



# Understanding Community Care Organizations

A case study of 100% Access in Lane County, OR.

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## Chapter One – Purpose of the Study

### Statement of the Problem

In 2008 the measured healthcare spending of the United States was 16.5% of the GDP, or \$7,281.00 per resident<sup>1</sup>. The United States is the only developed country in the Western Hemisphere in which not all of its citizens are afforded basic health care<sup>2</sup>. In March of 2010, President Obama signed into effect the Patient Protection and Affordable Care Act (PPACA), a federal attempt to legislate change within the health care system in the U.S. The provisions of the PPACA are vast and began to go into effect in 2010 with implementation continuing until 2018<sup>3</sup>.

One of the main goals of the PPACA is to lower the costs of health care in the United States. Currently, the U.S spends a higher percentage of their Gross Domestic Product (GDP) on health care than any other developed country in the world. Further, as evidenced by the growing populations of uninsured or underinsured, the rising costs are not helping the nation become healthier. The United States is currently ranked 37<sup>th</sup> in terms of the healthiest nations<sup>4</sup>. The PPACA works under the assumption that healthcare is a basic human right, not a privilege, and it is under this ideal that the reforms take place.

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<sup>1</sup> Kaiser Permanente Health Fact Sheet

<sup>2</sup> Murray, C. J. L., & Frenk, J. (2010). Ranking 37th — measuring the performance of the U.S. health care system. *N Engl J Med*, 362(2), 98-99. doi:10.1056/NEJMp0910064

<sup>3</sup> PPACA.com

<sup>4</sup> <http://www.nejm.org/doi/full/10.1056/NEJMp0910064>

One aspect of the PPACA is federal attempts to create Community Care Organizations (CCO's). Community Care Organizations are defined in the Oregon Health Plan as "networks of care comprised of at least one large organization, one state organization, and one human services organization". Health care is a difficult problem to uniformly fix; each community faces different health needs and as such, needs different methods of addressing the problem.

In the state of Oregon, health care expenditures reached 13.2% of the Gross State Product (GSP), and the average annual growth of these expenditures (calculated since 1989) is 8.7%<sup>5</sup>. Yet almost 17% of Oregon's residents remain uninsured and the number of Oregon residents who are underinsured is growing every year. The declining economy only exacerbates the problem as Oregonians continue to lack adequate medical access and reasonable care. Many Oregonians who once had access to affordable health care through their jobs are finding the costs of unemployment to expand past the lost paycheck. In February of 2012, Oregon state legislation passed House Bill 3650, which proposes CCO's in order to administer and enact all aspects of the Oregon Health Plan within the communities<sup>6</sup>. Because of this legislation, this capstone is relevant in order to understand what creates successful health collaboration within community partners.

### **Justification of the study**

Oregon has been a leader in the attempt to increase accessibility; the Oregon Health Plan was a pioneer in beginning the uphill battle towards decreasing health costs in order to afford

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<sup>5</sup> Kaiser Permanente- State fact sheets

<sup>6</sup> <http://www.oregon.gov/OHA/OHPB/health-reform/docs/cco-faq.pdf?ga=t>

health care that works for more Oregonians<sup>7</sup>. Throughout the state there are multiple examples of Affordable Care Organizations (ACO) and CCOs that work within their local communities to make health care more accessible and more affordable. Within the current legislative framework, Oregon is beginning to take the stage in the setup of collaborative efforts of all providers and recipients of health care [Healthcare for All of Oregon). Oregonians for Health Communities, 100% Access Coalition, Care Oregon and the Oregon Coalition of Health Care Purchasers are among the myriad of groups and organizations that are starting the journey towards a new type of system.

Understanding the inner workings of these CCOs and how they work together is of utmost importance in being able to expand these models to other states. Collaboration between health care and social care organizations helps to ease the burden of services by streamlining the system so there is less overlap between services provided and more communication on the needs of each patient. The goal of this literature review will be to understand the legislative environment concerning emerging CCO's, as well as understanding existing case studies on health coalitions and practices.

The CCOs are most effective at the local community level, and as such a case study makes the most sense for understanding just why 100% Access has been so successful in its mission. The 100% Access Coalition is a community based coalition that encompasses not only hospitals and doctors, but also social service offices, government and non-profit organizations within the Lane County Community. The 100% Access Coalition's efforts in engaging state policy

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<sup>7</sup> Bodenheimer & Grubach

through community forums and meetings will be analyzed in conjunction with its evolving goals.

### *Lane County Demographics*

Lane County is one of the larger counties in Oregon and encompasses the cities of Eugene and Springfield, as well many smaller rural communities and extends out to the coastal town of Florence, Oregon [Figure 1]. It is a diverse population of both blue and white-collar workers, alongside diverse ethnic populations and income levels.

Lane County Demographics	2010
Population	351,715
Median Household Income	\$42,923.00
White	88.3%
Black	1%
American Indian/Alaska Native	1.2%
Asian	2.4%
Hawaiian/Pacific Islander	0.2%

Figure 1



In 2004, United Way of Lane County performed a Community Needs Assessment and found that for the first time, the top three problems for residents of Lane County included lack of access to medical care and insufficient funds to pay for both health insurance and prescription costs. Members of the health community decided to take action and the 100% Access Coalition began to form.

