

NN/LM PNR
Environmental Scan

Prepared by the Environmental Scan Committee:

Maryanne Blake, Chair
Alison Aldrich
Nikki Dettmar
Linda Milgrom
and
Susan Barnes (OERC consultant)

Working Draft
10/16/08

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The environmental scan reports current issues and emerging trends in those areas that might influence the NN/LM PNR's program into the future. The areas included: state and regional demographics and economics, including education and health status; healthcare infrastructure in the states and region, including health professionals access to health information and technology; states investment in health education and health programs; consumers access to health information and technology; and the status of libraries, public, academic and hospital, and their role in health information.

Demographics:

The Pacific Northwest Region of the NN/LM has several distinguishing demographic characteristics that are worth noting because they influence our programs and services. (See Appendix A for census by state).

- The states of Alaska, Idaho, Montana, Oregon and Washington comprise 27% of the land mass of the United States.
- The population of these states, as a region, is 4.4% of the population of the United States.* (US Census Bureau – 2006)
- The nation's four largest states in total area are Alaska, Texas, California, and Montana. California and Texas are the nation's most populous states; Alaska and Montana are two of its least populous. The region's two largest states, geographically, are sparsely populated. Alaska, with 670,053 total population as of 2006, has a population density of 1.1 per square mile (The population of Baltimore County, MD, in comparison, was 631,366 in 2006, density 1,260.1 per square mile). Montana, with 944,632 residents as of 2006, has a population density of 6.2 per square mile (Fairfax County, VA's population in 2006 was 1,010,443, density 2,454.8 per square mile).
- All the Pacific Northwest states have a higher percentage of their population as Native American and Alaska Native than the national average of 1%. Alaska has 15.4%. There are also growing Asian, Native Hawaiian and Pacific Islander, and Latino populations in places in the Northwest.*(Census) Alaska has the youngest population in the United States with 7% of its citizens over 65. All of the other states in the region hover near the US average of 12.4% of their population over age 65. *(Census)
- American Indians and Alaska Natives (AIAN) living in urban areas are a diverse and growing population. Over the past three decades, AIAN have increasingly relocated from rural communities and reservations into urban centers. This so-called "invisible" population now makes up more than half of all American Indians and Alaska Natives living in the United States. Urban AIAN suffer from significant health disparities and, since they are generally spread out across urban centers they are often not recognized by the wider population. According to the 2000 Census there are 18,941 AIANs living in Anchorage, Alaska, which is the 4th largest urban population of AIAN in the U.S. Anchorage is the 75th largest US city. Seattle, WA and Portland, OR are in the top 20 largest urban AIAN population, each with 5,659 and 5,587, respectively.
- The region has a small African American population compared to other parts of the country: Idaho and Montana's populations are the smallest in the nation, each with less than 1%; in Oregon less than 2% of the population is African American; and in Washington and Alaska, less than 4% of the population is African American, compared with the US average of almost 13%.*(Census)

- All of the states in the region, except Idaho, have above the US average of 24.4% of people who have a Bachelors degree or higher.*(Census)
- The percent of uninsured people in the United States is 15.9% as of 2006. In the Pacific Northwest, Washington (12.6%) and Idaho (15.1%) have under the national percent of uninsured, while Alaska (17.2%), Montana (16.5%) and Oregon (16.8%) all have above the national percent. (Source: Kaiser Family State Health Facts <http://www.statehealthfacts.org/>)
- As of July 2008 the national unemployment rate is 5.7%. In Alaska it is 6.9%, in Idaho it is 4.1%, in Montana it is 4.0%, in Oregon it is 6.0% and in Washington it is 5.7%.
- As of 2006, the national percentage of people below poverty level during the previous 12 months was 13.3%. In Montana, there were more people below poverty level (13.6%), and Oregon was at the national average (13.3%). For the other states in the PNR, all 3 had less people below the federal poverty level compared to the national percentage. In Idaho, it was 12.6%, in Washington it was 11.8%, and in Alaska it was 10.9. Source: 2006 American Community Survey http://factfinder.census.gov/servlet/GRTTable?_bm=y&-geo_id=01000US&-box_head_nbr=R1701&-ds_name=ACS_2006_EST_G00_-format=US-30
- Among the country's 25 largest metropolitan areas, the Seattle-Bellevue-Tacoma region had the highest concentration of mixed-race residents, with the Portland-Vancouver-Beaverton region ranking 5th. (Source: Census as reported in Seattle Times, Sunday, September 28, 2008, page A13).

Education

The Pacific Northwest relies heavily on public education for school-aged children. 80% of K-12 schools around the region are public, and 20% are private. In higher education, the split is about even between the number of public versus the number of private colleges around the region that grant associates, bachelors, or advanced degrees.

	Total	Alaska	Idaho	Montana	Oregon	Washington
K-12 schools	808 private 4,116 public	55 private/ 261 public	76 private/ 504 public	77 private/ 513 public	225 private/ 1,133 public	375 private/ 1,705 public
Colleges	85 private 86 public	2 private/ 5 public	8 private/ 7 public	5 private/ 5 public	36 private/ 26 public	34 private/ 43 public

Sources:

PSS Private School Universe survey data for the 2005-2006 school year, National Center for Educational Statistics

<http://nces.ed.gov/surveys/pss/privateschoolsearch/>

CCD Public school data for the 2005-2006 school year, National Center for Educational Statistics

<http://nces.ed.gov/ccd/schoolsearch/>

College Navigator, National Center for Educational Statistics

<http://nces.ed.gov/collegenavigator/>

Health Professional Programs

The Pacific Northwest region has only three medical schools: Oregon Health and Sciences University in Portland, OR; Pacific Northwest University of Health Sciences, College of Osteopathic Medicine in Yakima, WA; and The University of Washington which serves as the medical school for the states of Washington, Idaho, Montana and Alaska, as well as Wyoming, under the WWAMI agreement.

