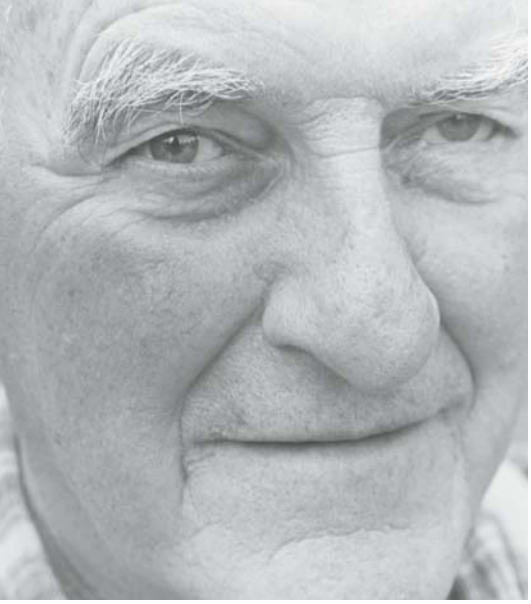
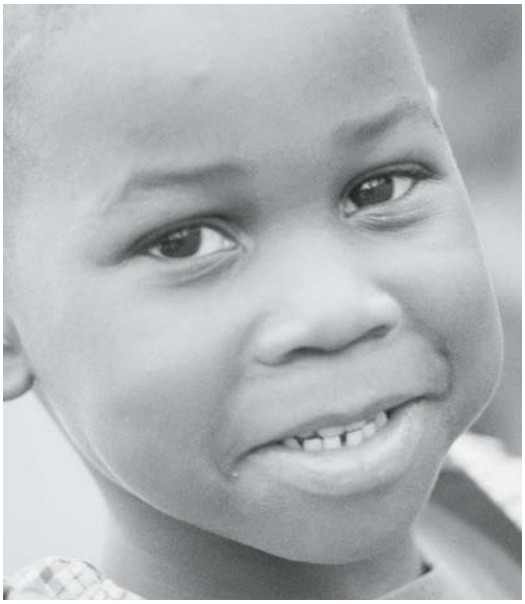


Making Coverage for the Uninsured
The Role of Community Initiatives:
Finding From a Study of Five States

prepared for

Georgia Health Policy Center
Georgia State University


Karen J. Minyard, Ph.D.
Executive Director
October 2004

Georgia Health Policy Center

MAKING COVERAGE FOR THE UNINSURED

The Role of Community Initiatives:

Findings from a Study of Five States

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

October 2004

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

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ABOUT THE AUTHORS

Karen J. Minyard, **Ph.D**., is the Executive Director of the Georgia Health Policy Center at Georgia State University. The policy, research, and technical assistance programs of the Center focus on care at the end of life, child well-being, health philanthropy, rural health, cancer, and access to care for the uninsured. She is an advocate for basic restructuring of local health care systems to focus on access to care and health status improvements, and an officer on the founding board of Communities Joined in Action, a national partnership dedicated to helping networks achieve healthcare access. She regularly consults with and presents to groups and organizations that seek to build health and access. Dr. Minyard is the former director of the Networks for Rural Health Program at the Health Policy Center, and she conducted a major external evaluation of Georgia Medicaid's primary care case management program. Her research interests include the study of health care markets; the relationships among identity, image, and willingness to make strategic change in changing environments; and the role of targeted external facilitation and technical assistance in improving local health systems' clinical relevance and financial viability.

Deborah Chollet, Ph.D., is a senior fellow at Mathematica Policy Research, Inc. in Washington, DC, and a national expert on state health insurance markets and public/private-sector health care reforms. She has led numerous studies on individual and small-group health insurance markets; the impacts of state regulation and policy actions on insurance markets and coverage; the cost, financing, and economic feasibility of major state reforms of public programs and private insurance; and the effects of state high-risk insurance pools on health insurance coverage. Chollet is a senior consultant to the RWJF State Coverage Initiatives program and a frequent consultant to state officials on health insurance market dynamics and policy options for expanding private health insurance coverage.

Laurie E. Felland, M.S., is a Health Researcher at the Center for Studying Health System Change (HSC) in Washington, DC. She is a qualitative researcher, focusing on low-income people's access to medical care, public insurance coverage, and safety net providers, as well as public health issues. Felland has been a policy analyst at the Massachusetts Division of Health Care Finance and Policy and a redesign analyst at Regions Hospital in St. Paul, Minnesota. She earned a bachelor's degree in Economics from Carleton College and a master's degree in Health Policy and Management from the Harvard School of Public Health.

Lindsey Lonergan, M.H.S., is a Research Associate at the Georgia Health Policy Center. In this capacity, she provides technical assistance to communities in the process of building networks to improve access and enhance residents' health status. Her interests and work include Medicaid case management and building leadership capacity in communities. She has been a health policy analyst at the Center for Health Services Financing and Managed Care in the Georgia Department of Health and Human Services, where she reviewed Medicaid managed care waivers, demonstration plans, and SCHIP state plan amendments; and developed and managed special projects on managed care, managed behavioral health care, the uninsured, cultural competence, and disease case

management. She earned a bachelor's degree in Biology from Mercer University and a master's degree from the Johns Hopkins University Bloomberg School of Public Health.

Chris Parker, M.B.B.S., M.P.H., is a Research Associate at the Georgia Health Policy Center. He has managed research studies related to cancer initiatives, health care access for the uninsured, health care disparities and public health in Georgia. His earlier experience includes serving as a healthcare provider and manager for a faith based clinic and conducting a primary care practice in Kingston, Jamaica. He earned his medical degree at the University of the West Indies in Mona, Jamaica and earned a master's degree in public health (policy and management) in the Rollins School of Public Health at Emory University.

Tina Anderson Smith, M.P.H., is a Senior Research Associate at the Georgia Health Policy Center. Smith oversees the conceptual, resource, and strategic development of the Health Policy Center's research, policy, and technical assistance programs. She has served as Director of the Center's community health systems development program. Smith has been involved in efforts supporting access to care for rural citizens, including Networks for Rural Health, a program to provide technical assistance and facilitation for rural communities attempting to develop and sustain local and regional health networks and partnerships. Her academic and professional experience includes hospital business development, public health program design, grassroots policy research, economic evaluation of existing programs, and community development. She often makes national presentations and provides technical assistance to leaders in other states to support rural communities in improving the health of residents. Smith earned a masters degree in public health the Rollins School of Public Health at Emory University.

Claudia Lacson, M.D., M.P.H., was a research associate and community health systems developer at the Georgia Health Policy Center. She provided technical assistance to state and federally funded networks seeking to improve access to care and health status of populations in Georgia and nationwide. Before joining the Center, Lacson had worked at the South Carolina Department of Health Migrant Health Program, consulting to state agencies and community organizations on community outreach, cultural competence, and Hispanic health issues. She had also worked as a rural physician in Colombia, South America, where she provided primary care services to medically underserved populations and directed public health initiatives on prenatal care, immunizations, and family planning. *(Dr. Claudia Lacson died on July 31, 2004.)*

Jaclyn Wong is a senior programmer/analyst at Mathematica Policy Research, Inc., in Washington, DC. She has worked on projects targeting a range of social policy issues, with a primary focus on qualitative and quantitative analysis of health policy. Ms. Wong earned a bachelors degree human biology at Stanford University, with a minor in economics.

ACKNOWLEDGMENTS

The authors thank the senior staff of the Commonwealth Fund for their creative energy throughout this project. They urged the project to focus on beta sites instead of alpha sites and therefore to investigate more systematically how innovations are transferred.

We also thank the local and state stakeholders who generously shared their insights. We especially thank Anne Nelson in Wichita, Bob Redford and Kendall Poe in Paris, Paula Lucey in Milwaukee, Kristen West and Anna Shelton in Olympia, and Greg Dent and Shannon Harvey in Forsyth for the extensive information they provided and their assistance in coordinating our site visits.

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.

Vondie Woodbury (Director of the Three Share Plan in Muskegon, Michigan, an alpha site), Alan McKenzie (Executive Director of the Buncombe County Medical Society and Founder of Project Access, an alpha site), Ann Wiess and Terri Stoller (Robert Wood Johnson Foundation's Communities in Charge Program, Marguerite Johnson (Kellogg's Community Voices Program), Rick Wilk and Susan Lumsden (HRSA Healthy Communities Access Program) provided advice on the research questions, recommended potential case study sites, and identified relevant types of key informants.

EXECUTIVE SUMMARY

As health care costs and the number of uninsured Americans continue to increase, community initiatives across the country are steadfast in their efforts to bridge the growing gap between public and private health insurance coverage. This report summarizes an 18-month research study of five initiatives—in Wichita, Kansas; Paris, Arkansas; Milwaukee, Wisconsin; Olympia, Washington; and Forsyth, Georgia. Selected because of their geographic and operational diversity, each of these initiatives attempts to provide coverage and/or access to care to individuals who have difficulty finding or navigating conventional insurance arrangements and public programs. The purposes of the study were to:

a. Describe these initiatives' efforts to increase coverage or access and the impact of these efforts on their target populations.
b. Examine the cost effectiveness and efficiency of their operations.
c. Identify the factors that enhance or challenge their sustainability and expansion of the initiatives.
d. Understand the lessons for their replication.
e. Examine how states and communities cooperate to close gaps in funding and access.

Access and Coverage

All five local community initiatives attempt to provide access and coverage to a specific population: nonelderly adults. Most limit the duration of enrollment and offer comprehensive benefits (though often narrower than Medicaid's very broad benefit design). All use "high touch" methods of caring for clients or chaperoning them through the system.

On average, the programs have been operational for about 6 years. Anecdotal evidence suggests that they have succeeded in improving access to care in their communities, adding value to a "safety net" that is burdened by the growing number and complexity of the uninsured population. Forced to be flexible and adaptable in their approach to coverage, the initiatives nevertheless have held to their respective visions and missions. They view themselves as important though stopgap measures; all appreciate that, in their current form, they do not have the capacity to address the health care needs of all uninsured individuals.

Cost Effectiveness

In each community, local leaders contend that providing more appropriate health care services is cost effective both for providers and for the community at large. Though each offered evidence that it is cost effective in providing care to the uninsured, variation in how and what program leaders measure made it difficult to compare their experiences. Estimated annual cost per enrollee varies widely (from $178 to $5,556), as does

estimated program penetration (from 3.3 percent to 34.7 percent of the eligible population).

The initiatives use various cost control strategies to achieve net savings to the community. All of the programs require cost sharing in the form of modest co-payments, administrative fees, and/or membership dues. Health care providers bear significant risk in the form of voluntary participation, discounted rates, or capitated reimbursement.

While attempts at quantitative evaluation have been limited, it seems likely that some of the initiatives have reduced hospital utilization and uncompensated care. For example, one initiative concluded that its enrollees use 27 percent less hospital care and 15 percent less ER care than a statistical control group. A few communities have measured hospitals' return on investment in the program, most finding fair to moderate success.

Sustainability & Expansion

With diminishing grant funding, program leaders have fought to maintain momentum and remain relevant to community efforts to cover the uninsured. Though most of the programs are believed to be sustainable in the short run, all recognize that ongoing sources of funds are needed to thrive in the long run.

Questioning around the sustainability of the programs and opportunities for expansion produced a number of common themes.

- The mission of the program must be grounded in the needs of the target population.
- Strong leadership at all levels of the organization is essential.
- The programs require sustained financial support to be viable.
- Programs should develop data to evaluate and demonstrate success throughout implementation.
- Any model based on provider volunteerism has limited growth potential.
- Flexible and adaptive programs can be sustained in a changing environment.

Lessons for Replication

The difficulty of replication can be attributed both to the complexity of the innovations attempted and also to differences in context between alpha and beta sites. Innovations are most easily transferred when they are simple and quick, and when their benefits are easily observable. However, initiatives to improve access and health status are necessarily complex, and their results generally are not quickly or clearly observable. As

a result, every factor that influences the diffusion innovation of innovation must be pursued more intensively. Essential to replication of these programs are: (1) extensive interpersonal communication in face-to-face exchanges between multiple individuals in alpha and beta program sites; (2) high levels of knowledge among highly interconnected parties to the initiative; (3) a formalized organizational infrastructure; (4) strong local leadership; and (5) a state environment with opinion leaders and change agents who value local initiative innovation.

The beta sites replicated alpha sites with varied success. In only one site was the replication complete: this beta site differed from the others in the study in having a local and state context that is similar to the alpha site, as well as having had extensive communication and collaboration with the alpha site.

State/Community Interface

The context of community programs – the presence of supportive public programs and/or strong private insurance capacity – is an essential factor in successful replication. Public policy that supports provider participation and state-level leaders who believe in local innovation are important to programs that entail provider volunteerism or acceptance of reduced compensation. Local programs can support or complement state public and private insurance programs, but they are unlikely to thrive independent of them. All of the study sites are involved in enhancing enrollment in state programs, especially for hard-to-reach populations.

There are many opportunities for national and state policies and resources to combine to support local initiatives; just a few of these possible support strategies were implemented in each site. Examples include:

- The Arkansas General Assembly passed legislation which established a statutory framework for community-based health care access programs (Act 549 and Act 660).
- In Washington State, the Medicaid program contracts with CHOICE to provide outreach and enrollment services to the Medicaid population in their service area.
- In Wisconsin, the state Medicaid agency collaborates with the county and program to draw down Disproportionate Share Hospital (DSH) dollars through Intergovernmental Transfer (IGTs).

Implications for Future Research

This study suggests that local initiatives can contribute to building a bridge between private insurance and public programs for individuals who have difficulty remaining or thriving in either. Three types of research could guide states and communities that are

considering local initiatives to improve access to care and decrease the cost of care for the uninsured:

- A multi-site evaluation of the impact of local initiatives;
- An analysis of the state-level contextual factors that make a conducive environment for introducing local initiatives of different types; and
- An investigation of options for overcoming provider capacity issues in local models that rely heavily on physician volunteerism.

These research projects would provide an evidence base for national, state, and local decision making regarding how to design, sustain or replicate relevant local programs.

I. CONTEXT AND BACKGROUND

For a growing number of Americans, the problem of finding and keeping health insurance is acute. Low-wage workers may hold several part-time jobs, rely on seasonal work, and be unemployed or underemployed during the year. They are less likely to work in establishments that offer a health plan and less likely to be eligible for coverage when it is offered.[1] Individual health insurance coverage is prohibitively expensive for them, even if it would cover the health conditions they may have developed over years without consistent access to health care.

Many low-income working families have relatively little history with means-tested public programs, and for various reasons do not enroll in Medicaid or do not remain enrolled even when eligible. Many are adults who do not qualify for public coverage, though their children typically do. A significant number are older adults without children and, therefore, may not qualify for public coverage.

The consequences of being uninsured are well documented.[2] Health care needs are addressed late, and opportunities to avoid serious and chronic illnesses are missed. Poor management of chronic conditions, often related to lack of access to prescription drugs, creates acute episodes and avoidable hospitalizations. Health outcomes are compromised, productivity is reduced, and lives are shortened. The quality of life and the economic security of families are eroded. The cost of care, when families are unable to pay, falls on just a few providers – in most communities, a small safety net for a very large problem.

Encouraged by private foundations and government efforts to strengthen local health care safety nets, some communities have developed programs to integrate piece together access and financing for individuals and families who live between the worlds of private insurance and public coverage. These efforts attempt to weave the threads of provider discounts, free care, and public financing into a more coherent system of coverage and care.

[1] Even when insured, low-wage workers are more likely to pay a significant share of income toward coverage, and less likely to have any coverage for prescription drugs or dental or vision care. Sara R. Collins, Ph.D., Cathy Schoen, Ph.D., Diane Colasanto et al., *On the Edge: Low-Wage Workers and Their Health Insurance Coverage.* New York: The Commonwealth Fund, April 2003 (http://www.cmwf.org/usr_doc/collins_ontheedge_ib_626.pdf).

[2] See, for example, National Academy of Sciences, Institute of Medicine, *Coverage Matters: Insurance and Health Care.* Washington, DC: National Academy Press, 2001.

II. INTENT AND DESCRIPTION OF INITIATIVES

Each of the initiatives is a locally crafted response to problems of health care access among uninsured and indigent residents in its community. By uniting community leaders, providers and other key stakeholders, they build and capitalize on good-faith relationships to reduce uncompensated care and support the local safety net.

Each program is concerned about reducing local health care costs, but their missions also emphasize real efforts to enable "user friendly" access to care. They employ common strategies of building coverage, coordinating access, integrating care, and conducting outreach in their varied economic and political environments. The community initiatives have made significant efforts to coordinate with the local network of private providers, FQHC, health departments, and hospitals to ensure service to their clients and provide a medical home for their clients. None of the programs studied is simply a health insurance plan.

In all of the initiatives, program staff enroll applicants in their own programs and also screen them for eligibility and enrollment in state-sponsored health insurance programs. Program employees stationed in clinics, health centers or hospitals all provide eligibility assistance. Significant resources and energy have been expended to enroll initial populations, and the programs use multi-media approaches to connect with eligible populations. Nevertheless, much of the programs' outreach continues to be "word of mouth."

By providing a medical home for clients, the programs attempt to achieve earlier preventive and preemptive medical intervention to improve health outcomes and reduce costly hospitalizations. Even in instances where secondary or hospital services are often the reason for first contact with the initiative, post intervention attempts are made to link individuals who retain eligibility to local primary care physicians.

The initiatives typically use case management and health education to control use of services. They provide a "high touch" approach to care that helps to chaperon individuals through a complex care system to improve the appropriate use of local health care services. Key features of each initiative are summarized in Table 1.

Table 1 – Description of Programs

	Project Access Wichita Kansas	**Community Health Link** Paris Arkansas	**GAMP** Milwaukee Wisconsin	**CHOICE** Olympia Washington	**Community Health Works** Forsyth Georgia
Administration	501c(3) organization under Medical Society leadership	501c(3) with independent Board	County government	501c(3) organization	501c(3) organization under joint hospital leadership
Number Enrolled	625 active; 4,472 over program life	130 active	22,000	17,000* * duplication	2,200
Number Presumed Eligible	10,000	4,000	75,000	93,000	6,500
Period of Enrollment	3 months primary care/ 6 months secondary care	Indefinite period once eligible	6 months with mandatory reapplication	N/A	Indefinite period once eligible
Income Eligibility	< 150% of FPL	< 300% of FPL < 200% of FPL subsidized	< $902 per month for single individual	< 250% of FPL	< 200% of FPL
Other Eligibility	▪ County residents ▪ US citizen ▪ Not eligible for other insurance	▪ Resident of county ▪ Working uninsured	▪ Resident of county for > 60 days ▪ US citizen ▪ No other insurance ▪ Seeking service	▪ Resident of participating county	▪ Resident of participating county US citizen ▪ No other insurance ▪ Diagnosis of DM,HPT, CHD and depression
Intent	Short-term enrollment of individuals who require services for specific conditions, with a link to a medical home for ongoing care. Screening for public program eligibility and enrollment	Provide working low income uninsured or underinsured adults with affordable access to care. Link eligible individuals to primary care providers and reimburse providers for care	Provide services in community care settings rather than hospitals. Decrease inappropriate use of hospital ERs. Client self-determination and sensitivity to cultural norms and expectations.	Stabilize the safety net Identify and enroll low income residents in a medical home Improve efficiency of care to reduce costs and expand coverage	Cover care in four chronic disease states. Improve use of primary care services to reduce inappropriate ER use Create systematic change in local safety net and improve community health status

Project Access - Wichita, Kansas

Administered by the Sedgwick County Medical Society, this program is a modified replication of Project Access in Buncombe County, North Carolina. Program staff coordinates donated primary and secondary care services for uninsured clients with income below 200 percent of the Federal Poverty Level (FPL). The program attempts to enroll eligible people who require services for specific conditions and link them to a medical home for ongoing primary care. The Dental Society provides emergency dental services, and the city of Wichita and Sedgwick County offer funding to provide prescription drugs.

Like its "alpha site," Wichita's Project Access relies heavily on physician leadership and volunteerism. The initiative links more than 600 physicians with local hospitals six outpatient clinics, 36 dentists, and 69 participating pharmacies. Enrollment in the program is limited to three months.

Community HealthLink - Paris, Arkansas

Operated by the Arkansas River Valley Rural Health Cooperative as a non profit 501(c) 3 organization, Community HealthLink is a subsidized, capitated health insurance plan that operates much like a preferred provider organization, or PPO. It provides fairly comprehensive health care coverage for working uninsured residents with income below 300 percent FPL.

The program is broadly patterned on the "three-share" program in Muskegon, Michigan. Employers and employees (clients) together support two-thirds of the cost of care, with the final third covered by a subsidy fund set up by the Cooperative. Participating providers agree to accept Medicare rates and also to continue seeing patients whose care may exceed the plan's reimbursable limit. 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. It also is seeking to branch into the use of telemedicine. The program recently completed its initial 2-year pilot phase.

General Assistance Medical Program (GAMP)- Milwaukee, Wisconsin

GAMP functions as a county-operated managed care organization that purchases services for enrollees. Administered by Milwaukee County, GAMP provides access to primary and secondary health care services for uninsured county residents with income less than $902 per month. Reflecting the program's primary care emphasis, 17 clinics (including FQHCs) at 23 sites act as gatekeepers for care. Eligible residents are enrolled when they seek medical services. The program reimburses providers at Medicaid rates with funding from leveraged state contributions, local taxes and intergovernmental transfers. Enrolled individuals must requalify for coverage every six months.

CHOICE Regional Health Network - Olympia, Washington

CHOICE attempts to improve access to care for uninsured individuals residing in a five county service area with income at or below 250 percent FPL. Governed by a non-profit Board of Directors, CHOICE enrolls eligible individuals in state sponsored programs or links them to donated or discounted local provider services. It does not provide either coverage or medical services directly. CHOICE also collaborates with other regional stakeholders—including three hospitals, 11 outpatient clinics, local FQHCs and hundreds of physicians—to increase coverage options where possible. There currently is a waiting list for admission to the Washington Basic Health Plan (BHP). Aside from Medicaid, BHP is the major state program for which CHOICE is, in effect, an outreach agent. CHOICE plans to design an insurance product for state government and local businesses, but it currently only brokers available public coverage and services for low-income residents.

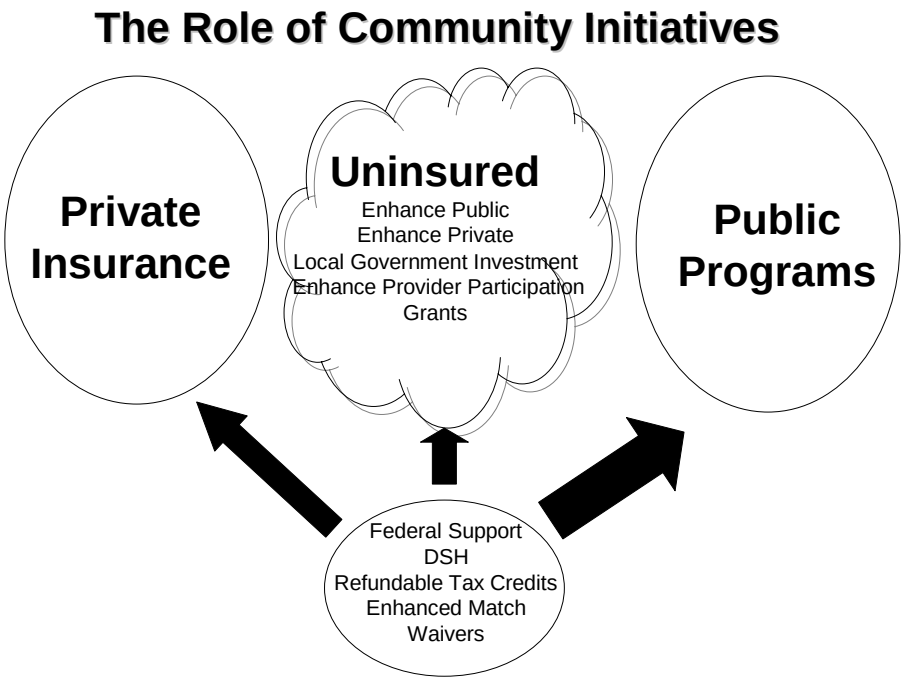
Community Health Works - Forsyth, Georgia

Community Health Works is a significantly modified version of the Buncombe model that operates across a seven-county region in central Georgia to serve uninsured residents with income at or below 250 percent FPL, with one or more of four specific chronic diseases—hypertension, diabetes, heart disease, or depression. Administered as a 501(c)3 organization, the program relies heavily on provider volunteerism and hospital leadership, emphasizing appropriate utilization of services and a rigorous case management element across the continuum of care. The program relies on a medication bank to provide access to affordable prescription drugs. The local care network consists of 3 hospitals, 2 clinics, nearly a hundred physicians, and 21 pharmacies; it has developed software to track client service use and assist in care planning. Currently, there is a waiting list for admission to the program.

The initiatives' general strategies to serve the uninsured are summarized in Figure 1. Located between public programs and private insurance, they seek to avail themselves of either—enrolling applicants in public programs when they are eligible and capitalizing on provider volunteerism which in part relies on adequate reimbursements for care of patients enrolled in public programs and private insurance plans.

However, local initiatives also draw new funds to care for the uninsured. These new funds include private grant funding as well as federal funding in the form of federal matching and use of disproportionate-share hospital (DSH) payments.

Figure 1


The Role of Community Initiatives
Private Insurance
Uninsured
Enhance Public
Enhance Private
Local Government Investment
Enhance Provider Participation
Grants
Public Programs
Federal Support
DSH
Refundable Tax Credits
Enhanced Match
Waivers

III. EFFECTIVENESS OF MODELS

Effects on Coverage

The community initiatives primarily cover the subset of the uninsured population who are young to middle-aged adults. In contrast, low-income children and seniors are much more likely to be eligible for federal/state public insurance programs. Eligibility by income ranges from approximately 120 percent of the federal poverty level (FPL) in Milwaukee to 300 percent of FPL in Paris. Most enrollees have incomes near poverty—substantially lower than the programs' income limits.

In most of the sites, coverage for undocumented immigrants is a contentious issue. This was most tangible in Wichita, where some provider dissatisfaction with treating this population led the program to make undocumented immigrants ineligible for coverage. The programs in other communities either cover few undocumented immigrants or program staff have adopted a "don't ask, don't tell" policy about enrollees' immigration status.

All of the programs identify eligible individuals only after they present for medical care; two cover only uninsured individuals with particular conditions. As a result, the covered populations typically are ill, and many have chronic diseases. Yet the programs typically limit the enrollment period. Some offer coverage for just three or six-months, with the ability to reenroll if health needs require ongoing care. In Milwaukee, an estimated one-third of clients are enrolled for one six-month period; another third are enrolled for two six-month periods; and the last third are enrolled continuously.

