

“Better Health...For More People...At Less Cost”

Communities in Action: Reforming the Health Care System from the Inside Out
A Report for the U.S. Bureau of Primary Healthcare

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Introduction

Better health for more people at less cost. It is tempting to dismiss such a phrase as a trite sentiment or a utopian vision. The problem with either assessment is the fact that communities across the United States have turned this slogan into reality.

Many of the community leaders responsible for producing unprecedented levels of quality and affordable health care for uninsured and underinsured populations gathered in Washington, D.C. in June 2001 for an explicit purpose: to celebrate their success and to enhance action at the local level to further their cause.

The national conversation surrounding health care reform has long fixated on federal solutions, such as legislation and funding. But the leaders engaged in locally driven health care reform recognize that through new partnerships and relentless innovations, they already have access to the local resources and possess many of the tools necessary to effectuate real and sustainable reform.

This is not to say there is no longer a significant role for federal, state and local government. Indeed, there are many vital contributions that government can provide, such as funding, technical assistance and others (see Campaign Leadership Agenda). Another function pertains to its role as convener, the value of which was manifest in the Communities in Action conference, attended by over 500 community leaders who came together from dozens of states.

Indeed, to maintain the momentum generated at the June conference, BPHC is sponsoring a videoconference on September 26, 2001 and collaborating with the Health Research and Educational Trust, National Association of Community Health Centers and others on a conference in late November.

Campaign Leadership Agenda

1. Leadership - set ambitious and realistic goals.
2. Bully Pulpit - assert that it can be done.
3. Identify, profile and promote models that work.
4. Declare a model and stand by it.
5. Track results.
6. Help communities overcome barriers.
7. Help communities invest to capture resources already in system.

This paper is not intended to summarize the entire conference just held, but rather its aim is to address each of the three interrelated goals contained in the conference title: improved health outcomes, access to care and cost savings. Access and health outcomes are directly related – access leads to health care, and quality care to improved health. And the better the access and quality of the health care system, the lower the total cost – not only the direct health care costs, but also the indirect costs of poor health – to patients, providers, and payers.

“Better Health ...” – In Search for Quality

Crossing the Quality Chasm

The recently released Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, outlines six characteristics as goals for the nation’s health care system in the 21st century. According to the report, health care should be safe, effective, patient-centered, timely, efficient, and equitable. But the IOM report also describes the reality today: a fragmented system, wasted resources, and untapped knowledge.

From acute to chronic care. Before it can cross the quality chasm, the health care system must catch up to the realities of disease at the beginning of the 21st century. Fifty years ago, the more serious threats to health were from acute diseases such as infections. But today, the most serious health threats arise from chronic conditions such as diabetes. This shift reflects real successes in health care: infections have been brought largely under control, and the rise in chronic illnesses reflects a population that is living longer. The shift also represents a new challenge for the health care system.

Persons suffering from chronic illness are likely to enter the system only episodically for acute symptoms related to the underlying condition, and there is frequently no follow-up after they leave the hospital, clinic or doctor's office – until the next crisis. The shift to chronic illness also increases the importance of pharmaceuticals – such as drugs for asthma, diabetes or hypertension – in the overall health care system.

The 100% Access/Zero Disparities campaign addresses the need for continuity of care through an integrated system of health care providers. And communities involved in the campaign are devoting an increasing share of attention and resources to ensuring that pharmaceuticals are available and affordable to clients. In addition, the campaign is promoting initiatives to identify and treat population-based conditions and to provide culturally competent care. As Edward Dismuke, M.D., told a breakout session at the conference, most physicians are not trained to address population-based approaches.

In these and many other ways, providers and partners in the 100% Access/Zero Disparities campaign are improving the quality of health care for the uninsured and underserved in communities across the United States. There are myriad manifestations of this claim:

- Increased number of people in care.
- Increased percentage of communities' uninsured population in care.
- Increased numbers of community systems that have been established.
- Reduced costs for hospital admissions.
- Reduced emergency room visits.

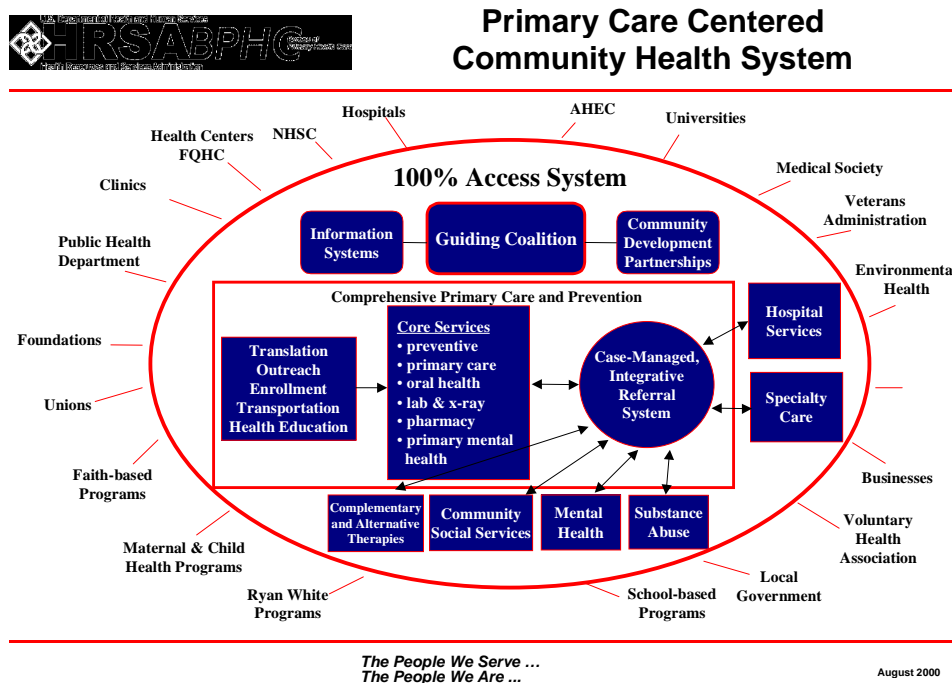
Through measures such as the ones described earlier (integrated systems, pharmaceuticals, culturally competent care) cost savings will be even greater in the long term. Yet, the true measure of the reforms is in the improved quality of life for millions of Americans.