Health Professional Programs by State	<u>Regional total</u>	<u>Alaska</u>	<u>Idaho</u>	<u>Montana</u>	<u>Oregon</u>	<u>Washington</u>
<u>Medicine</u>	3	0	0	0	1	2
<u>Nursing (all levels)</u>	42	2	7	8*	13	12
Health Professional Programs by State	<u>Regional total</u>	<u>Alaska</u>	<u>Idaho</u>	<u>Montana</u>	<u>Oregon</u>	<u>Washington</u>
<u>Physician Assistants</u>	5	0	1	1	2	1
<u>Masters in Public Health</u>	5	1	1	1	1	1
<u>Dentists</u>	2	0	0	0	1	1
<u>Pharmacists</u>	6	0	1	1	2	2
<u>Dieticians</u>	5	0	1	0	0	4**
<u>Speech, language, and hearing disorder specialists</u>	7	0	1	0	2	4

*Programs at 4 branch campuses of Montana State University and 2 branch campuses of the University of Montana

**Two programs from WSU – Pullman (general emphasis) and Spokane (integrated exercise and nutrition)

Nursing: [Peterson's Nursing Programs \(2009\)](#) covers baccalaureate and graduate programs; [NLN Guide to State Approved Schools of Nursing \(2006\)](#) covers LPN/LVN programs

Physician Assistants: data from the American Academy of Physician Assistants, <http://www.aapa.org/pgmview.php3?state=WA>

Masters in Public Health: from Council on Education for Public Health - <http://www.ceph.org/i4a/pages/index.cfm?pageid=3406> + University of Montana (accreditation expected in 2011) + University of Alaska Anchorage (accreditation expected in 2009)

Dentists (DDS/DMD): from the American Dental Association (all accredited programs) http://www.ada.org/prof/ed/programs/search_dds_dmd_us.asp

Pharmacists: from the Accreditation Council for Pharmacy Education <http://www.acpe-accredit.org/>

Dieticians (RD or DTF): from American Dietetic Association Accredited or Approved Programs - http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/CADE_401_ENU_HTML.htm

Speech & Hearing: from Council of Academic Programs in Communication Sciences & Disorders http://www.capcsd.org/cgi-bin/caplist.exe/Programs_By_State

Some regional health facts:

- Oregon has the highest rate of asthma in the United States (15.1% of adults) (Source: The State of your Health: Oregon <http://healthyamericans.org/state/>)
- In Washington obesity increased from 9.4% to 24.3% of the population since 2000. Obesity rates in all the states of the Pacific Northwest have gone up dramatically from under 10% in 1988 to over 25% for Alaska, Oregon and Washington and over 20% in Montana and Idaho in 2008.

- Nationally, more than 77-percent of children ages 19 months to three years of age are vaccinated against tetanus, polio, measles and other diseases. But in Washington, Oregon and Idaho the immunization rate is 70 percent or below. Reported on September 5, 2008. (Source: <http://nwpr.org/07/HomepageArticles/Article.aspx?n=4282>)
- 4 of the 5 states in the Pacific Northwest Region rank among the top 10 in the nation for suicide rates, with Montana as #1 followed by Alaska (3), Idaho (7) and Oregon (10). (Source: <http://www.suicidology.org/associations/1045/files/2005datapgs.pdf>)

Health disparities

Reports available on the websites for each state health department reveal data and concern about a high prevalence of health disparities.

Alaska has set a single target for every health status indicator for all racial and ethnic groups, with the intention of developing strategies to improve health status for all, and to focus on reduction of the disparities by promoting health and preventing disease and by ensuring access to appropriate care. Although a great deal of progress was made during the 1990s to decrease health disparities between Alaska Natives and non-Natives (for example, infant mortality decreased, injury mortality decreased, and homicide mortality decreased), significant disparities persist. (Source: Healthy Alaskans 2010: Target and Strategies for Improved Health—Table 8 Health Alaskan 2010 Leading Health Indicators <http://www.hss.state.ak.us/dph/targets/ha2010/PDFs/ExecWeb.pdf>)

For a statistical summary that reveals health disparities in *Idaho*, see Profile of Idaho Health Disparities: A Compilation of Data from US Census, American Community Survey, Idaho Vital Statistics and the Behavior Risk Factor Surveillance System prepared by Idaho State University for the Idaho State Office of Rural Health and Primary Care, Principal Investigator Galen Louis, Ph.D. March 31, 2007. The Idaho Department of Health and Welfare conducts its minority health and health disparities activities through the State Office of Rural Health & Primary Care, located within the Bureau of Health Planning and Resource Development. Via a scan of its website, there are at least 2 current initiatives to address diabetes and tobacco-related disparities in Idaho.

In *Montana*, the risks that yield most of the disease burden for all populations are: smoking, misuse of alcohol, too little physical activity and poor diet choices. Smoking kills more Montanans than all infectious diseases, motor vehicle injuries, suicide, homicide, and breast cancer, combined. The rate of smoking in pregnancy is higher in Montana (19% in 2003) than in the U.S. (11% in 2002) and even higher in American Indian women in Montana (30% in 2003). American Indians comprise only 6% of Montana's population, yet account for 53% of the cases of tuberculosis in the state. The heart disease and stroke mortality rates for American Indians are notably higher than the rates for Montanans overall. (Source: Major Prevention Opportunities to Improve Health in Montana, prepared by Montana Department of Public Health & Human Services, Public Health & Safety Division 2006 http://www.dphhs.mt.gov/PHSD/prevention_opps/pdf/2006-Major-Prevention-Oppls-9-25-06.pdf)

In *Oregon*, chronic diseases such as cancer, heart disease, stroke, lung disease, diabetes and arthritis are the major causes of disability and death for Oregonians. They account for 62% of deaths in the state and are closely related to three modifiable factors: tobacco use, physical inactivity and poor diet. From 1996-2004, the incidence of lung cancer among Oregon men was highest for African Americans. The lung cancer rate for African American men was significantly higher than the rate for non-Latino white men (127 vs. 85 per 100,000). Among Oregon women during the same time period, American Indian and Alaska Native women had the highest incidence rate for lung cancer (78 per 100,000). This was significantly higher than the rate for non-Latina white women (61 per 100,000). While tobacco use is declining, not all communities are receiving the benefits of tobacco prevention and education equally. Tobacco industry marketing targets some communities. As a result, for example, American Indians and Alaska Natives smoke at almost twice the rate of the general population. African Americans and

members of the lesbian, gay, and bisexual community also smoke at rates much higher than the general population. (Source: Keeping Oregonians Healthy: Preventing Chronic Diseases by Reducing Tobacco Use, Improving Diet, and Promoting Physical Activity and Preventive Screenings, July 2007. <http://www.oregon.gov/DHS/ph/hpcdp/docs/healthor.pdf>)

