

Oregon Health Fund Board

Tuesday, January 15, 2008

11:30 am – 4:00 pm

Port of Portland

Commission Room

121 NW Everett

Portland, OR

(All agenda items are subject to change and times listed are approximate)

(The Board will be served a working lunch at approximately 12:30 am)

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
11:30 a.m.	Call Board Meeting to Order, Introductions, Review and Approve Meeting Agenda and Meeting Minutes with Working Lunch	Bill Thorndike OHFB Chair	X
12:00 pm	Oregon Health 101	<ul style="list-style-type: none"> • Jeanene Smith -OHPR • Jim Edge – DHS Division of Medical Assistance (DMAP) • Kelly Harms Office of Private Health Partnerships/Family Health Insurance Assistance Programs (FHIAP) 	
12:45 pm	Community Mental Health Overview	Gina N	
1:15 pm	Introduction to Community Health Clinics and Other Safety Net Providers	<ul style="list-style-type: none"> • Craig Hostetler Oregon Primary Care Association • Scott Ekbald Office of Rural Health • Jackie Rose Oregon School-Based Health Network • Tracy Gratto Coalition of Community Health Clinics 	
2:00 pm	Oregon's Community Collaborative	<ul style="list-style-type: none"> • Mike Bonetto Zoomcare • Susan Stearns 100% Access Healthcare Initiative • Tracy Gratto CCHS and Project Access NOW 	

2:45 pm	Break		
3:00 pm	Invited Testimony and Public Testimony	<ul style="list-style-type: none"> • Ellen Pinney- Oregon Health Actino Campaign 	
3:45 pm	Other Business and Discussion	Bill Thorndike – OHFB Chair	
4:00 pm	Adjourn	Bill Thorndike	X

EXHIBIT MATERIALS

1. Health Fund Board Draft Meeting Minutes

Office of Private Health Partnerships
***Family Health Insurance
Assistance Program***

*Overview for
Oregon Health Fund Board*
January 2008



Revised 1/11/2008

FHIAP's Mission

- ◆ Remove economic barriers to health insurance coverage for uninsured Oregonians.
- ◆ Build on the private sector and encourage self-reliance through participation in and access to the health benefit system.

Legislative Intent in 1997

After the passage of Ballot Measure 44 in November 1996 (which raised cigarette taxes specifically to fund health benefit programs), the State was looking for new and innovative ways to extend health benefits to lower-income, working families. During the 1997 session, the Legislature created the Family Health Insurance Assistance Program (FHIAP) to help those families who through their tax dollars helped pay for both Medicaid and Medicare, but were unable to qualify for those programs and could not afford private health insurance.

Program Principles

In designing the concept for FHIAP, the Legislature wanted to develop a model program that not only protects the well-being of economically disadvantaged Oregonians, but helps them to become self-reliant. Towards that goal, the program is designed based on the following principles:

- ◆ **Fosters independence and self-reliance** — The subsidy amount decreases as family income increases, so the affordability of health coverage will not end when families work their way off of welfare or increase their income through job advancement.
- ◆ **Encourages comparison shopping and consumer choice** — Eligible families without employer-sponsored coverage may apply the subsidy to their choice from among a variety of health benefit plans in the individual market.
- ◆ **Respects confidentiality and maintains personal dignity** — Oregonians using the subsidy are not stigmatized in any way.
- ◆ **Assures administrative simplicity and efficiency** — Program administration does not require the development of a new government agency, and the program design encourages participation and is easily accessible to the customer.
- ◆ **Not an entitlement** — Program expenditures are limited to the funding allocated and the expenditures authorized by the Legislature. Being eligible for the program doesn't guarantee that a person or family will receive the subsidy.
- ◆ **Responds to “real life” issues of maintaining a household budget on a modest income** — Subsidies are adequate enough to make health insurance more affordable, as well as recognize a family's cash flow needs.
- ◆ **Builds on strengths of the current system** — Encourages and builds upon employer-based coverage, and recognizes that providing access to health care to all Oregonians requires collaboration between the private and public sectors.

Program Overview

- ◆ **Extends health coverage to the uninsured** — The goal of the program is to remove economic barriers and increase the number of Oregonians with access to health care.
- ◆ **Emphasizes health insurance for children** — Adults are eligible for the subsidy only if all eligible children in the family are covered by a health benefit plan or the Oregon Health Plan.
- ◆ **Promotes equity in health care financing** — The program targets those working Oregonians who through their tax dollars help pay for both Medicaid and Medicare, yet cannot afford health coverage themselves.

History & Background

The Legislature created the Family Health Insurance Assistance Program (FHIAP) to help those families who through their tax dollars helped pay for both Medicaid and Medicare, but were unable to qualify for those programs and could not afford private health insurance.

Created by HB 2894 during the 1997 Session, the Insurance Pool Governing Board (changed in 2006 to the Office of Private Health Partnerships or OPHP) designed and implemented the program in just nine months, with the first subsidy paid in July 1998.

As directed by 2001's HB 2519, the agency worked with various legislative committees and commissions to develop the Section 1115 and Health Insurance Flexibility and Accountability (HIFA) waivers that would bring federal funding to FHIAP. Oregon was granted both the 1115 and HIFA waivers on October 15, 2002, and implemented them in FHIAP starting November 1, 2002.

Some of the waivers highlights were: the ability of clients to choose which program they wanted to get coverage under (ie, people weren't forced into OHP or SCHIP if they wanted to use FHIAP); FHIAP could use Title XXI funds to cover adults (as of November 1, 2007, FHIAP can't use Title XXI funds for adults, but is allowed to use Title XIX funds); and Oregon was able to subsidize insurance plans that met a benefit benchmark (actuarial equivalent of federally mandated Medicaid benefits — slightly different than the benchmark defined in Oregon state statute.)

Targets lower-income, uninsured Oregonians, and focuses on employer-sponsored coverage

- ◆ FHIAP specifically targets low-income, uninsured Oregonians. The program focuses on uninsured families with average monthly gross incomes between 100 and 185 percent of the federal poverty level (FPL), though roughly 49 percent of FHIAP enrollees earn less than 100 percent of the FPL.
- ◆ Oregon also has regions with high rates of uninsurance, particularly in southern and eastern Oregon. There was concern during FHIAP's implementation phase in 1998 that the program could be filled with people from the I-5 corridor where uninsured rates are lower, and that people in more rural areas would be excluded. FHIAP's initial marketing and outreach efforts focused on these regions, and has been successful in reaching and enrolling Oregonians in these areas. In addition, recent marketing efforts to expand the group market have focused on these regions. The geographic distribution of FHIAP enrollees roughly mirrors the geographic distribution of the state's population.

- ◆ FHIAP statutes require that members be uninsured, and FHIAP rules define the period of uninsurance at six months. The only exception to this is for individuals and families leaving Medicaid. The six month period of uninsurance is consistent with the federal government's State Children's Health Insurance Program and is significant enough to prevent insured individuals and employers from dropping their coverage to enroll in this program.

Removes economic barriers to health insurance by paying for much of the premium

- ◆ FHIAP set its subsidy levels high enough to allow low-income families not only to afford their premium payments, but also be able to pay the other costs associated with health insurance, such as co-payments, co-insurance, and deductibles. Consequently, FHIAP established its subsidies as shown on Page 4.

Uses private-sector insurance market and delivery systems

- ◆ The backbone of FHIAP is the private-sector health insurance market. To leverage private-sector dollars and encourage participation in the employer-based market, members who have coverage available from their employer must take that coverage, provided the employer makes a contribution toward the payment of the premium. This lessens the amount of premium the program subsidizes. However, if a member does not have employer coverage available or the employer does not contribute toward the coverage, FHIAP has a select group of individual market insurance companies participating in the program who have met certain criteria. To serve individuals who cannot purchase this coverage due to pre-existing health conditions, the Oregon Medical Insurance Pool (also known as OMIP) is also a participating carrier in FHIAP.
- ◆ Providers support FHIAP because of the commercial insurance payment rates they receive, which are higher than for either Medicaid or Medicare. However, providers don't know which of their clients are receiving FHIAP assistance (unless the patient tells them) because FHIAP members only present their commercial insurance card at the time of service.

Emphasizes coverage for children

- ◆ The uninsured rate of children has been of concern to both state and national leaders for several years. To provide an emphasis on coverage for children, FHIAP requires parents to have insurance coverage for their eligible children in place before the adult can become eligible to receive a subsidy. A parent may accomplish this by having their children in the State Children's Health Insurance Program (SCHIP) or Medicaid programs, or apply for a FHIAP subsidy for their children, as well as themselves.

Marketing challenges in current state climate

- ◆ FHIAP began to market the expansion to health insurance agents and employers in the early fall of 2002. After the waivers were approved, FHIAP conducted statewide training for insurance agents and began a media campaign, using radio and television non-commercial sustaining announcements. Aggressive marketing efforts continued in the individual market until those enrollment targets were reached in October 2005. Since that time, more than 25,000 requested to be placed on the individual marketing reservation list.

Program Overview

Eligibility

- ◆ Must reside in Oregon.
- ◆ Must be a U.S. citizen or a qualified non-citizen.
- ◆ Must have been without health insurance for the previous six months.
- ◆ Must have investments and savings less than \$10,000.
- ◆ All eligible children in the family must have health insurance before adults can use the subsidy.
- ◆ People eligible for or receiving Medicare cannot use the subsidy.
- ◆ Eligibility period is 12 months.

Subsidy Levels

- ◆ Subsidy levels will be based on a family's average monthly gross income and are a percentage of the premium cost.
 - ❖ Up to 125% of FPL (\$2,152 for a family of 4 in 2007) — 95% subsidy
 - ❖ 125% up to 150% of FPL (\$2,582 for a family of 4 in 2007) — 90% subsidy
 - ❖ 150% up to 170% of FPL (\$2,926 for a family of 4 in 2007) — 70% subsidy
 - ❖ 170% up to 185% of FPL (\$3,184 for a family of 4 in 2007) — 50% subsidy

Application & Enrollment Process

Whether or not a person has access to employer-sponsored health insurance dictates which application and enrollment process is used to determine their eligibility and can influence such factors as when they can apply for the program, and whether they will be billed for their portion of the premium or if they will be reimbursed for premiums withheld from their paychecks.

Group Market Process

- ◆ **Application distribution** — Employees can get FHIAP information from their employer, or they can call the FHIAP toll-free phone number and have an application sent to them by mail.
- ◆ **Completion of application** — Applicants fill out the Application, then return it to FHIAP with the required documentation (including proof of citizenship and identity).
- ◆ **Eligibility determination** — FHIAP Eligibility staff check to see if the application is complete, and if it is, determine whether or not the applicant qualifies for the program and at what subsidy level. They notify the applicant of the decision in writing.

- ◆ **Enrollment in group health plan** — If approved for a subsidy, the member is sent an approval letter and an Employer Verification Form. They need to have their employer fill out the form and send it back to FHIAP. They also need to enroll in their employer's group health insurance plan as soon as possible. Almost all of the domestic insurance carriers have said that FHIAP eligibility is considered a “qualifying event” so the member can enroll within 30 days of eligibility notification.
- ◆ **Subsidy payment** — In the group market, the member's portion of the health insurance premium is withheld from their paycheck(s), so FHIAP reimburses the subsidy portion of the premium. The Employer Verification form gives FHIAP all the information needed to determine the subsidy *amount* that the member will be reimbursed. The member needs to send in their paycheck stub each month to verify they are still enrolled and having a premium deducted from their check. Once this is received, FHIAP sends them a check, usually within 3-5 business days.

Individual Market Process

- ◆ **Application distribution** — People interested in a subsidy must call the FHIAP toll-free phone number and be put on the individual market's first-come, first-served Reservation List. When there is availability in the program, an application will be sent to them by mail.
- ◆ **Completion of application** — Applicants fill out the Individual Application, then return it to FHIAP with the required documentation.
- ◆ **Eligibility determination** — FHIAP Eligibility staff check to see if the application is complete, and if it is, determine whether or not the applicant qualifies for the program and at what subsidy level. They notify the applicant of the decision in writing.
- ◆ **Enrollment in individual market health plan** — If approved for a subsidy, the member is sent an approval letter and a Certificate of Eligibility form. The member sends this form (in lieu of the first month's premium) in with their health insurance application to one of the seven insurance carriers certified by FHIAP. If approved for an insurance plan, the carrier will notify FHIAP of the enrollment, and the billing process will start. If the member is declined coverage, they are eligible to apply with the Oregon Medical Insurance Pool (the state's high-risk health insurance program).
- ◆ **Billing** — Once a member is enrolled in a plan, the insurance carrier notifies FHIAP electronically and sends us a bill for one to two months premiums. FHIAP then bills the member for their portion of the premium. Once received by FHIAP, the agency sends the member's portion and subsidy payment to the insurance carrier.

Program Overview

For More Information

If you'd like more information about the Family Health Insurance Assistance Program, please contact:

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FHIAP

Federal Funds Benchmark for Group Health Insurance

FHIAP General Provisions	
Lifetime Maximum	\$1,000,000
Pre-existing Condition Waiting Period	6 Month
Medical Cost Sharing ❶	
Annual Deductible	\$750 per individual
Member Coinsurance Level	20 percent
Stop Loss Level	\$10,000 per individual
Out-of-pocket Maximum (Includes Deductible)	\$4,000 per individual
Required Services	
Prescription Medication Cost Sharing ❶	
Member Coinsurance Level ❷	50 percent
Out-of-pocket Maximum	No out-of-pocket maximum
Other Required Services ❸	
Doctor Visits	Covered Benefit
Immunization	Covered Benefit
Routine Well Checks ❹	Covered Benefit
Women's Health Care Services	Covered Benefit
Maternity	Covered Benefit
Diagnostic X-Ray/Lab	Covered Benefit
Hospital	Covered Benefit
Outpatient Surgery	Covered Benefit
Emergency Room	Covered Benefit
Ambulance	Covered Benefit
Transplant	Covered Benefit
Mental Health/Chemical Dependency Inpatient	Covered Benefit
Mental Health/Chemical Dependency Outpatient	Covered Benefit
Skilled Nursing Care	Covered Benefit
Durable Medical Equipment	Covered Benefit
Rehabilitation ❺	Covered Benefit
Hospice	Covered Benefit
Home Health	Covered Benefit

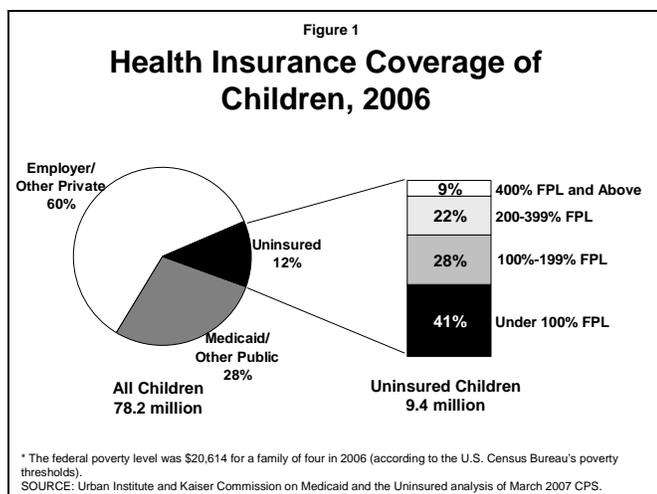
FHIAP

Federal Funds Benchmark for Group Health Insurance

- ❶ The group benchmark is based on the actuarial value of the member's out-of-pocket expense for the core benefit design. The core benefit design is described by the required benefits and the general member cost sharing. The actuarial value of the member's out-of-pocket expense for all plan types (indemnity, PPO, POS and HMO) is compared to the actuarial value of the benchmark plan's medical cost-sharing and prescription medication cost-sharing. If the actuarial value of the member's out-of-pocket expense for medical and prescription benefit cost-sharing meets, or is less than, the benchmark, the benefit plan meets the benchmark and no further evaluation is necessary. If a benefit plan's member cost-sharing level for medical exceeds the benchmark, the benefit plan can still meet the benchmark if the **combined** actuarial value of the member's cost-sharing for medical and prescription benefits is less than or equal to the benchmark's **combined** actuarial value of the member's cost-sharing for medical and prescription benefits. When both in-network benefits and out-of-network benefits are provided, the measurement of benchmark compliance is made using the in-network benefit level. The benchmark is **not** the listed deductible, coinsurance level, out-of-pocket maximum, and prescription drug copays. These are an **example** of a plan with the actuarial value of the FHIAP benchmark. Other benefit designs can have the same actuarial value.
- ❷ The prescription medication benefit has a specific member cost-sharing standard. This benefit is the only required service that has a specified member cost-sharing. This has been done because most plans administer prescription medication benefits with a separate member cost-sharing. If a benefit plan's member cost-sharing level for prescription medications exceeds the benchmark, the benefit plan can still meet the benchmark if the **combined** actuarial value of the member's cost-sharing for medical and prescription benefits is less than or equal to the benchmark's **combined** actuarial value of the member's cost-sharing for medical and prescription benefits.
- ❸ Under the Other Required Services, a "Covered Benefit" means that service is offered in this benefit category. If all service in this category is excluded, the plan fails the benchmark.
- ❹ If any benefit is provided for routine well checks this benefit requirement is satisfied. Since immunizations are a separate benefit category both benefits for routine well checks and immunizations must be provided for the plan to meet the benchmark.
- ❺ Either inpatient or outpatient rehabilitation benefits will satisfy this requirement.

HEALTH COVERAGE OF CHILDREN: THE ROLE OF MEDICAID AND SCHIP

Medicaid and SCHIP play a crucial role in the U.S. health insurance system by providing coverage for more than one in four children. These children are typically from lower income families for whom private plans are often unavailable or unaffordable. During 2005, about 28 million children were on Medicaid and more than 6 million were covered through the State Children's Health Insurance Program (SCHIP). However, 9.4 million children remain uninsured, and the vast majority of these children are from low and middle income families (Figure 1).



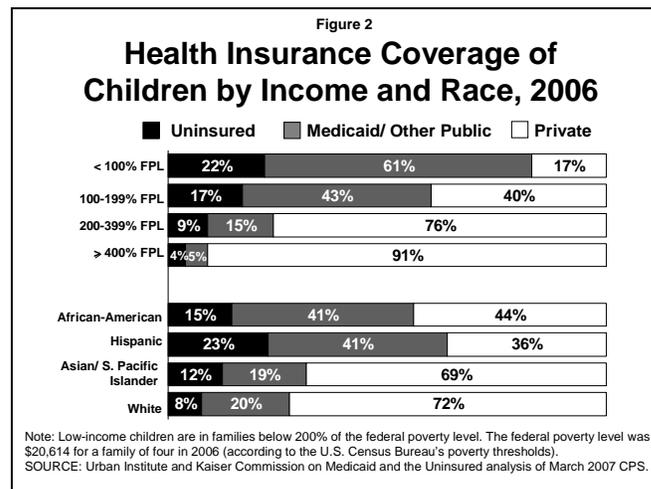
UNINSURED CHILDREN

More than two-thirds of the 9.4 million uninsured children in the U.S. live in families with household incomes below 200% of the federal poverty level (\$41,228 for a family of four in 2006). The majority of uninsured children (72%) live in families with at least one full-time worker. These families often are not offered coverage or cannot afford the premiums. Since 2001, premiums for family coverage have increased 78%, while wages have gone up 19%. The average total premium in 2007 for a family of four with employer coverage is over \$12,000 per year.

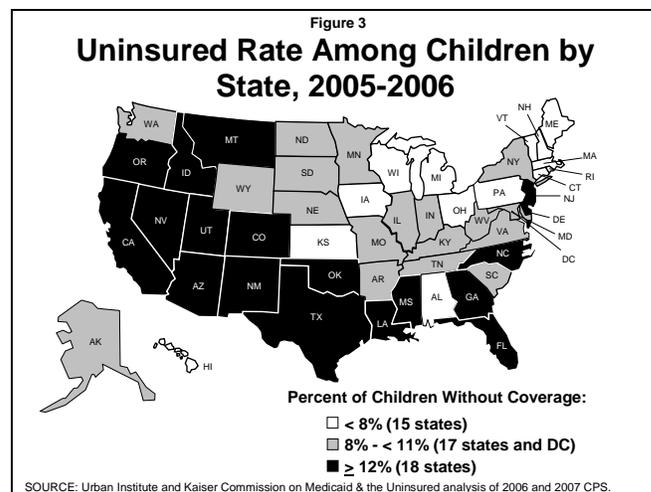
Public coverage targets lower income children who are more likely to be uninsured (Figure 2). Almost all of the 6.5 million uninsured children below 200% of poverty are eligible for Medicaid or SCHIP, but are not enrolled. Nearly one in 10 children from middle income families (200-399% of poverty) is uninsured. Those children are less likely to be eligible for public coverage.

Hispanic and African-American children are more likely to be uninsured than white children. Adolescents are also more likely than younger children to be uninsured, due in

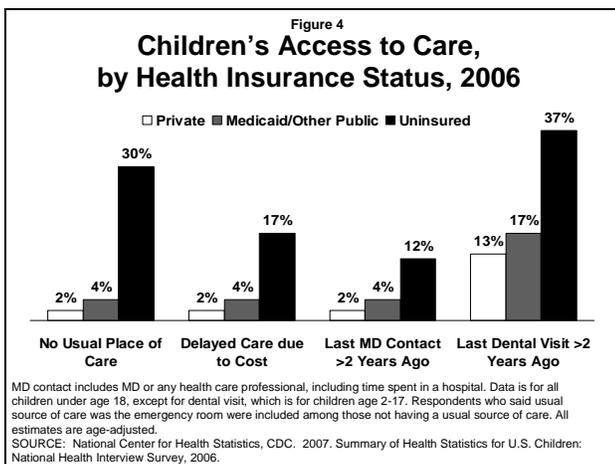
part to lower Medicaid income eligibility levels for older children in some states.



The risk of being uninsured also differs depending on where a child lives, as the share of children who are uninsured varies widely across states (Figure 3). While in Michigan only 5% of children are uninsured, in five states (AZ, FL, NV, NM, TX) over 16% are uninsured. Although those five states have large immigrant populations, they also have some of the highest uninsured rates among children who are U.S. citizens.



The role of health insurance coverage in improving access to care is well documented. Uninsured children have markedly worse access to care than those with Medicaid or private insurance. Medicaid provides children with a level of access to care that is comparable to that of children with private insurance coverage (Figure 4).

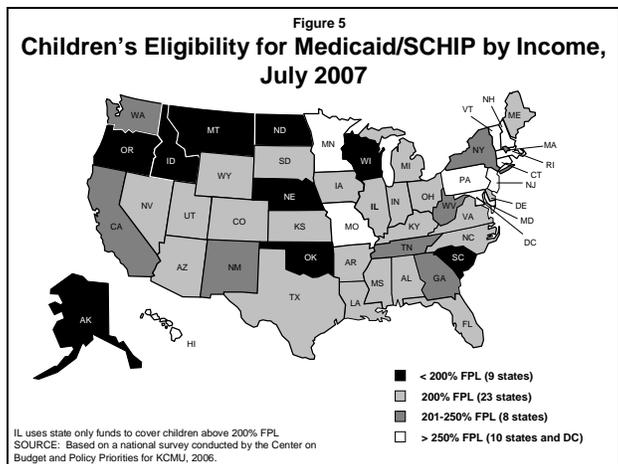


MEDICAID AND SCHIP COVERAGE OF CHILDREN

The Medicaid program provides coverage for millions of low-income children. Children represent half of all Medicaid enrollees, but account for only 17% of total program spending. Medicaid pays for a comprehensive set of services for children, including physician and hospital visits, screening and treatment (EPSDT), well-child care, vision care, and dental services.

States are required to extend Medicaid eligibility to children under 6 years old living in families with incomes at or below 133% of poverty, and to children ages 6-18 living in families with incomes at or below 100% of poverty. Low-income, recent immigrant children are barred from federally-financed public coverage.

SCHIP was created in 1997 as a block grant to give states the flexibility to cover uninsured children in families with incomes above Medicaid eligibility levels (Figure 5). The program will expire on September 30, 2007 if it is not reauthorized. Within SCHIP, states can set premiums and co-payments on a sliding scale based on income and can cover a more limited set of benefits than Medicaid. SCHIP provides an enhanced federal match, but each state's federal funding for SCHIP is capped; as a result some states have experienced funding shortfalls.



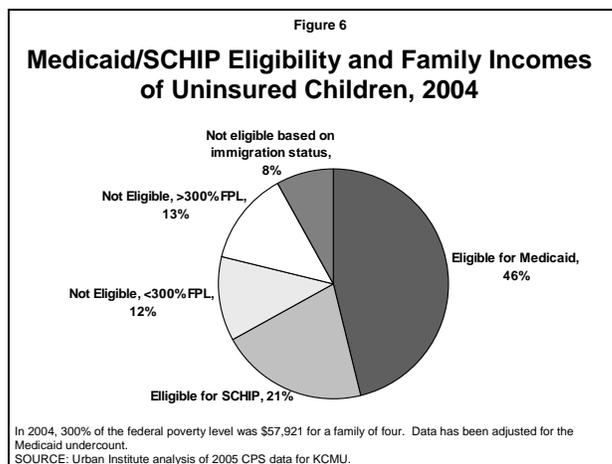
ISSUES IN IMPROVING COVERAGE

The enactment of SCHIP spurred states to invest heavily in outreach and improve their enrollment processes for both Medicaid and SCHIP while expanding coverage for children. As employer-sponsored coverage rates have declined, many states have extended coverage to children in families with higher incomes. Forty-two states including the District of Columbia cover children in families with incomes of 200% of poverty or higher.