Upon inception, the Coalition set the health care goal of providing affordable and quality care to 15,000 residents of Lane County by 2020, and in 2011 has achieved that goal for 15,000 of its residents (United Way of Lane County). United Way's official statement release says:

Between 2007 and 2010 the Safety Net Clinics, partners and members of the 100% Access Coalition, achieved this goal for the community. Safety Net Clinics provided care to 42,272 patients in 2010, a 60% increase since 2007. The Coalition is working together to establish a new goal by late fall for our community to achieve by 2020.

One of the underlying goals of 100% Access is to increase collaboration and community-based care within Lane County (100% Access, UWLC). Health care is not limited to hospitals and emergency rooms; it is a collaboration of a multitude of organizations and entities, both public and private, which works together to achieve a healthy community [United Way of Lane County 100% Access]. 100% Access works to streamline the services and organizations within Lane County to increase the effectiveness of the continually decreasing funding in the health care field, and to answer the needs of the people within Lane County.

## **Chapter Two- Methodology**

### **Methodology**

#### **Design and Participation**

The research design of this capstone is a case study of the 100% Access Coalition. The coalition was chosen because of the duration of its existence and because of its reach and size within the community.

5 interviews were conducted in order to understand the perceived impact of the CCO within Lane County and to collect subjective data on the perceived changes the coalition has made.

Interviews took place WHERE with various members of the coalition and will be transcribed

and coded in order to see how participating in the coalition has affected the ideal of community based health in Lane County.

Participants were chosen because of their involvement in the coalition and because of the position and organization they represented. I wanted to have people from many different sectors represented- human services; business and health care, in order to see how different organizations, with vastly different needs would be impacted by the existence of the coalition. My survey instrument was a semi-structured interview. The interview comprised of 5 open ended interview questions, listed in Appendix C.

#### **Study Participants:**

- Tom Hambly, RN, Director- Medical Access Program
- Tom Wheeler, Director- South Lane Mental Health
- Stephen Marks, MD – Medical Director Pacific Source Health Plans
- Dan Reece, Director – Peace Health Hospital System

The interview procedure was done in the participant's office, or another quiet location. All interviews were recorded and later transcribed. The semi structured format allowed for the participants to clarify, expand, and focus on their perceptions of the coalition. Since the intention of the study was to understand the perception of impact on the coalition was having, participants were free to define the coalition however they liked.

The interviews were transcribed and coded - coding the interview along the 3 areas of perceived impact completed analysis of the transcription: Care, Collaboration and Access. When the first round of coding was completed, the actual quotes were then further coded out

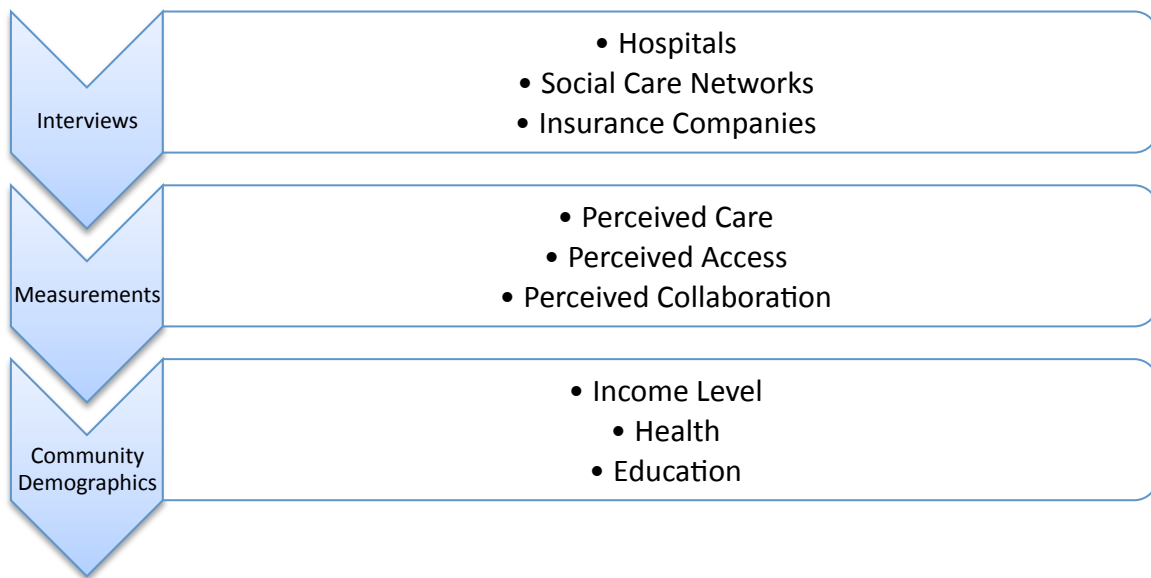
in order to be able to tease out a deeper breadth of information. One the targeted data was collected, these categories were then further broken down to understand what the perception of the coalition was and how that aligned itself with the data from the cost benefit analysis.

