

Community Health Access Initiatives

National Health Policy Forum
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Project Access:

Voluntary Physician Led Access to Care

- Buncombe County, NC – now 210,000 + pop
- 1994 RWJF grant–Health Partners–assessment
 - Buncombe County Medical Society
 - County Government
 - Faith-based
 - Hospital
- 1996 Project Access – serving patients, donated care
- 1998 Ford Found – Innovations in Gov Award
- Additional grants
- County added 3 community primary care clinics
- Continuous operation to date
- Growing operational replications nationally

Population of Concern

1995 Buncombe Co Survey

- Est 15,000 persons
- < 200% FPL
- Uninsured
- Lower age, education, married, employed
- Perceived poor health (17% v 6%)
- Higher risks – smoke (49%/22%), sedentary(73% v 57%)
- More depression (40% v 18%)
- Less have designated provider (57% v 79%)
- Not seen MD in year (51% v 7%)
- More ED use (28% v 12%)

Voluntary Vertical System Solution

- Primary Care – mostly public health clinic
- Specialty Care – majority of private MD's
- Hospital-based – dx, rx, out-pt/in-pt. (brain surg)
- Pharmacy – all retail pharmacies
(formulary)
- Enabling – reminders (BCMS), transportation
(County)
- Disease management
- Timely, systematic, coordinated
- No cost to patients but pharmacy adm fee (\$4)
- ED visits not covered unless admitted as in-pt.

Voluntary Vertical System Solution

- County does enrollment – low income/uninsured/need
- Refer to DSS for Medicaid enrollment as approp
- BCMS maintains the referral process – pledges and ref's
- Primary care primarily county clinics
 - Some private practice (10 pts/yr) – All donated services
- Specialty primarily private MD's – All donated services
 - Faith-based clinic or in practice
 - 20 pts/year
- Diagnostic, therapeutic and hospital referrals like insurance but No Pay – All donated services
- All retail pharmacies take PA Rx card – PBM pays pharmacies and County pays PBM
- BCMS resp HCFA 1500/UB 92 collection/reports

Enrollment

- < 200% FPL
- Uninsured
- Have medical need
- Referred by safety net clinics/MD's
- Formal enrollment with ID card
- Personal responsibility form – miss < 3 appt's
- Ave enrollment ~ 6 mos

Evaluation

- Continue > 85% of all MD's participation
- Added county primary care sites
- Productivity of main primary clinic ~ 2x
- 24,000/25,000 primary visit (2004)
- 2,800 received specialty/hospital (2004)
- ED use 8% enrolled vs 28% prior
- > \$3 million/yr in MD care
- ~ \$2.5 million/yr hospital care
- 22% reduction in HC costs/uninsured

Evaluation – cont.

- 33%/44% rate of employment enroll/roll off
- 25% stated PA helped get job/>perform
 - 17% report less absenteeism
- 80% health better/much better
- 25% with insurance in f/u
- SF-12 no diff with insured

Administration

- 0.25% FTE Director
- 1 FTE adm asst
- 0.75% FTE clerical
- Physician volunteer Board
- Software
- Pharmacy (\$650,000)
- Third party adm function for “claims” analysis
- ~ \$7 pm per year adm (excl pharm) from County

Motivation: Physicians

- Traditionally donated care – unrecognized (1/3 unin'd)
- Non-systematic – inefficient, fragmented
- Now can refer
- System to support – efficient, quality
- Patient responsibility
- Fair and finite
- Mitigate ED call burden
- Ease of administration -truly in need, HCFA 1500
- Liability protection
- Professional fulfillment – camaraderie/renewal
- Community recognition (annual) – enhanced standing/clout
- Subtle sanctions for non-participating

Motivation: Hospital

- Traditionally donated care
- Report ave \$3 million annual charity avoided
- Partnership with medical staff
- Community recognition

Motivation: County Government

- Adds value to public safety net expenditure
- Achieves leadership vision
- Significant community draw – retirees
- All American City designation - businesses
- Incumbents run as “Healthy Asheville” candidates

Project Access Replicability

- > 13 NC counties with operational PA
- Nationally
 - Wichita, KS, Spokane, WA, Austin, TX, Dallas, TX, Marquette, MI, dozens in process
- Urban and Rural
- Starts with leadership
- Finishes with partnerships that assure system
- Strong peer benchmarking component
- American Project Access Network – www.apanonline.org
- Communities Joined in Action – www.cjaonline.net

Project Access

Replication Keys

- Runs on “enlightened self-interest”
- Physicians will often enough rise to rational approach
- Physicians generally must lead their effort
- Convening is initiator
- Run on generally accepted principles of health system
- Need for broader community pub/priv sector role
- Adjunctive to paying market