In *Washington*, per a 2009 progress report from the Washington Health Foundation, *Toward a State Action Plan to Eliminate Health Disparities*, http://healthequity.wa.gov/Pubs/docs/ProgRpt_2009.pdf, health disparities data remains incomplete, but sufficient now to report at least some rough indicators in relation to all of our measures except public health investment. As the report states: "While we do have certain measures in which the health of racial and ethnic groups is better than Caucasians, in most measures African Americans, Hispanics and American Indians/Alaska Natives have greater rates of illness, disability and death than Caucasians. For instance, there is a disproportionate share of years of life lost among these groups before age 75, disturbingly large disparities in infant mortality in some groups and alarmingly elevated rates of infectious disease among African Americans, whose HIV/AIDS cases are reported at five times the rate of those for Caucasians. In addition, we are most troubled by smoking and motor vehicle deaths among our state's American Indian/Alaska Native population, and lower rates of physical activity among Hispanics." (Source: Washington Health Foundation: 2008 Healthiest State Report Card <http://www.whf.org/spotlights/Healthiest-State-Report-Card-2008.aspx>)

Health disparities for urban American Indians and Alaska Natives

While data are difficult to gather, studies have found that AIAN living in urban areas suffer from significant health disparities compared with the general population. These disparities include higher rates of tobacco use, infant mortality, late prenatal care, interpersonal violence, attempted suicide, and deaths due to diabetes, accidents and chronic liver disease.

A report by the Urban Indian Health Institute highlights health issues faced by American Indians and Alaska Natives living in counties served by the network of Title V urban Indian health organizations (UIHO), including: Seattle Indian Health Board, Seattle WA, N.A.T.I.V.E Project, Spokane WA; Spokane Indian Health Board of Billings, Billings MT; Big Horn, Yellowstone Indian Family Health Center, Great Falls MT; Cascade Helena Indian Alliance, Helena MT; Jefferson, Lewis & Clark North American Indian Alliance, Butte MT; Silver Bow Missoula Indian Center, Missoula MT; and Missoula Native Am. Rehabilitation Association of the NW, Portland OR

(Source: Reported Health and Health-influencing Behaviors Among Urban American Indians and Alaska Natives: An Analysis of Data Collected by the Behavioral Risk Factor Surveillance System, March 2008, Updated July 2008 Urban Indian Health Institute, Seattle Indian Health Board http://www.uihi.org/wp-content/uploads/2008/08/health_health-influencing_behaviors_among_urban_indiansupdate-07-2008.pdf)

Technology:

Looking at information technology on state, regional and national levels and as it pertains to health professionals, network members and the general public the following current conditions and future trends can guide RML planning.

- Nationally:
 - Web 2.0 use is becoming widespread. Some network members, especially hospital librarians, find themselves blocked from access to Web 2.0 tools now. Once these tools are more accepted by the powers in organizations that control access to them, our network members need to be ready to utilize the tools to push information to their users. The RML should continue to support network members in this area.
 - Web-based productivity tools like Google Docs and Open Office will promote easier sharing of documents so people can work more collaboratively.

- Distance education tools are improving. At present all someone needs to access a distance learning session from the RML is a computer and a telephone; this is a huge improvement over fairly recent earlier technology, such as satellite programs. In our region distance learning, not just for network members but also for our target health professional and special public populations may grow in importance. It is one way to overcome long distances, high travel costs and low attendance because of sparse population.
- Electronic health records (EHR) and personal health records (PHR) have been slow to take off. If the U.S. government makes EHR mandatory in the next five years especially hospital librarians need to be informed about the role they can play in EHRs and PHRs and be ready to work with others in their institutions in this effort.
 - A vision of healthcare IT of the future from Microsoft:
<http://www.youtube.com/watch?v=6F1u36Y-qIE>
 - Hospitals have made little progress since 2006 in developing PHRs and patient portals.
http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/07JUL2008/0807HHN_MW_MainArticle_SB6&domain=HHNMAG
- Open source software (OSS) makes access to free software easier. Though meant for the technologically savvy, the ability of non-profit community and cash-strapped organizations to have access to high quality software could help health IT to take a leap in the near future.
- Telemedicine is still an important technology in the Pacific Northwest states with vast distances to travel to get health care, especially specialty health care. Could this technology be used for education of both health professionals and patients? Costs and procedures are still hampering its widespread use.
- Cloud computing – wireless web applications
- Consumer access to health information and to new technologies; the digital divide, etc.
 - 80% of US adults have searched online for health information. 66% of them started with a search engine. 75% of health searchers fail to consistently check the sources they find for quality indicators like source and date. (Source: Pew Internet 2006: *Online Health Search*:
http://www.pewinternet.org/PPF/r/190/report_display.asp)
 - “These (online consumer health) tools show great promise for enhancing the health of users; at present, however, they fall short of offering population-wide benefits. This study found that *there do not appear to be intrinsic deficiencies in technology or insurmountable access obstacles; rather, the issue is that not enough tools have yet been designed and disseminated with an eye to the diverse experiences, requirements, and capacities of end users.*”
<http://www.health.gov/communication/ehealth/ehealthTools/executivesummary.htm>
 - *From the same report, graphs illustrating socioeconomic differences in prevalence of disease and Internet habits.*

