

October 29, 2009

PRESENTATION by Julie Thompson, Community Health Care Capacity Project

Models reviewed

**WELD COUNTY/NORTHERN COLORADO HEALTH ALLIANCE**

Greeley and Loveland, Weld and Larimer Counties, CO

Goal: All underserved residents will have access to appropriate, affordable, comprehensive quality care

What They Did: Focused on un-/under-insured. Created a stand-alone non-profit that provides no services but selects community projects for implementation. The Board of Directors consists of representatives including medical clinics, the community health center, public health, United Way, county government, hospital and local university.

How It Is Financed: Each member entity pays dues based on the entity's budget. The hospital has the largest contribution

Key Factors in Success:

- Focused on building a strong primary care system and integrating all other programs into it. First project was creation of the community health center
- Identified overlapping interests. Agreed that no one agency can meet the need alone.
- Strong partnerships among member organizations
- Strong leaders who have a collaborative mindset, a view towards relationships vs. individual interests and an expectation of achieving results.
- Continual presence in the community. Showed THAT they were doing things and WHAT they were doing: programs, training, etc.
- Developed own software program as electronic single point of entry which could be used by an entity in the Alliance. It is the electronic medical record for all entities.
- Worked on getting people enrolled in all public health programs they were eligible for

Lessons Learned:

- County has been involved but City has not been. They should have been at the table from the beginning
- Representatives on the Alliance board need to be closely involved with the boards of their own organizations
- Plan from the beginning to measure outcomes

## **GRAND JUNCTION/MESA COUNTY CO**

Goal: Access for all to quality care at a low cost.

What They Did: Created a community health care system that reimburses providers for quality, cost-effective care and crates access for all members of the community.

How It Is Financed: The local physician network and Rocky Mountain Health Plan have worked together to create a quality-based incentive plan. The size of the incentive is based on the financial performance of the health plan. This encourages quality care and at the same time takes away any incentive based volume. Rocky Mountain Health Plan is also the fiscal intermediary for the federal government for both Medicaid and Medicare and pays essentially the same reimbursement rate for all patients. Marillac Clinic is supported by grants, donations and limited reimbursement from Colorado's Indigent Care Program. They utilize a sliding fee scale for those that can afford to pay.

### Key Factors in Success:

- Strong physician leadership
- Medical culture has long-standing commitment to community
- Close-knit relationships between health care institutions
- Commitment to high quality, patient-centered care for ALL
- Sense of trust from longevity of local physician network
- Collegial relationships between primary and secondary care
- Health information network is critical partner
- Data sharing is "open." Providers see each other's results
- Community-supported clinic cares for uninsured
- Other community service organizations are involved in care delivery (Hospice, residential care, prenatal, home health)

### Lessons Learned:

- With the right incentives in place, costs go down and quality goes up
- With the right incentives in place care gets delivered by the right person, typically more cost-effective
- With the right model, payer mix can be a non-issue
- Practices can remain independent and still work effectively together
- Insurer(s) can bring a lot to the table
- Communities can carve out a very specific niche to address

### *Answers to questions after site visits:*

Marillac uses employed physicians as well as resident physicians

Marillac does serve a substantial population of undocumented residents

Hospital leadership was not present in the meetings, however financial success at St. Mary's seemed evident in the substantial building project underway. Lengths of stay at local hospitals in Grand Junction are lower than the state and national averages. They have lower uncompensated care due to the successful care provided at Marillac.

Provider recruitment and retention are just as challenging as they are elsewhere in the state and nation. They are approx. 25 primary care providers short. So, while they have a model that has access options for all populations, there still can be a sizeable wait for an appointment time. “Acculturation” is important here as in other medical practices. Providers need to agree to the way care is provided and the cooperative, communicative relationships among care givers.

### **PARTNERSHIPS FOR HEALTH INITIATIVE – NORTHWESTERN COLORADO VISITING NURSES ASSOCIATION**

Steamboat Springs and Craig, CO

Goal: Create a single source of eligibility determination, with consistent criteria accepted throughout agencies and organizations in VNA service area. Address concerns about cost of care.

What They Did: Created a steering committee with hospitals, VNA and independent community health center to establish criteria and processes.

How It Is Financed: Pooled resources already being used in individual organizations. Received foundation funding to support payment for care for individual between 200-250% of Federal Poverty level.

#### Key Factors in Success:

- Did not attempt to create a single sliding fee scale. Limited efforts to single eligibility determination and let each organization keeps its own fee scale
- Created easy process for determination – only 1 paycheck stub.
- Medicaid or CHP+ eligible people will still be granted eligibility for dental and behavioral health services
- Patients have co-pays for most services

#### Lessons Learned:

- No physician groups are involved, only the community health center in Craig
- Glut of physicians in Steamboat Springs may be an opportunity
- Working towards electronic connectivity. Sharing the program’s database with participating organizations would be helpful.