The programs typically require enrollees to pay an application fee or premium to enroll, as well as copayments when they obtain services. For a low-income population, these costs affect enrollment. For instance, in Milwaukee a recently established $35 application fee was reported to have "*... kept more people out of the program than any [other] single thing."* In Paris, with low employer participation and loss of the program subsidy, now 70 percent of enrollees must themselves pay the full cost of the premium—from $60 to $200 per month, depending on age and gender. It is not yet clear how this cost will affect enrollment and retention in the program.

Reflecting differences in community structure, demographics and available funding, enrollment in the programs varies widely—from fewer than 200 enrollees in Paris to approximately 26,000 in Milwaukee. However, none of the initiatives has the capacity to cover most of people eligible for the program, even though eligibility is defined to include just some in the community who are uninsured. Even Milwaukee's relatively large program has reached approximately 35 percent of people believed to be eligible, and just 23 percent of the estimated 115,000 uninsured in the county.

Because people often stay in the programs for short periods, the number of people served over time is significantly higher than current enrollment. For instance, Wichita's

program has approximately 625 active enrollees, but since 1999 it has served more than 4,000 people—40 percent of the 10,000 people believed to be eligible.

All five of the programs offer generally comprehensive medical coverage. The programs typically provide primary, specialty and hospital services, as well as prescription drugs. For example, the program in Forsyth, which enrolls people with specific chronic illness, offers comprehensive coverage all of the enrollee's health needs. All programs offer more holistic care and support services than what is considered traditional medical care. However, in an attempt to reduce their clients' reliance emergency departments, some restrict the use of emergency services or do not cover them at all. Some programs provide 24-hour nurse call lines to direct enrollees to appropriate services, address their concerns, and offer care management for chronic illnesses. Services such as dental, vision and behavioral health typically are limited.

Effects on Access

Across the five communities, the initiatives are perceived as having improved access to care for the uninsured by expanding the network of providers willing to treat them. For instance, the uninsured in Milwaukee now can seek care at any community hospital; formerly they could obtain care at just one public hospital. More people have a medical home or ready access to a primary care facility, as well as access to specialty referrals, prescription drugs, and hospital care—all conducive to obtaining more timely and appropriate care with less reliance on emergency departments.

However, the extent to which local initiatives can measure their impacts on access varies. Much of the information they are able to provide is anecdotal. Their relatively short enrollment periods also make it difficult to gauge impacts on utilization by a consistent group of clients. While most of the programs attempt to track utilization for their enrollees, they typically do not yet have data to share.

In most cases, local key informants perceive that program enrollees use more outpatient care—particularly primary care—than they had before they enrolled. For example, Olympia's access coordinators not only help people enroll in public insurance, but key informants report that these staff have also helped the uninsured—clients and others alike—find medical homes and obtain specialty consultations and prescription drugs. In Paris, a local health agency representative reported receiving fewer calls from people who cannot find a doctor to treat them since the program was implemented. In the Wichita program tracks the "charges" that providers submit for services they have donated; these data indicate that the average number of outpatient encounters per patient increased from 1.5 to 1.8 in the program's first three years.

The programs' effect on access to outpatient specialty care is mixed. The donated care models that focus heavily on clients' specialty care needs were reported to offer good access to specialists, though none were able to measure program impact. For example, though the Forsyth program has provided $13.6 million in donated care since 2001, it is unclear how much care was donated before, but in a less structured way (and therefore

not measured). In programs that do not focus on specialty care specifically, access to specialty care continues to be difficult.

Because the programs focus on increasing outpatient care (addressing medical conditions early to avoid hospitalization), local leaders expect inpatient utilization to decline among enrollees. Tracking utilization of its enrollees against a statistical control group,[3] the Forsyth initiative concluded that its enrollees use 27 percent less hospital care—even though the average enrollee has three medical conditions compared to an average of just one medical condition in the control group. In addition, clients' use of hospital care declines further as they are in the program longer. In Milwaukee's program, disease management is believed to have contributed to "significant declines" in the rate of claims for inpatient care among enrollees with for asthma, hypertension, or diabetes. In contrast, in Wichita's program, the average number of inpatient admissions and length of hospital stay per enrollee have increased over three years, possibly due to a greater number of chronically ill enrollees.

In each program, emergency department utilization is believed to have declined as a result of the program. Again, however, few data exist to confirm whether this is true. Compared to a statistical control group, enrollees in Forsyth's program do use less emergency room care (13 percent fewer visits) and client use of the emergency room declines the longer they are enrolled. However, evaluators of Milwaukee's program found no significant reduction in emergency department use among enrollees with asthma, diabetes, heart conditions, or hypertension.

Finally, some of the communities have attempted to measure impact on clients' health status, but none have conclusive evidence. Case managers in Forsyth administer the Behavioral Risk Factor Surveillance System (BRFSS) survey to their clients every six months and a health risk assessment every three months; the evaluators observed just slight improvements in health status. Nevertheless, key informants in Forsyth believe that the program has improved its clients' health status.

Effects on Cost and Efficiency

While the focus of the initiatives is to increase access to health care services for the uninsured, community leaders contend that providing more appropriate health care services is cost effective for providers and for the community at large. Indeed, the communities recognize the need to develop a business case in order to obtain grant funding and provider support. All of the programs depend on the participation of community hospitals and physicians, and they must demonstrate to stakeholders that the initiatives make financial sense. There is evidence that the community initiatives are cost effective in providing care to the uninsured, although variation in how and what program

[3] This control group was a national sample constructed from the Medical Expenditure Panel Survey (MEPS), conducted by the federal Agency for Healthcare Research and Quality.

leaders measure makes it difficult to compare communities' experiences. Efforts to quantify the cost effectiveness of each program is reflected in Table 2.

Table 2 – Estimates of Program Cost and Penetration

Community	Annual Budget/Cost	Estimated Annual Enrollment	Estimated Annual Cost per Enrollee	Current Enrollment	Estimated Potentially Eligible	Estimated Program Penetration
Wichita	$2,000,000*	1,125	$178	600	10,000	6.0%
Paris	$500,000**	90	$5,556	130	4,000	3.3%
Milwaukee	$49,400,000	26,000	$1,900	26,000	75,000	34.7%
Olympia	$1,800,000	20,000	$90	20,000	93,000	21..5%
Forsyth	$1,660,000	1,300	$1,277	800	6,500	12..3%

*Estimate excludes reported $5 million generated in donated services.

**Researcher estimate based on grant funding and dues income for 2003; key informants did not provide total budget figure.

The cost per client served within the Olympia program is relatively low, reflecting the program's limited role as a coverage broker. The Wichita program is also inexpensive, if the estimated value of donated services is not included in overall cost per client. However, inclusive of those services, the average cost exceeded $6,200 per enrollee in 2003. In Wichita (and also in Milwaukee, a program that offers comprehensive coverage), program leaders have found some reductions in inpatient and/or outpatient costs per member per month.

All else being equal, the average cost of programs that provide comprehensive coverage and do not limit duration of eligibility is expected to be higher than programs that only broker coverage and limit the period of eligibility. However, average cost in the Forsyth program appears very low ($1,277 per enrollee in 2003), when it is considered that the program enrolls only individuals with any of four specific chronic diagnoses. The program most like a conventional insurance program—in Paris, Arkansas—incurs the highest estimated average cost per enrollee ($5,556), although the plan's ratio of medical expenditures to total premiums is low relative to the individual coverage that is commercially available.

The programs enroll a relatively low percentage of their estimated target populations. Milwaukee enrolls about a third of its target population of 75,000. The Paris, Arkansas initiative enrolls just three percent of its target population. Forsyth and Olympia—both programs encumbered by waiting lists—enroll 12 percent and 22 percent of their target populations, respectively.

Because the initiatives need to demonstrate their cost-effectiveness to the participating providers, some focus on measuring the impact on uncompensated care at area hospitals.

For example, the Forsyth program estimates an annual reduction of over $500 in uncompensated care per enrollee—totaling more than $650,000 in 2003.

Across communities, however, total uncompensated care costs have increased over the past few years due to the economic slowdown and increased numbers of uninsured residents. For instance, hospital uncompensated care in Milwaukee reportedly increased approximately 20 percent between 2002 and 2003. While the community initiatives may have stemmed those increases, it is difficult to know by how much.

Community initiatives have attempted to measure the return on investment (ROI) for providers participating in the community initiative. Leaders of the Olympia program report that their hospitals' ROI increased steadily from 2:1 to 20:1 over the course of three years, and hospital leaders interviewed from other programs found these initiatives to be good investments as well.

Moreover, program leaders are trying to demonstrate positive return on investment for the community at large in order to attract more public or private funds – especially to attract more state and local funding and to recruit providers and employers to support the cost of the program. Some are turning to a measure of return on community investment (ROCI) developed by Communities Joined in Action. Communities calculate measures such as direct and indirect health care costs, the amount of federal and state funding drawn down by local investments, and how health status improvements benefit local businesses and the economy by increasing worker productivity. For example, Milwaukee estimates that every county dollar invested leverages one dollar in state and federal funding.

While a number of local leaders are working toward calculating their initiative's ROCI, many components of the equation appear yet to be theoretical. For example, the ROCI model assumes that providing medical homes and coordinating care will reduce the costs of care by one third; Olympia estimates $3.5 million in annual savings based on that assumption.

Overall, while program leaders point to apparently more rational spending for care of the uninsured (more use of outpatient care and prescription drugs, and less hospital and emergency department use), it is difficult to know whether the initiatives offer savings to the community beyond the costs of running the program. Given the complexity of local health care systems and care delivery, it is difficult for program leaders to isolate the effects of their initiatives to determine how they have affected net cost to the community.

IV. LESSONS FOR SUSTAINING AND EXPANDING LOCAL INITIATIVES

In questioning key informants in each site, several lessons emerged from their collective experience in attempting to sustain and expand their efforts, despite substantial differences in the programs' visions and strategies.

- **The mission of the program must be grounded in a comprehensive understanding of the needs of the uninsured**. Each of the programs had to balance the factors compelling change—the burden of uncompensated care and compassion for the uninsured—with the needs of the local uninsured population. Each program gauged the needs of the community in a different way. In Paris, a community health needs assessment provided data on the number of uninsured in the community. In Forsyth, analysis of self-pay hospital discharge data revealed the highest-cost diagnoses amenable to disease management services to reduce the cost of care for the uninsured. In other sites, a review of public programs—Medicaid and the State Children's Health Insurance Program (SCHIP)—identified gaps that a new initiative could fill.

- **Strong leadership is needed at all levels of the organization, and especially at the Program Director level.** All phases of program development—initiation, implementation, and ongoing operation and change—require strong leadership. In each of the study sites, the program director was pivotal to the program's success. In every community, key informants believed it was difficult to find a program director who possessed the qualities and skills essential to success. "Finding competent operational leadership is a challenge. The skill set that is required... is not something you can go to school to learn." Successful program directors were described as having "a strong business perspective," "creativity," and "dedication." They also were connected to local and state government, and strongly committed to the mission and vision of the program. In addition, strong leadership is required within all parties to the initiative—such as government agencies and the healthcare provider community. In each community, strong medical leadership drove program development, recruitment of volunteers, and outreach to potential enrollees.

- **Developing sustainable financial support is key to the ability of a community initiative to stay operational.** Each of the programs currently receives funding from local and state government, federal grant programs, and philanthropies. Key informants in each site observed that time-limited grant funding is inconsistent with financial sustainability and that new funding streams are essential to support operation in the long term. The programs were seeking this funding by developing programs or products to be marketed to other community initiatives, local hospitals, or state or local governments. They also were seeking financial commitments from local and state government including Disproportionate Share Hospital (DSH) funding or dedicated tax levies.

- **The collection of data to evaluate program success should be planned and started early in program implementation.** Formal evaluation is essential to demonstrate the effects of the program and return on investment. In several sites, community partners looked for "short-term wins" as an incentive to continue their financial and organizational commitment to the initiative.

- **Provider participation is important to the success of local initiatives.** Three of the programs relied heavily—or hoped to rely—on health care provider volunteerism; the other programs relied on health care providers assuming risk for providing care to enrollees, even when program funds were exhausted. However, it is difficult or impossible to harness volunteerism over the long term, and in each community the numbers of uninsured have grown beyond the service capacity of available programs. As the states have frozen or reduced Medicaid and SCHIP reimbursement rates, "doctors are struggling to sustain their own practices." Low public-program payment levels have hampered recruitment of volunteer providers, stalling program growth. To continue to recruit volunteer providers, the programs need strong incentives for participation—including payment for services. In addition, physician "champions" are essential to the ability of community initiatives to sustain physician volunteerism, recruiting additional physicians and motivating those already involved to continue.

- **Flexibility to adapt to a changing environment, programs is essential to sustaining the program.** Changes in the health care market disproportionately affect programs that serve the uninsured: they feel the cumulative impacts of changes in the economy, state regulation, political administration, and available funding on all other insurers and programs. The initiatives most likely to be sustained, therefore, are those able to adapt their goals and approaches to achieving their goals, while staying true to their mission of serving the uninsured.

V. LESSONS FOR REPLICATING LOCAL INITIATIVES

Innovations are most easily transferred when they are simple and quick, and when their benefits are easily observable.[4] However, the intricacies of health care financing necessarily make initiatives that focus on access and health status complex, and their results generally are not quickly or clearly observable.

The complexity of the programs and their organizational structures creates the need for more intensity in every factor that influences diffusion of innovation. The comments offered by key informants in each site suggest a number of important lessons for replication of local initiatives in other sites—including thoughtful adaptation of models to local circumstances, strong leadership, communication, and leveraging context. Each is discussed below.

- **Adaptation**. Community programs develop in response to a specific local culture; it is unlikely that another community will have exactly the same culture among either providers or uninsured residents, and therefore the same needs. Each local initiative must be realistic about what will succeed in its community. A member of the network in Olympia articulated the uniqueness of its community and the process of adaptation: *"One type of model will not result in 100-percent access. Our network has engaged in a continuous blending of programs to shape a complex portfolio of efforts to connect the community to care."*

- **Leadership and structure.** Local initiatives focused on health care also require a special kind of leadership and a strong sense of organizational structure, sentiments expressed in nearly every interview. Moreover, more complex initiatives require still stronger leadership and greater formalization of the initiative's organizational infrastructure. Components of successful leadership include the ability to develop a wide variety of highly interconnected network partners with high levels of knowledge, and to manage and facilitate the collaboration and communication among partners. *"You need passion, intelligence, flexibility, political savvy, and dedicated workers."*

- **Communication.** More complex innovations require greater interpersonal communication.[5] In each site, key informants reported "significant interface"

[4] Rogers (2003) defines innovation as "an idea, practice, or object that is perceived as new by an individual or other unit of adoption (p12)" and diffusion is "the process in which an innovation is communicated through certain channels over time among the members of a social system (p5)". When local health access initiatives seek to replicate programs from other communities, they are entering into the process of diffusion of innovation. Rogers, Everett M. (2003). *Diffusion of Innovations*. 5th ed. The Free Press, New York: NY.

[5] Diffusion theorists suggest that interpersonal channels of communication are more effective in the program diffusion process than mass media (Rogers, 2003). Personal intercommunications among multiple initiatives will foster the transfer of innovation.

with the alpha site prior to starting the program, involving numerous consultations and conversation with leaders from the alpha community and, change agents traveling to and from the alpha site to visit, observe, and discuss. Expanded opportunities for interpersonal communication among initiatives are likely to increase diffusion and replication of local initiatives.

- **Leveraging context.** The context of community programs—the presence of supportive public programs and/or strong private insurance capacity—can contribute importantly to a successful replication.[6] Programs that capitalize strategically on their context are most likely to succeed. For example, in the presence of strong state programs, Milwaukee's GAMP has succeeded in enrolling a relatively large share (35 percent) of its target population. In contrast, the Paris, Arkansas initiative—which attempts to transplant a model developed in heavily industrialized Michigan—has had considerable difficulty gaining enrollment. Because the program attempts to attract employer participation in an environment where employers are unlikely to offer coverage at all (and to low-wage workers, in particular), enrollment has remained very low: just 130 people currently are enrolled. a state environment with opinion leaders and change agents who value local initiative innovation.

The success of beta site replication of alpha sites varied among the initiatives (Table 3). In only one site was the replication complete. That site differed from the other study sites in that the contexts in the alpha and beta site were similar and there was extensive communication/collaboration with the alpha site. The site with the least success had a context that was very different from the alpha site and there was no communication with the alpha site. The difficulty with replication can first be attributed to the complexity of the innovation and second to the differences that exist between alpha and beta site contexts.

[6] The literature documents the strong influence of the social system (community attributes/attitude, system norms, opinion leaders and change agents) on the diffusion of innovation (Rogers, 2003). The social system in which these five community initiatives operate is the state. The state level attitude toward community innovations, the state level norms and the influence of state level opinion leaders and change agents will influence the diffusion of innovation at the local level. As with the other factors that affect innovation, the complexity of these innovations requires a stronger state "social system" of support.

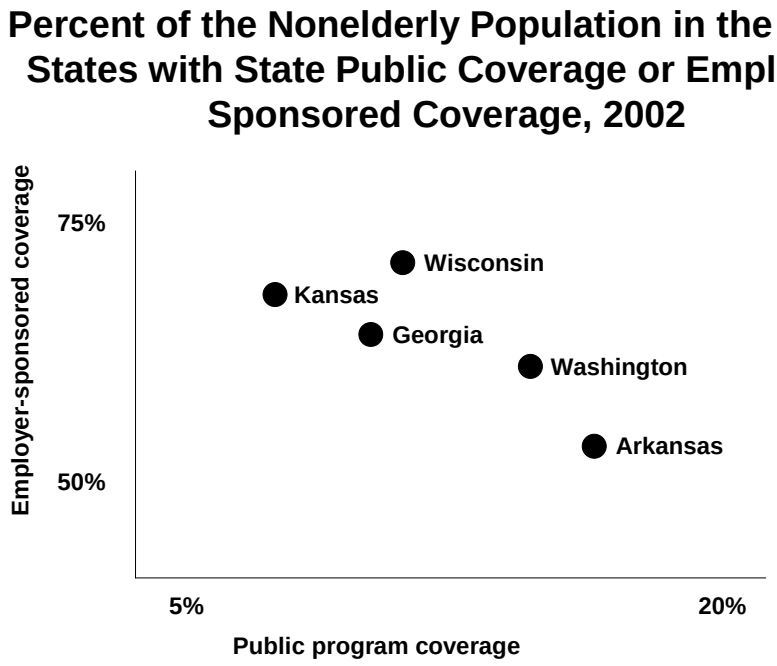
Table 3 – Replication Comparison					
Site	**Project Access** **Wichita, Kansas**	**Community Health Link** **Paris, Arkansas**	**GAMP** **Milvaukee, Wisconsin**	**Choice** **Olympia, Washington**	**Community Health Works** **Forsyth, Georgia**
Replication Alpha Site	Project Access Buncombe, NC	Three Share Program Muskegon, MI		Jesse Tree Galveston, TX Project Access Muskegon	Project Access Buncombe, NC
Communication with Alpha Site	Extensive	None	Visited Michigan and Florida	Yes	Limited
Similarity of Context	Yes	No	No	No	No
Simple Program with Easily Observable Benefits	No	No	No	No	No
Wide Variety of Easily Observable Partners	Yes	Yes	Yes	Yes	Yes
Leadership	Yes	Yes	Yes	Yes	Yes
State Level Opinion Leaders and Change Agents	No	Mixed	Yes	Mixed	Mixed
Success of Replication	Complete	Very limited	NA	Too Soon to Tell	Limited

VI. STATE/COMMUNITY INTERFACE

Each of the initiatives attempts to bridge public and private coverage: each serves individuals who have difficulty finding or staying public or private coverage, or navigating between the two systems. Because the programs operate close to the world of public coverage, they are especially sensitive to political, financial and administrative changes in public programs.

Because Washington has strong public programs—including the state-subsidized Washington Basic Health Plan, the CHOICE network was able to cover many uninsured simply by extending outreach to enroll eligible residents. The three-share program in Paris, Arkansas has struggled in an environment of systematically low employer support for private group coverage; in contrast, the Michigan program on which it is modeled 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 2.

Figure 2 – Public and Private Coverage in Study States



Source: Fronstein, Paul. (2003). *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*. Employee Benefit Research Institute (EBRI) Issue Brief No. 264.

The state/national context can affect the ability of local initiatives to add value to their community by:

- Developing policies that support provider participation;
- Supporting robust public programs that recognize the benefits of local initiatives and provide financial support for them;
- Developing state policies and resources that strengthen the private insurance for low-wage workers and low-income families; and
- Encouraging opinion leaders and change agents who believe in local innovation.

States have supported the studied local initiatives by enacting legislation to exempt them from state insurance regulation (Arkansas), extending malpractice insurance to providers in clinics (Kansas), changing good Samaritan laws (Washington), placing state eligibility specialists in safety net clinics (Kansas), giving grants for local network development (Georgia), providing block grants (Wisconsin), and participating with local and federal government to use Disproportionate Share Hospital dollars to support the local initiative (Wisconsin). These state policies and resources foster innovation in the community and provide critical support for community initiatives do develop funding streams and volunteer support.

Community Enhancement of State Initiatives

Each of the study sites attempts to place clients in state programs—usually Medicaid or SCHIP—when they are eligible. In the CHOICE network, applicants who received assistance with enrollment were twice as likely to be enrolled in public programs (98 percent) as those who did not receive such assistance (40 percent). With CHOICE assistance, 96 percent of enrollees remain enrolled after three years, compared to only 40 percent of unassisted enrollees. Key informants described the local programs as *"slowing the frazzling of the safety net"* and *"catching some of those falling through the safety net."*

State and National Enhancement of Local Initiatives

While there are many opportunities for national and state policies and resources to come together to support local initiatives, the programs survived with the state having implemented just a few of the support strategies possible. Much of the potential for state and national leaders to create contexts that enhances the abilities of local initiatives remains untapped. Such strategies would include:

- Allowing tax write offs for volunteer services to build provider participation.

- Modify medical liability coverage laws to protect and/or insure participating providers.

- Allowing communities to partner with Medicaid to supplement employer/employee contributions to insurance, and allowing access to government rates on prescription drugs.

- Encouraging local innovation, recognizing the potential of communities to contribute to solutions, and thinking of local initiatives as potential vendors or partners.

Rural areas require additional support from state and national government as they have fewer resources upon which to build community programs. "*[Building on] employer based health care is not easy in rural communities*" where employers are more likely to be small and less likely to offer insurance. In addition, there are fewer providers to support a volunteer program. As a result, a higher percentage of rural residents are without insurance, the private insurance infrastructure is weaker, and there is less potential for local initiatives to build on provider volunteerism.

VII. IMPLICATIONS FOR FUTURE RESEARCH

Insights from this study imply that local initiatives can contribute to closing the gap between private insurance and public programs. Three types of research might help to guide communities and states in building local initiatives to enhance coverage and access, and to improve the efficiency of care for the uninsured. These include:

1. A multi-site evaluation of the impact of local initiatives;

2. A description of the state context conducive to different models; and

3. An investigation of options for overcoming provider capacity issues in local models that rely primarily on physician volunteerism.

Taken together, these research projects would help to build an evidence base for national, state, and local decision-making regarding how to design, sustain, or replicate successful local programs. Findings would:

- Help national leaders, state elected and agency leaders, academic institutions, and foundations to understand the potential of communities to work together in new ways to provide increased access to care for the uninsured at a reduced cost in a time of shrinking resources and growing need.

- Help national and state policymakers will better understand how state-level policy and infrastructure can support communities' ability to attract and retain health care provider volunteers to staff local community initiatives and support the local health care safety net.

- Help local leaders who are faced with enormous challenges in caring for the uninsured to make informed decisions about alternative options based on their compatibility with the context and the range of local provider and population needs.

Multi-site Evaluation of Effects

Credible, objective evidence of impact is critical to understanding of the value of local access initiatives and, in turn, to the long-term success of local initiatives that serve the uninsured. Demonstration of value and effectiveness can help keep partners engaged, inform mid-course program corrections, and encourage investors (public and private) to contribute over time. However, valid research documenting the outcomes of most of these programs is very limited. The prevalent impression among key informants that each initiative improves health care access and efficiency for enrollees is largely grounded in anecdote and theory.

The complexity of the health care systems being built or modified, the interaction of multiple community-based interventions, and state and local context of the interventions

present important challenges for formal evaluation. But limited evaluation experience, capacity and resources in the community are also important barriers. Because rigorous evaluations of effects are rare, aggregating evidence to inform state and national policy discussions and decision-making is impossible.

To better understand the contribution made by local initiatives and to advance the policy conversation regarding their role in the larger system of health coverage, a utilization-focused, participatory evaluation is proposed that could be applied across sites. The goals of such a study would be to:

- Identify a set of common indicators and methods for measurement across study sites;

- Provide technical assistance to strengthen skills and build evaluation capacity at the local level, building appreciation for the connection between strong documentation of outcomes and program sustainability; and

- Aggregate data across local initiatives to answer state and national policy questions about the potential of local initiatives to offer long-term solutions to issues of the uninsured.

Understanding State Context

The replicability and effectiveness of different local models depend critically on state context. A state's public and private insurance markets, culture and larger policy environment all drive what is possible and needed to build community-based programs to assist the uninsured. Both communities and states would benefit from a better understanding of the contextual factors that constitute a conducive environment for the implementation of various models.

Research to build that understanding would address the following questions:

- Which state policies or regulations promote community-led solutions to care for the uninsured, and in which states are those policies and regulations found?

- Which models require a culture of provider volunteerism, and how does/can state policy or regulation support and encourage that culture?

- Which models work best in states with a robust private insurance market, and why?

- Which models are best suited for rural communities, and why?

A simple, initial approach to these questions would involve constructing a scale to measure state context. The research would review the states' characteristics and place

each state within a continuum on selected factors in order to identify models of community initiatives that each state might best support. Factors would be identified based on additional case studies, building on the research reported here, and might include: (1) the nature and penetration of public coverage; (2) private insurance markets—including the rate and terms of employer offer, and regulation to improve health insurance access or reduce cost; (3) state-level vision and supportive programs and policies; (4) provider and community culture; (5) investment partnerships; and (6) technical support. Each factor and combinations of factors would be considered in light of the apparent relationship to communities' ability to develop different types of local solutions.

Evidence regarding the contextual "fit" of alternative models would facilitate communities' ability to sort through their options for adopting any of the approaches in the study, with the goal of improving the rate and degree of their success. Armed with a descriptive framework for creating a more conducive state-level environment for local initiatives, state leaders would be better positioned to develop strategic state-level relationships, investments, policies, and technical support to improve the sustainability and effectiveness of local efforts. State leaders interested in catalyzing community-level innovation would have a better understanding of levers that might be used to create a supportive policy environment for local efforts.