http://www.health.gov/communication/ehealth/ehealthTools/appendix4_part2.htm

- Regional and state level:
 - Our region has four hospitals on the “Most Wired Hospitals” list (2008). (<http://shrinkify.com/ctf>) Criteria for inclusion on this list include progressive use of information technology for safety and quality, customer service, business processes, workforce, and public health and safety. The report also found that, while patient satisfaction was higher at hospitals with better information technology, overall progress toward IT development was slow.
 - Inland Northwest Health Services– Washington and Idaho Region Spokane, Wash. www.inhs.org
 - Kootenai Medical Center, Coeur d’Alene, Idaho www.kmc.org
 - Madigan Army Medical Center, Tacoma, Wash. www.mamc.amedd.army.mil
 - Sacred Heart Medical Center, Spokane, Wash. www.shmc.org
 - We also have two on the “Most Wired Small & Rural Hospitals” list (2008). Neither of these hospitals have a librarian. <http://shrinkify.com/bv0>
 - Mason General Hospital Shelton, Wash. www.masongeneral.com
 - St. Peter’s Hospital, Helena, Mont. www.stpetes.org
 - Washington State passed innovative legislation to improve information access for health professionals. Washington Senate Bill 5930 and HEAL-WA. The HEAL-WA project will provide access to eligible users via a variety of online health information including selected full-text journals, databases and eBooks via a web “portal”. A librarian has been hired to lead the project, including providing training to health professionals around the state.
 - Pacific Northwest corporations working on healthcare IT or consumer health information on the web:
 - Microsoft - <http://www.microsoft.com/industry/healthcare/default.mspx>
 - Healia - <http://www.healia.com/healia/>
 - Google – <http://www.google.com/intl/en-US/health/about/>
 - Healthwise – <http://www.healthwise.com>
 - Northwest involvement in telehealth:
 - HRSA funded 19 telehealth development programs in our region between 2005 and 2007. They funded 148 projects total. <http://www.hrsa.gov/telehealth/granteedirectory/organizations.htm>
 - From a 2004 report on the Alaska Federal Health Care Access Network (AFHCAN) Telemedicine Project (Source: <http://www.alaska.edu/health/downloads/Telemed/AFHCAN.pdf>)
 - According to a survey, 51% of Alaskan rural healthcare providers had used AFHCAN hardware or software. 79% of those said the resources “positively changed the way they did healthcare.”

Healthcare spending, public health and health education:

According to the World Health Organization (WHO) the U.S. spends more on health care per capita than any other nation in the world. Current estimates put U.S. health care spending at approximately 15.2% of GDP ...” (Source: “Health System Resources” *World Health Statistics 2008: Global Health Indicators*. World Health Organization (2008). Flat funding and budget cuts for public health programs exist in all the states of our region.

Alaska:

State public health spending \$45.06 per capita (16th highest in the nation), total with federal funding including CDC and HRSA is \$482 (2nd highest).

(Source <http://www.apha.org/NR/rdonlyres/78321624-5D84-47C1-AC97-735E082872E5/0/PHACTCampaignSheetAlaska2008.pdf>)

- The Alaska Health Care Strategies Planning Council was established by Governor Palin by Administrative Order #232 (<http://www.gov.state.ak.us/admin-orders/232.html>) in February 2007. It was to identify both long and short-term strategies to address issues of cost, access and quality of health care for Alaska residents. It identified a lack of consistent statewide leadership for the development of a comprehensive state health and health care policy as a challenge. Their final report in Dec 2007 concluded with "Many of the solutions presented within this report fall squarely within the purview of state government"
(Source http://www.hss.state.ak.us/commissioner/legislature/pdf/HCSPC_report.pdf)
- Alaska State House Bill 337 and Senate Bill 245 are the Health Care: Plan/Commission/Facilities bills requested by Governor Palin in January 2008, but both were referred to the Finance Committee back in March 2008 with no further action taken. No other current & relevant legislative action concerning health concerns could be identified during this session, which ended in April 2008..
(Source <http://w3.legis.state.ak.us/index.php>)

Idaho:

State public health spending \$76.04 per capita (6th highest in the nation), total with federal funding including CDC and HRSA is \$115.62.

(Source <http://www.apha.org/NR/rdonlyres/8768D378-3777-466D-BC2F-70ACF764F5B9/0/PHACTCampaignSheetIdaho2008.pdf>)

- A state public health worker in Boise notes, *"We had to eliminate contract with our local health departments (our implementation arms in 44 counties) and reorganize our Bureau to accommodate the fickleness and fragileness of federal funding. With federal funds coming to states very categorically, we do not have the luxury of being creative with how we implement and integrate our programs to suit our local needs"*
(Source <http://www.apha.org/NR/rdonlyres/8768D378-3777-466D-BC2F-70ACF764F5B9/0/PHACTCampaignSheetIdaho2008.pdf>)
- Idaho Senate Concurrent Resolution 135 in April 2008 authorized the Legislative Council to appoint a committee to undertake and complete a study of medical education needs in Idaho due to previous study findings that "(1) Idaho has a need for more physicians as evidenced by statistics showing that Idaho ranks extremely low in the nation, and at the bottom among states of similar population, for number of physicians per capita; (2) Idaho's physicians are relatively older than the national average age of physicians and (3) many Idaho counties are designated as "health professions shortage areas." (Source <http://www3.state.id.us/oasis/SCR135.html#daily>). The interim Medical Education Interim Committee is meeting in response to SCR 135 (<http://www.legislature.idaho.gov/sessioninfo/2008/Interim/interimcommittees.htm#medical>).
- Another interim committee, the Health Care Task Force (<http://www.legislature.idaho.gov/sessioninfo/2008/Interim/interimcommittees.htm#health>) is charged "To ask and find answers for the unprecedented increases in health insurance premiums; to determine a method of limiting the assessments that may be imposed on carriers providing reinsurance by way of excess or stop-loss coverage and on carriers selling insurance in the individual market; to review options regarding initially limiting enrollment of the Individual High-Risk Reinsurance Pool in order to preserve the financial integrity of the pool."
- No legislation to the effect of creating or funding new health care or medical education needs was located for the 2008 session.

Montana:

State public health spending \$14.58 per capita (40th in the nation), total with federal funding including CDC and HRSA is \$293 (5th highest).