Community Solutions

Communities are improving health care by incorporating into their health care systems the three imperative qualities cited in the IOM report. They are creating health care delivery systems that are patient-centered, and evidence-based with equitable access.

Systems Focus: An integrated approach. The 100% Access/Zero Disparities campaign is built around an integrated model of health care. The model is

designed to ensure that every patient is in a primary care medical home and to provide a full complement of resources *after* the patient’s initial visit to a primary care provider. And it is organized around a central referral point, so that a patient is not caught in a dead-end corner of the traditional health care maze. The following figure illustrates the BPHC template for a fully integrated system, which is a future aspiration for some communities while it is present day reality for the early innovators.



The lack of a systems approach is a problem throughout the health care system, but it is especially difficult for uninsured and underserved patients to reach appropriate care. For example, primary care providers cite the frustration of finding specialist physicians to whom they can refer low-income and uninsured patients. Health centers and doctors cite the futility of treating symptoms of chronic illness when they know that patients will not have the pharmaceuticals necessary to manage their condition.

Communities that have successfully implemented the campaign vision – such as Buncombe County, North Carolina – have enlisted a roster of specialist physicians to provide care, and have created a central clearinghouse to make patient referrals and to track providers’ contributions. To ensure broad based participation, the Buncombe County Medical Society has created a ceiling for primary care physicians (10 patients per year) and specialty care physicians (20 patients per year) to protect participating doctors from over-extension.

The average wait for a physician appointment in Buncombe County has dropped from 6 months to 1-2 weeks. The number of repeat visits per patient per year has declined from 8.6 to less than 5. The integrated system has cut the time patients spent per office visit and has decreased the no-show rate. These improvements are reflected in patient satisfaction: 99% of patients in 1998 survey said that they were satisfied with their health care, and 80% reported improved health. In addition, absenteeism from work is down 13% for area employers.

Many communities are also addressing the futility of providing free care by physicians without providing affordable access to the medications they prescribe. The practice established in Buncombe County – and replicated in Sedgwick County, Kansas, and elsewhere – is to fund prescription programs through county government. At the conference, Mary Lou Anderson, former Deputy Director of BPHC, presented strategies for making pharmacy an integral part of a community agenda for 100% access and zero health disparities. The CommuniCare program in South Carolina and the Federal drug-purchasing program were among those featured.

And many communities are improving the quality of health care by offering a broader range of services to address issues that impact on health. These services include dental, mental health, and substance abuse care. Conference attendees heard about programs to expand access to dental services through a federally qualified health center in Michigan, a school-based program in Rhode Island, and systems of base clinics and mobile offices in Minnesota and North Carolina.

The key to the effectiveness of these services is providing easy access to the people who need them. Cretta Johnson, Director of Health and Social Services in Hillsborough County, Florida, told the *Communities in Action* conference about the county's "holistic" approach to meeting the needs of indigent and working uninsured citizens. The Hillsborough HealthCare Plan is an integrated system employing managed care principles. The plan provides "one-stop shopping" from 24 locations, with an internal referral network of more than 50 services: including not only health care, but services such as food vouchers, energy assistance, job placement, and child care.

The following section of this report, dealing with access to health care, will discuss another aspect of the systems-based approach: consistent, centralized information systems that are increasingly electronic and web-based.

Patient-centered: Case management. Case management applies the resources of an integrated health care system to serve patients who need ongoing intervention.

Hillsborough HealthPlan's case management program, for example, is designed for chronic or severely impaired members who will benefit from intervention and connection with community resources, or based on eligibility factors such as three or more ER visits in three months, high pharmaceutical utilization, or medical or

social non-compliance. The program assigns a social worker and nurse to each case, creates a care plan with goals, and offers intensive services to attain maximum medical improvement and self-sufficiency.

Johnson presented figures from Hillsborough County indicating sharp reductions in hospital admissions for chronic disease. In 1992-1993, diabetic complications accounted for 26% of all hospital admissions; in 1999-2000, that share had been reduced to 0.03%. In 1992-1993, asthma accounted for 9% of all hospital admissions; in 1999-2000, the figure was 0.03%.