United Way of Lane County uses these community needs assessments to understand where the highest needs of the population are and how 100% Access is helping, or how it needs to expand and evolve in order to have the most impact.

Secondary quantitative data will be analyzed from the Community Needs Assessment, performed every two years by United Way of Lane County, to understand the demographics and needs of the community in which 100% Access is operating. Data from the United States Census will also be used in conjunction with the CNA in order to get a clearer picture of the demographics and needs of Lane County. Other sources of secondary data that were analyzed was the program evaluation of the 100% Access Healthcare Initiative completed by Health Policy Research Northwest.

Interviews will be the primary source of data and will focus on what the perceived impacts of the independent variable, 100% Access, have had on the dependent variables; low-income patients access to care, affordability of care, and quality of care. Participating members of the coalition will be asked to participate to complete the survey (Appendix B) for a list of members of the coalition and the organizations they represent).

The Community needs assessment; program evaluation and the literature review were used as secondary data in order to corroborate what the participants were saying. They gave context to the interview results by explaining the atmosphere of a CCO and the goals of particular CCOs in accordance with the community it is attempting to serve.



### Timeline for Capstone

Date	Deliverable	Completion Goals
November 2011	Literature review, methodology	
December 2011	Capstone Proposal IRB Human Subjects Review Application Submitted	Methodology, lit review, statement of problem Application reviewed and submitted
January 2012	Interviews Started	
February 2012	Interviews Completed	
March 2012	Compile interview & data analysis	Literature review completed
April 2012	Begin write up of results & discussion	
May 2012	Complete presentation	
June 2012	Final Product	Final Product Due

### Legislative Environment concerning Community Care Organizations

In the 2011 session, Oregon Legislature met over Senate House Bill 3650. This bill established the Integrated and Coordinated Health Care Delivery System where Community Care Organizations (CCO's) are implemented to improve the health care system. The intent of this legislation is to improve the health of the communities while reducing cost<sup>8</sup>. CCO's are being implemented in Oregon as the new mechanism for administering Oregon Health Plan, since they target uninsured and underinsured clients, as well as the expanding population of people who are eligible for Medicaid and Medicare it becomes important on a fiscal as well as social level to improve access and quality of care while decreasing costs overall.

Oregon Legislation does not specify how the CCO's must be organized or structured, nor does it specify if they should be for profit or non-profit organizations.<sup>9</sup> Certain eligibility requirements have been put in place and will be monitored by Oregon Health Authority. The criteria dictate the methods in which care will be coordinated alongside government and finance management. Rewards for patient centered care, health disparity reduction, and good

<sup>8</sup> <http://www.health.oregon.gov/OHA/OHPB/health-reform/docs/hb-3650-summary.pdf?ga=t>.

<sup>9</sup> HB 3650 (2011) – OR Legislation <http://www.leg.state.or.us/11red/measupdf/hb3650.pdf>

health outcomes will also be built into the OHA structures. There is only requirement of one CCO being present in the state however, if the CCO model becomes successful and demonstrates that it is an effective and efficient way of providing health care, multiple CCO's will be implemented across geographical areas in Oregon.<sup>10</sup>

The motivation for the implementation of CCO's in Oregon stem from a concern about rising health costs in the state of Oregon, as well as an increase in populations lacking health coverage. Since 2011, the estimated number of uninsured Oregonians is 560,000.<sup>11</sup> The increase in unemployment in Oregon has increased the number of uninsured, and the cost of health care has also risen. (CITE) Oregon legislation hopes to both improve the health of Oregonians as well as save money on health costs. The anticipated savings from implementing the CCO's come in around \$239 million over a 12-month period.<sup>12</sup>

Oregon will be modeling its CCO's after existing community coalitions. The CCO's will be the primary organizations shouldering the financial risk – since they will be accepting state contracts from Oregon Health Plan if they are able to run programs with costs below what the OHP provides them, they will benefit. However if costs are greater than funds provided, CCO's will be responsible for the difference.

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<sup>10</sup> SB 1580 (2012) Section 4-20, Oregon Legislation

<sup>11</sup> Oregon Health Authority

[http://www.oregon.gov/OHA/OHPR/RSCH/docs/Uninsured/2011\\_OHIS\\_Initial\\_Results.pdf?ga=t](http://www.oregon.gov/OHA/OHPR/RSCH/docs/Uninsured/2011_OHIS_Initial_Results.pdf?ga=t)

<sup>12</sup> Statement of Health Management Associates, January 16, 2012.

<http://www.oregon.gov/OHA/OHPB.meetings/2012/2012-012-hma-report.pdf>

## **Future Policy Implications**

Understanding what the perceived impacts of a coalition are can help in the future of health policy for communities. As communities look forward to different and innovative ways to lower the costs of health care while increasing accessibility, understanding the impacts that a coalition can have on collaboration and streamlining and what the positives and negatives are within a community can make it easier for other locations to develop their own methods. Given the legislative environment currently in Oregon, understanding what makes successful community collaborations in the health care field is of utmost importance, and plays a huge role in developing future policy. Perceived impacts play a big role in whether or not a coalition is successful, participation and buy in from community stakeholders is essential when attempting to build a model based on collaboration rather than competition. Community Care Organizations are one such model and the 100% Access Coalition of Lane County presents a unique opportunity of understanding how to build, manage, and maintain a coalition which successfully integrates health care, human care, and social care into a healthier community.

