

A Framework for Improving Community Health Care Delivery: “8 Critical Activities”

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Big Picture: Health Care in America Today

- Disjointed, uncoordinated care (multiple providers in multiple settings with limited communication between providers and with patient)
- Care mainly based on “disease model” as opposed to “health model”
- Many lack access to care, due to financial or other reasons
 - Uninsured
 - Underinsured (e.g., Medicaid Basic Health)
 - Geography (rural areas/transportation issues)
 - Cultural barriers (language, religion)
 - Educational barriers/low health literacy (understanding of health needs)
- Chronic conditions are the major factor in cost of health care (83% of health care spending is for people with chronic conditions) *PFS, 2004*
- Chronic conditions are rising in numbers due to aging, lifestyle, medical advances prolonging life. Most chronic conditions are in people who are not elderly, though risk increases with age. Older adults are more likely to have multiple chronic conditions.
- Many chronic diseases can be delayed, prevented or controlled through lifestyle intervention (e.g., weight loss and exercise for diabetes) and/or appropriate medical management (e.g., inhaled steroids to control asthma)
- Seventeen percent of non-elderly adults with chronic disease are uninsured (2005 national data from Urban Institute)
- Uninsured individuals are less likely to have a “usual source of care” and less likely to receive preventive services
- Uninsured/underinsured individuals with chronic disease more likely to use ER or inpatient stays for preventable complications (??? data)
- Small businesses with low wage workers are less likely to offer health insurance due to the high cost
- Lack of health insurance and lack of access to health services contributes to decreased worker productivity (sick days/absenteeism)?
- Health care providers provide a significant amount of uncompensated care for people without insurance or whose insurance plans provide inadequate reimbursement for services (e.g., Medicaid/Medicare).

In Washington, 12.1% of the population are uninsured with an estimated 533 million dollars per year in uncompensated care. Many health care providers, consumers, health care institutions, payers, and communities are working to develop innovative solutions to address these concerns.

A Framework for Improving Community Health Care: “8 Critical Activities”

In response to growing concerns about health care access for the uninsured and underinsured, the federal government (Bureau of Primary Health Care) provided grants to communities in 45 states to develop community-level solutions. Over 400 million dollars were invested over a period of 5 years (2000-2004) through the Healthy Communities Access Program (HCAP). The program was unfunded in 2006 due to federal budget issues. The purpose of HCAP was to “assist communities and consortia of health care providers and others they represent to develop or strengthen integrated community health care delivery systems that coordinate health care services for individuals who are uninsured or underinsured and to develop or strengthen activities related to providing coordinated care for uninsured or underinsured individuals with chronic conditions”.

www.bphc.hrsa.gov/cap

Many communities involved in HCAP formed a national coalition called [Communities Joined in Action](#) (CJA). From experience gained in the HCAP program and ongoing work of communities across the nation, a framework was developed for “providing better care to more people at less cost”. This framework included the concept of “eight critical activities tied to best practices demonstrating outcomes”. Kristen West, the executive director of [CHOICE Regional Network](#) in Olympia, WA configured these eight critical activities into a model that shows cost savings that can be generated and reinvested into the system to increase health care access for everyone.

The original framework included the following community level activities:

1. Outreach and enrollment into existing programs
2. Connection to medical home and other social and language services
3. Access to free and reduced price prescription drugs
4. Care coordination/case management of ER frequent flyers
5. Chronic disease management
6. Premium subsidies for small employers of low-income residents
7. Organize, count, stabilize & increase appropriate care capacity for low-income residents
8. Automate 1-7 and track clients on a common information system

“Best practices” in this conceptualization refer to model community-based programs that have demonstrated success in improving access and health outcomes. For example, critical activity # 6 (premium subsidies) reflects the model “three-share” program (government subsidies, employer contributions, and employee contributions) developed in Muskegon, Michigan which has successfully improved health insurance coverage for low-wage workers. This model is being replicated in other communities.

The framework has undergone some modifications over the last several years as evidenced through chronological review of materials from CJA and Communities Connect. As currently framed, activity #8 (integrated information systems) is moved to a coordinating function and prevention/wellness is added to the “critical activity” list.