Over the past decade, Medicaid and SCHIP helped reduce the uninsured rate for low-income children by about one-third. That trend reversed in 2005. From 2004 to 2006, public coverage rates did not change and the decline in employer coverage resulted in 1 million more uninsured children.

In 2006, about half of the increase in uninsured children occurred among children in families from 200% to 400% of poverty (\$41,228 to \$82,456 for a family of four) and was driven by a decline in employer coverage. When such families lose employer coverage, many cannot afford insurance in the individual market and in most states they have incomes above Medicaid and SCHIP eligibility.

States are moving forward to reach uninsured children who are currently eligible for public coverage and to extend coverage to middle income uninsured children without access to private coverage (Figure 6). Educating families about Medicaid and SCHIP and simplifying enrollment/renewal processes will help children gain consistent coverage and access to care.



Efforts to use SCHIP to improve children's coverage could be impeded by new guidance issued in August by the Bush administration that precludes states from expanding SCHIP coverage to children in families above 250% of poverty unless states meet a series of strict benchmarks. Recent increases in uninsured children point to the potential for past gains to be reversed if states are unable to expand SCHIP to reach the growing numbers of children without affordable private coverage and if program funding is inadequate to secure coverage.

Additional copies of this publication (#7698) are available on the Kaiser Family Foundation's website at www.kff.org.

FHIAP Snapshot of Program Activity - 01/07/2008

Summary Enrollment Information

RESERVATION AND ENROLLMENT

<i>Approved:</i>	<u>Group</u>	<u>Individual</u>	<u>Total</u>	<u>Projected Enrollment</u>
Approved and Enrolled Lives	5,586	11,585	17,171	17,171
Approved Lives - to be enrolled	162	351	513	335
Total Lives:			17,684	17,506

<i>Reservation List (lives):</i>	<u>Group</u>	<u>Individual</u>	<u>Total</u>
Initial Applications under review	55	26	81
Initial Applications Outstanding	564	0	564
Waiting list for Application	4,551	19,329	23,880
Total Lives:			24,525

FHIAP Snapshot of Program Activity - 01/07/2008

PROGRAM ENROLLMENTS

Group Enrollment:						
<i>Subsidy Levels:</i>	50%	70%	90%	95%	Total	
Children 0-18	173	433	640	1,323	2,569	
Adults 19-UP	203	498	769	1547	3,017	
Totals	376	931	1,409	2,870	5,586	32.5%

Non-OMIP Individual Enrollment:						
<i>Subsidy Levels:</i>	50%	70%	90%	95%	Total	
Children 0-18	59	141	299	1,298	1,797	
Adults 19-UP	95	287	739	3630	4,751	
Totals	154	428	1,038	4,928	6,548	38.1%

OMIP Enrollment						
<i>Subsidy Levels:</i>	50%	70%	90%	95%	Total	
Children 0-18	6	12	33	130	181	
Adults 19-UP	67	254	682	3853	4,856	
Totals	73	266	715	3,983	5,037	29.3%

Enrollment Summary for both Group and Individual Markets						
<i>Subsidy Levels:</i>	50%	70%	90%	95%	Total	
Children 0-18	238	586	972	2,751	4,547	
Adults 19-UP	365	1039	2190	9030	12,624	
Totals	603	1,625	3,162	11,781	17,171	100.0%
Percentages:	3.5%	9.5%	18.4%	68.6%	100.0%	

FHIAP Snapshot of Program Activity - 01/07/2008

AVERAGE SUBSIDY & PREMIUM VALUES FOR INDIVIDUAL & GROUP

Average Premium and Subsidy for Individual Market					Weighted Average
<i>Subsidy Levels:</i>	50%	70%	90%	95%	
Premium Per Month	\$279.04	\$296.21	\$328.04	\$334.23	\$329.85
Subsidy Per Month	\$139.52	\$207.35	\$295.23	\$317.51	\$303.81
Member Contribution	\$139.52	\$88.86	\$32.80	\$16.71	\$26.04

Average Premium and Subsidy for Individual OMIP					Weighted Average
<i>Subsidy Levels:</i>	50%	70%	90%	95%	
Premium Per Month	\$453.77	\$428.51	\$461.11	\$437.04	\$440.24
Subsidy Per Month	\$226.88	\$299.96	\$415.00	\$415.19	\$406.16
Member Contribution	\$226.88	\$128.55	\$46.11	\$21.85	\$34.08

Average Premium and Subsidy for Individual NON-OMIP					Weighted Average
<i>Subsidy Levels:</i>	50%	70%	90%	95%	
Premium Per Month	\$195.84	\$206.98	\$230.62	\$245.16	\$239.07
Subsidy Per Month	\$97.92	\$144.89	\$207.56	\$232.90	\$219.64
Member Contribution	\$97.92	\$62.09	\$23.06	\$12.26	\$19.43

Average Premium and Subsidy for GROUP Market					Weighted Average
<i>Subsidy Levels:</i>	50%	70%	90%	95%	
Member Contribution	\$63.60	\$41.25	\$14.81	\$8.54	\$19.28
Subsidy Per Month	\$63.60	\$96.24	\$133.25	\$162.27	\$137.15
Employee Share	\$127.20	\$137.49	\$148.05	\$170.81	\$156.43
Employer Contribution	\$127.26	\$122.97	\$115.87	\$101.33	\$110.46

Avg Premium and Subsidy for GROUP Market - excluding Self-Employed & COBRA/Portability					Weighted Average
<i>Subsidy Levels:</i>	50%	70%	90%	95%	
Member Contribution	\$63.17	\$40.64	\$13.70	\$7.81	\$19.22
Subsidy Per Month	\$63.17	\$94.83	\$123.32	\$148.36	\$126.05
Employee Share	\$126.34	\$135.48	\$137.02	\$156.17	\$145.27
Employer Contribution	\$132.53	\$131.61	\$129.53	\$119.46	\$125.24

Average Premium and Subsidy				Overall Weighted Average
<i>Subsidy Levels:</i>	Weighted Average			
	<u>Individual</u>	<u>Group</u>		
<i>Premium Per Month (includes employer contribution for Group)</i>	\$329.85	\$266.89		\$309.37
*Premium Per Month	\$329.85	\$156.43		\$272.06
Subsidy Per Month	\$303.81	\$137.15		\$249.59
Member Contribution	\$26.04	\$19.28		\$23.92

*Group is the subsidizable portion of the employee's payroll deduction

FHIAP Snapshot of Program Activity - 01/07/2008

GEOGRAPHIC TRENDS

Number accessing the program by region				
	<u>Lives</u>	<u>Percentage</u>	<u>Population Percentage</u>	<u>Percent of Uninsured</u>
NW/ North Coast	14,715	4%	4%	5%
Metropolitan Portland	89,619	23%	45%	31%
Willamette Valley	80,301	21%	25%	27%
Southern/ South Coast	58,978	15%	13%	18%
Mid-Columbia	13,616	4%	4%	5%
Central	15,976	4%	4%	6%
Southeast	8,374	2%	3%	4%
Northeast	9,541	2%	2%	4%
Other	95,209	25%	0%	0%
	386,329	100%	100%	100%

Total percent may not equal 100% due to rounding differences

Number enrolled in the program by region				
	<u>Lives</u>	<u>Percentage</u>	<u>Population Percentage</u>	<u>Percent of Uninsured</u>
NW/ North Coast	884	5%	4%	5%
Metropolitan Portland	5,800	34%	45%	31%
Willamette Valley	5,077	30%	25%	27%
Southern/ South Coast	3,082	18%	13%	18%
Mid-Columbia	611	4%	4%	5%
Central	748	4%	4%	6%
Southeast	455	3%	3%	4%
Northeast	514	3%	2%	4%
Other	-	0%	0%	0%
	17,171	100%	100%	100%

Total percent may not equal 100% due to rounding differences

Number of Oregonians requesting information and/or application materials:	
<u>Type of information</u>	<u>Number of lives</u>
Received applications waiting to be processed/determined	77
Approved applications not yet enrolled; still within the allowed time period	513
Approved applications not enrolled in insurance within 120 days	11,174
Pended applications	4
Denied approval of application	43,636
Reservation list	23,880
Outstanding application within allowed return time	564
Outstanding application not received within allowed return time	224,378

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ENROLLMENT BY AGE GROUP

Individual Market Only

AGE GROUP	LIVES	PERCENT
0-5	530	4.6%
6-18	1,448	12.5%
19-29	1,720	14.8%
30-39	2,075	17.9%
40-49	2,413	20.8%
50-59	2,355	20.3%
60+	1,044	9.0%
Total	11,585	100%
Average Age =	37.4	
Median Age =	40.0	

Group Market Only

AGE GROUP	LIVES	PERCENT
0-5	723	12.9%
6-18	1,846	33.0%
19-29	837	15.0%
30-39	1,065	19.1%
40-49	728	13.0%
50-59	318	5.7%
60+	69	1.2%
Total	5,586	100%
Average Age =	24.1	
Median Age =	22.0	

Both Group and Individual Markets

AGE GROUP	LIVES	PERCENT
0-5	1,253	7.3%
6-18	3,294	19.2%
19-29	2,557	14.9%
30-39	3,140	18.3%
40-49	3,141	18.3%
50-59	2,673	15.6%
60+	1,113	6.5%
Total	17,171	100%
Average Age =	33.1	
Median Age =	34.0	

Adult and child enrollment across markets

	Under 19		Adults		Total	
Individual	1,978	43.5%	9,607	76.1%	11,585	67.5%
Group	2,569	56.5%	3,017	23.9%	5,586	32.5%
Total	4,547	100.0%	12,624	100.0%	17,171	100.0%

Adult and child enrollment within markets

	Individual		Group		Total	
Under 19	1,978	17.1%	2,569	46.0%	4,547	26.5%
Adults	9,607	82.9%	3,017	54.0%	12,624	73.5%
Total	11,585	100.0%	5,586	100.0%	17,171	100.0%

FHIAP Snapshot of Program Activity - 01/07/2008

ENROLLMENT BY GENDER AND MARKET TYPE

Gender	Individual		Group		Total	
Male	4,403	38.0%	2,488	44.5%	6,891	40.1%
Female	7,182	62.0%	3,098	55.5%	10,280	59.9%
Total	11,585	100%	5,586	100%	17,171	100%

LENGTH OF ENROLLMENT BY MARKET TYPE

Average Enrollment Months of Active Lives		Average Enrollment Months of Terminated Lives	
Market:	Avg Months Enrolled	Market:	Avg Months Enrolled
Individual Market - OMIP only	19.4	Individual Market - OMIP only	14.6
Individual Market - Non-OMIP only	28.1	Individual Market - Non-OMIP only	17.1
Group Market	26.2	Group Market	19.0
FHIAP - ALL	25.1	FHIAP - ALL	17.0

CARRIER & BENEFIT PLAN ENROLLMENT PATTERNS

Individual Market Carrier	50%	70%	90%	95%	Plan Total	Percent
<i>Regence BCBSO</i>	110	267	608	2,560	3,545	30.6%
<i>Health Net</i>	6	38	116	613	773	6.7%
<i>Kaiser</i>	15	50	137	737	939	8.1%
<i>Lifewise</i>	13	43	101	550	707	6.1%
<i>ODS Health Plans</i>	1	6	15	108	130	1.1%
<i>OMIP</i>	73	266	715	3,983	5,037	43.5%
<i>Pacificare</i>	1	0	19	141	161	1.4%
<i>PacificSource</i>	8	24	42	219	293	2.5%
	227	694	1,753	8,911	11,585	100%

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CARRIER & BENEFIT PLAN ENROLLMENT PATTERNS

Carrier	Plan	50%	70%	90%	95%	Total	Percent
RBCBSO	Blue Selections Basic	0	0	0	0	0	0.0%
	Blue Selections Basic w/Dental	0	0	0	0	0	0.0%
	Blue Selections Plus \$500 Ded	42	150	313	1,107	1,612	45.5%
	Blue Selections Plus \$500 ded w/Dental	53	96	267	1,367	1,783	50.3%
	Blue Selections Plus \$1000 ded	2	11	14	43	70	2.0%
	Blue Selections Plus \$1000 ded w/Dental	13	10	9	36	68	1.9%
	CHEC/\$500	0	0	0	0	0	0.0%
	CHEC/\$1,000	0	0	0	0	0	0.0%
	Consumer Advantage/\$500	0	0	0	0	0	0.0%
	Consumer Advantage/\$1,000	0	0	0	0	0	0.0%
	Oregon Youth Care	0	0	0	0	0	0.0%
	PPO Portibility	0	0	5	7	12	0.3%
	SureChoice Plan \$300 Deductible	0	0	0	0	0	0.0%
	SureChoice Plan \$500 Deductible prevailing	0	0	0	0	0	0.0%
	SureChoice Plan \$1000 Deductible	0	0	0	0	0	0.0%
		110	267	608	2,560	3,545	30.6%

Health Net	Diamond \$250 Deductible	6	38	116	613	773	100.0%
	Diamond \$500 Deductible	0	0	0	0	0	0.0%
	Diamond \$1000 Deductible	0	0	0	0	0	#DIV/0!
	HMO PLAN	0	0	0	0	0	0.0%
	PPO Plan (80/50) (\$500 Ded)	0	0	0	0	0	0.0%
	PPO Plan (80/50) (\$500 Ded) w/PCB	0	0	0	0	0	#DIV/0!
	PPO Plan (80/60) (\$500 Ded)	0	0	0	0	0	0.0%
	PPO Plan (80/60) (\$1000 Ded)	0	0	0	0	0	#DIV/0!
	Value Plan \$500 Deductible	0	0	0	0	0	0.0%
	Value Plan \$1000 Deductible	0	0	0	0	0	0.0%
	Value Plan \$1000 Deductible Children	0	0	0	0	0	0.0%
			6	38	116	613	773

Kaiser	Gold Rx \$500	3	6	25	92	126	13.4%
	Gold Rx \$1000	0	0	0	0	0	0.0%
	Platinum Rx	12	44	112	645	813	86.6%
		15	50	137	737	939	8.1%

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CARRIER & BENEFIT PLAN ENROLLMENT PATTERNS

Carrier	Plan	50%	70%	90%	95%	Total	Percent
Lifewise							
	WiseChoices \$500 Deductible	13	43	101	550	707	100.0%
		13	43	101	550	707	6.1%

ODS	Plus (POS) \$1000 Deductible	0	0	0	0	0	0.0%
	Preferred (PPO) \$1000 Deductible	0	0	0	0	0	0.0%
	Traditional (Ind) \$1000 Deductible	0	0	0	0	0	0.0%
	Beneficial Rx \$1000	1	1	4	31	37	28.5%
	Beneficial Rx \$1000 w/ Preferred Dental	0	2	6	33	41	31.5%
	Beneficial Rx \$1000 w/ Premier Dental	0	3	5	44	52	40.0%
		1	6	15	108	130	1.1%

OMP	\$500 Deductible	57	239	691	3,832	4,819	95.7%
	\$750 Deductible	16	27	24	151	218	4.3%
	\$1,000 Deductible	0	0	0	0	0	0.0%
		73	266	715	3,983	5,037	43.5%

Pacificare	Plan I	0	0	0	0	0	0.0%
	Plan II	1	0	19	141	161	100.0%
		1	0	19	141	161	1.4%

PacificSource							
	HMO Individual Plan ++ No Deductible	8	24	42	219	293	100.0%
		8	24	42	219	293	2.5%

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TERMINATION TRENDS

Termination Reason	Current Month				Overall Terminations			
Member Request								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
50% Subsidy Level	3	0	3	27.3%	198	43	241	6.7%
70% Subsidy Level	1	0	1	9.1%	606	92	698	19.4%
90% Subsidy Level	2	0	2	18.2%	703	99	802	22.3%
95% Subsidy Level	5	0	5	45.5%	1,632	224	1,856	51.6%
	11	0	11	25.0%	3,139	458	3,597	14.2%

Ineligible based on review of application								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
50% Subsidy Level	3	0	3	11.1%	195	564	759	6.7%
70% Subsidy Level	3	2	5	18.5%	979	891	1,870	16.4%
90% Subsidy Level	4	0	4	14.8%	1,904	1,163	3,067	26.9%
95% Subsidy Level	15	0	15	55.6%	4,112	1,605	5,717	50.1%
	25	2	27	61.4%	7,190	4,223	11,413	44.9%

Rescission of coverage by insurance carrier - Never Effective								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
50% Subsidy Level	0	0	0	0.0%	9	0	9	6.8%
70% Subsidy Level	0	0	0	0.0%	22	2	24	18.0%
90% Subsidy Level	0	0	0	0.0%	16	0	16	12.0%
95% Subsidy Level	0	0	0	0.0%	79	5	84	63.2%
	0	0	0	0.0%	126	7	133	0.5%

Carrier Termination								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
50% Subsidy Level	0	0	0	0.0%	2	1	3	6.1%
70% Subsidy Level	0	0	0	0.0%	9	2	11	22.4%
90% Subsidy Level	0	0	0	0.0%	13	0	13	26.5%
95% Subsidy Level	0	0	0	0.0%	22	0	22	44.9%
	0	0	0	0.0%	46	3	49	0.2%

Eligible for Medicare Coverage								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
50% Subsidy Level	0	0	0	0.0%	13	1	14	2.0%
70% Subsidy Level	0	0	0	0.0%	59	1	60	8.6%
90% Subsidy Level	1	0	1	16.7%	184	3	187	26.8%
95% Subsidy Level	5	0	5	83.3%	435	1	436	62.6%
	6	0	6	13.6%	691	6	697	2.7%

Failed to make premium payments to FHIAP								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
50% Subsidy Level	0	0	0	0.0%	250	0	250	3.6%
70% Subsidy Level	0	0	0	0.0%	1,082	0	1,082	15.8%
90% Subsidy Level	0	0	0	0.0%	1,526	0	1,526	22.3%
95% Subsidy Level	0	0	0	0.0%	3,997	1	3,998	58.3%
	0	0	0	0.0%	6,855	1	6,856	27.0%

continued on next page...

FHIAP Snapshot of Program Activity - 01/07/2008

TERMINATION TRENDS - continued

Failed to submit employer verification								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
<i>50% Subsidy Level</i>	0	0	0	0.0%	1	134	135	7.0%
<i>70% Subsidy Level</i>	0	0	0	0.0%	92	373	465	24.1%
<i>90% Subsidy Level</i>	0	0	0	0.0%	143	377	520	26.9%
<i>95% Subsidy Level</i>	0	0	0	0.0%	176	637	813	42.1%
	0	0	0	0.0%	412	1,521	1,933	7.6%

Deceased								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
<i>50% Subsidy Level</i>	0	0	0	0.0%	1	1	2	1.9%
<i>70% Subsidy Level</i>	0	0	0	0.0%	9	0	9	8.5%
<i>90% Subsidy Level</i>	0	0	0	0.0%	25	0	25	23.6%
<i>95% Subsidy Level</i>	0	0	0	0.0%	69	1	70	66.0%
	0	0	0	0.0%	104	2	106	0.4%

Covered in OHP								
	Individual	Group	Total	Percent	Individual	Group	Total	Percent
<i>50% Subsidy Level</i>	0	0	0	0.0%	8	10	18	2.9%
<i>70% Subsidy Level</i>	0	0	0	0.0%	21	12	33	5.3%
<i>90% Subsidy Level</i>	0	0	0	0.0%	74	43	117	18.9%
<i>95% Subsidy Level</i>	0	0	0	0.0%	374	77	451	72.9%
	0	0	0	0.0%	477	142	619	2.4%

Current Terminations as % of Current Enrollment

	<u>Lives</u>	<u>Percent of Enrollment</u>
Current Month Terminations:	44	0.3%
Current Active Enrollment:	17,171	

Distribution of current and to date terminations by termination reason

	<u>Current</u>	<u>Percent</u>	<u>To Date</u>	<u>Percent</u>
<i>Member Request</i>	11	25.0%	3,597	14.2%
<i>Ineligible</i>	27	61.4%	11,413	44.9%
<i>Rescinded Coverage</i>	0	0.0%	133	0.5%
<i>Carrier Termination</i>	0	0.0%	49	0.2%
<i>Medicare Eligible</i>	6	13.6%	697	2.7%
<i>Failed to pay premium</i>	0	0.0%	6,856	27.0%
<i>Failed to submit employer verification</i>	0	0.0%	1,933	7.6%
<i>Deceased</i>	0	0.0%	106	0.4%
<i>Covered in OHP</i>	0	0.0%	619	2.4%
Total	44	100%	25,403	100%

FHIAP Snapshot of Program Activity - 01/07/2008

ENROLLMENT BY ETHNIC/RACIAL HERITAGE AND MARKET TYPE

Heritage	Individual		Group		Total	
	Lives	Percent	Lives	Percent	Lives	Percent
<i>African-American</i>	217	1.9%	138	2.5%	355	2.1%
<i>Asian/Pacific Islander</i>	646	5.6%	118	2.1%	764	4.4%
<i>Hispanic</i>	422	3.6%	385	6.9%	807	4.7%
<i>Native American</i>	100	0.9%	74	1.3%	174	1.0%
<i>Not Given</i>	475	4.1%	215	3.8%	690	4.0%
<i>Other</i>	340	2.9%	274	4.9%	614	3.6%
<i>White</i>	9,385	81.0%	4,382	78.4%	13,767	80.2%
TOTAL	11,585	100%	5,586	100%	17,171	100%

ENROLLMENT BY FEDERAL POVERTY LEVEL AND MARKET TYPE

Poverty Level	Subsidy Level	Individual Lives	Group Lives	Total Lives
<i>170-185%</i>	50%	227	376	603
<i>150-169%</i>	70%	694	931	1,625
<i>126-149%</i>	90%	1,753	1,409	3,162
<i>0-125%</i>	95%	8,911	2,870	11,781
Totals		11,585	5,586	17,171

Community-Created Health Care Solutions in Oregon

January 2006



Oregon Health Policy Commission

Community-Created Health Care Solutions in Oregon

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January 2006

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Background

The Oregon Health Policy Commission (OHPC) recognizes that there is no single viable model for ensuring access to needed health services in Oregon. Each community's optimal health care delivery system must be responsive to its unique environment, populations, and infrastructure. Consequently, the OHPC recruited a group of experts from throughout Oregon to investigate what can be done to support local or "community-created" solutions to improve access to health care within Oregon communities. This Local Delivery System Models Work Group aimed to:

- Identify viable community-created responses to ensuring access;
- Catalogue lessons learned and best practices;
- Disseminate findings to interested stakeholders.

Furthermore, the Work Group was convened to identify specific recommendations to the OHPC regarding:

- State policy changes that would create a more supportive environment for local health care solutions;
- Technical assistance needs of communities in the development of local health care solutions; and
- The type of assistance from state agencies that would be beneficial.

To begin to reach these objectives, the Local Delivery System Models Work Group conducted an initial survey of five Oregon communities currently developing local solutions to improve health care access for their residents. Local leaders of the identified community-created solutions were interviewed. These leaders were asked to (1) identify lessons learned from their collaborative efforts and (2) offer

recommendations identifying ways the state can better support community health care access solutions. (See Appendix A for specific questions and summaries of replies.) The following is a summary of findings based on key informant interviews.

Overview

The difficulty in providing coverage and ensuring access to health services has reached critical proportions.

Each community's optimal health care delivery system must be responsive to its unique environment, populations, and infrastructure.

45.8 million people are without insurance in the United States. Nationally, between 2000 and 2004, the number of uninsured people in America increased by six million people.¹ Similarly, between the years of 2002 and 2004, the percentage of Oregonians lacking health insurance increased from 14% to 17%, with the number of uninsured in Oregon over 600,000.² This predicament is likely to grow, given the fiscal challenges of the state and the rising cost of health insurance for the government, private employers, and individuals. As a result of inadequate coverage and access to needed health services, many severe consequences can be identified, e.g., infection rates increase; people miss work and productivity declines, homelessness increases resulting in overburdened

¹ Cook, Alison. Holahan, John. Changes in Economic Conditions and Health Insurance Coverage 2000-2004. (2005) Market Watch, *Health Affairs*.

² Office for Oregon Health Policy and Research. *Rising Number of Uninsured in Oregon*. (2005).

social service agencies. In addition, as health insurance premiums soar, employers shift the cost of health insurance to their workers by reducing or dropping benefits altogether.³ Yet, even as these and other challenges are being felt by more and more people, the demand for health services continues to increase.

