



IMPROVING  
**HEALTH CARE**  
**ACCESS:**

FINDING SOLUTIONS *in a* TIME of CRISIS

COLLABORATIVE PROBLEM SOLVING  
*for STATES and COMMUNITIES*

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*The National Policy Consensus Center (NPCC) recently hosted a colloquium on community-based approaches to health care access in the United States. Experts in public health, health care policy and financing, community collaborations, and coalition and consensus building met to explore continuing dilemmas and past successes. The aim of the colloquium was to identify models and elements that can be adapted to create more collaborative approaches to health care access. This report is an outgrowth of that colloquium.*

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The **National Policy Consensus Center** assists public leaders and state dispute resolution programs in establishing and strengthening the use of collaborative practices to address difficult public policy issues.

**Greg Wolf, Director**

National Policy Consensus Center

Portland State University

720 Urban Center

506 SW Mill St.

P.O. Box 751

Portland, OR 97207

503-725-9077

gwolf@pdx.edu

**www.policyconsensus.org**

**Text by**

Tina Castañares, MD, NPCC Fellow

tina.castanares@gorge.net

**Design by**

Dan Abeln Graphic Design

danabeln@earthlink.net

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# FOREWORD

*John A. Kitzhaber, M.D*  
*Governor of Oregon, 1995–2002*  
*Co-Chair, Board of Directors*  
*National Policy Consensus Center*



As a 14-Year veteran of the state legislature and two-term governor of Oregon, I have had the privilege to work for nearly 25 years in state policy and financing to increase access to health care.

The lessons have been varied—some gratifying, some painful.

In its first decade, the Oregon Health Plan demonstrated how creativity and teamwork at this level can produce innovation, reform, and real gains for the citizens of our state. Over 100,000 previously uninsured Oregonians were enrolled in health plans, and a gratifying movement in the direction of national policy was emerging. Yet some of the best potential elements we conceived were sabotaged by unduly rigid regulatory environments, and by competition and conflicts of interest among stakeholder groups.

By 2002, Oregon—like so many states—was bracing for budget shortfalls that threatened to unravel the significant progress we had achieved. Substantial federal reforms around health care access looked like a remote possibility at best, and it was clear that states by themselves could not create or carry out all the solutions needed.

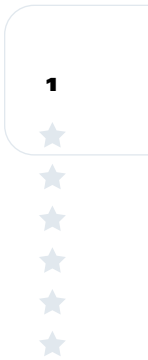
Obstacles to health care access represent a profound national problem that grows worse each year. Despite ever-more innovative technologies and advances, more and more Americans are left behind or at risk. These people are our friends and neighbors, our co-workers and their families, our parents, and even ourselves. They are essential parts of our communities, where the health of one directly or indirectly affects the health of all.

Some communities have stepped forward to find their own solutions. Community collaborations, partnerships, and coalitions for health care access are slowly appearing throughout the country. So far, most of them have focused

on specific health topics or important issues—teen pregnancy rates, drug addiction treatment, HIV-AIDS care, and others. But some communities are tackling access problems more broadly. They are finding ways to obtain insurance coverage for community residents, securing provider networks and delivery systems offering everyone essential primary and preventive care, creating new clinics with robust partner agencies and community investments, and aligning payment incentives so that keeping people as healthy as possible is acknowledged and rewarded as the best strategy for citizens and for health care providers alike.

Collaborative problem solving at the community level holds great promise for improving health care access, just as it does for environmental protection, stewardship of resources, education, and regional economic development. To be successful and sustainable, community collaborations require committed state support. When states thwart community-based initiatives by imposing rigid regulations or irrational requirements, our society cannot move forward. When they fail to participate actively in collaborative processes or to commit financial and technical assistance, opportunities are lost and intended reforms fail.

This report summarizes the results of a colloquium sponsored by the National Policy Consensus Center involving experts on health care access and community collaborations from across the country. It concludes with specific recommendations to state agencies and elected officials. The aim of the report is to inform both new and seasoned public servants in designing and implementing successful community-based collaborations that result in better basic health care for all citizens.