1. Outreach and enrollment into existing programs
2. Establishing health homes with coordinated services
3. Access to affordable prescription drugs
4. Chronic disease management
5. Coverage of low wage workers
6. Organizing donated medical care services
7. Prevention and wellness services
8. Maintenance of an adequate and stable public and private provider safety net network

Additional background information can be found on the CJA website (www.cjaonline.net)

Activity 1: Outreach and Enrollment into Existing Programs and Services

What is this and why is it important? Health care services are expensive and costs continue to increase. Without insurance coverage, individuals (particularly low income) often delay or forego necessary medical care or do not receive preventive services leading to poorer health status and increased cost. Low income individuals often have additional social service needs. Many people (particularly children and families) may be eligible for existing programs and services but are unaware or have difficulty accessing these programs. Duplicative and complicated application processes are a barrier to enrollment.

What is the goal? *100% of people who are eligible for existing programs are enrolled*

What is the target population? Primarily uninsured below 250% of FPL, some recertifications for Medicaid

What are promising practices or “model programs” in this area?

- Jesse Tree (Galveston, TX)- universal social service application
- ConneXions (Choice Regional Health Network, WA)- connected community referral process

Where can I find more information?

How can we measure success?

Activity 2: Connect Individuals and Families to “Health Homes” with Coordinated Services

What is this and why is it important? A health home* is a health care practice that is designed to provide comprehensive primary care health services in a high quality and cost-effective manner with coordination of specialty and community-based services. The “health home” concept may have particular relevance for individuals with chronic illnesses or multiple health and social needs who face a complex care system that is often fragmented leading to missed opportunities and redundancies, decreased quality and increased cost. Individuals without health homes may use the ED inappropriately as their source of primary care. This “critical activity” was originally focused on “ER frequent flyers” (people who use the ER for non-urgent health needs on a regular basis).

What is the goal? *100% of children and individuals with chronic illnesses or complex needs will have an identified “health home”*

What is the target population Emergency dept users (?), Medicaid/State Children’s Health Insurance Program (SCHIP), uninsured/underinsured with chronic illness/multi-need,

What are promising practices or “model programs” in this area?

How can we measure success?

- ER utilization (Number/frequency of inappropriate ED visits (as determined by...))
- Proportion of individuals with chronic illness who report “usual source of care” (including coordinated health and social services?)
- Proportion of primary care practices including community health centers that provide care coordination services and other components of health home

Where can I find more information?

www.medicalhomeinfo.org/modle/learning.html

(*The Washington Health Foundation believes a “health home” promotes wellness for individuals and their families by coordinating care across all health circumstances, underlying conditions, health service needs, and settings over time. A Health Home assures that an individual or family has: a) a central resource for health and wellness information; b) a person serving as a health partner, advising on health decisions and coordinating all care; c) a central point for collection and coordination of key individual health information; and d) an individualized health plan actively implemented both by the individual or family and by their health service provider team. Similar concept of “medical home” promoted by American Academy of Pediatrics particularly for children with special health needs)

Activity 3: Assure Access to Affordable Prescription Drugs

What is this and why is it important? Retail prescription drug costs are increasing at an alarming rate, preventing many individuals from obtaining the medications they need for optimal care of their conditions. This is of concern particularly for individuals with chronic illness and those without prescription drug coverage. Most pharmaceutical companies have assistance programs for low-income, but access to these programs is limited by administrative burden. The federal government has established programs for qualified health centers (FQHCs and look-alikes) to obtain prescription drugs at significantly reduced cost through a program called 340B.

What is the goal? *100% of patients receive the medications they need for optimal management of their health conditions.*

What is the target population? Uninsured or underinsured for prescriptions (including Medicare), primarily with chronic conditions

What are promising practices or “model programs” in this area?

- Community-Wide Pharmaceutical Access (Coordinated Care Network, Pennsylvania)

How can we measure success?

- Number of clients utilizing community pharmacy services
- Cost savings for drugs obtained through 340B and Pharmacy Assistance programs
- % Individuals with prescriptions who took as prescribed (past 30 days, past 6 months)

Where can I find more information?