Access Emanuel in Emanuel County, Georgia, provides case management services to chronically ill patients upon referral from the primary care provider. An initiative supported by the Hospital and Health Department has reduced the cost of care for 58 chronically ill patients from \$829,272 in fiscal year 1999 to \$168,897 fiscal year 2000.

Personnel include a Registered Nurse, a staff member hired by Emanuel County Department of Family and Children Services to assist in home visits and needs assessments of patients, and a staff member solely responsible for completing indigent medication programs applications to pharmaceutical companies. The program supports chronically ill patients referred by hospital and primary care providers by providing:

- intensive disease state monitoring,
- care coordination with various providers,
- health education programs and support groups, and
- provision of free diabetic supplies.

The program offers prescription assistance, with 192 patients currently being served, and

prescriptions with a retail value of approximately \$65,000 distributed in the first five months of the program beginning in February 2001.

Evidence-based: Targeting risk groups. While the goal of the BPHC campaign is universal – 100% access to health care and 0 health disparities – it uses targeted approaches. Rather than aiming at some least common denominator, communities are applying sophisticated knowledge of risk factors to target groups with that can benefit most from intervention. In fact, according to the Health Care Financing Administration, between 3% and 5% of patients account for 50% to 60% of the medical costs paid by their insurer.

Many communities are taking approaches similar to those of “population risk management firms.” One such firm is FutureHealth, which manages 400,000

people in insurance pools nationwide. According to the *Washington Post*, FutureHealth “operates under the revolutionary principle that identifying the small percentage of patients in an insurance pool who are most likely to land in the hospital and then devoting resources to keeping them healthy can significantly reduce the cost of caring for the entire group.”

Dr. Ken Jennings, an adjunct fellow of Hudson Institute, made a similar point in a breakout session at the June conference when he advised communities to “go at risk.” While insurance companies may try to avoid risk groups, going after those groups holds the best opportunities for improving health and reducing costs. And many communities are doing just that. Two examples of these kinds of efforts are programs for asthma and for expectant mothers at risk for pre-term births.

Asthma: - HealthNet Community Health Centers in Indianapolis is piloting a program to attack high rates of asthma among African American women. Design elements include clearly identifying medical records of asthma patients, following up on planned care visits, and providing self-management support. Program goals include the following: 100% of patients with persistent asthma receive treatment and long-term control medication; less than 1% of patients make an ER visit for asthma; and less than 2% will be admitted to the hospital for asthma.

After approximately 10 months, nearly 60% of patients had a written asthma action plan, up from zero when the pilot program began. There has been a significant decline in the percentage of patients with ER visits, from around 20% through the first 26 weeks of the program to the low single digits. The percentage of patients with hospital admission has steadily declined from 10% at the beginning of the program to about half that amount. But much progress is still to be made in measures of self-care and symptom control.

Pre-term Births: The Prematurity Prevention Program in Asheville, North Carolina, identifies pregnant women who have had a prior pre-term delivery or who display other risk factors, such as age under 17, weight below 100 pounds, or cigarette smoking.

Once a provider to the system refers a woman, she is contacted by phone, and a home visit is scheduled if the patient desires one. Women who agree to participate in the program receive calls every one or two weeks, and targeted reports are prepared at specific points in the pregnancy.

The following table shows the decline in the percentage of babies delivered pre-term in Buncombe and Madison counties in the first year of the program, which began in February 1999:

	<u>1st Qtr '99</u>	<u>1st Qtr '00</u>
All Deliveries	12.95%	11.13%
African American	21.28%	13.16%

In addition, the direct cost per delivery for women participating in the prenatal initiative was \$884 compared with \$3,524 for non-participants.

BPHC role in quality. The BPHC is tracking these quality initiatives and assisting the transfer of innovation through its quality improvement initiative spearheaded by Dr. Frank Zampiello, who informed participants that quality is one of the main determinants of improved access and reduced cost. HRSA Associate Administrator Dr. Marilyn Gaston, who established the Quality Center that Zampiello directs, has also been a leader in infusing quality principles in community health center practices.

Dr. Gaston challenged community health centers to gain JCAHO accreditation. In the face of resistance and objections that “we’ll never meet the standards,” Dr. Gaston launched a full-scale offensive to help community health centers qualify for certification – including process manuals, technical assistance, and mentorships whereby newly accredited centers would shepherd applicants through the process. The result: 95% of centers earned JCAHO accreditation within three years.

The IOM report cites the BPHC as one of three models of quality in its effective administration of health centers. The Bureau’s key contribution to quality is its effort to replicate best practices in health centers across the country, which they are pursuing in partnership with the Institute for Healthcare Improvement.

“... for More People...” – The Access Challenge

40 Million and Counting: Good People Trapped (Outside) Bad System

In a March 2001 address announcing his appreciation for the work of community health centers, Health and Human Services Secretary Tommy Thompson cited the need that drives the BPHC’s efforts to reach the underserved: “Among our most important responsibilities is improving the health care safety net for all Americans. Currently, there are 43 million uninsured Americans, and this is simply unacceptable. In a nation as compassionate as ours, we need to find ways to provide access to affordable health care for all Americans. This isn’t just responsible leadership or government – it’s responsible citizenship.”