Recognizing the lack of comprehensive policies at the state or federal level to ensure needed services, local leaders in Oregon are designing and implementing innovative ways to provide health services that will improve the health of their entire community. These community leaders are working with unlikely partners. They are doing business differently by reorganizing services at the local level. They are looking for savings within the current system by increasing communication and coordination. These local champions are exploring, designing, and implementing community-created solutions to the health care crisis.

Community-Created Solutions

The continued and growing challenges of providing health services have been identified by many as unsustainable. This crisis has motivated communities to seek different ways to operate and work with others. These community-created solutions feature broad efforts involving many stakeholders*, which coordinate resources, work, incentives and capacity. These solutions result in better

³ Castañares, Tina. Improving Health Care Access: Finding Solutions in a Time of Crisis. Collaborative Problem Solving for States and Communities. (2004). *National Policy Consensus Center*. 1-13, <http://www.policyconsensus.org/publications/reports/docs/Healthcare.pdf>.

* One who has a share or an interest, as in an enterprise, www.dictionary.reference.com

access to health services for more people and often focus on prevention, primary care, and care management. These efforts tend to:

- Involve sharing the risks and rewards across stakeholders;
- Engage multiple, diverse public and private stakeholders;
- Need community leadership or “champions”;
- Leverage financial commitments from stakeholders;
- Coordinate the process of delivering comprehensive health services;
- Offer significant stability to the local health care system; and
- Be politically challenging and time-consuming.

...local champions are exploring, designing, and implementing community-created solutions to the health care crisis.

It is worth noting what community-created solutions *are not*, for the purpose of this study. These local solutions are not designed and implemented by a lone organization. They are not targeted projects funded by a single source. Nor are they a specific service or program, unless it is the building block for a broader community-wide initiative to improve the delivery of health services.

Collaboration

Collaboration is the crux of building community-created solutions. Collaboration is a mutually beneficial and explicit relationship entered into by two or more organizations to achieve results they are more likely to achieve

together rather than single-handedly.⁴ Collaboration requires shared goals as well as values and vision, to which all stakeholders have a commitment. Collaboration embraces the tenets of shared decision making, ownership of outcomes, and risk to all participants.⁵

Collaboration, as a strategy for restructuring service delivery, is gaining momentum throughout the country. Several forces are propelling this development, among them:

- Emerging social policy issues for which there are no existing solutions;
- General agreement that fragmentation is unproductive and cooperation is a more efficient approach to service delivery;
- Shrinking of traditional funding sources, requiring organizations to address common issues jointly in order to conserve resources;
- Policies and programs which support the merging of existing and new resources to focus on commonly defined issues;
- Blurring of traditional boundaries between public and private roles; and
- Movement toward decentralization and an increasing shift of responsibility to the local level.⁶

Collaboration, while presently required by many funding agencies, is ultimately

a commitment on the part of organizations and communities to invest in long-term and sustainable planning.

Survey Process

This report provides a survey of five of Oregon's community-created solutions to improve the delivery of needed health services. It documents the experiences of leaders involved in building and sustaining local collaborative efforts committed to increasing access to needed health services, reducing/controlling costs, and improving health care quality as well as the health outcomes of their entire communities. It shares lessons learned from local or regional health collaborations. It also identifies barriers and challenges to these and similar innovations. Furthermore, the report relays recommendations for policy makers and government officials on how best to support community innovation.

The community-created solutions survey process was conducted between the months of August and November, 2005. Five community initiatives were surveyed, comprising 34 key informants from fifteen Oregon counties. These communities were identified by the Local Delivery Systems Work Group as local public-private collaborative efforts at various stages of development. They also were selected due to their innovation, collaboration, and geographic diversity. Key informants included stakeholders actively involved in the community collaboration and representing multiple sectors, disciplines, and organizations. The five community-created solution initiatives were:

- 100% Access Coalition, comprising Lane county - Appendix B
- Central Oregon Health Care Collaborative, comprising Crook,

⁴ Winer, Michael. Ray, Karen. (2000). Collaboration Handbook: Creating, Sustaining and Enjoying the Journey, Wilder Publishing Center.
<http://www.wilder.org/pubs/pubcatlg.html#collabh>

⁵ Graham John R., Barter, Ken. (1999). Collaboration: A Social Work Practice Method. *Families in Society*. Vol. 80 (1) 6-13.

⁶ Community Based Collaboration: Community Wellness Multiplied. Chandler Center for Community Leadership.
<http://crs.uvm.edu/ncco/collab/wellness.html>

- Deschutes, and Jefferson counties - Appendix C
- Northeast Oregon Network-NEON, comprising Baker, Union and Wallowa counties - Appendix D
- Samaritan Health Services, comprising Benton, Lincoln and Linn counties - Appendix E
- Tri-County Safety Net Enterprise, comprising Clackamas, Multnomah and Washington counties – Appendix F

Lessons Learned

Lesson 1

Community collaborative efforts require sharing risks and rewards

Collaboration, as noted above, requires each member to be actively engaged - both in terms of creative problem solving and in the sharing of financial risks and rewards. Several of those interviewed indicated that sharing risk is a barrier to further and more meaningful collaboration. They acknowledge the challenges of moving from competition to consensus building, from working alone to including others from diverse fields and sectors, from thinking mostly about activities and services to also thinking about larger results and strategies, and from focusing on short-term accomplishments to demanding long-term results.⁷ Despite these challenges and changes, there is broad agreement that business must be conducted differently. Having identified that the health system is not as efficient and effective as it could be, those interviewed recognized these collaborative efforts as opportunities to

⁷ Winer, Michael. Ray, Karen. (2000). Collaboration Handbook: Creating, Sustaining and Enjoying the Journey, Wilder Publishing Center.
<http://www.wilder.org/pubs/pubcatlg.html#collabh>

utilize existing resources more efficiently. Furthermore, some communities have used their collaborative effort as a platform for bringing additional resources into their community.

Many discussed the potential of their collaboration to address the perceived inequities of care among the provider/practitioner communities. Others cited the possibility of being able to better influence policy makers and/or leverage new funding, by strengthening their voice and numbers.

Lesson 2

Successful collaborations require the participation of diverse stakeholders

In order for collaborative efforts to be effective, a widely diverse group of stakeholders need to be actively involved. Many of those interviewed agreed that local communities must embrace access to health care as a

These collaborative efforts are opportunities to utilize existing resources more efficiently.

community-wide concern and not one limited to hospitals and practitioners. Many of those interviewed suggested the importance of going beyond “the usual suspects” when building collaborations. Hospitals, safety net clinics, and other private providers must be involved. However, insurers, local health departments, social service agencies, the business community, academic institutions, and labor and faith-based organizations are valuable and needed partners. Many of those interviewed expressed that the broader the representation within a collaborative effort, the deeper the resource pool in terms of skills, funding, and creative problem-solving capacity. Many have involved the broader community through

public forums, kick-off events, interactive summits and conferences, key-informant interviews, and media/press releases. Galvanizing the entire community to “buy in” to the importance of healthy people and health care is seen as an important task of these collaborations.

Lesson 3
Community leadership or “champions” are fundamental

The need for community leadership was identified as a key component to achieving improved access and healthy communities. Leaders who are tenacious in their commitment to making positive change and who share a vision of what that change should look like are essential to successful collaboration.

Leadership and trust among leaders should not be underestimated when developing community-created solutions.

According to those interviewed, little to no positive outcomes can occur without on-going leadership dedicated to the collaboration. These leaders tend to include public health and health provider administrators, academics, researchers, practitioners, government officials, and representatives from faith-based, business and philanthropic organizations. These leaders possess many diverse traits, however an identified theme among them is their authority to make institutional changes and allocate resources to the collaborative effort. It is worth noting that no consumer or advocacy voices were identified as leaders or champions of these local efforts.

It also was noted that trust among leaders is necessary for a collaborative effort to be successful. Building this trust is often challenging due to a lack of

prior experience with working together or to these leaders’ historically competitive roles. Leadership and trust among leaders should not be underestimated when developing community-created solutions.

Lesson 4
Stakeholders must be willing to make financial commitments to the effort

Particularly as community-created solutions evolve, it is important that each stakeholder bring something tangible to the table in the way of resources. As stated above, collaborative efforts involve pooling resources to meet objectives that an individual organization could not reach as easily. The survey responses pertaining to financial commitments were most often framed in terms of the prospect for pooling resources and reducing inefficiencies, rather than implying a need for additional dollars. Seed money, donated staff time, facilities, and technical equipment were mentioned as concrete contributions to community collaborations. All of the communities surveyed see the need for skilled and extensive staffing in order to sustain their collaborative efforts. Although each community recognizes the importance of dedicated staff and infrastructure to support and sustain their community-created collaboration, those interviewed commented on the lack of on-going funding for such vital roles.

Lesson 5
Community-created solutions seek to provide coordinated, comprehensive health care services

Stakeholders in each community expressed that presently, the health care system – both the financing and delivery of services - is in a state of fragmentation. There is no comprehensive policy at the federal or state level ensuring that the basic health

needs of all people are met. As a result of this fragmentation, there are both unnecessary duplications of services as well as large gaps in service. Delivery of health services is local by its very nature; many of those interviewed stressed that their communities are the natural environment for developing solutions. Although developing and implementing strategies for mitigating fragmentation and enhancing the overall coordination of service delivery was identified as laborious and challenging, interviewees believed such improvements necessary.

Consequently, communities are seeking to better coordinate services in many ways. For example: (a) building on the efforts of existing health care safety net clinics, (b) developing information system capacity for sharing health data across institutions, (c) improving communication among providers and other community partners, (d) further coordinating preventive, primary, secondary and tertiary care, and (e) integrating services such as public health, medical care, and behavioral health.

Lesson 6

The long-term goal of community-created solutions is to create stable, sustainable local health care systems

Each community solution is intended to build a stronger, more efficient and more effective way to conduct business. However, all but one community-created solution included in the survey is in an early stage of development. Those interviewed identified several key factors to building and sustaining community created solutions: (a) committed and trusted leadership; (b) time; (c) identifiable short- and long-term outcomes; and (d) shared vision and understanding of challenges, problems, and opportunities; and (e) clear and on-going relationships with both public and private sector leaders. A number of

those interviewed expressed concern regarding the ability to sustain their community-created solutions.

Although many share the commitment to the community collaboration and have invested time and resources to move the work forward, more assistance and time is needed to deliver meaningful outcomes. Those interviewed continue to try to collaborate with more and different partners to help assure the sustainability of their efforts. However, with limited local resources and reductions in technical and fiscal support from the federal and state governments, community-created solutions are often jeopardized.

Lesson 7

Developing collaborative relationships is time-consuming and politically challenging

The most often-cited challenge in forming these relationships is politics, turf and fairness issues, followed closely by busy schedules. Conflict will occur and must effectively be resolved. Nurturing unlikely partnerships is the “bricks and mortar” of building and sustaining a meaningful collaboration.

Delivery of health services is local by its very nature; many of those interviewed stressed that their communities are the natural environment for developing solutions.

Communities must be willing to take the time that is needed (and it will be different for each community) to germinate and nurture new or fragile relationships, to cultivate a shared vision, and to plan strategically. Not only must the collaboration involve diverse stakeholders, a case must be made for how each stakeholder can expect to

benefit and why organizations must be willing to stretch beyond their core missions. State and federal regulations and bureaucracies are often a barrier to successful community-created solutions. Confusion and the lack of relationships with government officials/employees make it challenging to overcome these bureaucratic barriers. In order to attend to the political challenges of community collaborative efforts, committed and skilled staffing is needed. Staff must be responsible for ensuring concrete and timely products or “deliverables”. Stakeholders, including the broader community, must employ a high degree of patience and a broad interpretation of success, when evaluating staff and their community-created solutions, especially in the early stages of the collaborative.

Recommendations for State Support

Those interviewed were asked to offer specific recommendations relating to ways the state could better support community-created solutions that are intended to improve access to needed health services and improve health outcomes within their community. Six general recommendations on how state policy-makers, government officials, and state employees can better support communities build and sustain such innovative efforts were identified.

View and recognize communities as equal and unique partners

- Recognize the important role of communities in improving the delivery of health care;
- Learn from innovations at the local level;
- Involve community stakeholders in a meaningful and on-going fashion;
- *“One size doesn’t fit all.”* Create and support state and local programs that adapt to the differences in how

a community provides health services;

- Realize and support the time and expertise needed to build and sustain community-created solutions that ensure health services; and
- Permit and actively support the development of community-created solutions to providing health services.

Support and strengthen the health care safety net

- Establish and support policies, programs, and services specifically supporting health care safety net providers and populations; the health care safety net is a community’s response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
- Further strengthen infrastructure responsible for supporting Oregon’s safety net;
- Devote adequate funding and staffing for efforts that support safety net development and involvement;
- Encourage the growth of health care safety net providers in underserved communities; and
- Provide information, referral, and technical assistance to communities relating to how/if to pursue the development of a health care safety net clinic.

Provide the “connective tissue” between communities

- Share information and data relating to best practices, lessons learned, and opportunities to receive technical and funding support; and
- Provide opportunities/venues for communities to learn from one another and gain important exposure to innovative outside ideas.

Ensure technical assistance is offered to interested communities

- Help build a common health information system to improve communication and coordination among local/regional providers;
- Gather health data at the local/regional level with community stakeholders;
- Help communities interpret the findings of data;
- Translate data with communities into responsive strategies;
- Assist communities in their efforts to apply for grants;
- Assist with evaluating community-created solutions;
- Assist with identifying appropriate/desired outcomes;
- Provide consultation relating to how to build and sustain community-created solutions; and
- Support and expand the Office of Rural Health’s Community Health Improvement Partnership program, which provides technical support in order to improve local health care systems in rural/frontier Oregon.

Create flexible and supportive policies

- Seek ways to individualize approaches and remove barriers experienced at the local level;
- Provide flexible state policies and regulations to support local solutions to delivering and financing health services;
- Ensure adequate supporting and funding for prevention/public health and chronic care management; and
- See Appendices A-F for *Key Informant Interview Summaries* and Appendix G for further information.

Make financial investments in community innovation

- Stabilize publicly funded programs;

- Provide “seed money” to help collaborations get off the ground; and
- Target grant funding for promising collaborations improving access to needed health services and health outcomes.

A “one size fits all” approach to addressing the fragmentation and inefficiencies of the health system was reiterated as being both unrealistic and inappropriate.

Conclusion

According to those interviewed, policy makers and government officials have an important role to play in promoting and sustaining innovative solutions that help ensure healthy Oregon communities. Possible and appropriate roles for the state were reiterated from leaders in the Willamette Valley, the Tri-County area, as well as Central, Northeastern, and Coastal Oregon communities. While many shared perspectives were evident among the responses of key informant interviews, a “one size fits all” approach to addressing the fragmentation and inefficiencies of the health system was reiterated as being both unrealistic and inappropriate.⁸ Consequently, state leaders, policies, and programs are asked to support community-created solutions if health outcomes for Oregonians are to improve.

Policy makers and government officials have extremely complex roles to play and challenging choices to make – life

⁸ This was also a theme of the 2002 study, *Small Market Communities: Challenges and Opportunities in Serving OHP Enrollees and the Uninsured*. *Office for Oregon Health Policy and Research*.

and death choices. So do local communities, where the delivery of health services actually occurs. These communities cannot afford to continue to do business in the same way. They are no longer willing to allow their neighbors to go without adequate access to quality and needed services. They are building collaborative efforts in order to re-evaluate and re-design how health services are delivered. These communities are convening diverse stakeholders from both public and private sectors. They are bringing time, resources, creative problem solving and tenacious energy to the table. However, these community innovations face many challenges, barriers, and confusion. Consequently, these communities acknowledge that they cannot do all they need without government assistance and supportive public policies.

Appendix A

Survey Summary

Question 1: Innovation of project (Do you see anything about this project that you would identify as innovative and if so, what do you think it is?)

Range of Responses:

Incidence:

Collaboration (the breadth and/or depth of skill, key players/diversity)	(12)
Structure of collaborative	(5)
Scope of the project	(4)
Tenacity of core leaders	(4)
Over-arching shared sense of purpose among leadership and staff	(4)

Question 2: Timing of project (What contributed to this project being undertaken now?)

Range of Responses:

Incidence:

Consensus around health care crisis	(11)
Financial imperative	(4)
Vision shared by key leaders	(3)
“Stars aligned”	(2)
Collaborative efforts provided credibility by earlier successes	(2)

Question 3: Project goals

Range of Responses:

Incidence:

Increase access for uninsured/underinsured	(8)
Achieve 100% Access	(6)
Relationship building	(5)
Shore up existing safety net clinics	(5)
Integrate system/include schools, social service etc.	(5)
Achieving fairness/equity	(4)
Increase efficiency/decrease cost	(4)
Improve measurement tools/capacity	(4)
Provide education/added value to community	(4)
Influence policy	(3)
Project should be replicable	(2)

Appendix A continued

Question 4: Methods/strategies to reach goals

Range of Responses:

Incidence:

Relationship building	(12)
Begin with winnable tasks (“low hanging fruit”)	(8)
Recruit key people	(5)
Network/info-share with others around state/country	(5)
Get provider “buy-in”	(4)
Cultivate ability to share health information	(4)
Partners need to commit tangible resources	(4)
Use of workgroups for targeted issues	(4)
Focus on prevention	(3)
Use of professional facilitation	(2)
Reduce # of medical errors	(1)
Position project to influence funders	(1)
Reduce unnecessary medical care	(1)

Question 5: Sources of project funding and/or projected funding issues

Range of Responses:

Incidence:

Will need FTE designated to project (to maintain)	(6)
Have or will apply for grant funding	(6)
Have utilized donated resources	(3)
Need seed money in order to move project forward	(3)
Need to stabilize funding of project	(1)

Question 6: Desired/achieved outcomes (How will you know if you’ve impacted access, how will service delivery be different?)

Range of Responses:

Incidence:

Track statistical data (E.D. use, immunization rates, surveys etc)	(13)
Improved trust among partners	(6)
Evidence of increased access	(6)
Improved/increased community dialogue	(5)
Increased visibility of project	(3)
Achieve 100% Access	(2)
Improved efficiency/decreased costs	(3)
Better understanding of how to measure projects developmentally	(2)
Sustainability	(1)
Project expands	(2)

Appendix A continued

Question 7: Significant challenges and/or barriers facing project

Range of Responses:

Incidence:

Politics/turf issues	(18)
Fairness/equity issues	(8)
Busy schedules	(7)
Getting provider community on board	(7)
Distance between communities (geographically and/or culturally)	(6)
Project concept hard to grasp/too vague-what are the “products”	(7)
Project too overwhelming/maintaining momentum	(5)
Insufficient data-especially re: unserved/underserved	(6)
Path unclear for undertaking a project of this type	(6)
Scarce number of doctors/recruiting challenges	(4)
Burden of mental health needs	(4)
Risk of becoming a “beacon city”	(4)
Lack of consumer or broader community voice	(4)
Instability of state funding	(4)
Lack of ability to share health information across systems	(4)
Managing inclusiveness	(3)
Cost of medications	(3)
Burden of dental needs	(2)

Question 8: Strategies considered or implemented to attempt to address challenges and/or barriers

Range of Responses:

Incidence:

Honest communication	(9)
Individualize strategies to meet needs of specific community/population	(8)
Focus on building relationships	(6)
Recruit/maintain those participants who are dedicated and optimistic	(5)
Focus on the development process of building the collaborative	(5)
Include a diversity of participants	(4)
Use outside consultants	(3)
Must be willing to give something up	(2)
Invest in electronic health records system	(2)
Use of mediation	(2)
Use of professional facilitators	(2)

Appendix A continued

Question 9: Lessons learned that might be helpful to other communities

Range of Responses:

Incidence:

Investing in the <i>process</i> is key	(15)
Be inclusive	(7)
Build a winning team of principal players	(5)
Build in the public health system	(4)
Get the provider community on board	(4)
Do what is best for patients and communities	(3)
A non-profit is a good convener	(2)
Marketing of the concept is very important	(3)
Use of targeted workgroups is beneficial	(2)
Organizations must be willing to stretch beyond their core missions	(2)

Question 10: What can the state do to assist this project (In the form of policy, technical or agency assistance?)

Range of Responses:

Incidence:

Provide technical assistance (consultation re: data, grant writing etc.).	(15)
Provide “connective tissue” between communities and other models.	(11)
Value that communities have an important role and that each is different.	(10)
Provide seed \$ for project start up/fund promising pilots/programs.	(8)

Appendix B

100% Access Coalition Lane County - Community Profile

Number of interviews conducted: 11

Lane County's 100% Access initiative was conceptualized by a small group of core leaders from United Way, PacificSource Health Plans, Lane Individual Practice Association (LIPA), and the offices of Congressman Peter Defazio and U.S. Senator Ron Wyden. The leaders were struck by the profound needs relating to health care among all sectors of their community as identified by United Way of Lane County's 2004 community needs assessment. Consequently, the United Way convened a small planning workgroup, which resulted in inviting and recruiting community leaders from the public and private sectors to a meeting. At this meeting, leaders were asked the question: "Can we do better with our own resources?" The majority of those in attendance believed that Lane County could do better.

In December 2004, an even broader spectrum of community stakeholders convened to further explore the health of Lane County and begin to identify action steps that would move them toward 100% access. This meeting resulted in five workgroups responsible for exploring and developing strategies related to: medical home, chronic illness/prevention, mental health, medications and insurance/enrollment. These work groups were supported by skilled staff. Each group had a professional facilitator who volunteered their services as well as workgroup champion(s) who were notable for their content expertise and/or their community visibility. Workgroup members were recruited from diverse disciplines. Each workgroup received administrative support donated from numerous coalition organizations.

In May 2005, the five workgroups shared priorities and strategies to move their work forward at a public forum. Several "promising opportunities" were endorsed¹ and workgroups agreed to continue to meet and refine their work plans. In addition to the five original workgroup, a metrics group has been established to address measurement and documentation needs.

Initial seed money was provided by several of the core organizations. This funding contributed to the hiring of a 100% Access Coalition Director/Coordinator and other infrastructure needs. Additionally, the coalition applied for, and received a federal grant, "Healthy Communities Access Program," HCAP. Although many participants expressed the need for a permanent FTE position, there was also a shared perspective that planning should

¹ Promising opportunities defined: All opportunities should result in improved access to health care in Lane County. Other criteria for selecting promising opportunities include: doable locally, leadership momentum exists, immediacy of the opportunity and constituent readiness. Opportunities may utilize resources differently, or may require the development of new resources and systems.

100% Access: A United Way of Lane County Healthcare Initiative.

Appendix B continued

be done without the expectation of any additional resources. This was identified by some informants as a strategic method for keeping participants invested and engaged in the collaborative without being dependent on external or additional funding.

100% Access is coordinated by a steering committee of approximately 20 members. The steering committee reports back to the United Way board. Workgroup members report to the steering committee.

Those interviewed attribute “the convergence of need and willingness” among community stakeholders as key to the development of the collaborative. Furthermore, the breadth and depth of stakeholders and the commitment from leaders who have the authority to allocate resources and make organizational changes were identified as vital to developing the collaborative. The 100% Access Coalition has successfully recruited participants from the provider/practitioner community, hospitals, social service, insurance, business, governmental leaders at the local and the national level, safety net providers and more. One key informant stated the 100% Coalition is the result of “the right people, in the right place, at the right time, talking about the right things”.

Upcoming strategies for improving access

- Establish a community-wide charity care standard.
- Develop, test and implement a health care outreach, eligibility and screening, enrollment, and assignment partnership
- Create, test and implement a Medical Assistance Program Care (MAP Card) Network
- Develop a Volunteer Physicians Network support by the MAP System Navigators, Mental Health Champion and MIS
- Expand availability and enrollment in chronic condition self management groups
- Establish a Coordinated Lane County Pharmacy Program with a unified Prescription Assistance Program (PAP) and 340B program linked to MAP Card eligibility/membership
- Provide earlier, non-institutionalized mental health interventions for uninsured and underinsured individuals through development of 24/7 referral and scheduling capacity, linkage with the MAP Network, and the expansion, coordination and mobilization of lay and professional behavioral health resources
- Develop and pilot a low cost insurance product for non-profit employees with potential application to the small business market

Appendix B continued

100% Access Coalition Members

Organization	Type	Contact
United Way	Human Service/ Non-profit	Priscilla Gould
PacificSource	Insurer	Ken Provencher
U.S. Congressman DeFazio	Elected public official	Libby Page
U.S. Senator Wyden	Elected public official	June Chada
Direction Service	Human Service/ Non-profit	Marshall Peter
PeaceHealth	Hospital	Loren Barlow MD
PeaceHealth	Hospital	Thomas Jefferson MD
LIPA	Insurer	Rhonda Busek
LIPA	Insurer	Terry Coplin
Kathleen Howard Consultants	Private Consultant	Kathleen Howard
St. Vincent de Paul	Human Service/ Non-profit	Terry McDonald
Lane County	Local Government	Steve Manela
Lane County	Local Government	Rob Rockstroh
Temple Beth Israel	Faith	Rabbi Husbands-Han
Oregon Medical Group	Medical Practitioner	Leo Cytrnbaum MD
KidSports	Non-profit Child Recreation Organization	Jim Torrey
Sacred Heart Medical Center	Hospital/Faith	Sister Barbara Haase
McKenzie Willamette	Hospital	Roy Orr
The Ulum Group	Private consultant	Jenny Ulum
Dept of Human Services Health Systems Planning	State government	Laura Brennan

Appendix C

Central Oregon Health Care Collaborative Crook, Deschutes, Jefferson Counties - Community Profile

Number of interviews conducted: 4

Core leaders of the Central Oregon Health Care Collaborative (COHCC) describe this initiative as being in the earliest of developmental stages. Three key leaders, representing Deschutes County Public Health, Volunteers in Medicine, and Clear Choice Health Plans are responsible for generating interest in a central Oregon collaborative and for doing the research and networking necessary to begin moving the conversation out to the broader community.