Investigation of Provider Capacity Options

Provider capacity limits program expansion, particularly in local initiatives that rely heavily upon physician volunteerism. Therefore, understanding provider motivations and expectations—and the incentives and conditions that would prompt greater volunteerism—is critical to understanding the potential for community initiatives to serve the uninsured.

Preliminary research investigating these questions would entail approximately thirty interviews with physicians selected from community initiative models that rely on volunteerism and approximately twenty interviews among physicians in three states (to be selected) with high uninsured rates but no community initiatives contemplated or in place. The community initiative models would include Project Access, a three-share model, and free-clinic model. Both rural and urban physicians would be recruited for participation, and states would be selected to achieve geographic diversity. Data would be analyzed and summarized to offer lessons learned.

CONCLUSIONS

Local initiatives can enhance coverage and access for "high touch" populations who often are not well-served by conventional systems of public programs and private insurance. Moreover, they may improve the efficiency of serving these populations. However, some factors clearly contribute to their chances of success: visionary and capable leadership; responsiveness to a well-understood need in the community; and a context of provider resources, supportive state leadership and programs, and/or strong private insurance capacity.

Community initiatives typically build on public programs or private insurance by garnering local government investment, enhancing provider participation, and drawing grant monies into communities. But they also draw federal support by assisting enrollment in Medicaid and SCHIP, and by creative use of indigent care trust fund dollars. Those that provide coverage or direct services could possibly benefit were federal refundable tax credits or other federal funding (such as payment vouchers) made available. However, community initiatives are characteristically pragmatic and none have plans based on the expectation of imminent federal relief.

The project team rated each local initiative on their impacts (do they enhance coverage, decrease the cost of serving the uninsured, or offer better care?) and whether they seemed replicable. The scoring of each initiative, reflecting informed judgments by the research team, is summarized in Table 4.

Table 4

Rating of Selected Community Initiatives 

	Wichita, Kansas	Paris, Arkansas	Milwaukee Wisconsin	Olympia, Washington	Forsyth, Georgia
Coverage					
Cost Effectiveness					
Better Care					
Replicable					

Note: Green indicates a positive rating; yellow indicates insufficient evidence.

With respect to coverage, efficiency, and quality of care:

- These programs generally enhance coverage, although in one case the program was very small.

- The program leaders have been able to show in various (though typically subjective) ways that the programs reduce the costs of caring for enrollees.

- It is generally believed that those who are enrolled in these initiatives get better care.

The replicability of a program fundamentally depends on the similarity of local context and the program's ability to adapt to differences in local context. But in addition, successful replication requires the right combination of leadership, shared responsibility, and state support—all at the right time.

Because local initiatives typically build on public programs or private insurance, the state context in which they operate is critical. They rely heavily on strong systems of public programs, private insurance, or both. All operate in part or in total as outreach agencies for public programs, enrolling applicants whenever they are eligible for these programs. In addition, to the extent that they rely on volunteer providers, they also rely on adequate financing for care used by the insured population. States that have frozen or reduced Medicaid and SCHIP reimbursement rates have created a more difficult environment for local initiatives to recruit and sustain provider volunteerism. Similarly, in states and communities where private insurance plans have negotiated low rates or raised enrollee cost sharing (potentially contributing to provider bad debt), local initiatives may have more difficulty relying on volunteer providers.

Where public and/or private reimbursements are frozen and reduced eligibility or higher premiums increase the number of uninsured, community initiatives may find it especially difficult to succeed. This combination of circumstances appears largely to explain the problems that each local initiative has experienced in serving undocumented immigrants.

However, many local initiatives appear to have succeeded in various and important ways despite significant challenges. They represent a potentially important link in the nation's pluralistic approach to health care financing. Gaps in coverage are most visible at the local level, where approaches to bridging gaps can be most tailored to local circumstances.

Greater resources could be devoted to cultivating community initiatives that demonstrate basic components for success—including strong leadership and capacity to adapt strategically to state and local context. However, to argue for greater resources, more compelling evidence of their success is needed. Without rigorous and systematic evaluation evidence, it is impossible to gauge their real potential for ensuring access to care for the uninsured.

APPENDICES

Appendix A: Research Methods

The Georgia Health Policy Center and Mathematica Policy Research, Inc. (MPR) collaborated on this joint study. Two Co-Principal Investigators guided the development of the research questions, and provided oversight to the process of data gathering, assimilation and interpretation. They were assisted by two primary researchers from each institution whose responsibilities were information gathering and assisting in the methodology design.

Research Questions

Research questions were defined with an eye toward developing lessons for local initiatives attempting to expand coverage and access for uninsured populations:

1. *Eligibility* - Whom do community initiatives serve, how do they identify need, and why do their clients fall outside the community's larger public and private insurance systems?

2. *Cost* - Is there evidence that the net cost to the community is less than if the initiatives' clients were served by the conventional safety net?

3. *Funding* - What are the funding streams supporting the community initiatives? How much funding do they provide, how do they work, and how were they captured?

4. *Replication potential* - Are these initiatives replicable? What are the lessons to be learned and what adaptations are needed to help other communities develop similar initiatives?

5. *State/community relationship* - How can states and communities cooperate to close the gaps in funding and access?

Choice of Study Sites

Selection criteria for study sites received considerable attention from the research team, Commonwealth Fund leaders, and the Commonwealth Fund project officer. Local, state and national leaders were also consulted. The final criteria were:

- a track record of successfully covering the target population
- a funding stream other than contributions or volunteers
- preference to initiatives that have adopted strategies from other sites in order understand the process of replication

- the potential to go to statewide scale
- demonstration of some cost effectiveness
- variety in the replication sites with regard to financing, organizational structure, geography and community size

Five sites were selected, and letters were sent to program leaders inviting them formally to participate in the study.

The sites and timing of the site visit were:

- Project Access – Wichita, Kansas (December 2003)
- Community Health Link – Paris, Arkansas (February 2004)
- General Assistance medical Program – Milwaukee, Wisconsin (April 2004)
- CHOICE Regional Health Network – Olympia, Washington (June 2004)
- Community Health Works – Forsyth, Georgia (July 2004)

Research Process Design

The principal method of gathering information was site visit interviews. Seven individuals representing access initiative funders and alpha sites were asked to provide feedback on the research questions, potential case study sites, and relevant types of key informants. They were also asked to share key lessons learned and unanswered questions related to their programs.

Interview protocols specific to each type of key informant were developed and aligned to the research questions was developed; the protocols were reviewed throughout the project period to assure quality and uniformity of information across the sites. Each site study was divided into three phases, pre-site visit, site visit, and post site visit.

Pre site visit. Approximately six weeks prior to each site visit, the research team conducted a teleconference with the program director to obtain an overview of their initiatives operations, and to begin the process of identifying key informants at sites. The research team also conducted searches and reviews of electronic, printed and published materials describing the community's economic circumstances, health status indicators, and state and local context. The team also reviewed all available information about the work of the initiative, including previous assessments and evaluations.

Site visit. At each site, researchers conducted in person interviews with 10-25 key informants using the interview protocol that track responses from interviewees. The key informants from each site included: (1) the network director, (2) system implementers, (3) participating and non-participating health care providers, (3) other human services

providers, (4) community leaders—including local government, school, faith, and business leaders, (5) community advocates, (6) Medicaid/ SCHIP directors, and (7) the Governor's health policy advisor.

Researchers conducted interviews in pairs, over a two to three day period. The program director's interview occurred in the program office and with all the researchers present. Otherwise, interviews typically were conducted at a "neutral" site, not directly associated with the initiative's operational home. Interviewers carried laptop computers for on-site input of electronic data and notes during all interview conversations. Daily briefings with the principal investigators were held to review information and to address gaps in data gathering as far as was possible prior to the conclusion of the visit.

A combined total of 82 persons were interviewed in this process.

Post site visit. Follow-up telephone conversations were arranged with key informants who were unavailable at the time of the site visit or to clarify or enhance information gained from the site visit. The researchers prepared summary reports in a structured format to facilitate comparison of information across sites and met to discuss these reports and explore thematic elements.

Qualitative Analysis and Development of the Report

All interviews were uploaded to a qualitative analysis database, *Atlas-ti*. Individual responses were coded by themes and key informant quotes were extracted for use in writing the report. Information on the key theme areas of sustainability, leadership, and replication was assembled and a project team member was assigned to review all information from each site.

The full team met in Atlanta over two days to assimilate all of the data, draw inferences, and design the report outline. The team member assigned to review the site visit material provided an overview of that site, and the complete team discussed key questions about each site:

1. What is the role/place in the system of the program?
2. What is broken that this fixes?
3. Is it the solution to:
    - Insurance coverage
    - Participation in health care
    - Access/efficient use of care
    - Decreased cost

- Improved health outcomes

- What are the limits to the solution?

Information on the key theme areas was reviewed. Contributions to existing knowledge were identified, and the report outline was drafted. Team members took responsibility for drafting specific sections. The report went through numerous revisions, and received both peer and editorial review.

Appendix B: Key Informants List

Informant Types	Wichita	Paris	Milwaukee	Olympia	Forsyth
Director	Anne Nelson	Bob Redford	Paula Lucey	Kristin West	Shannon Harvey
					Greg Dent
Program Implementer	Ruth Weta-Hall	Rosemary Alcon	Lee Holloway	Douglas Burt	Sydney Cutts
	Allen Nelson	Kendall Poe		Jan Crayk /Anna Shelton	Betty Miffin
		Debbie Veach		Holly Detzler/ Annette Brown	Bill Custer
		Kate Stewart		Doug Busch/ Dan Rubin	Monique Barnes
Provider	Sister Marie Kuhn	Wayne Enns	Bill Bazan	Jean Roberts	Frank Fields
	Susie Schwarz	Jim Maddox	Marie Wolff/Stacy Young	Bob Appel	Fred Gatan
	David Neville		Tom Brophy	Kathy O'connor	Gale Tanner
	Thomas Purcell		Bill Solberg	Dr. Albrecht	Patton Smith
			CC Henderson	Kevin Haughton	Frank Aaron
			Ellyn McKenzie	Scott Bond	Don Faulk
Governors Office		Joe Thompson		Jonathan Seib	Trey Childress
Medicaid/State		Kurt Knickerham	Russ Pederson	Maryann Lindeblad	Tim Burgess
				Michael Arnis	
				Laura Hjelm	
Local Agency	Paul Meals	Ron Ford	Seth Foldy	Selia Evans	
		Paula Dozier	Scott Walker	Vicki Wilson	
				Cathy Wolfe	
				Sherri McDonald	
				Steve Kutz	
Community Advocate		Ted Darling	Ken Germansson	Kim Klint	J Roy Rowland
			Cordelia Taylor	Heather Newman	Leila Anderson
Funder/Community Leader	Dwight Allen	Bill Elskin	John Petersen	Bill Perkins	Ethel Cullinan
Medical Society	Dr Dismuke			Don Sloma	

Appendix C: Sample Interview Protocol

Research Question 1: Who do community initiatives serve, how do they identify need, and why do their clients fall outside the system?

Q1. How long have you participated/been involved in the program?

Q1A. Who is eligible for the program? Confirm eligibility information from background materials

Q1A1. Are people who already have employer or public insurance coverage eligible?

Q1A1s. If not, what if their current coverage does not meet all of their needs (i.e., they are underinsured)? *Probe: Are there any instances in which people with public or private insurance are served by your program, such as for services otherwise not covered or for people with high deductible policies?*

Q1A2. Do you know the number of people potentially eligible for your program?

Q1A3. Has the population served changed within those eligibility criteria?

Q1A4. Have the eligibility criteria changed over the course of the program?

Q1K. Which populations are ineligible for the program?

Q1K1. Do you have estimates of how many uninsured people are ineligible?

Q1K2. Are there any eligibility restrictions related to one's immigration status?

Q1K3. Are migrant workers eligible?

Q1B. How is income eligibility determined? Request copy of any income eligibility tool used.

Q1B1. Are there documentation requirements?

Q1B2. How easy or difficult is it for people to demonstrate eligibility?

Q1B3. Do you waive documentation for workers who have difficulties proving their income or other requirements?

Q1C. How were eligibility criteria created?

Q1C1. Was a needs assessment done?

Q1C2. Who was involved in setting criteria and how has that affected the breadth of the program?

Q1D. How does the program identify and connect with eligible people? *Probe for outreach activities*

Q1D1. Are employers a source of referrals?

Q1H. How was the initial group of clients enrolled?

Q1G. What are the trends in enrollment?

Q1E. How many people are enrolled currently?

Q1E1. How many have been enrolled over the life of the program?

Q2E2. How many enrollees are you committed to treat?

Q1F1. Is your program at capacity? Are you at capacity for the number of program patients you are treating?

Q1F2. What are the demographic characteristics -- such as gender, average income, race/ethnicity, education level -- of the client population?

Q1L. Which populations are likely eligible but not enrolled in the program?

Q1L1. Do you have estimates of how many people are eligible but not enrolled?

Research Question 2: Is there evidence that the net cost to the community is less than if the initiatives' clientele were served by the conventional safety net?

Q2A. How does the program define and evaluate success and is it meeting those goals?

Q2B. Which needs or services does the program cover?

Q2B1. What are the most important needs or services that the program does *not* cover?

Q2C. What types of strategies, if any, does the program employ to encourage appropriate use of health care services?

Q2C1. Does the program use care management or disease management strategies?

Q2D. What impact has the program had on utilization of services, if any? *Probe for comparisons between the enrolled population and the uninsured population who rely on the conventional safety net system*

Q2D1. How is utilization tracked and measured?

Q2D2. Has utilization of primary care or preventive services changed?

Q2D3. Has emergency department utilization changed?

Q2D4. Has the number of inpatient admissions or avoidable hospitalizations changed?

Q2D5. Has hospital length-of-stay changed?

Q2E. What types of strategies, if any, does the program employ to control costs?

Q2F. What impact has the program had on costs of caring for the uninsured, if any? Do you have data you could share with us? *Probe for comparisons between the client population and the uninsured population who rely on the conventional safety net system*

Q2F1. How are costs measured?

Q2F1s1. How have uncompensated care levels changed at your hospital/among participating hospitals?

Q2F1s2. (For physicians) Do you provide more charity care than you did before participating in the program?

Q2F2. What is the per member cost of the program?

Q2F3. How does the program's effect on costs compare to program goals or expectations?

Q2F4. Do you expect additional cost savings in the future?

Q2G. What impact has the program had on patient health status or outcomes? Do you have data you could share with us?

Q2G1. How is the impact measured? (i.e. BRFSS, chart reviews, etc)

Q2G2. How do these effects compare to program goals or expectations?

Q2H. How has the community's overall safety net changed since the program was implemented? *Probe for the role of specific hospitals, clinics, physicians, overall adequacy*

Q2I2. Which gaps in the safety net does the program target? Which does it not address? *Probe for gaps for specific populations, geographic gaps, types of providers, types of services*

Q2J. How has the safety net in this community changed as a result of the program?

Research Question 3: What funding streams support the community access initiatives, how big are they, how do they work, how were they captured?

Q6B. Which agencies and organizations are partners in the program?

Q6B1. Are there any organizations or agencies that are not as involved as you would like them to be?

Q6B3. How do health care providers fit into the program structure?

Q3A. What are the key funding sources for the program? *Note: If there are multiple funding sources, ask the following questions of each source.*

Q3B. What was the process for securing these funds?

Q3B1. Which organizations or individuals were integral to the process?

Q3C. What is the funding amount?

Q3D. Are the funds time-limited or ongoing?

Q3E. How do the funds flow throughout the program?

Q3E1. Which types of organizations receive funding?

Q3E2. How are providers reimbursed, if at all? *Probe for lump-sum payments, grants, capitated or FFS reimbursement*

Q3F. Since the program's inception, how has funding for the program changed, if at all?

Q3G. How do you expect program funding to change in the next few years, if at all?

Q3G1. Could the funding expand to include more communities or become a statewide program?

Q3G2. What steps would be necessary to make that happen?

Q3H. Do you expect the program to be sustainable over the next 3, 5, 10 years? How?

Q6E1. What steps need to be taken to meet these goals?

Research Question 4: Are these initiatives replicable? What lessons exist and what adaptations are needed that would help other communities develop access initiatives?

Q4A. Was your community's program modeled after a particular program or programs?

Q4A1. How did you learn about the original program?

Q4A5. Why did your community choose this model?

Q4A5S. What about the situation in [Fill in site] suggested that this would be a good model?

Q4A2. How did you go about replicating that program?

Q4A2S1. Did you implement the program independently, or consult or contract with the original program's administrator?

Q4A2S2. Did you travel to [Fill in site] (or anywhere else) to observe this model in operation? What did you learn by first-hand observation? What else was gained?

Q4A2S3. Was/How was [Fill in site] involved in the development of your program?

Q4A3. Which components of the original program did this program adopt?

Q4A4. Were there any components of the original program that were not adopted? If so, why?

Q4A6. How does your community differ from [alpha community]?

Q4B. What factors have been critical in designing, implementing and administering the program?

Q4B1. What local working relationships were in place when you were considering this model? How have they changed?

Q4H. What decisions about the direction of the program or program activities are made centrally? Who is involved?

Q4H1. Are some decisions about service delivery or other matters made by others? What decisions, and by whom?

Q4C: What have been the greatest challenges in designing, implementing and administering the program?

Q4C1. Does any constituency perceive the program as complex? Beneficiaries, providers, others? In what ways?

Q4D. If the program were designed and implemented over again, what would you like to see done differently?

Q4F. Could the program be replicated in other communities? *Probe for relevant ways in which their community is unique.*

Q4F3. Which communities, if any, have copied your program and how was that accomplished?

Q4F1. Which conditions are necessary for replication?

Q4G. What lessons would you share with other communities implementing a similar program?

Research Question 5: How can states and communities cooperate to close the gaps in funding and access? OR: How do these programs fit into state and national solutions to provide care and coverage to the uninsured?

Q6D. What changes in the program would you like to see in the future?

Q6D1. What specific changes in the policy arena or marketplace would facilitate such change? *Probe for both potential and probable changes.*

Q6D2. What could be done to reduce any barriers for the program? *Probe for both potential and probable changes.*

Q5A. How do the community and the state interface with regard to the program?

Q5A1. Does the program support or complement state public insurance programs?

Q5A2. How does the state support the community's efforts?

Q5A3. Are there any state or national barriers to the community's success?

Q4E. If your clientele and other low-income families and individuals were given a federal or state voucher to buy private health insurance, how might the role of the program change?

Q4D1. Would it be possible to integrate this program into a public insurance program such as Medicaid or SCHIP?

Wrap-Up and Background Questions

Q6A. What motivated you/your organization to participate in the program?

Q6A1. What factors keep you involved?

Q6A2. What changes would discourage your involvement in the future?

Q6C. Have any key components of the program changed since it was implemented?

Q1J. Why do people need your program?

Appendix D: Site Visit Reports

PROJECT ACCESS
Wichita, Kansas

Organization and Leadership

Program Description

Project Access is a community program in Sedgwick County (Wichita), Kansas that provides health care to low-income uninsured people through the charitable contributions of local providers. Physicians, hospitals and pharmacies donate medical care and services. The program staff coordinates the donated services for the patients and providers, in an attempt to save time for primary care providers and improve access to needed care for patients. Project Access provides comprehensive inpatient and outpatient services. Although the program focuses on specialty care – or services to people who are already ill – it also helps the uninsured find a "medical home" through primary care clinics and practitioners. Approximately 70 percent of physicians in the county participate in the program.

The Board

The Project Access Board is composed of 11 members, most of whom are physicians. Other members represent hospitals and the United Way. The Board was created out of the Central Plains Regional Health Care Foundation established by Dr. Paul Uhlig, who is considered the program's "founding father." An Operations Council—comprised of 26 members including the hospital CEOs, indigent care clinic directors, physicians, local officials, and other key people in the community—provides day-to-day direction and makes formal recommendations for policies and procedures to the Board. There is also a Physician Participation Committee that focuses on recruiting doctors to the program, as well as creating some clinical protocols for participating practitioners. To make changes to the program, the Council and Committee may submit proposals to the Board for approval. To date, the Board has not voted against any such proposals.

Staffing

There are seven staff members working at the Project Access program office, which is housed at the Medical Society of Sedgwick County. These include the Program Director, Administrative Assistant, four Patient Service Coordinators, Secretary, and a Prescription Service Coordinator. Anne Nelson has been the Program Director since 1999.

Coverage

The "Face" of the Population Served

The Project Access patient population is composed of uninsured U.S. citizens and legal residents who reside in Sedgwick County, Kansas. Since the inception of the program 1998, 4,472 patients have been enrolled and 73,067 prescriptions filled. There are currently 625 active patients. The latest demographic data indicate that Project Access patients are predominantly female (64.5 percent), young, middle-aged (31-50 years), and unmarried (72.4 percent). Approximately 45 percent are racial minorities. Nearly 75 percent report having a high school education or less, and approximately 54 percent report one-person family status. More than 50 percent report being employed; 5.1 percent report being unemployed; less than 10 percent report receiving SSI, Social Security or a pension; and the remaining 27.2 percent report no income. Approximately 70 percent of patients have incomes that are at or less than 100 percent of the Federal Poverty Level (FPL), which is approximately $9,300 annually for a single person. Enrollees tend to be chronically ill, often with dual diagnosis conditions and significant health care needs.

The intent of the program is to enroll eligible people for a short period, while they require services for a particular condition, and then to link them to a medical home for ongoing care. Indeed, the majority of program participants from (what year) to (what year) were enrolled for only 61-80 days (61.2 percent). However, 26.5 percent of those served were enrolled for more than 100 days because their conditions required ongoing care. Most disenrollments occur because eligibility expires (69.4 percent), although patients can be disenrolled if they fail to keep three provider appointments. The program screens people for eligibility for public insurance programs and helps them to enroll in these programs; to date 40,000 people have been reviewed for eligibility. In 2002, approximately 5.0 percent (56 people) of people screened by Project Access were enrolled in Medicaid, became insured, or were enrolled in another program.

Eligibility Criteria

To enroll in Project Access, a person must be a citizen or legal immigrant residing in Sedgwick County, and earn less than 150 percent of the federal poverty level. Project Access largely adopted these criteria from the alpha program in Buncombe County, NC (see Replication section). In addition, the University Of Kansas School Of Medicine performed a community health assessment in 1996 to build the case for the program to potential funders. That study estimated the uninsured population in Sedgwick County at 55,000, of which 65-70 percent were employed. Approximately 10,000 of that group were potentially eligible for Project Access. Although generally one must be uninsured to enroll, Project Access recently added an emergency dental component that allows individuals receiving Medicaid benefits to participate, because Medicaid does not currently provide a dental benefit in Kansas.

At its inception, undocumented immigrants comprised 5-6 percent of the program population. However, after approximately two years, their continued eligibility was jeopardized when a few provider groups threatened to withdraw from the program for several reasons. 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, not undocumented citizens, this provider group's drug costs became extremely prohibitive and the group decided to no longer participate as long as undocumented citizens were eligible for Project Access services. Second, other providers expressed dismay that some undocumented residents were bringing their relatives from abroad to obtain care from Project Access. Third, doctors found this population relatively non-compliant with recommended treatments and one such patient died as a result. Consequently, undocumented immigrants are no longer eligible to enroll in Project Access.

Since the program is designed to address specific health care needs, the eligibility period is rather short: three months for primary care and six months for specialty care. As the program received more federal grants, it had to adhere to stricter guidelines for verifying program eligibility. If care is needed beyond the established period, enrollees must again demonstrate that they continue to meet the other eligibility criteria (e.g., income, residency).

Conclusions

- Project Access is intended to be a short-term safety net for people in need of specialty care, with linkages to primary care services and a medical home. Enrollees are predominantly female, young to middle-aged (31-50 years) and unmarried. Although the program initially had no restrictions on immigration status, due to physician frustration with some aspects of serving undocumented immigrants, the program is now limited to citizens and documented immigrants.

Net Cost to the Community

Utilization and Cost within the Program

Between September 1999 and September 2003, hospitals donated $17.8 million in free care for Project Access enrollees. Physicians donated an additional $7.6 million in free services. Indeed, the main component of Project Access' annual $7 million budget is volunteer provider services, valued at approximately $5 million per year. This amount is calculated from the charges associated with the CPT codes on the standard Medicare billing form that physicians submit for each Project Access patient seen. The budget includes approximately $2 million annually to pay for administration and staff, case management activities, the Call-a-Nurse line and prescription drugs. The city and county provide the $500,000 for the drug component.

Due to the donated care aspect of the program, the director argues it is difficult to estimate the program's effect on system-wide health care costs and savings. Yet, there are a number of notable trends in costs and utilization. The University Of Kansas School Of Medicine conducts several evaluations for Project Access using hospital and physician office administrative data. Measures related to utilization and costs include medical resource use, diagnoses, procedures, donated services (charges) and health status, with some specific to the Call-A-Nurse and case management functions.

On par with Project Access's intent to increase access to needed services, donated hospital (inpatient and outpatient) and physician encounters have increased over the course of the program. Patients treated in the hospital increased from 566 in 1999 to 726 in 2003. Total hospital charges were approximately $4.6 million in the first and third years (with a slight dip in year two). The number of donated physician visits increased from 1,010 in the first year to 1,269 in year two, and then dipped to 1,172 in year three. These services were valued at $1.6 million in year three.

While utilization has increased, unit costs of caring for enrollees have gone down. Average hospital (inpatient and outpatient) and physician charges per encounter have declined, even as their demographic characteristics, medical diagnostic categories and procedure codes remained consistent. Average charge per inpatient admission declined from $6,903 in year one to $4,044 in year three. The average charge per physician office visit declined from $1,899 to $1,410 between years one and three.

Key informants attribute much of the cost reduction to efforts to control significantly high service use among a small set of enrollees. The program relies on case management to link enrollees to needed community services and to help them find a medical home. Estimates indicate that the Project Access case management function at hospitals has reduced emergency department utilization among Project Access enrollees by approximately 60 percent, for a total charge avoidance of $1.5 million between December 2001 and February 2003. Enrollees with the lowest perceived social support had the greatest reduction in emergency department use.

However, a program report indicates that hospitalizations have become more frequent and severe for program enrollees overall, contributing to program costs. The average number of hospital admissions per enrollee increased from 2.9 in year one to 4.1 in year three, and the average length of stay increased from 15.0 to 17.3 in the same period.

To control drug costs, Project Access switched to a generic drug formulary and requires enrollees to pay a $4 co-payment for each prescription. The program also hired a staff member to enroll clients in pharmaceutical companies' charitable drug programs. This change resulted in $260,000 in cost savings the first year, for which the city and county are reportedly "tickled pink"

Although somewhat early to estimate savings, preliminary data show that one-third of enrollees calling the Call-A-Nurse telephone triage Project Access indicated they

would have sought care at an emergency department if they had not had the nurse consultation by phone. Visits to clinics or physicians increased after the calls, which program staff report interpret as an indication that enrollees received more appropriate care.