Local Health Access Initiatives

Local Health Access Archetypes

- Outreach for traditional programs
- Faith-based/CBO programs – Jesse Tree, Galveston
- Free clinic programs - VA
- Community Health Center Networks - Milwaukee
- Local government systems – Denver Health
- Safety net collaboratives – HCAP, rural
- Volunteer plans – Project Access
- Multi-share coverage programs – 3-Share
- County sponsored coverage - FL
- Hybrids/other

What Communities Want

- Better Health for
- More People for
- Less cost

ACCESS AND DISPARITIES ELIMINATION
FOR ALL COMMUNITY RESIDENTS IN A
SUSTAINABLE WAY

Community Access Initiatives

Role in National Solution

- Fundamental Equation =
 - get everyone into timely, systematic, accessible, acceptable, quality, affordable health and enabling services
- Coverage, when possible – market will serve
- Safety net system – when no coverage AND for broader services needs for vulnerable populations

Convergence of Opportunities for Local Health Access Initiatives

- Increasing cross-sector convergence of interests
- More proven strategies for cost cutting/revenue
- Some funding from government and foundations
- Growth of HIPAA compliant web-based systems
- Growth of peer exchange organizations
- Growth of technical assistance/transfer organizations
- Communities can't wait passively

Community Access Initiatives

Role in National Solution

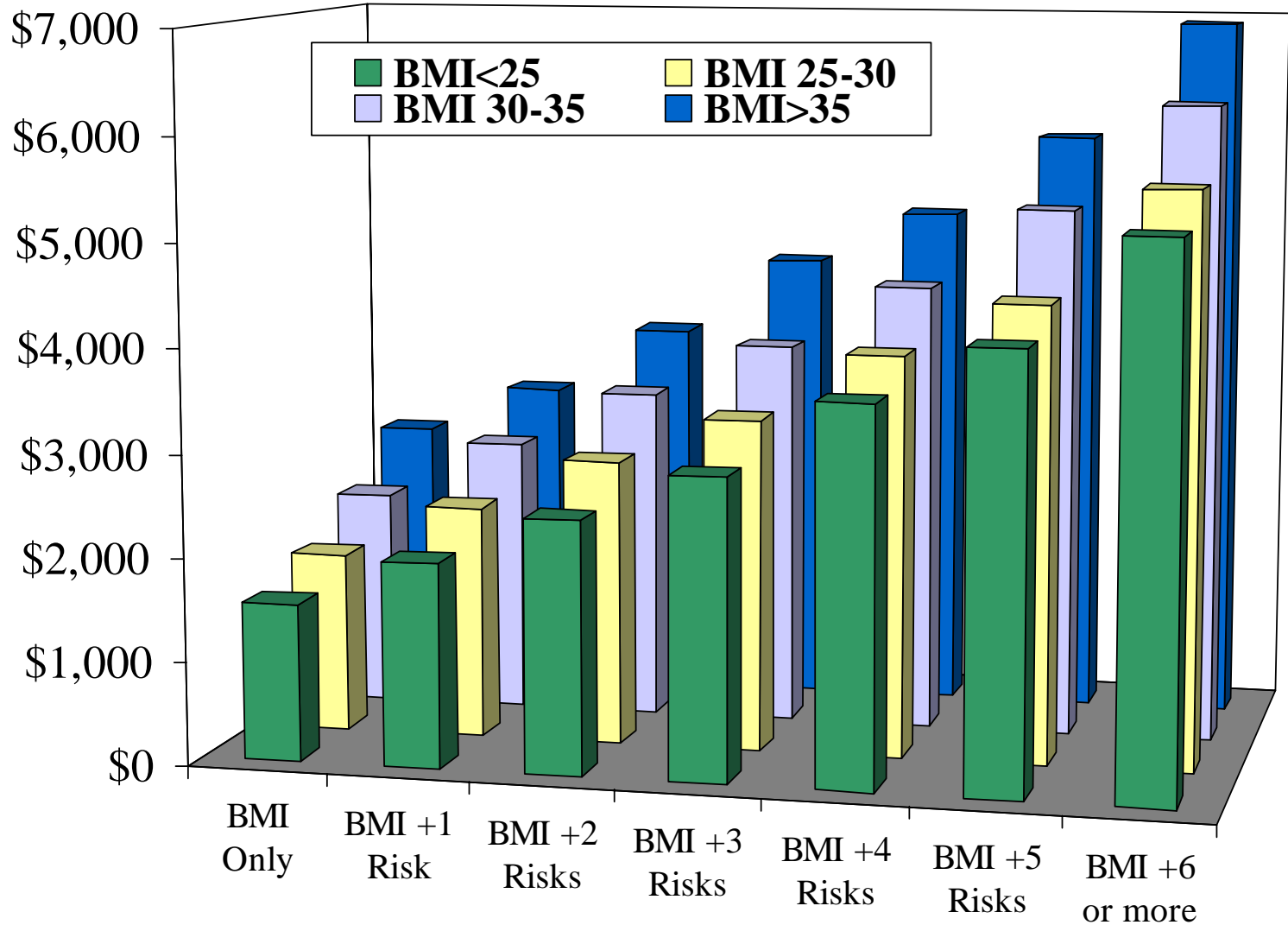
- Health care is NOT zero sum gain
 - Can alter the health and health care utilization signature of a population
- All about value – prevention (pre-emption), effectiveness (improved health), efficiency (productivity)
- Optimizing value require cross sector coordination, discipline, feedback cycle
- Resourcing can be direct funding (3-Share) or cost containment (cost-shifted) (Project Access)