The COHCC leadership prepared a “concept paper” focusing on the health care crisis and opportunities for addressing cost, quality and access at the local level. These leaders are now selectively distributing the concept paper among key community stakeholders to gauge interest.

Leadership agrees that COHCC is about more than improved access. In other words, access does not improve health in and of itself. COHCC aims to look at the gross inefficiencies within the health care system and begin to examine how to provide access, contain costs, and provide quality health care in a way that is sustainable over time. COHCC asserts that “with its unique geographic location, collaborative medical community, responsive business leaders, and dedicated citizens, Central Oregon can build upon its solid foundation to launch a successful health care initiative that would *reform* health care.”²

The core group is working at broadening its stakeholder involvement and actively in the recruiting. Focus is presently being spent on recruiting the key players with the expectation that they will help to shape the goals and objectives of the collaborative. Recruitment goals for COHCC focus on maintaining a manageable number of partners and enlisting people who have both the time to invest as well as the willingness to commit concrete resources. The group hopes to host a community panel within the next couple months, as well as a summit-type event in the spring. The group is receiving consultation from the Lane County 100% Access coalition and is actively networking with communities across the state and nation who are undertaking or have implemented similar projects.

COHCC seeks start up funding to be able to organize the initial panel as well as coordinate and host the summit in the spring. Concern was expressed over whether this small group can maintain the momentum needed to promote the collaboration during this critical period of development. All members of the leadership group see this project as one that requires a long-term vision and commitment.

² DRAFT White Paper. Central Oregon Health Care Collaborative. September, 2005.

Appendix C continued

Upcoming strategies for improving access

- Disseminate concept paper to key stakeholders
- Host a key-leaders community meeting/panel to build coalition and develop specific strategies
- Host a community summit

COHCC Core Leadership

Organization	Type	Contact
Clear Choice Health Plans	Insurer	Mike Bonetto
Volunteers in Medicine	Safety Net Provider	Christine Winters
Deschutes County	Public Health/ Local Government	Dan Peddycord

Appendix D

Northeast Oregon Network, NEON Baker, Union, Wallowa Counties - Community Profile

Number of interviews conducted: 5

The Northeast Oregon Network (NEON), is a collaborative effort between Wallowa, Union and Baker counties, and was established in August, 2004. NEON was originally led by a small group of individuals who had discussed and recognized the value of a community collaboration to ensure needed and quality health services are provided in an efficient fashion.

NEON is an entirely rural/frontier collaboration led, in large part, by public health and human service organizations. NEON is **not** centered on the direct provision of health care. It is focused on the coordination and efficiency of needed services.

Recruited in part around the prospect of applying for a Rural Health Development Planning grant from the federal Health Resources and Services Administration (HRSA), key stakeholders from the three counties were drawn together to discuss the potential for building a community-created solution to address mutual concerns related to access and health care. Attendance at this initial meeting was much larger than expected. Eleven of the participating organizations wanted to pursue the NEON collaboration whether grant funding was received, or not. Although NEON did not receive the HRSA funding initially, a small group of these leaders continued to meet and plan, with no financial support, throughout this past year.

NEON seeks to create an integrated health care network. To build a strong and sustainable network, key informants stressed the need to (a) involve diverse stakeholders, (b) prepare and follow a strategic plan, and (c) influence local, state and national rural health policies.

NEON is committed to including diverse stakeholders, which includes both public and private partners. Recruiting the provider/practitioner community however, has been a challenge for NEON. Practitioners in rural and frontier areas are stretched extremely thin, as are all NEON members. The distance between each community compounds these challenges further; travel time and unmet expenses have made recruitment difficult. Marketing the concept has also been somewhat challenging, as some stakeholders have found the project amorphous and difficult to grasp. When it was learned that the HRSA grant had not been initially awarded the numbers of those actively participating in the Network, dwindled substantially.

Collaboration is a familiar way to do business throughout northeast Oregon. Nevertheless, recruiting key stakeholders, laying the foundation and infrastructure for NEON, and “nurturing alliances” each require a great deal of time and must be done with the utmost care. Key informants pointed out that each stakeholder involved in NEON wears “multiple hats” in their rural communities. According to some key informants, “You don’t often get a second chance in rural communities if you mess it up the first time.” NEON members stated that adequate time and

Appendix D continued

skilled staff specifically dedicated to the collaborative are important to achieve positive outcomes.

NEON members see the potential for NEON to facilitate innovative services tailored to specific areas and to create meaningful system changes. Members of the NEON recognize the importance of timely concrete outcomes, and yet anticipate tangible outcomes may take one or two years.

In September 2005, HRSA informed NEON that there were funds left over from the previous grant cycle. Consequently, NEON was awarded \$72,000 to plan their collaborative. This incentive provided an important outcome for NEON, and allows the Network to hire .3 FTE staff. NEON submitted another federal government grant application to assist in the considerable planning and development necessary to move the collaborative forward.

Upcoming strategies to improve access

- Reconvene earlier partners
- Actively recruit provider/practitioner community
- Hire Kristen West from CHOICE Regional Health Network/Communities Joined in Action to assist in strategic planning
- Hire consultant to help set-up and train NEON members in using GIS
- Hire a consultant to help conduct a tri-county feasibility study relating to a Federally Qualified Health Center (FQHC)
- Hire FTE to assist in the administration of NEON
- Evaluate potential projects for most promising opportunities

Some Additional Potential Strategies are:

- Integrated Mobile Access Teams
- Development of Traumatic Brain Injury Resources
- Dental Services for uninsured patients
- Expanded Community Resource Team (CRT) Model
- Access to Free Medication Assistance Program
- Prescription Drug Abuse Screening Protocol

Appendix D continued

Northeast Oregon Network Members

Organization	Type	Contact
Center for Human Development Inc.	Non-profit/ Public health	Lisa Ladendorf
Elgin Health Clinic (OHSU)	Safety Net/ Public Teaching Hospital	Ginny Elder
Grande Ronde Hospital	Hospital	Vicki Hill Brown
Union County Commission on Children and Families	Human Services/ Local Government	Vicki Brogoitti
Wallowa County Commission on Children and Families	Human Services/ Local Government	Ann Gill
Wallowa County	Public Health/ Local Government	Laina Fisher
Wallowa Memorial Hospital	Hospital	Tami Perrin
Wallowa Valley Mental Health Center	Human Services/ Non-profit	Stephen Kliewer
Mountain Valley Mental Health Programs Inc.	Human Services/ Non-profit	Tim Mahoney
Baker County Commission on Children and Families	Human Services/ Local Government	Judy Barzee
Baker County	Public Health/ Local Government	Debbie Hoopes
Seniors and People with Disabilities	Human Services/ State Government	Libby Goben
School of Nursing (OHSU)	University	Jeannie Bowden
State House District 57	Elected Official	Representative Greg Smith

Appendix E

Samaritan Health Services Benton, Lincoln and Linn Counties - Community Profile

Number of interviews conducted: 7

Samaritan Health Services (SHS) is a non-profit organization, serving approximately 250,000 residents throughout Linn, Benton, and Lincoln counties as well as in portions of Polk and Marion counties. SHS is locally owned and directed by leaders from each of its five hospitals, physicians, and community representatives from throughout the region. Samaritan Health has over 150 affiliated physician primary care clinics and an independent/assisted living facility. SHS offers several insurance related services. SHS self-insures its employee and their dependents and has a Medicare product for eligible beneficiaries living in Linn, Benton and Lincoln counties. As an option for external employers, SHS offers Third Party Administration (TPA) to self insured groups. Within the upcoming year SHS will launch an insurance product for the Public Employees Benefit Board (PEBB). Furthermore, SHS has a managed care plan under contract with the state of Oregon to administer the Oregon Health Plan in Linn and Benton counties known as the InterCommunity Health Network (IHN). IHN was founded in 1993 by Albany General, Good Samaritan and Lebanon Community hospitals, and serves 16,000 Oregon Health Plan members in Linn and Benton counties. Although IHN's contract with the state of Oregon is not exclusive, it is currently the only managed care organization (MCO) in Linn and Benton counties that administers the Oregon Health Plan.

The early leaders of SHS and its partnering organizations came together around a very cohesive vision which has since been translated and embraced by the larger community throughout the region. Periods of distrust among partners in the developing stages of the collaborative existed. Key informants indicated the importance of a clear vision, tenacious leadership, and nurturing relationships were significant to the success of SHS.

Key informants identified several reasons for the achievements of SHS. Agreement was expressed that SHS's vision and commitment to "patient-centric" and community-based care contribute to it being an effective collaborative. In the early period of consolidation, SHS went to a model of equal pay for equal work. This has evidently engendered genuine buy-in from the practitioner community whose level of engagement and coordination with the regional hospitals is extremely high. Another innovative element is SHS's Social Accountability Budget or "institutional tithing". SHS allocates up to 10% of the previous years net revenue to support a variety of community health initiatives. These initiatives focus on unmet community needs and collaboration, prioritize prevention, measure and disseminate progress results throughout the wider community, plan for self-sufficiency, and operate efficiently.

Appendix E continued

SHS supports safety net clinics in East Linn, Corvallis, Albany, and in Lincoln City through financial contributions, sharing lab technologies, and providing free medications through a limited generic formulary. In addition, SHS has developed the Samaritan Health Medical Assistance Program which takes patients with complex conditions who require brand name pharmaceuticals and helps them to apply for pharmacy assistance programs.

Some concern was expressed that SHS's value of turning no patient away may result in the region becoming a "beacon" for people who are low-income or uninsured. Eligibility criteria may be needed to manage demand from people outside of the service area. In addition, because much of the decision-making is consensus driven, it takes more time. There is a strong value for communication across and between systems and as a result, SHS is moving toward developing the capacity to share electronic health records. This is seen as a concrete and needed step toward better coordination and access, yet is extremely complex and time consuming.

Community partners involved with SHS indicated many benefits of working collaboratively. While there was acknowledgement that SHS is "the only show in town" due to the size and scope of its consolidation, most informants expressed appreciation and benefit in SHS's willingness to bring needed resources on the table. Others note that SHS is in a position to spearhead certain kinds of initiatives that other public or private/non-profits would be less able to undertake due to differing mandates, resources and level of political persuasiveness. There was a sense among some that nurturing the relationship between SHS and local health departments is still an area which requires growth. There have however, been several successful joint partnerships between local health departments and SHS including maternal child health services, emergency preparedness and community health planning in Lincoln county.

Upcoming strategies to improve access

- Develop electronic health records capacity
- Develop broader partnerships with the business community
- Further develop partnership with county health departments
- Undertake a systematic assessment of community resources/gaps to promote greater coordination

Appendix F

Tri-County Safety Net Enterprise Clackamas, Multnomah, Washington - Community Profile

Number of interviews conducted: 7

The Tri-County Safety Net Enterprise (SNE) is the result of an intergovernmental agreement between Multnomah, Clackamas and Washington Counties. The three Counties created the Enterprise to align public and private access efforts for low income and uninsured residents into a cohesive regional approach. Its major objectives are to (a) create community ownership and accountability for the health care safety net, (b) assure all underserved residents have access to affordable and appropriate medical care, and (c) improve the environment for those caring for low income and the uninsured.

The Enterprise formed as a result of the Robert Wood Johnson's Communities in Charge project, a 3-year planning and development grant. After 3 years of relationship and trust building, researching best practices, and strategically planning, the Enterprise was developed in 2004. This intergovernmental structure is the only one of its kind focused on health care issues in the state. The mission of the Enterprise is to support and improve healthcare access in the three counties.

In creating the Enterprise, the three Counties also created an independent board. The board is comprised of three county commissioners (one from each county), three hospital administrators, three safety net providers, three public health directors, a member from the Oregon Primary Care Association, an Oregon government official, and one consumer. Some key informants identified that a more diverse board may assist the Enterprise in moving forward with its objectives. For example, including business, insurers, faith, and other sectors could broaden resources and expertise. Although an independent board, the Enterprise is still a public entity. Washington, Multnomah and Clackamas are very different counties, with varied governance structures, diverse demographics, and significantly different socio-political cultures. It was noted that these differences must be understood and appreciated while moving forward with any and all collaborative efforts.

The Enterprise is funded by a Healthy Communities Access Program (HCAP) grant from the federal government. Enterprise stakeholders acknowledge that seeking long-term sustainable funding for the collaboration is one of the essential next steps. There is not yet consensus on how the Enterprise should be funded.

The Enterprise continues to clarify its role in the community, its relationship with other access efforts, continues to interpret its mandate, and align its leaders around a shared vision. Key informants identified the importance of, and time involved in, building relationships and trust in order to produce positive outcomes. The Enterprise was recognized as playing a significant role in bringing the three distinctly different counties and county governments into an alliance

Appendix F continued

around health care. It has supported or led community efforts such as the Maternal Newborn Care Access Workgroup, which aims to develop a coordinated system of health care access for all pregnant women in the region, and the continuing effort to expand coverage for uninsured pregnant women statewide. The Enterprise is also working to further identify the highest access needs within the three counties by working with OHSU to create a complete picture of what is happening in community emergency departments. However, some informants expressed the need for immediate and more tangible outcomes to sustain the collaborative.

In 2005-2006, the Enterprise plans to work more effectively in the community to (a) build community relationships, (b) provide partner organizations with technical assistance, and (c) represent the regional health care safety net, and (d) convene a broad advisory group to develop community involvement and accountability for health care access.

Upcoming strategies to improve access

- Build on a pilot project completed in partnership with the Medical Society of Metropolitan Portland and the Coalition of Community Clinics, introduce and implement ‘Project Access’ across the region
- Expand pharmacy services to safety net clinics
- Based on what is learned from regional emergency department utilization information, identify and implement focused primary care access strategies, such as siting and opening new service delivery sites
- Participate in/support hospital charity care discussions

Appendix F continued

Tri-County Safety Net Enterprise Board

Organization	Type	Contact
Multnomah County Commissioner	Elected Official	Serena Cruz
Providence Milwaukie Hospital	Hospital	Jacquelyn Gaines
Department Human Services	State government	Bruce Goldberg, M.D.
	Consumer	Bill Hancock
Oregon Primary Care Association	Safety net	Craig Hostetler
Washington County	Human Services/ Public Health/ Local government	Susan Irwin
Virginia Garcia Memorial Health Center	Safety Net	Gil Muñoz
OHSU	Public Teaching Hospital	Peter Rapp
Washington County Commissioner	Elected Official	Dick Schouten
Clackamas County Commissioner	Elected Official	Martha Schrader
Multnomah County	Public Health/ Local government	Lillian Shirley
Clackamas County Safety Net	Public Health	Alan Melnick, M.D.
Clackamas County	Public Health/ Local government	Maryna Thompson
Native American Rehabilitation Assoc. of the Northwest, Inc.	Safety net	Jackie Mercer
Tuality Healthcare	Hospital	Dick Stenson

Appendix G

Policy and Program Recommendations for State Government Selected Responses from Key Informants^{II}

View and recognize communities as equal and unique partners

- Ensure that public and private sectors are being treated with fairness and equitably, note economies of scale.
- Measure successes thru outputs and “products” *as well as* the value of community development.
- Regard that local collaborations require time and plenty of “feeding and watering” as they develop.
- Invest in piloting innovation at the local level (“low-risk”).
- Share information about community collaborations into “layman’s” terms so legislators and other state decision makers can better comprehend and address the issues with communities.
- Tailor policies and programs to reflect the specific benefits and challenges of rural/frontier communities, e.g., grant programs which impose population requirements that are too steep for many rural communities, funding requirements which do not allow for reimbursement of travel time/expenses, physician recruitment regulations which do not make it plausible for new doctors to locate in rural communities i.e. the 40 hours per week direct service requirement).

Support and strengthen the health care safety net

- Stabilize the Oregon Health Plan and develop legislative priorities which place value on health, education and well-being.
- Require every licensed provider see Medicare and Medicaid patients.
- Ensure capitation payments to Medicaid managed care plans are ensuring access to care for patients (medical, dental, and mental health).
- Encourage communities to apply to be Federally Qualified Health Centers (FQHC).
- Require Medicaid managed care plans contract with FQHC’s and other qualified safety net providers.
- Ensure reimbursement for safety net clinics and other primary care providers for behavioral health services (integration of primary and mental health care).
- Make licensing of out-of-state doctors easier in Oregon to promote volunteering in safety net clinics.
- Emphasize and pay adequately for prevention services.

^{II} Recommendations may fall into one or more category, however for brevity they are only listed once.

Appendix G continued[¶]

- Utilize certificate of need programs more often and effectively.

Provide the “connective tissue” between communities

- Provide better coordination and communication between public and private health services.
- Create venues for communicating and learning from local and national community leaders.
- Provide information relating to stability, grants, and best practices.
- Sponsor forums such as the Oregon-Washington 100% Access Summit.

Ensure technical assistance is offered to interested communities

- Work with communities that want to do something different around obtaining Medicaid waivers.
- Promote inter-operability between systems through monitoring, evaluating and helping to shape the public will.
- Embrace/employ *Communities Joined in Action* assistance around measurement and best practices to improve health care access at the local level (Return on Community Investment principles).
- Provide consumer data on quality that looks at the variations of health care opportunities around the state and analyze why those variations exist. State can highlight and mitigate (if necessary) these variations.
- Offer technical assistance, e.g., evaluation, grant writing, infrastructure development.

Create flexible and supportive policies

- Ensure a health policy expert/advocate within the Governor’s office, who can be the point person for community efforts around health care.
- Un-encumber or de-categorize money.
- Reduce the bureaucratic requirements (“for every hour of clinical service there is 35 minutes of supporting paperwork”).
- Pursue Medicaid presumptive eligibility policy for homeless people.
- Create anti-trust “safety zones” around collaborative efforts.
- Reinvest the health care premium dollars into prevention programs.
- Tort reform.
- Disconnect the health care dollar from the individual-pursue a demonstration project through the Medicaid waiver.

[¶] Recommendations may fall into one or more category, however for brevity they are only listed once.

Appendix G continued[¶]

Make financial investments in community innovation

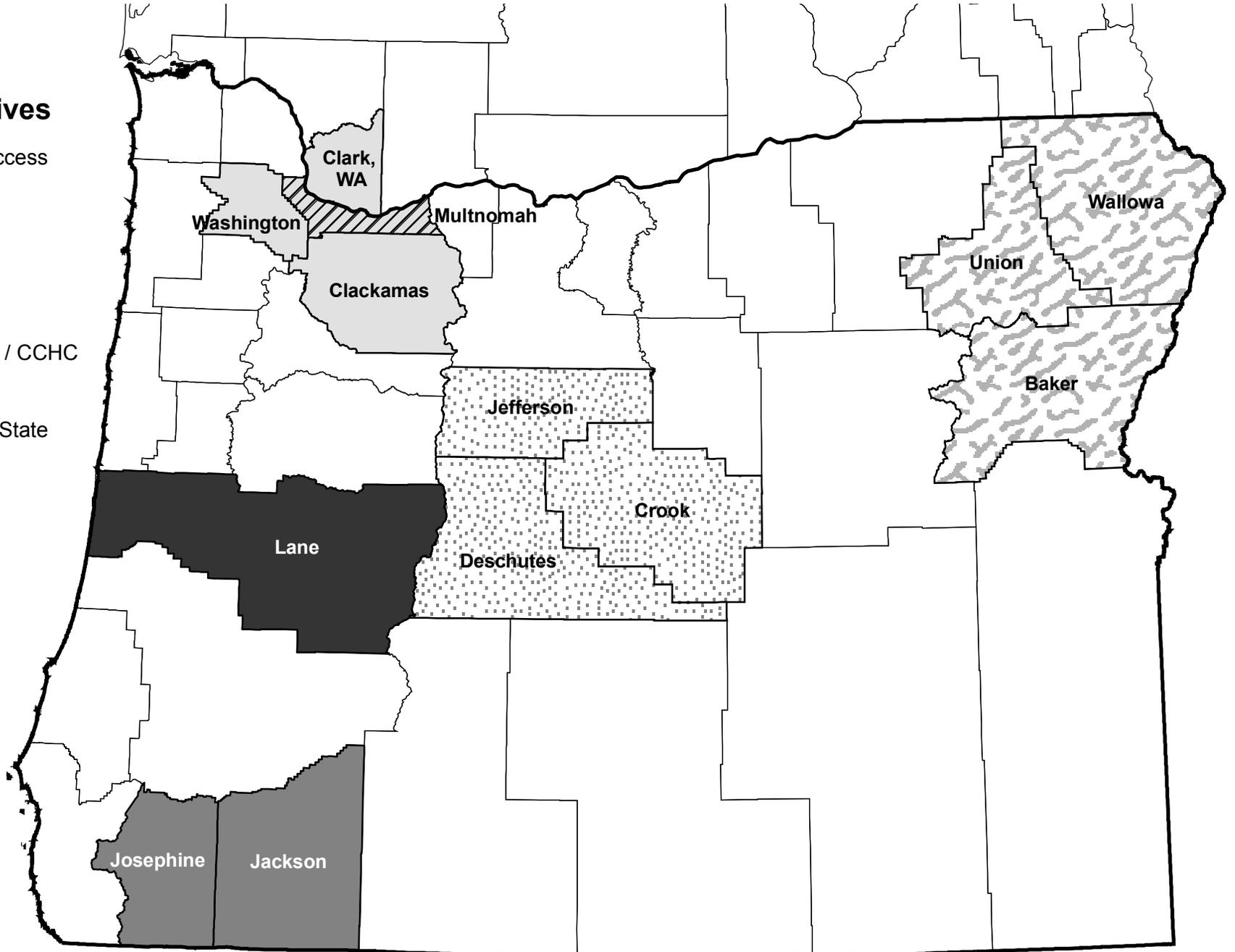
- Engage in more public/private partnerships with foundations to support communities.
- Offer seed funding for community-created solutions.
- Connect economic development and health status.
- Replicate electronic health records capability and interoperability at the local level throughout the state.

[¶] Recommendations may fall into one or more category, however for brevity they are only listed once.

2007 Community Health Access Collaboratives in Oregon State by Counties Served

Collaboratives

- 100% Access
- COHC
- JRHA
- NEON
- PANOW
- PANOW / CCHC
- Oregon State





LESSONS FROM LOCAL ACCESS INITIATIVES: CONTRIBUTIONS AND CHALLENGES

Karen Minyard, Deborah Chollet, Laurie Felland, Lindsey Lonergan,
Chris Parker, Tina Anderson-Smith, Claudia Lacson, and Jaclyn Wong

August 2007

ABSTRACT: Community health initiatives—locally crafted responses to health care access problems—have been steadfast in their efforts to connect uninsured and medically indigent people to health care services and health insurance. These programs assist in outreach, coordinate and integrate care, and help clients use limited resources efficiently. This report offers five case studies of community health initiatives. All five local community initiatives seek to improve access and coverage for those most likely to be uninsured: low-income, nonelderly adults. Some, like Community Health Works in Forsyth, Ga., offer coverage for a limited period of time, often for individuals who seek care after contracting an illness, while others, like Choice Regional Health Network, in Olympia, Wash., manage care for clients with complex needs, chaperoning them through systems they characteristically have trouble navigating.

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Lei Zhang and Karen Fink patiently coded many pages of interview notes, and Lei Zhang investigated and summarized the literature on the replication and transfer of innovation.

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EXECUTIVE SUMMARY

The United States health care system is plagued with at least three serious problems: rising costs, deterioration of the health care safety net, and inadequate public and private health insurance. With 47 million people uninsured, comparative health statistics that rank the U.S. below other industrialized nations, and wide performance variations within the country, it is clear that bold strategies—requiring public and private resources from national, state, and local levels—are essential.

Community health initiatives—locally crafted responses to health care access problems—have been steadfast in their efforts to connect uninsured and medically indigent people to health care services and health insurance. Typically, they unite community leaders, providers, and other key stakeholders, building on good-faith relationships to reduce uncompensated care and support the local safety net.