(Source: <http://www.apha.org/NR/rdonlyres/41D34EF0-4D34-4081-A424-3B81E1BDF8C8/0/PHACTCampaignSheetMontana2008.pdf>)

- Of interest is a letter the Committee sent to Governor Schweitzer on July 1st concerning HealthShare, a non-profit organization, Montana's demonstration of a "uniform continuity of care system" that is a type of electronic medical record. The Committee voted unanimously to request \$1.5 million in the 2010-2011 biennium to include pilot system testing, noting "Health information technology has the potential to benefit not only patients and their physicians but also overall health outcomes for Montanans while improving our state's healthcare delivery system."
(http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sjr15sc_hweitzer-hitltr.pdf)
- A number of health services bills concerning health and health education died in committee during the 07-08 session according to [http://laws.leg.mt.gov/laws07/LAW0203W\\$BSRV.ActionQuery?P_BLTP_BILL_TYP_CD=&P_BILL_NO=&P_BILL_DFT_NO=&P_CHPT_NO=&P_SBJ_DESCR=Health++%28see+also%3A+Health+Care+Services%3B+Safety%29&P_SBJT_SBJ_CD=HLTH&P_LST_NM1=&P_ENTY_ID_SEQ=&Z_ACTION2=Find](http://laws.leg.mt.gov/laws07/LAW0203W$BSRV.ActionQuery?P_BLTP_BILL_TYP_CD=&P_BILL_NO=&P_BILL_DFT_NO=&P_CHPT_NO=&P_SBJ_DESCR=Health++%28see+also%3A+Health+Care+Services%3B+Safety%29&P_SBJT_SBJ_CD=HLTH&P_LST_NM1=&P_ENTY_ID_SEQ=&Z_ACTION2=Find)
- As of August 28, 2008 there are 22 proposed bills concerning health services in Montana. Bill Draft LC0340 has been submitted to address the \$1.5 million budget request and LC0183 is for "rural Montana healthcare delivery assistance" with no additional details yet available.
(Sources [http://laws.leg.mt.gov/laws09/LAW0203W\\$BSRV.ActionQuery?P_BLTP_BILL_TYP_CD=&P_BILL_NO=&P_BILL_DFT_NO=&P_CHPT_NO=&P_SBJ_DESCR=Health++%28see+also%3A+Health+Care+Services%3B+Safety%29&P_SBJT_SBJ_CD=HLTH&P_LST_NM1=&P_ENTY_ID_SEQ=&Z_ACTION2=Find](http://laws.leg.mt.gov/laws09/LAW0203W$BSRV.ActionQuery?P_BLTP_BILL_TYP_CD=&P_BILL_NO=&P_BILL_DFT_NO=&P_CHPT_NO=&P_SBJ_DESCR=Health++%28see+also%3A+Health+Care+Services%3B+Safety%29&P_SBJT_SBJ_CD=HLTH&P_LST_NM1=&P_ENTY_ID_SEQ=&Z_ACTION2=Find) and [http://laws.leg.mt.gov/laws09/LAW0203W\\$BSRV.ActionQuery?P_BLTP_BILL_TYP_CD=&P_BILL_NO=&P_BILL_DFT_NO=&P_CHPT_NO=&P_SBJ_DESCR=Health+Care+Services++%28see+also%3A+Health%29&P_SBJT_SBJ_CD=HLTC&P_LST_NM1=&P_ENTY_ID_SEQ=&Z_ACTION2=Find](http://laws.leg.mt.gov/laws09/LAW0203W$BSRV.ActionQuery?P_BLTP_BILL_TYP_CD=&P_BILL_NO=&P_BILL_DFT_NO=&P_CHPT_NO=&P_SBJ_DESCR=Health+Care+Services++%28see+also%3A+Health%29&P_SBJT_SBJ_CD=HLTC&P_LST_NM1=&P_ENTY_ID_SEQ=&Z_ACTION2=Find))
- Oregon:
State public health spending \$14.68 per capita (a dime ahead of Montana, 39th in the nation!), total with federal funding including CDC and HRSA is \$174 (16th highest).

An Oregon Health and Sciences University (OHSU) Public Health worker notes, "*being 100% grant funded in disability and health work, we are all in fear of losing our jobs and no longer being able to provide any health promotion services to this vulnerable population.*"

(Source: <http://www.apha.org/NR/rdonlyres/8753EBEA-CF1A-4D3E-B387-7C24F0953932/0/PHACTCampaignSheetOregon2008.pdf>)

- The Library at OHSU provides access to some databases, full-text journals and other licensed resources for certain licensed health professionals, especially MDs and DOs. The funding for these resources have been paid for from licensing fees charged by the state, as mandated by legislation. Oregon was the first state in the Pacific Northwest to provide such services. (Source: Needs source)

Washington:

State public health spending \$39.72 per capita (just above national median of \$39.72), total with federal funding including CDC and HRSA is \$81 (7th lowest in the nation). (Source:

<http://www.apha.org/NR/rdonlyres/AC9644A7-9AAF-4FA7-96A0-058451A9BE51/0/PHACTCampaignSheetWashington2008.pdf>)

- A University of Washington faculty member notes, *“We have written numerous grants for CDC funded research projects that received very high marks. We were told every time that these are very fundable projects for which there was little to no funding to support them. It has also been difficult to keep faculty and staff in our school as both state and federal funding cuts have been so severe.”*
(Source: <http://www.apha.org/NR/rdonlyres/AC9644A7-9AAF-4FA7-96A0-058451A9BE51/0/PHACTCampaignSheetWashington2008.pdf>)
- *“The Snohomish Health District is facing a \$4.4 million budget shortfall. Administrators say 35 employees will likely be laid off in November as part of the first round of cuts. King County announced in July that it may have to close some public-health clinics because of a loss of \$10 million in county funds. Tacoma-Pierce County Public Health Department cut \$1 million earlier this year and expects to cut another \$1 million next year. Clark County Public Health Department faces \$2.4 million in cuts next year.*
The reductions come as health departments around the state face similar funding crises. The economic slowdown has meant plummeting tax revenues for the state and local governments that fund public health at the same time rising medical costs make it harder for families to afford private care.
Public health enjoyed a dedicated stream of revenue from motor-vehicle excise taxes until 1999, when those were repealed by voters in Initiative 695. The Legislature backfilled 90 percent of the lost funds but did not increase funding in subsequent years even as health care and labor expenses rose. In addition to the county and the state, Public Health receives funds from grants and sales-tax revenue.” Source: Seattle Times, August 1, 2008
http://seattletimes.nwsourc.com/html/localnews/2008085344_snohealth01m0.html
- Sections 11(c) and 12 of Engrossed Second Substitute Senate Bill 5930 (chapter 259 Laws of 2007), now codified as RCW 43.70.110(2)(c) and RCW 43.70.112 require the University of Washington Health Sciences Library to provide electronic access to professional resources in support of evidence-based practice to certain groups of licensed health care providers. The HEAL-WA web site will be separate from the Health Sciences Libraries web site, and will give providers online access to selected evidence-based resources, tools, databases and full-text journals to support patient care.
(Source: V.J. Lawrence email, August 26, 2008)