In addition to the unacceptably high number of uninsured, evidenced by conference representatives from Houston which suffers a population of 828,022 that lack insurance, there is a total of 48 million people nationally who lack access to a regular source of care. Of these, about half represent minority groups. The Institute of Medicine report describes a health care system that is a “nightmare to navigate,” and that is particularly true for low-income and uninsured individuals.

Hence the second major goal of the BPHC's campaign for 100% access and zero health disparities is to expand access to care.

The BPHC campaign complements action by President Bush to expand access by increasing funding for consolidated health centers. The President's budget for FY 2002 adds \$124 million for health centers, amounting to a new total of \$1.3 billion, as part of a multi-year initiative to support 1,200 new or expanded health center sites. Approximately 11 million people are currently being served at over 3,000 health center sites, and President Bush wants to increase the number of people served by 6.1 million and increase the number of clinics by 40% over the next five years.

Researchers at the BPHC and Johns Hopkins recently published a study on "The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care," in *Medical Care Research and Review*. The study found that health centers reduce disparities by "establishing themselves as their patients' usual and regular source of care."

Indeed, health centers have often played a pivotal role in community efforts to achieve 100% access and zero disparities. Indianapolis has demonstrated this kind of action in response to the crisis created by a dramatic increase in Medicaid recipients. Douglas Elwell, President and Executive Director of The Health and Hospital Corporation of Marion County, said that his agency was determined not to clamp down on access, but rather to make access real. Thus, his agency created Wishard Advantage, an integrated system of health care providers to serve the target population. In fact, the program intends to "knock on every door" in Indianapolis (literally) to double participation from 25,000 members today, to 50,000 in two years.

Community health centers are one element in a larger effort to expand access. A study published in the *Journal of the American Medical Association* in October 2000 found that most primary care for persons with Medicaid or no insurance was provided in physicians' offices. The study concluded that increasing the number of community health centers would significantly reduce race/ethnicity inequalities in use of primary care, but eliminating such inequalities "will require policy directed at improving vulnerable populations' access to mainstream physicians' offices as well as traditional safety-net delivery site."

Muskegon, Michigan, expanded access to physicians by addressing the gap between privately funded and government-funded coverage. Muskegon County estimated that 102,000 residents were covered by commercial health plans, and Medicaid/CARE covered 45,000 low-income residents. But that left a gap of 17,000 uninsured individuals, most working, many of them moving off welfare, according to Vondie Moore Woodbury, project director of the Muskegon Community Health Project.

Another side of Muskegon's problem in providing health coverage for many individuals was its negative impact on the local labor market. A 1999 survey of county businesses with fewer than 20 employees found that 64% could not offer health coverage, with 69% citing cost as the primary reason. Two-thirds said that coverage would reduce turnover, and over 80% would offer coverage if it was affordable. Thus, Muskegon officials created Access Health as a health coverage benefit program available to individuals through their employer. Muskegon County businesses are eligible if they have fewer than 20 employees and a median hourly wage of \$10 or less, and have not offered health insurance for the previous 12 months.

Access: Linking Resources to Needs

Access is the necessary correlate of efficient resource utilization. A guiding principle of the 100% Access /Zero Disparities campaign is that communities can and should look first to the resources they already have. Enhanced access is the result of linking those resources to the people who need them.

Wichita: Leveraging resources. Project Access in Sedgwick County, Kansas, is designed to leverage the community's health care resources to serve those in need. In the group's own words, "The goal of Project Access is to coordinate patient enrollment and referrals that make a broader range of donated services available for uninsured people. This also frees the physicians and their office staffs from tracking down additional donated services allowing them more time to provide patient care. The additional recruitment effort will increase the numbers of available providers."

Project Access leverages a budget under \$200,000, which supports a staff of five, to tap the health care resources of the entire community. More than 500 physicians have pledged care sufficient for approximately 9,300 patients annually. The total value of contributions during the first 15 months of the program was \$6.9 million, including \$4.7 million from hospitals, and \$2.0 million from physicians.

These contributions enable Project Access to provide a broad range of health care services. County residents are eligible for the program if they have no medical insurance, are not currently receiving state or federal medical benefits, and have a family income that does not exceed 150% of Federal Poverty Level. Approximately 70% of patients are enrolled through the area's six low-cost, primary care clinics, 30% at the request of physicians.

Health centers benefit significantly from the new system because they now have organized sources of additional specialty, pharmacy and hospital care for their patients who need it.

Community Solutions

Three approaches for expanding access to care that have been especially evident in the BPHC campaign include:

- **reducing complexity and barriers,**
- **increasing entry points,** and
- **coordinating providers of care.**

This section of the report describes three different approaches described at the conference, with an example of each. Of course, these approaches are interrelated, and each program cited here contains elements of the other approaches.

Reducing complexity – Emanuel County. Improving access means seeing the health care system through the eyes of those who are – or are not – being served. Complicated enrollment procedures place barriers in the way of people who are embarrassed to ask questions – or to even seek treatment.