Recognizing that merely referring people with complex medical and social needs to care is often insufficient, these initiatives assist in outreach, coordinate and integrate care, and help clients use limited resources efficiently. Previous research has catalogued and described individual community efforts, evaluated the results of specific funding programs, explored how local efforts can substitute for national or state programs, and examined the role of local efforts in changing national policy. This study offers new insights about community initiatives and the successes and challenges they face. Findings fall into the following three areas: 1) the critical importance of state context; 2) the need for community health initiatives and, paradoxically, the difficulty of sustaining them; and 3) the challenges of replication.

The research team developed case studies of five community health initiatives that seek to improve access and coverage for those most likely to be uninsured: low-income, nonelderly adults.

Highlights from the five case studies include:

- Community Health Works in Forsyth, Ga., has served nearly 4,000 uninsured residents with incomes at or below 200 percent of the federal poverty level since 2001. The program emphasizes appropriate use of services and a rigorous case management element across the continuum of care, and enrolls only residents with any of four specific chronic diseases: hypertension, diabetes, heart disease, or

depression. Community Health Works estimates that its clients use 40 percent less hospital care and 18 percent less emergency room care than a national control group.

- The General Assistance Medical Program (GAMP) in Milwaukee, Wis., served approximately 26,000 county residents in 2004 with incomes less than \$902 per month. The program makes services available at 17 clinics (including federally qualified health centers) in 23 sites and 10 local hospitals. It leverages millions of national, state, and local dollars to serve the county's uninsured.
- Choice Regional Health Network in Olympia, Wash., helps people enroll in Medicaid, the State Children's Health Insurance Program (SCHIP), and the Washington Basic Health Program. The program has enrolled as many as 17,000 local residents since 1996. Ninety-eight percent of its applications result in enrollment (compared with 4% of individuals who enroll on their own) and 96 percent remain enrolled three years later (compared with 40% who enroll on their own).
- Community HealthLink's Health Care Access Program in Ratcliff, Ark., is a network health insurance plan currently serving 120 working uninsured residents with incomes below 300 percent of the poverty level. Employers and employees support two-thirds of the cost of coverage, and HealthLink has developed a subsidy fund to cover the final third.
- Project Access in Wichita, Kan., serves uninsured residents with incomes below 200 percent of the poverty level. The program enrolls eligible residents when they seek care for a health problem and links them to a "medical home" for ongoing primary care. The program covers primary care for three months and specialty care for six months.

Success Factors and Barriers

Context matters. Across the five case studies, it is apparent that state political, economic, and social context matters. Local programs can support or complement state public and private insurance programs, but are unlikely to thrive independently. Community initiatives that do not capitalize on state policies and resources struggle against greater barriers.

Sustainable leadership, funding, and evaluation. Despite their value to both individuals and the community as a whole, local initiatives are difficult to sustain. Community leaders identified several organizational attributes as necessary for sustainability: strong, dedicated leadership; funding sources, including provider volunteerism, Medicaid partnerships, and federal grants; and data to evaluate and demonstrates initiatives' success.

Challenges of replicating local initiatives. Diffusion of innovation among community health initiatives is more likely when there is extensive face-to-face communication between individuals in the original and replication sites, and when there are contextual and organizational factors that are common to both sites. This research indicates that important contextual factors include strong local leadership, high levels of knowledge among interconnected parties, and a state environment with opinion leaders and change agents who value local innovation.

Policy Implications

Organizing local resources to contribute to health care access and health status improvement is a critical and often neglected component of the health care system. Local initiatives provide bridges to public and private coverage, create steps to care for those who are not covered, and serve as a vehicle for investment.

Because all community health initiatives are, in effect, created by national and state policy, it follows that changes in policy would cause the initiatives to adapt and change. Policy change in the current environment, however, would not eliminate their purpose: to serve low-income residents at the edges of both public programs and private coverage. Some proposals at the national level—in particular, block grants to finance Medicaid—could greatly increase the need for community initiatives if states were forced to respond by narrowing program eligibility. Without greater resources for community initiatives, however, the volunteerism they rely on would be strained and could fray.

Other national proposals—in particular, those that offer new opportunities for financing coverage—might be used to provide much-needed support to these programs, if care were taken to define qualified coverage to include that offered through community initiatives. In turn, the initiatives could leverage and amplify the value of those funds. For example, refundable tax credits could be used to buy the coverage offered through these networks and their providers. Community initiatives also might be allowed to qualify as “association health plans” that could enroll any small group that includes a threshold proportion of low-wage workers. Small employers might offer these programs as an option available to low-wage workers or to their entire group. Certainly such proposals would warrant careful review by state insurance regulators, but they may be quite feasible with narrow and strategic changes in regulation and oversight and highly beneficial to workers who otherwise could not afford coverage.

LESSONS FROM LOCAL ACCESS INITIATIVES: CONTRIBUTIONS AND CHALLENGES

INTRODUCTION

The United States health care system is plagued with at least three serious problems: rising costs, deterioration of the health care safety net, and inadequate public and private health insurance. With 47 million people uninsured, comparative health statistics that rank the U.S. below other industrialized nations, and wide performance variations within the country, it is clear that bold strategies—requiring public and private resources from national, state, and local levels—are essential.

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Recognizing that merely referring people with complex medical and social needs to care is often insufficient, these initiatives assist in outreach, coordinate and integrate care, and help clients use limited resources efficiently. Previous research has catalogued and described individual community efforts, evaluated the results of specific funding programs, explored how local efforts can substitute for national or state programs, and examined the role of local efforts in changing national policy. This study offers new insights about community initiatives and the successes and challenges they face. Findings fall into the following three areas: 1) the critical importance of state context; 2) the need for community health initiatives and, paradoxically, the difficulty of sustaining them; and 3) the challenges of replication.

METHODS

The research team developed case studies of five community health initiatives that intentionally or de facto replicated significant components of previously implemented community initiatives. Over 18 months, the researchers visited each of the five sites: Wichita, Kan., Milwaukee, Wis., Ratcliff, Ark., Forsyth, Ga., and Olympia, Wash. Selected to represent a range of geographic areas and operational models, each of these initiatives provides coverage, access to care, or both to individuals who have difficulty finding or navigating among conventional insurance arrangements and public programs.

To derive lessons for sustainability and replication, the study team:

- described the initiatives' efforts to increase coverage or access and the impact of these efforts on their target populations;
- examined the cost-effectiveness and efficiency of their operations;
- identified factors that affected their sustainability and expansion; and
- examined how states and communities cooperated to close gaps in funding and access.

To conduct this research, the study team obtained feedback about the research design from public and private experts; developed beta-site selection criteria and selected the sites; assembled all available information about each initiative; developed interview protocols; and conducted site visits with 10 to 25 key informants in each site, meeting with a total of 82 informants. Following the site visits, all information was integrated, coded, and uploaded to a qualitative database (ATLAS.ti). Analyses of intent, effectiveness, sustainability, replication, state/community interface, and leadership were developed for each site, and comparative analyses were developed across sites.

LOCAL INITIATIVE CONTRIBUTIONS AND CHALLENGES

Local initiatives can make several types of contributions to the larger national, state, and local system. These contributions include: chaperoning people through the system and changing patient behavior patterns; drawing resources to the community; improving efficiency; creating innovation; and garnering grassroots support for solving these problems. However, these local contributions do not come without challenges. This research sheds light on the challenges that communities face: context (i.e., the political, economic, and social environments); replication; and the financing, leadership, and evaluation necessary for sustainability. All five of the cases touch on all contributions and challenges to varying degrees; however, there tends to be a dominant theme for each case that serves as an illustration of a contribution or a challenge or both.

SITE HIGHLIGHTS

1. Access and Coverage

All five local community initiatives seek to improve access and coverage for those most likely to be uninsured: low-income, nonelderly adults. The programs that offer coverage typically provide comprehensive benefits for a limited period of time, often for individuals who seek care after contracting an illness. Other programs manage care for clients with complex needs, chaperoning them through systems they characteristically have trouble

navigating. Community leaders see the programs as important stop-gap measures for a failing health care system, and recognize that they cannot address the health care needs of all the uninsured in the community.

Examples of these programs include:

- Community Health Works in Forsyth, Ga., has served nearly 4,000 uninsured residents with incomes at or below 200 percent of the federal poverty level since 2001. The program emphasizes appropriate use of services and a rigorous case management element across the continuum of care, and enrolls only residents with any of four specific chronic diseases: hypertension, diabetes, heart disease, or depression. Its provider network includes three hospitals, two clinics, nearly 100 physicians, and 21 pharmacies that work with a medication bank to provide access to affordable prescription drugs. There is a waiting list for admission to the program.
- The General Assistance Medical Program (GAMP) in Milwaukee, Wis., is a county-operated managed care organization that purchases services for its clients. In 2004, it served approximately 26,000 county residents with incomes less than \$902 per month. The program makes services available at 17 clinics (including federally qualified health centers) in 23 sites and 10 local hospitals. GAMP providers accept Medicaid rates.
- Choice Regional Health Network in Olympia, Wash., helps people enroll in Medicaid, the State Children's Health Insurance Program (SCHIP), and the Washington Basic Health Program. The program has enrolled as many as 17,000 local residents since 1996.
- Community HealthLink's Health Care Access Program in Ratcliff, Ark., is a network health insurance plan currently serving 120 working uninsured residents with incomes below 300 percent of the poverty level. Together, employers and their employees who enroll in the program support two-thirds of the cost of coverage. HealthLink has developed a subsidy fund to cover the final third. The program's provider network includes two tertiary care hospitals, four critical care access hospitals, six primary care clinics, four mental health counseling centers, and 200 medical specialists. Network providers agree to accept Medicare rates and to continue seeing patients whose care may exceed the plan's reimbursable limit.
- Project Access in Wichita, Kan., serves uninsured residents with incomes below 200 percent of the poverty level. The program enrolls eligible residents when they seek care for a health problem and links them to a "medical home" (i.e., a primary

care practice that provides them with accessible, continuous, and coordinated care) for ongoing primary care. The program covers primary care for three months and specialty care for six months. It connects more than 600 physicians with local hospitals, six outpatient clinics, 36 dentists, and 69 participating pharmacies. The program served 625 uninsured residents in 2004 and has served nearly 4,500 residents since 1998.

2. Cost and Effectiveness

In each community, interviews for this report found that local leaders contend that providing more appropriate care is cost-effective for both providers and the community. The initiatives use various strategies to control cost. These include cost-sharing in the form of modest copayments, administrative fees, or membership dues; and health care providers bearing significant risk in the form of discounted rates or capitated reimbursement.

While few of the initiatives had made the necessary investment to develop strong evidence of cost-effectiveness, some were able to demonstrate cost-effectiveness on selected measures or a positive return on investment. For example:

- Community Health Works estimates that its clients use 40 percent less hospital care and 18 percent less emergency room care than a synthetic control group developed from national data.¹ Moreover, the probability that a client has an inpatient stay declines the longer the client stays in the program²—inpatient stays had decreased by 20 percent in the first six months, and by the time clients were in the program for 24 months, their inpatient stays had decreased by 40 percent.
- Choice Regional Health Network claims success in enrolling and retaining eligible adults in the Washington Basic Health Plan. Ninety-eight percent of its applications result in enrollment (compared with 4% of individuals who enroll on their own) and 96 percent remain enrolled three years later (compared with 40% who enroll on their own). For each dollar the participating hospitals have invested to enroll eligible uninsured in state programs, Choice estimates that they have received \$20 from increased reimbursement.
- GAMP reports it has raised an additional dollar for every local dollar used to pay for the care of individuals enrolled in the program—offering a 100 percent rate of return to local funds, not even considering potential gains made in population health and efficient use of care.

SUCCESS FACTORS AND BARRIERS

Context Matters

At the community level, lack of access to health care coverage takes on personal aspects lacking in the national debate: it affects friends and neighbors struggling either to find care or to provide it. Communities motivated to organize a response to this problem typically look to other successful local initiatives as models. Often, they are unaware of the contextual factors that help or impede the success of the local programs they seek to replicate. For example, a program that builds on private insurance may succeed in a state with a strong culture of employer coverage, but is more difficult in a state where employers are reluctant to offer coverage.

Across the five case studies, it is apparent that state political, economic, and social context matters. Local programs can support or complement state public and private insurance programs, but are unlikely to thrive independently. Community initiatives that do not capitalize on state policies and resources struggle against greater barriers. Several measures of state context seem especially useful in differentiating whether a community initiative can survive and succeed, as follows:

- *Supportive public programs or a strong private insurance base.* Programs that leveraged either of these resource were generally larger and more successful. Conversely, it is extremely difficult to succeed by attempting to leverage a weak base. For example, in Olympia, Wash., the Choice Regional Health Network focuses exclusively on enrolling eligible individuals in the state's arsenal of strong public insurance programs: Medicaid, SCHIP, and the state-funded Washington Basic Health Plan. However, in Ratcliff, Ark., where employer coverage is low statewide, Community HealthLink struggles to encourage employers to offer and contribute to coverage.
- *State-level vision and supportive programs and policies.* The willingness of states to make regulatory exceptions and work cooperatively with initiatives can be essential to their survival. For example, Arkansas exempted the local initiative from state insurance regulation, easing its implementation and lowering start-up costs; Georgia assembled a public/private partnership to give grants and technical assistance for local network development; Kansas extended malpractice insurance to providers in safety-net clinics and placed state program eligibility specialists in the clinics; Washington changed charitable immunity laws and also contracted with Choice to provide outreach and enrollment services; and Wisconsin provided block grants and allowed the local initiative to use disproportionate share hospital (DSH) funds—a payment adjustment under Medicare for hospitals that serve a relatively large volume of low-income patients.

- *Community and provider culture.* Most community initiatives rely heavily on providers and other community members volunteering time and services. Both a strong provider sense of attachment to the community and a sense of a common future are critical. For example, in Milwaukee, GAMP's network providers accept Medicaid rates; in Ratcliff, Ark., HealthLink's network providers accept Medicare rates and also take on financial risks for care that exceeds the plan's reimbursement limits.

Sustainable Leadership, Funding, and Evaluation

Local initiatives typically offer a bridge to public and private coverage, creating steps to coverage and care for individuals who are eligible but have difficulty in finding coverage, staying insured, or assembling the care they need within available coverage. Local initiatives also offer communities a vehicle for investment in the form of grants, state contracts, and organized volunteerism. Without such initiatives, there may be no entity in the community able to receive or organize these resources.

Despite their value to both individuals and the community as a whole, local initiatives are difficult to sustain. Community leaders identified several organizational attributes as necessary for sustainability. These include:

- *Strong leadership.* Successful program directors had a strong business sense, creativity, and dedication.
- *Funding.* Local access initiatives need partnerships that result in payment for services, government funding, and grants.
- *Evaluating outcomes.* It is essential that local access initiatives be able to demonstrate their value over time to a wide array of stakeholders.

Strong leaders were able to create programs that were solidly grounded in the needs of the target population. They flexibly adapted to the changing environment and engaged in a continuous blending of programs to shape a complete portfolio connecting their clients to care. In two cases the initiative directors has previously been part of state government. These long and trusted relationships translated into financial contracts between the local initiative and the state.

Obviously, funding is essential to the sustainability of these programs. Each relied on provider volunteerism to some degree. Health care providers, too, bear significant risk in the form of voluntary participation, discounted rates, or capitated reimbursement. However, community and program leaders recognized that reliance on volunteerism

ultimately would limit programs' potential for growth. Communities walk a thin line between physicians' desires to serve and their fear of being taken advantage of by the system.

With diminished grant funding and increasing numbers of uninsured, program leaders have fought to maintain services for the uninsured. Four of the five programs may be financially sustainable in the short run, but all recognize that ongoing sources of funds are needed in the long run. Foundations, provider–members (providers who are partners in local initiative and donate their services or take lower payments), Medicaid partnerships, and federal grants have been important sources of funding for these initiatives. For example:

- Project Access has built sustainable funding for its \$2 million operating budget from diverse sources. Physicians and hospitals provide donated care. Local governments pay for prescriptions, and a local community foundation supports the dental component of the program. An ongoing relationship with the local United Way pays for basic staffing. All these partners are committed to continue. Additional funding has come from a federal grant and a national foundation.
- GAMP has funding from a county tax levy (\$15.6 million in 2003) and a combination of state and federal government block grants and DSH payments (\$33.8 million). The program also receives revenue from the application fee.

Finally, community leaders frequently mentioned the importance of having data to evaluate and demonstrate the initiatives' success. Better information might help the initiatives obtain additional funding, but the organizations typically lack the resources to create data systems.

CHALLENGES OF REPLICATING LOCAL INITIATIVES

Successful replication of community health initiatives in a larger number of communities could help more people find coverage and help the uninsured obtain care. Previous studies of replication have investigated how innovations become diffused among individuals or organizations. These studies suggest that replication is more difficult when the innovations are complex, the network organizations are complex, and there are differences between the initial (alpha) and replication (beta) sites. Conversely, innovations are most easily transferred when they are simple and benefits are easily observable.

Initiatives to improve access are necessarily complex, and their results are not quickly or clearly observable. Therefore, it should not be expected that the transfer of access innovations from community to community would come easily or without careful attention to factors that are known to affect successful diffusion of innovation.

Diffusion of innovation among community health initiatives is more likely when there is extensive face-to-face communication between individuals in the alpha and beta sites, and when there are contextual and organizational factors that are common to both sites.³ This research indicates that important contextual factors include strong local leadership, high levels of knowledge among interconnected parties, and a state environment with opinion leaders and change agents who value local innovation. The organizational factors that appeared to encourage diffusion included strong leadership and creating a new formal provider organization to make decisions about implementing the program.

The fact that the extent of replication varied across sites speaks to the complexity of diffusing local access initiatives. In only one site was the replication complete. The Wichita example differed from the others in that it had local and state contexts that were similar to the alpha site, as well as extensive communication and collaboration with the alpha site. Other sites: 1) had a very different state context and little communication with the alpha site; 2) visited other sites with different contexts and implemented only certain aspects of the other programs; or 3) had extensive communication with multiple alpha sites and implemented different facets from different programs?

POLICY IMPLICATIONS

Organizing local resources to contribute to health care access and health status improvement is a critical and often neglected component of the health care system. Local initiatives provide bridges to public and private coverage, create steps to care for those who are not covered, and serve as a vehicle for investment. They also translate and apply national and state policies, helping local providers understand and utilize these opportunities and enhancing the effectiveness of national and state programs.

Local health initiatives take different forms in different communities. These variations are due to differences in local context and the complexity of replicating organizations in different locations. Although it can be difficult to make the general case that they warrant investment of national and state public and private funds, each site in this study—as well as those investigated in prior studies—earnestly believes it makes a difference and some offer intriguing evidence to support these claims. Their importance to the communities that they serve is undeniable; at minimum, each bears witness to the failures of an undifferentiated application of federal and state policy to local communities.

Because all community health initiatives are, in effect, creatures of national and state policy, it follows that changes in policy would cause the initiatives to adapt and change. Policy change in the current environment, however, would not eliminate their

purpose: to serve low-income residents at the edges of both public programs and private coverage. Some proposals at the national level—in particular, block grants to finance Medicaid—could greatly increase the need for community initiatives if states were forced to respond by narrowing program eligibility. Without greater resources for community initiatives, however, the volunteerism they rely on would be strained and could fray.

Other national proposals—in particular, those that offer new opportunities for financing coverage—might be used to provide much-needed support to these programs, if care were taken to define qualified coverage to include that offered through community initiatives. In turn, the initiatives could leverage and amplify the value of those funds. For example, refundable tax credits could be used to buy the coverage offered through these networks and their providers. Community initiatives also might be allowed to qualify as “association health plans” that could enroll any small group that includes a threshold proportion of low-wage workers.⁴ Small employers might offer these programs as an option available to low-wage workers or to their entire group. Certainly such proposals would warrant careful review by state insurance regulators, but they may be quite feasible with narrow and strategic changes in regulation and oversight and highly beneficial to workers who otherwise could not afford coverage.

**CASE STUDIES:
FIVE LOCAL EXPERIENCES**

NEAR PERFECT REPLICATION: PROJECT ACCESS

Wichita, Kansas

WHAT THEY DID

Led by one philanthropically minded, yet entrepreneurial, physician, local leaders carefully copied a program from a similar community to provide primary and specialty care to low-income uninsured residents. The program uses less than \$180,000 in administrative costs per year to leverage \$5 million in donated services. To date, 5,000 people have been served. Physicians, hospitals, and pharmacies donate care and services. Local government, the United Way, and a local foundation support the program financially.

BACKGROUND

Project Access in Sedgwick County, Kan., is a community program that provides health care to low-income uninsured people through the charitable contributions of local providers. Project Access provides comprehensive inpatient and outpatient services. Although the program focuses on specialty care for people who are already ill, it also helps uninsured individuals find a medical home by matching them with primary care clinics and practitioners. The program staff coordinates donated services for patients and providers. Approximately 70 percent of physicians in the county participate in the program.

Project Access is governed by a 12-member board and supported by committees that guide operations and promote physician participation. Eight staff members work at the Project Access program office, which is housed at the Medical Society of Sedgwick County. These include the program director, an administrative assistant, four patient service coordinators, a secretary, and a prescription service coordinator.

The Population Served

Project Access is intended to be a short-term safety net for people in need of specialty care, with link to primary care services and a medical home. Enrollees are predominantly female, young to middle-aged (31 to 50 years), and unmarried. They tend to be chronically ill, often with dual-diagnosis conditions and significant health care needs. Although the program initially had no restrictions on immigration status, due to physicians' frustration with some aspects of serving undocumented immigrants, the program is now limited to citizens and documented immigrants.

To enroll in Project Access, an uninsured person must be a citizen or legal immigrant residing in Sedgwick County and earn less than 150 percent of the federal poverty level (FPL). Project Access largely adopted these criteria from the alpha program in Buncombe County.

In 1996, the University of Kansas School of Medicine performed a community health assessment to build the case for the program to potential funders. That study estimated the uninsured population in Sedgwick County at 55,000, of which 65 percent to 70 percent were employed and approximately 10,000 were potentially eligible for Project Access. In the first six years of the program, nearly 5,000 patients enrolled.

HOW THEY DID IT

Project Access is a beta site modeled after a prototype program in Buncombe County, (Asheville) N. C. Buncombe County's program became operational in 1996. It is a physician-led initiative providing primary and specialty care for the low-income uninsured.

Paul Uhlig, a Wichita-based physician, became aware of the Buncombe County federal poverty level and started championing the establishment of a similar program in Sedgwick County. In 1998, Dr. Uhlig mobilized key stakeholder groups—including private and clinic-based providers, city and county managers, and potential funders—to consider ways to replicate the Buncombe model in Sedgwick. He encouraged the Medical Society of Sedgwick County to assume a leadership role and reorganized the Central Plains Regional Health Care Foundation—previously established to address the community's health needs—to administer the new program. He also convinced representatives from the aircraft industry headquartered in Wichita to provide private jet transportation for local leaders to visit the alpha site.

The principal stakeholders convened several times in Asheville, where they learned more about the operational elements of Project Access. In April 1999, leaders from the Buncombe program were invited to make presentations to the many stakeholders in Wichita. Buncombe's involvement in Wichita's local strategic meetings and presentations was pivotal in garnering city and county support to help drive the process.

Once Sedgwick County decided to replicate the program, local stakeholders purchased technical assistance from the Project Access team in Buncombe, including software and training to track patient flow. To build partnerships, raise funds and complete grant applications, the Wichita initiative used trend data from the Buncombe program documenting its successes. Sedgwick also acquired Buncombe's "Blue Notebook," which provided the details of Buncombe's daily operations, as well as patient referral forms, physician recruitment materials, and other printed materials.

Many of the characteristics of Buncombe's model were replicated exactly in Wichita, especially in the area of program leadership. Some modifications were made in

eligibility, support services, and funding. In September 1999, Project Access of Sedgwick County was launched and began enrolling patients from the smallest of the six participating clinics. The second clinic was brought on two months later, followed by the third six weeks after that. The gradual enrollment allowed time to iron out bugs, as patients established their medical homes. All of the six clinics were on board within six to seven months.

Innovations are most easily transferred when they are simple, can be implemented quickly, and when benefits are easily observable. However, initiatives such as Project Access are complex, with results generally not quickly or clearly observable. Leaders in Wichita were able to overcome this replication challenge by intensely having ongoing communication with the alpha site, capitalizing on the similarities between the two communities, and leveraging the entrepreneurial and pioneering spirit of the community.

Wichita's experience with Project Access points to a number of key elements for replicating such a program in other communities, including: a strong and involved medical society, influential leadership and a day-to-day administrator, extensive public and private partnerships, and diverse and committed funders. Many communities across the country have expressed interest in replicating Wichita's program, including four or five in Kansas.

CONTRIBUTIONS

Key informants overwhelmingly reported Project Access is a valuable program for the low-income uninsured and said that enrollees are receiving needed services. The program has helped enrollees obtain more consistent care, with a focus on education and prevention. Although it is difficult to measure the change in the net cost to the community as a whole, hospital admission data indicate people enrolled in the program are receiving appropriate services at a lower cost.

