An Environmental Scan of State and Local Healthcare Reform Efforts

By
G. Abraham Dabela
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Abstract

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By Gugsa Abraham Dabela
CBMP Preceptors: Marcia L. Comstock, M.D., M.P.H.
Carol A. Staubach, M.P.H.
CBMP Advisor: Mary G. Duden, M.B.A.

The healthcare system in the United States is widely regarded as the best in the world. Unfortunately, the ability of the system to survive in the face of rising costs and decreasing financial resources is the topic of considerable debate. The need for healthcare reform in the near future is something that many experts agree on. Wye River Group on Healthcare is a non-partisan consultant conducting an environmental scan of domestic healthcare reform efforts with the goal of compiling a list of "best practices" for healthcare reform. Wye River Group on Healthcare will then be uniquely positioned to advise national reform efforts on these best practices. In support of their goal, this Community Based Master's Project utilized internet sources to compile a list of successful state and local reform efforts with measurable results that showed the characteristics of replicability and scalability. The goal of this project was to find common characteristics in these programs that helped ensure that they achieved their goals of addressing cost, quality, or access. The characteristics uncovered in this project were: dedicated funding streams, collaboration, primary and preventive care, and service utilization management. These four characteristics and their subcategories represent recurring themes that helped to ensure the success of the programs they were a part of. Wye River Group on Healthcare will continue the environmental scan by delving deeper into the reform efforts covered in this community based master's project in order to learn more about implementation strategies, and the intricacies of the four characteristics discussed in this paper.

Introduction

Healthcare Today

The National Healthcare Crisis

The healthcare system in the United States is at a crossroads. It is generally accepted that the system is in trouble due to rising costs and decreased insurance coverage. As insurance companies try to contend with rising costs, they begin to price more and more individuals out of the market leading to a downward spiral in coverage and higher costs due to uncompensated care. The aging baby boomer demographic will be leaving the workforce, their care and security supported by fewer American workers.

Healthcare costs have been increasing at an alarming rate. Annual expenditures increased by 7.9% in 2004.[1] In 2004, Americans spent $1.9 trillion on healthcare and this number is expected to double by 2015.[2] This represents 16% of the nation's gross domestic product. With increasing numbers of Americans facing the prospect of long term illness in the form of diabetes, heart disease, and obesity their own productivity will diminish while the cost of caring for them increases. This grim set of circumstances calls for innovative means to find solutions.

Insurance Coverage

Insurance coverage has been decreasing for Americans. Currently there are 46 million Americans without health insurance. Programs to combat lack of insurance have been in place for many years through Medicaid but a growing number of Americans exist in the gap between Medicaid coverage and commercial insurance coverage. Fully 80%[3] of uninsured people are employed individuals. The traditional employment-based health insurance model is quickly becoming a thing of the past as many employers stop offering health insurance, and employees either choose not to purchase insurance or simply cannot afford to purchase insurance. The majority of the working uninsured are working for small businesses. These small businesses are the hardest hit by increases in premium costs, often over 15% per year. These increases force many employers to cease to offer insurance to their workers. The consequences of lack of insurance are well recognized. The Institute of Medicine has called lack of health insurance "life threatening" through various avenues from lack of primary care to substandard care for serious injury.[4]

The fastest growing segment of the uninsured population is individuals and families with annual incomes over $75,000. This segment experienced a 9.1% jump in size from 1999 to 2001 and currently numbers approximately 6.6 million persons. Clearly, lack of insurance is affecting more and more high-income, and employed individuals than in the past.

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[1] National Coalition on Health Care, 2004
[2] National Coalition on Health Care, 2004
[3] Regence Blue Cross, Oregon 2006
[4] Regence Blue Cross, Oregon 2006

Healthcare Reform

The healthcare reform landscape has been fertile since the late 1980s with local, regional, and state-based programs emerging to address cost, quality, and access. These programs have met with varying levels of success. Now is an excellent time to survey such efforts with an eye toward what might be relevant on a national scale in the coming years. Wye River Group on Healthcare is conducting an environmental scan of which this is the first step, a search of the nation's numerous healthcare reform efforts and a discussion of their strong points with regard to their replicability and scalability to the national stage.

Wye River Group on Healthcare

Wye River Group on Healthcare (WRGH) is a nonprofit, nonpartisan organization with the goal of examining the healthcare reform landscape in the United States. For the last four years WRGH has been surveying healthcare stakeholders from across the country to develop a clearer picture of just what healthcare means to Americans. WRGH has done this by hosting roundtable discussions where stakeholders meet to share their views on what they expect of healthcare institutions, practitioners, patients, financiers, regulators, governmental, and nongovernmental entities. WRGH is interested in formulating a "one-voice" message to all Americans outlining what kinds of things must be done in order to rescue the healthcare system from the crisis it finds itself in. The lack of a singular voice has meant that stakeholders have been competing for their own narrow self-interests at the expense of a cohesive plan of action for addressing rising costs, and decreasing quality and access. For many years we have seen hospital failures, rising costs, and increasing numbers of uninsured Americans.

When the time comes for major national reform, WRGH will be well positioned to advise legislators and regulators about the kinds of practices that have been successful at reforming the system on the state and local levels. It is the goal of WRGH to define key components of successful reform efforts that can be replicated across the nation, and more importantly, scaled to the federal level at the appropriate time.

Study Aims

A. To determine which state and local, public and private programs have had significant success in improving healthcare finance and delivery.
B. To determine what factors are common to the most successful healthcare reform programs captured in the scan.
C. To outline key components which are scalable to a national reform plan and what key elements must be present to support of these components.

Methodology

Information Sources and Program Profiles

Data for this project was gathered from five primary internet sources:

1. The Commonwealth Fund
   http://www.cmwf.org

2. Agency for Healthcare Research and Quality
   http://www.hsrnet.net/ahrq/newleg/

3. Kaiser State Health Policy
   http://www.kff.org

4. National Governors' Association Center for Best Practices
   http://www.nga.org

5. National Academy for State Health Policy
   http://www.nashp.org/

6. Wye River Group on Healthcare
   http://www.wrgh.org/

Inclusion Criteria and Areas of Interest

Programs that were described through these five policy outlets were then analyzed in detail using information they made available via the internet. In order to be included in the scan, programs had to show measurable results in whatever area they intended to improve. The majority of the programs scanned improved access to services by covering more of the population using an insurance model. Improvements to access often had benefits realized in terms of cost reductions and improvements in quality. Some other areas of improvement were reductions in emergency room encounters and their associated costs, as well as improvements in visit times, and reductions in billing errors.

Out of these analyses, Program Profiles were constructed which describe each program in terms of impact and aims. The categories or areas of interest, which make up the Program Profile include: Aims, Scope, Collaborators, Funding Source, Summary, Direction, Duration, and Outcomes.

