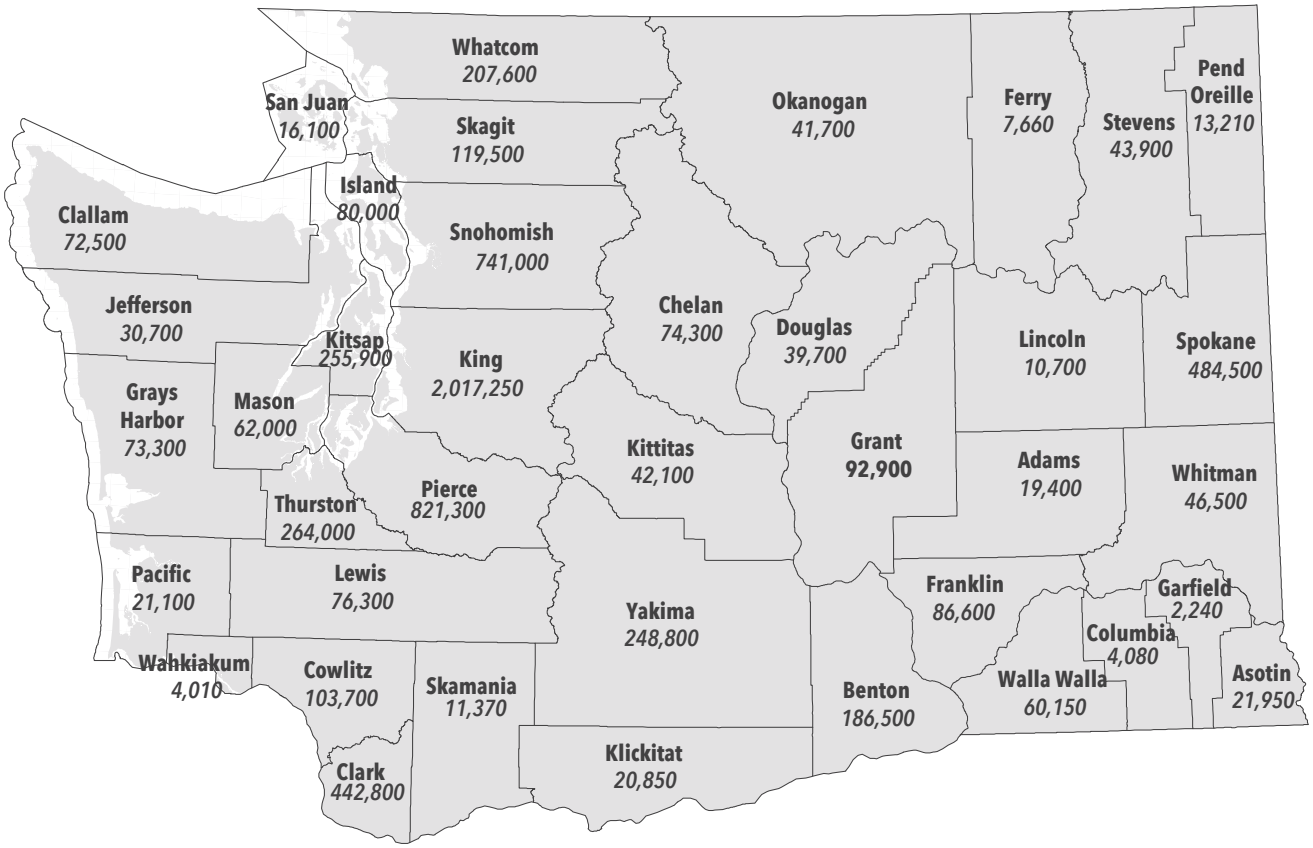
Population and Demographics

The majority of Washington's population is concentrated in Western Washington, in the populous, urban areas. Rural areas exist throughout the state, primarily in Eastern Washington and the Pacific Coast. Approximately 95% of the state is designated as rural and underserved for the purposes of federal funding supporting access to care. Washington has 31 rural counties with density defined as less than 100 persons per square mile (U.S. Department of Agriculture, 2007).

As of April 2015, the Washington State Office of Financial Management estimated Washington's population to be 7,061,410, with more than 75% of residents located west of the Cascade mountain range.

The state's five largest counties are King, Pierce, Snohomish, Spokane, and Clark. The five smallest counties are Lincoln, Ferry, Columbia, Wahkiakum, and Garfield (**Figure 2**). With 662,400 people in 2015, Seattle is Washington's largest city. Five other cities with populations greater than 100,000 are Spokane (213,100), Tacoma (202,300), Vancouver (170,400), Bellevue (135,000), and Kent (122,900) (Office of Financial Management, 2015).

FIGURE 2–Population by County



Washington State Total Population, 4/2014 – 6,968,170

(Washington State Department of Health, 2015)

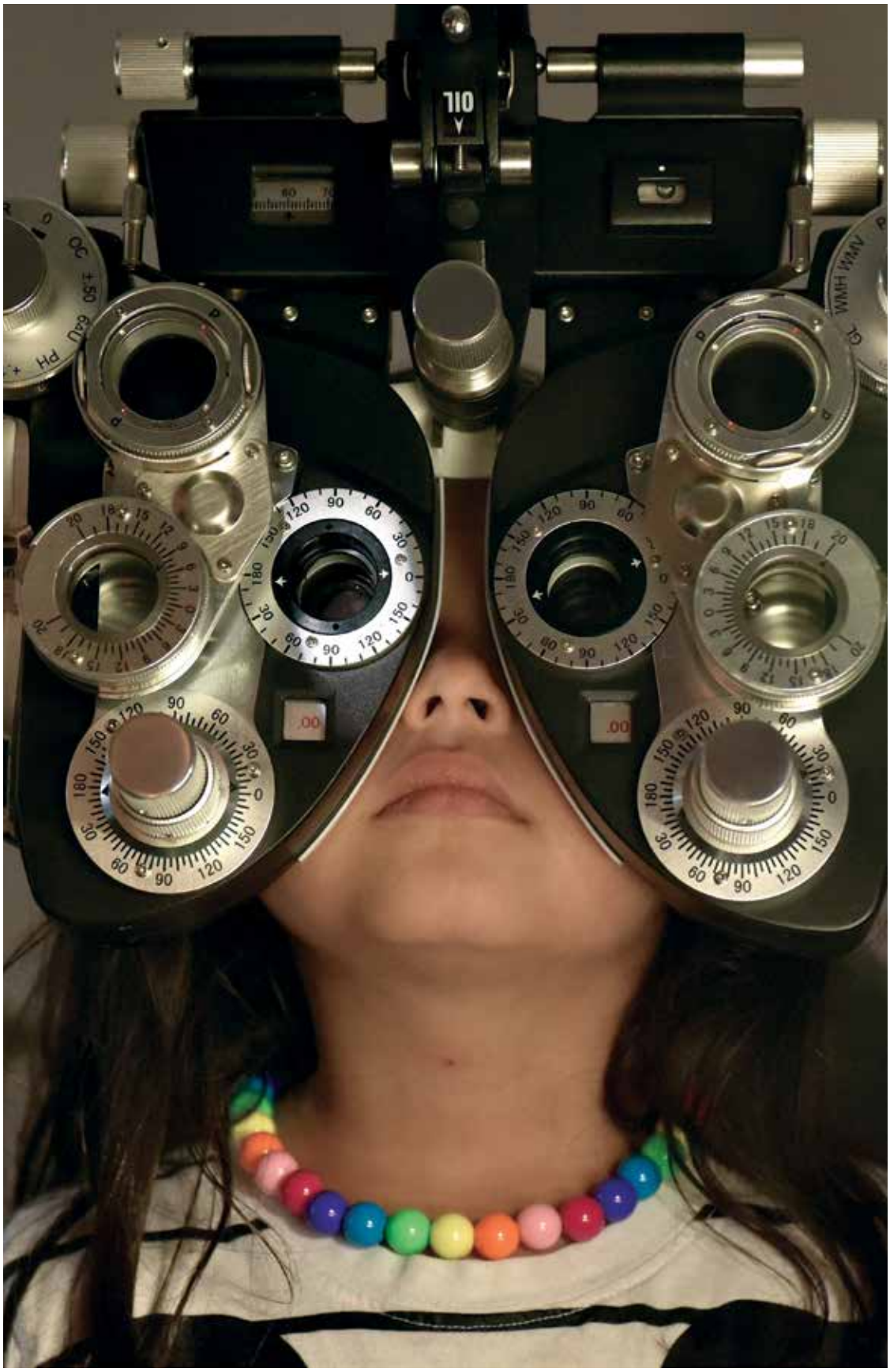
From 2010 to 2015, Washington State's population increased by 5.01%, compared with the national growth rate of 5% for that same period. In 2015, 14.47% of Washington's population was 65 years old or older (Office of Financial Management, 2015).

Washington State has a higher percentage of white, non-Hispanic residents than the national average, although long term racial distribution trends toward increased percentages of African American, American Indian and Alaskan Native, Asian and Pacific Islander, and Hispanic residents (**Table 5**).

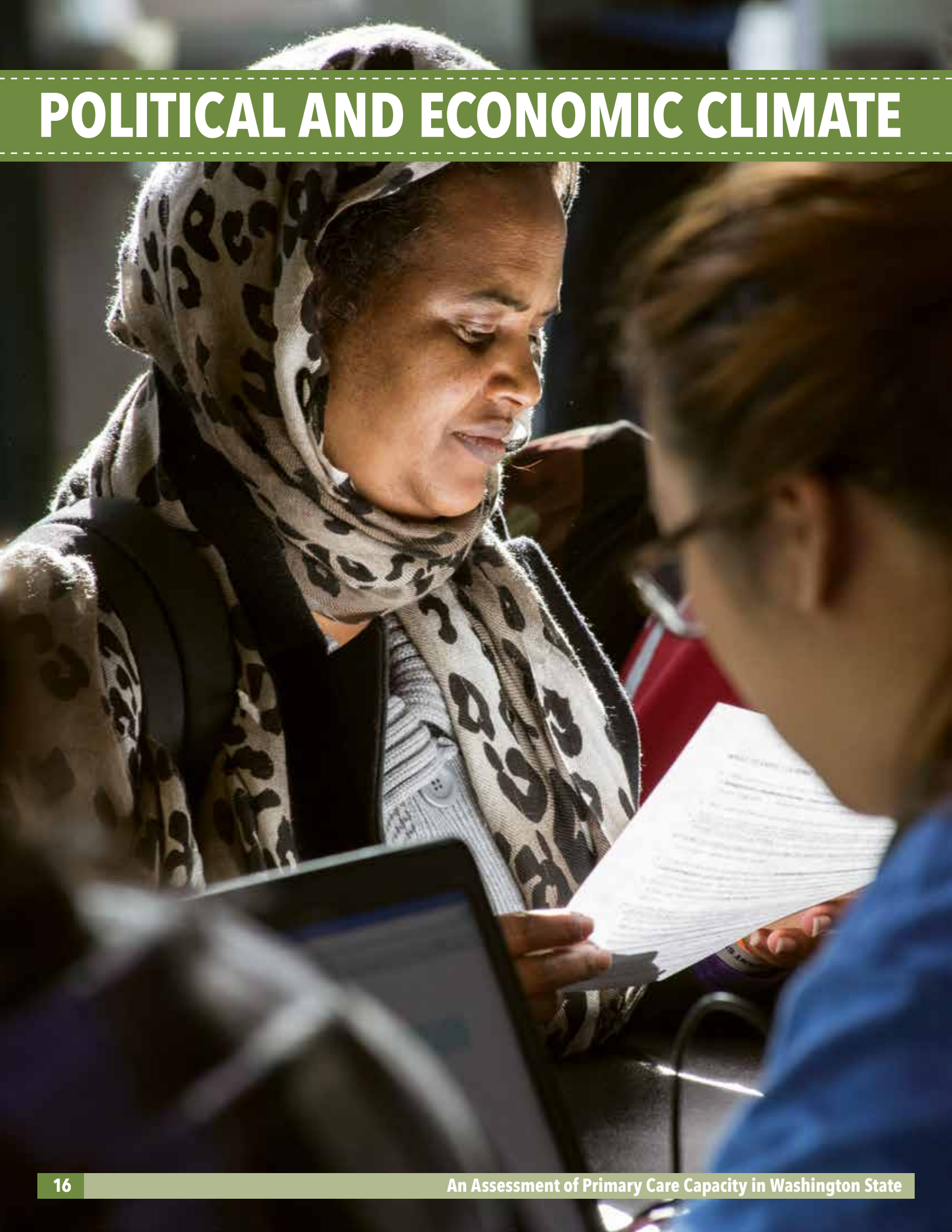
TABLE 5–Changes in Statewide Distribution of Race, 2010 to 2014

Year	White, Non-Hispanic	Black/ African American	American Indian and Alaska Native	Asian and Pacific Islander	Latinos of Any Race	Native Hawai'ian or Other Pacific Islander	Two or More Races
2010 WA	73%	3.6%	1.54%	8%	11%	not measured	5%
2014 WA	70.4%	4.1%	1.9%	8.2%	12.2%	.7%	4.5%
2014 National	62.1%	13.2%	1.2%	5.4%	17.4%	.2%	2.5%

(U.S. Census Bureau, 2015)



POLITICAL AND ECONOMIC CLIMATE



The Affordable Care Act

With implementation of the Affordable Care Act (ACA), Medicaid eligibility was expanded in Washington, and a state insurance exchange established. A 2015 Gallup Poll reported a reduction in Washington's uninsured rate from 16.8% in 2013 to 6.4% in the first half of 2015 (Witters, 2015).

Despite this dramatic increase in access to insurance, not all residents are eligible for coverage, due to immigration status. Legal immigrants with fewer than five years of residency and undocumented workers are unable to access this benefit.

Newly enrolled Medicaid patients find it difficult to obtain care, due to the limited number of Medicaid providers. Patients seeking care in free and charitable clinics report being unable to afford the copays and deductibles associated with their insurance plans.

In 2013 and 2014, Washington State Medicaid providers were allowed enhanced reimbursement rates for primary care services. These increases expired in 2015. The WWAMI Center for Health Workforce Studies surveyed Medicaid providers and reports that nearly 75% of physicians in small practices stated intent to restrict access for Medicaid patients at the time of the study. Over one third of the physicians in small practices also stated intent to stop accepting new Medicaid patients. Reimbursement rates have since been reduced.

Many enrollees are unable to maintain their new healthcare coverage. A September 2015 Washington State Health Care Exchange publication reports a net decrease in enrollment of 26% from the end of October 2014 to the end of January 2015 (Washington Health Benefit Exchange, 2015). This represents more than 30,000 healthcare plan enrollees.

Table 6 shows that just over 15% of patients who sought care at the 2015 Seattle/King County Clinic event were enrolled in Medicaid. Free clinics reported serving patients unable to access their new health plan due to out of pocket expenses.