Project Access appears to coordinate and expedite the process of obtaining referrals for patients who need them, which helps individuals gain access to appropriate services before conditions become severe. Without Project Access, the uninsured would rely more on the traditional safety net in Wichita. In addition, attempts to access care from private physicians would be more challenging and disjointed. In the past, primary care clinics spent a lot of time—and experienced great frustration—begging specialty physicians to see patients. Without Project Access, many physicians might again shy away from treating the uninsured for fear of becoming overwhelmed with requests.

Project Access enrollees generally have lower physical and mental health functioning scores than the general population. However, enrollees' health status has shown some improvement and enrollees in case management have demonstrated small, positive changes in control over their health.

The program estimates that approximately \$180,000 in administrative funding generates \$5 million worth of donated services a year. Plus, evaluators report donated services are relatively constant while average cost per patient is decreasing. Furthermore, many key informants pointed to David Rogoff's algorithm for return on investment, which hypothesizes that the move toward coordinated health care has reduced total health care costs by one-third.

CHALLENGES TO FUTURE SUSTAINABILITY

Provider and partner contributions are crucial to the long-term sustainability of Project Access. County and city governments and the United Way are committed to providing ongoing funding for the prescription assistance program and basic program operations, and physicians and hospitals seem committed to continue offering donated services to patients. Yet, program funding is not sufficient to meet the needs of all uninsured residents of Sedgwick County, and some of the program's grant funding will end this year. However, key informants expect that, with continued physician involvement and efforts to better manage high- utilization enrollees and control pharmacy costs, the program will be sustainable as long as necessary.

Because grant funding is limited, Project Access is exploring ways to ensure its long-term sustainability by reducing its dependence on grants. Leaders would like to see local businesses contribute to the program in some way and are exploring the possibility of creating a small business insurance model to allow more people eligible for Project Access to have health insurance. Also, given the United Way's goal of replicating similar programs in 500 communities, Project Access staff expects to generate program revenue by consulting for other communities that wish to create similar programs.

Strong leadership is also key to sustaining Project Access. Although the program's original champion, Dr. Paul Uhlig, moved out of the state shortly after the program's implementation, leadership appears to be stable and strong. The current director, Anne Nelson, has been engaged with the project since 1999, and received high marks from key informants. The governing body, providers, and partners appear to have ongoing commitments to the program.

The Project Access Board would like the state government to provide regular funding for the program and others like it. Ultimately, program stakeholders would like to see state and federal governments directly address the problem of the uninsured through insurance coverage and other access initiatives, making the need for Project Access obsolete.

Project Access has weathered a very serious challenge to its sustainability. The program was built on the philosophy of pulling together to provide help to all those who need it, yet one group challenged the system. At its inception, undocumented immigrants comprised 5 percent to 6 percent of the program's population. However, after approximately two years, their continued eligibility was jeopardized when a few provider groups threatened to withdraw from the program. First, the largest oncology group in the area was providing free pharmaceuticals as well as free health care services to program participants. Because pharmaceutical companies only provided indigent care for legal citizens, this provider group's drug costs became extremely prohibitive, and the group decided to cease participating as long as undocumented citizens were eligible for services. Second, other providers expressed dismay that some undocumented residents were bringing relatives from abroad to obtain care from Project Access. Third, doctors found this population relatively noncompliant with recommended treatments, with one patient dying as a result of noncompliance. Consequently, undocumented immigrants are no longer eligible for Project Access.

**THE POWER OF LOCAL, STATE,
AND NATIONAL FINANCIAL LEVERAGE:
GENERAL ASSISTANCE MEDICAL PROGRAM (GAMP)
Milwaukee, Wisconsin**

WHAT THEY DID

A unique partnership of local, state, and federal government; county public health; hospitals; physicians; and clinics turned a \$15.6 million local tax into \$49.4 million in program funding. As a result, 27,000 of Milwaukee's uninsured are served each year by a broader, more organized safety net. In this program, participating providers both give and receive; they bear risk for their patients needs when resources run out but receive a new funding stream to serve program enrollees.

BACKGROUND

The General Assistance Medical Program (GAMP) is a Milwaukee County-administered program designed to provide access to primary and secondary health care services for uninsured residents earning less than \$902 per month. The initiative is an update of the county's hospital-based indigent care program, which was threatened when the hospital closed in 1995. The county now plays the role of purchaser of modified managed care services, rather than a provider of those services. As a part of the program's primary care emphasis, health centers act as the main gatekeepers for residents who must seek medical services to be eligible for enrollment. Providers are reimbursed at Medicaid rates, with program funding coming from leveraged state contributions, local taxes, and intergovernmental transfers. Services are available at 17 clinics in 23 sites, including federally qualified health centers (FQHCs), and 10 local hospitals.

The County Board of Supervisors of Milwaukee County has responsibility for setting program policy and direction. This Board is made up of 19 elected officials who represent supervisory districts and face re-election every two years. Eligibility requirements (intended to simulate the FPL) are set by the Milwaukee County Board of Supervisors and are subject to review each year during budget review.

From an operations standpoint, GAMP is administered by the Milwaukee County Department of Health. The program employs more than 20 staff members, some located in the participating clinics. Billing functions are contracted out to a third-party administrative group.

THE POPULATION SERVED

About 100,000 to 120,000 uninsured people live in Milwaukee County; 60 percent are eligible for GAMP. To be qualified for the program, an applicant must be: a Milwaukee

resident for the previous 60 days, ineligible for any other entitlement program or third party public or private insurance, and able to provide a verifiable Social Security number. Unlike traditional insurance, clients do not pre-enroll for coverage; instead, they must be seeking services or treatment due to a medical need.

Eligible individuals can enroll in GAMP at any of the contracted community clinics and all Milwaukee County hospital emergency departments. Participating hospitals and clinics have trained financial counselors who assist individuals with their applications. At the time of enrollment, the applicant chooses the community clinic that he or she would like to use for primary care. The client, if approved, must use this clinic and its network for the 6-month eligibility period. At the end of this period, the client must reapply to determine continued eligibility and may do so at any site.

HOW THEY DID IT

GAMP has total funding of \$49.4 million. Of this, \$15.6 million is provided from the Milwaukee County tax levy for medical services and \$33.8 million is provided from the state and federal government through state block grants and disproportionate share hospital (DSH) payments. A total of \$13.5 million of state and county funds are matched with \$20.3 million in federal Medicaid DSH payments. This total payment is funneled through DSH eligible hospitals in Milwaukee County to the GAMP program. The county portion of the match is transferred to the state through intergovernmental transfer (IGT). The program also receives funding from the \$35 application fee; participants are eligible for six months at a time and the fee is charged with each re-application.

Capturing and Retaining Funding

Milwaukee County has a long tradition of providing quality health care to residents in need, and has operated a program similar to GAMP since the late 1970s. Historically, the program served as a funding mechanism between the county and the State of Wisconsin to address the costs of providing medical care to the county's indigent population. These funds were primarily allocated to the John L. Doyne Hospital, which was owned by the county. On December 23, 1995, the county closed this hospital and transferred its assets to the Froedtert Memorial Lutheran Hospital, which continued to serve as the primary provider to GAMP patients for two years. In April of 1998, a restructured GAMP program was approved by the County Board of Supervisors.

This program focused on providing access to cost-efficient primary care services. Within this same time period, the state legislature, at the Governor's request, modified Chapter 49 of the Wisconsin statute so that no level of government was statutorily

responsible for providing health care services to indigent populations. After this decision, the state began to provide block grants to counties to provide these services. Milwaukee County is the primary beneficiary of this state funding.

Milwaukee County and the State of Wisconsin have leveraged their funding to maximize the amount of DSH funding available to the county through IGT. An IGT may take place from one level of government to another (e.g., from counties to states, or within the same level of government). The federal Medicaid statute expressly recognizes the legitimacy of IGTs involving tax revenues, such as the tax levy imposed by Milwaukee County. The Wisconsin state legislature gave Milwaukee County permissive authority to increase the amount of the IGT to further maximize DSH payments. To the extent that the state is able to justify additional DSH payments to the DSH-eligible Milwaukee County hospitals, additional funding in the form of Medicaid hospital payments will be made. The state legislature remains committed to attempting to increase the amount of funding that supports the program.

CONTRIBUTIONS

Since 1998, GAMP has leveraged millions of national, state, and local dollars to serve many of the county's uninsured residents. In addition, as one community key informant reported, "The county administrative team has done a remarkable job to improve efficiencies over the years . . . the GAMP program has been a remarkable investment." GAMP's overall administrative costs are 7 percent. It has been able to achieve these low costs in part by outsourcing claims payment, limiting pharmacy contracts to one major vendor, and instituting a formulary.

The program has also implemented strategies to change enrollee utilization patterns. These include: a very active patient education program on emergency utilization; a 24/7 nurse call line; disease management programs for enrollees with asthma, hypertension, and diabetes; and enrollee cost-sharing for application (\$35) and pharmaceuticals (\$1 for generics and \$3 for brand).

An independent evaluation found that between 1997 and 2000, costs per claim decreased from \$260 to \$194, inpatient services expenditures decreased 7 percent, and per member per month costs declined.⁵

The GAMP structure has effectively distributed responsibility for the uninsured across providers, enabling the 135,000 to 150,000 uninsured in Milwaukee County a broader choice of providers. Before GAMP, the county hospital, which is now closed, had

uncompensated care levels of approximately 12 percent, while other hospitals had levels of 1 percent to 2 percent. Now, all hospitals in the community have uncompensated care levels of approximately 6 percent. If GAMP in its current form had not been implemented, the community would likely continue with a costly, struggling public hospital and little community support for bolstering its financial position. Key informants indicate that there would be a dramatic increase in emergency department volume as well.

Distributing responsibility for the uninsured across providers has created a strong provider constituency in support of GAMP. GAMP clients reside in all Milwaukee County zip codes, strengthening mainstream political support for the program. Most key informants view the uninsured as more of a community issue because of GAMP, although a few still consider the uninsured and GAMP to be largely below the radar screen of most residents.

CHALLENGES TO FUTURE SUSTAINABILITY

GAMP officials and community leaders wish to continue the program to improve cost-effective access to primary care for patients who generally rely on hospital emergency departments. Most key informants saw the program as being sustainable over three years, but were uncertain about longer term viability because of its dependence on state and federal participation.

The GAMP program faces challenges going forward. There is uncertainty regarding the local, state, and federal financial partnership that supports the program. Some informants are concerned about the program's limitations: no active outreach and limited services for mental and dental health. In addition, the \$35 application fee is seen as a barrier for some enrollees. Limited funding and growing cost add strain to the safety net and may tip the scale against continued participation for some providers.

Shortly after the completion of the GAMP case study, the founding leader of the program retired. Since that time there have been two subsequent leaders. The stability of local collaboratives is often threatened when leadership changes, in part because local organizations are built on a complex nexus of relationships.

GAMP was able to use grant funding to commission a cost-benefit evaluation of the program. The information in that evaluation was helpful in building the case for continued support of the program. However, continued evaluation and feedback are needed to sustain the program. Resources and expertise to accomplish ongoing evaluation are often not built into implementation budgets.

STATE CONTEXT MATTERS: COMMUNITY HEALTHLINK

Ratcliff, Arkansas

WHAT THEY DID

Community leaders and providers developed a network to serve low-income uninsured residents in their communities. They designed a subsidized health plan and the Arkansas General Assembly enacted legislation to exempt the pilot plan from insurance regulations. The health plan pieced together employer contributions, individual dues (similar to a premium), grant subsidies, pharmaceutical discounts, and provider risk-sharing to offer an affordable product to 181 members during its two-year pilot phase.

BACKGROUND

Community HealthLink is a capitated, subsidized health insurance plan operated by the Arkansas River Valley Rural Health Cooperative, a nonprofit organization. The program provides comprehensive health care coverage for working uninsured residents with incomes below 200 percent of the federal poverty level (FPL) who live in the three contiguous counties of its service region. It is similar to the three-share approach of Muskegon, Mich., in which employers contribute one-third, employees contribute one-third, and the final third comes from a combination of local and state contribution and federal match. In 2005, Community HealthLink completed a two-year pilot phase.

Employers and employees provide two-thirds of the cost of care, while the third share is covered by a subsidy fund set up by the Cooperative. Local primary care providers are reimbursed at Medicare rates and are asked to provide services and assume risk for care in excess of the reimbursable limit.

The Cooperative's health plan contains three elements: health care access, prescription drug assistance, and disease management/health education. The provider network currently includes two tertiary care hospitals, four critical care access hospitals, six primary care clinics, four mental health counseling centers, and 200 medical specialists.

The Cooperative is governed by a Board of Directors comprised of representatives and community leaders from each of the counties in the service region. A 12-member staff is led by an executive director and guided by program leads for the health care access program, health education/telehealth services and support/prescription drug assistance services.

THE POPULATION SERVED

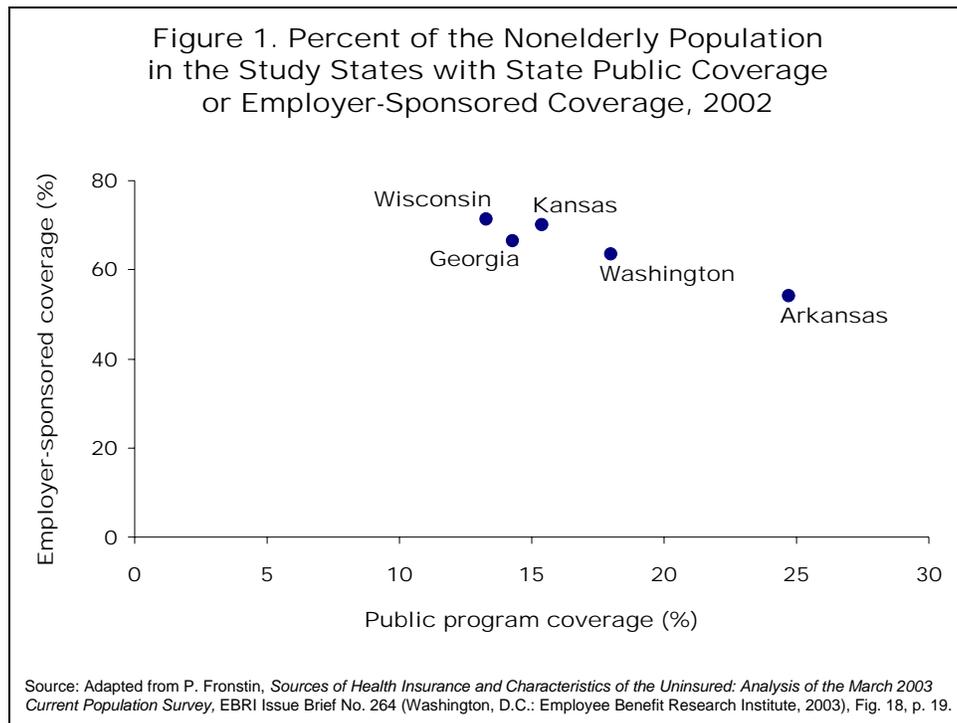
In this sparsely populated rural area of Arkansas, an estimated 4,000 to 6,000 people are eligible for the Cooperative's health plan. The HealthLink program targets working,

uninsured adults with incomes 200 percent below FPL and who are ineligible for Medicaid, The client population is composed of 51 percent adult females, 41 percent adult males, and 8 percent children. The population is 99 percent white. The average age of members is 46 years old, and the average family has is 2.6 members. The average client has an income of 134 percent of the FPL. Enrollees were uninsured an average of 5.5 years before entering the program.

HOW THEY DID IT

The work in Ratcliff reveals an important lesson: local programs can support or complement state public and private insurance programs, but are unlikely to thrive independently.

The three-share program in Ratcliff, Ark., has struggled in an environment of systematically low employer support for private group coverage. In contrast, the three-share model in Michigan was built on a relatively strong base of employer group coverage. The general context of public programs and private coverage for each of the five initiatives is summarized in Figure 1.



As shown, Arkansas has the lowest percentage of private coverage of any of the study's states. At the community level, lack of access to health care coverage takes on personal aspects lacking in the national debate: it affects friends and neighbors who are struggling either to find care or to provide it. Communities motivated to organize a

response to this problem typically look to other apparently successful, local initiatives as models for how they might proceed. Often, they are unaware of the contextual factors that help or impede the success of the local programs they seek to implement.

CONTRIBUTIONS

Even though it is a very small program, Community HealthLink has provided potentially life-changing insurance access to people who have lived without it for an average of 5.5 years. Before the program, uninsured people avoided seeking outpatient care, relied on over-the-counter medications when prescriptions were needed, and often landed in the emergency department.

The use of strategies like encouraging primary care, tapping into pharmaceutical charity care programs, adding health promotion interventions and utilization controls, and providing disease management, has helped control costs and maintain a sustainable medical loss ratio. Additionally, costs are controlled by limiting emergency department visits to two per year unless the visit results in hospitalization. All of these strategies control costs and change the local culture. Individuals are more likely to be healthy when they have a medical home, instead of using the emergency room; take prescription rather than over-the-counter medications; and have their chronic diseases managed.

Community HealthLink also supports providers by paying for care provided on a reduced-fee schedule, equal to Medicare rates. Prior to the program, providers were only paid what they were able to collect from the patients. However, the program is not without risk to providers. Costs are contained through a capitated amount of \$10,000 in outlays per enrollee per year. After the capitated amount is reached, any additional costs of care are absorbed by the enrollee's provider.

Local leaders has woven together a network of state forgiveness of traditional insurance requirements, provider discounts and risks, pharmaceutical charities, employer contributions, individual dues and grant subsidies, along with behavior-changing and cost-saving strategies to offer affordable health care coverage in the community.

CHALLENGES TO SUSTAINABILITY

Community HealthLink is fragile. It struggles to encourage employer to offers and employees to contribute to employee coverage in a state with very low employer-sponsored coverage. The grant funding that provided the subsidy to the insurance product is disappearing. Program leaders are seeking a federally qualified health center (FQHC) in the community, partly to offer access to enhanced dental and mental health services.

However, local providers are opposed to the FQHC, arguing they have the capacity to serve the uninsured. This tension threatens the provider participation in the program, which is central to its success. Even though the state has been supportive by passing legislation that supports the local effort, some state leaders are skeptical about the value of the program.

The challenges to sustainability faced by Community HealthLink are not different from those in other communities; however the small size of the community and the difficult state environment make this initiative more vulnerable.

MEASURING OUTCOMES: COMMUNITY HEALTH WORKS

Forsyth, Georgia

WHAT THEY DID

A multi-county, multidisciplinary initiative provides care management and access to medical care, services, and medication to uninsured people with hypertension, diabetes, heart disease, or depression, who earn less than 200 percent of the federal poverty level. Because a control group was not available for comparison, the program was evaluated by composing a synthetic sample from the Medical Expenditure Panel Survey (MEPS) data. Patients in the national data set with similar diagnoses, incomes, and other demographics were selected and their hospital utilization patterns and emergency utilization were compared to the patients in the community. Those enrolled in the program had 40 percent fewer admissions and 15 percent fewer emergency room visit than those in the sample.⁶

BACKGROUND

Community Health Works (CHW) was created in 2001 to more effectively address problems of uncompensated care. The program was designed by a collaboration of five nonprofit hospitals in the seven-county region, two public health and mental health districts, representatives from county governments, the medical school, and representatives from business and civic organization. CHW is designed for people with incomes below 200 percent of the federal poverty level who are uninsured and not eligible for any publicly-sponsored or employer-health insurance. The services address adults between the ages of 19 and 64 with high-risk diagnoses of hypertension, heart disease, diabetes, or depression . CHW is administered by a nonprofit organization and relies heavily on provider volunteerism and hospital leadership. The local care network consists of five hospitals, two clinics, nearly 100 physicians and 21 pharmacies.

The CHW Board of Directors is composed of 18 members, representing hospitals, nonprofit groups, mental health agencies, community foundations, health care providers, public health departments, and local government. These individuals are also geographically representative of the CHW service area. CHW has five full-time administrative staff, eight care managers located throughout the service area, and two staff members for data entry.

THE POPULATION SERVED

Program designers studied the regions' hospital discharge data to identify the four diagnoses, which are costly to treat in the hospital but could be easily treated with regular access to primary care. It was initially estimated that 6,000 to 7,000 individuals were eligible for the program. To date, nearly 4,000 have been served.

The average annual income of the CHW population is \$7,000; the average educational level is the 11th grade. Seventy percent of CHW clients are female, 67 percent are African American, 31 percent are white, and 45 percent are employed. Enrollees have an average of three diseases and use five medications. Seventy percent have comorbidities.

HOW THEY DID IT

In their original plans, the CHW founders made a commitment to evaluation an important aspect of sustainability. Three key components of the evaluation include: health status, utilization, and financial impact of the network's activities.

To measure changes in enrollees' health and determine the intensity of care management needed, CHW administers questions from the Behavioral Risk Factor Surveillance System (a health survey developed by the Centers for Disease Control) every six months and a health risk assessment every three months. Overall, these assessments find that patients' conditions stabilize or improve throughout their time enrolled in CHW. Although enrollees typically stay in the program indefinitely, some enrollees' health improves enough for them to return to work, potentially with health insurance benefits, allowing them to disenroll from CHW and make room for additional clients.

Disease management and case management strategies are intended to change the costs of chronic illness, partly by preventing emergency room visits and hospitalizations. CHW focused on these two utilization measures as short-run indicators of the effectiveness of the program.

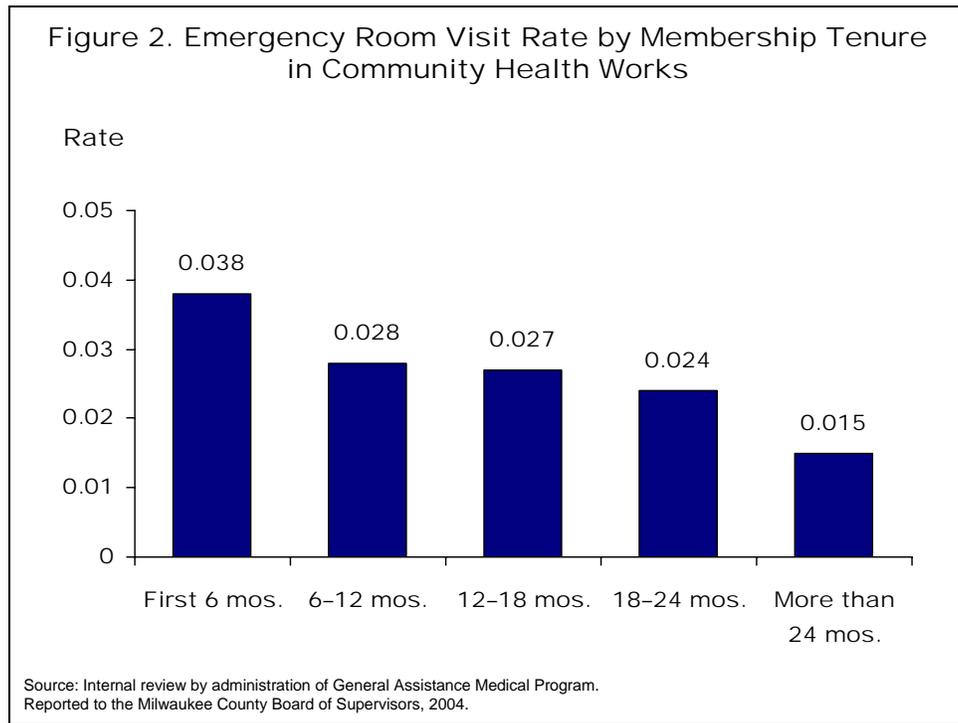
Creating a comparison group to measure the effect of CHW on its members' use of emergency room visits and inpatient stays proved difficult. The solution was to create a comparison group using data from the Household Component of the 2002 MEPS⁷. The Household Component collects data for a sample of families and individuals across the county, drawn from a nationally representative sub-sample of households that participated in the previous year's National Health Interview Survey. It produce annual estimates for a variety of measures of health status, health insurance coverage, health care use and expenditures, and sources of payment for health services.

The comparison group was constructed by identifying uninsured individuals in MEPS, with age and income requirements that would qualify them for enrollment in CHW. The comparison group included only those MEPS respondents who had one of the four diseases: hypertension, diabetes, heart disease, and depression. This

comparison group may be healthier than CHW members since MEPS respondents may include individuals with one specific disease, while the average CHW member has at least three comorbidities.

CHW focused on annual inpatient stay rates, defined as average number of inpatient stays per individual per year, and average number of emergency room visits per individual per year. CHW members are admitted to the hospital at a rate that is 40 percent lower than the comparison group. They also use the emergency room about 15 percent less frequently. Both of these differences are statistically significant.

Over time, it has become possible to examine changes in outcome measures for CHW members. If the combination of case management and disease management approaches is effective, inpatient stays and emergency room visits should decline over time. This trend plays out in CHW data. Sixty-five percent of hospital admissions and 70 percent of emergency room visits by CHW members took place in the first year of membership.