The ***Aims*** category highlights the specific "arm" of healthcare reform the program was intended to address, cost, quality, and access. Many of the programs were initiated to address one specific leg, but through their mechanism had secondary benefits realized in one or both of the remaining arms. The most common association was between efforts to address cost which resulted in increased access because of the significant linkage between access to primary care and overall cost savings.

Program scope was defined as the scope of the program, whether state, county, city, or other area designation.[5] Scope was mainly a geographic designator which often impacted the number of institutions participating in a given program and the number of people serviced.

[5] See Appendix: Inland Northwest Health Services

The ***Collaborators*** segment was used to describe the participants involved in planning, implementing, and operating the programs. For example, state and local governments, private sector healthcare, private sector businesses, and other types of participants who contributed cash and in-kind donations as well as agreements to provide services, or in some cases to campaign for quality improvements.

The ***Funding Source*** category outlined just how programs obtained funds for start-up and operations. The many and varied methods employed for paying for reform efforts were novel and not always replicable. The innovative means for obtaining funding was a universal theme and this paper will outline some of those means.

Summary, Duration, Direction and Outcomes is a descriptive category used to outline the program in some detail. This is the most detailed segment of the Program Profile and provides sufficient opportunity to highlight the strengths of each program as well as its history and accomplishments.

Analysis Strengths and Limitations

The Program Profiles were useful in quickly comparing the basics of each program in order to determine which programs had certain strengths in common. These strengths could then be analyzed for similarity, in detail, and finally for the scalability, and replicability that Wye River sees as relevant to reform efforts at the national level.

Some challenges to this methodology came in the form of the metrics analyzed. With no easy means for quantifying the degree of collaboration, or aims, these had to be simply described in the best way possible. In some instances, programs outlined the number of participants, or provided other quantifiable means for gauging their success:

- Access improvements would result in an increased number and percentage of eligible individuals obtaining services.

- Cost improvements were often stated in various terms of cost per individual, cost per emergency room encounter, and other such concrete means of measuring improvements.

- Quality improvement measurement was often elusive because of its qualitative nature. Some programs attempted to measure quality in terms of reductions in visit cycle times, billing errors, and readmissions.[6]

Not all programs attempted such measurements and so this measure was often less than reliable for comparing programs, while being useful as an example of a method for comparing quality improvement across programs.

Some limitations of the analysis resulted from the differences in the type of data reported by programs, the depth, and perhaps most important, adequate description of program

[6] See Appendix: New York Primary Care Development Corporation

history. Perhaps the most important means of gauging a program's replicability is reviewing its history of implementation. A description of how a program was implemented, which entities were instrumental in making things happen, and how parties were encouraged to participate is perhaps the most important metric when it comes to program analysis. Unfortunately such information is often lost in the rush to post quantitative results when programs seek to continue operations in the face of oversight and limited funding.

From a policy standpoint, implementation history is a crucial element to program analysis. Unfortunately this information could not be gleaned reliably from the internet sources of the programs scanned. Only in rare instances were descriptions of implementation challenges to the programs actually discussed. As part of Wye River's environmental scan, this element will be addressed through targeted interviews with key players in successful programs. It is hoped that such information will be brought to light through this avenue of research.

Results: What works

There are several components of successful healthcare reform efforts that appeared repeatedly throughout the research which was conducted. These characteristics, broadly defined were:

- Dedicated funding
- Collaboration
- Primary and preventive care
- Service utilization management

There are various subcategories within these four characteristics that are specific to certain types of reform efforts. For example, employer-based pay-or-play schemes function as dedicated funding streams to bolster Medicaid contributions from states in order to cover employees of companies that do not insure their employees. In addition to such program-specific nuances there are instances where certain components serve to address primary and preventive care via a utilization management strategy, and still other instances where one exists without the other. These components are crucial to the success of programs meant to address rising costs, and decreased quality and access.

Discussion: Characteristics and Strategies[7]

The characteristics that emerged from this segment of the environmental scan are, generally replicable and scalable to larger areas. When it comes to funding streams, the more contributors to a funding pool or "healthcare tax," the lower the burden is on each contributor, resulting in a positive feedback system of greater participation and decreased individual burden. In many instances, the more participants a system brings together, the more effective collaborative efforts will be. The caveat to this idea is that there must be greater operational simplification with larger collaborations in order to assure that the system will not collapse under the weight of administrative and operational hurdles.

[7] See Appendix for Program Profiles

Increasing access to affordable primary and preventive care will result in improved public health from which society will gain in terms of productivity and prosperity. Finally, proper service utilization, when seamless and in some cases invisible, can provide a comfortable level of care and ensure accurate matching of service to sickness.

Dedicated Funding Streams

The presence of a dedicated funding stream is a common component of successful healthcare reform initiatives. Those initiatives that have endured with successful results have done so because of reliable funding that has come in many forms. Care pools are a mechanism to pay for healthcare costs for indigent patients by recognizing that such care is part and parcel of a community's demographic. Perhaps most progressive in nature, the simple agreement on the part of localities to pay for the care of indigent patients through municipal funding budgeted, or taxed for, seems to be a very effective means for caring for large numbers of citizens. Finally, Medicaid expansion is a common form of increasing coverage for state residents.

Funding Pools

One method of obtaining dedicated funding is through the use of funding pools. Georgia and Massachusetts have both established funding pools as a means of defraying the costs of caring for indigent populations. In Georgia,[8] this program is called the Indigent Care Trust Fund.[9] The program serves to redistribute monies to so-called Disproportionate Share Hospitals (DSH)[10] in the state. This serves to keep hospitals that care for those less well-to-do patients in business. The trust fund also serves to pay for programs that help those indigent patients gain access to primary and preventive care in order to ensure that they do not incur higher costs through lack of access. In Massachusetts,[11] the Uncompensated Care Pool[12] serves to care for indigent populations in the state and all hospitals contribute to the fund. In 2004, the fund collected $693 million from hospitals, insurers, federal DSH payments, and tobacco settlement funds to make up the pool.[13] The Massachusetts program pays providers a portion of the claims they submit to the pool for uncompensated care. The funds are expected to be used to fund primary care programs for indigent patients. Some participants have used the money to enroll patients into a free care program that ensures that they see primary care. These programs function as "health plans" for eligible patients to access primary and specialty care as necessary. In recent years, the pool has streamlined administrative operations as well as switched to a prospective means of paying for services rendered. The program also does not pay for services rendered to patients in a hospital setting within 15 miles of a community health center that could offer the same, appropriate, level of care.[14]