Healthcare Infrastructure

All of the states in the Pacific Northwest have large areas that are designated HPSAs or MUAs.

The entire state of Alaska is designated a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA). (Source: University of Alaska Anchorage News <http://www.uaa.alaska.edu/news/ahec.cfm>)

Number of Hospitals per state, 2000 and 2006

<u>State</u>	<u>2000</u>	<u>2006</u>
Alaska	18	22
Idaho	42	38
Montana	52	52
Oregon	59	58
Washington	84	88
US TOTAL	4915	4927

While total number of hospitals nationwide is showing a slight increase, Idaho and Oregon have fewer hospitals in 2006 than in 2000, and Montana showed no increase.

(Source: AHA Annual Surveys as reported by Kaiser Family Foundation State Health Facts, <http://www.statehealthfacts.org>)

Perhaps a better measure: Total hospital beds per 1,000 population:

<u>State</u>	<u>2000</u>	<u>2006</u>
Alaska	2.3	2.3
Idaho	2.7	2.3
Montana	4.7	4.3
Oregon	1.9	1.8
Washington	1.9	1.7
US TOTAL	2.9	2.7

In none of our states did beds per population increase. Four of five states decreased, and Alaska remained level. (Source: <http://www.statehealthfacts.org>)

Hospital Room Visits per 1,000 population by state
(This implies people need and use hospitals more)

<u>State</u>	<u>2000</u>	<u>2006</u>
Alaska	298	901
Idaho	315	349
Montana	300	352
Oregon	294	339
Washington	327	337
US TOTAL	366	396

Dramatic increases in all states, in Alaska rate more than tripled. Can this be true?
(Source: <http://www.statehealthfacts.org>)

Number of Certified Nursing Facilities

(This implies that as we age, we need and will need more. US totals are up, but all our states are DOWN)

State	2000	2006
Alaska	13	13
Idaho	75	74
Montana	90	85
Oregon	147	133
Washington	259	237
US TOTAL	15,064	15,294

(Source: www.pascenter.org/nursing_homes/nursing_trends_2006.php)

Additional quote from this source: "The average number of registered nurse (RNs) hours per resident day declined by 25 percent between 1998 and 2000 and by 14 between 2000 and 2006. The number of nursing assistants (NAs) increased to make up for the reduction in registered nurse hours. This shows a dramatic decline in the skills and training of staff since the implementation of the Medicare prospective payment system in 1998. Studies have shown facilities with more RN staffing have higher quality of care on average."

Number of Federally Qualified Health Centers

FQHCs are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities.

Federally Qualified Health Centers			
State	Organizations	Service Delivery Sites	Patients Served
Alaska	26	115	80,784
Idaho	10	63	100,732
Montana	13	79	79,937
Oregon	23	155	236,418
Washington	25	225	636,275
TOTAL	97	637	1,134,146

Data from National Association of Community Health Centers (2007)
http://www.nachc.org/client/documents/state_X_key_facts_20071.pdf

(See Appendix B for Map of Federally Qualified Health Centers)

Employment in Health Care

(These figures include employees at those establishments within the North American Industry Classification System classifications 621 [ambulatory health services], 622 [hospitals], and 623 [nursing and residential care facilities])

State	2000	2006
Alaska	23,340	19,950
Idaho	46,428	45,870
Montana	40,793	33,100
Oregon	131,439	115,530
Washington	237,666	198,910
US TOTAL	12,172,956	10,489,440

Following national trend, between 2000 and 2006 the number of health care employees decreased substantially in each of the Northwest States.

(Source for 2000 data: Morgan KO and Morgan S. Health Care State Rankings, 2003: Health Care in the 50 United States, 11th ed. Lawrence, KS: Morgan Quitno Press, 2003.

Source for 2006 data: www.statehealthfacts.org)

Physicians

State	2000			2006
Alaska	1,362			1,697
Idaho	2,370			2,934
Montana	2,188			2,548
Oregon	9,312			11,741
Washington	16,693			19,864
US TOTAL	802,156			908,065

(Source for 2000 data American Medical Association cited in: Morgan KO and Morgan S. Health Care State Rankings 2002: Health Care in the 50 United States, 10th ed. Lawrence, KS: Morgan Quitno Press, 2002.)

(Source for 2006 data: American Medical Association cited in: Morgan KO and Morgan S. Health Care State Rankings 2008: Health Care Across America. Washington DC: CQ Press, 2008.)

Other Health Professionals

State	Physician Assistants	Community Health Aides	Dieticians	Nurses	Dentists	Speech, Language, Hearing Disorder Specialists
Alaska	353	550 (approx, 2006)	22	5150	492	Data coming
Idaho	475	n/a	21	9600	902	
Montana	339	n/a	20	7160	526	
Oregon	740	n/a	44	29,700	2264	
Washington	1,800	n/a	94	49,910	4710	
TOTAL	3,707	n/a	201	101,520	8894	

Data for Nurses and Dentists is from 2007

<http://www.statehealthfacts.org/>

For PAs, this is the Projected Number of Physician Assistants in Clinical Practice as of January 1, 2008

<http://www.statehealthfacts.org/comparemactable.jsp?ind=440&cat=8>

“Home Health Aides” in Alaska – 1603 in 2004 and expected to increase to 2,568 (60%) by 2014.