TABLE 6–2015 Seattle/King County Clinic Patient Distribution by Insurance Status

Insurance Status	Percent
No Insurance	44.1%
Medicaid	15.1%
Medicare	13.6%
No Answer	9.0%
Other	6.4%
Privately Acquired	5.7%
Employer Provided	4.9%
Through Spouse/Parent	1.2%

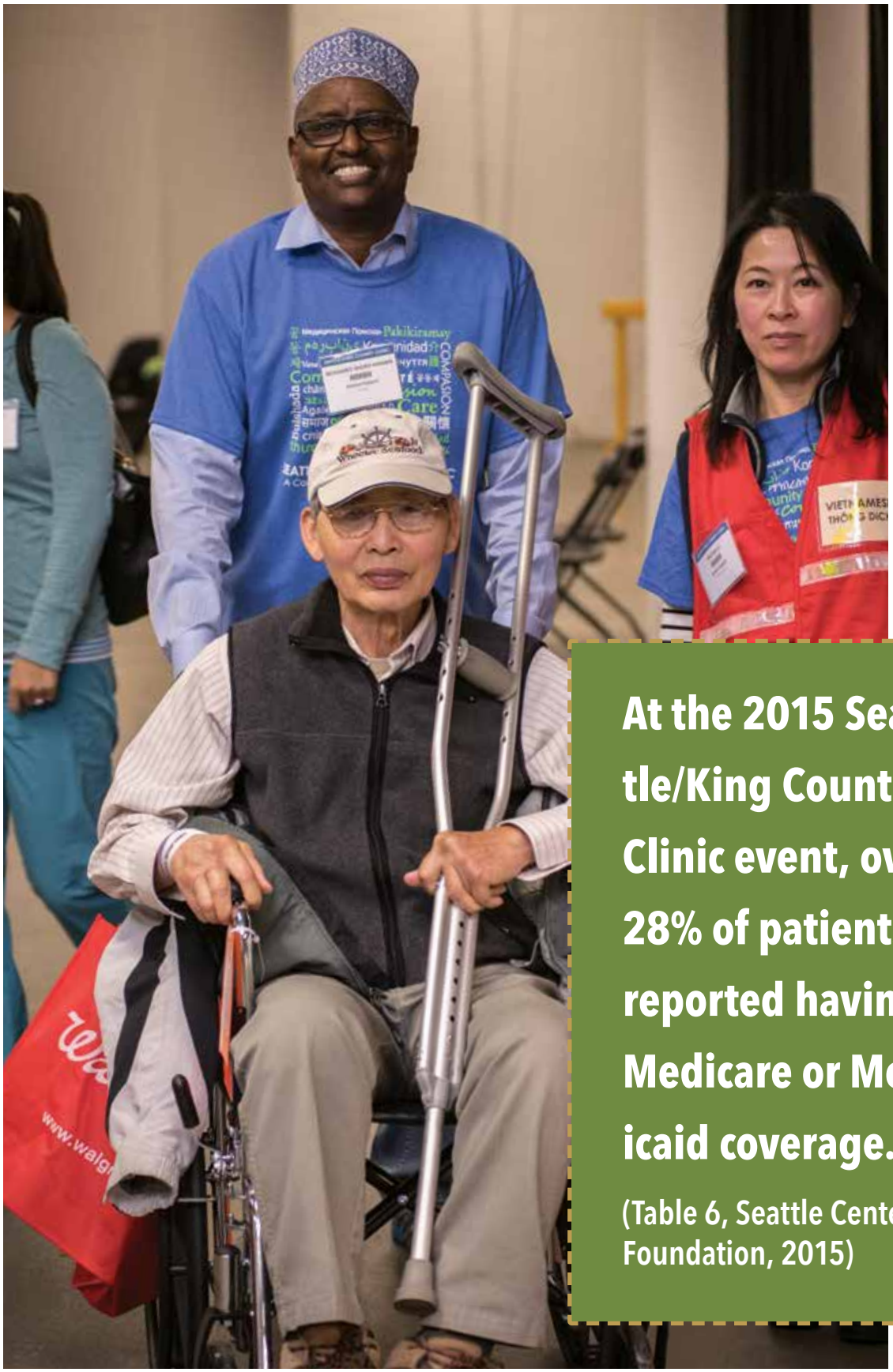
(Seattle Center Foundation, 2015)

At the 2015 Seattle/King County Clinic event, over 28% of patients reported having Medicare or Medicaid coverage (**Table 6**, Seattle Center Foundation, 2015). When asked why they sought care at the event, 10% of the patients stated that they couldn't afford to access their health insurance, 31% indicated they didn't have health insurance, and 16% stated their insurance didn't cover needed care (**Table 7**).

TABLE 7–Reasons for Seeking Care in Free Clinic Setting Among 2015 Seattle/King County Clinic Event Patients

Reasons or Seeking Care In Free Clinic Setting	Percent
No Insurance	31.4%
Free, Can't Afford Otherwise	21.0%
Insurance Doesn't Cover Needed Services	16.0%
No Answer	13.7%
Have Insurance, Still Can't Afford Costs	10.5%
Other	4.0%
Don't Have Healthcare Provider	1.5%
Simpler Process (No ID, Little Paperwork)	1.1%
Can't Find Provider to Take Medicaid/Medicare	0.3%
Can't Take Time Off During the Week	0.2%
On Wait List to Get Care Elsewhere	0.2%

(Seattle Center Foundation, 2015)



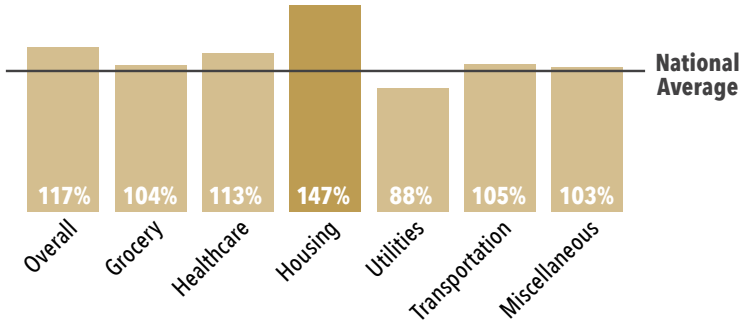
At the 2015 Seattle/King County Clinic event, over 28% of patients reported having Medicare or Medicaid coverage.

(Table 6, Seattle Center Foundation, 2015)

Cost of Living

Washington has a high cost of living. Common expenditures, with the exception of utilities, are higher in Washington than the national average. Housing costs in Washington are particularly expensive compared to the rest of the country, at nearly 1.5 times the national average (**Figure 3**, Sperling's Best Places, 2015).

Figure 3–Washington State Comparative Cost of Living Overview



(Sperling's Best Places, 2015)

Housing costs in Washington are particularly expensive compared to the rest of the country, at nearly 1.5 times the national average.

(Figure 3, Sperling's Best Places, 2015)

The 2015 Washington minimum wage of $9.47 per hour is not a living wage in the state, even for a single person with no dependents. For a family of four with one parent working, the hourly wage necessary to cover basic expenses is $26.55 per hour, and the minimum wage is lower than a poverty wage of $11 per hour. Living expenses are particularly high for families needing childcare (**Table 8**).

TABLE 8–Washington State Hourly Wage Necessary to Support a Family

Hourly Wages	1 Adult	1 Adult 1 Child	1 Adult 2 Children	1 Adult 3 Children	2 Adults (One Working) 1 Child	2 Adults (One Working) 2 Children	2 Adults (One Working) 3 Children	2 Adults
Living Wage	$10.34	$22.40	$26.55	$34.03	$20.43	$23.01	$26.55	$8.41
Poverty Wage	$5.00	$7.00	$9.00	$11.00	$9.00	$11.00	$13.00	$3.00
Minimum Wage	$9.32	$9.32	$9.32	$9.32	$9.32	$9.32	$9.32	$9.32

(Glasmeier, 2015)

High housing prices in Washington prevent middle and low income families from purchasing homes, building equity and gaining long-term, economic stability. As of November 2015, the average home value in Washington was $278,400, which represents an increase of 7.6% over the previous year.

The national average home value was $182,500 for the same period, up 3.7% over the previous year. (Zillow, 2015)

Housing prices in Washington vary significantly, with an average list price ranging from $123,530 in Grays Harbor County to $718,240 in San Juan County (**Table 9**).

Rental housing affordability in the state has been a growing problem over the past decade. Since 2000, incomes in the state have declined by 2.4% but median rents have increased 7.8% in real dollars. A 2015 Department of Commerce report finds that, for extremely low and very low income households, Washington State has a deficit of 327,136 affordable and available housing units (State of Washington, 2015). For every 100 extremely low and very low income households, only 51 units are affordable and available. The remaining 49-unit gap represents households paying more for housing than they can reasonably afford.

TABLE 9–Average Housing List Price by County

County	Average Housing List Price	County	Average Housing List Price
Grays Harbor	$123,530	Okanogan	$264,433
Garfield	$127,430	Klickitat	$275,858
Adams	$142,411	Benton	$276,954
Pacific	$174,373	Clallam	$278,955
Grant	$178,661	Thurston	$281,932
Lincoln	$184,638	Douglas	$308,396
Whitman	$188,291	Pierce	$310,652
Mason	$193,096	Chelan	$311,411
Columbia	$197,042	Skamania	$353,331
Ferry	$201,435	Kitsap	$353,571
Lewis	$208,095	Skagit	$356,491
Cowlitz	$217,400	Kittitas	$367,054
Pend Oreille	$221,693	Jefferson	$373,245
Spokane	$223,893	Whatcom	$378,302
Stevens	$230,538	Snohomish	$386,097
Asotin	$230,756	Clark	$391,012
Yakima	$243,990	Island	$420,650
Walla Walla	$247,770	King	$612,222
Wahkiakum	$248,275	San Juan	$718,240
Franklin	$252,338		

(Trulia, 2015)

Income Distribution

Rising income inequality is a pervasive problem across the country, and a specific challenge in Washington State. Distribution of wealth and opportunity is dramatically uneven, with high levels of unemployment and poverty in rural Washington, concentration of wealth among few people in largely urban areas, and a regressive tax system that favors very wealthy residents and penalizes the state's lowest wage earners. A 2013 Business Insider report refers to Washington as the "Best Place for Rich People" (Durisin, 2013).

As a result of the Great Recession, nearly all income levels dropped. Since 2009, when the recovery period began, the top one percent of all earners captured between half and all income growth in 39 states. Washington is among 17 states in which all post-recession income growth between 2009 and 2012 was accrued by the wealthiest residents.

Between 2009 and 2012, Washington State was ranked ninth in the nation for income growth to the wealthiest residents, at 175% of total growth. During that same period, the bottom 99% of Washington residents lost an additional 3.5%, of income compared to a national loss of 0.6%. This has created an extreme difference between the average incomes of the top one percent and the bottom 99 percent in Washington State. The ratio of top to bottom incomes is 26.8:1, with Washington ranked 10th nationwide for top to bottom income ratio (Sommeiller & Price, 2015).

Between 2009 and 2012, Washington State was ranked ninth in the nation for income growth to the wealthiest residents, at 175% of total growth. During that same period, the bottom 99% of Washington residents lost an additional 3.5%, of income compared to a national loss of 0.6%.

Distribution of wealth geographically showed significantly higher levels of poverty in Eastern Washington than in Western Washington, with poverty rates ranging from 32.6% in Whitman County to 9% in Island County (**Table 10**).

TABLE 10–Washington State Poverty Rates by County

County	Poverty Rate	County	Poverty Rate
US Non-metropolitan	16%	Whatcom	16.4%
Washington Non-metropolitan	14%	Douglas	15.8%
Whitman	32.6%	Lewis	15.4%
Adams	22.9%	Spokane	15.4%
Kittitas	22.6%	Clallam	14.6%
Wahkiakum	22.6%	Lincoln	14.2%
Yakima	22.6%	Asotin	13.6%
Ferry	20.7%	Skagit	13.5%
Okanogan	20.7%	Jefferson	13.3%
Pend Oreille	20.4%	Chelan	13.2%
Grant	20.3%	Benton	12.8%
Franklin	20.2%	Skamania	12.5%
Grays Harbor	19.0%	Clark	12.4%
Walla Walla	17.8%	Pierce	12.4%
Cowlitz	17.6%	Garfield	12.1%
Klickitat	17.5%	Thurston	11.7%
Mason	17.3%	King	11.5%
Pacific	17.2%	San Juan	10.8%
Columbia	17.1%	Kitsap	10.4%
Stevens	16.5%	Snohomish	10.4%
		Island	9%

(U.S. Census Bureau, 2013)

Recent unemployment rates across the state show additional disparity in professional opportunity from county to county, ranging from 9.5% unemployment in Ferry County to 3.6% in San Juan County (**Table 11**).

TABLE 11–Unemployment Rate by County

County	Unemployment Rate	County	Unemployment Rate
Ferry	9.5%	Klickitat	5.8%
Pend Oreille	8.8%	Whatcom	5.7%
Grays Harbor	8.2%	Island	5.6%
Lewis	7.7%	Kittitas	5.6%
Mason	7.5%	Thurston	5.6%
Clallam	7.4%	Grant	5.4%
Pacific	7.4%	Douglas	5.3%
Cowlitz	7.3%	Columbia	5.2%
Stevens	7.3%	Kitsap	5.2%
Wahkiakum	7%	Walla Walla	5.2%
Yakima	6.8%	Adams	5%
Skamania	6.4%	Lincoln	5%
Jefferson	6.3%	Okanogan	4.8%
Skagit	6.3%	Chelan	4.7%
Clark	6.2%	Whitman	4.7%
Pierce	6.1%	Garfield	4.5%
Benton	6%	Asotin	4.3%
Franklin	6%	Snohomish	3.9%
Spokane	6%	King	3.6%
		San Juan	3.6%

(Washington State Employment Security Department, 2015)

Over the last four decades, wages and income for working and middle class families have decreased or stagnated, while the share of income and wealth accruing to those at the top of the income scale has increased. This unequal distribution of wealth is enabled by Washington's income tax system.

A 2015 report comparing tax systems across the country finds Washington State's tax system the most regressive in the country, allowing the state's wealthiest residents to pay a much lower effective tax rate than middle and low income families (Davis et al., 2015).

In 2014, the wealthiest one percent of Washington residents, with an average income of $1.1 million, paid 2.8% of their income toward state taxes. Washington's poorest 20 percent, earning an average income of $11,500, paid 16.8% of their income in taxes.

In Seattle, new legislation was signed into law in 2015 providing for an increase in the minimum wage to $15 per hour, phased in over time, beginning in April 2015. Businesses with fewer than 500 employees will reach a $15 an hour minimum wage in seven years. Temporary guaranteed minimum compensation of $15 an hour to be met within the first five years was also established, by combining employer-paid health care contributions, consumer-paid tips, and employer-paid wages. Businesses with 500 or more employees will be required to reach $15 per hour in three years. The wages of employees who receive health care benefits will reach $15 per hour in four years (City of Seattle, 2015). As progressive politics in Seattle tend to drive policy statewide, this is likely to influence the minimum wage elsewhere in Washington.

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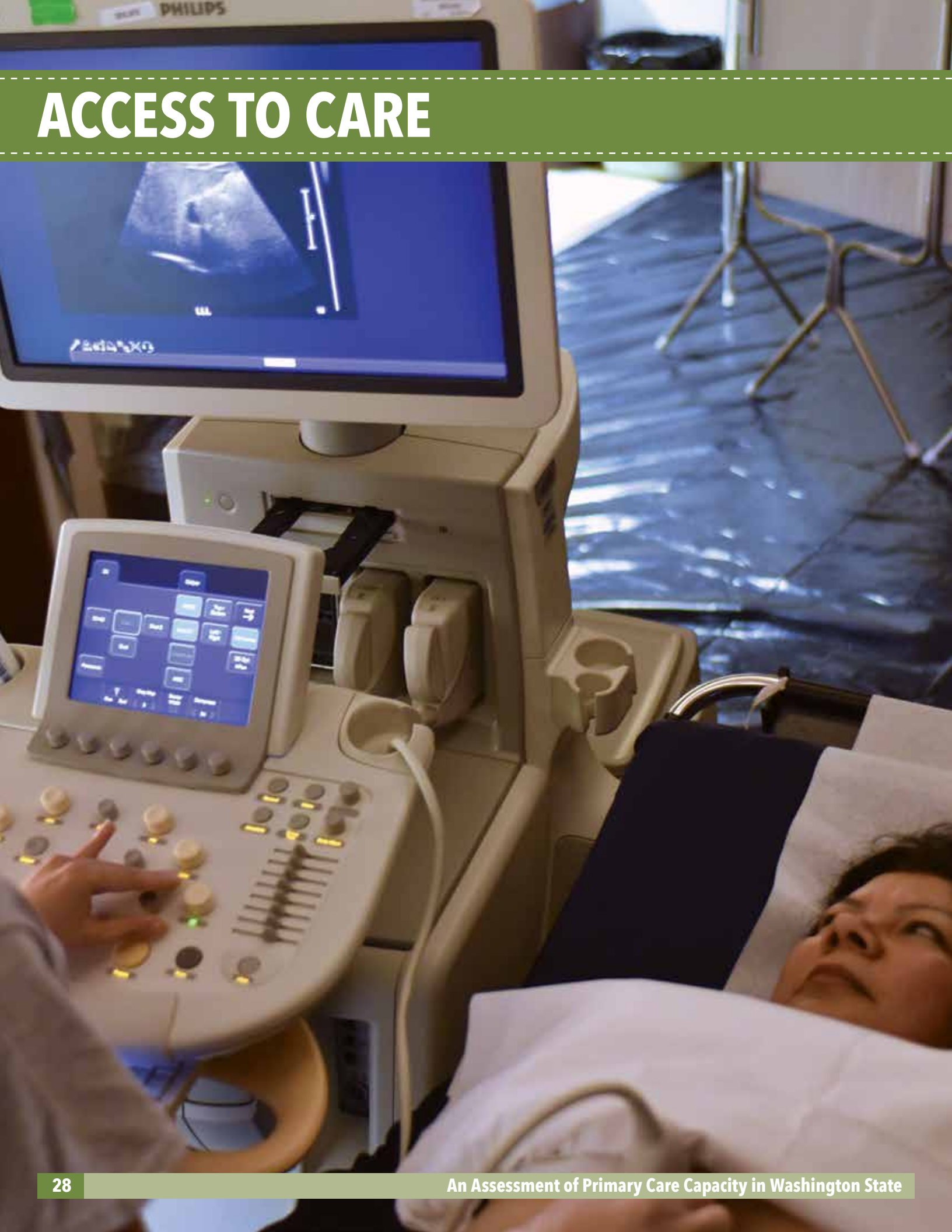
ACCESS TO CARE



Primary Care

Washington's rate of physicians per capita is comparable to national levels. The WWAMI Center for Health Workforce Studies reported 220 physicians per 100,000 residents providing direct patient care in 2014, including 79 generalist physicians per 100,000 residents (Stillman & Stover, 2014).