Activity 4: Implement Chronic Disease Management (and Case Management Programs)

What is this and why is it important? Chronic health conditions are the primary factor driving increases in health care cost and are the leading cause of morbidity and mortality today. Eighty-three percent of health care spending is for people with chronic conditions (*PFS, 2004*). Numbers of individuals with chronic conditions is rising due to aging, lifestyle, and medical advances prolonging life. Many chronic conditions can be delayed, prevented or controlled through lifestyle intervention (e.g., weight loss and exercise for diabetes) and/or appropriate monitoring and medical management (e.g., inhaled steroids to control asthma). Seventeen percent of non-elderly adults with chronic disease are uninsured (*2005 national data from Urban Institute*). There has been considerable interest and work in recent years on improving chronic disease care. In 1998, individuals at MacColl Institute for Healthcare Innovation developed the “chronic care model” based on available literature*. Since that time, the model has been refined and numerous chronic disease management programs have emerged. Studies have demonstrated improved health outcomes with the implementation of these programs for conditions such as diabetes and asthma. Some studies suggest these programs reduce cost, though long-term savings are unclear. Chronic disease management includes: population identification processes (registries), evidence-based practice guidelines, collaborative practice models, patient self-management education, process and outcomes measurement, and routine reporting/feedback between patients, providers and health plans. Coordination of these services is a key feature.

What is the goal? *100% of patients with chronic health conditions will have access to comprehensive, coordinated services for optimal management of those conditions*

What is the target population? Uninsured, Medicaid/Basic Health and Medicare with chronic conditions

What are promising practices or “model programs” in this area?

- Indiana Chronic Disease Management Program
- Many others....

How can we measure success?

- Proportion of individuals with various chronic conditions whose conditions are monitored according to evidence-based best practices
- Proportion of individuals with various chronic conditions whose conditions are under control (e.g., asthma, diabetes)

Where can I find more information?

* Chronic care model includes the following elements: the community, the health system, self-management support, delivery system design, decision support and clinical information systems.

www.improvingchroniccare.org

Activity 5: Provide Coverage for Low-wage Workers

What is this and why is it important? Largest proportion of uninsured are employed but unable to afford health coverage due to low income. Most do not qualify for Medicaid.

What is the goal? *100% of workers (and their families) will have access to affordable health coverage*

What is the target population? Uninsured low-income workers (and families)

What are promising practices or “model programs” in this area?

- 3 share plan (Muskegon, MI, UTMB Galveston, New Mexico-contributions from government, employers and employees)
- Access to Care (Cook County Illinois-small reimbursement for physicians, small co-pay, designed for working poor)

How can we measure success?

Proportion of businesses/small businesses who provide health insurance for workers
Proportion of workers who are insured

Where can I find more information?

Activity 6. Organize Donated Clinical Care Services

What is this and why is it important? Many physicians and other health care providers (e.g., dentists) have been donating services, but have not had a way to capture this information or understand extent of donation. Certain providers provide disproportionate share of “charity” care. Also, there

What is the goal? *100% of patients without health care coverage will have access to the health services they need*

What is the target population? Uninsured below 250% of FPL, underinsured (Medicaid Basic Health)

What are promising practices or “model programs” in this area?

- Project Access (volunteer physicians donate services)-model being replicated in many communities
- “Access to Care” (Cook County Illinois-small reimbursement for physicians, small co-pay, designed for working poor)

How can we measure success?

- Proportion of providers participating in Project Access
- Number/cost of donated services
- Number of individuals cared for
- Peripheral benefits of participation (care coordination and navigation assistance)?

Where can I find more information?

Activity 7. Promote Prevention and Wellness Services

What is this and why is it important? Effective preventive services are key to reducing the burden of chronic diseases and poor health status. [Need more]

What is the goal? *Prevent disease and improve health status*

What is the target population? All low income (general population??)

What are promising practices or “model programs” in this area?

- Health Plan for Life (Dr. Barchet-Seattle)
- Kids Get Care (King County)
- Muskegon Community Health Project
- Duke Prospective Health (personal health assessment, personal health tracker, care management, coaching, referral and awards/incentives program)
- Employee wellness programs including Health Risk Assessment (HRA) and incentives for behavior change

How can we measure success?

- Number/proportion of individuals receiving age-appropriate health screening and assessment
- Number who receive smoking cessation counseling and assistance → Number who quit smoking
- Number who receive nutrition/physical activity counseling and assistance → Number who lose weight or maintain healthy weight
- Proportion of children who are fully immunized

Where can I find more information?