Access Emanuel is aimed at serving 4,100 uninsured residents, 21% of the total population of Emanuel County, Georgia. A primary objective of reform was to improve access to rural residents who were not only unfamiliar with the health care system, but also reluctant to accept “charity,” according to Rebecca Riner, director of Access Emanuel. A common enrollment and eligibility form makes it possible for residents to access the system through any of more than 20 entry points, enrollees become regular patients of local providers, and services are provided according to a sliding fee scale.

Access Emanuel’s primary health care network, includes 13 primary care providers, 6 specialty physicians, the East Georgia Healthcare Center (a Federally Qualified Health Center), Emanuel Medical Center, Mullins Lab, the Emanuel County Health Department, Bass Physical Therapy, and Behavioral Health Services. Four local participating pharmacies provide prescriptions from the Access Emanuel formulary for \$7.

The county had a history of fragmented, ineffective care delivery to those without insurance. Despite increasing costs for the local hospital, providers, and community, the health status of the community was showing no sign of improvement. From March 2000, when enrollments began, through June 2001, Access Emanuel has achieved the following outcomes:

- served more than 1,500 residents without health coverage;

- enrolled 45% of the targeted uninsured population, providing them with access to primary care and a “healthcare home” ; and
- made more than 400 referrals to state and federal health care programs resulting in eligibility and increased PeachCare (CHIP) enrollments from 217 to 602.

The program reduced hospital indigent care costs from \$590,000 to \$150,000, while facilitating access to a broader range of health care services. The value of the health care services provided breaks down as follows:

Primary care providers:	\$594,000
Emanuel Medical Center	273,000
Pharmacies:	<u>15,000</u>
Total	\$882,000

Increasing entry points – Pittsburgh. As noted above, communities are increasing the number of entry points through the existing health care system by adopting common procedures. But communities are also expanding access by creating entry points *outside* the health care system itself.

A leading initiative to expand access is to tap faith-based organizations as advocates and entry-points. Churches, for example, are likely to be aware of the health problems of their congregation, and many faith-based organizations have a tradition of attending to the health needs of their communities. Members who might be fearful of a clinic or agency might feel more comfortable seeking health care services through their faith community.

Health care reformers in Pittsburgh, many of them representing faith-based organizations, have utilized those organizations in a variety of ways to improve access to health care, according to Douglas M. Ronsheim, Executive Director of the Pittsburgh Pastoral Institute.

One example is Families & Youth 2000. This collaborative consists of two primary care centers, an outpatient psychiatric clinic, a life skills tutoring and mentoring organization, and four African-American churches. The collaborative provides the church congregations ready access to an array of medical and other resources, in a setting that feels more comfortable and less stigmatizing than traditional intake points. In turn, the churches support providers and funders by creating an efficient source of referrals and establishing trust with prospective clients.

An offshoot of Families & Youth 2000 is The Centers for Healthy Hearts and Souls, a church-based initiative to address the high risk of heart disease among African-Americans. This program offer health fairs, diabetes screening, blood pressure screening and monitoring, and informative workshops and support groups – such as a smoking cessation program.

Coordinating Care – Galveston. Information systems are a central element of the 21st century health care system proposed in the Institute of Medicine report. And information systems are a central element of community initiatives to improve access. Creating streamlined, consistent, accessible information systems makes it easier for patients to enter and re-enter the system through many providers. Better information systems also support the goal of continuity in management of chronic conditions.

“Low-tech” initiatives to create a common application or to centralize record keeping provide a basis for the implementation of more advanced technology. Some communities are already working toward the goals cited in the IOM report for electronic, on-line information systems.

A web-based, universal application form is at the center of reforms in Galveston County, Texas, which bring together aspects of the first two approaches: reducing complexity and increasing entry points. The universal, bilingual application is used to coordinate screening, health care and social services for all applicants among all social service agencies, faith-based groups, and other providers.

The web-based tool was developed by The Jesse Tree, which was founded in 1995 at the request of a multi-denominational group of ministers who were concerned about locating services for those in need and which had already developed a comprehensive web site of regional resources and services. The Jesse Tree also serves as the centralized point of referral in Galveston County’s integrated primary care system, following the BPHC model (refer to Figure 1).

Use of the universal, web-based application has created a rich database on health and health care in Galveston County, including the health problems and other characteristics of clients and the value of services provided. This information is being used to help design the county’s Community Access Program.

Other communities are also using improved information systems to support integrated health care systems. CLASS, the Client Assistance System, is an eligibility and enrollment database for the Hillsborough HealthCare Plan. CLASS supports 230 on-line social work staff in 24 Neighborhood Service Centers, clinics, and hospitals. Cretta Johnson cited other advantages of an automated system. Not only does such a system improve access and reduce waiting times, but it also reduces fraud and improves the perceived objectivity of eligibility decisions.

Buncombe County's Centralized Applications, Referrals and Enrollment (CARES) on-line status system provides accessible information on enrollees in Project Access. The CARES system is also used to track providers' contributions. The system supports recruitment of new providers, because Project Access can demonstrate the ability to ensure that all participants are contributing their fair share.

The creation of electronic information systems also supports the development of databases that can produce meaningful information on outcomes to guide future health care decision-making.

Improving access to quality health care has often been connected to subsequent increases in spending in the public debate. However, the reality is that many of the community-led reforms described above actually result in cost savings. This underscores HRSA Associate Administrator Dr. Marilyn Gaston's premise that enough money exists in the current system to support comprehensive reform. The question is how to secure a better return on our present investment.