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[8] Appendix Profile #5
[9] GA Department of Community Health, 2006
[10] Disproportionate Share Hospital Payments are extra Medicaid funds distributed to hospitals that provide a disproportionate share of care to non-paying or Medicaid eligible patients.
[11] Appendix Profile #9
[12] The Commonwealth Fund, 2004
[13] The Commonwealth Fund, 2004
[14] This is an important component of service utilization management that the program enacted to cut costs to the pool

Taxing and Budgeting

Two interesting programs have emerged from the scan as being quite novel in their approach to caring for indigent populations. In Hillsborough County, Florida,[15] a 1/2cent sales tax was enacted to pay for comprehensive healthcare services for eligible patients in the county. In a very short time, the program proved effective at lowering costs per covered individual, as well as reducing the frequency of ER encounters with patients in the program. The program was so successful that the sales tax was cut in half due to a surplus of funds. In Milwaukee, Wisconsin,[16] the county budget includes appropriations for caring for the county's indigent population. This budget item is included in each budget alongside emergency services and other necessary budget items. The county has recognized that the problem of indigent care is not going away, and so decided to deal with the issue head on. The Milwaukee program funds primary care services as a purchaser of them, rather than a provider. This program was created in response to the closing of the county hospital in December 1995.

Medicaid Expansion

A common theme in state-level programs to expand access has been to expand Medicaid eligibility to individuals and families at 100%, 200%, and even 300% of the Federal Poverty Level. This increase in the number of covered individual makes the state eligible to receive more federal funding. By expanding coverage to less costly individuals, such as children, the state attracts more money for more costly indigent adults. This method has been replicated across the county as states and even localities attempt to attract Medicaid funding through State Children's Health Insurance Programs (SCHIP.)

Community Collaboration, Not Competition

Community healthcare systems have long been in competition for technological advancement, patient mix, and ultimate financial solvency. Recent trends show that healthcare providers are having a harder time maintaining financial well being in the face of rising costs. In an environment of shrinking financial resources, collaboration, not competition, will be the saving grace of future operations. In the course of this scan, reform programs that emphasize collaboration end up being sustainable because they share the burdens and risks as well as the rewards of providing care to communities. These programs recognize that communities will always have uninsured, uncompensated care, and limited financial resources. Operating in such an environment, with competitive and short-sighted narrow self-interest leads to failures in the long term. A hospital that successfully outcompetes its neighbors will eventually find itself picking up the pieces after its competition fails. It is in the interest of all stakeholders to share the burdens and risks of caring for populations and collaboration is the key to success.

Cooperative Charity Care: Coordination plus Continuity

While dedicated funding streams in the form of care pools and trust funds are a good means of collaboration, there are many ways in which healthcare competitors can work together to become allies in care. An excellent example of such collaboration started in

[15] Appendix Profile #6
[16] Appendix Profile #10

North Carolina[17] and has expanded across the country as The American Project Access Network. This program enlists the efforts of healthcare providers in a locality or state to coordinate the charity care they provide citizens. By coordinating charity care rather than each site acting independently, often competitively, costs are minimized and access to care is improved. The full continuum of care is provided, which results in improved outcomes. Project Access accepts cash and in-kind donations from community businesses and healthcare providers to pay its administrative costs and help cover the cost of prescriptions for indigent patients. Primary and specialty care coordination as well as hospital visits are all part of the coverage that Project Access provides. Physicians agree to accept a certain number of indigent patients under the care of Project Access and through this share and coordination of charity care proved improved access for patients as well as reducing the costs associated with discontinuities in care. The program has been so successful that it has been replicated, in various forms, in over 20 communities in the country.

Third Party Nonprofits

Another means of achieving implementation is through the establishment of third-party institutions to oversee coordination between former competitors.[18] Participating organizations can donate expertise and manpower to the collaborative effort. The stand-alone nature of the new organization ensures that no collaborator has undue influence over the activities of the collaborative and that all sides are protected from potential conflicts of interest. A good example of a third-party organization is the Spokane, Washington Inland Northwest Healthcare System (INHS.)[19] INHS was established by the CEOs of four major healthcare providers in the Spokane Washington region to coordinate the activities of formerly competing healthcare institutions in order to provide care to residents in the Spokane area and surrounding states. Through nine programs INHS provides services to the community. These programs range from information technology to critical care transport and even health education outreach. INHS has been a model of corporate collaboration because the services it provides benefit all participants, as well as the community, in a profound manner by providing direct healthcare services, as well as operational improvements that allow all participating organizations to improve their own service delivery.

Challenges to Collaboration

The value of collaboration must be communicated effectively to potential partners. One of the greatest challenges to establishing cooperation among healthcare providers was seen in the establishing of the Massachusetts Uncompensated Care pool.[20] Hospitals in the western part of the state initially balked at the idea of a state-based pool fearing that funds would be redistributed from the western part of the state into Boston hospitals. A consulting group modeled the program and found that while Boston suburbs would find their contributions redistributed into the city, the western part of the state would not suffer from such redistribution. This study calmed initial skepticism and helped pass the

[17] Appendix Profile #1
[18] See Appendix: Inland Northwest Health Services
[19] Appendix Profile #7
[20] Appendix Profile #9

program. Such predictive modeling helped solve the problem of mistrust due to competitive interests. Communicating the benefits of the program, while reassuring potential participants that they stood to gain, and at the very least had little to lose from collaboration, was key to achieving implementation.

Primary and Preventive Care

The benefits of primary and preventive care (PPC) have long been known to care providers. The idea of low- and no-cost PPC for individuals has been gaining momentum in the healthcare reform world. The rationale for providing low and no cost care is quite simple and elegant. Individuals who do not have access to primary care will simply wait until their symptoms become so unbearable that they show up at the doors of the emergency room. By this time, their symptoms will be more difficult to treat, and in some cases irreversible. Costs to the hospital then increase with little chance of adequate reimbursement for the hospital. By providing a non-emergency setting, primary care, and chronic disease management, patients can experience a better quality of life and become agents of their own care.

Once seen as a simple loss of income for hospitals and other care providers, the societal benefits of providing PPC to those who cannot afford it is now seen to be a sound economic strategy for avoiding higher cost uncompensated care. The costs associated with treating individuals in medical settings that are not ideally suited to their needs are well recognized. Increasingly, patients are using emergency rooms for primary care, where they receive palliative care but little direction about how to manage chronic disease, adopt healthier lifestyles, and other helpful advice which could improve their condition in the long run, and reduce costs to themselves and institutions. An increasing number of patients presenting to emergency rooms are insured patients who could not obtain a doctor's appointment soon enough and so presented to the ER. This important demographic highlights that simply insuring patients does not necessarily solve the problem of access to care.