Differences in distribution of physicians can be seen between urban and rural areas of the state, with many fewer total physicians and generalist physicians in rural areas. There are also some differences in distribution between the eastern and western counties of the state, with a generally lower per capita supply of physicians on the eastern side of the state.

Current and long-term distribution of primary care physicians between rural and urban communities is an area of concern. **Table 12** shows the difference in distribution of physicians between rural and urban areas. There are more than twice the number of general internal medicine, general pediatric, OB-GYN and psychiatric providers per capita in urban than in rural areas.

TABLE 12–Ratio of Physicians Providing Direct Care per 100,000 Population in Urban and Rural Areas

Physicians Providing Direct Care	Urban	Rural
Family Medicine	41.0	39.1
General Internal Medicine	26.6	11.9
General Pediatrics	14.3	6.0
OB-GYN	12.5	6.0
General Surgery	4.3	5.5
Psychiatrists	10.8	2.4

(Skillman & Stover, 2014)

There are more than twice the number of general internal medicine, general pediatric, OB-GYN and psychiatric providers per capita in urban than in rural areas.

Washington's healthcare infrastructure is generally more precarious in rural than in urban areas. Difficulties achieving economies of scale lead to greater fixed costs in rural areas. Weaker local economies limit health investment, meaning that there are fewer providers, less infrastructure, and more barriers to access per capita in rural areas than in urban areas. Geography and weather across the state create additional access barriers. Many rural communities are objectively and significantly isolated from larger populations and services.

The mean age of Washington's practicing physicians is 52 years, and a large percentage of Washington's primary care workforce is nearing retirement age. Along with the aging population, these conditions imply an increasing imbalance between supply and demand. The Washington Workforce Training and Education Coordinating Board projects significant gaps between supply and demand for several healthcare occupations, including physicians and dentists (**Table 13**).

TABLE 13–Healthcare Occupations with Large Projected Gaps Between Supply and Demand

Occupation	New Supply	2017-22 Projected Annual Net Job Openings	Annual Gap Between Supply and Projected Demand
Physicians (all)	222	340	-118
Medical and Clinical Lab Technicians	26	212	-186
Registered Nurses	2,367	2,384	-17
Physical Therapists	118	259	-141
Occupational Therapists	87	124	-37
Physician Assistants	100	95	5
Dentists	85	200	-115

(Workforce Training and Education Coordinating Board, 2014)

Not only do most rural areas have fewer physicians providing direct care per capita than urban areas, but rural areas also show a higher percentage of physicians age 55 or older. Many of Washington's most rural counties have the highest percentages of physicians age 55 and older in the state. In 2014, two thirds or more of all physicians providing direct patient care in Garfield, Ferry, Columbia, Clallam, Pacific and Skamania counties were age 55 or older (Stillman & Stover, 2014).

As of March 2015, all Washington State counties are designated as underserved, either partially or in full (**Figure 4**, Washington State Department of Health, 2015).

Figure 4–Federally Designated Health Professional Shortage Areas for Primary Care

(Washington State Department of Health, 2015)

Health Professional Shortage Area designations (HPSA) can cover a sub-area in a county, an entire county, a group of counties, an area's low income population, or special populations (such as migrant/seasonal farm workers). Qualifications for this determination are based on an index value, which includes the infant mortality rate, the poverty rate, the percentage of elderly, and the ratio of available providers (measured by direct patient contact) to population. The requirements and methodology for making these designations are fixed by the federal Health Resources Services

Administration (HRSA). While HPSA designations are not a scientific way to point out access or workforce limits, they can be a reliable programmatic guide for directing resources.

Primary care access for Medicaid patients is another area of challenge for Washington State, with low reimbursement rates cited as a key reason for physician reluctance to provide care to Medicaid patients.

In an effort to encourage providers to care for Medicaid patients, implementation of the ACA included a 2013 and 2014 payment increase for primary care services to Medicaid patients. Medicaid reimbursement rates were raised to the same level as Medicare reimbursement. This rate increase expired at the end of 2014. As the numbers of Medicaid patients increase in Washington, access to primary care services may be further restricted if ending enhanced payments causes some primary care physicians to limit care for Medicaid patients.

A 2014 study found that nearly three quarters of primary care physicians in smaller practices intend to stop or limit their care for Medicaid patients due to the 2015 end of enhanced reimbursement. Underscoring the importance of adequate remuneration, the vast majority of providers surveyed indicated that higher reimbursement rates could encourage them to continue seeing current Medicaid patients or accept new Medicaid patients (Patterson & Andrilla, 2014).

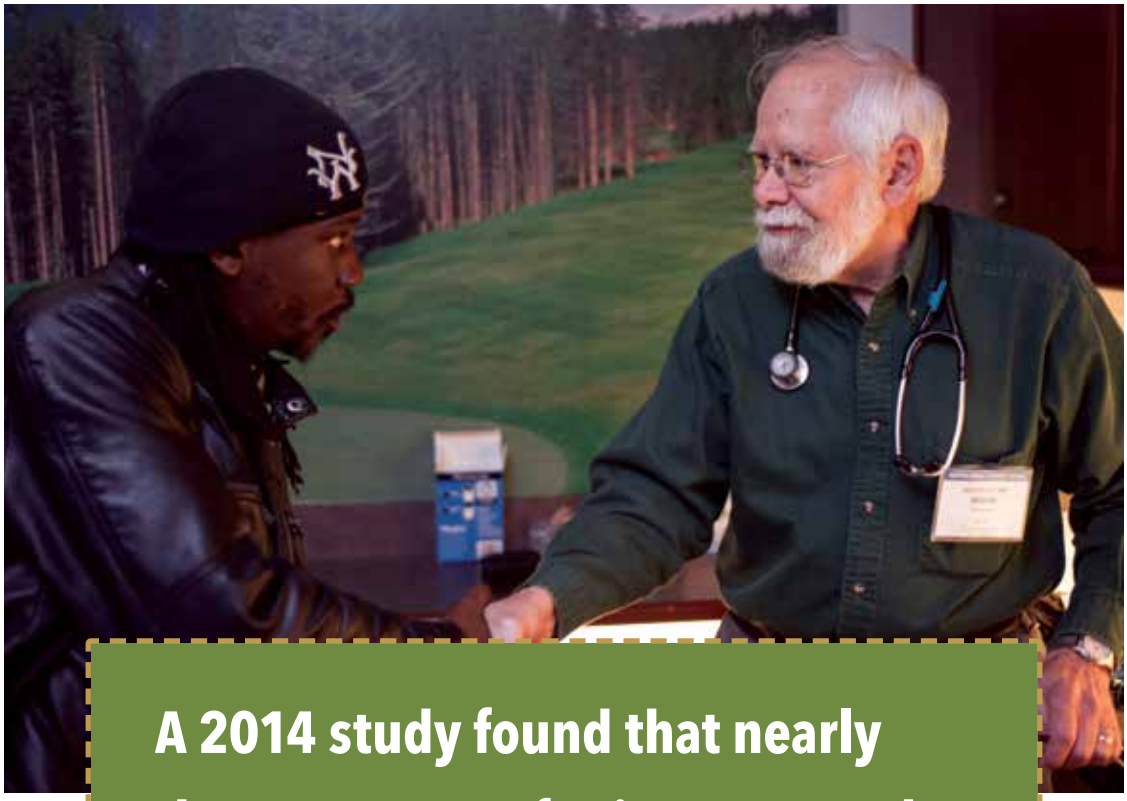
New investments in training and residency opportunities in rural and undeserved areas may help address primary care provider distribution across Washington. The 2015 Washington State budget provided over $16 million to increase residency opportunities for primary care practitioners in rural and underserved areas (Workforce Training and Education Coordinating Board, 2015).

Washington's medical schools and residency program capacity have long been below market demand. An additional medical school at Washington State University in Spokane has been funded by the legislature, and will enroll the first group of medical students in the fall of 2017 (Dudley, 2015). This new school is located on the eastern side of the state.

The Washington State Health Care Authority has initiated integration of behavioral healthcare into primary care in an effort to improve patient care and achieve systemic efficiencies. The goal of this model is to create a statewide, patient-centered, integrated program serving clients with medical, mental health, and substance abuse needs.

Although the program is still under development, to date, 17,000 patients have been served within this new model, and 107 federally qualified community health centers

and 36 mental health centers are participating. The population served is mostly patients with high incidence of mental health diagnoses. To date, 49% of patients diagnosed with severe depression have shown clinical improvement in depression symptoms, and 36% of patients diagnosed with severe anxiety have shown significant improvement in anxiety symptoms (AIMS Center, 2016).



A 2014 study found that nearly three quarters of primary care physicians in smaller practices intend to stop or limit their care for Medicaid patients due to the 2015 end of enhanced reimbursement.

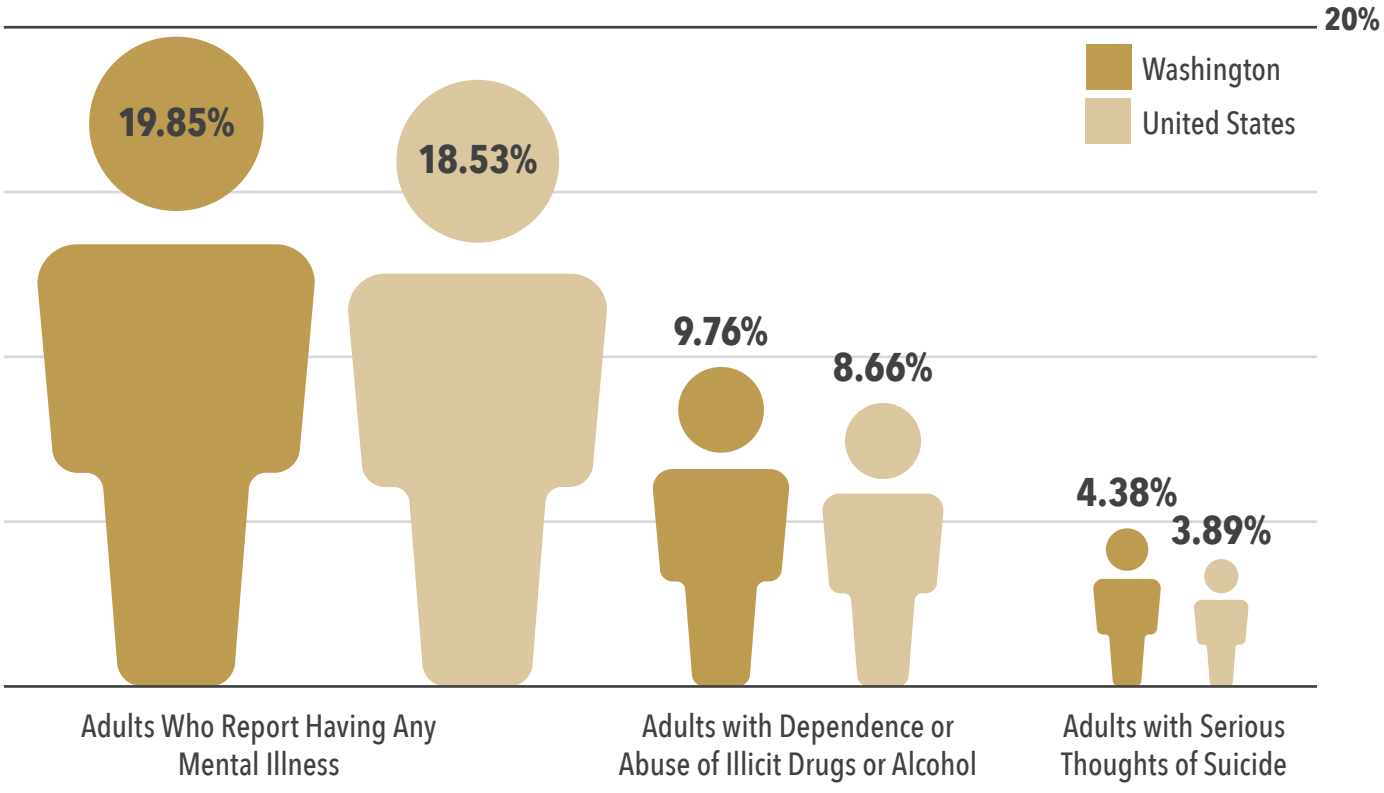
Mental Health

Access to reliable, affordable mental and behavioral healthcare is a considerable challenge for the residents of Washington, a state in which a larger percentage of the population reports living with a mental illness than the national average.

The State of Mental Health America 2016 ranks Washington State 47th out of 51 (including the District of Columbia) for mental healthcare access, with combined scores of 13 measures making up the overall ranking (Nguyen, Davis, Counts, & Fritz, 2015). The report finds a high prevalence of mental illness combined with low rates of access to care. Washington State's high rates of homelessness and low rates of high school graduation are additionally correlated to its high prevalence of mental illness.

Of the 51 states, Washington is ranked 50th for adult mental health. **Figure 5** illustrates prevalence measures for mental illness in Washington compared to national levels.

Figure 5–Washington State vs. National Prevalence Measures for Mental Illness



(Substance Abuse & Mental Health Services Administration, 2013)

Regional Support Networks (RSN) in Washington administer publicly funded mental health services in their region, including outpatient treatment, crisis and involuntary detention, residential mental health services, and authorization for inpatient services for Medicaid and non-Medicaid patients. In 2014, approximately 1.1 million Washingtonians (15.7% of the population) were enrolled in managed mental health care services (Washington State Department of Social & Health Services, 2014). **Table 14** illustrates the percentage of Washington State mental health plan enrollees by RSN.

In 2012, Washington's Regional Support Networks were reduced in number from 13 to 11. These consolidations were intended to promote organizational efficiencies. The scope of services required by each network did not change.

While services were consolidated, funding was reduced. Between 2005 and 2013, Washington spent less on state funded mental health services than the national average, at $113.67 million per fiscal year in 2013, compared with a national average of $119.62 million for the same year (The Henry J. Kaiser Family Foundation, 2015). In fiscal years 2014 and 2015, Washington's mental health spending increased (Ollove, 2014).

Washington is ranked 50th among the states for adult mental health.