## HOW CAN COLLABORATION IMPROVE ACCESS TO HEALTH CARE?

Many important initiatives to engage communities in addressing their health care crises are currently underway throughout the United States. National organizations are convening community dialogues and organizing consumer advocacy projects. Foundations and academic centers are identifying effective community strategies, analyzing the secrets of their success, and disseminating them as effective models and approaches. State governments, many of which are dealing with significant budgetary shortfalls, are monitoring the creative initiatives of certain pioneering communities. In some regions, federal, state, and community stakeholders are working together to improve access and coverage.

The body of experience and lessons learned from these collaborative approaches to improving access to health care are valuable for a number of reasons. As states assume a larger role in developing programs and reforming their health care systems, existing models of collaboration allow policy makers to evaluate what works and what doesn't, and can help identify the most promising and effective approaches to ensuring access to basic care.

Effective collaborations involve a process through which citizens, providers, advocates, government officials, and other stakeholders explore obstacles, differences, and alternative strategies for improving access to health care.

A supportive role by government is critical to the success of such collaborative initiatives. Community efforts undertaken without the participation of key leaders are far less likely to succeed. Early and sustained government involvement leads to more innovative and flexible approaches that respond to communities' specific problems of access to health care.

With an overarching focus on exploring community collaboration for improved health care access, the NPCC health care access colloquium had several goals: 1) to share examples of community-based models that have already proven successful, 2) to inspire more communities and funders to do critical experimentation and community-based research, 3) to help state and federal policymakers recognize the array of opportunities for ensuring health care access in the United States, and 4) to emphasize the essential role of consensus in creating effective partnerships.

### Key recommendations

The following three key recommendations are based on research and experience from a number of community-based collaboratives throughout the country, and from input by the NPCC colloquium participants and others involved in collaborative approaches to improving health care access:

1. Many more community-based collaboratives, of differing sizes and scales, should experiment with improving health care access.
2. Policy leaders and funders should convene, support, and champion the efforts of those community-based collaboratives.
3. Research on the outcomes and effectiveness of community-based collaboratives aimed at improving health care access should be supported and disseminated.





## REASONS FOR STATES TO SUPPORT HEALTH CARE ACCESS COLLABORATIONS

Despite our country's abundance of resources and advanced technologies, Americans' health status compares poorly with most other industrialized countries. The gaping health disparities that exist between rich and poor, insured and uninsured, rural and urban, black and white (and other racial and ethnic groups) are demonstrably linked to access barriers.

Health care is the fastest growing sector of spending in the United States. In addition to the costs of basic services, people—and society—pay a huge price when so many citizens go without the care they need. Individuals suffer preventable illness, pain, complications, bankruptcy, family disruptions, job loss, disability, and even premature death. Others pay, too. Infection rates increase, public health and safety are compromised, children miss school, adults miss work, productivity drops, crime and homelessness increase, social agencies are drained. Health care rates and insurance premiums soar as a consequence of cost shifting. Employers drop benefits for workers or buy policies so lean that even their insured employees can't afford necessary care.

### Truly “accessible” health care means three basic things:

1. **Care is available.** People are diagnosed and treated promptly, and can obtain quality preventive care early enough to avoid illness or complications. Services are offered within a reasonable distance from where people live.
2. **Care is appropriate.** The right mix of health care professionals exists to attend to people's most frequent needs. Cultural and linguistic barriers are addressed in such a way that patients get proper diagnoses and can communicate effectively with their providers.

3. **Care is affordable.** Basic health insurance coverage, the linchpin of accessibility in the U.S. system, is provided for all. Additional, out-of-pocket costs are adjusted for those with low incomes.

In the United States, insurance coverage is so central to access that the terms are often used interchangeably. But the distinction between them is crucial for communities to think more broadly in addressing barriers to access. Communities usually cannot close the coverage gap by themselves, but they can reduce the impact of that gap by ensuring available, appropriate care that is affordable even to many of their uninsured residents.

In addition, communities can collaborate effectively with state and federal funders on coverage initiatives. In several cases, such public-private partnerships, initiated

3





at the community level and administered there, have achieved significant gains in insurance coverage.