## **Chapter Three – Literature Review**

### **Community coalitions in health care**

Community coalitions in health care have been documented in several case studies across the country. The first case study was of a health coalition in northern California entitled the

Redwood Community Health Coalition<sup>13</sup>. The methodology for this case study was to review background documents of the coalition and then conduct open-ended interviews with the coalition participants. The coalition was being measured for outreach collaboration and enrollment activity to benefit clients. This case study was interesting in its similarities to 100% Access, although the analysis was more quantitative in nature. The results discussed the involvement of the United Way of Wine Country and how the collaboration between the coalition and other participating organizations helped the coalition to achieve its outreach and enrollment goals.

### Social Capital and Health Promotion

The theory of social capital discussed by Putnam has begun to be expanded and discussed in literature more thoroughly.<sup>14</sup> An interesting aspect of the health care reform is the focus of community health workers and the development of community based participation in individual health outcomes. As indicated by the Emergency Department Utilization study, and moreover by further studies in different communities, a major source of cost increase in the U.S. health care system is over utilization of the emergency room by chronic care patients. Involving community health workers (CHW's) into the health promotion, and understanding the role of social capital in the creation of community based health initiatives is imperative for their success.

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<sup>13</sup> Expanding Access to Care for Uninsured Californians: Clinic-Based Enrollment in Health Insurance Programs: *Gardner, A.L., Toledo, P.*, UC San Francisco Institute for Health Policy Studies. June 2010

<sup>14</sup> Putnam R. *Social Capital*. <http://www.oecd.org/dataoecd/25/6/1825848.pdf>

This success becomes hinged on the fact that different communities will have different social norms and identities that must be identified before certain theories and practices can be implemented. 100% Access Coalition utilizes the social planning framework for its coalition activities. This framework emphasizes the utilization of leaders within the community taking initiative in identifying the problem and creating solutions, after which they engage the community in participation (Wakefield, et. al.). 100% Access was created after the Community Needs Assessment was completed by United Way, and is mainly spearheaded and led by Pacific Source Health Insurance – a locally based nonprofit health insurance company. Identification of their leadership throughout the process was cited by many of the participants of this study as being fundamental in the success of this particular coalition.

Another aspect of social capital that has begun to emerge in health promotion literature is the use of CHW's. 100% Access Coalition has only recently begun to undertake the use of CHW's in their program, housing them in South Lane Mental Health. These community health workers are intended to hotspot patients who are frequent users of the emergency department to see if they can't find alternative care homes for them. The initiation of this program is new and the effects have not yet been measured.

### **Emergency Department Utilization in Lane County**

Funded by United Way of Lane County, Health Policy Research Northwest conducted a study from 2004 to 2008 to examine the utilization levels of the emergency departments in Lane County. This study utilizes the variables of emergency room visits that have been coded

according to need (i.e. mental health, drug abuse, etc.) to see how many visits have happened in the course of a year, and of those how many are repeat visits. Because many citizens lack access to preventative care, they will use expensive emergency room procedures in order to tackle problems that could potentially be taken care of outside of the hospital venue. Using this particular metric to track the utilization offers one potential snapshot of how expenses are being funneled in Lane County, and what the particular needs are of the community.

### Overview of Oregon Health Legislation

State of Oregon legislation has been a forefront in establishing CCO's, in hopes of improving benefits for members and providers. Oregon hopes to save a projected \$239 million between 2012-2013, however these financial projections by the state are tempered by independent expert analysis which shows that projected savings for the first year will top out around \$114 million, with following years showing significant savings as well (OCCP "ABC's of CCO's").

### Overview of the Patient Protection and Affordable Care Act of 2010 (PPACA):

The PPACA is a pivotal piece of legislation that is changing the face of health care in many ways. Implemented in March of 2010, the timeline extends until 2014 with several key pieces of legislation being implemented at different time periods. The PPACA is divided into nine sections<sup>15</sup>:

- Quality, affordable health care for all Americans
- The role of public programs
- Improving the quality and efficiency of health care
- Prevention of chronic disease and improving public health
- Health care workforce
- Transparency and program integrity

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<sup>15</sup> PPACA: Executive Summary - <http://dpc.senate.gov/healthreformbill/healthbill04.pdf>

- Improving access to innovative medical therapies
- Community living assistance services and supports
- Revenue provisions

The most important aspect in regards to the 100% Access Coalition will be Title III: Improving the quality and efficiency of health care;

The Patient Protection and Affordable Care Act will improve the quality and efficiency of U.S. Medical care services for everyone, and especially for those enrolled in Medicare and Medicaid. Payment for services will be linked to better quality outcomes. The Patient Protection and Affordable Care Act will make substantial investments to improve the quality and delivery of care and support research to inform consumers about patient outcomes resulting from different approaches to treatment and care delivery. New patient care models will be created and disseminated. Rural patients and providers will see meaningful improvements. Payment accuracy will improve. The Medicare Part D prescription drug benefit will be enhanced and the coverage gap, or donut hole, will be reduced. An Independent Medicare Advisory Board will develop recommendations to ensure long-term fiscal stability.