Access to mental healthcare, both inpatient and outpatient, was negatively impacted by this prolonged

TABLE 14–Mental Health Regional Support Networks and Enrollees

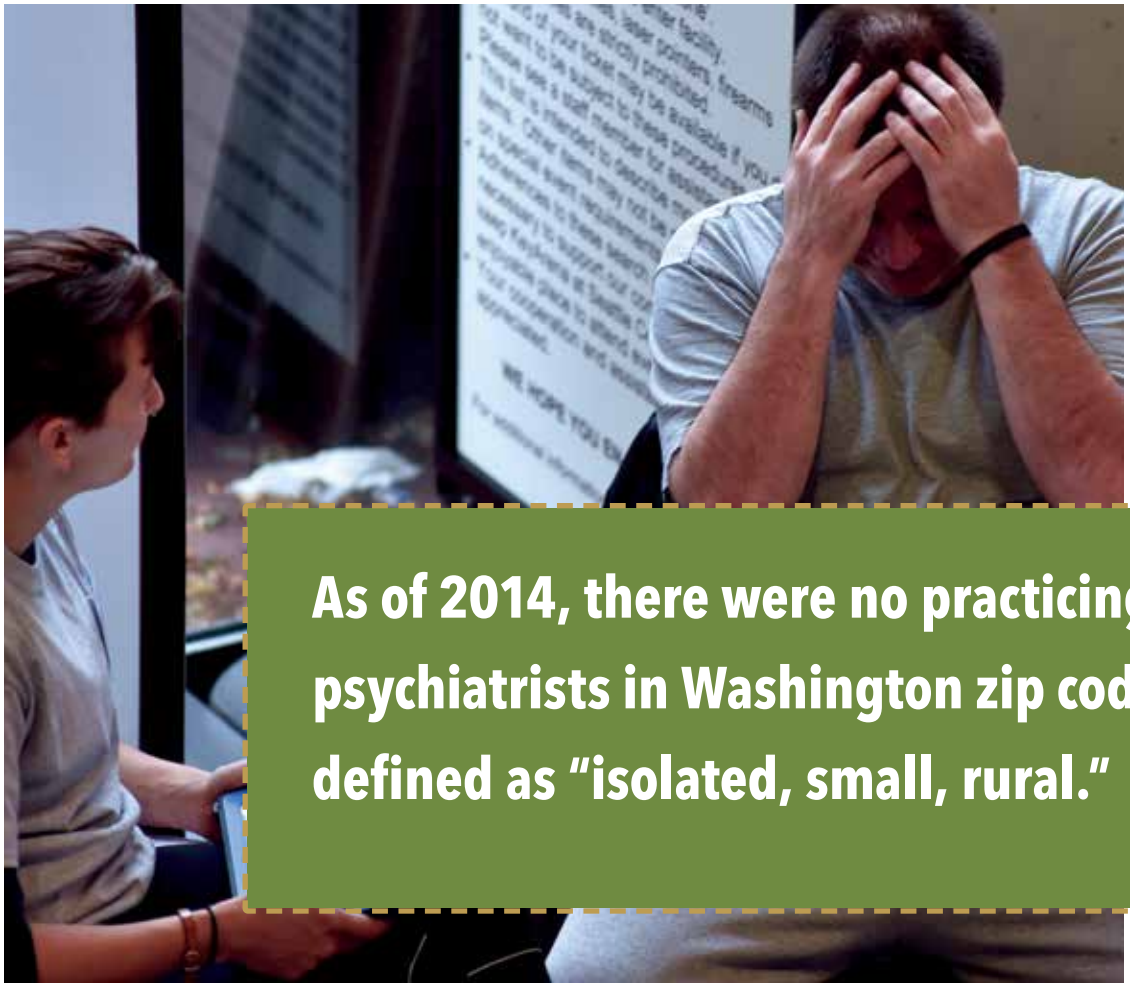
Regional Support Networks	% of All Health Plan Enrollees Served by RSN
Chelan-Douglas RSN	2.2
Grays Harbor RSN	1.5
Greater Columbia Behavioral Health	14.9
King County RSN	21.7
North Sound Mental Health Administration	14.4
Peninsula	4.3
OptumHealth Pierce RSN	12.4
Southwest Washington Behavioral Health	8.7
Spokane County RSN	13.6
Thurston-Mason RSN	4.4
Timberlands RSN	2.0
Total	**100.00**

(Washington State Department of Social & Health Services, 2012)

period of reduced funding. Washington saw a decrease in the number of mental health beds available statewide. This, in turn, led to an increase in psychiatric boarding.

Boarding refers to the delay in transfer of psychiatric patients when there are no voluntary or involuntary beds available. It applies to patients who are kept in emergency departments for long periods, sometimes in restraints. This experience creates significant hardships for both psychiatric and non-psychiatric patients (Bloom, 2015). In 2014, the Washington State Supreme Court ruled that the boarding of psychiatric patients is illegal.

In late 2014, 159 new adult psychiatric beds were added to licensed facilities across the state. The addition of these new beds brought the total number of adult psychiatric beds in Washington to 819, the highest level in 15 years (Burley & Scott, 2015). The impact of these changes has yet to be assessed.



As of 2014, there were no practicing psychiatrists in Washington zip codes defined as "isolated, small, rural."

Figure 6–Federally Designated Health Professional Shortage Areas for Mental Healthcare

(Washington State Department of Health, 2015)

Shortages of mental health providers are seen throughout Washington, especially in rural areas. As of March 2015, 35 of Washington's 39 counties were designated as Health Professional Shortage Areas for Mental Healthcare (**Figure 6**).

The WWAMI Center for Health Workforce Studies reports that, as of 2014, there were no practicing psychiatrists in Washington zip codes defined as "isolated, small, rural," and just over two non-federally employed psychiatrists under age 75 practicing per 100,000 residents in rural Washington zip codes. This compares to 10.8 non-federally employed psychiatrists under age 75 practicing per 100,000 residents in urban Washington zip codes (Skillman & Stover, 2014).

Mental health parity became effective in Washington in 2008, requiring mental health services be covered by health insurance, with "reasonable deductible amounts and copayments" (Cauchi & Hanson, 2015).

Oral Health

In 2013, adult dental care was restored as a service covered by Medicaid in Washington (Camden, 2013). Low income adults seeking dental care experience multiple barriers, including an imbalance in distribution of dental professionals working in underserved areas, a shortage of dentists willing to bill for Medicaid, and high out of pocket expenses.

The WWAMI Center for Health Workforce Studies reports shortages of dentists and dental hygienists in both rural and urban areas of the state (Skillman & Adrilla, 2009). The number of dentists per 100,000 residents ranges from nine in rural Skamania County to 103 in urban King County. Areas or populations in all but five Washington counties are Federally Designated Health Professional Shortage Areas for Dental Healthcare, as exhibited in **Figure 7**.

Figure 7–Federally Designated Health Professional Shortage Areas for Dental Care

(Washington State Department of Health, 2015)

A Washington State Hospital Association report found that dental discomfort was the most common, non-urgent reason that uninsured adults visit the emergency room (Washington State Hospital Association, 2011). These inappropriate ER visits create additional burdens to the healthcare system and fail to meet the treatment needs of the dental patient.

A Washington State Hospital Association report found that dental discomfort was the most common, non-urgent reason that uninsured adults visit the emergency room.

(Washington State Hospital Association, 2011)

Due to the small number of dentists willing to accept Medicaid in Washington, many patients are unable to obtain care, despite Medicaid coverage. When comparing Medicaid dental utilization by eligible users across the state, large differences between counties are observed. Medicaid dental utilization by eligible users ranges from 19.77% in Jefferson County to 49.35% in Yakima County (**Table 15**).

TABLE 15–2014 Washington State Medicaid Dental Utilization by Eligible Users by County

County	% Medicaid Dental Utilization Among Eligible Users	County	% Medicaid Dental Utilization Among Eligible Users
Jefferson	19.73%	Kittitas	32.65%
San Juan	20.61%	Garfield	32.91%
Skamania	25.09%	Lewis	32.95%
Whitman	25.15%	Adam	33.36%
Wahikiakum	25.50%	Pierce	33.87%
Clallam	25.66%	Cowlitz	34.58%
Kitsap	26.61%	Skagit	34.60%
Island	26.86%	Clark	34.68%
Asotin	27.42%	Stevens	36.81%
Thurston	27.76%	Spokane	37.06%
Klickitat	28.09%	Okanogan	37.98%
Pacific	28.11%	Columbia	38.62%
Mason	29.59%	Walla Walla	39.04%
Ferry	29.82%	Benton	40.78%
Pend Oreille	30.05%	Chelan	44.50%
Grays Harbor	31.01%	Douglas	46.84%
Snohomish	31.24%	Grant	48.19%
King	31.46%	Franklin	48.59%
Lincoln	31.78%	Yakima	49.35%
Whatcom	31.89%		

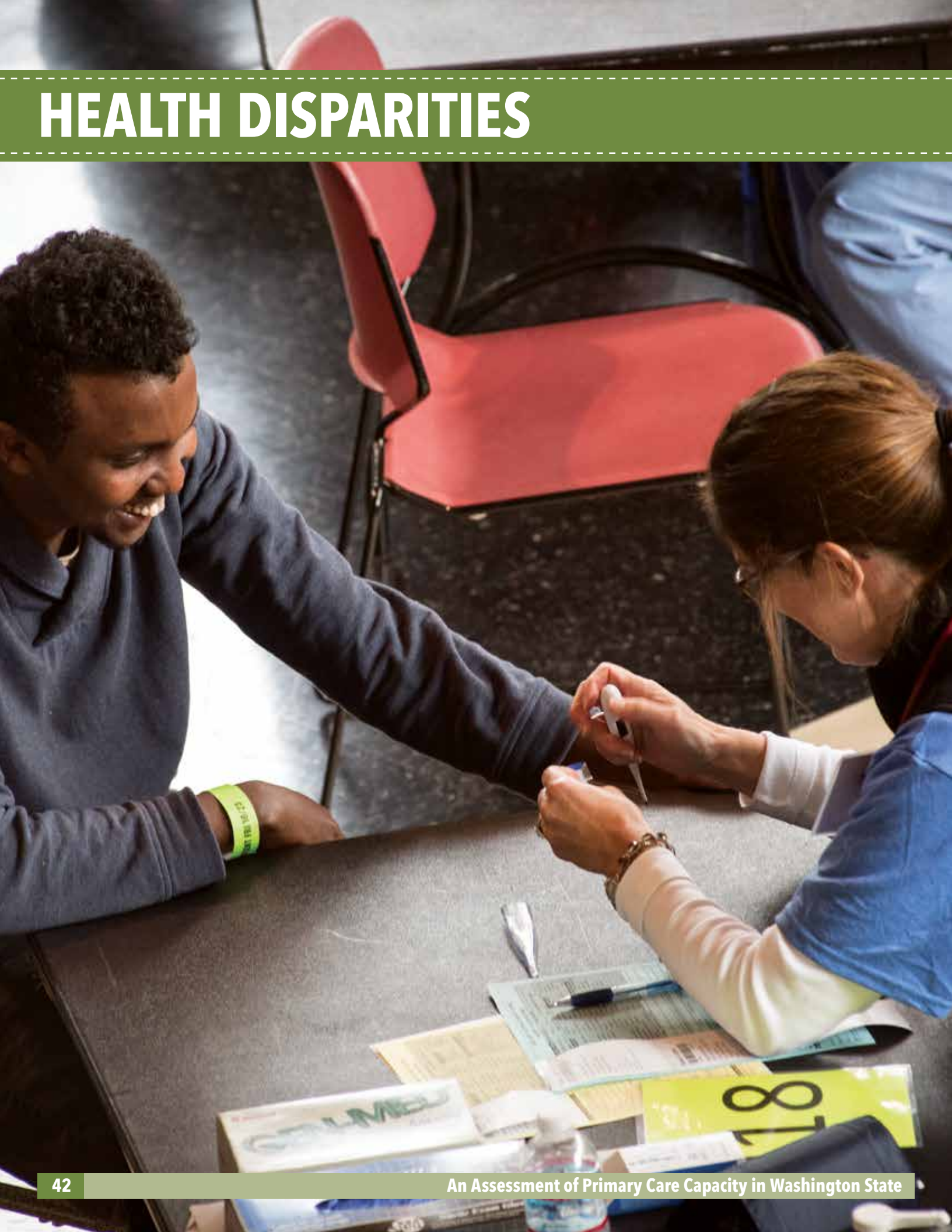
(Washington State Health Care Authority, 2015)

In a 2015 survey of Washington State free clinics, more than half of the respondent clinics identify dental care as a top need of their patient population, and report intent to develop or expand dental services (Lindquist, 2015). Of patients seeking care at the 2015 Seattle/King County Clinic event, more than 18% stated that they had not seen a dentist in more than five years, and 2.8% reported never having visited a dentist (Seattle Center Foundation, 2015).

Of patients seeking care at the 2015 Seattle/King County Clinic event, more than 18% stated that they had not seen a dentist in more than five years, and 2.8% reported never having visited a dentist.

(Seattle Center Foundation, 2015)

HEALTH DISPARITIES



General Overview

Health disparities refer to differences in health outcomes, and their causes, between population groups. Race or ethnicity, sex, sexual identity, age, disability, socio-economic status, and geographic location all contribute to an individual's ability to achieve and maintain good health, and often also determine the level of access and quality of care available to them.

Socioeconomic inequality and geography contribute to significant barriers to primary care access in Washington State, impacting health outcomes. Due to Washington's mountainous topography, emergency travel between communities can be difficult. Across the state, and between population groups, significant health disparities were identified.

Racial and ethnic minority groups are disproportionately underserved by Washington's healthcare system, and less likely to have adequate insurance coverage and access to primary care services. Distribution of race among patients seeking care in safety net settings is not reflective of the racial distribution of the population of the state, suggesting severe inequities. **Tables 16** and **17** demonstrate the racial distribution of 2014 Seattle/King County Clinic event patients, as well as patients seen in federally qualified community health centers, compared to the racial distribution of the state's population.

TABLE 16–2014 Seattle/King County Clinic Event Patient Distribution by Race

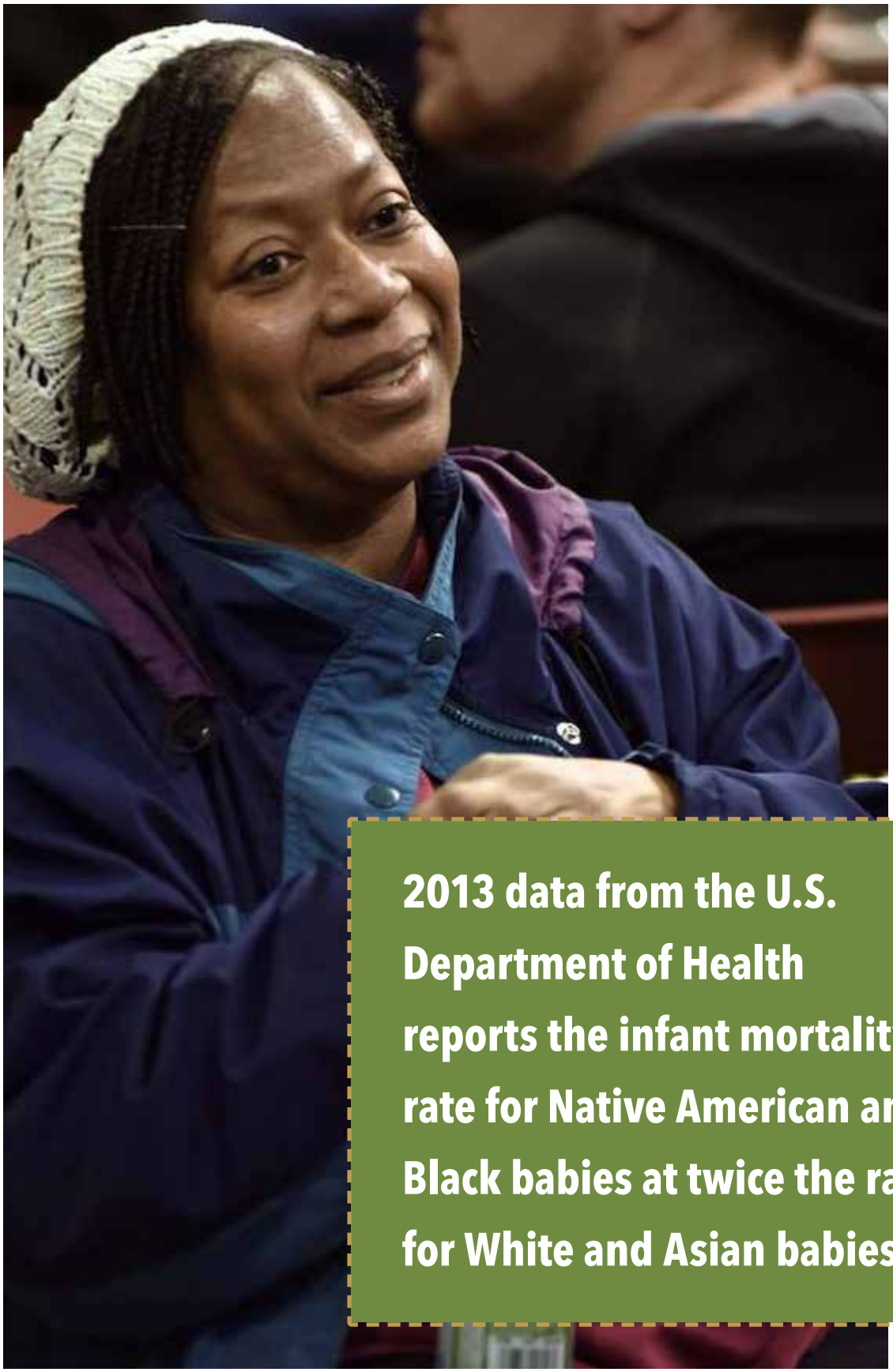
Population Group	White, Non-Hispanic	Black/ African American	American Indian and Alaska Native	Asian and Pacific Islander	Latino/ Hispanic of Any Race	Native Hawai'ian or Other Pacific Islander	Two or More Races
2014 WA Population	70.4%	4.1%	1.9%	8.2%	12.2%	.7%	4.5%
2014 Seattle King County Patient Population	31%	14.5%	1.5%	15.7%	16.7%	2.9%	4.3%

(Seattle Center Foundation, 2015)

TABLE 17–2014 Washington State Federally Qualified Community Health Center Patient Distribution by Race

Race/Ethnicity	2014 Community Health Center Patients	2014 Washington State
White or European American	51%	70.4%
Hispanic/Latino	29%	12.2%
Black or African American	6%	4.1%
Asian or Pacific Islander	7%	8.2%
American Indian or Alaska Native	2%	1.9%
More than one race	5%	4.5%

(Washington Association of Community & Migrant Health Centers, 2015)



2013 data from the U.S. Department of Health reports the infant mortality rate for Native American and Black babies at twice the rate for White and Asian babies.