CHW tracks program utilization and costs through an information technology (IT) system developed specifically for the program—an investment that was part of the board’s original sustainability plan. The CHW care management model and IT system have the

potential to create savings for other populations and programs, as well as generate additional dollars to sustain and grow CHW.

Financial impact was measured in several ways: costs avoided because of the utilization improvements, the value of donated physician visits and reduced medication prices, and the new state and federal money that was brought into the community because of CHW.

CONTRIBUTIONS

The CHW model has demonstrated desired changes in utilization. The evaluation results show changed behavior in terms of inpatient hospital admissions and ED visits, resulting in subsequent decreased costs, and potentially improved health status. The hospitals perceive their contributions to the network to be cost-effective and physicians appreciate knowing upfront what their charity care will be and being part of a team that seeks to improve the health of patients.

CHW has generated \$13.6 million in free care to date through a model of case management and patient education. CHW also connects patients to free medications, which help them maintain compliance with their physicians' health care plans.

CHW aspires not to be a solitary program, but to create systemic change in the safety net. To that end, it has brought together leaders across the seven counties and across different types of organizations. For instance, prior to the development of CHW, the county commissioners reportedly had little involvement in health care and the safety net, but they now collaborate with the program and providers. The efforts of CHW have helped create a larger, more collaborative safety net for the uninsured.

The safety net has improved dramatically for CHW enrollees. They have a medical home and know who to contact for services. In addition, the CHW model imparts a holistic approach focused on meeting the social need of its clients, such as transportation, child care, and employment search assistance, not just the clinical needs. Once patients are in the CHW system, they are treated for all their health care needs, including preventive screenings.

While CHW has clear boundaries for membership, care is not necessarily limited to the four diseases, mostly due to the physicians' wishes to treat patients in a comprehensive manner. CHW also brings an added benefit by providing a touchstone for local health care providers with a common mission. For example, if a smaller hospital has a

pressing need, it may feel more comfortable about contacting larger hospitals for assistance because of the relationships it has developed through CHW.

Since 2001, CHW reports it has brought \$4.3 million in new state and federal money to the seven counties in which it operates. The program estimates this additional revenue has produced more than \$5.3 million in economic development to the area.

CHALLENGES TO SUSTAINABILITY

CHW has an operating budget of \$1.66 million. However, a large portion comes from time-limited grant funding. The network does receive investments from hospital partners, who are firm in their support. The return on investment of the program to the hospitals surpasses the original investments, as CHW reduces emergency room utilization and hospital admissions for its members.

While physician participation is not sufficient to allow the program to grow beyond its current scale, continued participation by physicians is essential to ensure sustainability. For the program to expand beyond its current scope, would require a stronger, funded primary care safety net, such as a federally qualified health center and more specialist volunteers. A source of even partial payment for physician participation would ease the burden of physician volunteerism.

CHW has a strong and stable board and has weathered a transition in executive leadership over the past two years,. The new director has built on previously brokered relationships and has added strong business, economic development, and local political connections.

The state environment is a factor in the success of community programs, including CHW. For example, an administrative change resulted in the loss of an expected partnership with Medicaid and an investment of state dollars. In addition, changes in state reimbursement rates to providers can change the willingness of providers to participate in the program.

To increase the network's flexibility and allow for expansion, CHW leaders are looking for more stable state, federal, and private investments.

**CHAPERONING THE SYSTEM:
CHOICE REGIONAL HEALTH NETWORK
Olympia, Washington**

WHAT THEY DID

Choice Regional Health Network began as a seven-hospital response to the threat of a hostile takeover by a for-profit hospital and has transformed into a vehicle to chaperone clients with complex needs through systems of care and coverage they characteristically have trouble navigating. Using a variety of funding sources including membership dues and fees paid by the hospitals, Medicaid match, federal grant programs, and private foundation grant programs, Choice has put together programs to serve 17,000 people.

BACKGROUND

Choice uses a multi-pronged approach to improve access to care for uninsured individuals, with incomes at or below 250 percent of the federal poverty level (FPL) who reside in a five-county service area. Choice enrolls eligible individuals in state-sponsored programs or links them to donated or discounted local provider services. The program benefits from collaboration with three hospitals, 11 outpatient clinics and federally qualified health centers (FQHCs), and hundreds of physicians. The Choice Board consists of 10 members representing hospitals, physicians, public health agencies, and communities. A three-member executive committee makes administrative decisions related to personnel and reviews financial reports. Choice has approximately 20 staff members and has operated with a budget of approximately \$1.6 million for each of the past three years. The staff guide various projects, serve as “geo-leads” (i.e., enrollment specialists for a certain geographic area in the network’s region) in communities, and act as enrollment specialists.

THE POPULATION SERVED

The target population is the estimated 93,000 individuals who are uninsured, have incomes below 250 percent of the FPL, and live in the five-county service area. Choice has provided access to health services or coverage to 20 percent of the low-income uninsured in the five-county region. Most clients are under 39 years of age and most of the adult clients are employed in low-wage jobs that offer unaffordable coverage or no coverage at all. Almost half the clients have incomes below 65 percent of the FPL. Thirty-one percent of clients are Latino, compared with five percent of the region’s total population.

The pharmacy assistance program connects Choice clients to pharmaceutical companies’ free or reduced-price drug programs. Most prescription drugs received by clients are for chronic conditions, including those associated with cardiac, mental health, diabetes, and asthma diagnoses. During the first five months of its pharmacy assistance

program, Choice assisted with applications for pharmaceutical products having a market value of more than \$11 million.

HOW THEY DID IT

Choice board members are using the following question to guide the organization's operations: "How can we plan together to reallocate the health care resources available; to improve access to primary care; improve the care patients receive; and, ultimately, improve the health status of the people who live in our region?" Several programs help them accomplish this mission.

Through its Regional Access Program, Choice has developed extraordinary capacity and experience in enrolling—and keeping enrolled—those eligible for Washington's various programs. Data from the state indicate 98 percent of Choice-assisted applications result in enrollment, compared with 40 percent when people attempted to enroll on their own. Further, 96 percent of the persons enrolled via Choice were still enrolled up to three years later, compared with 40 percent of clients who enrolled independently.⁸ The Regional Access Program is staffed by counselors/enrollment specialists called access coordinators. When enrollment in public programs is not an option, access coordinators chaperone clients through the system to get needed health and social support. This model attempts to increase the use of some services (e.g., primary care and prescriptions) and reduce others (e.g., emergency departments). Access coordinators describe their clients as being in a severe cycle of poverty, which is difficult to break. The Access Coordinators work to break powerful behavior patterns to get people engaged in their own care.

Geo-leads work in eight Choice communities to develop community collaboration, weave together available services for the uninsured, and build capacity where none exists. In the PharmAssist program, access coordinators help clients enroll in assistance programs offered by pharmaceutical companies. They also work to connecting clients to medical homes and care management services to change utilization patterns. Choice also offers Tu Salud, a program targeted to Latino clients with limited English proficiency.

In addition to aggressive enrollment and chaperone programs, Choice is building other programs to strengthen the safety net or increase insurance capacity. One program is focused on building and organizing faith-based capacity (i.e., programs organized by churches, synagogues, etc.) and developing a community-based system to allow information sharing across multiple agencies. Another seeks to replicate the Project Access

concept, using physicians as volunteers to increase safety net capacity. Yet another program replicates the Muskegon, Mich. three-share model—in which employers contribute one-third, employees contribute one-third, and the third comes from a combination of local and state contribution and federal match. This model is designed to help small businesses and their employees have access to affordable health insurance.

CONTRIBUTIONS

Choice links low-income people to existing public insurance programs and also helps people find needed providers and services. Through its emphasis on medical homes and care management, the program changes utilization patterns. It is estimated Choice’s case management and care coordination efforts reduce the annual cost of care per client from an average of \$4,000 to an average of \$3,000 for a total savings of \$3.5 million.⁹

Choice helps shore up the financial stability and increase the capacity of the safety net directly through programs and indirectly through relationships. Of all Choice activities to date, the Regional Access Program appears to have the most significant positive impact on the safety net. Community informants report that the faith-based dental and community clinics have grown with the help of revenues received via Choice.

Choices’s relationships with policymakers helped bring in the self-sustaining Sea Mar FQHC to the Olympia area. This allowed the hospital in Sea Mar to close a comparable clinic, that costs \$100,000 to run annually. Choice also helped alleviate private physicians’ concerns about the potential for the FQHC to compete with their practices.

Overall, \$160,000 in member dues generated \$410,000 in grants and Medicaid matching funds. With this total investment of \$570,000, hospitals were estimated to receive \$2.5 million in additional to reimbursement from patients who became insured. The member hospital return on investment has steadily increased to 20:1. In addition, low-income people have insurance and better access to care, and Choice has helped communities build their own programs. Given continued shortfalls in the safety net, Choice is broadening its reach to more community partners and exploring ways to generate more savings to cover more people.

CHALLENGES TO FUTURE SUSTAINABILITY

Indicators show the safety net is crumbling faster than Choice activities can repair it. The Choice director, Kristen West, reported she is hearing “more sad stories and fewer happy endings.” Obtaining access to certain services such as mental health care and substance abuse services is still considered extremely difficult. Several large grants are coming to an

end, and the financial futures of the smaller hospitals may interfere with ability to continue to pay dues.

The executive leadership of Choice provides a driving force for the organization. The executive director has garnered and maintained statewide political interest and state agency engagement, ensuring some program stability. This leadership is both a benefit and a liability, with so much of the program's success tied to one person.

Choice has evaluated some components of the program and published some findings in reports, however, it has been more focused on building and delivering services than on measuring its direct impact on utilization and cost-effectiveness.

NOTES

- ¹ Internal evaluation by Community Health Works, 2005.
- ² Ibid.
- ³ E. M. Rogers, *Diffusion of Innovations*, 5th ed. (New York: The Free Press, 2003).
- ⁴ The Healthy New York program, a reinsurance program operated by the State of New York, uses such a formula to define small-group eligibility for Healthy New York coverage.
- ⁵ Internal review by administration of General Assistance Medical Program. Reported to the Milwaukee County Board of Supervisors, 2004.
- ⁶ Internal evaluation by Community Health Works, 2005.
- ⁷ For a full description of MEPS go to: <http://www.ahrq.gov/data/mepsix.htm>.
- ⁸ Report to the board of directors, Choice Regional Health Network, 2004.
- ⁹ Ibid.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

[*States in Action: A Bimonthly Look at Innovations in Health Policy*](#). Newsletter.

[*Closing the Divide: How Medical Homes Promote Equity in Health Care—Results from the Commonwealth Fund 2006 Health Care Quality Survey*](#) (June 2007). Anne C. Beal, Michelle M. Doty, Susan E. Hernandez, Katherine K. Shea, and Karen Davis.

[*Aiming Higher: Results from a State Scorecard on Health System Performance*](#) (June 2007). Joel C. Cantor, Cathy Schoen, Dina Belloff, Sabrina K. H. How, and Douglas McCarthy.

[*Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*](#) (April 2007). Kathryn Kuhmerker and Thomas Hartman.

[*Health Care Opinion Leaders' Views on Priorities for SCHIP Reauthorization*](#) (April 2007). Katherine K. Shea, Karen Davis, Anne Gauthier, Rachel Nuzum, Barry Scholl, and Edward L. Schor.

[*State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers*](#) (January 2007). Alice Burton, Isabel Friedenjohn, and Enrique Martinez-Vidal.

[*Creating Accountable Care Organizations: The Extended Hospital Medical Staff*](#) (December 5, 2006). Elliott S. Fisher, Douglas O. Staiger, Julie P. W. Bynum, and Daniel J. Gottlieb. *Health Affairs* Web Exclusive (*In the Literature* summary).

[*State Policy Options to Improve Delivery of Child Development Services: Strategies from the Eight ABCD States*](#) (December 2006). Neva Kaye, Jennifer May, and Melinda Abrams.



IMPROVING
HEALTH CARE
ACCESS:

FINDING SOLUTIONS *in a* TIME of CRISIS

COLLABORATIVE PROBLEM SOLVING
for STATES and COMMUNITIES

★
★ National
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The National Policy Consensus Center (NPCC) recently hosted a colloquium on community-based approaches to health care access in the United States. Experts in public health, health care policy and financing, community collaborations, and coalition and consensus building met to explore continuing dilemmas and past successes. The aim of the colloquium was to identify models and elements that can be adapted to create more collaborative approaches to health care access. This report is an outgrowth of that colloquium.

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FOREWORD

John A. Kitzhaber, M.D
Governor of Oregon, 1995–2002
Co-Chair, Board of Directors
National Policy Consensus Center



As a 14-Year veteran of the state legislature and two-term governor of Oregon, I have had the privilege to work for nearly 25 years in state policy and financing to increase access to health care.

The lessons have been varied—some gratifying, some painful.

In its first decade, the Oregon Health Plan demonstrated how creativity and teamwork at this level can produce innovation, reform, and real gains for the citizens of our state. Over 100,000 previously uninsured Oregonians were enrolled in health plans, and a gratifying movement in the direction of national policy was emerging. Yet some of the best potential elements we conceived were sabotaged by unduly rigid regulatory environments, and by competition and conflicts of interest among stakeholder groups.

By 2002, Oregon—like so many states—was bracing for budget shortfalls that threatened to unravel the significant progress we had achieved. Substantial federal reforms around health care access looked like a remote possibility at best, and it was clear that states by themselves could not create or carry out all the solutions needed.

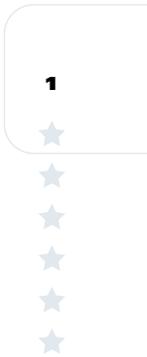
Obstacles to health care access represent a profound national problem that grows worse each year. Despite ever-more innovative technologies and advances, more and more Americans are left behind or at risk. These people are our friends and neighbors, our co-workers and their families, our parents, and even ourselves. They are essential parts of our communities, where the health of one directly or indirectly affects the health of all.

Some communities have stepped forward to find their own solutions. Community collaborations, partnerships, and coalitions for health care access are slowly appearing throughout the country. So far, most of them have focused

on specific health topics or important issues—teen pregnancy rates, drug addiction treatment, HIV-AIDS care, and others. But some communities are tackling access problems more broadly. They are finding ways to obtain insurance coverage for community residents, securing provider networks and delivery systems offering everyone essential primary and preventive care, creating new clinics with robust partner agencies and community investments, and aligning payment incentives so that keeping people as healthy as possible is acknowledged and rewarded as the best strategy for citizens and for health care providers alike.

Collaborative problem solving at the community level holds great promise for improving health care access, just as it does for environmental protection, stewardship of resources, education, and regional economic development. To be successful and sustainable, community collaborations require committed state support. When states thwart community-based initiatives by imposing rigid regulations or irrational requirements, our society cannot move forward. When they fail to participate actively in collaborative processes or to commit financial and technical assistance, opportunities are lost and intended reforms fail.

This report summarizes the results of a colloquium sponsored by the National Policy Consensus Center involving experts on health care access and community collaborations from across the country. It concludes with specific recommendations to state agencies and elected officials. The aim of the report is to inform both new and seasoned public servants in designing and implementing successful community-based collaborations that result in better basic health care for all citizens.





HOW CAN COLLABORATION IMPROVE ACCESS TO HEALTH CARE?

Many important initiatives to engage communities in addressing their health care crises are currently underway throughout the United States. National organizations are convening community dialogues and organizing consumer advocacy projects. Foundations and academic centers are identifying effective community strategies, analyzing the secrets of their success, and disseminating them as effective models and approaches. State governments, many of which are dealing with significant budgetary shortfalls, are monitoring the creative initiatives of certain pioneering communities. In some regions, federal, state, and community stakeholders are working together to improve access and coverage.

The body of experience and lessons learned from these collaborative approaches to improving access to health care are valuable for a number of reasons. As states assume a larger role in developing programs and reforming their health care systems, existing models of collaboration allow policy makers to evaluate what works and what doesn't, and can help identify the most promising and effective approaches to ensuring access to basic care.

Effective collaborations involve a process through which citizens, providers, advocates, government officials, and other stakeholders explore obstacles, differences, and alternative strategies for improving access to health care.

A supportive role by government is critical to the success of such collaborative initiatives. Community efforts undertaken without the participation of key leaders are far less likely to succeed. Early and sustained government involvement leads to more innovative and flexible approaches that respond to communities' specific problems of access to health care.

With an overarching focus on exploring community collaboration for improved health care access, the NPCC health care access colloquium had several goals: 1) to share examples of community-based models that have already proven successful, 2) to inspire more communities and funders to do critical experimentation and community-based research, 3) to help state and federal policymakers recognize the array of opportunities for ensuring health care access in the United States, and 4) to emphasize the essential role of consensus in creating effective partnerships.

Key recommendations

The following three key recommendations are based on research and experience from a number of community-based collaboratives throughout the country, and from input by the NPCC colloquium participants and others involved in collaborative approaches to improving health care access:

1. Many more community-based collaboratives, of differing sizes and scales, should experiment with improving health care access.
2. Policy leaders and funders should convene, support, and champion the efforts of those community-based collaboratives.
3. Research on the outcomes and effectiveness of community-based collaboratives aimed at improving health care access should be supported and disseminated.





REASONS FOR STATES TO SUPPORT HEALTH CARE ACCESS COLLABORATIONS

Despite our country's abundance of resources and advanced technologies, Americans' health status compares poorly with most other industrialized countries. The gaping health disparities that exist between rich and poor, insured and uninsured, rural and urban, black and white (and other racial and ethnic groups) are demonstrably linked to access barriers.

Health care is the fastest growing sector of spending in the United States. In addition to the costs of basic services, people—and society—pay a huge price when so many citizens go without the care they need. Individuals suffer preventable illness, pain, complications, bankruptcy, family disruptions, job loss, disability, and even premature death. Others pay, too. Infection rates increase, public health and safety are compromised, children miss school, adults miss work, productivity drops, crime and homelessness increase, social agencies are drained. Health care rates and insurance premiums soar as a consequence of cost shifting. Employers drop benefits for workers or buy policies so lean that even their insured employees can't afford necessary care.

Truly “accessible” health care means three basic things:

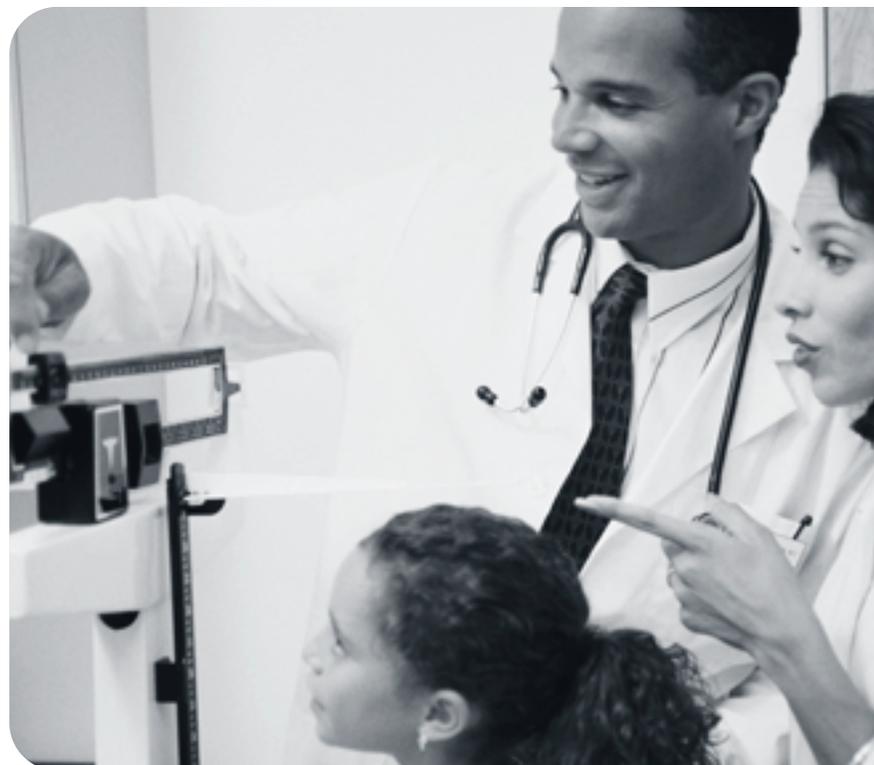
1. **Care is available.** People are diagnosed and treated promptly, and can obtain quality preventive care early enough to avoid illness or complications. Services are offered within a reasonable distance from where people live.
2. **Care is appropriate.** The right mix of health care professionals exists to attend to people's most frequent needs. Cultural and linguistic barriers are addressed in such a way that patients get proper diagnoses and can communicate effectively with their providers.

3. **Care is affordable.** Basic health insurance coverage, the linchpin of accessibility in the U.S. system, is provided for all. Additional, out-of-pocket costs are adjusted for those with low incomes.

In the United States, insurance coverage is so central to access that the terms are often used interchangeably. But the distinction between them is crucial for communities to think more broadly in addressing barriers to access. Communities usually cannot close the coverage gap by themselves, but they can reduce the impact of that gap by ensuring available, appropriate care that is affordable even to many of their uninsured residents.

In addition, communities can collaborate effectively with state and federal funders on coverage initiatives. In several cases, such public-private partnerships, initiated

3





at the community level and administered there, have achieved significant gains in insurance coverage.

The problem is that governmental regulation sometimes hinders rather than supports community solutions to problems of health care access. By learning what communities need to collaborate effectively, government leaders will be better equipped to offer meaningful support. And as state and federal decision-makers grapple with how to reform health care financing policy, their work can be strengthened by successful community-based efforts to make health services more widely accessible to the public.

This report includes a number of case examples of how communities have enhanced access to health care, and the vital roles that state and federal government have played in those successes.

Grassroots Health Care Coverage in Muskegon County, Michigan

In Muskegon County, every dollar of public money leverages two dollars of private funds. State government has allowed federal “disproportionate share hospital” (DSH) funding to be administered at the county level, attracting a favorable match from the business community, whose smaller employers have been unable to offer or sustain insurance coverage for their workers. As a result, the county’s “Access Health” program generates \$2 million annually in new revenue to pay for local health services for previously uninsured people. More than 400 businesses are enrolled and over 1,500 people are newly insured. Ninety-seven percent of local providers (more than 200 physicians) participate, as well as both county hospitals.

Created in 1999, the program was initially designed to help small- and mid-sized businesses provide employee health care. The \$2 million annual budget is financed through a three-way split. Employers and employees each contribute 30 percent (\$42 per month per member) with a community match of 40 percent that comes from federal DSH money and state, local, and private funding.

“We’ve provided for local businesses and for people who don’t have health care — the waitress, the child care worker,” said Michigan State Representative Julie Dennis. “This has helped stabilize the workforce.”

The benefit plan includes primary care, hospitalization, outpatient services, prescriptions, diagnostic lab work and x-rays, home health, and hospice care. “It’s more about managed health than managed costs,” Dennis says. “We get people into primary care first so they’re not walking into the emergency room when something happens.”

In the long run, the stress on primary care and prevention has saved the state and the county money that would otherwise have paid for uncompensated care — probably in an emergency room.

Adapted from an article by Dianna Gordon in *State Legislatures* magazine, October 2003.





WHAT SOME COMMUNITIES ARE DOING TO IMPROVE HEALTH CARE ACCESS

Ingenuity and determination are behind efforts in a number of American communities that are successfully overcoming barriers to health care access. The models vary widely, but all involve diverse community partners who have come together and reached consensus on strategies. Virtually all the effective projects involve regular monitoring and cost-benefit analysis, projecting or demonstrating dramatic savings to local and regional economies.

Some have tackled the issue of coverage by creating local, nonprofit managed care plans for low-income workers, other uninsured residents, or people living with chronic diseases. Among the most promising programs for future sustainability are those where financing involves cost sharing—in which employers, employees, government and community funders all contribute.

Other communities have addressed different elements of access. Volunteers and staff members may find underserved patients a “medical home.” Or they may facilitate patients’ enrollment in public programs, ensure transportation to health care appointments, provide translation and interpretation services, or case-manage those with chronic and costly illnesses.

Effective community collaborations usually enlist health care providers, social service agencies, pharmacies, and even insurance agents to donate or deeply discount their services to support the newly created systems.

With increasing frequency, communities are establishing bricks-and-mortar health care facilities for the underserved. More than 900 federally qualified community health centers now exist nationwide, with more opening their doors each year. These private, non-profit organizations rely on support from a variety of sources. An essential primary care safety net is emerging, made up of these health centers as well as

county health departments, rural and school health clinics, health programs for the homeless and residents of public housing, and other entities.

While these salutary projects neither “fix” the American problem of uninsurance nor reach the goal of “100 percent access, zero health disparities” (a widely cited national objective), they are a vital piece of a larger solution.

Communities that are accomplishing their immediate objectives have all required some degree of financial assistance (from taxes, set-asides, foundations, employers, and other sources). They also have relied on policymakers to create vital regulatory flexibility, to participate in or even convene collaborations, and to provide technical assistance.