Key informants proposed some strategies for achieving greater cost savings in the future, many of which have a case management focus. A shared database (called the Clinic Patient Index) is being implemented among the community clinics to help coordinate patient care, although one clinic's reluctance to use the database could weaken its overall value (see Replication section). In addition, the program evaluator argues that involving nurses more in the program would generate more cost-effective care, especially for patients with chronic diseases who are likely to re-enroll in Project Access. Targeting enrollees with significant psychosocial problems for case management could also reduce utilization of services, because only 20 of the 1,500 enrollees consume approximately one-third of all services. Finally, some key informants that additional cost savings could be achieved in the drug benefit. For example, relying on the 340b federally-sponsored pharmacy at the largest community health clinic could potentially reduce drug costs in the program by 50 percent, although the federal requirements associated with such funds could be a deterrent.

Impact on the Safety Net

Project Access appears to coordinate and expedite the process of obtaining referrals for patients who need them, which helps these individuals gain access to appropriate services before their conditions become severe. Without Project Access, the uninsured would rely more on the traditional safety net in Wichita, which consists of six primary care clinics and four primary care residency clinics, as well as the emergency rooms and inpatient and outpatient services at the two major hospital systems. Uninsured people with acute specialty needs would presumably wait longer or go without care and needed pharmaceuticals; perhaps they would ultimately turn to the emergency department and be admitted to the hospital for their ailment. Even the harshest critic with whom we spoke professed that "Project Access has saved lives."

In addition, attempts to access care from private physicians would be more challenging and disjointed without the program. Prior to Project Access, the director of the largest CHC reported that its staff maintained a list of area physicians who they would contact and beg to see their patients, which involved a lot of physician and staff time and frustration. The other clinics reportedly used the same process. Without Project Access, many physicians might again shy away from treating the uninsured for fear of becoming overwhelmed with requests. The uninsured may not be treated with the respect that the current program reportedly provides them.

Furthermore, the uninsured would return to a safety net that reportedly is more strained now than it was before Project Access, given a poor economy and rising numbers of uninsured. Emergency department visits have increased from approximately 18,000 in May 1999, to 24,000 in April 2002. Over the last few years, the number of patient encounters at the community clinics has increased; visits at the

largest CHC jumped from 44,500 to more than 70,000 annually. On the other hand, without the program, some clinics would have fewer volunteer primary care physicians and arguably might see fewer patients because there would not be the same community effort to link people with a medical home. Even in the presence of Project Access, many uninsured rely on the traditional safety net because eligibility for the program is restricted and the enrollment period is limited.

In addition, Wichita and Sedgwick County have experienced a tremendous influx of Hispanic immigrants, posing challenges for the way the community addresses the needs of low-income, uninsured people. A large majority of this population lacks health insurance, is undocumented (and therefore ineligible for Project Access), and does not speak English. Additional strategies are necessary to reach out and help this population gain access to adequate primary care services.

Net Contribution of the Program

Program leaders are working to determine how Project Access ultimately affects health. Using the SF8 instrument (a self-administered tool to measures social functioning, emotional and physical health and perceived general health), Project Access patients generally have lower physical and mental health functioning scores than the general population. However, enrollees' health status has shown some improvements, and enrollees in case management have demonstrated small, positive changes in control over their health ("locus of control"). Patient satisfaction surveys conducted by Project Access also show that enrollees feel more empowered, get healthier and become more productive than they were before they enrolled. Overall satisfaction with the program averaged four points on a scale of one to five (with five signifying "very satisfied").

The program estimates that approximately $180,000 in funding generates $5 million worth of donated services a year. Plus, evaluators report that donated services are now 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 movement to coordinated health care would reduce total health care costs by one-third. Although they have no empirical evidence to demonstrate that Project Access has achieved such cost avoidance, this model suggests that the program has saved $9-10 million in health care costs over its three years.

Conclusions

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

Sustainability

Funding

To date, Project Access has received approximately $2 million in funding. United Way provided the seed money as a Venture Grant in 1999 and now pays for Project Access staffing. The city of Wichita and Sedgwick County provide support for prescription drugs. Wichita Community Foundation provides funding for the dental component of the project. In 2000, Project Access received a $150,000 grant under the Robert Wood Johnson Foundation's (RWJF) "Communities In Charge" initiative. RWJF followed up in the following year with a three-year, $700,000 grant. Also, the Kansas Health Foundation awarded Project Access $150,000 in 2000 for outreach and interpreter services. The following year, the Health Resources and Services Administration (HRSA) Community Access Program gave the program $1 million for expansion efforts. The program reportedly has capacity to serve more enrollees, although the funding received to date is not enough to meet the needs of all of the uninsured residents of the county.

Provider and partner contributions are crucial to the long-term sustainability of Project Access. The county and city governments and the United Way are committed to providing ongoing funding for the prescription assistance program, and the physicians and hospitals seem committed to continue offering donated services to patients. However, the project will lose two funding sources soon: the RWJF and CAP grant funding.

Because grant funding is limited, Project Access is exploring ways to ensure its long-term sustainability by reducing its dependence on grants. Its leaders would like to see local businesses contribute to the program in some way and is exploring the possibility of creating a small business insurance model to allow more people now eligible for Project Access to have health insurance. Also, given the United Way of America'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.

Other Concerns about Sustainability

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, Ann Nelson, has been engaged with the project since 1999, and received high marks from the other key informants with whom we spoke. The governing body, providers and partners appear to have ongoing commitments to the program. The city and county reportedly expect to be long-time partners in Project Access. Already they have increased allocations to cover the rising cost of drugs.

In addition to leadership, a number of environmental factors need to be maintained to sustain the program. Wichita's diverse economic base and its entrepreneurial, independent spirit are important contributors. For instance, many companies, such as aircraft industries, are headquartered in the Wichita area. Also, to maintain high physician participation, the program relies on strong community commitment to helping one another. The city government has had success in creating and maintaining public/private partnerships in Wichita, and elected officials realize the importance of their collaboration with the health care system. Local government recognizes the program's contributions to the population's well being and its positive financial impact.

In addition, Project Access's relationship with the state Medicaid agency will be important to maintain. By positioning state outreach workers in the safety net clinics (see State and Community Interface section), state government is more user friendly for low-income people. At the same time, Project Access is able to ensure that uninsured people eligible for state insurance programs enroll in those programs instead of Project Access. In addition, getting people insured creates a way for providers to receive reimbursement for services that would otherwise have been donated. Loss of this relationship would be harmful to the sustainability of Project Access: currently, Medicaid outreach workers process 70 percent of the program's enrollment.

Furthermore, 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.

Conclusions

- Project Access has received approximately $2 million in funding to date from a variety of sources. Project Access has worked well with the community and its relationship with the state has improved outreach to individuals potentially eligible for state insurance programs. Yet, program funding is not sufficient to meet the needs of all uninsured residents of Sedgwick County and some of the funding will end this year. However, key informants expect that, with continued physician involvement and efforts to better manage enrollees with high utilization and control pharmacy costs, the program will be sustainable as long as necessary.

Replication

Beta Site Development

The Project Access program of Sedgwick County (Wichita), Kansas, is a beta site modeled after the prototype program in Buncombe County, (Asheville) North Carolina. Buncombe County's program became operational in 1996 and continues to be a physician-led initiative providing primary and specialty care for the low-income uninsured.

Paul Uhlig, a Wichita-based physician, became aware of the nationally recognized program in Buncombe County 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, as well as potential funders—to consider ways to replicate the Buncombe model in Sedgwick. He encouraged the Medical Society of Sedgwick County (MSSC) 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 under the auspices of the Medical Society.

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 reportedly 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 the Centralized Applications, Referral and Enrollment Status (CARES) 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"

outlining details of daily operations, as well as patient referral forms, physician recruitment materials and other printed materials.

In September 1999, Project Access of Sedgwick County was launched and began enrolling patients from the smallest of the six participating SCAMU [can this be spelled out?] clinics, Guadalupe Clinic. 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 the bugs" as patients established their medical homes. All of the clinics were on board within six to seven months.

Table A1 (on the following page) illustrates the similarities and variations between the beta site and the original model. In some instances, the initial replication was modified in response to issues arising in implementation between 1999 and 2003.

The Wichita program replicated Buncombe's leadership model exactly, relying heavily on physician leadership and involvement. The Medical Society of Sedgwick represents 90–95 percent of the community's physicians and provides oversight to the program through an incorporated non-profit organization. Other similarities in the leadership structure include the formation of an Operations Council charged with program operations, and a second group responsible for continued physician participation.

Both programs have the same structure for physician involvement (e.g., number of patients assigned to each provider) and utilize similar types of providers (primary care, specialists, hospitals, dentists and pharmacists). However, the structure of the primary care safety net differs in each community. In Buncombe County, the local health department reportedly is the hub of outpatient primary care; in Sedgwick County, six outpatient clinics provide most of the direct patient care, with the health department playing a much smaller role. The Robert Wood Johnson Foundation, the primary source of funding for planning and initial implementation in Buncombe, played a similar role in Sedgwick, along with the United Way of the Plains. However, Wichita has since sought additional and different funding sources, including its CAP grant from HRSA.

One significant difference in the Wichita program is its more restrictive eligibility limitations. From the outset, leaders in Wichita agreed to reduce the income criteria from 200 percent FPL to 150 percent. This was based on the expected costs associated with larger numbers of persons to be covered compared with the eligible population in Asheville. (Sedgwick County's population is more than twice that of Buncombe County.) Wichita also placed general limits on the length of time people could stay in the program: three months for primary care and six months for specialty care. Covering all qualified residents of the county, regardless of immigration status, became one of the most contentious issues of the replication. After two and a half years, the program started enrolling only legal residents and U.S. citizens living in the county. Both programs used state personnel (Department of Social Service in Buncombe and the Social Rehabilitation Services in Sedgwick) stationed in the

community to screen applicants for eligibility. Because of its CAP grant, the Wichita program has been required to conduct stricter eligibility verification.

Table A1 – Project Access Replication Table, Wichita

Buncombe County (1999)	Sedgwick County (2003)
Leadership	
Medical Society/ Physician led	
Operations Council/ Physician Participation Committee	
Administered by charitable non-profit Organization	
Eligibility	
All residents of county	Undocumented immigrants excluded
Serve the needs of uninsured at <200%FPL	Serve the needs of uninsured at <150%FPL
Out-stationed state employed eligibility personnel	
Benefit Design	
Primary and secondary care covered	Primary Care - 6months; Secondary Care - 3months
	Call A Nurse Program
	Case Management
Lab and radiology services covered	
Inpatient/outpatient hospitalizations covered	
Prescription benefit caps	
$4 co-pay per prescription	
Use of Insurance and pharmacy cards	
Signed patient Agreement	
Release from program for failure to keep 2 appointments	
Emergency Room not covered	
Added Dental Initiative	
Provider Services	
Physicians accept referrals from 6 Clinics	
Participating physicians enroll own patients	
Primary Care – 10 patients per year	
Specialist – 20 patients per year	
Pharmacies provide prescriptions at 15% cost	
Use of Pharmacy Benefit Manager	
Funding	
	United Way of Central Plains
	HRSA grant - Community Access Program
Robert Wood Johnson Foundation	
City/ County funding of pharmacy benefit	
Private Donors	

At the same time, Wichita added some services that Buncombe County did not. Wichita added a Call-A-Nurse line and case management program to reduce the inappropriate utilization of health care services, particularly emergency department services. Both the alpha and beta sites added dental benefits later in their programs by engaging their respective dental societies in leadership and participation. Sedgwick capped the pharmacy benefit at $1,000, adopted a generic only prescription model and hired a staff member to assist enrollees in signing up for charitable prescription programs of pharmaceutical companies.

Wichita key informants highlighted key factors found in their community that facilitated the creation of their Project Access program.

- *A strong medical society.* More than 90 percent of practicing physicians in Sedgwick County are members of the society, allowing for potentially greater provider involvement in the project.

- *An entrepreneurial and pioneering spirit.* Wichita was accustomed to innovation and was home to many pioneering industries. Also, as a Midwestern community, residents reportedly want to be self-sufficient and not rely on state and federal government to implement programs and services.

- *A large number of social services in the community.* Wichita key informants purport to have more social services available to them than the average community, making implementation of Project Access easier.

- *Established public/private partnerships.* Both groups in Wichita had a history of working together for other purposes, which facilitated their relationship around Project Access.

- *Commitment of the local branch of the United Way and of city and county governments*. These groups provided reliable and sustainable funding.

But a number of challenges have hindered replication in Wichita:

- *Integration into the already complex system of care.* Efforts had to be made to develop trust within each of the clinics and with physicians.

- *Continued disagreement on the issue of undocumented immigrants.* Although some providers are satisfied that undocumented immigrants are no longer eligible for Project Access, at least one clinic (the FQHC) is dismayed by the change. Approximately 25 percent of that clinic's patients are undocumented immigrants.

- *Insufficient funding for primary care.* The FQHC (Hunter Clinic) is upset that the program emphasizes primary care but does not share any funding with the health centers that have higher patient loads as a result. Hunter's patient volume

increased from 44,000 to 70,000 in one year. Also, the clinic feels that the funds for emergency dental services could be better spent on a clinic dentist who could provide comprehensive care.

- *Language barriers.* Though interpreter services for non-English speaking patients existed in the clinics, no such service was included for enrollees in Project Access.

- *Recruitment and retention of physicians in some specialty areas*. The volume of referrals initially overwhelmed some specialists, particularly orthopedists and psychiatrists (who were unwilling to donate their services). Recruitment of ophthalmologists and neurologists has been easier because they are relatively more abundant.

Prospects for Further Replication

Wichita's Project Access staff has already begun assisting other communities in adopting the Project Access model. The program is a member of the America Project Access Network (APAN) that assists communities throughout the country with replication. Some 400 communities are said to be in some stage of adopting the program.

Presently the Sedgwick group is a resource for four to five communities, including some within Kansas (such as Manhattan, Topeka, Kansas City and Wyandotte). To date, Project Access has provided free technical assistance but is considering producing a manual that will be available for a fee.

Community key informants described the following as being key to successful replication in other communities:

- The role of the alpha site in the transfer of the vision to the broader community of stakeholders at the beta site.

- The ability to demonstrate that the program will be economically viable.

- A physician champion and leadership from the medical society, although the program director thinks medical society leadership may not be mandatory.

- A shared vision and early agreement on participation from partners (hospitals, pharmacies, city and county governments).

- Appropriate Board composition with large physician representation and rotating members.

- Strong experience in grant proposal writing and management.

- Relationship building experience and negotiation skills.

- Flexibility and recognition that such a program is not a panacea.
- Diverse sources of funding.

Some particular factors could make replication more challenging:

- *Insufficient physician leadership.* Regions where doctors are more independent and have low membership in medical societies may have more difficulty getting a program off the ground.
- *Lack of a pharmacist association*. The engagement of the regional pharmacist association makes for greater access to medications.
- *Geographic location.* In rural areas providers are more isolated and transportation becomes an issue.

Conclusions

- The alpha Project Access program in Buncombe County had a significant influence on Wichita as it replicated the model. Wichita adopted many of the same program components, yet modified others to fit unique characteristics of its 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 day-to-day administrator; extensive public and private partnerships; and diverse and committed funders.
- A large number of communities across the country have expressed interest in replicating Wichita's program, including four or five communities in Kansas.

State/Community Interface

Community Support

The support of the community has been a vital component in creating a Project Access program in Wichita. All the diverse community players have been involved from the program's inception: doctors, hospitals, foundations, county commissioners, city council members, the mayor, pharmacists, and safety net clinics and county health department staff. Collaboration among these players has been essential to the survival of the program.

Some people in the medical community were skeptical at first, but soon became strong supporters. As the city manager remarked, "When the medical community showed support – which sometimes isn't that easy – when they showed they were

behind this, it just kind of fell into place." As the program has progressed, the medical community continues to play a key role. The medical society has ensured sufficient physician participation and become a leader in coordinating and bolstering community support and involvement in the program.

State Support

The state finds its relationship with Project Access a "natural partnership" and one it is likely to continue. However, the state's role in Project Access is rather limited. The program does not receive any funding from the state directly, although it benefits from the involvement of the state's Medicaid agency, Social and Rehabilitation Services (SRS). An eligibility specialist from SRS is based in each of the six safety net clinics to determine which program a patient might be eligible for: Medicaid, Healthwave (SCHIP) or Project Access. This function helps people obtain insurance coverage if eligible and preserves Project Access resources for those who cannot get coverage. There was some initial concern about the presence of SRS staff at the clinics and how it would potentially impact patients' comfort levels, but patients reportedly prefer speaking with the agents at the clinics rather than at the state agency. In addition, the state has extended malpractice protection to physicians engaged in the treatment of Project Access patients.

Local key informants do not feel that Project Access should become a state-administered program, but rather that it needs to remain locally-based to have sufficient provider support and meet the community's unique needs. Some fear that practitioners will withdraw from the program if it evolves to resemble Medicaid with relatively low reimbursement from the state. As one key informant said, "Physicians will feel better if they give it (care) away rather than get inadequate reimbursement for it." Plus, the typical Wichita resident reportedly has distaste for state or federal involvement in daily life. However, some community key informants would like to see the state get more involved in funding the present program in Sedgwick County as well as additional Project Access models across Kansas, where rural/urban differences in resources would be a barrier to success.

State or National Barriers

Many key informants identify Project Access as a "stop-gap" safety-net measure to help the uninsured until the state or nation addresses their plight directly. Yet some changes at the state or national level could enhance the current program. Also, some federal requirements have deterred the program from seeking certain federal funds, for instance, federal funding for prescription drugs. In addition, state/federal policy changes to allow donated care to be tax-deductible might encourage more physicians to participate and help ensure their long-term commitment.

Conclusions

- Although the state makes no direct financial contribution to Project Access, its placement of Medicaid eligibility specialists in Wichita's safety net clinics helps secure insurance coverage for eligible residents and controls demand for Project Access's limited resources.
- State laws have provided malpractice protection to providers donating services to Project Access.

COMMUNITY HEALTHLINK

Paris, Arkansas

Organization and Leadership

Program Description

This capitated subsidized health insurance plan is operated by the Arkansas River Valley Rural Health Cooperative, a non profit 501(c) 3 organization. The program provides fairly comprehensive health care coverage for working uninsured residents of three contiguous counties whose incomes fall below 300 percent of the Federal Poverty Level (FPL). It patterns the Three Share approach of Muskegon, Michigan, and recently completed a 2-year pilot phase.

Employers and employees (clients) together provide for 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 the initiative relies on them to provide services and assume risk for care that may exceed the reimbursable limit.

There are three programmatic elements: health care access, prescription drug assistance and disease management/health education. The provider network currently includes 2 tertiary care hospitals, 4 critical care access hospitals, 6 primary care clinics, 4 mental health counseling centers and 200 medical specialists.

The Board

The Arkansas River Valley Rural Health Cooperative is governed by a Board of Directors that includes a mix of representatives and community leaders from each of the counties that form the service region. There is also representation from diverse provider groups, although getting physician participation on the Board has been a challenge.

Staffing

A 12-member staff is headed up 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.

Coverage

The "Face" of the Population Served

From the inception of the Community HealthLink demonstration project in March 2002, a total of 181 individuals have been enrolled. The business plan initially

targeted 40 percent of the eligible population, estimated to be 6,500 persons. The average age of enrollees is 46 years, with an average family size of 2.6. The average family income is $18,734, and the average client's income is 134 percent FPL. The average length of time without health insurance is 5.5 years. The client population is composed of 51.1 percent adult females, 41.2 percent adult males, and 7.6 percent children. The vast majority (99 percent) are Caucasian, with Hispanic and African-American patients making up the remaining 1 percent of the population. The average cost to enrollees for membership is $96.54 per month.

Eligibility Criteria

In March 1999, a group of community leaders and local health providers from three counties in Arkansas (Franklin, Logan and Scott) met with representatives from the Arkansas Center for Health Improvement to discuss the development of a network of health care providers to serve the low-income uninsured residents in their communities. An informal steering committee, established during this meeting, formed the Arkansas River Valley Rural Health Cooperative (ARVRHC). The ARVRHC received technical assistance in the form of grant development from the Robert Wood Johnson Foundation Southern Rural Access Program (SRAP), which led to them receiving grants from the Health Resources and Services Administration (HRSA) as well as other nonprofit groups. With these funds, the ARVRHC designed its Health Care Access Program (HCAP), a subsidized health plan to provide low-income, uninsured working adults and their dependents affordable access to needed medical services. Enrollment criteria were initially defined to serve those who were ineligible for Medicaid: working, uninsured adults with incomes below 200 percent FPL.

Through the efforts of the cooperative, the Arkansas General Assembly enacted temporary legislation in March 2001, that enabled the ARVRHC to operate Community HealthLink on a small-scale, pilot basis. The ARVRHC began enrolling individuals in the two-year demonstration project in March 2002. Eligibility for the subsidy is restricted by legislation to uninsured adults between the ages of 18 and 65 who reside in Franklin, Logan and Scott counties. These individuals must not be eligible for any public coverage program, and must have an income at 200 percent FPL or below. Due to limited funding, only 80 enrollees can receive the subsidy. Individuals with incomes between 200 percent and 300 percent FPL are eligible to receive services from the program, but are not eligible for the subsidy. Income eligibility is verified through a recent tax return or a statement from the current employer.

Enrollment in Community HealthLink is also available to small businesses that do not currently provide health insurance benefits to their employees, as well as to uninsured individuals. In order to be qualified for group enrollment, the small business must agree to offer the program to all employees who meet eligibility criteria, and must also agree to be responsible for a certain percentage of their membership dues. To help negate potential crowdout effects, employers must not have offered insurance six months prior to enrollment of their employees.

Since the program's inception, eligibility criteria have not changed. However, the ARVRHC's Community HealthLink program now operates permanently under the statutory framework established by Arkansas Act 660 of 2003. This legislation enables the formation of community-based health care access programs that can serve as a bridge to connect and assist government, communities and citizens in expanding access to health care services for the economically disadvantaged, uninsured working population in a manner similar to Community HealthLink. The program is now looking to expand enrollment and participation in its prescription drug assistance program to residents outside of the service area counties.

Conclusions

- The average age of the client is 46 years old, and the average size of enrolled families is 2.6. The average client has an income that is at 134 percent FPL. On average, enrollees were uninsured 5.5 years before entering the program. The client population is composed of 51.1 percent adult females, 41.2 percent adult males, and 7.6 percent children. The population is 99 percent Caucasian.
- Health Care Access Program (HCAP) criteria target the persons who are ineligible for Medicaid: working, uninsured adults with incomes below 200 percent FPL.

Net Cost to the Community

Utilization and Cost within the Program

As in most states, individual insurance policies are relatively expensive for the people who need them – those without employer-sponsored coverage or public insurance. A 2003 premium schedule by the Arkansas Comprehensive Health Insurance Pool indicates that coverage for a man aged 60-64, with a $1000 deductible, is $986. The Mayor of Paris, who sells different types of insurance policies, rarely sells health insurance policies any longer because when people are told the amount of the private health insurance premiums, "*they go into shock*."

The ARVRHC (or "the Cooperative") created the Community HealthLink as a more affordable option for uninsured people living in Logan, Franklin and Scott Counties. Premiums vary according to enrollee gender and age, ranging from approximately $59 for a child aged 7-18, to $209 for a man aged 60-64. HCAP is a three-share model, distributing the costs of health care coverage across the individual, his or her employer, and subsidies generated by the Cooperative.

The subsidy (generated through private grants) has been depleted, however, eliminating one-third of cost sharing. Furthermore, only 30 percent of enrollees have employer sponsorship, leaving 70 percent of program enrollees to pay the entire premium themselves. Current enrollment has increased slightly, from the 80 people

enrolled in the pilot when a subsidy was available to current enrollment of 130 people. While 50 people have dropped out over the life of the program, it is too early to know how enrollment numbers will be affected by the lack of a subsidy.

Program leaders define success as the ability to reimburse providers for care provided. Participating providers accept a reduced fee schedule, equal to Medicare rates or approximately 50 percent of commercial rates, and also collect a co-payment for each visit. The program has had discussions about increasing co-payment amounts. The program contracts with a third-party administrator (TPA) to process and pay provider claims; diagnosis and CPT codes from these claims allow program staff to track utilization and costs.

On average, health care provided through Community HealthLink costs $888 per member per year, compared to $3,320 under Medicaid in 1999. Average monthly dues are approximately $136, and the program's average expenditure per client served is $92.50. The medical loss ratio was 0.73 in 2002 and 0.42 in 2003. Currently, the program is running a medical loss ratio of 0.6, which they and other key informants consider very good and "*ahead of where we thought we would be.*" The leftover money is split between a reserve for provider claims and a fund to subsidize premiums on a sliding scale (although it appears no subsidies are being offered currently). There are no plans to reduce the premium as a result of the cost savings.

Overall costs of HCAP are contained through a cap of $10,000 in outlays per enrollee per year. After the cap is reached, any additional costs of care are to be absorbed by the enrollee's provider, increasing that provider's financial risk. Roughly 1 percent of enrollees have exceeded the limit each year. The program director reported that if providers are very worried about the potential financial risk of participating, the program could investigate purchasing reinsurance with the premium reserves. Since other key informants did not mention this option, it is unclear whether reinsurance has been widely discussed or is a reasonable and likely solution.

Key informants described additional strategies the Cooperative uses to control program costs. First, to encourage the appropriate use of health care services, enrollees are encouraged to select a primary care provider (PCP) and to seek care early. Approximately half the enrollees have designated a PCP. In addition, program enrollees are limited to two emergency departments (ED) visits each year, unless a visit results in a hospitalization. The program reports that only 7 percent of claims are for ED visits, as compared to 13 percent locally and 14 percent regionally for the population as a whole. However, the local hospital administrator reports that program enrollment is not large enough to have had an effect on overall ED volume.

Additionally, although the Cooperative offers a fairly comprehensive benefit package of inpatient and outpatient services, it keeps costs down by not covering certain services. First, services that could be obtained through other public insurance programs are generally excluded. For example, maternity is not offered because if a

woman enrolled in the Cooperative gets pregnant, she likely will become eligible for Medicaid. Furthermore, dental, optometry and drugs are not included by Community HealthLink at this time.

The prescription drug program (PDAP) offered through the Cooperative was mentioned frequently as another cost saving component. For the 800 people enrolled, PDAP offers a prescription discount card and helps low-income people obtain certain medications through pharmaceutical companies' indigent care programs. There is a monthly enrollment fee of $10 to $30, depending on one's income. Key informants indicate that PDAP has saved money for uninsured people and their physicians who previously spent time trying to secure medications.