Insurance Models, Coverage Improving Access

Efforts to provide primary and preventive care vary in their focus and their comprehensiveness. The majority of programs covered in this scan address the issue of paying for medical services obtained as a means of increasing access. Such programs enroll individuals at various income levels into an insurance-modeled program whereby they receive comprehensive services for little or no out-of-pocket expense. Enrollment is almost exclusively based on income requirements as a percentage of Federal Poverty Level. These programs cover primary and sometimes specialty care, prescriptions, hospitalization coverage, and even mental health services. Some programs provide incentives to employers and individuals for obtaining risk-screening for various chronic conditions.[21] These programs are a means for covering large numbers of people and reassuring them that they can receive care without facing undue financial hardship. This reassurance is the key to the care-seeking behavior of the patients they cover. Paying for

[21] Appendix Profile #8

care is only part of the answer. Preventive care and the adoption of healthy lifestyles may prove to have longer term benefit if behaviors are picked up by large populations.

Preventive Care and Lifestyle Modification

When it comes to preventive care there are many avenues that health reform programs adopt in order to give populations a chance at improved health. A particularly innovative program in Bexar County, Texas[22] seeks to improve the health of all county residents through collaborations that provide social marketing about increased physical activity, and healthy diets. Components of the program provide healthy alternatives for food choices at schools and businesses, and even mental health services for youths.[23] Programs to improve levels of physical activity such as Walk San Antonio cost very little to implement but provide dividends that be measured using simple survey tools asking how much activity individuals are engaging in. The San Antonio example is exceptional for its focus on preventive care and healthy lifestyle focus. The program does not attempt to achieve quick results but rather has taken on a more long-term approach by encouraging and facilitating healthier lifestyles for its citizens with an eye toward improved public health. In addition to the services and social marketing, the county conducts a periodic health assessment of the population so that improvements can be tracked and deficiencies addressed. The strength of its preventive health component is remarkable.

Service Utilization Management

The management of resources is a major component of cost reduction in the healthcare reform world. The majority of programs scanned have some built-in measure for addressing improper use of services on the part of providers and patients.

Passive Utilization Management, Incentives/Disincentives

Most common is the use of a patient co-payment for the use of some services as opposed to others. For instance, a co-payment may be required for emergency services while primary care visits are made free of charge. This forces the patient to seriously consider the severity of their illness, as well as to value their primary care access and not miss appointments. Providing a disincentive for the easiest to obtain services (e.g. emergency room care) while incentivising, either in a comparative manner (e.g. free primary care visits) or by paying patients to see their physician for risk assessment, and not miss appointments, is a passive method of utilization management that many programs adopt. Impressing upon patients the importance of making and keeping doctor's appointments is a sound method for ensuring that patients do not become disconnected from their care and neglect their health. This represents a refocusing of care management onto the patient and assumes that patients will choose appropriate care if given avenues for obtaining it.

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[22] Appendix Profile #2

[23] See Appendix: Bexar County Health Collaborative (Healthy Vending Initiative)

The Medical Home and Primary Care as Utilization Management

Other means of utilization management consist of providing patients with a so-called "medical-home" through which they must pass before obtaining other services. This ensures that medical professionals help patients to make medical decisions. The concept of a medical home gives patients a sense of predictability to their care which can improve their compliance with care and disease management instructions. This can lead to decreased costs and improved matching of medical services to care needs. The New York Primary Care Development Corporation,[24] as part of its many services requires patients to select a medical home through which they must pass prior to obtaining specialty services. Many other programs utilize the concept of a "medical home" to address this issue.

Assigning patients to a utilization management team of professionals is a more expensive method for ensuring that patients utilize the proper services at the right time. The hiring of staff to decide what care patients get, and where they obtain it is useful but can simple replace one cost with another.

Conclusion

The enhancements to this environmental scan conducted by Wye River will capture even more programs that illustrate the values articulated in this report. Factors such as involvement of many stakeholders working toward a common goal, with people acting both as partners and beneficiaries, are key to a significant level of program success. Building and acting within a framework of mutual gain, sharing burdens, and pledging to provide care to all will ultimately be sustainable and beneficial for healthcare providers.

Efforts to reform healthcare systems must adapt to an environment with shrinking financial resources and increasing costs. With little relief in sight, steps must be taken to finance reform efforts that address the problems of the healthcare system, not simply the symptoms. Viewed in this context, innovative efforts such as, care pools, simple public budgeting and taxation, and Medicaid expansion may work to fill in gaps in care coverage for populations. The public will must be invoked in the latter case which requires a systematic effort to educate citizens about the potential results of a system left to collapse under its own weight. The societal benefits may outweigh the cost of providing care to all, and may be the more financially viable alternative.

Secondly, collaborative efforts that recognize the mutual benefit to decreased competition in the face of impending crisis will result in fewer negative consequences and better service to communities. Whether in the form of charity care provision, or third-party oversight commissions, the gains from collaboration far outweigh the long term losses.

Thirdly, the issue of primary and preventive care as a means for reducing costs and improving the public health is a well recognized relationship. By providing a public service at low cost, healthcare systems small and large can head off much larger costs that stand a lower chance of being reimbursed. The insurance model of coverage

[24] Appendix Profile #14

improving access has some roots in truth, but the key to reducing costs will be to promote primary and preventive care as a critical component of the contract. If patients covered by a program are encouraged to utilize primary care and chronic disease management, they can experience better health.

Finally, the use of service utilization management strategies, in the interest of driving down costs and ensuring proper matching of services to illness is an excellent means of addressing the cost issue. Through the use of passive means such as differential reimbursement, or active means such as medical homes as a gateway to further services, patients can be encouraged, with the help of medical professionals, to utilize the correct services in a proactive manner.

The reform landscape is a fertile environment and the efforts of Wye River Group on Healthcare to scan the environment in a non-partisan manner will net a great deal of helpful ideas to the issue of national healthcare reform. The future of the scan will consist of in-depth surveying of successful programs as well as assembling a detailed list of "best practices" for healthcare reform.

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Appendix[25]

1. Program Name: American Project Access Network
Aims (Cost, Quality, Access): Access
Scope (Organization, Locality, State): On a local basis project access helps coordinate charity care into a continuous care system for indigent populations
Collaborators: The project access network consists of all levels of healthcare provider as well as government agencies in a given locale
Funding Source: Funding comes in the form of donations both cash and in-kind. The monies cover the administrative costs of the project access network as well as the costs of prescriptions provided to patients for a nominal copay.
Summary, Duration, Direction and Outcomes: Created in North Carolina in 1994 to solve the problem of the gap between Medicaid eligibility and being able to afford healthcare coverage the program was designed to coordinate charity care in Buncombe County. The care provided by the county's providers was used to leverage donations from businesses, government, and other sources in a cooperative effort to care for the county's residents who could not afford coverage. The program met with such success that approximately 13,000 of the county's 15,000 uninsured received care and prescriptions through the program. Over $3.5 million in care was administered that first year. The program was so successful that it was replicated across the country.