Early prenatal care is an important strategy to improve maternal and child health. As a measure of access, it is a strong indicator. In 2014, on average, 74% of pregnant women in Washington State entered prenatal care during the first trimester of pregnancy. Across Washington, there was a significant difference in the percentage of women who received prenatal care in the first trimester between counties, with a range from 60% in Jefferson County to 85.6%, in Kittitas County (**Table 18**).

TABLE 18–Prenatal Care in First Trimester by County

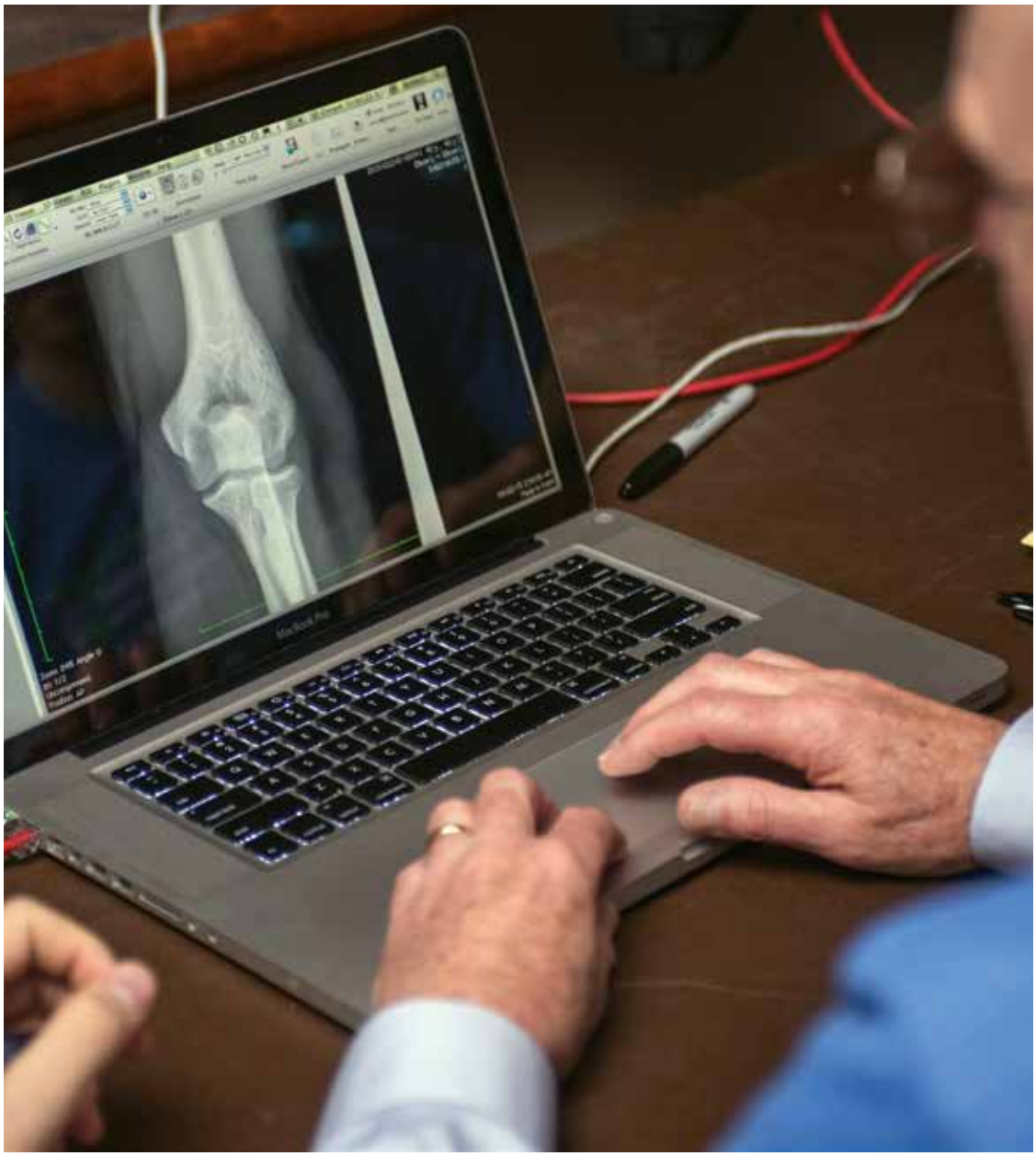
County	% Woman Receiving Prenatal Care in First Trimester
Statewide	74%
Jefferson	60.2%
Whitman	61.7%
Ferry	63.9%
Garfield	65%
Franklin	67%
Mason	67.1%
Okanogan	67.6%
Clallam	67.6%
Clark	68.4%
Skagit	68.9%
Cowlitz	69.5%
Stevens	69.6%
Asotin	70.3%
Grays Harbor	70.4%
Pierce	70.9%
Pacific	71.4%
Columbia	71.9%
Benton	71.9%
San Juan	72%
Kitsap	72.4%
Klickitat	73%

County	% Woman Receiving Prenatal Care in First Trimester
Grant	73.1%
Whatcom	73.4%
Snohomish	73.5%
Walla Walla	73.8%
Adams	74.1%
Pend Oreille	74.3%
Yakima	74.6%
Lewis	75.2%
King	76.2%
Chelan	76.4%
Island	76.5%
Thurston	77%
Skamania	77.6%
Douglas	77.7%
Wahkiakum	80.8%
Lincoln	81.5%
Spokane	83.1%
Kittitas	85.6%

(Washington State Department of Health, 2014)

Measures of health status in Washington vary by race, and patterns across health status measures in Washington are similar to national averages.

Eighty-seven percent of those who identify as White report being in very good or excellent health, compared to 77% of Blacks, 73% of American Indian or Alaska Natives, and 69% of Hispanics. While the rates of overweight and obesity statewide are low, those who identify as American Indian or Alaska Native (79%), Black (76%), or Hispanic (69%) are more likely to be overweight or obese than those who identify as White (61%) or Asian, Native Hawaiian, or other Pacific Islander (42%). In addition, those who identify as Black (44%) and White (42%) are more likely to report mental



health issues, compared to those who identify as Asian, Native Hawaiian, or other Pacific Islander (33%), or Hispanic (26%). The rates of reported mental health issues in Washington are higher than national averages across racial and ethnic groups, except for Hispanics (The Henry J. Kaiser Family Foundation, 2014).

Regarding benefiting from a medical home, 75% of those who identify as White and 71% of those who identify as Asian, Native Hawaiian, or other Pacific Islander report having a usual source of care, the rate is only 63% for Blacks, American Indians and Alaska Natives, and 46% for Hispanics (The Henry J. Kaiser Family Foundation, 2014). 2013 data from the U.S. Department of Health reports the infant mortality rate for Native American and Black babies at twice the rate for White and Asian babies. Significant geographic disparities also exist across the state, between urban and rural communities.

Age-adjusted mortality rates for treatable illness, by county, show a dramatic range between counties, as seen on **Table 19**.

TABLE 19–Age-Adjusted Mortality Rates per 100,000 Residents by County

County	Diabetes	Cardiovascular Disease	Pneumonia and Influenza	Chronic Lower Respiratory Disease	Chronic Liver Disease
Statewide	21.4	34.7	9.4	38.3	11.2
Adams	*	43.8	*	94.2	*
Asotin	41.3	27.0	21.0	52.5	*
Benton	32.9	23.7	10.3	35.2	9.8
Chelan	19.0	35.1	15.1	44.9	18.9
Clallam	9.3	42.0	5.6	35.2	11.2
Clark	22.7	30.5	7.0	41.7	12.4
Columbia	*	58.3	*	108.4	*
Cowlitz	31.9	43.2	11.3	64.6	18.7
Douglas	19.9	35.1	*	64.0	*
Ferry	*	*	*	50.3	*
Franklin	34.6	26.3	*	34.1	10.7
Garfield	*	*	*	*	*
Grant	24.6	29.7	14.2	58.4	10.4
Grays Harbor	24.3	36.6	25.3	59.2	14.3
Island	12.2	35.2	15.1	24.2	14.4
Jefferson	25.3	25.8	*	22.2	*

County	Diabetes	Cardiovascular Disease	Pneumonia and Influenza	Chronic Lower Respiratory Disease	Chronic Liver Disease
King	19.4	30.4	8.8	27.6	9.1
Kitsap	19.2	35.6	7.7	40.8	16.5
Kittitas	15.4	21.5	*	24.0	16.9
Klickitat	*	34.5	*	44.9	*
Lewis	13.2	45.3	17.2	42.8	10.0
Lincoln	*	*	*	24.8	*
Mason	25.2	33.4	7.4	48.5	14.0
Okanogan	27.8	61.1	8.2	43.7	22.7
Pacific	16.1	47.7	14.0	35.4	19.9
Pend Oreille	26.7	28.3	*	49.5	*
Pierce	22.9	39.3	10.1	43.5	10.7
San Juan	*	34.2	*	28.9	*
Skagit	15.8	36.3	8.5	38.5	15.5
Skamania	*	*	*	*	*
Snohomish	25.6	38.2	8.8	40.6	9.8
Spokane	22.1	41.3	11.8	46.5	12.7
Stevens	21.7	50.7	14.9	61.0	18.5
Thurston	19.8	30.7	6.6	40.0	11.6
Wahkiakum	*	*	*	*	*
Walla Walla	32.9	38.4	9.9	44.9	14.0
Whatcom	24.0	34.2	5.5	33.6	8.5
Whitman	15.2	43.4	16.5	35.6	15.5
Yakima	19.9	33.1	10.5	35.7	16.4

*** Denotes rates not calculated due to fewer than five deaths occurring within the reporting period.**

(Washington State Department of Health, 2015)

Under- and Uninsured

As of 2014, 9.2% of the population in Washington was without health insurance, which was slightly lower than the national average of 11.7%. Research by the Henry J. Kaiser Family Foundation (2014) indicates that 27% of uninsured adults went without needed medical care in the previous year due to financial constraints. The same study cites that 36% of low and middle income uninsured adults had problems paying medical bills (The Henry J. Kaiser Family Foundation, 2014).

Lack of health insurance coverage spans all population demographics, but not equally. Washington's uninsured rates by race are proportional to national levels, with American Indian or Alaska Native residents least likely to be insured, at 21.8%, followed by Hispanic or Latino residents at 21.4%.

Nearly one third (32.2%) of all foreign-born Washington residents who have not gained citizenship are without health insurance, which is lower than the national rate of 40%. Foreign-born residents of Washington who have become American citizens have a significantly lower rate (8.4%) of uninsured than the national average (26.5%). The lowest income residents are the least likely of any income group to have health insurance. **Table 20** shows Washington's uninsured population data compared to national percentages.

TABLE 20–Washington State and National Uninsured Population Data

Health Profile	% National	% Washington
Uninsured by race:		
White or European American	10.4%	8.4%
Hispanic or Latino	23.5%	21.4%
Black or African American	13.6%	9.4%
American Indian or Alaska Native	23.1%	21.8%
Asian	10.6%	8.2%
Native Hawaiian or other Pacific Islander	13.5%	14.6%
Some other race	26.1%	25.1%
Two or more races	10.4%	9.4%
Uninsured by citizenship status:		
Native born	9.4%	7.4%
Foreign born – naturalized	26.5%	8.4%
Foreign born – not a citizen	40%	32.2%
Uninsured by income:		
Under $25,000	18.3%	14.9%
$25,000 - $49,999	16.9%	13.5%
$50,000 - $74,999	12.2%	10.7%
$75,000 - $99,999	8.5%	6.8%
$100,000 and over	5.0%	4.6%

(U.S. Census Bureau, 2014)

Healthcare Insurance does not guarantee healthcare access. Although many Washington residents receive coverage under the Affordable Care Act, patients continued to seek care in safety net clinic settings. Of the 4,010 2015 Seattle/King County Clinic event patients who waited overnight for healthcare services, more than half reported having some form of healthcare insurance (**Table 21**).

TABLE 21–Health Insurance Status Among 2015 Seattle/ King County Clinic Patients

Insurance Status	% of Patients
Employer Provided	4.9%
Medicaid	15.1%
Medicare	13.6%
No Insurance	44.1%
Other	6.4%
Privately Acquired	5.7%
Through Spouse/Parent	1.2%
No Answer	9.0%

(Seattle Center Foundation, 2015)

Healthcare Insurance does not guarantee healthcare access.

Elderly

As of 2014, Washington has the 16th largest elderly population in the country, with 992,516 residents (14% of the population) over the age of 65.

Nationally, the total number of elderly residents in the U.S. increased by 14% between 2005 and 2014. Within that same period, Washington State's elderly population showed an increase of 18%.

Washington State's elderly population reflects national averages in terms of percent living alone, percent living in poverty, and percent living with a disability. Washington demonstrates a 4.5% higher percentage rate of seniors with veteran status than the national average (**Table 22**).

TABLE 22–2014 Elderly Population Data in Washington State Compared to the National Aggregate

Population Group	% National	% Washington
Number of Elderly	14.5%	14.1%
Percentage of Elderly with Veteran Status	20.3%	24.8%
Percentage of Elderly with a Disability	36.0%	36.6%
Elderly Living Below Poverty Level	9.5%	8.4%
Elderly Living Alone in Household	43.1%	43.5%
Uninsured Elderly	0.9%	0.7%

(U.S. Census Bureau, 2014)

Many low income seniors seek healthcare in Washington's safety net system. The Washington Association of Community and Migrant Health Clinics reports that 7% of their 2014 patient population was age 65 or older (Washington Association of Community & Migrant Health Centers, 2015). Of the 2015 Seattle/King County Clinic

event patients, 11.4% reported their age as 65 or older (Seattle Center Foundation, 2015). In 2015, the Free Clinic of SW Washington reported that 88% of urgent dental clinic patients were Medicare recipients (Free Clinic of Southwest Washington, 2015).

Washington State's healthcare workforce may be reduced even further for Medicare patients. The number of Medicare providers in Washington State is predicted to decrease in 2016, as a Medicare incentive program expires. Since 2010, primary care practitioners have received a 10 percent bonus for caring for Medicare patients. As a result of this potential expiration, Medicare patients could have a harder time finding a doctor and/or could wait longer for appointments (Andrews, 2015).

A Washington Dental Service Foundation study finds that, for seniors, income level is correlated with oral health. As income increases, oral health improves and as income decreases, oral health among seniors declines (Delta Dental of Washington, 2015).

Survey respondents with higher incomes report higher rates of dental visits, higher rates of having all their original teeth, having healthy gums and teeth, and having dental insurance that covers the cost of appointments. These patients also report being in better health overall. Low income seniors are significantly more likely to be affected by dental disease, and are least likely to have dental insurance.

LGBTQ

Nationally, sexual and gender minorities have many of the same health concerns as the general population. As a distinct group, they experience certain health challenges at higher rates. In particular, research suggests that some subgroups of the LGBTQ community are likely to develop more chronic conditions, as well as higher prevalence and earlier onset of disabilities than heterosexuals. Other major health concerns include HIV/AIDS and sexual and physical violence (Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2015).

LGBTQ individuals are at increased risk for suicidality, depression and anxiety, substance abuse, and homelessness. They also experience difficulties with when and how to disclose their identity status to their doctors, due to safety concerns. Transgender patients nationwide report having their healthcare providers refuse to see them, and/or provide non trans-affirming, or even substandard, care (Heck, Lindquist, Machek, & Cochran, 2014).

In a 2012 Gallup poll, Washington State ranked 11th in the country (including the District of Columbia) for population percentage self-identified as lesbian, gay, bisexual, or transgender, with 4.0% of the population. The national range for population percentage self-identified as lesbian, gay, bisexual, or transgender was 1.7% to 10%.

Washington State is socially progressive, driven by the largely liberal populous urban centers west of the Cascade mountain range. Several state laws have been passed to protect LGBTQ residents.

In 2012, Washington State passed Referendum 74, legalizing marriage for same sex couples. Washington was among the first six states in the country to do so (Procon.org, 2015). Referendum 74 passed by 53.7%, with the majority of support coming from urban communities, which implies more concentrated homophobia in rural Washington.

Washington State supports rights specifically for LGBTQ residents, including legislation addressing housing, employment, hate crimes, public accommodations, anti-bullying, education, gender marker change, and transgender healthcare.

Housing, employment, or public accommodation discrimination based on sexual orientation and gender identity are prohibited, and Washington has laws that address hate or bias crimes and discrimination, harassment and/or bullying of students based on sexual orientation and gender identity. Washington has a ban on insurance exclusions for transgender healthcare and provides transgender-inclusive health benefits to state employees. Additionally, it has laws and policies that facilitate gender marker change on both driver's licenses and birth certificates (Human Rights Campaign, 2015).