To minimize the typical 80/20 rule, in which 80 percent of program expenditures are generated by 20 percent of enrollees, the Cooperative has recently embraced health education and disease management activities targeted at enrollees with chronic conditions. Health education consists of health resource centers in the four participating hospitals, the first of which opened in July 2003. Counseling sessions are offered in the areas of arthritis, diabetes, heart disease, tobacco cessation and weight management/physical fitness. If the health educator recommends a particular intervention and the enrollee does not comply, the premium increases. The health educator is writing protocols to encourage providers to refer patients to these programs when necessary. Key informants indicate it is too early to know how much of an effect these programs will have on the distribution of program expenditures.

Program staff reportedly conduct utilization review of inpatient admissions to control lengths-of-stay. Average length-of-stay has declined slightly at the North Logan Mercy Hospital in Paris since the onset of the program. Finally, a board member mentioned that adjustments had to be made to staff salaries in order to keep costs down. Currently, 13 percent of the premium is dedicated to administrative costs.

Impact on the Safety Net

In the absence of the Cooperative, uninsured people in the Paris regions would rely on local hospitals, particularly emergency departments, for health care. Although not tied to the Cooperative, the local hospitals have received Critical Access status, which has stabilized their financial status. North Logan Mercy Hospital also receives revenues from a dedicated one percent local sales tax; and emergency services receive revenues from a ½ cent sales tax. There are no safety net clinics in the area currently and local private physicians reportedly will not continue treating uninsured patients who owe them money. Given the weakened economy of the last few years, some key informants indicate that the safety net is somewhat more strained now than before the creation of the Cooperative.

Key informants agree that the Cooperative makes a positive difference to the people enrolled in it. Before Community HealthLink, uninsured people avoided seeking outpatient care and relied on over-the-counter medications, and often ultimately ended up in the emergency department. The local human services agency reports that,

since the program was implemented, the number of calls to their office from people with unmet medical needs has dropped precipitously. Also, without the drug benefit through PDAP, people would have a difficult time obtaining medications, especially because it has become more difficult for local providers to get drug samples. Reportedly, due to the high fee Wal-Mart now charges drug companies for utilization data, many drug companies stopped visiting local providers.

Consistent with the Cooperative's goal of strengthening the local health care system, program enrollees are encouraged to obtain their care from local providers. Utilization trends show that 40 percent of program claims were paid locally. In the past, reportedly a higher percentage of care was obtained in the neighboring community of Fort Smith. Indeed, North Logan Mercy Hospital reports slight increases in admissions and bed occupancy since the program was implemented.

However, providers argue that the program as it stands does not fully utilize the local doctors. Key informants indicate that there is sufficient provider capacity to serve all of the estimated 3,000 uninsured in the Cooperative's service area. Plus, local physicians are opposed to the Cooperative's recent efforts to obtain federal support for a community health center (CHC) in Paris. Presumably, having a CHC would improve care options (particularly for mental and dental services) for program enrollees as well as those outside the program, but local doctors argue that a health center would create competition for them and that it is unlikely CHC doctors would help with the burden of after hours care.

Net Contribution of the Program

The Cooperative's design and strategies are producing some positive effects in health care utilization and costs, although many key informants contend that current program enrollment is too small to generate widespread change in the Paris region. A board member reported that the patients have been very impressed with figures on how much the program has saved them and that data show doctors have saved money as well.

Change in uncompensated care levels is one measure of the program's net contribution in the community. In 1999, the program staff calculated the amount of uncompensated care provided throughout the zip codes encompassing Franklin, Logan and Scott counties, which totaled $15 million. The Cooperative's goal, to decrease uncompensated care levels by 25 percent for its target population of 2,000 people, has been achieved. (Program staff extrapolated the change based on what the program paid out to providers for 100 enrollees, which turned out to be approximately 25 percent.)

Anecdotally, key informants believe the program has had a net positive effect for those enrolled. Program leaders contend that program enrollees are using more primary care and filling prescriptions instead of relying on over-the-counter drugs for relief, but it is too early to have data to prove it. One physician reported that HCAP has reduced the reluctance of the uninsured to ask for help for their medical problems.

A few key informants remarked that the talks given by the health educator are extremely useful and helpful to community residents. Indeed, as Arkansas was recently ranked as the 47th healthiest state in the county, local key informants hope the Cooperative ultimately will contribute to improved health status as well. Changes in health status could be tracked against self-reported baseline information collected on each person upon enrollment.

Given concerns about high-risk cases that could deter providers from continued participation, key informants feel that the Cooperative needs to demonstrate significant cost savings or cost avoidance in order to be sustainable and grow over the long term. The Cooperative has proposed spreading the costs among more entities. This "dual-level three share model" would seek federal funding to support 25 percent of coverage costs and state funding to support eight percent, in lieu of the grants formerly used for the subsidy. The enrollee and enrollee would each contribute one third. State funds would be generated through a refundable state income tax credit for low-income people, which would then be used to generate a federal match under a Medicaid HIFA waiver. Through this mechanism, the program estimated that every dollar supplied by the State of Arkansas would leverage $11 in additional funds. Program leaders estimate that full implementation of Community HealthLink (presumably enrollment of 1,600 people, or 40 percent of the 4,000 uninsured) would add "*almost $2 million yearly to the local economies*."

Conclusions

- Discounted provider rates permit relatively affordable "insurance" premiums. In effect, providers are at financial risk for costs over $10,000.
- Use of strategies – such as encouraging primary care use, tapping into pharmaceutical charity care programs, adding health promotion interventions and utilization controls – has helped control costs and maintain a sustainable medical loss ratio.

Sustainability

Funding

Current Funding Sources

The Health Resources and Services Administration (HRSA) has been the major funding source for the network (Table A2). The Office of Rural Health Policy (ORHP) Network Development grant was received in 1999 and has already come to an end. In September 2001 the network received a Community Access Program (CAP) grant which will finish in August 2004. In 2003 the cooperative received an ORHP Outreach grant whose funding is currently utilized for the direct provision of services to the enrollees. United Way of Fort Smith started providing a small amount of money in December 2003. Other current sources of income for the network are:

hospital member dues, program dues from enrollees of the Prescription Drug Assistance Program and the Health Education and Disease Management Program, Health Care Access Program administrative fees, telehealth network, and the Commercial Wireless Service Provider contract.

Table A2 – COMMUNITY HEALTHLINK Funding Sources					
Source of Revenue	**2001**	**2002**	**2003**	***2004***	***2005***
Hospital Member dues	12,800	12,800	9,600	12,800	16,000
PDAP member dues	8900	41,500	86,500	201,600	252,000
HCAP Admin fees		4,500	8,500	30,000	72,000
Health Education Program			2,500	50,100	60,600
Telehealth Network			3,000	47,250	68,250
Commercial Wireless Service				9,500	54,500
Other			4,500	8,600	10,600
Total	**$21,700**	**$58,800**	**$114,600**	**$359,850**	**$533,950**

Process of Capturing and Retaining Funding

The Arkansas River Valley Rural Health Cooperative has been successful in leveraging funding, having received over $1.7 million in grant funds in five years. In 1999, healthcare providers and community leaders from the three-county area met with representatives from the Arkansas Center for Health Improvement (ACHI), the implementing agency for the RWJF Southern Rural Access Program (SRAP), to discuss the development of a network to serve the low-income uninsured residents. SRAP support was instrumental in jump-starting the network by providing technical assistance in the form of grant development to the network. This resulted in receipt of a rural health network development planning grant from HRSA Office of Rural Health Policy in 1999 which finished in 2001.

In 2000, the network received a program development grant ($150,000 for three years) from the Foundation of Sisters of Mercy of the Americas and it was incorporated as a private non-profit organization. Initially the network partnered with hospital administrators from the three counties, who started paying dues. Also in

2000, funding from the Arkansas Department of Health Revolving Fund was received for one year. In 2001 the network applied and was awarded a three-year Community Access Program. In 2003 and Outreach grant was also awarded to them. Currently the network is capturing funds from patients enrolled in the different programs, hospital member dues, and the development of shared services with partners.

Budgeting: Even though HRSA and RWJ have provided ample access to funding and technical assistance, funds are not enough to match the costs and goals of the program overtime. In spite of the network's success in leveraging resources, most grant sources do not allow funds to pay for services. Therefore, subsidy funding continues to be the most challenging financial need to be addressed. Another issue is the capacity of the network to expand its programs and the number of enrollees. This also requires additional funding and paid human resources.

Prospects for Future Funding

Changes in funding balance: Most of the grants received by the network have come or are soon coming to an end. Since long-term sustainability is the goal of the Cooperative, the desire is to decrease reliance on grant funding and generate at least 60 percent of income from services provided (i.e., member dues, enrollee dues, telehealth, and other shared services). A key of restructuring will also be the expansion of board membership to include consumers participating in each of the network's programs.

Expectations, sources and reasons for new/stable/reduced funding: A critical challenge facing the network today is the need for ongoing subsidy funding. Network leaders are pursuing legislation for a federal demonstration of the Health Care Access Program and similar programs which would enable full implementation and evaluation of this model. Evaluation of the impact of the network is needed to determine whether there have been changes in out-migration of patients and services; whether participation in the network has helped provider members to improve their financial performance; and whether network programs have had an impact on the utilization behavior and health status outcomes of patients.

Other Concerns about Sustainability

Internal Change

Crucial elements for the long term viability of the network include: continued involvement of the network director, staff, physicians and other providers; balancing the interests of the network members; and having a collaborative governing board with an entrepreneurial vision. Although there has been some level of provider participation and involvement in the network, it has not reached an ideal stage. The network is currently pursuing designation for a Federally Qualified Health Center (FQHC) in order to attract a more stable medical community and improve physician involvement.

Environmental Change

Local economy: Employers are a source of referrals for the network. Currently there are about six small businesses that have people enrolled in the program. However, the network directives are continually striving to enroll other businesses. Also, the network and its programs have been able to reduce the amount of uncompensated care by at least 25 percent, which translates to about $15 million dollars in savings for the local hospitals and providers. Network directives expect that the local health care system will invest part of those savings back into the network's programs.

Community/state policy: Securing buy-in from state policy leaders is crucial for program survival particularly since state legislation was required to create an insurance regulation waiver for the network. Because of the program's success, the Arkansas General Assembly has provided continued support and the temporary legislation enabling the Cooperative to begin operations of the Health Care Access Program in 2001 was made permanent. Since then it has also enabled other community-based organizations within the state to develop and administer similar programs.

Other: The large influx of immigrants that have moved into the state, attracted by agriculture, retail, meat packing industries and slaughter companies, is increasing the need to provide access to care for uninsured populations. Unfortunately, large companies like Tyson and Wal-Mart, with headquarters in Arkansas, only provide health insurance to a small percentage of their employees. In addition, some stakeholders feel that the program may be unable to deliver care to "really sick people" And is sustainable only if it can avoid more than one or two high loss, high risk cases.

Conclusions

- ARVRHC has been successful in leveraging funding, having received over $1.7 million in grant funds in a span of five years.
- Most of the grants received by the network have come or are soon coming to an end.
- Even though HRSA and RWJ have provided ample access to funding and technical assistance, funds are not enough to match the costs and goals of the program overtime. In spite of the network's success in leveraging resources, most grant sources do not allow funds to be used to pay for services. Therefore, subsidy funding continues to be the most challenging financial need to be addressed.
- While valuable to those enrolled, this is a small program and has not had a large impact on the community's overall safety net or overall costs of caring for the uninsured.

Replication

Beta Site Development

Variation from Model

For all its similarities to the Muskegon Three-Share model, ARVHC, the 501C3 organization set up to administer *Community HealthLink*, does not believe this program to be beta site replication of any other in the country. While elements of the program may resemble others, the development of *Community HealthLink* and in particular its HCAP was accredited to visionary and uniquely creative leadership informed by research and investigation of other nationwide plans designed to assist the uninsured in accessing care. The group—and the Executive Director in particular—examined (among others) the Washington Basic Health Plan, MinnesotaCare, and TennCare.

The ARVHC was interested in programs that it thought had successfully utilized:

- Cost sharing by participants on a sliding fee scale basis
- Public-private partnerships
- Prepaid Medical Assistance Programs
- Better coordination among health services, social services and providers
- Locally managed data
- Improved local economic development opportunities by ten retention of local providers
- Potential surplus revenues to retain and improve health infrastructure in rural communities.

In its initial business plan, the ARVHC asserts that they have "taken advantage of the lessons learned from these programs" in the development of the individual features of their own plan. Further, the HCAP model is described as being based of the same philosophies which are at the heart of the American Medical Association (AMA) proposals supporting the federally mandated formation of Health Insurance Marts by affinity groups that would include coalitions of small employers, chambers of commerce, church and religious groups. The philosophies included individual responsibility, risk sharing, income-scaled subsidy, and development of small local coalitions.

The Executive Director was then (and continues to be) the visionary who, while doing social work rounds within the community, became acutely aware of the difficulties that working uninsured and their families experienced. The four safety net critical access hospitals involved in providing healthcare also were under significant financial stress.

The initial model called for the establishment of a subsidized health insurance plan for low income uninsured but grew into a more comprehensive "three pronged" program that would address other areas of medical need. The Pharmacy Drug Assistance Program, which forms a part of the benefit package of the plan actually predated the establishment of *Community HealthLink* and was set up to serve a larger community which now includes all uninsured below 300 percent FPL and the Medicare population. A project timeline is provided in Table A3.

Table A3 – COMMUNITY HEALTHLINK Timeline

Time	Event
Mar 1999	Meeting of Community stakeholders and SRAP
Sept 1999	Incorporation of ARVHC
Sept 1999	Business plan developed/survey of local businesses
Sept 2000	State awarded HRSA State Planning Grant
Mar 2001	Enabling legislation enacted
May 2001	HRSA ORHP grant awarded for *Community HealthLink* program development
Oct 2001	HRSA CAP grant awarded for capital expense and infrastructure development
Dec 2001	Negotiations with insurance carrier/providers/TPA
Dec 2001	Contracts completed and signed
Mar 2002	HCAP demonstration program begun
Mar 2003	Permanent legislation enacted

Environmental Impacts

Federal/State Agency

Most key informants agreed that programs such as *Community HealthLink* have been a direct consequence of a non-response at a "philosophical level" by the Federal government on this issue.

In the developmental stages of *Community HealthLink*, local legislation was needed to allow the ARVHC to carry out its mission. Key informants suggested that the state's legislature and top ranking officials wasted little time in drafting and approving an initial demonstration project bill that would last for 2 years, expiring in 2003. Another Act was unanimously passed in 2003, continuing the work and giving permanence to the operations of the ARVHC. The Speaker of the House is reportedly a good friend and supporter of the program.

At the same time "state politics" was thought by the Director of the Program to have been the one of its biggest challenges, given the continuing struggle and debate for direction of effort between education and health. There was also a perception that the state was quite inclined to send its experts into the community to "tell" them how to get things done but were not as inclined to listen and learn from community initiatives. At any rate, it was thought that the state was more interested in a different model. (Arkansas is pursuing a HIFA Medicaid demonstration project grant).

Local/Community factors

Some of the local challenges faced by program included turf battles, inadequate communication, personality differences, naiveté and learning by trial and error, hospital closures and area economics, and insufficient provider involvement at the board level.

Prospects for Further Replication

Key informants vary in their views on the potential for successful replication of *Community HealthLink*. Most believe that replication would generally be possible by some other rural communities in Arkansas and the country. Communities in the Delta and other rural parts of Arkansas have shown some interest; the relative isolation, the small size of the tri-county area, and the importance of good relationships are all key to the replication potential in such communities.

Other elements thought to be important to successful replication include:

- Vision
- Honesty, openness and friendliness of community
- Leadership with insight, foresight, passion and initiative

- Community involvement
- Adequate funding
- Employer buy-in
- Provider buy-in at all levels
- Three-share legislation
- Network development assistance
- Ability to exploit grants
- Strong ties to state policy

A few key informants are concerned about the program's readiness for replication when sustainability has not yet been demonstrated. In addition, the ethno-cultural composition of the Paris population, along with differences in employment rates, may also preclude successful replication in other Delta communities.

The State Medicaid representative, while affirming the value of the work being carried out by the Cooperative, was uncertain of the program's replication potential, insofar as the provider base in other communities (especially larger ones) being willing and/or able to accept the financial risk of the program.

Key Lessons Learned

- Where there is no template, learning is mostly by trial and error.
- Go for low hanging fruit like the pharmacy program that will generate public support
- Network nationally by finding out what others are doing and tying in.
- Promote what you are doing. Get the word out.
- Combine technical assistance with funding. Use the knowledge gained from others.
- Remember that leadership is a double-edged sword
- Choose the right manager for the program, someone inclusive and not focused on self-interest.

Conclusions

- Legislation was required for the network to operate this three-share model program. The Arkansas General Assembly initially enacted temporary legislation that enabled the ARVRHC to operate the HCAP on a small-scale, pilot basis. In 2003, the state legislature enacted permanent legislation, exempting ARVRHC from regulation as an insurer.
- Though similar to the Muskegon model, ARVHC plan is thought to be unique in design.
- The Director is the program visionary and dynamo. He is responsible for bringing together the stakeholders; which has been seen as a double-edged sword.
- The program has not been replicated and depends heavily on grants.

State/ Community Interface

Community Support

The demonstration or pilot phase of the project has only recently been concluded; thus, the extent to which it applies to the entire state cannot yet be determined. It has, however been the intention of the ARVHC to assist in "patching the hole in the Arkansas Health care safety net" and in so doing assist the state in its effort to serve the uninsured. Many key informants feel that the program was designed in such a way to complement the state public insurance programs by catching those who are fall through the safety net. The program because of its dependence on proof of eligibility is also able to serve as a referral point for persons who might be found to qualify for public health insurance schemes.

In the ARVHC Business Plan of 2001, the HCAP model is described as being designed to provide a means for the state and Federal Government to partner with local/regional healthcare providers and small business in providing an affordable health plan for the low income insured population. Going forward, the Cooperative sees two primary ways in which it may further support the state's programs. These are:

- Cost Sharing – The program provides a way for local communities to participate in sharing for health care costs along with the state and Federal government while assisting the plight of the uninsured. The group is also willing to work with the Department of Health in establishing similar community based programs across the state.

- Data collection – ARVHC at present uses an actuarial model to project program cost. Updating this model will allow the state to perform cost analyses as it designs a statewide program.

Interface at the state/ federal level is anticipated to be more significant, with the expected introduction of a FQHC in the region, a matter that has caused some disquiet among the provider population.

The State Medicaid Agency has also described the program as being supportive of the public insurance program, perhaps due to its small size and the nature of its partners. There is a suggestion that the program might prove even more complementary of the state's work if it were to expand to provide "wraparound" services to other underserved groups within the community. Pharmaceutical Assistance is one area of potential promise in this regard. In terms of its potential for integration into a state administered program, possibilities include using Community HealthLink:

- As a conduit for assisting people moving from Medicaid to work to maintain some health care coverage;
- As a delivery model within the state; and
- Alongside the TANF program.

Some key informants, however, feel that integration might be unsuccessful given that the focus of the program is improving local access. The bigger the program gets, the more difficult this may become.

State Support

State support for the program has been, for the most part, legislative in nature. The Arkansas General Assembly passed Act 660 in March 2003, making permanent the provisions of Act 549 for the functioning of community initiatives throughout the state of Arkansas. Section 1B of the Act 549 refers to The Rural Health Access Pilot Program as a "bridge connecting and assisting government, communities and citizens to build a more comprehensive health care system." Section 1A(4) goes even further in setting out the state's intent: " New relationships are needed between state government, local communities private service agencies and the uninsured in this state, so that the health care services for the uninsured will be more accessible, more affordable and more effective."

Notwithstanding the law, given the state's present economic situation, the interface from a financial standpoint has not occurred. There has been no programmatic source of federal or state funding available to subsidize the cost of service for enrollees in HCAP. This is resulting in enrolled individuals being asked to pay the full amount of the program dues regardless of income level. The interviewed State representative, while acknowledging that the program has received no funds from Medicaid, opined that the state could perhaps do more in terms of offering technical assistance to communities setting up similar programs and that it might be beneficial for Medicaid waiver demonstration projects to be used along with similar community-based projects. The state holds to the view that community programs like *Community*

HealthLink will be jeopardized if sustainability is dependent on federal or state funding.

The leadership of the ARVHC suggest that there may yet be ways for the state to get involved in similar projects. One such way, which is now the subject of a draft proposal, involves the use of a refundable income tax credit and state Medicaid subsidy funding to shore up the "Three Share model" already in existence in *Community HealthLink,* and expand coverage for the working poor. The group suggests that based on the operations of *Community HealthLink* over the past two years, the projected cost to the state would be less than $150 per enrollee per year.

In its proposal, the ARVHC recommends that "the DHS establish a Medicaid expansion program using a community based three-share service delivery model similar to that of the HCAP model … state matching funds contributions to this program come from a refundable state income tax credit for uninsured and families with incomes less than 200 percent FPL … that tax credit could be sent directly to a community based health cooperative … licensed to receive Medicaid funding."

The proposal recognizes that all this would be predicated on three occurrences:

- Enactment of new state legislation authorizing tax credit and licensing cooperatives for Medicaid funding;
- Authorization of statewide program to assist in the development of community initiatives; and
- Successful application for a HIFA waiver by Arkansas DHS.

State or National Barriers

Not many barriers at the state or national level were identified as potentially impacting the program. Perhaps the most commonly reported barrier to the success of the *Community HealthLink* program is the difficulty in securing non-grant program funding (third share) as it goes forward. State policy was also identified as being a barrier; the courts have ruled that education is the state's number one priority, leaving slim prospects for health allocations within the state budget to assist projects such as

Conclusions

- State legislators showed substantial support by unanimous passage of Bill allowing the model to develop.
- There are some philosophical differences between the state and the program in approach to the problem of the uninsured. The state doubts that providers elsewhere would be willing to accept the financial risk.
- Courts have ruled that education is a higher state priority than health.

GENERAL ASSISTANCE MEDICAL PROGRAM

Milwaukee, Wisconsin

Organization and Leadership

Program Description

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 of care 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 made available at 17 clinics in 23 sites (including Federally Qualified Health Centers, FQHCs) and 10 local hospitals.

The Board

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.

Staffing

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

Coverage

The "Face" of the Population Served

Target Population

About 100,000 -120,000 uninsured persons live in Milwaukee County, but only 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. The GAMP program does not screen for Milwaukee County residents that are in the country on a visa until they have been granted resident alien status. Applicants can demonstrate their residency with a driver's license, current lease or utility bill. An applicant must also meet monthly gross income limitations that are based on family size. For example, a family of 1 has a monthly gross income limitation of $902, while a family of 10 has a monthly gross income limitation of $3,306.

The GAMP program shares an online system with the state of Wisconsin and the Department of Workforce Development. Through these systems, the program can check information on the verification form. Proof of income can be demonstrated through check stubs, award letters or employer's statement. Unlike traditional insurance, clients do not pre-enroll for coverage; instead, they must be seeking services or treatment due to a medical need.

Demographics of Patient Population

GAMP is reaching nearly 100 percent of eligible residents seeking care. In 2003, the GAMP program served 26,000 individuals. In a four-year period, from 1999 through 2002, 35,101 applicants requested coverage through GAMP and 23,885, or 68 percent, were approved. Over the same time period, more GAMP applicants tend to be male (51.25 percent), single (68 percent) and 36-45 years of age (23.5 percent). An estimated one-third of all clients are seen once and never again, another third participate for one or two enrollment periods, and the last third are chronic users.

GAMP applicants reside in all zip codes of Milwaukee County and their demographics reflect the city's racial mix. In 2003, most GAMP enrollees self-report their health status as good (36 percent) or fair (43.8 percent).

Others Served

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. While some homeless individuals are covered, they pose unique challenges related to their eligibility and payment of an administrative fee on their behalf.

Eligibility Criteria

Eligibility requirements are set by the Milwaukee County Board of Supervisors and are subject to review each year. Income limitations continue to be refined by the Board; in fact, they have been raised twice since 1996 in reaction to reduced

enrollment and in preparation for implementation of an application fee. A $35 nonrefundable application fee, pharmaceutical formulary and co-pays for pharmaceuticals were instituted in recent budget seasons. Initially, the monthly income cap of $800 for a single individual was used as an approximation to the Federal Poverty Level (FPL). Increases since that time have been the result of decreased enrollment.

Conclusions

- General Assistance Medical Program (GAMP) applicants tend to be male (51.25%), single (68%), and fall within the age range of 36-45 (23.5%). In 2003, most GAMP enrollees self-report their health status as good (36%) or fair (43.8%).
- Eligibility requirements are set by the Milwaukee County Board of supervisors and are subject to review each year during their budget review.
- Income limitations have been raised twice since GAMP was restructured in 1996: first in reaction to reduced enrollment and, a second time, in preparation for the implementation of an application fee.

Net Cost to the Community

Utilization and Cost within the Program

Current and Projected Costs

GAMP's mantra, "*the money is the money,*" reflects the policy that once a participating provider reaches its funding cap, the provider is required to continue treating GAMP patients without additional dollars. GAMP reimburses hospitals at 30-40 percent of costs and pays clinics at Medicaid rates, which are slightly higher. Yet changes in underlying costs have allowed GAMP to serve additional people over time with its $38 million budget. These changes include redirecting clients from emergency departments to primary care in community settings, patient education, administrative changes, limits on certain services and cost-sharing.

Most of the information on costs is tracked at the GAMP office. While providers have spoke little data on the GAMP enrollees they treat, they support the model of directing patients towards clinic services first 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*." The program used federal CAP grant dollars to conduct a return on investment study, which identified initial savings for the period 1997-2000 (see Table A4).

Table A4 – GENERAL ASSISTANCE MEDICAL PROGRAM Costs			
	1997	**2000**	**1997-2000 Change**
Budgeted			
Total administrative expenses	$1,276,918	$2,585,558	103%
Staff Costs	$424,476	$1,056,714	149%
Claim Processing Costs	$416,667	$900,000	116%
Other expenses	$435,775	$628,844	44%
Total expenses (Medical + administrative)	$38,106,890	$39,474,447*	4%
Number of staff	12 FTE	24.5FTE	104%
Number of claims	130,623	322,845	147%
Actual			
Number of clients	19,217	20,807	8.3%
Number of claims	130,623	322, 845	147.2%
Average cost per claim	$260	$194	(25.4%)
Average claims per client	6.8	15.6	229.4%
Total Medical Costs	$33,914,416	$36,888,889	8.8%
* Includes $5M of IGT funds.			