Increasing the efficiency of deliverable medical care means increasing the number of people who are served. Community Care Organizations become fundamental in this attempt because they bring in a multitude of organizations within the community and identify neediest demographics.

### **Community Needs Assessment:**

The Community Needs Assessment (CNA) is a survey conducted by United Way of Lane County which presents information on the needs and obstacles faced by citizens of Lane County in regards to three main target areas: health, education and income. These target areas are reflective of United Way's targeted priorities. The study hopes to discern certain patterns of need within the community. Methodology used in the study is a random

telephone survey conducted on 1,200 Lane County households (CNA 2009) an independent survey research firm, Northwest Survey and Data Services, was contracted by United Way to develop the administered survey. United Way of Lane County Research and Evaluation Committee first approved the survey before being administered. The survey design has remained consistent since the 1992 CNA in order to be able to have comparable results. There are issues with the survey method in that those who are homeless, do not have a landline, or cannot speak English are underrepresented in the survey. The data can still be used to understand basic trends within the county.

## **Program Evaluation of 100% Access Coalition of Lane County**

### **History of 100% Access Coalition**

100% Access Coalition is a community care organization begun in Lane County in 2004; its founding members began with a specific vision and its evolution to present day is through the thoughtful and considerate effort of its members. Understanding the member perspectives and the role that the Coalition has played in the development of health care within Lane County will demonstrate how the Coalitions perceived effects are important to study. 100% Access Coalition is comprised of several different programs each attempting to connect uninsured clients to a network of care within the community.

***Community Health Worker Program:*** Community Health Workers (CWH's) are an extension of the primary care team available through the Medical Access Program. The intention of the CWH is to help the client navigate through any treatment plan, including interactions with

health systems that fall outside of the Medical Access Program. The purpose is to be able to interact with the client in similar method as a life coach.

***Chronic Disease Self-Management classes:*** This program branch of 100% Access Coalition is intended to create self-sufficiency among adults with chronic illness conditions. Self-sufficiency includes managing medications, dealing with depression, dealing with fatigue, as well as managing existing and new symptoms.

***Prescription Money Savings:*** The beginnings of 100% Access Coalition originates with creating a savings program for prescriptions. Low-income clients having a hard time being able to acquire their prescriptions are able to access this program and receive medications either at no cost, or at warehouse cost. Prescription Money Savings is part of the Medical Access Program as well.

***Medical Access Program (MAP):*** Medical Access Program is intended for individuals with multiple health issues. Clients cannot have access to any other form of health insurance – including being eligible for Oregon Health Plan. Eligibility for Oregon Health Plan is dependent on income eligibility. MAP coordinates care for its clients through an intricate network of donated care including medical, dental, and mental health care. Recent evaluations of the MAP's program demonstrate a 313% return on investment for every \$1 invested. Figure 1.1 is a map of the services provided by the medical access program. All of these services are provided free of cost to the client through networking of the MAP coordinators.

Figure 2



## **Community Care Organizations- History, Federal Legislation,**

Community Care Organizations, also known as Affordable Care Organizations, are relatively new concepts but are emerging from a long term ideal of centralizing care within communities in order to best serve the individuals living there in the most efficient way possible. A brief overview of other CCOs will be provided, including a review of the first federally recognized organization in Trenton, New Jersey, as well as 100% Access Coalition's structure in comparison to these other models. Appendix A delineates these differences and does a side-by-side comparison of the two methods. Federal legislation and state legislation concerning these CCO's will be reviewed in order to understand how local and state policy can potentially be developed for these to exist in other communities.

## **Chapter Four- Results and Analysis**

### **Discussion and Conclusions**

The participants saw the coalition as being a fundamental meeting point for the multiple organizations within the county. Participants cited the neutral meeting ground of the coalition as being a crucial method for being able to coordinate between the larger organizations – especially the two competing hospitals. The smaller organizations found a great benefit from participating in the coalition because of increased funding opportunities, which resulted in them being able to serve larger populations. Tom Wheeler of South Lane Mental Health said the following;

*“We’ve really benefitted from Lane County Health Services, from OHP, from 100%, and this was a great opportunity for us to say lets give back. And we’ve been able to create a model*

*here in South Lane that other people in Lane County should pursue... And then I had this really remarkably positive experience with 100% Access Coalition. The leadership of it, not just progressive and enlightened sort of folks, but they really knew how to put a program together and keep us on track”*

Another benefit was the simple networking opportunities afforded to them by being involved in the same project. This shared goal that was represented by the coalition encouraged people to “Check their weapons at the door” – the coalition served as a round table where the interests of the community were at the forefront and organizations were working towards that end goal together, rather than in competition with each other for an increasingly smaller pie slice.