The problem is that governmental regulation sometimes hinders rather than supports community solutions to problems of health care access. By learning what communities need to collaborate effectively, government leaders will be better equipped to offer meaningful support. And as state and federal decision-makers grapple with how to reform health care financing policy, their work can be strengthened by successful community-based efforts to make health services more widely accessible to the public.

This report includes a number of case examples of how communities have enhanced access to health care, and the vital roles that state and federal government have played in those successes.

### **Grassroots Health Care Coverage in Muskegon County, Michigan**

In Muskegon County, every dollar of public money leverages two dollars of private funds. State government has allowed federal “disproportionate share hospital” (DSH) funding to be administered at the county level, attracting a favorable match from the business community, whose smaller employers have been unable to offer or sustain insurance coverage for their workers. As a result, the county’s “Access Health” program generates \$2 million annually in new revenue to pay for local health services for previously uninsured people. More than 400 businesses are enrolled and over 1,500 people are newly insured. Ninety-seven percent of local providers (more than 200 physicians) participate, as well as both county hospitals.

Created in 1999, the program was initially designed to help small- and mid-sized businesses provide employee health care. The \$2 million annual budget is financed through a three-way split. Employers and employees each contribute 30 percent (\$42 per month per member) with a community match of 40 percent that comes from federal DSH money and state, local, and private funding.

“We’ve provided for local businesses and for people who don’t have health care — the waitress, the child care worker,” said Michigan State Representative Julie Dennis. “This has helped stabilize the workforce.”

The benefit plan includes primary care, hospitalization, outpatient services, prescriptions, diagnostic lab work and x-rays, home health, and hospice care. “It’s more about managed health than managed costs,” Dennis says. “We get people into primary care first so they’re not walking into the emergency room when something happens.”

In the long run, the stress on primary care and prevention has saved the state and the county money that would otherwise have paid for uncompensated care — probably in an emergency room.

Adapted from an article by Dianna Gordon in *State Legislatures* magazine, October 2003.





## WHAT SOME COMMUNITIES ARE DOING TO IMPROVE HEALTH CARE ACCESS

Ingenuity and determination are behind efforts in a number of American communities that are successfully overcoming barriers to health care access. The models vary widely, but all involve diverse community partners who have come together and reached consensus on strategies. Virtually all the effective projects involve regular monitoring and cost-benefit analysis, projecting or demonstrating dramatic savings to local and regional economies.

Some have tackled the issue of coverage by creating local, nonprofit managed care plans for low-income workers, other uninsured residents, or people living with chronic diseases. Among the most promising programs for future sustainability are those where financing involves cost sharing—in which employers, employees, government and community funders all contribute.

Other communities have addressed different elements of access. Volunteers and staff members may find underserved patients a “medical home.” Or they may facilitate patients’ enrollment in public programs, ensure transportation to health care appointments, provide translation and interpretation services, or case-manage those with chronic and costly illnesses.

Effective community collaborations usually enlist health care providers, social service agencies, pharmacies, and even insurance agents to donate or deeply discount their services to support the newly created systems.

With increasing frequency, communities are establishing bricks-and-mortar health care facilities for the underserved. More than 900 federally qualified community health centers now exist nationwide, with more opening their doors each year. These private, non-profit organizations rely on support from a variety of sources. An essential primary care safety net is emerging, made up of these health centers as well as

county health departments, rural and school health clinics, health programs for the homeless and residents of public housing, and other entities.

While these salutary projects neither “fix” the American problem of uninsurance nor reach the goal of “100 percent access, zero health disparities” (a widely cited national objective), they are a vital piece of a larger solution.

Communities that are accomplishing their immediate objectives have all required some degree of financial assistance (from taxes, set-asides, foundations, employers, and other sources). They also have relied on policymakers to create vital regulatory flexibility, to participate in or even convene collaborations, and to provide technical assistance.