“... for Less Cost” – The Economics of Health Care Reform

Cost savings are not only a measure of the campaign's success in achieving the other goals of access and quality, but such savings are the manifestation of wiser investments by local health systems. Thus, the challenge is not only to achieve savings, but also to find a meaningful way to measure costs, benefits, and the return on investment in community health systems. Such investments pertain how, from which sources, and to whom resources are deployed. These collective measures provide a barometer for success and a guide for future action. The right measures are critical, because restricting access and reducing quality could achieve a narrow focus on near-term reductions in direct costs, but this would likely raise costs – both direct and indirect – over the long term.

In fact, cost is the direct or indirect driver behind efforts in many communities for 100% access and zero disparities, and savings are frequently the incentive to gain participation by key players. This is particularly true for engaging business – employers, insurance providers, hospitals – in the campaign. At the June conference, in a breakout session on writing business plans, cost savings were frequently cited as a key element in generating public support and business buy-in for community programs.

Shared savings. The Coordinated Care Network (CCN) in Pittsburgh provides an example of the power of cost savings. CCN is a non-profit integrated delivery system encompassing 187 faith-based, medical, social and behavioral health programs in 72 sites. CCN provides case management, prevention and disease state management services to the region's largest Medicare managed care

organizations (MCOs). CCN approached the MCOs with the prospect of reduced costs, in return for a share of the savings.

Serving approximately 60,000 clients, CCN has decreased hospital bed days for a patient population of 6,000 by 83 days per 1,000 per month. It has decreased emergency room use for a patient population of 6,000 by 140 visits per 1,000 per month – a decline of 17% to 20%. CCN is now applying its share of cost savings funds to offer discounted prescription drugs at Federally Qualified Health Center sites.

Measuring savings and returns on investment

What are the benefits of 100% access and zero health disparities? How are they measured? How are they achieved?

Measuring the benefits, according to David P. Rogoff of Community Health Partnerships, means comparing the cost of ad hoc uncoordinated health care services for underinsured patients, to coordinated service delivery for those patients. The key determinant in this process is getting all the community stakeholders to agree on what kinds of results they are aspiring to, what their shared values resemble, and to capture progress on these components through a coordinating mechanism.

David Rogoff presented a measure of Return on Community Investment (ROCI) from improved health care access to the June conference audience. ROCI includes both objective measures and less determinate measures such as improved quality of life, increased productivity at work, and benefits to future generations. Objective measures include decreases in direct and indirect health care costs and increased leverage of funds. Direct costs are those incurred in providing health care for the target population. Indirect costs include those incurred by the community to support the sick and injured, other social services for targeted population, and lost taxes due to people not working.

An important step in achieving an optimal return on investment is to properly allocate fiscal responsibility among taxpayers, providers, employers and others in the community. The goal is to ensure that costs help achieve the best possible return. For example, Rogoff asks, do new costs to the community generated by taxpayer payments for previously uncompensated care create a better outcome than the costs to the community under the former way of doing things?

Funding leverage can be increased through the draw down of state and federal government funds, coordination with other payers, and access to private sector funds.

The appropriate scope for measuring return on investment on this point remains an issue for discussion. By limiting cost to those incurred by the local

community, Rogoff's model classifies federal funding as a benefit to the community. Of course, federal funds represent a cost to larger society. Also, success in a given community can create benefits that go beyond that community, such as replication in other communities, which are not captured by the ROCI. A total ROCI will need to account for a community's interface with larger society, both in terms of what it takes from and what it contributes to communities beyond itself.

Turning to the issue of how benefits are achieved, there were at least three alternative models for investment in improved health care presented at the June event:

- the **volunteer model**, in which providers bear responsibility;
- the **tax-supported model**, in which providers are paid by a tax-supported plan; and
- the **shared-cost model**, in which the taxpayer subsidized model is supplemented with incentives for employers to provide health coverage to employees, often with employee contributions.

Volunteer model: Buncombe County. Project Access in Buncombe County, North Carolina, is founded on the voluntary commitment of the county's medical community. Project Access is an integrated system providing universal, on-demand access to the full continuum of health care for all low-income uninsured citizens in the county, which includes the city of Asheville.

Project Access was initiated and is administered by the Buncombe County Medical Society (BCMS). Private primary care and specialist physicians and area hospitals donate care to patients referred from neighborhood clinics, and county government funds prescription medications. Physicians pledge to see 10 to 20 patients a year. Physician volunteer commitments and patient referrals are managed through a centralized on-line database.

Since its inception five years ago, Project Access has nearly doubled the number of patients with a regular source of care and has coordinated the provision of \$20 million worth of free care during the period 1996-2000, according to Alan McKenzie, executive director and chief executive officer of BCMS.

In FY 2000, 61% of free care was provided by doctors and 39% by hospitals, in contrast to the conventional wisdom that the bulk of care is provided in hospitals, and particularly emergency rooms. This development is due to the extraordinary efforts of the BCMS to expand the number of physicians providing pro bono care as a routine part of their practice, to document care provided by physicians, and to systematize the process.