LGBTQ youth are disproportionately overrepresented among homeless individuals, and homelessness in Washington State is significantly higher than the national average. YouthCare, an organization serving homeless youth in Washington, estimates that 40% of their client population is LGTBQ, and 2% of their client population is transgender, compared with .3% of the overall US population (Youthcare, 2014).

LGBTQ individuals are at increased risk for suicidality, depression and anxiety, substance abuse, and homelessness. They also experience difficulties with when and how to disclose their identity status to their doctors, due to safety concerns.

Veterans

As of 2014, Washington has the 12th largest veteran population in the country, with a total of 604,000 veterans (U.S. Department of Veterans Affairs, 2015).

The total number of veterans in the U.S. decreased by 17% between 2000 and 2015. Washington State's veteran population showed between a 6.0% decrease and a .1% increase in the number of veterans within the same timeframe, a lower decrease than the national average (U.S. Department of Veterans Affairs, 2015).

Table 23 shows Washington State's veteran population and healthcare utilization data. In 2014, fewer than one third of Washington State's veterans were enrolled in the Veterans Administration Health System, which suggests that the veteran population seeks healthcare elsewhere within the state's service delivery system.

TABLE 23–2014 Veteran Population Data in Washington State Compared to the National Aggregate

Population Group	National	Washington
Population Numbers		
Number of Veterans	22.0 M	604,000
Number of Women Veterans	2.02 M	64,000
Number of Veterans Age 65 and Over	9.95 M	257,000
Healthcare Utilization		
Number of Enrollees in VA Healthcare System	9,106,480	205,845
Number of Unique Patients Treated	5,869,487	123,993

(U.S. Department of Veterans Affairs, 2015)

Total Veterans Administration medical expenditures in Washington State were over $1.2 billion for fiscal year 2013 (U.S. Department of Veterans Affairs, 2015). This represents a lower level of spending per Washington State veteran than is reported in states with comparable veteran populations (**Table 24**).

TABLE 24–Veterans Administration Health Facilities and Health Expenditures in Washington State Compared with States with Similar Veteran Populations

Population Group	National	Arizona	Michigan	Illinois	Washington
Veteran Population	22 M	532,000	658,000	722,000	604,000
Total Health Expenditures	>$59 Billion	>$1.3 Billion	>$1.4 Billion	>$2 Billion	>$1.2 Billion
Number of VA Hospitals	150	3	5	5	4
Number of Community-Based Outpatient Clinics	820	19	22	25	10
Number of Vet Centers	300	7	8	11	8
Number of Total of Enrollees in VA Health System	9.2 M	225,480	232,514	290,254	205,845

(U.S. Department of Veterans Affairs, 2015)

Washington State has a significantly lower number of community-based outpatient clinics compared to states with similar veteran populations, but the number of Veterans Administration hospitals and vet centers is similar to other states with comparable populations of veterans. The number of enrollees in the Veterans Administration health system is lower than enrollment reported in other states, such as Arizona, with lower veteran populations.

Homelessness

As of November 2015, Washington has the 6th largest homeless population in the country, with a total of 19,419 homeless residents (**Table 25**).

The number of homeless individuals in the U.S. has been on a steadily decreasing trend since 2007 with a reduction of 12.8%. Until 2013, Washington experienced a similar trend, which has since reversed. Although the state saw an overall reduction of 16.9% since 2007, between 2013 and 2015, there was a 9.3% increase in homelessness.

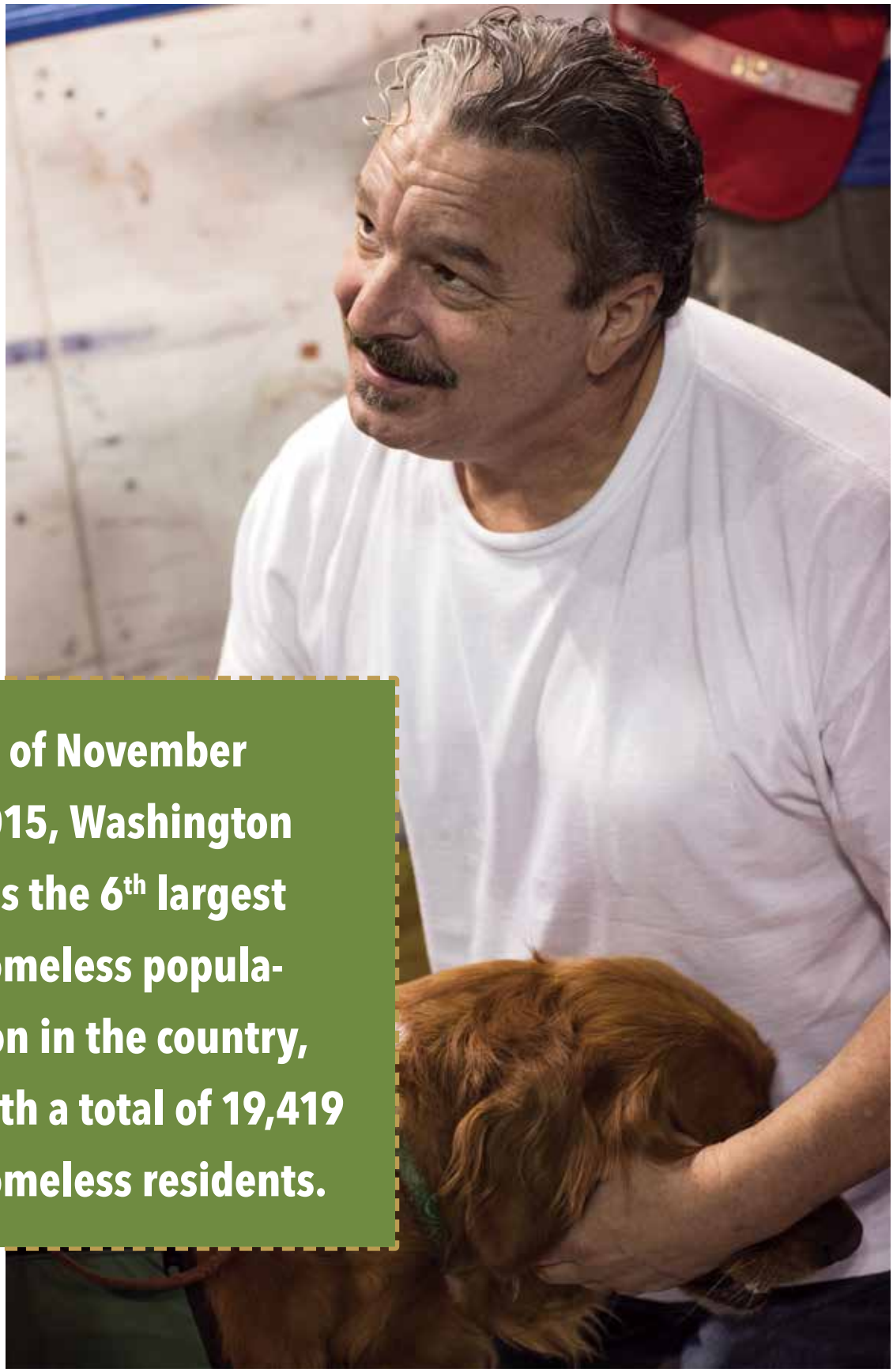
More than 7,000 people in Washington are reportedly without any form of shelter, including 154 children without adult accompaniment. In fiscal year 2013, Washington spent roughly $42 million on short-term housing assistance, however, fees supporting homelessness reduction efforts will expire in 2017, reducing this funding by 62.5%.

In 2015, a state of emergency was declared by the mayor of Seattle. The 2015 King County count of homeless individuals found 3,772 people without shelter, including more than 2,800 in Seattle, which represents a 21% increase over 2014. There are an additional 2,993 people in transitional housing, and 3,282 in homeless shelters in the county, for a total of more than 10,000 homeless residents overall (Beekman & Broom, 2015).

TABLE 25–2015 Homeless Data in Washington State Compared to the National Aggregate

Population Group	National	WA State
Total Homeless	564,708	19,419
Sheltered homeless	391,440	12,298
Unsheltered homeless	173,268	7,121
Homeless veterans	47,725	1,293
Chronically homeless	96,275	2,482
Unaccompanied homeless children	4,667	154
Change in homeless numbers:		
2007 to 2015	- 12.8%	-16.9%
2013 to 2015	- 4.3%	+ 9.3%

(U.S. Department of Housing & Urban Development, 2015; Washington State Department of Commerce, 2013)



As of November 2015, Washington has the 6th largest homeless population in the country, with a total of 19,419 homeless residents.

RESOURCES

Healthcare Safety Net Programs

PROJECT ACCESS

Project Access is a model of donated specialty care. In this model, a primary organization recruits healthcare volunteers who agree to serve a specified volume of patients with specified services for free. These services are provided in the healthcare professional's office. All care, including screening, preliminary lab work, and follow up is coordinated and supported by the Project Access organization.

Intense case management of Project Access patients ensures that barriers to care, such as transportation, language interpretation, and child care are addressed. Project Access Northwest report their patient show rates at 95%. The Project Access model has been very successful in securing complex healthcare services and maintaining networks of volunteers willing to provide this significant support within a very structured agreement.

Figure 8–Washington State Project Access Service Areas

(Project Access Northwest, 2015)

Washington State Project Access organizations operate in collaboration with free clinics and community health centers, which provide the patient referral. One Project Access organization is located within a free clinic (The Free Clinic of Southwest Washington, in Vancouver).

Project Access organizations currently serve King, Pierce, Kitsap, Snohomish, Spokane, and Clark Counties. **Figure 8** shows the Project Access services areas in Washington State.

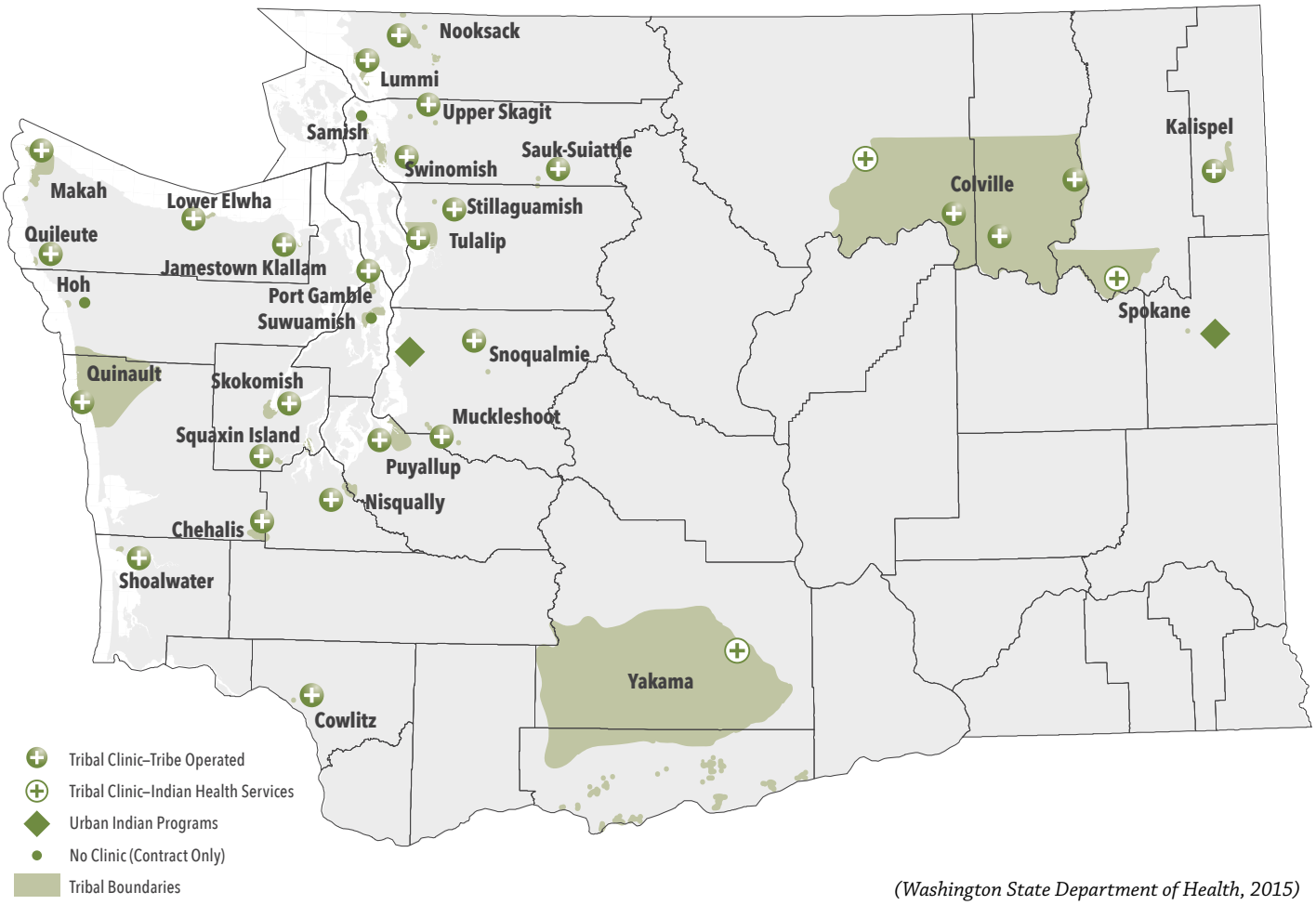
TRIBAL HEALTH CLINICS

In 1989, the governor of Washington State and tribal chairs signed the Centennial Accord. (Governor's Office of Indian Affairs, 1989, para.2).

The intent of the accord is to enhance the government-to-government relationship between the tribes and the state, stressing the importance of state agencies and the legislative branch in working with tribes to develop and implement policy affecting tribal communities.

In Washington State, tribes and urban Indian health clinics have formal working relationships to advance tribal-state collaboration on the delivery of healthcare services. The involvement of tribes in the development of public health and human services policy promotes locally relevant and culturally appropriate approaches to issues of mutual interest or concern.

Figure 9–Washington State Tribes and Tribal Health Clinics



(Washington State Department of Health, 2015)

According to the Washington State Department of Health, there are a total of 29 tribal clinics in Washington, three of which are Indian Health Service clinics. There are also two urban Indian programs, one in Seattle and one in Spokane. Tribal health clinics are leaders in implementing cutting edge models of integrative medicine. They provide a very broad range of services, which may include medical, dental, traditional medicine, mental health, chemical dependency, pharmacy and WIC programming (**Figure 9**).

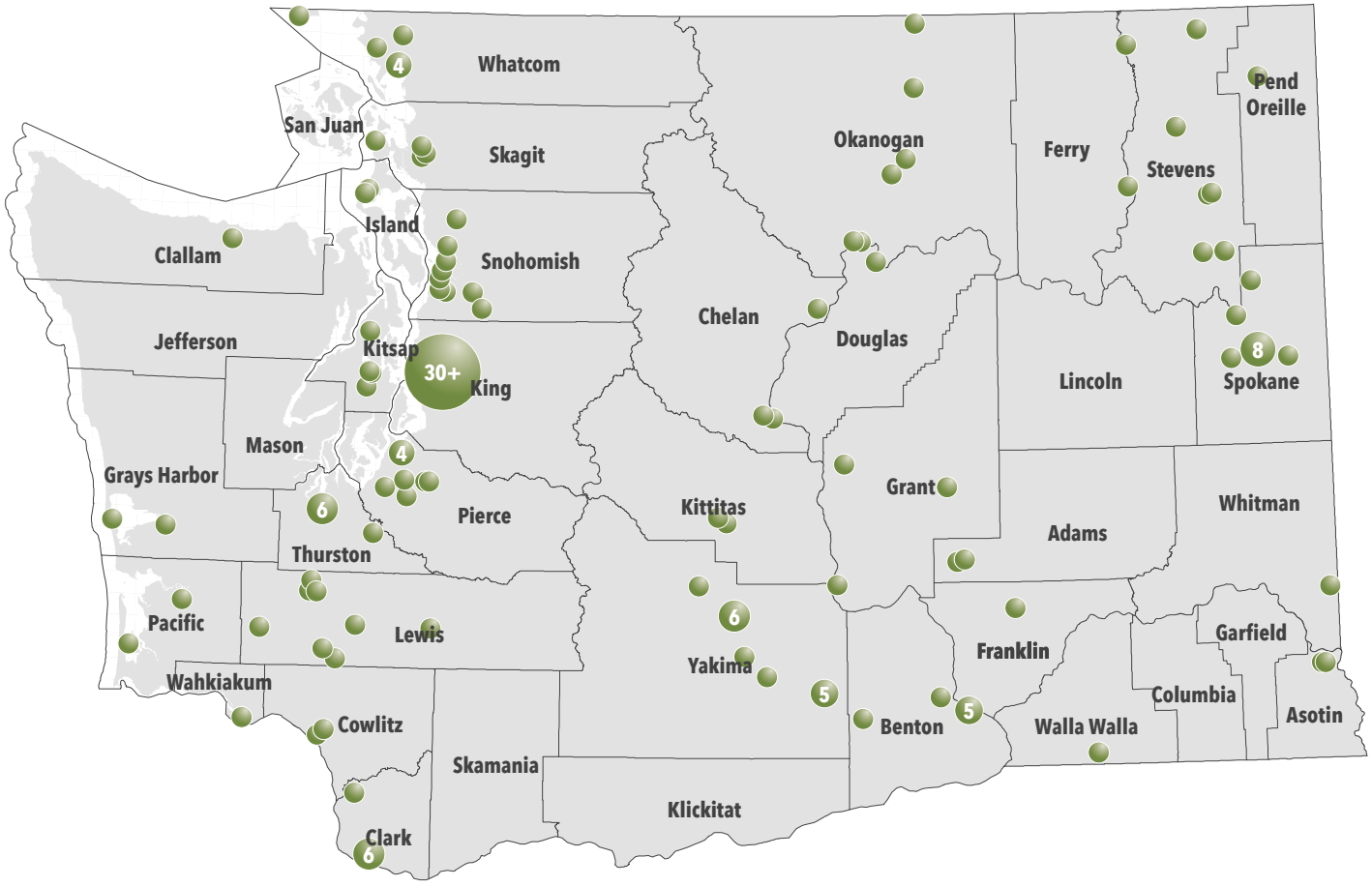
Although some services and programs are only offered to eligible Native patients, many tribal health clinics provide primary care services to anyone, regardless of tribal affiliation. The Seattle Indian Health Board in Seattle, for example, serves all patients and offers discounted fees to those who qualify (Seattle Indian Health Board, 2015).