Trends

The return on investment study found that GAMP leverages over one dollar for every local dollar invested. In 2000, the county costs were approximately $18 million, from which $36 million was leveraged in additional funding and cost savings. Indeed, the study found that, between 1997 and 2000, costs per claim decreased from $260 to $194, inpatient services expenditures decreased 7 percent, and hospitals generated over $1 million in savings. Per member per month costs also have declined over the

course of the program. In total, the report found that GAMP saved over $4 million compared to the cost projections for the previous county system.

The study also identified indirect cost savings, such as improved productivity, reduced claims processing and payment time. The report contends that GAMP helps the business community avoid productivity losses generated by sick employees. It is estimated that, for example, if each employed enrollee missed one day of work, a loss of $112,229 in wages and taxable income would result (based on minimum wage). Average payment time to providers declined from six months to six days through use of a fiscal intermediary. Also, GAMP's overall administrative costs are 7 percent, which the report notes is well below the typical 10-15 percent administrative costs of commercial insurance carriers. However, since that report, staffing at GAMP has been constrained due to a decrease in the county contribution. A provider lamented that, as a result, the time to process enrollment applications has grown from just a few days to 3-4 weeks.

Although GAMP has been able to serve more people over the past few years, the program controls enrollment and service levels. There is no active outreach to let residents know the program exists and, while a person is to be seeking services in order to enroll, there are mixed views among key informants on how "sick" the patient needs to be. Also, despite a large need in the community, GAMP does not cover mental health or substance abuse services. Dental care is limited to emergency extractions.

As one key informant put it, "*The goal of GAMP is to decrease inappropriate use of emergency departments (EDs), not total usage*." County officials agree that utilization patterns need to shift toward more primary care, yet there are no strong measures or consensus on the degree to which primary care utilization has increased. The hospital association argues that there has not been much success in changing behavior patterns; however, the Program Director noted that once enrollees establish themselves with a primary care clinic, they do not appear on the list of individuals using the ED. While no solid data on overall ED utilization exists, evaluators tracked ED utilization from 1999 to 2002 for ambulatory care sensitive conditions of asthma, diabetes, heart conditions and hypertension and found consistent use across the years, with some reduction in claims. Also, questions asked through the nurse call line demonstrate that, without the nurse line service, "some" people would have turned to the ED.

To encourage appropriate use of health care services, and in response to requests from a patient focus group, GAMP developed a "very active" patient education program. Each enrollee receives a patient education packet that contains information on how to use the ED appropriately, how and when to seek primary care, and when to treat symptoms themselves. However, some providers report that this population does not respond well to such written materials, and another added that its patients have a low literacy rate. As an alternative, a nurse call line is operational 24 hours a day, seven days a week to help patients make these determinations.

Through the Medical College of Wisconsin and participating providers, GAMP enrollees with asthma, hypertension and diabetes have access to disease management programs. A claims analysis showed that 75 percent of asthma and diabetic claims were for inpatient services initially, but this percentage reportedly has declined "significantly" over time. Heart conditions consistently constitute the highest cost diagnoses – making up over 30 percent of total claims paid each year. GAMP also has a utilization management program, but key informants did not say much about it.

More recently, GAMP has turned to ways to control escalating pharmaceutical costs, which have doubled over three years. In November 2003, GAMP limited its pharmacy contracts to those in the Aurora system, which simplifies administration and brings a steady revenue stream to the program. On January 1, 2004, the program instituted co-payments for drugs: $1 for generic and $3 for brand name. There is also now a closed formulary, which has shown "significant progress" in its first quarter. Providers find the formulary reasonable overall.

As another cost-sharing strategy, a $35 application fee was instituted. This change has stirred controversy, particularly because the fee is not waived if the individual is found to be ineligible for the program. As one advocate reported, *"[The application fee] has wreaked more havoc and kept people out of the system than any single thing*." No evaluation has been conducted on the effect of the fee, but hospitals and clinics report that there are a fair number of patients unable to pay the fee and insufficient guidelines on when the provider should step in to assist with it. In addition, one clinic key informant suggested that GAMP add co-payments for medical services to make people value the services more and, presumably, generate revenue.

In the future, the Program Director expects GAMP to produce continued incremental savings and hopes to tackle any escalating costs on a case-by-case basis. No major cost savings are expected unless eligibility criteria change substantially. In any case, as one clinic provider reported, "*GAMP was constructed in a good faith way. It was not constructed with the sole objective of cutting costs. A real effort was made to try and have it be available in a community setting and not be too onerous for people to access care*."

Impact on the Safety Net

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 1-2 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 ED volume as well.

GAMP provides a new funding stream to providers for taking care of their enrollees, which presumably stems provider losses and positively impacts their capacity and viability. Yet even with GAMP in place, hospitals' uncompensated care levels have increased, from approximately $70 million in 2002 to $84 million in 2003. A hospital association key informant states, "*While GAMP makes a small dent into charity care, it doesn't approach what hospitals actually incur*." These increases are attributed to a poor economy and job losses.

For many of the same reasons, key informants concur that the total number of ED visits in the community has increased over the life of GAMP. One provider noted that there was a "*fairly substantial drop in ED visits for the first years of GAMP, but that the funding limits have contributed to increases of late*." Despite some success in redirecting GAMP clients to community settings, a hospital key informant observed that there are two groups of GAMP enrollees: those that readily choose primary care and are connected to a clinic; and another, smaller but persistent group that resists "logical follow up care" and continues to use the ED as a "crisis solution." GAMP has attempted to start an urgent care center to treat some of this ED volume, but it was not sustainable because it became primarily a clinic for uninsured people.

Due to GAMP's capped funds, key informants have observed a "declining commitment to GAMP patients" among some providers. As GAMP volume and general health care costs have grown, the available funds to reimburse the hospitals for treating GAMP patients are spent by mid-year, adding to hospitals growing uncompensated care costs in the second half of the year. The Aurora system reportedly is closing some clinics that GAMP and other uninsured people use because they are seen as "feeders" to costly inpatient expenses for the hospital system. Because clinics have preferential treatment in the funding stream, they generally do not "max out" until the fall, but are reportedly at or approaching capacity for all patients. The remaining health centers are feeling the pressure from the influx of patients who have been turned away from the hospital systems.

In its focus on community-based services, GAMP financially supports community clinics but also demands much of them. Five FQHCs and additional community health centers in Milwaukee have experienced closures and expansions, with a net loss in capacity over the course of GAMP. The hospital systems and FQHCs are in the process of applying for a joint federal grant to expand services. Yet GAMP has brought more clinics in to participate. GAMP revenues are "not insignificant" for one clinic and another reports that, due to GAMP, its self-pay patients make up only 5-9 percent of its patients, which is "extremely low" for community health centers. At the same time, the GAMP model puts health centers in the role of gatekeeper and coordinator of care, which some clinics find challenging because they report having no leverage with providers to arrange needed hospital and specialty services. Specialty care remains difficult to access. Payment levels are viewed as the key barrier; general supply of certain specialties is also problematic.

Because the intention of GAMP is to provide coverage to people when they are ill, the program does not focus on preventive screenings and other types of primary care. The City of Milwaukee Health Department offers such services, although there does seem to be extensive coordination between the GAMP eligibles and ineligibles for such services from which they might benefit. The local public officer considers working on that relationship "a worthy goal."

Distributing responsibility for the uninsured across providers reportedly has created a strong provider constituency in support of GAMP. The fact that GAMP clients reside in all Milwaukee County zip codes) has strengthened 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.

Net Contribution of the Program

There is no analysis on GAMP's effects on the health status of the uninsured. Enrollees complete questions about their health status on the application and patient satisfaction surveys, but that information has not been analyzed nor is it tracked over time. A study of the nurse line, however, found that the number of patients who felt very or somewhat confident in their ability to take care of their health tripled since 2001. As one provider responded, "*The program has definitely had an impact…it is very helpful and positive for our patients*." Another stated, "*We can speculate that indices that were bad would be worse if not for the GAMP program*."

Overall, GAMP appears to have created a broader, more organized safety net for the uninsured in Milwaukee. Uninsured people now have a greater choice of providers and those eligible for GAMP seemingly are able to access appropriate health care services more readily. The program offers a more cost-effective way of providing health care services for 27,000 of the uninsured each year through a number of relatively successful cost-control strategies. Yet, GAMP only goes so far. Some important services remain uncovered, efforts to redirect some program costs to patients may keep them out of the program and redirecting patients to appropriate care venues remains a challenge. Also, many low-income uninsured people are outside the system and even those enrolled do not carry reimbursement with them for the entire calendar year. Limited program funding and the growing costs of caring for the uninsured outside the GAMP program have contributed to the volume of unpaid services and ED visits for Milwaukee's safety net providers. There are signs that these pressures may erode the broad network of providers GAMP has developed.

Conclusions

- Small community investment has leveraged significant outside funding and cost savings. Providers hold financial risk once available funding is exhausted each year.
- Range of strategies – including nurse call line, disease management, pharmaceutical controls, cost-sharing with enrollees -- has helped contain the costs of serving enrollees, but hasn't reversed overall rising ED use and uncompensated care costs in the community.
- This community initiative changed safety net structure for uninsured both within and outside of the program and has helped pull the community together on issues related to the uninsured. However, even this relatively large program is financially constrained relative to the size of the uninsured population and to the comprehensive services that are needed.

Sustainability

Funding

Current Funding Sources

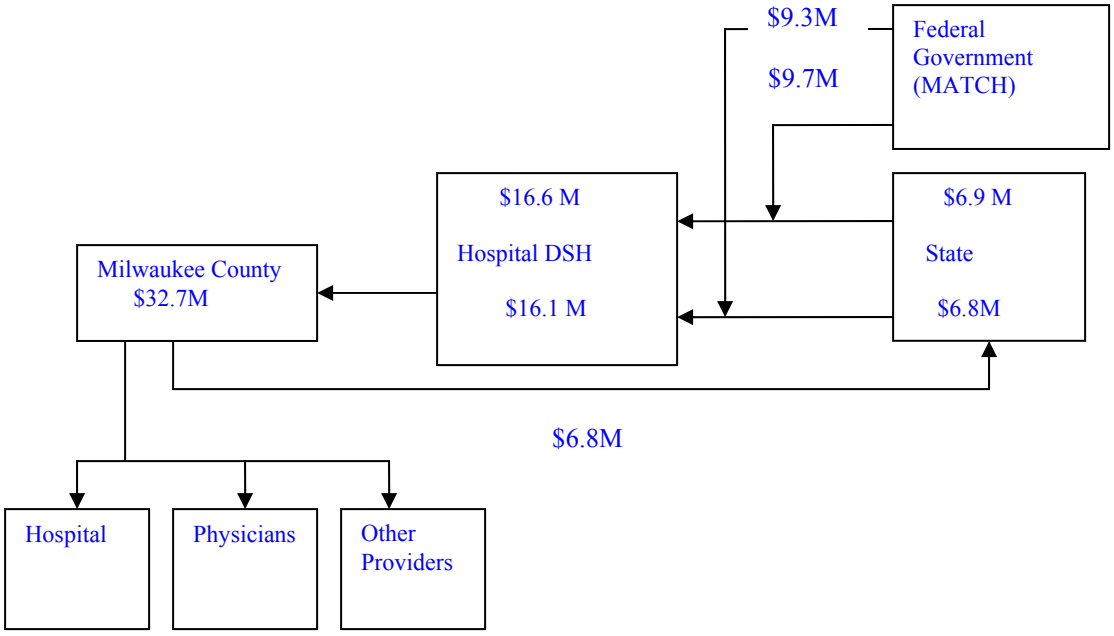
GAMP has total funding of $49.4 million (Figure A1). $15.6 million dollars is provided to the program from the Milwaukee County tax levy for medical services. $33.8 million dollars is provided to the program from the state and federal government through state block grants and Disproportionate Share Hospital payments. $13.5 million of state and county funds are matched with $20.28 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.

Process of capturing and retaining funding: Milwaukee County has a long tradition of providing quality health care to those residents most 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 the county-owned hospital. On December 23, 1995, the County closed this hospital and transferred its assets to the Froedtert Memorial Lutheran Hospital (FMLH), 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 more 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 Milwaukee 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.

Figure A1. GENERAL ASSISTANCE MEDICAL PROGRAM Funding Structure



Budgeting: GAMP's budget is not sufficient to meet the total commitment of providers to GAMP patients throughout the entire calendar year. In spite of the program's success in leveraging resources from a variety of governmental sources, funding to reimburse hospitals, clinics and other providers is limited. Several hospitals stated that they were no longer reimbursed for their services after July of the calendar year. GAMP is committed to providing primary care services to their patients, so reimbursements targeted to clinics continue to be available until approximately September of the calendar year. In spite of the network's success in leveraging resources, most grant sources do not allow funds to be used to pay for

services. Therefore, subsidy funding continues to be the most challenging financial need to be addressed.

Prospects for Future Funding

The Milwaukee County Board of Supervisors has had a long-standing commitment to this program. However, county and state budgets are extremely limited. For the first time, in the last county fiscal cycle, GAMP funding was reduced by a little over $1 million. GAMP has completed a Return on Investment (ROI) analysis to determine its value to the community. Data show that each dollar invested in the GAMP program has returned to the community $1.98 in services and benefits or an additional $0.98 in excess of the original expenditure. GAMP must continue to encourage support from its partners and the community utilizing evaluative data on its success to ensure that county funding is retained. The legitimacy of IGTs in Medicaid also continues to be a concern for GAMP. The Program Director would like to further maximize the amount of DSH payments that are available to the program through the IGT, but is concerned that limitations may be imposed by the federal government.

Other Concerns about Sustainability

Internal Change

Continued involvement of the network director, staff, physicians and other providers is necessary to ensure the sustainability of this program. There is some belief that the hospitals could become more invested in the program; however, most key informants seem to believe that collaboration of providers with the program is at a high level. On the other hand, some " key people" have left and changes in Board make-up are pending. There was some concern expressed that the same level of passion would be found in incoming members.

External Change

Limited state and county budgets continue to be a primary concern. Also, significant turnover among the County Board of Supervisors may impact the level of funding available to the program as those individuals who were primarily invested in the program are no longer serving. Doubt exists on how long Milwaukee County would have the fortitude to remain committed to the program.

Local Economy

The GAMP program has show a 25.4 percent reduction in the average cost of non-pharmacy and pharmacy claims from 1997 to 2000. The GAMP program also was able to decrease its reliance on the county tax levy through the enhancement of the IGT; the average tax levy reduction was $3.6 million. The program will need to continue to demonstrate its value to employers, the business community, the political community and local providers to ensure its sustainability.

Community/State Policy

The GAMP program continues to rely on the availability of the IGT to maximize the amount of DSH funding that it receives from the state and federal government through its partner DSH eligible hospitals. County funding must continue to remain available to match with state and federal funding to ensure appropriate levels of funding for the program. The state continues to see the importance of providing a stable "wheel of funding." As was expressed by one official," *if we backed away from the whole moral and ethical issue, parochially we would have some significant compounded impact due to the loss of funds*."

Long-term Goals

GAMP officials wish to continue improving access to primary care as a cost-effective option for GAMP patients who still rely on hospital emergency departments for their health care services. Another concern of the program is the continued eligibility of undocumented citizens. The large influx of immigrants that have moved into the state attracted by agriculture, retail, meat packing industries and slaughter companies is increasing the need to provide access to care for uninsured populations. The GAMP program will also continue to determine what cost savings strategies are available to them, including advancing their technological capabilities and reviewing their drug formulary. Though most key informants saw the program as being sustainable over three years, they were less were less confident of it still being viable beyond that point without significant change in the state's economy.

Conclusions

- The General Assistance Medical Program (GAMP) has a total yearly funding of $49.4 million. $15.6 million dollars is provided to the program from the Milwaukee County tax levy for medical services. $33.8 million dollars is provided to the program from the state and federal government through state block grants and Disproportionate Share Hospital payments.
- Milwaukee County and the State of Wisconsin have leveraged their funding to maximize the amount of DSH funding available to Milwaukee County through Intergovernmental Transfer (IGT).
- The General Assistance Medical Program budget is not sufficient to meet the total commitment to providers of care to GAMP patients throughout the entire calendar year. In spite of the program's success in leveraging resources from a variety of governmental sources, funding to reimburse hospitals, clinics, and other providers is limited.

Replication

Beta Site Development

Variation from Model

Based on the responses of the interviewed stakeholders, GAMP is not a replication of any other model in the country. A timeline of significant events is summarized in Table A5. In the early 1970s, the program was the Indigent Care component of the John L. Doyne County Hospital. This hospital provided services to the vast majority of the county's indigent population. At the time there was a statutory mandate requiring that the hospital provide or make available, medical and mental health services for persons who would otherwise not have access to such care

In 1980, some reorganization occurred to determine what populations were eligible and the nature of the services that were to be provided. The benefit package was redesigned to match that of Medicaid and similar reimbursement rates made to apply. The statute was changed to allow the state to reimburse Milwaukee County for up to 49 percent of the cost of indigent care for the next ten years. Over that period of time administrative issues at the hospital, increasing volume of indigent care and the pull out of the Medical school combined made imminent the closure of the hospital. At about the same time, a further modification in the statute rescinded the mandate that the county be responsible for providing indigent care and with that the hospital was closed.

The closure occurred in December 1995. A bridging arrangement with the Froedtert Memorial Lutheran Hospital, that shared ER services with Doyne, allowed for the

continued provision of patient care while four task forces deliberated on how to proceed with the issue of the indigent care that was previously provided. There continued to be a strong interest within the county to find ways to continue provision of this care.

Though it is not completely clear as to whose "brain child" the reformed GAMP program was, the conceptual thinking behind the program was that the county would cease operating as a service provider and begin acting as a purchaser and organizer of those services. The Director of GAMP, who has been in the position since 1998, was the Chief Operating Officer at the now defunct hospital and was charged with the responsibility of finding a model that "hit the buttons" of the county Board executive. It was expected that the new GAMP program would have the following core values:

- Provision of services in community care settings rather than a hospital setting which had been the prior history of the program
- Provision of services that focused on primary and preventive care
- Inclusion of a full range of medical service providers rather than a single source of service
- Self-determination of the individual clients and sensitivity to cultural needs and expectations

The Supervisor of the County Board at the time advised that the program needed to be "community-centric" and should perhaps utilize a HMO design. Most key informants felt that there was good leadership in place, and a sincere desire on the part of all concerned not to "drop the ball."

This model was felt to be appropriate as the community health centers using state-supported funds could act as purchasers of secondary and tertiary care on behalf of patients they were to see at the primary care level. At any rate they felt that they could do a better job than the hospitals at being the program's primary fiscal agents.

By the time GAMP was "reborn" in April 1998, the model was adjusted to reflect the community health centers' role as primary care service providers with no fiscal agency responsibilities. The change reflected the initial challenges of capacity at the primary care level. and a decision was made that the GAMP program office would act as the fiscal agents and purchasers of specialist care. Patients would be given the option of choosing their primary care homes from a collection of community health centers, FQHC's and private provider offices that were GAMP certified. These centers would organize for secondary care but reimbursement would be at Title XIX rates (except for the FQHCs) paid through a third party reimbursement agency contracted by the GAMP office on behalf of the county.

Though this program was not a replication, in designing the new GAMP program the Task Force reviewed other community based models throughout the country. These

included Wayne County in Michigan and Hillsborough County in Florida. There was also some limited exposure to the work being done by other CAP grantees. There appeared to be some early consensus among the group that a system with a gatekeeper approaches would be ideal for their community to help reduce unnecessary utilization of the ED.

Environmental Impacts

During the start-up and implementation phase of the new program, several factors at the local, state and national levels had an impact on the program.

State/Federal

- The redesign of GAMP was precipitated by the fiscal crisis facing Doyne Hospital and the change in the law that allowed the County to get out of the provision of service and attempt to procure some services for a specific component of the indigent population.

- The state was categorized as being helpful in the changeover process and the use of IGTs enabled more Federal dollars to be leveraged to fund the program. There was also a suggestion that from a Federal level, the state's involvement was being viewed as favorable.

Local

- The leadership of County Board and current county executive during the process was described as being critical, and many were actively involved in the initial design and implementation of the program. There is a concern, however, that as time passes some of the progenitors are no longer involved in the process and GAMP is becoming less about the community being served and more about cash.

- Large number of groups demonstrated a moral commitment to the county's plan to continue to care for the indigent. These groups included the nurses union, the Wisconsin Hospital Association, ASME, task forces, and Community Advocates, Inc.

- Key local working relationships between GAMP and the County Board had long been established prior to the redesigned program. There was also significant leveraging of influence and credibility of a few of the designers/implementers who had previously held substantial county and state positions. This still continues to occur as the present Director of the program, who believes that a part of the strength of GAMP is its ease of political support, is also the current Director of the Department of Human Services.

- Not as much cooperation was had from health system based groups (like Aurora) perhaps because of the relatively low reimbursement rates.

- Use of the web-based eligibility system has been vital to ensuring a smooth process both for clients and providers.

Prospects for Further Replication

While the Director of GAMP visited communities in other states that expressed interest in the program, the model had not yet been replicated in any another community. One community in Jacksonville, Florida, was said to be of similar design; and some limited informal exchange of knowledge had occurred between the two sites.

Most key informants felt that the program could be replicated in other communities, including some in Wisconsin. The following conditions were considered necessary for successful replication:

- Leadership at the level of policy making and operations
- Political collaboration and commitment
- A tax levy system
- A capacity need in the system
- Willing clinic providers, hospitals or network willing to take on the burden
- Hospital buy-in
- Good community based primary care delivery system
- Some crisis similar to the closure of the hospital that would act as a catalyst
- A method to provide incentive for hospital participation.

At the same time, there was uncertainty expressed as to the potential for other Wisconsin communities to replicate this program, as not many low income or uninsured persons were perceived to be seeking care from other hospitals in other parts of the state. Since most of Wisconsin's DSH payments are made to hospitals in Milwaukee County, attempts to replicate this program elsewhere will require adjustments.

Lessons Learned

During implementation, GAMP leadership learned some critical lessons that would change how they would design the program if it were implemented again in another community. These are:

- Allowing patients the choice of primary care home for the start of the program

- More engagement of specialists from the start
- Better reimbursement rates
- A disease management or care management approach for "high fliers"
- Greater caution in benefit package to avoid roll backs at later date
- Use of nominal cost sharing strategies earlier rather than later in implementation
- In house utilization review and quality assurance capacities are key
- Clear administrative rules
- Patient access to community advocates early in the program
- Use of a needs assessment for program design.

Conclusions

- Program was triggered by hospital closure and is thought to be unique in its design.
- Leadership has been an important to the design and implementation; the program has a strong director.
- Increasing federal scrutiny of the "creative" use of intergovernmental transfers may frustrate easy replication.
- The program has not been replicated.

State/ Community Interface

Community Support

Many key informants believed GAMP to be working in tandem with the state public insurance programs to form a significant part of the state's safety net. The eligibility criteria for both programs were seen as complementary and the sharing of eligibility data and information in different forms between the program and the state was also regarded as evidence of community support. Further, because FQHCs are reimbursed for Medicaid patients at cost by the state, these GAMP certified clinics are actively engaged in enrolling eligible patients into the state's Medicaid programs.

State Support

The support of the state is primarily fiscal, through the block grant and the state's role in the use of IGTs. The legislation does not require any state oversight in the

program. Though the Department of Audit was in fact at the table as an observer during the initial planning of the program, the state at this time does not carry out any audits of the program. There is direct interface with the State Medicaid Officer who is described as being an advocate for continued funding. The relationship was categorized as "strong" though some key informants felt that the strength of association may appear to be greater if one is looking in from the outside.

It should be pointed out that while Milwaukee County receives more than $30 million dollars of leveraged state funds for the provision of medical services; the other 71 counties in the state average approximately $800,000 in block grants to be used for medical and other social service provision

In terms of combining or merging GAMP with other public programs, some key informants thought that integration of GAMP into a state Medicaid or Badger Care program would be possible, though unlikely to occur at any time soon given the state's economy. Two of the suggested ways of accomplishing this were:

- A change in the eligibility criteria of GAMP to cover the obvious gap of empty-nesters and non-custodial single parents; and

- Creation of an 1115 or HIFA waiver that would allow the Badger Care program to include single uninsured adults who could find provider service through the network already established by GAMP.

Given the economic situation in the state and the greater relative importance of education as a state priority, some key informants declared that they would be happy if GAMP were to be successful in maintaining its current level of state funding. There was also a view that if GAMP were to consistently demonstrate good returns on investment and significant trend reduction in the inappropriate utilization of the hospital emergency rooms across county, then the state would perhaps be willing to extend an even larger share of funds to the program.

State or National Barriers

At the state level, there is a need for a re-education of political leadership with respect to the importance of the program. The moral imperative, resulting from the closure of the hospital, is at risk of being lost as time passes.

And at the national level, Title XIX reimbursement rates are seen to be a mixed blessing: not high enough to inflate delivery costs but likewise not high enough to attract or keep providers on board. A further barrier is the limit to the amount of DSH payment that will be available, jeopardizing any further expansion of program.

Table A5 – GENERAL ASSISTANCE MEDICAL PROGRAM Timeline of Significant Events	
1968	• Change in state law that mandated the county hospital to see all residents of the county
1980	• Establishment of General Assistance Program using Title XIX benefit package and reimbursement schedule • State legislation to amend chapter 49 and provide for reimbursement to Milwaukee county for indigent care costs incurred • Department of Administration oversees distribution and acts as third party payer
1995	• Change in legislation: county hospital no longer mandated to provide Care • Hospital closure and set up of multiple Task Forces to decide on how to proceed on GAMP • Two year bridging contract signed with Froedtert Hospital following sale of hospital • Demonstration/ feasibility project set up by Board Chairman
1998	• Redesign of GAMP program under the Division of County Health Programs approved by the County Board of Supervisors • Selects new fiscal intermediary (third party payer) to reduce delays in reimbursement time • Use of IGTs to augment block grant and county property tax levy
2000	• Awarded BPHC Community Access Program Grant ($900,000) matched at 1:1 by Chamber of Commerce
2002	• Non refundable enrollment administration fee of $35.00 imposed
2004	• 17 clinics; 23 sites operational; 13 hospitals; pharmacy co-pay of $1.00 per generic script and $3.00 per brand preparation instituted

Conclusions

- The state is committed at this time to keeping the program going.
- The program design lends itself to the possibility of integration with state programs in more prosperous economic times.
- The program assists the state in Medicaid enrollment.

CHOICE REGIONAL HEALTH NETWORK

Olympia, Washington

Organization and Leadership

Program Description

CHOICE uses a multi-pronged approach to improve access to care for uninsured individuals at or below 250 percent of the Federal Poverty Level (FPL) residing in a service area covering five counties. Governed by a non-profit Board of Directors, this regional network does not provide direct medical services but, rather, enrolls eligible individuals in state sponsored programs or links them to donated or discounted local provider services. Through its Regional Access Program (RAP), CHOICE collaborates with other regional stakeholders to increase coverage options where possible.