## WHAT COMMUNITIES NEED TO COLLABORATE EFFECTIVELY

Participants in the NPCC Health Care Access Colloquium identified a number of key elements necessary for communities to collaborate to improve access to health care:

- **Adequate resources.** Communities in financial crisis are unlikely to succeed. What the community can bring immediately to the table—including money—must be articulated. Often there are sufficient resources and assets that have yet to be tapped or consolidated to accomplish certain objectives.
- **Initiatives that are small to moderate in scale.** Although some successes have occurred in larger metropolitan areas or counties, collaborations usually come together faster and more effectively if they address smaller geographic areas, pockets, neighborhoods, or special populations.
- **Proper framing of the work to be done.** Vision may be broad and conceptual, but shared mission and objectives must be clearly defined in simple, concrete, do-able terms. Partners must identify initial priorities, then proceed incrementally to build larger successes upon smaller ones. Most steps require clear consensus and resolution of any conflicts that emerge along the way.
- **Measurable indicators.** It is difficult to measure all the benefits of improved access to health care, particularly clinical outcomes at the community level. However, progress on objectives must lend itself to reasonable monitoring and reporting. Examples of quantifiable indicators include rates of uncompensated care, number of women lacking prenatal services, number of dentists volunteering their time, immunization rates, etc.
- **Local champions and empowered leaders.** Diverse, credible leaders from key arenas must be the visible champions of collaborative processes. These may include people from churches, schools, local government, businesses, hospitals, clinics, social service agencies, and consumer advocacy groups, as well as health care providers such as doctors, dentists, and therapists. Those involved in the discussions and decision-making must be authorized to act for their groups or constituencies.
- **Participation of people with other necessary resources.** Participants from outside the local community, but who may still have a stake in the decisions being made, also should be at the table. These include state and federal government representatives, as well as philanthropic and corporate funders.

6



- **Commitment, a well designed process, and accountability.** All participants must commit to full involvement and maintenance of effort. They must agree to group norms, the goal of consensus, negotiating in good faith, and transparency. Along with outcomes and accomplishments, follow-through by all participants should be reported

### State Convenes Collaborative Process for Migrant Health Clinic in Oregon

Acknowledging the vital role that migrant and seasonal farm workers play in the state's economy, Oregon applied to the U.S. Bureau of Primary Health Care to fund a new position. Alberto Moreno, MSW, became the first Migrant Health Specialist at the Oregon Department of Health Services in December 2002.

In response to disturbing findings from a survey of Oregon farm workers, Moreno convened a group of stakeholders in Wasco County to discuss challenges, opportunities, and the urgent need to provide health care for farm workers.

Moreno's legwork both before and during the first meeting had an immediate payoff. A federally qualified community and migrant health center from a neighboring county stepped forward as the logical applicant for new federal startup funding. Other community participants at this state-convened discussion pledged support, and later delivered on their promises.

Assistance from the St. Vincent de Paul Society, the local hospital, the state Primary Care Association, the county health department, primary care physicians and dentists, the mental health agency, the County Board of Commissioners, Migrant Head Start, and numerous others resulted in a successful grant proposal that was submitted within one month of the stakeholder meeting.

Nine months later, La Clínica del Cariño's satellite health center began serving residents of Wasco County who had previously faced severe obstacles to accessing basic health care.

regularly, including to the public at large. Involvement of the media can be very useful if engaged appropriately.

- **Neutral, skilled facilitation.** An external facilitator with knowledge of health care access issues can ensure a respectful, safe environment for discussion.
- **Ongoing external assistance.** Financial support and technical assistance are crucial for convening meetings, coordinating communication, and monitoring and reporting progress.
- **A flexible regulatory environment.** State and local rules and regulations must be flexible enough to allow creative ideas to be put into motion.
- **Useful data and analysis, presented constructively.** Most statistical reports fail to inspire people, especially when they are about concerns already widely felt. Motivating the public and community partners with information presented as marketing messages with relevance to local residents may be a more successful strategy than scientific reports. Also, analysis must be sophisticated and tailored to local interest. For example, the direct and indirect costs to the community when the local emergency room is over-utilized is likely to capture the interest and attention of local citizens.
- **Clear articulation of the benefits of a consensus approach.** The return on an investment in a collaborative process must be clear to people. For example, improved access to health care can mean less absenteeism and greater productivity from workers. People paying taxes and insurance premiums may experience less cost-shifting. Providers are likely to see more patients at earlier stages of illness, before complications and poor prognoses occur, and peoples' reliance on uncompensated care may be reduced.