*“What we’ve found out early on in that process is that there were some pockets of organizations around town that sort of helped patients with that [free medication] but they were all doing it differently and didn’t talk to each other, they didn’t even know each other existed, they didn’t even know that there were some better ways to do it, kinda through some of the work that we did of just getting them together in the same room and saying “here as part of this coalition we’d like to figure out what you’re all doing and how you’re doing it and what you’ve learned and what your recommendations are” got them sort of collaborating with each other and you know, saying ‘oh I didn’t know you did that, well can I come over to your place and see it?’” – Steve Marks, Pacific Source Health Plans*

The most interesting aspect that came out of this study was the overwhelming positive response to the idea of collaboration. Again and again, participants emphasized the increased amount of collaboration between organizations, and multiple participants reiterated the concept of “breaking down silos”.

*...What it has done has allowed people to safely get out of their silos to work on a group-focused project. We kept using this as safety- look what we are building together as a coalition, because people, we all started in our own silos at the table and people were very unwilling to share information, unwilling to commit resources, unwilling to do anything else*

*but in this process of focusing on something specific they felt that there was less risk of getting out of their silos and that has begun something where I think we have significantly chipped away at peoples silo's in this community.*

– Tom Hambly, Pacific Source Health Plans

Dr. Steve Marks, the medical director for Pacific Source Health Plans, was one of the founding members of the coalition back in 2006 and gave the example of collaboration between organizations in regards to mental health and chemical dependency. Previous studies have shown that many times patients who are over utilizing emergency departments, a costly behavior, will have higher rates of mental health issues and chemical dependency issues. Interestingly, before the establishment of the coalition the organizations that dealt with these issues had never sat down and coordinated care. After the establishment of the coalition mental health workers and chemical dependency workers were in constant contact, and the decrease of these users in the Emergency Department corroborates the usefulness of this example of collaboration.

*“We have a group of mental health workers, many of whom never talked to each other before, and they are sitting down with the chemical dependency people. And believe me, interestingly the mental health and the chemical dependency people didn't know each other or talk to each other, or have any collaboration with each other, and now through the creation of this coalition they...are saying ‘oh gee I didn't know you guys were doing that!’*

Steve Marks, Pacific Source Health Plan

However, increased collaboration between coalition organizations is of little use if it doesn't mean better access for patients who were otherwise unable to get medical care. Tom Hambly, of United Way and Pacific Source, discussed the idea that it cannot be surprising the

emergency departments are the number one source of care for people who have nowhere else to go.

It was in this vein that Dan Reece of Peace Health Hospital System discussed the concept of access in terms of incentives: Organizations that provide health care must have incentives, be they either financial or social, for creating opportunities for access for patients. The coalition was viewed as being part of this incentive – there were grant opportunities that could be taken advantage of by participating organizations, as well as the Community Health Worker model that was funded by United Way, which worked as a personalized social worker that increased patients access to the multiple organizations within the Coalition. For the two hospitals, the incentive was more monetary in nature – participating in the coalition and ensuring that mental health workers could be funded meant lower utilization of their emergency departments – and therefore lower costs.

*“... What needs to happen is we need to create incentives for preventative care. This coalition does that; it creates an incentive to buy in to a community model. And that pays off with lower costs for the big players, and better care and access for the individual patients” –Dan Reece, Peace Health Hospital*

Drilling further down into the outcomes of the coalition is the idea that access means nothing if quality of care is not present. The concept of MAP’s was that doctors would not be seeing more patients whom they could not run any sort of tests, refer to specialists, or in any manner improve their health – rather that access by the patients to this medical system meant improved care, not just increased exposure to a doctors office lobby.

*The program at its core is designed to provide primary care to people, to give them a medical home, and I think one of the things that makes this program unique is that when we asked providers, doctors, if they would be willing to take these clients on we told them that the concept wasn't for them to take yet another uninsured client that they couldn't order any diagnostic work on, that they couldn't get referrals, they couldn't get diagnostic imaging, they couldn't get their prescriptions filled – in fact this program would get those pieces in play for them so they (Providers) could manage them towards improved health. And that we would actually measure that, and we did. So that's what made it unique. There are a lot of access programs that get people connected to a provider, but access isn't the same as care. And access isn't the same as improving your health. –Tom Hambly Pacific Source Health Plans-*

Tom Hambly refers to the MAP's assessment to illustrate that clients were actually getting healthier, and that this in turn was saving the system and the county dollars. People were getting healthier who in many cases had not been to a doctor for many years, people who had not been able to access a dentist, or get prescriptions for controlling blood pressure, or in many cases were now able to get mental health help, counseling, substance abuse, emotional issues- MAP's allowed for a holistic approach to access which translated into improved care.

*“Yes clients got better. They were clinically medically healthier than before they got in the program and their self-assessment of their health improved dramatically. Return on community investment was 3:1, 5:1 if we were to use commercial claim costs. Clients got a continuum of care. Some clients just needed dental care one time, so they went into MAP and got dental access, got an abscess tooth removed and then they were out of MAP. Other people had cancer treatments, surgeries, heart attack and bypass surgeries, things like that, and on going support. So it was a pretty dramatic impact on these people. These were people who in some cases hadn't had access to health care in many, many years.” – Tom Hambly,*

The participants saw the coalition as being a fundamental meeting point for the multiple organizations within the county. Participants cited the neutral meeting ground of the coalition as being a crucial method for being able to coordinate between the larger organizations – especially the two competing hospitals. The smaller organizations found a great benefit from participating in the coalition because of increased funding opportunities, which resulted in

them being able to serve larger populations. Another benefit was the simple networking opportunities afforded to them by being involved in the same project. This shared goal that was represented by the coalition encouraged people to “Check their weapons at the door” – the coalition served as a round table where the interests of the community were at the forefront and organizations were working towards that end goal together, rather than in competition with each other for an increasingly smaller pie slice.