Community Access Initiatives

Role in National Solution

- Models today speak to distinct initiators and developmental tracks – coverage, voluntary
- Ending points have more in common than not: vertical panels of services providers in deliberate referral/enabler relationships for target population outreach/vetted by community process
- Intent to drive population risk -> ~ primary acuity

GM Cost for Weight plus Additional Risk Factors



* Average annual paid health care cost (including pharmacy) from 1997 to 2000; N=222,933.

Community Access Initiatives

Role in National Solution

- Local initiatives can broker partnerships to:
 - Best understand and meet particular needs of local population
 - Establish local program buy-in
 - Align federal, state, local public dollars/programs
 - Negotiate with local health care providers
 - Engage personal and employer private funding

Community Access Initiatives

Role in National Solution

- Can provide additional leveraging options to meet various uncovered subpopulations between Medicaid and commercial
 - low income working – 3-Share
 - lower income working/nonworking – Project Access
- Can compliment State efforts
 - Ex. local subsidy to expand state premium subsidy or state “3-Share”

Getting to the Next Level

Where communities' relative starting points may vary...

...each community can identify and realize “the next level” of capacity for health services.

Community Health System Design

- Simply run on:
 - Prevailing clinical guidelines and case/disease/demand management
 - Generally accepted principles of integrated delivery systems
 - Market approaches to health sector administration, including e-Health
 - Increasingly available and affordable information systems

National Lessons Learned for Local Coverage Initiatives

- Communities can develop products at the local level
- Variety of Vehicles:
 - as insurance (Jax, Brooklyn)
 - as non-insurance direct purchase, ex. 3-Share
 - As managed care, ex. Hillsborough, FL

National Lessons Learned for Local Coverage Initiatives

■ Community funding sources:

- Local public funds- ex Jacksonville; Hillsborough, other FL
- DSH local match(no state \$) - ex. MI, LA - pending
- State – ex. Brooklyn, NY (Healthy NY)
- Grants - ex. Ratcliff, AR: San Diego, CA

National Lessons Learned for Local Coverage Initiatives

- Experience to date is that utilization and medical costs are modest
- Improve health of population and costs by better managing chronic or high acuity cases and emphasizing prevention
- Can reduce cost of population relative to expected growth

- BUT, scale of impact has been small!!

What Successful Communities Run On

- Leadership
- Cross Sector Inclusion
- Shared vision and goals
- Appeal to both mission and margin
- “Fair and Finite”
- Reciprocal accountability
- Enlightened Self-Interest
- Community/Political Will-building

Community Access Initiatives

Potential State and Federal Roles

- Leadership
- Policy – new federalism
- Convening – State and local gov, marketplace
- Expertise
- Ease of linkage with programs
- Translation/replication support
- Incentives – grants
- Recurring funding
- Administrative support
- Evaluation support

Local Access Initiatives

At the End of the Day...

- Through their actions and inactions, communities decided the level of health and well-being of their residents.
- The limit to a community's capacity for accessible, quality, affordable and sustainable health-related services is the level of cooperation the community will muster.
- These models demonstrate that, by dealing successfully with the intangibles of partnering, an abundance of tangibles assuredly follow.
- How can national policy better engage this secular phenomenon of inclined communities and systematically leverage its potential as a key feature of "the American Solution" to health care?

For more info:

- Communities Joined in Action
 - www.cjaonline.net
- American Project Access Network
 - www.apanonline.org

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