The program in NC touts $120,000 annual savings to each hospital in the county and 80% participation by the county's physicians.

Current Project Access Network Members:

1. Buncombe County, (Asheville, NC)
2. Cumberland County (Portland, ME)
3. Dallas County (Dallas, TX)
4. Emanuel County (Swainsboro, GA)
5. Greenville County (Greenville, SC)
6. Guilford County (Greensboro, NC)
7. Hernando County (Brooksville, FL)
8. Marquette County (Marquette, MI)
9. Montgomery County (Silver Springs, MD)
10. Oklahoma County (Oklahoma City, OK)
11. Pitt County (Greenville, NC)
12. Pittsylvania County (Danville, VA)
13. Richmond County (Augusta, GA)
14. Salt Lake County (Salt Lake City, UT)
15. Santa Fe County (Santa Fe, NM)
16. Sedgwick County (Wichita, KS)
17. Shawnee County (Topeka, KS)
18. Spokane County (Spokane, WA)

[25] This is a fast-glance write-up of the programs scanned in this report

19. Utah County (Provo, UT)
20. Vance County (Henderson, NC)
21. Wake County (Raleigh, NC)
22. Watauga County (Boone, NC)

Website: http://www.apanonline.org/

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2. Program Name: Bexar County Health Collaborative
Aims (Cost, Quality, Access): Access (preventive care)
Scope (Organization, Locality, State): County Initiative at prevention and well being
Collaborators: Private and Public Sector backing in the form of the county medical society, healthcare institutions, ministries, and the metro health district. City of San Antonio.
Funding Source: Funded by donations from the county and participating private sector institutions.
Summary, duration, direction and outcomes: The Health Collaborative began informally in 1997 when the healthcare organizations agreed to put aside their competitive business practices to conduct a comprehensive health needs assessment. The evolution in 2000 to an incorporated entity with a long-range strategic plan is in response to the founding members' interest in improving the health status of the community by working together. The result is a more robust, less duplicative, more synergistic approach to solving critical community health needs, while efficiently utilizing resources.

The BCHC has worked to become a user-friendly means for county residents to engage in healthier activities via its web-based directory. Residents can access a directory to find interest groups and programs that they may be interested in. such areas as walking, running, dancing, martial arts, wellness, and team sports are just a few of the clickable options with links to places residents can engage in these activities. The health collaborative also provides information on proper nutrition as well as the healthy vending initiatives.

The BCHC conducted health assessments in 1998 and 2002 to chart improvements to the public health. VISION:

Enhance positive community health outcomes by leveraging
appropriate resources
Play a leadership role in evaluating, developing, funding and implementing health initiatives
Increase the number of partners in the collaborative
Decrease duplication of health services in the community and promote coordinated efforts for the best possible community health outcomes
Adopt appropriate community health improvement measurement system

Website: http://www.healthcollaborative.net/

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3. Program Name: Community Care of North Carolina (CCNC)
Aims (Cost, Quality, Access): There are four quality improvement program areas that each network is required to address: disease management; high-risk and high cost patients; pharmacy management; and emergency department utilization.
Scope (Organization, Locality, State): Statewide, 3,000 physicians in 13 networks
Collaborators: Collaboration among the state government, counties, community institutions, and physicians, and relies on care management, adoption of best practices, and accountability by local providers to reduce duplication and fragmentation of services.
Funding Source:
Summary, Duration, Direction, and Outcomes: Begun in 1991 as the NC Primary Care Case Management (PCCM) program **Community** Care of North Carolina (CCNC)—also known as ACCESS II and III began in 1998—develops local networks of primary care providers to coordinate prevention, treatment, referral, and other services for Medicaid enrollees. PCCM links Medicaid patients with a primary care provider who assists them in managing their health and access to further levels of care. ACCESS II and III providers receive $2.50 per patient per month. Healthcare sites are paid an additional $2.50 per month per patient. Patients and services are identified based on their risk of high cost, chronic disease, and other factors. Plans are made to manage utilization via primary and preventive services, as well as tracking ER and Pharmacy costs in order to head off over utilization. As of May 2005 there were

640,000 patients participating in the program. Planners and administrators are exploring ways to build on the disease management program to include congestive heart failure. They are also in the early stages of a provider incentive/pay for performance initiative.

Disease management initiatives started for asthma and diabetes were successful in saving the state several million dollars. Asthmatic admissions for those under age 21 were reduced by almost one-quarter. Diabetic admissions and number of prescriptions were lower by almost 10%.[26]

Website: http://www.dhhs.state.nc.us/dma/mangcarewho.html

Contact: Jeffrey Simms, Assistant Director of the NC Office of Research, Demonstrations and Rural Health and of the NC Division of Medical Assistance *Phone:* (919) 857-4016 *E-mail:* jeffrey.simms@ncmail.net

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4. Program Name: Delaware Community Health Access Program

Aims (Cost, Quality, Access): Access

Scope (Organization, Locality, State): State

Collaborators: Medical services are provided in the community through Community-based Health Care Centers and private doctors who participate in the Medical Society of Delaware's Voluntary Initiative Program (VIP.)

Funding Source: CHAP is administered by the Delaware Health Care Commission with funding support from the Delaware Tobacco Settlement Funds. VIP is administered by the Delaware Foundation for Medical Services, a supporting foundation of the Medical Society of Delaware, with funding support from the Delaware Foundation for Medical Services, the Medical Society of Delaware and the DHCC.

Summary, Duration, Direction, Outcomes: CHAP is for DE residents who are uninsured, ineligible for state medical assistance, and who meet income requirements. This program puts these individuals in contact with primary care services as well as specialty, prescription, lab and imaging resources. The Community Healthcare Access Program, through the volunteer initiative programs VIP puts these patients in contact with a physician who has volunteered to be the "medical home" for CHAP participants. Nearly a third of CHAP patients are referred through VIP while almost half are referred through the various healthcare systems in the state. The community care coordinators are responsible for putting patients in

Initial numbers of enrollment were low due to difficulties in routing potential enrollees to the right program for sign-up. This process was streamlined as application s were taken over the phone resulting in a sharp increase in the speed at which clients could access care. 45% of enrollees are employed.

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5. Program Name: Georgia Indigent Care Trust Fund[27]

Aims (Cost, Quality, Access): Access, Cost, and Quality

Scope (Organization, Locality, State): The ICTF is a state-based initiative among the state's hospitals to improve access to primary care for the state's medically indigent.