## Chapter Five – Conclusions

The case study of 100% Access Coalition scratches the surface at what CCO’s and community coalitions are able to accomplish. As the nation moves forward in its attempt to address the growing inequities that exist in the health care system, as well as the sky rocketing cost which could lead to a heavy anchor on the economy, beginning to look at health care first and foremost as a human right, and secondly as a service that can be efficiently administered will lead to improvements in many areas. Understanding what problems and obstacles populations are facing will mean that communities can individualize their method of health care delivery. As 100% Access demonstrates, it is a unique solution to a unique problem.

Coalitions have issues – often times they can be bogged down with too many organizations and little actual improvement. Implementing measureable metrics of success will help to facilitate this issue by showing quantitative change. Further, while the coalition may have the best intentions it will not be able to reach all of the population. Knowing which populations

are still not being served by the coalition, and ensuring that this type of knowledge is replicated in other community organizations, will help to keep the model evolving in the attempt of getting care and access in an efficient and affordable way.

## Policy Implications

Policy implications from this study vary – within Lane County the coalition is beginning its transition to apply for CCO status with the state of Oregon. The Oregon legislation does not specify best practices for CCO's as of yet, but as more and more parts of the state begin to take part in the CCO model understanding how to coordinate collaboration, and to improve access and care, will be fundamental in being able to move forward in the goal of increasing the quality of health care without the skyrocketing costs.

The community care model is a hopeful method for future policy decisions because of the concept of lowering emergency department utilization. This concept is seen in 100% Access Coalition, as mentioned by Tom Wheeler [South Lane Mental Health]

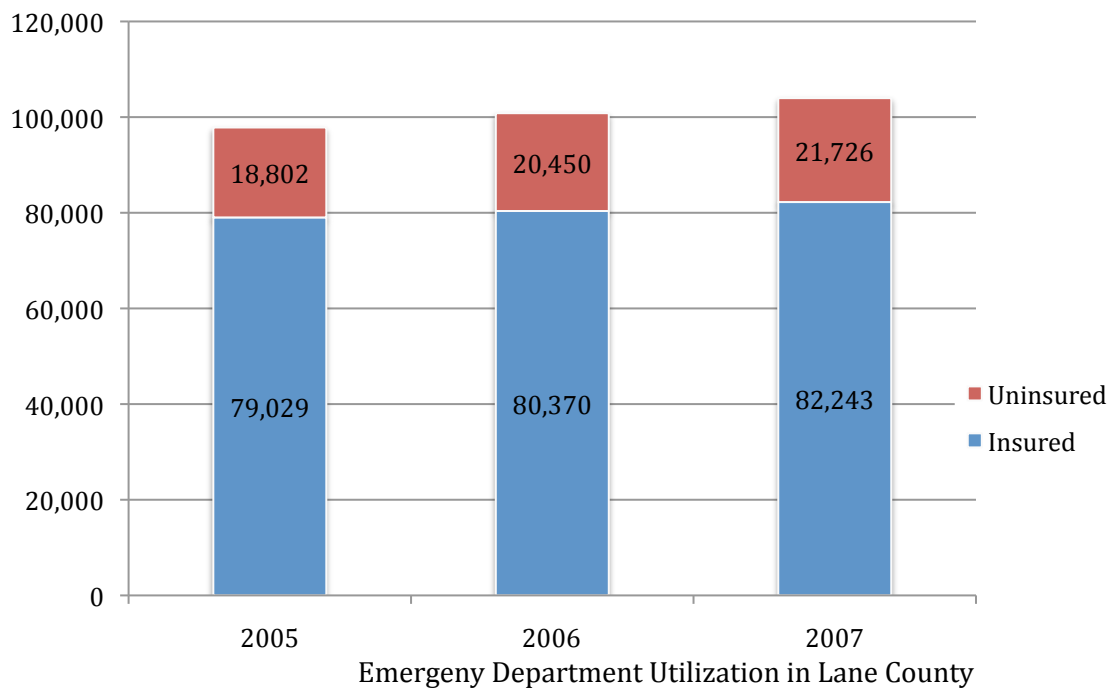
*“...It's tremendously effective because once people get hooked up with us, they stop going to the ER and I think that the idea of the project was that we would work with somebody, help them address their health care issues and then they would move on...”* – Tom Wheeler

This concept can also be quantitatively understood and measured by Emergency Department Utilization studies, conducted in Lane County [Figure 3]. This chart shows the number of uninsured growing in Lane County as it pertains to emergency department utilizations. As uninsured populations rise due to economic downturn and increasing unemployment, being

able to reduce the number of patients using the Emergency Department through programs such as MAP's, can help to reduce costs to the county, and state overall.