## RECOMMENDATIONS FOR POLICY MAKERS AND OTHER STATE AND FEDERAL LEADERS

The following recommendations are directed to governors' offices, agency heads, and other state leaders who are seeking to improve the effectiveness of collaborative approaches to health care access. They also will be useful to federal officials, local and state agency staff members, and community health care professionals whose programs and services can benefit from greater involvement of citizens and government in matters of health care delivery.

The recommendations are drawn from the ongoing experiences and lessons learned in communities where collaborative strategies are being used to address the crisis in health care access.

1. **State and federal regulations and requirements should be flexible enough to be changed when needed.** Regulations are meant to protect the public and its resources—but not from the public's own good ideas.

*To support the development of community-based, collaborative health plans, the Arkansas State Legislature passed an exemption for such collaboratives from the legal and financial requirements governing other health insurance entities. One legislator noted, "Sometimes we just need to get out of the way."*

*In California, North Carolina, Mississippi and elsewhere, state leaders are working with community stakeholders to assist in developing and growing community networks. Georgia has eight Team Leaders—trained in facilitation, strategic planning, mediation, and leadership development—who serve as community catalysts. Through a partnership with the National Conference of State Legislators and the National Association of County Commissioners, the Georgia team has convened some 100 state and local leaders to develop more effective support of community health access projects.*

*At the federal level, the U.S. Office of Rural Health Policy and the Health Resources and Services Administration are making strides—via state-administered Offices of Rural Health, Primary Care Associations, Community Access Programs, and other entities—to strengthen and support more than 60 community-based networks in some 30 states.*

2. **Top-level leadership should be willing to participate fully, and take risks.** Governors, legislators, state officials, and foundations often recognize windows of opportunity that community members are unaware of. Officials who show up only because they are expected to, then do little to contribute to the process, are unlikely to be able to demonstrate success. Instead, leaders should treat community collaborations as a significant tool for addressing the complex problems associated with access to care, and as a complement to more traditional models. They should encourage agency staff to participate in community collaborations, and empower them to reach and implement agreements with those communities.

*In Louisiana, some 20 partners—including foundations, state and county agencies, professional associations, and others—stepped forward as leaders in coordinating the efforts of communities working to improve health care access. The state's Office of Rural Health is now looking at ways to reconfigure its funds, and has expressed a willingness to change how it does business by providing more support (such as technical assistance) to community networks.*

3. **Policymakers and convenors should ensure that skilled technical assistance, including data analysis and conflict resolution, is available to stakeholders.** Communities often lack the infrastructure and resources necessary to manage collaborative processes efficiently. Lack of access to



useful databases such as Medicaid utilization figures can be significant barriers to effective negotiating and implementation strategies.

*Georgia state policymakers joined forces with local and national foundations to provide grants and technical assistance to communities, noting the alignment of goals: increased access, health status improvement, and economic sustainability of local community projects. The state also commits economists and researchers to work with community groups who are building collaborative access projects.*

4. **State leaders should look creatively at financing, particularly leveraging and rearranging of resources.** For example, are state funds available that could be matched with local monies? Can indigent care trust funds be used for a community coverage initiative? Are private sector contributions a possibility? Can modifying state tax structures free up vital funding?

*In Michigan, the state uses federal Medicaid DSH (“disproportionate share”) funds as the third, governmental element in counties’ “three-share” market-oriented coverage programs. The state is currently exploring even more opportunities within state and federal funding environments, including Medicaid administrative monies and their potential federal match, to support community-based networks.*

*Habersham County, Georgia, is involved in a new demonstration project in which state employee benefits funds are paying for a four-county community collaborative to undertake case management for high-risk beneficiaries with chronic illnesses. This allows counties to use the same infrastructure to case-manage both Medicaid patients and the uninsured, and to sell their valuable service to businesses. The project could turn a state experiment at one level into a sound investment at several other levels, even generating its own revenue.*

5. **The state should provide incentives for both private and public sector participation.** State leaders can require or offer incentives to businesses, foundations, and others in the private sector to come to the table.