Project Access has reduced per capita hospital charity care costs by 45% from 1996 to 2000. The emergency room utilization rate has dropped from 28% in 1995 to 8% in 1998. The percentage of uninsured patients who used the ER for medical reasons in 2000 was actually slightly lower than that of insured patients (22.6% compared with 23.4%).

The following table lists several measures of improvement in the health of the population of Buncombe County residents following the launch of Project Access.

Buncombe County	1995	2000	HP 2010 Goal
Regular source of health care*	78.7%	93%	➤ 96%
Have a personal physician*	76.5%	83.1%	➤ 85%
Did not get care in past year because of cost*	11%	5.5%	---
Cholesterol check in past 5 years	78.3%	89.9%	80%

*statistically significant change

Tax-supported model: Hillsborough County. The Hillsborough HealthCare Plan in Hillsborough County, Florida, is funded by a local sales tax, under authorization approved in 1991 by the state legislature. The program is founded on a vision of a delivery system that shifted the access to health care from the most costly – hospitals and emergency rooms – to the least costly – primary care and other preventive medical measures. The purpose of taxpayer funding was to provide the investment in a more efficient system, based on the principles of managed care that would reduce overall costs over time. Explicit taxpayer support also reflected the program’s vision of a true public/private partnership.

The Hillsborough HealthCare Plan consists of a system of primary and specialty care, in-patient and outpatient services and other preventive medical services, including prescription drugs. It has increased the number of primary care clinics from 4 to 14 and the number of persons served by 45%. The program has reduced average length of hospital stay by 50%, from 10 days to 5.1 days, and has reduced inpatient costs by 45%. It has saved an average of \$10 million annually in emergency room diversions. In fact, the success of the program has allowed a reduction in the sales tax rate that funds the county’s indigent care from 0.5% to 0.25%.

The table below estimates the ROCI of the Hillsborough HealthPlan, with indirect costs and benefits yet to be determined.
Shared-cost model: Muskegon County. Access Health, in Muskegon County,

HCHCP ANNUAL RETURN ON COMMUNITY INVESTMENT
UTILIZING AVAILABLE NUMBERS (In \$ Millions)

BENEFITS

Decrease in Direct Costs	\$10.0 M
Decrease in Indirect Costs	(?) LESS IMPACT
Add'l Funds Brought into Community	\$17.2 M
Increased Quality of Life	(?) LARGE IMPACT
TOTAL BENEFITS	\$27.2 M + TBA

COMMUNITY INVESTMENT

Direct Cost to Run Program (*)	\$14.5 M
Increased Indirect Costs to Max.Benefit	(?) RELATIVELY SMALL
Add'l \$ to Leverage Funding	\$4.0 M
TOTAL COSTS	\$18.5 M + TBA

<u>RETURN ON COMMUNITY INVESTMENT:</u>	
Total Dollars	\$8.7 M + TBA
ROCI	\$1.47 + to \$1

(*) Direct cost is the sum of taxpayer, provider, and cost shift impact. The mix is a policy decision.
 (?) Area that need further evaluation. Would probably increase ROCI.

Michigan, is a “one-third share plan.” Financing of Access Health (which is described in the previous chapter) is shared three ways, with the employer and employee each paying 30% of the cost and the remaining 40% covered by the community. The community match is a combination of federal, state, and local funds, so that every \$1 of public money is leveraged by \$2 of private money. All federal dollars come from Disproportionate Share Hospital funding. The employee’s share is \$38 monthly for adult coverage and \$22 monthly for dependent coverage.

After 18 months, Access Health served 1,000 individuals and 300 businesses, with continuing growth. Both local hospitals and 200 physicians – 97% of local providers – participate.

The Broader Vision and Benefits to Society

The benefits of the campaign can go beyond the goals of better health for more people for less cost, and the impact far beyond the vision of 100% access and zero health disparities – reaching to other aspects of health care and society.

This vision can also have *positive ripple effects* within the communities where it is adopted. Operating the health care system for uninsured and underserved

citizens in a coordinated, results-focused way can result in better health practices and greater public responsibility throughout the community.

Building a health care infrastructure that accounts for costs and investments means that there is *no “shadow” population*. Charity care is no longer an undocumented phenomenon but a quantified service. The contributions of health care providers, employers, and taxpayers are on the table – and so are their responsibilities.

Finally, a coordinated, integrated system creates *“connectivity.”* This is the payoff from having multiple partners working together so that their self-interests are met and their best possible contribution to the public good is realized. This connectivity extends to other communities, which can enhance benefits and reduce costs from knowledge transfer and adoption best practices. The June Communities in Action conference was an explicit effort to connect participants within and across communities.

For example, a community can reduce costs by adapting software that has already been developed in another community for its information system. Or a community can reduce start-up costs and risks by bringing in representatives from a successful program to generate public support more quickly and effectively.

The Communities in Action conference resembled a “living manual” of the nation’s collective knowledge and expertise about how to create and administer integrated, primary-care-based community health systems. The conference focused on what’s working, and how to replicate it – sharing strategies and making connections. Led by professional facilitators John Scanlon and Dennis Wagner, conference session leaders were prepared to focus on achieving progress toward major campaign goals using a process illustrated in the following chart.