### **HEALTH ACCESS PUEBLO**

Pueblo County CO

Goal: Provide reasonably priced health coverage for individuals working in Pueblo County not covered by employer-provided health insurance

What They Did: Created a non-profit organization that sponsors a limited benefit package for qualified employees. Board members come from hospital, clinics, employers, county medical society and county government.

How It Is Financed: The program is a “multi-share” program. Employer, Employee and the Community each pay a \$60 share per month for each individual in the program. Members have co-pays for some services.

Keys Factors In Success:

- Benefit design by collaborative effort with doctors, hospitals and employees
- Patients much take responsibility for their own health by participating in required health activities recommended by the provider
- Community health center and some local providers participate
- Wide range of benefits
- Very specific criteria for eligibility and enrollment

Lessons Learned:

- May require legislative action since states have very specific regulations on what might appear to be health insurance
- Enrollees cannot drop existing coverage to enroll.
- Program needs detailed rules to prevent “gaming”
- They did not use actuaries to set the first year premium rates. Were lucky and have used actuaries in subsequent years.

**ECHO (Enchanted Circle Health Outreach for Kids)**

Taos, NM

Goal: Access to care for low-income kids in Taos and Colfax Counties, NM

What They Did: Organized a non-profit which negotiates with providers for pediatric and pre-natal care. Created a voucher program to pay for care for children and pregnant moms who meet eligibility criteria.

How It Is Financed: Grants and private donations

Key Factors in Success:

- Limited eligibility to 235% of Federal Poverty Level
- Help people enroll in public programs
- ECHO schedules the appointments and negotiates referrals to specialists when necessary
- It is hard to say No to a sick child
- Approved care is flexible but is typically limited to 1 well child visit/year 2 sick visits/year

Lessons Learned:

- Providers will see uninsured patients if reimbursement gets up to Medicaid rate
- Individuals, no matter how poor, will make an effort to make small co-pay
- With careful negotiation ECHO was able to obtain over \$150,000 of care in the first year by paying out \$48,000 in vouchers

**PROJECT ACCESS**

Asheville/Buncombe County, North Carolina

Goal: Provide access to care for the county's uninsured population

What They Did: The County Medical Society assumed administrative ownership of a program designed as a donated services model. Participating primary care providers agree to see 10 patients/year from the program. Secondary specialists agree to see 20 pts/year. Pharmacies dispense medications at cost.

How It Is Financed: In the beginning the program was largely grant funded. Donated services from providers and hospitals cover the costs of care. Federal and State funding covers the costs of the eligibility staff and other administrative costs are shared by the Buncombe County Medical Society and Buncombe County which reallocated funding traditionally provided to local hospitals for indigent care. Patients have \$4/prescription co-pays.

Key Factors in Success:

- Significant history of medical volunteerism in the community
- Physicians were involved in planning and design of the program
- Strong physician leadership
- Program was started with a focus on the satisfaction of the participating providers and their staff in order to make it easy for clinics to decide to participate

Lessons Learned:

- Once program participation is solidified, focus needs to turn to health status of patients
- Per capita cost of free care in the community has been reduced. Total value of charity care in all area hospitals has been reduced by 15%
- Inappropriate Emergency Dept visits have been virtually eliminated
- Reduction in avoidable repeat clinic visits has resulted in savings that has allowed the program to increase the # of patients enrolled in the program at no additional costs
- That same reduction in unnecessary repeat visits has opened clinic schedules so that access has improved for all patients
- Health care organizations are working together in ways they had not done before

## **VERMONT BLUEPRINT FOR HEALTH**

State-wide

Goal: Decrease the economic impact of chronic health care conditions

What They Did: Created a multi-prong approach to reducing the cost of care, involving insurance reform, creating community care teams, integrating public health and private health care delivery systems and using health information technology.

How It Is Financed: Insurers, including commercial, Medicaid and Medicare are covering the cost of the pilot programs with savings realized from reductions in the cost of care. Medicare contributions are subsidized by the State of Vermont

### Key Factors in Success:

- All major insurers are involved
- Payment for the same service is the same from all insurance carriers
- Payment is based on quality measures for the condition
- Started small. First year focus only on diabetes
- Health information technology provided information enabling a common level of care in different practice settings (clinical guidelines, electronic prescribing)
- Internet based technology much more economical than major software purchase
- Health information exchange among providers improved communication and also created cost savings in practice overhead
- Community Care Teams assure that each medical practice can engage patients in the same level of health maintenance, prevention and care – regardless of the size of the practice

### Lessons Learned:

- After only 1 year with only 2 pilot clinics and less than 7% of the eligible Vermont population participating, estimates are that the program will begin to reduce the overall growth of health care cost in Vermont by 2011.
- Reducing the growth of health care expenses provides for the sustainability and expansion of the program. Within 5 years the program grow to 13 clinics
- Savings for diabetes care alone could exceed \$5million within 5 years