CHAC Presentation on Communities Joined in Action conference, October 21-23, 2009
Report dated December 4, 2009

CJA: National organization of community organizations, individuals and corporations who are working on improving the lives of the uninsured and underinsured in their communities. The group is dedicated to growing the reach and influence of communities through a national effort.

The mission of the group is to mobilize and assist community health collaboratives to assure better health for all people at less cost.

Their key goals are the following areas of emphasis:

1. Improving health status of community members
2. Decreasing disparities in health services
3. Finding solutions to unmet needs
4. Focusing on primary care and prevention
5. Building on the community's current capacity
6. Working to create a seamless continuum of care
7. Developing collaborative governance

The group has over 200 communities as members and offers a set of service and resources designed around access to experienced leaders, peers from established programs and models, and experts who have "been there." They offer a Health Leadership Network that uses coaches to help communities organize for action and keep

coalitions moving forward. They are actively involved in keeping members up to date on legislative issues and sources of financial support (and we'll talk about that a little later).

The members of the group focus their work on 8 "Critical Activities" in their communities. They are:

1. Get community members enrolled in programs for which they are eligible – there is a focus on outreach
2. Provide culturally and linguistically competent medical homes
3. Assure access to prevention and wellness services
4. Provide affordable prescription drugs
5. Assure access to specialty and hospital care
6. Manage chronic disease
7. Coordinate comprehensive care
8. Develop strategies to cover low-wage workers

It was an incredible opportunity to spend time with 100's of people involved with CJA – to hear about 100's of programs and communities. It allowed me to gather a lot of information very efficiently. And, I think Jill would agree.

We thought what we would do is have each of us tell you some of the highlights among the vast amount of material we heard. We'd like this to be a discussion – so please feel free to ask questions, etc.

Key comments/take-aways for me:

1. Financial stability is a concern for everyone and every program
2. Strong recommendations to work with local hospitals – "community benefit" changes for non-profit hospitals creates natural partnerships with community efforts.
3. Be sure to include ALL community efforts at the table. United Way – organizational goals: Health care access is in the top 3
4. Be sure you can measure your success. Which means, of course, identifying goals and measures up front. Track your metrics and talk about them.
5. The efforts of the members of CJA seem to center around 3 main models:
    - project access models (donated care)
    - multishare models
    - FQHCs

Lastly, I attended 1 specific session that discussed engaging physicians. It helped me to learn that we are not the ONLY community where some physicians are disengaged. There was good discussion on how to bring those reluctant or uninvolved people to the table. The "how-to's" included getting agreement on what the problems are. I think to

some degree the project I am working on has done that. There was also talk about having the "heart-to-heart" conversations about shared accountabilities in the community. But the speakers were also quick to say that it is important for non-physician members of the community to demonstrate and understanding of the difficulties and challenges of every day work in a medical practice.

Jill's take away points were:

1. All people need their basic needs met first(food, housing, etc.) before they will access health care.
2. Health literacy(how to use services that are available) must be taught before some persons access available health care.
3. Emergency department (ED) statistics are valuable to determine the basic health care needs of a community. Missy Rodey is contacting MRMC to obtain this data. The universality of the data enables a county to compare itself with other counties & states. For example, who uses the ED, ages of users, their diagnoses, time of day & days of the week the ED is used, related charges; such data are useful. Comparisons then can be made to what's available in the community & what insurance typically covers. One county's data revealed higher numbers of ED visits because of mental health diagnoses, dental problems, and alcohol abuse related problems. That county had 3.2% of their ED visits related to dental problems so they used the data to support a program with $100 slots for emergency dental work covered by local dentists in the community.
4. In a Project Access model, a nurse's hotline was highlighted related to ED visits. If a client called the hotline first & then visited the ED, their co-pay was waived. If a client

did not call the hotline first and went to the ED the client had to pay the co-pay. Discussion around this model pointed out that this was obviously for an insured population. Kathleen McGuinness pointed out that Pediatric Partners in Durango uses the nurse's hotline based out of Children's Hospital in Denver after hours, using diagnostic related protocols that appear to be very effective.

5. Multi-share models is a program where an employer, an employee and a 3rd party pay for health care coverage for employees. It has generally been for small businesses & qualifications vary. Pueblo, CO has such a model. They require State legislation, include a wellness/prevention component & the 3rd party varies; e.g. gov't entity, hospital district, community group or some combination of these. If the federal health care legislation includes a health care coverage mandate, advocates want to ensure that multi-share models will qualify.

6. ROCI - the return on community investment is important for all community based models. Julie has details coming to her about this.

7. A Pathways model pressed communities to identify the individuals at risk in their community. A holistic approach was used to set up mechanisms to access health care & other basic needs. Rio Arriba County in New Mexico presented their program addressing drug abuse & is willing to share their experience with La Plata County. This approach is also present locally on a limited scale at the San Juan Basin Health Department.

8. In Tucson, AZ., mobile vans are used to care for the homeless population. The vans serving urban & rural areas, are staffed by a driver, who also determines client eligibility, a nurse practitioner &/or a physician's assistant. They treat wounds & dermatological problems, & offer lab work, behavioral health & optometry services.

9. A CD with many of the presentations is available.