Communities In Action: Breakout Sessions

<p><u>Create & sustain the community mission.</u></p> <ul style="list-style-type: none"> • Generating the public will for community action. • Generating momentum: pacing events to move your community forward. • Generating media attention to grow your health system. 	<p><u>Operate an integrated system and realize the benefits</u></p> <ul style="list-style-type: none"> • Crossing the quality chasm: building integrated community health systems • Eliminating disparities: holistic approaches & access to quality care • Achieving results through culturally competent care. • Using referral systems as an integrative force for 100%/0. • Substance abuse and mental health services as key parts of an integrated 100%/0 system • Generating 100% access to oral health • Pharmacy as a key part of an integrated community health delivery system. • Improving health and access for Native Americans • Growing primary care safety net programs as the cornerstone of an integrated delivery system. • Case Management to improve health & save money
<p><u>Enroll all the players</u></p> <ul style="list-style-type: none"> • Engaging the business community • Mining your community's untapped resources • Effective use of grants to grow your health system. • Faith community, the universal resource • Creating State government support for community health results. • Engaging physicians as community health leaders. • Hospitals as partners in community solutions 	
<p><u>Take care of business</u></p> <ul style="list-style-type: none"> • Developing a business plan to transform your community health system. • Marketing the ROI for community health systems • Engaging the range of financing strategies 	

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An example of how this philosophy translates into local action can be found in Buncombe County, which is assisting nine communities that have operational systems replicating Buncombe's Project Access. Buncombe leaders are assisting another thirty communities that are in the development phase.

In short, success builds on success. A key objective of the Communities in Action conference was to generate and maintain momentum. One means was by soliciting and documenting commitments for future action by participants. Examples include:

- a commitment by Buncombe County Project Access to meet with small business owners and develop a health insurance program like that in Muskegon, Michigan;
- a commitment to mark progress toward a national system of pharmaceutical distribution to low-income individuals, as part of the BPHC-sponsored conference in November;
- a commitment from Rick Wilk of Communities in Action and David Rogoff to refine methodologies and establish benchmarks for Return on Investment, and to provide tools and examples for communities to use; and

- commitments for statewide conferences in Oregon, Alaska, Iowa, Florida, and other states to generate support and increase momentum for the 100/Zero campaign.

Other national conference partners – the United Way and the National Association of Counties – are effecting positive change at both the national and local levels. In addition to the support of the national United Way organization, local United Way campaigns are supporting 100/Zero initiatives. For example, the United Way of the Plains provided a \$180,000 grant to Project Access in Wichita, Kansas, to help leverage over \$7 million in donated physician and hospital care. NACO recruits and trains local officials to advocate and implement 100/0 strategies.

In addition, this connectivity will make it possible to apply lessons learned to all segments of health care. In that way, the BPHC campaign for 100% access and zero health disparities is taking a lead role in creating a 21st century health care system for the United States from the bottom up.

Conclusion

The underlying theme of *Communities in Action* conference was that communities aren't waiting for the federal government to solve their health care crises, and (better news) that they don't need to. More than 500 community leadership teams from across the nation have begun to create integrated, primary-care based, community health systems that are realizing the 100/0 campaign's three main virtues: better health for more people at less cost.

Many do not acknowledge that health care reformers can match the halcyon days enjoyed by welfare reform over the past decade. However, the community-led success stories such as Buncombe County provide stark resemblance to Wisconsin's county-led welfare reform experiments in the early 1990s that became the building blocks for national welfare reform in 1996.

Buncombe County Project Access director, Alan McKenzie reflects on his community's parallel to Wisconsin's role in welfare reform: "Just as Wisconsin did not wait for federal action to reform its welfare program, Asheville, North Carolina, did not wait to reform its approach to access to care for the uninsured. Just as then-Governor Thompson moved people from welfare to work,

We must strengthen the health care safety net, and we must build a healthier America. Community health centers provide access to health care for millions of Americans who have been locked out of the traditional health care system, and this administration will do everything it can to break down those barriers.

HHS Secretary Tommy Thompson

Asheville has moved people from illness to wellness and work.”

Both President Bush and DHHS Secretary Thompson left their respective governor’s mansions to assume federal posts. Much evidence exists to demonstrate that each leader is highly committed to continuing the devolution of social services to states and localities where care is closer situated to those who need it. Recent speeches by both men demonstrate an equal vigor to providing new solutions for the lingering problems of elusive or uneven health care for fragile families.

The Bush-Thompson agenda could be well understood by considering the imagery of hardware and software in systems redesign. Pledging to allow states increased flexibility in running Medicaid and State Children’s Health Insurance Programs, as well as providing budget increases to Community Health Centers and tax credits for low-income families, the new administration is improving the health system’s hardware.

The 100/0 campaign presents an excellent vehicle for the administration to upgrade the software of the health care system in complementary fashion. Through the intelligent (albeit common sense) design of an integrated system, local communities will improve the execution of their services within their new hardware package.

The national campaign spearheaded by the BPHC to support local communities’ efforts to develop integrated public health systems offers an ideal match between the new administration’s values and the desire of forward-looking communities to solve their own problems. How many more such communities will be inspired and equipped to assume the mantle of change will be largely proportionate to the degree that federal, state, and other leaders join them in their cause.

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