Collaborators: The GA ICTF is a cooperative effort among the state's hospitals to provide care for the medically indigent and help DSH hospitals cover the costs of uncompensated care. The program is administered by the GA Department of Medical Assistance.

Funding Source: Hospitals contribute to the trust fund. Intergovernmental transfers of monies as well as federal matching, ambulance licensure fees, CON penalties, NH provider fees, and other sources all contribute to the trust fund. Federal matching is 60:40 to what the hospitals contribute. Payments from the ICTF are based on the amount of uncompensated care that a member hospital performs.

Summary, Duration, Direction, Outcomes: Established in 1990 to provide care to indigent persons (up to 200% FPL) in the state of Georgia as well as to ensure the continued financial solvency of hospitals caring for a disproportionate share of the state's poor. In addition, the ICTF also expanded Medicaid coverage and services.

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[26] North Carolina Rural Health Research and Policy Analysis Program

[27] GA Dept. of Community Health

For the last 16years the program has been instrumental in ensuring that all the state's hospitals share the cost of caring for the medically indigent as well as providing expanded access to primary and preventive care for those who are Medicaid ineligible yet too poor to afford regular insurance.
Website: http://www.georgia.gov

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6. Program Name: Hillsborough HealthCare
Aims, Mission (Cost, Quality, Access): Cost and Access.
Scope (Organization, Locality, State): County
Collaborators: Public and private sector healthcare providers. The county Department of Health and social services administers the program. 1,000 participating physicians
Funding Source: The program is funded by a special sales tax in the county.
Summary, duration, direction and outcomes:
The program is intended to reduce the number of ER presentations by indigent patients for whom the hospitals would not be paid. This is done by providing primary and preventive managed care as well as a host of comprehensive mental health and prescription benefits to enrollees. The program also aims to cover the working poor.
To assure within available resources, the delivery of quality health care for
the County's eligible medically poor residents who lack other coverage.
This mission will be accomplished by achieving the following goals:
· Promoting efficient and effective access to health care services within the County.
· Giving special emphasis to health education, prevention, early intervention, and disease and case management with measurable outcomes.
· Promoting coordination among appropriate health and social service agencies.
· Motivating and educating program participants to be responsible for their health.
· Establishing information technology systems that support effective program management and the delivery of quality health care services.
· Structuring reimbursement and other incentives to support achieving the above goals.
The program was implemented in 1991 as a managed care program within the county. Financed through the sales tax the program provides low and no-cost care to the county's indigent residents as defined by 100% FPL. There are no premiums for enrollees. Enrollees are individuals who demonstrate a financial need (at or below FPL) and who do not have any other coverage. There are co-pays for prescriptions.

The program has seen success in reducing the number of avoidable ER visits from the target population. The typical ER visit rates and reasons are in line with the general population. Average cost per ER encounter has dropped by 50%.
Website: http://www.hillsboroughcounty.org/hss/hhcprogram/
Contact: Toni Beddingfield, Hillsborough County Dept. of Health & Social Services
PH: 813-301-7346 Email: beddingfieldt@hillsboroughcounty.org

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7. Program Name: Inland Northwest Health Services
Aims (Cost, Quality, Access): Cost and Quality
Scope (Organization, Locality, State): INHS offers services to the healthcare providers in the region through nine discrete services: Community Health Education and Resources, Children's Miracle Network, Information Resource Management, Northwest TeleHealth, Northwest MedVan, Spokane MedDirect, Northwest MedStar, Regional Outreach, St. Luke's Rehabilitation Institute
Collaborators: Started in 1994 as a collaboration between four regional healthcare providers: Deaconess Medical Center, Holy Family Hospital, Sacred Heart Medical Center, and Valley Hospital and Medical Center
Funding Source: Funded through the INHS Foundation, dedicated to continuing the services of INHS.
Summary, Duration, Direction, Outcomes: Inland Northwest Health Services was created in 1994 when executives from Spokane's four major hospitals – Deaconess Medical Center, Holy Family Hospital, Sacred Heart Medical Center, and Valley Hospital and Medical Center – collaborated to merge competing business lines and form a new non-profit organization to oversee them; the first of which was Northwest MedStar. In the years that followed, it became clear that there were many more joint venture opportunities,

and INHS now oversees nine collaborative health care services, including critical air transport, medical rehabilitation, health education and information technology.

Mission[28]

"On behalf of our sponsoring health care systems, we provide unique, effective, affordable services using collaborative and innovative approaches for the benefit of the entire health care continuum. These local, regional, national and international solutions promote positive health outcomes through disease and injury prevention and wellness programs in rehabilitation and clinical services; critical care transportation; information technology; health care education; and other health care services. We incorporate the highest ideals from our sponsors' joint Christian heritage in the provision of high-quality medical care."

Five-Year Goals[29]

Be the provider of choice for our customers and sponsors based upon reputation, quality outcomes and innovative programs and services.

Provide an accountable work environment and a culture valued by all employees.

Increase collaboration and system integration through Inland Northwest Health Services.

Promote the image and identity of Inland Northwest Health Services regionally, nationally and globally.

Maximize existing, and create new products, services and markets to increase the financial viability of Inland Northwest Health Services.

Information Resource Management

The IRM system has successfully implemented an electronic medical records system covering 2.6 million patients and accessible at 30 different hospitals.

Regional Outreach and Management

Regional Outreach provides regional hospital management, education and coordination services including full or partial management, preparation for site surveys, facility assessments, code interpretation, construction project review, interface with regulatory agencies and assistance with Meditech services. Accounting and legal services are available through Inland Northwest Health Services, as well as consulting services in the areas of strategic planning, marketing, and human resources.

St. Lukes Rehabilitation Hospital

Located in Spokane, WA St. Lukes was established with the help of INHS as the region's only pure rehab facility. St. Luke's finished 2004 with a positive bottom line.

Website: http://inhs.info

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8. Program Name: Maine Dirigo Health Plan

Aims (Cost, Quality, Access): Cost and Access

Scope (Organization, Locality, State): This public/private collaboration uses the state's department of health and human services to determine eligibility and private (BCBS) tools for marketing/enrollment

Collaborators: BCBS Maine (Anthem) and the State

Funding Source: First-year administrative costs paid by state funds. The program collects premiums from covered individuals and employers as well as Medicaid matching funds from the federal government.

Summary, Duration, Direction, and Outcomes: Began in 2005 Maine's Dirigo Health plan provides insurance coverage to Maine residents who qualify. In the first year enrollment was capped at 31,000 with a maximum of 4,500 individual-coverage plans being offered.