WHAT COMMUNITIES NEED TO COLLABORATE EFFECTIVELY

Participants in the NPCC Health Care Access Colloquium identified a number of key elements necessary for communities to collaborate to improve access to health care:

- **Adequate resources.** Communities in financial crisis are unlikely to succeed. What the community can bring immediately to the table—including money—must be articulated. Often there are sufficient resources and assets that have yet to be tapped or consolidated to accomplish certain objectives.
- **Initiatives that are small to moderate in scale.** Although some successes have occurred in larger metropolitan areas or counties, collaborations usually come together faster and more effectively if they address smaller geographic areas, pockets, neighborhoods, or special populations.
- **Proper framing of the work to be done.** Vision may be broad and conceptual, but shared mission and objectives must be clearly defined in simple, concrete, do-able terms. Partners must identify initial priorities, then proceed incrementally to build larger successes upon smaller ones. Most steps require clear consensus and resolution of any conflicts that emerge along the way.
- **Measurable indicators.** It is difficult to measure all the benefits of improved access to health care, particularly clinical outcomes at the community level. However, progress on objectives must lend itself to reasonable monitoring and reporting. Examples of quantifiable indicators include rates of uncompensated care, number of women lacking prenatal services, number of dentists volunteering their time, immunization rates, etc.
- **Local champions and empowered leaders.** Diverse, credible leaders from key arenas must be the visible champions of collaborative processes. These may include people from churches, schools, local government, businesses, hospitals, clinics, social service agencies, and consumer advocacy groups, as well as health care providers such as doctors, dentists, and therapists. Those involved in the discussions and decision-making must be authorized to act for their groups or constituencies.
- **Participation of people with other necessary resources.** Participants from outside the local community, but who may still have a stake in the decisions being made, also should be at the table. These include state and federal government representatives, as well as philanthropic and corporate funders.



- **Commitment, a well designed process, and accountability.** All participants must commit to full involvement and maintenance of effort. They must agree to group norms, the goal of consensus, negotiating in good faith, and transparency. Along with outcomes and accomplishments, follow-through by all participants should be reported

State Convenes Collaborative Process for Migrant Health Clinic in Oregon

Acknowledging the vital role that migrant and seasonal farm workers play in the state's economy, Oregon applied to the U.S. Bureau of Primary Health Care to fund a new position. Alberto Moreno, MSW, became the first Migrant Health Specialist at the Oregon Department of Health Services in December 2002.

In response to disturbing findings from a survey of Oregon farm workers, Moreno convened a group of stakeholders in Wasco County to discuss challenges, opportunities, and the urgent need to provide health care for farm workers.

Moreno's legwork both before and during the first meeting had an immediate payoff. A federally qualified community and migrant health center from a neighboring county stepped forward as the logical applicant for new federal startup funding. Other community participants at this state-convened discussion pledged support, and later delivered on their promises.

Assistance from the St. Vincent de Paul Society, the local hospital, the state Primary Care Association, the county health department, primary care physicians and dentists, the mental health agency, the County Board of Commissioners, Migrant Head Start, and numerous others resulted in a successful grant proposal that was submitted within one month of the stakeholder meeting.

Nine months later, La Clínica del Cariño's satellite health center began serving residents of Wasco County who had previously faced severe obstacles to accessing basic health care.

regularly, including to the public at large. Involvement of the media can be very useful if engaged appropriately.

- **Neutral, skilled facilitation.** An external facilitator with knowledge of health care access issues can ensure a respectful, safe environment for discussion.
- **Ongoing external assistance.** Financial support and technical assistance are crucial for convening meetings, coordinating communication, and monitoring and reporting progress.
- **A flexible regulatory environment.** State and local rules and regulations must be flexible enough to allow creative ideas to be put into motion.
- **Useful data and analysis, presented constructively.** Most statistical reports fail to inspire people, especially when they are about concerns already widely felt. Motivating the public and community partners with information presented as marketing messages with relevance to local residents may be a more successful strategy than scientific reports. Also, analysis must be sophisticated and tailored to local interest. For example, the direct and indirect costs to the community when the local emergency room is over-utilized is likely to capture the interest and attention of local citizens.
- **Clear articulation of the benefits of a consensus approach.** The return on an investment in a collaborative process must be clear to people. For example, improved access to health care can mean less absenteeism and greater productivity from workers. People paying taxes and insurance premiums may experience less cost-shifting. Providers are likely to see more patients at earlier stages of illness, before complications and poor prognoses occur, and peoples' reliance on uncompensated care may be reduced.





RECOMMENDATIONS FOR POLICY MAKERS AND OTHER STATE AND FEDERAL LEADERS

The following recommendations are directed to governors' offices, agency heads, and other state leaders who are seeking to improve the effectiveness of collaborative approaches to health care access. They also will be useful to federal officials, local and state agency staff members, and community health care professionals whose programs and services can benefit from greater involvement of citizens and government in matters of health care delivery.

The recommendations are drawn from the ongoing experiences and lessons learned in communities where collaborative strategies are being used to address the crisis in health care access.

1. **State and federal regulations and requirements should be flexible enough to be changed when needed.** Regulations are meant to protect the public and its resources—but not from the public's own good ideas.

To support the development of community-based, collaborative health plans, the Arkansas State Legislature passed an exemption for such collaboratives from the legal and financial requirements governing other health insurance entities. One legislator noted, "Sometimes we just need to get out of the way."

In California, North Carolina, Mississippi and elsewhere, state leaders are working with community stakeholders to assist in developing and growing community networks. Georgia has eight Team Leaders—trained in facilitation, strategic planning, mediation, and leadership development—who serve as community catalysts. Through a partnership with the National Conference of State Legislators and the National Association of County Commissioners, the Georgia team has convened some 100 state and local leaders to develop more effective support of community health access projects.

At the federal level, the U.S. Office of Rural Health Policy and the Health Resources and Services Administration are making strides—via state-administered Offices of Rural Health, Primary Care Associations, Community Access Programs, and other entities—to strengthen and support more than 60 community-based networks in some 30 states.

2. **Top-level leadership should be willing to participate fully, and take risks.** Governors, legislators, state officials, and foundations often recognize windows of opportunity that community members are unaware of. Officials who show up only because they are expected to, then do little to contribute to the process, are unlikely to be able to demonstrate success. Instead, leaders should treat community collaborations as a significant tool for addressing the complex problems associated with access to care, and as a complement to more traditional models. They should encourage agency staff to participate in community collaborations, and empower them to reach and implement agreements with those communities.

In Louisiana, some 20 partners—including foundations, state and county agencies, professional associations, and others—stepped forward as leaders in coordinating the efforts of communities working to improve health care access. The state's Office of Rural Health is now looking at ways to reconfigure its funds, and has expressed a willingness to change how it does business by providing more support (such as technical assistance) to community networks.

3. **Policymakers and convenors should ensure that skilled technical assistance, including data analysis and conflict resolution, is available to stakeholders.** Communities often lack the infrastructure and resources necessary to manage collaborative processes efficiently. Lack of access to



useful databases such as Medicaid utilization figures can be significant barriers to effective negotiating and implementation strategies.

Georgia state policymakers joined forces with local and national foundations to provide grants and technical assistance to communities, noting the alignment of goals: increased access, health status improvement, and economic sustainability of local community projects. The state also commits economists and researchers to work with community groups who are building collaborative access projects.

4. **State leaders should look creatively at financing, particularly leveraging and rearranging of resources.** For example, are state funds available that could be matched with local monies? Can indigent care trust funds be used for a community coverage initiative? Are private sector contributions a possibility? Can modifying state tax structures free up vital funding?

In Michigan, the state uses federal Medicaid DSH (“disproportionate share”) funds as the third, governmental element in counties’ “three-share” market-oriented coverage programs. The state is currently exploring even more opportunities within state and federal funding environments, including Medicaid administrative monies and their potential federal match, to support community-based networks.

Habersham County, Georgia, is involved in a new demonstration project in which state employee benefits funds are paying for a four-county community collaborative to undertake case management for high-risk beneficiaries with chronic illnesses. This allows counties to use the same infrastructure to case-manage both Medicaid patients and the uninsured, and to sell their valuable service to businesses. The project could turn a state experiment at one level into a sound investment at several other levels, even generating its own revenue.

5. **The state should provide incentives for both private and public sector participation.** State leaders can require or offer incentives to businesses, foundations, and others in the private sector to come to the table.

Indicative of Georgia’s strong commitment at many levels to community-based access projects, the state now requires its hospitals to spend 15 percent of their

Partnering for Health Care Access in Wichita

In Wichita, Kansas, uninsured residents are eligible for donated services from physicians, hospitals, and pharmacies through “Project Access,” a program sponsored by Central Plains Regional Health Care Foundation, Inc. (CPRHCF).

Thanks to the vision and sustained support of the Medical Society of Sedgwick County, United Way, the city, county, state and others, CPRHCF has been able to organize and maintain services, and even grow the organization. With 55,000 uninsured in the region, volunteer-only services will not be sufficient to address all access problems. But the seed is there, the participants are involved and invested, and the successes are mounting.

Sixty-five percent of local physicians and all area hospitals treat “Project Access” patients, and 65 pharmacies fill prescriptions at 15 percent below wholesale prices, with no filling fees. In addition, the City Council and the County Commission each pledged \$500,000 annually to pay for prescription medications.

Program Director Anne Nelson predicts a business case will emerge to spur a larger community health initiative, perhaps even some kind of coverage plan. And Governor Kathleen Sebelius, a former state insurance commissioner, may prove to be uniquely knowledgeable and open to such collaborations, Nelson says.

In the meantime, United Way support of \$180,000 per year has been a hugely effective investment. In 2002 this funding translated to \$5 million in donated health care. CPRHCF founder Dr. Paul Uhlig and Wichita United Way President Patrick Hanrahan received a Mary M. Gates Award for this work. In accepting the award, Hanrahan challenged all United Way chapters to fund local community collaborations for health care access. As a result, such activity is now a formal arm of the United Way of America.



indigent care funding on primary care, thus stimulating their investment in community programs outside their usual inpatient care purview.

6. **States should support development of community health centers and safety net providers.** State support of safety net clinics can mean the difference between expansion and closure. The safety net today makes possible the implementation of Medicaid and, increasingly, Medicare. This safety net uniquely serves immigrants, the uninsured, and other special populations. State- and foundation-sponsored demographic studies can offer support for the development of new clinics. Solid relationships between state Medicaid offices and these safety net providers are essential.

*Several states provide funds to their **Primary Care Associations, Offices of Rural Health,** and other agencies specifically to assist communities in developing needs assessments, grant proposals, and recruitment and training of Boards of Directors to establish federally qualified community health centers. Other states provide direct financial assistance to established centers. For example, the **State of Virginia** sponsors a network of state-qualified community clinics that encourages collaboration between safety net providers and state agencies.*

7. **Leaders—including governors, legislators, and state and federal agencies—should use their ability to convene to bring all essential parties to the table.** While direct involvement of the governor's office in a collaborative process may be infrequent, its convening authority can be direct and powerful. In most cases, the governor will be able to impart that authority to a community leader, staff member, or agency head. The governor, staff member, or agency head can recognize, support, or encourage on-going efforts by local collaboratives that are already convened under a skilled leader. The encouragement of governors and agency heads demonstrates their commitment to the process and outcome.

Improving Health Access for Seven Cities in California

More than 60,000 of the 370,000 residents of Solano County, California were uninsured in 1988, and another 45,000 on Medicaid faced a dwindling supply of physicians willing to treat them because of low and complex reimbursement rates. Although California requires counties to provide health care to indigent residents, Solano had no county hospital. A budget crisis threatened the viability of two county clinics, the primary points of care for this population.

A small group of health care leaders began meeting to address this problem, and soon formalized a non-profit partnership called the Solano Coalition for Better Health. The thriving Coalition includes high-level county administrators, CEOs of the three area hospitals, clinic administrators, United Way, federal and state legislative staff, providers, consumers, insurers, and churches.

By 1994 the Coalition opened what is now the county-run Partnership Health Plan of California that serves its Medicaid population. The plan has resulted in 45,000 residents with new access to integrated and comprehensive primary care; a 50 percent drop in emergency room use; a 33 percent decrease in hospital inpatient days for Medicaid enrollees; and a successful prenatal case management plan. Medicaid reimbursement rates to providers have increased substantially, and primary and specialty care physicians have assumed leadership roles in operations.

The Solano County Commission has been a key player. It allocated all its tobacco settlement monies to health care, and developed a Strategic Plan for Health Care Access in partnership with the Coalition.

State involvement also has been essential. The Coalition needed California's approval to be one of three counties allowed to organize their own single health plans for administering managed care Medicaid. Not only was the state open to piloting Solano's model, it also has continued to support the 10-year-old plan, which is no longer a pilot.





CONCLUDING CONSIDERATIONS FOR LEADERS AND CONVENORS

The traditional delivery and financing models for health care in America have proven inadequate. Despite accelerating expenditures, highly advanced technologies, and a rich variety of professional providers, an increasing number of people lack ready access to even the most basic primary health services.

The crisis has compelled community leaders, health care providers, advocates, states, and other key stakeholders to apply collaborative practices to resolving the complex problem of access to health care. These community-based initiatives have the potential to expand access to care, improve health outcomes and productivity, and even reduce health care costs over the long term.

Yet for collaborative approaches to be successful, leaders at all levels of government must be committed participants. By supporting existing collaboratives aimed at improving access and coverage, governors and other leaders can help move projects beyond the demonstration or pilot stages into sustainable programs with enduring benefits.

Convenors and participants in a process must think and act for the long term. In doing so, there are a several important factors to consider before committing time and energy to collaborative processes. First, successful collaborations take time. Where financial and technical support is needed, it likely will be required for some years or—for some projects— indefinitely. In addition, providing “seed money” alone can lead to failure in communities requiring some amount of continued external funding or other resources. Secondly, program evaluation requirements may stall community initiatives when the reporting measures or bureaucratic details are onerous.

Modest investments of state funds to enable and support community collaborations can have a big payoff. States can play a key role in assisting with data collection and

dissemination, and in developing new data to provide the factual basis for agreements. State agencies can assign resources for monitoring the outcomes and effectiveness of programs, or by assisting community groups in developing assessments and plans that are manageable and compliant with existing regulations.

State and federal involvement in community level collaboratives holds great promise for improving health care access, just as it does for environmental protection, stewardship of resources, education, and regional economic development. Based on past experiences and the growing record of accomplishments across the country, community collaborations to improve access to health care will achieve greater success and sustainability with increased state support and active participation by leaders at all levels.





REFERENCES AND RESOURCES

Useful websites

Agency for Healthcare Research and Quality: State and Local Policymakers

<http://www.ahrq.gov/news/ulpix.htm>

Federal scientific agency focused on quality of care research. Coordinates all federal quality improvement efforts and health services research.

American Project Access Network

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

National, nonprofit that assists communities in establishing and sustaining coordinated systems of charity care based on the Project Access model.

Assessing the New Federalism (Urban Institute)

<http://www.urban.org/Content/Research/NewFederalism/AboutANF/AboutANF.htm>

Multi-year Urban Institute research project that analyzes the devolution of responsibility for social programs from the federal government to the states.

Bureau of Primary Health Care Models That Work Campaign

bphc.hrsa.gov/programs/MTWProgramInfo.htm

Public/private partnership of national foundations, associations, nonprofits, federal agencies and business. Promotes access to primary and preventive health care for underserved populations.

Center for Collaborative Planning

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

Promotes health and wellness in California by engaging local communities to identify their own issues, assemble resources, and find solutions.

Communities Joined in Action

www.cjaonline.net

Private, nonprofit that brokers access to technical talent, peer-mentors, and experts to help communities gain commitment of political leaders and evaluate health care delivery options.

Community Health Leadership Program

<http://communityhealthleaders.org/>

Program of the R.W. Johnson Foundation that honors 10 outstanding individuals who overcome daunting odds to expand access to health care and social services to underserved populations.

Community Tool Box

<http://ctb.ku.edu/>

Provides practical information to support community health and development. Tool Box offers "topic sections" with guidance on how to promote community health and development.

Community Voices

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

Works to ensure survival of safety-net providers and strengthen community support services. Eight Community Voices sites are part of a national effort to meet the needs of people who receive inadequate or no health care.

FACCT (Foundation for Accountability)

<http://www.facct.org/facct/site/facct/facct/home>

National organization working to improve health care by advocating for an accountable and accessible system in which consumers are partners in their own care.

Georgia Health Policy Center

<http://www.gsu.edu/ghpc>

Nonpartisan forum for consensus building aimed at improving the health of Georgians through research, policy development, and program design and evaluation.

Health Affairs: The Policy Journal of the Health Sphere

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

Bi-monthly peer-reviewed journal that explores current health policy issues.

National Governors Association Center for Best Practices

<http://www.nga.org/center/>

Helps governors and key policy staff develop and implement innovative solutions to challenges facing states. Among its five divisions is Health, covering a broad range of health financing, service delivery, and policy issues.



Sierra Health Foundation

www.sierrahealth.org/

Private philanthropy supporting health and health-related activities in a 26-county region of northern California. Focuses on collaboration, communication, and sharing successful strategies.

State Coverage Initiatives

<http://www.statecoverage.net/>

A R.W. Johnson Foundation initiative aimed at planning, executing, and maintaining health insurance expansions in states. Policy experts work with states to expand coverage to working families, build on employer-based health insurance, and foster collaboration among stakeholders.

Center for the Advancement of Collaborative Strategies in Health

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

Helps partnerships, funders, and policy makers in collaborative efforts to solve complex problems related to health and other areas. Works closely with people and organizations involved in collaboration.

The Center for Studying Health System Change

<http://www.hschange.com/>

Nonpartisan policy research organization that conducts studies on the U.S. health care system to inform policy makers in government and private industry.

The Commonwealth Fund

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

Private foundation that supports independent research on health and social issues. Makes grants to improve health care practice and policy.

The Institute for Health Policy Solutions

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

Nonprofit that develops creative solutions to health system problems related to access, cost, and quality.

The Henry J. Kaiser Family Foundation

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

Private, nonprofit operating foundation focused on the nation's major health care issues.

Volunteers in Health Care

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

National resource center funded by the R.W. Johnson Foundation for organizations and clinicians caring for the uninsured. Provides technical assistance and small grants.

Wye River Group on Health Care

<http://www.wrgh.org/index.asp>

Forum for collaboration and exchange of ideas to promote constructive healthcare system change.

Publications

An Online Version of this report is available at www.policyconsensus.org.

Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics (August 2002). *Chartbook on Trends in the Health of Americans*. Excerpted from *Health, United States, 2002*.

IBM Endowment for The Business of Government, *New Ways to Manage* series (March 2003). *Extraordinary Results on National Goals: Networks and Partnerships in the Bureau of Primary Health Care's 100% / 0 Campaign*.

Institute of Medicine of the National Academies, Committee on the Consequences of Uninsurance. Series of six reports on Uninsurance in America, The National Academies Press:

1. Coverage Matters: Insurance and Health Care (2001)
2. Health Insurance Is a Family Matter (2002)
3. Care Without Coverage: Too Little, Too Late (2003)
4. Hidden Costs, Value Lost: Uninsurance in America (2003)
5. A Shared Destiny: Community Effects of Uninsurance (2004)
6. Insuring America's Health: Principles and Recommendations (2004)

Hadley, Jack and Holahan, John, "How Much Medical Care Do The Uninsured Use, And Who Pays For It?" *Health Affairs*, February 12, 2003, and "Covering The Uninsured: How Much Would It Cost?" *Health Affairs*, June 4, 2003.

Holahan, John, et al. "Which Way For Federalism And Health Policy?" *Health Affairs*, July 16, 2003.

The Kaiser Commission on Medicaid and the Uninsured, The Cost of Not Covering the Uninsured project, *Sicker and Poorer: The Consequences of Being Uninsured*, May 2002.

Lesser, Cara S. and Ginsburg, Paul B. Health Care Cost and Access Problems Intensify, *Issue Brief No. 63: The Center for Studying Health System Change*, May 2003.

Silow-Carroll, Sharon, et al, *Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity*. One in A Series of Community Voices Publications, prepared for the W.K. Kellogg Foundation, November 2001.

The Wye River Group on Healthcare, *Communities Shaping a Vision for America's 21st Century Health and Healthcare*, September 2003.





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Definition of Oregon's Health Care Safety Net

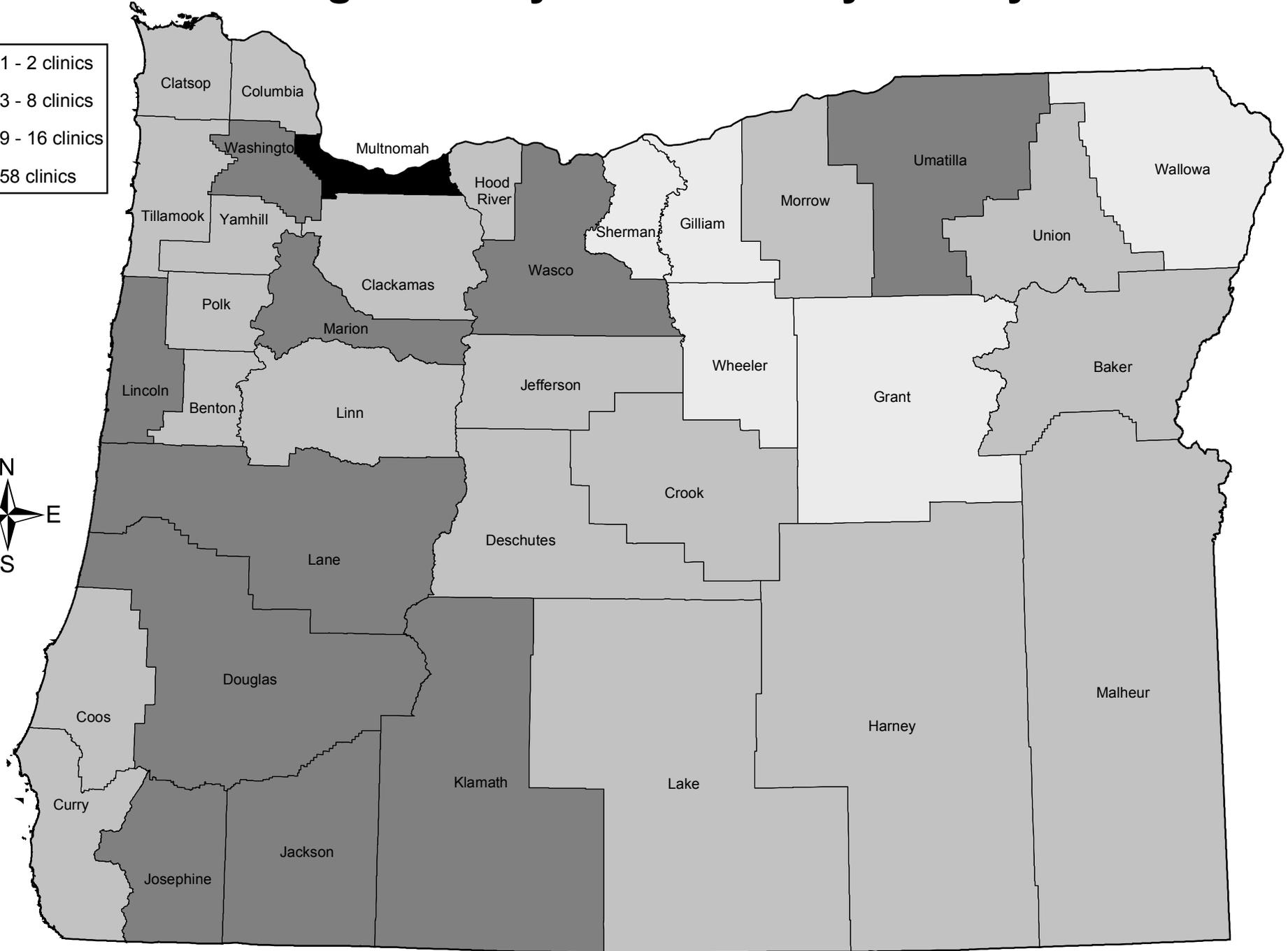
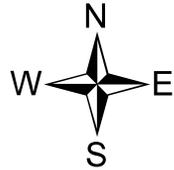
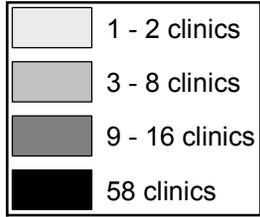
As developed by the NGA Health Care Safety Net Policy Team and the Safety Net Advisory Council.

*The **health care safety net** is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.*

The following is the statutory definition of the Health Care Safety Net, resulting from the Healthy Oregon Act (SB 329).

- **Section 2 (8)** "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.
- **Section 2 (2)** "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance, and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.
- **Statement of Principle:**
Section 3 (16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

Oregon Safety Net Clinics By County



Includes Federally Qualified Health Center's, Rural Health Center's, School Based Health Center's, Local Health Department Clinics, Indian/Tribal, Clinics, and Community Volunteer Clinics.

Prepared By: ORDHS, Health Systems Planning, 1/10/08