<http://www.labor.state.ak.us/research/trends/feb08ind.pdf>

For Dieticians, these are the people in the ADA directory, so probably just ADA members, not total practitioners. The number includes RDs and DTRs (technicians)

http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/home_4874_ENU_HTML.htm

“National Public Radio’s Think Out Loud program recently aired a segment titled “[No Doctor in the House](#)” which chronicled Oregon’s physician shortage and the challenges this causes for rural communities across the state. The story mentioned that “John Day has lost three of their six family physicians in the last nine months and that individuals in Reedsport “have to drive 40 miles to Coos bay to have a doctor deliver a baby.” The continuation of this trend is making it more difficult for rural Oregonians to locate convenient and appropriate care. Oregon Health Go Local will play a significant

role in helping Oregonians figure out where they can go to get appropriate care.”---(Source: Oregon Go Local: June/July 2008 Oregon Health Go Local E-Newsletter, accessed via email 8/11/08)

In 2007, NPR's All Things Considered profiled Dr. Andy Jones, the sole physician in Cottonwood, Idaho (population 900). "Jones has served the county for 20 years, and many of the procedures he does — including colonoscopies — are ones specialists usually perform in urban areas. Though many specialists balk at generalists performing specialized procedures, Jones takes it in stride. 'If only gastroenterologists did colonoscopy, probably the majority of rural America wouldn't get that procedure done. And same with a lot of surgeries in rural America.'" (Source: Idaho Doctor Brings Vital Services to Rural Patients, <http://www.npr.org/templates/story/story.php?storyId=14620394>)

Status of Public Health in the States

Alaska

- **Public Health Funding:** The state of Alaska spends an average of \$45.06 a year for the public health needs of each resident, the 16th highest level in the nation. Total public health spending in Alaska, including federal sources such as money from HRSA and CDC, amounts of an average of \$482 per person, the 2nd highest level in the nation.
- **Chronic Disease:** Alaska has among the lowest rates in the nation of cancer (2,650 cases in 2008), diabetes (4.8 percent of adults) and hypertension (21.4 percent of adults).
- **Access to Care:** Yet, Alaska faces health challenges as well: 16.5 percent of Alaskans do not have health insurance and only 73.5 percent of children ages 19 to 35 months receive complete immunizations.
- **Health Disparities:** Racial and ethnic minorities (excluding Africa Americans) experience 73 percent more premature deaths than whites and 56 percent more than African Americans.
- **The Road Ahead:** Although Alaska has made some recent improvements to public health, including reducing the percentage of smokers in the state from 34.3 percent to 24 percent since 1990, the state still faces many public health challenges.

Idaho

- **Public Health Funding:** The state of Idaho spends an average of \$76.04 on the public health needs of each resident. Although this is the 6th highest amount in the nation, it still falls short of the \$100+ allocated by other states. When this state funding is combined with federal sources of public health funding, such as money from HRSA and CDC, Idaho spends an average of \$115.62 per person.
- **Infectious Disease:** Idaho has a low rate of childhood immunizations, with over 22 percent of children not receiving complete immunizations. Idaho has the 9th highest rate of West Nile disease, with 131 new cases reported in 2007.
- **Access to Care:** 15.4 percent of Idaho residents are uninsured. Among children 13 percent have no health insurance, giving Idaho the 14th highest percentage of uninsured children in the nation.
- **The Road Ahead:** Idaho has made recent improvements in many public health areas, such as decreasing the number of children who live in poverty. However, the state still faces many public health challenges, including a shortage of primary care physicians with only 79.9 primary care physicians per 100,000 people.

Montana

- **Public Health Funding:** The state of Montana spends an average of \$14.58 a year on the public health needs of each resident, placing Montana 40th in the nation. Total public health spending

in Montana, including federal sources such as money from HRSA and CDC, amounts to an average of \$293 per person, the fifth highest level in the nation.

- Children's Health: Montana has one of the lowest rates of childhood immunization coverage with 34.4 percent of children aged 19 to 35 months not receiving complete immunizations. The state also has the 10th highest rate of uninsured children (14.5 percent).
- Health Disparities: African Americans living in Montana experience 44 percent more premature death than whites. Other racial and ethnic minorities are 111 percent more likely to die prematurely than whites.
- The Road Ahead: Montana has many public health strengths, including a low incidence of infectious disease (4.7 cases per 100,000) and a low prevalence of obesity (21.2 percent of the population). However, the state still faces many public health challenges, including a high rate of uninsured (17.1 percent of the population) and limited access to primary care with only 103.5 primary care physicians per 100,000 people.

Oregon

- Public Health Funding: The state of Oregon spends an average of \$14.68 a year on the public health needs of each resident, the 11th lowest amount in the nation. Total public health spending in Oregon, including federal sources such as money from HRSA and CDC, amounts to an average of \$174 per person, the 16th highest amount in the nation.
- Children's Health: Oregon has the second lowest rates of low birth weight babies (6.1 percent) and preterm labor (10.2 percent of live births are born preterm). The state also ranks among the bottom 15 states in infant mortality (5.8 per 1,000 live births).
- Access to Care: Nearly 18 percent of Oregon's residents do not have health insurance, the 11th highest rate of uninsured in the nation. 13.1 percent of children under age 18 also lack access to health insurance.
- Health Disparities: African Americans living in Oregon experience 26 percent more premature deaths than whites. Deaths from cancer are 17 percent more common among African Americans than whites.
- The Road Ahead: Oregon has made some recent improvements to public health, such as increasing the percentage of children ages 19 to 35 months who receive complete immunizations from 72.9 percent to 78.4 percent in the past year. However, the state still faces many public health challenges, including the highest rate of asthma in the nation (15.1 percent of adults).