Activity 8. Maintaining an Adequate and Stable Public and Private Provider Safety-net network

What is this and why is it important? Many private physicians have closed practices to new Medicaid and Medicare due to poor reimbursement. Community health centers have taken on major responsibility for safety-net care but are reliant on unstable/insecure funding sources.

What is the goal? *Assure adequate supply of providers (primary care and specialty) and open practices to meet community need*

What is the target population? Uninsured/under-insured, Medicaid, BH and Medicare

What are promising practices or “model programs” in this area?

How can we measure success?

- Proportion of Medicaid/Medicare with an identified primary care provider
- Proportion of providers “open” to new Medicaid, Medicare patients

Where can I find more information?

Eight Critical Activities Coordination

The “8 critical activities” framework also includes the following items to assure community level coordination of the eight activities:

- Accountable to health status, disparities and service effectiveness outcomes
- Integrated information systems
- Interoperable safety net care among providers
- Client tracking & referral systems that are connected

RESOURCES

National Resources

Healthy Communities Access Program www.bphc.hrsa.gov/cap/

Communities Joined in Action www.cjaonline.net

Association for Community Health Improvement www.communityhlth.org

- National association for community health, healthy communities and community benefit. Convenes and supports leaders from the health care (hospital focus), public health, community and philanthropic sectors to help achieve shared community health goals, and works with hundreds of members to strengthen community health through education, peer networking and the dissemination of practical tools.

National Governors' Association (NGA) Center for Best Practices www.nga.org

- Explores best practices in health with a focus on aging/long term care, chronic disease management & prevention, health care regulation, health insurance coverage/financing, maternal & child health programs, mental health & substance use, prescription drug coverage, and special projects.

Centers for Disease Control and Prevention (CDC) www.cdc.gov

- Promising Practices in Chronic Disease Prevention and Control, 2003

Partnership for Solutions: "Better lives for people with chronic conditions"

www.partnershipforsolutions.org

- Chronic conditions: making the case for ongoing care (Sept. 2004)

Urban Institute www.urban.org

- Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey (2005)
http://www.urban.org/uploadedpdf/411161_uninsured_americans.pdf#search=%20proportion%20of%20uninsured%20with%20chronic%20disease%22

Robert Wood Johnson Foundation: "Improving the health & health care of all Americans" www.rwjf.org

Commonwealth Fund Innovative Projects

<http://www.cmwf.org/tools>

Improving Chronic Illness Care: "chronic care model" www.improvingchroniccare.org

Washington State Resources

The Uninsured and Cost of Uncompensated Care in Washington: A Data Report by Region and County. Washington Office of Insurance Commissioner, August 2006
[www.insurance.wa.gov/special/coverwashington/Report\(August2006\).doc.pdf](http://www.insurance.wa.gov/special/coverwashington/Report(August2006).doc.pdf)

Choice Regional Health Network (www.crhcn.org)

- Regional Access Program
- ConneXions

Puget Sound Health Alliance: focus on improving quality and affordability of health care in Puget Sound Area www.pugetsoundhealthalliance.org

Kids Get Care (King County): “integrated preventive health care for children regardless of insurance status” www.metrokc.gov/health/kgc

Other Regions/Communities

The Archimedes Movement: “creating a sustainable system which uses the public resources spent on health care to ensure everyone has access to a defined set of effective health services” www.archimedesmovement.org

Duke Prospective Health www.dukeprospectivehealth.org

- Personal health risk assessment (online), personal health tracking, care coordination and coaching (if needed), awards/incentives

Access Health (Muskegon, Michigan “three-share” project) www.access-health.org
Woodbury, Strugar-Fritz & Shaheen. *Out of the Box and Over the Barriers: Community Driven Strategies for Addressing the Uninsured*, 2002 (guide for communities interested in replicating similar program)

University of Texas Medical Branch three-share program
<http://www.utmb.edu/cehd/programs/3share/concept.html>,

Whatcom County Resources/Projects

Whatcom County Coalition for Healthy Communities (health in its broadest sense)-
Community Counts project, leadership development www.whatcomcounts.org

Whatcom Physical Activity Coalition-promoting active community, walking maps, bike to school/work, etc.. www.beactiveforlife.org/Whatcom/

Pursuing Perfection-RWJ funded project -coordination of care through “clinical care specialists” [Does a summary of learnings exist?]

Whatcom Health Information Network-HInet www.hinet.org