*Indicative of Georgia’s strong commitment at many levels to community-based access projects, the state now requires its hospitals to spend 15 percent of their*

### **Partnering for Health Care Access in Wichita**

In Wichita, Kansas, uninsured residents are eligible for donated services from physicians, hospitals, and pharmacies through “Project Access,” a program sponsored by Central Plains Regional Health Care Foundation, Inc. (CPRHCF).

Thanks to the vision and sustained support of the Medical Society of Sedgwick County, United Way, the city, county, state and others, CPRHCF has been able to organize and maintain services, and even grow the organization. With 55,000 uninsured in the region, volunteer-only services will not be sufficient to address all access problems. But the seed is there, the participants are involved and invested, and the successes are mounting.

Sixty-five percent of local physicians and all area hospitals treat “Project Access” patients, and 65 pharmacies fill prescriptions at 15 percent below wholesale prices, with no filling fees. In addition, the City Council and the County Commission each pledged \$500,000 annually to pay for prescription medications.

Program Director Anne Nelson predicts a business case will emerge to spur a larger community health initiative, perhaps even some kind of coverage plan. And Governor Kathleen Sebelius, a former state insurance commissioner, may prove to be uniquely knowledgeable and open to such collaborations, Nelson says.

In the meantime, United Way support of \$180,000 per year has been a hugely effective investment. In 2002 this funding translated to \$5 million in donated health care. CPRHCF founder Dr. Paul Uhlig and Wichita United Way President Patrick Hanrahan received a Mary M. Gates Award for this work. In accepting the award, Hanrahan challenged all United Way chapters to fund local community collaborations for health care access. As a result, such activity is now a formal arm of the United Way of America.



*indigent care funding on primary care, thus stimulating their investment in community programs outside their usual inpatient care purview.*

6. **States should support development of community health centers and safety net providers.** State support of safety net clinics can mean the difference between expansion and closure. The safety net today makes possible the implementation of Medicaid and, increasingly, Medicare. This safety net uniquely serves immigrants, the uninsured, and other special populations. State- and foundation-sponsored demographic studies can offer support for the development of new clinics. Solid relationships between state Medicaid offices and these safety net providers are essential.

*Several states provide funds to their **Primary Care Associations, Offices of Rural Health,** and other agencies specifically to assist communities in developing needs assessments, grant proposals, and recruitment and training of Boards of Directors to establish federally qualified community health centers. Other states provide direct financial assistance to established centers. For example, the **State of Virginia** sponsors a network of state-qualified community clinics that encourages collaboration between safety net providers and state agencies.*

7. **Leaders—including governors, legislators, and state and federal agencies—should use their ability to convene to bring all essential parties to the table.** While direct involvement of the governor's office in a collaborative process may be infrequent, its convening authority can be direct and powerful. In most cases, the governor will be able to impart that authority to a community leader, staff member, or agency head. The governor, staff member, or agency head can recognize, support, or encourage on-going efforts by local collaboratives that are already convened under a skilled leader. The encouragement of governors and agency heads demonstrates their commitment to the process and outcome.

## **Improving Health Access for Seven Cities in California**

More than 60,000 of the 370,000 residents of Solano County, California were uninsured in 1988, and another 45,000 on Medicaid faced a dwindling supply of physicians willing to treat them because of low and complex reimbursement rates. Although California requires counties to provide health care to indigent residents, Solano had no county hospital. A budget crisis threatened the viability of two county clinics, the primary points of care for this population.

A small group of health care leaders began meeting to address this problem, and soon formalized a non-profit partnership called the Solano Coalition for Better Health. The thriving Coalition includes high-level county administrators, CEOs of the three area hospitals, clinic administrators, United Way, federal and state legislative staff, providers, consumers, insurers, and churches.