The program benefits from collaboration with 3 hospitals, 11 outpatient clinics, local Federally Qualified Health Centers (FQHCs) and hundreds of physicians.

The Board

The Board of CHOICE consists of 10 members representing hospitals, physicians, public health, and communities. The members of the group serve as co-owners of the organization and oversee administration of programs, set vision and mission, supervise the executive director, approve budgets and strategic priorities and are accountable for grants. A three- member executive committee makes administrative decisions related to personnel and reviews financial reports. In addition to the board and executive committee, Twin Harbor Pharm Assist Board, Tu Salud Advisory Committee, Sustainable Healthcare Access Council and Design Team Thurston County Project Access Steering Committee, 8 local collaboratives, and CJA's Board of Directors provide guidance for various aspects of CHOICE's function.

Staffing

CHOICE has approximately 20 staff and has operated with a budget of approximately $1.6 million for each of the last 3 years. The staff guide various projects, serve as geo-leads in communities, and act as enrollment specialists. The money comes from member dues, Medicaid match, the Robert Wood Johnson Foundation (RWJF), Outreach and Network grants from the Health Resources and Services Administration (HRSA) , the Community Access Program (CAP), and a Kellogg grant.

Coverage

The "Face" of the Population Served

The target population for CHOICE is the estimated 93,000 individuals who are uninsured, have incomes below 250 percent FPL, and live in the five county service area. From 1996 to 2003, RAP has provided access to health services to over 17,000, or 36 percent of the low-income uninsured in the five-county region. However, some of the 17,000 people are repeat clients. Over time CHOICE staff are seeing more adults which they attribute to the economic downturn. The majority of clients are under 39 years of age. Most of the adult clients are employed in low-wage jobs that offer unaffordable or no coverage. Almost half of CHOICE clients have incomes below 65 percent FPL. In 2000, RAP began to serve Limited English Proficient Latino clients and found that 31 percent of their clients were Latinos, compared to 5 percent of the region's total population.

Data show a significant increase in the number of very low-income clients from Lewis and Mason counties. Data from the Health Care Authority for Basic Health applications reveal that:

- 98 percent of CHOICE applications result in enrollment compared to 4 percent of people who enroll on their own; and

- 96 percent of clients CHOICE enrolls are still enrolled in insurance (90 percent still enrolled in Basic Health) up to three years later compared to 40 percent who enroll on their own.

The pharmacy assistance program connects CHOICE clients to the free or reduced drug programs of pharmaceutical companies. Most pharmaceuticals received by these clients have been for chronic conditions. The most common prescriptions filled for RAP clients are for cardiac, mental health, diabetes and asthma diagnosis. From January 24 through June 30, 2003, CHOICE assisted with applications for pharmaceuticals having a market value of over $11,254.00.

Eligibility Criteria

RAP connects clients to Medicaid, Basic Health Plan, the state's Children's Health Insurance Program (SCHIP) and other state or federal subsidized coverage programs, so eligibility criteria vary depending on the program (Table A6). The target population for CHOICE services has an upper income limit of 250 percent FPL, as that is the threshold of eligibility in Washington's SCHIP.

Table A6 – Eligibility Criteria for Medicaid and SCHIP in Washington State

Program	Family Income Limit (percent FPL)
Medicaid	
Infants	200%
Children Ages 0-1	200%
Children Ages 6-19	200%
Pregnant Women	185%
Supplemental Security Income	74%
Medically Needy - Individual	78%
Medically Needy - Couple	61%
SCHIP	250%

The Basic Health Plan is for Washington State residents who are not eligible for free or purchased Medicare, not institutionalized at the time of enrollment and are within Basic Health's income guidelines. Monthly premiums are based on age, income, family size, and health plan chosen. There is a $150 annual deductible, 20 percent coinsure rate with a $1,500 annual out-of-pocket maximum. Enrollees have the flexibility to select a health plan that is available in their county of residence and offers the best value, location and providers for that client.

Conclusions

- CHOICE has developed extraordinary capacity and experience in enrolling (and keeping enrolled) those who are eligible for Washington's various public programs.
- Those working with the people believe that severe poverty – grinding poverty – is difficult to break through.
- Sometimes you have to touch a nerve to get people to do what they need to do.
- Fear and peer pressure work.

Net Cost to the Community

Utilization and Cost within the Program

With an overall budget of $1.8 million, CHOICE's major focus is to link low-income people to existing public insurance programs, as well as help them people find needed providers. Because CHOICE's goal is to get people covered or treated in an appropriate manner, their model attempts to increase the utilization of some services

(e.g., primary care and prescription) and reduce utilization of others (e.g., emergency departments).

Key informants generally believe CHOICE to be successful in changing utilization patterns, through its emphasis on medical homes and care management. For instance, one provider reported that CHOICE has had an impact in reducing emergency department (ED) utilization and increasing diabetes education and managing care through the diabetes collaborative. While community key informants often referred to CHOICE data, but the program did not appear to have as much information, particularly changes in ED use, as outside key informants thought. Yet CHOICE staff did point to small projects that have controlled utilization for specific conditions. For instance, PharmAssist program, in which access coordinators help clients enroll in assistance programs offered by pharmaceutical companies, is also getting off the ground. Apparently in that program's first five months, CHOICE helped 94 clients receive 190 prescriptions with a market value of over $11,000. And a support group program for patients with fibromyalgia reduced the average number of visits per patient from 16 to 3 (time period unknown).

CHOICE indicated that hospitals think its case management efforts are a bit of a black hole without clear benefits. That sentiment does not seem to be shared by providers, although one smaller hospital was not aware of any care management efforts. CHOICE is implementing a pilot program at Providence St. Peter Hospital (the largest hospital in the area) to better manage the "frequent fliers" to the ED. Although it is too early to know the impact of that effort, the hospital CEO is optimistic: he was surprised to learn that some patients present to the ED 50-60 times per year.

While the CHOICE model is expected to be a more cost-effective way of treating low-income and uninsured people, CHOICE's primary focus appears to be getting services for people, not measuring the direct cost reductions of those efforts. One provider indicated that for CHOICE to be sustainable it must be cost effective, but there may not be many specific strategies for obtaining it; rather, cost-effectiveness is "*embedded in what we're trying to do.*" One specific strategy is CHOICE's investment in some clinical redesign efforts intended to increased efficiency of patient care. Using David Rogoff's methodology, CHOICE estimates that all of their efforts to provide case management and care coordination reduce the annual cost of care per client from $4,000 to $3,000, or a total savings of $3.5 million to the health system annually.

Impact on the Safety Net

In the CHOICE region, the hospitals (and their clinics) reportedly providing the highest percentages of charity care are Providence Central, Providence St. Peter and Mark Reed, a public hospital. Eleven outpatient providers (private practices and community clinics) across the five southwestern counties that accept uninsured patients on a sliding fee scale, including a free clinic and a new FQHC. There is also a community call program for after-hours assistance and a few urgent care clinics.

County health departments conduct a range of public health activities, but have moved away from providing direct primary care. A 2003 United Way assessment of Thurston County's services indicates that approximately 31 FTEs of provider capacity (26 percent) is directed at care for low-income people, representing a shortage of 5-10 FTEs for these needs.

Key informants report that CHOICE has helped "shore up the financial stability" and "increase the capacity" of the overall safety net, both directly through its programs and indirectly through the relationships it has developed. Of all the CHOICE activities to date, RAP appears to have had the most significant, positive impact on the safety net. Seven area hospitals pay dues for RAP membership, primarily for the Health Resource Coordinators to be stationed in their facilities. In helping to get uninsured patients enrolled in available public insurance programs, the coordinators bring additional revenues to the hospitals for patients they otherwise would see for free or on a sliding fee scale. However, the for-profit hospital system, Capital, is not financially committed to CHOICE. CHOICE reportedly has not tried to engage them, which some key informants see as a "blind spot" in improving the safety net.

There are also reports that the faith-based, dental and community clinics have grown with the help of revenues received by way of CHOICE's efforts. In addition, CHOICE's relationships with policy makers helped bring in the "self-sustaining" SeaMar FQHC to the Olympia area. As a result, Providence St. Peter hospital was able to close its comparable clinic which relied on $8,000 to $9,000 in hospital funding each month. CHOICE also reportedly helped alleviate some private practitioners' concerns that the FQHC would create competition for their practices.

Through the work of the Geoleads (CHOICE staff responsible for particular counties in CHOICE's region), CHOICE helps other communities build up their own programs, rather than CHOICE simply imposing its name and strategies on the communities. CHOICE is invited to forums that attempt to improve various aspects of the safety net. Furthermore, one key informant indicated that CHOICE has raised the profile of Southwest Washington, which has helped the area get grants for health care projects.

However, there are indications that the safety net is crumbling faster than CHOICE activities can repair it. The CHOICE director reported that she is now hearing "*more sad stories and fewer happy endings.*" Access to certain services, such as mental health care and substance abuse, is still considered "extremely difficult." Some providers noted a need for broader primary care options as well. A health department key informant indicated that there are improvements in the safety net as a result of CHOICE, but that the safety net is "so sick" that it will take a long time to see quantifiable improvement. To have a more immediate impact, many feel that more should be done to help recruit physicians willing to treat low-income people.

In addition, uncompensated care at area hospitals is on the rise and "getting worse quickly" due to the economy, increasing insurance premiums and cuts in

Washington's public insurance programs – including a waitlist for Basic Health Plan, additional requirements for the Medicaid Healthy Options program, and the elimination of the Medically Indigent program. However, one rural hospital key informant indicated that they receive state grants to compensate for some of their uncompensated care, so those costs have not been as much of a burden.

Stabilizing the safety net is one of the six principle goals of CHOICE's 100% Access project for the future. There is movement from hospitals being the "sole owners" of the safety net to having the broader community becoming more involved. Changing the makeup of the Board is one step toward this goal. Staff are working with the regional medical society on creating a Project Access program, which key informants think will help the community health centers (CHCs) and their patients access specialty and other services more readily (although one key informant claimed there still are not enough providers to meet the needs of the population). Also, one key informant felt that CHOICE has the potential to better integrate dental and mental health with primary care and to develop an electronic medical record to be used across providers.

Net Contribution of the Program

The general consensus is that more low-income people in southwestern Washington have insurance and better access to care because of CHOICE's efforts. CHOICE's caseload is approximately 20,000 people. CHOICE staff report that the enrollment rate through the applications they help clients complete is far higher than the success rate of applications generally. The Medicaid agency reports it is difficult to provide exact figures on the effectiveness of CHOICE's outreach because outreach is an indirect process. Yet the state recognizes the value CHOICE adds and "wishes we could pay them for what they do because they are very essential." While reportedly some legislators are concerned that CHOICE is adding people to the public insurance rolls at a time when the state budget is so tight, one key informant speculated that CHOICE saves state dollars because the uninsured are encouraged to call CHOICE instead of the state agencies.

In 2003, CHOICE estimated that the $160,000 in member dues generated an additional $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 reimbursement for patients insured through RAP efforts. Indeed, hospital return on investment (ROI) was commonly mentioned as a measure of CHOICE's financial impact on the community. The hospitals' average ROI has steadily increased from 2:1 to 20:1 between 1999 and 2001. The hospital with the largest financial commitment, Providence St. Peter Hospital, also receives the largest return and its CEO said, "RAP is one of the best investments we've ever made." Although Mark Reed's ROI is much smaller because they do not have many inpatient services, they still feel the financial commitment to RAP is "the right thing to do." Given state cutbacks in public coverage programs over the last year or so, however, there is speculation that decreasing numbers of people with coverage will also slightly reduce the ROI for hospitals in the near future.

CHOICE staff acknowledge that, while they are perceived as being good fundraisers for the community, they are considered mediocre at spending the money at the community level. Reducing costs and redirecting the savings to help more people is the fourth of the six principles of CHOICE's 100% Access initiative. Towards this end, the CHOICE board will move from being hospital centric to being more community oriented. This and other changes will allow CHOICE to evaluate its return on *community* investment instead of just *hospital* investment.

Conclusions

- CHOICE has been an effective outreach vehicle for getting low-income people enrolled in public insurance. This model has encouraged the use of appropriate health care services and shored up the financial stability of safety net providers.
- CHOICE has been less focused on measuring its direct impact on utilization and cost-effectiveness than other programs studied.
- 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.

Sustainability

Funding

Current Funding Sources

CHOICE is fully operational with an annual operating budget of $1.7 million. This budget is made up from a variety of funding sources including membership dues and fees, Medicaid match, federal grant programs and private foundation grant programs. A nine-member Board of Directors sets the strategic direction. A full-time Executive Director reports to a five-member Executive Committee. Nineteen full-time staff and other part-time employees perform activities according to a work plan adopted by the Executive Committee.

Process of Capturing and Retaining Funding

The CHOICE rural health network has had a great deal of success creating funding streams for its multiple projects. The cornerstone of the network's funding is the commitment of their member hospitals. To receive services from CHOICE staff and through RAP, these hospitals are levied dues on a sliding scale based on hospital size.

Member hospitals have seen a significant return on their investment as these dues not only provide them with staffing for special projects that benefit the hospital, but also through improved reimbursements. RAP provides Access Coordinators in each of the five counties in the CHOICE service area. These Access Coordinators facilitate access to health insurance, medical homes, prescription drugs and specialty consultations for the CHOICE target population. A primary responsibility of the Access Coordinator is to connect uninsured persons with state-subsidized coverage programs for which they are eligible. From October 1998 through September 2001, 63.8 percent of those individuals received hospital services. This resulted in a total health plan reimbursement to the seven member hospitals in the amount of $4.8 million. Reimbursement amounts varied among hospitals due to hospital size and scope of services. However, the average return on investment for all hospitals in 1999 was 9.13:1. For 2000, it was 11.40:1; and for 2001, it was 20.96:1.

CHOICE also has had significant success winning grant awards from a variety of federal and private grant programs. They currently have several grant awards from the RWJF and HRSA.

Budgeting

As CHOICE does not provide direct funding to providers for services, there is not a problem in this location where funding is not sufficient to reimburse participating providers. However, CHOICE does rely significantly on grant funding for sustainability. Approximately 61 percent of the CHOICE budget for 2004 is comprised of grant funding. As is the case with many communities, several of their large grants will end over the next several years. For example, CHOICE will seek fourth year continuation funding for its HCAP grant; however, due to the current political and economic situation, that small amount of funding may not be available. It is possible that the budget could be reduced when these grants lapse.

CHOICE does continue to have the commitment of member hospitals to the 100 percent access goal. However, smaller member hospitals may, in the future, have to make a decision whether or not they can afford to continue in this program depending on their financial situation. CHOICE staff stated that some requests from member hospitals cannot be accommodated because staffing is unavailable due to the stringent staffing requirement required by the 100% Access Project. It was acknowledged by both CHOICE and hospital members that this may have an impact on some hospitals' continued participation as dues paying members.

Other Concerns about Sustainability

Hospital members expressed their long-standing and continued commitment to the CHOICE network programs. However, depending on the financial future of those hospitals, they may not be able to continue if their hospitals' goals are not being met. Also, current grants awarded to the program will run out over the next two years. Therefore, CHOICE will have to continue to be innovative and creative in creating new funding streams. Government officials expressed their appreciation for the

efforts of CHOICE and its programs; however, several stated that their funding does not allow them to commit funds to CHOICE at this time.

CHOICE must continue to encourage support from its partners and other funders utilizing evaluative data on successes. This includes engaging support for the 100% Access Project. A significant amount of CHOICE staff time and funding is dedicated to the activities of this project, which is currently funded through a multi-year HRSA CAP grant. However, the CAP grant is due to sunset in the next year. Therefore, CHOICE and its partners in this endeavor will have to demonstrate the value of this project to its members, collaborators and community partners to ensure that funding continues to be available. It was expressed in several interviews that the 100% Access Project efforts will need a "win" in the next six months for those individuals to continue to participate at the same level of effort as they have maintained over the last 18 months.

Internal Change

Continued involvement of the network director, staff, physicians and other providers is necessary to ensure the sustainability of CHOICE programs. It was stated in many interviews that the success of CHOICE is due to the efforts of the Executive Director and the relationships that she has built within the community. These individuals stated that their continued commitment to CHOICE efforts would be questionable if the Executive Director or her staff were no longer with the organization.

Environmental Change

The political environment in the state continues to be a factor in the success of CHOICE programs, especially the 100% Access Project. It was noted that the failure of state health care reform in the mid-1990s has had a long-lasting impact on the advocacy community's ability to promote any real change at the state level. Therefore, any endeavor that has the theme of health care reform is met with concern by state government. Several interviewees noted that local and state government could become more invested in the program; however, most key informants seem to believe that a high level of community collaboration exists. It was noted in interviews that this community, and Thurston County in particular, is liberal and has a history of collaboration for social change. It was also noted that there may be a shift in the political majority in either of the houses of the state legislature, which may have an impact on the 100% Access Project efforts.

Long-term Goals

CHOICE has a long-term goal of creating a portfolio of programs that will provide 100% access to health care for individuals who reside in their five-county region. CHOICE was selected as one of three demonstration sites in Washington State to design a community-based 100% Access Demonstration Project that will:

- Increase access to affordable health care in the region;
- Sustain providers' ability to care for limited-income consumers; and
- Coordinate funding and programs to serve as a model health care system.

CHOICE and local and state partners are currently designing an enhanced health care service delivery system that will ensure 100 percent access in the form of an insurance product that can be marketed to state government and local businesses.

Conclusions

- The program attracts resources that would not otherwise be in the community.
- CHOICE cobbles together a series of funding.
- Community Health Management Districts are a possibility for the future.

Replication

Beta Site Development

The operational and programmatic model of CHOICE Regional Health Network was not a beta site replication of any other model throughout the country. However, in its continuing evolution, to improve access to health care, new elements are being added to portfolio programs which draw inspiration from similar, more well-known and established alpha sites.

Initial impetus for the formation of the network in 1992 occurred in response to what was perceived at the time, by seven hospitals in a five-county region of the southwestern portion of the state, to be a hostile takeover by a for-profit hospital system. This health system had acquired a hospital in the Olympia area and, in an effort to ensure market share, began setting up satellite clinics that were in direct competition with rural providers already in place.

In response, rural providers strengthened an already firm collaboration with Providence Health Systems. Then, in 1993, CHOICE was established with a $40,000 grant from the Washington Health Foundation with the stated goal of developing a rural network consisting of hospitals, physicians and ancillary providers dedicated to sharing resources and capable of providing capitated comprehensive care to residents of the five-county area. The goal was never achieved due to the failure of state health care reforms and, in 1996, CHOICE was reorganized to shift its strategic focus from providing joint contracting services to access and public health improvement.

Variation from Model

The fluid nature of network design in response to the needs of the community has led to the planning of 100% Access, a portfolio of programs which aims to "cover all bases" in an effort to ensure access. For all of its unique complexity, there are some nationwide models that have influenced and shaped some of the singular programmatic elements of the network. Some of these other initiatives include:

- *Jesse Tree – Galveston, Texas.* The RAP was conceptualized to increase access to state subsidized programs and to assist low-income persons in finding primary care. In many ways this program was and still continues to be viewed as the flagship effort of the network. It is of a similar design to The Jesse Tree in Galveston, Texas but differs sharply in the role of the faith-based community in the administration of that program. The Connexions program which is in developmental stages in Olympia has also borrowed from the Galveston Safety Net Information project in Galveston. The emphasis here for CHOICE is the development of a community-owned information system that permits sharing across multiple agencies rather than an information system for use primarily by providers as occurs in the Jesse Tree Model.

- *Project Access – Buncombe, North Carolina.* This portfolio element, partially staffed but not governed by CHOICE, is yet to be implemented. Key informants suggest, however, that the necessary preparatory work has been done and the program will begin shortly. There has been some reported discord with APAN given the proposed variation on the model being contemplated by CHOICE. The network desires to broaden the leadership of the program to include non-physicians "who understand low income people" rather than the usual "pure" Medical Society led design. The Thurston-Mason Medical Society is at present the only active society in the region, and the network is interested in including providers who are not affiliated with this peer group. Further, the Olympia proposal intends to start with uninsured persons but would expand to include low-income insured persons as well. Accordingly, the Buncombe County designed software that has been a part of APAN replications is unlikely to be used in the CHOICE proposal which will instead seek a local business partnership to provide for a sustainable relationship and easy expansion.

- *The Three Share Model – Muskegon, Michigan.* Perhaps the most embryonic of the portfolio pieces insofar as planning is concerned, the Network is facilitating discussions within the community on how to engage the business community in a way that is similar to the Three Share model in Muskegon County. The group reports, however, that Disproportionate Share Hospital dollars, are unlikely to be available; the variation under consideration might include, among other things, a premium subsidy from the Basic Health Plan as the potential third share.

Though the RAP program was the initial thrust of the network, a Design team was established to advise the Sustainable Healthcare Access Council in "guiding, boosting and protecting" the 100% Access Project. CHOICE engaged the services of the leadership of nationally recognized initiatives to introduce the concepts, articulate the benefits and address issues related to project development.

Prospects for Further Replication

Key informants from the network report that there has been some interest by a few communities in replicating at least some of the portfolio elements. The Director of the network has used a few of these opportunities to help raise additional project funds by charging consulting fees, but in general believes that the network is not yet ready to spend much energy on community replication when work remains with respect to community organization in the region that they serve.

CHOICE is a member of Communities Joined in Action a national organization dedicated to the principle of 100% Access which assisted Community Choice RAP replication. That program serves four counties in North Central Washington and commenced in August 2001. Other communities that have been in consultation with the Network include Spokane (Health Improvement Project).

Most of the key informants felt that there was no special characteristic of the five-county region that would need to be in place for successful general replication of the model. Some interviewees, however, believed that the more specific the replication became in terms of the programs, the more specific community criteria would have to be.

Key informants felt that the following specific conditions that would be necessary for greater ease and success of replication:

- Fearless, visionary leadership
- Determination and focus
- Flexible and imaginative staff
- Cooperative spirit; partnering with existing stakeholders in the system
- Track record of previous collaboration
- Available resources within community
- Solid hospital partnerships
- Significant community autonomy
- Ability to engage people in a sustainable way

- Grant-writing ability
- Measurable successes and demonstrable short term wins
- Partnering with Public Health
- Getting beyond "provider –centricity" in designing operational models
- Putting a face on the issue to increase buy-in

➢ Involvement of a program champion

Conclusions

- The project leadership realizes that one type of model will not result in 100% access. Therefore, the network has engaged in a continuous blending of programs to shape a complex portfolio of efforts to connect the community to care. Few stakeholders fully understand the scope of the project, much of which is relatively new.
- The dynamo of the network appears to be the executive level leadership of CHOICE. The executive director has been able to garner and maintain statewide political interest and state agency engagement, ensuring some program stability.
- A large number of collaborative partners "sit at the table" with a peculiar organizational and governance structure that may be difficult to replicate.

State/Community Interface

Community Support

RAP was seen by nearly all key informants as being highly supportive of and complementary to the state's insurance programs. In particular the impact of the community's efforts in assisting persons to enroll in the Basic Health Plan administered by the Health Care Authority (HCA) has been significant.

Data from the HCA suggest that 98 percent of CHOICE-assisted applications resulted in enrollment, compared to 40 percent when people attempted to enroll on their own. Further, 96 percent of the persons enrolled that way were still enrolled up to three years later, compared to 40 percent of clients enrolling on their own. Approximately 42 percent of the time of Access Coordinators is said to be spent enrolling clients and about 20 percent spent assisting with recertification.

The state agency recently introduced recertification after 6 months of being enrolled in the program, a matter that was perceived as a barrier to the work of the network. Coordinators have also been involved in assisting the enrollment of children and families in other state- sponsored programs. It should be noted that 50 percent of

Washington's population obtains coverage covered under some type of public sector insurance, including workers in state government.

One key informant opined that CHOICE is pushing the state to better serve their common missions of providing access for the uninsured. To that extent the community's program was thought to go a long way as an outreach arm of the public programs, perhaps saving the state dollars in reducing the need for its own outreach campaign.

State Support

Though state funds do not generally find their way into the program, the network views the "legislative interest and state agency engagement" as "significant and positive." Some specifics of engagement include:

- Some local and state legislators acting as legislative champions, convening with program staff and agency directors to encourage and monitor progress for three months.

- Support of 100% Access Project with the signing of two bills regarding changes in the Good Samaritan laws.

- Letters from state representatives to the heads of state agencies seeking modification to the pre-existing condition policies of the Basic Health Plan to allow "credit" for the period of time an uninsured individual is enrolled in Project Access.

- An invitation by the Senate Health Care Committee staff for CHOICE to be part of a workgroup to look at the issue of access to 340B prescription drug pricing programs.

Other stakeholders concurred that the state, for the most part, welcomed the creative approach of the network to the problem of access to care, though it was felt in some quarters that the Governor's Office could perhaps be more engaged. Some key informants also believed that some state leaders need to be convinced not only about staying involved but also about not taking action that would harm or adversely impact the operation and sustainability of the network's programs or expansion.

At any rate, most saw a natural fit between the program and Medicaid with a limited potential for merging the community work into the Medicaid program. Some thought that an 1115 waiver or demonstration grant might help shore up the work of CHOICE.

State or National Barriers

A few of the persons interviewed felt that the state was being disingenuous in some of its tacit support of the program. They (the state) were weary of the changes CHOICE

was seeking to make and concerned about how much of health care should be provided at the local level. There was a minority view that the legislature was sometimes not very helpful if they did not have a significant part in creating the program.

Generically, the state's inability to contribute funding, as well as the state's choice of "strategic" priorities (education ahead of health care), were also seen by some to challenge the network's success. Further, the recently imposed six-month recertification for BHP, and discontinuation of the Medically Indigent Program by state legislators in July 2003, provided more barriers to the network's efforts to enroll needy populations in public service programs. The Washington Basic Health Plan's waiting list, made necessary due to periods of closed enrollment, continues to be an impediment to CHOICE's efforts.

Though most key informants did not identify any barriers at the federal level, they acknowledge the lack of sustainable funding available to communities undertaking these initiatives.

Conclusions

- The program gives voice to patients.
- The program harnesses the power of communities.

COMMUNITY HEALTH WORKS

Forsyth, Georgia

Organization and Leadership

Program Description

Community Health Works (CHW) is a seven-county regional initiative that is a significantly modified version of the Buncombe model. It is administered by a 501(c) 3 organization and relies heavily on provider volunteerism and hospital leadership. Eligible uninsured individuals must have incomes at or below 250 percent of the Federal Poverty Level (FPL), and a diagnosis of one or more of the four chronic disease states covered. The program utilizes a Medication bank that allows clientele to access pharmacy benefits. There is also emphasis on appropriate utilization of services and a rigorous case management element across the continuum of care.