Washington

- Public Health Funding: The state of Washington spends an average of \$39.72 a year on the public health needs of each resident, which is slightly above the nation median of \$33.26. Total public health spending in Washington, including federal sources such as money from HRSA and CDC, amounts to an average of \$81 per person per year, the seventh lowest amount in the nation.
- Children's Health: In Washington, over 20 percent of children ages 19 to 35 months do not receive complete immunizations. The state also has a high school graduation rate well below the national median, with only 74.6 percent of incoming freshmen graduating within four years.
- Health Disparities: African Americans living in Washington are 33 percent more likely to die prematurely than whites.
- The Road Ahead: Washington has made many recent public health improvements, such as reducing the rate of uninsured population from 13.3 percent to 11.8 percent in the past year. However, the state continues to face many public health challenges, including a prevalence of obesity that has increased from 9.4 percent to 24.2 percent of the population since 1990.

(Source for the all above statistics come from the APHA Advocacy websites for individual states <http://www.apha.org/advocacy/tips/StateFactSheets2008.htm>)

“Years of flat funding and budget cuts to vital public health agencies and programs at both the federal and state levels have taken their toll on [state name] and the nation as a whole, complicating public health efforts. Additional resources are needed to adequately support improving access to care, controlling diseases, eliminating health disparities, and other public health activities....”

(Source: this quote comes from the lead paragraph for each of the state Fact Sheets at <http://www.apha.org/advocacy/tips/StateFactSheets2008.htm>)

Libraries:

According to the American Library Association there are an estimated 123,291 libraries of all kinds in the United States today. (Source: ALA Fact Sheet 1 <http://www.ala.org/alalibrary/libraryfactsheet/alalibraryfactsheet1.cfm> on August 11, 2008)

Data for total # of public libraries is from FY2005

<http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2008301>

Trends in public libraries:

Quoted below from Executive Summary of The State of America’s Libraries 2008, from the American Library Association (<http://www.ala.org/2008state>).

- “Teenagers—far from confining themselves to their school library media centers—are also regular users of public library services. Almost all of the nation’s public libraries now offer programs tailored to the needs and interests of young adults, and more than half employ at least one full-time staff equivalent in this area, a sharp increase in the past decade.”
- “Going to the library is more and more often a virtual outing rather than an actual visit, and growing patron enthusiasm for the computer and Internet services offered by public libraries has stretched existing Internet bandwidth, computer availability, and building infrastructure to capacity. Budgets have not kept up with demand, and many libraries cannot provide enough computers or fast-enough connections speeds to meet patron needs.”
- “In another important victory, librarians were instrumental in seeing the NIH Public Access Policy become mandatory through Congressional action....” Taxpayers invest \$28 billion annually in the NIH to fund a wide variety of research in health, scientific, and other fields, resulting in more than 60,000 peer-reviewed articles per year. Now, wide, rapid, and easy access to the results of this research will help everyone in community college, college, and university libraries who wishes to apply it or build on it, advancing research and serving the public good.”

Hospital Libraries :

National perspective:

In January of 2007 the Medical Library Association released a report of a survey of hospital libraries in the United States. It shows that hospital libraries are under threat.

“It is estimated that there were between 5,795 (AHA) and 6,224 (Directory) hospitals in the U.S. in 2004/2005 based on the AHA data and information in the *Directory of Hospital Personnel*, 2005 edition. According to the AHA, there were 6,853 registered hospitals in the U.S. in January 1990, a decline of 15.5 % from the 2004 figure. It is further estimated that there were between 1,950 (NN/LM) and 2,513 hospital libraries (*Directory of Hospital Personnel*) in 2004/2005.

According to the AHA, it is estimated that there were 3,030 hospital libraries in 1990. Therefore,

comparing this figure to the 2004/2005 data it is estimated that the number of hospital libraries has declined between 17.1% and 35.7% between 1990 and 2004/2005.”

“About 45% of the libraries have experienced a change in the number of staff over the past five years, with 68% of those respondents experiencing a decrease in staff. ... In the 1989 survey, 71.7% of the respondents reported that their staffing numbers were unchanged. Of those libraries that did experience change, 50% saw increases in staff and 50% decreases.”

(Source: Hospital Library Survey Executive Summary. Medical Library Association Hospital Library Survey Task Force, January 2007)

A survey of hospital libraries in 2006 states that “More than 50% of the libraries serve patients and patients’ families while 43% serve consumers.” (Source: Hospital Library Survey Executive Summary. Medical Library Association Hospital Library Survey Task Force, January 2007)

Hospital Libraries and Health Facilities in the Pacific Northwest

There are no firm statistics on the number of hospital library closures in the PNR since the beginning of the current contract. In 2007, the RML did an audit of the PNR network membership directory, followed by a membership renewal campaign. Before the audit there were 153 hospital library network members. As of October 1, 2008, 113 network members identify themselves as hospital libraries (85 are in DOCLINE). Compared to the pre-audit count, this means there was a net loss of 40 hospital members. Of those, 5 had been DOCLINE libraries and the rest were affiliate members identified as “libraries” in the Network member directory.

Network members are not required to report hospital library closures to the RML. Anecdotally, we know that when some hospitals choose to downgrade their libraries, the professional librarian may be let go and another person, usually administrative services personnel or continuing education personnel, takes on “library” tasks along with their regular work. When the RML hears about a hospital librarian being let go, the Network Coordinator calls to find out what the status of the library is and whether the institution will continue to be a network member. The new person in charge of the “library” often asks “how do I continue to get articles for my doctors”. They do not know anything about the kind of tasks that the librarian performed or about being a network member.

To review the number of hospital libraries by size of health facility in the PNR, see Appendix C.
(Added in 10/16/08 draft)

PNR Network Members:

Type of Library Network Members by State

State	Total Network Members	Hospital Libraries	Academic Libraries	Public Library members/ Total PLs in State	State Library	Other organization or library
Alaska	14	5	2	3/89	0	4
Idaho	30	13	10	3/104	1	3
Montana	49	15	22	4/79	1	7
Oregon	71	36	19	0/125	1	15
Washington	149	44	30	7/65	1	67
Total	313	113	83	17/462	4	96

Source: PNR network members’ database as of October 1, 2008.