By 1994 the Coalition opened what is now the county-run Partnership Health Plan of California that serves its Medicaid population. The plan has resulted in 45,000 residents with new access to integrated and comprehensive primary care; a 50 percent drop in emergency room use; a 33 percent decrease in hospital inpatient days for Medicaid enrollees; and a successful prenatal case management plan. Medicaid reimbursement rates to providers have increased substantially, and primary and specialty care physicians have assumed leadership roles in operations.

The Solano County Commission has been a key player. It allocated all its tobacco settlement monies to health care, and developed a Strategic Plan for Health Care Access in partnership with the Coalition.

State involvement also has been essential. The Coalition needed California's approval to be one of three counties allowed to organize their own single health plans for administering managed care Medicaid. Not only was the state open to piloting Solano's model, it also has continued to support the 10-year-old plan, which is no longer a pilot.





## CONCLUDING CONSIDERATIONS FOR LEADERS AND CONVENORS

The traditional delivery and financing models for health care in America have proven inadequate. Despite accelerating expenditures, highly advanced technologies, and a rich variety of professional providers, an increasing number of people lack ready access to even the most basic primary health services.

The crisis has compelled community leaders, health care providers, advocates, states, and other key stakeholders to apply collaborative practices to resolving the complex problem of access to health care. These community-based initiatives have the potential to expand access to care, improve health outcomes and productivity, and even reduce health care costs over the long term.

Yet for collaborative approaches to be successful, leaders at all levels of government must be committed participants. By supporting existing collaboratives aimed at improving access and coverage, governors and other leaders can help move projects beyond the demonstration or pilot stages into sustainable programs with enduring benefits.

Convenors and participants in a process must think and act for the long term. In doing so, there are a several important factors to consider before committing time and energy to collaborative processes. First, successful collaborations take time. Where financial and technical support is needed, it likely will be required for some years or—for some projects— indefinitely. In addition, providing “seed money” alone can lead to failure in communities requiring some amount of continued external funding or other resources. Secondly, program evaluation requirements may stall community initiatives when the reporting measures or bureaucratic details are onerous.

Modest investments of state funds to enable and support community collaborations can have a big payoff. States can play a key role in assisting with data collection and

dissemination, and in developing new data to provide the factual basis for agreements. State agencies can assign resources for monitoring the outcomes and effectiveness of programs, or by assisting community groups in developing assessments and plans that are manageable and compliant with existing regulations.

State and federal involvement in community level collaboratives holds great promise for improving health care access, just as it does for environmental protection, stewardship of resources, education, and regional economic development. Based on past experiences and the growing record of accomplishments across the country, community collaborations to improve access to health care will achieve greater success and sustainability with increased state support and active participation by leaders at all levels.





## REFERENCES AND RESOURCES

### Useful websites

#### Agency for Healthcare Research and Quality: State and Local Policymakers

<http://www.ahrq.gov/news/ulpix.htm>

Federal scientific agency focused on quality of care research. Coordinates all federal quality improvement efforts and health services research.

#### American Project Access Network

<http://www.apanonline.org/>

National, nonprofit that assists communities in establishing and sustaining coordinated systems of charity care based on the Project Access model.

#### Assessing the New Federalism (Urban Institute)

<http://www.urban.org/Content/Research/NewFederalism/AboutANF/AboutANF.htm>

Multi-year Urban Institute research project that analyzes the devolution of responsibility for social programs from the federal government to the states.

#### Bureau of Primary Health Care Models That Work Campaign

[bphc.hrsa.gov/programs/MTWProgramInfo.htm](http://bphc.hrsa.gov/programs/MTWProgramInfo.htm)

Public/private partnership of national foundations, associations, nonprofits, federal agencies and business. Promotes access to primary and preventive health care for underserved populations.

#### Center for Collaborative Planning

<http://www.connectccp.org/>

Promotes health and wellness in California by engaging local communities to identify their own issues, assemble resources, and find solutions.

#### Communities Joined in Action

[www.cjaonline.net](http://www.cjaonline.net)

Private, nonprofit that brokers access to technical talent, peer-mentors, and experts to help communities gain commitment of political leaders and evaluate health care delivery options.