DirigoChoice™ is a program of goods and services, not only an insurance program. In addition to unique benefits, such as fitness club discounts, participating employers pay a modest program fee ($150–$300, depending on the size of the workforce) and support the Maine Quality Forum, an entity of the Dirigo Health Agency that will collect and disseminate research, adopt quality and performance measures, issue quality reports, promote evidence-based medicine, and educate consumers.

Healthy Maine incentive program pays enrollees for choosing and seeing a PCP upon enrollment. Employers receive a benefit if a large proportion of their employees choose and see their PCP for a health risk assessment.

Wellness and prevention services are covered at 100 percent in order to encourage timely care that can reduce the incidence of more serious illnesses and complications and result in more

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[28] From INHS Website, 2006

[29] From INHS Website, 2006

expensive services. For example, well-child visits and physical exams for adults, including blood and screening tests, such as mammograms, are covered without enrollee co-payments. Some important prevention services, such as vaccinations, are fully covered, as well.
Website: http://www.dirigohealth.maine.gov/

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9. Program Name: Massachusetts Uncompensated Care Pool
Aims (Cost, Quality, Access): Cost and Access
Scope (Organization, Locality, State): Statewide, hospitals and community health centers participate to provide care to the medically indigent. The pool covers individuals who are not able to obtain Medicaid and cannot afford care.
Collaborators: Hospitals and health centers across the state.
Funding Source: Monies are collected from all participating hospitals in the state as well as insurers, federal DSH payments and tobacco settlement funds. There was some initial resistance to this scheme as hospitals in the western part of the state were concerned that money would simply be redistributed to the city of Boston. A consultant was hired in order to look into the "money flow" that might result from adopting the care pool and found that money would only be redistributed into Boston from the metro area but that hospitals in the western part of the state were unaffected by the adoption of the care pool. This act, of addressing the issue head-on cleared the way for the establishment of the care pool.
Summary, duration, direction and outcomes: The MA UCP has been successful in covering residents at or below 200% FPL with primary and preventive care as well as emergency care. In FY2004 the UCP paid for 44,000 inpatient visits and 2million outpatient visits for over 450,000 residents of the state. 85% of these inpatient visits were urgent or emergent care. 20% were outpatient emergent care. There are three grades of coverage offered via the UCP. Full, Partial, and Medical Hardship. Full is for individuals and families below 200%FPL. 200-400% FPL qualifies for Partial coverage for which a small deductible/co-pay is charged. Medical Hardship is for when a patient's bills exceed the sum of 30% annual income plus assets. The patient must contribute up to this amount before coverage.

The application process is standardized and conducted by Mass Health at the point of service. The patient will complete a Medical Benefits Request form which is processed by Mass Health.
Website: http://www.mass.gov/dhcfp

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10. Program Name: Milwaukee General Assistance Medical Program
Aims (Cost, Quality, Access): Cost and Access
Mission statement:[30] Our Vision is a fully integrated program providing comprehensive care to knowledgeable clients in the community setting of their choice.
Scope (Organization, Locality, State): County funding is provided to pay for costs incurred by participants at clinics and the two hospitals Froedert and the former county hospital now run by Froedert.
Collaborators: The privatized county hospital agreed to provide services to GAMP participants in addition to the primary care offered by the community health centers. The closing of the county hospital made the county into a purchaser of health services for its residents.
Funding Source: The county budget provides funding. Payments are a negotiated percentage of regular charges.
Summary, duration, direction and outcomes: GAMP is a County and State funded program which purchases health care for qualified Milwaukee County residents. As the program has limited funds, a set of eligibility requirements has been established. A network of providers, including thirteen community-based clinics, has been established to act as the gatekeeper for all services the client requires. Some of these clinics have more than one site. Services include, but are not limited to: Inpatient hospitalization, diagnostics, prescriptions, labs, and specialty care

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The program was implemented in 1996 to pay for the healthcare of indigent persons in the county. Participants are REQUIRED to select a clinic where they will receive primary care so that they will make and keep such appointments. Providers agree to provide services for patients up to a maximum amount after which they are required to foot the bill. This is a cap on aggregate funding such that the GAMP program does not exceed annual budgeting. ER co-payments are administered to all participants at $20 per visit so that patients evaluate the appropriateness of the ER prior to presenting. Utilization Management (UM) is in place to ensure that patients access the correct level of care. UM staff also assesses the quality of care at participating clinics and hospitals by inspecting records and authorizing specialty and inpatient admissions.

From 1999 to 2000 the per-member costs declined. Membership can be initiated when a patient seeks care so such costs take into account membership at any time in a given month. This also means that participants all receive some care while on the program, unlike a regular insurance program. Essentially, utilization is 100%.

Website: http://www.milwaukeecounty.org

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11. Program Name: Minnesota Smart-Buy Alliance

Aims (Cost, Quality, Access): Cost and Quality

Scope (Organization, Locality, State): Coalition of public and private purchasers of health insurance

Collaborators: The state has teamed up with the private sector to align expectations and demand better performance from healthcare outlets.

Funding Source: Public and private funding from participants.

Summary, duration, direction and outcomes: The formation of the alliance was announced in November 2004 with the intent of pooling purchasing power in order to lower costs and improve quality. Together with labor unions and other private sector entities the state has brought together the entities that cover 3.5 million (70%) Minnesotans.

The members of the alliance purchase their healthcare separately, the old-fashioned way, but also push for four main goals adopted by the alliance. 1. Reward institutions for "best in class" performance 2. Adopt uniform quality/results measures 3. Provide consumers with comprehensive access to cost/quality information 4. Require the use of IT. The job of pursuing these four avenues of improvement is headed by a different member of the alliance.

The objective of the program is to pool the health purchasing power of these groups as well as to provide a unified voice to Minnesotans for demanding improved quality of care, improved use of technology, administrative simplification, lowered cost, and fewer unnecessary procedures. The idea is to shift the focus from simple purchase of services to looking at the purchase of services as a reward for good performance. Performance measures will be comprehensive with better performing healthcare systems receiving more "business."

Website: http://www.maximumstrengthhealthcare.com/smartbuy/smartbuy.html

Contact: Susan McDonald, Governor's Health Cabinet PH: (651)-259-3637 Email: susan.mcdonald@state.mn.us

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12. Program Name: Muskegon Community Health Project

Aims (Cost, Quality, Access): Cost, Quality, and Access

Goals of MCHP: [31]

1. To facilitate the community's identification and resolution of health issues.
2. To assist the evaluation and coordination of activities to improve outcomes for citizens of Muskegon County.
3. To initiate health-related projects, providing support and oversight when other community resources are not accessible

Scope (Organization, Locality, State): MCHP is a countywide program involving all strata of public health, charity foundations, federal funding, and community members.

Collaborators: The collaboration is between providers, community organizations, state health departments, charities, and volunteers.