The local care network consists of 3 hospitals, 2 clinics, nearly a hundred physicians and 21 pharmacies.

The Board

The CHW Board of Directors is composed of 18 members who represent hospitals, non-profit groups, mental health, community foundations, health care providers, public health and local government. These individuals are also geographically representative of the CHW service area. They provide direction and make policy recommendations to the Executive Director and staff.

Staffing

CHW has five full-time administrative staff, eight care managers located throughout the service area, and two staff for data entry.

Coverage

The "Face" of the Population Served

CHW is designed for persons with incomes below 200 percent FPL, who are uninsured and not eligible for any publicly-sponsored or private market health insurance program. The services address adults ages 19-64 with high-risk diagnoses of hypertension, heart disease, diabetes or depression. As of May 31, 2004, CHW has screened 3,806 individuals for eligibility and has served a total of 2,348 individuals. There are currently 1,326 individuals enrolled. The average annual income of the CHW population is $7,000 and the average educational level is 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 3 disease states and 5.09 medications; 70 percent have co-morbidities.

CHW strives to connect its members to public and private insurance programs and other types of assistance. The program has helped its members complete 60 applications for Medicaid and PeachCare for Kids, and assisted 58 individuals with disability applications. Two individuals are awaiting health insurance coverage from a private source and 55 individuals are awaiting Medicaid coverage.

Eligibility Criteria

Eligibility criteria were developed by a group of community leaders in Central Georgia who came together to design a community-based solution for the uninsured in their region. Formed in response to the Communities in Charge grant program offered by the Robert Wood Johnson Foundation (RWJF), the group believed that the current health care system was not set up in a manner that was efficiently able to provide care, especially to the uninsured. Initially, the collaborative was made up of 100 individuals from the seven- county region in Central Georgia. Within that collaborative were the five not-for-profit hospitals in the region, two public health and mental health districts, representation from county governments and the medical school, and representation from business and civic organizations. Outside assistance was obtained from Georgia State University to generate data that could be used in the proposal to demonstrate community need.

The region was selected by RWJF in Phase One of the Communities in Charge program. Grant funding provided monies to further develop their proposal and refine the target population to respond to financial constraints. The target population of CHW initially included individuals living in the seven-county CHW service area between the ages of 19 and 64, who are not typically eligible for Medicaid or Medicare and whose income was below 200 percent FPL. To further define their target population, hospital discharge data for the area were studied to identify the diagnoses that were costly to treat in the hospital but could be easily treated with regular access to a primary care provider. Four disease states emerged: hypertension, diabetes, heart disease and depression. Therefore, eligibility is also focused on individuals who are diagnosed with those four disease states. It was initially estimated that 6,000 to 7,000 individuals were eligible for the program. However, the program currently serves approximately 800 individuals, and has served a total of 2,200 over its lifetime.

Proof of income eligibility is determined in a number of ways including W-2 forms, social security award letters or three months of paycheck stubs. Initially, the program allowed applicants to self-declare their income level. However, they found out that it was easier to connect members to other programs of assistance, especially free prescription drug programs offered by pharmaceutical companies, if proof of income was obtained. Proof of residence is also required. Undocumented individuals and migrant workers are not eligible for this program.

It is clear that the program is meeting the needs of a population that would otherwise be uninsured and would have extreme difficulty receiving adequate health care services for their significant health care issues. However, many residents have conditions other than the diseases that CHW covers. While program staff and participating community members and physicians would like to expand eligibility criteria and serve more individuals, they are well aware of the current financial situation of the state and CHW, as well as the limited ability of physicians to see more uninsured patients. Currently, there are approximately 100 physicians participating in the program and waiting lists for each of the counties served.

Conclusions

- Community Health Works (CHW) is designed for people with incomes below 200% of the Federal Poverty Level (FPL) who are uninsured and not eligible for any publicly-sponsored or private market health insurance.
- The services address adults with high-risk diagnoses of hypertension, heart disease, diabetes, or depression in adults between the ages of 19 and 64.
- The program was designed by a collaborative of five not-for-profit hospitals in the region, two public health and mental health districts, representation from county governments and the medical school, and representation from business and civic organizations.

Net Cost to the Community

Utilization and Cost within the Program

CHW has generated $13.6 million in free care to date through a model of case management and patient education. This model relies on a network of local physicians who provide charity care to individuals enrolled in the program, and case managers employed by the program. The premise of this model is the belief that appropriate primary care provided in a community setting will reduce the need for hospitalization and unnecessary emergency room visits. CHW also connects patients to free medications that help them maintain compliance with their physicians' health care plans. Through an Information Technology (IT) system developed for the program through the HRSA Community Access Program, CHW tracks program utilization and costs.

Across the board, interviewees stated that participation in the CHS program has had a positive effect on the health status of patients as well as increased use of primary care services. A formal evaluation has been undertaken by the program in partnership with Georgia State University through funding from the HRSA Community Access Program. The evaluation measures CHW's progress on hospital and emergency

department (ED) utilization by comparing data collected on CHW patients to a similar cohort of patients utilizing national Medical Expenditure Panel Survey data. These two cohorts are comprised of individuals with similar incomes, diagnoses, insurance status, age and gender. CHW clients, who average three co-morbid conditions and five prescriptions, use emergency departments and hospital care far less often (13 percent and 27 percent, respectively) than people in the control group who have only one condition. However, the evaluator acknowledges that comparing such usage patterns across different regions of the country is difficult, and also reports decreases in clients' use of hospital and emergency care over the length of time they are enrolled.

From the program's inception, CHW staff and Board have emphasized the "business focus" of the organization, including attempts to reduce costs. This focus is considered necessary to gain support among its needed partners and to be sustainable. By changing utilization patterns, the program has demonstrated reductions in cost for its enrolled population – a reduction of $517,000 in uncompensated care per 1000 enrollees per year. Estimates also show that program efforts to link clients and other uninsured people to Medicaid has led to a recovery of $670,000 in Medicaid reimbursement over the course of the program.

Providers have little information on the changes in utilization and costs for their particular organization, primarily because the number of CHW patients they serve is relatively small compared to total patient volume. At first some stakeholders reportedly felt that ED costs were fixed costs for the hospitals, so that decreases in utilization would not save them money. However, most providers are confident that CHW's aggregate estimates of changes in utilization and costs are accurate and in line with their own organization's experience.

Overall, the hospitals did not report that their financial investment (in the form of Indigent Care Trust Fund, ICTF, funds) to CHW was particularly burdensome, and one of the smaller hospitals estimated that its investment of indigent care dollars to CHW produced a 5-to-8 fold return on investment. One physician reported that, by committing to pro bono services up front, his practice saves money by not billing patients and spending time trying to track down payments. And the pro bono care is considered an investment, with the hope that if patients' conditions stabilize or improve, they can return to work, potentially obtain health insurance and hopefully become paying patients.

Key informants think that additional savings will be recouped over time as the hospital and ED utilization trends continue to come down, but that significant additional cost savings would require more funding and provider capacity for enrollment expansions. Key informants reported that a promising way to generate more dollars would be to sell their care management model and systems to the state Medicaid program. If the CHW care management model produces similar improvements in utilization and costs for the Medicaid population, the state should save money as well.

Impact on the Safety Net

A goal of CHW is not just to be a solitary program, but to create systemic change in the safety net. CHW has brought together leaders both across the seven counties and across different types of organizations. For instance, prior to CHW, the county commissioners reportedly had little involvement in health care and the safety net, but now they collaborate with the program and providers. Also, the hospitals and physicians now talk more often and share ideas – both about CHW and its clients, as well as about broader health delivery issues. One mental health provider remarked that before CHW he had no way to keep up with all the people with behavioral health issues presenting to the ED. Now he can sit down with the medical center leaders to discuss how to better manage these patients.

Although the program evaluator reported that CHW's effect on the safety net is part of the five-year evaluation plan and that there is currently not enough information to assess the impact, other key informants gave some examples of the effect CHW is having on the safety net. For instance, CHW has helped shift safety net capacity from hospital care to outpatient primary care. The program has created an accessible and broad network of providers for its enrollees – consisting of five hospitals, two clinics, 90 doctors and 21 pharmacies. CHW also helped create a safety net clinic staffed with volunteer physicians. Houston Medical Center and reportedly Mercer Medical School also are planning to add volunteer clinics by the end of the year.

Yet safety net capacity for the program is strained, with inadequate physician participation a significant limiting factor. In some counties, potential enrollees are placed on waiting lists because there are no primary care physicians to serve them. The care manager in Houston County, for example, has a caseload of 200 and over 100 patients on her waiting list. A few key informants thought that the timing of the volunteer clinic's opening presented competition for CHW's efforts to recruit physicians. This is likely not an ongoing concern, however, because the clinic relies on a fair number of retired physicians, which CHW reportedly cannot use.

The program has had different effects on the rural and urban components of the safety net. Doctors in the rural areas are considered "lone rangers" who often need to treat any patient who presents to them yet who have few resources to support this care. Reportedly, those physicians were thrilled to participate in CHW because the program brought them resources for needed prescriptions and care management. Urban physicians, such as those in Macon and Bibb Counties generally "*take more convincing*" to get them to participate because many of them did not have a safety net role and did not serve Medicaid or uninsured patients. Their participation often relies on data that prove the program saves money and has a positive impact on patients' health.

Many key informants find that access to specialists is generally adequate in the program because of the leverage the referring primary care physicians have over the specialists. Reportedly there is implicit pressure on specialists because they know that if they do not accept a CHW patient, that primary care provider may stop referring

other commercially-insured patients. Yet a case manager said that specialists and surgeons in Houston County often initially deny requests to see CHW patients; in those cases, she visits them in person and they usually ultimately agree to see the patient.

Key informants report that, in order to expand the physician capacity and keep current participating doctors from "burning out," CHW must start paying them. One key informant suggested even $10 a visit would help with practice overhead costs; another suggested 50 cents on the dollar. A few others hoped the program would be able to pay Medicaid rates.

Net Contribution of the Program

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

The safety net has "improved dramatically" for the CHW enrollees. Enrollees now 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 needs of its clients, not just the medical needs. Once patients are in the CHW system, they are treated for all of their health care needs, including preventive screenings. Care is not necessarily limited to the four disease states covered by CHW, mostly due to the physicians' wish to treat patients in a comprehensive manner. There is also the added benefit of CHW serving as a forum to bring local health care providers together with a common mission. For example, if a smaller hospital has a pressing need, they may now feel more comfortable in contacting larger hospitals for help.

However, because program enrollment is small relative to need, the program's impact on certain safety net factors is small. Although hospital and ED use for program enrollees has declined, there have not been enough enrollees or experience to see a change in uncompensated care for participating providers. The evaluator indicated that the original plan considered changes in uncompensated care an intermediate five-year goal. Overall, however, uncompensated care at the region's hospitals has been on the rise over the past few years, in line with national trends. Key informants attribute this increase to the weaker economy and increased unemployment leading to an increase in the number of uninsured people, although no one had data to show a change in the number or percentage of uninsured.

Some key informants indicated that the ultimate goal of the program is to improve the community's health status. Providers and other key informants claim that enrollees' health status has improved. CHW administers the Behavioral Risk Factor Surveillance System (BRFSS) questionnaire every six months and a health risk assessment every three months to measure changes in enrollees' health and determine the intensity of care management needed. These assessments find that, overall, patients conditions stabilize or improve throughout their time enrolled in CHW,

although the evaluator remarked that those slight improvements were not significant and that objective changes in health status are difficult to measure. Although enrollees typically stay in the program for an indefinite period, reportedly a fair number of enrollees' health improves enough to allow them to return to work, potentially with health insurance benefits, enabling them to disenroll from CHW and make room for additional clients.

Finally, it was noted that while physicians are now committed to treating these uninsured patients, the level of effort expended by physicians for the uninsured may be reduced. One physician noted that because these individuals are managing their chronic conditions, they are now being seen in his office less frequently.

Conclusions

- The Community Health Works model has demonstrated desired changes in utilization, costs and health status.
- The efforts of CHW have helped create a larger, more collaborative safety net for the uninsured, yet physician participation is not sufficient to allow the program to grow beyond its relatively small size.
- The CHW care management model and information technology system have the potential to create savings for other populations and programs, as well as generate additional dollars to sustain and grow the CHW program.

Sustainability

Funding

In 2003, CHW had an operating budget of $1.66 million. Initial funding for program development was awarded by the RWJF in Phase One of the Communities in Charge program. Currently, 7 percent of the operating budget is contributed by local hospitals, 17 percent by the state of Georgia through grant programs and demonstration funding, and 58 percent by the Health Resources and Services Administration's Community Access Program. The remaining 18 percent of the budget is made up of local and national private foundation grant program support.

The program has had a great deal of success creating funding streams for their case management program for the uninsured. When initially conceived, the development committee sought to have member hospitals provide funding to the state to match DSH dollars so the state could take advantage of the upper payment limit. This initiative had broad-based support from its partners as well as the state's Department of Community Health (DCH) which administers the Medicaid program. However,

when a new administration came into the Governor's office, this funding mechanism was no longer available.

At that time, the program became one that utilized volunteer physicians to provide care to the uninsured. Utilizing data that had been collected in the development process, CHW was able to demonstrate the potential of this program to create a significant return on investment for hospitals. With outstanding leadership from a newly hired Executive Director and the physician community, and a strong quantitative case built for this program, CHW has been awarded several large grants that have been used to develop information system infrastructure and continue their mission of serving the uninsured.

Funding for this program is not sufficient to meet the needs of all of the uninsured in the seven county region, even those who meet the eligibility criteria of CHW. This is demonstrated by the waiting list that is currently in place to receive CHW services. The operating budget is composed of 93 percent time-limited grant funding; therefore, the need for new funding is crucial. CHW is exploring the option of selling services to the state's Medicaid program as an option for financial sustainability. A business plan has been developed which demonstrates the value of allowing a community-based organization coordinate the care of those Medicaid recipient in their region. This business plan has had significant political support; however, the final decision will rest with the current administration.

CHW has a long-term goal of developing products that can be marketed and sold to increase their financial sustainability. A business model has been developed which will allow them to become a provider of disease management services for the Medicaid enrollees in their area. The program has also had success creating an innovative information system that can be marketed to other communities. It was noted that education of local and state policymakers is needed to demonstrate that health care can be more efficiently provided through local collaboratives.

It was also noted by community partners that there needs to be some method of financially reimbursing participating physicians for their services, especially in this time of reduced public insurance reimbursement. Recruitment is hampered by inability to reimburse physicians which results in the program's inability to grow or deliver care to more patients. Interviewees noted that sustainability of the program could be in question if recruitment of providers stalls and the program is unable to grow.

Other Concerns about Sustainability

The sustainability of CHW will be affected in the coming years by a variety of factors including the viability of its financials, its infrastructure, and its political support. Community Health Works is bolstered by the long-standing and continued commitment of their member hospitals. The return on investment of the program to the hospitals surpasses their investment as CHW reduces ER utilization and length of stay in hospitals for its members. Therefore, CHW does continue to have the

financial commitment of their member hospitals to the program. However, these contributions alone will not provide sufficient funding to operate the program, especially if their smaller rural hospital partners continue to deal with difficult economic times. However, CHW will have to face the sunset of several of their time-limited grant programs over the next several years. CHW is strengthened by the innovation of its leadership to develop funding streams that are not grant-related, but must continue to demonstrate the value of this project to members, collaborators, community partners and local and state government to ensure that funding remains available. The program has also developed an innovative information system that could be sold to other community-based programs.

The Executive Director of CHW recently resigned and the COO is now acting in her stead. In interviews it was stated that although there is faith in this individual, there is significant concern that the loss of the former Executive Director might result in a loss of momentum for the program. However, community partners asserted that their involvement would not be affected due to this staffing change. Continued involvement of staff, physicians and other providers is essential to ensure the sustainability of this program; therefore, relationship with partners must continue to be created and strengthened.

The political environment in the state is always a factor in the success of community programs, including Community Health Works. For example, an administration change resulted in the loss of the expected financial investment from DSH dollars. Fluctuations in Medicare or Medicaid reimbursement rates can change the willingness of a provider to accept patients without reimbursement or a hospital to make financial contributions to the program. Overall, the community seems committed to the project.

Conclusions

- Currently, 93% of the operating budget of the program is collected from a combination of grant program awards from state and federal government, and local and national private foundations.
- A business plan has been developed by the program to develop new funding streams which demonstrates the value of allowing a community-based organization coordinate the care of those Medicaid recipients in their region.
- The return on investment of the program to the hospitals surpasses their investment as CHW reduces ER utilization and length of stay in hospitals for its members.

Replication

Beta Site Development

The current programmatic model of CHW reportedly took its primary inspiration from Project Access in Asheville (Buncombe County), North Carolina, approximately 4 years ago. It was thought that this model was the best fit for the community given the minimal flow of Federal and state dollars in the region. Executive Directors of Project Access beta sites were also consulted in the construction of the current CHW model. Some of these sites included Project Access in Wichita, Kansas, Project Access in Austin, Texas, and Access Emmanuel in Swainsboro, Georgia.

In the replication process, the leadership of the alpha site (Buncombe) visited once to share their experience with the stakeholders in the region. Further onsite consultation costs were said to be prohibitive, so phone consultations with other secondary sites were used to help guide the process. During its formation, the leadership of CHW also gained valuable insight from traveling to a few other sites such as Austin, Texas, where the use of a Master Patient Index was observed and incorporated into the design of its plan.

The Georgia Health Policy Center, with its experience in the development of rural health networks, was credited as the catalyst for CHW by acting as neutral facilitators for the initial contact between the leaders from the alpha and beta site communities, as well as the meetings necessary for building local collaboration. They were also credited with providing ongoing analyses of data (from hospital discharge and physician clinic surveys) that would set the parameters for eligibility by disease or diagnostic codes and allow for program evaluation.

The CHW program design differs from the alpha model in a number of ways:

- *Number of Counties*. Community Health Works incorporates seven contiguous counties as compared to single county entities that are found in other Project Access communities. These counties were based on hospital market patterns. Given the prevailing culture of non-cooperation across county lines, it was a challenge initially to get the involved counties to work together. Key informants felt CHW had managed to change that culture; local leadership now views healthcare as an important issue. The initiation of the program was in a single county (Monroe) before the stepwise introduction of the others so as to prevent overload and capacity stresses on the system. The more urbanized counties were brought in later though all the county boards were on board at the start-up.

- *Medical Society Involvement.* In the usual design of Project Access, the local Medical Society is the administrative "home" of the program. This was not the case with CHW, where the only active Medical Society in Bibb County opted out of any direct involvement but committed its "backing and support

for the mission and principles" of the program. This resulted in another slight variation on the use of a local physician champion to aid in recruitment of clinicians. Though the Medical Society was not involved in this regard, two physician champions were identified by key informants. One key informant observed that they were not as successful in recruiting physicians as the Buncombe group.

- *Eligibility.* Though the original criteria of income (less than 200 percent FPL) and insurance status (19-64 years with no other form of medical insurance) remained the same for both the alpha site and CHW, the eligibility of the latter also included the characteristic of diagnostic codes. CHW decided to concentrate its limited resources on specific diagnoses based on the analysis of discharge data suggesting that depression, hypertension, heart disease and diabetes were the largest "consumers" of uncompensated hospital care in the region. This meant that only approximately 7,000 persons would be potentially eligible for this program.

- *Care Management.* With the exception of a program in Pittsburgh, the care management element of the CHW initiative is unique. Disease management approaches are utilized to reduce the consumption of ER services by chronically ill patients. This is not dissimilar from what occurs in some other Project Access sites, but the use of care coordination services supported by a highly integrative IT system has provide the basis for tracking and evaluation of users of the system.

- *Funding.* City and county governments play a fiscal role in most Project Access sites, usually by making funds available for pharmacy assistance. In this case, however, the funding has been provided by participating hospitals, many of whom use some portion of their ICTF dollars to make this happen. Like other similar communities, there was in the initial start-up period a reliance on grant funding including Robert Wood Johnson and HRSA-CAP funding.

Grant funding from the state and federal government as well as private foundations have been pivotal to the replication process. These funds have been used to develop the infrastructure necessary to manage the CHW programs, as well as providing the program with funding to develop their innovative IT program. This program has been sought after by other communities, and will hopefully provide sustainability to CHW.

The state policy that has been most instrumental to the operation of CHW is the provision in law requiring a 15 percent "set-aside" of ICTF dollars for the purposes of primary care. This has allowed the group to be beneficiaries of a portion of the draw down from hospitals of these federally matched dollars to be able to provide care. The program is now faced with the reality that as ER utilization changes and the cost of uncompensated care decreases, fewer ICTF funds into the system and hence the operation is jeopardized over time. It also appears that there was some significant

state involvement in the group procuring the initial Communities in Charge grant award from the RWJF.

At the local level, the great enthusiasm of county leadership and hospital buy-in reported at the front end of the program has sustained its replication to date. The fact that many of the local physicians were already engaged in "pro bono" service provision to this population was said to have helped initially in getting at least some of them on board. Many of the persons interviewed viewed physician recruitment as one of the weak areas of the program; many primary care physicians located especially in the more relatively urban areas have not yet gotten involved. There is also widespread disappointment that Coliseum, one of the major for profit hospital systems in the region, was not an initial participant in the initiative and has opted not to participate to this point.

Prospects for Further Replication

To date, though much energy had been expended responding to inquiries from other communities, none had actually replicated the exact model in place at CHW. The care management aspect of the model was described as being the most replicable part of the program. Project Access in Wichita, Kansas, an earlier beta site of the Buncombe model, was said to have successfully replicated that element by incorporating it into their original program model. Another community organization in Spring Creek GA was also said to have replicated the care management piece of CHW's program.

Most of the stakeholders interviewed believed that the initiative was replicable but varied in their views about which conditions would be necessary for successful replication. In describing the factors that had been critical to the success of CHW, most of the key informants indicated that the energy and commitment of the executive leadership of the program (and in particular the ED) was the most pivotal. Other factors thought to be important were:

- Visionary leadership from reputable persons in the community
- Willingness of CEO's of hospitals be collaborative partners
- Ability to put together a good IT software system
- Commitment of board
- Support of local and state politicians
- Energy
- Trust
- Behavioral health being a significant issue

- Engagement of doctors
- Ability to negate potential adversarial relationship of hospitals
- Relatively large hospital acting as the hub in a small rural area

Key lessons learned include:

- Leadership is critical and being a pioneer is very challenging.
- External and neutral facilitation and technical assistance is critical.
- The program should be based on sustainable funding which will not evaporate after a few months.
- The energy of the CEOs must be transmitted to the clinical staff of their institutions.
- Primary care physicians should be on board earlier and given an incentive for offering their services.
- Culture, clientele and funding mechanisms should be carefully examined before taking on a specific model.
- The process is going to be slow; take a good faith pill
- It is important for the hospitals to see the savings that the program is making for them.
- Program should be based on community needs.

Conclusions

- Visionary leadership and energy are key to the successful of replication of this program.
- There was a need for a brokered relationship between the alpha and beta sites to ensure a successful initiation.
- The care management aspect of the program was thought to be the most replicable part of the model.

State/ Community Interface

Community Support

The history of the relationship of this program to the state was varied in its beginning and continues to be dynamic. At the outset of the program the state was also said to be pivotal in assisting the community in procuring the RWJF grant by the involvement of the Commissioner of DCH lobbying on their behalf for funding. Funding for the initial model of CHW was designed to come from DSH dollars; however, due to political changes, that funding failed to materialize.

The program model of CHW was said to be complementary to, and supportive of, state public insurance programs. From the perspective of the enrollment services, CHW case managers were involved in assisting uninsured persons to enroll in public programs. For 2003, they report assisting 58 persons with applications for social security and another 60 individuals with applications for Medicaid and PeachCare. Many thought the program was a natural fit with Medicaid using ICTF dollars or perhaps by using a waiver. One observer also felt that, although Medicaid would be the natural fit primarily, Medicare could benefit from the coordination of care aspect of the program especially in a managed care environment. The leadership of CHW recently made steps towards creating a link between the program and Medicaid by proposing to the state the previously discussed care management option. State key informants cited budgetary restraints as a significant obstacle to the implementation of this proposal in the near future.

From an operational standpoint many of the individuals interviewed opined that the support of public programs might also be measured in the "huge" savings to the average taxpayer and public insurance due to the reduction in the cost of care associated with CHW clientele. Further key informants believed that the specific focus on that segment of the population was in fact filling a void in an area for which the state had no solutions.

State Support

Generally, the state is perceived to support the program, even though few state dollars have been allocated to it. Some financial support is indicated in the Statement of Activities for 2003 which shows CHW being the beneficiary of two grants (including a demonstration project) through the DCH for approximately $230,000. Although most persons interviewed felt that there was a strong relationship between the state and the community, a few expected that with time and continued economic challenges, state support would be unlikely to continue.

ICTF legislation is also supportive of community primary care programs such as CHW. A stipulation that requires 15 percent of ICTF dollars be allocated for use in primary care has continued to enable the operations of CHW. In addition, a former state representative, who has a medical background and is on the Governor's Task

Force for a Healthy Georgia stated his intention to suggest state level backing of programs such as CHW throughout the state. Legislatively to this point, there has not been a necessity to enact or amend laws to allow CHW to operate.

State or National Barriers

One of the biggest barriers to community success has been the state's inability to allocate more money to the program. Other barriers or concerns expressed about the viability of the program include:

- *Changing cast of characters.* Multiple individuals expressed the great challenge of having to educate government officials after administration changes. Most felt that they were starting from almost ground zero to build rapport and interest. This was the case following elections in 2002.

- *Community being seen as a viable vendor of services.* Some persons felt that the state did not always see small community collaborations as vendors or collaborative partners. This may continue to adversely impact the state's funding stream to these programs.

- *Liability coverage.* A few key informants felt that a change in the state's liability coverage laws that would hold physician providers harmless would remove the barrier for greater clinician involvement. It was also felt that perhaps some legislation could be passed providing for a tax write-off for services offered by providers to achieve the same goal of greater participation rates.

- *Federal and state apathy.* There is not agreement about acting to solve the problem at more central levels. As one key informant summed up the situation, "*Federally it makes no sense that the richest country in the world has a safety net insurance system that provides the worst ineffective kind of socialized medicine*."

Conclusions

- The state is supportive of the program but is hamstrung in its ability to allocate dollars to the program.
- There is a recognized potential of this program to be incorporated into or to work in tandem with state Medicaid programs.
- There is a perception that the state does not see these community initiatives as viable collaborative partners.

Georgia Health Policy Center
14 Marietta Street, Suite 221
Atlanta, GA 30303
404-651-3104
www.gsu.edu/ghpc