As federal and state legislation begins to act in order to implement the PPACA, taking into account the concept of CCO's can be a useful tool in lowering the cost of health care while still being able to afford care to the neediest population demographic.

Figure 3



Source: Health Policy Research Northwest

## Limitations of Study and Further Research

The limitations of this study include the low number of participating interviewees. While there were only 5 members interviewed, this did allow for a deeper conversation and more unique viewpoint from each member. However the small number of participants means that the study cannot be generalized for larger populations. The participants were chosen for their range of representation of organizations in the coalition, in order to offset the small sample size. Another limitation is the lack of representation of patient experience with the coalition and the medical programs. However, this limitation was also addressed by referencing the MAPS program evaluation, which included a quantitative and qualitative study of patient experience and health care improvement. Further research should be done on the improvement of patient health, as well as the patient's perspective on the existence and administration of the coalition and the medical programs. Another interesting vein of research that could be done would be a financial analysis of participating organizations, however this could not be done until after the establishment of legally recognized CCO's in order to be able to do a comparative study.

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## Appendix A: Defining Terms

### Community Care Organizations (CCO)

Community-based organizations using patient centered primary care homes, fixed global budgets and efficiency and quality improvements to reduce costs for Oregon Medicaid patients. CCOs align and integrate the care of Oregonians eligible for both Medicare and Medicaid to reduce administrative costs, waste and duplication.

<b>CCO</b>	A majority of interest of persons that share financial risk
<b>Governance:</b>	Major components of the health care delivery system
<b>A Community Advisory Council</b>	The community at large
	Local governments
	Consumers
<b>Reporting:</b> <b>OHA Reporting</b>	Benchmarks & Quality Measures
	Progress eliminating health disparities
	Rules adopted
	Customer satisfaction
	Costs
	Financial data
<b>Payments:</b> <b>Global Budgets</b>	Calculation methods of global budgets to be determined by the Global Budget Work Group
	CCOs are encouraged to use alternative payment methodologies
	Reimbursements based on outcomes, not volume of care
<b>Work Groups:</b> <b>A meaningful process to establish</b>	Qualification Criteria
	Global Budget Process
	Process for resolving providers refusal to contract with CCOs
	Processes for reporting financial information
	Plan for adding PEBB and OEBC
<b>Providers</b>	May participate in more than one CCO
	Emphasize prevention
	Removed if they fail to meet quality standards
	May not unreasonably refuse to contract with a CCO
	Work together to develop best practices for culturally appropriate care

## Appendix B: 100% Access Coalition of Lane County & Members

Started in 2005, managed care consortium, engages all levels of social and health organizations in the county, coordinate care, backed by United Way of Lane County.

### Member List:

#### 4J School Based Health Centers

Maxine Proskurowski, RN

#### Care Oregon

Laura Brennan

#### Cascade Health Solutions

Cheryl Boyum\*

Lora Nyburg, RN

#### Cawood

John Lively

#### Center for Community Counseling

Nancy Weisel

Steve Guerber

#### City of Eugene

Jon Ruiz\*

#### City of Springfield

Gino Grimaldi

#### Community Health Centers of Lane County

Jeri Weeks

Rob Rockstroh\*

#### Community Member/Former Mayor

Jim Torrey

#### Direction Service

Marshall Peter

#### Head Start of Lane County

Valerie Haynes, RN

#### Health Policy Research Northwest

Erin Owen

Heidi Hascall

#### HIV Alliance

Diane Lange

Renee Yandel

#### Housing and Community Service Agency

Suzanne Gatch

#### Human Rights Program- City of Eugene

Francisca Leyva-Johnson

Kathleen Howard and Associates

Kathleen Howard

#### Lane County Human Services

Diana Alldredge

#### Lane County Human Services Commission

Steve Manela

#### Lane County Dental Society

Jossi Stokes, DDS

#### Lane County Medical Society

Richard Barnhart, MD\*

#### Lane Transit District

Mary Adams

#### LCOG- Senior and Disabled Services

Kay Metzger

#### Lipa

Barbara Gleasman

Terry Coplin

McKenzie-Willamette Medical Center

Debi Farr

Maurine Cate

Monaco Coach, LLC

Rick Kangail

Oregon Medical Group

Cris Noah\*

Scott Johnson, MD

Oregon Research Institute

Tony Biglan

Pacific Benefit Consulting

Dean Kortge

Pacific Source Health Plans

Marian Blankenship

Ken Provencher

Lisa Zenev

Steven D. Marks, MD\*

Sujata Sanghvi

Tom Hambly, RN

Rhonda Busek

## Appendix C:

### Framing your participation

- Can you please describe your organization and your involvement with the 100% Access Coalition?

### Perceived Care

- Since the inception of the coalition in 2006, how do you perceive that care for your clients has been impacted?
- Do you see the level of care across different organizations as having changed, and if so how?

### Perceived Collaboration

- How has the coalition affected your perception of collaboration with colleagues within coalition organizations?
- Do you feel that you are more willing to engage in collaboration within coalition organizations? What type of examples of this collaboration do you have?

### Perceived Access

- How has the existence of the coalition changed your perception of access for your clients?
- how do you perceive accessibility of different health organizations within the organization have changed?