#### Community Health Leadership Program

<http://communityhealthleaders.org/>

Program of the R.W. Johnson Foundation that honors 10 outstanding individuals who overcome daunting odds to expand access to health care and social services to underserved populations.

#### Community Tool Box

<http://ctb.ku.edu/>

Provides practical information to support community health and development. Tool Box offers "topic sections" with guidance on how to promote community health and development.

#### Community Voices

<http://www.communityvoices.org/>

Works to ensure survival of safety-net providers and strengthen community support services. Eight Community Voices sites are part of a national effort to meet the needs of people who receive inadequate or no health care.

#### FACCT (Foundation for Accountability)

<http://www.facct.org/facct/site/facct/facct/home>

National organization working to improve health care by advocating for an accountable and accessible system in which consumers are partners in their own care.

#### Georgia Health Policy Center

<http://www.gsu.edu/ghpc>

Nonpartisan forum for consensus building aimed at improving the health of Georgians through research, policy development, and program design and evaluation.

#### Health Affairs: The Policy Journal of the Health Sphere

<http://www.healthaffairs.org/>

Bi-monthly peer-reviewed journal that explores current health policy issues.

#### National Governors Association Center for Best Practices

<http://www.nga.org/center/>

Helps governors and key policy staff develop and implement innovative solutions to challenges facing states. Among its five divisions is Health, covering a broad range of health financing, service delivery, and policy issues.



### Sierra Health Foundation

[www.sierrahealth.org/](http://www.sierrahealth.org/)

Private philanthropy supporting health and health-related activities in a 26-county region of northern California. Focuses on collaboration, communication, and sharing successful strategies.

### State Coverage Initiatives

<http://www.statecoverage.net/>

A R.W. Johnson Foundation initiative aimed at planning, executing, and maintaining health insurance expansions in states. Policy experts work with states to expand coverage to working families, build on employer-based health insurance, and foster collaboration among stakeholders.

### Center for the Advancement of Collaborative Strategies in Health

<http://www.cacsh.org/>

Helps partnerships, funders, and policy makers in collaborative efforts to solve complex problems related to health and other areas. Works closely with people and organizations involved in collaboration.

### The Center for Studying Health System Change

<http://www.hschange.com/>

Nonpartisan policy research organization that conducts studies on the U.S. health care system to inform policy makers in government and private industry.

### The Commonwealth Fund

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

Private foundation that supports independent research on health and social issues. Makes grants to improve health care practice and policy.

### The Institute for Health Policy Solutions

<http://www.ihps.org/>

Nonprofit that develops creative solutions to health system problems related to access, cost, and quality.

### The Henry J. Kaiser Family Foundation

<http://www.kff.org/>

Private, nonprofit operating foundation focused on the nation's major health care issues.

### Volunteers in Health Care

<http://www.volunteersinhealthcare.org/>

National resource center funded by the R.W. Johnson Foundation for organizations and clinicians caring for the uninsured. Provides technical assistance and small grants.

### Wye River Group on Health Care

<http://www.wrgh.org/index.asp>

Forum for collaboration and exchange of ideas to promote constructive healthcare system change.

## Publications

An Online Version of this report is available at [www.policyconsensus.org](http://www.policyconsensus.org).

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1. Coverage Matters: Insurance and Health Care (2001)
2. Health Insurance Is a Family Matter (2002)
3. Care Without Coverage: Too Little, Too Late (2003)
4. Hidden Costs, Value Lost: Uninsurance in America (2003)
5. A Shared Destiny: Community Effects of Uninsurance (2004)
6. Insuring America's Health: Principles and Recommendations (2004)

Hadley, Jack and Holahan, John, "How Much Medical Care Do The Uninsured Use, And Who Pays For It?" *Health Affairs*, February 12, 2003, and "Covering The Uninsured: How Much Would It Cost?" *Health Affairs*, June 4, 2003.

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National Policy Consensus Center  
Portland State University  
720 Urban Center  
506 SW Mill St.  
P.O. Box 751  
Portland, OR 97207  
503-725-9077  
[www.policyconsensus.org](http://www.policyconsensus.org)