The American Indian Health Commission of Washington State reports that several Washington State Tribes participate in a premium assistance program for tribal members, through which the tribe pays the patient's insurance premium.

FEDERALLY QUALIFIED COMMUNITY HEALTH CENTERS

Washington's community health centers are federally qualified, nonprofit clinics designated to provide care for low income and medically underserved communities. As of October 2014, there are 26 community health center systems, and 210 health delivery sites across the state (**Figure 10**).

Figure 10–Federally Qualified Community Health Centers



(Washington State Department of Health, 2015)

Washington's federally qualified community health centers reported treating just under 900,000 patients in 2014 (Washington Association of Community & Migrant Health Centers, 2015).

According to the Washington Association of Community and Migrant Health Clinics, 68% of patients seen in community health centers in 2014 were at or below the federal poverty level. Most reported being either uninsured or receiving government subsidized insurance benefits (**Table 26**).

In addition to medical, dental and behavioral healthcare, many community health clinics also provide social and wrap-around services.

Washington's federally qualified community health centers serve a patient population that is more racially and ethnically diverse than the population of Washington State as shown in **Table 27**.

TABLE 26–Washington State Federally Qualified Community Health Center Patient Insurance Status and Income

Insurance Coverage and Income Status	Percentage
Medicaid	57%
Uninsured	21%
Private Insurance	13%
Medicare	8%
Public Insurance	1%
At or Below Poverty Level	68%
101–150% of Poverty Level	17%
151–200% of Poverty Level	8%
More than 200% of Poverty Level	7%

(Washington Association of Community & Migrant Health Centers)

TABLE 27–Washington State Federally Qualified Community Health Center Patient Distribution by Race

Race/Ethnicity	2014 Community Health Center Patients	2014 Washington State
White or European American	51%	70.4%
Hispanic/Latino	29%	12.2%
Black or African American	6%	4.1%
Asian or Pacific Islander	7%	8.2%
American Indian or Alaska Native	2%	1.9%
More than one race	5%	4.5%

(Washington Association of Community & Migrant Health Centers, 2015)

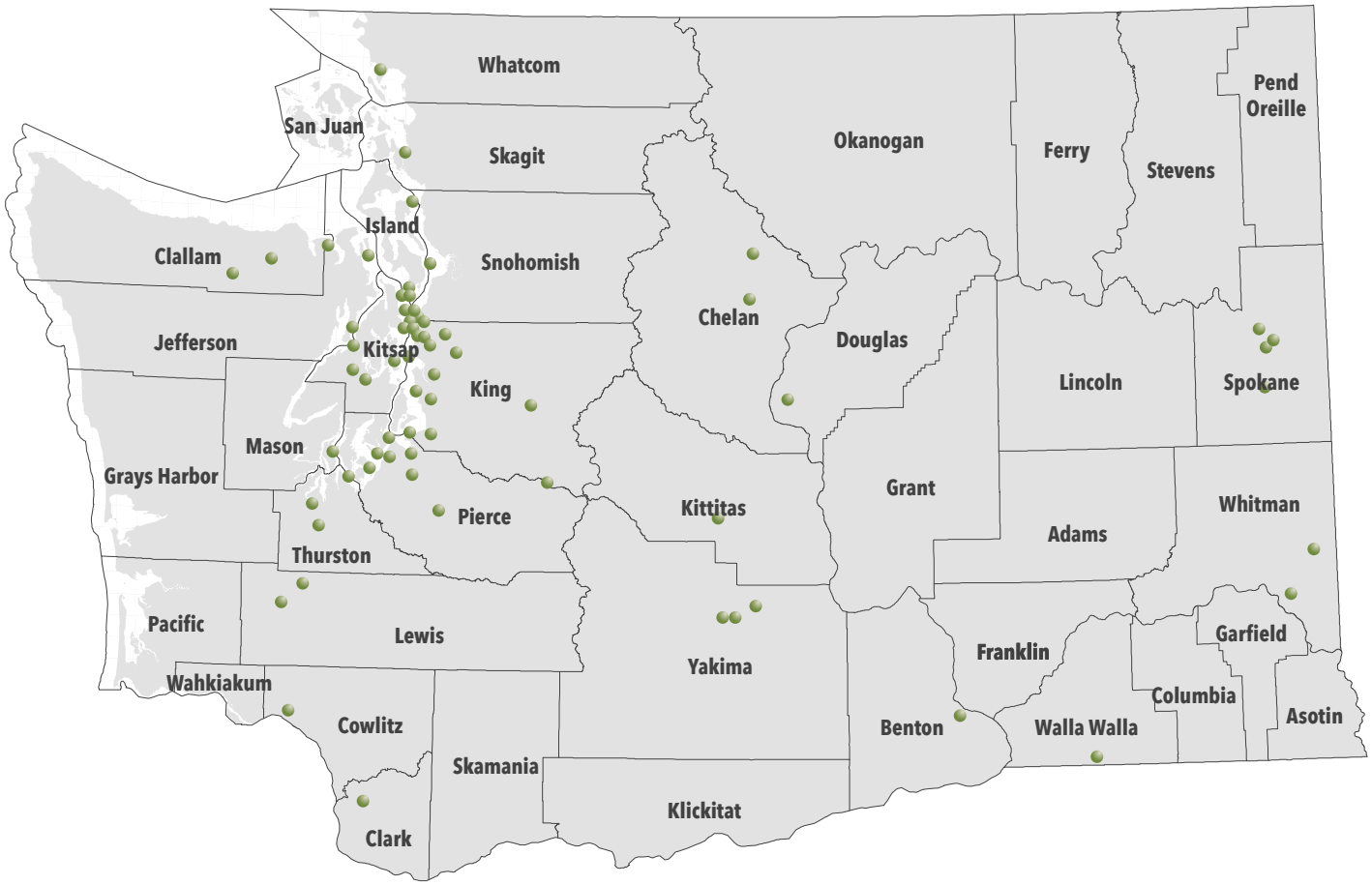
FREE AND CHARITABLE CLINICS

"Free" and "charitable" are definitions established individually by each clinic, and refer to nonprofit clinics that provide healthcare services regardless of the patient's ability to pay. Some clinics bill Medicaid, some have sliding fee scales that start at zero, and many accept no payment whatsoever. Nearly all of Washington's free and charitable clinics are staffed primarily by volunteers.

Washington State's free and charitable clinic network is one of the youngest in the country. In 2006, a handful of free clinic leaders in Washington first came together with the intent to network and share resources. They agreed that there was significant need for free healthcare services in the state.

A modest, informal conference took place that year, and the small group of attendees was delighted to find that they were not alone in their work. The Washington Free Clinic Association was established in 2008. The organization was renamed in 2012 to Washington Healthcare Access Alliance, to reflect the quickly evolving relationships beyond free clinics, within the healthcare safety net (Washington Healthcare Access Alliance, 2015).

Figure 11–Washington State Free and Charitable Clinics



(Washington State Department of Health, 2015)

As of June 2015, there are 101 free and charitable healthcare sites in Washington (**Figure 11**). Most clinics focus on medical care, but dental, vision and behavioral healthcare are also provided at some sites, as well as chronic disease management, social services, specialty care referrals, and health behavior change programming.

Most of the clinics are site-based; however, some provide mobile medical or dental services, which helps to meet the needs of rural, isolated communities. Other healthcare events, such as the Seattle/King County Clinic, or several veteran stand-downs, are large-scale, short-term free clinics.

Washington's free clinics are geographically clustered around the Interstate 5 corridor, running north and south, with few clinics located in the rural coastal, central or eastern portions of the state.

Free clinic leaders report significant deficits in dental and mental healthcare for their patients. A 2015 survey on dental care in free clinic settings in Washington found that more than half of all respondent clinics were exploring developing, or expanding dental services.

Washington State has specific legislation to encourage healthcare volunteerism. Written into Washington State law is language authorizing support for volunteer healthcare providers, which includes malpractice insurance and license renewal, funded through the Primary Care Office (Washington State Legislature, 2005).

This unique law is the cornerstone of Washington's free clinic network, and serves many other systems that utilize healthcare volunteers. Volunteers from free clinics utilize the program, as well as volunteers in other settings, such as camps with a medical component, rural health clinics, Indian Health Service Clinics, and federally qualified community health centers. In total, more than 1,200 Washington State healthcare professionals receive state-funded malpractice insurance to support volunteer work.

In 2014, The Western Washington Area Health Education Center, which administers this program, reported that over 200,000 patients received care from program volunteers. The minimum estimated value of uncompensated care provided by all clinic types for the first six-month period of 2014 was $36 million (Western Washington Area Health Education Center, 2015).

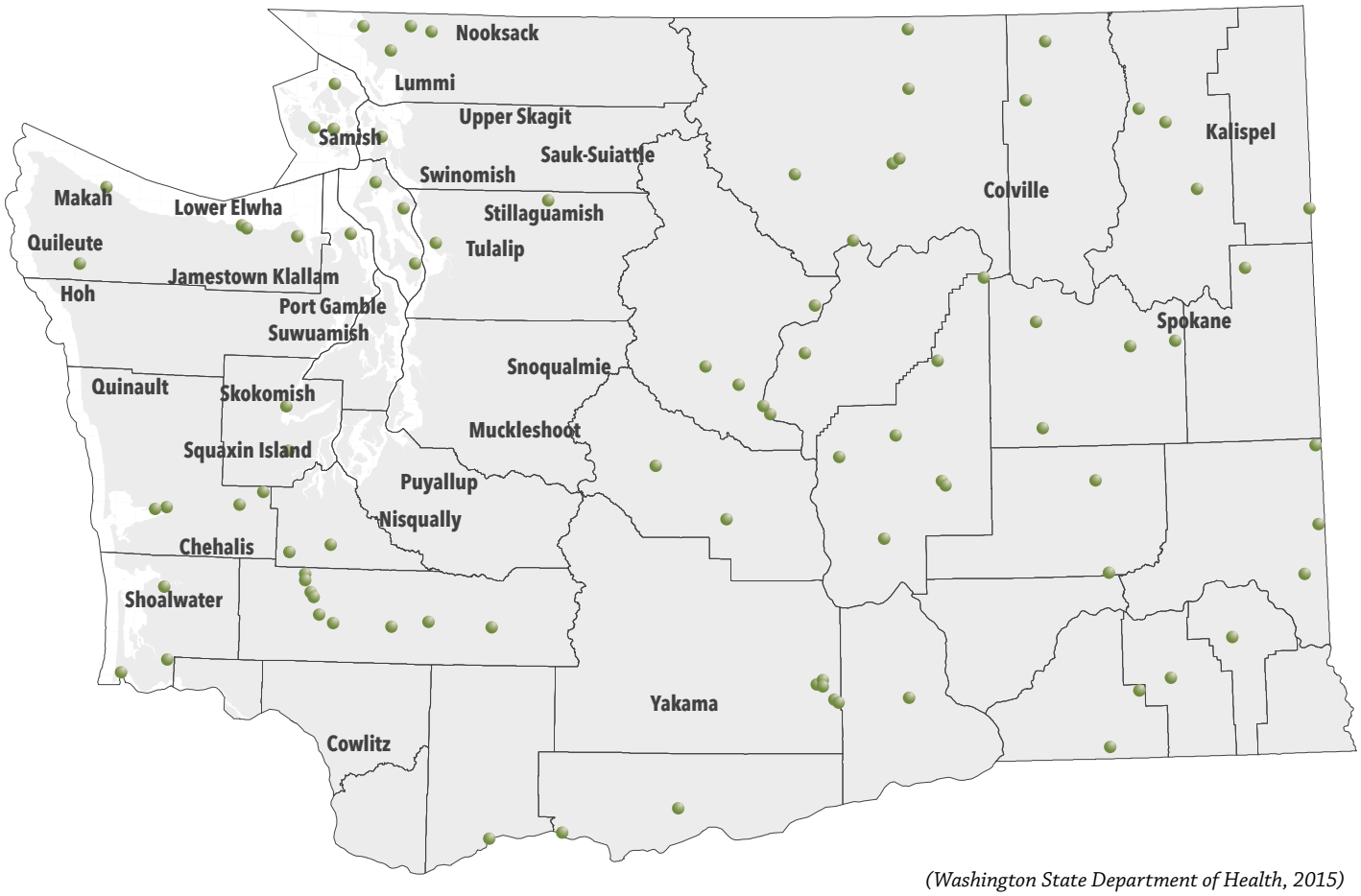
Washington's expanded Good Samaritan Law provides additional protection from liability for uncompensated healthcare volunteers (Washington State Legislature, 2014).

RURAL HEALTH CLINICS

As of January 2016, there are 118 rural health clinics in Washington State (**Figure 12**).

Washington's rural health clinic (RHC) program was established to provide reliable access to outpatient primary care in underserved rural areas. Under the program, the U.S. Centers for Medicare & Medicaid Services designate private and nonprofit clinics meeting conditions for certification as rural health clinics. These clinics must be located in a rural or non-urbanized area, which qualify as either a Health Professional Shortage Area or a Medically Underserved Area. Rural or non-urbanized areas must meet the criteria defined by the U.S. Census Bureau. Additional requirements include provision of primary care services at least 51% of the time the clinic is in operation.

Figure 12–Washington State Rural Health Clinics



(Washington State Department of Health, 2015)

Rural health clinics are eligible for enhanced Medicare and Medicaid reimbursement for primary care services.

The Washington State Office of Rural Health provides technical assistance to existing RHCs and clinics interested in pursuing RHC certification. All Washington State rural health clinics are surveyed periodically by Washington State Department of Health to assure they meet federal requirements (Washington State Department of Health, 2015).

Washington's rural health clinics vary greatly in size and composition, from a single, midlevel provider practicing mostly independently, with limited physician oversight, to a group practice comprised of multiple physicians, midlevel providers and ancillary staff. Several RHCs offer specialty services, either regularly, or on a rotating basis. Ownership also varies as approximately 30% are free standing independent clinics and 70% are provider-based, owned by critical access hospitals.

There are many challenges to providing care in rural settings, including economies of scale, provider recruitment and retention, and lower payment for large, generally poorer, and sicker concentrations of Medicaid and Medicare patients. In 1996, Washington's RHCs came together to form the Rural Health Clinic Association of Washington. The association works to advocate for Washington's rural health clinics, and to ensure sustainability of the network.

Many rural health clinics have closed in the past five years due to financial constraints and a reconciliation process with the state Medicaid administrator. The state is now working on an alternate payment methodology to reduce the burden of the reconciliation process and retain the rural health clinics. One of the primary goals of the alternate payment methodology is to reduce administrative burdens on safety net clinics.