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[31] MCHP Website

Funding Source: MCHP is an official United Way Partner and also receives much of its operational funding from charities and federal and state grant monies.
Summary, Duration, Direction, Outcomes: For the last 12 years MCHP has been involved in a wide array of activities aimed at improving the health status of county residents. For example:[32] "**Access Health in Muskegon is** an innovative approach to the challenge of providing health coverage to uninsured working families in Muskegon County. It has become one of the most successful programs in the country, helping to recruit and maintain a stable workforce for over 400 local businesses and nearly 1,500 individuals annually. The unique, three-share model distributes the benefit cost equally among employer, employee and the community, enabling small and mid-size businesses to provide a comprehensive mainstream benefit plan that includes local physician services, in-patient hospitalization, out-patient services, emergency services, behavioral health, prescription drugs (formulary), diagnostic lab and x-ray, home health, and hospice care. A shining example of a community-based solution to a national problem, the Health Project is helping other communities develop similar programs."

11,000 People screened for diabetes in Muskegon County since 1998
371 African-American participants in diabetes management education outreach since 2002
2,691 Children receiving dental care through *Miles of Smiles* since 1998
176 Uninsured children received free dental care on *Give Kids a Smile Days,* 2003-2005
100% Oral health access for Head Start children through *Muskegon Community Dental Health Coalition*
4,000 Pedometers distributed countywide to promote walking through *Stay Active Muskegon* since 2004
24 Translators participated in Translation Class through *Hispanic Community Services Coalition* in 2004
33% Countywide reduction in antibiotic use for colds and flu through *MCAAT* since 2001
1,500 Children participated in *MCAAT Healthy Kids School Hand washing Initiative*
over 4,500 Children receiving health care coverage through *MIChild / Healthy Kids* outreach since 1999
151 Expectant mothers signed up for *MOMS* program since 2002
over 300 Non-English speaking families received Medicare and Food Stamps since 1999
300 Families in Muskegon, Oceana and Newaygo Counties assessed for Food Stamps since 2002
250 People pre-screened for free eye exams and glasses since 2003
over 450 Individuals referred for health and dental care through *Muskegon Care* and *Access Health* since 2002
160 Diabetes retinopathy exams for the uninsured through the Lions Club and
Community Foundation since 2001

Annual revenues and support total 2,000,000 per year combined federal and state grants, as well as software licensing sales, donations, and interest income.
Contact: info@mchp.org ph: (231)-728-3201

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13. Program Name: New Hampshire Healthcare Access Network (HAN)
Aims (Cost, Quality, Access): Cost and Access
Guiding Principals, Values, and Mission:
1. to maintain an "open door", providing dependable access to care for vulnerable residents in our community, regardless of their ability to pay.
2. To offer levels of free and discounted care that meet or exceed eligibility thresholds adopted collaboratively through the Network, subject to any conditions that apply locally. The framework for free and discounted care is currently the federal requirements for community health centers.
3. To collaborate with others through the Network to reduce or eliminate structural barriers to access for low-income seniors and low-income uninsured and under-insured children and adults statewide.
4. To collaborate with others through the Network to enhance continuity of care and coordination of care for low-income seniors and low-income uninsured children and adults statewide.
Goals: The goal of HAN is to provide the community with access to healthcare "regardless of ability to pay." Additionally, no-cost or low-cost care is provided to the most vulnerable populations provided they meet income eligibility requirements.

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[32] MCHP Website

Scope & Targets (Organization, Locality, State, Patients): Statewide, voluntary participation of healthcare providers provided they adhere to the guiding principals. The HAN also targets vulnerable populations to make them aware of the program and its benefits.
Collaborators: HAN is a collaborative with over 200 healthcare providers in the state.
Funding Source: Currently financed entirely by the FHC though federal grant applications are in the works.
Summary: The NH HAN is a statewide voluntary program of hospitals and physician practices with the common goal of providing access to care for residents of NH. The primary goal is to provide access to hospital care, physician visits, and other care to uninsured patients. The HAN is an expansion of local efforts that existed in Laconia, Exeter, and Derry. The program was expanded because many residents sought care outside their home area. Eligibility for low and no-cost care is based on the federal requirements for care at FQHCs. Some hospitals have volunteered to set their income requirements at up to 300% FPL.

HAN is financed by the Foundation for Healthy Communities, a nonprofit corporation established in 1968 with the original intent of healthcare system education and research. The tasks of FHC were expanded to administering the HAN program. Currently the program is in the process of standardizing the application process, spreading the word about the program and eligibility, and educating providers about the intricacies of eligibility and sign-up for new members. According to their website, 5% of those seeking financial assistance used the HAN in the first six months in operation when participation was roughly 100 hospitals and physician practices. The number of participating programs has since doubled.
Website: http://www.healthynh.com/fhc/initiatives/access/NHHAN.php

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14. Program Name: New York City Primary Care Development Corporation (PCDC)
Aims (Cost, Quality, Access): Cost, Quality, and Access
Scope (Organization, Locality, State): Community Health Centers in NYC
Collaborators: The PCDC worked with city health centers in order to address key components of patient care. Federal, state, and local government funds were obtained to finance the consulting and infrastructure improvements.
Funding Source: Federal, state, city, and private foundations all provide monetary support for PCDC's operations.
Summary, Duration, Direction, Outcomes: Founded in 1994, PCDC has worked with over 100 teams at 22 of New York City's healthcare centers. PCDC provides loans, technical expertise, and other operational and social services to the healthcare centers in order to improve cost, quality, and access. The strength of PCDC's collaborative and comprehensive approach lies in its targeting of key components of service delivery. The ultimate goal of PCDC is to build a patient-centered healthcare experience for the city's low income population. By improving the customer service aspects of operations, as well as reducing the occurrence of key operational holdups, all parties benefit. By maximizing revenue through focused efforts at reducing billing lag time and reducing billing errors the centers have realized gains in income while at the same time seeing improvements in clinical operations. The improvements in clinical operations are the result of efforts to reduce wait times for visits, improving cycle times per visit, and reducing no-show occurrences.

Phase I involved expansion of service points in NYC. Construction loans paid for improvements to the infrastructure available to the city's residents. The funds were obtained through public and private sources from federal to local levels. The aim was to modernize and expand the number of facilities available to the city's low income residents. The PCDC report states that 32 centers have been built or renovated in all five boroughs with a capacity to serve 300,000 patients. There are both hospital-affiliated and freestanding primary care centers, as well as special needs centers targeting subpopulations including HIV/AIDS patients, the elderly, and the disabled. Some health centers operate within a continuous network of providers while others are solo affairs. The majority of patients served are ethnic minority (African American, Hispanic, and Asian.) Primarily un/under-insured, Medicaid-eligible populations.