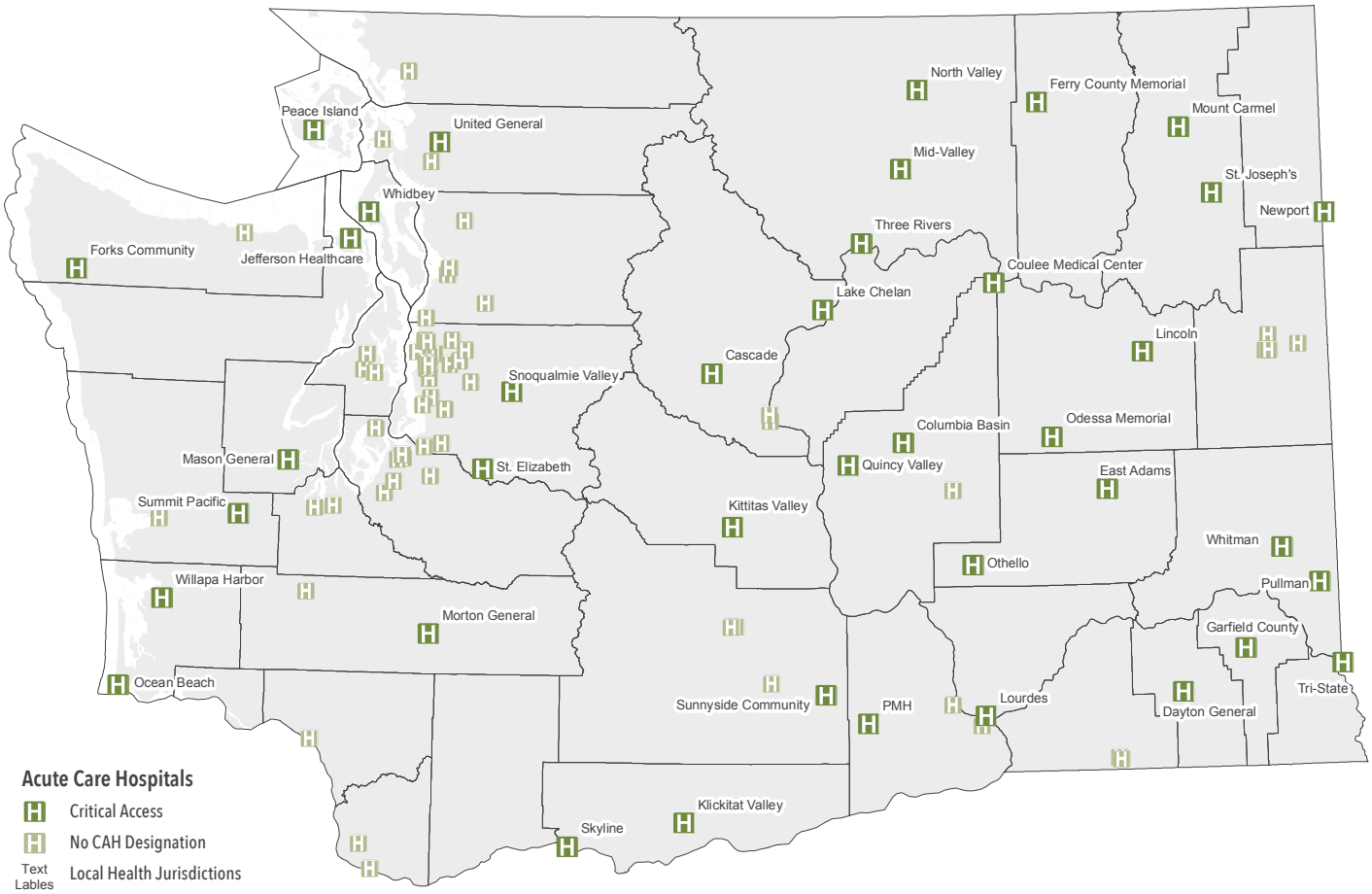
Many rural health clinics have closed in the past five years due to financial constraints.

CRITICAL ACCESS HOSPITALS

Nearly half of all hospitals in Washington State are public hospital districts. Fifty-eight local communities in Washington have established public hospital districts. Forty-four have hospitals, and the others provide services such as ambulance transport, urgent care, and nursing home services. Thirty-one of them are critical access hospitals.

Critical access hospitals are small hospitals with fewer than 25 beds. They are intended to serve rural communities, although not all rural hospitals have critical access hospital designations. The critical access hospital program was established to ensure that people enrolled in Medicare have access to healthcare services in rural areas, particularly hospital care.

Figure 13–Washington State Critical Access Hospitals



(Washington State Department of Health, 2015)

There are 39 critical access hospitals in Washington, as seen in **Figure 13**. Public hospital districts in Washington operate most critical access hospitals. In at least eight areas, the critical access hospital is the only healthcare provider in the community. Several are transitioning from an acute care model to a more integrated healthcare delivery system. Twenty-seven of Washington's critical access hospitals own one or more rural health clinics.

Critical access hospitals provide primary care, long-term care, physical and occupational therapy, cardiac rehabilitation and other services in addition to emergency room and acute care. (Association of Washington Public Hospital Districts, 2015).

An assessment of the environment for critical access hospitals by the Washington State Office of Rural Health indicates current challenges to providing high quality

care due to many factors. These include declining revenues, increasing costs, administrative burdens, healthcare provider recruitment and retention, and changing expectations of hospital care. All of these challenges are common to critical access hospitals across the nation.

VETERANS ADMINISTRATION CLINICS

As of 2014, Washington had 10 outpatient veterans clinics, and eight veterans readjustment counseling centers. Of the 10 outpatient clinics, six are located west of the Cascade Mountains.

The number of outpatient resources is significantly lower than in states with comparable veteran populations.

Innovative Programming

Although barriers to healthcare exist in Washington, several innovative programs have developed specifically to expand access to care for vulnerable populations.

In addition to specialty care coordination, many Project Access organizations have developed programs to complement existing services and to meet community need. One such program is Premium Assistance Sponsorship, initiated by Project Access Northwest, and currently under development by Pierce County Project Access (Project Access Northwest, 2015).

Through the Premium Assistance Program, patients at 250% of the federal poverty level or below, who are not eligible for Medicaid, and unable to afford their healthcare premium on the Washington State Healthcare Exchange, are referred to Project Access through a hospital partner. Project Access is contracted to help the patient enroll and pay the premium directly, with funding from the hospital system.

Two University of Washington (UW) programs are currently under development to help address mental healthcare access issues for rural Washingtonians.

The UW Department of Psychiatry and Behavioral Science will train psychiatrists to partner and consult with primary care providers and other healthcare workers in primary care clinics, school and community health centers, rural hospitals, and correctional facilities. The program will expand the training of psychiatry residents and create a clinical fellowship for psychiatrists seeking additional specialty training in integrated care. The program also will offer continuing medical education for practicing psychiatrists (Sladek, 2015).

An interdisciplinary organization based out of the University of Washington's School of Social Work will provide suicide prevention training to professionals and lay people in six underserved rural communities. Its multipronged approach is intended to address a number of the factors that contribute to higher suicide risk in rural areas, including isolation, stigma, and lack of access to mental healthcare (UW Today, 2015).

School based health clinics are emerging in Washington State as an effective way to deliver primary care to children and adolescents who may experience barriers in accessing care elsewhere.

Generally located within or close to school buildings, most school based health centers provide a wide range of direct services, which may include preventive well-child care, immunizations, urgent care, chronic care, mental and behavioral health

counseling, family planning, drug and alcohol counseling, nutritional counseling, and oral healthcare.

In 2015, the Washington School Based Health Alliance reported a total of 34 school-based health clinics across the state, 26 of which were located in Seattle. These clinics operate under a managing sponsor, many of which are federally qualified community health center systems (Washington SchoolBased Health Alliance, 2015).

The Washington Dental Service Foundation's Access to Baby Child Dentistry (ABCD) program is a successful model for engaging primary care providers in oral healthcare, and supporting pediatric dental care for low income children (Access to Baby and Child Dentistry, 2016).

ABCD is a public/private partnership of organizations and individual providers, intended to engage families in oral health for their babies and young children. The program works with community organizations, such as Head Start providers, to identify families with Medicaid-eligible children and remove barriers to dental care. The program also recruits and trains dentists and primary care medical professionals to provide preventive care and treatment to Medicaid-enrolled children from birth to age six.

Healthcare Workforce Recruitment and Retention

No single effort can create the ideal healthcare workforce, and Washington has adopted a multi-pronged approach to improve the size and distribution of the primary care workforce.

Washington's recruitment and retention efforts include coordinated planning, pipeline and education efforts, support for service programs, and employer technical assistance programs. Clinician retention is woven into much of the recruitment programming. Great efforts are made to provide clear communication of and exposure to the unique challenges and rewards that rural and underserved clinical opportunities can bring.

COORDINATION OF WORKFORCE PLANNING

Washington's Health Workforce Council serves as the main planning and leadership body around healthcare workforce issues for the state. The council publishes an annual report to inform policy and programming. One of the 2013 recommendations was to create an Employer Sentinel Network to provide employer feedback on industry healthcare needs, which was recently initiated. (Workforce Training and Education Coordinating Board, 2014).

Over the last several years, external funding for the Health Workforce Council had been exhausted. The work of the council has continued with support of the Washington Training and Education Coordinating Board, but with minimal staff time. This reduced capacity significantly limits the work that the council can accomplish.

In order to aid in informed planning, enhanced data collection of Washington's primary care workforce by the Washington State Department of Health is under development for implementation by 2018. Additional health professional surveys will be conducted, including a required survey for MDs, DOs and PAs. This will allow improved tracking of where providers are practicing and other workforce trends

PIPELINE AND EDUCATION EFFORTS

Washington's pipeline programming includes projects aimed at developing a healthcare workforce that accurately reflects the state's underserved communities. Among these is the Health Occupations Preparatory Experience program (Project H.O.P.E.), administered by the Area Health Education Center of Eastern Washington.

Project H.O.P.E. is a six-week, paid summer internship for high school students at healthcare facilities within the student's local community. The program targets

students who are first generation college-bound, and are from rural areas, or from populations that are under represented in the health professions.

Student interns rotate through several settings within one facility to gain maximum exposure to a variety of health professions, and typically work 20 hours per week. Project H.O.P.E. interns are provided a stipend at the end of the internship, and upon receipt of a journal documenting the student's activities in the health care setting (Eastern Washington University, 2016).

The Targeted Rural and Underserved Track (TRUST) program was developed at the University of Washington to provide a connection between underserved communities, medical education, and the health professional.

The TRUST program creates a workforce pipeline by guiding qualified students through a curriculum that connects underserved communities in Washington, Wyoming, Alaska, Montana and Idaho to the University of Washington School of Medicine and its affiliated residency programs.

Beginning the summer before medical school, TRUST scholars participate in clinical and classroom experiences, discussions, and conferences. Scholars gain a clear understanding of the benefits and challenges of a practice in rural and underserved areas (University of Washington, 2016).

The Rural/Underserved Opportunities Program, administered by the Western Washington Area Health Education Center and the Area Health Education Center of Eastern Washington, creates clinical placements for University of Washington students between the first and second years of medical school. Students are placed with a preceptor in a rural or underserved clinical site. This program was developed to encourage primary care careers in clinical practice and expose students to a rural or undeserved community.

Students receive broad clinical experiences and contact with the community. They may complete histories and physicals, assist with office procedures, attend births, and assist in surgery. Students also receive a stipend, funds for travel, and assistance in locating and paying for housing.

Washington's current efforts to train more healthcare professionals include recent funding of a new medical school at Washington State University, an expanded number of family medicine residency programs in Health Professional Shortage Areas, and an increased number of nursing training slots statewide (Washington State Department of Health, 2015).

SERVICE INCENTIVES

Washington State incentivizes licensed primary care health professionals to serve critical shortage areas by providing financial assistance through either academic scholarship or loan repayment (Washington State Department of Health, 2015).

Established in 1990, the program has funded over 1,000 professionals, serving in 38 Washington counties. In 2014, approximately 100 scholarship and loan repayment program participants worked in underserved areas of Washington through this program.

The loan repayment portion of the program is comprised of two parts: a federal-state program, which uses matching federal grant funds for awards, and the Washington State Health Professional Loan Repayment Program, which uses state dollars only for awards. These programs have different award amounts and contract lengths.

This program is intended to meet both immediate community healthcare needs, and increase the likelihood of continued service within the placement site, as providers develop relationships within the community. A survey of loan repayment and scholarship recipients nationwide found that over 80% of the recipient responders anticipated remaining in their placement site for two additional years following the service term.

The Washington State Health Professional Loan Repayment Program offers specific retention awards, and uses factors correlated with increased likelihood of retention when making award decisions. In the most recent application cycles the number of applications has far exceeded the state's ability to make awards.

Washington State sites and clinicians benefit from participation in National Health Service Corps (NHSC) programs (U.S. Department of Health & Human Services, 2015). Washington State currently has 301 loan repayment participants and 30 scholarship program participants working at 173 sites across the state. There are 33 NHSC scholars training in the state. The state Department of Health works to help provide eligible NHSC job opportunities for these scholarship recipients in order to retain them in Washington following graduation (Washington State Department of Health, 2015).

The Washington State Department of Health also administers a J-1 Physician Visa Waiver program. The goal of the program is to increase the number of physicians available to work in rural and underserved areas of the state. The program is considered a secondary tool in recruitment, used when efforts to recruit a U.S. trained physician have been unsuccessful for an extended period of time. Washington sponsors 30 waivers per federal fiscal year. At least 20 of the total waivers are available to primary care physicians. Up to 10 of the total waivers are available to specialists (Washington State Department of Health, 2015).

EMPLOYER TECHNICAL ASSISTANCE PROGRAMS

The Washington Resources Group is a coalition of nonprofit organizations focused on the recruitment and retention of primary care providers for medically underserved populations. The coalition represents state and federal government, universities, community health centers, Indian Health Service and community-based programs.

The Washington Resources Group recruits for rural areas, tribal settings, and urban sites caring for medically underserved patients and correctional facilities. Group members provide outreach to primary care medical residents, medical students, dental students, advanced registered nurse practitioners and physician assistant students, in order to promote opportunities in rural and underserved Washington, and information about the loan repayment program.

Through a collaborative partnership with the Washington Resources Group, The Washington State Department of Health offers direct provider recruitment services for healthcare facilities located in rural and underserved areas. These sites include rural health clinics, federally qualified, community health centers, tribal clinics, urban sites catering to medically underserved patients, and state correctional and mental health facilities (Washington State Department of Health, 2015).

RECOMMENDATIONS

1. **Expand Medicaid eligibility or alternative coverage, as may be legally applicable, to provide access to care for all income-eligible residents, regardless of immigration status**

   Patients served by Washington's healthcare safety net system reflect the working poor, many of whom are left out of the healthcare system due to immigration status. Having a significant percentage of the population marginalized from healthcare creates serious risk to the health of everyone. Investing in the provision of reliable, comprehensive healthcare for all residents is good public health practice.

2. **Increase Medicaid reimbursement rates for medical and dental providers**

   Current Medicaid reimbursement rates in Washington create hardships for providers and barriers to care for low income patients. Increased Medicaid reimbursement is proven to incentivize providers to serve Medicaid patients. Continuation of the enhanced reimbursement rate for rural health clinics, and reduction in the administrative burden associated with the enhanced rate payment, is crucial to sustaining primary care access in rural Washington.

3. **Invest in coordinated workforce planning**

   Washington's Health Workforce Council serves as the main planning and leadership body for the state. The council has been underfunded for several years and has reduced current programming. Washington has several challenges related to healthcare provider recruitment, retention and distribution. Robust and detailed data is necessary to effectively forecast, plan and address the state's healthcare workforce needs. The Health Workforce Council needs to be comprehensively resourced to provide strong engagement and reporting.

4. **Expand medical, dental and mental health residency and internship opportunities in rural and underserved communities**

   Distribution of healthcare providers across the state is uneven. Existing disparities result in access barriers that primarily impact rural Washington and other underserved communities. Residency and internship experience is positively correlated with long term service in such communities. Strengthening rural residency and internship opportunities will mitigate disparities in provider distribution.

5. **Continue to strengthen public mental health funding**

Washington State shows a higher percentage of individuals living with mental illness than national levels, as well as multiple barriers to access. Extended periods of low, per capita funding for mental health services have negatively impacted the mental health system and the people it serves. Washington's mental health system will benefit from strategic investments that increase service capacity, integration with primary care, service coordination, and reduced administrative barriers to care.

6. **Mitigate the impacts of socioeconomic status as an important determinant of health**

   Current socioeconomic inequities in Washington State have considerable impact on health outcomes. Policy solutions are needed that will require strong public and private sector leadership. Unequal distribution of wealth, regressive taxation, transportation funding levels and models that fit the rural needs of the state, and adequate funding for social and health programs are all critical areas for improvement.

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